Submission
No 12

INQUIRY INTO THE EXERCISE OF THE FUNCTIONS OF THE MOTOR ACCIDENTS AUTHORITY AND THE MOTOR ACCIDENTS COUNCIL - ELEVENTH REVIEW

Organisation: Injury Management I.Q. Pty Ltd

Name: Ms Frances O'Connor

Position: Director

Date received: 4/10/2011

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

4 October 2011

Dear Minister,

RE: Legislative Council Standing Committee on Law and Justice
The exercise of the functions of the Motor Accidents Authority and the Motor Accidents Council - Eleventh Review (Inquiry)

Please find enclosed a submission to the Honourable Greg Pearce, NSW Minister for Finance and Services, with recommendations for review of this scheme and other personal injury insurance schemes.

My intention is to provide greater insight and clarity on an underlying cause of the issues raised by key respondents to the Standing Committee. I would be happy to provide further information if required.

Yours sincerely,

Frances O'Connor
Director
Injury Management IQ

The Hon. Greg Pearce
NSW Minister for Finance and Services
Parliament House
Macquarie Street
SYDNEY NSW 2000

4 October 2011

Dear Minister,

RE: Legislative Council Standing Committee on Law and Justice
The exercise of the functions of the Motor Accidents Authority and the Motor Accidents Council - Eleventh Review (Inquiry)

Recent media reports have drawn my attention to the submissions to this inquiry and the call for government review of the NSW CTP insurance scheme due to increasing insurer profits. In support of the need for review I am providing a candid overview of insurer practice based on my firsthand experience (below) and the attached article (as yet unpublished), ***Personal Injury schemes must expect more of insurers***. I have also sent this to the Committee, key non-insurer respondents who have raised related issues (NSW Bar Association, Law Society of New South Wales and Australian Lawyers Alliance), and the Australian Medical Association.

My intention is to provide insight into insurer claim practice standards as the most critical and overlooked aspect of creating sustainability in a disability scheme. Imbalance between insurer profits and poor claim outcomes must be understood as a symptom of this underlying problem. Without this clarity, attempts to address the issues will continue to be misdirected and create even more unnecessary complexity.

Current industry standards

My experience in both healthcare (Intensive Care) and personal injury claims provides a 'bird's eye view' of these parallel industries. This perspective reveals an insurance culture unable to progress from the adhoc claims practice and inappropriate use of claim funds that actually contributes to unsatisfactory scheme outcomes. The scale of these issues is not clearly visible within insurance companies (or to regulators) because current work practice standards keep it buried within individual claim files. But it is occurring universally and is being unwittingly paid for by the whole community.

The current standard is not the fault of front line claims staff. It is the product of systemic failure to evolve institutionalised practice to a specialist discipline befitting the scale of health, social and economic outcomes required and profit enabled. Personal injury claim management intersects with medicine, allied health and law, yet has few, if any, controls to overcome the knowledge deficits of a workforce not required to be professionally educated

in those fields. Hence, extensive mismanagement of scheme funds occurs in claim practice. In addition to the legal case studies of obviously under-compensated claimants, vast numbers of claims incur long term compensation due to poor management rather than the true extent of disability sustained. Many injuries and illnesses have a 'window of opportunity' in which well-coordinated treatment and claim management could achieve full recovery and financial independence. Instead, delays and misunderstanding of the requirements of individual cases are caused by ignorance, bureaucracy, inefficiency and poor communication between claim stakeholders. The outcome is preventable chronic disability, entrenched barriers to return to work and long term dependence on insurance benefits. Apart from the health, social and commercial impact for the community, this is a significant but unseen factor in claim costs and, therefore, premium rates.

Underutilised Information Technology*

Despite the increased uptake of IT, the potential to create the intelligence vital to scheme objectives is not being utilised. Injury Management IQ methodology will address this issue when software can be funded, but in the meantime, there is no regulator leadership in this area. Insurers are not required to use a claim management model that creates a capability for evidence-based claim practice, i.e. to develop business intelligence that **guides** accurate claim assessment and decisions. This minimum requirement for scheme sustainability includes:

i. Standardised data capture designed to enable comprehensive analysis of practice and results across the scheme for distinct disability claim segments,
ii. A 'feedback loop' of analysis and research of past results to develop evidence-based content for claim decision support tools (including claim triage), and
iii. Decision-support functionality built into claim management systems: relevant medical and claim information integrated into the claim management process as a control to guide frontline practice by claim assessors.

As the industry transitions from paper to electronic files, even the most interventionist regulators have failed to initiate this capability. Now scheme outcomes are being further compromised because IT applications are not being underpinned by a practice model designed to **generate** improved claim outcomes, but are simply superimposed onto existing task-oriented practice. As such, the current standard for electronic file management essentially comprises document imaging, soft copy file notes, and workflow to monitor process compliance.

*A previous IMIQ article published in Actuary Australia magazine (June 2009 edition) is available on my website: *Why aren't personal injury insurers using evidence-based practice to improve claim outcomes and control premiums?*

Recommendation

The lack of defined intelligent claim practice standards across personal injury schemes undermines any potential for improved outcomes. A long history of tunnel vision and inaction within the industry has only increased bureaucracy and complexity without any progress towards equity and sustainability (in fact the same mistakes are occurring in income protection insurance). Despite the benefits available, there is significant inertia to be overcome in engaging insurers (and regulators) in understanding the need for this new level

of practice. I do not believe this entrenched culture will alter at all without significant government influence stipulating a minimum requirement for claim practice that demonstrates rigorous method to achieve scheme objectives. I therefore recommend urgent government review of claim practice standards across all personal injury insurance schemes.

I would be happy to respond to any requests for further insight on the matters I have raised in this correspondence and the attached article.

