Submission No 4

FIRST REVIEW OF THE COMPULSORY THIRD PARTY INSURANCE SCHEME

Organisation: New South Wales Bar Association

Date received: 13 May 2016

NEW SOUTH WALES
BAR ASSOCIATION

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13 May 2016

The Hon M S Mallard MLC
Chair
Standing Committee on Law and Justice
Legislative Council
Parliament House
Macquarie Street
Sydney
NSW 2000

Dear Mr Mallard

Review of the Compulsory Third Party insurance scheme

I write regarding the above review being conducted by the Standing Committee of Law and Justice. As you would be aware, the NSW Government is also conducting a review of the Compulsory Third Party system and released an Options Paper earlier this year entitled "On the road to a better CTP scheme".

Enclosed is a copy of the New South Wales Bar Association's submission to Government of 6 May 2016 in response to that Paper. Also enclosed is a copy of a joint letter to the Minister for Innovation and Better Regulation dated 23 March 2016 from the Presidents of the Bar Association, Law Society of New South Wales and the NSW Branch of the Australian Lawyers Alliance.

The two documents represent the Bar Association's current policy position regarding CTP reform and should be regarded as our submission for the purposes of the Standing Committee's review.

Please do not hesitate to contact the Association's Deputy Executive Director, Mr Alastair McConnachie, on or at if any further information is required.

Yours sincerely

Noel Hutley SC
President

Submission No 4

Attachment No 1

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SUBMISSION

6 May 2016

OPTIONS FOR REFORMING GREEN SLIP INSURANCE IN NSW

A submission in response to the NSW Government Options Paper *On the Road to a Better CTP Scheme*.

NEW SOUTH WALES
BAR ASSOCIATION®

Contents

Introduction

It is noted that the Options Paper focuses on four key objectives:

- Increasing the proportion of benefits provided to the most seriously injured road users;
- Reducing the time it takes to resolve a claim;
- Reducing opportunities for claims fraud and exaggeration; and
- Reducing the costs of green slip premiums.

The Bar Association supports these objectives and supports efforts to improve the efficiency of the NSW Compulsory Third Party scheme. However, the association does not support stripping the benefits currently paid to those with moderate and economically severe injuries in order to provide benefits to those who cause accidents or to further pad insurer profits or to undermine the entire CTP scheme so that private insurers can make greater profits selling private income and disability protection policies to those who can afford it.

The Bar Association notes that the historical long-term policy behind a scheme of compulsory third party insurance for motor vehicles in NSW is that the scheme should provide proper compensation to injured victims and that the scheme is not designed to be a first layer of minimal benefits which the community is then expected to supplement by expensive private income and disability insurance. The Bar Association cautions that if the CTP

scheme becomes a scheme that only provides minimal benefits then by that process the CTP scheme becomes the stepping-stone for the need to purchase private income and disability policies. The Bar Association discusses the problems with that type of insurance later in this submission.

The Bar Association very much appreciates the open and collaborative approach the NSW Government has been adopting in relation to the Options Paper and reform proposals. This is in stark contrast to the failed efforts to pass ill-considered scheme reform in 2013.

The Bar Association looks forward to continuing consultation with government and other scheme stakeholders once all submissions in response to the Options Paper are lodged and Government is considering the best means to move forward.

The Bar Association supports Option C in the Options Paper – a hybrid fault-based scheme, with an appropriate mix of fault-based and no fault benefits.

It is worth bearing in mind that this is what NSW currently has – a mixed fault/no fault scheme. While the basic premise of the scheme is the establishment of fault, there are now extensive exceptions to that principle:

(i) the Accident Notification Form (ANF) scheme available up to $5,000 for all injured motorists on a no fault basis;

(ii) the Lifetime Care and Support (LTCS) scheme, which takes care of the treatment and care needs of all those catastrophically injured on a no fault basis;

(iii) the provision of treatment and care expenses for all children who are injured (under the age of 16) irrespective of fault; and

(iv) the development of the '*blameless accident*' provisions, which, as a consequence of court interpretation, have effectively created a full no fault scheme for very young children across all heads of damage and has provided no fault protection to a range of other '*innocent*' accident victims.

The challenge in adjusting the fault/no fault mix is that any expansion by way of further benefits to drivers at fault will usually necessitate removing benefits from those who can establish fault. Where those innocent accident victims who are having benefits removed are undoubtedly deserving (such as in the case of wage earners with moderate injury with a severe economic impact) then the association strongly opposes stripping these benefits to provide payments to drivers at fault.

What is a small claim?

Central to the discussion surrounding the Options Paper is the concept of a *'small'* claim. The Bar Association emphasises that it is necessary to understand what is and what it is not a *'small'* claim. This submission later discusses how injuries impact different people in different ways. However, it is important to caution against an approach to what is a classified as a *'small'* or *'minor'* or *'not serious'* claim and recognise that the greater than 10% whole person impairment (WPI) gateway imposes a too high level of injury to meet such a description.

The current CTP scheme has a medical assessment procedure that calculates WPI as a percentage. That calculation is based on the system in the 4th Edition of Guides to the Evaluation of Permanent Impairment produced by the American Medical Association. Incidentally, the current American Medical Association publication is the 6th Edition. The calculation is also supplemented by guidelines published by SIRA.

The current CTP scheme has a gateway of greater than 10% WPI for the purposes of non-economic loss damages for pain and suffering and loss of amenity of life. Satisfying that test means that an injured person can recover damages for non-economic loss, but the percentage calculated is not used as the basis for the award of damages. Only about 10% of accident victims satisfy this requirement and these claims involve very serious orthopaedic and/or psychological injuries. This shows rather unequivocally that the gateway cannot define what is a *'small'* or *'minor'* or *'not serious'* claim: far from it, the one in ten gateway simply points to a high level of injury.

The system of calculation – including by the supplementary SIRA guidelines – was deliberately designed to only let the most serious of injuries pass the WPI threshold.

The Bar Association is opposed to any use of the gateway to define notions of *'small'* or *'minor'* or *'not serious'* claims.

It is important to note that if cases with a lower monetary value which include the cohort of claims targeted under

'soft fraud' measures are not settled by insurers, there is a strong likelihood that the average value of such claims will reduce significantly. The Bar Association emphasises that if action is required it should be directed at dealing with those claims and not removing the rights of others.

The strengths and weaknesses of the current scheme

It is very important to move forward appreciating the strengths and weaknesses currently observable in the CTP scheme.

The primary strength is the remarkable stability of the scheme at a number of levels.

For moderate and severe injury claims, the scheme is very stable and actuarially highly predictable. There is no superimposed inflation. There are no claims blowouts. In these injury severity categories, the scheme is performing at a model level.

Further, the 10% WPI threshold has also worked far more efficiently than might have been expected. Fifteen years ago, roughly 10% of those injured in motor vehicle accidents were assessed as having injuries over the 10% WPI threshold. A decade and a half later, almost exactly the same number (10%) get over the threshold and access non-economic loss. Again, this is a model of actuarial consistency and predictability.

