21 May 2014

Access to Justice Arrangements
Productivity Commission
LB2 Collins Street East
MELBOURNE VIC 3000

email: access.justice@pc.gov.au

Dear Sir/Madam

Productivity Commission - Access to Justice Arrangements

As the sole professional body for actuaries in Australia, the Actuaries Institute represents the interests of its members to Government, the business community and the general public. We are committed to providing independent and expert advice on public policy issues where there is uncertainty of future financial outcomes.

Actuaries assess risks through long-term analyses, modelling and scenario-planning and provide expert comment on a broad range of business-related issues including enterprise risk management, finance and investment, prudential regulation, retirement income policy, general insurance, life insurance and health financing.

As a professional body, the Institute holds the 'public interest' or 'common good' as a key principle in developing policy. Our contributions to public policy are guided by the following principles:

- Individuals should be given fair treatment;
- The need to take a long term policy view, with appropriate transitional arrangements;
- Ensuring that consequences of risk taking behaviour are borne by the risk taker;
- Public sector involvement where the market does not meet societal needs; and
- Clear and reliable information available for decision making.

Draft Recommendation 18.1 – Damages-based Billing

There is just one aspect of the Draft Report on which the Actuaries Institute wishes to comment – that relating to draft recommendation 18.1 on damages-based billing. Our wish to comment arises from the long-standing function of the actuarial profession in trying to assist with the sustainability of various financial systems including insurance and accident compensation.

We urge the Productivity Commission to carefully consider the implications for the whole of the community in respect of changes that relate to 'Access to Compensation' (rather than 'Access to Justice' per se).

Institute of Actuaries of Australia
ABN 69 000 423 656
Level 7, 4 Martin Place, Sydney NSW Australia 2000
t +61 (0) 2 9233 3466 **f** +61 (0) 2 9233 3446
e actuaries@actuaries.asn.au **w** www.actuaries.asn.au

A considerable amount of the damages paid in civil cases is paid for by compensation schemes and/or insurance companies, which in turn are funded by premiums paid in one way or another by members of the community. There have been many examples where the 'system' of Access to Compensation based on legal services has proven excessively costly and difficult to control.

Reforms have often been made to attempt to rebalance the respective interests of the complainants (or claimants in this circumstance) and the premium payers.

The current system is inherently vulnerable to financial incentives that are not necessarily in the best interests of the community. In these insured systems the 'insurer' provides all of the money for the compensation and the legal costs of both plaintiff and defendant. With conditional fee arrangements in place there is little incentive on the plaintiff side to prefer low cost resolution arrangements. There is a clear situation of information asymmetry and agency costs.

From a public policy perspective the issue is complicated by the common use of solicitor-client costs as well as party-party costs. Many settlements are 'costs inclusive', and even when party-party costs are specifically awarded there is an unknown further transfer from the plaintiff to their legal representative in the form of party-party costs.

The Actuaries Institute has no policy view about the relative advantages and disadvantages of conditional fees versus damages-based fees. We do recommend, however, that any decision to make a change be fully informed about the likely impacts on civil actions for compensation and the behaviour of parties.

We note the references in the Draft Report to transparency of costs and informed consumers. It is important that transparency take account of both party-party and solicitor-client costs in conjunction. We trust that the Commission is also aware that many consumers (especially those of most concern for access to justice) are not a position to make well-informed objective decisions on the basis of disclosures and therefore other regulatory or self-regulatory measures are justified.

One thought regarding the level of damages-related costs is that there be a 'safe harbour' level of say 20% or 25% with any higher level subject to prior agreement by the court.

Institute of Actuaries of Australia
ABN 69 000 423 656
Level 7, 4 Martin Place, Sydney NSW Australia 2000
t +61 (0) 2 9233 3466 **f** +61 (0) 2 9233 3446
e actuaries@actuaries.asn.au **w** www.actuaries.asn.au

We have included a list of papers in Appendix 1 and some past actuarial papers in Appendix 2 that may be relevant to the Productivity Commission's considerations. Should the Commission wish to obtain further information about the implications for insured systems of the Access to Compensation arrangements please contact us and we will try to assist.

The Institute would be pleased to discuss any of these recommendations in more detail. Please do not hesitate to contact our Chief Executive Officer, David Bell, if you wish to discuss the matters raised in this submission.

Yours sincerely

Daniel Smith
President

Institute of Actuaries of Australia
ABN 69 000 423 656
Level 7, 4 Martin Place, Sydney NSW Australia 2000
t +61 (0) 2 9233 3466 **f** +61 (0) 2 9233 3446
e actuaries@actuaries.asn.au **w** www.actuaries.asn.au

Appendix 1 List of relevant papers

Principal material

Industry Commission 1994, *Workers' Compensation in Australia,* Report No. 36 4 February 1994; in particular Chapter 4 and Appendix D

Productivity Commission 2002, Public Liability Claims Management, Research Report, Canberra; in particular Chapter 5

Actuaries Institute Financial Services Forum May 2014, *Chasing Your Tail on TPD Claims – Insights from Injury Schemes*, Bozenna Hinton, Richard Yee (see Appendix 2)

National Competition Policy Legislative Review, *Workshop on Statutory Monopoly CTP Arrangements, Understanding Scheme Failures*, 24 July 1998, Geoff Atkins (see Appendix 2)

Institute of Actuaries of Australia Xth Accident Compensation Seminar 2004, *Workers' Compensation Western Australia The Last Decade*, Dr Rob Guthrie, Mr Peter Lurie (see Appendix 2)

Actuaries Institute Injury Schemes Seminar 2013, *Commitment to SA Motorists – A New Era*, Jerome Maguire

South Australia's Compulsory Third Party Insurance Scheme *2012 Green Paper*

Motor Accidents Authority of NSW 2013, *Reforms to the NSW Compulsory Third Party Green Slip Insurance Scheme*

Actuaries Institute Injury Scheme Seminar 2013, Sustainability of Common Law, Geoff Atkins (see Appendix 2)

Secondary material

Institute of Actuaries of Australia Xth Accident Compensation Seminar 2004, *MAS A successful work in progress*

Institute of Actuaries of Australia Xth Accident Compensation Seminar 2004, *The Victorian Transport Accident Scheme,* Heather Evans

Institute of Actuaries of Australia Xth Accident Compensation Seminar 2004, *The Queensland Scheme An Insurer Perspective*, Tracy Green, Peter Worthy

Institute of Actuaries of Australia XIth Accident Compensation Seminar 2007, *Reforming the NSW Workers' Compensation System,* Rob Thomson

Institute of Actuaries of Australia
ABN 69 000 423 656
Level 7, 4 Martin Place, Sydney NSW Australia 2000
t +61 (0) 2 9233 3466 **f** +61 (0) 2 9233 3446
e actuaries@actuaries.asn.au **w** www.actuaries.asn.au

Appendix 2 – Actuarial papers and presentations

Workers Compensation Western Australian – The Last Decade
By Dr Rob Guthrie and Mr Peter Lurie 2004

Chasing your tail on TPD claims – Insights from Injury Schemes
By Bozenna Hinton and Richard Yee 2014

Sustainability of Common Law
By Geoff Atkins 2013

National competition policy legislative reviews – Workshop on statutory monopoly CTP arrangements: Understanding Scheme Failures
By Geoff Atkins 1998

Institute of Actuaries of Australia
ABN 69 000 423 656
Level 7, 4 Martin Place, Sydney NSW Australia 2000
t +61 (0) 2 9233 3466 **f** +61 (0) 2 9233 3446
e actuaries@actuaries.asn.au **w** www.actuaries.asn.au

Institute of Actuaries of Australia

Workers' Compensation Western Australia
The Last Decade

Dr Rob Guthrie, School of Business Law
Curtin University of Technology

Mr Peter Lurie
PricewaterhouseCoopers Actuarial Pty Ltd

Presented to the Institute of Actuaries of Australia
Accident Compensation Seminar 28 November to 1 December 2004.

The Institute of Actuaries of Australia
Level 7 Challis House 4 Martin Place
Sydney NSW Australia 2000
Telephone: +61 2 9233 3466 Facsimile: +61 2 9233 3446
Email: insact@actuaries.asn.au Website: www.actuaries.asn.au

ADVENTURES OF A REPORT WRITER, THE ACTUARY AND THE POLITICIANS

WORKERS COMPENSATION WESTERN AUSTRALIA THE LAST DECADE

DR ROB GUTHRIE, SCHOOL OF BUSINESS LAW, CURTIN UNIVERSITY OF TECHNOLOGY

MR PETER LURIE, ACTUARY, PRICEWATERHOUSECOOPERS ACTUARIAL PTY LTD

1. Introduction

As the West Australian Labour Government moves towards amending the *Workers Compensation and Rehabilitation Act* 1981 (WA) (the Act)[1] this year it is an appropriate time to reflect upon the last decade of workers compensation legislative changes. The last ten years have been a tumultuous time for most of the stakeholders in the compensation system. This paper is a rough guide to that last decade.

This paper traces the significant changes made to the Act in WA starting from the June 1993 changes, through the protracted process leading to the 1999 Pearson Review[2] and amendments to the Act and moves on to the current package of changes currently before State Parliament.[3]

The paper reviews the objectives, intended impacts and key drivers behind the amendments and observes the extent to which the objectives have been achieved, in both qualitative and quantitative terms. The varying success of the 1993 and 1999 amendments to the Act in relation to behavioural change, robustness and erosion are also considered.

Finally, the paper includes commentary on the aspects which were successful/unsuccessful and what lessons can be learnt from the WA experience by report writers, actuaries, scheme regulators and politicians.

---

1 The Act is to be renamed the Workers Compensation and Injury Management Act 1981(WA)

2 Report of the Review of the Western Australian Worker's Compensation System 1999 WAGP

3 We anticipate events will unfold regarding the latest package of changes while the paper is being written and before it is presented at the Accident Compensation Seminar

2. The June 1993 changes

The starting point when looking at significant changes to the Act is 1993. In 1993 the Conservative Coalition Government amended the Act principally to reduce the potential for workers to make common law claims for damages. The accepted wisdom at the time of these amendments was that the workers compensation system in Western Australia was overheating and that the cost of common law claims in particular was increasing and the number of those claims was also on the rise. Overall, insurers claimed that if the trend continued and the cost of the scheme increased they would be unable to continue to support the system. It's worth reflecting that at the time in 1993 there were approximately 20 private underwriters in the West Australian system. At present there are less than 10.

The rapid acceleration of common law claims frequency and the accompanying reduction in average common law claim size in shown in the table one[4] below. A key driver of this trend appears to be the increased propensity of insurers offering increased lump sum redemption[5] at claim closure in exchange for a discharge of common law liability. This process may also distort the assessment of what is actually a common law component as against the true workers compensation payment. In practical terms this increased component is often referred to as a payment based on an "assessment of the likely costs of litigation".

---

4 The tables in this report are all extracted from published information available on WorkCover WA's website, mainly from P Lurie, PricewaterhouseCoopers 'Actuarial Assessment of Recommended Premium Rates for 2004/05' and 'Quarterly Overview of WA Workers' Compensation Experience : June 2003' and earlier years versions of both these reports

5 Redemption is a payment made pursuant to section 67 of the Act, being a lump sum to redeem all liability for future weekly payments. In practice although the Act has a formula for this type of payments, it is often calculated without reference to the formula and is based on the insurer's perception of the potential weekly payments that might be made in the future. In this way redemption is often less than the payment that would have been made under section 67. However, negotiated payments are often accepted as orders made under section 67 are rare and require that the worker should permanent incapacity.

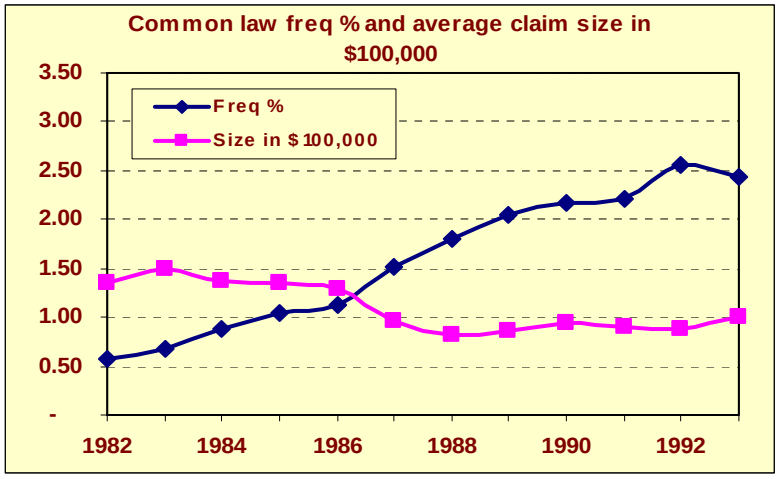


TABLE ONE

Table two shows the progress of payments per claim incurred by financial year for common law claims and lump sum payments[6], weekly benefits and medical plus other payment types. The rapid rise in payments rates is shown extending for a year beyond the 1993 changes. Common law claims were escalating at 19% compound in real terms, 'other' at 17% pa while weekly benefits rose more moderately at 8% pa real. The data is in 30 June 2004 values.

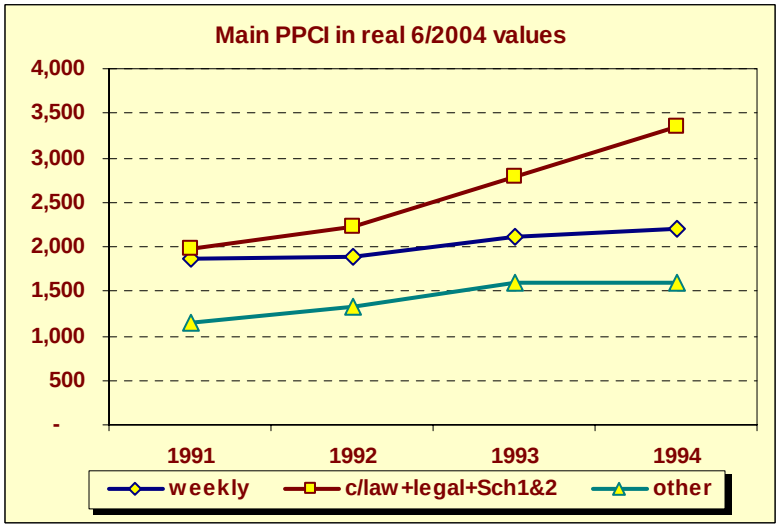


TABLE TWO

Table three below shows the payments per claim incurred across all payment types and accident years in 30 June 2004 values. The real increase over the four year period

6 This may include payments under section 67 of the Act by way of redemption and/or payment pursuant to schedule 2 of the Act by way of a payment for a permanent disability. In some cases this payment would be a combination of the both forms of lump sum.

is 13% pa compound. The increase once again extends for a year after the 1993 changes.

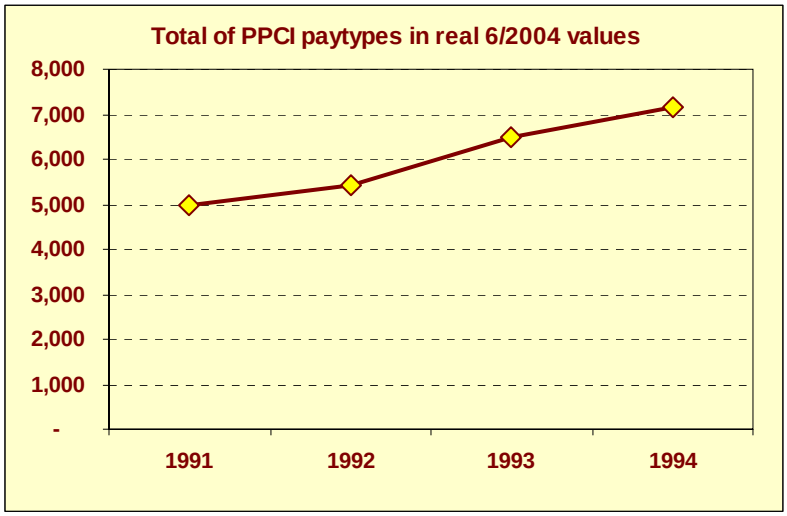


TABLE THREE

Given the trends shown above the Coalition Government moved to amend the Act in a number of ways to reduce common law claims against employers for damages for negligence. First, it set in place two thresholds through which workers were to pass in order to make a common law claim[7]. These thresholds, which later became known as gateways, required in the first instance a worker to establish a 30% disability of the body as a whole[8]. If that threshold could not be established a worker could still proceed with a common law claim by establishing an entitlement through the second gateway which required the worker to prove that as a result of the disability their pecuniary loss[9] was greater than the prescribed amount[10]. Damages under these provisions were not capped so that if the worker was able to establish the necessary thresholds they could proceed to the District Court for assessment of a negligence claim unrestricted as to level of damages, which could be awarded.

---

7 Amendments were made to section 93 of the Act to put in place the thresholds.

8 This was calculated by a medical panel having regard to a variety of medical guides, including the AMA Guides to impairment and Schedule 2 of the Act.

9 This terminology proved to be very elastic. District and Supreme Court decisions in the mid 1990's held that this could include loss of wages, medical expenses, superannuation and other employment related remuneration and/or benefits.

10 The prescribed amount is the maximum amount of weekly payments available under the Act. As at 1993 it was set at $100,000, but it is indexed to increase each year. It is also the benchmark for the level of medical expenses and rehabilitation allowances to be paid. In respect of the former this is set at an additional 30% of the prescribed amount and in respect of the latter it is set at 7% of the prescribed amount.

