Submission No 65

FIRST REVIEW OF THE WORKERS COMPENSATION SCHEME

Organisation: The Law Society of NSW

Date received: 12 October 2016

THE LAW SOCIETY
OF NEW SOUTH WALES

Our ref: GUlw:1195575

11 October 2016

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

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

Dear Mr Mallard,

First Review of the Workers Compensation Scheme

The Law Society of New South Wales welcomes the opportunity to provide a submission to the Law and Justice Committee's review of the NSW workers compensation scheme, the first since the establishment of the State Insurance Regulatory Authority ("SIRA") in 2015.

The Law Society is the state's peak legal representative body and our members represent workers, scheme agents, self-insurers and employers, all of whom are key stakeholders in the scheme. Law Society representatives would be pleased to assist the Standing Committee by providing oral testimony to supplement this submission. We note that the Committee is particularly interested in hearing from stakeholders with respect to "affordability, efficiency and sustainability".

In order to properly consider issues of affordability and sustainability the Law Society wrote to Insurance and Care NSW ("icare") seeking financial information including actuarial valuations of the Nominal Insurer in 2015 and 2016. We have been provided a response, a copy of which we attach for your reference. We understand from the response provided that in 2015 there was a surplus of $3.992B, with $2.7B of that surplus in net assets over the *target funding ratio* of 110%. The scheme's funding ratio in 2015 was 131%, significantly higher than it was at the last Standing Committee on Law and Justice review of the scheme in 2014. Notably for the 30 June 2015 valuation, a risk margin of 16.2% over the central estimate has been adopted to provide an estimated 80% probability of sufficiency (Tab B). These figures are significantly higher than those adopted previously and the Law Society concludes that the scheme was in a very strong financial position as at 30 June 2015.

The most recent valuation results provided to the Law Society disclose that for the period to 31 December 2015 the surplus has shrunk to $2.905B but includes "an allowance for the 2015 benefit reforms and the anticipated premium discounts provided as part of the 2015 reform package". The consequential funding ratio is currently 120%.

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The Law Society understands that the current solvency position is significantly higher than the target funding ratio. We consider that the additional funds should be used by way of measured restoration of benefits to injured workers and further measured premium reductions for employers. However, most importantly, various amendments are urgently needed to address the problematic aspects of the current scheme to unlock the existing benefits which, by virtue of the convoluted legislation, are not currently fully accessible to injured workers.

This submission includes the issues identified by the Law Society as requiring attention and reform and which are relevant to the objectives of affordability, efficiency and sustainability.

1. Work Capacity Decisions and Suitable Employment

Fundamental to the return to work focus of the 2012 reforms was the notion of 'suitable employment' in s 32A of the *Workers Compensation Act 1987* ("the 1987 Act"). This is because the entitlement to weekly payments under ss 36, 37 or 38 of the 1987 Act now depends on whether a worker has any 'current work capacity' for the purposes of s 32A. The definition of whether a worker has current work capacity is also contained in s 32A and this relevantly reads as follows:

> ***Current work capacity***, in relation to a worker means a present inability arising from an injury such that the worker is not able to return to his or her pre-injury employment but is able to return to work in suitable employment.

The problem is that the definition of suitable employment includes any employment for which the worker is currently suited, regardless of whether such a job is available in the labour market and regardless of the worker's pre-injury employment and place of residence. The Law Society believes that if a workers compensation system is to have 'return to work' as a key objective then it must adopt a realistic approach to what alternative employment is suitable in the labour market and reasonably accessible to the worker. Any system that puts the determination of suitable employment solely in the hands of an insurer and entitles an insurer to disregard factors such as the state of the employment market or the claimant's place of residence is inherently unfair. It encourages insurers to adopt unrealistic approaches to return to work and to use the work capacity decision process as a means by which to terminate a worker's benefits rather than to achieve a sustainable and realistic return to work objective.

Despite the wording of the definition of 'suitable employment' in s 32A, some lawyers had hoped that the courts, or the Workers Compensation Commission ("the Commission), would have applied the very stringent definition beneficially to workers. However, the cases dealing with the definition of suitable employment have reinforced the very wide ambit of the suitable employment test. For instance, in *Wollongong Nursing Home Pty Ltd v Dewar* (2014) NSWWCC PD 55, Deputy President Roche came to the conclusion that the definition of suitable employment merely required that the job for which the worker is considered to be suitable must only be 'real work in the labour market' regardless of whether such a job is actually available.

The inequity associated with the existing definition of suitable employment is reflected in the burgeoning area of vocational capacity assessment. There are numerous organisations performing these types of assessment to determine what work is said to be suitable for the worker. It is our members' experience that they focus almost exclusively on the hypothetical availability of a job in the open labour market for which the claimant may (and often may not) be physically and psychologically suited. However, these organisations often avoid consideration of whether the type of job is realistically available to the claimant in the current labour market or whether it is realistically suitable to the claimant having regard to his or her education, training and work history and/or residence.

In order to maintain a real focus on sustainable return to work and in keeping with considerations of fairness, the Law Society recommends that paragraph (b) in the definition of suitable employment at s 32A of the 1987 Act should be removed. The former definition of suitable employment, which afforded fairness to injured workers and delivered some support when challenging employers who would not provide suitable employment to their injured employees, should be reinstated.

2. Dispute Resolution and Settlement

The Law Society has, on several occasions, drawn to the attention of the Minister and the Regulator (now SIRA) the significant difficulties which arise in the present dispute resolution system in relation to claims for workers compensation benefits.

There is unnecessary complexity and uncertainty with the dispute resolution process which substantially limits accessibility to the scheme and increases associated scheme costs. The two problematic elements involve:

(i) dispute notification, and
(ii) dispute management and resolution.

2.1 Dispute Notification

In essence, there are three different types of notification that an insurer is required to give in response to various claims for workers compensation benefits.

(a) Section 74 Notices

If an insurer seeks to dispute primary liability for the payment of statutory compensation benefits (for example where the dispute relates to whether an injury has been sustained at all) the insurer is required to give a notice in accordance with s 74 of the *Workplace Injury Management and Workers Compensation Act 1998* ("WIM Act").

While the WIM Act requires such a notice to be concise and understandable, the formal requirements of the s 74 Notice have been read (by reason of the WIM Act and the Regulations) as requiring a high degree of detail and particularisation. The attachment of all documents that are said to be relevant to that decision (whether or not they support the decision) is also required.

The consequence of the s 74 Notice being defective or deficient is often that an insurer is precluded from disputing liability before the Commission on any basis not precisely particularised or detailed in the s 74 Notice, whether or not such a basis has merit. In addition, an insurer may be precluded from relying on documents not provided with the notice even where that material may be very relevant to the determination of the dispute in question.

(b) Work Capacity Decisions

Where a dispute about an entitlement to the payment of compensation is limited to the extent of a claimant's entitlement to weekly compensation, the legislation and regulations require a different decision making process and a different form of notification. The extent of a claimant's entitlement to weekly compensation is determined by means of a work capacity decision ("WCD") as defined in s 43 of the 1987 Act. While s 43 does not provide for any specific requirements for notification by an insurer of a work capacity decision, s 54 of the 1987 Act requires that notice be given to a worker where the amount of weekly compensation is to be discontinued or reduced.

A series of guidelines, issued by the WorkCover Authority (as it then was) in respect of work capacity decisions, impose significant obligations on insurers regarding the manner in which work capacity decisions are to be made and the manner in which those decisions are to be notified. Those requirements have resulted in a substantial administrative burden being imposed on insurers and as a consequence notifications are being issued which are almost always unintelligible to the average injured worker.

In the recent reissue of the 'Claims Guidelines' SIRA has not modified or lessened the requirements for WCDs and they remain burdensome and problematic.

(c) Lump Sum Compensation

The third form of notification involves claims for lump sum compensation benefits (for permanent impairment) where primary liability is not in dispute but where the amount of the claimed lump sum compensation is disputed.

2.2 Dispute resolution

In addition to the three forms of notification of disputes, there are now at least three pathways by which those disputes are dealt with and what amounts to three separate "jurisdictions".

(a) Primary liability:

The Commission has jurisdiction to deal with a dispute as to primary liability notified by means of the s 74 Notice but does not have jurisdiction to deal with the dispute as to the extent of an entitlement to weekly compensation consequent upon a WCD. It has limited jurisdiction to deal with a claim for the payment of lump sum compensation.

(b) Work Capacity Decisions

Disputes about the extent of a worker's entitlement to weekly payments of compensation consequent upon a WCD are dealt with, at first instance, by an internal review by the insurer followed by a "merit review" by SIRA and then a procedural review by the Workers Compensation Independent Review Office ("WIRO"). The Law Society considers that internal reviews and reviews to a division of SIRA do not satisfy the necessary requirements of a fair and transparent dispute resolution model, namely impartiality, independence and integrity.

Importantly, injured workers are still required to navigate the complex route of a review process in respect of a WCD without the benefit of legal advice. We note that the *Workers Compensation Amendment Act 2015* allowed for the potential for legal practitioners to be paid for assisting a worker or an insurer with a WCD review. However, the Regulation to detail its execution has still not been finalised.

(c) Lump Sum Compensation:

Claims for lump sum compensation, where the only dispute relates to the extent of the entitlement to lump sum compensation, are lodged with the Commission but then dealt with by an Approved Medical Specialist with appeal rights to a Medical Appeal Panel. The jurisdiction of the Commission in respect of such a claim is limited to the issuing of a Certificate of Determination that reflects the assessment made by the Approved Medical Specialist or the Medical Appeal Panel.

Decisions as to primary liability in the Commission are subject to appeals to a Presidential Member and then to the Court of Appeal. All three of the dispute resolution processes are subject to potential administrative review by the Supreme Court in certain circumstances.

It must be emphasised that the summary set out above cannot adequately capture the extreme complexity and difficulty of the current dispute notification and dispute resolution processes. These disjointed and dysfunctional processes are nothing short of an administrative nightmare for all interested parties, but particularly for injured workers who are currently only able to access legal advice and assistance with respect to a limited part of the dispute resolution process.

Some of the difficulties which arise from this disjointed dispute resolution process were identified, in a limited way, in the Sabanayagam decision (*Sabanayagam* v *St George Bank Limited* [2016] NSWCA 145) which proceeded, essentially concurrently, before the Commission, including to a presidential member, the Court of Appeal, the merit review service and WIRO.

It should be noted that although this matter has now been determined in the Court of Appeal, the decision has not resolved the difficulties and confusion identified in any final sense.

It has been and remains the very strong recommendation of the Law Society that the dispute resolution process for claims involving statutory workers compensation benefits should be rationalised, unified and simplified.

The starting point for this process should be that an insurer is required to issue only one form of notification to an injured worker dealing with the issues of whether or not an injured worker is entitled to the payment of statutory compensation benefits and if so, the nature and extent of those entitlements. The requirement for such a notification should be simple, concise and understandable. Such a notice should be required only to properly identify the nature of any dispute and the reasons for it. The notification should not be rendered invalid simply by reason of any deficiency in its form or content or the manner in which any entitlement to the payment of statutory compensation benefits has been calculated and/or determined.

If an injured worker is dissatisfied with the decision made in respect of the payment of statutory benefits, any such dispute should be referred to a *single forum for resolution of disputes,* irrespective of the nature of the statutory benefits to which the dispute relates.

While the form of that single forum for dispute resolution is not of primary importance, the Law Society considers it is imperative that such disputes should be dealt with by an independent tribunal with properly trained and experienced judicial officers. The "one stop shop" should enable and encourage early conciliation or mediation. Issues which are legitimately in dispute should be quickly and efficiently identified and the process should allow for the prompt and efficient exchange of the information and documentation which is relevant to the resolution of those issues.

The process should be flexible enough to accommodate an expedited resolution of small claims or claims involving single or limited issues, while also providing a proper process by which disputes involving complex claims and multiple issues are heard and determined in a manner which affords justice and procedural fairness to the parties in dispute.

To this end, disputes must be triaged at the gateway to this single forum by appropriately trained personnel who can then determine the appropriate dispute resolution path for that specific case. The dispute resolution process should, as far as possible, make use of available technology to provide an effective and efficient process. For example, the process could include online dispute resolution for small claims or claims involving single or limited issues.

It is imperative that all parties engaged in the dispute resolution process should be able to access properly remunerated legal representation.

2.3 Settlement

The Law Society is very strongly of the view that the dispute resolution process should also include the availability of a proper mechanism by which claims can be resolved including, if necessary, on a final basis. One of the great frustrations of the present dispute resolution process is that, while the legislation focuses on the resolution of disputes, the options available to resolve disputes are either extremely limited or simply unavailable.

For this reason the Law Society considers the restrictions presently placed on the party's ability to commute liability for the payment of statutory compensation benefits as set out in s 87EA of the 1987 Act should be removed altogether so that all parties have the ability to agree to a settlement, however described, on a final basis, of statutory compensation entitlements. The availability of settlement on this basis should be subject only to the requirement that a claimant first obtain legal advice concerning any such settlement and that in cases where a person is operating under a disability (by reason of age or mental capacity) such a settlement has the oversight of a judicial officer within the dispute resolution system.