Although the upper end of the scheme (in terms of severity of injury and payments) is highly stable, it is acknowledged that there is a problem with small claims. It is a multi-faceted problem that is going to require multiple responses. At the heart of the problem is a blowout in the number and expense of low severity injury claims. This blowout includes:

(i) a rapid increase (centred around south-west Sydney) in nervous shock claims by young children with a number of suspicious elements as to fraud;

(ii) a blowout in claim numbers (centred around south-west Sydney, but also more widely across the Sydney basin) in soft tissue injury claims, seemingly being driven by claims harvesting practices; and

(iii) a disproportionate amount of the benefits paid for these small claims being consumed in legal costs, rather than payment going to those pursuing the claims.

It is recognised that these three factors are a threat to the premium and to the stability of the scheme. Addressing these undesirable developments is central to scheme reform.

The history of fault, no fault and rationing

The roots of the current CTP scheme lie in the common law of torts. The legal right to sue and recover damages to make good an injury caused through the fault of someone else is at the heart of the development of CTP insurance across the western world. The principle is one that most of us were taught by our parents as children – if you break something or damage something, then you have an obligation to help fix the damage you have caused.

The damage that can be caused by the modern motor vehicle in high speed collisions has extended well beyond any individual capacity to make good the damage. Accordingly, over time, governments have progressively collectivised the risk of causing injury by requiring all motor vehicle owners to carry CTP insurance and creating statutory bodies such as the Nominal Defendant fund to ensure that all those injured through no fault of their own can recover compensation from the (collectivised and insured) wrong-doer.

As a consequence of this evolution, the need to establish fault is well entrenched in CTP systems. Those who are at fault in causing accidents do not recover compensation and have to rely upon other social welfare safety nets (such as unemployment benefits and Medicare).

In NSW, this fault based system has (predominantly over the past fifteen years) been significantly supplemented by no fault benefits (identified above – the LTCS scheme, the ANF, Special Benefits for Children, blameless accidents). One notable feature of these additional benefits is that they have to date been able to be extended without the need to cut back on the already established benefits being recovered by those who could prove fault. This is the current hybrid scheme that we have.

Since the 1940s, the CTP scheme has, in a variety of fashions, involved rationing. We do not pay all accident victims their full entitlement to damages. The rationing mechanisms are numerous:

(i) the need to establish fault and discounting for contributory negligence;

(ii) the 10% WPI threshold, applicable to the recovery of non-economic loss;

(iii) the 5% discount rate applied to all claims for future losses (when the real rate of return on money is closer to 2% - even the seriously injured subsidise the scheme through inadequate awards for future losses);

(iv) Restrictions on the recovery of damages for voluntary care on the *Griffiths v Kirkemeyer* principle.

In a perfect world all accident victims, irrespective of fault, would be fully compensated for all their injuries, with full and fair payments for non-economic loss, a 2% discount rate applied to future loss and no consideration of fault or contributory negligence.

The problem is that the cost of providing such an expansive CTP scheme would likely exceed $2,000 per vehicle, a figure considered politically unacceptable.

Therefore, rationing in one form or another, continues to be required. If the government wants downward pressure on premiums, then further rationing may be required, although the association urges that addressing excessive insurer profits is also a critical aspect of scheme reform. This point is addressed in further detail later in this submission. The Bar Association considers that it is counter-intuitive for a compulsory insurance program built around rationing to deliver excessive levels of profit to participating insurers – such a result is neither fair or justifiable.

Rationing involves making choices between those who should be compensated as a matter of priority and those who should not.

Exaggerated and fraudulent claims for children too young to realistically experience nervous shock can and should be discouraged and deterred. Those with minor severity soft tissue injuries, with minimal treatment needs and no real impact upon their earning capacity, should not be being encouraged to pursue claims through claims harvesting from call centres, especially where the legal costs involved in such claims are disproportionately high.

On the other hand, the critical issue for consideration is who the government should continue to assist and protect through the CTP scheme as suffering '*serious injury*'. The Bar Association urges the government to avoid scheme reform that uses arbitrary and unjust WPI numbers to exclude from the recovery of economic loss those who suffer genuine injury with a genuine impact upon earning capacity. It does not take an 11% WPI injury for that injury to have a catastrophic effect upon earning capacity, as the following examples illustrate.

Example 1 – The apprentice

The third year apprentice mechanic or plumber or welder who suffers a nasty orthopaedic injury to a shoulder or a knee or an ankle has that injury assessed at 8% WPI. The inability to squat or kneel or crawl in confined spaces or work with the arm raised above the head may all have catastrophic consequences for this young man or woman. She or he may not always be easily or readily re-trained into sedentary occupations. She or he can and will suffer a significant future loss of earnings. Devastatingly, she or he may have just wasted three years of their life if they cannot complete their apprenticeship or trade. This loss is deserving of an award for future economic loss.

Example 2 – The truck driver

The interstate truck driver suffers orthopaedic or psychiatric injuries such that they can no longer spend 8 or 10 hours behind the wheel. He or she can and do find alternate employment doing short urban runs, but will often lose $200 to $300 per week as a consequence. Over 20 years, their economic loss is over $100,000.

Example 3 – The nurse

The recently graduated nurse can no longer continue working hospital wards or operating theatres as a consequence of a low lumbar disc prolapse (10% WPI). No-one disputes that a bulging disc pressing on the nerves in the spinal cord causing shooting pains into the leg and foot can cause a significant diminution in earning capacity.

It probably puts the nurse out of nursing, in turn requiring re-training – not easily achieved when sitting through a course of lectures is enough to produce significant back pain. This nurse might be awarded in excess of $200,000 for the destruction of his or her earning capacity.

Example 4 – The mother

The 40 year old recently divorced mother who was planning to go back to fulltime work with children now old enough to come home and be unsupervised in the afternoons undergoes an ankle fusion (4% WPI). She will not return to her previous trade as a hairdresser – she can no longer stand for long periods of time. Although not working at the time of accident, her future economic loss claim is real.

All of the above examples have injuries under 10% WPI and yet may have very significant economic loss claims. Indeed, the medical profession acknowledges and accepts that even amongst those who suffer soft tissue '*whiplash*' injuries, there is a category where the musculoligamentous strain is permanent and so severe that it will cause lifetime disability and, more importantly, will cause permanent loss of income.

A medical student training to become a specialist needs to study up to 4 or 5 hours per night (after working a full shift as a registrar). The necessary concentration and time spent at computer screen or over text books is difficult if a permanent and severe cervical strain injury makes focusing on the computer or the book all but impossible beyond half an hour at a time. Missing out on the opportunity of a career as a specialist generates substantial economic loss.

The Psychiatric Impairment Rating Scale (PIRS) makes it difficult to get over 10% WPI with psychiatric injury. There are genuine, severe and disabling psychiatric injuries at 8%, 9% and 10% WPI, with the disability sufficient to rob a teacher or a small business person of the capacity to pursue their professional career and to pursue promotions within that career.

All of this group can currently pursue economic loss claims within the CTP system, subject to rationing by establishing fault (and the effect of the 5% discount rate on future losses).