The second gateway creating the pecuniary loss threshold was a late addition to the 1993 amendments, as part of the political process. The 1993 amendments were foreshadowed by the Minister in a speech to parliament in June 1993. However the amendments did not pass through both houses until November 1993. The interlude between the announcement of the proposed changes and the passing of the legislation resulted in considerable lobbying and political compromise. As a result of pressure from potential common law claimants, their advocates and advisors, a transitional register was opened which in effect allowed claimants retrospective common law access under the pre-June 19993 rules. The transitional register was initially open for a three month period but was extended a number of times. The effect of the creation of the transitional register was a rush to register potential claims under the pre-June 1993 provisions.[11] Not surprisingly the resultant publicity created a heighten awareness of the need to claim and an increased exposure for insurers.[12]

The role of the actuary and the report writer advisors in the 1993 changes is not entirely clear, but it is noted that an actuarial costing of the impact of the second gateway showed minimal extra cost, assuming the access would be tightly controlled.[13] The outcome of the 1993 amendments was very different to the projections due mainly to the design features of the common law thresholds and the drafting of the second gateway which allowed for expansive judicial interpretations of the thresholds.[14]

There are several basic lessons to learn from these events.

A number of other amendments were put in place, as well as the changes to the common law structures. Of significance was the fact that for the first time in Western Australia workers would be paid their average weekly earnings, including overtime, bonuses or allowances, under the compensation scheme for the first 4 weeks of their

---

11 Which did not inhibit common law claims in any way.

12 Neither author was involved in these amendments.

13 Report by Trowbridge Consulting to *Assess the effect of restricting common law in workers compensation in Western Australia to claimants whose injuries exceed a defined level of impairment,* for Hon Yvonne Henderson 1991 referred to by the Minister for Labour Relations Western Australian *Debates* 1993 Legislative Assembly 21st September

14 In fairness to the actuaries the report referred to in footnote 13 above was probably relied upon for purposes for which it was not prepared.

incapacity. After 4 weeks, benefits stepped down to exclude overtime, bonuses or allowances for non-award workers. In addition Schedule 2[15] of the Act was amended to provide lump sum payments for permanent disabilities to the neck, back and pelvis. These forms of injury had not previously attracted lump payments. These additional payments to workers were included to compensate in part for the reduction in common law access[16]. Restrictions were also introduced on lump sum redemptions of future weekly benefits.[17] The clear intention was to reduce the participation in lump sum payments in favour of weekly benefits.

As well as changes to benefits under the Act the dispute resolution system was radically overhauled and the Workers Compensation Directorate was established in place of the apparently adversarial Workers Compensation Board. The purpose of moving away from the Board to the Directorate was to put in place a less formal dispute resolution process. Importantly in an effort to contain legal costs legal representation at the Directorate was severely restricted.[18]

In addition to the changes to weekly payments and common law thresholds the government put in place section 84AA of the Act, which attempted to provide some employment security for workers with disabilities. This provision required employers to retain a workers position for at least 12 months after a compensable disability in the expectation that if the worker was fit to return to work during that period the position would be open for that worker's return. The drafting of the section was however lame as no real sanction was imposed on the employer for failure to retain the worker and no rights to reinstatement were created where the worker was dismissed within the 12 month period.[19]

---

15 Often referred to a table of maims – it is a schedule which lists body parts and senses. If a worker suffers a permanent disability a lump sum payment can be calculated according to the schedule when a medical assessment has been made.

16 In hindsight these trade offs increased the overall costs of the system as the thresholds were not sufficiently robust to reduce costs.

17 Section 67 was amended to allow redemption only for workers who had reached age 55. The intention of this discriminatory age restriction was to prevent younger workers gaining access to a lump sum – but in fact created an incentive to pursue a common law claim in order to obtain a lump sum payment.

18 The changes to dispute resolution were modelled on the changes made by the Victorian government to the *Accident Compensation Act 1985* (Vic) in 1992 following the election of the Kennett liberal government.

19 For a full commentary on the effect of section 84AA and a comparison with provisions in other States see R Guthrie 'The Dismissal of Workers Covered by Return to Work Provisions

The clear expectation and indeed the Coalition rhetoric as at 1993 was that the amendments would lead to reductions in scheme costs through the containment of common law and redemption costs. However, the significant changes as a result of the introduction of the common law thresholds and the dispute resolution procedures had many unintended consequences during the mid 1990's.

Contrary to the expectations of both Government and private insurers the cost of claims and the frequency of common law claims declined only in the short term as the thresholds removed the smaller common law claims and almost doubled the average claim size. However within a few years the frequency of common law claims increased to its pre-June 1993 levels, but with a much higher average claim size than the pre-June 1993 levels, as shown in table four below. It is important to note that the chart does not allow for the impact of the October 1999 amendments which we discuss in a later section of this paper.

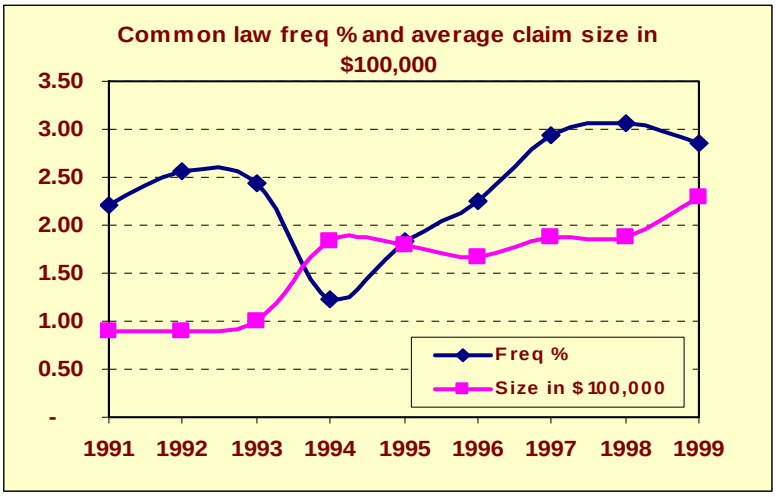


TABLE FOUR

The most influential claims driver was the number of District Court common law claims under the pecuniary loss common law threshold, which increased from 148 in the 1994 calendar year to 2,409 in 1998. The 1998 applications represented close to 4% of reported claims.

---

under Workers Compensation Laws' (2002) 44 (4) *The Journal of Industrial Relations* 545-561

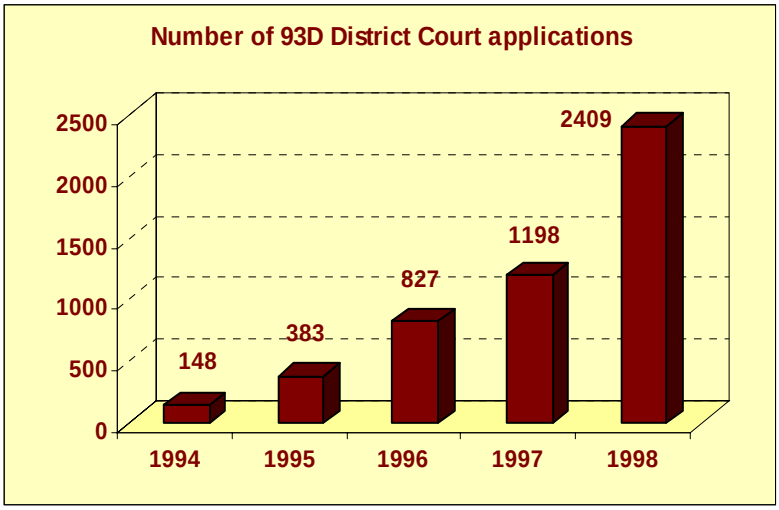


TABLE FIVE

Given that workers needed to establish the high *pecuniary loss* thresholds and/or the high levels of disability there were inbuilt incentives for workers to remain off work in order to satisfy these requirements. As a consequence of the drive towards establishing the prescribed amount in pecuniary loss, the duration of claims began to extend. In addition the District Court, which was the gatekeeper in relation to common law claims, gradually interpreted the threshold provisions in an expansive manner. The wording of section 93D of the Act allowed the District Court to interpret *pecuniary loss* as the loss of full pre-injury earnings to normal retirement age of the claimant, in some cases even where there was a retained earning capacity or the duration of the injury/claim was limited. In addition as the phrase *pecuniary loss* was novel the Court included in its calculations hitherto neglected losses such as loss of superannuation entitlements – the effect being that it was easier for workers to satisfy these requirements. [20] In short the thresholds, which were intended to reduce the cost for insurers of common law claims, had the contrary effect, as shown in table six below which shows the rise in payments per claim incurred by financial year for common law claims and lump sum payments, weekly benefits and medical plus other payment types.

The temporary impact of the June 1993 changes on common law payment rates is shown by the declines in 1995 and 1996 followed by the resumption of a strong real

[20] See in the Supreme Court Crombie v Uniting Church in Australia Property Trust (WA)(1997)17WAR 291

increase trend. The 'other' payment type is stable to declining from 1993 to 1995 and then increases again while the increasing weekly benefit trend appears largely unaffected. This delay in impact is probably attributable to the effects of the take-up of the registration of claims in the rush to register in November 1993. Table six is in 30 June 2004 values.

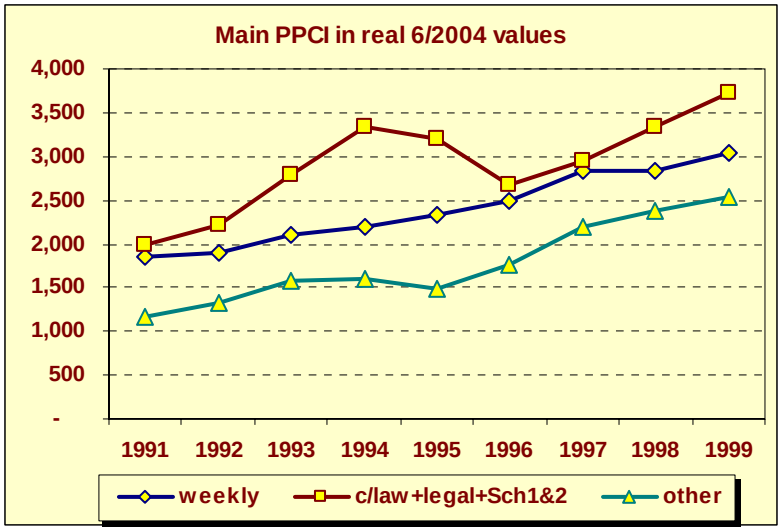


TABLE SIX

Table seven shows the payments per claim incurred across all payment types and accident years in 30 June 2004 values. The overall trend is dominated by common law claim increases with real growth at 10% pa over 1996 to 1999, consistent with the expansion of the second gateway (pecuniary loss threshold) discussed above.

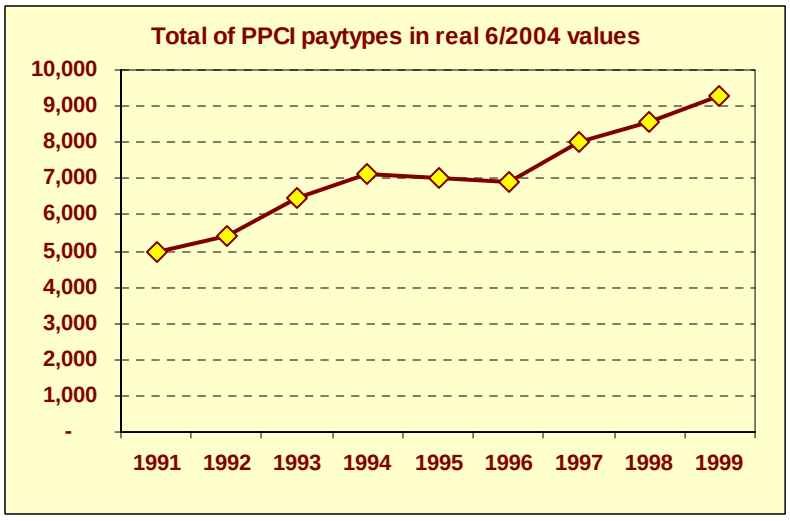


TABLE SEVEN

By the late 1990's it became clear that further legislative amendment was required to retard the effects of increased common law claims.

3. The October 1999 changes

In 1999 the Coalition Government requested the Auditor General Mr Des Pearson to review a number of features of the State's workers' compensation legislation. The *Pearson Report* in 1999[21] recommended that the common law thresholds be adjusted by replacing the (narrative) pecuniary loss threshold by a disability-based only threshold. Further, the ***Pearson Report*** recommended that workers be required to elect whether or not to stay in the workers compensation scheme or to move to the common law damages scheme. In order to facilitate this process the ***Pearson Report*** recommended that workers be required to make an election, within 6 months of receiving compensation, whether to proceed with a common law claim or remain under the statutory compensation system.

As well as making recommendations in relation to common law thresholds the ***Pearson Report*** recommended that a cap of twice the prescribed amount be placed on damages for those workers who could not establish that they had a 30% disability of the body as a whole. A cap was also recommended for weekly payments at 1.5 times average weekly earnings. This meant that workers with wages in excess of 1.5 times average weekly earnings would be subjected to an immediate reduction of income at the time of suffering a disability.

The bulk of the recommendations of the ***Pearson Report*** were accepted however there were two significant departures. The report did not actually recommend that those workers who elected to proceed with common law claims and who could not establish a 30% disability would be subject to any alternative threshold. The Pearson Report recommended that in effect if a worker had less than a 30% disability, the threshold or disincentive to proceed with common law claim was the requirement to elect. At election the workers compensation payments would cease, providing a further disincentive to proceed. Instead of accepting this recommendation the Government

[21] DR Pearson, B McCarthy and R Guthrie (1999) Report of the Review of the Western Australian Workers' Compensation System WAGP

moved to put in place a threshold which required that workers who could not establish a 30% disability would only be entitled to proceed to a common law claim if they could establish a disability of between 16% and 29% disability of the body as a whole. Those workers who came within this threshold would be entitled to proceed with a damages claim but that claim would be capped at twice the prescribed amount; that is a maximum of about $250,000 as at 1999.

A further departure from the recommendations of the ***Pearson Report*** was that no significant changes were made to the dispute resolution process. The Pearson Report in fact recommended the reintroduction of legal practitioners into the dispute resolution process. As noted above as a consequence of the 1993 amendments and the establishment of the Directorate, legal practitioners were to all intents and purposes prohibited from appearing in the jurisdiction.[22]

The affects of the 1999 amendments were significant and immediate. The number of common law claims dropped sharply after 1999 and since that time have remained low but with a recent increasing trend. Payments per claim incurred also dropped sharply but with a one year lag, as for the June 1993 changes. There is evidence that this trend has stabilized in 2003-4.

Table eight below is estimated from somewhat immature data particularly for 2003 and 2004, but extends the common law frequency and average claim size trends by accident year from 1998 to date.

[22] It is also interesting to note that the recommendation to remove psychological overlay from the assessment of disability was removed during the Parliamentary process with an undertaking to support its removal if it became an element in a material number of common law lodgements. This has now occurred and the removal of psychological overlay in the assessment of whole person impairment is part of the current Government's package of changes. Anecdotally, psychological overlay is a factor in more than 40% of lodgements and is used to add sufficiently to the assessed physical disability levels and thereby achieve the necessary level for common law access.

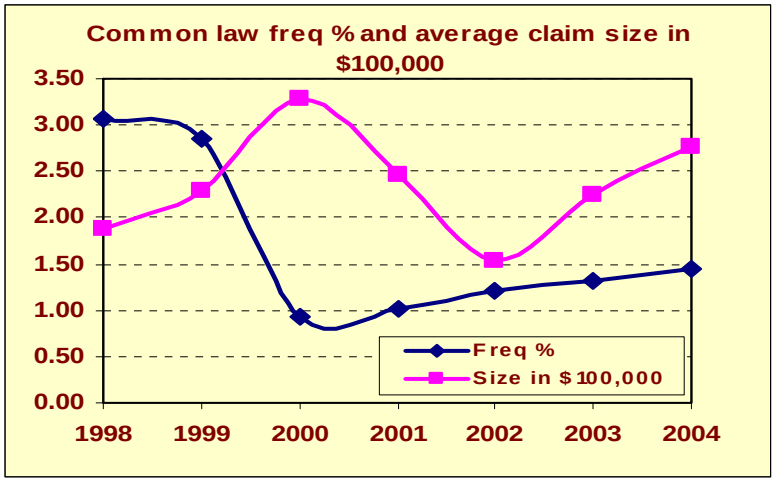


TABLE EIGHT

The apparent volatility in average common law claim size over 2000 to 2004 is due to the influence of a few very large claims over $1M, with 2002 having no claims over $1M and other accident years having 2 to 7 claims over $1M with total case estimates of $5.2M to 19.1M.

Table nine below shows the progress of payments per claim incurred by financial year for common law claims and lump sum payments, weekly benefits and medical and other payment types. Common law payment rates continue increasing for a year after the October 1999 amendments, decline significantly in 2001 and then are relatively stable. The 'other' and weekly payments decline slightly in 2000 and remain relativelt stable thereafter. The chart is in 30 June 2004 values.

