Submission No 7

FIFTH REVIEW OF THE EXERCISE OF THE FUNCTIONS OF THE LIFETIME CARE AND SUPPORT AUTHORITY

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THE LAW SOCIETY
OF NEW SOUTH WALES

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The Hon David Clarke MLC
Committee Chair
Standing Committee on Law and Justice
Legislative Council
Parliament House
Macquarie Street
Sydney NSW 2000

By email: lawandjustice@parliament.nsw.gov.au

Dear Mr Clarke,

The Twelfth Review of the exercise of the functions of the Motor Accidents Authority and the Motor Accidents Council and the Fifth Review of the Lifetime Care and Support Authority and the Lifetime Care and Support Advisory Council

The Law Society's Injury Compensation Committee ('the Committee') is pleased to make this submission to the Standing Committee on Law and Justice's Twelfth review of the exercise of the functions of the Motor Accidents Authority and the Motor Accidents Council ('the Twelfth MAA Review') and the Fifth Review of the Lifetime Care and Support Authority and the Lifetime Care and Support Advisory Council ('the Fifth Lifetime Care Review').

The Standing Committee has advised that it is holding these reviews concurrently and the Committee therefore provides this submission in response to both reviews.

The Twelfth MAA Review

Smalley v Motor Accidents Authority of NSW

The Committee believes the recent Court of Appeal decision in *Smalley v Motor Accidents Authority of NSW* [2013] NSWCA 318 warrants close analysis and action by the Motor Accidents Authority. In the Committee's view this decision potentially makes it considerably easier for both insurers and claimants to obtain an exemption from the Claims Assessment and Resolution Service ('CARS'). In particular the Court of Appeal appears to be saying that in every case where a notice pursuant to section 81 of the *Motor Accidents Compensation Act 1999* (MACA) has not been issued within three months of service of the claim form, liability will be taken to be denied and an exemption certificate should automatically issue from CARS. The Committee's interpretation of the decision is that where a section 81 notice only admits breach of duty of care this does not comply with the requirements of sections

81(1) or 81(2) and it becomes a deemed denial of liability pursuant to section 81(3) which will also result in an automatic exemption from CARS.

Following the *Smalley* decision the Committee contends there is a real danger that many, or most, motor accident claims will be exempted from CARS if the present practices of insurers concerning the issuing of section 81 notices continue. The experience of Committee members is that many insurers delay making a decision for more than three months after the claim form has been served and most insurers that do issue a section 81 notice within three months only make an admission of breach of duty of care without mentioning the other aspects of liability such as damage.

It is accepted that the CARS system is fundamentally an efficient and cost effective system of assessment of motor accident damages. To function effectively as a dispute resolution mechanism CARS should be handling the majority of those disputes which arise as a result of motor accident injuries. The Committee believes that urgent action is required by the Motor Accidents Authority to ensure that the majority of cases continue to be dealt with at CARS. Legislative amendments may provide an answer but the Committee recognises that this may not be possible in the short term. For instance the requirement in section 81(1) for there to either be an admission or denial of liability for the claim within three months rather than just an admission of breach of duty of care appears to be the source of the problem.

However in the short term the Committee takes the view that further action needs to be taken by the Authority to ensure that insurers do actually comply with their duty to make an admission or denial of liability (not just an admission of breach of duty of care) within three months of service of the claim form. Section 81(5) does in fact state that it is a condition of the insurer's license under part 7.1 of the MACA that the insurer comply with this obligation to admit or deny liability within this three month timeframe. The Authority should also make it quite clear to the insurers that it is no longer acceptable to say in the section 81 notice that breach of duty of care is admitted without making reference to any damages entitlements. It needs to be emphasised that this is a compliance issue and whatever flexibility may have been allowed in the past will not be permitted in the post *Smalley* environment.

