WorkCover NSW

Inquiry into the NSW Workers Compensation Scheme – benefit package costing

WorkCover NSW

Joint Select Committee Inquiry into the NSW Workers Compensation Scheme

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pwc

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1 Introduction

1.1 Introduction

A Joint Select Committee of the NSW Parliament has been established to inquiry into the NSW WorkCover Scheme (the Inquiry).

The Inquiry has requested WorkCover to provide advice to the submission on the possible financial implications of two distinct packages of potential benefit reforms, namely:

- A package of benefit reforms consistent with the options discussed in the Government's Issues Paper
- A package of benefit reforms consistent with the points raised in the submission to the Inquiry by the NSW Bar Association (Submission 77).

NSW WorkCover in turn has requested PwC provide advice as to the possible financial impact of each of the above two options.

1.2 Considerations

Depending on how the reforms are introduced they may potentially have an impact on:

- The existing outstanding claims and hence the outstanding claims liability, and/or
- The cost associated with future new claims and hence an impact on premiums.

We have considered both in this report. The cost implications contained in this report are only with reference to the WorkCover Nominal Insurer Scheme.

The costings have assumed the reforms are introduced as a package. It is imperative that they be considered as such. Various elements of the package work to reinforce each other, removal of one element of the package might undermine the assessed cost implication of other elements of the package. The costing has also occurred as a hierarchy. The cost impact of a particular change can depend on what order the costing has occurred. As a result of these two issues the cost impact of a single change considered as a stand-alone change may be different from that allowed for within this package.

Our analysis of the possible financial impact has been made by reference to the recently completed December 2011 valuation of the Nominal insurer's outstanding claims as documented in the PwC report *WorkCover NSW Actuarial valuation of outstanding claims liability for the NSW Workers Compensation Nominal Insurer at 31 December 2011* dated 12 March 2012.

1.3 Risks and uncertainty

It is important to recognise there is considerable uncertainty associated with the financial cost impact results contained in this report. They should be considered more as indicative of the magnitude of the possible cost impact rather than being precise.

There must be recognition that legislation is just one part of the necessary change and there also needs to be a strong focus on change management and implementation. In particular it requires a focused capability by the regulator (WorkCover), the Nominal Insurer and Scheme Agents.

The estimated cost impacts we have calculated are based on the assumptions that any legislative changes are made in the way interpreted, and that they are well implemented. This costing assumes the immediate application of any new legislative requirements, the longer a transition period applies implies that benefits would continue to be paid under the current regime, posing a greater risk of further Scheme cost deterioration in the interim.

Areas of uncertainty and risk associated with costing the financial implication of these reform packages include:

- **Estimating reform impact** – Evaluating the cost implications from reforms is extremely difficult and relies in large part on subjective interpretation of the likely impact of the various reforms. There is likely to be a range of possible outcomes corresponding to more optimistic or pessimistic views compared to that presented in this report.

- **Behavioural impacts** – In particular the impact of reforms, especially major reforms such as those considered in this report, can be expected to lead to significant behavioural changes by all Scheme participants which will impact on the utilisation of benefits. It is not possible to estimate the impact of these behavioural changes accurately.

  These behavioural changes can be reinforced or conflicted by various elements of a reform package. Thus it is extremely important that reforms be considered as part of a package rather than just individually.

- **The honeymoon effect** – There are 'short-term' versus 'long term' issues to consider. Shortly after a major benefit reform, it is not unusual for there to be a 'honeymoon' of very favourable experience while participants better understand the implications of the new benefit structure. This honeymoon effect will then dissipate with time. We have not tried to estimate any initial honeymoon effect in our cost estimates. However, it is important for this issue to be considered when interpreting initial experience once a reform package has been implemented.

- **Drafting and legislative amendments** – This report is prepared based on a high-level understanding of the reform package(s). It is possible that any legislative changes introduced may differ from this understanding. Similarly, it is entirely possible that legislative amendments may occur prior to the passing of any legislative change, which may significantly change what is then implemented from the version of reforms considered in this report.

- **Effectiveness of implementation** – The impact of legislative reform is only as effective as how well it is implemented. As an illustration, many of the proposed reforms in the Issues Paper are modelled on the Victorian WorkSafe Scheme. The WorkSafe Scheme is regarded as a well run scheme which has been able to optimise scheme outcomes under a particular set of legislation. For example, WorkSafe appears to achieve significant cessation of weekly benefits prior to the 78 week work capacity test being performed, by implementing claim management strategies that work towards the looming work capacity test.

  It is not clear to what extent the NSW Scheme would be able to operationally implement the same or similar legislation, and supporting work practices, to achieve a similar level of outcomes, at least initially. It must be recognised that legislation is just one part of the necessary change and there also needs to be a strong focus on change management and implementation. In particular it requires a focused capability by the regulator (WorkCover), the Nominal Insurer and Scheme Agents.

  The estimated cost impacts we have calculated are based on the assumptions that any legislative changes are made in the way interpreted, and that they are implemented well.

- **Impact on management costs** – The costs of managing the Scheme will change significantly as a result of a major change in benefit structure. The overall impact is unknown. To be prudent we have not allowed for any management cost savings.

- **Slippage** – Over time, Scheme participants also begin to better understand the new benefit structure and begin to optimise their benefits and/or potentially exploit any loopholes identified. An example of a current loophole is the recent increase in Permanent Impairment "top up" payments. This is the opposite of the honeymoon effect described above.

- **Timeframe and information available to complete this analysis** – With more time, greater clarity on the specifics of the proposed reforms and the identification of additional information (potentially from other Schemes) to support the analysis, the results documented in this report could potentially be refined.

In summary, it is important to recognise there is considerable uncertainty associated with the financial cost impact results contained in this report. They should be considered more as indicative of the magnitude of the possible cost impact rather than being precise.