These problematic issues of dispute resolution and settlement are of course most relevant to the Standing Committee's stated interest in scheme efficiency.

In summary the Law Society recommends that:

- The dispute notification process be simplified with only one form of notification required.
- The dispute resolution process be simplified with one dispute resolution system.
- All parties to disputes involving statutory compensation benefits have access to properly remunerated legal representation.
- The restrictions and constraints that are currently imposed on settlement options for statutory compensation benefit claims be removed altogether.

3. Legal Costs

Generally, costs are governed by Schedule 6 of the *Workers Compensation Regulation* 2016. While the Schedule was remade in 2016 as part of the wider remake of the Regulation it is essentially in the same form as it has been since 1 November 2006. The system is based primarily upon payment of a fee to a solicitor for the resolution of a matter at various points in the dispute resolution system.

The current Schedule contains a number of difficulties and anomalies and is now largely unresponsive to the dispute resolution process. Prior to the 2012 amendments members of the Law Society worked with WorkCover, as it was then, to substantially review both the structure of the cost regime and the rate of remuneration in order to address numerous anomalies identified in the Schedule. In the spirit of cooperation, substantial work was done by both the profession and WorkCover on this issue between 2008 and 2010, but the revised Schedule was not ultimately gazetted. These longstanding anomalies remain and new problems have arisen with the Schedule as a result of changes to the scheme and increased complexities following the 2012 changes.

The Law Society now proposes a wholesale review of Schedule 6 to be conducted as soon as possible to address these problems. Such a review should include all legal professional organisations together with SIRA, icare and WIRO.

Below we have listed some specific points on topics recently discussed in engagement with SIRA.

3.1 Rates of pay, including indexation

As set out in earlier submissions, the Law Society is of the view that both the fixed sums and the rate upon which those sums have been provided for in Schedule 6 are wholly inadequate and represent a significant underfunding of the work required of lawyers working in the system.

While most benefits including those to injured workers, treatment expenses and fees for medico-legal reports are indexed (by means of annually gazetted fee orders), legal costs are not. Since 1 November 2006 there has been only one increase in fees, in 2012, which represented an increase of 15% on the rates originally set in 2006.

When this is compared to inflation rates published by the Reserve Bank of Australia, it is clear that legal representatives have taken a substantial reduction in earnings in real terms. The Law Society is receiving feedback from its members as to the financial difficulties they face in representing injured workers and insurers.

The Law Society is concerned that if this trend continues, legal practitioners will be unable to provide the expert legal advice many workers require because of financial constraints. This will inevitably have an adverse impact on the capacity of decision makers to resolve disputes in a timely and cost effective manner.

In the event that Schedule 6 is not reviewed in its entirety the Law Society recommends, as an interim measure, that indexation of fees under the Schedule be introduced to bring these fees into line with other scheme expenses that are indexed.

3.2 Difference for Applicants and Respondents

For the most part, lawyers representing injured workers are paid by the WIRO's Independent Legal Assistance and Review Service ("ILARS") scheme, and lawyers representing insurers are paid by their clients pursuant to Schedule 6 of the *Workers Compensation Regulation 2016*. The circumstances and rate at which WIRO pays lawyers has, in part, diverged from Schedule 6. The WIRO should be commended for listening to the profession as to the practical requirements involved in adequately representing injured workers and adjusting its policies to reflect those needs. The Law Society considers that any divergence has been beneficial for those paid under the ILARS scheme.

One example of this is the manner in which the costs for counsel are treated. The ILARS scheme allows legal practitioners to make an application for the use of counsel in certain prescribed circumstances. When that application is successful WIRO reimburses the law firm for the costs of counsel as a disbursement.

This can be contrasted with solicitors who represent insurers. If these solicitors are instructed by their insurer client to brief counsel they are required to absorb the fees of counsel, who is invariably briefed because it is not practical or affordable for a senior lawyer to spend many hours out of the office at the modest rates that are chargeable. Counsel may also be briefed because most matters have a degree of complexity and difficulty which require experienced advocacy. In a complex matter, or a matter that is heard over multiple days, this can result in

lawyers not being paid at all, as any fees generated are absorbed by counsel. This effectively requires respondent solicitors to prop up a scheme that is in an extremely strong financial position. In circumstances where the retention of counsel is at the discretion of insurer clients, the Law Society submits that the client insurer should bear the costs rather than the legal provider.

In the event that Schedule 6 is not reviewed in its entirety, the Law Society calls for counsels' fees to be regulated as a recoverable disbursement for the purposes of Schedule 6.

3.3 Costs for reviewing Work Capacity Decisions

The *Workers Compensation Amendment Act 2015* contains the following provision that has yet to commence:

> **44BF Legal costs**
>
> (1) A legal practitioner is not entitled to be paid or recover any amount for a legal service provided to a worker or an insurer in connection with a review if:
> (a) the review is of a prescribed class, or
> (b) the regulations do not fix any maximum costs for providing the legal service to the worker or insurer in connection with the review.
>
> (2) Despite section 341 of the 1998 Act, the regulations may provide that, in prescribed circumstances, a party to a review under this Subdivision (other than an internal review) is to bear the other party's costs in connection with the review.

In October 2015 SIRA issued a discussion paper entitled "Regulation of legal costs for work capacity decision reviews". SIRA noted that the Regulation would be designed to:

- provide fair, equitable and appropriate access to professional legal services
- target key risks and drive desired outcomes
- not be unnecessarily complex and written in a way that is easy to understand
- impose minimal regulatory and administrative costs on individuals and business
- establish pricing controls that will assist to maintain the system's financial sustainability without unduly compromising the quality or availability of services
- encourage and support early agreement on work capacity
- promote sound judgment and effective primary decision making
- focus on supporting workers to achieve early and sustainable return to work.

The Law Society was pleased to attend a meeting to discuss the proposed Regulation with SIRA representatives and then provided a detailed submission in December 2015 (attached). In July 2016 members of the Law Society attended a further meeting with SIRA at which the terms of a draft Regulation were discussed.

The Law Society is disappointed that more than one year after the introduction of the *Workers Compensation Amendment Act 2015,* paid legal representation in relation to the review of work capacity decisions remains unavailable. The Law Society hopes that a sensible and timely solution to this problem is found so that practitioners for both workers and insurers can adequately represent their clients.

4. Pre-injury Average Weekly Earnings ("PIAWE") and weekly payments

The Law Society was pleased to provide a submission to SIRA in April 2016 to inform the development of a new Regulation designed to address the complexities surrounding the calculation methodology used to determine a worker's PIAWE.

We understand further consultation is taking place with the appointment of an independent consultant to determine in what manner PIAWE should be modified and by what mechanism. The common view from submissions to the consultation process (which closed on 5 April 2016) was that the current methodology was unnecessarily complex, and simplification was required to provide a fair and efficient system. There has been as yet no progress in amending the legislation relevant to PIAWE issues, found in ss 44C to 44I of the 1987 Act. The appointment of a consultant to conduct further consultation after lengthy, detailed and considered submissions from stakeholders is disappointing.

The Law Society endorsed all the recommendations of the Parkes Project Inquiry on this issue, see http://wiro.nsw.gov.au/sites/default/files/Statement%20of%20Principles.pdf, which included a recommendation that the definition and computation method of PIAWE be simplified, using some of the features of the former s 43 of the 1987 Act.

The Law Society submits that this aspect of the legislation, which is vital for a quick and efficient determination of a worker's entitlement to weekly payments, should be reformed on an urgent basis by legislative amendment, rather than by regulatory change.

Bearing in mind that the scheme has a very substantial surplus, we submit that the first entitlement period or first 13 weeks of benefits should be increased to 100% of PIAWE and the "step- down" at 52 weeks should be removed.

5. Return to Work provisions

There were no focused measures in the 2012 reforms that were specifically designed to enhance and improve the process of returning workers to work after injury, or measuring the rate of return to work. Rather, the new benefits arrangements focused on 'capacity' to work instead of 'incapacity' and by means of a subjective test introduced a blunt tool by which insurers could 'cut' workers off weekly benefits.

In its Report 54 – September 2014, the Standing Committee on Law and Justice stated[1]:

> Some review participants raised concerns regarding the adherence of employers to the return to work provisions contained in the workers compensation legislation, suggesting that employers may not fully understand their legislative obligations.

The Law Society considers that nothing has altered with respect to this issue.

There has been no change in relation to the process of returning to work, or incentives for workers or disincentives for employers to improve the rate of injured workers returning to work or outcomes for injured workers in terms of returning to their place of work and maintaining employment. The Return to Work Assistance package delivered in the 2015 amending Act provides financial assistance in terms of one off grants to assist workers once they have secured employment or in limited circumstances, to undergo retraining. The measures have been in place for a relatively short period of time. The Law Society is of the view that these measures will do little to improve return to work outcomes.

The Law Society is of the opinion that the focus of benefit delivery, particularly medical treatment, on establishing impairment to secure the duration of the benefit may contribute to worsening return to work outcomes. Workers who return to work and so 'cease' their weekly

[1] Standing Committee on Law and Justice, Parliament of New South Wales, *Review of the exercise of the functions of the WorkCover Authority* (2014) at [5.50].

benefits will also lose access to medical treatment after a defined period. There is no greater disincentive to returning to work than to have medical treatment curtailed within a defined period of time.

The Law Society repeats its recommendation, consistent with the recommendations of the Standing Committee's Report No 54, and the unanimous outcome of the Parkes Project Advisory Committee that disputes about provision of suitable employment or return to work should be simply and quickly managed; incentives should be provided to employers to provide suitable employment to injured workers and to workers to return to work after injury; and that rehabilitation following work injury should be meaningful and provided in a timely manner.

6. Stakeholder Engagement and Consultation

The Law Society would strongly suggest more meaningful consultation and stakeholder engagement by the Regulator.

Following the 2014 review of WorkCover and the report of the Standing Committee on Law and Justice, Minister Perrottet responded to the recommendations and offered that WorkCover would in 2015 action "developing and then publishing an engagement plan in consultation with all stakeholders"[2].

In June 2015, the Law Society met with consultants from Newgate Consulting, engaged by the Regulator to consult with stakeholders on the Regulator's consultation model. The Law Society expressed concerns with WorkCover's consultation processes to date and made recommendations for improvement of the consultation process. In June 2016 the Better Regulation Division published "The Better Regulation Stakeholder Engagement Strategy", see http://www.sira.nsw.gov.au/about-us/stakeholder-engagement-strategy.

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We note that the Executive Director of the workers compensation Regulator has established a quarterly consultation process with the Law Society. This development is welcomed.

7. Medical and Treatment Expenses

As a result of the 2012 legislative changes, the scheme now has a very substantial surplus. The Law Society submits that a return of medical benefits to injured workers should be a high priority.

The *Workers Compensation Amendment Act 2015* increased the scope of medical and treatment expenses available. Workers with 10% or less whole person impairment ("WPI") can receive medical benefits for up to 2 years after weekly payments cease (or from the date of claim if no weekly payments are made). Workers with greater than 10% WPI and less than 21% WPI can receive benefits for up to 5 years, and workers with greater than 20% WPI can receive benefits indefinitely.

However, the fact that eligibility for these benefits is now linked to a WPI assessment in addition to being linked to the cessation of weekly payments is problematic. The Law Society considers that a WPI assessment is not an appropriate threshold test for recovery of medical treatment expenses. The various thresholds introduced in the 2015 amendments also create additional friction points resulting in increased disputation, delay and costs and decreased efficiency.

It should be emphasised that one of the objectives of the NSW workers compensation scheme is "to provide ... payment for reasonable treatment and other related expenses" (s 3(c) of the

[2] The Government's response to the Standing Committee on Law and Justice Report, 4 May 2015.

WIM Act). The Law Society considers the scheme should be simplified and returned to a straightforward system in which reasonably necessary medical expenses are payable to all injured workers.

The Law Society also recommends repeal of the pre-approval requirements in s 60(2A) of the 1987 Act which prevent the scheme from fulfilling its fundamental function of providing prompt, effective and proactive treatment of injuries. This provision enables insurers to undermine medical recommendations by delaying or refusing approval. These delays and backlogs are exacerbated by the convoluted dispute resolution process applicable to medical treatment.

8. Lump Sum Compensation

The Law Society submits that the Committee should review the application of s 66(1A) of the 1987 Act which restricts injured workers to one lump sum payment only. The Law Society considers that, at the very least, the section requires amendment to create an exception to the "one lump sum only" rule where there is a significant deterioration in the worker's condition or the first lump sum claim does not result in receipt of any financial compensation.