All of the foregoing would have been stripped of any payments for economic loss beyond a statutory period of defined benefits under the 2013 Bill. This was one of the reasons the association and other legal profession organisations fought so vigorously against the 2013 proposal - the removal of the rights to recover economic loss from all of the examples identified above in order to pay modest compensation for a statutory period to the at fault drivers who caused their injuries. It is recognised that fault is not a frictionless rationing mechanism. Nonetheless, the association believes that the retention of proper economic loss benefits for the group identified above is integral to the social justice and fairness that ought to be central to the CTP scheme.

For all of the above examples, the individuals' economic futures very much depend upon their capacity to recover damages for economic loss. Whilst in some cases CTP insurers make excellent efforts to help procure return to work for the injured, there are far too many examples of those whom employers are not willing to give a chance or who are difficult to re-train.

Any government proposal to strip economic loss benefits from the group identified above needs to clearly explain how many are affected, the scope of the effect (how much they are losing) and provide comprehensive justification for why their rights are being removed.

For all of the groups identified above, their injuries are '*serious*' in terms of the havoc being wreaked upon their future earnings. Determining '*seriousness*' by an arbitrary number (a WPI score) is fundamentally unjust. What really makes an injury severe is its economic consequences. Can an injured person continue to meet the mortgage? Can they continue to provide for their children? Or are they reduced to a lifetime of social welfare dependence after whatever meagre statutory benefits are allowed run out, with all of the consequential detriments to their children resulting from growing up in an impoverished household?

In economic terms, a foot fusion (4% WPI) may be more severe for a bricklayer's labourer than a foot amputation (28% WPI) for a deskbound computer programmer or corporate executive.

The income protection fallacy

One of the insurers involved in the NSW CTP market (Suncorp) has been enthusiastically advocating a low

benefit, defined benefits, no fault scheme. They advocate re-visiting the 2013 Bill without in any way acknowledging its catastrophic effects on the entitlements of those with moderate severity injuries with significant economic consequences.

Despite various pronouncements about the benefits of first party schemes, what the insurer proponents of such reforms do not usually disclose is their real agenda – shrinking the CTP scheme in order to build and expand upon their far more profitable income protection insurance lines.

Occasionally these proponents advocate income protection as the solution to the unjust and arbitrary removal of the right to recover economic loss damages. What they fail to mention is the following:

income protection insurance is unavailable for many – the student, the apprentice, the mother planning to return to the workforce. They cannot insure their future income;

parents cannot reasonably be asked to insure their children against future economic loss.

income protection insurance is particularly expensive. Most teachers and nurses and other ordinary wage earners just cannot afford it. The CTP scheme (even at current pricing) is far better value income protection insurance against injury in an motor vehicle accident than anything a private insurer might sell;

many cannot obtain income protection insurance. If you have a heart condition or diabetes or a prior mental health condition, insurers are just not interested;

the conduct of insurers in the CTP field is subject to considerable regulatory oversight by the State Insurance Regulatory Authority (SIRA) that sets minimum standards for conduct. As a series of recent scandals involving income protection and total and permanent disability (TPD) insurance shows, unregulated private insurers can and will put profit before the interests of their own injured customers. The CommInsure example is far too fresh in the memory to be ignored.

For all the above reasons, any thought that stripping economic loss benefits out of the current scheme can deliver a '*just*' outcome through the substitution of income protection insurance is a fantasy. The motivations of those who promote income protection insurance as the answer to the injustices of the 2013 Bill are not in the community's best interests.

The first party fallacy

Whilst addressing misconceived ideas being floated by some in the insurance industry, one of the greatest fallacies to be promulgated during the debate over the 2013 Bill was that a move to first party insurance would somehow see an improvement in the way insurers treat accident victims.

The theory goes that if you insure with NRMA (or Suncorp, QBE or Allianz) and if that is the insurer you or your family have to make a claim against, then you will somehow get quicker or better claims handling treatment because the insurer wants to keep you as a loyal customer.

There are at least two good reasons why such a suggestion is false:

(i) At present, insurers adopt no such practice. The market leader, NRMA, insures over 30% of the vehicles on the road. A significant number of accidents will involve NRMA insured drivers being injured by another NRMA insured. It is the collective and universal experience of the legal profession that those NRMA *'customers'* insured by an NRMA insured receive nothing by way of quicker, kinder or more professional treatment by virtue of their status as an NRMA customer.

To the contrary, the legal profession are well familiar with the comment from the injured motor accident victim '*I've been an NRMA policy holder for forty years – why are they treating me like this when I've made a claim?*' [The above comment is not exclusive to NRMA – they simply happen to be the largest CTP insurer in the market. Similar comments are made about all CTP insurers.]

(ii) The foregoing experience makes sense when the economics are considered. A CTP claim can cost an insurer hundreds of thousands of dollars. If a tough, aggressive, uncompromising attitude to the claim can save $20,000, then that is a significant saving. If the

> CTP insurer is making $100 per year in *'profit'* from selling a CTP policy to that accident victim or a family member, then it would require that policy holder to buy CTP premiums for two hundred years to make up for the $20,000 that might have been saved by a more aggressive approach to claims handling.
>
> Given the disparate sums involved as between the profit from sale of a CTP premium, as against the cost of any individual claim, insurers are going to adopt the approach that makes economic sense – fight the claim. The savings in claims handling outweigh the benefits from customer loyalty.

The idea that somehow insurers will develop a warmer attitude to CTP claims just because they are made on a first party basis defies current experience (where no such thing occurs) and defies economic sense. Insurers maximise profits by minimising claims payouts and lobbying government to reduce benefits to the injured.

The options paper and reform of the CTP scheme

Addressing the specific policy considerations raised in the reform paper, the association submits as follows.

Expanding the CTP Scheme to cover injuries caused by bicycles and the like

Given the current issues being experienced within the CTP scheme over claims numbers and small claims this is probably not the most opportune time to consider expansion of the scheme. This is especially so where the number of new claims that would be generated and the cost to the scheme is entirely unknown.

Is it better to make a claim against your own insurer?

For the reasons addressed above, the belief that making a claim against your '*own*' insurer will reap some greater benefit in terms of compassion in the claims handling process is simply wrong. The majority of those injured on the road are not making a claim against their own insurer – they are passengers or pedestrians or pillion passengers or cyclists. Even in a first party scheme, a relatively small percentage would be making a claim against their '*own*' insurer.

Moreover, as identified above, the chance to save $10,000 or $20,000 on a claim is far more important to a profit driven insurer than retaining an individual customer in order to make $100 in greenslip profit from them each year for a further ten, fifteen or even fifty years. Those insurers propounding this fallacious argument are invited to identify a scheme anywhere in the world where privately underwritten first party CTP insurance sees better claims handling practices than currently exist in NSW.

The CommInsure scandal has shown that insurers will not give any preferential treatment to their own customers – the Commonwealth Bank used hardline tactics against its own loyal staff.

Private or public underwriting

Since 1988, it has been the desire of consecutive NSW governments to keep the risks associated with the underwriting of the CTP scheme off the State Government ledger. Given the consistent high profits that have been reaped by NSW CTP insurers, it appears that treating private underwriting as an article of faith might have been a mistake.

On the other hand, those with long memories of the disasters of the then Government Insurance Office (GIO) and the Transcover scheme and its operations in 1986 and 1987 can offer some justification for the retention of private insurers in the market.

