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Standing Committee on Law and Justice

Review of the exercise of the functions of the Motor Accidents Authority and the Motor Accidents Council

Fourth Report

Ordered to be printed according to the Resolution of the House

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Provisions of the *Motor Accidents Compensation Act 1999* relating to the role of the Parliamentary Committee

Part 8.3 Supervision of Authority and Motor Accidents Council

210 Appointment of Parliamentary Committee

(1) As soon as practicable after the commencement of this Part and the commencement of the first session of each Parliament, a committee of the Legislative Council is to be designated by resolution of the Legislative Council as the designated committee for the purposes of this Part.

(2) The resolution of the Legislative Council is to specify the terms of reference of the committee so designated which are to relate to the supervision of the exercise of the functions of the Authority and the Motor Accidents Council under this Act.

28 Insurers to disclose profit margins

(1) A licensed insurer is required to disclose to the Authority the profit margin on which a premium is based and the actual basis for calculating that profit margin.

(2) The Authority is to assess that profit margin, and the actual basis for its calculation, and to present a report on that assessment annually to the Parliamentary Committee.

Terms of Reference

1) That, in accordance with the provisions of section 210 of the *Motor Accidents Compensation Act 1999*, which commenced on 5 October 1999, the Standing Committee on Law and Justice be designated as the Legislative Council Committee to supervise the exercise of the functions of the Motor Accidents Authority and the Motor Accidents Council under the Act.

2) That the terms of reference of the Committee in relation to these functions be:

a) to monitor and review the exercise by the Authority and the Commission on their functions;
b) to report to the House, with such comments as it thinks fit, on any matter appertaining to the Authority or Commission or connected with the exercise of their functions to which, in the opinion of the Committee, the attention of the House should be directed;
c) to examine each annual or other report of the Authority and Commission and report to the House on any matter appearing in, or arising out of, any such report;
d) to examine trends and changes in motor accidents compensation, and report to the House any changes that the Committee thinks desirable to the functions and procedures of the Authority or Commission;
e) to inquire into any question in connection with the Committee's functions which is referred to it by the House, and report to the House on that question.

3) That the Committee is required to report to the House in relation to the exercise of its functions under this resolution at least once each year.

4) That nothing in this resolution authorises the Standing Committee on Law and Justice to investigate a particular compensation claim under the *Motor Accidents Compensation Act*.[1]

[1] Motion moved by the Hon J Della Bosca MLC, Special Minister of State, and agreed to by the Legislative Council, Minutes of the Proceedings, No 28, 30 November 1999, p 296.

Committee Membership

The Hon Ron Dyer MLC Australian Labor Party *Committee Chair*

The Hon John Ryan MLC Liberal Party *Deputy Chair*

The Hon Peter Breen MLC Reform the Legal System

The Hon John Hatzistergos MLC Australian Labor Party

The Hon Peter Primrose MLC Australian Labor Party[2]

[2] The Hon P Primrose MLC replaced the Hon J Saffin MLC on 28 August 2002 (NSW Legislative Council Minutes No. 27)

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Chair's Foreword

This is the Law and Justice Committee's fourth report reviewing the exercise of the functions of the Motor Accidents Authority (MAA) and the Motor Accidents Council (MAC). The report collates the evidence from the Committee's fourth public hearing with the representatives of the MAA and MAC, which was held on 2 December 2002.

The Committee's review of the MAA and MAC over the past four years has repeatedly raised a number of issues as topics of discussion and ongoing concern, including the compensation of parents of children killed in motor vehicle accidents, the long term care of the seriously injured, structured settlement arrangements, and insurer profit margins. These matters were the subject of questioning and discussion again at this year's hearing, and the Committee was pleased to note the MAA's progress in a number of these areas. Other issues will be the subject of further monitoring in the future.

I would like to thank a number of people for their contributions to the Committee's review of the MAA and MAC. The cooperation of the senior managers of the MAA and the MAC in responding to the Committee's requests for information has been very much appreciated. The Committee has also found the input of various stakeholders from legal professional bodies, the insurance industry and the general community to be of great value.

I would like to thank my colleagues on the Committee for their participation during this inquiry. As usual, they have taken a bipartisan and constructive approach to the matters under consideration. I am also grateful to the Secretariat for its assistance in organising the hearing and drafting the report.

As this is the final report the Committee will issue prior to the State Election and my retirement from Parliament, I would like to express my thanks to my Committee colleagues and especially the Deputy Chair, the Hon John Ryan MLC, for their hard work and support over the past four years. I also convey special thanks to the Committee's past Director, Mr David Blunt, and its current Director, Ms Tanya Bosch, and their staff for their outstanding efforts in preparing the Committee's often complex reports and assisting the Committee in many other ways.

I wish the Committee and its staff every success in the future.

Hon Ron Dyer MLC
Committee Chair

Summary of Recommendations

Recommendation 1 *Page 2*

The Committee recommends that the Motor Accidents Authority provide its statutory Report on Insurer Profits to the Parliamentary Committee at least one week in advance of the scheduled hearing.

Recommendation 2 *Page 4*

The Committee recommends that the Special Minister for State consider an amendment to the *Motor Accidents Compensation Act 1999* to provide for a statutory monetary benefit to parents whose children are killed in a motor vehicle accident as a means of providing them with some form of direct and untied financial assistance. The amount paid should not exceed $100,000.

Chapter 1 Commentary

The Standing Committee on Law and Justice is required under the *Motor Accidents Compensation Act 1999* and by resolution of the Legislative Council to review the exercise of the functions of the Motor Accidents Authority and the Motor Accidents Council. The Committee has in recent years carried out this function by way of annual public hearings with the senior managers of the Motor Accidents Authority (MAA) and the Chairman of the Motor Accidents Council (MAC).

This year, the public hearing was held on 2 December 2002, with Mr David Bowen (General Manager), Ms Concetta Rizzo (Manager, Insurance Division) and Dr Stephen Clough (Principal Compliance Officer) representing the MAA, and Mr Richard Grellman (Chair) representing the MAC. As a result of the imminent rising of the Parliament, and the Committee's wish to table the report before the end of the session, the Committee has decided to issue this report in the form of a collation of the evidence taken at the hearing and the answers to the questions on notice provided to the MAA from the Committee and stakeholders. A short commentary on the key issues raised at the hearing is provided below.

Insurer Profits

Section 28 of the *Motor Accidents Compensation Act* requires all licensed Compulsory Third Party (CTP) insurers to disclose to the MAA their profit margins and the basis for calculating them. The MAA in turn is required to assess the insurers' profit margins and report on that assessment annually to the Parliamentary oversight committee (which the Legislative Council has designated to be the Standing Committee on Law and Justice).

The supervision of insurer profit margins by both the MAA and the Parliament has a clear purpose: to provide a level of external assessment of the profit margins of insurers to ensure that consumers achieve the best possible outcomes whilst maintaining a viable motor accidents compensation scheme.

In this regard, the role of the Committee is, on behalf of the Parliament, to evaluate the MAA's performance of its functions in relation to insurer profits. For the Committee to undertake this role effectively, access to relevant information is essential. Unfortunately, the Committee was markedly restricted in its capacity to examine this area of the MAA's performance as a result of the delayed provision of the Report on Insurer Profits. That report was only provided to the Committee during the hearing on 2 December 2002. Without sufficient opportunity to examine the Report on Insurer Profits, the Committee's ability to engage in informed questioning on this issue was clearly limited, notwithstanding the short briefing provided by the Manager of the Insurance Division during the hearing.

The information received relating to the profit margins of CTP insurers indicates that the insurers' reported profits are on the high side of reasonable. While the Committee recognises that assessment of profits and prediction of future trends can be difficult, nevertheless insurer profits should be kept within reasonable limits. This issue will require careful monitoring and close attention by the Committee in future years. To facilitate this, the Committee requests that the MAA provide future Insurer Profit Reports to it at least one week in advance of the scheduled hearing.

Recommendation 1

The Committee recommends that the Motor Accidents Authority provide its statutory Report on Insurer Profits to the Parliamentary Committee at least one week in advance of the scheduled hearing.

Structured Settlements

The Committee was pleased to learn of recent initiatives relating to structured settlements for seriously injured persons. Legislation currently before the Federal Parliament seeks to facilitate structured settlements by providing for more favourable tax treatment of periodic payments made to injured persons under structured settlement arrangements. This should overcome a key obstacle to compensation being paid by way of structured settlements. As the Committee has for many years been interested in this issue, and has favoured the more general availability of structured settlements, it is pleased to note the Federal Government's intention to legislate in a manner that is supportive of that approach.

Long Term Care of the Seriously Injured

The MAA's work on initiatives for the long term care of seriously injured persons was also discussed at the hearing. The Committee notes the MAA's advice that it is considering preparing guidelines relating to the care needs of brain injured persons and persons with behavioural or cognitive disabilities arising from motor vehicle accidents. The project has involved input from a number of brain injury experts. The work builds on the MAA's recent preparation of guidelines for attendant care for persons with spinal injuries. The Committee commends the Authority for its work on this project, and notes the MAA's advice that a draft document should be available for comment in the first few months of 2003.

The Committee also acknowledges the MAA's contribution to discussions on this issue in the federal sphere, where the subject of care of the catastrophically injured has been examined in recent times.

Parents of Children Killed in Motor Vehicle Accidents

In previous reports the Committee has raised with the Motor Accidents Authority the situation of parents whose children are killed in motor vehicle accidents. At hearings conducted in May 2000 the General Manager of the MAA advised the Committee that:

> **Mr Bowen**: There clearly will be occasions where a parent has lost child and it has led to a significant disability which translates to a greater than 10% impairment. There will be other cases where parents do get on with their lives, often because they have no option if they are other children and family members to look after, and on that sort of test they would not necessarily get over the 10 percent mental and behavioral impairment. So this is an issue that needs to be looked at. It probably needs to be more broadly looked at in the context of statutory change to see whether a death benefit should be introduced rather than trying to fiddle with

> the impairment levels as a means of achieving that end in a roundabout sort of way. [3]

In its third report the Committee recommended that the Motor Accidents Authority should give further consideration as to how parents who lose children as a result of a motor vehicle accident might be compensated, particularly parents who would not qualify on economic loss according to current medical and psychological guidelines.

In response to Committee questions sent prior to this fourth hearing, the Motor Accidents Authority advised that:

> The Motor Accidents Authority does not consider that there is a need to review existing monetary compensation entitlements for psychological or psychiatric injury. However, the Motor Accidents Authority does acknowledge the importance of accessible bereavement counselling and support services for the family members of someone killed in a motor vehicle accident.
>
> In response to the recommendation of Law and Justice Committee the Motor Accidents Authority commissioned a preliminary investigation of grief support services currently available. The WorkWise Group carried out the study and a copy of the Study Conducted in April 2002 was submitted to the Committee. The Study found from ABS and RTA road deaths statistics that approximately 90 young people aged between 0-19 years killed in road accidents in any year.[4]

The Committee agrees with the MAA that the provision of grief counselling and support services to families in such tragic circumstances is extremely important. The Committee commends the MAA's initiatives to address the need for better bereavement services for parents. However the Committee remains concerned that the provision of these services alone may not be sufficient to adequately meet the needs of parents whose children are killed in motor vehicle accidents.

The Committee accepts that it is impossible to compensate for such a loss, however the provision of a limited amount of direct and untied financial assistance appears to have obvious merit. Families facing the loss of a child in the tragic circumstances of a motor vehicle accident frequently incur significant expense from the actions they may need to take in order to cope with their loss. These actions can include taking an extended period of time off work, moving away from the area where the accident occurred, changing jobs or taking an extended holiday. Some parents experience a complete marital breakdown after such a tragedy and may require financial resources to re-establish themselves after a family breakup.

The Committee accepts that it is inappropriate for the Motor Accidents Authority to pursue this matter any further without legislative change. This issue is now appropriately a matter for the Government and the Parliament to consider. The Committee has also been advised by the MAA that the cost of extending such a benefit would not be a significant impost on the scheme:

> **The Hon. JOHN RYAN:** If there were a provision for a statutory benefit for parents who have lost their children as a result of an accident which was not their fault it would not present a very large difficulty in financing the scheme would it?

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3 Evidence, 8 May 2000, p 17.

4 Answers to Questions on Notice, page 5.

> **Mr BOWEN:** It would depend upon the value put upon it but in terms of numbers of people, no, it is not a large number.
>
> **The Hon. JOHN RYAN:** If it were a benefit in the area of from $50,000 to $100,000, as was suggested by using the Victorian scheme, it would not exactly trim the profits of the insurers.
>
> **Mr BOWEN:** It would not be a very significant impact. To some extent we do not know the full number of cases because a number of people currently in that circumstance would not be making a claim but it could be worked out, I suppose, having regard to the total number of child fatalities in this State.[5]

The Committee therefore recommends that the Special Minister for State consider an amendment to the Motor Accidents Compensation Act 1999 to provide for a statutory monetary benefit to parents whose children are killed in a motor vehicle accident as a means of providing them with some form of direct and untied financial assistance. The amount paid should not exceed $100,000.

Recommendation 2

The Committee recommends that the Special Minister for State consider an amendment to the *Motor Accidents Compensation Act 1999* to provide for a statutory monetary benefit to parents whose children are killed in a motor vehicle accident as a means of providing them with some form of direct and untied financial assistance. The amount paid should not exceed $100,000.

[5] Evidence, 2 December 2002, p 20.

Chapter 2 Answers to Questions on Notice

Issues raised by the Standing Committee on Law and Justice

1. *Audit Program*

Could you provide the Committee with information about the outcomes of the following audits that were mentioned at the previous hearing or in this year's annual report:

Question 1.1
Could you provide the Committee with information about the outcomes of the audit of Compliance with Claims Handling Guidelines (flagged at last hearing to occur be finalised by June 2002 – see Appendix 4 of Committee's previous report).

Response 1.1
The MAA's Compliance Unit has completed its first Claims Handling Compliance Audit and has prepared a draft industry report. The report is titled "Draft - Industry Claims Handling Compliance Audit Report - November 2002". The background, findings and recommendations of the compliance audit have been summarised in the report's Executive Summary. The Draft Industry Claims Handling Compliance Audit Report is attached as Attachment 1 (Appendix 1).

Question 1.2
Could you provide the Committee with information about the outcomes of the remaining/postponed audit of compliance with Treatment, Rehabilitation and Attendant Care Guidelines (not completed by previous hearing – see page 1 of the Committee's previous report).

Response 1.2
All insurers have now passed the audit of the Treatment, Rehabilitation and Attendant Care Guidelines. Two insurers, who are not currently writing business, but managing run-off claims, failed the first audit. They passed on re-audit. All insurers will be re-audited in 2003.

Question 1.3
Could you provide the Committee with information about the outcomes of the audit of MAA's prudential and financial responsibility, conducted by Ernst and Young. This was due to be finalised by the end of 2001 (referred to on page 42 of the Committee's previous report).

Response 1.3
A copy of the Ernst & Young Report is attached as Attachment 2 (Appendix 2). The report concluded that the most effective prudential supervision of MAA's licensed insurers would be achieved through a closer working relationship with APRA.

The Board of the MAA considered the Ernst & Young Report at its meeting on 11 June 2002. The Board agreed that it was important to re-establish the relationship between APRA and the MAA in line with the report recommendations. The Board asked the General Manager to write to APRA forwarding a copy of the Ernst & Young report noting that the MAA relies upon APRA for prudential regulation and seeking to re-negotiate the MAA/APRA MOU to better clarify the relationship and responsibilities in accordance with the review recommendations.

The Board will revisit these issues following the release the HIH Royal Commission findings.

Question 1.4
Could you provide the Committee with information about the outcomes of the Claims Resolution Profile, anticipated to be finalised by April 2002 by the Justice Policy Research Centre (see Appendix 4 of the Committee's previous report).

Response 1.4
The report from the Justice Policy Research Centre (JPRC) on the claims resolution profile has been delayed within the University of Newcastle in obtaining Ethics Committee approval of the survey methodology. The JPRC advises that the insurer file review has been completed and that contact has been made with claimants for the second part of the study. The JPRC advises that the report will be available in December 2002.

Question 1.5
Could you provide the Committee with information about the outcomes of the Legal Costs Survey, anticipated to be finalised by July 2002 by the Justice Policy Research Centre (see Appendix 4 of the Committee's previous report).

Response 1.5
The Legal Costs Survey will be finalised by the JPRC following the completion of the claims resolution profile. The JPRC advises that the research will be completed in April 2003.

Question 1.6
Could you provide the Committee with information about the outcomes of the MAA sample survey of claims involving contributory negligence (proposed on page 61 of Committee's previous report).

Response 1.6
The limited number of new scheme matters which have to date been subject to CARS/court determination has been insufficient to enable a suitable survey of contested claims involving contributory negligence. The MAA proposes to include the survey in its 2003-2004 proposed activities.

Question 1.7
Could you provide the Committee with information about the outcomes of the Audit of Allianz's management of CTP claims on behalf of MAA (referred to on page 69 of Committee's previous report).

Response 1.7
The MAA has a comprehensive audit plan for the audit of all HIH related matters. The focus of the audits is on the following:

- Detailed financial audits by MAA staff to check payments to CIC/FAI Claimants and Service Providers including lawyers,
- Audit and periodic testing of internal processes and procedures used by Allianz in making these payments (done by independent auditors appointed by the MAA).

Items covered in the audit of management of CTP claims by Allianz are broadly described below:

- MAA Consultant and Staff carry out a pre-audit of all major claims (claims exceeding $0.5 million),
- An overview of the Claims Database to clean up lapsed/closed claims,
- Periodic checking to see if the processes introduced by MAA for smooth and efficient running of the HIH run off portfolio are being followed,

- Audit of the quarterly Clearing House Schedules to ensure that all finalised shared claims have been properly recorded and included,
- Audit to ensure that monies have been claimed readily on Claims in excess of $500,000 and Section 45 Medical Payments of $50,000 and above in the next Clearing House quarter,
- Random checking of files prior to archiving for ensuring that all Shared out claims have been included in the Clearing House Schedules,
- Monitoring of new and re-opened claims and confirming if these belong to run off and relevant sharing issues have been addressed,
- Review of claims trends, quantum and of service provider quality,
- Determine whether Allianz achieved their targets, objectives and strategies including an appraisal of the key performance indicators.

Both the MAA's internal auditors and Audit Office have indicated that they are satisfied with arrangements the MAA has put in place. Following discussions with Treasury, the MAA is seeking expressions of interest to undertake a process review.

2. *Consumer Attitudes to CTP Insurance*

Question 2

At last year's hearing, Mr Bowen mentioned that market research was being conducted to determine consumer attitudes to Compulsory Third Party insurance (p 33). Could you tell the Committee what the findings of that research were?

Response 2

The MAA commissioned Woolcott Research to survey consumer attitudes to CTP insurance and to report on the findings. The research report's summary of conclusions and implications is attached as Attachment 3. The research was designed to build on a number of previous studies that have been undertaken in the area of Green Slips, hence the key areas of investigation were to confirm previous information as needed and identify "gaps" for a communication strategy. The key areas explored were:

1. Understanding of Green Slips.
2. Perceptions and expectations of the Government's role.
3. Reasons for shopping around for Green Slips.
4. Communication issues.

The survey found that over time, there has been an increased acceptance of Green Slips by the public. In 1998 when research was undertaken in this area, it was evident that there was real resentment about the need for Green Slips. In this research, it appeared that Green Slips were much more strongly associated with "peace of mind" qualities, and regarded as absolutely essential in case of an accident. The increased awareness of litigation and compensation payouts for events in everyday life appeared to have moved people to a situation where they recognised the "peace of mind" aspects of Green Slips, which in turn, lessened resentment to them.

There was, however, still a strong sense that their compulsory nature meant they were unavoidable, so cost became a real issue. The survey found that psychologically, pricing and price savings are the key drivers which will motivate vehicle owners to shop around for Green Slips.

The survey found that there was low awareness of the MAA's Green Slip and Helpline and website services to assist vehicle owners to "shop around" for the best prices. The MAA is currently looking at strategies to address this issue.

3. *NEL performance audit*

Question 3

What progress has been made by insurers in implementing the recommendations of the Non-Economic Loss performance audit completed last year?

Response 3

Four recommendations arose from further observations during the NEL Performance Audit:

- Recommendation 1: Improve documentation for determinations of %WPI - Some insurers are now providing claimants with details of %WPI determinations obtained from the Medical Assessment Service for other claimants with comparable injuries. In terms of outcomes, it would appear that the insurers are generally making accurate determinations of %WPI.
- Recommendation 2: Develop in-house knowledge for determining %WPI-One hundred and sixty five personnel from CTP insurers attended 5 training workshops during 2001/2002. Each workshop was restricted to 31 participants to allow the tutorials to be interactive. Registrations were allocated to insurers based on CTP market share. The objective of the training was to assist insurers identify, from files, claimants that are likely to have a greater than 10% whole person impairment.
- Recommendation 3: Allocation of advance payments against NEL - Insurers have advised that advance payments are being made against the applicable Head of Damage. In some cases of financial hardship, insurers consider it appropriate to earmark advance payments against NEL if WPI>10%.
- Recommendation 4: Making standard letters concise and relevant - Some insurers were assessed as having high levels of non-compliance in relation to making requests for information (see MAA's report titled "Draft - Industry Claims Handling Compliance Audit Report - November 2002"). These insurers have undertaken to tailor their standard letters to make them more concise and relevant. The MAA will be verifying this in a follow up audit in 2003.

4. *Compensation of parents*

Question 4

In its previous report on the Motor Accidents Authority (Report 19, February 2002, page 4), the Committee recommended that the MAA give further consideration as to how parents who lose children as a result of motor vehicle accidents might be compensated. Could you advise the Committee what progress has been made on this matter?

Response 4

The needs of parents who lose children as a result of a motor vehicle accident was raised in the third report of the Legislative Council Standing Committee on Law and Justice on the review of the exercise of the functions of the MAA and the Motor Accidents Council, issued in February 2002.

The Standing Committee recommended that the MAA should give further consideration as to how parents who lose children as a result of a motor vehicle accident might be compensated, particularly parents who would not qualify for non-economic loss according to current medical and psychological guidelines.

Currently, under the MAC Act, the family of a person killed in a motor vehicle accident (in which the deceased person is not wholly at fault) are entitled to claim compensation for psychological or psychiatric injury. The Act requires that for a daim for compensation for psychological injury, the

family member must suffer a demonstrable psychological or psychiatric injury and not merely a normal emotional or cultural grief reaction.

The MAA does not consider that there is a need to review existing monetary compensation entitlements for psychological or psychiatric injury. However, the MAA does acknowledge the importance of accessible bereavement counselling and support services for the family members of someone killed in a motor vehicle accident.

In response to the recommendation of the Law and Justice Committee the MAA commissioned a preliminary investigation of grief support services currently available, in particular those available to families of children killed in a motor vehicle accident. Please see Attachment 4 (Appendix 4). This involved consultation with service providers and some stakeholders. Arising from the preliminary investigation of grief support services, the MAA is giving consideration to initiatives to improve assistance to families of people killed in motor vehicle accidents and how to deliver such a service, possibly in conjunction with other relevant Government agencies

5. *Long term care of the seriously injured*

Question 5

In your answers to last year's questions, you noted that a working party has been established by the Cabinet Office to consider options for long term care of the seriously injured, particularly the proposal for a no-fault scheme. On page 6 of the Committee's report, you note that the MAA would contract an actuary to cost the proposals, which would be completed around the middle of 2002. Could you update the Committee on this work?

Response 5

This project has been overtaken by Commonwealth/State discussions of a national scheme for long term care. The Hon John Della Bosca, MLC, Special Minister of State presented a background paper on a national 'no-fault' long term care model to a meeting of the Heads of Treasury in October 2002. Commonwealth/State Treasuries have agreed to examine the proposal further in consultation with AHMAC. In the course of this work the MAA has met with representatives of the other State and the Federal agencies to discuss the feasibility of a national scheme to the deliver no-fault long term care services to all trauma-caused brain and spinal cord injured people.

Actuarial costing for a national "no-fault" long term care model and for a NSW motor accidents no-fault long term care model for children has been done by John Walsh of PriceWaterhouseCoopers.

The MAA has commenced preliminary work on a model for the provision of long term care for catastrophically injured claimants. The elements of such a model could include:

- Remove future care as a head of damage from common law and provide it through a statutory benefit scheme on a no-fault basis,
- Pool funds for future care. This will remove some of the uncertainties around estimating cost of care for each individual,
- Criteria for eligibility to enter the scheme, for example, require more than 1 hour of care a day for more than 2 years,
- Provide services rather than funds,
- Case management model and purchaser/provider split for the delivery of services,
- Establish standards for the delivery of services and guidelines for assessment of need for services, and
- Encourage development of appropriate services to meet the needs of claimants.

The MAA has also developed guidelines to provide assistance in determining what is a reasonable level of attendant care for adult claimants with a spinal cord injury. The working party consisted of representatives from Australian Quadriplegic Association, Paraquad, Spastic Centre, Northcott Society, attendant care agencies, Occupational Therapy Association, the Royal North Shore and Prince of Wales Spinal Cord units, Moorong Spinal Unit, Department of Ageing, Disability and Home Care (DADHC), the Insurance Council of Australia and the Law Society.

The MAA is also undertaking work on guidelines for the assessment of the care needs of brain injured adults and children. These guidelines will provide guidance on assessment tools suitable to measure disability and assist in the estimation of the amount and type of care required by brain-injured claimants. Two working parties have been formed with representatives from the Adult and Paediatric Brain Injury Rehabilitation Units, NSW Health, DADHC, Brain Injury Association, service providers, CTP insurers and the MAA. A literature review has been done on assessment tools that may be suitable to measure and estimate disability and care needs in traumatic brain injury. The review identified 110 tools. The working parties narrowed the selection of tools to 8 to be trialled for adults and 5 for children. This work is ongoing.

6. *Brain injury rehabilitation*

Question 6
Can the MAA provide details as to the allocation of the rehabilitation grants for brain injury?

Response 6
Please see Attachment 5 (Appendix 5) which provides details of the MAA's allocation of the rehabilitation grants for brain injury.

7. *Claim payments*

***Question** 7*
What factors have contributed to the reduction in the average claim payments to brain injured claimants (decreased by 25% - page 8 of Annual Report information)?

Response 7
The averages that the Committee is referring to are based on all payments made on open and finalised notifications divided by the total number of open and finalised notifications. It is only when claims are finalised that the final payment is known. Detailed information on finalised brain injury claims is set out below and also reported in the attachment on Scheme Performance Indicators - Attachment 6 (Appendix 6).

Finalised brain injury claims
Approximately equal numbers of claims were finalised with liability fully accepted in the two time periods. While legal representation was high in both schemes and even higher in the new scheme, no litigation was recorded for claims finalised in the new scheme.

The average payment overall increased by 37%, as did average payments in all individual payment categories.

Finalised brain injury claims (liability fully accepted)

	Old scheme	New scheme	% difference
Number of finalised claims	23	24	4%
Legally represented	87%	96%	9%
Litigated	26%	0%	-26%
MAIS (maximum severity score)			
3	10	12	20%
4	11	10	-9%
5 (most severe)	2	2	0%
Average payment	$167,963	$230,331	37%
Average payment (excl legal & investigation costs)	$155,684	$214,314	38%
Average payments by category			
Economic loss	$51,366	$147,199	187%
Long term care	$42,641	$80,344	88%
Medical	$31,412	$34,139	9%
Non economic loss	$86,069	$122,997	43%
Rehabilitation	$2,749	$4,655	69%
Investigation costs	$1,833	$2,874	57%
Legal costs	$15,118	$15,209	1%

8. *Investigation Costs*

Question 8

What factors have contributed to the reduction in investigation costs, halved from $36.2 million to $17.5 million?

Response 8

At September 2002, investigation costs dropped from $42.8 million to $20.6 million. Insurers have advised that the average cost of an investigation has increased slightly, but that there has been a significant decrease in the number of investigations commissioned by insurers. The following factors have been attributed to the decrease in the number of investigations:

- ANFs allow early decisions and access to medical payments. Those that do not convert to full claims therefore reduce the need to investigate liability by conducting factual investigations or to conduct surveillance investigations to eliminate fraudulent or exaggerated claims.
- The introduction of the Medical Assessment Service which can make objective, standards-based assessments of claimants' injuries, has reduced the need for many surveillance investigations that previously were used to confirm the nature and extent of injuries.
- The reduction in the average cost of a claim means investigation costs are proportionally higher per claim so not as economical to investigate smaller claims.
- The reduction in litigation has reduced the need for supplementary investigations.

Issues raised by the Australian Plaintiff Lawyers Association

1. *Delays at the Medical Assessment*

Background 1

Since the introduction of the Motor Accidents Compensation Act, our members indicate that resolution of their clients' claims has been severely prejudiced by delays at the Medical Assessment Service. They are routinely experiencing a delay of more than seven months from the date of application to MAS to the provision of a MAS certificate. In the case of one of our members' clients, an application for assessment was made on 13 December 2001 and a MAS certificate was received on 1 October 2002, representing a delay of more than nine months in the progression of the claim. The MAS certificate, when provided, was dated 11 April 2002, suggesting that the delay involved was due to MAS rather than the assessing doctor.

Our members indicate numerous claimants have waited more than three months after their appointment for a certificate to be provided. Gross delays occur even in the initial stages of MAS. They are routinely waiting more than two months from the date of application to the allocation of an appointment. One member tells us of a claimant who is still awaiting allocation of an appointment five months after the initial application.

Our members' numerous complaints to MAS regarding the delays do not elicit a satisfactory explanation. In most cases they do not even elicit a response.

Response 1

During 2002 MAS has continued to experience significant increases in applications for medical assessment. At June 2001 MAS had received a total of 739 applications. At June 2002 the total was 2,116. To date, MAS has registered in excess of 3,900 applications.

Contrary to anecdotal reports from all parties, the MAA's survey of year 1 open claims showed that MAS was not responsible for the majority of delays. MAS was the main delay in only 17% of the claims. See Attachment 7 (Appendix 7) – Survey of Year 1 Open Claims.

It is expected that most medical disputes should, if the parties co-operate be resolved within four and half to six months, as reflected by the timeframes in the Medical Assessment Guidelines. Urgent matters, particularly disputes over treatment or referrals of permanent impairment assessment from the Court are dealt with and will continued to be dealt with in under two – three months.

However many cases will take longer than the above timeframe for reasons such as:

- Requests for extension of time to provide reply,
- Late notification of additional injuries (requiring further appointments),
- Non-attendance and rescheduling of appointments by claimants,
- Failure to advise of need for interpreter, resulting in cancellation of appointment, and
- Additional disputes lodged later (eg treatment disputes and/or earning capacity disputes lodged after Permanent Impairment dispute is lodged) requiring deferral of PI assessment in some cases to allow all disputes to be assessed at one appointment.

Approximately 40% of PI assessments at MAS result in a 0% Whole person impairment. There seems a reluctance by some plaintiff lawyers to concede that the impairment threshold has clearly not been reached. This is impacting significantly on the MAS caseload.
MAS has taken the following steps in response to the significant increase in the medical dispute caseload:

- recruited more staff to deal with greatly increasing application numbers,
- provided more space to allow for increasing staff numbers,
- introduced its case management system – Sirius – to more efficiently process applications and replies,
- recruited more assessors and introduced a system of block bookings to reduce waiting time for parties seeking a medical appointment (recognising that the assessment of permanent impairment is technical and requires expertise and that treatment disputes must be assessed by treating practitioners whose primary 'business' is clinical practice and not dispute assessment),
- improved education and training for assessors to improve their report/certificate accuracy rate (recognising that nearly all medical assessors are acting in a role quite new to them), and
- increased insurers, claimants and legal representative information to encourage more appropriate applications (recognising that 40% of permanent impairment disputes result in a whole person impairment of nil [0%]).

MAS receives a large number of queries on a daily basis in relation to progress with applications. MAS is not aware of any unanswered correspondence or unreturned phone calls.

2. *The greater than 10% whole person impairment threshold*

Background 2

Our members indicate that they have a number of clients who have suffered significant physical and psychological injuries and have been assessed by MAS as having a 10% whole person impairment. Our members indicate that it is difficult to explain to these people that due to the operation of the legislation they will receive nothing for pain and suffering whereas a further 1% in their assessment would have resulted in compensation for the loss of enjoyment of life caused by the subject motor vehicle accident.

To provide an example, one of our members has a client who suffered a significant psychological injury as a result of being the driver of a truck that collided with an out-of-control vehicle, killing two people in the vehicle. He was assessed as having a ten per cent whole person impairment due to his psychological injuries. The accident had not had an effect upon his earning capacity, he did not require domestic assistance and was not receiving further treatment for his injuries. As such, his claim is worth nothing beyond the $23.45 paid in past out of pocket expenses.

People assessed at 10% whole person impairment have suffered a significant to injury which has had a severe and detrimental effect upon their enjoyment of life and caused them great pain and suffering. The threshold for general damages should be reduced.

Question 2

Is it now appropriate to reduce the threshold in light of the disproportion between insurer revenue (premiums) and payout (damages)?

Response 2

The MAC Act reformed the threshold by which an injured person's entitlement to NEL would be assessed. The setting of a higher threshold for NEL loss compensation was considered reasonably

balanced against reduced Green Slip premiums experienced under the reformed scheme. The position of claimants who reach, rather than exceed the threshold, is retained across schemes and will be experienced in any scheme utilising such a feature in an effort to control access to compensation.

If the NEL threshold was lowered to 10% or less, it would impact significantly on premiums as soft tissue injuries (whiplash) would become eligible for NEL awards. The MAA estimates that to fund this, would add $60-$80 to premiums. Alternatively, to provide wider access to NEL at no increased cost, would mean significantly reducing NEL to seriously injured people.

In most cases where an injured person has a serious injury, the extent of non-economic loss will not be quantified until some considerable time after the accident as NEL entitlements cannot be quantified until an injury stabilises. Consequently at this stage of the scheme's development, actual NEL awards paid to date cannot be expected to fully reflect the ultimate pattern of NEL awards under the MAC Act.

Claim payments increase gradually and reach a peak around the 3rd and 4th years after the original underwriting year. The first underwriting year of the scheme will not reach this stage until 2003-2004. Each accident year, there are almost 100 catastrophic claims which settle for at least a million dollars each. The average size of these claims is approximately $2.5 million. These claims understandably tend to take longer to settle than other claims. However, there are individual claims under the new scheme which have already settled for amounts over a million dollars.

The MAA Compliance Unit has undertaken an audit of insurer files to determine the percentage of claims for which insurers have made reserve estimates for NEL and to assess whether this is consistent with the reform objectives. The MAA provided a full report on the audit to the Standing Committee on Law and Justice in December 2001. The audit report is contained in Appendix 3 of the Committee's Report 19 February 2002.

The market-weighted average of all MAC Act claims with NEL reserve estimates, based on the MAA random audit samples of Green Slip insurers, was 12%. This compares favourably with an actuarial forecast made prior to the commencement of the Act that the 10% most severely injured claimants would be eligible for NEL.

Consequently, it does not appear appropriate at this stage of the Scheme's development to reduce the NEL threshold. As previously advised to the Committee, 'if the MAA comes to the view that the Act is not working as intended, the MAA will make policy recommendations to the Minister'.[6]

3. *Reasonable offers of settlement*

Background 3

Our members indicate they have consistently found that insurers are breaching their obligations under the Claims Handling Guidelines to provide reasonable offers of settlement.

One of our members indicates that in a case where one of his clients had been assessed by MAS as suffering a greater than ten per cent whole person impairment due to psychological injuries, the insurance company made an offer allowing only

[6] Answer 1.8 New South Wales Bar Association Submission, Standing Committee on Law and Justice, Report 19-February 2002, page 48

$35,000 for non economic loss. A practitioner or insurance company with any amount of experience should recognise that an offer for non economic loss in the circumstances would have to exceed $50,000.00 to be considered reasonable. A CARS assessment of this matter later awarded $90,000 in damages for non economic loss, almost triple the insurer's offer.

Response 3

Under the *Motor Accidents Compensation Act 1999* ("the MAC Act") the MAA's supervisory role has increased and as a result, the MAA has established a Compliance Branch within its operation. This Branch monitors insurers' compliance with a range of guidelines and regulations under the MAC Act, including the Claims Handling Guidelines. It also investigates complaints brought against insurers in particular matters.

Any injured person, or their legal representative, can bring a complaint concerning an insurer to the MAA's Compliance Branch. This includes complaints in relation to whether an insurer has complied with its duty to make a reasonable offer of settlement within 1 month of the injury stabilising, or within 2 months of full particulars being provided, whichever is the later.

The following Table presents a summary of complaints about insurers' handling of CTP claims that were received by the MAA's Compliance Branch between 1 July 2001 and 30 June 2002.

Nature of complaint	**Number of complaints**
Alleged failure by insurer to take action eg. not providing medical reports or not paying accounts	36
Alleged wrongful action by the insurer	18
Alleged delays by the insurer	6
TOTAL	60

There was only one complaint out of a total 60 complaints alleging an unreasonable offer of settlement by an insurer. The claimant's solicitor complained that the amount initially offered by the insurer for NEL was too low. Subsequent assessment by MAS determined that the claimant was 5%WPI and therefore ineligible for NEL.

In conducting the Claims Handling Compliance Audit in 2002, the MAA auditors made a qualitative assessment of whether insurers were making obviously unreasonable offers of settlement. The auditors did not identify any obviously unreasonable offers of settlement made by insurers. An offer of settlement would have been considered unreasonable if, for example, at the time of the offer there was evidence on the file that a claimant was clearly eligible for a particular head of damage such as non-economic loss, but that head of damage was not included by the insurer in the offer.

4. *Contacting Legally Represented Claimant*

Background 4

A claims officer from the NRMA recently contacted one of our member's clients directly less than a week after our member lodged her claim. The claims officer requested information from our member's client in relation to, among other things, her intentions regarding employment. Our client answered and later complained to our member's office about the intrusive nature of the questions.

It is difficult to understand why, more than three years after the commencement of the Act, insurers are still contacting legally represented clients directly for reasons unrelated to their rehabilitation needs.

Response 4
Without further information about the complaint described above, the MAA is unable to provide further comment.

Four out of sixty complaints received by the MAA's Compliance Branch between 1 July 2001 and 30 June 2002 arose because a claimant's solicitor complained that the insurer had contacted their client directly. Where the MAA found that inappropriate contact had taken place directly between an insurer and a legally represented claimant, the MAA asked for the insurer to provide an apology.

The findings of the Claims Handling Compliance Audit indicate that insurers are generally complying with the Claims Handling Guidelines provisions governing direct contact with claimants (Guidelines 4.1, 4.2, 4.3, 4.4).

Any injured person, or their legal representative, can bring a complaint concerning an insurer to the MAA's Compliance Branch. This includes complaints in relation to insurers contacting represented claimants contrary to the Claims Handling Guidelines.

5. *Disclosure of Documents*

Background 5
One of our members indicates that an insurer in a Compensation to Relatives Claim made an allegation of contributory negligence, relying upon statements it claimed were obtained by an investigator and related to the behaviour of the deceased person on the night of the accident in which she died. The insurer refused to provide our member's office with copies of the statements. Witnesses whom the insurer alleged had provided statements refused to speak to our member's investigator.

We discovered that there is no provision in the Act to compel the insurer to produce evidence without commencing court proceedings. The Act therefore aims to avoid litigation but provides no mechanism whereby insurers can be forced to substantiate their allegations of contributory negligence without the need for court proceedings.

Response 5
The matter raised here was the subject of a formal complaint which the Motor Accidents Authority's (MAA) Compliance Branch has investigated.

The compulsory exchange of witness statements and like documents is not presently dealt with in the Claims Handling Guidelines. The Claims Handling Guidelines are due to be reviewed. The MAA intends to consider this matter further at the proposed review. The MAA invited the law firm that lodged the complaint to make a submission in relation to the issue of prior disclosure of material.