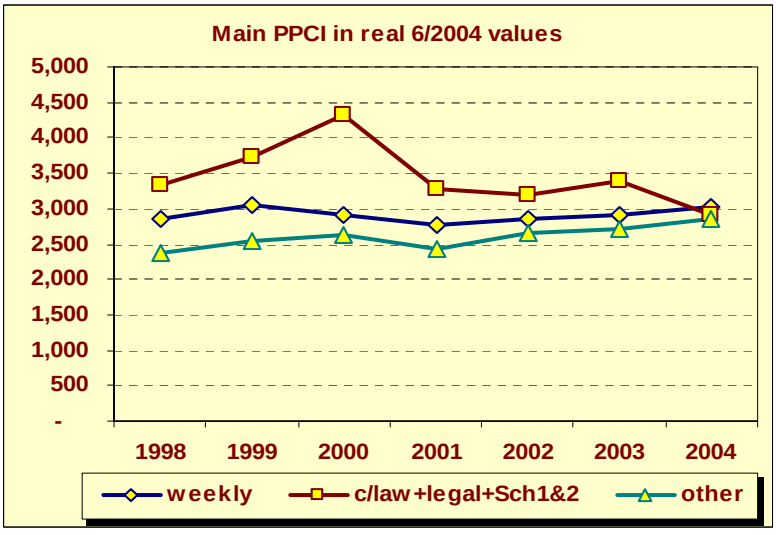


TABLE NINE

The next chart shows the payments per claim incurred across all payment types and accident years in 30 June 2004 values. The overall trend is dominated by common law with real growth over 1998 to 2000, followed by its significant decline in 2001. An increasing payment per claim incurred trend re-emerged over 2002 to 2004 but still at a much lower overall level than up to 2000.

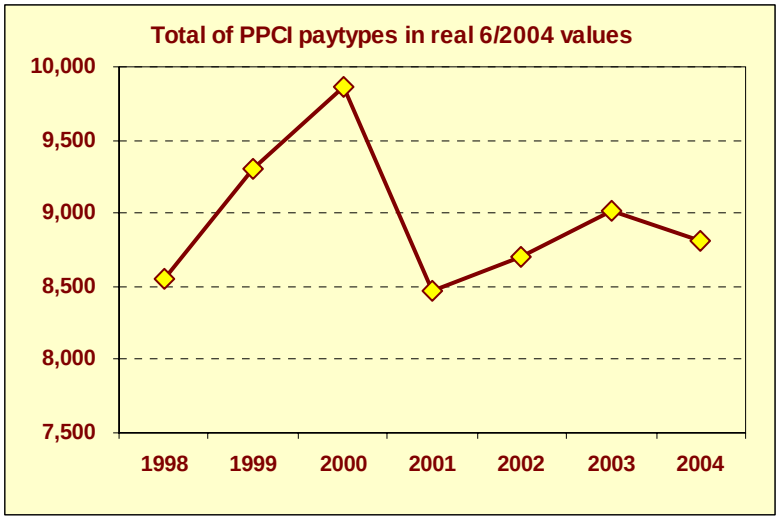


TABLE TEN

4. The proposed 2004 changes

In 2001 following the election of the Labor Government a further Report was prepared reviewing a wide range of workers compensation issues. The ***Guthrie Report*** was predicated upon the release of a Labor Party Direction Statement setting out a comprehensive policy on workers compensation prior to the 2000 election.[23]

The 2001 ***Guthrie Report*** contained over 100 recommendations and covered many aspects of the workers compensation legislation. The ***Guthrie Report*** was released for public comment in about September 2001 and between that time and most of 2002 the Labor Government received submissions and sought consultations and comments from the public and major stakeholders. A Government policy was developed over that time based upon the 2001 ***Guthrie Report***, and accepted the bulk of the recommendations of that report. A number of issues were not taken up in the

[23] R Guthrie (2001) The Report on the Implementation of the Labor Party Direction Statement in Relation to Workers Compensation WAGP

Government policy namely the introduction of second injuries schemes, the establishment of performance based insurance premium setting and a number of recommendations in relation to return to work provisions and incentives dealing with stress claims. Nevertheless, the current Government policy in relation to workers compensation reflects by and large the recommendations of the 2001 ***Guthrie Report***. The current Labor Government policy is contained in a document entitled ***Restoring Fairness – Balance and Certainty Workers Compensation Reforms*** and appears on the Western Australian government website.

The actuarial assessment of the estimated cost impacts of the current package of changes at the time of writing this paper are summarised below. Two sets of cost estimates are presented for each element of the proposed package of changes, an initial cost impact and the estimated impact after erosion from better understanding and behavioural change of claimants and their advisors. Certain changes, mainly those to statutory benefits, will have a retrospective cost impact and the estimated cost of this is also separated. All actuarial costings only quantify the estimated impact on insurance premiums to employers and do not include the implementation costs or changes to the ongoing cost of running the system.

The estimated initial cost impact is an increase of 12.7% of the annual insurance premium pool rising to 20.4% allowing for some erosion. The once-off retrospective cost is $41M and is due to the statutory benefit changes applying to all open claims at date of change; in this sense the effect is retrospective. The new common law claims access rules will apply to claims with date of accident on or after the effective date of the proposed changes. The estimated once-off cost of the ***Dutch***[24] decision remedy was initially in the range $27M to $120M but this was later refined to reduce the top end of the range by around half.

The current Government proposals depart from the 2001 Guthrie Report in a number of ways. First, the recommendation that the common law thresholds be reversed so as to include a narrative threshold rather than a disability or impairment based threshold has not been taken up. The government currently proposes that a second gateway

[24] Discussed below

threshold of 15% impairment be established in order to allow workers to proceed with a common law claim. The first gateway threshold will be set at 25% impairment rather than 30% disability of the body. Weekly payments at the average weekly earnings will be extended from 4 weeks to 8 weeks initially, now extended further to 13 weeks. Payments will be capped at twice average weekly earnings. Workers with serious disabilities who cannot proceed with a common law claim will be entitled to specialised retraining programs. Legal representation will be introduced into the dispute resolution process with strict timeframes and cost thresholds for legal practitioners. The election period, which was previously 6 months, will be extended to 12 months and there will be provision for further extensions for workers who have injuries, which have not stabilised.

For those workers who do proceed with common law claims an election will be required. However, those workers who do elect will not have compensation payments ceased immediately as the present law provides. The government has proposed a gradual step down of weekly payments after election over a period of 6 months. The determination of common law thresholds will be shifted from the workers compensation jurisdiction to the District Court.

A number of other procedural amendments have been proposed by the government, which deal with various Supreme Court decisions, which have impacted upon the system. In particular the decision of the case of ***Dutch***[25] which caused considerable concern for workers who had received medical assessments based upon total body disability. The Supreme Court held that in that case the worker who relied upon a medical certificate, which did not properly set out a medical opinion in accordance with the Act, could not use that certificate as the basis to establish the necessary common law threshold. Amendments will be made to allow some of the workers who were affected by that decision to proceed to common law claims. In another important decision of ***Hewitt v Benale***[26] the Supreme Court held that the common law thresholds, which applied to claims against employers also applied to claims against negligent third parties. Amendments will be made to reduce the impact of that decision.

---

25 Re Monger: Ex parte Dutch [2001] WASCA 220

26 Hewitt v Benale Pty Ltd [2002] WASCA 163

These changes retrospectively increase the number of post- October 1999 common law claims, because it will allow some claims to be reactivated, but the estimated common law frequency in the tables above implicitly cover this impact but the PPCI tables do not as they are based on actual payments.

Interestingly, no action to remedy the impact of ***Dossett v TKJ Nominees Pty Ltd***[27] is proposed. This High Court decision allowed workers injured prior to the 5 October 1999 amendments the right to access common law under the previous June 1993 regime. By June 2004, 34 new 93D applications have so far been lodged on the basis of *Dossett*. This creates a further window of latent erosion potential for the otherwise remarkably robust October 1999 changes. The estimated common law frequencies shown above are unlikely to contain any implicit margins for erosion from this source given the potential for this to be significant source of new unexpected common law claims.

Reflecting on the compensation system since 1999 there are a number of features of the current system, which demand attention and invite comment.

First, the current dispute resolution process is severely hampered by the number of features. As outlined in the 2001 ***Guthrie Report*** there is a lack of continuity between the conciliation and review dispute resolution processes. This causes the system to operate on a stop, start basis. Further, the prohibition on legal practitioners representing workers at various levels of the dispute process has had a counter intuitive effect. Workers, employers and insurers have not restricted their appetite for legal advice. Instead, they are continuing to seek legal advice and opinions and the current system has maintained an adversarial outlook. Although legal practitioners are limited in appearing at conciliation and reviews there are a number of advocates from law firms who regularly appear in the jurisdiction. There are numerous decisions of the Compensation Magistrates and now the Supreme Court, which have criticized the level of advocacy in the jurisdiction. It is hard not to accept that this is a

[27] Dossett v TKJ Nominees Pty Ltd (2003) 202 ALR 428

consequence of inexperienced advocacy caused through the restriction on legal practitioners appearing in the jurisdiction[28].

Also significant is the fact that the Directorate continues to be influential in determining the common law thresholds. There is a significant amount of litigation involved in determining the common threshold issues. For example there are numerous over the proper procedures involved in determining such claims.[29] Likewise there are arguments about whether pre-existing and degenerative conditions should be taken into account.[30] There are arguments about whether or not the symptoms of a disability should be considered and whether or not various disabilities should be aggregated or segregated when a Review Officer makes a determination.[31] Further, there are voluminous claims, which relate to the capacity of medical panels to make confident determinations. There is a clear indication from the Supreme Court that the numbers of matters going to that court via prerogative writ to challenge the jurisdiction of medical panels is a source of irritation to the court.[32]

Those who claim that the current system does not need to be changed must be unaware of the very dire condition of the some aspects of the current dispute resolution process.[33] It is argued that if there is no other change made to the Act then it should be to the dispute resolution process which is the cause of the highest number of complaints. The dispute resolution process affects all claimants not just those who are proceeding with common law claims. A move to restrict the use of medical panels and simplify the transition to common law claims is essential. Savings will be made in legal costs and costs relating to long duration claims by such changes.

---

28 See for example *Summit Homes v Lucev* (unreported SC(WA) 67/95 3 April 1996) and *Kuligowski v Metrobus* [2002]WASCA 170

29 See *Ansett Aust Ltd v Finn* (unreported CM(WA) 57/00 21 July 2000 and *Thorp v Wanneroo CC* (unreported CM(WA) 49/00 31 July 2000) and *Re Monger; Ex Parte United Construction Pty Ltd* [2002] WASCA 253

30 *Jacob v BHP Iron Ore* (unreported CM(WA) 147/00 9 February 2001)

31 *Dzonlagic v the Mattress Renovators Perth Pty Ltd* (unreported CM(WA) 129/00 24 November 2000)and Girrawheen Tavern v Joseph (unreported CM(WA) 131/00 19 January 2001)

32 See the opening comments of Barker J in *Re Narula NG and Hammersley; Ex Parte Atanasoki* [2003] WASCA 156

33 Recently a Chamber of Commerce spokesperson suggested no changes were necessary. See *West Australian* 9th February.

The current system is subject to huge logjam of cases which are unproductive; they are concerned with procedural and technical matters and do not, for the most part, concern the substantive rights and entitlements of workers. Employers often feel the after-affects of such claims as workers who suffer from delayed payments often engage in multiple claims. One striking example of this is the litigation between ***Suleski v Sons of Gwalia Ltd***, a matter which has been to the Supreme Court on at least five occasions on technical points and which, at last count, showed no signs of resolution.[34] Following the decision in ***Dutch*** referred to above a vast flow of litigation erupted, so much so that in ***Re Monger; Exparte ABB Service Pty Ltd*** [35] Roberts-Smith J noted (at para 16) that

> *I do not propose to go through the detail of the course of events related by Mr Harben in that affidavit as to the considerations that were given by the applicant and its solicitors thereafter. It is sufficient to observe that the panel solicitors for SGIO Insurance, McAuliffe Schwikkard, Jackson McDonald and Phillips Fox determined that SGIO had in excess of 100 matters that might require a prerogative writ.*

The same judge said in ***Mitchell v Canal Rocks Beach Resort***[36] *(at para 17)*

> *The nature of proceedings before a review officer under the Workers Compensation and Rehabilitation Act 1981(WA) ("the Act") is of a curious sort. While the proceedings are adversarial in character, a Review Officer may, in resolving a dispute, inspect any document, question any person or require any person to attend to answer such questions (s84ZB)…*

The curious adversarial nature of the proceedings was also noted by McLure J in ***Kuligowski v Metrobus***[37] who in a dissenting judgement held that the doctrine of

---

34 See for example *Suleski v Sons of Gwalia Ltd* [2004] WASCA 2, *Suleski v Sons of Gwalia* Ltd [2001] WASCA 289 , Sons of *Gwalia Ltd v Suleski* [2003] WASCA 289, *Sons of Gwalia Ltd v Suleski* [2003] WASCA 279, *Re Bannan; ExParte Suleski* [2001] WASCA 289. Bear in mind that on many occasions these matters would have been on appeal to the compensation magistrates' court as part the appeals process.

35 [2002] WASC 299 (Emphasis added)

36 [2002] WASCA 331

issue estoppel in relation to decisions and orders of Review Officers should be excluded. The dispute processes in place at present were touted by the coalition Government in 1993 as being non-adversarial quick and informal. None of these claims have been realised. There is a desperate need to reform the dispute resolution processes.

The current proposed amendments will no doubt increase the cost of workers compensation claims in the statutory scheme. The addition of a further 9 weeks of weekly payments at the average weekly earnings and the increase of those weekly earnings capped to twice average weekly earnings will no doubt increase the cost of most compensation claims. Added to this is the proposal to increase access to medical expenses and benefits and also increase access to payments beyond the prescribed amount will no doubt add to the cost for employers and insurers. On the other hand the government proposes to make changes to the injury management scheme, which should if put in place correctly, assist employers in returning injured workers to work and thereby reduce their costs. There is some strong evidence that a significant portion of this potential saving has already been made through the injury management programs introduced by the more proactive insurers. The actuarial costing of the proposed changes assumed injury management would be cost neutral, because of the subjectivity involved in quantifying the overall impact and the portion already achieved through insurers' programs.

Some commentators[38] claim that the common law thresholds will restrain the costs of common law claims and the increased benefits in the statutory system are likely to be an incentive for some workers to stay on weekly payments of compensation rather than seek a lump sum for common law damages. Costs savings are likely to result from these choices. However the actuarial analysis may not support these claims for of a number of reasons:

(a) the maximum statutory benefit under the proposed changes may exceed the current capped common benefit (where an application is made under section 84E to extend the prescribed statutory payments)

---

37 [2002] WASCA 170 at para 322.

38 Various plaintiff lawyer advocates.

(b) the later election requirement (12 months instead of 6 months) could increase common law frequency

(c) the continuation of statutory benefits for six months after election, may remove the strongest disincentive to pursue common law.

Therefore the actuarial costing projects that common law frequency will increase somewhat for the lower impairment common law threshold.[39]

The data in table twelve below on claims in Western Australia shows in general terms a significant decline in a number of claims for compensation over the past decade, with some stability over 1995 to 1998 and a slight increasing trend since 2002. The estimated number incurred decline by 37% from 61,600 in 1995 to 38,600 in 2004 while active claims declined by 32% from 32,100 in 1995 to 21,900 in 2004.

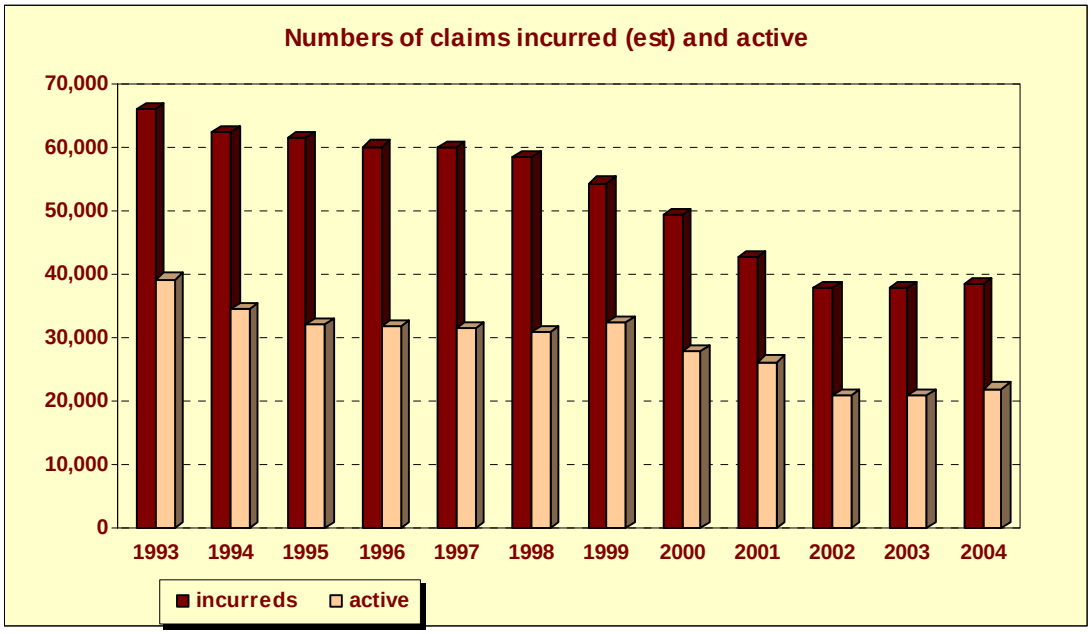


TABLE TWELVE

Table eight above shows a decline in the number of common law claims since 1999. It is a remarkable testimony to the robustness of the 1999 threshold and the circuitous litigation process that in the time of writing that very few common law claims under the current legislation has been processed for the District or Supreme Court. As noted

[39] The authors recognise this is a matter of serious debate. The change to an impairment based assessment structure is a feature that will be of considerable interest. For a discussion of some of the issues see R Guthrie 'Compensation: Problems with the Concept of Disability and the Use of the American Medical Association Guides' (2001) 9(2) *Journal of Law and Medicine* 185-199

above the effect of the imposition of thresholds based on disability only has had a striking affect on access to common law. This has been aggravated by the quagmire of medical panel and Supreme Court decisions around those thresholds which are referred to above. The current system simply does not in practice allow access to common law via the second/lower disability gateway although in theory it is open to workers to proceed through the twin gateways. However we must not forget that *Dossett vs TKJ Nominess Pty Ltd* now in effect reinstates the 93D pecuniary loss threshold for claims incurred prior to the October 1999 amendments and table five above shows graphically the dramatic effect that had on common law frequency. The proposal to change the common law thresholds should have a beneficial affect for workers and also employers and insurers because if common law claims are dealt with in a more timely fashion it is almost certain that long duration claims will be reduced. In other words it is possible to interpret the current system as aggravating long duration claims. In many ways the 1999 amendments have had counter intuitive effects on the statutory system. Whilst the number of common law claims has been reduced the number of long duration claims has increased. These are matters of continuing concern.