If the current scheme is retained with its current fault based premise, then the association supports the retention of private underwriting, albeit with far more stringent controls being placed on insurer profits than have occurred to date.

On the other hand, if the government does wish to revive the 2013 Bill and move to a low benefit, defined benefit scheme that sees the vast majority of claimants reliant on only Medicare and Centrelink benefits after two, three or four years, then the underwriting risk becomes minimal and the necessity for private underwriting becomes far more questionable.

The Transport Accident Commission (TAC) scheme in Victoria operates on a government underwriting model

and if, contrary to the recommendations of the association, the NSW Government chooses Option D and moves to a TAC-style scheme, then public underwriting should be considered as part of that package.

How should government best deal with fault?

The Bar Association acknowledges the imperfections of fault as a rationing mechanism. It has a higher frictional cost than paying defined benefits. However, the fault based system also provides a greater degree of social justice to those who are more deserving of it.

What is often over-looked in the fault/no fault debate are the exclusions proposed from recovery of damages by those '*at fault*'. The 2013 Bill would not have provided benefits to anybody who was charged with a serious criminal offence. The definitions in the 2013 Bill provided that negligent driving causing injury would have constituted a disentitling serious criminal offence.

Much was made in 2013 about the poor mother who was momentarily distracted by children in the back seat and ran off the road. It was said that there was no '*intent*' to have an accident. That is undoubtedly true. However, if that same inattentive mother (or father) in running off the road collides with another vehicle and causes injury, then the provisions of the 2013 Bill would have excluded that parent from no fault compensation. Indeed, injury to one of the children in the car would justify a charge of negligent driving causing injury.

We thus have the bizarre and capricious outcome that running off the road and injuring yourself entitles an individual to compensation, but the moment they run off the road and injure someone else, they are disentitled.

Under such a scenario, the possibility of CTP insurers lobbying police to charge and prosecute the injured at fault driver on the basis that a negligent driving charge will help the CTP insurer escape liability for no fault payments and preserve profits becomes very real. Insurers have from time to time in the past funded the criminal defence of at fault drivers.

The idea that moving to a no fault system will somehow '*protect*' those who cause accidents can only be maintained by a steadfast refusal to read the fine print and consider its consequences.

Moreover, bringing '*at fault*' drivers into the CTP scheme and delivering benefits to them is very expensive. Given the government's desire to reduce rather than increase premiums, extending no fault benefits has to be funded from somewhere within the existing premium envelope.

In 2013, it was proposed this be achieved by stripping the majority of benefits from the majority of existing claimants. Both future economic loss and future treatment became dependent (after a set statutory period) on surmounting artificially high thresholds, with WPI scores entirely unrelated to the associated loss of earnings and future treatment needs. Just one example was that a whole foot amputation with lifetime prosthetic needs was not enough to get over the WPI threshold for the recovery of lifetime medical expenses.

As previously stated, fault is a rationing mechanism. Remove this rationing mechanism and some other rationing mechanism has to be imposed. The reality that proponents of no fault schemes do not want to acknowledge is that such schemes only ever pay minimal subsistence wages and involve using dependable medico-legal opinions from pro-insurer doctors in a no-lawyer environment to remove claimants from the system, leaving them with only Centrelink and/or Medicare benefits.

Recent changes to the NSW Workers Compensation system that placed far too much power in the hands of insurers have led to predictable results – unfair and unjust outcomes for workers, substantial boosts in scheme profits and a major drop in the standard of living of those injured in workplace accidents. There is a clear distinction between '*getting people back to work*' and '*getting them off the books*'. The two are not the same. Removing injured people from a scheme and leaving them to be covered by meagre social security benefits is no triumph of policy.

Further, the current crisis in claims numbers has only one precedent in NSW – the fraud and claims boom that accompanied the no fault Transcover scheme in the 1980s. The last NSW no fault scheme saw claims numbers exceeding accident rates and injury reports. It fostered a claim mentality that has not been seen since. No fault schemes can fail and spectacularly so.

Given that there is to be continuing rationing of the CTP premium dollar, the association would prefer to see the primary focus on providing adequate economic loss

compensation to the innocent victims of motor accidents rather than stripping economic loss benefits in order to provide modest and short-lived benefits not only to the innocent victims, but also the drivers who caused their injuries.

Choosing an option

The Bar Association endorses Option C, subject to the caveat expressed above – expanding no fault benefits by stripping the rights of current moderate severity accident victims and those with genuine economic loss claims is strongly opposed.

The foregoing submissions should make clear the Bar Association's opposition to moving to Option D – changing to a low defined benefit, no lawyer, stepping stone to Centrelink and Medicare, CTP scheme. Undoubtedly, such a scheme will be more efficient. The only thing that is more efficient than allocating minimal benefits according to inflexible rules is awarding no benefits at all [reminiscent of '*Yes Minister*' and the awarding of an efficiency prize to an empty hospital that was nonetheless very efficiently administered].

We currently have a scheme with no fault elements and some definition of benefits, with common law benefits retained in parallel. This is Option C. There are also elements of Option A (process improvements in the current scheme) and Option B (consideration of benefit levels and process improvements) that can and should be adopted as part of an Option C based reform.

Given that the current scheme operates stably and well in relation to moderate and high severity injuries, the focus of reform should be on addressing the crisis in low severity claims, in bringing insurer profits back into balance and in reducing legal costs especially in smaller claims.

The Bar Association's proposals set out below focus primarily on cutting legal costs, cutting small claims and cutting insurer profits, rather than cutting benefits to the injured.

Insurer profits

The single largest factor contributing to inefficiency in the NSW CTP scheme over the last fifteen years has been the consistently high level of insurer profits. For half a decade, the profits were close to 30% of the premium dollar and the long-term average is 19% of the premium dollar. It is stunning to think that this has been achieved as against a background of continued insurer filings predicated on around an 8% profit.

The one-sided nature of the profit figures (not a single year where it is predicted that insurer profits will not beat filings by at least 50%) indicates that something is broken. The reasons proffered by the insurers do not go far enough to explain such extensive profits over such an extended period. The reasons that have been put forward include:

For a period, falling accident numbers (with the insurers, experts in actuarial estimating, unable to get sufficiently ahead of the trend to restrain profits);

Falling superimposed inflation (again, with the insurers, actuarial experts that they are, never able to get ahead of the trend of falling superimposed inflation).

More recently, the insurers have claimed that it is lack of actuarial predictability that means they need to build large contingency margins into premium filings, but have failed to properly articulate exactly what these unpredictable aspects of the scheme are. The fact that moderate and severe injury claim numbers and payments have flat-lined for half a decade is never mentioned.

It is worth repeating and emphasising that if NSW CTP insurers had been held to an 8% to 10% profit over the past decade, then the efficiency of the NSW scheme would have been comparable to other schemes around the country. Alternately, premiums could have been $100 cheaper and therefore, comparable to other schemes around the country.

It is appreciated the government is doing separate work in relation to insurer profits. However, if the government is determined to drive down CTP prices, the starting point ought to be reining in excess insurer profits rather than attacking benefits to the injured.