The MAA's preliminary view is that there is considerable merit in mandatory disclosure of information held by both parties. If such a change were to be adopted, it would require legislative amendment.

6. *Insurers Breaching Claims Handling Guidelines*

Background 6
One of our members indicates that an insurer acting on behalf of the Nominal Defendant has been non-responsive to repeated attempts to obtain treatment for his client and an offer of settlement and medical reports from our member's

client's treating doctors, breaching its obligations under section 82 and 83 of the Act and Paragraphs 3.6 of the Claims Handling Guidelines. Further information will be provided concerning this particular instance on request. Our member has been assured the matter is being investigated by the Motor Accidents Authority but he has received no further communication from the insurer other than a telephone request for a copy of his file as the insurer's file has been mislaid.

Response 6

This matter is currently under investigation by the MAA's Compliance Branch.

Issues raised by the Insurance Council of Australia

Question 1
Does the MAA have a view about the overall operation of the 1999 Act and whether it is matching the reform principles agreed by all parties (including plaintiff lawyers) during the Miller review of the NSW motor accidents scheme?

Response 1
The reform principles or recommendations formulated by the working party included;

- privately underwritten insurance,
- compensation based upon proof of fault by another person,
- early and defined medical treatment for claimants,
- early provisional decision on liability by insurers,
- determination of disputes concerning treatment, rehabilitation, and care by way of independent medical assessment,
- objective assessment of impairment as a gateway for non-economic loss,
- an accessible forum for early resolution of disputes over most claims,
- retention of access to the courts for decisions on liability, causation or for non-CTP defendants and as a forum of last resort,
- more clearly defined benefits, with an emphasis on ensuring that seriously injured and catastrophically injured persons are properly compensated,
- scheduled fees for health professionals and lawyers undertaking motor accidents matters,
- acknowledgement of reduced profit levels for insurers in response to the above reforms,
- a more competitive market for Green Slips.

The MAA considers the present operation of the Scheme closely reflects the spirit and content of the recommendations formulated by the working party.

Question 2
Could the MAA comment about the operation of procedures/practices with CARS and MAS and whether they are fully meeting both the spirit and legislative objects of the 1999 Act? Specifically, could the MAA comment on whether disputes are genuinely being resolved in a non-adversarial manner with a much greater emphasis on an administrative model?

Response 2
MAS and CARS have been established to promote the progress and timely resolution of claims. Having jurisdiction to assess interim claims disputes enables the smoother passage of a claim to finalisation.

The procedures developed to facilitate the processes ensure that the highest standard of procedural fairness is afforded to parties, information is shared and the process is readily accessible to all parties to the dispute. Where a claimant is involved in a dispute to be assessed by either MAS or CARS, the MAA offers an outreach programme through the Claims Advisory Service (CAS) where a claimant will be provided with procedural assistance and support.

The alternative dispute resolution processes established requires a move away from the traditional adversarial approach of both lawyers and insurers and requires improved communication between the parties.

It has been the experience to date that adversarial disputation at MAS and CARS is most often a product of the parties to the claims mind set and approach rather than arising from procedures. There has been a reluctance by some parties to engage in a full and frank exchange of information by way of completion of lodgement and attesting documentation. It is hoped that familiarity with the process will assist in a move away from the adversarial approach taken under the old Scheme.

It is acknowledged that the cultural change required will take time.

Question 3

Can the MAA comment about improvements that could be made to the 1999 Act to ensure that time limits on various procedures cannot be exploited to unduly or unfairly delay the final resolution of claims?

Response 3

If the ICA would expand upon the nature of the problem that is believed to exist the MAA would be pleased to respond.

Question 4

There are numerous obligations for insurers under the 1999 Act and associated guidelines in terms of handling of claims, disclosure of information and complying with various time limits. Can the MAA comment about whether similar obligations should apply to claimants' legal advisers, as a means of ensuring the speedy and efficient resolution of claims?

Response 4

Private insurers licensed to write CTP business within the NSW Motor Accidents Scheme operate under a number of duties associated with the pricing and issuing of policies and the management of claims against policies written or allocated through the Nominal Defendant Scheme.

In order to expedite the passage of a claim through the claiming process, parties to a claim, that is the injured person, the CTP insurer of the alleged at-fault vehicle and the owner/driver of that vehicle, all have responsibilities in respect to the timely provision of information.

It should be remembered that legal representation is a service sought by a CTP claimant voluntarily and almost half of injured people making a claim chose not to engage a legal service provider. However, a claimant may engage a legal service provider for a number of reasons at various points in the claim's passage, depending upon their perceived ability to successfully negotiate the claim's passage to finalisation with the insurer.

It is clear to the MAA that there is considerable variation in the quality of legal services being provided to claimants. Despite running regular forums and training sessions throughout the year the MAA is aware that there remains considerable ignorance about the operation of the new scheme leading to claimants being given incorrect advice.

Indeed there are many examples of claimants having contacted the MAA Claims Advisory Service to indicate that they have been advised that because of the new impairment threshold they have no entitlement to make a claim, whereas it operates as a threshold only to non-economic loss. This is just one example.

As well there are many examples of inadequate and incorrect applications to MAS and CARS that need to be returned for correction or which are rejected. In addition there are a small number of solicitors who try and obstruct and thwart the operation of the scheme, for example by advising their client not to attend medical assessments despite the fact that the client has an obligation under the Act to do so.

As against this there are solicitors who work to achieve the best outcome for their client within the operation of the scheme. The practitioners have taken the trouble to be informed as to the operation of the scheme and to understand how the assessment system works. They may take this approach even though they are critical of the scheme.

The MAA will continue to provide educational resources to the legal profession to assist practitioners in gaining knowledge and understanding of the scheme. To ensure that those practitioners who are well acquainted with the scheme are known the MAA is considering providing a public endorsement of those practitioners who have completed MAA training courses.

It would be inappropriate for the MAA to regulate the manner in which legal services are provided to CTP claimants, particularly in view of the operation of the *Legal Profession Act 1987* as amended by the *Civil Liability Act 2002.*

Question 5
Does the MAA have a view about the closer regulation of the legal profession as a service provider to the NSW motor accidents scheme?

Response 5
See Response to Question 4.

Question 6
What is the MAA doing to address particular issues arising out of MAA's recent survey of Year 1 claims?

Response 6
The MAA has undertaken a review of year 1 open claims. The purpose of the survey was to identify what issue might be impacting on the settlement of the more serious claims for the first year of the scheme.

A major cause of delay (in 40% of open claims) is the failure of plaintiffs (90% of whom are legally represented) to make counter offers and to provide particulars. The MAA intends to have further discussions with insurers and the Law Society to assist them in identifying ways in which all parties may better assist claimants.

Contrary to anecdotal reports from all parties prior to the survey, MAS was not responsible for the majority of delays. It was the main reason for delay in 17% of open claims. The MAA will continue to address the delays at MAS by

- Staff recruitment
- Recruitment of more assessors
- Improving accuracy of assessors' reports by providing tailored training
- Increasing the appropriate use of MAS especially in impairment disputes.

In addition to requesting detailed information from insurers on year 1 claims, the MAA also followed up directly with claimants to gather their view of the claims settlement process. The MAA has not

analysed the results of the survey at this stage. However, the MAA intends to make further contact with claimants where there appears to be a delay due to poor responses from the insurer or the solicitor, with a view to prompting early attention to these claims.

Question 7

Can the MAA comment about the effect on scheme costs arising from the potential for an injured person to make both a workers compensation and a CTP claim?

Response 7

Where there is a workers compensation claim involving a CTP covered motor vehicle accident, the costs are met by the CTP insurer, although the claim may be managed by a workers compensation insurer. CTP insurers have provided the MAA with anecdotal information on differing approaches to claims management under workers compensation and CTP. However, the CTP insurers have not provided any substantive information on possible cost impact.

The MAA has raised the issue with the Motor Accident Insurer Standing Committee with a view to CTP and workers compensation insurers meeting to discuss the management of overlapping claims.

Question 8

Can the MAA comment on the effect of overlapping workers compensation and CTP claims on the injury management outcome for an injured person?

Response 8

The MAA is aware of the need for standards in approach and treatment of injured people and seeks to work co-operatively with WorkCover to ensure comparable approaches. Where there are common injury areas, the two organisations have worked cooperatively on developing treatment guidelines. These have included the Whiplash Guidelines and the Anxiety Guidelines and currently, both organisations, together, with the AMA and the Law Society, have advised on a brochure for Medico-Legal examinations. It is anticipated that this cooperation will be on-going to ensure good injury management and recovery outcomes for the injured.

Question 9

Could this issue be addressed by placing an obligation on an injured person to make a binding election (within a reasonable time) between claims? That is, so that an injured person can only proceed to recover benefits under one scheme

Response 9

The MAA does not believe that imposing an obligation on an injured person to make an election would necessarily ensure the best injury management outcome for the injured person.

Question 10

Can the MAA comment on the recent report of the ACCC into general insurance pricing, and the ACCC's analysis of profit levels in the NSW CTP scheme? Are the conclusions of the ACCC in this regard at odds with the findings of the MAA?

Response 10

The ACCC findings in regard to the analysis of profit levels in the NSW CTP scheme are wrong. The ACCC report has reported on compulsory third party insurance in NSW, Queensland and the ACT as a whole and has not attempted to discuss the situation in each separate jurisdiction. The MAA has

attached advice provided by Adrian Gould of Taylor Fry Consulting Actuaries - Attachment 8 (Appendix 8).

The MAA reports annually to the Standing Committee on Law and Justice on the profit of NSW Green Slip insurers. The MAA reports profit on an underwriting year basis. This method appropriately compares premium earned during the year against claims liabilities incurred for that year.

The ACCC figures, based on financial reporting years, are affected by releases of profit or reported losses from all previous years compared against premium earned during the reporting year.

The basis adopted by the MAA is the appropriate method to evaluate the NSW legislative reforms as it specifically compares premium collected with claims to be paid out from that premium, and it allows the period after the reforms to be isolated from the effect of profit or loss experience from the previous scheme.

Question 11
Can the MAA comment on the outcome of the recent Law Society Settlement Week in relation to claims under the 1999 Act that were presented for settlement?

Response 11
The MAA provided $60,000 towards the 2002 Law Society Settlement Week. The aim of the week is to identify matters suitable for mediation and settlement. The Law Society has indicated that there will be an independent evaluation of the outcome of the activities associated with Settlement Week and it is anticipated that this evaluation will be available shortly.

Issues raised by the NSW Bar Association

1. *Reporting by Motor Accidents Authority*

1.1 The terms of reference for the annual review by the Standing Committee on Law and Justice into the performance of the MAA requires consideration of the performance of the Motor Accidents Compensation Act 1999 and the scheme for compensation that it established. In conducting its enquires the Committee is obviously heavily reliant upon information supplied by the MAA.

1.2 It is thus of concern that the MAA has not provided any critical or independent appraisal of the performance of the scheme since the introduction of the 1999 Act. The report on scheme performance indicators dated 13 September 2002 supplied to the Committee does not provide recommendations or suggestions for improving the affordability, effectiveness, fairness and efficiency of the scheme.

1.3 In accordance with the Minister's obligations under Section 233 of the Act, the General Manager of the MAA has just concluded a review of the first three years' performance of the scheme under the 1999 Act. The review identified a number of issues in relation to the operation of the scheme that require critical evaluation and discussion:

- *The scheme has experienced some significant teething problems, especially with delays in the conducting of medical assessments.*
- *The seriously injured appear to have suffered a significant diminution in their compensation, contrary to the intentions of the new scheme.*
- *It is taking longer to finalise compensation for the seriously injured, despite a supposedly streamlined alternate dispute resolution system having been put in place.*

Response (1.3)
See Response to APLA Question 1 for the Medical Assessment Service.

See the response to the L&J Committee Question 7 on brain injury claims.

Refer to the analysis of finalised leg fracture claims in the MAA's Report on Scheme Performance Indicators (see Attachment 6).

The Bar Association has stated that 'it is taking longer to finalise compensation for the seriously injured, despite a supposedly streamlined alternate dispute resolution system having been put in place.'

The difference for brain injury is minimal being 3.5% at the end of September 2002 an increase from 563 days to 583 days.

By the end of September 2002, the finalisation rate for serious leg fractures was 33% in the new scheme compared to 44% in the old scheme. In its survey of open year 1 claims, the MAA found that insurers had made offers in one third of serious leg fracture claims that were still open. Of the remaining claims:

- Parties agreed that the injury is not stable, or only recently stable (23%)
- Insurers were awaiting particulars from plaintiffs (17%)
- MAS decision were expected (15%)

- 12% were CARS exempt and half had commenced litigation
- Liability was in dispute but not at CARS (11%)
- The claimant also pursuing their workers' compensation rights (8%).

Of the matters where the insurer had not made an offer, the claimant has made an offer in only 5% of cases.

The Association is of the view that these are serious issues requiring discussion.

1.4 The Association submits that the MAA should be asked to provide the Committee with a critical analysis of the performance of the scheme, identifying the weaknesses as well as the strengths. Recommendations for addressing the areas of weakness should thereafter follow.

1.5 Shortly prior to the deadline for filing of these submissions, the Bar Association was provided with a copy of the tabled Review of the Motor Accidents Compensation Act 1999. That document does not contain a consolidated list of recommendations to improve and fine-tune the scheme. Nor does it address the following issues:

- *delays in MAS medical assessments;*
- *significantly reduced compensation payable to the more seriously injured; or*
- *delays in the finalisation of claims for the more seriously injured.*

1.6 Concern also arises in relation to the first premium collection year under the new scheme. The Association questions whether payments to date have been in accordance with actuarial projections. If payments are below actuarial assumptions, where has the surplus moneys gone ?

Response (1.6)
No. The MAA has commissioned Taylor Fry actuaries to update the estimate of profit and will provide the committee with a detailed report on profit.

1.7 The Association further notes that no information has been given to the Standing Committee for the 2002 review about the performance of the scheme as against the actuarial costings for the scheme.

2. *Non-Economic Loss*

2.1 The introduction of the 10% whole person impairment threshold in relation to non-economic loss (NEL) was designed to eliminate compensation for modest soft tissue injuries whilst preserving full entitlements for the seriously injured. It was anticipated, that of all claimants, the 10% who are most seriously injured would receive an award of non-economic loss. Actuarial projections anticipated that total payments for non-economic loss would fall by approximately $100 million from $250 million per premium collection year under the old scheme to $150 million under the new scheme.

2.2 On 31 May 2001 the Special Minister for State with responsibility for the Motor Accidents Authority, The Honourable John Della Bosca MLC, advised the Legislative Council that he had been informed by the MAA that there had been 15,000 full claims in the first eighteen months of operation of the scheme and, on that basis, it could be anticipated that 1,500 accident victims would receive non-economic loss payments for pain and suffering for that period.

2.3 Despite addressing the issue of non-economic loss in the Review, some important questions appear to be left unanswered. For example, there is no information as to what is the budgeted dollar figure for payments of non-economic loss out of each premium collection year in the current scheme. The Association notes that the figure of $150 million per premium collection was cited. If this is the correct figure, does the MAA remain confident that the scheme, as currently structured, will see accident victims from the first premium collection year receive $150 million for non-economic loss? Similarly, does the MAA remain confident that the scheme, as currently structured, will see 10% of accident victims from each premium collection year receive payments for non-economic loss?

Response (2.3, 2.7)
Yes. The NEL Performance Audit conducted in late 2001 indicated that up to 12% of claimants making full claims may be eligible for NEL on the basis that 12% of full claims had reserve estimates for NEL.

2.4 The Committee may like further information in respect of the following issues:

- *the amount of money that has to date been paid for non-economic loss for accidents occurring during the first premium collection year;*
- *the number of claimants injured during the first premium collection year that have to date received payments for non-economic loss; and*
- *the percentage of claimants from accidents occurring during the first premium collection year that have to date received payments for non-economic loss.*

Response (2.4)
This information is not available by underwriting year.

2.5 The MAA reports that non-economic loss payments in the first 33 months of the new scheme totalled $13 million, compared to $81.4 million for a comparable 33 month period under the old scheme. This is a percentage reduction well beyond actuarial projections for the performance of the new scheme. The Committee may like to know - if payments to date are reflective of the performance of the new scheme – whether total payments for non-economic loss under the new scheme will be reduced by considerably more than $100 million per year?

Response (2.5)
Please refer to the findings of the MAA's NEL audit – see 2.3 above.

2.6 Payments to the seriously injured decreased under the new scheme, despite the purpose of the 10% whole person impairment threshold, was to maximise and maintain payments to the seriously injured. The Committee may like to inquire as to why payments for non-economic loss for those with serious brain injuries have dropped from $4.5 million for the last 33 months of the old scheme to $1.8 million for the first 33 months of the new scheme? Similarly, the Committee might like to know why payments for non-economic loss to those with severe leg fractures have decreased from $10 million in the last 33 months of operation of the old scheme to $2.5 million in the first 33 months of the new scheme?

2.7 The Committee may wish to raise with the MAA whether it remains confident in light of the above figures that the 10% of accident victims from the first premium collection year of the new scheme (representing the most seriously injured) will ultimately receive payments for non-economic loss? (see response to 2.3 above)

2.8 Prior to last year's Standing Committee review the MAA had conducted an audit of insurers' reserves and concluded that insurers were holding reserves for non-economic loss payments in 12% of cases. The Committee

may wish to know whether this audit exercise been repeated and, of the 12% of claims with non-economic loss reserve estimates, what percentage has been resolved and in what percentage of those resolved matters was non-economic loss in fact paid.

Response (2.8)
No. The MAA Compliance Unit will conduct a follow-up NEL performance audit in August/September 2003.

3. *Affordability*

3.1 This is the first of the MAA's four self-selected assessment criteria. The Bar Association acknowledges that reforms to the scheme have resulted in the stabilisation of premium levels. Although savings have not been as great as initially promised by the Government, the CTP premium remains stable whilst all other personal lines of insurance are experiencing escalating premiums.

3.2 The so-called 'insurance crisis' arises as a consequence of a convergence of a number of factors:

- *escalation in international reinsurance premiums as a consequence of September 11;*
- *the collapse of HIH; and*
- *cyclical features of the insurance industry.*

These factors have had a significant effect upon all lines of personal insurance, except for CTP.

3.3 The 1999 Act was designed to stabilise premiums. The reforms have in fact seen CTP premiums remain stable through a period of unprecedented upheaval in insurance premiums. The absence of any increase in CTP premiums suggests that insurers are either holding premiums at an unsustainable level as they face escalating reinsurance costs, or the 1999 reforms reduced the CTP insurers' costs to the point where they can afford to reduce their profit margins.

3.4 Affordability involves consideration of more issues than merely the price of a Green Slip. Affordability also requires consideration of other dollar and social costs associated with the scheme.

3.5 Firstly, there are the costs to injured persons who are now denied proper compensation for injuries which they have sustained through no fault of their own.

3.6 Secondly, as the scheme succeeds in deterring and minimising compensation, society incurs additional costs through public hospital and Medicare payments for treatment and Social Security payments for the permanently impaired.

3.7 Finally, affordability entails consideration as to whether society can and should afford a higher premium in order to ensure proper compensation for those injured in motor accidents. There is no magical improvement in the state of society when premiums fall under $330 per year. There is, however, a failure in our collective responsibility for providing a fair society when those seriously injured in motor vehicle accidents are not properly compensated for their injuries.

3.8 The Committee may wish to know how CPT insurers have been able to hold the price of Green Slips when the costs of other lines of personal and property insurance are increasing and whether the new scheme has proved to be harsher than anticipated in reducing benefits to claimants, thus allowing insurers to maintain the price of

premiums without reducing profit levels. The Committee may also wish to know if it is the long term goal of the MAA to hold premiums at current levels or to support modest escalation of premiums in line with CPI increases, so that benefits can be increased in line with inflation.

3.9 The MAA has commented that it anticipates further drops in the price of premiums for metropolitan passenger vehicles. The Committee may wish to ask whether the drop would be as a result of insurers trimming profit margins or are there surplus funds available in the scheme? The Committee might also inquire, if there are in fact surplus funds within the scheme, which does the MAA treat as the greater priority – further cuts to premiums or returning benefits to the injured?

3.10 The Association notes the MAA's imperative to maintain premiums below $330 to $350 per year. The Association submits that the MAA should provide the Committee with reasons as to what makes a $400 premium 'unaffordable'?

Response (3.8 – 3.10)
Affordability of premiums is measured against a number of criteria including as against AWE. However the Motor Accidents Compensation Act 1999 changed the operation of the Motor Accidents Scheme to improve its operation and to achieve a significant reduction in the price of Green Slips.

It is a matter for the government to set the balance between the cost of Green Slips and the level of compensation. The MAAs responsibility is to ensure that the scheme continues to operate to achieve this balance.

In relation to paragraph 3.6 the Bar submission is incorrect. No scheme changes effects compensation for medical costs that would impact upon hospital costs or Medicare. No scheme changes effects compensation for future economic loss or future medical or care costs that would impact upon the cost of social security for the permanently impaired. It is wrong and duplicitous to suggest that this would be the case.

In relation to paragraph 3.7 it is a matter for Government to achieve the balance between affordability and compensation. It cannot be said that seriously injured persons are 'not properly compensated for their injuries'. Every injured person received compensation for all of their economic loss (except first 5 days lost income) and those who are most seriously injured have access to non-economic loss payments as well.

In relation to paragraphs 3.8 and 3.9, CTP insurance has seen reductions in premiums at a time when all other insurance products are increasing significantly because of the impact of the Government's scheme reforms. The MAA has reported to the Committee on these premium reductions and the fact that as more information becomes available about scheme performance it if continues to reflect current trends then there is scope for further premium reductions. The MAA will report further on this matter in evidence to the Committee.

In relation to paragraph 3.10 as to what constitutes an unaffordable premium, the NSW government and Parliament endorsed scheme changes to achieve a $100 reduction off the average premium on the basis that the pre-reform premium had reached a level where it was unaffordable for many members of the community. It is the role of Government to set just such measures and it is noted that in the course of the passage of that Bill through Parliament the submissions from the Bar Association to members suggesting that the level of premium under the old scheme was affordable was specifically rejected.

4. *Effectiveness*

4.1 The Bar Association accepts that the ANF system has resulted in providing quicker access to payment for early treatment expenses. It is noted that such compensation is limited to $500, which would pay for only about ten visits to a general practitioner and/or physiotherapist and would not pay for a single radiological investigation.

Response (4.1)
While insurers are not obliged to pay more than $500 on an ANF, insurers have paid over $1,000 in individual cases, and have paid more than $500 in almost 20% of ANFs.

4.2 The Bar Association also accepts that the new scheme has resulted in insurers improving the speed with which they reach determinations as to liability.

4.3 However, there appears to be a fundamental flaw emerging in the new system. Accident victims are not considered when the insurer makes a formal admission of liability. The claimant knows who is at fault when another vehicle drives into the back of their vehicle and a formal admission by the insurer is largely irrelevant to their physical and financial well being.

4.4 Similarly, a significant number of medical practitioners do not charge the accident victim when it is anticipated that there will be reimbursement by a CTP insurer. The doctor or physiotherapist sends their account direct to the CTP insurer. The claimant never sees the account. It accordingly makes little difference to an injured claimant whether the first payment to reimburse the general practitioner or physiotherapist is made ten days faster.

4.5 What really matters to claimants is the amount of money they receive in total compensation and the speed with which they receive it. These are by far the most important criteria of effectiveness and it is in this area that the new scheme is showing serious difficulties. There are extensive delays in the operation of MAS. CARS appears to be ineffective in delivering compensation to claimants in the finalisation of claims.

Response (4.5)
Please see Response to APLA Question 1.

4.6 The Association notes that MAA statistics indicate that the finalisation rate and the average time taken to finalise claims for serious brain injuries and severe leg fractures has increased under the new scheme. The statistics raise several important questions that the Committee may wish to consider. For example, what is the reason for the delays in finalisation of more serious injuries under the new scheme? Is there an issue as to the effectiveness of the new scheme in terms of the speed at which compensation for the more seriously injured is finalised? Is this the case for all categories of serious injuries?

Response (4.6)
Please see Response to Bar Association Question 1.3

4.7 The MAA advise that total payments made to claimants in the first 33 months of the new scheme total $164.8 million, compared to $321.1 million for a comparable 33 month period at the end of the old scheme. This represents a reduction of 49% in payments to accident victims. It is not clear however whether the total payments are a reduction in payment to accident victims greater than, equal to or less than the intended performance of the new scheme. Nor is it apparent why a 50% reduction in payments to the injured result in less than 25% reduction in premiums or what amount of damages has been awarded to accident victims as a consequence of CARS assessments in dollar terms.

Response (4.7)
Claims payments for the first three years of the scheme reduced from $417 million to $207 million, a reduction of $180 million. This represents the expected savings from the reduction in payment on smaller claims that are finalised earlier that other claims. The reduction in claim payments is considerably less than the reduction in premiums, which over this period reduced by $405 million.

4.8 The Committee may wish to consider asking the MAA to provide it with statistics by way of comparison, for a 33 month period under the old scheme from 1996 to 1999, how many accident victims received compensation as a consequence of verdicts in the District Court and what was the total sum awarded.

Response (4.8)
In addressing the effectiveness indicator, the MAA has compared the first three years of the new scheme as at the end of September 2002 with the last three years of the old scheme at the same stage of development. The old scheme covers the period October 1996 to September 1999 as at September 2001. The statistics for both periods would include all verdicts.

4.9 The Committee may wish to know how the Senior Assessment Service is operating and in particular how many claims have to date been referred to and resolved by the Senior Assessment Service.

Response (4.9)
No cases have yet been referred to the Senior Assessor's Service. Exempt or exemptible matters may be referred to the Senior Assessors service for a determination, but this is not binding on either party. It is important to note that the parties must consent both to the referral and the proposed Senior Assessor.

The MAA is aware of three current Applications for General Assessment proceeding through CARS in which the claimant is a minor and the matter is clearly exemptible. The parties in each matter have been advised of the Senior Assessors Service provisions in the guidelines and their consent has been sought for the allocation of the matter to a Senior Assessor. If consent is received from the parties the matters are due to be allocated to Senior Assessors in late December 2002.

5. *Fairness*

5.1 The MAA have stated that the scheme is intended to provide a fair and equitable system for claimants, ensuring that 'the most seriously injured receive maximum compensation'. This misstates the objects of the Act. Section 5 of the Act defines the objective of the Act in terms of keeping premiums affordable, limiting compensation for non-economic loss in cases or relatively minor injuries, 'while preserving principles of full compensation for those with severe injuries involving ongoing impairment and disabilities'. Nowhere in the discussions or documents relating to the introduction to the 1999 Act is it suggested that the Act would result in any significant reduction in compensation for the seriously injured.

5.2 Previous reports to the Standing Committee from the Motor Accidents Authority tested fairness as against the claims brought by the severely brain injured. The Bar Association had objected to this approach on the basis that those with a serious brain injury would always be categorised in the 10% of most seriously injured.

5.3 It appears from the statistics that serious brain injury cases are taking longer to finalise. Payments to the seriously brain injured have decreased by 33%, with total payments for non-economic loss decreasing by over 60%. Although a greater percentage of all payments under the scheme are going to the seriously brain injured (29% as against 21% under the old scheme), the net effect is less compensation for the seriously brain injured.

5.4 The situation is even starker in relation to those with severe leg fractures. Rates of finalisation have dropped more dramatically, whilst total payments have dropped by 51%. Payments for NEL have dropped by 75% and payments for economic loss have dropped by over 60%.

Response (5.2 – 5.4)
See Response to Bar Association Question 1.3.

5.5 In short, this scheme does not provide comparable levels of compensation to the seriously brain injured or those with severe leg fractures. This is clear on the MAA's own figures for finalised claims in those two categories.

5.6 The MAA has concluded that it is 'fair' that total payments to those with brain injuries decrease by one third under the new scheme. The Committee might like to ask the MAA whether it is fair that payments for NEL under the new scheme for those with serious brain injury drop by 75%, that total payments to those with severe leg fractures drop by 51% or that total payments for NEL to those with severe leg fractures have dropped by 75%. Is this the intended consequence of the Act?

5.7 Measuring fairness entails consideration of whether injured persons are receiving the compensation to which they are properly entitled under the Act. The Association is concerned that in measuring the fairness of the scheme the MAA is not giving sufficient consideration to whether litigants are recovering their full entitlement to damages. The Committee might wish to inquire on what basis the MAA believes that the objects set out in Section 5(e) of the Act to preserve principles of full compensation for those with severe injuries are met by current indicators of dramatic falls in payments to those with severe brain injury and serious leg injuries.

6. *Efficiency*

6.1 The MAA states that an efficient CTP scheme is one where as much as possible of the premium dollar is returned to motor accident victims as compensation. The Bar Association agrees. The MAA's most recent report concludes that the scheme's efficiency has improved because 'claimant benefits' have increased from 59% to 64%. Claimants are certainly receiving a higher percentage of total payments made. However, total payments made have fallen by nearly 50%. Claimants are receiving 5% more of 50% less. Comparing the first 33 months of the new scheme as against the last 33 months of the old scheme, claimants are worse off to the tune of $155 million.

6.2 It would appear that the only efficiency improvements in the operation of the scheme have been at the expense of the injured and those lawyers trying to represent their legitimate entitlements to compensation. There has been no significant reduction in payments to the medical profession for providing expert opinions. Nor has there been any significant reductions in insurers' claims handling costs or in insurers' acquisition costs.

Response (6.2)
Insurers identify the claims handling costs and acquisition expenses in their premium filings. These costs have dropped by 15% or approximately $35 million.

Efficiency is based on prospective figures provided in insurers' premium filing. Insurers have identified that acquisition costs represent 13% of the premium. Based on the actual premium collected in year 1, acquisition costs equal $172.35 million.

Acquisition costs include

- computer systems to house customer databases, interfacing with RTA,
- identify individual policyholder premiums based on filings, relativities and bonus/malus schedules,
- send renewal notices to 3.5 million customers,
- establishment and maintenance costs for on-line green slips,
- mailing house costs,
- printing costs for production of letters and green slips,
- printing and design costs of brochures required to comply with federal privacy legislation, GST legislation,
- agents' commission,
- agents' training,
- training of counter staff,
- call centres.

As part of the review of their premium filings, the MAA tests the levels of acquisition expenses and claims handling costs included in their filings against returns provided by insurers to APRA to ensure comparability.

At a different level, the MAA also provides support to insurers introducing measures to lower expenses over the longer term. One such initiative is the establishment of e-green slips which will incur an initial set up cost but in the longer term will be more efficient and convenient for customers and cost effective for insurers and the scheme.

6.3 In light of the above facts the Committee might wish to ask the MAA for the following information:

- *the annual dollar value of the expenditure of CTP insurers on acquisition expenses;*
- *why it costs up to $180 million per year to acquire customers when the Government makes purchase of the product compulsory for registration of a vehicle;*
- *whether the MAA can provide a more detailed breakdown as to where insurers' acquisition costs go;*
- *whether the MAA has considered if any greater efficiency can be obtained to reduce insurers' acquisition expenses;*
- *what steps MAA is taking to ensure greater efficiency and reduction in the cost of insurers' acquisition expenses;*
- *what progress the MAA has made with regulation of medical expenses in relation to both reports from treating doctors and medico-legal experts; and*
- *to what extent the new scheme has resulted in any reduction in the expenditure of CTP insurers on obtaining reports from treating doctors and medico-legal reports.*

6.4 The MAA advise that they will be commissioning Professor Ted Wright from the University of Newcastle to perform a full evaluation of the effect of the Legal Costs Regulations. The Committee may wish to know whether the study has been commissioned and if so, when the study is due for completion. The Committee may also wish to know further information concerning surveillance is available such as:

- *whether the MAA can provide a breakdown in insurers' investigation costs between investigations into liability and surveillance of claimants;*
- *whether the MAA has any concerns about and guidelines regulating the use of surveillance; and*

- *whether the MAA has given any consideration to its obligations under privacy and anti-stalking legislation with regards to surveillance carried out with claims where it is responsible for payment for that surveillance.*

Response (6.4)
The legal costs study being conducted by Professor Ted Wright will be finalised in April 2003.

The MAA does not have a breakdown of insurers' expenditure costs.

The MAA has verified that investigators used by insurers are licensed and has audited insurers' compliance with respect to Claims Handling Guideline requirements for factual investigations. Insurers have established investigator guidelines and Codes of Conduct, contractual obligations and programs to monitor and assess the performance of investigators. Insurers and its investigators are subject to State and Federal Privacy legislation and Privacy Commissions.

7. *Medical Assessment Service (MAS)*

7.1 The current operation of the scheme appears to be plagued by delays at MAS. There are complaints that it is taking up to nine months to obtain a medical assessment on the 10% whole person impairment issue. Although the MAA was aware of and acknowledged this problem as early as the MAAS Bulletin of March 2002, there continue to be extensive delays. However no optimal time frame for completion of assessment of a medical dispute as to whole person impairment, assuming that examination is only required in one specialty, has been decided. Nor have any performance standards been set for MAS (ie. 70%, 80% and 90% of assessments completed within set time frames).

7.2 The Committee may wish to inquire into the current state of MAS delays and possibly set an optimal time frame for completion of assessment of a medical dispute as to whole person assessment and set performance standards.

See Response 1 to Australian Plaintiff Lawyers Association

8. *Claims Assessment and Resolution Service (CARS)*

Exemptions

8.1 Section 92 of the Act allows the Principal Claims Assessor (PCA) to exempt claims from being processed through CARS. An exemption entitles injured persons to have their case determined by a Court rather than a CARS assessor. An exemption also carries with it exemption from the costs regulations. The Claims Assessment Guidelines provide for both mandatory and discretionary grounds for exemption.

8.2 As formulated, the guidelines allow for discretionary exemptions in cases where:

- *a material witness resides outside the jurisdiction;*
- *a party other than a CTP is a Defendant to the claim; and*
- *where the circumstances of the case involve complex and unusual issues on causation or assessment of damages.*

8.3 As at 31 March 2002, 593 cases had been exempted. Only one case appears to have been exempted on discretionary grounds.

8.4 It is noted that the PCA has rejected applications for exemption where the Plaintiff or material witnesses reside in Brisbane and Melbourne. An insurer's application for exemption in order to allow a CTP claim to be heard concurrently with another litigated personal injury claim by the same claimant was also rejected.

8.5 The Bar Association is concerned that an unduly restrictive approach is being applied to applications for exemption on discretionary grounds. The Bar Association is also concerned about the lack of information that has to date been provided in respect of the Scheme. No information has been provided to date about how many applications for exemption have been made, how many have been granted and on what grounds. Nor has any information been provided about the number of applications that have been made for discretionary exemption, on what grounds discretionary exemptions have been sought and how many such exemptions have been granted. The Committee may wish to ask the MAA to provide further information about the applications.

Exemptions (8.1 – 8.5)

Total Exemptions

In total there have been approximately 1,365 Applications for Exemption finalised to date, of which approximately 987 (72%) were Exempted and 344 (25%) were not Exempted, with 5 Settled (1%) and 29 Withdrawn (2%). This total is made up of the three different types of Application, which are:

- Section 92(1)(a) Mandatory Exemptions 1196 (88%)
- Section 92(1)(b) Discretionary Exemptions 61 (11%)
- Dual Applications on both grounds 13 (1%)
- Total Exemption Applications 1365 (100%)

Mandatory Exemptions

There have been approximately 1291 finalised Applications for Mandatory Exemption under Section 92(1)(a) on one of the four grounds listed in Clause 4.1 of the Claims Assessment Guidelines. In total approximately 948 (73%) of such Applications were Exempted, and 312 (24%) were not Exempted, with 5 Settled (1%) and 24 Withdrawn (2%).

Of those 948 that were Exempted, some have more than one grounds for the determination, and some have been determined on the basis of one of the discretionary factors to be considered under Clause 4.23 of the Guidelines and Section 92(1)(b), rather than the ground on which the application may originally have been sought under Section 92(1)(a). There are 993 reasons given for the 948 finalised Mandatory Exemptions that were exempted, which were as follows:

- Clause 4.1.1 Denial of Liability 716
- Clause 4.1.2 Contributory negligence of over 25% 10
- Clause 4.1.3 False or Misleading Claim 2
- Clause 4.1.4 Lack of Legal Capacity 124
- 4.23.1 - Heads of Damage not agreed 0
- 4.23.2 - Complex Legal Issues 1
- 4.23.3 - Complex Factual issues 1
- 4.23.4 - Complex Quantum Issues 4
- 4.23.5 - NEL and complex issues 0
- 4.23.6 - Complex Causation Issues 1
- 4.23.7 - Injuries not stabilised in 3 years 2

o 4.23.8 - Indemnity/Insurance Issues	0
o 4.23.9 - Deemed Denial 81(3)	123
o 4.23.10 - Witness outside NSW	0
o 4.23.10 - Claimant outside NSW	3
o 4.23.11 - Non CTP parties	1
o 4.23 - Other Reasons	5
o Total 92(1)(a) Reasons	993

Discretionary Exemptions and Combined Applications

Overall there have been approximately 61 finalised Applications for Discretionary Exemption under Section 92(1)(b) and 13 finalised Combined Applications under both Section 92(1)(a) and Section 92(1)(b), totaling 74 such applications in this category. In total 39 (53%) of such Combined Applications were Exempted, and 32 (43%) were not Exempted, with 0 Settled (0%) and 3 Withdrawn (4%).

Of those 39 that were Exempted the reasons were often as a result of one or more of the factors outlined in Clause 4.23 of the Guidelines, or as a result of one of the mandatory exemption grounds from Clause 4.1 of the Guidelines under Section 92(1)(a) and the breakdown of the reasons given are as follows:

o 4.23.1 - Heads of Damage not agreed	0
o 4.23.2 - Complex Legal Issues	2
o 4.23.3 - Complex Factual issues	2
o 4.23.4 - Complex Quantum Issues	2
o 4.23.5 - NEL and complex issues	0
o 4.23.6 - Complex Causation Issues	1
o 4.23.7 - Injuries not stabilised in 3 years	5
o 4.23.8 - Indemnity/Insurance Issues	0
o 4.23.9 - Deemed Denial 81(3)	9
o 4.23.10 - Witness outside NSW	2
o 4.23.10 - Claimant outside NSW	8
o 4.23.11 - Non CTP parties	1
o 4.23 - Other Reasons	0
o Clause 4.1.1 Denial of Liability	12
o Clause 4.1.2 Contributory neg. of over 25%	0
o Clause 4.1.3 False or Misleading Claim	0
o Clause 4.1.4 Lack of Legal Capacity	11
o Total 92(1)(b) Reasons	55

Assessment

8.6 The MAA initially appointed sixteen assessors, of who fourteen are still willing to perform assessment work. Of those fourteen, three were designated key assessors for the purpose of accumulating early experience with the assessment process. The panel of three key assessors has been expanded so that there are now additional assessors performing assessments. However, not all of the originally appointed assessors have yet been given work.

8.7 The legal profession was consulted as to the appointment of assessors and the appointment of the three key assessors.

8.8 Further, the remuneration paid to assessors has not increased over the three year period of the operation of the scheme. Some assessments are proving lengthy, with multiple preliminary conferences and large numbers of medical reports to be read. The Committee might like to ask the MAA whether it has reviewed fees paid to assessors in light of the experience in operating CARS and whether the MAA propose to increase assessors' remuneration in accordance with CPI increases.

Assessment (8.6 – 8.8)

Response
The number of Assessors on the panel who have been allocated matters has expanded, and will continue to expand, as the number of applications that are ready to be allocated for assessment increases. This increase in applications is now occurring, with more applications for General Assessment having been lodged with CARS in the eight weeks since 1 October 2002 (over 380) than were lodged in the prior initial three years of the scheme (363).

To date 8 of the original 16 assessors have been allocated matters, including the three key Assessors who are members of the Senior Assessors Service, as well as five other assessors.