2 Benefit model consistent with the issues paper

2.1 Summary of proposed benefit package

The NSW Government released an Issues Paper when it established the Inquiry. The Issues Paper contained a number of broad areas of potential reforms to current benefit structure without making any specific suggestions. At the request of the Inquiry, WorkCover has now provided PwC with a specific package of benefit reforms to be considered which might be considered aligned with the broad areas identified in the Issues Paper.

The specific reform package is extensive, with a number reflecting benefit design from the Victorian WorkSafe Scheme. The reform package costed involves a number of key changes impacting the following benefits:

- Weekly benefits – Resulting from:
    - Simplification in definition of pre-injury earnings
    - Changes in benefit levels before 13 weeks for both Total and Partial Incapacity benefits
    - A revised step down at 13 weeks, with changes in benefits levels for both Total Incapacity and Partial Incapacity benefits after 13 weeks
    - The introduction of a work capacity test similar to Victoria between 78 and 130 weeks
    - A requirement for claimants to be either Severely Impaired (30% WPI or more), Totally Incapacitated or Partially Incapacitated and working at least 15 hours per week to continue to receive incapacity benefits after 130 weeks
    - A cap on weekly benefits at nine years, with exceptions for the most severely impaired (greater than 30% WPI). For existing claims the nine year cap will apply from date of commencement of the new legislation rather than date of first incapacity. Alternative caps at 5, 7, and 11 years have also been separately costed.
- Medical benefits – Indirectly resulting from the weekly benefit reforms, and directly from introduction of a one year maximum period for the payment of medicals from date of injury/cessation of weekly benefits, with exceptions for the severely impaired
- Workplace Injury Damages – No change in the current 15% WPI threshold but amendments resulting in a stronger statute of limitations and indirectly via the elimination of Permanent Impairment "top up" payments and from the changes to weekly benefits
- Statutory lump sums – Combining Permanent Impairment with Pain and Suffering, reduction in legal involvement, introduction of a 10% Whole Person Impairment threshold to access, elimination of "top up" payments and a change in benefit scale to match Victoria
- Exclusion of journey and heart attack/stroke claims.

More detail on the specified benefit package is described in the relevant sub-sections of Section 2.

2.2 Exclusion of particular claim types

We have assumed these proposals would only be made prospectively with no impact on existing journey, heart attack or stroke claims reported and continuing on benefits in the Scheme.

2.2.1 Journey claims, except for work, workers compensation or training related journeys.

The specified package removes most journey claims from coverage.

A separate document has been provided to the Inquiry summarising Journey claim experience over recent accident years.

In summary:

- There is a variable on the WorkCover database which identifies Journey claims
- Approximately 6,500 to 7,000 journey claims are reported in respect of recent accident years. The proportion of claims reported which are journey claims has increased from 6.2% in 2000 to circa 8% for more recent accident years.
- Journey claim payments (net of CTP and other recoveries) have been approximately 6% to 8% of total Scheme net payments in recent years.
- Not all journey claims involve motor vehicles. The following table shows there are approximately 4,000 motor vehicle Journey claims each year.

Mechanism of injury = 92(Motor Vehicle accident)				
Financial Year of	Commuting Journey	At Work - road traffic accident	All other Dury Status	Total
2005/06	4,076	719	634	5,429
2006/07	4,319	804	464	5,587
2007/08	4,158	766	536	5,460
2008/09	4,093	746	491	5,330
2009/10	3,890	763	477	5,130
All	20,536	3,798	2,602	26,936

- Journey (and recess) claims are currently excluded from experience premium rating, so there is an incentive for employers to have these claims miscoded as journey and recess. The potential for this miscoding of motor vehicle claims is illustrated in the above table where approximately 80% of all motor vehicle claims are currently coded as commuting journey claims.
- The exclusion of journey claims from the Scheme may result in many motor vehicle claims being more appropriately classified. If this issue is important, then conclusions based on the net cost of journey claims shown in the following tables may overestimate the 'true' net cost of journey claims.
- We have allowed for slippage in our costing (circa 40-50%) to allow for the potential for reclassification of many claims rather than their exclusion if journey claims were to be excluded from the Scheme.

The following tables summarise the modelled cost impact of excluding journey claims assuming no other reforms occur:

Journey claims

	Outstanding claims liability (all benefits)			Next years premium (all benefits)			
		Difference		Breakeven premium		Difference	
Scenario	Liability	$m	%	$ m		$m	%
Baseline	n/a	n/a	n/a	2,601	1.64%		
Exclude journey claims				2,507	1.58%	-93	-3.6%

Excluding most journey claims is estimated to result in a cost saving of $93 million per annum in premium costs (reducing the estimated breakeven premium rate by 3.6%).

When costing the specified benefit reform package in its entirety, the allowance for a cost savings for removal of journey claims has been the last adjustment made after all other elements of the specified package have been allowed for. This reduces the cost saving calculated for excluding journey claims. For example, in the specified package with a 9 year cut off of weekly benefits, the calculated savings for also removing journey claims is reduced to $56 million (note this figure also includes a minor amount for excluding heart attack and stroke).

2.2.2 *Heart attack and stroke*

The specified package removes heart attacks and strokes from coverage.

Slippage may occur with respect to excluding these types of claims in that there will be an incentive for injured workers to have these claims coded elsewhere in order to have liability accepted by the Scheme. For heart attack and stroke there may also be challenges related to cause and effect (ie did the heart attack/stroke cause the accident or did the accident have a side effect of triggering a heart attack/stroke).

The following tables summarise the modelled cost impact of excluding heart attack and stroke claims assuming no other reforms occur:

Heart Attack and Stroke

	Outstanding claims liability (all benefits)			Next years premium (all benefits)			
		Difference		Breakeven premium		Difference	
Scenario	Liability	$m	%	$ m		$m	%
Baseline	n/a	n/a	n/a	2,601	1.64%		
Exclude heart attack and stroke				2,595	1.63%	-6	-0.2%

Excluding most heart attack and stroke claims is estimated to result in a cost saving of $6 million per annum in premium costs (reducing the estimated breakeven premium rate by 0.2%).