<u>Pre-Filing Requirements for the Assessment of Claims</u>

The Committee submits that Part 4.4 Division 1A (sections 89A to 89E inclusive) and section 91 of the MACA ought to be repealed. The provisions add an unnecessary, costly and time consuming layer of protocols for the parties to surmount prior to being permitted to file an Application for General Assessment. These provisions undermine one of the stated MAA objectives, namely, to provide "*an effective and efficient medical and claims assessment service*".

The CARS Application for General Assessment pre-filing requirements are summarised as follows:

(i) Once the Claimant's medical condition has stabilised, the provision of all relevant particulars of the claim sufficient to enable the insurer to make a proper assessment of the Claimant's full entitlement to damages (section 85A).

(ii) Further, in the event that there is a dispute to an entitlement to non-economic loss, such dispute must be lodged at the Medical Assessment

Service (' MAS') at least three calendar months prior to the lodgement of a CARS Application for General Assessment (clause 9.3.4 of the Claims Assessment Guidelines).

(iii) Participation in a mandatory settlement conference as soon as practicable after the insurer makes an offer of settlement to the claimant unless a claims assessor is satisfied that the party lodging the Application for General Assessment is ready and willing to participate in a settlement conference but the other party has refused or failed to participate despite having had a reasonable opportunity to do so (section 89A).

(iv) Mandatory exchange of documents upon which each party intends to rely prior to the mandatory settlement conference. Any documents not so exchanged cannot be considered at the subsequent assessment hearing unless a claims assessor admits the document after having been satisfied that the probative value of the document substantially outweighs any prejudicial effect it may have on the other party (section 89B).

(v) In the event the claim fails to resolve at a mandatory settlement conference, each party must make an offer of settlement within 14 days after the conclusion of the conference. Such a settlement offer is to include a schedule of damages sufficient to explain the calculation of damages. After the expiration of 14 days, a party who has made the mandatory offer of settlement may refer the claim for general assessment if a claims assessor is satisfied that the other party has refused or failed to make its mandatory offer (section 89C). If there has been an exchange of offers within 14 days of the mandatory settlement conference, then the claim may not be referred for assessment until 28 days after each party to the claim has made the mandatory offer of settlement pursuant to section 89C (section 91(1)).

(vi) A claims assessor may impose a costs penalty on a party if satisfied that there has been a failure by a party without reasonable excuse to participate in a settlement conference and exchange documents which were subsequently admitted (section 89D).

Some of the difficulties created by these quite rigid pre-filing requirements include the following:

(i) The relative inflexibility of the pre-filing requirements do not take into account the fact that no one claim or injury is the same. Complications in the claimant's case such as the need for surgery or further surgery, a deterioration of the medical condition, a change in employment circumstances, occur unexpectedly and more often than not require further medical or other evidence to update the situation. Often it is also necessary for a party to obtain evidence to respond to documents exchanged prior to the mandatory settlement conference.

(ii) The potential loss to the claimant of his/her important entitlement to apply for a re-hearing of a claims assessor's award if stabilisation of the medical condition occurs close to the approach of the three year time limit or a lawyer receives instructions to act for a claimant close to the approach of the three year time limit. The lodgement of a CARS Application for

General Assessment suspends the limitation period (section 109). The additional hoops through which the claimant must now jump as a result of the pre-filing requirements in order to be permitted to file the latter mentioned Application increase the risk that the claimant will not be able to "stop the clock" in time in such factual scenarios.

(iii) Insurers disputing that a settlement conference is a section 89A compliant settlement conference and delaying the CARS assessment process.

(iv) In the event the claim is not settled at the mandatory settlement conference the claimant, in particular, is faced with repeating and updating much of the legal work performed in preparation under the pre-filing requirements when completing the CARS Application for General Assessment. This is neither time nor cost effective.

The issues raised above were also the subject of a submission to and consideration by the Legislative Council's Standing Committee on Law and Justice in its Eleventh Review in 2011 ('the Eleventh MAA Review') giving rise to recommendation 12 which stated:

> That the Motor Accidents Authority meet with the New South Wales Bar Association and other stakeholders as soon as practicable with a view to finding a solution to the issue of pre-settlement conferences under section 89A of the Motor Accidents Compensation Act 1999.