Section 322A of the WIM Act also requires review. This section provides that only one medical assessment may be made of the degree of permanent impairment of an injured worker. The Law Society submits this section should be repealed to permit workers to access benefits of different kinds where an assessment of permanent impairment is required to qualify for benefits. At the very least the section should be amended to reflect the changes proposed above to s 66(1A) of the 1987 Act and to provide for the situation where a worker's condition is unstable at the time of assessment.

9. Parkes Project

The Law Society was represented on the Advisory Committee formed under the Terms of Reference to the Parkes Project, an Inquiry established by the WIRO pursuant to s 27(c) of the WIM Act. The Parkes Project sought to identify the mechanical and operational issues with the workers compensation legislation and work with all stakeholders to develop a workable solution and recommendations for Government.

A Statement of Principles to remedy the key issues was developed with unanimous support of the Advisory Committee, see http://wiro.nsw.gov.au/sites/default/files/Statement%20of%20Principles.pdf.

A set of recommendations to give effect to the Statement of Principles was prepared with input from the Advisory Committee in July 2015.

The work of the Parkes Project was not completed within the time allocated to the Advisory Committee and apparently further funding has not been granted. The Law Society submits that consideration should be given to restoring funding to enable completion of the Parkes Project and delivery of the report outcomes to the Minister and the SIRA Board for consideration as to implementation.

The Law Society thanks you for the opportunity to contribute to this consultation. Should you require any further information, please contact Leonora Wilson, policy lawyer for the Injury Compensation Committee on or .

Yours sincerely,

Michael Tidball
Chief Executive Officer

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15 September 2016

Mr Gary Ulman
The Law Society of New South Wales
170 Phillip Street
DX 362
SYDNEY NSW 2000

Dear Mr Ulman

Re: Review of the New South Wales Workers Compensation Scheme

Thank you for your letter of 5 September 2016 regarding The Law Society's submission to the review of the NSW workers compensation scheme that is being undertaken by the legislative Council Standing Committee on Law and Justice.

I am pleased to provide the following information as requested:

1. Summary of the actuarial valuation of the insurance liabilities for the NSW Workers Compensation Nominal Insurer as at June 2015 (Tab A).
2. Summary of the actuarial valuation of the insurance liabilities for the NSW Workers Compensation Nominal Insurer as at December 2015 (Tab B).
3. Actuarial valuation of the insurance liabilities for the NSW Workers Compensation Nominal Insurer as at June 2016 – icare is unable to provide this information at this time as the June 2016 actuarial valuation is yet to be finalised.
4. Full details of the severe injury criteria used to determine eligibility to participate in 'Workers Care', the new team within icare announced by Executive General Managers, John Nagle and Don Ferguson, including:
   (a) the meaning of "severe injury"
   (b) the number of current participants
   (c) the criteria used to determine the current participants
   (d) the expected number of participants by mid-2017 following transition, and
   (e) the projected annual numbers for new participants.

   (Tab C)
5. Actuarial valuation of the actual cost of the benefits package delivered by the Government in September 2015 (Tab B).
6. Peer review reports of each of the above valuations (Tabs A and B)

I trust this information is of assistance. Should you require any further information, please contact Dr Nick Allsop, Chief Actuary, on or at

Yours sincerely

Vivek Bhatia
Chief Executive Officer
Icare

Encl.

TAB A

Nominal Insurer Liability Valuation as at 30 June 2015

Background

Insurance & Care NSW (icare) commissioned PricewaterhouseCoopers Actuarial (PwC) to estimate the insurance liabilities of the NSW Workers Compensation Nominal Insurer (NI) as at 30 June 2015. This document summarises the results of PwC's independent assessment of the NI insurance liabilities.

The PwC valuation has been prepared with the intention of complying with the Actuaries Institute Professional Standard 300 'Valuations of General Insurance Claims' and producing results that comply with Australian Accounting Standard AASB 1023 'General Insurance Claims'.

Results

As at 30 June 2015 PwC have estimated the discounted net outstanding claims liability of the NI to be $11,786m. This figure includes a 16.2% risk margin over and above the central estimate which has been adopted to provide an estimated 80% probability that the combined liability estimate will prove to be sufficient. The components of the outstanding claims liability as at 30 June 2015 are set out in the following table.

Table 1: Outstanding claims liability

Items	Undiscounted Liability Estimate ($m's)	Discounted Liability Estimate ($m's)
Weekly compensation	4,451	3,422
Medical benefits	4,096	2,334
Work injury damages	2,292	2,028
Section 66 and 67	629	534
Investigation costs	340	273
Legal costs	300	258
Rehabilitation benefits	255	222
Commutations	171	115
Other	183	152
Asbestos	217	105
Uninsured employers	169	100
Gross outstanding claims liability	**13,104**	**9,542**
Excess recoveries	2	2
Tax recoveries	95	81
Other recoveries	249	228
Uninsured employer recoveries	13	8
Net outstanding claims liability (excl. CHE)	**12,745**	**9,223**
Claims handling expenses (CHE)	1,244	920
Net outstanding claims liability (incl. CHE)	**13,989**	**10,143**
Risk margin (16.2%)	2,266	1,643
Total outstanding claims liability	**16,255**	**11,786**

The discount rates used by PwC in the assessment of the outstanding claims liability were taken from the yields on Commonwealth Government Bonds as at 30 June 2015 for the first 15 projection years. Beyond the 15 year point a fixed discount rate was adopted. Future inflation rates were based on a number of economic forecasts. After the first 10 projection years a fixed gap between the discount and inflation rates was adopted. Blending to the fixed gap occurred between years five and 10 of the projection.

No allowance for the 2015 benefit reforms was included in the estimated outstanding claims liabilities. At the point the valuation was completed there was insufficient information to assess the impact of the reforms as much of the required regulation was still to be drafted.

The mean term of the outstanding claims liability was estimated to be 12.0 years on an inflated and undiscounted basis and 7.5 years on an inflated and discounted basis.

PwC estimated the premium liability of the NI to be $450m as at 30 June 2015. This figure includes a risk margin of 17.9% on the unexpired risk component, again with the intention of providing an estimated 80% probability that the unexpired risk liability estimate will prove to be sufficient. The components of the premium liability as at 30 June 2015 are set out in the following table.

Table 2: Premium liability

Items	Liability Estimate ($m's)
Unearned premium reserve	355
Unearned premium related to future adjustments	6
Total unearned premium reserve	**361**
Unexpired risk reserve	382
Risk margin (17.9%)	68
Total unexpired risk reserve	**450**
Required premium deficiency reserve	88
Premium liability	**450**

No risk margin is included in the pricing basis for the NI which will, in general, lead to a premium deficiency when comparing the unearned premium to the expected future claim costs including a risk margin. Premium under-collection can also impact the premium liabilities.

The following table shows the estimated financial position of the NI as at 30 June 2015.

Table 3: Financial position

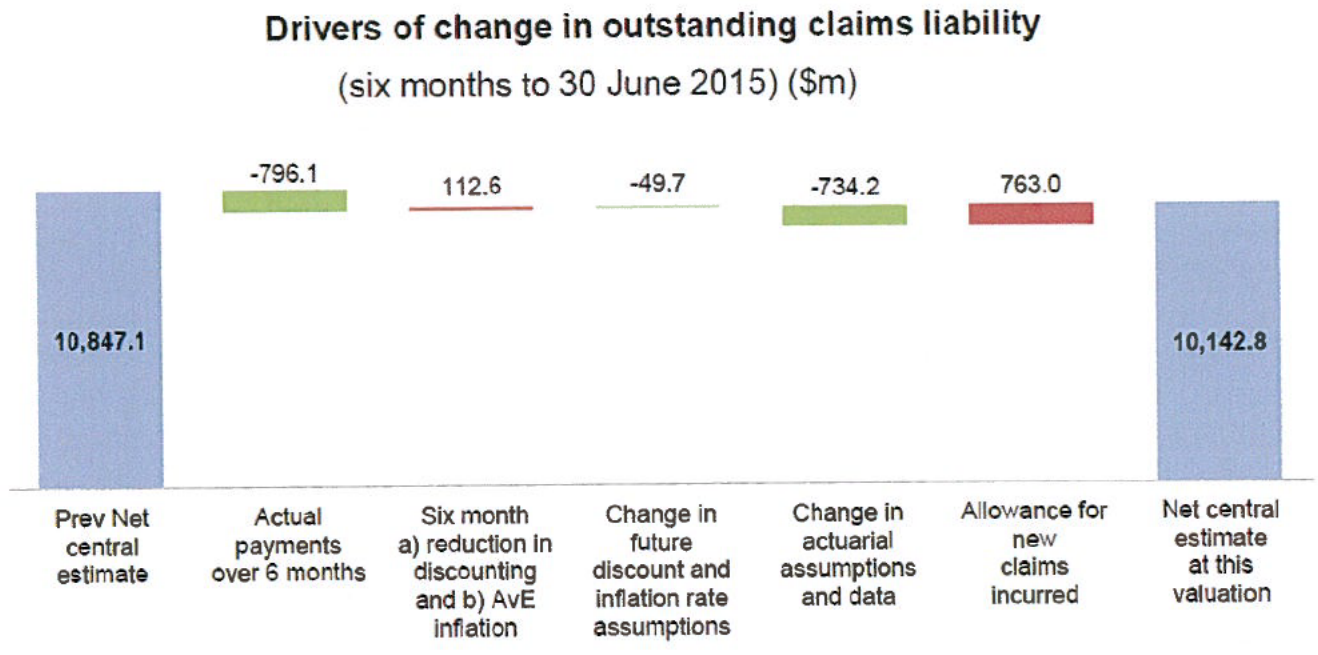
Items	$m's
Investments	15,176
Outstanding claims recoveries	371
Other assets	1,522
Total assets	**17,069**
Gross outstanding claims liability (incl. CHE)	12,157
Unearned premium reserve	355
Unexpired risk reserve	88
Other liabilities	351
Additional agent remuneration payable	126
Total liabilities	**13,077**
Target funding ratio	110%
Net assets in excess of the target funding ratio	2,684
Funding ratio	**131%**

The above funding ratio is prior to the application of any impacts from the 2015 benefit reforms.

Movement in results

The following figure shows the movement in the discounted net central estimate (i.e. excluding the risk margin) of the outstanding claims liability between December 2014 and June 2015 split by the key components of the change. Relative to expectations at 31 December 2014 the liability estimate has reduced by approximately $818m, or 6.5%, including the risk margin.

Figure 1: Change in the outstanding claims liability



The key drivers of the change were:

- An increase in the yields on Commonwealth Government Bonds and a reduction in the expected future Labour Price Index inflation rate have contributed to a reduction in the liability estimate. This has been almost entirely offset by a 0.2% reduction in the post 10 year gap between discount and inflation rates. Superimposed inflation on asbestos claims was also reduced from 2.5% per annum to 1.5% per annum. The combined impact was a reduction in the liability estimate for pre 31 December 2014 claims of $50m.
- Experience within the portfolio was favourable leading to changes in the assumptions underlying the valuation. This led to a reduction in the liability estimate for pre 31 December 2014 claims of $734m. The primary drivers of this reduction were;
  - A reduction in the number of claimants remaining on weekly compensation benefits was partially offset by an increase in the average weekly compensation cost for more severely injured claimants. Overall the weekly compensation experience and modelling changes led to a $257m reduction in the estimated liability.
  - The numbers of claimants in receipt of medical benefits had also fallen leading to a reduction in the liability estimate of $110m.
  - Average work injury damages settlement amounts reduced relative to expectations. This led to an $80m reduction in the liability estimate.
  - Across rehabilitation, investigation and other benefits the numbers of payments and the average amounts had both reduced. PwC reflected this through a $120m reduction in the liability estimate.
- The impact of the new incurred claims arising from the six month period to 30 June 2015 was broadly similar to the actual payments over the past six months.

Uncertainties

Any estimate of insurance liabilities will contain elements of uncertainty. In the case of the NI these uncertainties are compounded by past benefit reforms, including but not limited to, the 2012 reforms. The key uncertainties identified in the PwC valuation were:

- The limited data available on whole person impairment and the reliance of post 2012 benefits on this information has led to approximations of the whole person impairment distribution being used. This adds to the uncertainty in the valuation estimates.
- The 2012 reforms changed the way claims develop. Benefit utilisation and continuance could both be impacted and the post reform patterns may not be clear for a number of years. Estimates of the impact the 2012 reforms would have are being refined as experience emerges but the later development years are more uncertain as a result of the reforms.
- Aspects of the 2012 reforms were still being tested through the review process. As decisions were made, and in some cases overturned, certainty increased but the changes further destabilised the emerging post reform experience. Potential future decisions could alter the experience again increasing the uncertainty.
- Work injury damages were being accessed more frequently leading up to 2012. The nature of this benefit type is such that it is subject to significant volatility and may escalate rapidly. The cost impact of changes to work injury damages experience can be significant and as such this is viewed as a key risk area for the NI.
- The funding position of the NI may lead to benefit design changes or premium rate reductions. It may be a number of years until the full impact of such changes is known increasing the uncertainty in the future estimates.
- Increased disputes around the level of whole person impairment being assessed may lead to greater access to higher or ongoing benefits. Until this settles down the estimates may move around more than usual.
- The 2015 Scheme Agent Deed extended contracts to five of the then seven Scheme Agents. The impact of claims transition and the potential for service level changes from the discontinuing Agents may distort the experience making the valuation more uncertain.

