Submission No 10

INQUIRY INTO 2020 REVIEW OF THE COMPULSORY THIRD PARTY INSURANCE SCHEME

Organisation: Australian Lawyers Alliance

Date Received: 23 December 2020

SUBMISSIONS TO THE SCLJ ON THE *MOTOR ACCIDENT INJURIES ACT* 2017

1. The Australian Lawyers Alliance (ALA) is a National Association of lawyers, academics and other professionals dedicated to protecting and promoting justice, freedom and the rights of the individual.

2. We estimate that our 1,500 members represent up to 200,000 people each year in Australia. We promote access to justice and equality before the law for all individuals regardless of their wealth, position, gender, age, race or religious belief. The ALA is represented in every State and Territory in Australia. More information about us is available on our website.[1]

3. The ALA office is located on the land of the Gadigal of the Eora Nation.

4. The ALA is delighted to be able to provide submissions to the Standing Committee on Law and Justice ("SCLJ") in relation to its review of the operation of the motor accidents scheme.

5. The *Motor Accident Injuries Act* 2017 ("the MAI Act") is now into its fourth year of operation. There are significant aspects of scheme operation which require review and revision.

6. The State Insurance Regulatory Authority ("SIRA") are apparently intending to conduct a 3 year review of scheme operations. Full particulars of the scope and timing of this review have not been published. The ALA is concerned that if this review is primarily conducted internally by SIRA, then there may not be the necessary frank and fearless approach applied to the issue of which aspects of the scheme are not performing as expected or anticipated and require reconsideration.

7. The ALA views the SCLJ review of scheme operations as an important opportunity to put before the Parliament feedback with regards the performance of SIRA as regulator, as well as drawing attention to specific provisions of the MAI Act where the ALA has concerns with regards the clarity or efficacy of those provisions.

8. The ALA appreciates that it is the role of the SCLJ to look at the broad regulatory and policy issues. It is understood that it is not the role of the SCLJ to investigate individual claims or complaints. Having acknowledged that understanding of the role of the SCLJ, these submissions do include de-identified case studies. The SCLJ is invited to

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consider those case studies and ask SIRA questions in relation to them. The case studies are not raised so that the SCLJ reaches any conclusions about the individual cases, but rather as important illustrations as to the operation of SIRA as regulator and the operation of the MAI Act.

9. The ALA understands that there is the capacity for the SCLJ to provide questions on notice to SIRA. To assist the SCLJ with its enquiries, incorporated within these submissions are various questions for SIRA in relation to the topics raised. For administrative ease, those questions are additionally incorporated into an appendix. A soft copy can be supplied.

10. These submissions divide into two broad categories.

11. First, various aspects of the role of SIRA as regulator of the MAI Act are considered. Second, there is specific consideration of various provisions of the MAI Act and their efficacy. Where the ALA urges statutory reform, those recommendations are clearly set out. For administrative ease, those recommendations are additionally incorporated into a list of recommendations which form an appendix.

A COMPLIMENT FOR SIRA

12. The ALA enjoys a strong working relationship with SIRA. One of SIRA's strongest positive attributes as an organisation is its willingness to consult and its openness to discussions with regards operation of the motor accidents scheme.

13. The Executive Director of Motor Accident Insurance Regulation at SIRA, Ms. Mary Maini, is highly experienced with regards the practical issues that arise in motor accident claims. It is the ALA's view that it is a very considerable advantage to SIRA to have someone in charge with such a comprehensive understanding of motor accident claims process and underwriting issues.

14. Further, it has been the ALA's experience that Ms. Maini and her team are open, approachable, and patient when it comes to engaging in discussions with the ALA about the operation of the MAI Act. The ALA compliments SIRA upon its willingness to engage in stakeholder consultation.

THE SIX MONTHS OF NO-FAULT BENEFIT

15. The Standing Committee has expressed a particular interest in the operation of the six month liability period under the scheme where claimants are entitled to benefits, irrespective of fault. Unfortunately, the ALA is poorly positioned to comment with regards this aspect of scheme operations on anything other than an anecdotal basis. There are relatively low levels of legal representation for claimants utilizing these benefits.

16. On a positive note, it would appear that the vast majority of funeral expenses get paid promptly and efficiently. There is now income support and treatment expenses

payments for at fault claimants who would otherwise have been entirely reliant on the social welfare system.

17. Where the ALA does raise an issue with regards scheme performance is the transition at six months. Prior to the conclusion of the six month period, the insurer needs to make a decision both as to liability and as to minor injury. The general quality of this decision making is woeful.

18. With regards minor injury, insurers appear prepared to cut off claimants based on minimal information and without proper efforts being made to enquire of treating practitioners as to the nature and extent of the claimant's injury. It is all too common to see medically unqualified internal consultants at the insurer second-guessing treating practitioners, especially in relation to psychiatric injury.

19. The general approach of the insurers appears to be that if there is not clear and comprehensive evidence that the claimant exceeds the minor injury threshold, then any benefit of the doubt goes to the insurer and the claimant is cut off. Although the Guidelines impose an onus on the insurers to make proper investigations into the claimant's medical condition, there appears to be minimal policing of compliance with those obligations. Insurers do not seem prepared to put any significant effort into making enquiries. They seem prepared to cut off every claimant they can and to only properly investigate if the claimant challenges the decision.

Case Study – Allianz in a death case

20. A Liability Notice for Benefits after 26 weeks issued by Allianz on 3 November 2020 illustrates the point made above. Ms. TS suffered psychiatric injury following the involvement of her sister (DS) in a motorbike accident. Ultimately, Ms. DS' injuries proved fatal and her sister was responsible for the decision to switch off life support in hospital. It is hardly surprising that in the circumstances Ms. TS has suffered psychiatric injury.

21. The decision from Allianz cutting off benefits at 26 weeks reads as follows:

> *"You have provided an initial Certificate of Fitness from Dr. A dated 12 September 2020 following the passing of your late sister, D, on 14 May 2020. Dr. A provided a psychological diagnosis of PTSD. Dr. A does not provide any insight or diagnostic criteria for the actual diagnosis made nor is such diagnosis made in reference to the current edition of Diagnostic and Statistical Manual of Mental Disorders.*
>
> *In the Certificate of Fitness Dr. A has commented that you have been referred to a psychologist, AW, to date we are yet to receive any information to indicate you have seen a psychologist to request your clinical diagnosis.*
>
> *Based on the medical information we have received, the nature of your*

injury means it falls within the legislation's definition of 'minor'. Whilst the legislation places your injury in this category we acknowledge the injury and the loss of your sister is a very significant event in your life."

22. The only information that Allianz had available to them was a diagnosis from the treating GP of a PTSD (which constitutes more than a minor injury). On the basis that the GP had not provided a full analysis of the DSM criteria and on the basis that the psychologist had not written to Allianz providing a diagnosis, Allianz saw fit to deny ongoing benefits.

23. It is important to emphasise that there was no onus on the claimant to ensure that Allianz had sufficient information to make a proper decision. Rather, the onus was on Allianz to pursue the treating practitioners to obtain the information Allianz needed. It would appear on the face of the notice that Allianz have made no effort to contact either Dr. A or the psychologist required. This lack of investigative effort is all too typical.

24. If Allianz was unable to obtain necessary information from treating practitioners, then Allianz should have organized its own medical assessment in sufficient time to make a decision.

25. An Application for Internal Review was lodged. On Internal Review, Allianz conceded that there was more than a minor injury. The information considered on internal review was exactly the same information considered for the purposes of the original decision.

26. The approach adopted in this case, the cock-eyed reasoning and the failure to seek and obtain sufficient information from treating practitioners is a very, very common experience observed by lawyers when claimants seek their advice regarding a Liability Notice for Benefits after 26 weeks asserting a minor injury. The all too common experience is that claims are poorly investigated and claimants are denied ongoing benefits on the basis of delinquent investigations and deficient reasoning. The SCLJ is reminded that no lawyer can charge any fees to assist the claimant with the internal review process. SIRA expect that the claimant will be able to negotiate the internal review process unassisted.

27. In the case of Ms. TS a lawyer has donated their time to assist with the internal review application.

28. It is worth noting in passing that the grandparents of the late Ms. DS also brought statutory benefits claims. Each were diagnosed with a PTSD. Each had their statutory benefits denied by Allianz after 26 weeks in identical terms to those on which the benefits of Ms. TS were cut off. Again, Allianz reversed the position on internal review.

29. The experience of each of Ms. TS and her grandparents was sufficiently traumatic that they readily provided permission for their cases to be used as case studies to be put

before the SCLJ. It is fair to say that the mental health of these three victims of a traumatic death has not been assisted by their exposure to the claims process. Had they not had a lawyer willing to act (without charging) in seeking an internal review of the initial medical determinations made by Allianz, then these claimants may not have had the fortitude to pursue their proper and rightful entitlements.

30. If required, the ALA would be able to provide a multitude of further examples/case studies of poor quality decision making in relation to minor injury at the six month threshold.

31. To date, DRS has reviewed over 2,200 insurer determinations as to minor injury, treatment and care, weekly payments and fault. The various decisions made by the CTP insurers on internal review are being reversed over 40% of the time. The quality of insurer decision making is remarkably poor, ensuring substantial friction around both minor injury and liability decisions being made at six months.

SIRA AS REGULATOR

1. THE FINANCIAL PERFORMANCE OF THE MAI ACT

32. The MAI Act was preceded by the *Motor Accidents Compensation Act* 1999 ("the MAC Act").

33. For the eighteen years of operation of the MAC Act, insurers filed premiums with SIRA (or its predecessor, the Motor Accidents Authority or "MAA") with projected profits in the range of between 8% and 10% of premium income.

34. Over the same twenty years of operation, the MAC Act delivered continuous super profits to the CTP insurers. The average profit (as a percentage of premium) over an eighteen year span from 1999 was close to 20%. The super profits that the CTP insurers took from NSW motorists over that period runs to in excess of $2 billion. Various efforts by SIRA to trim the super profits proved largely ineffective.

35. There are design features of the MAI Act intended to prevent the repetition of such a sustained period of CTP insurer super profits. A profit clawback mechanism has been introduced, although the efficiency of that mechanism is as yet untested.

36. The ALA acknowledges that three years into the new scheme, it is too early to make any comprehensive analysis of scheme performance and insurer profits. However, the ALA is concerned with the shortage of any serious evaluation from SIRA analysing any early trends.

37. The starting point for any analysis is to have clear information on what the actuarial projections for the scheme were. What were the forecast claim numbers for year 1

and how has the scheme performed to date compared to those forecast numbers? What were the actuarial assumptions in premium filings as to claim numbers and costs for year 1 statutory benefit claims and how has the scheme performed to date compared to those forecasts?

38. The ALA acknowledges that SIRA does publish scheme performance data in its Quarterly Actuarial Monitoring from EY (Ernst & Young).

39. The two most recent reports with scheme performance data are:

    (i) Quarterly Actuarial Monitoring 30 June 2020 data published 13 August 2020 ("the 30 June EY report").

    (ii) Quarterly Actuarial Monitoring 30 September 2020 data published 30 October 2020 ("the 30 September EY report").

