Submission No 8

INQUIRY INTO 2020 REVIEW OF THE COMPULSORY THIRD PARTY INSURANCE SCHEME

Organisation: New South Wales Bar Association

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BAR ASSOCIATION

2020 Statutory Review of the Compulsory Third Party Insurance Scheme

10 November 2020

Promoting the administration of justice

The NSW justice system is built on the principle that justice is best served when a fiercely independent Bar is available and accessible to everyone: to ensure all people can access independent advice and representation, and fearless specialist advocacy, regardless of popularity, belief, fear or favour.

NSW barristers owe their paramount duty to the administration of justice. Our members also owe duties to the Courts, clients, and colleagues.

The Association serves our members and the public by advocating to government, the Courts, the media and community to develop laws and policies that promote the Rule of Law, the public good, the administration of and access to justice.

The New South Wales Bar Association

The Association is a voluntary professional association comprised of more than 2,400 barristers who principally practice in NSW. We also include amongst our members Judges, academics, and retired practitioners and Judges.

Under our Constitution, the Association is committed to the administration of justice, making recommendations on legislation, law reform and the business and procedure of Courts, and ensuring the benefits of the administration of justice are reasonably and equally available to all members of the community.

This Submission is informed by the insight and expertise of the Association's members, including its Common Law Committee.

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1. Executive Summary

1. Thank you for the opportunity for the New South Wales Bar Association (**the Association**) to make submissions to the Standing Committee on Law and Justice (**the Committee**) 2020 Review of the Compulsory Third Party Insurance Scheme.

2. This review is timely. It is approaching the third anniversary of the commencement of the *Motor Accident Injuries Act 2017* (NSW) (***MAI Act***) and the end of the three-year transition period.

3. Section 11.13 of the *MAI Act* provides that the legislation must be reviewed as soon as practicable after the period of three years from commencement and a report of the outcome of the review is to be tabled in each House of Parliament within 12 months.

4. The Association has maintained its engagement with the State Insurance Regulatory Authority (**SIRA**) in relation to the operation of the Compulsory Third Party (**CTP**) Scheme (**the Scheme**) generally, and more particularly the progress of the *MAI Act*. In 2017 the value of CTP insurance for those injured on the road was substantially reduced based on actuarial claims made by the government. The then existing scheme was said to be "inefficient" as it put less than 50% of the premium collected into the hands of the injured. However, the Association has consistently raised concerns that the new Scheme has performed even worse. As outlined in this submission, overall figures indicate that barely 5% of premium dollars are now being received by injured claimants under the *MAI Act*.

5. By way of contrast, CTP insurers have kept over $8 billion dollars, with no chance of clawing back any super profits for years to come, if at all.

6. The Minister claimed the new Scheme would herald a change in insurer behaviour, where claims would be accepted based on a straightforward exchange of information. It was said that the new system would be so easy for an injured person to navigate that they would no longer need a lawyer.

7. Why then are the CTP insurers retaining over 90% of premiums? How has that money been allocated? How much of that premium do the insurers have the benefit of for investment purposes?

8. First, there is no evidence that insurer behaviour has changed. Under the previous *Motor Accidents Compensation Act 1999* (NSW), insurers were rejecting and closing as many claims as possible because claims officers were set targets for the number of claims they should be closing and bonuses within insurers were paid based on the number of closed claims, irrespective of the legitimacy of closing any given claim. It is unclear whether that practice continues. In any event, whereas the Minister identified the exchange of information as the bedrock of the new Scheme, in practice insurers regularly retain experts rather than relying on the primary information provided in support of a claim.

9. Second, insurers have significant resources. Three in four people injured in a motor accident do not have a lawyer, and injured people are told that they do not need one. Because of the Scheme's complexity, most people will struggle to understand their rights and entitlements. This means

many will not appreciate that those rights are worth fighting for.

10. Third, there are so many friction points in the system that the insurer has multiple opportunities to reject a claim. Their resources extend to commonly using traffic reconstruction experts and interviews with police officers to decide that an injured person is at fault for the accident, forensic accountants to reject a claim for loss of income, and medical specialists to overrule a treating doctor's recommendations. Each of these areas of dispute would be time consuming and wearing for anyone but even more so for a person who has been injured and is without legal representation.

11. Thus, the opinions (including those of general duties police) are presented to claimants, who overwhelmingly have no legal representation and do not appreciate the legal avenues available as final. Another claim file is closed and the bonus flows to the insurer and its staff. Each of these decisions will be communicated by service of a letter with an explanation for denying the claim, such as "the police have decided that the accident was your fault" when the police officer who was interviewed may not even have attended the scene of the accident, let alone witnessed the event. Many people would think that their case was unmeritorious and give up when in fact the police officer "opinions" would be inadmissible in a court. Similarly, a report from a forensic accountant may appear insurmountable when faced with a cost of thousands of dollars to obtain a report in reply, assuming the injured person was even aware of the possibility of answering such material.