The above list is not exhaustive but does illustrate the uncertainty in the NI portfolio and the liability assessment process. Maintaining a sound solvency position is essential to ensuring the ongoing ability of the NI to deliver on its commitments to the workers and employers of NSW.

Peer review recommendations

At icare's request the PwC valuation has been peer reviewed by Taylor Fry Consulting Actuaries (Taylor Fry). To the extent that the scope permitted, the Taylor Fry review was prepared in accordance with the Actuaries Institute Professional Standard 315 'External Peer Review of General Insurance Liability Valuations'.

Taylor Fry concluded that, having reviewed the methodologies and assumptions underlying the PwC valuation and when considered as a whole (subject to the limitations in the scope of their review), the valuation results were reasonable. There were two recommendations made as part of the Taylor Fry review, namely:

- Given the importance of the Whole Person Impairment data as it pertains to the benefits and hence the valuation, collecting and validating this data should be a particular focus.
- Progress towards the five year cap on weekly compensation benefits should be monitored to better understand the potential impact and plan for it.

There were also three suggestions around allowances for seasonality, applying a more statistical approach in the assumption setting and the consistency between the case estimates and the valuation results for catastrophic medical claims.

The recommendations were discussed with icare and PwC and action has been taken in both cases.

TAB B

Nominal Insurer Liability Valuation as at 31 December 2015

Background

Insurance & Care NSW (icare) commissioned PricewaterhouseCoopers Actuarial (PwC) to estimate the insurance liabilities of the NSW Workers Compensation Nominal Insurer (NI) as at 31 December 2015. This document summarises the results of PwC's independent assessment of the NI insurance liabilities.

The PwC valuation has been prepared with the intention of complying with the Actuaries Institute Professional Standard 300 'Valuations of General Insurance Claims' and producing results that comply with Australian Accounting Standard AASB 1023 'General Insurance Claims'.

Results

As at 31 December 2015 PwC have estimated the discounted net outstanding claims liability of the NI to be $12,535m. This figure includes a 15.6% risk margin over and above the central estimate which has been adopted to provide an estimated 80% probability that the combined liability estimate will prove to be sufficient. The components of the outstanding claims liability as at 31 December 2015 are set out in the following table.

Table 1: Outstanding claims liability

Items	Undiscounted Liability Estimate ($m's)	Discounted Liability Estimate ($m's)
Weekly compensation	4,432	3,393
Medical benefits	5,126	2,958
Work injury damages	2,370	2,096
Section 66 and 67	613	519
Investigation costs	278	232
Legal costs	286	247
Rehabilitation benefits	288	255
Commutations	164	113
Other	180	150
Asbestos	209	107
Uninsured employers	161	101
Gross outstanding claims liability	**14,107**	**10,171**
Excess recoveries	2	2
Tax recoveries	93	81
Other recoveries	237	217
Uninsured employer recoveries	12	9
Net outstanding claims liability (excl. CHE)	**13,763**	**9,862**
Claims handling expenses (CHE)	1,340	981
Net outstanding claims liability (incl. CHE)	**15,103**	**10,843**
Risk margin (15.6%)	2,356	1,692
Total outstanding claims liability	**17,459**	**12,535**

The risk margin was reduced between 30 June 2015 and 31 December 2015. The change from 16.2% to 15.6% reflects the reduced uncertainty from the 2012 reforms given that more post reform experience is available to fit the valuation assumptions to. The reduction has been partially offset by the increased uncertainty arising from the 2015 reforms.

The above liability estimates include an allowance for the anticipated impact of the 2015 benefit reforms. The details of this anticipated impact are set out in the following section of this document.

The discount rates used by PwC in the assessment of the outstanding claims liability were taken from the yields on Commonwealth Government Bonds as at 31 December 2015 for the first 15 projection years. Beyond the 15 year point a fixed discount rate was adopted. Future inflation rates were based on a number of economic forecasts. After the first 10 projection years a fixed gap between the discount and inflation rates was adopted. Blending to the fixed gap occurred between years five and 10 of the projection.

The mean term of the outstanding claims liability was estimated to be 12.8 years on an inflated and undiscounted basis and 8.1 years on an inflated and discounted basis. The increase relative to June 2015 was the result of benefit terms being extended through the 2015 reforms.

PwC estimated the premium liability of the NI to be $1,330m as at 31 December 2015. This figure includes a risk margin of 17.3% on the unexpired risk component, again with the intention of providing an estimated 80% probability that the unexpired risk liability estimate will prove to be sufficient. The components of the premium liability as at 31 December 2015 are set out in the following table.

Table 2: Premium liability

Items	Liability Estimate ($m's)
Unearned premium reserve	862
Unearned premium related to future adjustments	206
Total unearned premium reserve	**1,068**
Unexpired risk reserve	1,134
Risk margin (17.3%)	196
Total unexpired risk reserve	**1,330**
Required premium deficiency reserve	262
Premium liability	**1,330**

No risk margin is included in the pricing basis for the NI which will, in general, lead to a premium deficiency when comparing the unearned premium to the expected future claim costs including a risk margin. The 2015 reforms were not factored into the 2015/16 pricing and as such will have contributed to the deficiency. Premium under-collection can also impact the premium liabilities.

The premium liability at 31 December is larger than the comparable figure at 30 June as a direct result of the non-uniform pattern in which premium is written over the year.

The following table shows the estimated financial position of the NI as at 31 December 2015.

Table 3: Financial position

Items	$m's
Investments	15,217
Outstanding claims recoveries	357
Other assets	1,762
Total assets	**17,336**
Gross outstanding claims liability (incl. CHE)	12,892
Unearned premium reserve	862
Unexpired risk reserve	262
Other liabilities	347
Additional agent remuneration payable	68
Total liabilities	**14,431**
Target funding ratio	110%
Net assets in excess of the target funding ratio	1,462
Funding ratio	**120%**

The above funding ratio includes an allowance for the 2015 benefit reforms and the anticipated premium discounts provided as part of the 2015 reform package.

Impact of the 2015 reforms

On 13 August 2015 the NSW Government legislated benefit reforms with the intention of unwinding a portion of the 2012 reforms and returning $800m in benefits to injured workers. In addition to the benefit reforms $200m was returned to employers through performance related premium discounts.

The key impacts from the 2015 benefit reforms on the pre 30 June 2015 outstanding claims liability were:

- Weekly compensation – the removal of the 15 hours of work per week requirement for workers with highest needs who have exceeded 130 weeks on benefits has been estimated to add $120m to the liability estimate.
- Medical benefits – the reforms included extensions of the one year cap on medical entitlements post the cessation of weekly compensation entitlements to two years and five years for claimants with whole person impairment levels of 0-10% and 11-20% respectively. In addition, the provision of medical aids has been extended for life as have benefits for workers with highest needs. These changes have been estimated to add $664m to the liability of the NI.
- Rehabilitation benefits –the introduction of new grants for return to work and retraining was estimated to add $33m to the pre 30 June 2015 outstanding claims liability.

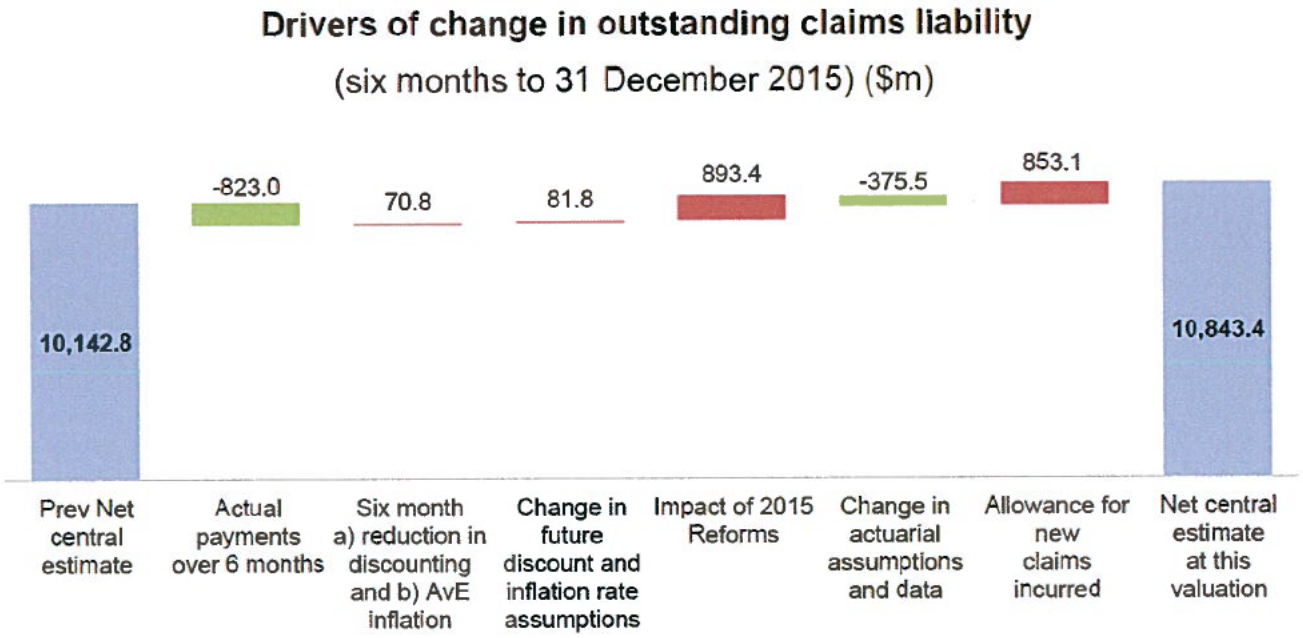
Other changes such as the increases in funeral grants and death benefits have also added to the liability. These entitlements are paid relatively quickly so the impact on the outstanding claims liability was not as significant.

It is worth noting that legal support for injured workers going through the work capacity process was also introduced as part of the 2015 reforms. The regulations around this change were not in place at the time the December 2015 valuation was finalised. As such no allowance for this change has been included in the estimates. Reintroducing lawyers into the system has the potential to lead to significant behavioural changes with material liability impacts. Once the regulation is available the estimated impact of this change will be included in the liability estimates.

Movement in results

The following figure shows the movement in the discounted net central estimate (i.e. excluding the risk margin) of the outstanding claims liability between June 2015 and December 2015 split by the key components of the change. Relative to expectations at 30 June 2015 the liability estimate has increased by approximately $749m, or 6.4%, including the risk margin.

Figure 1: Change in the outstanding claims liability



The key drivers of the change were:

- A reduction in the yields on Commonwealth Government Bonds has been partially offset by a reduction in the expected future CPI inflation rate have contributed to an increase in the liability estimate. The combined impact was an increase in the liability estimate for pre 30 June 2015 claims of $82m.
- Experience within the portfolio was favourable leading to changes in the assumptions underlying the valuation. This led to a reduction in the liability estimate for pre 30 June 2015 claims of $376m. The primary drivers of this reduction were;
  - A reduction in the number of claimants remaining on weekly compensation benefits was partially offset by an increase in the average weekly compensation cost. Overall the weekly compensation experience and modelling changes led to a $153m reduction in the estimated liability.
  - The numbers of claimants in receipt of medical benefits had also fallen. Combined with favourable catastrophic medical claim experience this has led to a reduction in the liability estimate of $195m. This was partially offset by higher average costs for the lower severity medical claims leading to an increase in the liability estimate of $73m.
  - Work injury damages intimation numbers increased relative to expectations. This led to a $39m increase in the liability estimate.
  - Lower investigation costs at longer durations and a precedent setting decision in the section 67 benefits led to an $82m reduction in the liability estimate.
  - Other modelling and assumption changes reduced the liability estimate by a further $27m.
- The 2015 reforms added $893m to the pre 30 June 2015 liability. These changes were described in the previous section of this document.
- The impact of the new incurred claims arising from the six month period to 31 December 2015 was broadly similar to the actual payments over the past six months.