    Various tables within these reports project claims experience to date as against the "*Schedule 1E Parameter*". [See pp13-20 of both reports]. That parameter is not explained in the reports. Other tables address "*Actual"* versus *"Expected"* claims experience for the six months from December 2019 to September 2020 [see pp25-28].

40. When considering this data, it is important to ask when and how the "*parameter"* or "*expected*" data is determined. Is it:

    (a) Actuarial projection set prior to or at the time of scheme commencement?

    (b) Actual projections from insurer filings?

    (c) Figures recently revised by the actuaries, well after the premium has been paid, based on lived claims experience?

41. The first two of the above methods for setting "*expected*" claims figures will highlight gaps in scheme performance between projections and actual results. This should provide some early indicator of potential insurer super profits. On the other hand, if "*expected"* (i.e. projected) results are continuously revised based on the actual experience, then the comparison between expected and actual scheme performance becomes fairly meaningless and super profits will be disguised rather than highlighted.

42. The first entry on page 25 of both reports says:

    > *"A full statutory benefits valuation was carried out for 31 December 2019 and expected payments and claim numbers projected for future quarters."*

43. Does this statement mean that the "*expected*" numbers were revised after all the premiums out of which payments were being made had already been collected? Does this mean the "*expectations*" are being adjusted to reflect the claims experience? If

so, any gap between actuarial projections when premiums are set and then actual performance against those projections is not being reported.

44. By way of illustration, page 13 of the 30 September 2020 EY report shows that for the first accident year, there have been 13,565 claims reported to date. This is compared to the "*expected ultimate*" claim numbers of 13,615. At first blush, it might appear that the scheme is spectacularly successful in predicting the likely number of claims.

45. However, the expected "*ultimate*" has been adjusted under "*Schedule 1E*".

46. The ALA has available an EY document produced when EY were costing the Costs Regulations for the new scheme. That report is dated 6 July 2017. This document gives some indication of the actuarial assumptions that actually founded the scheme and the anticipated claim numbers in Year 1. That document calculates the costs of legal disputes in the statutory benefits component of the scheme by assuming that there would be at least 6,000 at fault statutory benefits claimants seeking treatment and care and an additional 11,000 not at fault statutory benefits claimants seeking treatment and care. In short, the projection was not for 13,615 claims in Year 1. It was for 17,000 statutory benefits claims alone in Year 1.

47. Similarly, the ALA has a letter from EY to SIRA of 13 June, 2017, variously estimating either 17,000 or a range of 16,000 to 18,000 combined not at fault and at fault claims per year under the MAI Act.

48. The ALA understands that the reason the quarterly actuarial monitoring reports now being circulated do not incorporate any projected scheme claim numbers for Year 1 showing significantly less claims than initially projected is because the actuarial assumptions have been adjusted. The reality of projected claim numbers when premium was set is now being ignored in favour of revised claim numbers, seemingly designed to match the actual claim numbers experienced.

49. In short, the results are being adjusted (the more dramatic might suggest massaged) to make the projections match the actual outcome.

50. The ALA calls for SIRA to publish data based on the forecasts set when premium is collected, not based on subsequent revised projections. The Parliament is entitled to data that will identify whether ultimate insurer payments and scheme costs are matching the projections at the time the premium was set rather than some ex post facto projections.

51. Further, the ALA calls for publication of year one data showing payments made as against actual projections contained in filings. It is respectfully suggested that continuing to "*shift the goal posts*" by revising the expectations will result in far less meaningful measurements of scheme performance.

52. The ALA encourages the SCLJ to ask SIRA to clearly identify what the actuarial projections for scheme performance were at the outset of the scheme and before any

adjustments took place. This should set the benchmark for measurement of actual scheme performance. The ALA also urges the SCLJ to ask SIRA to provide any preliminary reporting that SIRA can as to scheme performance as against those standards to date, especially in relation to the performance of the statutory benefits component of the scheme.

53. To assist that process, the ALA suggests the following questions:

Questions for SIRA – Scheme Performance

(a) At the time the scheme was launched and Year 1 premium set, what were the actual, unadjusted, actuarially projected claim numbers for Year 1 of the scheme covering:

(i) The projected number of at fault claimants who would only receive statutory benefits for 6 months.

(ii) The projected number of statutory benefits recipients who would be cut off at 6 months due to their having a minor injury.

(iii) The projected number of statutory benefits recipients who were not at fault and had more than a minor injury and who would continue receiving statutory benefits past 6 months.

(iv) The projected number of damages claims anticipated to arise from Year 1 accidents?

(b) Does SIRA agree that the EY projections in June 2017 were for approximately 6,000 at fault claims and 11,000 not at fault claims for Year 1? How do those projections match the actual outcomes for Year 1 claims?

(c) It is noted that claims for statutory benefits need to be lodged within 3 months of the accident, so the number of claimants within each of the first three categories above should be well settled for year one of the scheme and even relatively well settled for year two of the scheme. What are the actual numbers? [With regards damages claims, there is still another twelve months before the last damages claims from the last month of year one need to be lodged, so it is acknowledged that any data with regards damages is likely to be very incomplete.]

SIRA should be able to provide some preliminary analysis of the performance of the new statutory benefits element of the scheme, with all year one statutory benefits claims having at least one full year of claims history. Accordingly, SIRA should be able to advise:

(i) Actual at fault statutory benefits claim numbers from year one (the number who received statutory benefits for 6 months and were then cut

off because they were deemed at fault). How many of these claimants were there and on average, how much assistance did they receive from the scheme?

(ii) How many at-fault claimants received 6 months (or less) of payments from year 1 accidents?

(iii) How many claimants were cut off at 6 months, on the basis they had only a minor injury?

(iv) How many claimants were there from year one who were determined to have more than a minor injury and to not be at fault and who continued receiving statutory benefits past 6 months?

How do these actual numbers from year one of the scheme compare to actuarial projections or premium filing projections?

(d) Based on premium filings for year one of the scheme, what was the range (across the five insurers) and average of profit projections for year one?

(e) On the basis of scheme performance to date, how are profit trends for year one tracking?

(f) What are the profit clawback provisions in place in relation to year one and when does SIRA first expect to have an indication as to whether those provisions may be applicable to year one (if there are excess profits to claw back)?

(g) Section 2.25 of the MAI Act provides for adjustment of premiums and fund levies in case of excessive profits or excessive losses. Have there yet been any reviews of scheme performance in accordance with Section 2.25? If so, what has been the outcome of those reviews? If not, then when does SIRA anticipate the first review pursuant to Section 2.25 occurring? Will these reviews be published?

2. DISPUTE LEVELS

54. One area of actuarial assumption in relation to the costs of scheme operations where it is anticipated that there is a substantial gap between projected payments and actual payments is in relation to the legal costs of statutory benefits disputes.

55. The EY documents from June 2017 referenced above provided that there was an allowance of $69 per premium for legal costs out of a $551 premium. No breakdown was provided as between the legal costs of statutory benefits disputes and the legal costs for damages disputes.

56. However, the EY projections appeared to anticipate close to 16,000 statutory benefits disputes, a substantial proportion of which fell within dispute categories that would

attract legal costs. The ALA has calculated that upwards of $11 million would have been incorporated within the Year 1 projections for scheme costs to cover the legal costs of claimants (a regulated fee) in relation to statutory benefits disputes.

57. The vast majority of Year 1 statutory benefits disputes have now been concluded. There will be a small tail of ongoing treatment disputes from Year 1 accidents over the next 80 years. However, it should now be possible to draw some meaningful conclusions about the accuracy of the projected statutory benefits dispute costs from Year 1 accidents.

58. Data published by SIRA indicates that to date, only $9 million has been paid in claimants' legal fees in total under the Act. This includes legal fees paid for statutory benefits disputes from Year 2 and Year 3 accidents and legal costs paid in damages claims. This figure grossly over-represents the costs of statutory benefits disputes in Year 1.

59. The ALA has projected a possible $15 million windfall gain to insurers (subject to SIRA applying any claw back provisions) in relation to the very substantial over-estimation of the number of Year 1 statutory benefits disputes.

60. The ALA annexes to this submission and marked **"A"** a letter sent to SIRA of 8 December 2020, seeking further information with regards the number of statutory benefits disputes arising from Year 1, how that number compares with actuarial projections and seeking information about whether there are likely to be windfall insurer profits because of the over-estimation of Year 1 disputes.

61. The letter poses some seven specific questions seeking to gain better data from SIRA and a clearer understanding of what has occurred in relation to Year 1 claims whilst at the statutory benefits stage. On the basis that the Standing Committee may have better success in obtaining clear answers to these questions, the Standing Committee is encouraged to ask these questions of SIRA.

Questions for SIRA – Claimants' legal costs of statutory benefits disputes – Year 1

(a) Was the $69 estimate for legal costs in the EY letter of 13 June 2017 backed by a breakdown as between statutory benefits and damages costs? Further, with the statutory benefits component, was there a breakdown between claimants' legal costs and insurer legal costs?

(b) Did EY assume that all of the disputes identified on page 8 of the 6 July 2017 PowerPoint would attract a regulated fee? If not, what percentage of disputes were estimated to attract a fee? Where is this assumption set out?

(c) Was there a component allowed in the statutory benefits portion of the costs estimate for exceptional costs orders? If so, what was the allowance made for exceptional costs orders?

(d) What was the total allowance for claimants' legal costs of statutory benefits disputes for Year 1 accident DRS disputes?

(e) Of the $9 million expended on claimant legal expenses to date, what portion of that figure is attributable to statutory benefit disputes from Year 1 accidents?

(f) How many statutory benefits disputes have there been in relation to Year 1 accidents and what is the breakdown across the categories of disputes identified in the EY PowerPoint? How well do the PowerPoint estimates compare to actual Year 1 data?

(g) Having permitted premium collection on the basis of the scheme incurring claimant legal costs for 4,000 minor injury disputes arising from Year 1 accident claims proceeding to DRS and the payment of a regulated fee, how many minor injury disputes have there in fact been from Year 1 accidents? Does the gap represent potential windfall profits to CTP insurers?

3. INSURER REGULATION

62. One of the stated intents of the MAI Act was to significantly reduce rates of legal representation and thus, reduce costs pressures on the scheme. The intent was that the vast majority of statutory benefits disputes would occur as between claimant and insurer, with the claimant not being legally represented.

63. Insurers still retain experienced claims staff. Most of the insurers have an in-house legal unit, so they effectively have lawyers on staff. The insurers also have available to them in-house rehabilitation staff to provide them with medical analysis. These are extensive resources that the legally unrepresented claimant does not have.

64. Upon the introduction of the MAI Act, the ALA acknowledged that there would be much lower rates of legal representation for claimants with statutory benefits entitlements on the basis of two clear commitments from SIRA:

(a) That insurer conduct would change to become less combative and more facilitatory of the claims process.

(b) That SIRA would become a tougher and more muscular regulator to ensure standards of fair conduct by CTP insurers.

If claimants are going to be forced to fight alone against well-resourced insurers and without the benefit of legal representation, then it was the ALA's view that it was incumbent upon SIRA to step up and ensure that claimants were treated fairly.

65. The ALA acknowledges that SIRA have introduced relatively robust Guidelines ("the Motor Accident Guidelines") designed to ensure appropriate standards of insurer conduct. The Guidelines read well. The ALA's primary concern is not with the provisions of the Guidelines, but rather SIRA's willingness and capacity to enforce them.