The remaining Assessors on the appointed panel who have not as yet been allocated any matters have been invited to attend a CARS Assessors conference on Wednesday 27 November 2002, with a view to allocating matters to them for assessment thereafter.

The fee structure originally set for CARS Assessments has been reviewed. The amount allowed for a Preliminary Assessment and Preliminary Telephone Conference, which represents the majority of work that has been undertaken by the Assessors to date, has been increased from $300 to $400.

It is anticipated that the next Review of CARS Assessors Fees will occur in April 2003 when the Assessors Panel is likely to again be reviewed given the current increase in Applications to CARS.

Claims Advisory Service

8.9 The MAA states that the Claims Advisory Service does not provide any 'legal advice'. The MAA has stated 'most callers are seeking information about how to make a claim and what may be covered under the scheme'.

8.10 A continuing difficulty with the MAA's position in relation to the Claims Advisory Service not providing legal advice is that information about what is covered under the scheme must involve the provision of legal advice. To advise a claimant whether or not they may be entitled to recover damages for the provision of voluntary domestic assistance is the provision of legal advice. To advise a claimant as to their entitlement to cover out of pocket expenses, economic loss and general damages without providing additional information about the entitlement to recover damages for loss of superannuation benefits and the provision of voluntary domestic assistance, may be thought to be negligent advice.

8.11 The Association is concerned with the operation of the Service and submits that the Committee should seek clarification as to whether the Service provides advice as to the damages the claimants may be entitled to recover or whether it has advised claimants about their entitlement to recover lost wages. The Association is also concerned about the fact that the Service may be providing advice about the entitlement to recover lost wages without providing advice about the entitlement to recover lost superannuation benefits. Such advice constitutes negligent advice.

Claims Advisory Service (8.9 – 8.11)

Response
The Claims Advisory Service does not offer advice on whether a claimant has an entitlement to any particular head of damage. It has no role in establishing whether an entitlement exists. Clients of the service are advised to discuss their entitlements with the insurer, or to seek legal advice if they are not confident of their ability to manage matters themselves.

The service does not quantify losses and would suggest that any client seeking assistance in quantification should consult a suitably qualified legal practitioner.

Where a client seeks assistance in settling an amount of damages, and does not want to seek legal advice, the Advisory Service recommends that the client seek to have the matter assessed by the Claims Assessment and Resolution Service. This provides the client with the benefit of guidance by a legally qualified assessor and an independent assessment of the true value of the claim.

The Claims Advisory Service does not give legal advice. All replies to requests for legal advice are prefaced by the statement that we are unable to provide legal advice and if this is the advice sought, then the client should see a lawyer.

The Service does not give any specific information about the components of any head of damage including lost earnings.

It may be of interest to the Committee that the Claims Advisory Service has taken approximately 40,500 calls to date (November 2002) since its inception in 1999. Of these calls nearly 5,000 have been from legal practitioners seeking procedural advice on the scheme or assistance with claims. There are many instances where practitioners contact the service seeking legal advice or guidance in managing their claims. In these instances procedural advice is offered and is usually gratefully received. Many members of the profession are glad of a service which can answer questions about the day to day management of the claims. Some are disappointed that there is no legal advice offered. These people are referred to the relevant professional association, either the Law Society or the Bar Association for advice.

The bulk of the work done by the Advisory Service is assisting in make new claims, identifying the vehicle at fault, providing claim forms or referring to insurers for forms, giving a general overview of the scheme and offering to explain any procedural issues arising during the course of the claim.

9. *Insurer Compliance*

9.1 *The MAA is charged with ensuring that the insurers under the scheme comply with various obligations imposed on them by the Act, Regulations and Guidelines. To this end the MAA has appointed a Compliance Officer.*

9.2 *In its review of the Motor Accidents Compensation Act recently tabled in Parliament, the MAA has indicated that significant delays are occurring in the scheme following the insurer making its first offer of settlement. Most of those offers of settlement make no allowance for non-economic loss. A plaintiff's solicitor needs to ensure that there is no entitlement to non-economic loss before being in a position to respond by engaging in settlement negotiations. Delays in MAS are preventing plaintiffs' solicitors from rapidly determining whether there is or is not an entitlement to NEL.*

9.3 It is not reasonable to expect a solicitor to have the necessary medical expertise to determine whether a claimant is entitled to recover non-economic loss. In most cases it will be prudent for the solicitor to obtain medical evidence before advising their client that they have no entitlement to NEL. Delays in MAS contribute to delays in settlement.

9.4 Further, it is easy for insurers to make a low opening offer. The legislative requirement is that the opening offer be 'reasonable'. The Committee might like to inquire whether the MAA has performed any qualitative assessment as to how 'reasonable' the opening offers are.

Response (9.4)
Please refer to response to APLA Question 3.

9.5 The MAA has advised that a sample indicates that 12% of cases have a reserve for non-economic loss. The Committee might like information concerning the nature of these offers, for example:

- *the percentage of initial offers contain a component for non-economic loss;*
- *details of any audits the Compliance Officer has conducted to date; and*
- *whether the work of the Compliance Officer has raised any concerns about insurer compliance with obligations.*

Response (9.5)
The percentage of initial offers containing a component for non-economic loss is not known. See response to Bar Association Question in 9.4.

Please see response to the Committee Question 1.1 in relation to audits the Compliance Branch has conducted. Please also see the Draft Claims Handling Compliance Audit Report.

9.6 Section 73 of the MACA requires the claimant to submit a claim form within six months of the date of accident. If the claim form is submitted later than six months the claimant is required to provide a full and satisfactory explanation to the insurer. If the insurer rejects this explanation, a CARS assessor can determine whether the application is full and satisfactory. The Committee may wish to obtain further information concerning these applications, such as:

- *the number of applications involving 'full and satisfactory' explanations for late claims determined by CARS assessors to date;*
- *the percentage of cases in which the explanation was challenged by the insurer and found by the assessor to be a 'full and satisfactory' explanation;*
- *whether the MAA audits the performance of insurers who are making reasonable offers of settlement within the specified time frame as required by Section 82; and*
- *the percentage of insurers' first 'reasonable' offers that contain an allowance for non-economic loss*

Response (9.6)
A total of 75 applications relating to disputes concerning section 73 late claims were lodged with the Claims Assessment and Resolution Service from 5 October 1999 to 14 November 2002.

Of these disputes, 46 have been finalised (61% of all 75 disputes lodged). The breakdown of the outcomes of those finalised disputes is as follows;

- A late claim may not be made - 4 (9%)

• A late claim may be made -	25	(54%)
• Dispute Withdrawn -	9	(20%)
• Matter Settled -	6	(13%)
• Application Rejected -	2	(4%)
• Total Section 73 disputes finalised	46	(100%)

In addition, there are 29 disputes pending (39% of all claims lodged) that have not yet been finalised. Of these unresolved disputes 12 have been allocated to an Assessor for determination, and 17 matters are yet to be allocated as they are still only in the Application and Reply stages.

In relation to offers of settlement and MAA audits of insurers, please refer to response to APLA Question 3.

10. *Costs Regulations*

10.1 The 1999 Act regulates the recoverable party/party legal costs in cases that are not otherwise exempt from CARS. Recoverable costs are based partly on a fee for service and partly linked to the total sum recovered. The MAA has agreed in principle that it was appropriate to index those fixed legal costs. It is accepted that at the same time it would be appropriate to index the thresholds.

10.2 The Regulations currently fix the cost of a solicitor or barrister attending an assessment conference under Section 104 of the Act at $400. That amount has not been increased since the Act was introduced in October 1999. The Committee might like to know when the MAA intends to index the fixed fees recoverable under the Act.

Response (10.1 –10.2)
As indicated in the Scheme Review report, the MAA considers it is appropriate that the cost scales be reviewed and will consult with the industry, legal and medical profession in undertaking that review.

10.3 In response to questions on this subject for last year's Standing Committee Review, the MAA stated that it had engaged the Justice Policy Research Centre to review the impact of Legal Costs Regulations. The Committee may like information about the Centre's report and what action has the MAA has taken as a consequence of receipt of that review.

Response (10.3)
See Response to Standing Committee Question 1.5.

See Response to Bar Association Question 6.4.

11. *HIH – CIC/FAI*

11.1 On 16 March 2001 the HIH Group was placed in provisional liquidation. As a consequence, two of the CTP insurers under the scheme owned by HIH (CIC and FAI) were also placed in provisional liquidation. The MAA thereupon exercised its statutory responsibilities and had the Nominal Defendant take over liability for claims brought against policies issued by CIC and FAI prior to 1 January 2001.

11.2 The MAA's actions raise a number of important questions. For example, what does the MAA estimate its current liability to be for the CIC/FAI tail and how is the MAA funding the payment of tail claims ? The Committee may like the MAA to provide information on the anticipated impact funding the CIC/FAI tail will

have on premiums and profits including any performance standards imposed by the management agreement with Allianz.

Response (11.2)
The discounted liability for the run off claims to be settled plus claims handling expenses less reinsurance proceeds has been estimated by the actuaries Taylor Fry at $423.8 million, based on actuals up to 31 December 2001 and estimates to 30 June 2002. The review of these estimates by the Government Actuary found this to be acceptable. This amount has been shown in MAA's accounts in the 2001-02 financial year as Provision for Outstanding Nominal Defendant Claims (Current $152.2 million and non-current $271.6 million).

The NSW Treasury funds the MAA for the above disbursements against claims made by MAA. The Treasury continues to fund the claims and other ancillary payments out of the Insurance Protection Tax.

The *Insurance Protection Tax Act 2001* Act specifically provides that insurers are not to include the tax in premiums. The MAA monitors this in premium filings and guarantees there will be no impact on CTP premiums.

11.3 In response to questions submitted to the Standing Committee for the 2001 review of the MAA, the Authority stated that as of December 2001, 'Allianz has advised that all accounts (for payments to service providers on the CIC/FAI tail), are up to date'. The Committee may wish to ask the MAA for information about the timeliness of the payment of accounts over the past twelve months.

Response (11.3)
The MAA made the following payments to claimants and service providers (including legal expenses):

- April to June 2001 period $32.4 million,
- during 2001-02 financial year $130.2 million,
- for the period 1 July to 14 October 2002 - $31.57 million.

There was an initial start up delay due to uncertainties about the funding plus dislocation due to office relocation and staffing shortages. During the last 12 months the process was much smoother and payment status is up-to-date for both claims and service provider expenses.

Last year a temporary bottleneck was experienced because of the pre-16 March 2001 legal and service provider expense claims. MAA after consultation with the HIH Liquidator agreed in October 2001 to pay these pre-liquidation matters.

- Delays of 60 days or more (commencing November 2001) were experienced by late submission of the accounts in correct form with deeds by lawyers and service providers. Also this process required verification of earlier payments to the providers to avoid double payment as some invoices concerned services provided 7 years back.

Delays of 30 days or more in payment of service providers occurred for the following reasons:

- Conversion of computer systems to POLISY to get better reporting and rationalise with Allianz's system,
- Staffing problems as the HIH run off had a 30% staff turnover,
- Dislocation due to the shifting of office from old premises to Allianz building,
- Submission of incorrect invoices and without deeds, where needed,

- Double-billing by the Barrister directly and again through the Solicitors,
- Inadequacy of accounting systems in Solicitor firms to raise invoices in correct format.

12. *MAA Advertising/Sponsorship*

12.1 The MAA appears to be embarking on a program as a major sponsor of rugby league. In addition to a $500,000 per year sleeve sponsorship of the South Sydney Rugby League team, the MAA has this year gone on to sponsor a number of other league events.

12.2 The Committee might wish to seek information as to the cost and manner of sponsorship/advertising this year. In particular, the breakdown of specific events for which sponsorship was provided and the relative cost of sponsorship, field signage, hospitality and so forth. The Committee may also like to inquire whether there has been any research as to the effectiveness of rugby league sponsorship in promoting the 'Arrive Alive' safety message.

In early 2002 the MAA entered a Partnership with South Sydney District Rugby League Club. The partnership provides the MAA with access to the team players to deliver the MAA's road safety messages to its key target audience, young males between the ages of 17 and 25. Players undertake celebrity presentations across the State, media interview appearances and participate in state-wide road safety initiatives. A video concerning the MAA's sponsorship of South Sydney has been included as Attachment 9 (Appendix 9).

The Partnership also provides branding opportunities that include the placement of an MAA road safety message on the official team apparel. The MAA Rabbitoh partnership is promoted under the road safety campaign title of Arrive alive.

In addition, the MAA has taken the opportunity to sponsor two other league events during 2002 including the Australia v Great Britain Test Match held in Sydney and the 2002 Telstra Premiership Finals Series

The costs for these two events were as follows:

	Test Match	Finals Series
Direct Sponsorship Costs	50,000	210,000
Operational Costs	85,000 ($20,000 subsidised public transport costs)	260,000 (includes subsidised public transport and media placement)

The purpose of these sponsorships was to capitalise on the MAA's sponsorship with South Sydney, and to promote the MAA's road safety role and road safety messages with a broad based audience. The sponsorship of both events included field advertising and road safety message promotion opportunities such as providing subsidised public transport, and using the teams for media promotion opportunities. Sponsorship of the Finals series provided the MAA with a unique opportunity at minimal cost to use the captains of all teams in a road safety television advertisement aired during the screening of the matches.

Evaluations of the sponsorships are currently being undertaken. However, preliminary advice indicates that the events have been effective in increasing awareness of the MAA's road safety agenda and messages. For example the Australian viewing audience for the Grand Final was more than 3.5 million.

13. *Insurer Profits*

13.1 In response to a question from the Bar Association for last year's Standing Committee review, the MAA estimated that the likely percentage profit to be made by CTP licensed insurers on the first year of operation of the scheme would be 5% of gross premiums. The Committee might like to know whether the MAA remains of the view that the likely insurer profit on the first premium collection year under the new scheme will be 5%? If not, why the change?

13.2 The Association notes that reference is made to the table supplied by the MAA and printed at page 93 of the Standing Committee's February 2002 report. The table contains a projected cash flow for premium collections during the first year of operation of the scheme. Those projections budget for payouts for bulk billing and to claimants of $245 million by 30 September 2002. The Committee may wish to know the total amount paid for bulk billing and claim payments from the first premium writing year under the new scheme as at 30 September 2002 and the reason why the scheme not performing to budget expectations.

Response (13.1 & 13.2)
The MAA has commissioned Taylor Fry actuaries to update the estimate of profit and will provide the committee with a detailed report on profit.

14. *Insurance Gap Between CTP and Public Liability*

14.1 The Bar Association has previously forwarded to the Motor Accidents Authority both on an informal and formal level submissions regarding an emerging gap between public liability and CTP insurance. A copy of those submissions is annexed for the reference of the Standing Committee on Law and Justice.

14.2 In short, until 1 January 1996, all accidents that arose out of the use or operation of a motor vehicle were covered by the CTP policy. However, with amendments to the definition of injury contained in the Motor Accidents Act 1988, the CTP policy only answered claims for injury that arose out of the use or operation of the vehicle and involved either the driving of the vehicle, a collision with the vehicle, the vehicle running out of control or a defect in the vehicle. It thus became possible for there to be accidents arising out of the use or operation of a vehicle which should not fall within the scope of the Motor Accidents Act 1988 or its successor, the Motor Accidents Compensation Act 1999.

14.3 Unfortunately, public liability insurance has not moved to cover this gap. Many public liability insurance policies still retain a broad exclusion for any accident arising out of the use or operation of a motor vehicle.

14.4 In circumstances where an accident occurred on or around a motor vehicle arising out of the use or operation of that vehicle but not falling within the definition of injury, the Defendant could find themselves uninsured and the injured Plaintiff could find themselves uncompensated if the Defendant proved impecunious.

14.5 There is no doubt widespread public ignorance as to the existence of this gap. Members of the public would be unaware that they are not fully insured, despite having both CTP and public liability policies. Commercial organisations, especially those that use fleets of motor vehicles, may be in an even riskier position.

14.6 The Association submits that it is undesirable to have a gap between CTP and public liability policies for accidents occurring on or around a motor vehicle not falling within the statutory definition of injury. The Association is of the view that the gap should be closed by the MAA.

Response:
This matter was raised at the May 2002 meeting of the Motor Accidents Council. The MAA, through the Motor Accidents Insurers Standing Committee, has referred the matter to the Insurance Council of Australia (ICA). The MAA understands that the issue is being examined by the ICA's Liability Working Party.

Chapter 3 Questions without Notice

Transcript of Public Hearing held on Monday 2 December 2002

Mr DAVID BOWEN, General Manager, Motor Accidents Authority, Level 22, 580 George Street, Sydney,

Ms CONCETTA RIZZO, Manager, Insurance Division, Motor Accidents Authority, Level 22, 580 George Street, Sydney, and

Dr STEPHEN JOSEPH CLOUGH, Principal Compliance Officer, Motor Accidents Authority, Level 22, 580 George Street, Sydney, affirmed and examined:

Mr RICHARD JOHN GRELLMAN, Chair, Motor Accidents Authority, Level 22, 580 George Street, Sydney, sworn and examined:

CHAIR: Could you briefly outline your qualifications and experience as they are relevant to the terms of reference for this inquiry?

Mr BOWEN: I have responsibility for the management of the Motor Accidents Authority and as such for the implementation of the scheme introduced by the Motor Accidents Compensation Act.

Mr GRELLMAN: My relevance to the inquiry is as chairman of the board of both the authority and the Motor Accidents Council. It acts in a governing capacity and as chairman I have a role to ensure that the board remains focused on the important issues regarding the scheme.

Ms RIZZO: I am responsible for significant aspects of the implementation of the Act and I am responsible directly to the general manager.

Dr CLOUGH: In my role as the principal compliance officer I am responsible for ensuring that insurers are complying with their statutory requirements under the CTP scheme.

CHAIR: Mr Bowen, I understand that you have a written submission before the Committee. Is it your wish that that submission be included as part of your sworn evidence?

Mr BOWEN: Yes, that is correct, Mr Chairman.

CHAIR: Mr Grellman, I think it is agreed that you proceed first to make a short statement to the Committee as you have to leave somewhat early.

Mr GRELLMAN: Thank you, Chairman. Firstly, might I apologise to you and the Committee for my inability to stay for the entire period of the hearing. I do have a clash courtesy of a longstanding commitment to be in another place attending a board meeting. My opening comments will be brief. I thought I would firstly make some comments regarding the governance of the authority. As I have said, I chair the board. It is a board of six people. Each member of the board has no alignment with any service providers or stakeholders in the scheme. So it is an independent board. The board was consistent for the first three years of the scheme with a change that has only just occurred—one change. It is that Alison Ray has stepped down after 10 years service under the various Acts governing the scheme and has been replaced by Mr Alan Hunt. Alison Ray was the deputy chairperson and that position has been taken by Penny Le Couteur, who is present here today as an observer.

The board of directors meets bimonthly but a number of special board meetings are called from time to time. As recently as last Friday we had the need to bring the board together. So it probably meets about a dozen times a year. It is focused on the integrity of the scheme; the way the scheme is operating. It is clear on its role as a board to effectively govern and hold management accountable for their actions. It is therefore clear to the board that it is management that do most of the day-to-day work in terms of the monitoring and management of the scheme. In addition to the board, from the governance point of view, we have the Motor Accidents Council. That is made up of eight independent individuals. The general manager, the chairperson and the deputy chair also sit on the council.

I will not go through the names of the individual council members; it probably will not help much. But I will mention that we have two representatives from the insurance industry, two health practitioners, a motorists representative, an injured persons representative, two legal practitioners and a consumer representative. So you can see that the idea of the council is that we have a group of people who broadly represent either service providers or members of the public who interface with the scheme in one capacity or another. As such, it is a very good forum for the authority to keep key stakeholders and service providers apprised of developments in the scheme. It is an advisory body, an information receiving body on behalf of their various constituents. It has, therefore, no real authority but it is a convenient and very hard-working group of people who often get involved in specific issues that might need dialogue where different and competing points of view can benefit from open discussion. Also, through the members of the council, it is a very convenient way to convey information to their constituents on the way the scheme is performing.

The final comment on governance is that we have a board audit committee which is chaired by Penny Le Couteur, the deputy chair of the board. This committee looks primarily at financial and control issues in somewhat more detail than the board is able to confront.

The main qualification that I would like to put before the Committee—it will read very similar to what was said last year—is that this scheme that is continuing to develop. Three years into a long-tailed scheme is still a little early to be drawing any definitive conclusions. If last year we were dealing with a scheme in its early adolescence, I think we would probably have to say that we are still in our teenage years. There are characteristics that are identifiable but it is still developing and it may well be a year—perhaps even a little longer—before we can be sure of the way the scheme is performing.

Having said that, there are some early pointers in terms of scheme performance. David and his colleagues will be taking you into more detail in that regard shortly. Suffice to say, as the authority continues to form its own view as to whether the scheme is performing properly—you will recall that we do so by looking under four headings of affordability, effectiveness, fairness and efficiency—we remain content that the scheme appears to be operating well. We are certainly not complacent. There is a philosophical change of approach being adopted by us as a regulator in relation to this scheme compared with perhaps the way we might have operated as a regulator under the old scheme. We attempt to form an early view as to whether or not any issues might be developing in the scheme that require attention and move on those before the event rather than waiting until all the statistical and actuarial data confirm that there is something happening and then try to fix it when the trend has well and truly become entrenched.

In conclusion, if I could simply invite you to look forward to what I hope is an encouraging report. There certainly is no complacency within the MAA. We are watching it very carefully. But sitting here today, we do believe that all of the key indicators are pointing to a statutory scheme that is performing as well as we could have hoped at this point in its life.

CHAIR: Just a moment ago you said in general terms that in your view the scheme is operating well. On the basis of your background, professional expertise and the role you play chairing the Motor Accidents Council, what do you mean in slightly more detail about the scheme operating well? I assume you mean it is operating on an actuarially sound basis but you would add some words of caution given that it is, as you say, a long-tailed scheme?

Mr GRELLMAN: Yes. The immediate pointer which we will be talking about in more detail this afternoon is the price that the underwriters feel comfortable to write their business at. The price of course is a reflection in one line of all the stresses and strains of a scheme like this. It reflects the costs of the capital needed to support the business in their own balance sheet. It reflects their own actuarial forecasts of the way the scheme is producing claims that will ultimately have to be met at some future point in time. On a simple point, the pricing that the underwriting community is prepared to write the product is holding and over the life of the new scheme it has been heading down—not markedly or materially, but heading down.

We take the view that the underwriting community—because it is privately underwritten—needs to get an adequate return on their capital. Otherwise they are not going to write the business, and if they do not write it then we have a whole different scheme to think about. The fact that prices have been easing back I think it is a positive sign. In fairness to the underwriting community, I would have to say that, as Concetta will tell you in more detail, only about 15 per cent of claims so far have actually gone through to conclusion—from year one, something in that vicinity, about 85 cent open claims from the first year.

Ms RIZZO: Put in terms of payment, about 20 per cent of payments have gone through.

Mr GRELLMAN: So there are still 80 per cent of incidents in the first year yet to be resolved and a cheque drawn. That is where the actuarial forecast comes in, but the underwriting community are taking a realistic view about that future exposure, and that is holding prices.

CHAIR: Mr Bowen, are you wishing to table the insurer profit report at this point?

Mr BOWEN: Yes. I have that report. I was going to comment on it in my opening comments and then, if the Committee wishes, Ms Rizzo can give a broader presentation. We can table it and distribute it and when Mr Grellman is finished we can go on with it in a little bit more detail.

CHAIR: Yes, we will follow that course, thank you.

Insurer profit report tabled.

Mr Grellman, you will recall that in past years we have asked you some questions about the number of insurers writing this type of business. I take it that the number of insurers is stable? It is as it was last year?

Mr GRELLMAN: Yes.

CHAIR: Some of those insurers account for a large part of the business that is written? Is there any prospect, in your view, of any new competitors, new insurers, entering the field?

Mr GRELLMAN: It remains an aspiration. At the moment, though, to be realistic, given the relative uncertainty facing the underwriting community globally on the back of a whole range of issues, firstly, and secondly, given that this scheme is relatively young and new players would want to be as satisfied as they could be that there was actual as opposed to perceived stability, the likelihood of attracting a new underwriter would be somewhat remote just at the moment. But it would be very healthy for the scheme if we could attract one or more fresh underwriters to take up part of the risk.

CHAIR: From an insurer's point of view would the long-tailed nature of business be an unattractive feature of this class of insurance?

Mr GRELLMAN: I am probably not the best person to comment on that but I think the underwriting community look at the sort of return they can get on the capital employed. That is one of the key drivers to determine whether or not they are prepared to persevere, and short-tailed business has a different capital dynamic to long-tailed. As long as they can get a reasonable return on capital they are probably content to remain. My own impression is that this would probably be regarded by those writing the business at the moment,

albeit with an air of uncertainty because of the immaturity of the scheme, as a reasonably attractive part of their book. But it would be a good question to ask an underwriter. They may have a different point of view.

CHAIR: As you are aware, Mr Bowen has tabled the insurer profit report. We will be inviting him shortly to speak to that and to other matters. Is there anything you would wish to say about that? I assume you are aware of its contents?

Mr GRELLMAN: Yes, I am, and I mentioned as part of my opening address that there was a special board meeting last Friday. It was to look at the draft paper that was coming to this Committee. So, I am familiar with its contents and I am content that the paper as now tabled is a fair reflection of our view of the scheme. Again, you may find that the insurers have a slightly different view on some aspects, but we are exercising our independent role as regulators to come to our own view as to how we think profits have been unfolding (in retrospect).

CHAIR: No doubt we will be asking other questions following what Mr Bowen has to say to us about the content of the insurer profit report. Is there anything additional you would like to say at this stage?

Mr GRELLMAN: No, thank you.

CHAIR: Mr Grellman, is there anything you would like to add for the benefit of the Committee regarding the role of the Motor Accidents Council?

Mr GRELLMAN: I think I have said all I wanted to say. Given the opportunity to expand on one aspect, I will take that opportunity. That is, in light of the fact that the council tries to do to ensure it has as broad an understanding of the scheme as possible, we have taken to having council meetings in different locations from time to time. For example, we have met out at the Royal Ryde Rehabilitation Centre at Ryde. That is an opportunity for us to take the council into an arena where actual services are being provided following a motor vehicle incident and we intend to continue that practice going forward. I think the council probably finds the occasional change of venue quite helpful and practical. Save for that, I do not think I need to say much more about the council.

CHAIR: From the point of view of a model of governance, is the council working effectively vis-a-vis the authority itself?

Mr GRELLMAN: I think it is a very effective model. We have a situation with a board that can govern the scheme without any accusations of vested interest. There is no need for directors to leave a hat on the rack outside the boardroom. They come in there quite independent of the scheme and the service providers, but to have a council in an advisory capacity to use as a pipeline back to their own constituents and through the same pipeline to hear what they are saying to us and through us to the board, I think is a very good governance model. When it was identified for this scheme I think it was somewhat unique in Australia and three years in I would have to say it is showing all the signs of being a very good governance model which I would be recommending to any other statutory schemes that are thinking about their own governance.

(Mr Grellman withdrew)

CHAIR: Mr Bowen, I invite you to make an opening statement to the Committee regarding general issues and also the insurer profit report that has just been tabled this afternoon.

Mr BOWEN: Thank you, Mr Chairman. We welcome the opportunity to again present a submission and answer questions on the operation of the scheme. Each year we are daunted as we go into this process but we find it a very valuable one to synthesise all the various bits of information and put them down in a collected form. In addition to the reports that have been tabled today I draw the attention of the Committee—I am sure all the members are aware—to the fact that the Minister recently tabled a review of the scheme in accordance with the provisions of the Act. That review was wide-ranging. It encompassed all the provisions. It looked at

licensing, insurance, claims and benefits, so it was much more wide-ranging than perhaps the more detailed presentation to this Committee but it forms part of the information on the scheme's operation at present.

In brief terms, the report indicates, in the view of the Motor Accidents Authority [MAA] that the scheme is operating within the cost assumptions that underpin the reforms that were introduced in 1999, and generally positively as against the scheme's performance indicators. One of the interesting things is the way matters are continuing to trend in a positive direction. There are a few counter-indicators but we will go into the details of those when we get into the matters of the report against the report indicators. The profit report is now tabled. My apologies that it was late. We were still having meetings on this as late as Friday, including with some of the stakeholders, to try to make sure that the report covered all the matters on which we might get questions. Ms Rizzo will be available to go through the details of that, including some of the tables. I might just make some comments by way of an overview of it.

Some necessary caveats are called for when reading the report. The first is that the assessment of profit is still very sensitive to the undeveloped assessment processes, to future court decisions and the way that those sorts of matters may lead to increased superimposed inflation in the scheme. It is necessary to recognise the possibility that in some years hence when we eventually look at how year one of the scheme performed, it may be very different from today's estimate, which is based on current information. As Ms Rizzo indicated, the payments today represent only 20 per cent of claimed payments for year one. That is based on an accident year. On year one as an underwriting year they represent only 9 per cent of the estimated payments. You will see in the table in the profit report there is a reference to 9 per cent of estimated payments based on the underwriting year. So, most of the payments out of that first year are still to come.

Having said that, the MAA believes that the current level of premium is based upon conservative estimates of scheme performance. In our view the actuaries providing advice to insurers have been factoring in the premium filings for the possibility of scheme deterioration, and it is quite appropriate that they do that, but they have not taken into account the nature of the scheme's operating environment and, in particular, the flexibility it has to respond to matters of deterioration through amendments to the guidelines and the like. So, we think it is a different operating environment. Perhaps because of that it is difficult for the actuaries to get a handle on it but it is certainly our intent, and continues to be our intent, to have the scheme operate as was intended when the scheme was introduced in Parliament.

I suppose the conclusion we will draw from that is that the current levels of risk premiums are within acceptable bounds, within reasonable bounds, but they are probably on the high side of what we think is reasonable. The MAA has to take into account what constitutes a reasonable return on capital when we review proposed premiums. We do that by looking at the risk premium and we assess whether or not risk premium is reasonable, having regard to the cost assumptions underlying the scheme and how the scheme has been performing. So, there is benefit in looking at past profit from the point of view of being able to inform ourselves as the overall performance of the scheme. The profit that is disclosed in the report for year one is certainly higher than the insurers filed for. There are some explanations for that. In year one the insurers filed without the benefit of any guidelines being in place and obviously without any experience. Therefore, there was an element of additional risk of uncertainty that was factored into the premiums. Those prices in year one reflected the view that the scheme would operate at about 75 per cent to 80 per cent of anticipated cost savings.

The Hon. JOHN RYAN: When you talk about year one, which table are you referring to?

CHAIR: You mean year one of the current scheme?

Mr BOWEN: Year one of the current scheme, I apologise. Table 3, primarily.

The Hon. JOHN RYAN: For the year ended 30 September 2000?

Mr BOWEN: Yes.

CHAIR: And you are focusing at this stage on table 3?

Mr BOWEN: I am focusing on table 3.

The Hon. JOHN RYAN: You said the premiums written and tabled there are $1,325 million. You said that is higher than the insurers have filed for?

Mr BOWEN: No. My conclusion is that the estimated profit on the premium is higher than was allowed for in premium filings for that year.

The Hon. JOHN HATZISTERGOS: What was allowed?

Mr BOWEN: Well, it varied by insurer, but it was around 8 per cent.

The Hon. JOHN HATZISTERGOS: That is in the year to 30 September 2000?

Mr BOWEN: Yes. So, they were filings that came in in August 1999 with effect from 5 October.

The Hon. JOHN HATZISTERGOS: What about the following year?

Mr BOWEN: The following year, you would have seen, our estimate drops. The overall premium dropped. I would caution about making any conclusions at all on the following year with such a low percentage of matters paid.

The Hon. JOHN HATZISTERGOS: In any event, it would have been a short year, only nine months?

Mr BOWEN: To June, yes.

The Hon. JOHN HATZISTERGOS: That probably explains why the premium is low?

Mr BOWEN: I am sorry, that is from 30 September?

Ms RIZZO: It is through to June but it is a year.

Mr BOWEN: It is a year to June so it is 12 months.

CHAIR: The estimated profit in the second underwriting year ending 30 June 2001 is less than the year ended 30 September 2000?

Mr BOWEN: Yes.

The Hon. JOHN RYAN: Did the MAA or the insurers do the estimate?

Mr BOWEN: This estimate is done by the MAA, based on our own actuarial advice.

CHAIR: In the text supporting this table you say:

> The estimates of profit under the Motor Accidents Compensation Act are volatile because the vast bulk of claim payments have not been made. These include payments on the most serious claims which take longer to settle. The estimates are therefore sensitive to the undeveloped assessment processes, future court decisions and consequent increase to superimposed inflation.

Would one assume that those factors would be taken into account by an insurer in arriving at estimates?

Mr BOWEN: These are our own estimates and our actuaries would take that into account in making an allowance for superimposed inflation.

CHAIR: When you refer to filings by insurers estimating what their profits level would be, I am simply suggesting to you that I would assume that the factors such as I have just mentioned in the quotation I read to you from your own document would be among the factors that would be taken into account?

Mr BOWEN: That is correct. As the scheme has developed we have seen the prices stabilise and then this year drop as the insurers have taken an increased level of confidence in the operation of the scheme.

The Hon. JOHN RYAN: Does the second year start at 30 September 2001?

Mr BOWEN: No, it is in fact starting on 1 July 2000.

The Hon. JOHN RYAN: Is there an overlap between those two years?

Mr BOWEN: Yes.

The Hon. JOHN RYAN: How many months are involved in the year?

Ms RIZZO: A three-month overlap.

The Hon. JOHN RYAN: Is the first year from 1 October 1999—

Ms RIZZO: So they are both years. Yes, that is right.

The Hon. JOHN RYAN: The only difference between the two in terms of the premium is about $35 million. How would that make such a big difference? The acquisition expenses are not very different.

Mr BOWEN: It is an increase in the vehicle fleet between 3 per cent and 4 per cent a year.

The Hon. JOHN RYAN: I am saying that all the figures in the other columns, other than premium, are very similar. For example, the acquisition expenses go from 201 to 199, the bulk bill and ambulance costs are only $1 million difference and the projected future payments are not enormously different so what makes the difference of 7 per cent in profit?

Mr BOWEN: That drop in premium.

The Hon. JOHN RYAN: An amount of $35 million makes a difference of 7 per cent?

Ms RIZZO: Also the drop in the costs of claims from 891 to 828.

The Hon. JOHN RYAN: That is a drop in costs, not an increase: The claim payments are reducing by an even greater margin and the premiums fall and yet no other figure seems to be different. What would have reduced the profit and loss if nothing else seems to be much different? In fact, the reduction in future claim payments should have increased the profit?

Mr BOWEN: Because there was a much lower amount paid there is a higher amount by way of a margin on the unpaid element for liabilities to meet appropriate Australian Prudential Regulation Authority [APRA] standards for sufficiency for liabilities. We value the liabilities at 75 per cent sufficiency so we add a margin on to the liabilities to achieve that. It might be appropriate if I could finish my statement and then we could work through the details of the paper.

CHAIR: You say in your paper that you have two measures to present of retrospective profit, the first being an estimate of the percentage that insurer profit represents the total premium written, without reference to the capital required by insurers to support the business. The second measure is an estimate of the insurer's after-tax return on capital. Are they the two different measures reflected in this paper?

Mr BOWEN: Yes, that is correct.

CHAIR: Would you complete the rest of your preliminary statement before the committee asks you further questions?

Mr BOWEN: I might pick up one more point on the premium profit, that is, there are a number of different ways to measure things such as affordability. We have tried to do that as accurately as possible in the scheme performance indicators. The raw figures themselves are in fact quite impressive and the most impressive is the actual drop in premium during the first three years of operation of this scheme compared with the last three years of the operation of the other scheme, that is, a drop of $450 million. That is against a climate where the number of vehicles is increasing in the vicinity of 4 per cent a year. I regard that as a very substantial reduction. I think that when we get into the scheme performance indicators, particularly one of affordability, it will show how that has come through in terms of average premiums.

The other comments I wanted to make relate to elements of claims management and the performance by both the insurance industry and the legal profession. The MAA believes that the insurers have made some very substantial changes to the claims handling practices as a result of this Act that have been to the benefit of claimants. In particular, we welcome the way that most insurers have moved away from an adversarial approach to dispute resolution and instead are trying to assist claimants with the conduct of their claim. But it is apparent to us that there is a difference in approach both between insurers and then within insurers as between represented and unrepresented claimants. Our view based on both audit and discussion with claims management is that unrepresented claimants are being well looked after by insurers. They are being given assistance in progressing their claim and the conduct of insurers is, by and large, very proper. But when it comes to represented claimants there is a bit of a tendency to drop back into an adversarial system and we are quite keen to continue to focus on that area in order to get some further improvements.

Included in our report today is a report on the audit of the claims handling guidelines. Dr Clough is available to speak in more detail on that. I think essentially it is a very positive report but it does show, as we expect, that there is room for improvement. We would welcome the opportunity to talk about how that might be progressed. In relation to the legal profession there is a great disparity in the quality of services offered by solicitors. There are a large number of solicitors who have taken the time and the trouble to get to know this scheme and who therefore operate within the requirements of the legislation. They use the dispute resolution mechanisms under the scheme to the advantage of their clients. But the MAA is concerned at the high level of ignorance that still remains about the scheme and how it is impacting upon claimants.

We still get far too many calls to our claims advisory service from claimants who have been to see a solicitor and who have been told by that solicitor that they are not entitled to any compensation under the new Act because they will not pass a whole person impairment threshold when that threshold only relates to noneconomic loss. That is a pattern of misadvice to claimants that we have taken up with the practitioners when individual names are brought to our notice and we continue to take up with the legal profession organisations. There is also a small rump of practitioners who are working hard to undermine the scheme. It is something like that old 90:10 or 80:20 rule that 10 per cent of practitioners are causing 90 per cent of the problems. I have a number of examples. I do not know whether you wish me to name names but I would certainly like to give the committee an indication of some of the potentially obstructive behaviour that some practitioners put in the way of their own clients in progressing matters.

CHAIR: Perhaps refer to them as firm A and firm B.

Mr BOWEN: There are five firms but I will not mention the names**.**

The Hon. JOHN HATZISTERGOS: Have you drawn this to their attention?

Mr BOWEN: Yes, we draw it to their attention. You will see from the nature of my comments that drawing it to their attention probably only exacerbates the situation. The nature of the concern is that the contact particularly with our assessment area is one of abuse: A refusal to comply with time lines of procedures and a continued attempts to delay matters. We have a number of firms that engage in a paper war. In the case of one firm, when an application comes in and it is sent out with a request for replies those replies come one answer at a time. Instead of answering all of the replies on the form they issue them one by one by letter, in an attempt to engage in paper warfare. One firm regards medical assessors as being biased and continually writes advising us that he has instructed his client that the assessor is biased and that they are not to attend the assessment examination. That is, in fact, a deliberate breach of the legislation which requires the co-operation of the client.

When the client does turn up, having had that sort of advice, it is one where the client is often hostile and aggressive to the assessor, despite the fact that I have written back to the practitioner on a number of occasions to say that those assessors are picked through a selection process that involves representatives of the legal profession every step of the way. One firm, on every assessment application, has sought a review: every review application has been word-for-word the same. It is incredibly poor practice. It is by a small rump of practitioners but the problem that it causes for the MAA is that it starts requiring us to bok at procedural guidelines and things like cost regulations as a way of moderating this behaviour which will end up penalising all of the good practitioners who work for the benefit of their clients and work to make the scheme work.

CHAIR: Have you raised the concerns you are now expressing with the Law Society?