12. A clear culture has developed in claims handling whereby insurers routinely deploy their access to experts, police and the medical profession to defeat a claim. Rather than an exchange of information as promised, what has arisen is a quasi-forensic approach fueled by an adversarial approach where in the vast majority of cases only the insurer is properly equipped and experienced. This imbalance has heightened the inequity of the scheme.

13. It can be anticipated that the regulator's position will be that at this stage the Scheme is not yet mature enough to determine whether it is meeting its objectives in terms of putting more premium dollars into the pockets of the seriously injured. There is however almost three years of data to draw on. The Association has endeavoured to understand how the Scheme is developing but despite its many attempts to obtain relevant information, the Association has not been given access to sufficient data to fully ascertain how claims, particularly claims for damages, are tracking compared with the actuarial assumptions which underpinned the original premium calculation of $551. The Ernst & Young (**EY**) *Quarterly Review as at 30 June 2020* was provided to the Association on 3 November 2020. It is a document which requires careful reading. The current figures for the operation of the Scheme which are included in this submission have been taken from that report, which is dated 13 August 2020. That this report was withheld until so close to the closing date for these submissions is consistent with a reluctance by SIRA to deal with stakeholders in an open way. The data it contains falls significantly short of what is necessary to understand how the Scheme is performing.

14. The actuarial assumptions underlying the *MAI Act* require examination. The pitifully low amount which has been paid out to date is the result of many factors, including:

    a. 60% of claims being closed after 26 weeks as minor injuries, where the Scheme actuary assumed a rate of 50%;

b. an over estimate of the number of disputes which would be determined in favour of the injured; and

c. a hugely reduced number of claims for damages due to the kind of insurer behaviour restricting the number of claimants who can access a claim for either continuing benefits or damages mentioned above.

15. The Government's objective of making premiums affordable has been met in the CTP Scheme. Any further changes should restore the balance between benefits and insurer profit in line with the stated objectives of the 2017 reforms.

16. On 14 October 2019 a request for data relevant to the CTP premium calculation was made by the Association under the *Government Information (Public Access) Act 2009* (NSW). The application was unsuccessful, and two reasons were given:

1. An asserted overriding public interest against disclosure; and

2. It was asserted that some of the data was not held by SIRA.

This is a publicly funded insurance Scheme. One of its stated objectives is "enhanced data collection and reporting, and real-time performance monitoring of insurer behaviour and claims experience, to enable SIRA to better regulate the scheme".[1] The reasons for refusing to make the data available were inconsistent with the spirit of the legislation. SIRA was given the power to collect and regularly publish a range of insurer profit, filing and loss ratio information. That information has been sought from SIRA and it has not been made available. Open consultation can only take place where there is open access to the necessary information.

17. The current CTP average premium in New South Wales is $486. The objective of reducing premiums has been met. In evaluating performance of the Scheme for the future, the focus should be upon delivering both the stated objectives and the legislative objectives relating to the payment of benefits under the Scheme, being:

a. To provide the fairest compensation regime possible consistent with maintaining the present premium;

b. To ensure that the majority of premium is paid to the injured with an emphasis on the most seriously injured;

c. To ensure that the restriction on claims for damages be confined only to injuries which are genuinely minor in nature without restricting or removing the right to claim damages for those with moderate or serious injuries;

d. To equip the regulator with sufficient resources to monitor insurer behaviour so that claims for statutory benefits are not rejected unreasonably and that unrepresented claimants are not discouraged from exercising their rights to claim compensation or damages because of that insurer behaviour. We note that currently 73% of claimants do not have legal

[1] New South Wales, *Parliamentary Debates*, Legislative Assembly, 9 March 2017 (Minister Dominello).

representation;

e. That CTP insurers, as receivers of public money that is compulsorily levied, should be required to act in all cases in a way which promotes the quick, cost effective and just resolution of disputes;

f. That the regulator in performing its statutory functions promotes genuine and open consultation for the purpose of the three-year review of the *MAI Act* and is equipped with sufficient resources to undertake a widespread consultation seeking feedback particularly from non-legally represented claimants who have left the Scheme.

18. The Association's submission addresses the following issues:

a. Scheme performance and claims for damages;

b. Data collection;

c. Role of the Regulator;

d. Legal costs;

e. Insurer behaviour;

f. Use of police opinion in liability decisions;

g. Minor injuries and Parliamentary scrutiny;

h. The Dispute Resolution Service; and

i. Future Action.