66. In commenting upon SIRA's effectiveness as a regulator, the ALA is at the disadvantage of not seeing the communications between SIRA and the insurers. Unfortunately, there is almost no transparency as to SIRA's dealings with the insurers. As will be addressed further below, members of the ALA are incredibly frustrated with the regulatory and disciplinary system operated by SIRA. Complaints are made and addressed without SIRA ever advising as to the ultimate outcome of the complaint and any regulatory or enforcement steps taken against insurers as a consequence.

67. The observation of ALA members is that there has not been any significant change in insurer conduct as between the MAC Act and MAI Act regimes. Claims are just as vigorously and, at times, brutally defended as they ever have been. Insurers continue to adopt an adversarial role. There is little pro-active processing of claims. Claimants are not advised of their full rights.

68. There has not been any observable change of culture in terms of insurers clearly explaining to claimants their rights. To give one simple example, take a claimant who, as a result of a serious fracture, is off work for 6 months or 12 months. He or she will receive statutory benefits at a percentage of their ordinary wage (95% for 13 weeks, 80-85% thereafter). They will not receive any payment for lost superannuation entitlements. Even assuming a full return to work at 6 to 12 months and no ongoing impairment, there will be a modest entitlement to damages. This will be the wages gap and the lost super that can be claimed as damages.

69. If SIRA can produce evidence that it is the practice of any of the regulated insurers (let alone all the regulated insurers) to advise a claimant about these damages entitlements and encourage the claimant to claim for them, then the ALA will be both delighted and surprised.

70. The Standing Committee is encouraged to ask SIRA what SIRA (through its Claims Advisory Service) has done to contact claimants in this category and encourage them to pursue their damages entitlements. The ALA will be delighted to hear that SIRA is committed to ensuring that this group of claimants are being encouraged and assisted to pursue their modest damages claims.

71. Similarly, the ALA has ventilated with SIRA whether CTP insurers are pro-actively advising claimants as to their right to seek paid domestic assistance as part of their statutory benefits treatment rights. A claimant who is on crutches will struggle to vacuum the floor or mow the lawn. The insurer should be offering paid assistance.

72. From what ALA members have observed, there is no systematic or SIRA enforced regime for ensuring that claimants are advised as to their entitlement to paid domestic assistance when their physical or psychiatric injuries prevent them from being able to attend to domestic tasks. It would appear to be the approach of the CTP insurers (tacitly endorsed by SIRA) to hope that family and friends will pick up the unpaid roles of caring for the injured. CTP insurers are not being proactive in offering paid domestic services. SIRA is invited to produce evidence of any pro-active

approach by CTP insurers to offering any domestic assistant services and any pro-active regulatory enforcement by SIRA.

73. To SIRA's credit, it does publish important comparative performance data for insurers on its website. The Standing Committee on Law and Justice is encouraged to review the document *"CTP Insurer Experience and Customer Feedback Comparison"* dated 30 June 2020, with its accompanying "*Explanatory Notes"*. There is a further report of 30 September 2020.

74. This document gives rise to an interesting case study with regards SIRA's frankness and robustness as a regulator when the scheme has experienced widespread delays.

Case Study – Insurer Compliance with Internal Review Timelines

75. Chart 7 on page 9 of the 30 June 2020 *Claims Experience* document sets out the compliance of the various CTP insurers with the timeframes set out in the Act and Guidelines for the conduct of internal reviews. Both QBE and Allianz have managed to meet their obligations under the set timeframes. The same cannot be said for NRMA, AAMI and GIO. (AAMI and GIO both being Suncorp brands).

76. From the 30 June 2020 report, in 2019, NRMA only completed 40% of their internal reviews within the designated timeframe. This increased to a still highly delinquent 57% in 2020. The figures improve in the September 2020 report to over 60%.

77. The Suncorp brands had the reverse performance. The 30 June 2020 EY report shows Suncorp completing approximately 50% of the internal reviews within the timeframe in 2019, but slipping back to under 20% in 2020. [Again, performance has marginally improved in the September 2020 report.]

78. The June report shows that during the period of 2020 being measured, four out of five claimants seeking a mandatory internal review from GIO and AAMI experienced delays.

79. The extent of the delays are partially presented in data at Chart 7B on page 10 of both reports. The June 2020 report shows that AAMI and GIO did not just run a few days late in conducting internal reviews. For internal reviews with a 14 day timeframe, GIO were (on average) taking over 50 days in some dispute categories. In some dispute categories an internal review that should have been completed within two weeks was being completed (on average) in 7 weeks.

80. It is worth noting that this data [at least for 2019] relates to a full year. The averaging out over the full year hides the extent of the periods of worst delay by including in the averaging any periods of modest or no delay. The data becomes flattering to AAMI and GIO when presented on an annual basis.

81. The ALA is concerned about these delays in their own right. There are serious questions about the need for there to be any internal review process within the motor

accidents scheme and submissions are made below that various categories of internal review be abolished. However, the point here is what SIRA as a regulator does when confronted with a major breakdown in the efficiency of scheme operations.

82. The ALA acknowledges that there may have been an enormous amount of work undertaken by SIRA behind the scenes with NRMA and Suncorp to address these delays. However, if there was such activity, then it is strictly concealed. There is next to no transparency about what has occurred.

83. The most anyone can learn by delving deep into the SIRA website is the following comment contained within the *Claims Experience* document for June 2020:

> *"Allianz and QBE have consistently completed their internal review claims within the allowable timeframes. In response to SIRA's regulatory action, NRMA have improved their review processing times in 2020. Both AAMI and GIO review times have increased and SIRA is currently undertaking a regulatory review of both insurers."*

As to what the regulatory action taken by SIRA has been in relation to the delays by NRMA is unknown. Whilst it is factually correct that NRMA improved to 57% in the June 2020 report, that still means that they ran late on over 40% of their reviews. Why SIRA does not condemn a compliance rate under 60% by NRMA in the June 2020 report is unclear. The "*regulatory review*" being undertaken by SIRA in relation to AAMI and GIO's woeful performance is not specified. Nor is there any criticism of any of the insurers involved.

84. The ALA wrote to SIRA with regards the delays being experienced by claimants awaiting internal reviews from Suncorp on 14 February 2020. That letter is annexed and marked **"B".**

85. The ALA letter asked a series of specific questions to try and understand why the delays had occurred, the nature and extent of the delays and the regulatory steps being taken by SIRA to address those delays.

86. The letter encouraged SIRA to be fully transparent in identifying insurers experiencing delays in conducting internal reviews, on the basis that this might be important information to the public when it came to choosing where they wished to purchase their greenslip.

87. The ALA letter stated:

> *"If RMS can manage to publish live traffic updates and the RFS can manage to publish bushfire updates, then surely SIRA could manage to publish (prominently on its website) information about insurers who are not meeting their statutory obligations.*
>
> *It is appreciated that SIRA has embarked upon publishing various forms*

of comparative data as between insurers. However, the averaging out of information over time means that major breakdowns in insurer performance will not necessarily be fully and accurately captured and reported."

88. The ALA received a response from SIRA on 14 April 2020. That response is annexed and marked **"C".** The response is a masterpiece of bureaucratic unresponsiveness. SIRA acknowledged that they are aware of the delays, state that they are taking those delays extremely seriously and state that SIRA is "*engaging*" with Suncorp on remediation. It is said that SIRA was also considering "*other regulatory enforcement activities".*

89. The letter answers none of the ALA's specific questions. The letter does not identify the nature and extent of the delay. The letter does not identify the remediation in progress. The letter does not indicate whether any "*other regulatory enforcement activities"* will actually be pursued. The letter does not address when the delays would come to an end. To this day, it is unknown whether SIRA ever actually got beyond "*considering*" regulatory enforcement activities and what, if anything, was done.

90. It is important for the SCLJ to understand the very considerable frustration on the part of claimants' legal representatives as to the inconsistent treatment of claims process defaults by claimants as compared to defaults by insurers.

91. Under Section 6.13 of the MAI Act, a claimant must lodge a claim for statutory benefits within 3 months. However, if the claim for statutory benefits is not made within 28 days, then weekly payments are not payable in respect of any period before the claim was actually made. In short, if the claimant misses the 28 day deadline for lodging a statutory benefits claim, the claimant is penalized by losing the income support for which the Act provides. This applies even to a claimant who is unable to lodge their claim because they are unconscious in hospital for six weeks post-MVA. A claimant who delays one day past 28 days in lodging a form loses the payments that help pay the rent or mortgage.

92. Similarly, Section 6.26 requires that at two years and six months post-accident, an insurer may give written notice to a claimant, with the claimant having three months to supply particulars of their claim. If the claimant fails to comply within that three months, then Section 6.26(3) provides that the claimant is taken to have been withdrawn. The claimant who misses the deadline can have their claim reinstated, but only if they have a full and satisfactory explanation for the failure to supply the particulars.

93. These are not isolated examples. The MAI Act is full of penalty provisions that impose harsh financial penalties, including termination of their claim, on claimants who fail to meet deadlines.

94. Compare that to the treatment of NRMA and the Suncorp brands over the past two years in response to repeated breaches of their obligations. There has seemingly been protracted and chronic failure on the part of NRMA and Suncorp to meet their obligations under the Guidelines. However, there does not appear to have been a single dollar in financial penalty imposed upon these insurers as a consequence. No Board member or Manager had their pay stopped whilst the chronic delays persisted.

95. One reasonable assumption as to at least one of the causes of the delays is a failure by NRMA and Suncorp to adequately resource their internal review teams. Put bluntly, if they employ less staff to conduct internal reviews they save money and maximise profits.

96. It is very hard for claimants' legal representatives to form any view other than that SIRA is keen to support draconian penalties being imposed on claimants who default in obligations under the Act, whilst never imposing any meaningful penalty, let alone a financial penalty, on the CTP insurers for systematic defaults. As far as the ALA can observe from SIRA's external communications, the sum total of the penalties imposed upon NRMA and Suncorp for extensive and protracted non-compliance with statutory obligations over a two year period, falls somewhere between a stern talking to and a black mark on the chart. The ALA would be delighted to learn otherwise.

Questions for SIRA – Insurer regulation and delays on Internal Review

97. The ALA encourages the SCLJ to ask the questions of SIRA that the ALA asked and that SIRA would not answer (expanded to also cover the NRMA delays):

    (a) What is the explanation from NRMA as to two years of failure to meet statutory requirements in relation to the timely conduct of internal reviews?

    (b) What is the explanation from Suncorp as to over one year of failure to meet statutory requirements in relation to the timely conduct of internal reviews?

    (c) What remedial action has been undertaken by NRMA to address their internal review delays?

    (d) What remedial action has been undertaken by Suncorp to address their internal review delays?

    (e) Is NRMA currently conducting more than 90% of internal reviews within the designated timeframe? If not, then why not?

    (f) Is Suncorp currently conducting more than 90% of internal reviews within the designated timeframe? If not, then why not?

    (g) What were the total number of claimants affected by delays in NRMA conducting internal review over the past two years?

(h) What were the total number of claimants affected by delays in Suncorp conducting internal review over the past two years?