Mr BOWEN: We have raised them up with the practitioners. In two or three of the cases we have raised those matters with the Legal Services Commissioner where we believe the conduct of the practitioner has been as a representative either unsatisfactory professional conduct or professional misconduct. It is appropriate that we raise it with the Law Society. However, again, it is a difficult situation of whether to raise the names of practitioners and then what can be done about it. There is not a lot the Law Society can necessarily do about people being rude to MAA staff or not complying with the provisions of the Acts and the guidelines. I want to put it on the record today because it is forcing us to look at solutions and tighten up guidelines. I do not want to do that. The Act introduced a lot of flexibility in procedures so matters could be dealt with informally and quickly. However, this sort of behaviour starts to force the hand a little bit.

The Hon. JOHN HATZISTERGOS: How frequent is this? You mentioned about 10 per cent.

Mr BOWEN: It is seven or eight firms that do a lot of this work. I am not talking about a practitioner who has had one matter and has dealt with in this way; I am talking about firms that do enough work with us that it has become a pattern of behaviour.

CHAIR: However, you are referring to a minority.

Mr BOWEN: It is a very small minority of the practitioners. We have good relations with most of them. We have regular meetings with representatives of the Law Society and the Bar Association through both informal and formal mechanisms. We also have meetings with the Australian Plaintiff Lawyers Association. We initiated those meetings this year and they were very positive and encouraging. They were aimed at identifying problems in insurance companies' claims areas and on behalf of the practitioners and working through them. Everyone was saying, "Okay, we might have differences and different views about the merits of the scheme, but at the end of the day it is there to make it work for clients." From the point of view of the organisations and most of the practitioners that is the case. It is now a significant enough problem, albeit a minority problem, that we wish to draw it to the committee's attention because it will generate a response. There are some other matters I wanted to comment on, but I will leave them because I anticipate they will come up in the course of questioning. I will leave my opening comments there and ask Ms Rizzo to walk members through the profit paper given that we have tabled it only today.

CHAIR: That would be appropriate.

The Hon. JOHN RYAN: Are the comments you made about legal practitioners included in the submission?

Mr BOWEN: Our submission involves a report on the operation of the scheme against performance indicators and contains answers to the questions from the organisations contacted by the committee and the committee's own questions.

CHAIR: Ms Rizzo, please take us through the profit paper.

Ms RIZZO: I will not spend any time on page one because that is background. I refer members to page two. Mr Chairman, you said previously that we are presenting two measures-retrospective and prospective profit. The first is retrospective profit. We look at past underwriting years and try to estimate what the profit will be for those years on the basis of the amount of claims payment and experience that has already happened. For those years in which large proportions of the claims have been made, we can consider that those estimates are very robust. Page two provides details of the very first years of the scheme in 1990 and 1991. We do not have to dwell on that page. Very large proportions of the premiums turned into profit.

CHAIR: What do you mean by a "robust" estimate?

Ms RIZZO: It is very strong and unlikely to change with more experience.

CHAIR: Expressed with a degree of certainty.

Ms RIZZO: That is right, because almost all of the payments for claims in those underwriting years have been made. I turn to table 2, which still looks at the Motor Accidents Act. The second last column indicates 98 per cent going down to 37 per cent. That is the proportion of all of the estimated claims payments that have already been made for each one of those underwriting years. One could say that for 1997 and backwards, those estimates in the last column are very solid. However, for 1998 and 1999, those estimates could very well change. As it stands, in 1998, 13 per cent of the premium turned out to be profit, and in the following year 15 per cent of the premium turned out to be profit.

The Hon. JOHN RYAN: When you estimate something like profit, what consideration is given to the fact that insurers obviously hold a substantial amount of premium for a considerable time prior to making a payment? I imagine a very significant profit earner is what they do with the premium while they are holding it. It is a financial management operation. Is any consideration given to the performance of that money by investment when profit is calculated?

Ms RIZZO: It is in our second measure. We have two measures for retrospective profit. One is the simple pie chart measure, and we do not take any account of investments in that. The second measure is return on capital, and we do take account of the investment earnings in that.

The Hon. JOHN RYAN: Is that reflected in these tables?

Ms RIZZO: The return on capital is on page five. For the old scheme, in the last two years the profit percentage was 13 per cent and 15 per cent. However, overall from 1992 to 1999 the profit percentage was 8 per cent. The next page deals with the current scheme. I must agree that there does appear to have been an arithmetical error for June 2001. I will check that. In the first underwriting year, some of the significant points to look at are that only 10 per cent of the projected claim payments have been made to date. Therefore, this estimate relies on a model in which 90 per cent of the claim payment is in fact an assumption, or a prediction. So the estimate of profit is 15 per cent. That is as a pie—15 per cent of the $1.3 billion. That is our first measure. As I said, the second measure is return on capital. That is summarised on page five. We have included three years of the previous scheme and two years of the current scheme. For the return on capital after tax, the figures for the

last two years of the previous scheme and the first two years of the current scheme are very similar at 12 per cent to 14 per cent. That is where investment is taken into account.

The Hon. JOHN RYAN: Do we have any figures on the premium collect during 2001-02?

Ms RIZZO: We have the amount—

The Hon. JOHN RYAN: It is obviously too early to talk about profit.

Ms RIZZO: We have figures for the premium, but it is too early to talk about profit.

The Hon. JOHN RYAN: Is that figure readily available?

Ms RIZZO: It is about $1.3 billion-a little higher than in 2001.

The Hon. JOHN HATZISTERGOS: What is the profit they filed for?

Ms RIZZO: It is about 8 per cent.

The Hon. JOHN HATZISTERGOS: For 2001-02?

Ms RIZZO: For all the years in the current scheme the insurers have filed for an industry average of 8 per cent prospective profit.

The Hon. JOHN RYAN: Is that return on capital or 8 per cent of the premium?

Ms RIZZO: It is 8 per cent of the premium.

The Hon. JOHN RYAN: That should wind up as profit.

Ms RIZZO: Yes.

CHAIR: I refer to page five and the consideration that has been given to return on capital. I note the statement is made:

> It should also be noted that for underwriting years since the legislative reforms as little as 4% of claim payments have actually been made to date.

Ms RIZZO: That is correct. Very small proportions of the estimated claim payments have been made. Even though a lot of claims have been finalised, it tends to be the less serious and less costly claims that have been dealt with to date. The bulk of the claim payments are still estimates.

CHAIR: Is a point being made inferentially that this is an important element in the mix of factors bearing on the profit ultimately made?

Ms RIZZO: Yes. Simplistically, we have the premiums that have been earned, which we have a figure for, and then we subtract all of the expenses and the claims estimates. That is the volatile figure.

CHAIR: Is there anything further you wish to say about the profit paper?

Ms RIZZO: There is one last section on the prospective profit at page six. We have discussed this already. These are the profit margins the insurers include in their filing, and it is a percentage of the pie chart. It indicates what I just referred to—that the industry average throughout this scheme has been about 8 per cent.

For individual insurers the figure ranges from 7.5 per cent to 9.5 per cent. The last page of that report is the cash flow for the first year of the new scheme.

The Hon. JOHN RYAN: Can you explain the meaning of the last paragraph on page six, which ends "therefore, the MAA considers that an industry average prospective return of 8 per cent is not inappropriate"?

Ms RIZZO: Page six gives a very brief and superficial overview of the methodology set up by Taylor Fry Consulting Actuaries to try to identify a range of premium that would be the minimum. The minimum they have identified is between 5 per cent and 5.6 per cent. In addition to taking that on board, the MAA has identified various current issues that are relevant-that is, the contraction in capital available, the fact that reinsurance rates have increased significantly over the past few years and also that in the current climate investment returns are very low. The MAA considers that on the basis of all this information the average prospective return of 8 per cent in the insurers' filings is not inappropriate.

CHAIR: You are saying that against the background of increasing reinsurance rates and the other factors mentioned that, although it is a larger percentage figure than first anticipated perhaps, it is not unreasonable.

Ms RIZZO: It is a larger figure than what is the theoretical answer in the modelling for prospective profit, which indicates to us what is the minimum required. Given the environment, we have come to the conclusion that 8 per cent is not inappropriate. That is right.

The Hon. JOHN HATZISTERGOS: Did Taylor Fry present any conclusions in relation to the actuarial study performed?

Ms RIZZO: On prospective profit?

The Hon. JOHN HATZISTERGOS: On the study undertaken. I note that some of this material is based on what has been provided.

Mr BOWEN: We tabled the discussion papers on profit that included the Taylor Fry report last year or even the year before for this committee.

The Hon. JOHN HATZISTERGOS: I cannot recall.

Mr BOWEN: We released a public discussion paper on the methodology the MAA was proposing to use to measure profit.

The Hon. JOHN HATZISTERGOS: I was more concerned about conclusions that Taylor Fry may have come to following the analysis.

Mr BOWEN: The conclusions are based on the level of profit shown here, with a lot of caveats.

The Hon. JOHN HATZISTERGOS: For example, the material on the last page reads, "Simple pie chart as to the profitability of New South Wales CTP written by insurers during the year 30 September 2000 based on Taylor Fry analysis of data". What is yours and what is theirs?

Ms RIZZO: This whole table is theirs. That was the heading they gave it, and I have not changed it.

CHAIR: Mr Bowen, what would you like to say to the Committee about the stability of the cost of obtaining a green slip in New South Wales?

Mr BOWEN: It might be appropriate if we take you to the short report we have on the performance indicators. I think the best demonstration of what has happened with the prices is the average premiums graph on page 2.

CHAIR: Could you articulate for the Committee in summary what you see as being the current position?

Mr BOWEN: The current position is that the average premiums are about $345 for the Sydney metropolitan area. I think it is necessary to explain that the average represents quite a higher figure than the median figure, because the majority of motorists will get at or around best price. The best price in Sydney metropolitan at the moment is $299, and for all the insurers it is costed in the range of $299 to about $312. For the great majority of people, their price now is more than $100 cheaper than it was before the scheme reforms, and the average dropped by $100 and it has stabilised. It went up a little in the second year, but the increase was less than indexation, so in real terms it continued to drop, and it dropped again this year. One of our good measures of it is to compare the premium to average weekly earnings because that factors into account indexation, and that is a very graphic indication of affordability. It has dropped from 50 per cent of average weekly earnings to 34 per cent in the three years of operation of the scheme.

The Hon. PETER PRIMROSE: Earlier you said that you believe most motorists would find $298 to be the most common. What does the MAA do to assist motorists who find the cheapest green slip?

Mr BOWEN: For some years we have been operating a telephone service and a web site, and we have upgraded them significantly this year. We have done some market research with motorists to see what sort of information they want and in what form they want it. As a result, we changed what was a pamphlet that went out with the registration papers into a fairly simple card, and that card has on it the number for the green slip helpline and the number for the MAA web site. The green slip helpline is a voice-activated system, that is, natural speech recognition. It is one of the better ones, if I may say so. Having tried a few of the others with other agencies, it seems to work very well. But we also maintain within the MAA operators who will take calls if people are having trouble with that particular service.

The web site has moved from being a passive price guide to an interactive price guide. Rather than just be able to look up the prices for roughly your category by way of age and location and then read the best prices with whatever caveats the insurance companies applied, you now fill in a list of questions on screen and that will bring up the best prices and provide them directly to the insurer. From our point of view that has proved to be extremely successful. To give you an indication of numbers, both the helpline and the web site get around 20,000 requests a month, which is a significant number. We always wondered how much attention was paid to these sorts of cards that go out with registration papers. It was not assisted by market research because people said that they did not particularly remember it. We had a three-week period when the cards failed to go out and the calls to our helpline dropped off significantly. So even if people are not recalling it, they are actually using it and we are getting quite a lot of positive feedback from customers about that as well.

CHAIR: Have you concluded your presentation, Mr Bowen?

Mr BOWEN: Yes I have.

The Hon. JOHN RYAN: How do the figures you have given with regard to profit compare with recent ACCC findings about profit levels in the New South Wales CTP scheme?

Mr BOWEN: They do not compare. We have included in our questions a response to the ACCC report, and the opening sentence of my response to that report is that the report is wrong. The estimates of profit are based on very different methodology. When they are estimating current year profits, they are doing it on an accounting basis, so it is actually measuring release of profits by way of release of capital. So it can be for profits from matters ranging back a number of years, whereas we are trying to measure it on underwriting and accident year.

But even then, I would question how they came up with the conclusion that they did. So much so that we asked Taylor Fry—who are the MAA's actuaries but also were the actuaries to the ACCC—to tell us how they could be so very different, and we have included that response as an attachment to our submission. It does go into some detail of different methodology between accounting and between measuring profit on an underwriting or accident year basis, but the conclusion is that the ACCC made some unsubstantiated estimates of profit for which we cannot find any verification in any publicly available information sources, including APRA data.

The Hon. JOHN RYAN: Is that the attachment No. 8 which appears in a letter from Adrian Gould?

Mr BOWEN: Adrian Gould is an actuary with Taylor Fry.

The Hon. JOHN RYAN: On page 7 of your responses there is a table related to finalised brain injury claims, liability fully accepted. Two figures are provided. One suggests that the average payments to brain-injured claimants decreased by 25 per cent; the other indicates that average payments increased by 37 per cent.

CHAIR: The Hon. John Ryan is referring to the fact that in question 7, arising from submissions made to the Committee, it was suggested that such payments had decreased by 25 per cent, whereas in your answers here you are saying the payments increased by 37 per cent.

Mr BOWEN: The information in these answers is up to the end of September, so it includes additional payment. We also did averages only on those claims where liability had been fully accepted, because otherwise it is confounded by matters involving contributory negligence which might vary significantly from claim to claim. So we have included here average payments on liability for the accepted matters. That is a better way to make a comparison, because you then take out those other matters that may vary. That was particularly important given the small number of matters involved.

The Hon. JOHN RYAN: The explanation you have just given suggests that the information drawn from the annual report is not as useful as the information you have given to us here.

Mr BOWEN: There is no information in the annual report. Some information was provided in advance in a draft form to enable some questions to be generated. We then updated the information to the end of September, which we cannot do in the annual report because it is to the end of June, and we thought the analysis was a better comparison on the basis of finalised claims and on the basis of liability fully accepted. The earlier reference was also to total payments, so it included payments on opening claims.

The Hon. JOHN RYAN: On page 9 of your responses you will note that the medical assessment service is responsible for 17 per cent of delays in claims. I note that you make the statement that the MAS is the main delay in only 17 per cent of the claims. How long are the delays you refer to?

Mr BOWEN: Our estimate is that a single impairment assessment, for example, should be able to be done in the vicinity of four months, if everyone plays their part properly. The current time taken from filing to completion of matters in medical assessment is getting closer to nine months, so they are reasonably significant delays. There have been delays within the MAA in the registering of files and in getting the process under way, although they are not significant and we have started to reduce them. The main delay is in obtaining an appointment for a practitioner, and we are reducing that by bulk booking practitioners in advance. Rather than waiting until a matter comes in, then ringing up and making an appointment—which, with the sort of specialist we have involved, can often be three or four months hence—we now know we are likely to get a number of matters that require that speciality, so we ask them for a booking for, say, a full day in a month's time, and then as matters come in we allocate them to those days. That has reduced the booking time substantially.

The other major delay has been in checking the reports that come back from the assessors, in particular that the right sections of the guides and the right tables have been used. Some assessors are extremely good at clinical examination but they do not necessarily do their arithmetic correctly. We have been making it a habit,

particularly with new assessors coming on board, of checking those and sending then back to the assessor for correction when those sorts of errors have been made. We have had a backlog within the Medical Assessment Service to do that checking. We now have the agreement of a number of senior assessors to check upwards of 150 of those files in the backlog for us, and that will be done over the next two months. I anticipate that by February-March next year we will have most of the backlog under control and we will be getting the time down to a much more manageable level, probably around about five months from the time the application is made until the certificate is issued to the parties.

The Hon. JOHN RYAN: At page 10 of your response you comment on the impact of plaintiff lawyers—we may have dealt with this to some extent—in medical assessment. You notice that 40 per cent of PI assessments of MAS result in zero whole person impairment, which would clearly be a factor in contributing to unnecessarily high caseloads. Does this suggest that plaintiff lawyers lack an understanding of the issues relating to the whole person injury threshold?

Mr BOWEN: I am not particularly surprised by that. I think that if I was in practice with the new system and I had a client, then in the absence of any other information that I had available to me, I would want to get it assessed by the independent assessment service. We have been trying to increase the knowledge of legal practitioners. We have now held a number of forums for legal practitioners on the whole person impairment system, so that those practitioners, particularly those who have a large caseload in this area, can be acquainted with it and, quite frankly, do not waste the time of their clients in sending them along to an assessment when the person is going to have a zero assessment. That is not what this was intended for. It was intended to deal with those matters where there might be some doubt, not whether the person had an impairment but whether or not it was over 10 per cent was in issue. Sending a client along who had no permanent impairment is wasting assessment time, but it is our responsibility to make sure that practitioners have the information so that they can feel comfortable in making a decision not to send their clients there.

CHAIR: At page 12 of the answers the Committee has received to the questions we sent to you dealing with the complaint handling function of the compliance branch of the MAA, you refer to 60 as the total number of complaints received during 2001-02. How many of the complaints were upheld? Also, if a complaint is upheld, what remedies are available and what are outcomes of cases where complaints are upheld?

Mr BOWEN: This is Dr Clough's area so it might be appropriate for him to answer.

Dr CLOUGH: When a complaint comes in, we try to resolve the complaint. In handling the complaints we endeavour to seek a satisfactory resolution of the complaint. In terms of the 60 complaints that were lodged between July 2001 and 30 June 2002, I would say that all of those complaints have been resolved to the MAA's satisfaction. I am not sure what other information you would like me to provide.

CHAIR: Do I understand you correctly to be saying that the complaints referred to were resolved ultimately one way or another?

Dr CLOUGH: That is right. Sometimes the complaints were resolved in favour of a claimant or a claimant's solicitor. At other times the complaints were resolved in favour of the insurer. Generally speaking, the complaints which were made against insurers and the behaviour of insurers were handled and resolved satisfactorily by the insurers. If there was considered to be improper conduct on the part of the insurer, then the MAA in some circumstances undertook remedial action. That may have been in the form of requesting the insurer to provide a letter of apology to the claimant or the claimant's solicitor.

The Hon. PETER PRIMROSE: Mr Bowen earlier mentioned an audit that had been undertaken in the claims handling area. Could you outline the key findings of that audit and the action that the MAA is taking in each case?

Dr CLOUGH: If I could refer specifically to the draft industry claims handling compliance audit report that was provided to the Committee. I will run through the major findings and the recommendations arising that are summarised in the executive summary.

The Hon. PETER PRIMROSE: Just the key ones.

Dr CLOUGH: I will not go through the detail of the background and methodology that was used because that is outlined in the report. The main findings were that in terms of the statutory requirements that relate to accident notification forms, insurers were generally complying with all of those claims handling requirements. In particular, where there was a requirement to pay reasonable and necessary medical expenses up to $500, it was found that in many cases insurers were routinely making payments up to $1,000. In relation to full claims—the requirements I am talking about are principally the requirements of the claims handling guidelines, which are a licence condition of insurers—the insurers were complying with the majority of those requirements.

As Mr Bowen indicated, there were some areas where there was room for improvement. As a result of those findings that there was room for improvement, recommendations made by the MAA auditors were to continue to measure and assess the insurers' compliance with their claims handling requirements. Also, the audit recommended that the MAA conduct a review of the claims handling guidelines. It was also recommended that the MAA develop a regulatory and enforcement policy and provide a clear explanation to insurers of this policy for dealing with future non-compliances. That is not to suggest that an enforcement policy is needed at the moment because overall I consider there is no need for any enforcement action on the basis of this audit, which I should add is a benchmarking exercise because it is the first audit of its type that has been conducted into the claims handling practices of insurers.

As a result of the findings that insurers could be more proactive in resolving and finalising claims, it was further observed during the audit that there was also room for claimant solicitors to be more proactive in endeavouring to resolve and finalise claims. The fourth recommendation arising out of the audit is for the MAA to explore ways of promoting the just and expeditious resolution of daims, which may entail, as Mr Bowen flagged earlier, looking at applying cost regulations. Those essentially, in summary, are the main findings and recommendations arising out of the claims handling compliance audit report.

CHAIR: The claims handling compliance audit report is attachment No. 1 to the answers we have been given. It appears to note what is described as high industry levels of non-compliance with the applicable claims handling requirement. Some examples are given, three of them being: making late offers of settlement; making late determinations of liability; and slow requesting of medical evidence. I take it that those criticisms are being taken seriously?

Dr CLOUGH: Absolutely. Those particular areas, where there were what we would describe as significant requirements, are taken very seriously. Those particular requirements relate largely to the timeliness of insurers. To be fair to the insurers I should qualify that. When we assessed compliance, it was a very strict assessment of compliance. There was a three-month time limit for making a determination of liability once a claim has been lodged. If insurers were one day late they would be assessed as not having complied with that requirement just as they would be assessed as not having complied if they were several months late. That is part of the development of the regulatory and enforcement policy. Those sorts of considerations would be taken into consideration in terms of how we, as the regulator, respond to such delays.

The Hon. JOHN HATZISTERGOS: Mr Bowen, you indicated earlier that the Motor Accidents Authority is receiving a number of complaints from individuals who have been to legal practitioners, who have informed them that they are not entitled to benefits because they do not get over the threshold. However, your Claims Advisory Service has seen fit to explain to them that that is not so and in some cases you have contacted the solicitor. That is what you said, is that correct?

Mr BOWEN: Separately to our Claims Advisory Service, yes.

The Hon. JOHN HATZISTERGOS: I am just intrigued how that response fits in with the response that you gave to the Bar Association on page 26, which states:

> The Service does not give any specific information about the components of any head of damage including lost earnings.
>
> The Claims Advisory Service does not give legal advice. All replies to requests for legal advice are prefaced by the statement that we are unable to provide legal advice and if this is the advice sought, then the client should see a lawyer.

You are obviously giving people some legal advice.

Mr BOWEN: No, it is not advice as to whether or not in their specific case they are entitled, but it is advice—and this, I do not think, is legal advice—that the whole of person impairment threshold acts only as a threshold to non-economic loss and it does not bar a person from making a claim for other heads of damage. They do not quiz the person on what the nature of their claim is or give any advice as to whether they have an entitlement, but they do correct the impression that people sometimes are given that they are not entitled to claim anything at all because of the whole person impairment test.

The Hon. JOHN HATZISTERGOS: So what does the advisory service actually do in terms of drawing a line between what advice it will give and what advice it will not give?

Mr BOWEN: It is a reasonably clear line to say to a person that you may or may not have a claim but you are not barred from making a claim at all because of the whole person impairment test. I do not regard that as legal advice. I do not try to analyse a person's particular circumstances. Most of the requests for from individuals are for help to fill in claim forms, or even earlier to fill in an accident notification form. It is a matter of reading through it and getting the person to fill in the form themselves, essentially. If the person making the inquiry asks questions about what they might get or what it is worth, the Claims Advisory Service does not attempt to answer those questions. They will ask the person whether they think that they might need a lawyer. If the person responds positively, the service directs them to the Law Society, who can give them the name of a solicitor in their area. I am confident that we are not crossing over the boundary. It is one that may not necessarily always be subject to writing down "You can say this, but you cannot say that". But it is a reasonably clear one, and often just commonsense.

The Hon. JOHN RYAN: Do you recall that in the Bar Association's questions it stated:

> The Association is concerned about the fact that the service may be providing advice about the entitlement to recover lost wages without providing advice about the entitlement to recover lost superannuation benefits. Such advice constitutes negligent advice.

Do you say to them that you are not giving that advice at all?

Mr BOWEN: The service might simply say to a person, "You may have an entitlement". We are very particular not to provide advice on an individual claim.

The Hon. JOHN HATZISTERGOS: In the first paragraph you said that in some cases clients of the service are advised to discuss their entitlements with the insurer. What sort of things would you send a client back to discuss with an insurer? Why are you not prepared to discuss it, but would send them off to an insurer to discuss it.

Mr BOWEN: There will be issues as to whether payments for certain medical services are reasonable and necessary. We would advise them that if they do not agree with the insurer they can bring that matter back to the medical assessment service. We are not trying to give them advice on whether a response from an insurer is appropriate or not. They need to talk to the insurer about it and if they are unhappy with that they need to talk

to a lawyer. Or, if they wish to proceed with it as a dispute, they can come back to our Claims Advisory Service for help to fill in the application forms to take them for medical assessment.

CHAIR: In answer to a question posed by the Committee, at page 16 you made some reference to what you describe as an adversarial mind-set. You stated:

> There has been a reluctance by some parties to engage in a full and frank exchange of information by way of completion of lodgment and attesting documentation.

What can be done about that? What are you really saying? Are you saying that there is an overlay from the old court-based system?

Mr BOWEN: Yes, that is correct. Patterns of behaviour in CTP are still far too often predicated on previous behaviour where it was resolved or litigated. You may recall, Mr Chair, that under the old scheme over 50 per cent of matters had litigation commenced and so it was quite easy—and I make this criticism of both sides, that at times they fall back into that type of behaviour. There was only a limited number of matters before CARS, and most of those are now proceeding well. There is at least one example I am aware of in which the assessor conducting it has advised me that it has taken her close to six months to do a preliminary assessment because instead of putting everything on the table, upfront, there is a continuing "How about this?"; then there is a response, and then "How about something else"; and then another response which may raise another issue.

It is quite contrary to the spirit of the legislation, which was to try to have the issue in dispute identified early so a decision could be made on it. I hope you have read the last sentence too; it is a matter of time. Earlier I indicated that partly because of volume and training opportunities, the insurers have significantly changed the way they are dealing with claims. A number of practitioners have done that as well. It is probably also the case, and this will come out in some of our other information, that there has been a slowdown in claims settlements in the past 12 months compared to the first two years. That has now started to turn; perhaps because we are at the three-year anniversary and because the limitation periods are starting to have effect. Therefore, minds are turning to the new system and a need to know it. Hopefully that will lead to making use of it to get things done quickly for the benefit of claimants.

The Hon. JOHN RYAN: It is time for my annual obsession. Last year the Committee recommended to the MAA that you should give further consideration as to how parents who lose children as a result of motor vehicle accidents might be compensated, particularly parents who would not qualify for non-economic loss according to current medical and psychological guidelines. A further consideration of this matter should include public consultation with interested stakeholders. Why, in your response to that, have you given no consideration to financial issues other than simply saying, on page 5 of your response:

> The MAA does not consider there is a need to review existing momentary compensation entitlements for psychological and psychiatric injury.

With that mere sentence all consideration of those facts appears to not be a part of the discussion paper that was developed and given to the Committee. It is purely a survey of the resources that might be available for psychiatric and other forms of counselling to bereaved parents. There is no consideration given to their financial concerns. To the best that I can work it out certainly there is nothing of what the Committee envisaged: some sort of public discussion. Are you refusing to carry out that public discussion? Are you frightened of it? Is there some reason why there could not be a reasonable discussion about financial assistance to parents who lose their children, given that the scheme essentially provides nothing other than counselling, were available?

Obviously it is not hard to imagine how many parents might be in a position, through no fault of their own, to lose a child and have a substantial non-economic loss arising from that, which does not appear to be adequately investigated. The earlier statements of Mr Bowen to this Committee gave the Committee the impression that some consideration was being given to a statutory scheme, which would give it a statutory benefit to parents in those circumstances. That appears to have disappeared off the agenda. Every time the

Committee asks about it, we are told that there is no need to review it. We have asked you to review it. Is there some reason why you refused to do what the Committee asked?

Mr BOWEN: We put the focus on counselling and bereavement and that lead to the papers we tabled today, the survey of parents who had had a child killed. Obviously that is a very sensitive document.

The Hon. JOHN RYAN: But that report was not done by yourselves, it was done by an agency that you consulted.

Mr BOWEN: Yes.

The Hon. JOHN RYAN: It has nothing to do with you. The Committee asked you to specifically prepare a consultation paper, to publish it and distribute it.

Mr BOWEN: This has to do with the issue, because the intent was to see what level of services were there already and how well they operated. Therefore, we were to identify whether there were any gaps. It does not deal with monetary benefits for parents, that is certainly the case.

CHAIR: You are saying to the Committee that you commissioned, or engaged, the Workwise Group to examine the matter on behalf of the MAA?

Mr BOWEN: Yes.

CHAIR: And to furnish a report to you as a basis upon which you would make further decisions regarding the issue raised by Mr Ryan?

Mr BOWEN: That is correct. The focus of it was upon the provision of bereavement and counselling services to parents.

The Hon. JOHN RYAN: But you have excluded any financial considerations at all.

Mr BOWEN: At this stage we have not thought of any financial considerations. We have not grappled with the problem of trying to put any value on it at all. It is a very difficult issue to put a value on the death of a child.

The Hon. JOHN RYAN: I am not suggesting for a moment that you even attempt to do that, Mr Bowen. I am suggesting that a piece of research and discussion that is worth having is whether some financial compensation to parents in that position the appropriate? I specifically asked the Committee to include that recommendation last year for the purposes of triggering some sort of discussion, to which bodies who would be interested in making a submission to you or to the Government might be able to do that. You appear to have had bodies do a survey without even mentioning to them or asking them to deal with financial issues. Of course it is not included in the paper, because they were not asked to provide it. Is there some reason why we cannot have an open discussion about finances? I accept that it is not appropriate for the MAA to place a value, but what is stopping the public from discussing the issue and you sponsoring some public discussion?

Mr BOWEN: The provision of bereavement and counselling services is something well within the charter of the MAA in terms of our broader objectives in providing services. It is one that we could do outside the CTP scheme. To look at new benefit levels is not something that I regard the MAA as having a charter to do, unless we are requested to do so by the Minister.

The Hon. JOHN RYAN: You gave evidence to the Committee two years ago that you were doing precisely that.

Mr BOWEN: No, I gave evidence that we had looked at it elsewhere. I hope I did not mislead the Committee. It was always our intention to focus on counselling. The outcome of this study suggests that counselling is not something that parents want; they want support immediately post the death of a child by way of assistance and someone to talk to about their loss. That is fairly clear from the report.

The Hon. JOHN RYAN: On 8 May 2000 I asked you specifically about this. You said:

> So it is an issue that needs to be looked at. It probably needs to be more broadly looked at in the context of a statutory change to see whether a death benefit should be introduced rather than trying to fiddle with impairment levels is a means of achieving that end in a roundabout way.

That was in the context of a review of what was going on in Victoria, and you said that it was included in earlier versions of the guides, but was taken out and is currently under continued review. I took the view that the MAA was reviewing that issue specifically and that we could expect a recommendation to the Minister, or some discussion with the Minister, and some legislation, as you have used the words "statutory change".

Mr BOWEN: Yes, it would need statutory change. We have not done that, but more broadly we have not reviewed the impairment guidelines either.

The Hon. JOHN RYAN: I have made the point to you for three years that this gap seems to be apparent in the scheme. I keep asking whether it will be reviewed. The Committee has made a recommendation to you that it should be. The MAA seems to refuse to examine this particular benefit other than by means of financial counselling. Last time you told us that financial counselling was provided and we made that recommendation notwithstanding that, to try to ask the MAA to take the investigation further. Are you telling the Committee that you will not take investigation further?

Mr BOWEN: I am telling you that we have not taken it further than looking at bereavement and counselling services to date.

The Hon. JOHN RYAN: Will you do that in the future?

Mr BOWEN: In the context of reviewing the whole person impairment test, if that is up for review, the death benefits as originally on the agenda, as I indicated two years ago, we would look at it again. I cannot promise the Committee that that will be a process of inviting submissions from members of the public because that sort of review of benefits is not a matter for me.

The Hon. JOHN RYAN: Although you did say to the Committee that some consideration was being given to that after the scheme was originally set up.

Mr BOWEN: It was in the course of looking at the set-up of the scheme. That was an issue as to whether there needed to be some benefit in lieu of a whole person impairment test to deal with a parent who has lost a child. The thinking of the MAA now is that the best form of assistance is to assist the person in that situation with bereavement counselling support. To take it beyond that is not something we are looking at at the moment.

The Hon. JOHN RYAN: But that is an opinion the MAA has.

Mr BOWEN: Yes.

The Hon. JOHN RYAN: It then becomes a player in the public discussion, does it not?

Mr BOWEN: We can only operate within the appropriate boundaries. I regard the issue of bereavement counselling as well within our objectives and charter. But making recommendations on benefit levels, unless we are particularly invited to do so—we can offer some informed comment but we do not just

invite comment on what other benefits should be in place. We do try to talk about how the current scheme is operating.

The Hon. JOHN RYAN: I am somewhat disappointed because had I known that this matter was not being more actively investigated by the MAA and that you had an intention to do so, as I had been led to believe in the earlier times we investigated this, I certainly would have brought a private member's bill to the Parliament to have it discussed in the Parliament. I did not do so because I thought that the matter was going to come through by means of a statutory review. I had basically taken your answer on face value that that would happen. In any event, the survey and the attachment that you have presented to the Committee do not suggest that the bereavement counselling services available for parents in this circumstance are great. Are you suggesting that as a result of the report that you have collected the MAA intends to do something to address that deficit?

Mr BOWEN: Yes. We have had discussions with other government agencies and we have also had discussions with some of the non-government organisations that are mentioned in that report about both improving and expanding the existing range of services. There are criticisms of the current range of services that are provided so we have made this report available to those who are criticised as well.

The Hon. JOHN RYAN: If there were a provision for a statutory benefit for parents who have lost their children as a result of an accident which was not their fault it would not present a very large difficulty in financing the scheme would it?

Mr BOWEN: It would depend upon the value put upon it but in terms of numbers of people, no, it is not a large number.

The Hon. JOHN RYAN: If it were a benefit in the area of from $50,000 to $100,000, as was suggested by using the Victorian scheme, it would not exactly trim the profits of the insurers.

Mr BOWEN: It was not be a very significant impact. To some extent we do not know the full number of cases because a number of people currently in that circumstance would not be making a claim but it could be worked out, I suppose, having regard to the total number of child fatalities in this State.

The Hon. JOHN RYAN: I cannot understand why insurers would not gratuitously offer such assistance. It would be good public relations for them but they have not chosen to do so. I can promise you that a private member's bill will be introduced in the next Parliament.

CHAIR: Mr Bowen, in past years I have expressed an interest in obtaining advice as to what the current position is regarding compensation for the very seriously injured. I know that is a matter that the Minister is interested in. Possibly that is a matter that needs a national approach. However, could you tell the Committee anything you are able to regarding any progress that might have been made on that matter?

Mr BOWEN: I have two matters to report on. The first is structured settlements. The bill is very close to going through the Federal Parliament. I believe it will be finally debated tomorrow. So it is about as close as we can get. As late as this morning emails were still coming to me from Jane Campbell, who is the manager of the structured settlements group, which I chair, on some government amendments, proposals from the Office of the Prime Minister and Cabinet, which all look satisfactory. So I anticipate that it will go through in the next day or so with bipartisan support, which is a very good thing. It is then a matter of getting all of the players in the compensation world to accept it. I think there is an acceptance at a higher level but not down at the lower level, the people at the coalface. And, of course, we have to get products developed. That is a good initiative.

In relation to matters that have interested this Committee before, and in particular long-term care, the MAA has continued to develop a proposal there and to cost it. The particular issue for costing it is to work out what the care needs are of people who are catastrophically injured and to assist in that. Last year the MAA tabled some guidelines for attendant care for persons with spinal injury. To some extent that was really the easy matter to do because it was a matter of assessing on the basis of the level of the spinal injury what the physical care

needs are. Earlier this year we initiated a process of looking at producing similar sorts of guidelines for persons with brain injury and looking at those care needs in terms of not only physical care but care as a result of behavioural disabilities or cognitive disabilities and a range of other needs.

They are progressing fairly well. We have got a big experts group together. It is pleasing that a number of the most eminent experts on brain injury in Australia are Sydney based, so we have had the benefit of their input into it. Once we agreed that it was possible to produce this, although not in the same form as the spinal cord guidelines, not as a matter of saying that you can get this many hours care but rather as setting up a methodology to measure care needs against those different heads—that is well under way and I would hope that we would be able to release a draft of those sometime in the first quarter of next year for comment, I suppose particularly amongst medical professional rehabilitation providers and the like. The issue of catastrophic care has got onto the national agenda, particularly through the medical liability crisis and the Commonwealth Government is looking at it through Health Ministers.

The MAA has been a participant in some of those discussions, probably more as an expert commentator because of our long interest in the matter and the progress we have made with Commonwealth and eastern State Treasurers, Treasuries and health departments. Recently Minister Della Bosca put a proposal for a national care scheme to heads of Treasury meetings. So it is progressing. It is a little like structured settlements, where it needs a bit of explanation as to both the economic benefits—the benefits to the individual are reasonably obvious. It is moving slowly but it is moving, and I think that is a very good thing. It seems to me that there can only be an increasing number of people who become persuaded by the merits of some national care scheme.

CHAIR: Is there anything you would like to say before we conclude the meeting?

Mr BOWEN: No. Thank you again for the opportunity.

(The witnesses withdrew)

(The Committee adjourned at 3.55 p.m.)

Appendix 1

Industry Claims Handling Compliance Audit Report

MOTOR ACCIDENTS AUTHORITY

DRAFT

INDUSTRY

CLAIMS HANDLING COMPLIANCE AUDIT REPORT

November 2002

EXECUTIVE SUMMARY

Background

The Compliance Unit of the MAA conducted a compliance audit of NSW CTP Insurers' claims handling practices under the Motor Accidents Compensation Act 1999 (the Act).

The objective of the audit was to assess whether the licensed insurers are complying with their statutory claims handling requirements including the Claims Handling Guidelines.

Officers of the MAA conducted the Claims Handling Compliance Audits between December 2001 and April 2002. The audit consisted of interviews with CTP claims managers and claims officers and an inspection of a total of 319 claim files made up of 70 Accident Notification Forms (ANFs) and 249 full claims.

Approximately 10 ANFs and 40 full claims were examined at each of the following CTP insurers' premises: AAMI, QBE, NRMA, Zurich, GIO and Allianz. A smaller sample of notifications with CIC Allianz and FAI Allianz was also examined at Allianz's premises.

Summary findings of MAA compliance audit

The lowest, median and highest levels of non-compliance by the insurers for each claims handling requirement audited are presented in Table 1 for ANFs and Table 2 for full claims.

The findings of the MAA's first claims handing audit indicate that the CTP insurers were generally complying with all of the claims handling requirements for ANFs, and with the majority of the requirements for full claims.

The results indicated that all insurers were paying reasonable and necessary medical expenses up to $500 for ANFs as required by the guidelines with many insurers routinely making payments up to $1000. Payments in excess of $500 were made where the insurer considered that the ANF could be finalised by making the additional medical payments and thus alleviating the need for some claimants to pursue full claims.

The audit results also indicated that insurers were complying with the majority of claims handling requirements for full claims which included making prompt requests for police reports and, once liability was admitted, making prompt payments for hospital, medical, respite & attendant care, rehabilitation & pharmaceutical expenses.

However, some important claims handling requirements for full claims had variable levels of compliance across the industry. The following actions by insurers resulted in high industry levels of non-compliance with the applicable claim handling requirement: making late offers of settlement; making late determinations of liability; slow requesting of medical evidence; late acknowledgement of receipt of claim; and not providing treating doctors' reports to claimants.

Whilst it was observed by the MAA auditors that some insurers could have been more proactive in their endeavours to resolve claims, the same was noted for some claimant solicitors who had not responded to insurer requests for further and better particulars or offers of settlement.

Since the establishment of the MAA's Compliance Unit in April 2001, the licensed CTP insurers have generally co-operated with the Compliance Unit's recommendations and responded in a timely manner to requests for information and the provision of statutory reports. All insurers have finalised claims handling complaints that have been directed to the MAA's Compliance Unit in a timely manner.

Recommendations

The MAA's Compliance Auditors have recommended that the MAA:

1. Continue to measure and assess insurers' compliance with the Claims Handling Guidelines;

2. Conduct a review of the Claims Handling Guidelines;

3. Develop a regulatory and enforcement policy and provide a clear explanation to insurers of this policy for dealing with future non-compliances;

4. Explore ways of promoting the just and expeditious resolution of claims as required by Section 80 of the Act.

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1. INTRODUCTION

1.1 Purpose of the Report

This report has been prepared to present the objective, scope, methodology and summary findings of a compliance audit of the handling of personal injury claims by licensed Compulsory Third Party (CTP) insurers under the NSW Motor Accidents Compensation Act 1999 (the Act).