Uncertainties

Any estimate of insurance liabilities will contain elements of uncertainty. In the case of the NI these uncertainties are compounded by past benefit reforms, including but not limited to, the 2012 and 2015 reforms. The key uncertainties identified in the PwC valuation were:

- The impact of the Worker Assistance Program and the application of the Section 39a benefit caps are still uncertain. As injured workers are assessed a better picture of the whole person impairment distribution and the likely outcome of the capping will emerge.
- The limited data available on whole person impairment and the reliance of post 2012 benefits on this information has led to approximations of the whole person impairment distribution being used. This adds to the uncertainty in the valuation estimates.
- The 2012 and 2015 reforms have changed the way claims develop. Benefit utilisation and continuance could both be impacted and the post reform patterns may not be clear for a number of years. Estimates of the impact the 2012 and 2015 reforms would have will be refined as experience emerges but the later development years are more uncertain as a result of the reforms.
- The impact of the legal changes in the 2015 reforms will not be clear for some time.
- Aspects of the 2012 reforms were still being tested. The indexation of transitional weekly compensation benefits and decisions impacting section 66 and 67 benefits have provided some clarification around the application of aspects of the reforms. As decisions were made, and in some cases overturned, certainty increased but the changes further destabilised the emerging post reform experience. Potential future decisions could alter the experience again increasing the uncertainty.
- Work injury damages were being accessed more frequently leading up to 2012. The nature of this benefit type is such that it is subject to significant volatility and may escalate rapidly. The cost impact of changes to work injury damages experience can be significant and as such this is viewed as a key risk area for the NI.
- The funding position of the NI may lead to benefit design changes or premium rate reductions. It may be a number of years until the full impact of such changes is known increasing the uncertainty in the future estimates.
- Increased disputes around the level of whole person impairment being assessed may lead to greater access to higher or ongoing benefits. Until this settles down the estimates may move around more than usual.
- The 2015 Scheme Agent Deed extended contracts to five of the then seven Scheme Agents. The impact of claims transition and the potential for service level changes from the discontinuing Agents may distort the experience making the valuation more uncertain.

The above list is not exhaustive but does illustrate the uncertainty in the NI portfolio and the liability assessment process. Maintaining a sound solvency position is essential to ensuring the ongoing ability of the NI to deliver on its commitments to the workers and employers of NSW.

Peer review recommendations

At icare's request the PwC valuation has been peer reviewed by Taylor Fry Consulting Actuaries (Taylor Fry). To the extent that the scope permitted, the Taylor Fry review was prepared in accordance with the Actuaries Institute Professional Standard 315 'External Peer Review of General Insurance Liability Valuations'.

Taylor Fry concluded that, having reviewed the methodologies and assumptions underlying the PwC valuation and when considered as a whole (subject to the limitations in the scope of their review), the valuation results were reasonable. There were four recommendations made as part of the Taylor Fry review, namely:

- The reassessment of whole person impairment as part of the Worker Assistance Program may give rise to an increased impairment distribution. This risk should be quantified as soon as possible.
- Given the importance of the whole person impairment data as it pertains to the benefits and hence the valuation, collecting and validating this data should be a particular focus.
- Progress towards the five year cap on weekly compensation benefits should be monitored to better understand the potential impact and plan for it. This should be considered in light of the Worker Assistance Program.
- The analysis of claims handling expenses should be refreshed and, if possible, refined.

There were also three suggestions around allowances for seasonality, applying a more statistical approach in the assumption setting, the consistency between the case estimates and the valuation results for catastrophic medical claims (and the criteria for the inclusion of these claims in the catastrophic classification) and modifying the approach used to estimate the ultimate number of work injury damage claims based on intimation numbers.

The recommendations were discussed with icare and PwC and, where possible, action has been taken.

TAB C

ICARE WORKERS CARE PROGRAM

The icare Workers Care Program has been established to improve the way treatment and care services are delivered to workers with severe injuries.

Workers in the Workers Care Program receive their treatment and care under New South Wales workers compensation legislation through icare Workers Care instead of one of the five Scheme agents contracted by the Nominal Insurer. The Scheme agent continues to manage weekly payments and other types of compensation.

The Workers Care Program is based on the Lifetime Care model that puts people with severe injuries at the centre of planning and decision making as soon as possible after injury, using specialised service providers.

How many people were in the pilot?

There are 54 workers currently in the icare Workers Care program. This includes workers who have been severely injured since 31 October 2015.

What are the projected number of participants?

Workers are currently transferring to the program in a staged approach from now until June 2017. This is to ensure the transition is a seamless and positive experience for workers. It is expected there will be 150 severely injured workers in the program by the end of 2016 and a further 150 workers by June 2017.

It is also expected that up to 700 additional workers with higher level care needs that do not meet specific severe injury criteria may transfer in to the program over time. The experience from the early stages of the program will assist icare to refine the approach for these workers.

What is the threshold – WPI or functional – for participation?

The threshold is not based on whole person impairment threshold. The initial cohort is workers who meet functional and severe injury criteria, which are aligned with the criteria for participation in the Lifetime Care and Support Scheme.

Severe injury includes moderate to severe brain injury, spinal cord injury, specific amputations, full thickness burns, and permanent blindness.

THE LAW SOCIETY
OF NEW SOUTH WALES

Our ref: InjComp:JDlw1066171

2 December 2015

Ms Caroline Walsh
Executive Director
Workers Compensation Regulation
State Insurance Regulatory Authority
Locked Bag 2906
Lisarow NSW 2252

By email: 2015benefitsreform@sira.nsw.gov.au

Dear Ms Walsh,

Regulation of legal costs for work capacity decision reviews

I write to you on behalf of the Injury Compensation Committee ("Committee") of the Law Society of New South Wales in response to the Discussion Paper on the regulation of legal costs for work capacity decision reviews. The Committee's members represent key stakeholders in the NSW workers compensation scheme ("the scheme") including worker, insurer and self-insured representatives. Members include specialist advisers with over 20 years' experience in the various successive schemes in NSW.

Some members were representatives on the now disbanded WorkCover Legal Regulatory and Process Working Group, which did significant work relating to scheme legal costs over the years. I note that members of the Committee together with representatives of the NSW Bar Association and the Australian Lawyers Alliance have also met with the State Insurance Regulatory Authority ("SIRA") representatives to discuss the issues.

The Government's 2015 workers compensation reforms include new provisions that allow for the payment of legal costs in connection with prescribed classes of work capacity decisions ("WCDs") and SIRA is undertaking consultation to inform the drafting of the proposed new regulation.

The proposed section 44BF of the *Workers Compensation Amendment Act 2015* states:

> **44BF Legal Costs**
>
> (1) A legal practitioner is not entitled to be paid or recover any amount for a legal service provided to a worker or an insurer in connection with a review if:
>
> (a) the review is of a prescribed class, or
>
> (b) the regulations do not fix any maximum costs for providing the legal service to the worker or insurer in connection with the review.

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(2) Despite section 341 of the 1998 Act, the regulations may provide that, in prescribed circumstances, a party to a review under this Subdivision (other than an internal review) is to bear the other party's costs in connection with the review.

Background and context

The 2012 changes to workers compensation legislation were far reaching, significantly amending the entitlements that an injured worker had to statutory benefits and in the case of weekly payments how such compensation was determined. The extent of a worker's entitlements to weekly payments is now determined by means of a WCD by an insurer (section 43 of the *Workers Compensation Act 1987* ("1987 Act")).

The 2012 reforms, significantly, introduced a distinction between a 'liability' dispute and a dispute about a 'Work Capacity Decision'.

The amendments provided that the Workers Compensation Commission ("Commission") does not have jurisdiction to determine any dispute about a WCD. Importantly, the Commission is also prohibited from making a decision in relation to a dispute before it that is inconsistent with a WCD of an insurer.

The 2012 legislation also introduced a new process to resolve a dispute about a WCD. The process is prescribed in section 44 of the 1987 Act and involves an internal review by the insurer, a merit review by the Authority and a procedural review by the Workers Compensation Independent Review Officer ("WIRO").

The review processes are supported by Guidelines issued under section 44(1)(a) and section 44A(5) of the 1987 Act and section 376 of the *Workplace Injury Management & Workers Compensation Act* 1998 ("the 1998 Act"). The current Guidelines are the Guidelines for Work Capacity Decision Internal Reviews by Insurers and Merit Reviews by the Authority dated 4 October 2013 and the Work Capacity Guidelines dated 4 October 2013 ("Guidelines").

Section 44(6) of the 1987 Act prohibits a legal practitioner for a *worker* from receiving payment for the provision of advice or assistance with respect to WCD reviews. Clause 9 of Schedule 8 of the *Workers Compensation Regulation 2010* prevents a legal practitioner for an insurer from being paid in connection with an internal or other review in relation to a WCD.

It is these prohibitions that the proposed section 44BF will affect.

Complexity of the current processes

The Guidelines set out both mandatory and suggested procedures *for insurers* in relation to the:

- processes leading to the making of a WCD (including the process of conducting a work capacity assessment (this will be discussed below)
- method of notice and communication of the intention to make a WCD and the processes
- making of a work capacity decision including the form and content of a WCD
- procedures for conduct of an internal review
- procedures for responding to an application for merit review
- procedures for responding to an application for procedural review.

The Guidelines also set out the procedures for *workers* to seek internal review, merit review and procedural review and the effect of a decision made at each stage of the review process.

The processes imposed by the Guidelines are lengthy, complex and unclear.

The complexity of the WCD process, and in turn the various review processes, is, of course, relevant to the issue of what is fair and reasonable remuneration for the provision of necessary legal services.

The Committee believes that addressing this problem in isolation and in advance of a complete overhaul of the dispute resolution system is a piecemeal solution which will only increase the scheme's dysfunction. The inherent unfairness to injured workers of the current WCD system will also remain. In the meantime, allowing payment for legal representation in relation to WCD reviews is a positive step.

Legal Costs

The 2012 legislative reforms also effected major changes to the system for payment of legal costs. The statutory provisions for costs are found in Part 8 Divisions 1 - 4 of the 1998 Act and in Part 17 of the *Workers Compensation Regulation 2010.*

Prior to an amendment in 2012, costs followed the event, meaning that a successful worker's costs were paid by the insurer following an award of costs by the Commission. An unsuccessful worker was not required to pay the insurer's costs. Then, as now, costs were modest and regulated and lawyers were prohibited from charging solicitor-client costs.

Prior to June 2012, section 341 provided:

> **341 Costs to be determined by Commission**
>
> (1) Costs to which this Division applies are in the discretion of the Commission
>
> (2) The Commission has full power to determine by whom, to whom and to what extent costs are to be paid
>
> (3) The Commission may order costs to be assessed on the basis set out in Division 1 of Part 3.2 of the *Legal Profession Act 2004* (or in relevant regulations under Division 4 of this Part) or on an indemnity basis
>
> (4) The Commission may not order the payment of costs by a claimant unless the Commission is satisfied that the claim was frivolous or vexatious, fraudulent or made without proper justification
>
> (5) If the Commission is satisfied that a part only of a claim was frivolous or vexatious, fraudulent or made without proper justification, the Commission may order the claimant to pay the costs relating to that part of the claim
>
> (6) Any party to a claim may apply to the Commission for an award of costs.

It was initially proposed in the *Workers Compensation Legislation Amendment Bill 2012* that section 341 be amended as follows:

> **Omit** section 341 (4) and (5). Insert instead:
>
> (4) Subject to this Division, if the Commission makes any order as to costs, the Commission is to order that the costs follow the event unless it appears to

> the Commission that some other order should be made as to the whole or any part of the costs, or as the regulations otherwise provide.

Following parliamentary debate on the Bill in 2012, section 341 of the 1998 Act was amended and now provides that *each party bear its own costs as follows:*

> **341 Costs**
>
> (1) Each party is to bear the party's own costs in or in relation to a claim for compensation.
>
> (2) The Commission has no power to order the payment of costs to which this Division applies, or to determine by whom, to whom or to what extent costs to which this Division applies are to be paid.

In addition, sections 342, 343 and 345 of the 1998 Act were repealed. These were important provisions which supported section 341 in its pre-2012 version, specifically:

- Section 342 gave power to the Commission to order costs to be paid if they were 'unreasonably incurred';
- Section 343 prevented recovery of costs unless those costs were awarded by the Commission and prevented legal costs from being deducted from a worker's compensation payment;
- Section 345 provided costs penalties where appeals were unsuccessful.

In order to address the unfairness created by the 2012 amendment, by which injured workers were required to fund their own legal costs regardless of the outcome, the Government invested in the WIRO the authority to administer the payment of a worker's legal costs through an administrative legal assistance scheme. The Independent Legal Assistance and Review Service ("ILARS") of the WIRO was established to pay a worker's legal and associated costs in the making or disputing of a claim.

Maximum legal costs

Section 337 of the 1998 Act provides that the regulations may make provision for the fixing of maximum costs for *legal services* or *agent services* and for services which are not legal services or agent services but which relate to a claim for compensation including medical report fees, expert reports, witnesses' expenses and the like. This includes the power to make regulations to provide that no amount is recoverable for a particular service, with the result that a legal practitioner (or agent) will not be entitled to be paid or recover any amount for the service or matter concerned.

Section 337(3) provides:

> A legal practitioner is not entitled to be paid or recover for a legal service or other matter an amount that exceeds any maximum costs fixed for the service or matter by the regulations under this section.

Relevantly, despite the repeal of section 343, section 337(5) provides:

> This section does not entitle a legal practitioner to recover costs for a legal service or matter that a court or costs assessor determines were unreasonably incurred.