The Committee submits that the pre-filing requirements add unnecessary complexity, uncertainty, cost and delay to the CARS assessment process. Accordingly, the Committee submits that Part 4.4 Division 1A (sections 89A to 89E inclusive) and section 91 of the MACA ought to be repealed as a matter of urgency.

Whole Person Impairment Threshold

The Committee refers to Recommendation 10 in the Eleventh MAA Review which stated:

> That the NSW Government review the threshold for access to damages for non-economic loss under the Motor Accidents Scheme in order to achieve a better balance between Scheme efficiency and compensation.
>
> That the Motor Accidents Authority publish a discussion paper outlining the issues relating to access to non-economic loss damages. This discussion paper should include an actuarial analysis of the ramifications to the Scheme, claimants, CTP pricing and insurers of:
>
> - changing the threshold to access non-economic loss damages to that of section 16 of the *Civil Liability Act*;
> - lowering the 10% whole person impairment threshold; and
> - allowing both physical and psychological injuries to be aggregated to determine the whole person impairment threshold.

This issue has also been the subject of previous recommendations including one that formed part of the 2005 Personal Injury Compensation Legislation Report 28, prepared by the Legislative Council General Purpose Standing Committee.

The Committee's position is unchanged to that outlined in its submission to the Eleventh Review dated 22 August 2011 (a copy of which is enclosed). It is noted that in this submission we refer to Recommendation 12 in the Tenth Report which proposed that the next review "include a focus on the issue of the 10% whole person impairment threshold for non-economic loss". The Committee strongly endorses this recommendation. Further, the Committee proposes that the 10% whole person impairment threshold should be abolished together with MAS and be replaced by the threshold set by section 16 of the *Civil Liability Act 2002*. The section 16 threshold for accessing an entitlement to non-economic loss is currently 15% of "a most extreme case" coupled with a sliding scale of damages until the severity of non-economic loss reaches 33% of "a most extreme case". Such an assessment would be made by CARS assessors.

The abolition of the 10% whole person impairment threshold and MAS would result in a significant costs saving and remove the current inefficiencies in its administration. Its replacement with a 15% of "a most extreme case" threshold would make the scheme fairer for the injured as more claimants would be entitled to damages for non-economic loss. CARS assessors have the experience and expertise to make assessments under the proposed 15% of "a most extreme case" threshold. These changes would result in a more effective, fair and efficient scheme, while maintaining its affordability through the dismantling of MAS and the removal of the associated administrative costs and delays.

The current manner in which whole person impairment is assessed and the threshold imposed is both harsh and arbitrary in nature. Many seriously injured claimants are excluded from accessing damages for non-economic loss. It is the Committee's view that eligibility for compensation for non-economic loss should be based upon indicia such as pain, depression, changes in lifestyle and future deterioration, and not just deterioration at the time of assessment.

The relevant AMA Guide (Fourth Edition) which is modified by the Motor Accidents Authority's Permanent Impairment Guidelines has not delivered the greater consistency and objectivity of assessment predicted by the Government and this has resulted in regular and expensive judicial review applications in the Supreme Court of NSW. Such inconsistency can be demonstrated by considering two injured people who have undergone a cervical spine fusion but can potentially be assessed at different whole person impairments. One claimant may have undergone a previous cervical spine fusion and then required a further spinal fusion at a different level in the same region. That claimant would be assessed at 0% whole person impairment, and would not be entitled to compensation for non-economic loss. The other injured person would be assessed at 20% whole person impairment and would be entitled to non-economic loss. Both claimants would have endured the same treatment and recovery process.

It is the Committee's position that prompt action is needed to address this recommendation, and that the 10% whole person impairment threshold should be abolished together with MAS and be replaced by the threshold set under section 16 of the *Civil Liability Act 2002*.

Legal Causation

The Committee refers to Recommendation 11 of the Eleventh MAA Review, which provided:

> That the Motor Accidents Council form a sub-committee to review, analyse and recommend a course of action to the Motor Accidents Authority on the issue of legal causation.