(i) What steps (if any) has SIRA undertaken to notify greenslip purchasers as to the delays experienced by NRMA and Suncorp in relation to internal review? Does the existence of these delays appear anywhere on the SIRA website, apart from buried within the details of the insurer *Claims Experience* materials?

(j) What does SIRA say about the ALA suggestion of incorporating links on the price comparison section of the website (which is heavily utilised by the general public) to the web pages identifying non-compliant insurer behavior in claims management?

(k) Has SIRA required NRMA to publish any remedial plan in relation to the delays in internal review? If not, then why not?

(l) Has SIRA required Suncorp to publish any remedial plan in relation to the delays in internal review? If not, then why not?

(m) Has SIRA published any material in relation to the work undertaken by SIRA in addressing the delays by NRMA and Suncorp in internal review? If not, then why not?

(n) Why is any/all regulatory work that SIRA has conducted with NRMA and Suncorp in relation to protracted non-compliance with statutory timeframes conducted in secrecy? Why are all of the SIRA directions to these insurers with regards these delays not made public? Is part of the reason for the lack of transparency that SIRA is trying to cover up deficiencies in scheme performance? Why is SIRA refusing to publicly acknowledge the full nature and extent of a serious aspect of scheme performance that has chronically malfunctioned?

(o) What *"regulatory enforcement activities"* has SIRA undertaken in relation to the delays by each of NRMA and Suncorp? Are these "*regulatory enforcement activities"* being kept secret and if so, why?

Case Study – The Secrecy Surrounding Enforcement

98. Page 15 of the *Claims Experience* documents contains (as far as the ALA is aware) the totality of the known public information regarding SIRA's enforcement processes against delinquent insurer conduct. The document sets out a variety of penalty processes that can be adopted, including:

- Education.
- Notification of breach.
- Letter of censure.
- Penalty provisions.
- Criminal prosecution & licensing withdrawal.

- Media release.

99. The 30 June 2020 report records that SIRA completed 40 investigations into insurer conduct between 1 July 2019 and 30 June 2020. There were 17 consequential regulatory actions summarized as follows:

Allianz	Letter of censure.	1
AAMI	Letter of censure.	1
GIO	Letter of censure.	1
NRMA	Notices of non-compliance; Letter of censure.	10 1
QBE	Notice of non-compliance; Letters of censure.	1 2
TOTAL		**17**

100. The 30 September 2020 report shows different data, as each report seemingly involves a rotating twelve month analysis. It would appear that some 41 matters were referred to the Enforcement and Prosecution team for investigation in the third quarter of 2020 alone.

101. Although broad categories of areas of regulatory activities are mentioned, there is no specificity. The document states that (unspecified) insurers were notified (on an unspecified number of occasions) of a failure to conduct internal review within timeframes stipulated under the Act and Guidelines. However, looking at the regulatory actions taken, it would appear that at most, two years of chronic non-compliance with statutory guidelines across hundreds of cases has earnt AAMI and GIO one letter of censure each (assuming that the one letter of censure issued to each of them even related to that specific non-compliance).

102. The secrecy around SIRA's regulatory and enforcement actions is incredibly frustrating for those who seek transparent accountability for insurer conduct.

103. It is anticipated that the two civil penalties imposed on NRMA recorded in the 30 September 2020 report stem from complaints lodged on behalf of clients by an ALA member. These complaints were first lodged in November 2017 and involved (in both cases) complaint that NRMA had made excessive allegations of contributory negligence and further, that in the case of Mr. BC, NRMA had failed to engage in the just and expeditious resolution of the claim. It has taken SIRA almost three years to resolve these complaints.

104. The complainant received a final report from SIRA advising as to the outcome of the complaints by letters of 9 December 2020. In relation to each matter, it was said:

    (a) "SIRA has undertaken a comprehensive investigation following receipt of your complaints."

    (b) "SIRA has taken enforcement action and imposed a civil penalty on NRMA."

    (c) "NRMA has accepted the penalty."

105. The complainant has not been told in either case what the comprehensive investigation involved, what the comprehensive investigation found, the nature of the enforcement action or the extent of the civil penalty imposed.

106. There is no accountability or transparency in the complaints process. For all the complainant knows, for all the public knows and for all the Standing Committee on Law and Justice knows, the *"civil penalty"* imposed on NRMA following this three year *"comprehensive investigation"* may comprise no more than a scolding letter or a "*late book return to the library"* sized fine.

107. Alternately, there may have been an incredibly thorough investigation and a substantial penalty imposed. No one knows, because SIRA maintains secrecy around the complaints process and its outcomes.

108. Copies of the spectacularly uninformative correspondence from SIRA of 9 December 2020 in relation to these two complaints and the consequential investigation and civil penalty are annexed and marked **"D"**.

Questions for SIRA – Regulatory Action

109. The ALA has the following suggested questions for SIRA and a recommendation for the SCLJ.

    (a) In terms of the various letters of censure and notices of non-compliance identified on page 15 of the *CTP Insurer Claims Experience and Customer Feedback Comparison* of 30 June 2020 and 30 September 2020, have any of these been made public? If not, why not?

    (b) Why aren't letters of censure and notices of non-compliance published on the SIRA website (if need be, de-identifying individual claimants if an individual claim is the source of a non-compliance)?

    (c) When there are systemic failures (such as those involving NRMA and Suncorp in relation to internal review) why aren't any letters of censure or notices of non-compliance published?

(d) Have any *"penalty provisions*" been pursued or imposed on any CTP insurer in relation to the operation of the MAI Act? What for? What was the outcome? How long did the process take?

(e) Why do two years of non-compliance with statutory timeframes for internal review by NRMA and two years of non-compliance with statutory timeframes by GIO and AAMI not warrant the imposition of penalty provisions? If penalties have been imposed, what were they?

(f) Does SIRA appreciate that the MAI Act contains multiple punitive financial provisions applied to claimants who fail to meet their obligations under the MAI Act? Does SIRA acknowledge that there is an imbalance of penalties as between the imposition of what are effectively financial penalties on claimants (through the loss of their rights) as compared to the seeming absence of any meaningful financial penalties imposed upon CTP insurers, despite those insurers engaging in widespread and systemic non-compliance? Does SIRA appreciate that this imbalance appears chronically unfair and unjust to the legal representatives who have to deal with the punitive penalties imposed upon claimants? Does SIRA have any explanation for this imbalance?

RECOMMENDATION: That in the interests of transparency with regards insurer performance under the MAI Act that SIRA take the following steps:

A. That SIRA publish all letters of censure and notices of non-compliance on the SIRA website (subject to appropriate privacy protections for individual claimants).

B. That SIRA create a link between the price comparison sections of its website to the insurer compliance sections of its website, including a link to published letters of censure and notices of non-compliance.

C. That where any insurer non-compliance with regulatory provisions extends consistently for over a period of 6 months, SIRA have a mandatory program for utilising its media release powers regarding the non-compliance and maintain a copy of any such releases on its website.

Case Study – The Complainant's Perspective – SIRA as a regulatory black hole

110. The submissions above addressed the broad subject of delays on internal review and the lack of public communication of SIRA's regulatory activities. Individual claimants have the same unsatisfactory experience. The complainant is not usually told by SIRA about any consequences of a successful complaint as to CTP insurer misconduct. A case study is provided, but ALA members could provide dozens.

111. Ms. EP was injured in a motor vehicle accident in 2018. Her husband was killed in the same accident. The vehicle that was at fault was registered in Victoria and insured by the Transport Accident Commission ("TAC").

112. The complexities of the MAI Act mean that statutory benefits claims arising from this accident are dealt with by the Nominal Defendant, whilst damages claims arising are dealt with by TAC. The statutory benefits claims were for Ms. EP's injuries and the recovery of funeral expenses from the death of her husband. The damages claims are for Ms. EP's injuries and her Compensation to Relatives claim in relation to her husband's death.

113. What subsequently occurred to Ms. EP would be regarded by any objective observer as an awful experience for a significantly injured widow.

    (a) On 2 October 2018, SIRA (CTP Assist) wrote to Ms. EP's solicitors advising that the funeral expenses claim was to be referred to AAMI for management under the Nominal Defendant scheme. [This was the appropriate allocation of a statutory benefits claim.]

    (b) On 2 October 2018, SIRA (CTP Assist) separately wrote to Ms. EP's solicitors allocating the Compensation to Relatives claim to AAMI for management under the Nominal Defendant scheme. [This was an incorrect allocation of a damages claim where there was an interstate insurer at fault. The CTP damages claim should have been allocated to TAC.]

    (c) Over the next six months, AAMI proceeded to acknowledge receipt of the CTR claim, requested particulars, made an offer of settlement and ultimately negotiated a settlement with Ms. EP's through her solicitors. A Deed of Release was sent. The deed was signed by Ms. EP and returned to AAMI. It was only at this point that AAMI identified that they were the incorrect insurer to meet the CTR damages claim and denied all liability for that claim.

    (d) Ms. EP has subsequently had to start the damages claims process again by relodging the damages claim with TAC. Over six months has been wasted and considerable emotional trauma inflicted upon Ms. EP as a consequence of SIRA allocating the claim to the incorrect insurer and that insurer (AAMI) conducting the claim on an incorrect basis.

    (e) Ms. EP lodged a complaint with SIRA in March 2020. The complaint was acknowledged by SIRA by email of 6 March 2010. This email relevantly said:

        > *"On receipt of the insurer reply,* [to the complaint] *one of our senior complaints advisers will contact you to further understand your complaint and will provide you with a copy of the insurer reply.*
        >
        > *We aim to respond to complaints within 20 working days, unless it involves a complex matter or requires specialist investigation.*

You will be provided with updates as we work through the complaint investigation."

(f) There was a phone call from a staff member at SIRA to Ms. EP's solicitors on 16 March 2020. However, that has been the only further communication from SIRA in response to the complaint.

114. Significantly:

(a) Neither Ms. EP nor her solicitors ever heard again from a senior complaints adviser who was seeking to further understand the complaint.

(b) Neither Ms. EP nor her solicitors were ever provided with a copy of the insurer reply.

(c) Ms. EP and her solicitors have never been informed as to the determination of the complaint, let alone as to what (if any) regulatory action was taken as against AAMI in relation to AMMI inappropriately conducting a claim for which they were not liable for a period of over 6 months.

In short, Ms. EP's complaint may have been pursued by SIRA, but there has been next to no feedback to Ms. EP over what explanation AAMI has for its mishandling of the claim and any actions taken by SIRA as regulator in response.

THE TYPICAL RESPONSE TO A COMPLAINT BY SIRA

115. ALA members experienced in making complaint to SIRA about insurer conduct can attest to the standard SIRA practice in response to a complaint.

(a) The complaint will be acknowledged and SIRA will request confirmation that the complaint can be provided to the insurer and (where a legal representative is involved) request completion of a privacy waiver authority executed by the claimant.

(b) SIRA will send the complaint to the insurer.

(c) The insurer will respond to the complaint to SIRA. This will usually involve maximum "*spin"* from the insurer to minimize the perceived extent of any non-compliance.

(d) SIRA will issue a decision, usually without further discussion with the complainant. The insurer's reply will be treated as wholly truthful. [There is seemingly no actual investigation into the accuracy of the insurer's reply at this stage in process.]