Restraining legal fees

The Bar Association acknowledges that if there is to be (as there must be) criticism of insurers for excessive profits, so too there must be action in relation to the disproportionate cost of small claims. It is noted that for cases under $100,000, the average takeout in legal fees is in excess of

40% of the benefit recovered by the claimant. This is an economically inefficient delivery of benefits.

In defence of the lawyers acting in such claims (and claims under $100,000 are close to 50% of total claims), the complexity of the scheme, excessive allegations of contributory negligence, refusal to fund reasonable treatment and unrealistically low opening offers are all part of why accident victims seek out the assistance of a lawyer. The injured are well aware of their disadvantage in dealing with an insurance company in trying to reach a reasonable settlement for their claim. They thus seek legal advice.

The legally represented do get better results in settlements and awards and it would be grossly unfair to attribute this entirely to some form of overservicing on the part of the legal profession. Rather, the unrepresented effectively subsidise the scheme by foregoing their entitlement to the benefits they might otherwise recover if legally represented.

Having said all of the above, small claims with high legal costs are a problem and the association appreciates that preserving economic loss benefits for those who genuinely have a need is a higher priority given restrictions on the premium funding envelope.

Addressing the small claims blowout

The starting point for CTP reform has to be addressing the recent blowout in small claims. The United Kingdom experience illustrates how badly and how quickly a CTP scheme can deteriorate under pressure from claims harvesters and fraud. However, the solution has to be multi-facetted as the problem has different aspects and origins.

Insurers' toughening up

One of the biggest drivers in the blowout in small claims has been the incentives generated by poor claims handling practices. If insurers are prepared to throw undue amounts of '*go away*' money at claims, then it is hardly surprising that a claims culture follows.

Whilst it might be considered unfortunate that the situation has been allowed to deteriorate as far as it has, insurers are now taking pro-active measures to identify fraudulent and exaggerated small claims and to take appropriate measures against them. The legal profession has already observed these measures taking effect. More small claims are being run to conclusion at the Claims Assessment and Resolution Service (CARS), with the modest results acting as a substantial deterrent to those firms who have built a practice around claims harvesting processes.

A significant part of the problem has become behavioural and it is going to take behavioural change to rein in small claim numbers. The Bar Association applauds and supports the action that SIRA are now taking to expose fraudulent practices and ensure that they are brought to the attention of police and regulators. The Bar Association accepts that a tougher approach to small claims by insurers is inevitable and necessary.

The challenge is to find the right balance so that smaller, yet meritorious, claims still receive an appropriate level of compensation. The child left with modest orthopaedic injury, but nasty scarring, usually cannot have scar revision surgery completed until he or she is 18 and the body has stopped growing. In such cases, it is entirely appropriate that there be a $10,000 to $15,000 allowance set aside so that the surgical work can be performed when required without the need to resort to a two to three year wait on a public hospital waiting list. No defined benefits scheme is going to make appropriate allowance for this child's future surgery costs.

Whilst a toughening up in approach by insurers is a large part of the solution to the small claims blowout problem, the association recognises that additional support will be required in the form of regulatory and legislative change to deter small claims from incurring undue expense. The Bar Association has already made constructive suggestions in that regard.

Fraudulent/exaggerated children's claims and the economic incentive

Children's claims are currently automatically exempted from the CARS process and dealt with in the court system. The Bar Association notes that there have been suggestions of keeping all children's cases in CARS and opposes such a change.

Most solicitors and barristers agree to act in children's cases charging no more than the amount recovered for party/party costs. It is relatively rare for there to be any charge for a solicitor/client component in a case involving a child.

Payment of any such solicitor/client gap requires approval by either the NSW Trustee and Guardian or a private trustee, protecting the child's interests.

The legal work necessary to pursue a child's claim can only be done on a *'no solicitor/client gap'* basis where regular party/party costs can be recovered. Such an approach could not be adopted up and down the range of children's claims if such cases were kept within CARS and were subject to the CARS regulated fee. As SIRA is well aware, the CARS regulated fee does not cover the true costs of pursuing a claim.

The Bar Association is deeply resistant to having any solicitor/client component come out of the damages recovered by children. Children should not subsidise the CTP premium. Proper costs should be paid for children's cases and they should recover the damages they are entitled to. Thus, these cases should not be kept in the CARS system and subject to regulated costs.

It should be noted that all children under age 16 are entitled to recover all of their past and future treatment costs, irrespective of fault. It is government policy that children legitimately injured in accidents are to have their treatment costs paid.

Having said the foregoing, it is recognised that it is necessary to rein in the costs in children's claims of small value. It is disproportionate to have a $5,000 to $10,000 settlement incurring $10,000 to $15,000 in unregulated legal costs.

To this end, the legal profession (the association, the Law Society and the Australian Lawyers Alliance) have already put a joint proposal to government to cap costs for smaller value children's claims. In essence, the proposal provided:

(i) A modest fixed fee with no contracting out for children's claims with settlement or judgment below $25,000;

(ii) A slightly higher fee with no contracting out for children's claims with settlement or judgment between $25,000 and $50,000;

(iii) Further restriction of fees where there are multiple children's claims arising from the same accident; and

(iv) The capacity for the court to *'otherwise order'* to avoid substantial injustice.

The vast majority of children's claims at the low end, and in particular, those that are suspected of being generated by current fraudulent or exaggerated practices, settle for $10,000 to $15,000. The $25,000 threshold figure was chosen to ensure that the vast majority of these claims were captured by the regulatory change. The layering of an additional level of costs restrictions between $25,000 and $50,000 is designed as a safety net so that there is no significant incentive to try and build up or boost claims over the $25,000 threshold.

SIRA have shared with the legal profession some preliminary work done by Ernst & Young (scheme actuaries) that is critical of this proposal. However, the association disagrees with the Ernst & Young analysis for a number of reasons.

Firstly, Ernst &Young have assumed that the $25,000 and $50,000 figures will simply become new benchmarks for plaintiffs' lawyers to try and build up claims. Whilst this has the potential to be true, the reality is that there is just no way to take a modest cushion for future treatment expenses of $5,000 to $10,000 and somehow stretch it into a $25,000 or $50,000 claim. It just cannot be done.

SIRA is encouraged to consult the insurers about this proposal and to seek their views as to its effectiveness. It is anticipated that the figures chosen and the thresholds recommended will have a very substantial deterrent effect, especially when matched with insurers being prepared to actually fight some smaller claims, rather than throw money at them.

The second Ernst & Young concern was based on the *'experience'* that such financial thresholds *'never work'*. The sole example cited in support was the failure of the section 79 threshold regarding non-economic loss in the *Motor Accidents Act 1988*.

What Ernst & Young have ignored in such analysis is three examples of such thresholds working since 1988. The revisions to Section 79 in 1995 (creating Section 79A) with higher threshold levels, were a success. Ernst & Young have conceded (over a number of years) that Section 79A actually worked in moderating payments for non-economic loss (NEL) under the 1988 Act.