19. The Association considers that the Committee will not be able to properly perform its statutory function to review the Scheme without the information identified in this submission, including in section 10, and recommends that this information be urgently requested from SIRA and made publicly available.

2. Scheme Performance and Claims for Damages

20. The current focus on Scheme performance in the EY *Report for Claims up to June 2020* is on claims made in the first year of the Scheme.

21. There was a total of approximately 10,000 not at fault minor and non-minor injury claims: 6,118 minor and 3,794 non-minor.[2]

22. 60% of not at fault claims have been classified as minor.

23. Only around 1,500 non-minor claims involving treatment expenses remained active as at June 2020[3] and around 580 non-minor claims involving weekly payments.[4] In other words, over 75% of claims were "not active". Does this mean the files are closed?

24. How many common law claims can there be given those numbers? The fact that only 345 claims for damages had been made by June 2020[5] is staggering given that the three year limitation period will be expiring for these claims from 1 December 2020, and that this Scheme was meant to be much faster and more efficient than its predecessor.

25. The original assumption was that there would be 6,000 claims for damages each year.[6] It has now been revised down. The current estimate is either 4,400 or 3,685.[7]

26. How can those figures have any credibility when there are only somewhere between 1,500 and 2,100 active claims?

27. Another factor which must operate to reduce the anticipated number of damages claims is the confinement of damages for non-minor injuries under 10% Whole Person Impairment (**WPI**) to economic loss. A significant proportion of those claimants will have no entitlement to damages because they were not and will not earn income in the future irrespective of the accident. Less than 600 of those claims from the first year have ongoing weekly payments. This is telling, and demonstrates that the number of common law claims will be much lower than assumed.

28. The statutory benefits scheme appears to be stable. Treatment expenses are around $30 million per quarter.[8] Weekly payments are not growing.[9]

29. The honeymoon period would appear to be over.

30. Based on the most recent data, 60% of not at fault claims are assessed as minor. The effect on delivery of benefits to the most seriously injured of capturing too many claims as minor is profound. The shift from a 50% to a 60% minor injury classification has this effect:

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[2] EY, June 2020, 17-18.
[3] Ibid, 43.
[4] Ibid, 43.
[5] Ibid, 20.
[6] EY, *Cost Regulation Costing*, 6 July 2017, 9.
[7] EY, July 2020, 12 and 20.
[8] SIRA Open Data.
[9] Ibid.

1. 1,000 minor injury claims at $5,900 each = $5 900 000 [$5.9 million], as opposed to
2. 1,000 non-minor injuries at 100K = $100 000 000 [$100 million]; or
3. 1,000 non-minor injuries at $500K if over 10% WPI = $500 million.

31. The contrast is staggering. Of course the reality is that those non-minor claims would be a combination of above and below the 10% WPI threshold, and so their value would be somewhere in the middle. The insurer retains the difference. On any account, this represents an extraordinary sum.

32. The minor injury test is not fair, and it is not easy to apply. The Association has previously advocated for a 5% WPI test for minor/non-minor injury. A recommendation from this Committee for amendment of the minor injury test to "at least 5% WPI" would assist in removing one of the greatest injustices in this scheme.

3. Data Collection

33. The CTP Open Data page on the SIRA website records gross amounts paid under the Scheme to date. There is no doubt that premium and claims numbers are well within Scheme design objectives. To determine whether the Scheme is meeting its objectives in relation to those injured in motor accidents, it is necessary to genuinely understand what has happened with the 32,000 claims which have been made to date.

34. The following information, which could be readily gleaned from data presently collected by SIRA, would give an excellent insight into how the Scheme is operating:

    a. How many current claims for statutory benefits are open on each CTP insurers' books;

    b. How many current open files include a concession or determination that an injured person has exceeded the 10% whole person impairment threshold;

    c. How many current and open claims for damages does each insurer have;

    d. How many current claims involve ongoing weekly benefits in the statutory benefits Scheme.

35. This is data which SIRA no doubt has and which should be made available immediately so as to put the overall figures into context and permit an understanding of whether claim numbers are escalating or whether they have stabilised.

36. The SIRA website states that there have been approximately 10,000 internal reviews out of around 32,000 claims (on average one in three) in relation to disputes undertaken by insurers and that there have been over 5,000 disputes. Again, further details about the current number of disputes would put those large numbers into context. This is a high number of disputes and we have no further information concerning them, or their outcome.