Prior to 2012, Schedule 6 of the *Workers Compensation Regulation* 2010 dealt with maximum costs for workers' and insurers' lawyers in compensation matters.

This Schedule remains applicable to claims from workers not affected by the 2012 amendments namely, police, firefighters, paramedics and coal miners.

For other claims, the Commission's power to award costs has been removed by the repeal of section 341. The Commission has confirmed that following the 2012 amendments it does not consider that it has any jurisdiction as to costs.

Schedule 6 underwent scrutiny by the Law Society and WorkCover in 2010 with considerable work completed to make relevant amendments to the Schedule (Parts A and B) to address anomalies identified by the legal profession and to bring the events in line with the Commission's practice and procedure. The amended schedule was approved by WorkCover and the Law Society in 2010 but never gazetted. These anomalies remain and new problems have arisen with the Schedule as a result of changes to the scheme and increased complexities post 2012.

Schedule 6 remains as the basis for the payment of legal costs to the insurers' legal practitioners post 2012 and by the ILARS scheme.

The Committee submits that the cost figures in the Schedule require amendment to reflect the work actually done by lawyers who have historically subsidised the scheme by performing work which is unremunerated and by working at an unsustainable rate. The Schedule was designed to encourage the early settlement of disputes with 'front end loading'. This is difficult to achieve due to the complexities of the 2012 amendments.

Regulatory controls and prescribed classes of review

Focus Question 1: Should the regulation provide for payment of legal costs in connection with all work capacity decision review types – ie Internal Reviews, Merit Reviews and Procedural Reviews?

The Committee considers that injured workers and insurers should have access to paid legal advice and assistance with respect to all three reviews, if required.

The Committee notes that the Law Council of Australia's Policy Statement with respect to Rule of Law Principles dated March 2011 provides that everyone should have access to a competent and independent lawyer of their choice in order to establish and defend their rights.

The Committee considers that the first internal review is most important and will be where the majority of legal assistance will be required. Such an approach is consistent with the stated objective of supporting workers to achieve early and sustainable return to work.

In fact, a considerable amount of work is required prior to applying for an internal review principally because the WCD guidelines require that a worker be given notice of the intention to make a WCD and be invited to provide further information that may influence the work capacity decision to be made. This may be the first opportunity that a worker has to engage in the decision-making process and it would be appropriate that a worker be able to access legal advice in relation to engaging in that process at that point in time. The guidelines require an insurer to contact the worker at least 2 weeks prior to the making of a work capacity decision and inform the worker:

- that a review of their current work capacity is being undertaken and that a decision is going to be made
- that the review of work capacity may include further discussions with others such as the employer, nominated treating doctor or other treatment providers
- the potential outcome of the review of work capacity detailing the information that has led the insurer to their current position
- that they have an opportunity to supply any further information to the insurer for further consideration
- when the work capacity decision is expected to be made.

Then this must be confirmed in writing in the form of a letter commonly called a "Notice of Intention to Make a Work Capacity Decision."

If the worker is able to obtain legal advice and legal assistance at this point, the worker may be encouraged to forward further information to the insurer to influence the decision. Such actions would be in keeping with the aim of the proposed regulation of encouraging and supporting early agreement on work capacity and promoting sound judgment and effective primary decision-making.

However, the Committee considers that before a legal costs regulation is framed, the processes should be rationalised. The merit review and procedural review should be one process. The internal review, although an opportunity for the insurer to make the 'decision that is more than likely to be right', essentially requires a doubling of effort to make a WCD. That process could be removed.

This rationalised process should be removed from a separate review body and placed with the Commission.

Focus Question 2: Should the regulation provide for payment of legal costs only where the review results in a recommendation to change the work capacity review decision?

There are essentially only 2 options available in relation to payment of costs:

1. Costs follow the event
2. Costs paid regardless of outcome.

There is potential for a hybrid of these options. However any hybrid costs regulation would be unlikely to fulfill the design criteria of the regulation (referred to on page 4 of the Discussion Paper).

1. Costs follow the event

The Committee does not support this option under the current WCD regime. As a result of the design of the review processes and the underpinning legislation, in particular the definition of "suitable employment" in section 32A of the 1987 Act, a worker has quite poor prospects of success at any of the reviews. Anecdotally, the Committee understands the prospects of success at the internal review stage are less than 35%, less than 40% on merit reviews and approximately 15% at procedural review. Generally, a legal practitioner will engage in a matter if there are "reasonable prospects" of success, a test which is not satisfied in the WCD arena. Few legal practitioners would be prepared to undertake work

in this area on a costs follow the event basis when the chances of success are so low. The ability of legal practitioners to provide high quality work or advice would be limited if engaged on this basis, which may defeat the purpose of these changes.

For reasons stated in the previous paragraph, the Committee submits that a success-based costs system is unworkable within the current dispute resolution system. If costs are to follow the event, "success" must be defined in such a way that it does not merely include the achieving of a stay of the original WCD. Success must be defined broadly to include recommendations on merit review and recommendations on procedural review that result in **a new WCD**, not necessarily a WCD where a change of quantum is provided.

This is because the Guidelines provide that the aim of the WCD process is to ensure sound, evidence based decision making and the making of decisions that are more likely than not to be correct. Where an insurer has failed to follow procedure or is criticised on the merits of their decision, and where the outcome is a recommendation that they re-issue a WCD to address the criticism, that should be sufficient to attract costs.

2. Costs paid regardless of outcome

The Committee notes that all three 'stages' of the review process can be initiated by workers only.

Assuming that the processes will remain the same and that there will be no substantial change to the Guidelines, the dispute resolution system or section 341, and assuming the ILARS scheme continues to fund worker's liability disputes, then the Committee submits that costs should be paid regardless of outcome. The Committee queries why a lawyer should be paid regardless of success in a liability dispute but not in a WCD dispute.

This focus question is extremely difficult to answer definitively without proper consideration of the following:

- Substantial change to the review processes including rationalisation of the current reviews into one review
- Rationalisation of the dispute resolution systems into one (with a preference for the Commission to manage WCD reviews)
- reinstatement of sections 341,342 and 343 of the 1998 Act if various reforms of the dispute resolution systems and other problems were addressed.

Focus Question 3: Should a new class of review be prescribed to regulate legal costs, such as reviews where legal services are provided by approved providers, or reviews where the worker first engaged an approved advocacy service?

The Committee considers that the scheme should only be meeting the costs of assistance and advice to workers or insurers provided by "Australian legal practitioners" as defined in the Legal Profession Uniform Law. The complexity of workers compensation law in New South Wales is now such that only fully legally qualified professionals should be able to advise vulnerable individuals. The Committee notes that insurance cover is mandatory and guaranteed in the case of legal professionals.

It is unsatisfactory for legal services in respect of reviews only to be performed by a panel of approved providers. Not only does this unnecessarily limit the ability of workers to engage a lawyer of their choice but it can also lead to difficulties being experienced by

workers seeking access to lawyers in rural and regional areas where there may not be any approved providers. If a worker wishes to know whether a lawyer has significant experience in the workers compensation field, then the Specialist Accreditation Scheme run by the Law Society is an excellent starting point.

Maximum legal costs

Focus Question 4: What is a fair and reasonable maximum cost for provision of legal services in connection with a work capacity decision review, and what criteria should be used to determine a fair and reasonable maximum cost?

The Committee considers it appropriate that the work capacity review work is regulated by way of fixed maximum costs. Workers compensation legal work has been subject to a fixed costs regime for many years and is appropriately accommodated by Schedule 6, which was an event based methodology. The Committee considers that the criteria should be fair and reasonable remuneration at an appropriate commercial rate for the work done.

The Committee has prepared a Schedule itemising some of the work required for the review processes of a WCD based on the current processes and the Guidelines. The document has been prepared with the assistance of a lawyer employed by a union whose main role since 2013 has been to conduct reviews for the union's members. The experience of that union lawyer has been that it is important that the worker engage with a lawyer early in the process and before the WCD is received. Further, the experience is that both procedural and merit issues must be identified and developed at the initial internal review stage and that this is where most work is required.

The Schedule divides work capacity decisions into two categories involving either:

1. PIAWE decision (pre injury average weekly earning)
2. Capacity, suitable employment or weekly payments.

Category 1 matters are likely to take 10 to 15 hours' work.
Applying an hourly rate of $375[1] produces a range of $3,750-$5,625.

Category 2 matters are likely to take no less than 15 - 20 hours' work
Applying an hourly rate of $375 produces a range of $5,625-$7,500.

Less work will be required at the merit review stage because much of the documentation will have already been assessed at the internal review stage. However, where the merit review process calls for further material, evidence or responses to either parties "submissions" the work, and the consequent cost, will increase exponentially.

More work will be required where there are multiple work capacity decisions affecting the entitlement of a single worker or where there are multiple insurers. These complex matters should be considered for a higher maximum fee or a 'complexity' uplift.

From a worker's perspective, all three review processes would require legal assistance. A worker cannot be expected to navigate the processes unassisted nor understand the complexities of what is a review of the merits or procedure of a decision, particularly when the Guidelines are complex.

[1] Surveys of legal firms conducted by consultants FMRC have found that $386 is the average quoted employed solicitor hourly rate for firms with more than 50% of work in compensation.

Legal costs of other party

Focus Question 5: Should the regulation use a single fixed maximum cost that will generally apply across all eligible reviews, or should the regulation use a more complex maximum cost structure to more directly influence behaviour (such as sound primary decision making) and achieve positive regulatory outcomes (such as early and sustainable return to work)?

As outlined above, the Committee considers that the maximum cost for a merit review will be substantially less than that for an internal review, with the bulk of work conducted at the internal review stage. The Committee considers that a more complex costs structure is warranted as it is for the legal work conducted in the Commission and set out in Schedule 6 of the *Workers Compensation Regulation* 2010. In order to achieve 'sound primary decision making' and to 'achieve positive regulatory outcomes' the costs should be front weighted. However, to achieve these outcomes the Committee considers the system of reviews, including the Guidelines, needs considered rationalisation and change. As discussed and noted in various submission, the Law Society would welcome the opportunity to discuss with SIRA reform of the dispute resolution systems.

Legal costs of the other party

Focus Question 6: In what circumstances should one party be required to bear the other party's legal costs?

As stated, the 2012 amendments effected a fundamental change to the way legal costs are paid under the scheme. Each party now pays their own costs, with the worker's legal costs funded by ILARS.

The Committee submits that except in cases that are fraudulent or vexatious, a worker should never be exposed to payment of insurers' legal costs. This has always been the position with respect to workers compensation in New South Wales.

The issue is then whether the worker's legal costs for those reviews are funded in the same way as legal costs with respect to other disputes or funded directly by the insurer responsible for the decision or funded from the scheme.

The Committee submits that the pre 2012 regime, whereby costs followed the event, worked well. However, the difficulty now in making such a recommendation is that the existing scheme is far more complex. In addition, the prospects of success in a WCD review are far lower than the prospects of succeeding on a 'liability' dispute. A legal practitioner's ability to accurately predict the outcome of a review is therefore made much more difficult.

This is partly due to the design of the review processes, and partly due to the legislation, particularly part(b) of the definition of *'suitable employment'* in section 32A of the 1987 Act and the insurer's discretionary assessment provision in sections 38(2) and 38(3) of the 1987 Act, with both provisions weighted heavily against a worker.

There are also issues about workers being disadvantaged due to an inability to fund independent expert reports, for example by vocational and functional assessors.

Of course there is also some difficulty advising with respect to an area of work where legal practitioners to date have little or no experience and where merit review decisions have in the main remained unpublished.

Compliance Mechanisms

Focus Question 7: What measures might be included in the regulation to better promote and encourage compliance?

The Committee notes the comments made with respect to compliance mechanisms and the issue of whether a worker should be able to fund additional costs beyond any maximum amount.

The Committee submits that the issue of additional legal costs should not arise if the maximum fees are set fairly and reflect the work required to conduct this work at a satisfactory and competent standard. Section 116 of the 1998 Act prevents payment of solicitor-client costs (unless awarded by the Court).

With respect to the issue of costs unreasonably incurred, the Committee notes that section 115 of the 1998 Act provides that the Court (or Commission) is not to make an order for payment of costs that it finds were unreasonably incurred.

In terms of regulation the Committee points out that a new regime governing solicitors' costs in NSW, namely the Legal Profession Uniform Law, commenced on 1 July 2015. Section 172 provides that costs must be fair, reasonable and proportionate.

The Committee notes that it is open for a complaint about a solicitor's conduct to be referred to the Legal Services Commissioner. The Committee submits that if the Government considers that these safeguards against over-charging are sufficient in the context of unregulated legal costs, then no further regulation is required in a fully regulated scheme.