(e) SIRA will write to the complainant summarizing the complaint, the insurer's reply and (sometimes, but not always) SIRA's determination. This determination

will occasionally involve "*findings"* that the insurer has breached provisions of the MAI Act and/or regulations and/or guidelines. The response will sometimes note that the matter has been referred to the "*Insurer Supervision Team*" for further consideration.

116. The final step set out above is the last communication the complainant ever receives in relation to the determination of the complaint. The "*Insurer Supervision Team*" may well exist. However, the complainant never hears further from them. There is never any follow through in telling the claimant the actual outcome of the complaint, in terms of any consequences for the insurer where misconduct is established.

117. Ms. EP and her legal representatives have never heard or found out what (if anything) were the consequences for AAMI in erroneously conducting her claim for 6 months and for settling the claim and then reneging on the settlement agreement.

118. There are multiple other examples that could be provided. ALA members who have made complaints are told that clearly established breaches of the Act and Guidelines have been referred to the Insurer Supervision Team. They then never hear anything more. Requests for the names of the persons in the Insurer Supervision Team giving further consideration to the complaint are ignored. Requests for follow up reporting from the Insurer Supervision Team as to the ultimate outcome of the complaint (in terms of penalty for the insurer) are more often than not ignored.

119. From the claimant's perspective, the Insurer Supervision Team is the ultimate black hole. From the claimant's perspective, any complaint that is forwarded to that team is forever lost. No further information or feedback is ever provided by the Insurer Supervision Team to the claimant.

120. The ALA understands that SIRA may be internally reviewing and reconsidering its approach to complaints handling. The ALA urges (in the strongest possible terms) that SIRA recast its processes so that claimants are informed as to the ultimate accountability of insurers for individual acts of misconduct. Every claimant who is mistreated by a CTP insurer, such that there is an established breach of the Act, Regulations or Guidelines, should be entitled to be told what the ultimate penalty (if any) imposed upon the insurer is.

121. The ALA urges the SCLJ to recommend that SIRA revise its complaint procedures so that complainants are told whether the determination of their complaint has resulted in any penalties for the insurer.

RECOMMENDATION: That SIRA redesign its complaint processes so that complainants are given clear information as to:

A. Each and every finding of any breach of the Act, Regulations and Guidelines in response to the specific complaint.

B. The ultimate consequence for the insurer concerned of any findings of breach of the Act, Regulations or Guidelines.

122. It is difficult for ALA members to avoid reaching the conclusion that the reason SIRA does not want to advise as to the ultimate outcome of complaints and penalties for insurers who breach the Act, Regulations and Guidelines, is that in the vast majority of cases, there are actually no penalties imposed. As previously addressed, claimants under the Act who fail to meet their obligations suffer very real financial consequences. It is suspected that insurers who fail to meet their obligations under the Act are "*educated, but* are rarely ever actually penalised in any meaningful fashion.

4. JOINT MEDICO-LEGAL EXAMINATIONS

123. For the claimant, one of the more stressful aspects of a motor accident claim is repeated medico-legal examinations. The repeated revisiting of the circumstances of accident and the continued need to "*justify*" the nature and extent of injuries is widely acknowledged to be damaging to the claimant's mental health.

124. Further, the use of "*the usual suspects*'" to conduct medico-legal examinations by both claimant and insurer results in polarised opinions and a much higher level of disputation.

125. The best answer to these issues and a workable mechanism for reducing the number of medico-legal examinations is for the parties to engage in joint medico-legal examinations.

126. SIRA first sought to encourage joint medico-legal examinations by setting up a regime for joint neuropsychometric testing over a decade ago. That scheme has been a resounding success. When there are joint examinations, the number of examinations the claimant attends has been dramatically reduced.

127. Under the MAC Act, with considerable encouragement from the ALA, SIRA introduced provisions for joint medico-legal examinations into the Claims Handling Guidelines. Under Clause 10.5 of the Guidelines, an insurer could not organise a medico-legal examination without first nominating three suitably qualified experts to the claimant, with the claimant having the opportunity to choose one of them to conduct a joint examination. Alternately, the claimant could counter with three suggested names of their own. Unfortunately, there was no tie-breaker mechanism. In the event of disagreement, each party proceeded with unilateral examination.

128. These provisions were not perfect and they were not well enforced by SIRA. There was nothing to prevent the insurer selecting three reliable experts from one highly partisan end of the available pool. SIRA seemingly never took any steps to measure insurer success rates in procuring joint medico-legal examinations and seemingly never took any steps to discipline insurers with poor joint examination rates. SIRA

seemingly never investigated whether a poor agreed joint examination rate was due to a consistent failure by the insurer to offer acceptable joint choices.

129. Nonetheless, under the MAC Act, joint examinations did occur and that resulted in reduced stress for claimants and reduced levels of disputation in those claims.

130. There is no equivalent provision to Section 10.5 of the Claims Handling Guidelines carried forward into the Motor Accident Guidelines under the MAI Act. Any obligation for insurers to offer joint examinations has been completely and mysteriously dropped. SIRA has not proffered any explanation as to why these provisions have been abandoned.

131. It is understood from discussions with SIRA that consideration is being given as to how to reintroduce some form of joint medico-legal regime for the MAI Act. However, any progress in that regard appears slow. The ALA is strongly in favour of SIRA developing a better and more robust system to encourage joint medico-legal examinations, but would urge that any system (such as that under the MAC Act) would be preferable to the complete absence of any system (such as currently prevails under the MAI Act).

132. SIRA as regulator should be endeavouring to streamline the claims process. Joint medico-legal examinations was an important step forward in streamlining the claims process. The ALA is at a loss to understand why the sensible compulsion for insurers to offer and engage in joint medico-legal examination has been removed from the motor accident scheme.

133. Insurers are not particularly interested in joint medico-legal examinations unless they are forced to engage in them. Insurers would much rather pick the reliable and known doctors off their panel who will produce the predictable results.

134. If SIRA is serious about joint medico-legal examinations (and the ALA urges that they should be), then it is necessary to both compel insurers to offer joint examinations and to measure insurers' success in reaching agreement for joint examinations.

135. If the insurers are measured as to their success in obtaining joint medico-legal examinations and if comparative rates are published, then it is likely that insurer conduct will change. If insurers are rated and ranked, then they will start offering three *"middle of the range*" choices to the claimant's solicitors because the insurer will know that this is the only way to secure a joint examination. If provided with three middle of the range choices, the claimant's solicitors are then incentivised through costs structures to engage in a joint examination.

136. SIRA as regulator should be trying to ease and smooth the claims experience for claimants. Joint medico-legal examinations delivers that outcome and yet SIRA has inexplicably stepped away from its previous modest efforts to promote joint examinations.

Questions for SIRA – Joint medico-legal examinations

137. The ALA suggests the following questions for SIRA:

(a) Does SIRA agree that joint medico-legal examinations reduce the stress upon claimants and reduce the level of disputation within the scheme?

(b) Assuming the answers to the preceding question is yes, does SIRA agree that the Guidelines under the MAI Act are less likely to encourage joint medico-legal examinations than the provisions still in place under the MAC Act?

(c) Why were the joint medico-legal provisions contained within the MAC Act Regulations/Guidelines not carried forward into the MAI Act Regulations/Guidelines?

(d) Why are there no provisions within the Motor Accident Guidelines applicable to the MAI Act compelling insurers to try and engage in joint medico-legal examinations?

RECOMMENDATION: In order to encourage the use of joint medico-legal examinations:

A. That SIRA introduce provisions into the Motor Accident Guidelines applicable to the MAI Act compelling insurers to offer joint medico-legal examinations to claimants who are legally represented.

B. That SIRA monitor, measure and publish data on insurer success rates in agreeing joint medico-legal examinations.

5. THE AUTHORISED HEALTH PRACTITIONER REGIME

138. Under the MAC Act, there were no limitations on who could provide a medico-legal report for the purposes of an MVA claim.

139. Section 7.52 of the MAI Act introduced a new regime to restrict the health practitioners who could provide reports in motor accident claims. This has become known as the Authorised Health Practitioner or "*AHP"* regime. Section 7.52(1)(b) provides that a medical report is not admissible unless "*the practitioner is authorised by the Motor Accident Guidelines to give evidence in the proceedings".*

140. There are multiple problems with the AHP regime. SIRA spent the better part of two years engaged in extensive consultations over how to try and authorise health practitioners. For all of those efforts, it appears that there is minimal regulatory restriction placed on who will be authorised under the regime. In making

appointments to the list, SIRA is not engaged in any qualitative review to eliminate partisan opinion providers. The most partisan of medico-legal opinion writers are appointed.

141. The reality is that SIRA is not well-equipped to be a regulator of the quality standard of the report writing sector of the medical profession.

142. It appears that the AHP scheme is entirely ineffective at removing partisan doctors from the motor accidents scheme. To give one example, the SCLJ is referred to the decision of Deputy President Roche in the NSW Compensation Court in *Patrick Stevedores Holdings Pty Ltd v Fogarty* [2014] NSWWC CPD 76.

143. In that case, the court observed in relation to a doctor that one of his assertions *"…was unsupported by any reasoning and stretched credulity to breaking…[*at 91]".

144. The court then commented in relation to various matters raised by that doctor that they:

> *"…raised serious issues about* [the doctor's] *objectivity that warrant investigation into his status as a WorkCover approved impairment assessor."*

145. These comments were drawn to SIRA's attention after the same doctor was and remains appointed an AHP. The response from SIRA (in an email of 11 September 2020) was as follows:

> *"The issue being re-agitated in your letter relates to comments made by a decision-maker several years ago in a different jurisdiction (not the motor accidents scheme) in* [the doctor's performance of] *a different role not as an authorised health practitioner. SIRA did not have any regulatory powers to act on the comments at the time they were made, and SIRA is not aware of any action taken by the bodies responsible for regulating* [the doctor's] *profession as a result of the comments. Consequently, the matter was closed and no further action will be taken by SIRA in response to those comments. If such a comment were to be made following a practitioner's appointment under the new terms, it may give SIRA cause to communicate with the practitioner to remind them of their obligations. According to the principle of procedural fairness, any such communication would need to provide the practitioner with an opportunity to show cause. An assessment would then be undertaken to determine whether a practitioner had complied with the requirements of the authorised health practitioner role following their appointment."*

146. It appears that SIRA is saying that they will give no regard to any prior conduct when considering the suitability of a doctor to be appointed an AHP. Further, if in the future, adverse judicial comments are made about a doctor on the AHP list, then it appears that SIRA might give the doctor a gentle reminder about their obligations, but

it does not appear as if SIRA has any real enthusiasm for removing doctors from the AHP register for extreme acts of partisanship.

147. Separately, the ALA has written to SIRA addressing issues with the drafting of Section 7.52 in the present tense. Annexed to this submission are the following letters from the ALA to SIRA as marked:

"E" 7 May 2020.
"F" 14 July 2020
"G" 11 August 2020
"H" 11 August 2020 (addressed to DRS)

148. These letters identify some of the issues with the drafting of the AHP provisions.

149. These letters contain numerous examples of the difficulties with the construction of the AHP provisions. To give just a few examples:

(a) The use of the present tense in Section 7.52 (the word "is") means that an insurer can send a claimant to a medico-legal examination with someone who is not an AHP. If that doctor or allied health professional is added to the AHP list the day before an assessment or hearing, then their report magically shifts from being inadmissible to admissible. This provides an unworkable lack of certainty for the claimant.