37. It is not sufficient for broad cumulative figures to be provided without the detail essential for a proper understanding of the Scheme's operation. The public are entitled to know how the Scheme is working and all reasonable efforts must be made to identify how the Scheme is operating now, at the conclusion of the three year "honeymoon period", a statutorily recognised (hence this review) point at which it was considered reliable assessment of the Scheme's performance would be possible. That the Scheme numbers suggest fewer claims than the modelling predicted can no longer be explained on the basis of the honeymoon period: three years was considered to be the time at which Scheme performance would be sufficiently indicative to justify formal review.

38. Despite its best efforts the Association has not been able to obtain any elucidation of this detail.

39. The premium assumption made in 2017 was that $129 premium dollars or 23.4% of the $551 premium would be paid as damages per annum. With 5.8 million registered vehicles in New South Wales, approximately $750 million of annual premiums was notionally allocated to damages claims when designing the scheme in respect of damages paid by 1 December 2020, a total of $2.25 billion over the three years from 2017-2020.

40. At this point total payments for modified common law claims are $54 million in 2019-20. The amount paid out in damages is less than 2.5% of the amount that the Scheme was designed to pay out for these claims over the last three years. Limitation periods are fast approaching: the shortfall in payments will be "baked in" every day after 1 December 2020.

41. The objective of putting a greater proportion of benefits into the pockets of the seriously injured has not been achieved.

42. The Schedule 1E assumption for the average not at fault claim, where WPI is greater than 10%, was $494,000. The assumed cost of such a claim is now recently estimated at $504,000. If that assumption has been borne out, there have been around 100 common law claims paid out under the Scheme to date. The regulator will know how many claims have been paid out to date. If injured persons' access to a claim for damages is working in accordance with the original design of the *MAI Act*, there should be thousands of claims for damages on foot by this stage. In practice such a claim is generally made between one and two years after an accident. There is no other rational or logical reason why so few claims would have been made, other than that the insurers have too much control over the process and are conducting themselves in a way which deters legitimate claimants from enforcing their rights.

43. SIRA and the CTP Insurers may seek to draw a comparison with a slow uptake in claims following the introduction of the *Motor Accidents Compensation Act 1999* (NSW) (***MACA***) in relation to damages claims. That is not a proper analogy. The *MACA* saw the introduction for the first time of the 10% WPI threshold which took some time for the legal profession to understand. The approach to a claim for damages under the *MAI Act* in terms of the threshold is identical to the *MACA* and so there has been no similar barrier to proceeding with a claim notwithstanding the change in the legislation. If damages claims are down significantly, which they appear to be, there must be some other explanation. The obvious factors include:

    a. A definition of minor injury which captures more serious injuries thereby removing the right to claim damages;

    b. The deliberate removal of the legal profession from the process;

    c. The imbalance of power in favour of the insurers; and

    d. The lack of knowledge on the part of self-represented claimants regarding their legal rights and the value of their claims.

44. It would greatly assist in the review of the Scheme if the Committee could identify with the assistance of the regulator the position in relation to the number of claims for damages that have been made to date and the number of claimants who have achieved the greater than 10% WPI threshold. There will also be available data on the size of awards for non-economic loss and economic loss damages.

45. The assumptions underlying the original premium calculation were recorded in the original publication of the 2017 Motor Accident Guidelines at Schedule 1E. These have subsequently been updated without recording the original assumptions and so it is necessary to go back to the

historical documents to identify whether, and to what extent, any of the assumptions have changed over time. There have been some significant changes. For example, the average claims size of a not at fault minor injury was originally assumed to be $12,700 as at 1 December 2017. By 15 January 2020, that figure had reduced to $5,900. The current claims data records that there have been 8,094 claims assessed as minor injury.

46. The total payments to date for treatment and care are $260 million. The original costing was $323 million per year for these payments in the mature scheme. The Scheme actuary predicted that 56% of these payments would be made in Year 1 and 68% by the end of year 2.

47. The total payments for treatment and care in the past 12 months have been $112 million. That is for 2.8 accident years. If you ignore year 1, there should be payments for 56% of $323 million for two years and 68% of $323 million for one year, a total figure of $400 million. Again, the reality falls far short of the Scheme design.

48. The overall figures show that still now barely 5% of premium dollars are making their way into the pockets of the injured.

4. Role of the Regulator

49. The Association is concerned with the role the regulator plays in the process of understanding the operation of the scheme.

50. As the substantive submissions above demonstrate, data is crucial to understanding the way in which the Scheme is performing. SIRA purports to consult with stakeholders including the Association and conducts forums, the ostensible purpose of which is to provide information to Stakeholders. Information is presented in pre-packaged form which, from the perspective of the Association's representatives, paints an inconsistent and impenetrable picture.

51. In particular, there is an apparent reluctance to recognise that different assumptions are being used now than those which informed Scheme design. The shifting assumptions regularly present a state of affairs which precludes ready comparison with how the Scheme designers said the Scheme would work.