Yours sincerely,

Frances O'Connor
Director

Cc:

The Hon. David CLARKE, Chair
Legislative Council Standing Committee on Law and Justice
Parliament House, Macquarie Street
Sydney NSW 2000

Mr Alistair McConnachie,
Deputy Executive Director
and
Mr Steve Campbell SC,
Chair, Common Law Committee
NSW Bar Association

Mr Stuart Westgarth
President
Law Society of New South Wales

Ms Jnana Gumbert
NSW Branch President
Australian Lawyers Alliance

Dr Steve Hambleton
President
Australian Medical Association

Personal Injury schemes must expect more of insurers

Frances O'Connor
BNurs, GradDip CritCareNurs, majoring in Intensive Care
Director
Injury Management IQ

27 September 2011

Recent media reports and government submissions have highlighted inequities in the NSW Compulsory Third Party insurance scheme. This is not a new phenomenon in disability insurance (just look closely at any injury and illness compensation scheme) so why is it still occurring despite ever-increasing rules, processes, criteria and legislation for all stakeholders to navigate? If the overarching objective of a scheme is to achieve sustainable balance between fair premiums and fair compensation for disability, then clearly the equation should not enable insurer profits to increase while premiums remain painfully high and cases of severe disability are inadequately compensated. Either the concept of 'fairness' in disability schemes needs to be reconsidered as unattainable, or it must be acknowledged that the current method to achieve it is flawed.

A fresh perspective on scheme design is essential to identify the type of accountability lacking. At a fundamental level, a disability scheme is comprised of only a legal framework, theoretically defining compensation application to individual cases, and insurance. Insurers charge premiums to fund claim costs – the cost of assessing and managing specific disability scenarios to achieve the optimal possible outcomes. Yet actuarial projections of future costs are based on claims that have not been closely analysed for accurate and cost-effective past management of disability. Even insurers would not suggest that every costly tail claim in their portfolio is an unavoidable case of long-term disability. Their various interpretations of 'early intervention' attempt to reduce ineffective claim management but preventable costs and unsatisfactory outcomes still occur. So why are premium rates accepted without review of whether past funds achieved scheme objectives? Clearly this indicates an integrity issue in scheme design; projection of future costs is not counterbalanced with comprehensive analysis of past management effectiveness.

Understanding the impact of claim management on scheme outcomes is critical to improving scheme design. Irrespective of the best intention of a legal framework to anticipate fair compensation of every possible disability scenario, overall scheme outcomes largely rely on the management of each unique claim. Case by case a claim assessor is required to determine entitlements by deciphering complex medical, work and social issues so that the optimal recovery is facilitated and the claim closed in the shortest necessary timeframe. Expenses are incurred for outsourced services such as costly independent medical examinations and rehabilitation programs (then legal costs if claim decisions are challenged). There is no requirement for any of this management to be based on standards

known to achieve the optimal outcome for a given disability scenario. This allows enormous variation between similar claim profiles within a portfolio and across a scheme. Add the impact of large case loads, varying skill levels, lack of decision-support tools and the emotive scenarios inherent to personal injury, and there is clear potential for claim funds to be spent ineffectively (even if it happens gradually and unintentionally).

This universal flaw in personal injury schemes is that cause and effect of day to day insurer practice is not visible in reporting – there is no mandated standard or method to ensure claim data is used to improve the management of distinct disability segments from year to year. Hence, there is no opportunity for comprehensive research confirming 'best' claim practice. Obviously such knowledge would benefit insurers greatly - the ability to reduce preventable costs, improve business intelligence, and build consumer trust by demonstrating tangible expertise. So it is astonishing that none have pioneered this level of practice to increase their own status and market share when it is not only possible but logical to manage claims from an informed position.

To visualise this flaw in practice, consider the inconsistency between the medical management of an injury or illness alongside the parallel and inter-related claim management for that condition. The accepted standard for diagnosis and treatment stems from deliberate cause-and-effect research on past methods and results for the condition. Collective medical 'best practice' is evidence-based and is now being developed into clinical decision support tools to improve case by case application. Yet, despite handling vast amounts of information that could achieve the health and economic objectives of a disability scheme, personal injury insurers do not produce any evidence-based practice. Why do we expect less of insurance companies in their assessment and management of disability when the fallout from ineffective claim management is so extensive?

Regulators are aware that ineffective claim management contributes to increased premiums and poor health, social and economic outcomes - insurer performance is monitored to a degree in all schemes. But the emphasis is on task-oriented process compliance and limited analysis of general outcomes instead of deliberately creating the intelligence required to improve future management. The enormous impact of claim practice dictates the need for rigorous analysis of insurer outcomes **relative** to the type and extent of disability they actually manage. Creating a practical and flexible legal framework also requires this level of application scrutiny. Relying on the legal profession to identify serious under-compensation implies this function has not been embedded into scheme design. Likewise, costs and durations inconsistent with average recovery for a condition must be identified and investigated to continually improve management of claim funds. This robust feedback loop must be incorporated into any disability scheme to create absolute transparency in the efficacy of insurer results. It is the only way to be sure premiums are spent appropriately and to create incentives for scheme objectives to be achieved on every case.

Personal injury schemes are established to serve an important purpose for society and the function of insurance companies is pivotal. Wherever government creates an opportunity for business to profit from a scheme, it must also place accountability to achieve the objectives. The implication for redesign of disability schemes is that the insurer role must be reframed to reveal the true impact of their practice. Anything less than a model designed for self-perpetuating knowledge of the most effective way to manage disability is illogical. Unless this ever-increasing clarity is expected of insurers, a sustainable method of identifying and meeting the true cost of disability will never come to pass.