The Committee does not understand the reference to cost disclosure in an environment where the 1998 Act provides in Division 1 of Part 8 an appropriate framework for regulation of legal costs. In particular, section 337 (1) of the 1998 Act provides that the regulations may fix maximum lawyer and agent costs in connection with any workers compensation matter. Section 337(3) provides that a legal practitioner is not entitled to be paid or recover for a legal service or other matter, an amount that exceeds any maximum costs fixed for the service or matter by the regulations under this section. Section 337(6) provides that the regulations can provide that no amount is recoverable for a particular service or matter or class of services or matters, with the result that a legal practitioner is not entitled to be paid for that service. In an environment where it is proposed that there be fixed fees regardless of the circumstances under which they are paid, cost disclosure to the authority is an unnecessary administrative burden that can achieve no purpose.

Operational and administrative considerations

Focus Question 8: How should eligible legal costs be billed, paid and claimed?

If the costs are to be met through an administrative scheme such as ILARS, then the process for billing, claiming and payment should be administered through that scheme in the way the ILARS scheme is administered at present. The Committee would recommend a simple system where a pro forma tax invoice could be lodged online.

If costs were to follow the event in an overhauled streamlined system discussed later at Focus Question 11, and to be met by the insurer on success (section 341, pre June 2012) then it would make sense to have a reinstatement of the costs powers to the Commission, specifically sections 342 and 343. The billing processes, payment and costs claims process are already housed in the legislation.

Focus Question 9: What are the important operational and administrative matters that must be considered when designing this regulation?

Issues relevant to this question have been discussed elsewhere in this submission. The Committee cautions against setting up another administrative bureaucracy to deal with costs under the WCD dispute resolution regime. It is important to avoid further increasing the complexity of an already cumbersome and difficult scheme.

Innovation

Focus Question 10: Do you have any innovative ideas that might be incorporated into the legal costs regulation or otherwise enhance the regulation?

Focus Question 11: Are there any other matters relevant to the legal costs regulation that have not been addressed elsewhere in the SIRA discussion paper or your submission?

The Committee has consistently advocated for the repeal of Section 44 (6) of the 1987 Act to allow for the payment of legal costs with respect to reviews of WCDs. However, the Committee has also pointed out in various submissions that the 2012 amendments have created a range of unnecessarily complex disjointed and dysfunctional dispute resolution pathways. There appears to be consensus amongst scheme stakeholders that the current dispute resolution processes are in urgent need of simplification and rationalisation. Disputes about primary liability for the payment of statutory compensation are dealt with by an Arbitrator at first instance in the Commission and disputes about lump sum compensation are dealt with by an Approved Medical Specialist through the Commission. Disputes about weekly compensation are of course dealt with by the complicated multi stage review process under consideration in the Discussion Paper.

The Committee has recommended on a number of occasions that there should be one dispute resolution forum, and the existing Commission would seem to be the obvious choice. The Commission would need to review and revise the current processes to accommodate the single forum for resolution of all disputes and adapt a more simplified expedited pathway for "minor" or urgent disputes. The Commission already has processes with varying levels of formality including an expedited and small claims process and an Arbitrator pathway with conciliation processes incorporated for more complex matters and a medical assessment pathway for pure medical disputes. It has established rules, practice guidelines and procedures for the resolution of disputes between workers and employers/insurers concerning workers compensation.

The Committee also considers that the scheme would be significantly improved if a single form of Dispute Notice was introduced that was simple, concise and understandable.

In any new streamlined dispute resolution system, workers and insurers would be permitted to engage legal advice in respect of any worker's compensation issue. Workers' legal costs could be met through ILARS.

Alternatively, under a simplified and unified dispute resolution system jurisdiction for costs could be returned to the Commission and the pre-2012 costs system (old sections 341, 342, 343 and 345) reinstated. Under this system costs would follow the event in most cases. The worker would only in exceptional circumstances be exposed to payment of insurer costs. As stated, such a system would only be workable if there are amendments to the legislation underpinning WCDs, namely section 32A and section 38(3) of the 1987

Act. Workers' prospects of obtaining a beneficial outcome from each of the reviews need to be significantly enhanced to the level of reasonable prospects.

An updated, simplified and rationalised Schedule 6, setting minimum fees, would apply to all legal practitioners. Once again, if the dispute resolution system was overhauled the Schedule could be correspondingly altered to encourage early resolution of disputes.

The Committee reiterates that the whole scheme dispute resolution system urgently requires reform by way of rationalisation and simplification.

The Committee thanks you for the opportunity to comment. Should you require any additional information or have any questions please contact the policy lawyer for the Committee, Leonora Wilson by email at or by phone on .

Yours sincerely,

John Eades
President

ITEMISATION OF WORK TO CONDUCT AN INTERNAL REVIEW, MERIT REVIEW AND PROCEDURAL REVIEW

Legend

I = Insurer

W = Worker

L = Lawyer/Agent for Worker

WIRO = WorkCover Independent Review Officer

IR = Internal Review

NIRD = Notice of Internal Review Decision

MR = Merit Review

MRS = Merit Review Service

MRD = Merit Review Decision

WCD = Work Capacity Decision

PIAWE = Pre Injury Average Weekly Earnings

Preamble

The practice of a lawyer employed by a union to assist members through the WCD review process was initially to only fill in the IR form with little detail. The lawyer did not address procedural aspects or merits aspects and simply sent it off to get the review process started. This was because there were a number of WCD's being issued and the initial experience was that on internal review by the Insurer, the insurers always endorsed their original decision.

In the first 12 months of WCD reviews, merit reviews were not achieving favourable outcomes and when the review proceeded to WIRO, WIRO would overturn decisions for lack of procedural compliance. As the Authority addressed the issues identified by WIRO, it became more and more important that both procedural and merit issues were identified at internal review because the process became one of diminishing attention (front end loaded) rather than increasing work along the review path.

In any event, the intention of the review process was to achieve quick outcomes and the process began taking longer and longer. If the process was going to achieve results then it became clear that the most attention should be put into the internal review.

By the end of 2013 and early 2014 merit reviews were taking longer and longer and the worker was waiting a very long time until WIRO determined that there had been a procedural error. Insurers started to correct their notices and so more attention had to be paid to merits at the beginning of the process as well as procedural issues.

The lawyer decided to streamline her processes and developed over time a procedural checklist from reading WIRO decisions and examining the Guidelines, rather than going to the Guidelines and the regulation each time.

Please note that the lawyer who provided this information is in the employ of a large NSW Union and her role is to respond to members' requests to advise on WCDs. She does not routinely send letters of advice to the member whereas in private practice Letters of Advice would be required periodically and at various stages of the process.

Categories of Work Capacity Decisions

WCD's fall broadly into two categories:

1. those involving PIAWE
2. those involving capacity, suitable employment or weekly payments

The process for 'internal review' or 'initial review' is slightly different for the two basic categories. This is because PIAWE disputes are not contemplated in the work capacity Guidelines and arise at the commencement of the matter. The PIAWE will be notified in the letter advising of acceptance of the claim which doesn't follow the guidelines in relation to notification of a WCD. A dispute about PIAWE is considered to be a WCD because in order to make weekly payments the Insurer has to make a decision about capacity.

PROCEDURE FOR INTERNAL REVIEW			
CATEGORY 1 - PIAWE disputes - Preliminary work			
W	L	Worker calls and advises has received letter accepting claim or a claim notice which states that benefits will be paid at the rate of $X per week. W explains that the rate doesn't look right.	5 – 10 mins
L	W	Asks worker to provide letter.	5 mins
L	W	Confirm 'instructions in writing' Prepare costs agreement	15 mins .....
W	L	Sends letter in	
L		Reads letter. Letter can take various forms because WCD guidelines completely overlook the fact that any correspondence about PIAWE is a WCD. The letter can say: "acknowledge injury of [date]. Will pay weekly benefits at $X pw. Keep Med Certs up to date and other cursory information" or it can say" ... Your ordinary earnings are $X, overtime and shift allowance is $Y; your pre-injury average weekly earnings (PIAWE) for the last 52 weeks is $Z. You are entitled to 95% of PIAWE for 13 weeks = $A.	15 mins
Note		**Can conduct review in 2 ways:** **1. S 42; and** **2. s 44.** **Process is essentially the same. Do not do both at the same time because section 42 process results in back pay.** **However, if either process delivers no favourable outcomes would then move to Merit review.**	
PIAWE DISPUTE Section 42 Process			
W	L	Advises not agree with PIAWE calculation	10 mins
L	W	Take instructions from worker about not agreeing with PIAWE including requesting worker to provide all payslips etc	30 mins (more if NESB)

L		If PIAWE incorrect: • sit with worker and request payslips for the prior 52 weeks or group certificate or any other pay information • have worker sign authority to insurer to release PIAWE form	½ hr
L	I	request PIAWE form from Insurer with Authority	5 mins
I	L	Sends PIAWE calculation form	
L		Read 'Letter' (see above) Check calculations against workers advice and documents provided by worker	½ hour ½ - 1 hr
L		Prepare spreadsheet of weekly payments from payslips provided by worker split into ordinary earnings, overtime and shift allowances depending on industry Allowances must be calculated separately based on ordinary hours and overtime hours	½ - 2 hrs
L		Once spreadsheet correct, work out the average weekly earnings then the calculation for the 1st 52 weeks then the calculation for the first 13 weeks and check against the PIAWE form	2 - 3 hours
L		Identify the differences	½ hr
L	W	Advise differences and ambit of review. Obtain instructions to proceed	½ hr
L		Prepare letter to insurer/PIAWE Form section 42 review section and attached spreadsheet and payslips and send to Insurer as section 42 review with letter explaining the review sought. Request backpay based on calculations	1 - 2 hrs
L	I/WIRO	Send letter (as above) *[Note that s 42 review does not address procedural compliance issues.]*	5mins
I	L	Response within 28 days (s 42 review) including telephone call to lawyer explaining the Insurer's perceptions of the inaccuracies in the review. Response will adjust PIAWE or advise that it will remain the same.	15min – ½ hr

L	W	Advise worker of the section 42 review result Check the result against the lawyer's calculations Obtain instructions to accept or press for MERIT REVIEW	10 min – 30 min
L	I	If the decision favours the worker lawyer must chase up backpay	5 min (repeated)
L	W	Advise workers of outcome and ensure payment made.	15 min
Note		***Note** 1. that payments are made directly between Insurer and worker and usually there is no confirmation to the lawyer even if the lawyer sought the review that back payments have been made.* *Note 2: if s 44 course is taken on PIAWE WCD the same work is required but a procedural compliance check will be conducted and in addition the completion of the internal review form but with the letter, spreadsheet and additional documents attached. On a s 44 internal review no backpay is required to be paid.* *If an internal review (s 44 internal review) is conducted the procedural checklist will be monitored to see if there are any procedural compliance issues which will be addressed in the internal review form.* *Note 3: The s 42 review process does not require a procedural check or address procedural issues. If the matter progresses to Merit Review and does not resolve the procedural issues will be addressed at IRO review.*	
PIAWE DISPUTE Section 44 process			
W	L	Advises not agree with PIAWE calculation	
L	W	take instructions from worker about not agreeing with PIAWE including requesting worker to provide all payslips etc	
L		If PIAWE incorrect: • sit with worker and request payslips for the prior 52 weeks or group certificate or any other pay information • have worker sign authority to insurer to release PIAWE form	½ hr
L	I	request PIAWE form from Insurer with Authority	5 mins
I	L	Sends PIAWE calculation form	
L		Read 'Letter' (see above) Check calculations against worker's advice and documents provided by worker	½ hour

L		Prepare spreadsheet of weekly payments from payslips provided by worker split into ordinary earnings, overtime and shift allowances depending on industry allowances must be calculated separately based on ordinary hours and overtime hours	½ - 2 hrs
L		Once spreadsheet correct, work out the average weekly earnings then the calculation for the first 52 weeks then the calculation for the first 13 weeks and check against the PIAWE form	2 - 3 hours
L		Identify the differences	½ hr
L		Conduct procedural compliance review of PIAWE WCD	½ – 1 hr
L		Complete internal review form and annexures	½ hr
L	W	Advise differences and ambit of review. Obtain instructions to proceed. Get client to sign IR form. Explain process	½ hr
L	I	Send IR form and covering letter with annexures	
I	L	Response within 30 days including telephone call to lawyer explaining the Insurer's perceptions of the inaccuracies in the review. Response will adjust PIAWE or advise that it will remain the same. If increase of payment, insurer will not pay back pay.	15 min – ½ hr
L	W	Advise worker of the IR outcome Check the result against the lawyer's calculations Obtain instructions to accept or press for MERIT REVIEW	10 min – 30 min
Note		*Note 1: If s 44 course is taken on PIAWE WCD the same work is required and in addition the completion of the internal review form but with the letter, spreadsheet and additional documents attached. On a s 44 internal review no backpay is required to be paid.* *Note 2: If payment is to be increased then ostensibly 3 months notice of the increase must be provided (in a new WCD).* *Note 3: If an internal review is conducted the procedural checklist will be monitored to see if there are any procedural compliance issues which will be addressed in the internal review form* *Note 4: at 52 weeks PIAWE has to be recalculated because it is not to include OT and SA. This would constitute a new WCD and would be subject to review under s 42 and s 44.*	