Where other reforms are made, the incremental impact of excluding Journey and Heart Attack/Stroke claims will reduce proportionately to the impact of the rest of the reform package.

2.3 Weekly benefit package with flow-on impact to medical benefits

2.3.1 Proposal for weekly benefits

The main elements of the specified reform package we were asked to consider are:

- A change in the wage definition to one based on the worker's own average weekly earnings over the 12 months prior to injury. This removes the concept of the "Current weekly wage rate" and the discrepancy between award and non-award workers:
    - Regular overtime to be included in the definition of average weekly earnings for the first 12 months only
    - Special provisions will apply for those who have been employed for less than 12 months.
- Total incapacity benefits (see table overleaf for full details):
    - Step down in wage replacement levels from 95% AWE to 80% AWE at 13 weeks (replacing current 26 week step down)
    - Workers to be subject to work capacity tests between week 78 and week 130. An exemption applies for serious injuries (WPI>30%). Only those determined to have continuing total incapacity can receive benefits after 130 weeks. Further capacity assessments will occur every 2 years.
    - There are 4 separate time caps on the duration of weekly benefits which we have been asked to cost as separate options. For new claims benefits to continue for up to 5, 7, 9 or 11 years from date of first incapacity unless have WPI>30%, or until 12 months post retirement age if earlier. For existing claims the 5, 7, 9 or 11 year cap will apply from date of commencement of the new legislation rather than date of first incapacity.
- Partial incapacity benefits:
    - Benefit is "make-up pay" to a target level of wage replacement:
        - The make-up pay is determined after considering the amount that the worker is "fit to earn" in suitable employment.
    - Step down in target level from 95% AWE at 13 weeks (replacing current 26 week step down):
        - to 80% AWE if working 0-15 hours per week
        - remain at 95% if working more than 15 hours per week.
    - Workers to be subject to work capacity tests between week 78 and week 82, or as soon as possible if a worker achieves partial incapacity after week 78. Further capacity assessments will occur every 2 years.
    - Further step downs in target level of wage replacement or cessation of benefits at 130 weeks:
        - Benefits cease if working 0-15 hours per week, unless severely disabled
        - Step down to target level of 80% AWE if working more than 15 hours per week or severely disabled

- There are 4 separate time caps on the duration of weekly benefits which we have been asked to cost as separate options. For new claims benefits to continue for up to 5, 7, 9 or 11 years from date of first incapacity unless have WPI>30%, or until 12 months post retirement age if earlier. For existing claims the 5, 7, 9 or 11 year cap will apply from date of commencement of the new legislation rather than date of first incapacity.

- Participating in vocational rehabilitation (previously Section 38 - retraining benefits):
  - No explicit benefit provisions apply. Claimants will access either total or partial incapacity benefits depending on whether working or not.

- Caps on weekly benefits:
  - The Section 35 cap which currently applies for the first 26 weeks remains unchanged (currently $1,805)
  - This cap will continue to apply beyond 26 weeks, replacing the statutory rate. (The statutory rate is currently $432.50 for a single person with additional components if the claimant has a dependent spouse and/or children).

- Safety nets:
  - A safety net of a minimum weekly compensation amount will apply. This is to be 95% of the Commonwealth government minimum wage for adults, which is currently $589.30 per week[1]. This will apply to all claimants, irrespective of age.

    The safety net does not apply for those whose pre-injury earnings is below this level (in practice this mostly occurs for those who are working part time).

[1] http://www.fairwork.gov.au/pay/national-minimum-wage/pages/default.aspx

Table 1 Summary of current and proposed weekly benefits

Duration of incapacity	Totally unfit for work		Partial capacity: performing suitable duties		Participating in voc rehab		Partial capacity – not working	
	Proposed	Current	Proposed	Current	Proposed	Current	Proposed	Current
0-12 weeks	95% Avg weekly earnings	Current weekly wage rate[2]	Make up pay[3] to 95% Avg weekly earnings	Make up pay to 100% average weekly earnings	95% Avg weekly earnings	Current weekly wage rate	95% Avg weekly earnings	Current weekly wage rate
13-130 weeks	80% Avg weekly earnings	13-26 weeks Current weekly wage rate 26-130 weeks Statutory rate[4]	Make up pay to 80% AWE if working 1-15 hours per week (hpw) 95% AWE if working >15 hpw	For the first 26 weeks after first received incapacity payments, make-up pay is capped at current weekly wage rate; for any later period, capped at the statutory rate	Total or partial incapacity benefits apply depending on work capacity.	13-26 weeks Current weekly wage rate 26-52 weeks Statutory rate[5] No benefits payable beyond 52 weeks.	80% AWE less any amount deemed able to earn in suitable employment	0-26weeks: Current weekly wage rate 26-52 weeks, statutory rate 52-130 weeks: Statutory rate less any amount deemed able to earn in suitable employment
131 weeks – 9 years*	80% Avg weekly earnings	Statutory rate	Cease entitlements unless working in excess of 15 hrs per week or severely disabled. Severely disabled or working > 15 hpw, make up pay to 80% AWE	Make up pay capped at the statutory rate	Total or partial incapacity benefits apply depending on work capacity.	Stat rate unless S38 benefits have not previously been accessed	Cease entitlements unless severely disabled	Statutory rate less any amount deemed able to earn in suitable employment
After 5, 7, 9 or 11 years* (depending on option)	Payments cease unless >30%WPI	Statutory rate	Payments cease unless >30%WPI	Make up pay capped at the statutory incapacity rate	Total or partial incapacity benefits apply depending on work capacity.	Stat rate unless s38 benefits have not previously been accessed	Payments cease unless >30%WPI	Statutory rate less any amount deemed able to earn in suitable employment
Retiring age	Payments cease the earlier of nine years after the first incapacity or 12 months post retiring age	Payments cease 12 after retiring age or 12 months after injury (if injury occurs post retiring age)	Payments cease the earlier of nine years after the first incapacity or 12 months post retiring age	Payments cease 12 months post-retirement age	Payments cease the earlier of nine years after the first incapacity or 12 months post retiring age.	Payments cease 12 months post-retirement age	Payments cease the earlier of nine years after the first incapacity or 12 months post retiring age	Payments cease 12 after retiring age or 12 months after injury (if injury occurs post retiring age)