52. SIRA has demonstrated a consistent reluctance to advance the position on matters of the provision of data and the identification of the changing assumptions. This has become a considerable concern.

53. SIRA's role is defined by section 23 of the *State Insurance and Care Governance Act 2015* (NSW). The relevant objects under that section are:

> (a) to promote the efficiency and viability of the insurance and compensation schemes established under the workers compensation and motor accidents legislation and the *Home Building Act 1989* and the other Acts under which SIRA exercises functions,
>
> (b) to minimise the cost to the community of workplace injuries and injuries arising from motor accidents and to minimise the risks associated with such injuries,
>
> …
>
> (d) to ensure that persons injured in the workplace or in motor accidents have access to treatment that will assist with their recovery,
>
> (e) to provide for the effective supervision of claims handling and disputes under the workers compensation and motor accidents legislation and the *Home Building Act 1989*,
>
> (f) to promote compliance with the workers compensation and motor accidents legislation and the *Home Building Act 1989*.

54. The Association considers that SIRA is failing to pursue the object of efficiency in the CTP Scheme, ensuring access to treatment and promotion of compliance with the *MAI Act*.

55. SIRA's statutory role as an independent regulator includes prudent stakeholder scrutiny of scheme performance. However, on all but a few occasions, requests for data made by the Association to SIRA have been rejected, the reasons given have been confidentiality or difficulty in obtaining the information. Occasionally we have not received a reply. Never has SIRA said that a piece of information sought by the Association is irrelevant or liable to be misunderstood. The Association

is concerned that not releasing relevant data, which is in the public interest to scrutinise the Scheme's operation, is contrary to the objects of the legislation which in turn impacts on public confidence in the regulator's ability to effectively perform its statutory mandate.

56. Where confidentiality is cited as the reason for not providing the data the Association has suggested anonymisation of data, however no response has been forthcoming.

57. Unless a request can be dismissed as frivolous, irrelevant or misconceived, SIRA as regulator should be investigating to ascertain whether the requested data does shed light on scheme operation. Rather, it obfuscates and delays, at best, and refuses or does not respond, at worst.

58. The Association suggests that legitimate requests for data on the operation of the Scheme should be dealt with by SIRA and if there is any commercial or other sensitivity the raw data may be provided in a de-identified format or under a commercial-in-confidence obligation.

59. Second, as outlined below, specific examples of improper claims handling have been supplied by the Association to SIRA for the purpose of investigating the prevalence and basis for them.

60. A particular concern is the use by insurers of police officer statements to "persuade" claimants as to their being "mostly at fault" with serious consequences for their entitlements. A practice has developed whereby insurers notify claimants of having formed the view that a claimant is mostly at fault by reference to observations made by police officers without them having attended the scene of an accident.

61. When raised with SIRA the response has been to seek to address the issue on a claim by claim basis rather than to look into or acknowledge what appears to be a systemic issue. In that way the offending practice and its underlying approach are not addressed and the result is that only the very few claims that ever come to a lawyer receive any type of action directed to insurer conduct.

62. It should never be the role of the regulator to deal with individual claims: its role is to regulate in accordance with the objects under which it was created. That involves dealing with requests for data in a way which promotes those objects: providing it to stakeholders is likely to assist, whereas denying it places the insurers beyond scrutiny and frustrates stakeholder input on the issues of scheme efficiency and outcome delivery, two primary objects for SIRA.

63. The approach which should be taken involves identifying undesirable trends in claims handling at the earliest possible opportunity before it becomes the norm.

5. Legal Costs

64. The public should be able to have confidence that state agencies and the schemes administering motor accidents injury compensation are accessible and transparent, and will afford the injured a fair opportunity to uphold their lawful rights. Unfortunately, the reality is very different. The system is failing to care for or adequately support the injured, with the effect of leaving the injured to fend for themselves against insurance companies and Scheme agents who have access to lawyers experienced in the areas in question. The legislation is extraordinarily complex, involving cross references to other pieces of legislation, regulations, claims and medical guidelines.

65. The Scheme has become increasingly technical, unnecessarily bureaucratic and difficult to navigate without legal assistance. The public are not informed of their rights, including the right to seek legal advice. In fact, victims are actively encouraged to seek to resolve the matter themselves, resulting in increased stress and emotional strain, which frequently results in an unfair outcome.