It was noted that the issue of causation would be considered in the development of the Pricing Strategy. No further action on this matter has been undertaken since the review of the Pricing Strategy in relation to this recommendation.

The Committee supports Recommendation 11 of the Eleventh MAA Review.

Late Claims

A claim must be made under the MACA pursuant to section 72 within six months of the date of the date of the accident and over 80% of claims are made in this period. However late claims result in a lengthy and costly process described below which the Committee submits is a disproportionately expensive drag on claims resolution.

Failure to submit a Personal Injury Claim Form within six months requires the claimant to provide a full and satisfactory explanation for the delay in making the claim. Invariably, the insurer will reject that the explanation is full and/or satisfactory. To then be able to proceed with a claim, the claimant is required, via the representatives if engaged, to make a CARS 5A Application for Special Assessment to have an assessor determine whether the explanation provided is full and/or satisfactory.

At the conclusion of the CARS special assessment hearing, a decision is provided as to whether the explanation for the delay in making the claim is considered to be full and satisfactory. This decision is not binding. In circumstances where liability has been accepted, to date, the principal claims assessor ('PCA') will not exempt the matter from CARS. Accordingly, the matter will proceed to a general assessment hearing if it is unable to be resolved earlier. The process, from the lodgement of the explanation for the delay in making the claim to the determination of a special assessment as to whether the explanation is full and satisfactory, takes between three to six months.

Once a general assessment hearing has been concluded, and a determination has been made as to a claimant's entitlement to compensation, that decision is unenforceable and an injured person is unable to recover the compensation which has been awarded to them by an assessor without pursuing separate District Court proceedings. This is an expensive process which most claimants would be unable to fund.

Insurers currently lose 90% of late claims disputes and it is the Committee's recommendation that consideration be given to dismantling the late claim dispute process and removing the right for insurers to reject claims lodged within three years.

At the very least the Committee recommends that the time period within which a claimant is required to submit a claim pursuant to section 72 of MACA be extended to 12 months. It is submitted that such an amendment would significantly reduce the number of late claims made, thereby reducing legal costs and the administrative costs of insurers and the Motor Accidents Authority.

Regulated Legal Costs

The issue of legal costs was also the subject of a submission to and consideration by the Legislative Council's Standing Committee on Law and Justice in its 2011 review giving rise to recommendation 6 which stated:

> That the Minister expedite the remaking of the Motor Accidents Compensation Regulation 2005, rather than waiting until its expiry on 1 September 2012.

The costs regulation referred to in recommendation 6 has still not been "remade".

The costs regulation governs the maximum costs recoverable by lawyers for services provided to their injured client or insurer client in a motor accident personal injury claim. The Committee submits that the December 2008 FMRC Report commissioned by the Motor Accidents Authority (referred to in the Legislative Council's Standing Committee on Law and Justice 2011 review) demonstrates that the regulated legal costs are far too low. It should be pointed out that prior to the last review the Motor Accidents Authority established two working parties to review the costs regulation in 2008 and 2010. Their recommendations have not been acted upon.

The Committee continues to be extremely concerned by the lack of progress regarding the amendment of the costs regulation which has been inadequate for many years. The costs regulation should have been updated long ago to provide a fair regulated fee for the recovery of legal costs in this front end loaded scheme. The ongoing delays with these amendments continue to burden the injured person as the commercial costs of legal services bear increasingly less correlation to regulated costs.

The Committee submits that urgent action should be taken to address the Standing Committee's recommendation.

Fifth Review of Lifetime Care and Support Authority

The Committee continues to applaud the fact that the Lifetime Care and Support Scheme ("the Scheme") provides for the medical treatment and care needs of those who are catastrophically injured in motor accidents regardless of the question of fault. However the Committee is concerned that some recent developments within the Scheme reflect a tendency to err on the side of paternalism over the individual autonomy of participants. In this respect the Committee points to the provisions of the UN Convention on the Rights of Persons with Disabilities, to which Australia is a signatory. One of the core principles of this convention is that a person with a disability should have the freedom to make his or her own choices (Article 3).