[2] *Current weekly wage rate* calculated as: for workers paid under an award, industrial or enterprise agreement, 100 per cent of the rate of remuneration for one week of work (excluding overtime, shiftwork, payments for special expenses and penalty rates) or for workers not employed under an award, industrial or enterprise agreement, 80 per cent of average weekly earnings (including regular overtime and allowances)

[3] *Make up pay* is the difference between pre-injury earnings and the amount earned while on suitable duties. 'Make up' pay cannot exceed the amount payable for total incapacity

[4] *The statutory rate* is the amount specified in section 37 of the *Workers Compensation Act 1987* and is indexed twice each year in April and October. The statutory rate from 1 April 2012 to 30 September 2012 is $432.50 gross for a single person, plus additional payments for dependents.

[5] *The statutory rate* is the amount specified in section 37 of the *Workers Compensation Act 1987* and is indexed twice each year in April and October. The statutory rate from 1 April 2012 to 30 September 2012 is $432.50 gross for a single person, plus additional payments for dependents.

2.3.2 *Proposal for medical benefits*

The main elements of the specified reform package we have been asked to consider are:

- Limit medical costs to a maximum period (whichever is later of):
    - 1 year post commencement of entitlement (either as a provisionally accepted or liability accepted claim)
    - 1 year post cessation of weekly benefits.

  Claims with WPI in excess of 30% are to be excluded from the maximum period.
- Define "reasonable and necessary" medical treatment and provide regulatory power to exclude unreasonable classes of medical service.

2.4 General comments

Wage definition

The proposed change in wage definition removes the differential between award and non-award workers.

The shift away from the use of the statutory rate (which previously applied post 26 weeks) will simplify the benefit calculation as it removes the need to assess components for dependents. This change also has the potential to benefit higher wage earners, although the Section 35 cap still serves to limit benefits to a maximum of $93,860 pa.

Proposed wage replacement levels

The proposed benefits include a number of step downs in the target level of wage replacement.

The major element is an initial replacement level of 95%, stepping down to 80% after 13 weeks. Within this there is a slight variation, in that after 12 months (52 weeks) regular overtime is no longer included. This is an implicit step down which will affect some workers more than others.

Work capacity tests

The specified work capacity test is modelled on the one which operates in the Victorian WorkSafe Scheme.

Currently approximately 25% of claims in the Nominal Insurer Scheme move off weekly benefits during that period post injury. It is estimated this would increase to approximately 60% if a work capacity test was introduced similar to the Victorian test.

Victoria has a reputation as a well run and proactively managed scheme. WorkCover NSW would need to work hard with Scheme Agents and others to ensure the implementation of any legislative reforms were supported by operating guidance and protocols and proactive management aligned with optimising any legislative intent. It would be important for WorkCover to be appropriately resourced and supported for this to occur.

For existing claims, the proposed changes are that work capacity tests will apply immediately from the date of enactment of any legislation. A transition period might need to apply to allow the necessary work capacity tests to be completed on the large number of existing weekly claims which are currently at or beyond the timeframes where this test will be applied. This costing assumes the immediate application of any new legislative requirements (ie work capacity tests). The longer a transition period applies, the more the cost reduction will be diluted.

Impact of the time cap (5, 7, 9 or 11 years) for weekly benefit entitlement

Only high WPI claims (those with >30% WPI) will continue on benefits after 5, 7, 9 or 11 years post injury (new claims)/date of legislation commencement (existing claims). This threshold is expected to have a major impact, only allowing a small number of the most serious claims to continue on benefits. However, this assessment is reliant on the threshold being implemented in the objective form of a single medical assessment of WPI and at the level stated.

Reasonable and necessary medical treatment

It is not possible for us to estimate any cost savings which might arise from more tightly defining the definition of “reasonable and necessary” medical treatment. Firstly, because a precise definition is not currently available, and importantly it is unclear how this would be interpreted in practice. Such a definition would ultimately need to be supported by consistent supporting guidelines and operating protocols.

However, it is difficult to argue that there is not room for efficiencies in medical spend by the Nominal Insurer Scheme. Anecdotal evidence from WorkCover supports the need for tighter controls on medical treatment.

It would also be important for any cost savings attributed to this change not “double count” medical cost savings resulting from other elements of the reform package (in particular the significant reduction medical costs expected indirectly resulting from the change in weekly benefit structure and the capping of medical costs to a maximum 1 year period post injury/cessation of weekly benefits).

Assessment of flow on of weekly changes to medical costs

Approximately 90% of medical costs other than those to severely injured claimants are paid while claims are on weekly benefits. The work capacity test, and the time cap limitation period, followed by medical costs coverage ending 1 year post cessation of weekly benefits, will flow on to reduce medical benefits.

The resulting change to the medical benefits is expected to impact medical cost for lower WPI claims more than for higher WPI assessed claims. While we do not have information on the medical costs for lower WPI claims only, we expect these claims to have a lower medical spend than the higher WPI claims. Our modelling assumes the medical spend on lower WPI claims is currently around 55% of the total medical outstanding claims liability. We are then able to translate the expected changes in weekly numbers, into an expected impact on medical costs.