66. A common denominator in the failure of both the workers compensation and motor accident schemes to produce fair results for claimants is directly linked to the restrictions placed on access to legal advice in these schemes. Lawyers bear witness to the system's operation and inequity. Yet, when the legal profession has sought to raise the alarm over the way the injured are being treated, our concerns have been maligned and misconstrued by governments and departments as self-interested or venal. The legal profession owes its paramount ethical and legal duty to the administration of justice. This means the Association has a duty to speak out on behalf of the vulnerable members of our community left to wrestle with a system that, on the available evidence, favours insurers, not the injured.

67. In almost three years, legal costs for claimants total $6 million, compared with $24 million for insurers' legal costs and investigations. There is no true comparison because insurers can afford to employ counsel. That is a sad reflection of the role of the legal profession in this Scheme because lawyers have been effectively cut out of this process. People have been told they don't need a lawyer. Approximately $1,600 is payable to a lawyer for a minor injury dispute which can involve several times that amount of work. Recourse to litigated claims, and an occasional exceptional costs order, are of no use to claimants in the day to day operation of this Scheme.

68. The principal reason that the available costs are so low is again due to the inflated assumptions made in July 2017 concerning the number of disputes which would involve lawyers in the statutory benefits scheme. It was assumed that there would be 12,000 disputed claims per annum, with each claim having multiple disputes.[10] That produced an allocation of $130 million for legal costs in the statutory scheme per annum.[11]

69. To date there have been 5,549 disputes in the Dispute Resolution Service (**DRS**) with total legal costs of $6 million in almost three years.[12] The approach to legal costs needs to be addressed as a matter of urgency in order to address the imbalance between injured motorists and CTP insurers.

[10] EY *Cost Regulation Costing*, 6 July 2017, 8.
[11] Ibid, 23.
[12] SIRA Open Data.

This is an example of a mistake which should be recognised and rectified.

70. The $50 000.00 and $75 000.00 no contracting out provisions are also operating perversely. It is possible for a lawyer to provide a service, which after disbursements can mean that most professional fees are written off. These limitations are unsustainable.

71. It was not presented that way in July 2017 when SIRA modelling suggested that there would be $130 million in non-contracted out legal costs in the statutory scheme per annum, and $258 million in common law costs per annum. There is obviously scope for increasing scale fees for legal services to a realistic level, which would benefit the operation of the Scheme by providing injured persons with recourse to proper legal advice, as opposed to the current situation where the scale costs in the statutory Scheme are unrealistically low, to the point that it is not viable to provide legal services in many cases.

72. That legal costs in the statutory Scheme are 4.6% of the annual assumption suggests that the Scheme is not working as intended.

73. The paucity of legal costs in the statutory Scheme has a malignant influence on the Scheme's performance: overwhelmingly people coming into the Scheme are generally not legally represented. The Scheme is presented, including on SIRA's website, as one not requiring a lawyer, notwithstanding that, on any view, the Scheme represents one of the most complex legislative regimes ever enacted, perhaps only bettered by the complexities of the *Income Tax Assessment Act 1936* (Cth).

74. As a result, most decisions, some of them determinative of wider rights such as the entitlement to damages, are made in the absence of a claimant having legal advice. In most cases no lawyer protecting the claimant's interests will ever see these decisions. Claimants then leave the Scheme, assuming they have been paid all of their entitlements and dealt with fairly. If they have been dealt with fairly, it must follow from these figures that the Scheme is not performing as intended. If they have not been dealt with fairly, the whole justification for the Scheme (a new era of insurer behaviour) is absent and it is not performing as intended.

6. Insurer behaviour

75. The *MAI Act* was meant to herald a new world of insurer behaviour. This has not occurred. Insurers are using all traditional means to reject claims. Of the 31,439 claims lodged since 1 December 2017 there have been 10,066 insurer internal reviews which have resulted in 5,306 disputes. On average one in three claims has been the subject of a dispute with an insurer. That does not take into account those claimants who will have accepted an insurer's decision without seeking internal review.

76. The Association has previously submitted in the workers compensation context and in relation to the *MAI Act* that requiring an injured person to carry a dispute from an adverse insurer's decision to adverse internal review to a hearing in the DRS is oppressive. The system is not quick or just in that regard. The Association stands by those submissions.

77. Insurers have spent $24 million investigating claims. This figure includes the cost of factual investigation, surveillance and actuarial and accounting reports. That sum is in addition to the insurer's receiving a proportion of every CTP premium for the costs of administering each claim file. The fact that the average claim size for a not at fault statutory claim is half what was expected is in significant measure due to insurers successfully defeating claims at an early stage, particularly against those without legal representation.

7. Use of Police Opinion in Liability Decisions

78. It is common for private investigators retained by CTP insurers to interview police officers when investigating liability disputes, part of which is recorded and takes place at a police station. That interview is then relied upon by an insurer when giving written notification to a claimant that their claim has been unsuccessful. The relevant liability notice will tell the injured person that the police consider them to be at fault for the accident.