Moreover, Section 79A worked so well that it was adopted by the NSW Government when introducing Section

16 of the *Civil Liability Act 2002*. There has been no complaint over the last decade about Section 16 in terms of its effectiveness at restraining NEL payments in small claims. There has been no bracket creep. There has been no blowout in non-economic loss payments for the simple reason that plaintiffs' lawyers just cannot turn a 20% of a most extreme case impairment into a 30% of a most extreme case impairment. Public liability insurers have fought hard to maintain the integrity of the threshold and it has worked.

Finally, the introduction of the *Civil Liability Act 2002* saw the introduction of a restriction on the recovery of legal costs in public liability claims up to $100,000. That threshold has been in place for a decade. Again, it has been effective.

The message is that Ernst & Young are incorrect when they say that financial or dollar thresholds can never work. Such a statement is not true. What is true is that thresholds set too low will be ineffective. Thresholds set at an appropriate level can, will and do work.

The legal profession is confident that the threshold amounts suggested in the joint proposal will be effective in deterring fraudulent and exaggerated small children's claims. What is critical is that the profit motive for solicitors to pursue or encourage such claims is removed. There is no longer access to unrestricted amounts of legal costs in relation to children's claims under $50,000. The fraud promoters should, can and will be put out of business by such a measure.

Shutting down the claims harvesters

The Fraud Working Party is considering a range of measures to try and restrict claims harvesting practices. It is recognised that a range of measures will be required and none of them is likely to prove overwhelmingly successful. The profit motive to find those previously not intending to pursue a claim and to encourage them to proceed with a low value claim needs to be attacked. It was removing the profit motive that was central to the legal profession proposal in relation to small value claims.

The proposal was that for claims under $50,000 and otherwise subject to the Costs Regulation, there be no entitlement to contracting out. For claims over $50,000, there is no contracting out on the first $50,000 agreed or awarded.

At present, contracting out is what motivates the claims harvesters. Contacting individuals who would not otherwise make a claim, offering them '*free money*' and getting the insurer to throw $30,000 or $40,000 at a settlement are the basic elements of the business model. The solicitor will take $20,000 out of the $40,000, some will go back to Medicare and Centrelink and the claimant might get $10,000 or $15,000 net in hand. For someone who was not going to claim and for someone of modest means, that is still an acceptable return. The claims harvester has delivered on the '*free money*' promise. The claimant is none too concerned that the lawyer who got them the $40,000 total settlement is taking $20,000 of it.

It is readily evident that the contracting out or the capacity to contract out is what generates the phone call that in turn generates the claim. If the regulated fee on such a claim was less than $5,000, then there is no incentive to contact the potential claimant, because there is not enough money to pay both solicitor and claims harvester for the work required out of the sum recovered.

Moreover, if there is no contracting out on the amount below $50,000, then there is no particular incentive to build up the settlement to $51,000. All that can be achieved by pushing the claim over the $50,000 limit is the capacity to contract out and to take the extra $1,000 generated. A properly advised claimant will want a quick and early settlement. There is no point letting a case drag on for three years in the hope of recovering $70,000 if the contracted out legal fees will chew up the damages from $50,000 to $70,000.

Such a restriction, when combined with a more robust approach by insurers in relation to small claims, will have a very significant effect upon the claims profile. Whilst the injured do not lose any benefits (apart from those they forego by not having as many lawyers willing to assist them to pursue their claim), the scheme will become vastly more efficient. There will no longer be lawyers taking forty cents out of the dollar in settlements below $50,000.

A further benefit is that there will be a very positive incentive for insurers to avoid exempting cases (taking them outside the Costs Regulations) given the additional disincentives to claims behaviour that will be in play for

cases under $50,000 to which the Costs Regulations apply.

One risk associated with this proposal is that insurers will string out the resolution of small claims to exhaust the very limited legal funds available. Queensland has a system that caps the costs in relation to small claims, but provides for additional payments where the claimant makes a reasonable offer of settlement and subsequently exceeds that figure. This is a sensible safeguard that is currently built into the restrictive costs provisions applying to public liability claims under $100,000. If the claimant makes a reasonable offer of settlement there should be some penalty for the insurer who does not accept it.

It is anticipated that there will still be lawyers willing to assist claimants with modest and meritorious claims below $50,000. It is anticipated that law firms will still be willing to provide modest assistance as part of the broader service the legal community already provides to the injured through its willingness to conduct cases on a speculative basis. However, there will no longer be any incentive to drag claims out and build up capacity to charge the client a contracted out fee to cover the legal expenses being incurred. Again, the legal profession believes that this proposal will bring immediate and considerable relief to the current small claims problem.

Altering the fault/no fault mix

The Bar Association appreciates that Option C seeks to expand the no fault/defined benefit element of the scheme, whilst preserving common law rights for the '*seriously injured*'. These submissions have already dealt at length with the difficulty in defining seriousness of injury according to a WPI number, rather than by looking at the effect of injury upon earning capacity. The Bar Association very much opposes a move to tie entitlements to arbitrary thresholds.

The challenge in expanding no fault benefits is how to pay for it. If no fault benefits can be expanded through reducing insurer profits or restricting legal fees at the low end of the claims spectrum, then some modest expansion of no fault benefits can be funded. However, the moment such an expansion starts being funded out of future economic loss awards for apprentices, students, manual workers, stay at home parents looking to return to the workforce and anyone else with an injury which will have a significant impact on earning capacity that falls below an arbitrary threshold, the association opposes such an expansion. Expanding benefits to pay drivers who cause accidents is then being achieved at the expense of the genuinely injured and innocent accident victims.

One option for government is to consider modest expansion of the ANF. The amount involved could be increased to $25,000 which would allow for medical expenses and (say) three months of lost wages. Insurers could be encouraged or compelled to pay weekly or fortnightly benefits for that three month period. [One of the weaknesses in the current ANF system and one of the reasons for its under-utilisation is that wage payments can only be made out of whatever is left from the $5,000 amount at the conclusion of a six month period. Insurers can and should be making more and earlier payments for lost wages.]

As part of such a change:

- the time for lodging of a full claim should be extended to twelve months;
- The lodging of a full claim should not bring ANF benefits to an end; and
- No legal fees should be payable or recoverable to obtain these benefits.

The proposal to expand the ANF is designed to ensure earlier payments, cut out lawyers from small claims and to deter small claims from turning into full claims.

The Bar Association has concerns that expanding the ANF up to $25,000 would still see it being under-utilised and that funding even such a modest proposal would require cuts to the benefits of innocent accident victims to pay for the additional fault based claims.

An alternative to the expansion of no fault benefits so broadly may be to increase the ANF up to $10,000 or $15,000 for the payment of past and future treatment expenses on a no fault basis. This would leave all economic loss out of the ANF and confine economic loss payments to fault based claims.

It is noted that one of the difficulties in having insurers move to any system of defined benefits whereby weekly or fortnightly payments are made is that their liability immediately increases – they have to pay the tax on the wages.

An alternative approach to ensure more timely payments is to instead amend the current hardship provisions already existent under the Act. There are provisions that are chronically under-utilised for insurers to make advance payments for hardship. Part of the reason they are under-utilised is it is the claimant who bears the onus and it is expensive to run a dispute to recover a modest amount for hardship payments.