2.5 Lump sum package

2.5.1 Proposal

In summary the key elements of the specified benefit package we were asked to consider are:

- Whole Person Impairment (WPI):
    - Only one assessment of WPI allowed.
- Workplace Injury Damages (WID):
    - Introduce a robust statutory of limitations three years post injury (on emergence of the injury).
    - Change in the definition of negligence to match that contained in the Civil Liability Act 2002
    - Prevent nervous shock claims.
- Permanent Impairment (Section 66) and Pain and Suffering (Section 67) lump sum benefits:
    - Introduction of a 10% WPI threshold to access Permanent Impairment benefits (30% for psychiatric or psychological impairment)
    - Replace existing Permanent Impairment benefit scale with the Victorian scale
    - Eliminate Pain and Suffering benefits (effectively blending into the revised Permanent Impairment scale)
    - No indexation (no change from current).
- Legal costs:
    - No requirement for legal involvement in paying of a Permanent Impairment benefit
    - Legal fees only associated with disputed Permanent Impairment payments
    - Current schedule of rates increased by 15% (to reflect that scheduled rates have not been increased for a number of years).

2.5.2 General comments

Whole Person Impairment (WPI)

Currently the Scheme has an increasing number of "top up" WPI assessments which are having the effect of undermining the robustness of the current WID benefit and Pain and Suffering benefit thresholds.

The requirement for there to only be a single assessment of WPI may be expected to eliminate this negative feature of current experience with an expectation of stability in the future Scheme experience.

There is a future risk of an incentive to delay having a WPI assessment until there is complete certainty as to the outcome of the injury (ie to minimise the risk of further deterioration). This may result in the same ultimate numbers exceeding threshold levels as is currently observed, but just delaying the emergence.

On balance we would still expect this amendment to be cost beneficial to the Scheme.

Workplace Injury Damages (WID)

The specified benefit package we have been asked to cost maintains the current 15% WPI Threshold to access WID.

There is a significant risk that the introduction of work capacity tests for weekly benefits may lead to an increased propensity for claimants to pursue WID prior to the work capacity test occurring. By intimating for WID prior to the work capacity test, claimants might potentially circumvent the work capacity test resulting in a loss of weekly benefits.

To an extent the elimination of "top up" WPI assessments and the application of the Civil Liability Act 2002 test of negligence may balance this. However, we have no data or expertise in the application of the CLA negligence test on which to consider whether this would be the case.

More than 80% of WID claims are lodged "out of time" (meaning lodged beyond the current statute of limitations). It is understood the District Court applies its discretion to hear out of time applications generously and as a result only the most exceptional circumstances will leave to have a claim heard not be given. Introduction of a more robust statute of limitations may only result in claims being lodged earlier rather than reduce the ultimate number of WID intimations. On balance we would still expect this amendment to be cost beneficial to the Scheme. **Although we have assumed this reform will not result in an immediate cost saving, we believe this reform is critical to stabilising the cost of WID which is currently a major source of Scheme instability.** If the statute threshold is effective, the majority of claims will be known after three years. This compares to the current environment where there is still significant uncertainty regarding the future number of WID intimations for accident periods that are ten years old. A robust statute threshold will provide more certainty when estimating premium rates.

Perhaps more powerful than the statute of limitations in changing speed of WID intimation will be the work capacity test (at 78 to 130 weeks). There would be an incentive for claims to pursue WID prior to undergoing a capacity test to eliminate the risk of the test undermining their argument for future economic loss. As a result, under the proposed package we might well see a spike of WID intimations well before 78 weeks.

Nervous shock claims are a relatively minor proportion of WID claims currently received. Consequently, excluding such claims will not likely have a material impact on total Scheme cost. However, the emergence of this category of claim is a relatively recent phenomenon and has been identified as an area of Scheme risk.

Permanent Impairment and Pain and Suffering lump sum benefits

The introduction of a 10% WPI threshold is expected to reduce the number of claims eligible to receive Permanent Impairment benefits significantly. There will always be a risk of WPI bracket creep so it is important to be continually diligent at monitoring its effectiveness, no matter what the threshold level is set at. This risk will be reduced by the prevention of secondary WPI assessments.

Currently claimants are entitled to claim both Permanent Impairment and Pain and Suffering benefits. The eligibility threshold for Permanent Impairment is 1% WPI and Pain and Suffering benefits is 10% WPI. The second change is to replace these two benefits with the Victorian permanent impairment scale which has a 10% WPI threshold. The revised scale provides for significantly higher benefits for the most severely injured compared with the current scale.

Legal costs

Currently a claimant receiving a Permanent Impairment or a Pain and Suffering payment is required to have legal representation. The current proposal removes this requirement for all non disputed payments. As the assessment of WPI explicitly determines eligibility for Permanent Impairment benefits and possible future entitlement to WID, the removal of legal representation may be difficult to achieve in practice. Legal costs will also reduce to the extent the Pain and Suffering benefits and small Permanent Impairment payments are eliminated.

2.6 A tightly controlled commutation strategy

No detail has been provided by WorkCover as to exactly how this might occur.

It is extremely important for any commutation program to be tightly targeted, operate for only a short period of time and have other controls to mitigate the real risk that behavioural changes by Scheme participants could occur (the development of the so called "lump sum" culture) which could be very detrimental to overall Scheme financial performance.

An example of the risks posed by a lump sum culture is the experience of the NSW Nominal Insurer Scheme in the period 1998 to 2001 when the use of commutations was liberalised. The widespread focus on commuting claims led to significant changes in the behaviour by all Scheme participants which, together with high transactional costs, contributed to an overall deterioration in the financial cost of the Scheme.

It is our recommendation that any proposed commutation strategy be kept tightly controlled to guard against the risk of a lump sum culture developing. Such controls include:

- Tightly defined cohorts of claims which are intended to be commuted. Claim cohorts which we consider might be reasonable to consider as part of a targeted commutation strategy include those which have a high ratio of ongoing management expense to claims liability.