Tables thirteen and fourteen below are taken from WorkCover WA's published Statistical Reports and show the distribution of claims by number and cost by duration/time lost.

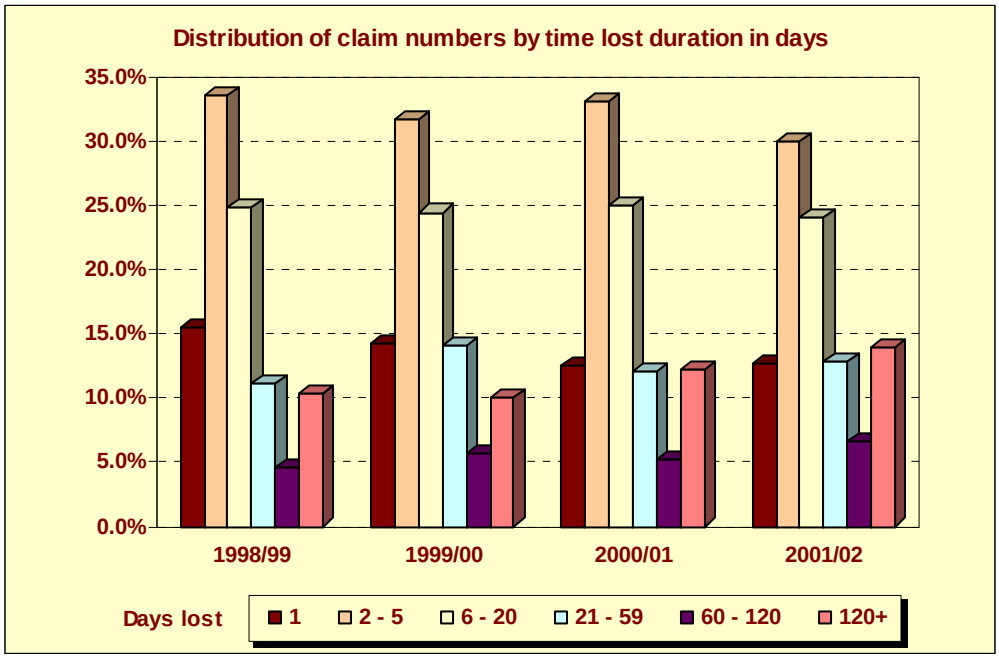


TABLE THIRTEEN

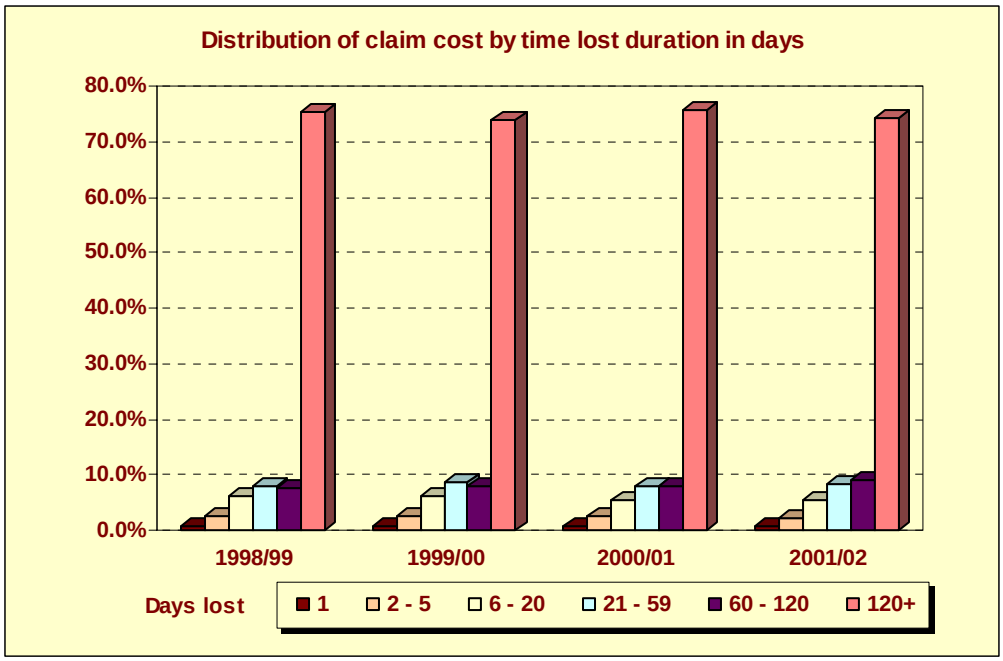


TABLE FOURTEEN

The above tables show that while the portion of claims with 60 days lost or more increased over the four year period from 15% to 21%, the distribution of the cost remained relatively stable at around 83%.

5. Conclusions

The process of amending the workers compensation Act since 2001 has been slow. Unlike the process, which occurred in 1993, the Labor Government has undertaken a detailed consultation process both in seeking submissions from stakeholders at the time of the 2001 ***Guthrie Report*** and almost continuously after the report. There is no doubt that the field of workers compensation has many interested stakeholders all of whom have a perception that their position or stance is the most appropriate, efficient and equitable. There is probably no other jurisdiction which is subject to so many competing interests. Not withstanding these competing interests a common cause of concern is the inability of workers to return to work after their disability. No worker can profit from the current system because of the thresholds and caps, which are in place. For example after 4 weeks all workers will suffer some decline in their weekly

earnings, and with the cap set at 1.5 or 2 times average weekly earnings, some workers will still suffer immediate income reductions.

There is therefore for most workers a heavy incentive to return to work and table thirteen above shows that 80% to 85% of injured workers do return after 12 weeks. The 15% to 20% of claims which remain open after 12 weeks consume 83% of the costs of the Western Australian workers' compensation system.

On the other hand it is has been asserted that, the higher the compensation benefit levels are as a percentage of pre-injury earnings ('the income replacement ratio') the lower the incentive for workers to return to worker. In this sense it can be argued that step-downs create a financial incentive for early return to work which if combined with proper and practical injury management processes and employer communication can lead to efficient and effective outcomes for all system participants. These arguments have not received a great deal of support from worker advocates who note the financial hardship caused by arbitrary reductions in payments.

In 1999 the ***Pearson Report*** isolated the longer term claims as the focus for attention. Unfortunately, the attention has all too frequently been on attempting to prevent these workers from proceeding with common law claims. The emphasis needs to shift to provide re-training for those workers and a more focussed attempt at the injury management and return to work. That is where the remedy may lie and it is probably a distraction to be too preoccupied with the mechanics of common law claims and the quantum of statutory benefits. However given the complexity of compensation systems, it is clear that none of the major drivers can be ignored with impunity.

October 2004

Financial Services Forum

Scoring Goals in a Changing World

5-6 May 2014
Hilton Sydney

Chasing Your Tail on TPD Claims - Insights from Injury Schemes

Prepared by Bozenna Hinton and Richard Yee

Presented to the Actuaries Institute
Financial Services Forum
5 – 6 May 2014
Sydney

Institute of Actuaries of Australia

ABN 69 000 423 656

Level 7, 4 Martin Place, Sydney NSW Australia 2000
t +61 (0) 2 9233 3466 **f** +61 (0) 2 9233 3446
e actuaries@actuaries.asn.au **w** www.actuaries.asn.au

Contents

Abstract

The Australian market for group Total and Permanent Disability (TPD) insurance has experienced significant losses in 2013 ($448m[1] after tax losses for Group Lump Sum Risk, excluding retroceded losses from local reinsurers).

What will be the experience for 2014 and beyond? We believe that there is potential for further industry losses as the life insurance industry has taken limited actions to react to the wave of claims so far. To address this issue and avoid a series of reserve increases ("chasing your tail"), we look at what can be learnt from injury schemes, most of which have faced similar challenges. We consider learnings and implications for product design, claims assessment, data, reserving and the influence of doctors, lawyers and unions. The industry needs to respond swiftly when faced with unsustainable claims experience.

Smarter product design

The current TPD product has become more generous over time. It has extended from a lump sum backstop for severely sick or injured workers unable to work, into a benefit that also encompasses claimants who are unlikely to return to their current job, without necessarily being medically incapacitated. The interpretation of the current TPD definition is often grey, resulting in more and more liberal interpretations, and legal precedents.

We recommend that the purpose and hence design of the TPD product is revisited. This includes introducing:

- An updated tighter definition of when the benefit would be paid, based on what the claimant can do:
    - Instigate the use of measures such as AMA[2] guides or FIM[3] scores to build an objective disability assessment process.
    - Introduce a definition for suitable employment, based on a work capacity test;
- Limits on the time period when claims can be submitted, moving towards a two year notification period after stopping work from the symptoms of the underlying injury or disease;
- Partial or income style benefits to be paid when there is still potential for the claimant to recover, along with active rehabilitation encouraged as part of the product structure, and a return to work focus; and
- Limits on the amount of cover without underwriting, to reduce the incentive for anti-selection and other behaviours from any party seeking lottery outcomes.

Other recommendations

Smarter product design alone is not enough. To counter the surge in claims we also recommend:

- Establishing independent doctor panels to assess claims, to improve objectivity.
- Routinely collecting additional and more granular data (such as on lawyer and doctor involvement) to better understand claims:
    - In addition, interrogate existing free form data, to better understand past claims;
    - Recognise that current data and reserving methodologies may not recognise step changes in claimants' and consumer advocates' behaviour.

[1] See APRA Quarterly Life Insurance Performance Statistics December 2013 (issued 18 February 2014). Note Group Lump Sum Risk covers Death and TPD insurance. As death insurance results have been steady, the driver of this poor experience has been TPD claims.

[2] American Medical Association. See section 2.2.1 for further information.

[3] Functional Independence Measure. See note 11 for further information.

1. Introduction

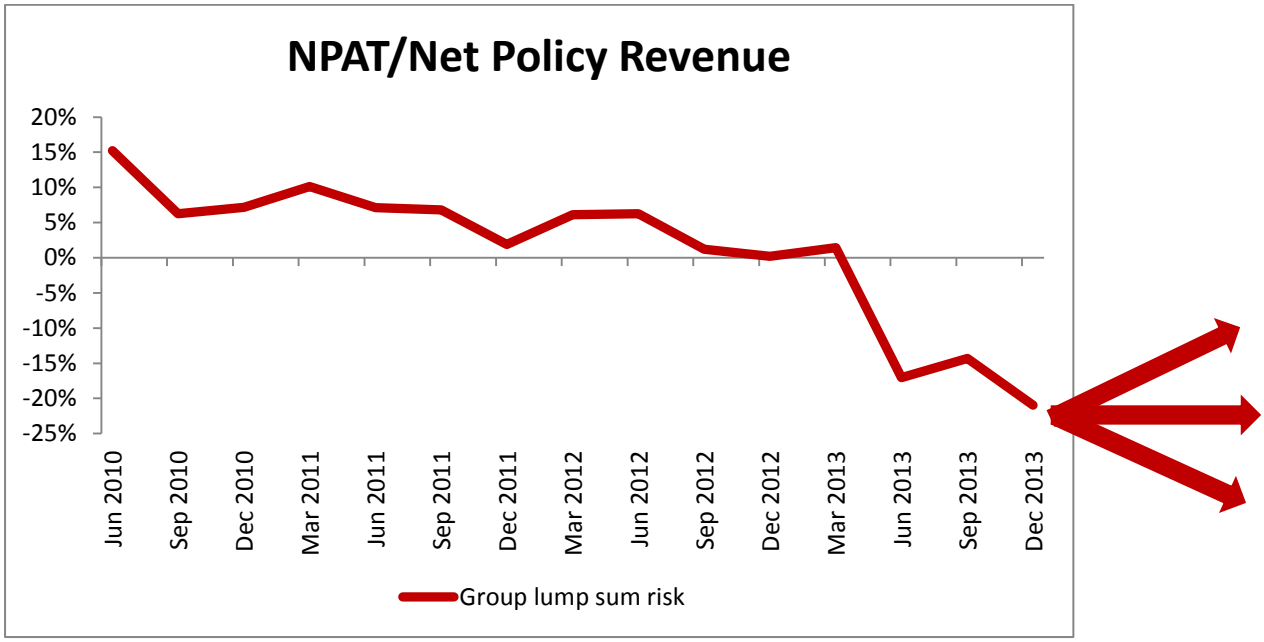
The Australian group insurance market and in particular lump sum Total and Permanent Disability (TPD) insurance has experienced significant losses over the last year ($448m[4] after tax losses in 2013 for Group Lump Sum Risk, excluding retroceded losses from local reinsurers). This paper looks at the issues facing the group TPD market, and what it can learn from general insurance injury schemes and other long tail classes in terms of what has (or hasn't) worked in addressing rising claims costs. We look at five areas of managing group TPD business which may assist in addressing the issues related to current losses:

- smarter product design,
- the historical and potential influence of doctors, lawyers and unions,
- rigorous claims assessment,
- comprehensive data, and
- reserving adequacy and its impact on pricing.

For each area we consider how this factor has been handled by injury schemes, how it has been approached in the area of group TPD insurance, and learnings we can take from this. We acknowledge that a variety of approaches are followed in managing injury schemes, and none are perfect. However the overall principles applied are instructive. If we don't learn from the past (in each of these five areas), we have the potential to enter into a series of reserve increases ("chasing your tail") by making the same mistakes. By implication, without change, there is potential for more industry losses.

Figure 1 below illustrates the lump sum group profit as a percentage of revenue between June 2010 and December 2013. Profitability has been on a clear downward trend over this period, to the point that in 2013 the industry experienced large losses.

Figure 1: Group lump sum risk Net Profit After Tax as a percentage of Net Policy Revenue



Source: APRA Quarterly Life Insurance Performance Statistics December 2013

[4] See APRA Quarterly Life Insurance Performance Statistics December 2013 (issued 18 February 2014). Note Group Lump Sum Risk covers Death and TPD insurance. As death insurance results have been steady, the driver of this poor experience has been TPD claims.

As the APRA figures exclude retrocessions by reinsurers, and a large share of the losses relate to reinsured business, we can assume that there are substantial additional losses not included in these numbers.

What will be the results for 2014 and beyond? Has the life insurance industry addressed the underlying causation of this very poor claims experience during 2013? What actions can be taken to avoid the industry chasing its tail?

This paper briefly examines some of the reasons behind the position we are in today and then explores some possible courses of action on how to mitigate each significant area of risk. A multi-pronged approach is needed for this complex problem.

1.1 Framework

TPD insurance provides a lump sum payment on the insured satisfying the definition of total and permanent disability. Injury schemes provide a compensation payment if a claimant is injured in a way that falls under the terms of the scheme. Typical injury schemes include Workers Compensation insurance and Compulsory Third Party (CTP) insurance. Other relevant long tail classes include Medical Malpractice insurance and Public Liability insurance[5]. While TPD insurance focuses on employment related disability, injury schemes are typically based on 'impairment', which is independent of employment. Further descriptions of TPD, injury scheme cover and other long tail classes are included in Appendix A.

1.2 Poor TPD experience.

The recent poor performance in 2013 in the group TPD insurance market is the culmination of a number of years where premiums and reserves have been found to be inadequate. In our view, the main drivers of the recent poor performance in the group insurance market have been many years in the making and are due to:

- **Increased awareness** by members of their cover, due to greater communication from superannuation funds, increased superannuation fund advertising and changes in government policy. Fundamentally, many members received cover by default but never realised it, even when they may have been eligible to claim. Recent increases in awareness have led to higher rates of claim from members. The Australian Tax Office 'SuperSeeker' web tool now quickly and easily allows individuals to locate any lost superannuation accounts, and any associated insurance cover. Lawyers have also

[5] Note that the new National Disability Insurance Scheme (NDIS) has not been considered in this paper, as it is too early to comment on its emerging experience.

been publicising their services, and their ability to help with insurance claims. Plaintiff lawyers who provide pro-bono services on employment and superannuation law to generate leads have also increased awareness of existing insurance cover. Insurers have previously benefited from this lower level of awareness for many years, and it was incorporated into the competitive cycle of pricing. Once all members are fully aware of their cover, the impact of this factor will plateau.