There is also some still residual cultural intransigence amongst some insurers – only '*good*' and '*co-operative*' claimants get hardship payments and it is better to keep all claimants hungry and poor as it helps persuade them to take cheap and early settlements. If the government wants to see more and earlier payments being made under the CTP scheme, then reverse the onus so that wage earners have a presumption in favour of hardship payments, with an insurer required to review each claim on a quarterly basis and to make a further advance on damages for those who are out of work. The advantages of such a change are that it would avoid taxation complications and avoid the disincentive for a return to work associated with receipt of a weekly or fortnightly payment.

The Bar Association believes there are creative solutions that can be applied to try and provide modest and defined benefits in small claims to facilitate return to work and minimise disputation.

There is a role for the Claims Advisory Service operated by SIRA to step up and assist claimants with such processes. The delivery of treatment expenses and modest hardship payments within the first six months post-accident ought to be capable of being achieved without the need for involvement of lawyers and the recovery of legal costs. However, much stricter regulation and supervision from SIRA to stop abuse of claimants and the onus being put on the Claims Advisory Service to provide full and accurate legal advice if they are going to act in substitution for lawyers becomes essential.

It is repeated that the association strongly opposes proposals to put the majority of claimants on defined benefits for one or two years and to then have the majority of claimants (including many who suffer significant ongoing economic loss) dependent upon their eligibility for a subsistence Centrelink payment. The repeated mistake of the advocates of a defined benefits scheme is the belief that injuries below arbitrary thresholds do not have significant economic impact.

The available benefits

Any review of scheme structures also compels consideration of the rationed benefits available under the scheme as to whether they are appropriately defined. The actuarial evidence is that a large part of the problem in the blowout of small claims is insurers allocating inappropriate amounts in settlement as cushions or buffers for economic loss and care. What follows is a review of the various heads of damage available responding to various propositions put forward in the Options Paper.

Non-economic loss

The 10% threshold, although at times arbitrary and capricious, has been remarkably stable in terms of the predictability of the number who get through the gateway. Although the long-term position of the association was that Section 79A *Motor Accidents Act 1988* was working when the much more draconian restrictions of the 1999 Act were introduced and that Section 16 *Civil Liability Act 2002* has shown that appropriately set thresholds and judicial discretion can work, in the current environment the 10% WPI threshold should remain.

The issue is raised in the Options Paper that NSW is more generous than other States in terms of the maximum amount recoverable for non-economic loss. It is noted that the currently indexed maximum figure is just over $500,000.

It should be a source of pride rather than an embarrassment that NSW leads the nation in recognising the seriousness of the pain and suffering of the catastrophically injured. Only 10% of accident victims qualify for a payment for pain and suffering. $500,000 is hardly excessive or overly generous in terms of the pain and suffering of a 20 year old paraplegic who is going to spend another fifty years in a wheelchair.

Similarly, it can hardly be termed too generous for an amputee to receive a likely award for pain and suffering for the loss of an arm or a leg of $300,000 or $350,000.

The Options Paper raises the prospect of shifting to an injury severity scale (ISV) on the basis that it would involve a lower level of disputation. What is not made clear is whether the '*top dollar*' on such an ISV would be over $500,000 or whether such a change is part of a move to take money out of awards for pain and suffering to paraplegics, quadriplegics and the grossly brain injured.

The reality is that for those who clear the 10% WPI threshold, arguments over quantification of the appropriate figure for NEL are relatively rare. It is only in unusual and infrequent cases that disagreement about the amount of damages for pain and suffering is a serious impediment to settlement.

What is far more common are extended disputes concerning whether injuries are over the 10% WPI threshold or not. Serious reform efforts should be devoted to cutting back on endless repeat journeys to MAS in this regard being driven by insurers and, to a much lesser extent, claimants.

The preparedness of insurers to seek judicial review in the Supreme Court in too many instances shows that they are prepared to spend more money keeping a claimant out of a payment for pain and suffering (in legal fees) than it would actually cost to pay the claim. Association representatives have been urging SIRA to do something about insurer conduct in pursuing excessive administrative appeals for the past twelve months, with no sign of any response from the regulator. Although the number of such administrative appeals is small, the disproportionate cost they generate is significant.

Claimants have a right to re-hear a CARS decision in the District Court. Insurers do not. Yet, currently there are more administrative appeals by insurers than District Court re-hearings by claimants. Regulatory intervention is required.

Within the current common law scheme the association does not recommend alterations in relation to payments of NEL except for measures to streamline the efficiency of MAS disputes. Easy examples as to where MAS processes could be streamlined include:

(i) allowing the parties to agree on component parts of the dispute to reduce the number of injuries needing to be assessed by MAS. If both parties agree that there is a 5% knee injury and the argument is over the back injury, then only the back injury should require assessment;

(ii) Measures to reduce applications for review and further assessment, especially by CTP insurers who have not properly prepared for the first MAS assessment. One of the design features of the current scheme was to prohibit insurers from challenging CARS assessments, yet insurers have been given the capacity to endlessly challenge the determinations of MAS by way of review and further assessment and administrative appeals.

Treatment expenses

Past treatment expenses, where legitimately incurred, should be paid in full. It is noted the Options Paper raises the issue of a deductible. If it is believed there is over-servicing, then this should be dealt with by way of professional conduct complaint (if there is mistreatment or over-treatment) or through the MAS treatment dispute process. Medical expenses legitimately incurred should be paid.

Economic loss

Soft cushions for economic loss have not been generated by decisions of the Court of Appeal, but rather by poor claims handling practices and insufficient effort on the part of insurers to promote a return to work. This paper has already extensively detailed the association's views that for many their loss of earning capacity is the most critical aspect of their claim. It is the loss of a job or the loss of overtime or the loss of promotional opportunity that can lead to the loss of the family home when the usual wage payments are no longer available to meet the mortgage.

It is the entitlement of injured workers to keep supporting their families that the association is most strongly committed to defending.

The Options Paper raises the prospect of reducing the maximum that can be awarded for economic loss from approximately five times average weekly earnings (AWE) to approximately three times AWE. This is done on the basis that the '*wealthy*' should take out income protection insurance. For all the reasons set out above, many do not have that option. Moreover, given the number of

tradespersons and others earning more than three times AWE, such a restriction appears unduly harsh. The reality is that any savings from such a change would constitute cents rather than dollars in the premium.

Voluntary and paid services

The Bar Association notes that damages payments for voluntary and paid services have increased over the last decade. On the information available, the increase in the cost of damages for voluntary and paid services has been from about $20 to $42 in the average CTP premium of about $650.

All members of a household participate to varying degrees in the performance of domestic, handyman and gardening activities and services. Payment of damages for voluntary and paid services reflects this broad performance of those activities by all members of the community because when a claimant is injured and he or she can no longer contribute by performing the activities and services he or she did before the injury, the claimant is entitled to damages if someone else has to do those activities and services and does those activities and services.

The Bar Association notes that the current scheme provides no damages for voluntary services to those members of a household who did nothing in the household before the accident, or those who did not do a lot.

The current scheme already imposes significant restrictions on accessing damages for voluntary and paid services:

the injuries in question have to prevent the injured person doing the activities and services without pain and restriction;

the activities and services in question have to be performed by someone else;

unlike the common law, there is a statutory threshold for voluntary services of at least 6 hours per week and 6 months which means that if either is not satisfied there is no entitlement.