- A short window (perhaps only 3 months) in which a program of commutation offers will be made to the identified claims. At the end of the window no future commutations occur for a period. To the extent possible minimise legal involvement in the commutation process. This could either require:

    - Preferably no legal involvement at all. If this is not acceptable then measures to minimise legal involvement (such as the payment of a once off meeting according to a scheduled rate).

    - A real risk is that any claim which approaches a legal provider for advice might lead to unintended consequences such as seeking of S66/S67 damages and perhaps even intimating for a WID, which might drive up total Scheme costs.

- Commutation amounts need to be proposed at a discount to the expected cost if the claim had continued on benefit. This is necessary to reflect the fact that a significant proportion of claims do not continually utilise benefits until retirement age (or beyond in the case of medical benefits) and that many do and would continue to exit the Scheme voluntarily in the absence of a commutation, but also to provide a margin to create savings (thus justifying the commutation action).

- Preferable consolidation of identified claims with a single Agent who will manage all commutations on WorkCover's behalf. The advantage of this approach is it prevents other Agents from being distracted by commutations from their core job of ongoing claims management. Furthermore, concentrating the necessary skills in a single Agent builds up expertise and experience to optimise Scheme outcomes.

If not tightly managed there is a real risk that a liberalised use of commutations might actually result in an increase in Scheme costs rather than a saving. Assuming the commutations strategy is tightly controlled we believe the main focus should be on groups of claims which have a high ratio of ongoing management expense to claims liability. In reality, commuting such groups of claims, while tidying up, is unlikely to result in material liability savings. As a result we do not believe it is appropriate to assume a cost savings from the implementation of such a strategy.

2.7 Overall package result

The following table summarises the estimated cost impact of the benefit reform package assuming a 5, 7, 9 or 11 year time cap on weekly benefits respectively. Although the estimated cost impact on each benefit type is shown separately in the table, the components of the package should not be considered individually but rather as a comprehensive package. Individual elements of the package support and reinforce the impact of the overall package.

It is important to recognise there is considerable uncertainty associated with the financial cost impact results contained in this report. They should be considered more as indicative of the magnitude of the possible cost impact rather than being precise. The estimated cost impacts we have calculated are based on the assumptions that any legislative changes are made in the way interpreted and that they are well implemented. This costing assumes the immediate application of any new legislative requirements (eg work capacity tests) the longer a transition period applies the more the cost reduction will be diluted.

It needs to be recognised that legislation is just one part of the necessary change to introduce substantive benefit reform as intended. There also needs to be a strong focus on change management and implementation. In particular it requires a focused capability by the regulator (WorkCover), the Nominal Insurer and Scheme Agents.

Option with a 5 year time limit on weekly benefits

Benefit reform scenario - 5 year cut-off

	Outstanding claims		Next years premium		
	Net Central Estimate	Change	Breakeven Premium		Change
	$m	$m	$m	% covered wages	% covered wages
Base	14,378		2,601	1.64%	
Reform impact					
Weekly (incl 5 year cut off)		-3,576	-339		-0.21%
Medical		-1,235	-151		-0.09%
WID		-36	-5		0.00%
S66/S67		-332	-101		-0.06%
Legal		-233	-56		-0.04%
Claim exclusions		n/a	-54		-0.03%
Revised Total Cost	8,965		1,894	1.19%	
% cost reduction	-38%		-27%		-27%

* There would also be a further reduction in the reported outstanding claims liability from release of a proportionate part of the 12% risk margin currently held in addition to the net central estimate

The current outstanding claims liability is $14,378 million excluding risk margin ($16,103 million including a 12% risk margin).

The possible reform package, if implemented immediately to apply to existing claims, is estimated to reduce the currently liability by 38%, reducing the outstanding claims liability to $8,965 million excluding risk margin ($10,041 million including risk margin).

The current estimated breakeven premium cost of the Scheme (actuarial estimate of required average premium to meet expected cost of claims for 2012/13 policy renewal year) is $2,601 million (an average premium rate of 1.64% of covered wages).

The possible reform package is estimated to reduce the breakeven premium cost of the Scheme by 27% to $1,894 million (an average premium rate of 1.19% of covered wages).

Option with a 7 year time limit on weekly benefits

Benefit reform scenario - 7 year cut-off	Outstanding claims		Next years premium		
	Net Central Estimate	Change	Breakeven Premium		Change
	$m	$m	$m	% covered wages	% covered wages
Base	14,378		2,601	1.64%	
Reform impact					
Weekly (incl 7 year cut off)		-3,315	-312		-0.20%
Medical		-1,164	-144		-0.09%
WID		-36	-5		0.00%
S66/S67		-332	-101		-0.06%
Legal		-233	-56		-0.04%
Claim exclusions		n/a	-55		-0.03%
Revised Total Cost	9,298		1,927	1.21%	
% cost reduction	-35%		-26%		-26%

* There would also be a further reduction in the reported outstanding claims liability from release of a proportionate part of the 12% risk margin currently held in addition to the net central estimate

The possible reform package, if implemented immediately to apply to existing claims, is estimated to reduce the currently liability by 35%, reducing the outstanding claims liability to $9,298 million excluding risk margin ($10,414 million including risk margin).

The possible reform package is estimated to reduce the breakeven premium cost of the Scheme by 26% to $1,927 million (an average premium rate of 1.21% of covered wages).

Option with a 9 year time limit on weekly benefits

Benefit reform scenario - 9 year cut-off	Outstanding claims		Next years premium		
	Net Central Estimate	Change	Breakeven Premium		Change
	$m	$m	$m	% covered wages	% covered wages
Base	14,378		2,601	1.64%	
Reform impact					
Weekly (incl 9 year cut off)		-3,099	-292		-0.18%
Medical		-1,102	-140		-0.09%
WID		-36	-5		0.00%
S66/S67		-332	-101		-0.06%
Legal		-233	-56		-0.04%
Claim exclusions		n/a	-56		-0.04%
Revised Total Cost	9,576		1,950	1.23%	
% cost reduction	-33%		-25%		-25%

* There would also be a further reduction in the reported outstanding claims liability from release of a proportionate part of the 12% risk margin currently held in addition to the net central estimate

The possible reform package, if implemented immediately to apply to existing claims, is estimated to reduce the currently liability by 33%, reducing the outstanding claims liability to $9,576 million excluding risk margin ($10,725 million including risk margin).