- **Definition creep**: TPD Definitions have been weakened over time. In addition, courts have interpreted definitions more liberally than intended, and in ways not anticipated by insurers when they priced the cover. This issue has been developing over a number of years, and is expected to continue to be a factor, unless action is taken to strengthen definitions, and to reduce the ability for courts to subjectively interpret definitions. As well, the eligibility for cover has gradually been extended, with cover extended to casual workers, spouses and the 'at work' test being reduced to only one day. This has extended cover to additional workers who would not have previously received it.

- **Anti-selection**: Some lives with health or other issues that would mean they may be declined cover or charged premium loadings if they were underwritten, are intentionally seeking cover in group schemes. This is made possible by easy eligibility criteria set by insurers through automatic acceptance arrangements (with limited risk controls). Issues may include current health problems, family history of certain illnesses, or the insured undertaking hazardous pastimes. Anti-selection may have been exacerbated by special interest groups such as the Cancer Council[6] and MS Australia[7] including advice to their clients via their websites about taking out insurance through group schemes, where they won't have to complete any health forms. In addition the impact of any anti-selection will mean that the assumed level of claims in the group will be understated.

  The anti-selection issue is likely to continue to increase over time, if increasing numbers of new members anti-select.

- **Higher levels of benefits**, with no underwriting required. In addition to anti selection occurring, higher levels of benefits have been provided without underwriting. Higher benefits may increase the incentive to claim for members with marginal claims. It also means that the impact of anti-selection has been magnified, as members who can't get cover elsewhere are more likely to take the maximum cover possible without underwriting, from a group insurer. For example, members of AustralianSuper could previously apply for up to $1.5m[8] cover without providing any evidence of health. (AustralianSuper has recently notified members that these arrangements are changing and that levels will reduce)

[6] See https://www.cancervic.org.au/downloads/CISS_factsheets/prac-superannuation.pdf
[7] See http://www.msaustralia.org.au/sites/default/files/Employment-and-MS.pdf
[8] Australian Super Insurances in your super guide, effective from 29 March 2014.

Extract from the AustralianSuper 'Insurances in your Super guide', 29 March 2014:

Type of cover	Cover you can apply for without health checks
Death and/or TPD cover	$1.5 million (Cover above $600,000 will be limited to $1.5 million or 10 times your salary*, whichever is lower.)

* Salary is your annual before-tax salary, excluding employer super contributions.

- **Increased involvement of lawyers in the claim process**: The number of claims that have come through to insurers at the initial notification stage where the claimant has first consulted a lawyer has increased over the last three years. While many of these claims will be valid, some may be ambit claims. The additional involvement of lawyers can make managing these claims harder for the case managers. From a review of lawyers' websites, it is clear that some lawyers are now actively targeting those with TPD cover, on a "no win no fee" basis. As well as making members more aware of their cover, lawyers are facilitating form filling and liaison with doctors etc., making it more likely that genuine and marginal claims will get paid. Also, lawyers are testing the current definitions and setting new precedents, which will lead to more claims being paid in future.

  While the data we have seen to date has been limited, and varies by scheme and length of delay in notification to the insurer, the general trend has been an increase in lawyer involvement. This is an area where it would be sensible to gather further data, so that the true scale of the issue can be understood, and appropriate actions can be taken to assess claims.

- **Uncertain economic environment**: The impact of the economic cycle has led to increased unemployment in some areas of the economy, and this has made it harder for some disabled people to return to work, especially outside the capital cities. This has meant there are less suitable job opportunities available for claimants to attempt to return to work. Some companies have viewed TPD payouts as a way to lay off a worker who requires reduced hours work following an injury or health problem, or for other reasons. There is also a greater incentive for a member to claim, rather than face redundancy. The poor economic outlook in some industries has also led to an increase in stress related claims, particularly in the self-employed. In these cases, once employees have been off work for a period, there may not be any work left for them to go back to.

- **Increased social acceptance of mental health issues**: It is now more accepted for people to acknowledge and seek help when they have mental health issues. This is a benefit for the community, as it can lead to greater treatment for those in need, however, the necessity of employees demonstrating that they are unable to work to qualify for their TPD payout can also act as a roadblock to pursuing effective treatment strategies. This has led to more TPD claims than in the past covering mental health issues. This is unlikely to change, unless effective rehabilitation is initiated earlier, to help claimants on the return to work process.

Appendix B provides a summary of the current state of the group lump sum risk insurance market in Australia.

2. Smarter product design

The typical TPD benefit definition is subjective and open ended, which can make it difficult to apply an objective assessment of claims. This makes this product open for exploitation from a consumer viewpoint and any consumer/member/industry/employee advocates. In a sense the group TPD market has become a path of least resistance for injured insureds seeking financial compensation or medical redundancy. In this section we look at:

- the definition of disablement,
- time limitations on making claims,
- partial benefits, and the
- sustainability of benefits.

2.1 Definition of disablement

2.1.1 Workers Compensation permanent impairment definition

Each State based workers scheme has its own rules and definitions, so there is no standard disability definition. However, it is illustrative to look at the NSW Workers Compensation definition of permanent impairment, as a typical example. WorkCover NSW's permanent impairment definition is neatly 'summarised' in its 100 page booklet "WorkCover Guides for the Evaluation of Permanent Impairment[9]", which describes how permanent impairment should be assessed. The evaluation is based on the "American Medical Association's Guides to the Evaluation of Permanent Impairment, fifth edition (AMA5)", with amendments. The assessment is based on what the person can do – how far they can walk, how well they can breathe, how they can see etc. It is not centred around a medical condition, which is central to the approach for assessing TPD claims. For example, the cover of the WorkCover NSW Medical Practitioners Guide to Work Cover[10] refers to "ability not disability – a back to work approach".

This mindset of capabilities is very different to proving what you *cannot* do. This methodical approach also involves collecting key pieces of medical data to support the analysis of whether or not the insured is entitled to a claim. It aims to be objective as possible.

The benefits of the WorkCover style definition are that it is:

- focused on what the claimant can do;
- based on an objective assessment, with trained medical providers (Whole Person Impairment assessors – see section 3.1) who can provide the assessment. This reduces the chance of any 'doctor shopping' (visiting various doctors until you get one whose opinion you agree with) on behalf of the claimant or insurer;
- tries to provide consistent results over time, without influence of subjective interpretation of a court in interpreting a medical report or applying a judgement (noting that there is some bracket creep in practice).

Although each of the injury schemes have their own disability definitions, which do have limitations, the key is providing certainty for claimants in what would qualify as disabled, enabling them to claim (or not) and then move on with their lives.

---

[9] See http://www.workcover.nsw.gov.au/formspublications/publications/Documents/workcover_guides_evaluation_permanent_impairment_3rd_edition_0970.pdf

[10] See http://www.workcover.nsw.gov.au/formspublications/publications/Documents/medical_practitioners_guide_1301.pdf

2.1.2 TPD definition of disablement

By way of contrast a TPD definition is subjective, typically involving words such as “ever”, “reasonable” and “likely”. The TPD assessment is based around evaluating the underlying medical condition or injury, and looking at the medical prognosis. It does not directly evaluate what the claimant can or cannot do, just whether they are reasonably likely to engage in their own occupation or one they are reasonably suited to by education training or experience.

The TPD style definition is:

- focused on the medical condition and employment potential;
- based on a subjective assessment, with the claimant’s usual doctor or a medical specialist (not necessarily an insurance specialist) to provide the assessment;
- requires an assessment of permanency;
- Not necessarily consistent between providers or also over time, as it is dependent on the interpretation of the claims assessor, or of the judge in the case of a tribunal process; and
- Potentially hypothetical in terms of occupation, if the claimant has a narrow range of experience and left their most recent employer, leaving open the possibility of distortion by courts, ombudsman, brokers etc.

Learnings definition of disablement: We recommend a tighter definition of disablement; one that is able to be applied objectively and is independent of those applying the definition. The definition should be sustainable and be based around meeting a meaningful consumer need. It should include allowance for the claimant to retrain.

2.2 Time limitation to claim

2.2.1 Injury scheme time limitation to claim

For injury scheme claims there is a time limitation as to when benefits can be claimed for, which varies by scheme and State, as shown in a simplified form in Table 1 below. Claims are to be lodged within a time period after becoming aware of the onset of the disease or injury. For all these schemes, the average period of notification is 6 – 12 months, with the longest delay being 3 years. In the past longer delays were possible, and the delay period has been shortened to reduce the risk of being caught with a sudden onset of IBNR claims many years after the accident period, to assist with managing the claims tail. For example in NSW CTP, the reporting delay was limited to six months from 1996, with a delay of three and a half years from 1987, and a delay of up to six years permitted prior to 1987.

For some claims with a long emergence period, there can still be a delay between the incidence and the claim. For example, new asbestosis claims are still admitted as long as they are notified within the time period since the date the injury is first recognised, and this could be 30 years after the initial exposure to asbestos. In addition, for certain classes there is no limitation period. For tort claims, the delay period permitted is six years. This means it is possible there are some long tailed surprises waiting to emerge, though this does not affect most claims, and it is generally only those claims that are non-injury related.

Table 1 – Time limitation on Injury scheme claims post being aware of the onset of the injury or disease (simplified), for Australian states, 2014

State	CTP	Workers' Compensation
NSW	6 months	6 months
VIC	1 year. This limit can be extended to 3 years if there are reasonable explanations.	Must be recorded in your workplace's register of injuries within 30 days of first becoming aware of your injury. - As long as both parties are aware of the situation there isn't a set reporting period
QLD	3 months if the vehicle cannot be identified. 9 months after the incident or the appearance of initial symptoms	6 months
SA	6 months	6 months
WA	3 years	12 months
NT	6 months	6 months
ACT	3 months if the vehicle cannot be identified. 9 months after the incident or the appearance of initial symptoms	Must inform the employer as soon as possible and they must inform the insurer within 48 hours
TAS	12 months	6 months

2.2.2 TPD time limitation to claim

For TPD claims, there is no limit on when claims can be made. This means that a claim could be notified even 20 years (or longer) after the date of event. Although 50% of TPD claims have generally been reported within two years, with the remainder mostly over the next five to eight years, with the current influx of late reported claims it is hard for insurers to know when and whether they can close off their older accident years or not.

The Financial Services Council has recently suggested[11] that there should be a seven year statute of limitation on TPD claims. A limitation on claims seems a practical way of assisting insurers to manage the risk of an emerging claims tail for the number of claims (and hence controlling the cost) while still catering to the needs of the majority of claimants. Note that a time limit (together with increased insurance awareness) is likely to result in a shortening in of the reporting period and reduced uncertainty around claims costs, but not lower ultimate claims costs.

The insurance needs of both claimants and non-claimants ought to be satisfied, and this means that affordable and sustainable insurance is in the interests of all. We support a limitation of when new claims can be notified to an insurer, and suggest moving towards a two year notification period after stopping work from the symptoms of the underlying injury or disease.

> Learnings time limits to claim: We recommend introducing a two year notification period after stopping work from the symptoms of the underlying injury or disease.

2.3 Partial/variable size benefits

2.3.1 Partial/variable size benefits injury schemes

Injury scheme benefits are not fixed, but instead depend on the *extent of the injury or loss*. In general insurance terminology this is expressed as a distribution of outcomes around the size

[11] See speech by John Brogden 3 April 2014, Financial Services Council Life Insurance Conference.

of the claim, with in some cases the possible liability being an unlimited amount. The amounts of claim are typically categorised by heads of damage. Heads of damage typically cover an amount to cover financial loss (loss of earnings), pain and suffering, medical costs and legal costs etc. The greater the injury and hence loss, the greater the payout (up to the very high upper limits or unlimited in some cases). This means for example, a worker in NSW with a degree of impairment, but not totally disabled, would be able to receive some payout, as long as they met the minimum payment threshold of 10%[12] whole person impairment.

In NSW CTP, the extent of payout (size of the benefit) is determined by the percentage at fault and then the extent of injury to qualify for general or non-economic loss damages. To qualify for non-economic loss damages the injured claimant must have a whole person impairment of greater than 10%[13].

2.3.2 Partial/variable size benefits TPD

For TPD insurance, no partial benefits are possible, and the outcome is an 'all or nothing' style approach. If there is some uncertainty about whether the claimant is permanently disabled, the usual approach of the insurer is to wait until they are certain before a payment is made. This can lead to delays in claimants receiving much needed payments. In some cases, it is hard to tell if there is really a genuine case, especially when the uncertainty may be more around the claimant finding another job, rather than a medical incapacity.

Example 1: Consider the case of a 63 year old obese panel beater, who had successfully recovered from a knee injury, after surgery and a rest period involving one year off work. At this stage his employer was reluctant to have him back "in case he injured himself again". The claimant considered himself retired (after a year at home) and declined any of the less physical alternative jobs recommended by the occupational physician as unsuitable.

Under a Workers Compensation style impairment definition, the claimant would be assessed as fit to return to work. However under a TPD definition, taking into account the state of the job market and the low number of jobs on offer for a person with his skills, he was considered to fulfil the TPD definition.

For claims such as these there is scope for a partial or instalment benefit, to take into account the uncertainty about whether the claimant could successfully be gainfully employed again.

[12] For claims made on or after 19 June 2012, to be eligible for lump sum compensation under section 66 of the 1987 Act a worker must have sustained an injury, as defined in section 4 of the 1998 Act that resulted in permanent impairment greater than 10% - refer section 66 (1) of the 1987 Act. From 19 June 2012, only one claim can be made under the 1987 Act for permanent impairment compensation that results from an injury – refer section 66 (1A) of the 1987 Act - and there can be only one medical assessment of degree of permanent impairment in the Workers Compensation Commission for the purposes of a claim for permanent impairment compensation, commutation or work injury damages claim – refer section 322A of the 1998 Act.

[13] For the catastrophically injured to qualify for the Long Term Care and Support Scheme, the extent of injury is measured by a Functional Independence Measure (FIM) score. A FIM score provides a uniform system of measurement for disability based on the *International Classification of Impairment, Disabilities and Handicaps*. It measures the level of a patient's disability and indicates how much assistance is required for the individual to carry out activities of daily living. It assesses physical and cognitive disability, and focuses on the burden of care – that is, the level of disability by indicating the burden of caring for the patient. See http://www.rehabmeasures.org/Lists/RehabMeasures/DispForm.aspx?ID=889

Learnings partial/variable benefits - We recommend that the paying of partial or instalment benefits is explored, as a way of making sure that potential claimants are able to receive some payment, in areas where they might miss out entirely, recognising that sometimes the decisions are not clear cut. Lump sum style benefits should be either phased out, or reserved for when an objective "Whole Person Impairment" (Workers Compensation style) threshold has been reached.

2.4 Sustainability of current benefits

2.4.1 Sustainability of current benefits - how injury scheme benefits have changed over time

Many injury schemes have been on a rollercoaster ride in terms of sustainability, before reaching their current state. WorkCover NSW is again a good example to illustrate this point. Figure 2 below shows that prior to the reforms in 2012, the scheme was heading towards a $4.5b deficit. The key reasons[14] for this loss were:

- Approximately 50% was due to deteriorating claims management since June 2008, mainly:
    - Significant increases in the number of Workplace Injury Damage claims ($1bn increase)
    - An increase in the number of weekly benefit claimants remaining on benefits. (weekly: $450m)
    - An increase in medical spend ($432m)
    - An increase in commutations ($89m)
    - An $18m increase in the number of "top up" payments for Permanent Impairment (Section 66) lump sums, which also led to a $26m increase in the utilisation of Pain and Suffering (Section 67) lump sums (total $44m increase).
- The other 50% ($2.3b) was due to external influences impacting investment returns achieved and particularly the "risk free" discount rate used to discount the outstanding claims liability. Investment return experience is not relevant for this paper and has not been explored further here.