(b) In a similar vein, SIRA is trying to work around the problem of the drafting incorporating the present tense by maintaining a list of "inactive" assessors. Apparently, assessors will have to remain on this list, years after they cease to practice or even die because they have to remain authorised as at the date of hearing from their report to be admissible.

(c) A claimant may attend a medico-legal examination on behalf of a worker's compensation insurer in circumstances where the WC insurer is administering statutory benefits (by virtue of Section 3.35 of the MAI Act). However, that report is inadmissible in the CTP claim unless the WC doctor coincidentally happens to be an AHP under the motor accidents scheme. This is patently ridiculous.

150. The ALA's primary recommendation is that the AHP regime be scrapped and that Section 7.52 be removed from the Act. The regulatory regime is pointlessly bureaucratic and is delivering no measurable benefit in terms of improvements in the standard of medico-legal report writing.

151. In the alternative, the ALA recommends that Section 7.52 be revised to remove the present tense (the word "is"), in terms of determining admissibility of reports based on the AHP status as at the date their medical report is tendered. The section would work much more smoothly if the requirement was that the AHP be on the authorised

list at the time he or she conducted the medical assessment and wrote the report, rather than some years later when somebody seeks to tender the report as evidence.

Questions for SIRA – The AHP Regime

152. The ALA suggests the following questions for SIRA:

(a) How many applicants have been denied status as an AHP? What has been the basis for such denials?

(b) Have any applicants been denied AHP status on the basis of any quality standard?

(c) Can SIRA identify any actual measurable benefit to the motor accidents scheme flowing from the introduction of the AHP regime? What objective measurement is there as to any such benefits?

(d) Does SIRA acknowledge that there are additional bureaucratic burdens created by the AHP regime when it comes to the conduct of medical assessments for claimants who are injured in NSW, but live interstate and overseas?

(e) Does SIRA acknowledge that there is a problem stemming from the use of the present tense and the word *"is"* in Section 7.52? Does SIRA acknowledge that the section would be more useful if the examiner had to be authorised as at the date of the examination, rather than potentially years later as at the date the report is tendered?

RECOMMENDATION: Given the lack of identified benefits flowing from the AHP regime:

A. That Section 7.52 and the AHP regime be removed from the MAI Act.

B. In the alternative, Section 7.52 be redrafted to require that the AHP be authorised as at the time the examination is conducted and report provided rather than as at the time the report is tendered in evidence.

REVISIONS TO THE MAI ACT

153. As the preceding submissions identify, there is substantial overlap between SIRA and its regulatory performance and the specific provisions of the MAI Act. What follows are some specific statutory construction issues that have arisen where the ALA encourages the SCLJ to recommend reform.

6. SECTION 4: THE DEFINITION OF MINOR INJURY – ADJUSTMENT DISORDERS

154. Whether or not a claimant has a minor injury is of critical significance under the MAI Act. Those with a minor injury lose all entitlements to any compensation from 6 months post-accident.

155. Section 1.6 of the MAI Act defines a minor injury as being:

    (a) A soft tissue injury; or

    (b) A minor psychological or psychiatric injury.

156. Section 1.6(3) provides that a minor psychological or psychiatric injury includes any injury that is not a recognized psychiatric illness.

157. Section 1.6(4) makes provision for the regulations to specify additional psychiatric injuries as being a minor psychological or psychiatric injury.

158. Section 4 of the Motor Accident Injuries Regulation 2017 defines the following injuries as constituting a minor psychological or psychiatric injury for the purposes of the Act:

    (a) Acute stress disorder.

    (b) Adjustment disorder.

159. An email from SIRA of 2 June 2017 [attached and marked **"I"**] makes clear that acute stress disorders (ASD) and adjustment disorders (AD) were considered by SIRA as appropriate to be deemed minor psychological injuries because they were both diagnoses that were only applicable to psychiatric injuries occurring and resolving within the first six months following the accident.

160. Calling these two conditions a minor injury would be consistent with the overall scheme of the Act that provided no-fault compensation for 6 months, but required more than a minor injury for those who could establish fault to continue to receive any benefits after six months.

161. The email of 2 June 2017 specifically flagged a risk that there would be inaccurate diagnoses of adjustment disorders *"such as overuse of the diagnosis when the clinician does not think a PTSD or major depression are appropriate."* It was suggested that this risk of inaccurate diagnosis could be addressed through the assessment guidelines and provider education.

162. Unfortunately, this risk was not addressed in any guidelines. It is unknown if there has been any "*provider education".* However, a significant issue has arisen in terms of the consideration of whether an adjustment disorder can extend beyond 6 months.

163. The ALA wrote to SIRA with regards this issue on 29 September 2020 [letter attached and marked **"J"**]. The ALA has not yet received a response. The letter addresses a specific case where a claimant was accepted by the insurer as having a PTSD for over two years post-accident. For those two years, the insurer paid statutory benefits. The claimant's medico-legal examiner determined that there was 16% WPI. The insurer's medico-legal examiner determined that there was 17% WPI. This claimant clearly has a significant psychiatric injury.

164. Nonetheless, over two years post-accident, the claimant now finds himself back in the DRS medical assessment system because the insurer medico-legal assessor slapped the label "*Adjustment Disorder*" on his psychiatric condition rather than PTSD. When this occurred the insurer put "*minor injury"* back in issue. The claimant has had to seek internal review of that decision and then take that minor injury dispute to DRS.

165. The case is yet to be considered by DRS and the ALA does not seek any comment from the SCLJ as to the specifics of the case. However, as the ALA letter emphasises, it is not crystal clear either within DSM 5 or any provision of the Motor Accident Guidelines that it is inappropriate or impermissible to diagnose a significant psychiatric condition that is persisting over two years post-accident as an Adjustment Disorder and thus, as a minor injury. Part of the problem stems from the fact that DSM 5 has two categories of adjustment disorder, being "*acute*" and "*persistent (chronic)".* There is also complexity around the definition of the applicable "*stressor".*

Questions for SIRA - The definition of Minor Injury – Adjustment Disorders

166. The ALA suggests the following questions for SIRA:

(a) Does SIRA acknowledge that the email of Ms. Baird of 2 June 2017 encapsulated the policy basis for regulating that an acute stress disorder and adjustment disorder be deemed minor psychiatric injuries? Was that basis that both diagnoses only applied to psychiatric conditions that would resolve within 6 months?

(b) Is the policy intent behind the regulation that a diagnosable psychiatric injury that persists beyond six months should not be diagnosed as an acute stress disorder or an adjustment disorder?

(c) Were any guidelines issued to address the misdiagnosis risk identified in the email?

(d) To ensure the proper function of the regulation as intended, does SIRA agree that the regulation requires amendment to limit the deeming of adjustment disorders as minor injury to "*acute*" adjustment disorders with the exclusion of "*persistent/chronic*" adjustment disorders?

RECOMMENDATION: To better reflect the drafting intent behind the Regulation:

A. That Section 4.2(b) of the Motor Accident Injuries Regulation 2017 be amended by removing the provision that every "*adjustment disorder"* is a minor psychological or psychiatric injury and instead provide that an *"acute adjustment disorder, but not a persistent (chronic) adjustment disorder"* is a minor psychological or psychiatric injury.

B. That there be a deeming provision in Section 4 of the Regulations that any injury that exceeds 10% WPI on either physical or psychological grounds at a point six months after the subject accident or later be deemed to be more than a minor injury.

7. THE EFFICACY OF INTERNAL REVIEW (Sections 7.11, 7.19 and 7.41)

167. The MAI Act has introduced an extensive regime of internal review by insurers prior to a claimant having access to the Dispute Resolution Service (DRS). There are serious questions with regards the efficacy of internal review.

168. These submissions have already addressed the considerable delays many claimants have encountered as a consequence of some CTP insurers being unable to conduct internal reviews within the prescribed timeframes.

169. Just as significantly, the data collected by SIRA indicates that in some dispute categories, internal review rarely leads to any change in the insurer's determination. In those dispute categories, internal review is a waste of time.

170. It is noted that just as the motor accidents scheme was introducing internal review, the workers compensation scheme acknowledged the lack of effectiveness of internal review and stepped away from substantial reliance on it as a dispute resolute mechanism.

171. The attention of the SCLJ is directed to the reports of SIRA dated 30 June 2020 and 30 September 2020 on *CTP Insurance Claims Experience and Customer Feedback Comparison.*

172. Chart 6 on page 8 shows that internal review does lead to a significant number of the initial decisions being overturned in relation to disputes regarding the quantification of weekly wage payments. However, there is a significantly lower overturn rate in relation to liability decisions (is the injured person mostly at fault) and an extremely low overturn rate in relation to insurer minor injury determinations.

173. The question is, how well do insurer decisions on internal review hold up when they are subject to the scrutiny of a DRS determination? The partial answer to this can be found in Chart 9 on page 11.

174. It is worth noting that the data in Chart 9 only encapsulates decisions by DRS. It does not incorporate or capture instances where the insurer abandons its position prior to DRS determination. There have been numerous examples of CTP insurers denying liability at first instance, continuing to deny liability on internal review, but accepting liability after a DRS application has been lodged and before a DRS determination has been made. [The change of mind may come when the dispute sees the insurer obtain legal advice that their decisions to date are not supported by the weight of the evidence.] The SIRA data most likely under-estimates the actual "*overturned"* rate of insurer internal review decisions by not including cases where the insurer surrenders before a decision is made.

175. What the SIRA data shows is that the measured overturn rate in actual DRS decisions is as follows [from 1 December 2017 through 30 June 2020]:

	OVERTURNED
Minor injury	32%
Treatment and care	45%
Liability (is injured person mostly at fault?)	66%
Weekly payments	53%

176. It is acknowledged that in some instances, there will be additional evidence adduced by the claimant between internal review and DRS determination. There are also cases where there is additional evidence adduced by the insurer.

177. However, what is clear is that the efficacy of internal review is questionable, given the relatively low internal overturn rate in relation to initial insurer decisions and the relatively high external (DRS) overturn rate in relation to initial insurer decisions. Why delay claimants from getting to the neutral and objective decision maker where there is a real chance of a proper decision?

178. For all of the effort and delays involved in internal review, the ALA is of the view that the CTP scheme would run more smoothly if claimants could proceed immediately after the initial decision on minor injury and liability to adjudication by an independent, external decision maker at DRS. The internal review system is not justifying its time and cost by providing a meaningful independent review of insurer decisions.

179. The ALA accepts that there is some utility in having wage disputes continue to go through internal review. Indeed, the ALA has no strenuous objection to the retention of Section 7.11 whereby all merit review decisions are subject to internal review.

180. In relation to Section 7.19 and medical disputes, there is some argument to retain internal review in relation to treatment disputes, but there is clearly little merit in retaining internal review in relation to minor injury decisions, as there is a negligible internal review overturn rate.

181. In relation to liability decisions, the ALA strongly urges the removal of Section 7.41 and any internal review regime in relation to liability decisions. Even with an overturn rate of 30%, the 70% of original decisions that insurers affirm are being overturned two-thirds of the time.