The objective of the audit was to assess whether the licensed insurers are complying with the claims handling requirements under the Act including the Claims Handling Guidelines (the Guidelines) issued under Section 68 of the Act. The Claims Handling Guidelines were developed by the MAA in 2000 following consultation with the Insurance Council of Australia Ltd, the Council of the Bar Association and the Council of the Law Society.

It is a condition of a CTP insurer's licence that the insurer must comply with the Guidelines.

This report also presents recommendations in relation to future monitoring and assessment of insurers' compliance with their claims handling requirements.

The summary findings presented in this report are based on information obtained from the MAA's Claims Register, the MAA Complaints Database and files, insurer complaint summary reports, insurer self-reports on compliance, information supplied by insurers' claims staff and observations made during the audit inspection of claims files. Matters of non-compliance with legislation beyond the scope of this audit are not addressed in this report. No personal information has been presented in this industry summary report in order to protect the privacy of claimants.

This report has been prepared for the purpose described and no responsibility is accepted for its use in any other context or for any other purpose.

1.2 Scope of the Audit

The scope of the audit was limited to CTP personal injury claims for accidents on or after 5 October 1999, the date the Act commenced, lodged with insurers licensed and authorised by the MAA to underwrite CTP business in NSW. The licensed CTP insurers audited were AAMI, Allianz, CIC Allianz, FAI Allianz, GIO, NRMA, QBE and Zurich.

At the time of the compliance audit Allianz controlled CIC Allianz and FAI Allianz which respectively undertook renewal of CTP insurance policies previously written by CIC Insurance and FAI General Insurance. Because these claim portfolios were being managed and supervised by Allianz staff, a small sample of claim files from CIC Allianz and FAI Allianz was also included in the audit in addition to Allianz claims. FAI Allianz subsequently ceased to write CTP insurance policies effective from 30 June 2002.

Insurers who do not manage claims for accidents on or after 5 October 1999 were excluded from the audit. These insurers (CGU companies, Mercantile Mutual, Royal & Sun Alliance and SGIO) continue to manage run off claims made prior to that date.

Activities examined on-site as part of this audit consisted of practices, policies and procedures in the handling of Section 49 Accident Notification Forms (ANFs) and Section 74 (Full Claims) for accidents which had occurred in NSW and are subject to the Act.

Interstate accident claims and workers compensation recovery claims were excluded from the audit.

An assessment of insurers' compliance with the Treatment, Rehabilitation and Attendant Care (TRAC) Guidelines, and Section 84(2) of the Act relating to the expeditious provision of rehabilitation services once an insurer has admitted liability, was beyond the scope of the audit.

An assessment of the insurers' compliance with Section 3.1.1 to 3.1.3 of the Guidelines, regarding actions taken by the insurer to assist claimants when making their claims, was beyond the scope of the audit.

An assessment of insurers' compliance with Sections 3.9.2 to 3.9.5 of the Guidelines, regarding the conduct of its investigators, was beyond the scope of the audit.

In the absence of formal audit criteria to assess the 'reasonableness' of an offer of settlement, assessments of unreasonable offers of settlement under Section 7.2 of the Guidelines were limited to obvious cases. For example, it would have been considered an unreasonable offer of settlement if at the time of offer there was evidence on the file that a claim was clearly eligible for a particular head of damage, but that head of damage was not included by the insurer in the offer of settlement.

An assessment of insurers' compliance with Sections 9.1.1 to 9.1.7 and 9.2 of the Guidelines, regarding detailed aspects of its in-house complaint handling system was beyond the scope of the audit. Nevertheless, all insurers were assessed for compliance with the Guidelines requirements for documenting internal complaints handling processes (Section 9.1) and complaint summary reports (Section 9.1.8).

An assessment of the insurers' self-reports on compliance and complaints has also been included in this industry report.

The insurers had previously been requested by the MAA to provide at the end of 2001 self-assessments of compliance with 27 of the Guidelines requirements. The MAA auditors determined what proportion of each insurer's assessments of compliance yielded an acceptable correlation with the MAA auditors' assessments of compliance.

The MAA auditors reviewed each insurer's 6-monthly complaint summary reports covering the first half of 2002. The insurers' complaint summary reports were compared for completeness with the MAA's internal Complaint Database.

1.3 Audit Criteria

The audit criteria were limited to the following claims handling requirements of the Motor Accidents Compensation Act 1999 and the MAA Claims Handling Guidelines.

The audit criteria against which compliance has been assessed are Sections 70(2) and 73(3) of the Act and Sections 2.2.a, 2.2.b, 2.3, 2.4, 2.5, 2.6, 2.7.a, 2.7.b, 3.1.4, 3.1.5, 3.2.1.a, 3.2.1.b, 3.3.1, 3.3.2, 3.3.3, 3.4.1, 3.4.2, 3.4.3, 3.4.4, 3.7.1, 3.7.2, 3.7.3, 3.7.4, 3.7.5, 3.8.1, 3.8.2.a, 3.8.2.b, 3.8.2.c, 3.8.2.d, 3.8.2.e, 3.9.1, 3.9.6, 4.1, 4.2, 4.3, 4.4, 5.1.a, 5.1.b, 5.1.c, 5.1.d, 7.2, 7.3, 7.4, 7.5, 9.1, 9.1.8, 10.1.1 and 10.1.2 of the Guidelines. Some of the section numbers described in the Guidelines may differ from those given above. See comments above under Scope of the Audit relating to the limited audit criteria for Section 7.2.

Refer to Tables 1 and 2 for a description of the above Guidelines requirements.

2. AUDIT METHODOLOGY

2.1 Information Analysed Prior To Audits

Prior to the on-site examination of claims files, the licensed insurers were requested to provide to the MAA a copy of the organisation chart for their CTP line of business, the names of all CTP claims staff and the number of claims managed by each staff member.

2.2 Selection of Audit Sample

Insurers' claims to be included in the compliance audit sample were selected from the random audit sample previously used for the NEL Performance Audit conducted in 2001. The audit sample consisted of both open and closed claims.

The total sample for the compliance audit consisted of **70 ANFs** and **249 personal injury claims** related to motor vehicle accidents on or after 5 October 1999 and for which claims had been lodged prior to September 2001. Approximately 10 ANFs and 40 full claims were examined at each of the following CTP insurers' premises: AAMI, QBE, NRMA, Zurich, GIO and Allianz. A further 5 ANFs and 5 full claims were examined from each the claims portfolios of CIC Allianz and FAI Allianz, now managed by Allianz.

The list of claim files to be audited was forwarded to the licensed insurers approximately 5 days prior to the commencement of the on-site audit.

2.3 On-Site Audit

The MAA audit teams were made up of the following MAA Officers:

- Principal Compliance Officer (PCO),
- Senior Compliance Officer (SCO), and
- Senior Compliance Officer – Nominal Defendant (SCOND).

The audit team presented to the insurer premises on the dates listed in the table below:

Insurer	Audit Team	Audit Dates
GIO	SCOND*, SCO and PCO	3, 4, 5 & 7 December 2001
Zurich	SCO* and SCOND	14, 15 & 16 January 2002
AAMI	SCOND*, SCO and PCO	11, 12 & 13 February 2002
QBE	SCO* and SCOND	4, 5 & 6 March 2002
NRMA	SCOND*, SCO and PCO	8, 9, 10, 11 & 18 April 2002
Allianz	SCO*, SCOND and PCO	6, 7, 8 & 9 May 2002
CIC Allianz and FAI Allianz	SCO*, SCOND and PCO	6, 7, 8 & 9 May 2002

* indicates lead auditor

Upon arrival at the licensed insurers premises the MAA audit team provided a copy of its 'Instrument of Authorisation' to the relevant CTP Claims Managers, which provides authorised officers of the MAA with the powers of entry and inspection pursuant to section 182 of the Act.

Initial discussions were also held between the MAA auditors with the CTP Claims Managers and other relevant staff from the insurance companies.

These discussions related to the claims management practices, policies and procedures of the licensed insurers, in particular the insurers' processing of ANFs and full claims, practices relating to contacting legally represented claimants, general medical and rehabilitation issues, settlement offers and strategies, and any feedback on the Guidelines. The discussions also included the insurers' use of investigators and their internal complaints and disputes handling system.

Following these discussions, the MAA auditors examined a sample of claim files as described above.

On the final day of the on-site inspection the MAA audit team conducted interviews with individual claims assessors. Discussions with these claims assessors related to their knowledge and understanding of the Guidelines in concert with the claims management practices, policies and procedures of the insurers, strategies to settle full claims, their internal complaints and disputes handling system and any feedback on the Guidelines.

2.4 Audit Reporting

Each insurer was sent a draft report on its individual levels of compliance and the reports were finalised taking into consideration the comments received back from the insurer. Every claims handling requirement was assessed for each ANF and full claim audited. There were four possible assessments of compliance: compliance, non-compliance, not applicable or not determined. Each insurer was sent a copy of its individual Claims Handling Compliance Audit Report in August 2002.

Compliance was assessed strictly in accordance with the Guidelines requirements. For example, if the insurer was required to acknowledge the receipt of a claim by sending an acknowledgement letter to the claimant within 5 working days, a non-compliance would have been recorded if the letter was sent on the 6th working day after receipt of the claim (see requirement 3.2.1.a in Table 2).

This report presents a summary of the key findings for the industry. The lowest, median and highest levels of non-compliance for each claims handling requirement from the insurers' individual compliance reports have been presented in Tables 1 and 2 of the following section.

3. FINDINGS – ASSESSMENT OF COMPLIANCE

The lowest, median and highest levels of %non-compliance found for the eight licensed insurers (including CIC Allianz and FAI Allianz) are presented in the following two tables. Table 1 presents these findings for the claims handling requirements relating to Accident Notification Forms and Table 2 presents the findings for full claims.

For example, the insurer with the highest % Non-Compliance for Requirement 3.3.1 in Table 2 was calculated as follows:
%non-compliance = (7 claims not complied/40 claims audited)*100 = 18%

TABLE 1 INDUSTRY NON-COMPLIANCE RESULTS FOR ACCIDENT NOTIFICATION FORMS

Ref	Description of Claims Handling Requirement	Lowest %Non-Compliance	Median %Non-Compliance	Highest %Non-Compliance
2.2.a	Provide written advice to injured person on whether provisional liability determined within 10 days of receipt	0	0	22
2.2.b	Insurer to advise ANF is not a claim and if additional damages to be claimed, a claim form needs to be lodged within 6 months	0	0	67
2.3	Provide written advice to injured person on whether provisional liability accepted for pedestrians and passengers within 10 days of receipt	0	0	14
2.4	advise claimant within 5 days if information contained in ANF insufficient to determine provisional liability	0	0	7
2.5	pay reasonable & necessary medical expenses up to at least $500	0	0	0
2.6	promptly respond to all reasonable requests for info and assistance from injured person	0	0	0
2.7.a	advise injured person nearing time limit or dollar amount expiration that full claim will be required for further payments	0	0	10
2.7.b	request new medical certificate only where condition has changed or injured person claiming for injuries in addition to those in ANF medical certificate	0	0	0

TABLE 2 INDUSTRY NON-COMPLIANCE RESULTS FOR FULL CLAIMS

Ref.	Description of Claims Handling Requirement	Lowest %Non-Compliance	Median %Non-Compliance	Highest %Non-Compliance
Making Claims				
3.1.5	provide reasons in writing for rejecting claim	0	0	0
S73(3)	explanation for delay in lodging claim outside 6 months accepted/rejected by insurer within 2 months of receiving explanation	0	0	3
Acknowledgement of Claims				
3.2.1.a	date claim received by insurer & acknowledgement letter sent within 5 days.	7	30	73
3.2.1.b	insurer to advise it will provide copies of treating doctors' reports & police report it has on file, unless otherwise directed by claimant	0	0	100
Claims Information & Investigation				
3.3.1	request police report within 5 days of receipt of claim	0	3	18

Ref.	Description of Claims Handling Requirement	Lowest %Non-Compliance	Median %Non-Compliance	Highest %Non-Compliance
3.3.3	follow up requests for police reports through dedicated liaison officer/s on weekly basis if delays occur	0	0	0
S70(2)	if applicable, explanation for delay in reporting accident to the police, rejected by insurer within 2 months of receiving explanation	0	0	0
3.4.1	admission or denial of liability (or breach of duty of care) as expeditiously and justly as possible within 3 months of proper notice of claim	5	21	50
3.4.2	advise claimant on decision of liability ASAP within 20 days of receipt of relevant information if that would be less than 3 months	0	12	20
3.4.3	If contributory negligence alleged insurer must advise claimant of % alleged.	0	0	0
3.4.4	admission of denial or admission of liability must be disclosed in a Section 81 Notice.	0	9	41
Requests for Information by the Insurer				
3.7.1, 3.7.2, 3.7.4	Insurer not to duplicate requests for information or request information that is irrelevant to the claim	5	21	62

Ref.	Description of Claims Handling Requirement	Lowest %Non-Compliance	Median %Non-Compliance	Highest %Non-Compliance
3.7.3	ensure all correspondence in plain English	0	0	0
3.7.5	As per stat declaration in claim form advise recipient of the date of accident what inquiries are about and ensure inquiries are relevant to the claim.	0	0	0
Medical Evidence				
3.8.1	promptly request hospital discharge summaries/clinical notes and any treating doctors reports	0	16	32
3.8.2.a	request a medical examination of the claimant, if considered appropriate	0	0	0
3.8.2.b	ensure examination is arranged at a time and place readily accessible to claimant	0	0	0
3.8.2.c	insurer should advise claimant of availability of MAA to resolve disagreements on any medical issues	0	0	0

Ref.	Description of Claims Handling Requirement	Lowest %Non-Compliance	Median %Non-Compliance	Highest %Non-Compliance
3.8.2.d	insurer to pay reasonable expenses to claimant for attendance at medical appointment arranged by insurer or assessment by MAS.	0	0	0
3.8.2.e	copy of treating doctor report to be provided by insurer to the claimant within 10 days of receipt, unless doctor has indicated in writing this would be inappropriate	0	44	100
Use of Investigators				
3.9.6	investigators shall not provide a legal opinion in their reports but provide a factual report	0	0	0
Contacting Legally Represented Claimants				
4.1	send requests for information to the claimant's solicitor directly, where requested to do so by the claimant	0	0	0
4.2	may contact legally represented claimant where there was no response or acknowledgement to correspondence within 10 days & an attempt has been made by insurer to confirm receipt of correspondence or after acknowledgement there is no substantive reply within 20 days	0	0	3

Ref.	Description of Claims Handling Requirement	Lowest %Non-Compliance	Median %Non-Compliance	Highest %Non-Compliance
4.3	copy of offer of settlement may be sent to legally represented claimant where there is no response to the offer within 10 days. Insurer to attempt to confirm offer received by sol before letter going to claimant.	0	0	3
4.4	may contact legally represented claimant about rehab assessment or plan. Copy of rehab plan or correspondence should be sent to solicitor and where possible be advised of any communication with client before contacting directly.	0	0	0
Payment of Medical and Treatment Expenses				
5.1.a	once liability admitted, insurer meeting reasonable & necessary (properly verified & relates to mva) hospital, medical, respite & attendant care, rehabilitation & pharmaceutical expenses on an as incurred basis.	0	0	3
5.1.b	insurer advised claimant, within 10 days of receipt of account if any medical treatment expenses will not be paid and claimant advised of right to refer dispute to MAS	0	5	10
5.1.c	insurer not to pay any treatment expenses once claim has settled and prior to settlement monies unless by agreement with claimant.	0	0	0
5.1.d	at the time of making offer of settlement of 24 hrs prior to settlement conference, CARS assessment or Court, insurer to provide a full list of paid and unpaid out of pocket expenses on its file	0	0	48

Ref.	Description of Claims Handling Requirement	Lowest %Non-Compliance	Median %Non-Compliance	Highest %Non-Compliance
Settlement				
7.2	duty of insurer to make a reasonable offer of settlement to claimant within 1 month of parties or MAS assessor agreeing condition has stabilised or within 2 months after claimant has provided all relevant info required to support the claim which ever is the later	0	3	18
7.3	offer clearly states the separate components of the damages and the amount for each head of damages and any relevant calculations	0	0	11
7.4	if not satisfied with offer, claimant advised matter can be referred to CARS	0	0	33
7.5	finalised claim – settlement monies paid within 21 days of settlement unless insurer waiting for workers comp, Centrelink of HIC payment notices. Settlement monies paid within 21 days of receipt of those notices.	0	0	10

4. FURTHER OBSERVATIONS

Further observations were recorded by the auditors where issues of concern were observed that are beyond the scope of the Compliance Audit. Further observations are considered to be indicators of potential non-compliances or areas where claims handling performance may be improved.

Whilst it was observed by the MAA auditors that some insurers could have been more proactive in their endeavours to resolve claims, the same was noted for some claimant solicitors who had not responded to insurer requests for further and better particulars or offers of settlement.

5. DISCUSSION and RECOMMENDATIONS

5.1.1 Compliance Assessment by MAA

Tables 1 and 2 indicate that the CTP insurers were generally complying with all the claims handling requirements for ANFs, and with the majority of the requirements for full claims.

The MAA auditors found that all insurers were paying reasonable and necessary medical expenses up to $500 for ANFs as required by the guidelines with many insurers routinely making payments up to $1000. Payments in excess of $500 were made where the insurer considered that the ANF could be finalised by making the additional medical payments and thus alleviating the need for some claimants from pursuing full claims.

The audit results also indicated that insurers were complying with the majority of claims handling requirements for full claims which included making prompt requests for police reports (3.3.1) and, once liability was admitted, making prompt payments for hospital, medical, respite & attendant care, rehabilitation & pharmaceutical expenses (5.1.a).

However, some important claims handling requirements for full claims had high levels of non-compliance across the industry as indicated by the median levels of %non-compliance. The MAA auditors considered that, as a general guide, non-compliance levels for an individual insurer were high when they exceeded 10% of the audit sample as this may indicate high levels of non-compliance across the insurer's entire claims handling portfolio.

The following practices by insurers resulted in high industry levels of non-compliance with the applicable claims handling requirement: making late determinations of liability (3.4.1); slow requesting of medical evidence (3.8.1); late acknowledgement of receipt of claim (3.2.1.a); not providing treating doctors' reports to claimants (3.8.2.e); and making unnecessary requests for information (3.7).

The highest levels of non-compliance for the above requirements were not confined to one or two insurers, but were spread across all of the insurers audited. These non-compliances often related to an insurer not acting within a specified time limit. It should be noted that a non-compliance was recorded against an insurer regardless of the amount of time by which the insurer exceeded the time limit. For example, requirement 3.4.1 was assessed as a non-compliance if liability for a claim was determined one day after the 3 month time limit had elapsed following proper notice of a claim.

One insurer had a high level of non-compliance (18%) with requirement 7.2 relating to making reasonable offers of settlement. This occurred as a result of the insurer failing to make an offer of settlement within the specified time limit – it was not that the MAA auditors considered the offer as being unreasonable.

5.1.2 Compliance Self-Reports by Insurers

Since the establishment of the MAA's Compliance Unit in April 2001, the licensed CTP insurers have generally co-operated with the Compliance Unit's recommendations and responded in a timely manner to requests for information and the provision of statutory reports.

All the insurers prepared an annual self-assessment report to the MAA on their compliance with the Guidelines (Guidelines requirement 10.1.1). These reports were submitted in January 2002 and covered the 2001 calendar year. The insurers completed a template table supplied by the MAA consisting of 27 of the Claims Handling Guidelines requirements listed in Tables 1 and 2. Whilst all insurers made a considerable effort in completing their self-assessments of compliance, it was noted that most insurers had not described the methodology used to make their assessments. In addition, the assessments of compliance were variable in the manner in which they were reported, ranging from semi-quantitative (eg. partially complied) through to quantitative (eg. 88% Compliance) assessments.

The MAA auditors determined the percentage of the 27 requirements for which there was an acceptable correlation between compliance assessments made by each insurer and the MAA. The extent of the correlation for each insurer is not a measure of compliance performance, rather it is an indicator of the reliability of the insurer's self-assessments of compliance. The percentage of compliance assessments with an acceptable correlation was determined for each insurer, and ranged from a minimum of 65% to a maximum of 85% across the industry.

All insurers complied with Guidelines requirement 9.1.8 by providing the MAA with a 6-monthly report on complaints and outcomes. Each insurer's complaint summary report for the 6-month period ending 30 June 2002 was compared with the MAA complaint database for accuracy and completeness. The insurers' complaint summary reports were generally complete and accurate, and complaints were generally being resolved to the MAA's satisfaction and in a timely fashion.

However, one insurer's complaint summary report did not include all the complaints that had been referred to it by the MAA. The insurer subsequently provided to the MAA an updated report that was complete and accurate. Another insurer did not include old Act complaints in its report although it wasn't clear from the Guidelines whether this was a requirement. The MAA advised the insurer that it would address this issue in its review of the Claims Handling Guidelines.

Recommendation 1: MAA to Conduct Further Compliance Monitoring and Assessment

It is recommended that ongoing monitoring be conducted of insurers' compliance with the claims handling guidelines.

Monitoring will include:

- reauditing the insurers' compliance with their claims handling requirements in 2003;
- comparing the audit results with the baseline results obtained for each insurer and the industry in 2002;
- analysing the insurers' compliance self-reports;
- reviewing the insurers' complaint summary reports;
- reviewing information relating to claims handling compliance and performance from insurer surveys and claimants surveys.

The next audit sample could also include sub-samples of mature and recent claims to monitor the effectiveness of any claims handling changes that may have been implemented by an insurer.

5.2 Adequacy of Claims Handing Requirements

Some insurers expressed concern to the MAA auditors that some Guidelines requirements with time limits had been set at maximum performance levels. For example, to comply with Guidelines requirement 3.2.1.a an insurer must acknowledge receipt of a claim within 5 working days. The MAA auditors accept that this particular timeframe sets a high performance standard rather than a minimum compliance standard.

The MAA auditors also noted that some of the Guidelines requirements were not clearly expressed or may not be achieving the best outcomes for claimants. For example, Requirement 4.1 is silent on whether an insurer may send courtesy copies of correspondence to a claimant's solicitor directly to the claimant.

Notwithstanding the difficulties insurers have experienced trying to comply with some of the guidelines, it should be noted from Tables 1 and 2 that for each requirement at least one insurer had a level of non-compliance less than 10%. Indeed in most cases the median level of non-compliance was 0%, indicating that most of the Guidelines requirements are achievable.

Recommendation 2: MAA to review the Claims Handling Guidelines

It is recommended that the MAA conduct a review of the Claims Handling Guidelines.

The purpose of the review will be to ensure Guidelines requirements are clearly expressed and will help to achieve appropriate outcomes for claimants and the Motor Accidents Scheme.

The review of the Claims Handling Guidelines is currently underway. The MAA has asked the insurers to rank the significance of each claims handling requirement. The insurers have also been requested to submit recommendations for any changes, deletion or additions to the Claims Handling Guidelines.

5.3 Promotion of Appropriate Claims Handling Outcomes

In order to promote continuous improvement in insurers' compliance with the guidelines the MAA will document its regulatory and enforcement policy. The policy will allow the insurers flexibility for innovative claims management to ensure appropriate outcomes are achieved for claimants.

Recommendation 3: MAA to develop a Regulatory and Enforcement Policy

It is recommended that the MAA document its regulatory and enforcement policy for dealing with non-compliances, which will provide insurers consistency and certainty regarding action that will be taken by the regulator for any breaches.

5.4 Expeditious Resolution of Claims

It was observed by the MAA auditors that some insurers could have been more proactive in their endeavours to resolve claims (see Further Observations in Section 4). The same was also noted for some claimant solicitors who had not responded to insurer requests for further and better particulars or offers of settlement.

Recommendation 4: MAA to Explore Ways to Expedite the Resolution of Claims

It is recommended that the MAA explore ways of promoting the just and expeditious resolution of claims as required by Section 80 of the Act. This may include:

- conducting surveys of scheme participants;
- developing new claims handling or medical assessment guidelines; and
- conducting a performance review of claims handling.

MOTOR ACCIDENTS AUTHORITY
REPORT TO THE LAW AND JUSTICE COMMITTEE
NOVEMBER 2002

Scheme performance indicators

In evidence to the Legislative Council's Standing Committee on Law and Justice in May 2000, the MAA identified four scheme performance indicators. Each of the performance indicators is addressed in this section based on the operation of the Motor Accidents Compensation Act 1999 since it started on 5 October 1999, to the end of September 2002. The four scheme performance indicators are affordability, effectiveness, fairness and efficiency.

Affordability

The affordability of Green Slips prices has improved according to three measures:

- Average premiums
- Ratio of premiums to average weekly earnings
- Price paid by the majority of Sydney metropolitan passenger vehicle owners.

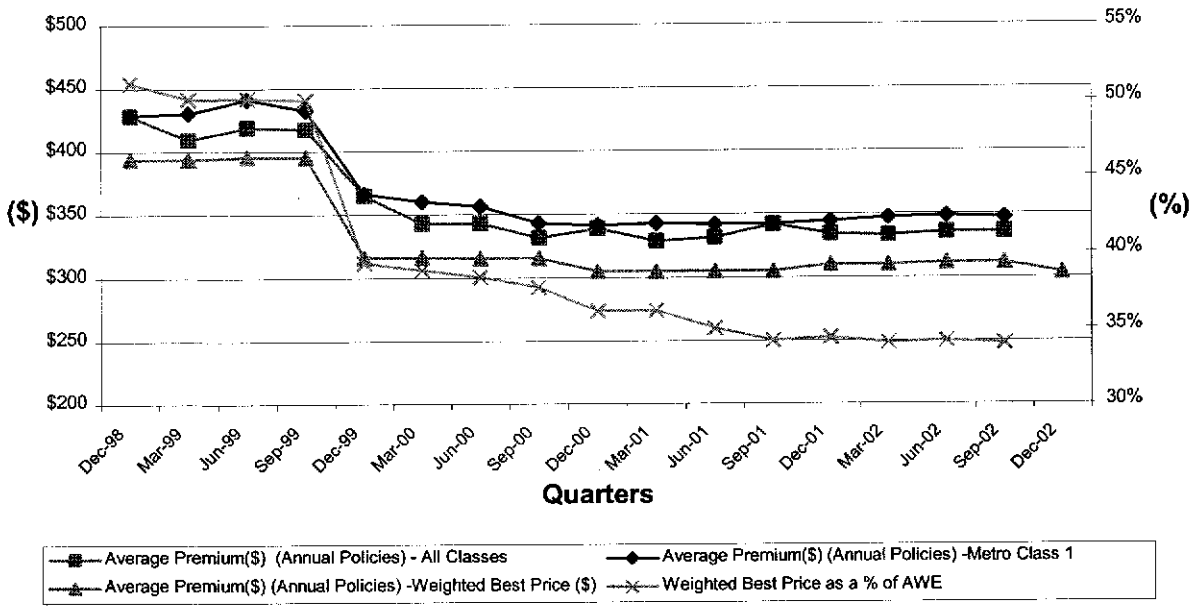
Average premium
The average premium for a Sydney metropolitan passenger vehicle dropped from $441 in June 1999 to $341 in December 2000 increasing to $347 (excluding GST) in September 2002. The average annual premium over all vehicle classes in NSW has dropped from $419 in June 1999 to $336 in September 2002.

Premiums and Average Weekly Earnings
The price of a Green Slip premium has dropped while average weekly earnings have increased. As a proportion of average weekly earnings, weighted best price has dropped from 50% before the reforms to 34% in September 2002.

Premiums reduce for most vehicle owners
At September 2002, more than 70% of owners of metropolitan passenger vehicles paid $318 or less (excluding GST) for a Green Slip.

For the first year after the commencement of the legislation, the MAA had the power to reject a premium if the MAA 'was not satisfied ... that the majority of policies relating to passenger motor vehicles in metropolitan areas will attract a premium of not more than approximately $330'. In the first year of the scheme, more than 70% of premiums for metropolitan passenger vehicles were $330 or less. The $330 mark has now dropped to $318 and is expected to drop further still.

Average Premiums



Effectiveness

To measure scheme effectiveness the experience of the first three years of the new scheme is compared with the last three years of the old scheme at the corresponding point of development.

Number of claims and time periods

		Old scheme	New scheme	% difference
Number of notifications	ANFs		17,654	
	Direct full claims		23,217	
	Converted ANFs		8,804	
	Full claims		32,021	
	Total notifications	40,834	40,871	0.1%
Average time to notification (days)	ANFs		25.5	
	Full claims	113.6	100.8	-11.2%
	Total notifications	113.6	84.5	-25.6%
Average time to liability decision (days)	Full claims	125.0	96.6	-22.7%
Average time to first payment to claimant (days)	ANFs		41.8	
	Total notifications	171.6	98.1	-42.9%
Finalisations	Full claims	15,383 (37.7%)	12,308 (38.4%)	
	Total notifications	15,383 (37.7%)	19,536 (47.8%)	27.0%
Average time to finalisation (days)	ANFs		156.2	
	Full claims	350.4	350.6	0.1%
	Total notifications	350.4	280.1	-20%

Appendix 2

Review of Prudential Responsibilities and Practices February 2002

Review of Prudential Responsibilities and Practices February 2002

ASSURANCE & ADVISORY
BUSINESS SERVICES

MOTOR ACCIDENTS AUTHORITY

ERNST & YOUNG

FROM THOUGHT TO FINISH.™

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Important Note

This report is intended for the sole use of the Board of Directors, Audit Committee and Executive Management of the Motor Accidents Authority of New South Wales ('MAA'). No other party or parties shall be entitled to place any reliance whatsoever on the contents of this report nor shall it be distributed to third parties without the knowledge and written permission of both MAA and Ernst & Young.

1. Introduction and Scope of Review

Ernst & Young has been engaged by the Motor Accidents Authority (MAA) to perform a review of its prudential responsibilities and practices as outlined in our agreed engagement letter dated 6 July 2001.

In particular, our review is focussed on identifying the MAA's prudential responsibilities and assessing the processes currently established by the authority to discharge these responsibilities. Our review has been broken into a number of phases summarised as follows:

1.1 Confirmation of the MAA's prudential responsibilities by reference to:

- appropriate legislation;
- discussions with MAA Board members / Executives; and
- reviewing MAA publications such as recent annual reports.

1.2 Reviewing the way in which the MAA discharges these responsibilities, including how it uses information provided by APRA. In addition we will provide feedback on whether we believe MAA does or can 'add value' to the prudential control environment taking into account the role of APRA.

1.3 Providing advice in relation to other potential mechanisms to allow the MAA to discharge its prudential responsibilities, including summarising how other Agencies with similar prudential responsibilities are managing the issue.

The following MAA officers were interviewed during our review:

- Richard Grellamn, Chairman, MAA
- David Bowen, General Manager, MAA
- Concetta Rizzo, Manager Insurance Division, MAA
- Steve Clough, Principal Compliance Officer, MAA
- Robert Dawson, Legal Counsell, MAA
- Noel Wong, Principal Financial Analyst, MAA
- Craig Thorburn, General Manager Diversified Institutions, APRA.
- Richard Philip, Manager Diversified Institutions, APRA

We also sought input from the following people during our review:

- Mr Doug Pearce, Chief General Manager Commercial Insurance and Financial Services, NRMA
- Ms Lesley Anderson, Insurance Commissioner, MAIC
- Mr Harry Neesham, Executive Director, WorkCover

Our conclusions and recommendations are set out in sections 9 and 10 of this report.

2. Use of Report

We understand and agree that our report will be used to assist the MAA in discussion with or providing advice to its Board, the Minister, APRA and NSW Treasury and may also be provided as part of any submission by the MAA to the HIH Royal Commission. Our report may not be publicly released in part or in full without our express written consent.

We note that the review does not constitute an audit or review in accordance with Australian Auditing Standards.

3. Executive Summary

This executive summary presents the key conclusions and recommendations arising from our review. A full appreciation of the work performed and the issues addressed can only be obtained from a reading of the full report.

- The Motor Accidents Compensation Act 1999 imposes on the MAA the responsibility for the prudential supervision of the insurers it licenses to underwrite CTP policies in NSW.

- It is our view that the most effective prudential supervision of MAA's licensed insurers would be achieved through a closer working relationship with APRA that encompasses the following:

  - MAA developing a stronger understanding of its licensed insurers and documenting this understanding.
  - MAA being actively involved with APRA in the planning of the prudential supervision.
  - MAA having direct and constant contact with the APRA staff members responsible for each of the MAA's licensed insurers.
  - MAA accompanying APRA on meetings and site inspections.
  - MAA and APRA holding regular meetings on each of MAA's licensed insurers.
  - MAA and APRA sharing information (not just data).
  - MAA forming its own conclusions on each of its licensed insurers and discussing these with APRA.
  - MAA consulting APRA prior to taking any action in respect of termination or suspension of a CTP license.
  - MAA ensuring relevant staff are adequately trained to implement this method of prudential supervision.

- To support this model of prudential supervision the MAA and APRA will need to co-develop a strategy and operational model outlining how they will cooperate acknowledging that the MAA will rely on the work performed by APRA.

- The MAA needs to develop a detailed plan addressing how it will be able to place reliance on APRA including:

  - how information will flow between the entities
  - how the MAA will work with APRA
  - how the MAA will get the necessary comfort it requires
  - how the MAA will make decisions from the information it receives from APRA

- The MAA needs to discuss and agree this detailed plan with APRA.

- The MAA then needs to determine its resourcing requirements based on the strategy operational model and detailed plan.

- To demonstrate that it is fulfilling its responsibilities for prudential supervision the board of the MAA needs to clearly document:

  - when it will rely on APRA
  - how it will rely on APRA
  - why it is reasonable to rely on APRA

  The Board also needs to sign off the work plan developed by the MAA regarding prudential supervision including noting the MAA reliance on APRA will work in practice.

- The role of the MAA and the method used by it to discharge its obligations should then be effectively communicated to all key stakeholders including MAA staff, insurers and customers.

4. MAA's Prudential Responsibilities

4.1 Background

The MAA is a statutory corporation that supervises and monitors the NSW Motor Accident Scheme ("Scheme"). The MAA was established on 10 March 1989 by the Motor Accident Act 1988 ("MA Act"). The Scheme was amended significantly by the Motor Accident Compensation Act 1999 ("MAC Act"), which commenced on 5 October 1999. The MAC Act also reconstituted the MAA. The MA Act now only applies to accidents that occurred prior to 5 October 1999.

4.2 Objectives Of MAC Act And MAA

The objectives of the MAC Act are set out in section 5 of the Act. The objectives of the Act are relevant to understanding the context within which the MAA performs it role. The Act's objectives, which are relevant to our review, include:

- promote competition in the setting of premiums for third party policies and **to provide the MAA with a prudential role to ensure against market failure**;
- keep premiums affordable;
- ensure that insurers charge premiums that fully fund their anticipated liability;
- deter fraud in connection with compulsory third party insurance.

The functions of the Motor Accidents Authority are set out in section 206 of the MAC Act. These are summarised in the MAA's 1999/2000 annual report as follows:

- monitoring the operation of the CTP Scheme
- collection and analysis of statistics on the Scheme
- publication and dissemination of information on the Scheme
- provision of funding for the reduction of trauma as a result of motor vehicle accidents
- issue certain guidelines
- advice to the Minister on the efficiency and effectiveness of the Scheme
- provision of support and advice to the Motor Accidents Council, and

- specific functions to support the provision of acute care treatment, rehabilitation, long-term support and other services for persons injured in motor accidents.

4.3 MAA's Vision and Purpose

The MAA's 1999/2000 Annual Report also describes its vision and purpose as follows:

> *"Our Vision is to have a Compulsory Third Party Scheme that is affordable, fair and accessible.*
>
> *Our Purpose is to keep Green Slips affordable, lower the level of litigation in resolving claims and improve the timeliness and effectiveness of medical treatment to injured persons through:*
>
> - *regulating the CTP Scheme and its participants*
> - *providing education and information to stakeholders and service providers*
> - *operating medical and claims assessment services; and*
> - *continuous improvement in all areas of the Authority's operations."*

Page 8 of the 1999/2000 Annual Report goes on to state that:

> *"The New Act has provided the MAA with a stronger prudential supervisory role than it has assumed previously and there will be greater emphasis in the coming year on monitoring the Scheme's performance. In addition, the Authority will be examining the compliance of insurers with their obligations under the new Act using performance audit procedures currently being developed. A new compliance unit within the Insurance Division is being established to undertake this work."*

It is noted that while a compliance unit has been created it has been focussing primarily on reviewing the effectiveness of the Scheme – in particular, compliance with claims handling and market practice guidelines. It has only assumed a limited prudential role.

4.4 Outline Of Provisions Of The MAC Act

This review is focussed exclusively on the scope of the prudential responsibilities imposed upon the MAA and the manner in which it discharges those responsibilities. The review does not focus on the MAA's broader role under the MAC Act. Therefore, the following summary focuses primarily on Chapter 7.

In this review, we have taken "prudential responsibilities" to be referring to the MAA's role in guarding against the risk of financial failure of the licensed insurer, which includes its role in monitoring capital and liquidity requirements.

Chapter 7 of the MAC Act

Overview of Chapter 7

Chapter 7 deals with the licensing and supervision of insurers who issue third party policies and with the management of insolvent third party insurers.

Part 7. 1 of Chapter 7

This part deals with the licensing of insurers to issue compulsory third party insurance. It:

- prescribes eligibility conditions;
- sets out provisions relating to the contents of licence applications (which includes details of directors, shareholders, re-insurance arrangements, proposed business plan);
- outlines the facts the MAA should take into account in determining an application for a licence;
- sets out rules dealing with the duration of the licence;
- authorises the MAA to impose conditions on a licence;
- permits the review of the MAA's decision by the Administrative Appeals Tribunal;
- sets out provisions relating to the cancellation, assignment and suspension of licences. It is worth noting that the MAA is authorised to cancel a licence for "any reason if thinks fit."; and
- provides for the imposition of a civil penalty of up to $50,000 for making of a false licence application or a contravention by a licensed insurer of the Act or its licence.

The MAA has previously taken advice from Phillips Fox on the scope of the term "any reason it thinks fit". We agree that with their comments and suggestions are sensible. The MAA's rights to suspend a licence are set out in section 165 and include the right to suspend if the licensee has contravened its licence or the Act, if the insurer is unlikely to meet its liabilities under its CTP policies, a provisional liquidator etc has been appointed, or an inspector has been appointed the Insurance Act. Clearly, this provision demonstrates the need for regular and close contact with APRA.

In October 1999 the MAA issued guidelines on "Applications for NSW CTP Licences". These guidelines describe the licensing process, identify the materials to be lodged with the licence application and sets out possible conditions that may attach to a licence. The MAA has also issued guidelines on the suspension and assignment of licences respectively, although the suspension guidelines only apply in circumstances where there is a transfer and withdrawal of business. There are no general guidelines on suspension powers.

Part 7.2 of Chapter 7

This part deals with the supervision of licensed insurers by the MAA. It authorises the MAA to issue to licensed insurers guidelines with respect to the issue of third party policies and makes it a condition of the licence that the licensed insurer comply with these guidelines. As we understand it, the guidelines that have been issued by the MAA do not have any prudential impact. It should be noted that a standard licence condition requires the licensee to provide the MAA with full details of the existence of or creation of any security, encumbrance or charge over its assets. It appears that this condition is not acted upon by insurers or adequately enforced by the MAA.