79. A particular concern is the use by insurers of police officer statements to "persuade" claimants as to their being "mostly at fault" with serious consequences for their entitlements. A practice has developed whereby insurers notify claimants of having formed the view that a claimant is mostly at fault by reference to observations made by police officers attending the scene of an accident.

80. The officers were not present at the accident scene when the accident happened. They are not experts in any discipline relevant to accident reconstruction or injury causation: they are general duties police. They are spoken to by an investigator.

81. The claimant – with no legal representation in nearly all cases – is told by the insurer "the police have been spoken to and they think you were speeding", or similar. The average person, with no knowledge of the laws of evidence, and assuming a reputable licensed insurer would not rely on such a statement unless such an opinion were admissible in court, will be strongly deterred from pursuing a claim confronted with this statement. The true position is, of course, that the opinion is likely, almost always, to be inadmissible.

82. For example, an elderly woman was parking her car in a suburban carpark when another vehicle

ran into the back of her. In the aftermath her vehicle travelled 50 or 60 metres before colliding with a tree. She was severely injured. There was significant damage to the rear of her motor vehicle. The liability notice issued by the insurer included the following:

> "Police also confirmed that they considered these as two separate motor accidents and have held you to be responsible for the motor accident".

83. That liability notice was issued even though the driver of the other vehicle had refused to provide a statement to the insurance company's investigator. The insurer did not inform the woman or her family of that fact, rather it relied on the assertion of a police opinion as to liability without proper disclosures of lack of expertise or jurisdiction for the police to so determine, and in a manner that relies on the statement and purported police authority to dissuade injured from pursuing appropriate claims. It is not an isolated event.

84. There is a similar problem with the use of accident reconstruction experts and accountants retained by insurers to refute aspects of claims. The average claimant would not know where to begin to obtain contradictory material and the scheme is structured so that they are not likely to find out.

85. When raised with SIRA, the response has been that it will only take an interest in our complaints about these type of issues if the names of the claimants are disclosed to it.

86. The result is that only the very few claims that ever come to a lawyer receive any type of action directed to the improper behaviour of the insurer.

87. It is submitted that the Committee should explore the use of police opinion in liability disputes with the CTP insurers.

88. The motivation for an insurer in defeating such a claim is obvious. This particular woman has lost her independence and is now living with her children who have to fund home modifications and provide care for their mother. Her ongoing needs, and her ongoing disabilities have not been compensated. She has legal representation, and so a remedy will be pursued, but that is not the point. This was meant to be a system which operates fairly for all injured motorists. Insurers should be obliged to act as model litigants given the guaranteed profit which they are permitted to make through the compulsory levy of CTP premiums. It is not meant to be a Scheme for the unjust enrichment of insurance companies.

89. Fraud is not a factor in these liability disputes.

90. The Committee should recommend that insurers be required to excise completely the use of police opinion in liability notices.

8. Minor Injury and Parliamentary Scrutiny

91. The Association has made submissions, including to the New South Wales Parliamentary Regulation Committee's inquiry into the making of delegated legislation, concerning the use of Henry VIII clauses to permit legislative change without debate in Parliament.[13] These concerns were acknowledged in the Regulation Committee's final report, published on 22 October,[14] which recommended that the Attorney General refer to the NSW Law Reform Commission terms of reference including:[15]

    a. The extent and use of delegated legislative powers in New South Wales; and

    b. the need for additional safeguards in relation to the use of Henry VIII provisions.

92. Section 1.6(4) of the *MAI Act* provides for the Regulations to amend the definition to either include or exclude specified injuries from the definition of minor injury. It is submitted that such a course which will affect the rights of individuals, inevitably including the removal of rights for either individuals or insurers, should not be undertaken by amending the Regulations.

9. The Dispute Resolution Service

93. The Association suggests that the Parliamentary Committee should enquire into the operation of the DRS in relation to:

    a. decisions concerning persons lacking legal capacity, and

    b. the approval of common law settlements for claimants without legal representation.

94. There is presently a lack of transparency in relation to these decisions are a result of the limited publication of decisions by SIRA.

10. Future Action

95. The three-year review of the *MAI Act* is an opportunity to reflect upon the operation of the Scheme, with the benefit of comprehensive data on its operation. There are shortcomings and they need to be recognised. This will only be achieved through an open and impartial consultation process. The Association is committed to maintaining its engagement with SIRA in that process. It is apparent that the Scheme is not meeting its objectives. At present the greatest beneficiaries from the *MAI Act* are the CTP insurers. It would be to their benefit to extend the honeymoon period indefinitely. That should not be permitted.