Questions for SIRA – The efficacy of Internal Review

182. The ALA suggests the following questions for SIRA:

(a) Having regard to submissions from the ALA, what comment does SIRA have with regards the efficacy of the internal review regime? Specifically, is internal review by insurers in relation to minor injury decisions and liability decisions enhancing the claimant experience or merely adding additional levels of complexity and dispute?

(b) Has SIRA set any benchmarks to measure the efficacy of internal review? If so, then what are those benchmarks and what are the results? If not, then why not?

(c) Has SIRA done any auditing of the quality of insurer internal review decisions? If so, what has been the finding of those audits?

(d) Does SIRA accept that the "*overturn*" rate of insurer internal review decisions is not fully captured by DRS decisions as there are additional claims where the insurer reverses the internal review decision after lodgment of a DRS dispute, but prior to a DRS decision?

(e) The data at Chart 9 on page 11 of the *CTP Insurer Claims Experience and Customer Feedback Comparison* of 30 June 2020 provides a breakdown of the outcome of resolved DRS reviews. However, there is no breakdown as between insurers. Has SIRA conducted any analysis as to the overturn rate of individual insurer internal review decisions in relation to minor injury, treatment and care and liability? Is there any significant difference as between insurers? Has SIRA taken any action in relation to any insurers who have a significantly higher percentage overturn rate of their internal review decisions? If so, what has that action from SIRA involved?

RECOMMENDATION: Given the modest efficacy of internal review:

A. That the applicable regulations under Section 7.19 of the MAI Act be amended to provide that treatment disputes remain subject to internal review, but that minor injury decisions be exempt from internal review.

B. That Section 7.41 be removed from the Act so that miscellaneous claims assessment matters (primarily liability disputes) not be the subject of internal review, with the intent that claims where liability is denied proceed straight to a DRS assessment, rather than internal review.

C. Alternately, that the Motor Accident Regulations provide that liability disputes be exempt from internal review.

8. ONLY ONE INTERNAL REVIEW PER DISPUTE CATEGORY

183. There are no restrictions with the MAI Act limiting the number of internal reviews per dispute category. There is power for the Regulations to impose limits, but they do not do so. Unfortunately, the Regulations do not make any provision limiting the number of internal reviews where an insurer makes multiple and varying decisions on an issue (such as the liability to pay statutory benefits).

184. The ALA wrote to SIRA regarding this issue on 17 July 2020 [letter attached and marked **"K"**]. That letter gives examples of cases where insurers can (as they do) issue multiple liability decisions over the course of the claim requiring the claimant to keep applying for internal review before being able to access DRS for a final determination.

185. To give just one example of the dysfunctionality of the nature of the scheme:

- An insurer initially denies liability.
- This decision is affirmed on internal review. The claimant lodges an application for determination by DRS.
- The insurer then issues a further liability notice admitting liability, but alleging 80% contributory negligence.
- Technically, as the Act and Regulations are currently structured, the DRS application would be dismissed and the claimant would then be required to seek internal review of this new 80% decision.
- Assume internal review confirmed the 80% decision.

- The claimant could then lodge again with DRS.

- If the insurer then issues a further liability notice still admitting breach, but alleging 60% contributory negligence, the claimant would be required to proceed through a third internal review before accessing DRS.

Hopefully, the SCLJ can see why there should be a limit of one internal review per dispute.

186. The ALA received a response from SIRA of 29 October 2020. The response indicates SIRA will consider the ALA submission as part of the three year review "*over the course of the next twelve months."* The SIRA response would seem to indicate that it may be upwards of 18 months before anything might happen to actually limit the number of internal reviews which a claimant is required to pursue. The ALA is unimpressed with that timeframe. This is a straightforward regulatory adjustment that should be more rapidly implemented.

Questions for SIRA –One Internal Review per dispute category

187. The ALA suggests the following questions for SIRA:

(a) Does SIRA agree that the Regulations made pursuant to Sections 7.11, 7.19 and 7.41 of the Act are capable of amendment to provide that there need only be one internal review per dispute category per claim?

(b) What objection (if any) does SIRA have to so amending the Regulation?

RECOMMENDATION: To improve the efficacy of the scheme:

A. That regulations made pursuant to Sections 7.11, 7.19 and 7.41 of the Act be amended to provide that there need only be one internal review per dispute category per claim.

9. WHAT DOES SECTION 8.10(4)(a) MEAN?

188. Some statutory benefits disputes under the MAI Act make no provision for the recovery of legal costs. Legal practitioners are prohibited from charging if they elect to assist a claimant.

189. Other dispute categories carry a regulated fee, which as currently indexed, is just over $1,660 (plus GST). Again, a legal practitioner is prohibited from charging more than the regulated fee.

190. SIRA is currently undertaking a review of the costs regime as part of the transition of the DRS into the Personal Injury Commission (PIC). The ALA will be making submissions to that review as to the grossly inadequate nature of the regulated fee for a number of dispute categories.

191. There is a safety valve built into the costs regulations in that Section 8.10(4)(b) allows for the recovery of costs in excess of the regulated fee in "*exceptional circumstances".*

192. Under the MAI Act, DRS assessors have made a number of exceptional costs orders, primarily in relation to complex liability disputes.

193. The other safety valve built into the Act is at Section 8.10(4)(a) where the Dispute Resolution Service can permit payment of legal costs in excess of the regulated fee incurred by a claimant who is under a legal disability.

194. The ALA strongly supports the existence of Section 8.10(4)(a). Whilst the ALA is firmly of the view that many otherwise competent adults could not navigate the MAI Act on their own (especially those of limited education or for whom English is a second language), it is absolutely beyond dispute that children or those with an intellectual disability could not navigate the scheme on their own. Legal assistance is essential.

195. The Parliament has rightly recognized that the intellectually disabled and children should be able to access legal assistance to navigate their way through the maze of the statutory benefits regime under the MAI Act.

196. However, there is ambiguity as to the construction of Section 8.10(4)(a). The use of the present tense ("*…the claimant is under a legal disability")* raises questions of statutory construction around claimants who are under a legal disability at the commencement of the claim (i.e. a child of age 16 or 17), but where the claimant is no longer under a legal disability (has turned age 18) at the time of the making of a costs order.

197. The ALA wrote to SIRA on 18 August 2020 [letter attached and marked **"L"**] asking for clarification around the construction of Section 8.10(4). SIRA has responded by letter dated 27 November 2020 [annexed and marked **"M"**]. The response leaves claimants in an entirely unsatisfactory position. Relying on a discretion to recover costs incurred during a period when those costs were initially recoverable as of right just because the claimant has turned 18 is unfair.

198. A solicitor acting for a 17 year old claimant ought to have clarity and certainty around getting paid for the work undertaken. It seems ludicrous that there could be an issue as to the costs that might be paid depending upon whether the DRS Assessor made a decision about the payment of costs the day before or the day after the claimant turned 18. The ALA seeks clarity and fairness in the statute.

Questions for SIRA – Costs for Exceptional Circumstances

199. The ALA suggests the following questions for SIRA:

    (a) How does SIRA understand Section 8.10(4)(a) is to be construed for a claimant under legal incapacity on the basis of age? Is that claimant entitled to recover

legal costs as permitted by DRS for the duration of their statutory benefits claim? Or is the exemption from the applicable costs regulations only applicable whilst the legal disability persists?

(b) If the claimant is 17 at the time of accident and turns 18 the day before a DRS assessment, then what costs are recoverable? Is that claimant entitled to permitted costs up to age 18 and regulated costs thereafter? What are the policy grounds behind the drafting of the Act?

RECOMMENDATION: That SIRA review the drafting of Section 8.10(4)(a) to ensure that a legal practitioner acting for a claimant under a legal disability is entitled to recover legal costs for statutory benefits claims outside the scope of the regulated costs regime whilst the claimant is under that legal disability.

10. SECTION 3.37 AND A SERIOUS DRIVING OFFENCE

200. It is never a popular cause to advocate on behalf of those who have committed driving offences. Nonetheless, punishments for driving offences should be fair and proportionate. Section 3.37 of the MAI Act denies any recovery of statutory benefits to a claimant who has committed a serious driving offence. A low range PCA with a BAC of 0.051 is defined to be a serious driving offence.

201. The ALA has an issue with the complete bar to the recovery of all past and future treatment expenses for a claimant who has a low range PCA where that low range PCA does not contribute to the circumstances of accident. The MAI Act denies any compensation for past and future treatment expenses to a motorist who is rear-ended at traffic lights and subsequently returns a reading of 0.051 on a breath test.

202. The civil law is imposing an unjust and disproportionate penalty on top of the criminal law. The ALA urges that the usual application of principles of contributory negligence provides the appropriate civil remedy.

203. This penalty would **not** have applied under the MAC Act and does not apply to any other tortious liability. With the MAC Act and the Civil Liability Act, any serious driving offence is dealt with as contributory negligence. If the serious driving offence is not causative of the accident or injury, there is no reduction in damages. The reason the situation changes with the MAI Act is that past and future treatment expenses are statutory benefits and cannot be recovered as lump sum damages. To bar recovery of statutory benefits on the basis of a serious driving offence is to bar any recovery of compensation for treatment expenses at all.

204. The ALA wrote to SIRA regarding this issue on 27 July 2020 providing a case study based on a DRS decision [letter attached and marked **"N"**]. In the particular case, the claimant returned a BAC of just over 0.05. The reading was from drinking the night before rather than on the day of the accident. The DRS Assessor held that the claimant's low range BAC reading was in no way causative of the accident. The claimant was rear-ended whilst turning into a McDonalds' carpark. Nonetheless, the

DRS Assessor held that the drafting of Section 3.37 meant that the claimant was not entitled to any statutory benefits. That in turn means the claimant will be denied any compensation for past or future treatment expenses.

205. The severity of this penalty runs well in excess of anything applicable under the MAC Act. It is consistent with common law principles. The low range PCA offence in no way causatively contributed to the circumstances of accident.

206. In the particular case study, the treatment expenses at stake were relatively modest. However, the same total prohibition on the recovery of treatment expenses would have applied if the claimant had lost a foot and was in need of hundreds of thousands of dollars of future treatment by way of prosthetic devices.

207. There was a response to the ALA letter of 27 July 2020 from SIRA dated 28 October 2020 [attached and marked **"O"**]**.** SIRA indicates that as the concerns raised were "*a departure from current policy, they will be considered as part of SIRA's 3-year scheme review over the course of the next twelve months."*

208. The ALA is occasionally disappointed by SIRA's unwillingness to look at a situation, declare an outcome to be unjust and commit to fix the issue. This is such a case.

209. The outcome in the case study contained within the letter is palpably unjust and legislative reform should be pursued.

Questions for SIRA - Section 3.37 and a Serious Driving Offence

210. The ALA suggests the following questions for SIRA:

(a) Take the case of a motorcyclist who is run down at an intersection by a truck. Assume the truck driver to be entirely at fault. Assume the cyclist has a foot amputated in the accident. The motorcyclist subsequently returns a BAC reading of 0.051, on the basis of residual blood alcohol from drinking the night before.

(i) Does SIRA agree that the current operation of Section 3.37 would deny the motorcyclist a lifetime of statutory benefits for treatment, including the very significant cost of prosthetics?