More relevantly, this part requires licensed insurers to prepare and provide to the MAA a business plan for its third party business when requested by the MAA. The MAA currently requires a business plan to be submitted at the time of the original application. The part also requires insurers to revise their business plans at least on twelve monthly intervals as the MAA directs or whenever they deviate from the plan. The business plan must be prepared in accordance with any guidelines issued by the MAA from time to time. The business plan is to deal with matters such as claims handling, management, expenses and systems. Although paragraph 13.10 of the Licensing Guidance Notes contains some commentary on business plans, the MAA has issued no general guidelines on the form and content of business plans.

The only regular formal correspondence between the MAA and licensed insurers regarding business plans appears to be the "Certificate of the CEO" provided when insurers submit a rate filing to the MAA. This certificate contains an affirmation by the CEO that the CEO is "satisfied that the company's CTP business plan ensures CTP insurance is available to all proposers in accordance with the terms and conditions of the insurer's licence. MAA Premium Determination Guidelines and MAA Market Practice Guidelines". This is clearly an affirmation on market practice issues rather than a tool for prudential supervision.

Part 7.2 also requires insurers to keep accounting and other records as prescribed by the Regulations.

Lastly, Part 7.2 imposes detailed notification obligations on licensed insurers including the obligation to:

- notify the MAA of the amount of insurance premiums received by it in relation to all third party policies taken to be issued during a relevant period. The MAA is then to determine, having regard to premiums received, the market share of the insurer;
- notify the MAA of actual or proposed reinsurance arrangements, the terms of any ISC(now APRA) approvals under the Insurance Act in relation to the reinsurance
- if requested by the MAA, provide details of the way in which its third party funds and other funds are invested;
- submit returns in the prescribed form on a quarterly basis; and
- notify the MAA within 21 days of certain events occurring (as listed in the "suspension of licence" provision) or of a decrease or proposed decrease in the issued capital of the insurer.

To assist it in performing its functions, the MAA may appoint an appropriately qualified person to audit and inspect the accounting and other records relating to the financial or business position of a licensed insurer.

The MAA may also require an insurer to provide any additional information or documents that the MAA requires relating to the business or the financial position of the insurer. This would include information that is relevant to insurance premiums filed by the insurer and the cost of claims handling and settlement of claims.

The MAA may apply to the Supreme Court to have it make orders to protect the interests of CTP policies issued by a particular licensed insurer or former licensed insurer. The court may make such an order if it satisfied that the relevant insurer is not able to meet its liabilities or may not be able to do so or has acted in a manner that is prejudicial to the interests of the holder of CTP policies. If the MAA wants to take such a course of action it must notify both APRA and ASIC of its intention to do so. Both of those other regulators have the right to appear in the proceedings.

Section 182 of the Act confers upon the MAA broad powers to enter the premises of the licensed insurer and carry out appropriate inspection, including questioning officers of the insurer.

Part 7.3 of Chapter 7

This part deals with matters relating to insolvent insurers. It includes provisions relating to the tasks of liquidators of insolvent insurers and the role of the nominal defendant as agent and attorney of persons insured under a third party insurance policy issued by an insolvent insurer.

4.5 MAA's Prudential Responsibilities

The MAC Act clearly imposes on the MAA the responsibility for the prudential supervision of the insurers it licences to underwrite CTP policies in NSW. The Act gives the MAA the means to monitor the financial position of insurers by giving it the ability to obtain relevant information, to carry out an inspection of the licensed insurer and to question officers of the insurer. The Act also gives the MAA the power to put conditions on licences and to suspend, cancel or assign licences.

It is our view that it is necessary for the MAA to have these responsibilities and powers if it is to fulfil its primary objective of creating and maintaining a Compulsory Third Party Scheme that is affordable, fair and accessible.

We do not believe that the MAA and the CTP Scheme would be best served by removing this prudential supervision. To effectively manage the Scheme the MAA needs to be able to effectively manage the entry and exit of licensed insurers.

4.6 Advice from Phillips Fox

In December 1996, the MAA took advice from Phillips Fox on the MAA's powers, obligations and role in the event of a licensed insurer's insolvency or anticipated insolvency (**"1996 Advice"**).

In April 1997 the MAA again took advice from Phillips Fox – this time on the question: at what point should the MAA exercise its suspension or winding up rights and which regulator should act first (**"1997 Advice"**).

Both of these advices pertained to the MA Act, not the MAC Act.

In the 1996 advice Phillips Fox made a number of suggestions as to how the MA Act could be modified to enable it to better guard against insurer insolvency including the introduction of whistle blowing provisions, an obligation on directors to provide a compliance declaration to the regulator, directors liability provisions and an obligation on insurers to notify the MAA of changes in information provided as part of the registration process. The one aspect of the advice that was implemented was the execution of a Memorandum of Understanding between MAA and APRA to facilitate a sharing of information.

The 1997 advice, which looked at the MAA's obligations to cancel or suspend a licence, concluded that the ISC (now APRA) has a greater prudential role than the MAA and the MAA's position can best be protected by:

- consistent and diligent examination of the statutory information provided by licensed insurers.
- general monitoring of the industry information; and
- regular consultation and full exchange of relevant information with the ISC or the new prudential regulator of the general insurance industry.

As noted above neither of these advices related to the MAC Act and neither advice was focused on the specific question of what is the scope of the MAA's prudential obligations and how to discharge them.

5. Current State

It is clear from our review that the main focus of the MAA to date has been to manage and monitor the effectiveness of the Scheme itself. Only limited attention has been given to the prudential supervision of its licensed insurers, the MAA relying almost entirely on APRA (and previously ISC). This is consistent with the 1997 advice of Phillips Fox.

The current state of the MAA's prudential supervision can be summarised under a number of headings.

5.1 Information collected

A condition of the licence that is given to each insurer licensed by the MAA is that the insurer provides the MAA with:

- copies of the forms that the insurer completes and submits to APRA ("APRA forms"). This includes both the unaudited quarterly returns and the annual audited returns.
- copies of any correspondence with APRA

The MAA does not request additional information from licensed insurers other than to clarify the contents of the APRA forms. Nor does the MAA have a formal programme to ensure compliance with this licence condition in regards to the correspondence.

5.2 Analysis of financial information

Currently, the, Principal Financial Analyst, prepares a two page summary of the financial information reviewed and analysed for each licensed insurer. This summary is updated quarterly upon the receipt of new data (APRA quarterly forms). These reports contain general corporate information, market information, financial information (financial information in respect of the previous three years and the current quarter), and details on the insurer's solvency position. The material received from APRA is augmented with general market information. The summaries for each licensed insurer are aggregated in a single report, which also contains some industry data and analysis.

An example document has been provided. The document contains only very basic information and a fairly rudimentary level of analysis. More detailed calculations are performed, both annually and quarterly, based on data in the APRA forms. The Principal Financial Analyst performs these calculations and a history is maintained for each insurer.

A detailed analysis of the trends in the results of the calculations could form a useful basis for further investigation. However as the calculations are based solely on APRA data it would be expected that APRA would also have to the ability to analyse this information.

The current information, without the benefit of additional investigation, provides the MAA with only a limited ability to assess the financial condition of the licensed insurer or to predict an impending insolvency.

5.3 Investigations, inspections and meetings

The MAA does not undertake regular meetings or discussions with licensed insurers on matters pertaining to financial position or solvency.

Nor does the MAA conduct its own onsite investigations of licensed insurers.

5.4 Exercise of other rights under Part 7

While the MAA examines business plans as part of the initial licence application process, it does not call for nor examine business plans on an ongoing basis. The only circumstance in which it would subsequently review a business plan is if there was a major change to the insurer's business. In any event it seems that business plans, when they are submitted, have typically been completed in a rather perfunctory way.

Similarly, although the MAA is empowered to call for information about the way in which its third party funds and other funds are invested it has never done so. While this may be justified because third party assets are not held as a discrete pool and the MAA is not really in a position to investigate the assets of the company as a whole, the MAA has not formally documented this position.

Further, the MAA's review of an insurer's reinsurance arrangements is also quite limited, with the MAA assuming that APRA will undertake all necessary reviews.

Lastly, as noted above, although it has the power to do so, the MAA has not issued guidelines in respect of a number of matters such as the form and content of business plans or suspension or cancellation of licences. Nor has it issued internal guidance notes in respect of the conduct of site inspections.

5.5 Complaints Review

One method commonly employed by regulators to assist them in forming a view on whether there are any potential prudential concerns about an insurer is to monitor complaints in respect of that insurer. For instance, a significant number of complaints that an insurer is late in making payments on claims or has unreasonably refused to admit claims may point to some underlying cash flow or solvency concerns.

The MAA does have an established process for dealing with claims handling complaints against insurers (of which there were 40 in 2001). We have been advised that the MAA has begun to develop a system for analysing complaints to identify systemic problems for particular insurers.

5.6 Relationship with APRA

Currently, the MAA has a cordial relationship with APRA however the relationship is, at present, fairly limited and would not be adding greatly to the MAA's ability to fulfil its responsibilities for prudential supervision.

The MAA and APRA meet every 6 months to discuss issues associated with the MAA's licensed insurers.

It is our assessment that the MAA is wholly reliant on APRA to determine the financial capability of a licensed insurer to remain in business and to continue to underwrite. Again, we note that this practice is consistent with the Phillips Fox 1997 advice.

However

- until recently (viz post Qu. 1 2001) there had been no formal decision by either management or the Board to delegate to APRA
- the rationale for MAA delegating its prudential supervisory role to APRA is not documented and not fully understood by the MAA and APRA
- the relationship between the MAA and APRA is not sufficiently strong to provide the MAA with:
  - sufficient comfort regarding the prudential supervision of their licensed insurers
  - sufficient information regarding their licensed insurers to support the management of the Scheme.

6. MAA Proposed Future State

It is recognised internally within the MAA, that the current state is inadequate to allow the MAA to fulfil its responsibilities for prudential supervision. This belief has been strengthened by the HIH collapse.

An alternative to the current practice of relying on APRA is for the MAA to perform a full function role as a prudential regulator. That is, it could attempt to become self reliant in terms of the prudential regulation of its licensed insurers effectively imposing a state based prudential regime. This could be achieved by either:

- building internal capability; or
- outsourcing to a third party

The alternative of building a fully functioning internal capacity has been examined internally. The Principal Financial Analyst has produced two internal discussion documents that relate to this issue.

- "Prudential Regulation Framework Blueprint", May – June 2001
- "Risk Based Assessment of Licensed Insurers and Minimising Risks of Insurer Failure", June 2001

The General Manager of the MAA has reviewed these documents, however we note, they have not been formally accepted and have only the status of internal discussion documents.

Our view of this alternative is summarised as follows;

- Both options involve duplicating to a large extent the role of APRA. If APRA is functioning effectively then this duplication involves an additional cost for the MAA and additional costs for insurers with no real gain.

- The option of building an internal capability has the following additional disadvantages.
  - due to scale issues (ie the MAA only supervises a limited number of insurers – currently 8 active licences and 6 suspended licences) it would be difficult to justify "experts" across the range of risks faced by general insurers

- due to scale issues the ability to benchmark indicator of financial strength and risk management best practices would be severely limited
- it introduces a range of management and human resource issues that would take senior management time to manage (eg is there sufficient career development opportunities to attract and retain the right staff)

- The option of outsourcing to a third party has the following additional considerations:
  - there will be issues associated with providing the third party the same powers and access as is available to APRA and the MAA.
  - with the possible exception of rating agencies there are no third parties with the required experience to operate a regulatory function.
  - it is possible that various components of the regulatory function could be outsourced rather than fully outsourcing the entire role.

Whether the MAA fulfils its responsibility for prudential regulation by relying on APRA, building an internal capability, or outsourcing to a third party the MAA retains the responsibility for dealing with an insurer in financial difficulty. This may include making a decision to suspend or terminate a licence or to transfer assets and liabilities to another insurer. It may also entail managing the MAA's position should an insurer become insolvent (raising funds to cover a deficit, organising appropriate claims management resources etc).

Hence,, it is our opinion that the MAA needs to be sure it has sufficient information to support the decisions required. It must also establish the tests or benchmarks it will apply to insurers to ascertain various levels of financial difficulty and the action it will initiate upon breach of each of the tests or benchmarks.

The internal discussion documents noted above include a suggestion to improve the MAA's knowledge gathering and documentation for each licensed insurer. These dossiers on each insurer are given the title of "Insurer Risk Profile".

The aim of the insurer risk profiles is described as follows:

> "Insurer Risk Profiles will attempt to identify insurers at risk. If possible, the Profiles would provide advance warnings of potential failure, to allow action to minimise the risk and impact of another licensed insurer solvency"

The information contained in the Insurer Risk Profiles are sourced from either:

- publicly available information; or
- APRA forms (as supplied by APRA or company as a condition of their licence)

In theory the MAA could also obtain its own data from its licensed insurers. This could be gathered from direct requests or from interviews with the Board and senior management.

The Insurer Risk Profiles could provide useful information regarding an insurer and its solvency position however they will not put the MAA in a better position than APRA, the rating agencies or the company's auditors in predicting a pending insolvency.

It is our view that the Insurer Risk Profiles discussed above:

- would put the MAA in a better position to understand its licensed insurers financial position
- would provide a useful tool to keep the Board of the MAA more up to date with the financial position of each of the licensed insurers. This would ensure the Board would have sufficient background information at the time important decisions need to be made.

In addition to these internal discussion documents the General Manger has put forward a paper to the Board of the MAA "Protecting CTP Funds and the role of the MAA as Regulator of CTP Insurers". This paper recommends that the MAC Act be amended to introduce the following components.

1. increase MAA's power to suspend or cancel a CTP licence and arrange for a transfer of business;

2. provide that the MAA may take a charge over the assets of a licensed insurer up to an amount equivalent to the outstanding claims reserves required for CTP claims; and

3. introduce an enhanced monitoring and inspections program.

As regards point (1) it is worth noting that the MAA already has very broad powers of suspension – see paragraph 4.4 above.

Point (2) is outside the scope of this review.

Our views on point (3) are discussed in section 8 As can be seen, we regard enhance monitoring and inspections as an activity that can be performed collaboratively with APRA.

We note that the Paper also states (at paragraph 2.2):

> *The Board does not believe that the MAA should impose a State based prudential regime. Prudential regulation of insurance companies is the clear responsibility of APRA and the MAA should concentrate on business regulation relating to CTP policies and claims.*

As can be seen from our comments in section 4 it is our view that the MAC Act already imposes a significant level of prudential supervisory obligations on the MAA and while APRA is clearly the prime regulator, the MAA still has a real prudential role to fulfil. We discuss at Section 9 how these obligations can be discharged in a manner which minimises duplication and inefficiency.

Consideration of the June 2001 Board paper lead the Board of the MAA to request Ernst & Young to undertake the current review documented in this report.

7. Other State Regulatory Authorities

We have reviewed the legislation associated with the operation of the MAIC in Queensland and WorkCover in Western Australia. We have also conducted short interviews with:

- Ms Lesley Anderson, Insurance Commissioner, MAIC
- Mr Harry Neesham, Executive Director, WorkCover

It has been requested that the content of these discussions remain confidential however the issues arising from those discussions have been dealt with in the substantive body of our report.

Both organisations have prudential responsibilities similar to those of the MAA. The following provides a short description on each authority.

7.1 MAIC Queensland

Division 2 of The Motor Accident Act 1994 provides the description of the general functions of the commission. Section 10(1) outlines the Commission's functions. The first two functions are given as:

10.(1) The commission's functions are to—

(a) supervise insurers operating under the statutory insurance scheme and issue, suspend or withdraw licenses for insurers operating under the scheme; and

(b) establish and revise prudential standards with which licensed insurers must comply; and

The requirements for an insurer to obtain a licence to operate in the CTP market in Queensland are set out in a letter provided to insurers upon request. The requirements are more heavily focused towards ensuring companies have sufficient capabilities to provide adequate claims management services to claimants (rather than financial security). Claims management and CTP administration being areas where the MAIC have sole responsibility.

The MAIC rely on APRA with regards to the prudential supervision of its licensed insurers. The prudential standards prescribed by the MAIC are that the insurer must comply with APRA's prudential standards. The MAIC imposes no additional standards. As is the case with the MAA, the MAIC obtain copies of APRA returns and companies are required to provide them with correspondence with APRA.

Again as with the MAA, the MAIC have half yearly meetings with APRA to discuss their licensed insurers, general market conditions and the activities of APRA.

7.2 WorkCover Western Australia

Responsibility for supervision of insurers is given to WorkCover under section 161 of the Workers' Compensation and Rehabilitation Act 1981. In particular section 161(3)(a) seems to be the most relevant to prudential supervision.

The Act sets out licensing requirements. Further, with regard to financial strength and solvency, the Act stipulates that the company must:

- be an incorporated company carrying on business in the State under the Insurance Act 1973 of the Commonwealth (ie licensed by APRA)
- have material and financial resources available to it that the Minister, on the advice of the Commission, considers sufficient to enable it to discharge its obligations for the purposes of this Act

As with the MAA and MAIC, WorkCover require the companies to provide to it:

- all returns provided to APRA
- correspondence with APRA relating to Solvency.

WorkCover do not require companies to provide any other information.

WorkCover do, however, monitor:

- complaints regarding the non payment of claims
- the level of claim payments made (as compared to the "normal" level of claim payments)

to provide an indication as to solvency or financial difficulties (on the basis that a company experiencing problems may start to have problems with cashflow or may start to become very strict on accepting liability and determining quantum).

We believe this is an important area where state authorities can provide additional information to APRA to add to the prudential supervision of its licensed insurers. APRA only receives information of this nature annually and often many weeks after the end of the year. State authorities, on the other hand, receive more regular (monthly or quarterly) and more up to date information than APRA on premiums written and claim payments made.

8. APRA

8.1 Transition from ISC

APRA was established on 1 July 1998 with its inaugural Board meeting taking place on that date. At that time APRA took over the functions of the ISC. By November 1998 staff had been relocated to their current premises however many ISC staff did not make the transition to APRA.

This had a number of consequences:

- APRA lost some of the corporate knowledge existing within the ISC
- APRA lost some expertise and in particular, expertise in general insurance companies
- MAA lost a number of close contacts it had built up within the ISC.

This transition has had an impact on the relationship between the MAA and APRA . It has probably also had a short term impact on APRA's ability to perform its role as prudential regulator for general insurance companies. This may receive some attention at the Royal Commission.

8.2 New Standards for General Insurers

APRA is in the process of introducing a new set of regulations and prudential standards for the general insurance industry. The new standards are fairly wide ranging and deal with:

- liability valuation
- capital requirements
- risk management
- reinsurance arrangements.

This new regime, which is due for implementation on 1 July 2002, will represent a significant improvement in the prudential regulation of general insurers in Australia.

This should provide both APRA and the MAA with a firmer base from which to regulate their licensed insurers.

8.3 Current Dealings with MAA

At present APRA's dealings with the MAA are relatively limited. APRA and MAA have meetings every six months to discuss the MAA's licensed insurers and the general environment for general insurers.

APRA have advised the MAA that it is currently conducting a series of visits to NSW CTP insurers to examine:

- reserving
- pricing
- reinsurance
- capital management

APRA discussed the general programme structure with the MAA and will talk to the MAA regarding the results of their investigations. The MAA are supplying APRA with a number of data sets to assist APRA.

8.4 Interview with APRA

APRA were of the view that they have a reasonable relationship with the MAA. This appears to be a comment that the relationship is friendly and cooperative rather a comment on the effectiveness of the relationship.

To date there has not been a practice of pro-activity on the part of APRA. In other words, if a matter came to APRA's attention that might be of interest to the MAA, APRA would not automatically think to immediately pass that information on to MAA.

APRA believe that their interests and those of the MAA are very much aligned and seem genuinely interested in working more closely and more effectively with the MAA in the future.

Ideas discussed included:

- involving the MAA in the planning of the prudential supervision of MAA's licensed insurers. This would involve planning the issues to be canvassed in and timing of site visits and inspections.
- MAA participating in the meetings which APRA has with the MAA licensed insurers. APRA have stated that these meetings are generally conducted informally on a "non legal" basis (ie not pursuant to statutory rights to inspect) and that if the MAA were to participate in these meetings it would need to do so on the same basis.
- a more direct relationship with APRA staff with responsibility for MAA licensed insurers.

APRA has significant resources working on general insurance companies, much more than had been the case with the ISC. It was estimated that approximately 30-40% of APRA's total resources (approximately 120 people or 60 full time equivalents) are either wholly or partly involved in the general insurance area. Each licensed insurer has allocated to it an APRA staff member who is responsible for that insurer. (Each staff member could be responsible for more than one insurer but would not have responsibility for more than one large insurer). There are also staff members who are specialists in certain areas (eg reinsurance arrangements) and who also have responsibility for a specific insurer.

In addition to these resources APRA has specialist teams (credit risk team, market risk team, operational risk team) that perform reviews across all of the financial institutions regulated by APRA.

Extrapolating from APRA's numbers, it could be expected that if the MAA were to perform a full prudential function itself (using its own resources) it would require 6 company specialists, two technicians and a specialist "visit" team (possible 12 people in total). APRA noted in passing that even if the MAA were to establish a full blown prudential supervision team it would still be difficult for effective supervision due to the limit to which the MAA can benchmark performance and practices and procedures. APRA can benchmark approximately 160 general insurers and then where appropriate, life insurers, banks, superannuation funds etc.

9. Conclusions

The following summarises our conclusions:

9.1 Prudential supervision of its licensed insurers is clearly a responsibility of the MAA.

9.2 Removing the responsibility for prudential supervision from the MAA may impact its ability to perform its other functions and achieve its aim of creating and maintaining a Compulsory Third Party Scheme that is affordable, fair and accessible.

9.3 It would be difficult and expensive for the MAA to put itself in a better position than APRA to perform the prudential supervision of its licensed insurers. It is therefore reasonable that to a large extent the MAA rely on the work performed by APRA.

9.4 If the MAA can not be more effective than APRA then there is little to be gained from duplicating APRA's work and imposing additional requirements on licensed insurers.

9.5 There is some information collected by the MAA that would be a useful supplement to the information collected by APRA. This information includes frequent and up to date information on premiums underwritten and claim payments. This information could be a useful indicator of liquidity or solvency problems.

9.6 The most effective prudential supervision of MAA's licensed insurers would be achieved through a closer working relationship with APRA that would encompass the following:

- MAA developing a stronger understanding of its licensed insurers and documenting this understanding (eg the enhanced insurer risk profiles, development of a rigorous complaints handling and analysis process). The task of gathering publicly available information about MAA's licensed insurers could be managed internally or outsourced to an external service provider (eg. rating agency). We attach as Appendix A a description of the services provided by some third party service providers.
- MAA being actively involved with APRA in the planning of the prudential supervision of MAA's licensed insurers.
- MAA having direct and constant contact with the APRA staff members responsible for each of MAA's licensed insurers.
- MAA accompanying APRA on meetings and site inspections with MAA's licensed insurers.

- MAA and APRA holding regular meetings on each of MAA's licensed insurers.
- MAA and APRA sharing information (not just data) regarding the MAA's licensed insurers (ie discussing the implications of the data and findings).
- MAA forming its own conclusions on each of its licensed insurers and discussing these with APRA.
- MAA consulting with APRA prior to taking any action in respect of suspension or termination of a CTP licence.
- The MAA ensuring that relevant staff undertake a level of general insurance training appropriate to their specific job function. This point should not be taken to mean we have discovered a lack of knowledge within the MAA. This point recognises that we are recommending a different method of operation for the MAA with regards to prudential supervision and that the staff of the MAA need to be equipped with the necessary knowledge and skills to implement the recommended change.

10. Recommendations

The following summarises our recommendations:

10.1 In conjunction with APRA develop a strategy and operational model for how the MAA and APRA will cooperate and how the MAA will rely on the work performed by APRA.

10.2 To demonstrate that it is fulfilling its responsibilities for prudential supervision as set out in chapter 7 of the MAC Act, the Board of the MAA needs to clearly document:

- when it will rely on APRA:
  - setting of prudential standards
  - determination of information requirements
  - gathering of collateral data
  - analysis of data
  - carrying out general and specific reviews
- how it will rely on APRA:
  - APRA will have prime responsibility
  - MAA to be involved in planning to understand APRA's approach and to provide input into issues of concern
  - APRA will collect information and perform analysis and provide regular feedback to MAA
  - APRA will perform site visits, inspections, investigations and reviews. Where appropriate MAA will attend these. If it does not attend, APRA will brief MAA on issues
  - MAA will form own conclusions based on APRA advice and discuss them with APRA
  - MAA will formulate their own actions and discuss with APRA before acting
- why it is reasonable to rely on APRA:
  - APRA has responsibility for prudential supervision arising from the Insurance Act
  - APRA has significant resources and budget
  - APRA has specialist teams and superior ability to benchmark practices and financial position
  - Changes to Insurance Act and accompanying standards and guidelines should enhance APRA's ability for prudential supervision
  - Duplication of APRA's function is waste of resources and imposes unnecessary obligations on insurers

- Better working relationship with APRA as outlined in detailed plan will keep MAA better informed and better able to plan and make decisions

This should be documented for each supervisory power which the MAA proposes to delegate to APRA. The Board also needs to sign off the work plan developed by the MAA for prudential supervision including how the MAA reliance on APRA will work in practice (see 10.3 below).

10.3 The MAA needs to develop a detailed plan on how the reliance on APRA will work including:

- how information will flow between the entities
  - information not just data
  - regular meetings on each insurer
  - direct contact with APRA staff responsible for each of MAA's licensed insurers
  - MAA information on claims and premiums to be shared with APRA
  - MAA conclusions and actions to be shared with APRA
- how the MAA will work with APRA (as per 8.6 above)
  - expansion of memorandum of understanding
- how the MAA will get the necessary comfort it requires
  - APRA needs to demonstrate that it fully understands each of MAA's licensed insurers
  - Impact of new standards, in particular approach taken by insurers to risk management requirements
- how the MAA will make decisions from the information it receives from APRA.
  - how many stages of warning will MAA adopt, what will indicate each stage, what will be done at each stage
  - what are the early warning signs MAA expect to see in the information obtained by MAA
  - what will MAA do in response to early warning signs
  - how will MAA resolve potential conflict of interest with APRA (eg insurer displays early warning sign, MAA decides to suspend CTP and seek portfolio transfer or security over assets, but APRA is concerned this action will hasten insurers' demise and reduce the possibility of rectification)

10.4 The MAA needs to discuss and agree this detailed plan with APRA.

10.5 The MAA then needs to determine its resourcing needs based on the strategy, operational model and detailed plan discussed above.

10.6 The role of the MAA and the method used by it to discharge its obligations should then be effectively to communicated to all MAA staff and customers.

Attachment A
Information Gathering Services

Information gathering and collation services are operated by a number of organisations including Ernst & Young (through our Centre of Business Knowledge or CBK). This attachment provides examples of the different types of service offerings as well as general indications of the cost of each service.

Service Solution 1: Research & Compliation of Information

The information gathering service will collect, collate and distil the relevant research from a range of sources and organise it into the appropriate categories on a monthly basis, for each company. The research would be provided to MAA in its raw state.

The estimated cost for this service would be between $200-$500 per company per month.

Service Solution 2: Monthly News Alert

The information gathering service will provide a monthly news alert, with information taken from press articles for each company. The information will be distilled, summarised and organised in a newsletter format. It may also be organised by company or by category.

The estimated cost for this service would be between $300-$600 per company per month.

Service Solution 3: Monthly or Annual Briefing Paper

The information gathering service will collect, collate and distill the relevant research from a range of sources and write a briefing paper on a monthly basis. The briefing paper would be organised into the appropriate categories (as advised) and be segmented by company, or separate reports may be provided.

The estimated cost for this service would be between $1,000-$1,500 per company per month.

Service Solution 4: Annual "Company Report"- style report

The information gathering service will provide a detailed report on each company. It will collect, collate and distill information from a range of sources to provide a complete "picture" of the company to the MAA's specifications.

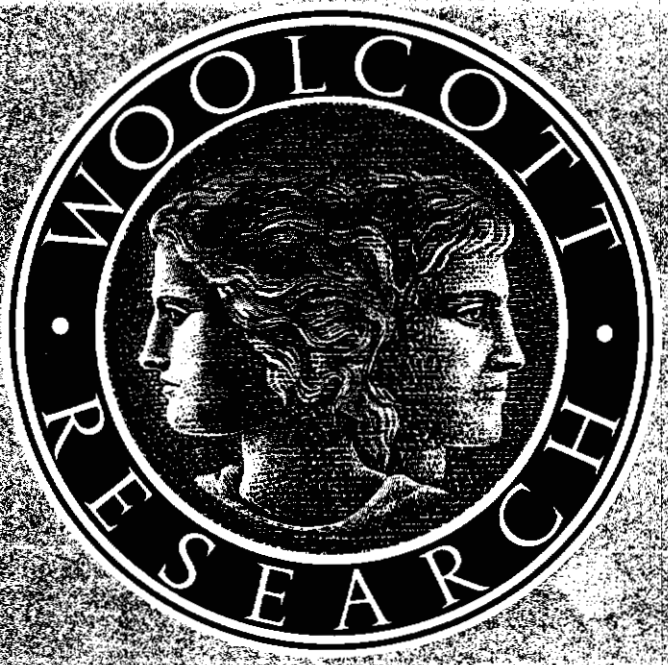
The estimated cost for this service would be between $5,000-$10,000 per company per annum.

Appendix 3

Developmental Research for the NSW Green Slip Campaign

Developmental Research for the NSW Green Slip Campaign

ATTACHMENT 3



RESEARCH REPORT

DEVELOPMENTAL RESEARCH FOR THE NSW GREEN SLIP CAMPAIGN

CONDUCTED FOR

MOTOR ACCIDENTS AUTHORITY

SEPTEMBER 2002

RESEARCH CONCLUSIONS AND IMPLICATIONS

1. From the research it was evident that there is currently an opportunity for a "shop around" campaign for Green Slips, provided that there are sufficient variations in prices between the different insurers to ensure that consumers will benefit significantly by comparing prices.

2. Shopping around is burdensome and time consuming, and may have some negative connotations attached to it. From a communications perspective, there may be a need to use slightly different language (e.g. compare prices), and to emphasise the ability to do this without taking up a lot of time (i.e. it could save time and money).

3. Psychologically, pricing and price savings are the key drivers which will motivate "shopping around" behaviour, and will most likely benefit consumers. This needs to be the underlying theme of communications activities.

4. The key information that needs to be covered in a campaign includes:
   a. The possibility of obtaining cheaper Green Slip prices by shopping around;
   b. How pricing for Green Slips is calculated to help consumers understand what they should look for;
   c. Information to create awareness and knowledge of MAA's Helpline and Website facilities, including what sort of information they provide, how they operate, and how/where to find them;
   d. Basic Green Slip facts (such as cover, claims and revenue, and peace of mind).

5. Communications must not be overtly positioned as coming from the NSW Government, as this will be seen as electioneering, rather than something of benefit. Information from the Motor Accidents Authority is fine and appropriate.

6. Lack of awareness and familiarity with the MAA may create some confusion over who the campaign is from. Hence, we would recommend that communications include some basic information, a tag line, or other 'obvious' signal that the MAA is a government authority, and therefore a neutral party.

7. The Helpline and Website are enough for delivery of comparative pricing information. No additional services are deemed to be necessary at this stage.

Appendix 4

An Investigation of the Services Available to Relatives of those killed in a Motor Vehicle Accident

An Investigation of the Services Available to Relatives of those killed in a Motor Vehicle Accident

An Investigation of the Services Available to Relatives of those killed in a Motor Vehicle Accident

For the

Motor Accidents Authority
Of NSW.

Prepared by The WorkWise Group

AN INVESTIGATION OF THE SERVICES AVAILABLE TO RELATIVES OF THOSE KILLED IN A MOTOR VEHICLE ACCIDENT

April 2002

The Brief:

The Legislative Council's Law and Justice Standing Committee raised with the Motor Accidents Authority the question of support services and compensability in relation to parents of children killed in a motor vehicle accident. The issue of concern is that the parents, (not involved in the accident themselves and who do not have a CTP claim) are not being "recognised" in that their grief goes uncompensated.

The WorkWise Group was appointed by the Motor Accidents Authority (MAA) in December 2001 to investigate what assistance in the form of counselling and support services is currently available to grieving parents/families or relatives of those killed in motor vehicle accidents.

The MAA has specifically asked for the report to include detailed information on:

- The range of services available eg. public, private and voluntary services, individual or group services offered
- The demand for these services and their accessibility (including location and waiting times)
- How and when grieving families access these services
- Costs of services
- The quality of services provided eg. training / accreditation of service providers.

METHOD

Developing the report:

1. A national and international literature search was undertaken to identify publications relating to the experiences of parents/families who have lost a child in a Motor Vehicle Accident (MVA).
2. Accessing the statistical information on the numbers of children who died in MVA's in Australia and New South Wales specifically.
3. An email request was made to members of the International Work Group on Death Dying and Bereavement for information and or experience in dealing with the target group
4. Contact with the Coroner's Courts throughout NSW and in particular the Psychologists and Social Workers at Glebe and Westmead courts for their knowledge and experience with parents of this group
5. Contact was made with organizations / individuals in Australia known to be involved in Grief support and counselling
6. Contact with Psychologists and Social Workers associated with the WorkWise Group
7. Contact with Employee Assistance Programs to discover how often clients present with grief associated with the accidental death of a child
8. Interviewing a representative group of parents who have lost a child in a MVA.

SUMMARY REPORT

- All grief and bereavement literature supports the belief that the traumatic death of a child has profound negative affects upon the parents
- Resolution of grief is frequently problematic
- The literature on road trauma and children does not deal specifically with incidents where parents are not involved in the accidents
- Statistical information does not specify the target group of this investigation
- There is no systematic provision of counselling and support services for this group of people
- Access to the services that are available are haphazard
- Department of Forensic Medicine Counselling Unit most likely point of contact
- Most people reported that they did not know what help was available or how to access it
- Private practitioners who specialise in grief and bereavement counselling are usually too costly for people
- Grieving families experience with health professionals generally and social workers / counsellors in particular was mostly negative
- Very limited support offered in hospitals and frequently viewed as not being helpful
- There is no specific training or accreditation of counsellors or service providers
- Regional and rural NSW has very limited availability of any kind of support service
- The consistently positive comment from grieving families was for Compassionate Friends
- Two organizations in NSW provide counselling and/or support to families of road trauma victims

Definition of child:

For the purposes of this report a child is defined as one who is in the age range 0 to 17 years. This means that these children are all under the legal driving age apart from those on 'L' plates.

This is not to say that children over the age of 17 years are not subject to traffic accidents where parents are not involved but for the focus of this project and to have some working parameters the age of 17 years was set as an upper limit.

Road Traffic Accident Statistics

There is a major difficulty in discovering the exact numbers of children involved in motor vehicle accidents where parents are not involved simply because the reports do not provide such detail. Accurate figures therefore for the target group are not possible.

Privacy laws which recently have been tightened (December 2001) meant that direct access to people who have lost a child in a motor vehicle accident through the Registrar of Deaths was not available. This placed some limitation on the writer gaining accurate information. However overall the number of road deaths in the age range 0 to17 years is relatively small suggesting that the numbers in the category of concern to this report are fewer still.

Information on road deaths was obtained from 3 sources

- Road Transport Authority of NSW (road traffic accident statistics) (RTA-NSW)
- Australian Bureau of Statistics (ASB)
- Australian Transport Safety Bureau (ATSB)

According to the ABS and RTA road deaths statistics for 1998 in NSW the total number was 89 for young people between the ages of 0 – 19 years. This was broken up into 3 age brackets:

	Total	Males	Females
• 0 – 9 years	22	13	9
• 10 – 14 years	9	3	6
• 15 – 19 years	58	49	9

Road fatalities by age, Australian States and Territories 2001

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	AUSTRALIA
Age:									
0	0	10	1	0	1	0	1	0	13
1	1	1	1	0	0	0	0	0	3
2	2	1	2	0	0	2	1	0	8
3	2	2	1	0	0	0	0	0	5
4	3	0	0	0	0	0	0	0	3
5	2	1	1	0	0	0	0	0	4
6	3	0	1	1	0	0	0	0	5
7	1	1	0	1	0	0	0	0	3
8	0	0	3	0	3	0	0	0	6
9	1	1	1	2	0	0	0	0	5
10	3	0	1	1	0	0	0	0	5
11	2	1	2	1	0	0	1	0	7
12	3	1	2	0	1	0	0	0	7
13	2	2	2	2	1	0	0	0	9
14	0	3	0	0	1	1	0	0	5
15	8	1	3	1	4	1	0	0	18
16	10	6	6	4	3	1	0	0	30
17	16	7	13	4	6	3	1	0	50
18 & over	472	413	284	136	144	53	46	16	1564
Age unknown	6	0	0	0	0	0	0	0	6
Total:	537	451	324	153	164	61	50	16	1756

Source: Australian Transport Safety Bureau, February 2002

As can be seen by the figures from the ATSB the February 2002 total road deaths of 59 (0 to 17 years) for NSW do not differ markedly from the RTA figures for 1998.

Literature search and Background information:

A national and international search under a series of word related or topic related headings revealed an abundance of literature on motor vehicle accidents, loss, grief and bereavement services. However none was specific to the target group of parents who have lost a child in an accident in which they were not personally involved. There were isolated references to this group such as on the American 'Mothers Against Drunk Driving' website. In fact a number of the websites visited provided information about children and death, parents reactions to the loss of a child etc but not relating that information to the death of a child as a result of a motor vehicle accident. The literature when dealing with the death of a child has tended to focus on 'sudden infant death', leukaemia, cancers or the more sensational and violent deaths through murder. The media for instance reports on accidental deaths of children at school crossings but after the initial public outrage the grieving parents are seemingly forgotten.

Traumatic Grief

Inspite of the development in our understanding of loss, grief and bereavement and how to manage grieving people there are still some situations that are problematic. In a society where there is an excessive dependence on motor vehicle transport, private and public, and where extremes of violence and terrorism affect many people we have reluctantly become familiar with sudden, unexpected and traumatic death. Exposure to these events through the media where the situation is graphically told or displayed is not accompanied by suggestions on how to cope for those impacted by the trauma. Where those traumatic incidents involve children the problem is exacerbated for family and friends partly due to social expectations of what it means to be a parent.

Parents tend to possess an unexpressed assumption that their children will out live them. When this does not occur and a child dies those assumptions for the parents and family

are shattered. There is something 'unnatural and unjust' about the death of a child and even more so when that death is accidental. Attig (1991) talks of that kind of death as a "choiceless" event. The death of one's child is a death out of sequence, one that seems to deny the natural order of things. Added to this is the thought and the feelings of the parents that they 'should' be able to protect their child from harm and this makes the pain of the loss more acute.

> *"One of my early thoughts was that my wife and I would have no grandchildren. There would be no passing on of either tangible or intangibles ...*
> *I have been surprised by how many assumptions that a man's child will marry and have children – and that they will all outlive him – are his constant companions moulding thought and actions in innumerable subtle ways. Suddenly my thoughts and actions were inappropriate because the assumptions on which they were based were no longer valid".*
> (Albert F Knight 'The Death of a Son' NY Times magazine in Staudacher 1991)

The death of a child has been identified as one of the worst possible events in adult life and according to Rando (1992) can lead to 'complicated grief'. Raphael and Middleton (1988: 281) have described such an event as a personal disaster encompassing, "shocking, overwhelming personal experiences that test the individual beyond his adaptive capacity and bring major stresses and sometimes changes to his life".

One of the greatest problems for the parents from a grief perspective is that sudden unexpected death provides no time for goodbyes.

Edward Rynearson (1987) in his work on "Psychosocial Adjustment to Unnatural Dying" spoke of the "three V's" of unnatural dying which catalyse a strong psychosocial aftermath for those affected by someone close to them dying an unnatural death. Rynearson suggests that where there is unnatural dying there are at least three phenomenologic peculiarities associated with that dying. They are:

- Violence – the act of dying is injurious
- Violation – the act of death is transgressive
- Volition – the act of dying is a wilful intention.