As without these changes NSW employers were set for significant premium rate increases, something had to be done beyond simply increasing premium rates, and the benefits of the scheme were radically overhauled in June 2012. There was a general tightening of workers compensation benefits and harder boundaries around claims imposed. Changes broadly included (not a complete list):

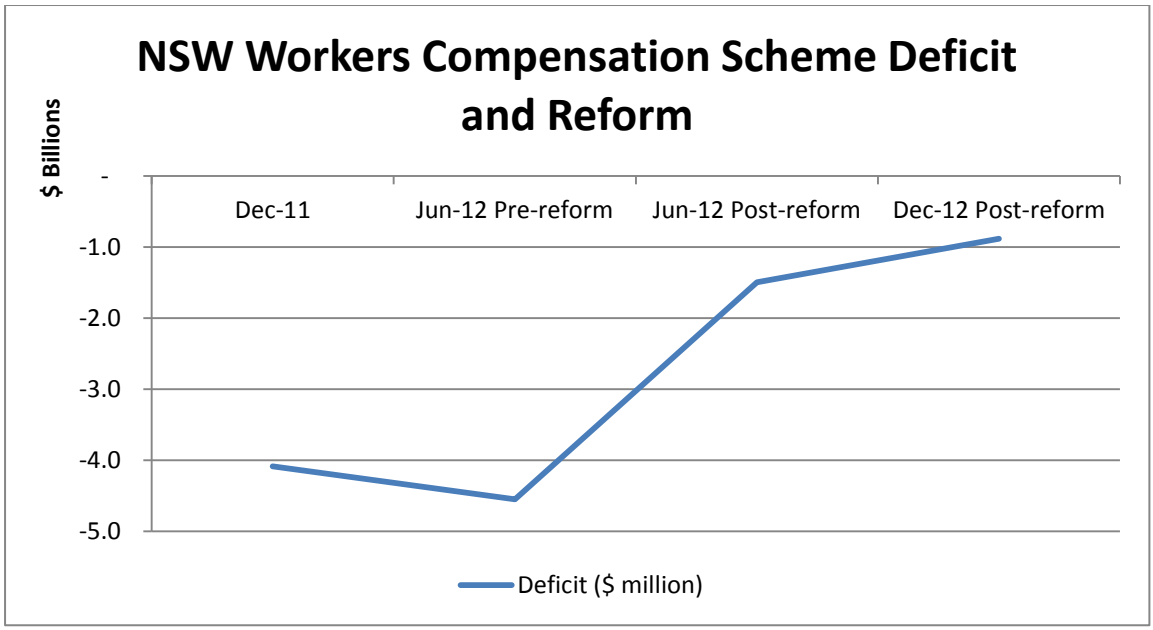
- A work capacity assessment between 78 and 130 weeks;
- Journey claims were generally eliminated (e.g. no longer covered for injuries arising from travelling to and from work)
- Weekly payments capped
- For statutory lump sums: Permanent impairment claims, a threshold of over 10% impairment was introduced, with a greater than 16% impairment threshold for psychiatric claims.

[14] See http://www.workcover.nsw.gov.au/formspublications/publications/Documents/pwc-executive-summary-actuarial-valuation.pdf

- Nervous shock[15] and heart attack/stroke claims were eliminated.

These changes substantially reduced future claim costs. The major changes were applied to any claims assessed after the changeover date and hence also applied retrospectively to prior accident years. (This was a significant reform when also applied retrospectively, as claim liabilities effectively disappeared overnight).

Figure 2: WorkCover NSW scheme deficit and reform



Source: *WorkCover NSW Key Results, Actuarial valuation of outstanding claims liability for the NSW Workers Compensation Nominal Insurer as at 31 December 2012 (including allowance for June 2012 benefit reforms), 6 June 2013, PricewaterhouseCoopers Actuarial Pty Ltd*

Other schemes have gone through similar periods of restricting benefits when costs have blown out. For example NSW CTP reforms occurred last year, as premiums were the least affordable in Australia. There were also changes in Queensland Workers Compensation a few years ago and SA CTP made changes last year to reduce premiums.

2.4.2 TPD sustainability of current benefits - how benefits have changed over time

TPD benefits have gradually become more generous over time due to intense competition in the marketplace. Typical practice has been to widen default cover to schemes where previously TPD cover was not offered, to offer higher levels of default cover in existing schemes, and offer higher levels of Automatic Acceptance Limits (AALs), where cover is provided without underwriting. In addition, qualifying for TPD cover has become easier, with eligibility for cover extended to casual workers, and the 'at work' test typically being reduced to only one day.

TPD definitions have also become more generous over time, with a move from requiring the member to be off work for a period of six months being reduced to being off work for a period of at least three months.

The previous "any" occupation definition has also been replaced by one that refers to "any occupation suited by education training and experience (ETE)". This definition is now required

[15] 'Nervous shock' is psychological illness or injury suffered by family members of the deceased or injured worker, due to the incident

for cover offered through superannuation. Insurers must supply products that are consistent with the SIS[16] conditions of release to beneficiaries who join a fund from 1 July 2014.

Providing sustainable benefits is also linked to making sure the benefits meet a genuine need at a reasonable cost. This includes considering whether the best way of assisting *all* disabled workers is to exclude them from the workforce, or as an alternative, to explore rehabilitation options and a return to work focus, where appropriate. Lump sum benefits encourage workers to remain disabled, to make sure they qualify. Rehabilitation and income style benefits are likely to be more effective at helping recovery, where recovery is possible.

Learnings sustainability - We recommend that schemes tighten the levels of default cover they provide and reduce AALs.

We recommend benefit design is re-evaluated, with a move to replace lump sum benefits with income style benefits, and focus on rehabilitation and return to work.

[16] Superannuation Industry (Supervision) Act 1993

3. Potential influence of doctors, lawyers and unions

There are a number of parties who may become involved in the claim assessment process. These parties have different perspectives to insurance companies. This section looks at the influence and involvement doctors, unions and lawyers may have on the financial outcome for claimants and whether a claim may ultimately be paid. We look at what has happened in relation to injury schemes, where we are for TPD insurance, and the learnings that can apply to life insurance.

3.1 Doctors

3.1.1 Doctors – injury schemes

To assess the level of disability, CTP schemes and Workers Compensation schemes have set up independent doctor panels to assess a claimant from the time of initial injury onset or to resolve disputes involving medical matters. This provides an assessment of the injury which is independent of the insurance company and the claimant. These panels consist of selected medical practitioners who perform different roles depending on the jurisdiction and the injury scheme and the nature of the medical issue. Generally they provide an impartial assessment of the potential claimant's injury, degree of impairment and whether the injury was related to the incident in question.

For example, WorkCover NSW makes use of both Independent Medical Examiners and Assessors of Whole Person Impairment[17]. Independent Medical Examiners are "specialist medical practitioners with qualifications relevant to the worker's injury who provide impartial medical assessments of an injured worker." The Independent Medical Examiners are referred to when:

- "*information from … the nominated treating doctor is unavailable, inadequate or inconsistent*" or
- "*the insurer has been unable to resolve issues after directing questions to the nominated treating doctor*."

Assessors of Whole Person Impairment are "*a medical specialist trained in the use of the WorkCover Guides for the Evaluation of Permanent Impairment to assess permanent impairment for injuries incurred after 1 January 2002*". An assessor of Whole Person Impairment is involved when "*there is a need to establish the level of permanent impairment that results from a work-related injury or disease. The assessment of permanent impairment is conducted for the purpose of awarding a lump sum payment under the statutory benefits of the NSW Workers Compensation Scheme and also for determining access to common law or a commutation*".

For example, NSW CTP provides CARS (Claims Assessment and Resolution Service) which is a broader (not only medical) binding dispute resolution service and MAS (Medical Assessment Service). The MAS panel is used to assess the entry of claimants for general damages claims based upon a whole person impairment of 10% which represents quite a significant injury.

As part of NSW CTP cover, the long term care and support scheme (LTCS) was set up for those catastrophically injured in motor accidents. The claimant enters into the LTCS if the appropriate FIM score is achieved.

[17] See http://www.workcover.nsw.gov.au/formspublications/publications/Documents/medical_practitioners_guide_1301.pdf

3.1.2 Doctors – TPD

TPD insurers do not use independent doctor panels and generally accept the medical advice provided by the claimant's medical practitioner. We have heard anecdotally from doctors that sometimes they feel pressured by the claimant and their accompanying family to give the 'right' answer, especially when the medical situation is not clear. If this has occurred, ideally this would be identified by a reference from the insurer to an independent specialist asking for a second opinion, which they can do at any stage (for a fee).

As part of the insurers' assessment of a claim, the insurer will ask the claimant to fill in a report from his or her usual doctor, describing the accident or illness and the likely prognosis. It has been known for some claimants to visit a number of doctors until they find one who is sympathetic to their cause. As also occurs in injury schemes, we have seen examples of cases where certain doctors have been over represented in reporting on claims to insurers. It is possible that 'doctor shopping' occurs, and claimants visit a number of doctors until they find the 'right' one. Sometimes this information is passed between claimants, particularly in a group or employment environment when many employees could claim for the same condition. This can lead to higher concentrations of reports from certain doctors than you would expect by chance. An example of where this may occur is in the area of mental health claims, where there is a higher degree of subjective assessment.

If a doctor is known to be liberal in his or her interpretation of the policy wording, it may be worthwhile for the insurer to seek an independent assessment in these cases. As a first step, the insurer needs to identify if this is in fact occurring, though collecting details of the claimant's recorded doctor, and alerting the claims assessor for any special steps to take if this is the case.

Learnings: Doctors – We recommend both claimants and insurers have access to independent doctor panels, who are experienced in assessing the degree of impairment according to objective scientific principles, and the likelihood of this impacting on future work opportunities.

We recommend collecting data on the claimant's treating medical practitioner so any concentrations of particular doctors can be understood and explored if appropriate.

3.2 Unions

3.2.1 Unions – injury schemes

In the area of workers compensation there have been anecdotal instances where unions have encouraged members through 'educational evenings' to make members aware of their rights, which may result in workers compensation claims.

In these situations whilst nothing officially was agreed, they allegedly may have made arrangements with a law firm and/or a doctor who is sympathetic to the plight of that particular group of claimants. There would be synergies in dealing with a group en mass, and it could simply be the union educating the workforce on the rights of employees to make a claim under various scenarios for that particular industry grouping. The underlying issue however, would potentially be the poor product design or poor work safety practices that ultimately resulted in the sudden outbreak of claims from say 'industrial deafness'.

3.2.2 Unions – TPD

It is not known if unions have encouraged groups to claim TPD insurance benefits to date. This may be an area of to watch, as it now has become harder to claim under worker compensation insurance. It will be useful to look for patterns in claims by say, the type of injury if this appears to be occurring. These types of claims are best dealt with by making sure the information from one claim assessment is shared among assessors of any similar claim, so an accurate decision can be made in the most cost effective manner.

Learnings: Unions – It is important to analyse the claims data, to be alert to any patterns in the claims in certain postcode areas or particular professions or in conjunction with certain doctors, and share any learnings across assessors of similar types of claims.

3.3 Lawyers

3.3.1 Lawyers – injury schemes

As well as spiralling costs in WorkCover NSW mentioned earlier, there are other examples where costs have blown out of control, resulting in subsequent scheme reform. The NSW CTP scheme undertook legislative reform in 1999 which restricted access to general damages/non-economic loss benefits to claims with a whole person impairment of at least 10%. This has reduced lawyer involvement. In addition, in 2013 the NSW CTP scheme had draft legislation put to the NSW parliament which would have legislated a no fault scheme thus eliminating lawyers' involvement in determining who was at fault.

A second example is the United Medical Protection (UMP) was a medical malpractice insurer that at one point provided cover to 60%[18] of Australia's doctors. Increasing numbers of medical malpractice claims and large court awards combined to produce spiralling claims costs that led to United Medical Protection becoming technically insolvent. Consequently, in 2002 the Australian Government intervened to bail out UMP.

The public liability crisis of the early 2000s[19] is another example. For several years, the competitiveness in the public liability market had driven insurance premiums lower to the point of unprofitability. While many public liability insurers withdrew from the market, some insurers stayed on. HIH wrote premiums at unprofitable levels and as it comprised a large proportion of the market other insurers were faced with unprofitable premiums if they followed suit. The subsequent failure of HIH reduced the supply of public liability insurance and also revealed hidden losses not reserved at all for. This allowed the remaining insurers to charge suitable premiums. The historically inadequate premiums meant past claims reserves were inadequate, and premiums were boosted to match the higher reserve levels. The spiralling premiums and claims reserves led to a public liability crisis where smaller organisations especially were unable to afford public liability insurance. Consequently tort law reform (reform to the scheme rules and associated access to common law) was implemented and has since contributed to a considerable improvement in the public liability market.

---

[18] "Australian government forced to bail out medical malpractice insurer", 6 April 2002, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1172115/
Also see NSW PARLIAMENTARY LIBRARY RESEARCH SERVICE Briefing Paper No 2/04, "Medical Negligence: an update" by Talina Drabsch, February 2004, https://www.parliament.nsw.gov.au/prod/parlment/publications.nsf/0/6C1BDA58607A7808CA256ECF0007223D/$File/02-04.pdf

[19] The Public Liability Crisis – Why did it occur and how has it been resolved, Tom McDonald, Deakin University, 2005, http://www.deakin.edu.au/buslaw/aef/workingpapers/papers/2005_20.pdf

The involvement of lawyers in claims is a significant factor in claims costs, and in injury schemes, where studies have shown that legal costs could represent anywhere from 20 to 40% of the total claims cost. Anecdotally, claims with a lawyer involved have generally been found to cost significantly more than claims without a lawyer.

The reform of schemes has led to a reduced ability for lawyers to have opportunities to assist claimants in this area, and as a result, those law firms with a large plaintiff personal injury practice have been innovative and looked for other areas to support consumers, including assisting claimants with TPD claims. Some of these law firms now have shareholders (e.g. Slater & Gordon and Shine Lawyers), and now need to look for other sources of revenue since their injury scheme work has reduced.

3.3.2 Lawyers – TPD

Anecdotally and a number of confidential case studies indicate that there has been an increase in the involvement of lawyers in TPD claims in recent years. As their work in injury schemes has likely decreased due to legislative reforms, lawyers have increased their use of litigation funding, increased their application of class actions in this space and increased their marketing. Lawyers are also going through old personal injury files and identifying where there may be a TPD claim, which may not previously been considered. As mentioned earlier, lawyers are facilitating claim applications, and some are hiring claims managers to assist with TPD claim applications. Lawyers are also making use of SuperSeeker, helping claimants submit claims for cover they were not aware they had. In addition, lawyers are testing definitions and setting precedents, which will lead to more claims being paid in future. In all these ways, lawyers have been very successful at generating additional work through assisting workers identify that they have a TPD claim, and applying to insurers to claim benefits on their clients' behalf.

For example, Slater & Gordon stated in its 2013 annual report[20] that "*The Australian Personal Injury (PI) practice delivered an 8.0% organic revenue increase on FY12. New client enquiry growth was 8.5% for the year, due largely to the success of the Australian advertising campaign launched in July 2012. ... Most of this work is performed on a No Win – No Fee™ basis. … Slater & Gordon … is the market leader in personal injury litigation in Australia.*"

Maurice Blackburn states on its website[21] "*Maurice Blackburn has the largest and most successful plaintiff superannuation and insurance practice in Australia. For more than 15 years we have acted for thousands of individuals, recovering many millions of dollars from insurance companies and superannuation funds. We specialise in superannuation and insurance claims and appeals, including superannuation disability claims (Total Permanent Disability (TPD) and Terminal Illness (TI)), death benefit claims and income protection insurance claims." "Maurice Blackburn has the largest legal department dealing with superannuation and insurance claims in Australia."*

In addition, when looking up TPD definitions with google, adverts for Shine, Gerald Malouf, Maurice Blackburn, Lawpartners and Turner Freeman lawyers appeared at the top of the search screen.

---

[20] Slater & Gordon Limited Annual Report 2013

[21] http://www.mauriceblackburn.com.au/areas-of-practice/superannuation-insurance.aspx
http://www.superclaims.com.au/?__utma=1.2125480494.1384944483.1384944483.1398088076.2&__utmb=1.3.10.1398088076&__utmc=1&__utmx=-&__utmz=1.1398088076.2.2.utmcsr=google|utmccn=(organic)|utmcmd=organic|utmctr=(not%20provided)&__utmv=-&__utmk=123855370

Injured workers who are no longer able to claim under workers compensation (e.g. for journey claims or psychiatric claims) have looked to other areas to claim such as income protection and or TPD insurance. These more recent claimants who have no longer been able to claim under workers compensation may appreciate lawyers pointing out to them an alternative way of receiving a benefit.

A further point that could influence the level of involvement of lawyers is that the current restrictions on legal advertising are proposed to be removed. It is possible that this situation will be further exacerbated following the release by the Productivity Commission of its draft report on *Access to Justice Arrangements* on 8 April 2014, with draft recommendation 7.2 that "state and territory governments should remove all bans on advertising for legal services".

Also, APRA released on 10 December 2013 *Draft Prudential Practice Guide LPG 270 Group Insurance Arrangements*, which mentions:

4(b) *"failure by the insurer to identify adverse trends affecting future claims experience or failure to give sufficient weight to the uncertainty inherent in such trends. Examples of issues that could result in adverse trends include….changes to the membership profile… greater involvement of* ***lawyers*** *in the claims process…. increasing delays in the reporting of claims"*

This implies that all group TPD insurers should be gathering data on the extent of any lawyer involvement in the claims process, so they can identify any associated trends.

Learnings: Lawyers are innovative in seeking new sources of revenue and in protecting the rights of consumers. This has perhaps encouraged some claims to be made that perhaps may not otherwise have been lodged. This additional claims activity is driving up the size of IBNR claims reserves and hence costs, and may result in a higher level of underlying claims.

Also some claims are now being made as lawyers are interpreting the TPD definition in ways not previously intended. While some of these claims may be valid under a strict legal interpretation, they may not match the intention behind the cover. This indicates that the wording of the cover should be tightened to match the need underlying the intention of the product. Definition wording should also be updated to reflect the current environment. A change to an income style benefit, which is better for claimants' recovery and return to work, is also less attractive for lawyers to pursue as a revenue source.

Trustees can also help spread the message to claimants that making a claim is straightforward and can be made without legal assistance, and approaching the insurer should be the first step in the claims process.