96. In order to obtain a full understanding of the current operation of the Scheme the following data is necessary. It will all be readily available. The Association has sought this information from

[13] See NSW Bar Association, *Submission No 8* (2020) pages 7-9 <https://nswbar.asn.au/uploads/pdf-documents/submissions/0008_New_South_Wales_Bar_Association_Regulation_inquiry.pdf>.

[14] NSW Legislative Council Regulation Committee, *Making of delegated legislation in New South Wales*, Report 7, October 2020, 28-29.

[15] Ibid, recommendation 2.

SIRA but it has not been provided. It is submitted that the Committee will not be able to properly perform its statutory function to review the scheme without the following information:

1. In relation to the Schedule 1E assumptions a breakdown is required between the different components (ie weekly statutory payments, care and treatment, common law economic loss, common law non economic loss), for each of the following:
    a. Average Claim Size – At Fault claims;
    b. Average Claim Size - Not at Fault Minor Injuries claims;
    c. Average Claim Size - Not at Fault Claims WPI greater than 10%;
    d. Average Claim Size - Not at Fault Claims WPI with less than or equal 10%;
2. The data for both the month of the accident month as well as the month the claim was lodged (i.e. for accidents that occurred in December 2017 the number of claims lodged in December 2017, January 2018, February 2018 etc.);
3. For each accident month, the number of claims classified as:
    a. At fault claims, not at fault claims and not yet determined claims;
    b. At fault claims or mostly at fault claims or not at fault claims involving minor injury;
    c. Not at fault claims involving non-minor injury;
    d. Not at fault claims involving non-minor injury, with less than or equal to 10% WPI;
    e. Not at fault claims involving non-minor injury, with greater than 10% WPI; and
    f. Compensation to relatives' claims;
4. For each accident month the number of claims that were classified initially as a not at fault minor injury then had this assessment subsequently overturned to non-minor injury. In this respect information regarding the date of the accident and when the month of the initial assessment was made and when this decision was overturned should be provided;
5. For each accident month, a monthly running accumulated total of payments made by the insurer for:
    a. All accidents;
    b. Weekly statutory payments;
    c. Care and treatment;
    d. All non statutory payments;

e. Common law damages;

f. Payments associated with at fault claims and not at fault minor injury claims;

g. Not at fault accidents with non-minor injuries claims; and

h. Compensation to relative claims;

6. The weekly statutory benefit payments for the last week of the years ended 30 June 2018, 2018 and 2020 and the number of individuals to which these payments related;

7. For each accident month:

a. The number of claims that have been settled;

b. The number of claims that are expected to be settled through common law claims;

8. The average lag time between the date of the accident and the date of the common law damages payments. In this respect information should be provided for each common law claim regarding:

a. The date when the common law claim is recorded;

b. The date of the accident;

c. The legal costs;

d. Details of any delays associated with the COVID-19 pandemic;

e. Whether the WPI was less than or equal to 10%; and

f. Whether the WPI % was greater than 10%;

9. In respect of each litigated matter:

a. The date when the litigation is recorded;

b. The date of the accident;

c. The legal costs;

d. Details of any delays associated with the COVID-19 pandemic;

e. Whether the WPI was less than or equal to 10%; and

f. Whether the WPI % was greater than 10%;

10. A copy should be provided of the:

a. Universal claims data (UCD) tier 1 and 2 motor vehicle accident as at 30 September 2020; and

b. Insurer premium returns as at 30 June 2020;

11. Since the commencement of the scheme, the number of workers compensation claims that have subsequently claimed damages and / or ongoing care under the *MAI Act*;

12. Details of:

    a. The month of the accident;

    b. The date of commencement of the *MAI Act* payments for each accident;

    c. A breakdown of the amount paid for each accident;

13. Details of each compensation to relatives claim including:

    a. The month of the accident,

    b. The legal costs per claim;

    c. Damages awarded.

11. Conclusion

97. Crisis intervention has become the method of choice for the systemic removal of rights in workers compensation and motor accident claims in NSW.

98. It is a feature of the Scheme that the general public know little of it unless and until they have an injury: they have no particular interest in the scheme until then. By contrast, insurers have a direct interest from the beginning of any discussion of reform and have the resources to amass actuarial, accounting and medical arguments without fear of being contradicted by the uninjured public.

99. The Scheme should be designed to provide the injured with the support that they need, with a minimum of bureaucratic complication.

100. It is unacceptable to expect an injured person to wage a lengthy campaign against an insurance company to obtain what is their legal right. The growth in bureaucracy associated with claims is astonishing and is a sure sign that the scheme is not designed for, or to assist, the injured.

101. Thank you again for the opportunity to make a submission concerning this important issue.