PROCEDURE FOR INTERNAL REVIEW			
CATEGORY 2 - CAPACITY, SUITABLE EMPLOYMENT, WEEKLY PAYMENTS REDUCTION OR TERMINATION FOLLOWING WCA			
Action by	**To**	**Description of work done**	**Time taken**
I	W	Telephone call advising they are going to cut off or reduce wages	
W	L	Telephone call advising has received a telephone call that Insurer is going to cut off or reduce wages	5 mins
I	W	Send Notice Of Intention (NOI) 2 to 3 weeks pre-decision identifying the likely outcome of a work capacity assessment and intention to make a WCD. Sometimes by phone call	
W	L	Advising has received a letter (NOI) that intend to make a WCD around [date] and has 5 -7 days to provide additional information.	5 mins
L	W	Arrange consult (within 5 days) and asks W to bring in all payslips, capacity or medical certificates, work trial information, anything that might address the "further information" request.	5 mins
L		Receives material from worker incl NOI Reviews all material provided.	30 mins – 1 hr
L	I	Sends to Insurer any relevant material in response to the NOI *[note that receipt of further material is often not acknowledged]*	15 mins
Note		*Workers are not prohibited from obtaining paid legal advice prior to a Work Capacity decision however, it is not feasible nor appropriate for a worker to meet a lawyer's costs and lawyers are highly unlikely to engage in 'pro bono' work other than at this stage because of the complexities of the process and issues.*	
I	W	Makes call to worker explaining that there has been a decision and that there will be a letter setting out the Work Capacity Decision (WCD) sent shortly.	
W	L	Received call from I re proposed WCD. L advises to get WCD and all documents provided to L as soon as received.	10 mins
W	L	Calls and advises that WCD received. Delivers copy to lawyer immediately. W delivers WCD to L with any documents provided.	5 mins
L		Briefly meets with W and asks them to sign Authority for Release of	5- 15

		information directed to insurer. Reads WCD.	mins
Note		*Some WCDs include the material and documents relied upon whereas some give means of access to information. Typically if the documents are not attached to the WCD an authority is required by the Insurer for release of the information.* *EML commonly do not attach information and documentation relied upon to the WCD.*	
L	I	Send Authority To Access All Information to I and requests all material relied upon.	5 mins
L	W	Arrange conference requesting that worker bring all information that might be relevant (and interpreter if required).	5 -10mins
Note		*Lawyers working in this area don't generally take statements at this point in time because a decision is made on the documents attached. If the documents include material not previously seen by the worker for example rehabilitation reports, vocational and functional reports then the lawyer has to read those documents thoroughly, discuss them with the worker and take instructions and get a statement in response.*	
L	W	In conference explains the WCD, all documents, advises on the process of review and of dispute resolution and obtains the history from the worker of injury and employment and matters relevant to the WCD.	1hr – 2 hrs dependin g on NESB
L	W	In conference the lawyer goes through the IR form with the worker and make sure the worker signs the form before the worker leaves the conference. Lawyers and agents experienced in completing the internal Review form have standardised responses to complete the form but in the section which requests additional documents attaches the arguments and material relied upon if there is additional material. If the worker is from an NESB, the worker generally provides his or her own person to interpret. This can make the conference and explanation quite difficult and lengthy. Generally, the lawyer will see the worker before they have the bundle of documents from the Insurer. In any event the bundle of documents can be between 5 to 10 cm thick and it is too difficult to review those documents in the presence of the worker.	1 hr + dependin g on NESB and interprete r or other issues
I	L	Send documents relied upon in the WCD.	
L		Review all documents relied upon by insurer. In absence of worker: Reads WCD & determine issues	½-1 hr

		Complete the internal review form Begins to work up the arguments and catalogues any additional material relied upon by the worker that the worker has made available. Workers are generally not capable of affording a vocational and functional reports or rehabilitation reports in reply and so generally, the internal review relies on arguments from the worker's knowledge and history or constructed from the Insurer's documentation. There are no external resources to obtain doctors reports and generally, it is the nominated treating whose report can be problematic.	
L		Examine the WCD against 'procedural compliance checklist' and accumulate arguments. Checks procedural compliance (against checklist prepared from Guidelines and legislation) and notes any procedural compliance issues (28 – 30 matters to consider for procedural compliance)	1/3 - ½ hr
L		Examine the WCD thoroughly and tease out salient points which led to reasons for decision: • Capacity determination • Suitable employment determination • Earnings	1 hr
L		Examine the WCD to tease out the flaws on the merits and list for consideration during detailed examination of documents (especially important for NESB workers – must be 'clear and concise')	½ - 1 hr
L		Review the documents to see what information can be used in favour of the worker and accumulate notes and list references	3- 5 hrs minimum dependin g on volume of document s
L		Match material to rely upon to issues eg suitable employment criteria (age, education, skills, training, language). Look critically at s 32A (a) and (b). – Work up arguments and prepare annexure to IR form. *This is analytical research on the papers to assist the worker.*	1 -2hrs
L		If worker has existing WC claim with a law firm, obtain documents from that firm [this scenario would probably not arise if lawyers were able to receive payment for this work]. Extract any helpful additional documentation or information from	½ hr – 1 hr

		material on legal file.	
Note		*Were reviews funded then the L may choose to obtain 'evidence' to counter the opinions of medical specialists, rehabilitation providers, doctors or vocational and functional assessors. This would take time and be quite costly.* *The accumulation of supporting material would take time to arrange appointments with providers and construction of letters of instruction and requests for reports – at least 15 minutes per letter per provider – and payment of disbursements. Response times for such evidence are slow.*	(15 mins – 1 hour)
L	W	Confer with worker on documents and discuss information that the worker can respond to. This can be done face-to-face (if an interpreter is required for example) or by telephone	½ hr – 1 hr depending on NESB
L		Compile the addendum to the internal review form: • address the PROCEDURAL defects • address the MERITS ARGUMENT • attach any additional documents type and settle (average 7 – 12 pages)	2 – 3 hrs minimum
Note		*The internal review is not a selective process .All potentially valued arguments should be raised because it is the first point of review and potentially the only chance to be heard. In addition, the process is advocated as one to reduce time taken to resolve disputes. Given the review process is based on the work capacity original WCD and the documents attached to it the internal review is the opportune time to examine all aspects of its merits and compliance.*	
L		Check final document	15 mins - ½ hr
L	I	Send IR form to insurer (*note photocopying costs and compilation time not factored in)*	10 mins
L	WIRO	Send IR form to WIRO as a record-keeping event for reporting purposes for the IRO (*note photocopying costs and compilation time not factored in)*	10 mins
Note		*Insurer has 30 days to provide a response. Insurer usually sends a letter or email to the worker acknowledging receipt of the review.* *The worker is instructed to provide a copy of that letter or email to the*	

		lawyer	
I	L/W	Insurer sends Notice of Internal Review decision (NIRD) (usually 5 to 6 pages long)	
L		Reads NIRD	½ hr
L	W	Explains NIRD to worker (note if interpreter takes longer) Potential outcomes: 1. "Withdraw WCD" 2. "Issue new WCD (in time)" 3. "Confirm part or all of original WCD". If NIRD favourable to worker, advise worker that Insurer has made new WCD. If NIRD not more favourable, proceed to **Merit Review**. Have worker sign form (majority of work has been done for IR process).	½ hr (> if NESB)
L		Ltr of Advice to W explaining stage of process and outcome, next steps, timeframes etc.	20 mins

PROCEDURE FOR MERIT REVIEW			
Action by	**To**	**Description of work done**	**Time taken**
L		Prepared MR form	½ hr max (assuming IR is conducted as explained above)
L		Have worker sign MR form (by post) or by attendance	15 min
L		Prepare addendum to MR form and develop arguments. Usually they are the same arguments used in the IR except that you seek "Merit Review" and not "Internal Review". Can excise the procedural arguments but usually leave them in.	½ hr
Note		*The W has 30 days to lodge the MR form.*	
L	SIRA	Lodge MR form (*note photocopying costs and compilation time not factored in)*	10 mins
L	I/ WIRO	Provide copy of MR form to insurer and WIRO and worker (*note photocopying costs and compilation time not factored in)*	10 mins

	/W		
SiRA	L/W	SIRA acknowledges receipt of MR form and explains that the insurer has 7 days to provide a reply	
I	L	Sends Reply and large bundle of documents (usually the whole file or at least everything that goes to SIRA.	
L		Read covering letter and check that there are no new documents.	10 – 30 mins
L		Note: if new documents have been provided by the linsurer to SIRA inform SIRA that the documents have not previously been provided to the worker and seek to exclude them from consideration [This usually receives no response from MRS].	15 mins
L	W	Contact worker and advise the status of the reply	5 – 15 mins depending on NESB
MRS (SiRA)	L	Letter requesting that worker provides up-to-date work capacity certificates for wage slips relevant to the issues.	5 mins
L	W	Conveys information required by MRS and asks that material be provided as soon as possible	2 mins
W	L	Provides material requested.	2 mins
L		Reviews material provided by worker	5 – 10 mins
L	MRS (SiRA) / I	Provides MRS and I with material requested by SIRA with letter by email. Copying of documents required.	15 mins
MRS (SiRA)	L/ I	MRS provides MR decision	
L		Reads MR Decision	30 mins
L		Considers outcome and availability of WIRO review and judicial review explaining to the worker the purpose, potential outcomes, potential for adverse costs orders and time delay	15 mins
L	W	Explains MR Decision to worker and advises as to outcome – findings and recommendations. Take instructions if appropriate on Procedural review to WIRO	1 hr – 1½ hrs (depending on NESB)
L	W	Confirms outcome and advice in writing in particular availability of judicial review of MRD and Procedural Review of original WCD.	½ hr

Note		**MR Decision Outcomes:** **1. A decision on the merits which may lead to binding recommendations which must be given effect by the Insurer independently of the original WCD and the IRD.** **2. Decision on the merits which makes no recommendation.**	
Note		**The further review path on the merits of a MRD is by way of judicial review. Judicial review is by way of application to a single judge of the Supreme Court. The SC is a costs jurisdiction where costs follow the event. Judicial Review can be sought by the INSURER or the WORKER. The worker is not protected against an adverse costs order if the INSURER seeks JR of a MRD. A worker can be asked to meet the costs of their own lawyer if they choose a JR.**	

PROCEDURE FOR WIRO REVIEW			
Action by	**To**	**Description of work done**	**Time taken**
L	W	Obtain instructions to proceed *(Confirm instructions in writing: allow up to an additional ½ hour)*	5 – 15 mins depending on NESB
L		Redo the procedural checklist on the original WCD (because WIRO can only procedurally review original decision) Check the arguments already provided in the IR. Make amendments to the arguments as necessary	1 – 2 hrs
L		Complete the WIRO Review Form. This form is different to the other two forms and requires different information.	½ hr – 1 hr
L	W	Get worker in to sign the form. Explain that this is only a procedural review and can only get an outcome that ensures the decision was made in a proper way.	½ hr
L	W	Ltr of Advice confirming proceeding with review	10 – 15 mins
L	WIRO	Lodge Form (by email – must compile attachments)	10 mins
L	I	Serve copy of WIRO Review on Insurer	5 mins
WIRO	L	Email acknowledging receipt of form	
I	WIRO	Insurer sends response to WIRO and Lawyer. Read response and	½ hr

	/ L	consider whether to prepare further reply.	
L	W	Obtain instructions on further response	15 mins – ½ hr
L		Prepare optional further reply	1 hr
WIRO	L/I	WIRO sends WIRO decision	
L		Read WIRO decision	½ hr – 45mins
L	W	Explain WIRO decision to worker. If decision favours worker the original WCD is invalidated and backpay is payable (if it involves weekly being cut or reduced)	15mins – ½ hr depending on NESB
I	W	The insurer will write to the worker and advise of the WIRO decision and will explain the consequences if the decision favours the worker including paying back weekly payments due.	
I	W	The Insurer pays the worker directly	
W	L	Confirmed received payment	5 mins
L	W	Explains that there will be a new WCD prepared shortly (this is the usual procedure – the WCD is reissued some months later and the process starts again)	5 – 15 mins
Note		If WIRO review does not favour the worker the lawyer must explain to the worker. This is a difficult conversation to have because the workers inevitably will say "I'm still injured". You have to explain that you've exhausted all "free" avenues and that judicial review is a costly procedure that may threaten the worker's home if they own one because of the capacity for costs orders to be made against them. You have to explain that you must have reasonable prospects of success before commencing judicial review. If the worker is of a non-English speaking background (NESB) this conversation is all the more difficult. The advice must also include an explanation of the right to payment of medical expenses and permanent impairment payments and anything else together with the availability of support services. The worker must be asked to contact the lawyer if their current work capacity changes.	1 -2 hrs (depending on NESB)