4. Rigorous claims assessment

It is difficult to objectively assess a claim by applying a claims definition with subjective elements. The lack of objectivity makes it more likely that there will be differences of opinion, and increases the opportunity for conflict when two parties have, generally speaking, opposing interests. This section looks at:

- Disablement threshold
- Work capacity test
- Changes in the definition of disablement over time (objectivity)
- Resourcing of the claims team
- Claims leakage reviews, and the
- Ease of making a claim

4.1 Disablement threshold

4.1.1 Disablement threshold - injury schemes

In the management of injury schemes, there has been a move to a more objective claims definitions over time to reduce the conflict between the insured and the insurer. The impairment threshold varies across CTP and Workers Compensation schemes. Examples of the types of thresholds used in injury schemes for serious injury taken from Geoff Atkins' 2013 paper on the Sustainability of Common Law access are[22]:

Table 2 – Serious injury thresholds – Workers Compensation

State	Serious Injury Definition	Year of Effect
NSW	At least 15% Whole Person Impairment	2012
VIC	Narrative test (deeming if at least 30% Whole Person Impairment)	1999
QLD	At least 5% Degree of Permanent Impairment	2013
WA	At least 15% Whole Person Impairment	2014
TAS	At least 20% Whole Person Impairment	2010
Comcare	Must have successful permanent impairment claim	1988

Table 3 – Serious injury thresholds – Motor Accidents

State	Serious Injury Definition	Year of Effect
NSW	At least Whole Person Impairment of 10% for non-economic loss access	1999
VIC	Narrative test (deeming if at least 30% Whole Person Impairment)	1987
QLD	No threshold	Always
WA	General damage threshold of $18,000 (inflated annually) no threshold for Loss of earnings	1994
SA	At least an Injury Scale Value of 7 for economic loss and at least an Injury Scale Value of 10 for non-economic loss and Gratuitous care. Provision for exception cases	2013
TAS	No restrictions	Always

Most workers compensation schemes use a whole person impairment threshold, based on the AMA guides, with various amendments. The motor accident thresholds are more varied, but again, the theme is an objective measure. (The Victorian schemes are an exception, and instead also use a narrative test, which is based around an explanation of what is wrong with

[22] See *Sustainability of Common Law*, Geoff Atkins, IAA Injury Scheme Seminar 2013

the claimant, in addition to an objective test.) The use of AMA Guides, while having acknowledged shortcoming by practitioners, still offers a preferred approach, for the advantage of certainty in assessment that they provide claimants.

4.1.2 Disablement threshold - TPD

TPD benefits are implied to be paid on the *total* and *permanent* disablement of the claimant. Although this may appear at first glance to be clear cut, wording of the definition means that this is harder to determine than first thought. Permanent disablement or incapacity is usually defined as, in the opinion of the insurer, it is reasonably satisfied that the claimant will be unable to work in their own occupation, or one they are reasonably suited to by education, training or experience. This does refer back to the ability the claimant may have to work, but is subjective, as the test threshold is only 'reasonably satisfied', which could have a range of interpretations.

> Learnings disablement threshold: We recommend that disablement is defined by an objective measure, in terms of what the claimant is able to do, with a clear disablement threshold. An objective definition is easier to apply and enforce. Look to what we can learn from the permanent impairment definitions from injury schemes such as from AMA guides and FIM scores.

4.2 Work capacity test

4.2.1 Work capacity test – injury schemes

The aim for injury schemes is to achieve a positive health outcome and for the worker who is injured to return to work in some capacity, if possible. It is a general view that for the long term wellbeing of a claimant, work is an essential part of healthy recovery and that staying home on benefits is not a preferred lifestyle outcome.

For some schemes workers must satisfy a work capacity test. For example, from the WorkCover NSW website[23] "*A work capacity assessment is an assessment conducted by an insurer of a worker's current work capacity in accordance with Workers Compensation Act 1987 (1987 Act). It is an ongoing process of information gathering, assessment and reassessment of a worker's functional, vocational and medical status to inform decisions about a worker's ability to return to work in pre-injury employment or* ***suitable employment*** *with their pre-injury employer, or at another place of employment. Seriously injured workers are not subject to work capacity assessments unless they request it and the insurer considers such assessment to be appropriate. A seriously injured worker is usually a worker who has been assessed as having more than 30% permanent impairment."* It goes on to say: *"A work capacity decision is a discrete decision made by an insurer about:*

- *a worker's current work capacity*
- *what constitutes suitable employment for a worker*
- *the amount an injured worker is able to earn in suitable employment*
- *the amount of pre injury average weekly earnings or current weekly earnings*
- *whether a worker is, as a result of injury, unable without substantial risk of further injury to engage in employment of a certain kind because of the nature of that employment,*

[23] http://www.workcover.nsw.gov.au/injuriesclaims/workcapacity/Pages/default.aspx

- *any other decision that affects a worker's entitlement to weekly payments of compensation, including a decision to suspend, discontinue or reduce weekly payments of compensation based on the points above.*"

A work capacity assessment is a useful measure of whether the claimant can return to work. As part of this definition, it is also necessary to consider what is meant by ***suitable employment***. The 1987 Act defines the concept of suitable employment, in Section 32, as *"employment in work for which the worker is currently suited:*
(a) having regard to:

(i) the nature of the worker's incapacity and the details provided in medical information including, but not limited to, any certificate of capacity supplied by the worker (under section 44B),
(ii) the worker's age, education, skills and work experience,
(iii) any plan or document prepared as part of the return to work planning process, including an injury management plan under Chapter 3 of the Workplace Injury Management and Workers Compensation Act 1998 (1988 Act),
(iv) any occupational rehabilitation services that are being, or have been, provided to or for the worker, and
(v) such other matters as the WorkCover Guidelines may specify, and

(b) regardless of

(i) whether the work or employment is available, and
(ii) whether the work or the employment is of a type or nature that is generally
(iii) available in the employment market, and
(iv) the nature of the worker's pre-injury employment, and
(v) *the worker's place of residence"*

This illustrates that a detailed framework exists for making a decision about the work capacity of the claimant, which provides clarity to both the claimant and the insurer.

4.2.2 Work capacity test – TPD

TPD insurers have no industry wide approach of assessing the work capacity of claimants. Each insurer follows its own approach, which may involve asking the claimant to complete a functional job description, and referring the claimant to an occupational physician to determine their capacity to return to their own occupation, or one they are suited to by ETE (education, training and experience).

There is no standard definition of "suitable employment", and usually whether the work or employment *is* available is taken into account, as well as taking into account the place of residence and likely work in that area. Note however, that these factors are not spelt out in the definition, so there is subjectivity as to the extent and appropriateness of including these factors in an assessment. Practice in this area varies between insurers, and often between claim assessors within an insurer. It would be useful for TPD providers if these factors were clarified in the definition, to provide certainty both at the pricing and the claims stage.

Learnings work capacity test: We recommend that the TPD definition defines suitable employment along the same lines as for Workers Compensation. We recommend a standardised approach to determining work capacity, to provide greater certainty to all parties.

4.3 Change to claims definition over time

4.3.1 Change to claims definition in injury schemes

Injury schemes have had a history of making changes to the terms and conditions and to the benefits provided, in response to unsustainable cost pressures. When situations have arisen when definitions have been interpreted more generously than originally intended, or at levels that are unsustainable for the scheme (taking into account that all workers ultimately have to fund these schemes) changes have been made. Schemes that have made changes to their terms in recent years include:

- WorkCover NSW
- WA WorkCover
- Queensland Workers Compensation
- Queensland CTP
- SA CTP, and
- Tasmania Workers Compensation.

To look in more detail about the sort of changes that have been made, we have looked at the changes in the serious injury threshold in the Western Australian (WA) WorkCover scheme. Adverse claims experience in the WA WorkCover scheme spurred on the WA government to refine its serious injury definition several times over the past two decades. These reforms were met by improved scheme performance. The following table summarised from Geoff Atkins' paper *Sustainability of Common Law* illustrates the changes that were made[24]:

Table 4 – WA WorkCover refinement to serious injury threshold

	Problem	Reform
1993	Rising costs	Access to common law restricted based on an impairment threshold (impairment based on WorkCover Guides WA), pecuniary loss threshold
1999	Low pecuniary loss threshold	Damages capped for lower % impairment, impairment based on WorkCover Guides WA, AMA Guides, Schedule 2 of the Act Election to be made within 6 months of first payment
2004	Impairment assessments highly variable and difficult for conditions not stabilized within 6 months	WPI assessments now based on AMA guidelines Election to be made within 12 months of termination, with possible extensions % impairment threshold with capped damages was reduced

This shows that a series of reforms were made, as each initial reform proved to be less effective than anticipated, further adjustments were necessary to rein in costs. Over the last 30 years this has been played out many times in injury schemes, as lawyers, doctors and claimants find a way around the existing legislation. Those involved suggest the schemes may need reviewing every five years.

4.3.2 Change to claims definition in TPD

TPD definitions have been relaxed over time. One change has been the move from "any occupation" and "own occupation" definitions, with a higher price charged for own occupation, to a move to "any occupation + ETE", which is very similar to an own occupation definition in practical terms and is much easier to claim under than the old style any occupation definition. Current interpretation of the "any + ETE" definition is along the lines of if the claimant has not undertaken that role before, or has not previously done a training course relating to that

[24] See *Sustainability of Common Law*, Geoff Atkins, ISS 2013, page 10

specialisation, then the insurer is not able to prove that the claimant would be suited to that occupation. For example, we have seen an example of a truck driver who may have been suited to an alternate occupation as a security guard, who was not deemed suited, as he had not previously completed the two week security guard training.

Another change has been the move from a *six month* requirement of being 'continually absent from your employment', to a period of only at least *three months* absence. Insurers have generally justified making this change as for genuine disablements, the situation should be clear by three months, and if it is not, it is still within the discretion of the insurer to delay difficult decisions until in its opinion, it can make a decision.

A further change in application, though not reflected in the definition wording, is the interpretation that the definition of occupation takes into account what jobs are currently available in the current geographical area in which the claimant is based. Again, this change is a more liberal interpretation, and when applied this way, results in more claims being admitted.

When claimants wish to dispute a decision they are able to approach the Superannuation Complaints Tribunal, for insurance cover through superannuation funds, or the Financial Ombudsman Service for cover outside superannuation. The insurer is then likely to take into account any precedents set by these tribunals in its future claims decisions, and decisions of how to interpret definitions.

One recent move to tighten definitions has been for a few schemes to replace "***unlikely*** *that the member will engage in gainful employment for which the member is reasonably qualified by education, training or experience"* with "***unable*** *that the member will engage…."*. This is a step in the right direction, though as there is no definition of 'unable', it is possible that assessors will interpret the chance of being unable as 'not likely.

> Learnings changes to definitions: When schemes have become (or are becoming) unsustainable, changes need to be made. For injury schemes, benefit creep is an ongoing process, and as a result, benefit definitions need revisiting on a regular basis to keep up. TPD insurers have recognised this as an industry wide issue, and it is sensible at this point to take up the opportunity for an industry wide solution.

4.4 Resourcing of the claims team

There is a general shortage of skilled claims assessors across the insurance industry. Claims assessors need to be multi skilled – to understand both medical and occupational aspects, as well as be able to have good communication skills and be able to deal with claimants in an empathetic way. The claims team should also be skilled in the area of 'return to work' outcomes. This is a complete subject matter in its own right and is outside the scope of this paper.

4.4.1 Resourcing of the claims team TPD

For life insurance claims it is important to have skilled claims assessors who are able to assess the claimant's eligibility, as well as occupational and medical capacity. The growth in insurance cover over recent years, and the subsequent growth in claims, and now the higher levels of claims for the reasons stated earlier, have increased the demand for life insurance claims assessors. This shortage has made it harder for existing staff to manage their case loads, and cope with additional demands, such as training new recruits. It is also likely to

have increased the workloads of existing assessors. Claims staff are not prepared for the large onslaught of claims currently occurring.

In response to the shortage of claims assessors, there has been some movement from general insurance to life insurance, as life insurers are looking to round out the skills of their existing assessors, and to seek fresh input into their claims teams.

The pressure on claims staff has meant it more likely that claims staff will pay claims rather than having time to objectively assess claims, depending on the pressure they may be under to meet targets. If this occurs, then this will further add to insurers' poor claims results. The increase of claims assisted by lawyers will put further stress on claims staff, as they may not be used to dealing with the additional level of communication and demands.

4.5 Claims 'leakage'

4.5.1 Claims 'leakage' injury schemes

The management of the claims process is important, as claims costs make up the majority of the insurance premium. Some observations from injury schemes (discussed in Natasha Anning and Peter McCarthy's paper on Claims Management in Injury Schemes) are[25]

- There is significant variability across the industry in the quality of claims management practices and claims outcomes;
- Claims management does not always attract the focus that it needs. It needs to balance, within the objectives of each scheme:
    - Fair and reasonable benefits for claimants,
    - Better financial outcomes for schemes/insurers/customers/claims agents,
    - A better experience for claimants, and
    - Improved health and quality of life outcomes for claimants.

Claims 'leakage' studies, which identify areas where claim payments have been higher than required under the terms of the scheme, have been conducted across both the life and general insurance industries. They have demonstrated that there are key opportunities for improvement which are generally consistent across the industry. A summary of the main areas identified from claims leakage studies[26] that have led to leakage are shown in Table 5 below:

Table 5: Claims 'Leakage' themes

Key theme	Description	Examples
People	Personnel competencies, training and career development, supervisory oversight, definition of roles, management capabilities.	By far the main cause Lack of negotiation skills, critical analysis and proactiveness, lack of training and skills
Process	Claims handling processes	Processes are inefficient or drive incorrect behaviour e.g. quantity at the expense of quality
Supplier Management	Key claim supplier relationships, management, negotiation, pricing, contracting, and vendor oversight.	Inadequate management of supplier relationships; 'us vs. them' mentalities A significant contributor
Governance / Organisation	Pervasive enterprise wide considerations including governance/oversight, authorities, roles/responsibilities, policies/procedures, operating model and internal controls.	Inadequate governance and oversight, lack of claims reviews Roles and responsibilities unclear and not linked to claims outcomes A significant contributor

[25] The Importance of Claims Management in Injury Schemes, Natasha Anning and Peter M^{c}Carthy, ISS 2013.

[26] The Importance of Claims Management in Injury Schemes, Natasha Anning and Peter M^{c}Carthy, ISS 2013.

Key theme	Description	Examples
Technology	Includes claims management systems, workflow systems, analytic systems.	An enabler but it should drive accurate data capture and enable analysis of data, primarily focused on speed of delivery vs. quality

People, supplier management and governance are key factors that contribute to claims leakage, and it is important to review the claim assessment process regularly to ensure that claim costs are focused on the insurers' contractual obligations.

4.5.2 Claims 'leakage' TPD

For group TPD insurance as well as for injury schemes there are occasions when claims management practices has resulted in unnecessary claim payouts. In this environment of rising claims costs, and continued pressure on company results it is sensible for companies to ensure that claims are being paid according to internal practice standards, and no unnecessary payments are being made. TPD claims managers are hampered by the decision being very much a binary decision, that is, the claim is paid or it is not. This is not the case with income benefits, where it is easier to manage the claim to a return to work outcome.

> Learnings claims leakage: It is a sensible cost minimisation strategy to make sure that no unnecessary claim payments are being made, and that claim benefits and expenses are paid only according to internal practice guidelines.

4.6 Ease of making a claim

4.6.1 Ease of making a claim injury schemes

Claim forms for injury schemes can be complicated, which may have led to the historic involvement of lawyers at the very start of the claim. One example of the complexity of filling out a claim form is for the Queensland Personal Injuries Proceedings Act 2002, where the claims form is 15 pages long. For some claimants the level of skill required to fill the form out may be overwhelming, and they may prefer having a lawyer to assist.

4.6.2 Ease of making a claim TPD

Generally TPD claim applications are not perceived as being unduly difficult or inaccessible by insurers. For example, AustralianSuper[27] promotes its TPD claims process as follows:

"*When you contact us to tell us you want to apply for a TPD payment, you'll be assigned a Claims Assessor. The role of your Claims Assessor is to help you understand the process and to look after your application from start to finish. Your Claims Assessor will work with you to make sure we receive all the necessary information so that your application can be processed as smoothly as possible*."

From this point, potential claimants are asked to call to set up a phone interview with a claims assessor, then following this complete a claimant's statement (claims form) and ask their medical practitioner to also complete a claims form. Proof of age and any other existing medical reports also need to be provided.

[27] See AustralianSuper *Applying for a Total & Permanent Disablement payment*

Forms are aimed at being able to be completed by the claimant without legal assistance. However, claimants are able to seek the assistance of a third party if they feel they require it, recognising that this may reduce the amount that they eventually receive. For Group TPD insurance, as the sum insured is fixed, any amount paid to a third party (for example a lawyer) would mean that there would be less available for the claimant.

Learnings regarding making a claim: Making the claims payment process as easy as possible for a claimant reduces any need to involve a lawyer up front to help submit the claim.

5. Comprehensive data

The general insurance industry has learnt the hard way that to collect more relevant data provides more confidence in understanding the portfolio of risks when new issues emerge. There have been a number of problems encountered by the general insurance industry, which has led to this drive to collect better data. We briefly cover some of these examples, then look at the parallels in group TPD in the areas of data collection and claims data.

5.1 Data collection

5.1.1 Data collection – injury schemes and other examples

The amount and the quality of data collected by those responsible for the pricing, monitoring and reserving for injury schemes has improved markedly over the last 25 years. For the long tail classes, including injury schemes, it can take five to ten years for experience to fully emerge and claims to be finalised and in some cases 30 to 50 years (asbestosis), which means accurate initial reserving and pricing for this business can be problematic. This means that, for cases where the claims experience emerges slowly over time and changes in underlying drivers are not easily recognised (exacerbated by lack of regular monitoring in some cases) the "true" picture may not be revealed when the annual valuation and pricing exercise takes place. This can result in the actuary 'chasing the claims tail' and revising reserves estimate upwards as the new claims experience data emerges. Changing the product design or terms and conditions such that experience emerges sooner can reduce the risk of later and longer 'tail blowouts' which cause unexpected losses down the track.