Individual autonomy and independence are always to be treated as paramount under the Convention. In this context the Committee wishes to reiterate the concerns that were expressed at the time of the previous review into the functioning of the Lifetime Care and Support Authority as follows:

(i) Participants should be entitled to paid legal representation to challenge any decisions made by the Lifetime Care and Support Authority ("the Authority") concerning whether a medical treatment or care regime is reasonable and necessary.

(ii) The Committee continues to believe that the consent of an injured person should be required before they become a lifetime participant in the Scheme.

(iii) In appropriate cases, and with appropriate financial and legal advice, participants should be entitled to exit the Scheme.

These issues were all canvassed at some length in the Committee's previous submissions dated 22 August 2011. The Committee does not intend to repeat those submissions but it is useful to highlight some recent developments with the Scheme which have done little to ease the Committee's concerns as to the importance the Authority is placing on individual autonomy and decision making.

The Committee draws to your attention the amendments to the *Motor Accidents (Lifetime Care and Support) Act 2006* ("the Lifetime Care Act") which commenced in June 2012. The Committee believes that many of these amendments reflect a reluctance on the part of the Authority to accept external scrutiny of its decision making. If the impetus for these legislative changes was provided by the Supreme Court decision of Garling J in *Thiering v Daly* then it should be noted that this decision has been reversed by the High Court decision in *Daly v Thiering* [2013] HCA 45.

The new section 11A and 11B now effectively say that the Authority, for the most part, has the sole discretion over whether a particular treatment or care regime is reasonable and necessary. The Committee questions why such provision was required if the Authority aspires to be a truly transparent organisation. What is reasonable and necessary in a particular person's case should be the subject of individual assessment without rigid adherence to Guidelines issued by the Authority. While the Committee recognises that the Authority has the best interests of the participant at heart it believes a participant's wellbeing will be better served if alternative views as to what is reasonable and necessary are available. The danger is that in the absence of any external scrutiny by way of a legal review process the Authority will have little reason to question whether entrenched views on treatment and/or care are appropriate and up to date.

In the above circumstances the Committee submits that the question of whether a treatment is reasonable and necessary should not be at the sole discretion of the Authority. Further the Committee submits that there should be an external system of review available to participants in appropriate cases to test whether a treatment or care regime is truly reasonable and necessary. Any such external review process must, in the Committee's submission, incorporate some access to legal representation in appropriate cases.

The Committee members have also observed an increased tendency of the Authority to impose further restrictions on the participant's decision making through the Lifetime Care and Support Guidelines. This is demonstrated by the new Part 18 of the Guidelines which became effective from 25 May 2012. This Part states that only care providers who have been appointed as approved attendant care providers can be paid under the Scheme. The new Part 18 also restricts the rates to be paid for attendant care to those set out in the Authority's own Fee Schedule. The Committee's experience is that these regulated fees for care are well below commercial rates. The Committee is concerned that this serves to further limit the independence of choice of the participant and cannot see why a participant should

not be able to choose his or her care provider if the primacy of individual autonomy is to be protected.

The Committee understands there should be some supervision of how a participant applies the allocated funds but suggests that participants be given a lump sum on a monthly or three monthly basis coupled with a significant element of discretion as to how these funds are to be applied. Of course a participant who proves incapable of managing the funds may have access to future lump sums curtailed but the Committee believes that the starting point should not be the assumption that the participant cannot make an informed and reasonable decision as to who to engage as a carer. The participant should be able to choose to pay the carer something more than the regulated rate or to choose a carer who is not an approved provider. Conceivably the participant may even achieve a saving during this process as a result of the removal of the extra administrative cost otherwise charged by a third party service provider.

Should you have any inquiries concerning the content of these submissions, please do not hesitate to contact the Committee's Policy Lawyer,

Yours sincerely,

John Dobson
President