This 6 hours per week and 6 months threshold means that those members of the household who did not do the equivalent of 6 hours per week are not entitled to damages for voluntary services. If this part of the scheme is correctly applied, it is a significant restriction. For example, the parent who works full-time but does 5 hours of cleaning on Saturday morning as his or her contribution to the keeping of the family home, before Saturday afternoon and Sunday are spent doing activities with the family, has no entitlement for damages for voluntary services.

Unlike the common law, if there was a pre-existing need for a service only the additional services can be recovered.

Unlike the common law, services in respect of children only apply to children at the time of the accident and no services can be recovered in respect of future children. This applies even where a chid has been born after the accident and before the finalisation of the claim.

Awards based on paid care must be established by evidence that demonstrates why the family members will not be able to provide the services or should not be expected to provide the services.

The Bar Association cautions against the misconception that paid services are simply an '*alternative*' to voluntary services, and paid services are simply awarded when the 6 hours per week and 6 months threshold is not met. This is not how the current CTP operates.

As indicated, properly applied, the current scheme should provide a sufficiently restricted entitlement. However, as the escalation in payments for this head of damage has shown, the rationing of benefits has not in fact been achieved as intended. Given the association's focus on preserving economic loss payments, if further rationing of benefits is to be imposed, the area of paid and unpaid domestic services is where it should be considered.

If there are to be revisions of entitlements to either voluntary or paid care, then there needs to be more detailed actuarial information addressing what is paid for the past and the future; what is paid for unpaid as against paid services and what is paid in minor severity injury claims compared to moderate and high severity injury claims. It is only with more detailed actuarial data that potential further restrictions in benefits can be properly considered.

Conclusions

The Bar Association recognises that the current scheme needs reform. However, it should be recognised that when it comes to moderate and severe injury claims, the current scheme is stable and predictable.

There is a view amongst some actuaries that any CTP scheme only has a *'shelf life'* of ten to fifteen years and that this scheme is already beyond its use by date. The Bar Association does not agree with such an analysis. The stability of moderate and severe injury claims experience is incredibly important and valuable. Moreover, if such an opinion were valid the Victorian TAC scheme is overdue for replacement.

The key to the current reforms is to rein in the negative claims experience with low severity claims. The Bar Association (in conjunction with other legal profession stakeholder groups) has put forward practical and effective measures to address that blowout. Attacking the economic drivers behind small claims is at the centre of the proposals put forward.

In reforming the CTP scheme, the government is encouraged to prioritise cutting insurer profits and cutting lawyers out of small claims before cutting the benefits of the injured. Unfortunately, the focus of too many is to start a new reform process with cutting benefits, overlooking the fact that the whole point of having a compensation scheme is to compensate the injured.

Given that benefits are to continue to be rationed, fault remains an appropriate rationing mechanism for those seeking to recover more substantial payments. To that end, the association supports the retention of the current fault based scheme.

Caution is urged as to the motives of those seeking to promulgate a low defined benefit, no fault scheme. Such schemes provide very little by way of proper compensation for anyone and are being pushed hardest by those with the agenda of selling income protection insurance, rather than CTP policies.

The shortcomings of the 2013 no fault scheme were made manifest at the CTP roundtable when a representative of the Insurance Council of Australia fairly and honestly advised that the 2013 Bill would in no way guarantee a reduction in premiums. Bringing up to 7,000 new claims into the system creates enormous unpredictability and does nothing to decrease premiums. At the same time, the expansion of no fault benefits could only have been achieved by slashing the existing benefits of innocent accident victims and in particular, payments for economic loss to those who are deserving of such awards.

Whatever reform proposal the government ultimately decided upon, the association wishes to continue working with the government to ensure that social justice is at the forefront of scheme redesign. Given that the premium dollar does not extend to providing fair and adequate compensation for all accident victims, the primary focus should be on properly supporting innocent accident victims from the funds available.

The Bar Association believes that implementation of the recommendations above in relation to eliminating small claims and claims harvesting will stabilise premium and will promote scheme efficiency and fairness.

Submission No 4

Attachment No 2

FIRST REVIEW OF THE COMPULSORY THIRD PARTY INSURANCE SCHEME

Organisation: New South Wales Bar Association

Date received: 13 May 2016

THE LAW SOCIETY
OF NEW SOUTH WALES

Our ref: ICC:GUgc:1099596

23 March 2016

The Hon Victor Dominello MP
Minister for Innovation and Better Regulation
52 Martin Place
SYDNEY NSW 2000

Dear Minister,

Review of the CTP Scheme

We are writing on behalf of our three organisations in relation to the current review of the NSW CTP Scheme. We note that there has been a significant increase in legally represented small claim numbers in recent years.

We have reached a consensus position on proposals to address this increase in claims. If approved, we believe that these proposals could be implemented very quickly, through amendments to the *Motor Accidents Compensation Regulation 2015* ("Regulation"). Therefore, we believe these proposals could provide immediate benefits in terms of premium relief.

1. Children's claims

We propose that the Minister should amend the Regulation to provide as follows:

(a) *Where a claim is exempted solely on the basis of a lack of capacity related to the age of a claimant and where the ultimate settlement or judgment in the matter is $25,000 or less, then:*

(i) *The maximum recoverable as party/party professional costs shall not be more than $5,500 inclusive of GST; and*

(ii) *No additional professional fees may be charged on a contracted out basis*

unless the court otherwise orders.

(b) *Where a claim is exempted solely on the basis of lack of capacity related to the age of a claimant and where the ultimate settlement or judgment in the matter is less than $50,000, but greater than $25,000 then:*

(i) *The maximum recoverable as party/party professional costs shall not be more than $11,000 inclusive of GST; and*

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(ii) *No additional professional fees may be charged on a contracted out basis*

unless the court otherwise orders.

(c) *Where a claim to which (a) or (b) above applies is the second or other subsequent claim brought on behalf of an occupant of the same vehicle involved in an accident, then the maximum recoverable as party/party professional costs shall not be more than $5,500 inclusive of GST and no additional professional fees may be charged on a contracted out basis, unless the court otherwise orders.*

In addition, our organisations would seek to work with the District Court to develop a streamlined process for the court to approve settlements in these matters, by considering them in chambers.

2. Small Claims

As a short term measure to contain the legal fees payable in small claims, we propose that the Regulation be amended to provide that:

> *Where the total damages recovered by way of settlement, award or judgment is less than $50,000 the legal practitioners acting in the matter may not contract out of the regulated legal fees in relation to professional costs.*

In practice, this option will reduce the incidence of such claims. It could be implemented pending consideration of the proposed broader scheme reform. However, there would need to be a corresponding consideration of a reasonable increase in the prescribed costs for these matters when this amendment is made.

We are also currently considering longer term reform options in relation to the CTP scheme. In the meantime, we would appreciate your consideration of these proposals, and would be available to meet with you to discuss any questions you may have in relation to them.

Yours sincerely,

Gary Ulman
President, Law Society of NSW

Noel Hutley SC
President, NSW Bar Association

Roshana May
NSW Branch President, ALA