The possible reform package is estimated to reduce the breakeven premium cost of the Scheme by 25% to $1,950 million (an average premium rate of 1.23% of covered wages).

Option with a 11 year time limit on weekly benefits

Benefit reform scenario - 11 year cut-off					
	Outstanding claims		Next years premium		
	Net Central Estimate	Change	Breakeven Premium		Change
	$m	$m	$m	% covered wages	% covered wages
Base	14,378		2,601	1.64%	
Reform impact					
Weekly (incl 11 year cut off)		-2,919	-277		-0.17%
Medical		-1,048	-137		-0.09%
WID		-36	-5		0.00%
S66/S67		-332	-101		-0.06%
Legal		-233	-56		-0.04%
Claim exclusions		n/a	-57		-0.04%
Revised Total Cost	9,809		1,967	1.24%	
% cost reduction	-32%		-24%		-24%

* There would also be a further reduction in the reported outstanding claims liability from release of a proportionate part of the 12% risk margin currently held in addition to the net central estimate

The possible reform package, if implemented immediately to apply to existing claims, is estimated to reduce the currently liability by 32%, reducing the outstanding claims liability to $9,809 million excluding risk margin ($10,986 million including risk margin).

The possible reform package is estimated to reduce the breakeven premium cost of the Scheme by 24% to $1,967 million (an average premium rate of 1.24% of covered wages).

3 An adversarial lump sum benefit model

The NSW Bar Association has made a submission to the Inquiry (Submission 77). At the request of the Inquiry, WorkCover has asked PwC to consider the potential financial implications of a benefit model consistent with the broad recommendations contained this in this submission.

Unfortunately the NSW Bar association submission's recommendations are not specific. However, it is suggesting an increase access to lump sum benefits and an increase in litigation and an adversarial approach to claim resolution. It might be that what was intended by that submission is different to how it has been interpreted.

3.1 High level cost observations

The Bar Association has advocated for the return to an adversarial lump sum benefit model with a litigated approach to dispute management. This has many features similar to the benefit and structural model which existed in the NSW Workers Compensation Scheme prior to the 2001 reforms. The most obvious approach to considering the likely cost implications of returning to such a Scheme is to consider the cost of the Scheme during that period.

Section 2.7 (page 14) of the Executive Summary of the PwC report *Actuarial valuation of outstanding claims liability for the NSW Workers Compensation Nominal Insurer at 31 December 2011* shows calculations of the Breakeven Premium rates for each policy renewal year since 1987. Of particular relevance is the average breakeven premium rate for the policy renewal years 1994/95 to 2000/2001 inclusive, which were most impacted by the lump sum environment which existed during the second half of the 1990s in the WorkCover Scheme. Assuming risk free discount rates, this average is 3.12% of covered wages. Adjusting for using long-term expected investment returns (based on WorkCover's current asset strategy) rather than risk free discount rates would reduce this average to 2.75% of covered wages.

Subsequent to the 2001 reforms, the experience of these policy years has been much improved compared to the trajectory of these policy renewal years if the lump sum environment had been allowed to continue. As a result, an average premium cost of 2.75% of covered wages should be considered as being a very optimistic view of the likely cost of reintroducing an adversarial lump sum scheme similar to the pre-2001 Scheme. In all likelihood, a more realistic cost estimate would be significantly higher.

Similarly, the workers compensation Scheme which existed prior to 30 June 1987 was also very much an adversarial lump sum based Scheme. The average premium rate set by the Government in the last year of the previous Scheme was 3.82% of covered wages. Insurers viewed that rate as significantly inadequate; they believed it should be about 5%, and hence left the market.

The above two examples illustrate the significantly higher likely premium cost of a scheme similar to that suggested by the Bar Association Submission compared to current Scheme costs.

3.2 Observations on elements of an adversarial lump sum based compensation model

Given the lack of specificity to the benefit costing and the available timeframe it has not been possible to undertake a detailed bottom-up costing of a specific model. Such an approach also runs the risk of challenge that a particular element of a package is not what was intended in order to invalidate the conclusions to be drawn.

The development of a lump sum culture in the 1990s was the key driver of the large deficit which emerged during that time and necessitated the significant changes in Scheme design which occurred in the 2001 reforms before the issue was controlled. Escalation in lump sum costs (with associated indirect cost escalation to weekly and other benefits) have been a key issue in the majority of cost escalations observed in Australian accident compensation schemes over the past three decades.

From an actuarial perspective a lump sum culture is how the changing behaviour of Scheme participants manifests itself in the claim and payment experience of the Scheme.

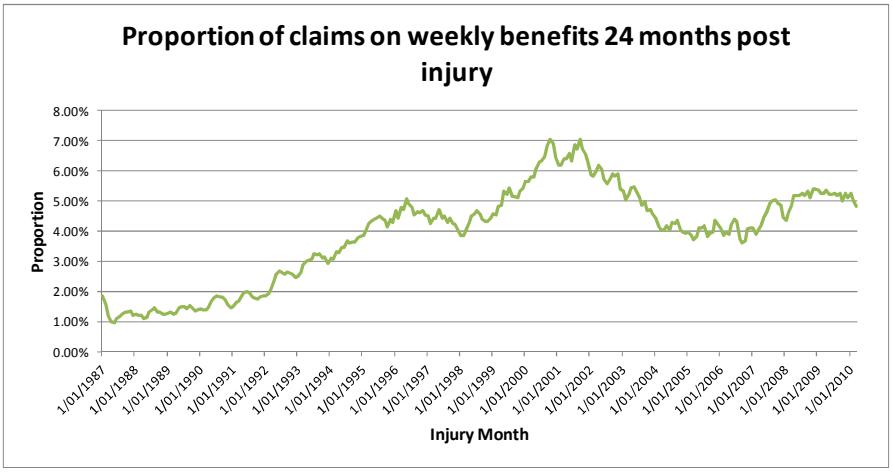
Some observations on some key elements of the Bar Association submission are:

Weekly benefits – The submission is to maintain the status quo with no changes to the definition of pre-injury earning, and unchanged benefit levels, with a step down at 26 weeks.