Rynearson proposed a conceptual framework for adjustment to unnatural dying.

While these propositions are tentative they are based on clinical research and in the context of this report are worth a brief mention.

In his propositions he suggests that adjustment to unnatural death such as homicide, suicide or accidental death involves dealing with a complex mix of violence, violation and volition creating problems in adjustment to the loss. It is suggested that each of these responses to unnatural dying is associated with a compensatory psychologic response:

- Violence with post-traumatic stress
- Violation with victimisation
- Volition with compulsive inquiry

The two responses of significance to this report are violation with victimisation and volition with compulsive inquiry. Keeping our focus on how people cope with a traumatic death the outworking of the grief can at times seem bizarre to those whose only experience has been dealing with so-called 'normal grief'.

Rynearson defined the violation –victimisation response in the following way:

"Violation as an unprovoked, trangressive, exploitative act is followed by the psychologic reaction of victimisation" (1987:83)

Ochberg (1996) has developed a list of symptoms to describe victimisation some of which are applicable to parents who have lost a child

- Self blame – feelings of responsibility - even though the person is innocent
- Subjugation – feeling helpless, dehumanised and powerless as a result of the trauma
- Morbid hatred – obsessed with vengeance, hurting or humiliating the perpetrator often associated with anger and rage
- Resignation – a sense of despair, diminished interest in the past and the future.

Volition – compulsive inquiry as defined by Rynearson is expressed as "irresponsible negligence leading to death" (accidental death is usually a product of human error).

Accidental deaths are usually followed by an official inquiry to establish the cause of death as well as who was responsible. While this 'official inquiry' is proceeding the family are often on a quest of their own. They are trying to 'make sense' of the incident which has taken their child's life.

This background information reinforces the fact that these grieving people are extremely vulnerable and in need of crisis intervention initially followed by counselling and emotional and practical support. As this investigation will reveal the grieving family is mostly left unsupported and emotionally disenfranchised from the time of death all the way along the grief continuum. Anger, frustration, misunderstood, alone, abandoned and helpless are some of the reactions reported to the writer.

Gender difference

When there is traumatic death especially we see a gender difference in response to managing the grief. In Western society men in the main are socialised in a 'stiff upper lip' tradition making it difficult for them to express openly their emotional reactions. This contrasts with the way in which women deal with grief and this difference can cause a communication breakdown with the couple. Women tend to get more depressed, tearful and their lives are much more adversely affected by the death. The man's response is to take over a protective, management role and in the main suppress his feelings by keeping active. Schatz (1986: 295) "outlined six roles that can impede the father's positive grief resolution. These are:

- The role of being strong – a macho man who always controls his emotions
- The role of competing, of winning in a crisis, and of being the best
- The role of being the family provider
- The role of being the problem solver – fixing things or finding someone who can
- The role of being the controller – controlling actions and the environment
- The role of being self-sufficient -- standing on his own two feet".

In order to cope with the mixed emotions that grief creates men as reported by Staudacher (1991:9) tend to:

- Remain silent
- Engage in solitary activity
- Take physical or legal action
- Become immersed in activity
- Exhibit addictive behaviour.

Marital problems:

There is both anecdotal and research evidence to support the notion that married couples have serious problems following the death of a child. Where there have been problems in the relationship prior to the death of the child the death itself exacerbates these difficulties. The estimated number of couples experiencing serious problems in their relationship ranges from 75% to 90% (Sanders:1999) but this does not mean all that number separate or divorce. Again some of the causes for these difficulties are gender differences in relation to grief and communication problems in the relationship. The most often reported difficulty in the relationship is that the wife and mother feels emotionally unsupported by the husband and father. It would appear that a breakdown in the relationship is not related to the age at which the child dies.

Sibling grief

The group of people most often forgotten where the death of a child occurs are the siblings of that child. Years later usually when the sibling experiences another loss the unresolved grief associated with the death of their brother or sister surfaces. The burdens that some of these young people or adults have carried over the time are at times heart rending. The death of a sibling can result in the brother or sister feeling abandoned. The parents are so overwhelmed by their loss that they have no emotional energy left for other children. Sometimes the children will express the feeling that they think their parents would have preferred it if they had died instead of the child who died. The writer's experience of two brothers who were out cycling and one was killed by a car when the driver lost control. The surviving brother not only felt the intense pain of losing his brother (his best mate) but also the pain of survivor guilt which unwittingly his parents conveyed to him. He left home and on one occasion he and friend were bashed by a gang and the sight of blood, the sound of the ambulance etc for his injured friend unleashed an intense emotional reaction. When the parents and the young man were united and could talk about their respective grief, each recognised they did not know how to communicate their feelings to one another.

Knowledge of & access to services

There appears to be no consistent pattern as to how people gain knowledge of and access to bereavement services. The telephone directory (white pages) has two listings under Bereavement and nothing under Grief. In the yellow pages in the Fast-Find index Bereavement and Grief counselling are both listed and can be accessed under the general heading of Counselling – Marriage, Family and Personal. (A-K p.805). Under the heading of Psychologists (L–Z p. 2461) there are some who indicate Grief as an area in which they specialise. Only fourteen psychologists, counsellors and psychotherapists indicate this specialisation. This number is in fact fewer as a number of psychologists are also listed as counsellors and vice versa. It is possible to phone the Australian Psychological Society who have an up to date list of psychologists who specialise in this area. As with any referral the APS can provide a list of names but they cannot vouch for the training and expertise of the people. In speaking with private practitioners they reported that most of the referrals come by 'word of mouth' or for psychologists a lesser number through the APA referral service.

Training / Accreditation of Service Providers

One of the problems for people working in the area of Grief and Bereavement is the lack of formally recognised academic training. Organisations such as the National Association for Loss and Grief (NSW) has provided a range of Bereavement Counselling courses from Introductory to Advanced. The writer was the Coordinator of a Trauma Counselling course run by the NSW Institute of Psychiatry but this was discontinued in 1998. The Bereavement Care Centre runs training course which are highly regarded but the tuition fees make this training economically problematic for many people. Most of the university courses in Counselling Psychology, Social Work, Nursing etc would refer to grief and bereavement issues and the need for counselling but it is extremely limited information.

How many psych Lec NACAP training.

There is no formal accreditation of bereavement counsellors or the service providers. Attempts are being made to rectify this.

Bereavement Counselling and Support Services:

Community Health Centres

Designated Bereavement Counsellors in the Community Health Centres are limited and those counsellors so designated are only part time in that role. Whilst Community Health Centres will offer some bereavement counselling again it depends on the background experience and interest of the counsellor provided. It is unlikely that many would in fact have the necessary time, skills and expertise to deal with parents who have lost a child through a MVA. As one might anticipate the problems for people in rural NSW seeking bereavement support are magnified. Those towns large enough to support a Community Health Team have found a reluctance by some members of the community to access their services for counselling and grief support. The main reason for this is not wanting to divulge thoughts and feelings to someone whom they might meet socially in the neighbourhood. This again is a greater problem for men.

Community Health Centres provide a free service but one of the problems for parents is there is often a waiting list for an appointment. If it is a crisis issue the Community Mental Health team may be available to provide immediate assistance but usually they are not available for long term counselling

Department of Forensic Medicine

The most likely source of assistance at the time of the death of a child is through the Department of Forensic Medicine Counselling Units. The Centres at Glebe and Westmead have a total of 5 counsellors who are trained as social workers and who would deal with anywhere between 5 – 15 deaths per day (Westmead figures). Of that total number those involving children (0 – 17) are 59 for the year suggesting that for NSW it is approximately 1 child death involved in an MVA per week.

For a death that is reported to the Coroner, the counsellors will contact the Next of Kin. This telephone contact is either on the day of the body arriving at the morgue or the day after. The counsellor is able to provide both emotional and practical support, for instance giving the grieving persons information on the post mortem process. Most people already shocked by the news of an untimely death of a child can be further traumatised if not given an understanding of post mortems. Counsellors are also on hand to provide support and assistance with the viewing process and identification requirements. At these times of intervention they are also able to make an assessment of those people who appear to be 'at risk' and offer them the opportunity of personal counselling. The service which the counsellors provide is free operating Monday to Friday from 9 .00 am to 4 .30 pm.

Qualifications and Experience:

All the counsellors at both Glebe and Westmead have professional training as Social Workers. The Senior Counsellor at Glebe has had extensive experience in loss, grief and death and dying and has been with the Coroner's Court for over 10 years. The other staff have been in Forensic Medicine for varying lengths of time. Internal and external supervision is provided and in-service education in relevant areas assists them in their role.

The counsellors at the Forensic Medicine Units have a list of a limited number of people to whom they can refer for on going counselling. One such list are those counsellors approved by the Victims of Crime counselling unit. These counsellors are almost exclusively in the greater metropolitan area again providing for difficulties for those in the country. The counselling unit at Westmead does have a series of pamphlets which are available to families. They include:

- Answers to common questions – When someone close to you dies
- Grief – When someone close to you dies
- Counselling at Forensic Medicine
- Arranging a funeral.

Coroner's Courts in NSW

There are approximately 170 courts associated with the Coroners Court System and of those 12 are in the greater metropolitan area. Those courts in regional and rural NSW for the period July 2000 to June 2001 show Newcastle 339 deaths, Gosford 251 and Wollongong 162. The next highest figures were at Nowra 68 and Tamworth 62. These courts do not have a counsellor and the most likely source of counselling assistance would be through the local hospital if in fact the family had any contact with the hospital.

Fee for service

Another factor in terms of referral is the ability of the bereaved parents to pay a fee for service. If they consult a registered psychologist and are in a private health fund there is provision by some funds to give a rebate. The number of counselling sessions a person is able to receive is dictated by the ceiling on the dollar amount they are able to claim. The amount of rebate payable varies with the funds but a total amount of $ 300.00 is most often quoted. However not all funds cover counselling for instance HCF does not cover one to one counselling. For many of the people interviewed for this investigation the cost factor was major deterrent in not seeking help.

Australian Psychological Society

The recommended fee from the APS is currently about $ 160.00 per session – usually one hour's duration. Most psychologists contacted were prepared to negotiate on a sliding scale depending on the circumstances of the clients. As was shown earlier very few indicate Grief and Bereavement issues as an area in which they specialise.

The Bereavement Care Centre, Eastwood (privately funded)

The Bereavement Care Centre has provided counselling education and training in grief and bereavement since they commenced in the early 1980's. They have provided counsellor training for people who in turn provided supervised counselling to clients. They reported that over the 20 years of their work they have seen many clients who have had a child die in an accident and some of which the parents were not involved.

Diane McKissock states, "We have always provided a counselling service for parents bereaved in this way as well as for siblings, and continue to do so, but are not in a position to provide the stats. you need ". She went on to say, " ... research is important ... but unfortunately we don't know any current clients we would feel OK about approaching in this regard at the moment – their grief is still too raw".

The Bereavement Care Centre thinks that the lack of support people feel is often focussed around the deficits in the legal processes. "Bereaved parents/siblings tend to feel less important than the person causing the accident ..they want justice and a recognition of their loss". These are the sentiments expressed by 'Enough is Enough' an organization formed to provide support and education and fight for justice for families involved with a road trauma. VOCAL in the Hunter Valley is similarly motivated.

Private Practitioners

Those working in the private sector all reported that at various times they had seen people who had lost a child in a motor vehicle accident but had little back up information to support that. They were often unable to verify whether the parents had been involved in the accident though most of the people contacted could recall instances where that had occurred. This was particularly the case with private practitioners who had experience in grief and bereavement. The majority of these referrals were by 'word of mouth' and usually the persons came some months after the death. The psychologists and counsellors contacted said that often the person presented with other issues, relationship problems, personal and/or work related stress and in the process of counselling the underlying issue of unresolved grief surfaces.

As the interviews with families reveal those who did see a Counsellor were not impressed and in the main were quite negative about their experience.

Grief Support

This is a telephone support service which operates 24 hours a day so is readily available to people. Grief Support also provides some counselling but as the majority of their volunteers are not trained as counsellors, those volunteers with the appropriate qualifications can provide a limited counselling service. Where the need for counselling

is perceived by the volunteer they can provide the names of people and organizations who may be of assistance to the grieving person.

Compassionate Friends

The one organization which consistently was referred to in positive terms was Compassionate Friends. This is an organization in which parents who have lost a child provide support to each other.

Compassionate Friends is part of an International organization founded in the United Kingdom by Rev Dr Simon Stephens.

In order to show the way in which TCF assists people in such a positive way the 7 Principles of the organization are reported.

The Seven Principles of the Compassionate Friends

- 1. TCF offers friendship and understanding to bereaved parents
- 2. TCF believes that bereaved parents can help each other towards a positive resolution of their grief
- 3. TCF reaches out to all bereaved parents across artificial barriers of religion, race, economic class or ethnic group
- 4. TCF understands that every bereaved parent has individual needs & rights
- 5. TCF helps bereaved parents primarily through local chapters
- 6. TCF chapters belong to their members
- 7. TCF chapters are coordinated by state to extend help to each other and to individual bereaved parents everywhere.

Compassionate Friends is the only organization which extends its services to regional and rural NSW. This is the 'life line' that country people say they need. As all participants in CF groups are grieving the loss of a child there is an understanding which does not need to be expressed. CF reinforces the known fact that the person who is going to be the most supportive to the grieving person is the person who has had a similarity of experience and not the health professionals.

Enough is Enough Anti Violence Movement Inc

VEHICLE INCIDENT SUPPORT TEAM AUSTRALASIA

This organization was founded by Mr Ken Marslew in November 1994 and he is its current President. Like many of these organizations this one developed as a result of the traumatic death of Mr Marslew's son. As a way of 'making meaning' out of his son's death and the intense grief he was experiencing he decided to try and make a difference in dealing with violence in the community.

Of particular interest to this investigation is the development of a group for Road Trauma Support that 'Enough is Enough' has formed.

Vehicle Incident Support Team Australasia + Education

The aims of this group are:

- To encourage emotional support and understanding at individual, group and community levels
- To promote legislative change to :
    a) introduce a more appropriate approach to laws relating to motor vehicle accidents
    b) create safer road environments and transport
    c) impact individual and community responsibility to road issues.

- To assist in the creation of education programs and initiatives to raise community awareness of the responsibilities and accountabilities of all road users
- To develop a supportive network of government and non-government organizations to advance the philosophy and effectiveness of VISTA+E.

The kinds of services they offer are referred to their objectives:

VISTA+E support services will seek to address the physical, emotional, psychological and where appropriate, the material needs of survivors of motor vehicle accidents.

VISTA+E will seek excellence at all levels with all endeavours and will address:

- Crisis intervention and de-briefing
- Emotional support and counselling
- Practical support
- Information sharing
- Effective and appropriate referral
- Assistance with procedures and processes of legal investigation, prosecution and court systems and systems of this nature
- Advocacy
- Reform and improvement at all levels
- Professional training and community education
- Prevention activities.

Support Groups:

VISTA+E has the vision to be the primary organization for the support and direction in addressing the specific needs of people who have been affected by motor vehicle accidents.

These Road Trauma support groups meet regularly and are held at present in Sutherland Wollongong and Parramatta.

Counselling:

Limited counselling is available from the Manager of Counselling Services and Cooperative Justice Strategies. This person has a degree in Social Welfare and advanced training in Family Therapy. The Manager of Counselling Services is supported by a volunteer team of professionals.

The counselling role in the service is still in its beginning stages.

VOCAL Inc

Victims of Crime Assistance League Inc is located in Newcastle and as such is the only organization formally registered outside the metropolitan area. The aims of the organization are broad "to help victims of all types of crimes". Within this broad framework the Coordinator reported that they frequently have families grieving who have lost a child in a motor vehicle accident.

They hold Open Support meetings monthly for all types of crimes which may deter some families dealing with the death of a child from attending.

VOCAL is an advocate for social justice issues in relation to violence and crime with the aim of making for a safer community. Apart from the Coordinator the staffing is with volunteers.

Mission Australia

Mission Australia provides the following victims support services

- 24 hour telephone counselling working in conjunction with the Victims of Crime Bureau
- face to face counselling by a registered psychologist
- information and support groups for victims of crime
- court preparation for victims of crime.

Families who have lost a child in a MVA occasionally utilise the services of Mission Australia and this has been mostly to gain information.

The 'Lived Experience'

Contact was made with the President of The Compassionate Friends in NSW – (Mrs Mary Carroll) explaining the nature of the project and asking if there were people in CF who had lost a child in the circumstances being investigated. Names and telephone numbers of seven people willing to be interviewed were provided and of these five responded to the request for an interview.

The importance of interviewing people who are 'living through the experience' of losing a child gives substance and 'heart' to an investigation which otherwise could be somewhat dry and arid. One of the problems for the interviewer was the realisation that in asking questions about the death of their child the parents could find the 'hurt' being reactivated. It was therefore important to clarify with the respondents that they were comfortable to proceed with the proviso that if at any time they were feeling distressed they were to say so. All the respondents were given the opportunity of either a face to face or telephone interview. All chose the telephone interview. Added to this number

were interviews with families whom the writer knew from his own clinical experience who also provided valuable information.

A series of questions were developed to initiate the discussion and gain a rapport with the person. This then led on to the respondent providing other insights into their experience.

The feedback from the interviews is presented in such a way as to maintain the anonymity of the participants without losing the valuable personal insights they provided.

For one family the death of their grandchild was particularly tragic as the boy's mother (and their daughter) had died prematurely 5 years before the boy's death. The grandparents had become the guardian of the boy. Two unexpected deaths of a child and a grandchild was for them a devastating experience.. The youngest death of a four year old boy was observed by the father, his twin brother and other family members. The next door neighbour with whom they had been speaking backing her car out of the drive ran over the child. Emergency first aid was applied to the child but he was dead before the ambulance arrived. The consequences of the death of this child has had a profound negative effect upon the entire family causing a major breakdown in relationships.

As will be revealed through the interviews support for these people was mainly non-existent and where it was offered was often inappropriate.

Death of a child in a MVA in which parents not involved.

Questionnaire:

1. When did your child die?
2. How old was he/she?
3. How did they die?
4. How were you informed of the accident?
5. Did the hospital provide you with emotional support?
6. What other support did you receive?
7. Did the funeral director suggest a bereavement counselling service to you?

8. Did you have contact with the coroner's court ?

9. Did you seek bereavement counselling yourselves?

10. Was the counselling a fee for service or free?

11. Did you find it helpful?

12. How many members of your family sought counselling?

13. What or who provided the most support to you?

14. What would have helped you most :

    At the time of the death

    3 months on from the death

    12 months on from the death.

Responses:

1. When did your child die?

The years in which the children died were from 1989 to 1998

2. How old was she/he?

The age of the children ranged from 4 to 19 years with all but one being in their teen years.

3. How did they die?

Most children were passengers in a car driven by friends or a family member. Two died at the scene of the accident and the other three died 1,3 and 4 days later. The youngest child's death was through a driveway accident.

4. How were you informed of the accident?

The way in which people learned of the accident was as varied as the cause of the accident itself. Most people learned of the accident from the police without them detailing the severity of it. The grandparents reported that before the police came into them they went next door to check with neighbours as to their health and well-being before giving them the news of the accident. As a safety precaution the neighbours

called the ambulance in case there was a traumatic reaction from either one of them. These older people were appreciative of both the police and their neighbours concern at 2 am. The lack of identification in one case delayed the police from contacting the parents and they in fact were informed by the father of another passenger that the accident had occurred and their son was hospitalised. In another instance a father himself a police officer was informed by his work colleagues as a way of protecting the mother. Only one family actually observed the death of the child. The people observing the accident also provided first aid but the damage done to the child's body suggested he died on impact. The ambulance was delayed in getting to the scene and on arrival according to one of those present tried to resuscitate the child and refused to believe them. Simply observing this added to the tension.

5. Did the hospital provide you with emotional support?

At this point in most of the interviews the respondents were expressing disappointment and anger towards the health professionals.

- *Nurses generally were considered to be supportive and helpful and this is consistent with the research on 'Delivering bad news'*
- *Doctors were often considered distant, unresponsive to requests for information – where they took the time to explain they were most helpful*
- *Social Workers were almost universally deemed to be 'hopeless' comments – such as a 'get a dog' (to replace the child!),*
- *text book statements, like 'how are you feeling' were infuriating*
- *the SW were young girls with a 'bit of paper' and no life experience so they were difficult to relate to – no empathy*
- *Chaplain – meant well but drove me mad*
- *People mentioned frequently being left 'wondering' for hours what the outcome might be when child on life support*
- *In a waiting area near ICU a large group of Non English speaking people who took over and the parents were forced to wait for hours in a corridor. Staff didn't do anything.*
- *Left in limbo*

- *One hospital offered bereavement counselling but at the time all the family wanted to do was get away from the hospital environment*
- *The promised follow-up telephone call never came.*

6. What other support did you receive?

The support that most people received was from family and close friends. One of the couples who had no family in Australia relied on friends and the telephone to overseas relatives. 'this is when you feel isolated and alone away from your family'

7. Did the funeral director suggest a bereavement counselling service to you?

With the exception of one family where the funeral director was known and he himself provided support and counselling none of the funeral directors provided information about grief and/or counselling.

An unfortunate situation arose for one family where the son's body went 'missing' between the morgue and the hospital for 24 hours!

8. Did you have contact with the Coroner's Court?

Only one of the families had contact with the Coroner's Court and that was outside the metropolitan area. .They were asked if they wanted to see photographs but declined the offer. No other support or counselling was offered.. One family who were involved with the Court at Glebe made positive comments about the support and assistance given by the counsellor there.

9. Did you seek bereavement counselling?

Most people were not aware that such services were available or how to access them. Only one of the families was offered Bereavement Counselling which was not taken up. Of those who actually sought out some counselling or as in one case their doctor arranged for a Psychiatrist to visit the mother, ***everyone reported a negative experience.***

- *Out of their depth – too young and inexperienced*
- *Did not know what to say or do*
- *Came uninvited with no knowledge of the circumstances of the death etc this was worse than useless – then sent a bill for the consultation!*

10. Did you find it helpful?

The only positive response to this question was from the family who reported knowing the funeral director who maintained contact with them for some time after the death and he was most helpful. What is important about this response is that the person was already known and trusted before the death occurred.

11. How many members of your family sought counselling?

None of those people interviewed sought or were offered family counselling.. Where there were other children in the family no counselling was provided for them. Some families reported that when School Counsellors were notified of the death of a sibling an offer of counselling was given. In the Catholic Educational system the 'Seasons for Growth' program runs groups for children who have experienced a loss but to the Program faciliator's knowledge no one in the groups had reported deaths of the kind under investigation.

12. What would have helped you most?

In considering what recommendations should be made the responses to this question seemed to be crucial. The major problem for most of them was at the time they did not know. Seemingly nothing could help because the pain was so intense. The things that were mentioned included:

- *Some who was prepared to listen to me*
- *Not imposing solutions*
- *Telephone numbers to contact*
- *Initially someone to help with the crisis.*

Appendix 5

Specific Allocation of the MAA's Rehabilitation Grants for Brain Injury

Specific Allocation of the MAA's Rehabilitation Grants for Brain Injury

Question 4

Can the MAA provide further detail as to the specific allocation of the rehabilitation grants for brain injury?

Response 4

The funding allocation of $354,677 for the Program Area for Rehabilitation Grants – Brain Injury 2001-2002 was the cashflow for approved projects within the Brain Injury Rehabilitation Program for that financial year. This program is the network within NSW Health that provides acute brain injury rehabilitation services. Details of the individual projects and total funding approved follow.

Paediatric Case Manager New England region

Organisation - ***Brain Injury Rehabilitation Program, Tamworth Base Hospital***

This project aims to improve the brain injury services offered to children and adolescents who live in the New England Region.

A full time case manager is employed to provide case management services to children and adolescents in all stages of their recovery and provide education and training to local service providers on traumatic brain injury

Total Funding Approved

February 2000 - $122,000

Budget

2001/2002 - $44,084

Paediatric Case Manager North Coast NSW

Organisation - ***North Coast Head Injury Service, Lismore NSW***

This project aims to improve the brain injury services offered to children and adolescents who live on the North coast of NSW

A full time case manager is employed to provide case management services to children and adolescents in all stages of their recovery and provide education and training to local service providers on traumatic brain injury.

Total Funding Approved

February 2000 - $100,000

Budget

2001/2002-$25,000

Brain Injury Outreach Worker, Illawarra Region

Organisation - ***Illawarra Brain Injury Service, Warrawong***

A full time outreach worker is employed to improve the provision of case management services for people who have sustained a brain injury and live between Gerringong and Milton/Ulladulla on the NSW South Coast.

Total Funding Approved

February 2000 - $120,000

Budget

2001/2002 - $43,500

Information booklets for families and carers of children with acquired brain injury

Organisation - ***Sydney Children's Hospital and New Children's Hospital***

There is currently very little information for families about brain injury apart from a mixed array of photocopied sheets from hospital services or other copied material. This information can be misleading or based on interstate or international information.
The development of booklets will provide information about brain injury for families and carers.

Total Funding Approved

February 2001 - $13,750

Budget

2001/2002 - $13,750

Clinical trial of stretching after traumatic brain injury

Organisation - ***Rehabilitation Studies Unit, Department of Medicine, Sydney University***

This project involves comparing the effectiveness of two types of treatment of elbow flexion contracture in people with traumatic brain injury.

Total Funding Approved

February 2001 $29,600

Budget

2001 – 2002 - $8295

Efficacy of stimulant medication in paediatric acquired brain injury

Organisation - ***Department and Developmental Cognitive Neuropsychology Research Unit New Children's Hospital***

This study aims to investigate the potential efficacy of central nervous [CNS] stimulants in the treatment of chronic attentional problems in children with an acquired brain injury [ABI] through a double blind placebo controlled trial using methylphenidate [Ritalin] and dexamphetamine. Changes in attention functioning will be measured on a range of behavioural and neuropsychological measures of attention.

Total Funding Approved

February 2001 $102,246

Budget

2001 – 2002 - $45,048

The time frame of recovery after traumatic brain injury: an evidence based approach

Organisation - ***Rehabilitation Studies Unit, University of Sydney***

The study aims to determine the time frame of recovery by following up a cohort of patients 20-25 years following severe traumatic brain injury. Data were previously collected on this cohort approximately 15 years ago, between 3-9 years posttrauma, examining neurophysical and neuropsychological impairments, along with physical and psychosocial disabilities and handicaps. Contrary to consensus opinion that patients stop improving well before two years posttrauma, it found that outcome was better in individuals who were much longer posttrauma. Ongoing clinical contact with other patients supports this observation, but empirical evidence is required for confirmation.

Total Funding Approved

February 2001 $200,000

Budget

2001 – 2002 - $75,000

Traineeships for people with a disability

Organisation - ***The NSW Office of the Director of Equal Opportunity in Public Employment [ODEOPE] and the Department of Education and Training [DET]***

The proposed program involves the establishment of a traineeship program targeted at placing people with a disability in the NSW Public Sector. The traineeships are jobs that combine work and structured training and which generally last from one to two years. Trainees are paid a training wage and enter into a training agreement or "indenture" with the employer. Trainees undertake a training program that is delivered by a registered training organisation and leads to a nationally accredited qualification and are released from work one or two days per week to complete formal off the job training.

Total Funding Approved

February 2001 $400,000

Budget

2001 – 2002 - $100,000

In addition to these projects the MAA also approved funding in February 2002 of **$698,193** for projects relating to brain injury as part of the 2001-2002 Injury Management Project Funding Round

Details of these projects follow

Evaluation of the Wisconsin Card Sorting Test and Category Test

Organisation - ***Westmead Brain Injury Rehabilitation Service, Westmead Hospital***

The aim if this project is to investigate the validity of the computer versions of the Category (CT) and Wisconsin Card Sorting Test (WCST). These are two of the most popular instruments used to detect frontal lobe impairment following traumatic brain injury.

Total Funding Approved

February 2002 $2,571

Fitness training after traumatic brain injury

Organisation - ***Brain injury Rehabilitation Unit, Liverpool Hospital***

The aim of this project is to evaluate the efficacy of a supervised fitness centre-based exercise program in improving fitness and psychosocial functioning in a traumatic brain injured population.

Total Funding Approved

February 2002 $98,000

The evidence base of psychological therapies for traumatic brain injury

Organisation - Rehabilitation Studies Unit, Department of Medicine, University of Sydney

The aim of this study is to develop a database of published papers about psychological therapies for TBI and knowledge of the role of evidence-based practice in the work of allied health professionals.

Total Funding Approved

February 2002 $81,000

Carer Respite Partnership for ABI carer skills training

Organisation - Brain Injury Rehabilitation Unit (BIRU) and the Carer Respite Centre. South Western Sydney Area Health Service.

The aim of this project is to enhance support skills for carers families and others who work with people who have a brain injury by developing 5 training kits, participant resources and VETAB accreditation.

VETAB accreditation is part of a nationally recognised framework that provides agreed standards to ensure quality of vocational education and training based on recognised competencies.

Total Funding Approved

February 2002 $67,000

Traumatic Brain Injury [TBI] Information Kit and Vocational Accreditation

Organisation - The Brain Injury Rehabilitation Unit, Liverpool Hospital

The aim of this project is to print and distribute to key TBI service providers the revised Brain Injury Information Kit including adjustments that include vocational competencies and VETAB accreditation.

Total Funding Approved

February 2002 $67,810

Development of Attendant Carer Support and Training Network

Organisation - ***Brain Injury Rehabilitation Service - Outreach Team, Brain Injury Unit, Westmead Hospital***

The aim of this project is to improve the skill and flexibility of care through the development of a network / cooperative / industry reference group. At the initial phase two main activities would be focused on;

- Information and data development
- Professional information and training

Total Funding Approved

February 2002 $50,000

Information Technology

Organisation - HeadEast Eastern Sydney Acquired Brain Injury Community Access Service

The aim of this project is to establish training in computer literacy/word processing skills for clients with a brain injury.

Total Funding Approved

February 2002 $18,880

Improving community support for Aboriginal people with head injuries.

Organisation - North Coast Head Injury Service (NCHIS), Coffs Harbour

The aim of this project is to employ an Aboriginal support worker with the North Coast Head Injury Service in partnership with the Galambila Aboriginal Health Clinic in Coffs Harbour and the Bulgar Ngaru Aboriginal Medical Service in Grafton.

The Aboriginal worker would assist NCHIS staff to access Aboriginal people who have had a head injury and would assist the workers to identify needs and plan appropriate rehabilitation. The project would also enable the development of culturally appropriate promotional material.

Total Funding Approved

February 2002 $87,270

You and Me sexuality resources

Organisation - Brain Injury Rehabilitation Unit, Liverpool Hospital

The aim of this project is to evaluate the– You and Me sexuality resource, rewrite and update relevant parts of the manual and publish a second edition that will become sustainable and self-funding.

Total Funding Approved

February 2002 $9,250

Management of TBI clients in the community with associated substance abuse.

Organisation - Hunter Brain Injury Service

The aim of this project is to develop a best practice approach to managing Hunter Brain Injury Service clients in the community who have substance abuse problems who are referred to the BIS following a TBI.

Total Funding Approved

February 2002 $26,665

InterActive – recreation, leisure & ABI working together

Organisation - South West Brain Injury Rehabilitation Service, Albury

The aim of this project is to improve access and participation in recreation and leisure activities for people with brain injury in the South Western region of NSW. This will be done by enhancing the support skills of workers in the recreation and leisure industry and providing guidelines for workers in brain injury rehabilitation.

Total Funding Approved

February 2002 $124,689

Social skills intervention groups for children with traumatic brain injury

Organisation - Brain Injury Rehabilitation Program, Sydney Children's Hospital

The aims of this project are to trial and evaluate group programs to improve social skills functioning for children with brain injury in schools.

Total Funding Approved

February 2002 $82,058

MAA 2002- 2003 grant funding round

Funding priorities related to brain injury in this round of funding include

Projects to improve retrieval services and acute care of people injured in motor vehicle accidents-

Initiatives to improve professional knowledge and practice among medical and health practitioners in-the retrieval and acute care of people sustaining serious injuries such as brain injury, spinal cord injury or orthopaedic trauma and the management of motor vehicle trauma generally.

Projects to investigate innovative methods to support evidence based practice by health professionals in managing motor accident trauma

The use of evidence based practice, ie using treatments that have been tested, validated and are regarded to be effective is critical in improving outcomes for injured people. The MAA has previously supported a number of projects, in particular the establishment of data bases for use by health professionals such as physiotherapists, occupational therapists and psychologists. Initiatives aimed at heath professionals using evidence based practices are now encouraged. These could include educational programs aimed at assisting practitioners to use an evidence based approach to solving real life problems.

Improving general practitioner involvement and collaboration in injury management of people with severe trauma related disability-

Applications closed in mid September 2002. These applications are currently being assessed.

Appendix 6

Scheme Performance Indicators

Scheme Performance Indicators

MOTOR ACCIDENTS AUTHORITY
REPORT TO THE LAW AND JUSTICE COMMITTEE
NOVEMBER 2002

Scheme performance indicators

In evidence to the Legislative Council's Standing Committee on Law and Justice in May 2000, the MAA identified four scheme performance indicators. Each of the performance indicators is addressed in this section based on the operation of the Motor Accidents Compensation Act 1999 since it started on 5 October 1999, to the end of September 2002. The four scheme performance indicators are affordability, effectiveness, fairness and efficiency.

Affordability

The affordability of Green Slips prices has improved according to three measures:

- Average premiums
- Ratio of premiums to average weekly earnings
- Price paid by the majority of Sydney metropolitan passenger vehicle owners.

Average premium
The average premium for a Sydney metropolitan passenger vehicle dropped from $441 in June 1999 to $341 in December 2000 increasing to $347 (excluding GST) in September 2002. It is anticipated that the average will drop to $345 in December 2002.

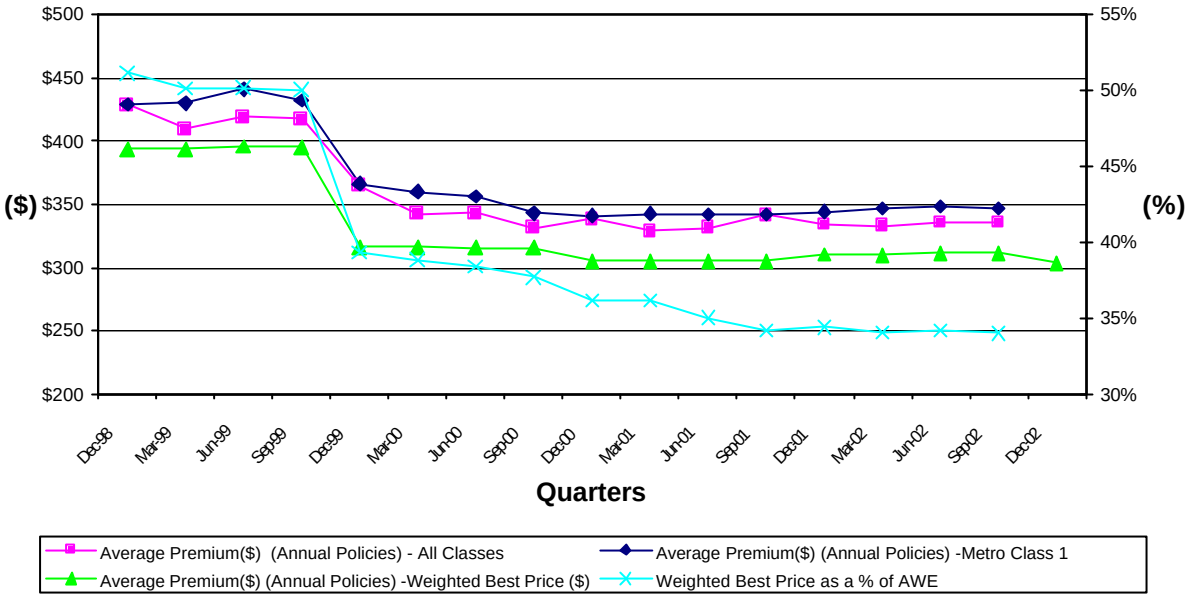
The average annual premium over all vehicle classes in NSW has dropped from $419 in June 1999 to $336 in September 2002.

Premiums and Average Weekly Earnings
The price of a Green Slip premium has dropped while average weekly earnings have increased. As a proportion of average weekly earnings, weighted best price has dropped from 50% before the reforms to 34% in September 2002.

Premiums reduce for most vehicle owners
At September 2002, more than 70% of owners of metropolitan passenger vehicles paid $318 or less (excluding GST) for a Green Slip.

For the first year after the commencement of the legislation, the MAA had the power to reject a premium if the MAA 'was not satisfied … that the majority of policies relating to passenger motor vehicles in metropolitan areas will attract a premium of not more than approximately $330'. In the first year of the scheme, more than 70% of premiums for metropolitan passenger vehicles were $330 or less. The $330 mark has now dropped to $318 and is expected to drop further still.

Average Premiums



Effectiveness

To measure scheme effectiveness the experience of the first three years of the new scheme is compared with the last three years of the old scheme at the corresponding point of development.

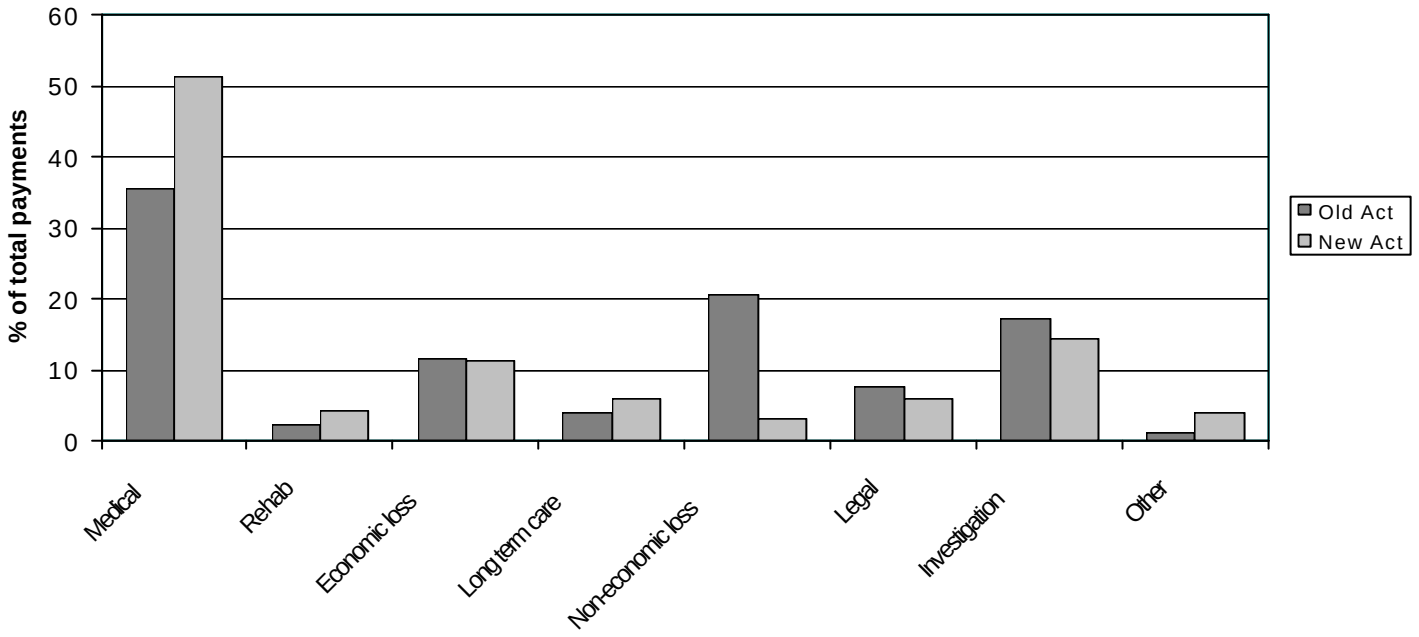
Number of claims and time periods

		Old scheme	New scheme	% difference
Number of notifications	ANFs		17,654	
	Direct full claims		23,217	
	Converted ANFs		8,804	
	Full claims		32,021	
	Total notifications	40,834	40,871	0.1%
Average time to notification (days)	ANFs		25.5	
	Full claims	113.6	100.8	-11.2%
	Total notifications	113.6	84.5	-25.6%
Average time to liability decision (days)	Full claims	125.0	96.6	-22.7%
Average time to first payment to claimant (days)	ANFs		41.8	
	Total notifications	171.6	98.1	-42.9%
Finalisations	Full claims	15,383 (37.7%)	12,308 (38.4%)	
	Total notifications	15,383 (37.7%)	19,536 (47.8%)	27.0%
Average time to finalisation (days)	ANFs		156.2	
	Full claims	350.4	350.6	0.1%
	Total notifications	350.4	280.1	-20%

Claim payments

Claim payments over this period have reduced from $417 million to $207 million, a reduction of $180 million. This represents the expected savings from the reduction in payment on smaller claims that are finalised at an earlier point in time. The reduction in claim payments is considerably les than the reduction in premiums, which over this period reduced by $405 million. The payment profile shows that as expected there has been an increase in payment going to medical payments rather than in direct compensation and a large reduction in non-economic loss payments. This is in line with expectations as the claims settled to date are less complex or relate to less serious injuries.