(ii) Does SIRA acknowledge that the financial penalty on this motorcyclist for returning a low range PCA extends beyond the criminal consequences to a penalty potentially amounting to hundreds of thousands of dollars in compensation rights foregone?

(iii) How does SIRA justify this policy outcome?

RECOMMENDATION: That Section 3.37 be redrafted to require that any non-causative serious driving offence not be a bar to the recovery of statutory benefits. Additionally, where there is fault on the part of someone other than the claimant, the serious driving offence should be treated as contributory negligence (to the extent applicable) rather than a complete bar to statutory benefits.

11. SECTION 6.14 AND THE 20 MONTH WAIT

211. Section 6.14 of the MAI Act provides that a claim for damages cannot be made until 20 months post MVA unless the claimant has greater than 10% WPI. This provision is causing major disruptions within the scheme.

212. One of the issues that arises is a "*chicken and egg*" question with regards DRS determination of disputes as to whether the claimant exceeds the 10% WPI threshold as a precursor to bringing a claim.

213. Section 6.14(1) provides that a claim cannot be made unless the degree of permanent impairment is greater than 10%. Section 7.20 provides that a medical dispute *"about a claim"* may be referred to the Dispute Resolution Service for assessment.

214. A vexing issue arises where the insurer disputes that injuries are greater than 10% WPI. Does a claimant have a dispute about the "*claim*" required by s.7.20 in order to apply to DRS if the claim cannot actually be made until DRS certify that injuries are over 10%? How can you have a dispute about a claim that the insurer says you are not eligible to lodge?

215. SIRA and DRS have been papering over this crack in the Act by accepting applications for determination of WPI in advance of the damages claim being lodged. The ALA agrees with this outcome. However, the statutory basis for this occurring is problematic. It should not be. The legislation should make clear that a claimant is entitled to apply to DRS for a determination of WPI in order that they can then pursue a claim for damages in advance of the twenty month barrier.

216. The imposition of a WPI threshold as a precursor to bringing the common law damages claim inside of 20 months is also causing considerable disputation within the scheme. Claimants are seeking concessions from insurers as to WPI so that they can progress their damages claims before 20 months. Insurers who are not yet ready to process the claim are endeavouring to stall the claimant by indicating that they are not yet in a position to make a decision on WPI. Some insurers assert that the claimant cannot proceed to a DRS determination on WPI as there is no dispute to resolve when the insurer refuses to make a decision.

217. To lodge with DRS, it is necessary that there be a dispute. The question then arises as to whether the insurer's non-decision decision (where the insurer says "*We can't yet say if you are over 10% or not*") creates a dispute that can be referred to DRS. There

are inconsistent decisions from the DRS registry as to whether a non-decision is a decision such as to generate a dispute.

218. Under the MAC Act, a determination about whether the claimant's injuries exceeded the 10% WPI threshold did not arise until well into the life of the claim. An insurer had to be notified of the claim within 6 months of the accident and a WPI decision did not usually arise until somewhere between twelve months and two years post-accident.

219. Under the MAI Act, the WPI decision is being front-end loaded as the very first decision a CTP insurer needs to make as to whether to accept a damages claim prior to 20 months. This in turn has created considerable disputation.

220. The ALA has engaged in correspondence with SIRA regarding this issue. Attached is the following correspondence marked as indicated:

"P"	ALA letter to SIRA and DRS dated 15 July 2020.
"Q"	SIRA response to the ALA dated 22 September 2020
"R"	ALA letter of 24 September 2020.

221. It is acknowledged that SIRA are trying to craft Guideline provisions to bring about the smoother operation of the twenty month/10% WPI barrier to claims. Whether any bandaid solution from SIRA ends up creating more disputes rather than less remains to be seen.

222. It is the ALA's position that the fundamental difficulty is the imposition of the twenty month barrier. The ALA urges the SCLJ to recommend the removal of the twenty month barrier to bringing a damages claim.

223. It is difficult to understand what policy imperative drove the twenty month barrier. The ALA questioned this provision when it was first introduced. The ALA assumes that the intent was to try and deter those with less serious injuries from bringing damages claims at all. Perhaps the hope was that the claimant who was kept waiting for twenty months would give up on a modest damages claim and abandon their entitlements.

224. The ALA submits that it is an incredibly unattractive deliberate design feature of a compensation scheme to structure it such that claimants lawfully entitled to recover damages are so frustrated by the system that the abandon their entitlements.

225. It may be that there is some health benefit to claimants in deferring consideration of compensable rights. The ALA is not aware of any objective medical evidence in support of such a suggestion or any magic to the twenty month figure. The ALA suggests that delaying the making of claims until twenty months simply extends the period for which the claim is afoot and that this in turn will have a deleterious effect on some claimants' mental health.

226. It is difficult to understand why SIRA would want to delay the resolution of damages claims. Take the example used earlier in these submissions of a claimant who suffers a significant fracture to their leg. The healing process means that the claimant is off work for twelve months. Assuming that there is no liability issue, that claimant will have more than a minor injury and will be paid a portion of their lost wages for the twelve months that they are off work as a statutory benefit.

227. Further assume that at twelve months, this claimant returns to their fulltime employment, has injuries that are under 10% WPI and is unlikely to face any future time off work.

228. This claimant will have a modest damages claim. He or she will be entitled to the top up of their lost wages over the twelve months that they were off work. He or she will also be entitled to the lost superannuation benefits from that period. For a claimant who was earning $50,000 gross per annum, that loss is likely to be in the order of $10,000 to $12,000 in damages. For a claimant who was on $100,000 gross per annum, that loss might be closer to $15,000 to $20,000.

229. Within a couple of months of their full return to work, this claimant would no doubt like to resolve all outstanding motor accident claim issues and move on with their life. However, the operation of Section 6.14 requires this claimant to wait until 20 months post-accident (8 months after their full return to work) before they can lodge a claim for damages and seek to recover the outstanding damages owed (the top up to past wage loss).

230. The ALA urges the SCLJ to closely question SIRA about whether SIRA actually wants this hypothetical worker to abandon their outstanding entitlements or whether SIRA wants this claimant to return after twenty months and claim their damages entitlements. The ALA would like to think that the answer from SIRA is going to be that they want this injured person to get the damages that they are entitled to. However, the ALA suspects that SIRA is currently doing nothing to ensure that this person returns to the scheme to make their damages claim.

Questions for SIRA– Section 6.14 and the 20 month wait

231. The ALA suggests the following questions for SIRA:

    (a) What is the policy imperative behind Section 6.14(1)?

    (b) Does SIRA acknowledge that there have been disputes arising from the front-end loading of WPI disputes by Section 6.14(1)?

    (c) Is it part of the policy intent of Section 6.14(1) to have claimants with a proper entitlement to modest damages abandon those entitlements by making those claimants wait 20 months to bring the claim?

(d) What steps has SIRA taken to educate and advise claimants as to their damages rights? Does SIRA have in place any mechanisms to alert claimants who have returned to work as to their entitlement to recover damages, even if those damages are limited to a top up of the past wage loss and past loss of superannuation benefits? If not, then why not?

(e) Has SIRA done any measuring of the "*walk away*" rate from damages claims? As a simple measure, every claimant who has received a payment of weekly benefits post six months is likely to have a damages claim. A claimant is only entitled to weekly payments post six months if liability rested with the insurer and there was more than a minor injury. The payment of weekly benefits necessarily involves a gap between those weekly benefits and the full entitlement to damages for past loss of earnings. SIRA ought to be able to make a rough measurement of year one claimants who recovered statutory benefits past six months and have not pursued a damages claim. How many claimants are there in this category and what steps has SIRA taken to check that these claimants are aware of their entitlement to damages, at least to the extent of a top up on their past wage loss (and lost superannuation benefits)?

RECOMMENDATION: Acknowledging that early notification of a damages claim allows for early preparation and resolution of that claim, it is recommended that Section 6.14 of the Act be amended to remove the requirement that a claimant with injuries less than 10% WPI be required to wait 20 months before lodging their claim.

12. TIDYING UP THE NO-FAULT ACCIDENT PROVISIONS POST *SINGH*

232. There have been relatively few judicial considerations of the MAI Act to date. In *AAI Limited v Singh* [2019] NSWSC 1300 Justice Fagan gave consideration to the no-fault accident provisions in Part 5 of the MAI Act. This Section replaced the blameless accident provisions under the MAC Act.

233. In issue was whether the provisions of Part 5 in relation to a no-fault accident had any application to the statutory benefits regime under Part 3. Justice Fagan ultimately determined they did not.

234. Justice Fagan concluded his judgment by recommending legislative reform of Part 5 to bring greater clarity to it. The judgment relevantly states:

> *26. Notwithstanding the path through the labyrinth of Pts 3 and 5 of the Motor Accidents Injuries Act has been found for the purposes of resolving this proceeding, it is apparent that these provisions, Pt 5 in particular, require careful and detailed consideration. Amendment will be necessary for a spate of litigation generated by the obscurities of these provisions is to be avoided. At the very least, the conflict between ss5.1 and 5.6 should be addressed by amendment. If the interpretation adopted in these reasons accords with parliament's intention then s5.6 should be repealed. If not, the definition of*

'no-fault motor accident' in s5.1 will require amendment in some respect, adopting a qualification to the concept of 'any other person' that I cannot presently envisage.

27. A further amendment to Part 5 that might be considered is the removal s5.3(2) and the reference to statutory benefits in ss5.2(1) and 5.5 (and s5.6, if it is not to be repealed). The words 'statutory benefits' have already been deleted, by amendment, from s5.4(1). They do not seem to have any place in s5.2(1), 5.5 or 5.6. …..There is no need for the provisions of Part 5 to deal with statutory benefits, at all.

235. The ALA is not aware of SIRA having implemented Justice Fagan's comments or addressed the recommended legislative reform to Part 5.

236. The ALA supports the legislative revisions recommended by Justice Fagan to bring clarity to the Act. There is no need for the words *"statutory benefits*" to appear anywhere in Part 5. The operation of Part 5 should be limited to damages claims.

Questions for SIRA – The No-fault Accident Provisions post *Singh*

237. The ALA suggests the following questions for SIRA:

(a) What consideration has SIRA given to the comments of Justice Fagan in *Singh* with regards legislative reform of Part 5? Does SIRA agree with Justice Fagan that Part 5 has no relevant application to statutory benefits claims?

RECOMMENDATION: That SIRA give consideration to the comments of Justice Fagan in *AAI Limited v Singh* with a view to recommending appropriate legislative reform of the no-fault accident provisions in Part 5 of the MAI Act.

CONCLUSIONS

238. These submissions are lengthy. There is good reason for that. It has been over two years since the last SCLJ review and there are serious issues that need addressing, both as to SIRA's regulatory approach to the MAI Act and as to the workability of some provisions of the MAI Act.

239. The ALA will continue to work collaboratively with SIRA to make constructive suggestions for improvement in the design of the scheme and the regulation of the scheme. However, recommendations from the SCLJ have the capacity to elevate issues on the reform agenda.

240. The ALA views the SCLJ enquiry as a critical opportunity to have the Parliament address the ongoing operation of the Motor Accidents scheme and to hold SIRA accountable as regulator of the claims experience.

241. The ALA would be pleased to expand upon any of the submissions set out above, either upon request from the SCLJ or through oral evidence at a hearing.