Comments

Weekly and medical benefits are likely to be adversely impacted by the shift in the balance of the scheme from one which pays the majority of benefits via periodic benefits to one which pays the majority of benefits via an adversarial lump sum process.

Although the weekly and medical benefit outstanding claim liabilities will reduce as claims substitute to being compensated more via the lump sum benefits available, the total costs of these two payment types are likely to be adversely affected by a deterioration in return to work (RTW) rates at early periods post injury. The following graph illustrates a measure of the proportion of claims which have received at least one day of incapacity benefits and remain on incapacity benefits 2 years post-injury.



The following observations can be made:

- Scheme benefits were enhanced in 1992 and almost immediately the Weekly benefit continuance rate in the above graph began to deteriorate.
- Two reform packages were introduced at the start of 1996 and 1997 to reduce permanent impairment benefits. During 1996 and 1997 the weekly continuance rate began to reduce.

- The weekly benefit continuance rate increased again during the period 1999 to 2001 inclusive, which coincided with the large numbers of commutations and common law settlements which occurred in the scheme during this period.

- The weekly benefit continuance rate reduced subsequent to the 2001 reforms as these restricted the use of commutation and common law benefits.

- The weekly benefit continuance rate increased again at the start of the GFC.

Increased role for lump sums benefits as a mechanism to achieve claim finalisation – The submission recommends that WID "*should be permitted not discouraged*". This has been interpreted as advocating the current threshold to access WID should be either weakened or indeed removed completely. Similarly the submission recommends a liberalisation of commutations as a major mechanism for finalising tail claims. This has been interpreted as a return to the environment which existing in the years immediately prior to the 2001 reforms.

Comments

The use of lump sum benefits as a mechanism to compensating injured workers is not efficient. I have attached to the costing report a copy of Chapter 17 of the Productivity Commission Report into Disability Care and Support which considers the issue. The arguments presented in this chapter are also relevant when considering the merits of common law compensation as well as other lump sum benefits such as commutations.

At an individual claim level, it is argued that a lump sum settlement may result in a Scheme liability saving compared with a continuation of the claim on periodic (weekly incapacity and medical benefits). This may be true of some individual cases. However the "averaging" approach to deciding on the amount of a lump sum results in some claimants being over-compensated (compared to the alternative of staying in the periodic benefits scheme (eg those who subsequently return to work) or under-compensated (eg those claims where their condition subsequently deteriorates). For the purpose of the following discussion, I have termed Category 1 and Category 2 claims respectively. A periodic benefit scheme is more efficient at directing a limited pool of funding to where it is best needed by individual circumstances.

Furthermore, in my experience the averaging amount tends to over-compensate Category 1 claims collectively more than it under compensates the Category 2 claims. This leads to an overall Scheme cost increase. Even more important as a cost driver is that benefit claiming patterns might potentially change with an increasing volume of the Category 1 claims utilising the available lump sum benefits. Lastly, there is likely to be material transactional costs (particularly legal costs) which add a further cost pressures to the Scheme. For example, legal costs accounted for 20% of the assessed Breakeven Premium Rate immediately prior to the 2001 reforms. Legal costs currently account for only 3% of the Breakeven Premium rate assessed at 31 December 2011 (NB these legal cost percentages exclude legal costs captured with common law and WID settlements over which there is no visibility).

Dispute management – There are a number of elements to the Bar Association's submission which would increase the adversarial nature of the Scheme and the number of disputes. Examples include the suggestions to:

- Revoke Section 151z(2) of the Workers Compensation Act

- Change claim handling guidelines for Scheme Agents with respect to pre-filing for workplace injury damage claims

- Reintroduce the concept of fault as a mitigating factor on journey claims.

Superficially each of these might be considered as assisting the Scheme to reduce costs. However, a large numbers of disputes can have a negative impact on Scheme costs. This can be via a direct increase in transactional (legal) costs. More significant though is that a litigative and adversarial environment might negatively impact the focus on achieving return to work, which would have an indirect cost impact via an increase in weekly and medical costs.

A feature of the pre-2001 Scheme was that there were almost 28,000 disputes per annum. Currently there are only 10,000 disputes per annum.

Death benefit lump sums should only be payable to dependents.

Comments

This represents a return to the requirements prior to 24 October 2007. It is estimated that approximately 43% of fatalities do not have dependants. The estimated annual cost impact of re-introducing this restriction would be to reduce the annual cost of the Scheme by approximately $20 million.

4 Reliances and limitations

The purpose of this report is to provide advice to NSW WorkCover as to the possible financial cost implications of two specific packages of possible benefit reforms to the NSW WorkCover Scheme. NSW WorkCover in turn will use this advice to respond to a request for information from the Joint Select Committee Inquiry into the NSW Workers Compensation Scheme. We understand that this report will be provided to the Inquiry.

Our responsibilities and liabilities are to NSW WorkCover in the context of using our report for the purpose set out above. We do not accept any liability or responsibility in relation to the use of our report for any other purpose or by any other third party. This report must be read in its entirety. Individual sections of this report could be misleading if considered in isolation from each other.

The results of contained in this report are subject to significant uncertainty. It is important that the reader of this report appreciate this uncertainty. We refer you to Section 1.3 of the report which discusses aspects of this uncertainty in detail.

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