Payment Profile – percent of total payments



Fairness

The scheme is intended to provide a fair and equitable system for claimants ensuring that the most seriously injured receive maximum compensation. Two groups of claimants have been selected for more detailed examination in this regard.

The first group consists of claimants with serious brain injuries who represent one of the most significant serious injury groups, and historically have been one of the most costly groups. The second group is those claimants with serious leg fractures. The second group is substantial in size and also in cost.

It should be noted that the level of severity that is used by the MAA is based on coding which categorises injuries according to threat to life, i.e. the higher the score the more likely a person is to die of their injury. An injury that is very life threatening at the time of the accident may not result in permanent impairment if it is successfully dealt with and the person lives.

Further, brain injuries represent a heterogeneous group impacting on individuals in different ways and having different impairment results. It also should be borne in mind that brain injury may not be the only injury sustained by people included in this group. Individuals can sustain a number of other injuries which will also impact impairment and the level of compensation.

The MAA has presented information on the major injury groups of brain injury and leg fractures because it is the best measure available to identify serious injury groups.

When looking at seriously injured claimants, it is necessary to allow some time for their claims to develop. For this reason the following basis has been adopted for this comparison. The accident year immediately before the reforms was compared with the accident year immediately after the reforms. Both were compared at the same relative stage of development.

The **Old scheme** refers to claims from accidents between 5 October 1998 and 4 October 1999, as at September 2001. The **New scheme** refers to claims from accidents between 5 October 1999 and 4 October 2000, as at September 2002.

Brain Injuries

	Old scheme	New scheme	% difference
Number of notifications	256	246	-3.9%
Average time to notification (days)	132.9	132.8	-0.1%
Average time to liability decision (days)	222.4	136.1	-38.8%
Average time to first payment to claimant (days)	212.8	173.9	-18.3%
Finalisations	63 (24.6%)	51 (20.7%)	-19.0%
Average time to finalisation (days)	563.4	583.0	3.5%

There has been an overall reduction in the amount paid from $23.7 million to $17.6 million. While total payment on these claims is lower this primarily reflects the fact that a smaller number of matters are finalised. For finalised claims the average claim payment has increased from $167,963 to $230,331 an increase of 37%.

Finalised brain injury claims

More detailed information is presented on finalised brain injury claims where liability was fully accepted. Approximately equal numbers of claims were finalised in the two time periods. While legal representation was high in both schemes and even higher in the new scheme, no litigation was recorded for claims finalised in the new scheme.

The average payment overall increased, as did average payments in all individual payment categories.

Finalised brain injury claims (liability fully accepted)

	Old scheme	New scheme	% difference
Number of finalised claims	23	24	4%
Legally represented	87%	96%	9%
Litigated	26%	0%	-26%
MAIS (maximum severity score)			
3	10	12	20%
4	11	10	-9%
5 (most severe)	2	2	0%
Average payment	$167,963	$230,331	37%
Average payment (excl legal & investigation costs)	$155,684	$214,314	38%
Average payments by category			
Economic loss	$51,366	$147,199	187%
Long term care	$42,641	$80,344	88%
Medical	$31,412	$34,139	9%
Non economic loss	$86,069	$122,997	43%
Rehabilitation	$2,749	$4,655	69%
Investigation costs	$1,833	$2,874	57%
Legal costs	$15,118	$15,209	1%

Leg Fractures

		Old scheme	New scheme	% difference
Number of notifications	Total notifications	645	573	-11.2%
Average time to notification (days)	ANFs		39	
	Full claims	117.3	111.8	-4.7%
	Total notifications	117.3	111.7	-4.8%
Average time to liability decision (days)	Full claims	499.8	550.5	10.2%
Average time to first payment to claimant (days)	Total notifications	208.8	165.9	-20.6%
Finalisations	Full claims	282 (43.7%)	187 (32.7%)	
	Total notifications	282 (43.7%)	188 (32.7%)	-11.0%
Average time to finalisation (days)	Total notifications	500	549	10%

Total claim payment have reduced from $36.3 million to $19.4 million but again this is on a smaller number of finalised matters. More detailed information is presented on finalised leg fracture claims where liability was fully accepted.

Fewer claims have been settled in the new scheme. The difference is accounted for by fractures with severity 3, the least serious among the severe leg fractures. Average payments dropped by 28%, and by 26% when legal and investigation costs were excluded.

Fractures are by and large injuries from which most claimants will recover, and while there will inevitably be some pain during the recovery process, there will not be lasting impairment. This is reflected in the lower number of claimants receiving NEL. The average NEL payment increased by 26% from $52,400 to $66,200.

Average claim payments on finalised claims dropped from $126,204 to $91,375. However, average settlement amounts increased for all payment categories except legal and investigation costs where there were decreases of 37% and 24% respectively.

Finalised leg fracture claims (liability fully accepted)

	Old scheme	New scheme	% difference
Number of finalised claims	135	84	-38%
Legally represented	88%	73%	-15%
Litigated	20%	2%	-18%
MAIS (maximum severity score)			
3	129	77	-40%
4	5	5	
5 (most severe)	1	2	100%
Average payment	$126,204	$91,375	-28%
Average payment (excl legal & investigation costs)	$117,998	$87,752	-26%
NEL payment recorded	125	29	-77%
Average payments by category			
Economic loss	$63,017	$64,228	2%
Long term care	$21,976	$24,177	10%
Medical	$18,958	$20,719	9%
Non economic loss	$52,432	$66,234	26%
Rehabilitation	$3,297	$4,277	30%
Investigation costs	$1,535	$1,306	-15%
Legal costs	$12,390	$7,517	-39%

Efficiency

Scheme efficiency has risen from 59 to 63 per cent of the premium dollar being returned to injured people as compensation. This has been achieved by the reduction of transaction costs, that is, those costs incurred to administer the scheme.

Transaction costs include costs incurred by insurers in the initial collection of premiums, payment of their staff and their agents, the cost of employing investigators to investigate claims, the cost of claims departments to handle claims and payments to legal practitioners claimants and insurers.

Legal and medico-legal costs

In order to contain legal and medico-legal costs, the Motor Accidents Compensation Regulations were passed. Legal costs accounted for $16.3 million in the first 36 months of the new scheme, compared to $47.1 million in the comparable period of the old scheme. At this stage of the new scheme claims for more serious injuries have not been finalised. Those claims can be expected to involve significant legal costs.

Investigation costs

Investigation costs have dropped from $42.8 million to $20.6 million.

Insurers' costs

Other transaction costs in the scheme include claims handling expenses, acquisition expenses and insurers' profit margins. Insurers identify estimates of these costs in the premium filings they submit to the MAA. During the reporting period, insurers submitted filings to the MAA for premiums to commence on 5 October 2001. by comparison with prior years:

- claims handling expenses still account for 4%, indicating a reduction in dollar terms as the premium has decreased
- acquisition expenses account for 14%, indicating a reduction in dollar terms as the premium has decreased
- legal & investigation costs dropped from 14% to 11%, and
- claimant benefits (scheme efficiency) increased from 59% to 63%.

Appendix 7

Motor Accidents Compensation Act (1999) Survey of year 1 Open Claims

Motor Accidents Compensation Act (1999) Survey of year 1 Open Claims

Motor Accidents Compensation Act (1999)
Survey of year 1 open claims

Summary and conclusions

The MAA conducted a survey of claims relating to accidents in the first year of the operation of the Motor Accidents Compensation Act, which were not finalised in 2002.

Insurer survey

Insurers provided detailed information on 4,726 open claims, in 90% of which claimants were legally represented which is not surprising as they are the more complex/serious claims.

Insurer made an offer

Insurers had made offers on 55% of the claims. In more than half of these claims with offers, the insurer was awaiting a counter offer from the plaintiff or some other action to be taken by the plaintiff.

Almost 20% of cases were awaiting MAS decisions.

In a small number of cases (3%) it was treating doctors or medical legal opinions that were needed before progress could be made.

In 14% there were disagreements between the two parties where it was not possible for the MAA to identify from the survey whose turn it was to act. A medical assessment would be appropriate to settle the majority of these disputes but neither side had approached MAS.

Of the claims where the insurer had made an offer there were very few issues concerning injury stability and only a handful of cases had proceeded to court.

Insurer has not made an offer

Insurers had not made an offer in the remaining 45% of cases. In a significant minority of these cases (13%) this was due to the fact that injuries had not stabilised or had only recently stabilised.

However, in one third of cases the progress of the claim depended on action from plaintiffs, for example by providing particulars or clarifying their intention to proceed with their CTP claim after consideration of their Workers' Compensation rights. MAS was the reason for delay in 14% of matters and CARS in 1%. Doctors were responsible for delay in 6% of cases. A small number of matters (3%) were awaiting court hearings.

There was a greater level of disagreement between parties in this group, with disputes in 19% of cases. The disputes were related to liability in 10% of cases.

Conclusions

A major cause of delay is the failure of plaintiffs (90% of whom are legally represented) to make counter offers and to provide particulars. The MAA intends to have further discussions with insurers and the Law Society to assist them in identifying ways in which all parties may better assist claimants.

Contrary to anecdotal reports from all parties prior to the survey, MAS was not responsible for the majority of delays. The MAA will continue to address the delays at MAS by

- Staff recruitment
- Recruitment of more assessors
- Improving accuracy of assessors' reports by providing tailored training
- Increasing the appropriate use of MAS especially in impairment disputes.

Claimant survey

In addition to requesting detailed information from insurers on year 1 claims, the MAA also followed up directly with claimants to gather their view of the claims settlement process. Responses have been received from 977 claimants (24% response rate). The MAA has completed its analysis of the survey of claimants at this stage.

The MAA intends to make further contact with claimants where there appears to be a delay due to poor responses from the insurer or the solicitor, with a view to prompting early attention to these claims.

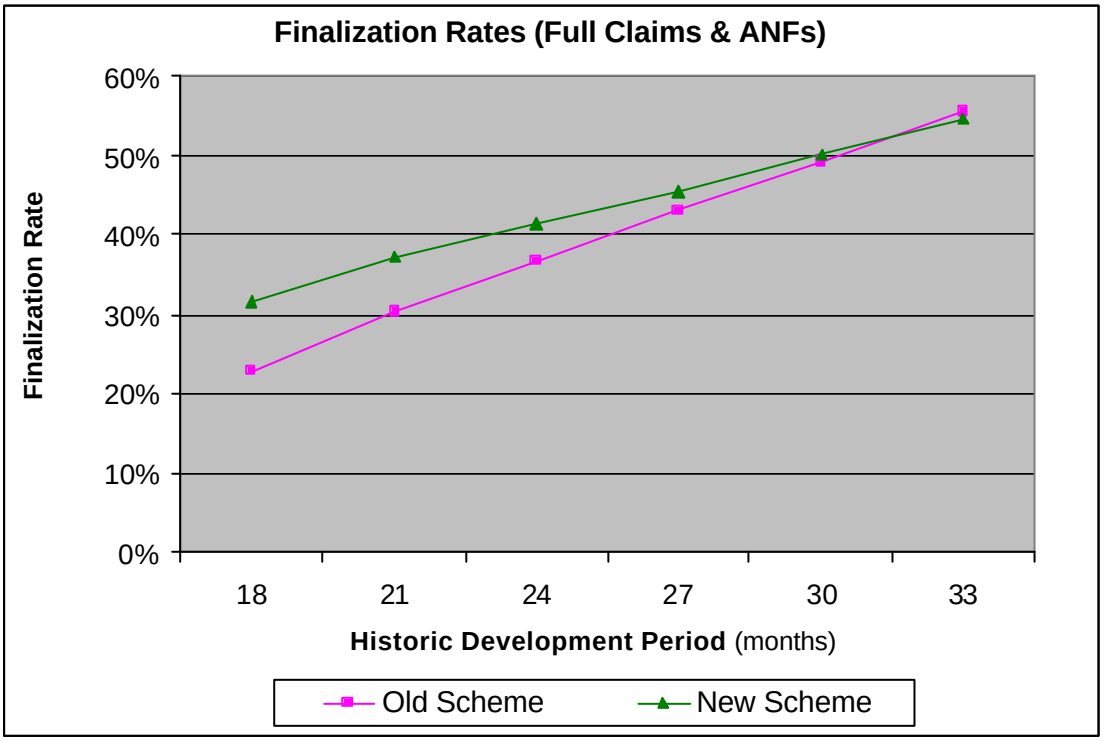
Introduction

At the end of March 2002, insurers had received over 37,000 notifications including both full claims and unconverted ANFs, since the new scheme was introduced on 5 October 1999.

The finalisation rate under the new scheme has been better than the finalisation rate under the previous scheme, as the graph shows and is still at a comparable level. However, the MAA was concerned that the variation in total payments between schemes might be a result of a slow down in finalisations of those claims for which there was an NEL entitlement under the old Act but which were unlikely to get over the 10% WPI threshold.

The MAA decided to obtain a clearer picture

1. by collecting specific reasons from insurers why year 1 open claims had not resolved and also
2. by asking claimants themselves for their views of the progress of their claims.



Survey of insurers

At the end of March 2002, insurers had received 13,323 full claims relating to accidents in the first year of the scheme. Of these 5,394 (41%) were finalised, leaving 7,929 full claims still open. The MAA surveyed a total of **7,113** open claims from year one where the claimant was over 16 at the time of the accident and the claims were notified before 1 January 2002.

The MAA asked insurers to provide information by the end of August 2002. Information was received on 6,272 claims (88%) of which 1,212 had finalised or settled since the end of March. A further 334 claims were excluded from the survey mainly because they were either workers compensation recoveries (from a workers compensation insurer not an individual claimant) or interstate claims, leaving **4,726** claims.

Insurer survey results

Legal representation amongst these 4,726 claims was approximately 90%, which is not surprising as they are the more complex/serious claims.

The main reasons that insurers identified for the delay in settlement were:

- Insurer awaiting a counter offer from claimant/representative (27%)
- Awaiting a determination from MAS (17%) (eco loss 4%, not eco loss 10%, tt 1%)
- Outstanding particulars (13%)
- Medical dispute, not at MAS (9%)
- Claimants' workers compensation rights being considered/pursued (8%)
- Injuries not stable (parties agree) or only recently stable (7%)
- Liability dispute, not at CARS (5%)
- Awaiting CARS special/general assessment (2%)
- CARS exempt – litigation not commenced (2%)
- CARS exempt – litigation commenced (1%)
- Awaiting CARS decision on exemption (<1%)
- Other main reason (8%)

There were very few cases where the main reason for delay was an unresolved dispute about quantum of NEL (<1%) or about any other head of damage (2%). There was a minority of claims (10%) awaiting a MAS decision on WPI and/or stability, which could become a dispute about quantum of NEL.

Of the 4,726 claims, insurers had made offers in 2,601 cases (55%) and had not made an offers in 2,125 cases (45%). The subsequent analysis looks at these two groups separately.

Insurer had made an offer

Insurers had made offers on 2,601 claims. The most common reasons for non-finalisation amongst these claims were:

- Awaiting counter-offer from claimant/representative (46%)
- At MAS (19%)
- Medical dispute (but not yet referred to MAS) (10%)
- Awaiting further particulars (7%)

Combined, these reasons accounted for 82% of the non-finalised claims where the insurer had made an offer.

The table below outlines all the main reasons that the claims were still open.

Main reason claim not settled (where insurer had made an offer)	**Number**	**Percent**
Quantum under negotiation	1,304	50.1
Awaiting counter offer from claimant/representative	*1,200}*	
Dispute over quantum (not non-economic loss)	*79}*	
Dispute over quantum (non-economic loss)	*25}*	
At MAS awaiting decision or result of assessment	497	19.1
Medical dispute but not yet referred to MAS	253	9.7
Outstanding particulars	181	7.0
Workers compensation being considered/pursued	89	3.4
At CARS awaiting assessment	70	2.7
Injury not stable or only recently stable	66	2.5
Exempt from CARS	18	0.7
Liability in dispute	8	0.3
Claim settled but legal costs in dispute	8	0.3
Procedural dispute	7	0.3
Other reason	100	3.9
Total	2,601	100.0

Negotiations

Of the 2,601 cases in which the insurer had made an offer, half (1,304 claims) were involved in negotiations over quantum before further progress towards finalisation could be made. The majority of those (1,200) were awaiting counter offers. Of the remaining 104, 79 were in dispute over quantum (not NEL) and 25 were in dispute over the amount of NEL.

Medical Assessment Service (MAS)

A further 497 claims (19%) were at MAS awaiting decisions on issues such as WPI, stability of injuries and economic loss. Most of the claims at MAS (295, or

60%) were awaiting a decision on Whole Person Impairment and/or stability (but not economic loss). The second major group of claims at MAS were 131 cases (26%) waiting for a decision on economic loss (with or without WPI or stability issues).

Medical dispute (not at MAS)

The third largest main group consisted of 253 claims (9.7%) that were in dispute about medical issues such as WPI or stability, but had not yet been to MAS. At least some of these could be expected to go through MAS in the future.

Outstanding particulars

In 181 claims (7%), the insurer needed more information, for example, a treating doctor's report, medico-legal report, initial particulars or further particulars. In a minority of these instances (5 claims) the information was required but had not been requested by the insurer. In the remaining claims it appeared that action was required on the part of the claimant or their representative.

Workers compensation

In 89 claims (3.4%) the claimant was pursuing or considering pursuing entitlements under Workers Compensation.

Claims assessment and resolution service (CARS)

Seventy claims (2.7%) were at CARS awaiting assessment. Most of these were awaiting general assessment (66) and the remaining 4 claims were awaiting results of a special assessment.

which is not surprising as they are the more complex/serious claims.
In 66 claims (2.5%) either the parties agreed that the injuries were not yet stable or injuries had only recently stabilised.

Other reasons

Other subgroups included claims that were exempt from CARS, claims where liability was in dispute, claims that were settled except for a dispute about legal costs, and claims involving a procedural dispute. These each accounted for less than 1% of the 2,601 claims.

Insurer had not made an offer

The insurer had not made offers in 2,125 claims. The most common reasons for non-finalisation amongst these claims were:

- Awaiting further particulars (20%)
- At MAS (14%)
- Delayed/absent injury stability (14%)
- Workers compensation rights being considered/pursued (13%)
- Liability in dispute (10%)

Combined, these reasons accounted for 70% of the non-finalised claims where the insurer had not made an offer.

The table below outlines all the main reasons that the claims were still open.

Main reason claim not settled (where insurer had not made an offer)	**Number**	**Percent**
Outstanding particulars	425	20.0
At MAS awaiting decision or result of assessment	289	13.6
Injury not stable or only recently stable	286	13.5
Workers compensation being considered/pursued	272	12.8
Liability in dispute	211	9.9
Medical dispute but not yet referred to MAS	173	8.1
Exempt from CARS	141	6.6
Under negotiation	97	4.6
Procedural dispute	63	3.0
At CARS awaiting assessment	12	0.6
Other	156	7.3
Total	2,125	100.0

Outstanding particulars

Amongst claims where the insurer had not made an offer, the largest group consisted of 425 claims (20%) with outstanding particulars. Of these, 267 cases (63%) were waiting for initial or further particulars from the claimant or their representative. In 129 cases the insurer was waiting for a treating doctor's report or a medico-legal report. In a small number of cases (29 claims) information was required but had not been requested by the insurer.

Medical Assessment Service (MAS)

A further 289 claims (13.6%) were at MAS awaiting decisions on issues such as WPI, stability of injuries and economic loss. Most of the claims at MAS (194, or 67%) were awaiting a decision on Whole Person Impairment and/or stability (but not economic loss). The second major group of claims at MAS were 55

cases (19%) waiting for a decision on economic loss (with or without WPI or stability issues).

Injury stability

In 286 claims (13.5%) injury stability was the major factor. In the majority of cases (184 claims) both parties agreed that the injuries were not stable.

Workers compensation

In 272 claims (12.8%) the claimant was pursuing or considering pursuing entitlements under Workers Compensation.

Liability

Liability was in dispute in 211 claims (9.9%) but no CARS exemption had yet been applied for or granted.

Medical dispute (not at MAS)

The next main group consisted of 173 claims (8.1%) that were in dispute about medical issues such as WPI or stability, but had not yet been to MAS. At least some of these would be expected to go through MAS in the future.

Exempt

A total of 141 (6.6%) claims were either exempt from CARS (131) or awaiting a decision on exemption (10). Liability had been in dispute in 119 of the exempt cases, and of those, 49 had proceeded to litigation and 70 had not.

Negotiations

Negotiations over quantum were the primary factor in 97 cases (4.6%).

Procedural dispute

There was a procedural dispute in 63 claims (3%), of which 53 concerned providing a full and satisfactory explanation (for example reasons why a claim was submitted late). The remaining 10 claims involved other procedural disputes.

Claims assessment and resolution service (CARS)

Twelve claims (0.6%) were at CARS. Six were awaiting a general assessment and six awaiting results of a special assessment.

Survey of claimants

In addition to requesting detailed information from insurers on year 1 claims, the MAA also followed up directly with claimants to gather their view of the claims settlement process. Claimants were sent a survey form if

- their postcode was in NSW
- the claim was not associated with a fatal accident
- the claim was not a workers' compensation recovery
- the injury sustained was not serious - only injuries with MAIS (maximum injury severity) between 1 and 3 were included.

After these exclusions, there was a pool of 4,504 claimants. The address information collected by the MAA includes street number, street name (excluding street, avenue, crescent etc). To find the full correct address for each claimant the file of 4,504 claims was matched against Australia Post addresses to provide valid postal addresses. As a result of this matching process, valid addresses could not be found for 179 claims, resulting in 4,325 letters mailed out.

Claimant survey results

Responses have been received from 977 claimants, and 313 envelopes were returned by Australia Post. The response rate then is 977/4,012 = 24%, which is to be expected from this kind of survey without follow-up.

Claimants reported that a further 94 claims in this group had settled.

Further action

The MAA has completed its analysis of the survey of claimants at this stage.

However, the MAA will make further contact with claimants where there appears to be a delay due to poor responses from the insurer or the solicitor with a view to prompting early attention to these claims.

Appendix 8

Estimates of rates of Return on Capital for NSW CTP Insurance Business

Estimates of rates of Return on Capital for NSW CTP Insurance Business

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22 November, 2002

Mr David Bowen
General Manager
Motor Accidents Authority of New South Wales
Level 22
580 George Street
Sydney NSW 2000

Dear David,

Estimates of Rates of Return on Capital for NSW CTP Insurance Business

1. Estimates of return on capital from different sources

Recent estimates of return on capital for insurers for CTP business are summarised in Table 1.

Draft

Table 1

Year ended 30 June	Underwriting year basis estimates for NSW CTP calculated for the MAA[a]	Financial reporting year basis estimates for ACCC reports for all CTP business combined[b]
	% p.a.	%
1990	44	Na
1991	72	Na
1992	15	Na
1993	7	24
1994	5	14
1995	7	(30)
1996	19	(24)
1997	17	2
1998	12	12
1999	14	28
2000	14	21
2001	Na	30
December 2001	Na	46[c]

Notes: (a) "Full analysis" approach estimates net of tax from Table 2.1 in our report to the MAA dated 17 October 2001.

(b) Gross of tax estimates underlying Figure 4.5 in report "Australian Competition and Consumer Commission Insurance Industry Market Pricing Review" dated March 2002.

(c) From Figure 2.11 in ACCC report "Second insurance industry market pricing review" dated September 2002. Based on insurers' year-end returns to APRA for year-ends during calendar year 2001. Gross of tax.

For this letter I have not undertaken detailed calculations regarding causes of the differences between the estimates shown in Table 1. However, four important general causes of the differences can be identified and are discussed in Sections 2 to 5 below.

2. Gross of tax v net of tax estimates

The underwriting year basis estimates calculated for the MAA were of net of tax return on capital.

By contrast, the financial reporting year basis estimates for each class of business in the ACCC reports were on a gross of tax basis.

3. Underwriting year v financial reporting year bases and their implications

3.1 Differences between underwriting year and financial reporting year bases

The estimates which we calculated for the MAA during 2001 were on an **underwriting year** basis, which is appropriate for assessing the estimated profitability for insurers of premiums written during each year. (As discussed, we are currently updating these estimates based on information on claims and expenses to 30 June 2002.)

By contrast, the estimates calculated for the ACCC reports were on a **financial reporting year** basis, because that is the form in which the information published by APRA is available. Profits or losses reported by an insurer for its financial reporting year consist essentially of:

[estimated profit or loss from premium earned during the most recent accident year

plus

profit or loss arising from restatement of provision for outstanding claims for all prior accident years].

(This is a deliberate over-simplification, in that other factors also affect insurers' reported profits or losses materially.)

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By comparison with the underwriting year basis of assessment, the financial reporting year basis tends to have the following effects:

(a) Apparent emergence of high or low reported returns in financial reporting years **after** the underwriting years which actually generated those high or low returns. Thus:

- The extremely profitable (fixed premiums) 1990 and 1991 underwriting years for NSW CTP resulted in high reported returns for the 1993 financial reporting year.
- Poor returns for the 1993, 1994 and 1995 underwriting years were (to a large extent) the cause of the negative reported returns for the 1995 and 1996 financial reporting years.
- Relatively high estimated returns for the 1996 to 2000 underwriting years resulted in high reported returns for the 1999, 2000 and 2001 (particularly) financial reporting years. Section 2.3.3 of the ACCC's September 2002 report includes the statement "Insurers indicated that part of the profit in 2001 is due to the release of excess reserves held in respect of accidents relating to the early and mid-1990s."

(b) **To accentuate reported changes in profitability** for insurers of the class of business. To illustrate why this tends to occur, consider deterioration in claims experience which is not recognised as such immediately. Say, two years after the deterioration started when the deterioration has been fully recognised, a large loss reported on a financial reporting year basis is likely to result from a combination of **both**:

- the estimated loss from the latest accident year due to recent premiums having been written at unprofitable rates, **and**
- additional reported losses from having to increase outstanding claims provisions for prior accident years to allow for the previously unrecognised deterioration in claims experience.

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Hence the large negative returns on capital for 1995 and 1996 on the financial reporting year basis.

3.2 Outlook for financial reporting year returns for the near future

The outlook for **financial reporting year** returns for each class of business was included in the "Market overview" section in the summary at the start of the ACCC's September 2002 report. For CTP, the outlook was shown as "Very High". For returns measured on a financial reporting year basis, it does seem likely that high returns will be reported for CTP for, say, the 2002 and 2003 financial reporting years. For NSW CTP business:

- It now appears likely that ultimate claims costs for at least the two accident years since the commencement of the New Act on 5 October 1999 will turn out to be less than was estimated when corresponding premiums had to be determined.

- Resulting profits for insurers greater than was originally anticipated would only have been reflected partly in financial reporting years to the end of 2001.
- The remainder of these profits are likely to emerge during the 2002 and later financial reporting years.

Hence the outlook for high returns for **financial reporting years for the near future**.

However, debating whether these financial reporting year gross of tax returns on capital for the near future might fall into the ranges defined by the ACCC as

- "high" – between 20% and 50%, or
- "very high" – over 50%

would be somewhat speculative given the uncertainties involved and the limited information which is available publicly.

It should also be borne in mind that, because of the differences between underwriting year and financial reporting year bases, the high recent returns on the latter basis do not necessarily imply a high level of profitability of NSW CTP premiums being written by insurers under their current premium rate filings which took effect from 1 October 2002.

The comments in this Section 3.2 are based on our assessment of NSW CTP business. For this letter, we have not attempted to consider how different prospects for Queensland and ACT CTP business might affect the outlook for financial reporting year returns for all three jurisdictions combined (refer Section 5 below).

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4. Capital allocation used for calculations and related issues

4.1 Bases for calculations in the ACCC's reports

Section 2.2 "Market update" of the ACCC's September 2002 report includes both:

- Estimates of insurers' net of tax return on **actual equity** for all classes of insurance business combined, on a financial reporting year basis. For the 2001 financial reporting year:
  - the calculated net of tax return on equity excluding the HIH Group was 5.5% (refer Section 2.2.5), but
  - if the HIH Group had been included in the 2001 APRA statistics, the return on equity would have been –30%, instead of 5.5% (refer Section 2.2.1).

- Estimates, again on a financial reporting year basis, of gross of tax return on capital for each class of business. For deriving these estimates, the capital allocated to each class by insurers was assumed to be the **minimum capital** required by APRA under its new requirements. (This is explained in Section 2.3 and Appendix F.6 of the ACCC's report.)

The "Summary" section at the start of the ACCC's September 2002 report includes the estimates of gross of tax return on (APRA minimum) capital for each class of business, but not the estimates of net of tax return on (actual total) equity. My (wholly personal) opinion is that it would have been preferable to include both estimates in the "Summary" section.

4.2 Different bases for determining amount of capital

Making generalisations which ignore differences between insurers, various bases for determining total capital can be arranged in **increasing** order of total capital as follows:

(a) former (pre 1 July 2002) ISC and APRA minimum capital requirements;
(b) new APRA stated minimum capital required ("MCR");
(c) effective new APRA MCR of 120% of (b), as we understand that APRA has advised insurers that it expects maintenance of capital of at least 120% of the MCR as representing a satisfactory capital management approach, and
(d) actual capital held by the majority of insurers.

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The estimates of gross of tax return on capital for each class of business in the ACCC's reports were calculated on basis (b).

Table 2 and the following graph show the estimates in Table 1 and the effect on the financial reporting year basis estimates in the ACCC reports of adjustment to base them on:

- 120% of the new APRA MCR, ie basis (c) above, and
- 150% of the new APRA MCR. This is simply an illustrative level of capital moderately more than basis (c) above. It is not intended to be representative of any particular CTP insurer.

Table 2

Year ended 30 June	Underwriting year basis net of tax estimates for NSW CTP calculated for the MAA[(a)]	Financial reporting year basis gross of tax estimates for all CTP business combined, based on capital of:		
		100% of new APRA MCR[(a)]	120% of new APRA MCR	150% of new APRA MCR
	% p.a.	%	%	%
1990	44	Na	Na	Na
1991	72	Na	Na	Na
1992	15	Na	Na	Na
1993	7	24	21	18
1994	5	14	12	11
1995	7	(30)	(24)	(18)
1996	19	(24)	(19)	(14)
1997	17	2	2	3
1998	12	12	11	10
1999	14	28	24	21
2000	14	21	18	16
2001	Na	30	26	22
December 2001	Na	46	9	33

Note: (a) From Table 1.

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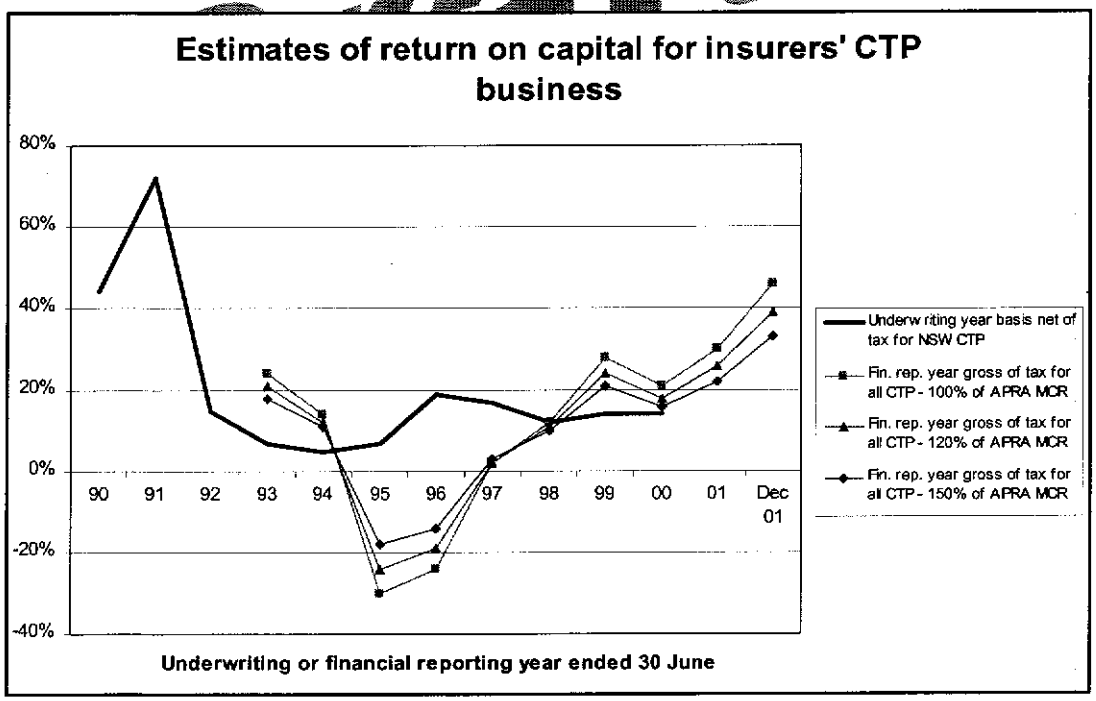

All other things being equal, assuming a greater allocation of capital tends to moderate both high and low values for estimated return on capital. Essentially, a greater allocation of capital "dilutes" the effect on return of the profits or losses generated by writing the insurance business, because the overall return depends more on the investment return on the capital and correspondingly less on the profits or losses generated by writing the insurance business. Thus:

- For the financial reporting year basis estimates, increasing the amount of capital assumed for the calculations from 100% to 150% of the APRA MCR **moderates** both the high and low values for estimated return.
- Ignoring the exceptional returns for the 1990 and 1991 (fixed premiums) underwriting years, the underwriting year basis estimates calculated for the MAA exhibit a much smaller range of returns than all of the financial reporting year basis estimates. The estimates calculated for the MAA were based on capital assumed to be allocated to CTP of approximately 3 times the new APRA MCR. The capital allocation used for the estimates for the MAA:
  - was based on allocating insurers' overall **actual** total capital, and
  - used a relatively sophisticated approach for allocating capital between classes, the general effect of which was to allocate more capital to the larger long-tail classes, such as NSW CTP, than most other capital allocation methods.

5. Business to which estimates relate

The estimates calculated for the MAA were for NSW CTP business only while those in the ACCC reports were for NSW, ACT and Queensland CTP business combined.

As agreed, for this letter we have not attempted to undertake further analysis of the extent to which this difference might affect the comparisons.

Draft

Please contact me if you want to discuss these issues further and/or have any queries.

Yours sincerely,

Adrian Gould

cc Concetta Rizzo, Motor Accidents Authority
Clive Amery, Taylor Fry
Greg Taylor, Taylor Fry

Appendix 9

Report to the Legislative Council Standing Committee on Law and Justice from the Motor Accidents Authority

November 2002

Report to the Legislative Council Standing Committee on Law and Justice from the Motor Accidents Authority

Appendix 10

Minutes of Proceedings

Minutes of Proceedings

Meeting No 78
2:40 pm, 29 November 2002
Room 1136, Parliament House, Sydney

1. MEMBERS PRESENT

Mr Dyer (in the Chair)
Mr Breen
Mr Hatzistergos
Mr Primrose
Mr Ryan

Also in attendance: Director, Ms Tanya Bosch; and Senior Project Officer, Ms Rachel Callinan

2. MINUTES

Resolved, on the motion of Mr Breen, that the minutes of meeting number 77 be adopted.

3. MAA HEARING

Resolved, on the motion of Mr Breen, that for the hearing to be held in pursuance of the Review of the MAA on 2 December 2002, the committee be enabled, if necessary, to sit as a sub-committee to take evidence.

4. THANKS

Resolved, on the motion of Mr Primrose, to congratulate and thank the Director, Ms Tanya Bosch, Senior Project Officer, Ms Rachel Callinan, for their work on the Committee's recent inquiries.

5. CONSIDERATION OF CHAIR'S DRAFT REPORT FOR THE INQUIRY INTO REGULATING COATS OF ARMS

***

6. ADJOURNMENT

The Committee adjourned at 4.35 pm, to reconvene at 2:00 pm, 2 December 2002.

Tanya Bosch
Director

Meeting No 79
2.00 pm, Monday 2 December 2002
Room 814/815, Parliament House, Sydney

1. MEMBERS PRESENT

Mr Dyer (in the Chair)
Mr Hatzistergos
Mr Primrose
Mr Ryan

Also in attendance: Director, Ms Tanya Bosch

2. APOLOGIES

Mr Breen

3. HEARING

The committee began the fourth hearing of the Review of the Exercise of the Functions of the MAA and the MAC.

The public was admitted.

Mr David Bowen, Ms Concetta Rizzo and Dr Stephen Clough were affirmed and examined.
Mr Richard Grellman was sworn and examined.

Mr Bowen tendered the answers to the Questions on Notice and the Report on CTP Insurer Profit.

Evidence concluded and the witnesses withdrew.

4. PUBLICATION OF PROCEEDINGS

The Committee resolved, on the motion of Mr Ryan, that in order to better inform all those who are participating in the inquiry process, the Committee make use of the powers granted under paragraph 25 of the resolutions establishing the Standing Committees, and section 4(2) of the Parliamentary Papers (Supplementary Provisions) Act 1975, to publish transcripts and tabled documents tendered at the public hearing held on 2 December 2002.

5. ADJOURNMENT

The committee adjourned at 3:50 pm *sine die*.

Tanya Bosch
Director

Meeting No 80
3.15 pm, 10 December 2002
Room 1136, Parliament House, Sydney

1. MEMBERS PRESENT

Mr Dyer (in the Chair)
Mr Hatzistergos
Mr Primrose
Mr Ryan

Also in attendance: Director, Ms Tanya Bosch; and Senior Project Officer, Ms Rachel Callinan

2. APOLOGIES

Mr Breen

3. MINUTES

Resolved, on the motion of Mr Ryan, that the minutes of meetings number 78 and 79 be adopted.

4. MAA REPORT

The Chair submitted his draft report on the Review of the Exercise of the Functions of the MAA and the MAC which, having been circulated to Members of the Committee, was accepted as being read.

Resolved, on the motion of Mr Ryan, that the draft report be the Report of the Committee and that the Chairman and Director be permitted to correct stylistic, typographical and grammatical errors.

Mr Hatzistergos abstained.

Resolved, on the motion of Mr Primrose that the report, together with the transcripts of evidence, submissions, documents and correspondence in relation to the inquiry, be tabled and made public.

5. THANKS

The Chairman expressed his heartfelt thanks to the Deputy Chair, Mr Ryan, the Committee Members and Committee staff for their participation, support and assistance over the past four years.

Resolved, on the motion of Mr Ryan, that the Committee record its thanks to the Chairman for his hard work, his consensus building and his thoroughness over the past four years.

6. ADJOURNMENT

The Committee adjourned at 3.35 pm, *sine die.*

Tanya Bosch
Director