Past challenges exacerbated by incomplete data

The general insurance industry has faced a number of challenges over the recent past, such as:

- Insurance failures of HIH and FAI General and reinsurance failures of REAC, New Cap Re, and GIO Re;
- Injury schemes going into significant deficits, most recently WorkCover NSW and WorkCover SA;
- Crises in particular classes of business that highlight the impact of legislation on insurance and the need for legislative reforms, such as the Medical Malpractice Government rescue[28], Builders Warranty issues and Tort Crisis of the early 2000s[29]; and
- Various asbestosis examples.

A quick overview of some of the causes of those company and scheme failures shows that lack of data to enable sufficient monitoring of portfolios was a contributing factor. For example, FAI had a 'hidden drawer' of liability claims[30] which were not represented on the balance sheet.

Looking at one example for injury schemes, injured workers can claim under the scheme legislation or under 'common law' (roughly, precedents set by the courts). There is generally a

[28] See "Australian government forced to bail out medical malpractice insurer", 6 April 2002, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1172115/
Also see NSW PARLIAMENTARY LIBRARY RESEARCH SERVICE Briefing Paper No 2/04, "Medical Negligence: an update" by Talina Drabsch, February 2004, https://www.parliament.nsw.gov.au/prod/parlment/publications.nsf/0/6C1BDA58607A7808CA256ECF0007223D/$File/02-04.pdf

[29] See LOOKING BACK ON TORT REFORM– A FIVE YEAR REVIEW, Insurance Council of Australia Industry in Focus, October 2009, http://www.insurancecouncil.com.au/assets/files/industry%20in%20focus%20tort%20law%20reform%20271109.pdf

[30] HIH Royal Commission Volume II 14. The Impact of the FAI acquisition, April 2003, http://www.hihroyalcom.gov.au/finalreport/Chapter%2014.HTML

time limit (a few years) whereby claimants can choose which approach they intend to claim under. The various Australian states and territories have different schemes with varying levels of benefits and common law access. Access to unlimited common law can be costly. Over the years, there has been substantial gathering of data and subsequent debate about the best way of structuring these schemes, to provide the most benefit to injured workers in the most equitable and cost effective manner. The detailed data gathered was a major factor in providing sufficient evidence or arguments to undertake the necessary tort reform (reform to the scheme rules and associated access to common law). Without this reform the costs of the various schemes would have escalated to unsustainable levels. For WorkCover NSW, the data collected was a basis for the subsequent analysis that provided a case to support the reform measures made, and hence contain the overall cost framework of the scheme. To illustrate the main drivers of claims costs, for each claim the data included a breakdown of the payment types involved[31], the year of incident and the year of payment. Analysis of the data, such as a comparison of claimed medical costs compared to economic inflation, formed objective evidence to provide a strong case for scheme reform.

5.1.2 Data collection - TPD

As group insurance can involve a large number of lives, only bulk exposure data has historically been collected. This was originally for simplicity due to system limitations when these schemes were first established and to save on costs. However, as the IT industry has progressed considerably over the last thirty years, the original constraints limiting individual data collection for group insurance no longer apply. Yet, there has been little or no change in the exposure data collected by TPD insurers. This is an area for improvement, and may help with better analysis of the claims data.

5.2 Claims data

Additional data is collected at the claim stage. For both TPD insurance and injury schemes, information collected includes basic claimant information, claim details, administration details and payment details. However, for injury scheme claims generally the amount of information collected at claim stage is more detailed. A summary of the type of information of data collected is shown in Table 6 below and indicates the extensiveness of data collection for injury schemes in a method suitable for analysis, as opposed to less analysable data collected for group TPD. For both CTP and Workers Compensation insurance, more data than that shown in Table 6 is available, but for the purpose of this paper we have provided a summarised list. More comprehensive data is recorded in free-form status in TPD paper files, but this data is not readily accessible for analysis purposes unless it is able to be digitised.

[31] Separate payments are awarded in injury schemes for heads of damages. For NSW Workers Compensation examples are workplace injury damages, permanent impairment, pain and suffering, medical costs and legal costs.

Table 6: Data collection - Claims

Group TPD	CTP	Workers Compensation scheme
Claimant Details: • Policy number/scheme name • Name • Age or DOB • Sex • Occupation or occupation grouping	Claimant Details: • Policy number • Name • Age or DOB • Sex • Occupation or occupation grouping • Employment Status • Personal Injury prior claim • Compensation to relatives flag • Fatality flag • Claimant postcode • Accident postcode • Garage postcode	Claimant Details: • Employer's scheme registration number • Name of employer • Address of employer • Name • Age or DOB • Sex • Residential street address • Occupation or occupation grouping • Employment status • **Any pre-existing injury/condition that relates to this injury/condition** • Relationship to employer (e.g. Director/relative)Medicare number
Claim Details: • Date of event • Cause of claim (mental, cancer, musculo-skeletal etc.) • Date finalised • Whether reinsured • Details of job description, including duties • Medical reports to ascertain level of disability and likelihood of its permanence	Claim Details: • Date of event • Cause of claim (mental, cancer, musculo-skeletal etc.) • Claim category (ANF, estimated injury severity) • Date finalised • Usual suburb where vehicle is kept. Usage of vehicle for business purposes E.g. rental/tow truck • Current state of registration • Year of vehicle, make, model, shape, engine size • Age of youngest driver • Any at-fault incidents in last 2 years • Rehabilitation Indicator • Economic Loss Flag	Claim Details: • Date of incident • Date that the injury/condition was first noticed • Cause of claim (mental, cancer, musculo-skeletal etc.) and location of incident • Other circumstances of accident e.g. journey claim • Other third parties who may have contributed to accident • **Explanation for any delay between incident occurrence and reporting** • Contact details of any witnesses • **Name and contact details of medical providers that have treated injury** • Whether claimant has returned to work
Administration Details: • Date notified • Whether claim reopened • Reason for reopening • Claim status • Date finalised/closed • Any other insurance policies • Date joined employer • Date joined scheme • Evidence of salary and contributions (e.g. pay slips) • Was a complaint raised? If so details.	Administration Details: • Date notified • Whether claim reopened • Reason for reopening • Claim status • Date finalised/closed • Any other insurance policies • **Litigation Indicator** • **Level of Litigation** • **Legal Representation** • **Law firm involved in the legal representation** • Settlement details • Impairment details • Liability Status • Arbitration details • Earnings details	Administration Details: • Name and position of person to whom the incident was reported Date employer first received claimant's claim form • Claim status • Date finalised/closed • Date joined employer • Usual weekly earnings and overtime/shift work earnings
Payment details • Date of payment • Total gross payment • Total net payment	Payment details • Last Payment Date • Outstanding Estimate • Total Gross Payments • Total Net Payments	Payment details • Last Payment Date • Outstanding Estimate • Total Gross Payments • Total Net Payments

5.2.1 Additional data that could be collected for TPD

Although the data shown in Table 6 above is generalised, and does not relate to any particular scheme or insurer, it does show that typically more detailed information is recorded for injury schemes. Particular areas of interest have been highlighted in blue. Some data that may be useful to collect for TPD schemes, that is already collected for injury schemes includes:

- whether a claim is subject to litigation or not
- name of legal firm
- address of legal firm
- name of doctor
- Medicare number
- address of doctor
- details of other medical advisers
- explanation of delay between event and reporting date
- any pre-existing conditions that relate to this claim.

Collecting this data would enable the extent of legal involvement in claims to be monitored and tracked. This could include the:

- Causes of claim brought by specific law firms/doctors; and
- Specific arguments/precedents used by particular law firms.

If there are particular trends in the data emerging then the insurer may be able to triage claims to better address the emerging trends. This may include extending any existing triage process to allocate claims staff to claims that originate from particular legal firms, for example.

APRA has recently released *SPS250 Insurance in Superannuation*, effective 1 July 2013 that requires the Registrable Superannuation Entity (RSE) licensee to maintain records of the claims experience, membership, sum insured and premiums paid for the insured benefits for at least the previous five years[32]. This highlights the added focus APRA has on the adequacy of the data being collected for group TPD cover, and the necessity of making sure that sufficient data is collected and retained

Learnings data: We recommend that additional data is routinely collected by insurers, so they can understand the potential causes of clusters of claims – including potential increases in litigation and potential fraudulent activity.

Having industry group TPD experience data open to the market would be useful for benchmarking at a detailed level.

We recommend that freeform data relating to legal involvement in claims and relating to medical providers is captured in a way suitable for analysis, so that a greater understanding of claims data is achieved, both for the last three years and going forward.

[32] See SPS250 paragraphs 15 and 19(k):
S15 "*An RSE licensee must maintain records of sufficient detail for a prospective insurer to properly assess the insured benefits that are made available. These records must include, for at least the previous five years, the claims experience, membership, sum insured and premiums paid in relation to beneficiaries.*"

S19 *"At a minimum, the insurance arrangement must address…. (k) the provision of complete claims information to the RSE licensee on an annual basis which, at a minimum, includes the information required to be maintained by the RSE licensee under paragraph 15."*

6. Reserving adequacy and impact on pricing

Setting reserves accurately assists in setting a strong foundation for realistic pricing. Consistent under-reserving will likely result in consistent under-pricing, and ultimately insurer losses. It is illustrative to look at some examples from injury schemes, where under reserving has led to losses, and what we can learn from this for TPD insurance.

Injury schemes have had a history of being under reserved, such as in the late 1990's for public liability insurance, or for workers compensation schemes at various parts of the pricing cycle. Although collecting better data and more sophisticated analysis helps, it does not solve the problem, especially when there is a step change in the data series. In times where there are fundamental shifts, reserving actuaries must recognise that a new paradigm exists and that you cannot rely on the veracity of the data or the past being a good guide to the future.

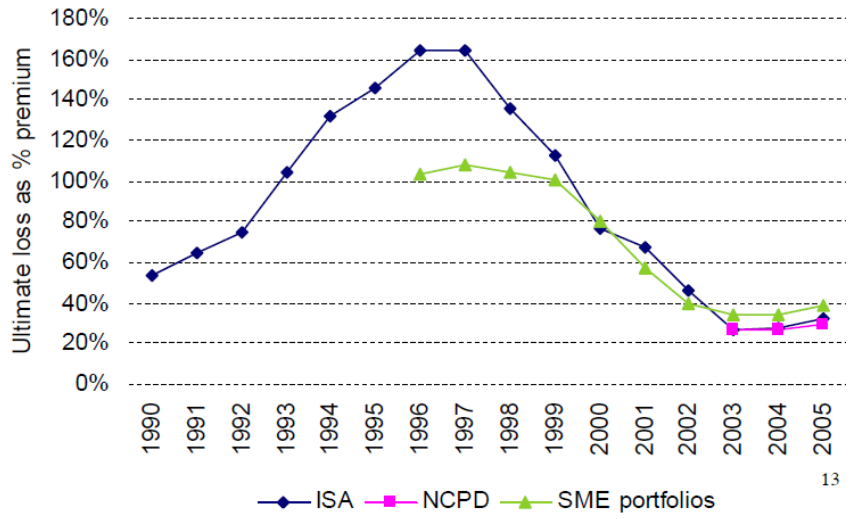
6.1.1 Examples of under reserving injury schemes

One example of under-reserving concerns the alleged encouragement of industrial deafness claims in the late 1980s / early 1990s. Allegedly, information evenings were held for all staff at Friday night drinks, to mention the benefits of making a Workers Compensation industrial deafness claim. The result was that a large number of claims for industrial deafness were lodged the following Monday morning. This resulted in a large increase in claims activity, and subsequent rounds of annual reserve increases, as the eventual level of claims was linked to the alleged rounds of encouragement.

A second example is anecdotal evidence that relates to the old State Transit Authority, which previously used very noisy buses on its routes. Allegedly, lawyers referred to the relevant bus rosters, and encouraged the drivers of the noisy buses to all put in claims for industrial deafness. This again resulted in a series of reserve increases until all claims had come through.

A third example shows the pattern of public liability insurance loss ratios, based on data from Insurance Statistics Australia (ISA), APRA's National Claims and Policies Database (NCPD) and from small/medium enterprises (SME) data[33].

Figure 3: Public liability "industry" underwriting year loss ratios



[33] See 'Public Liability Tort Reform –Assessing the Impacts an Update', Estelle Pearson and Ruth Lisha, XIth Accident Compensation Seminar 2007, Institute of Actuaries of Australia

Figure 3 illustrates how, as claim experience emerged each year, reserves were increased, driving up loss ratios during the mid 1990s. Through a combination of premium rate increases, underwriting and policy condition changes and structural reform, the position was turned around, and loss ratios dropped to around 30-35% during the period 2003 to 2005. Since 2005, the experience (not shown here) has been fairly stable, with a gradual increase in loss ratios to around 60%-75%.

In all these examples, reserving for claims using just past experience and practices would have produced insufficient reserves, leading to the need to repeatedly increase reserve levels.

In terms of reserving methods, common techniques now applied to analyse injury scheme data include variations on Generalised Linear Modelling (GLM), which may analyse factors such as accident period, completion period, payment pattern effect, seasonality, creeping changes in claim payment and abrupt changes in claim payments etc. These methods make use of the large quantity of data available, with thousands of model points analysed.

6.1.2 Observations for group TPD

Group TPD insurance can be considered to be in a comparable position to the left hand side of Figure 3. Over the last few years we have seen rising claims cost, with recent large increases in premiums and reserves. It is not clear whether the actions taken to date have been sufficient, and premiums are reserves are adequate for the level of notified and IBNR claims, or whether experience will continue to deteriorate. This means, in terms of Figure 3, we do not yet know if we are at the crest of the loss ratio curve, or still on the upwards slope. It is likely that if structural changes are not made, then claims will remain at least at current levels.

In terms of the responses undertaken to address the rising loss ratios, until recently, group TPD premiums have reduced each year, reflecting the competitive market and finer pricing. The pricing cycle has also contributed to this pattern. The soft market contributed to a reduction in insurers' margins, as they competed for market share. In this environment, there was little room to accommodate the emergence of other factors increasing claims, which has exacerbated and accelerated the emergence of insurer losses. The price reductions have reversed in the last year, with significant price increases (of up to 100% in some cases) now seen across the market. We are still yet to see any changes in policy terms and conditions or structural reform that we suspect will be necessary to turn the corner back to profitability.

The sophisticated reserving algorithms applied for injury schemes are largely out of reach for group TPD schemes, due to the relatively limited data available for all but the largest schemes. As mentioned earlier, industry wide data would assist in achieving scale, though allowances would need to be made for the fundamental differences between schemes, in terms of benefits, membership profile, experience and past scheme changes.

Nevertheless, the analysis generally carried out is often relatively crude, and further refinements in terms of causes of claim, sum insured size, accident development year etc. could prove insightful, where volumes of data permit. Particular IBNR reserving methods are not covered here, however it is worth noting that a variety of methods and approaches exist, and insurers should consider what approaches would provide the best fit for their data, taking into account the future outlook.

Learnings reserving: Reserving can generally be improved by using better data and by monitoring the drivers such as rates of return to work, health outcomes of claimants, relationships between AALs and claim rates, causes of claim (e.g. mental health claims versus musculoskeletal claims), claims with legal involvement and data mining for any sign of fraudulent clusters of claims.

Where data is available use an approach which analyses more segmented data.

Recognise that current methodologies may not recognise step changes in the data.

7. Learnings and recommended actions

There are many opportunities for TPD insurers to review what has worked and what has not for injury schemes, and this section summarises the learnings and recommendations made earlier.

7.1 Smarter product design

Recommendations:

- We recommend a tighter definition of disablement; one that is able to be applied objectively and is independent of those applying the definition. The definition should be sustainable and be based around meeting a meaningful consumer need. It should include allowance for the claimant to retrain.
- We recommend introducing a two year notification period after stopping work from the symptoms of the underlying injury or disease.
- We recommend that the paying of partial or instalment benefits is explored, as a way of making sure that potential claimants are able to receive some payment, in areas where they might miss out entirely, recognising that sometimes the decisions are not clear cut. Lump sum style benefits should be either phased out, or reserved for when an objective “Whole Person Impairment” (Workers Compensation style) threshold has been reached.
- We recommend that schemes tighten the levels of default cover they provide and reduce AALs. As noted, a move to tighten the TPD definition would need to be reflected in a SIS definition change.
- We recommend benefit design is re-evaluated, with a move to replace lump sum benefits with income style benefits, and focus on rehabilitation and return to work.

7.2 Historical and potential influence of doctors, lawyers and unions

Recommendations:

- We recommend both claimants and insurers have access to independent doctor panels, who are experienced in assessing the degree of impairment according to objective scientific principles, and the likelihood of this impacting on future work opportunities.
- We recommend it is important to analyse the claims data, to be alert to any patterns in the claims in certain postcode areas or particular professions or in conjunction with certain doctors, and share any learnings across assessors of similar types of claims.
- We recommend collecting data on the claimant’s treating medical practitioner so any concentrations of particular doctors can be understood and explored if appropriate.

Other learnings:

- Lawyers are innovative in seeking new sources of revenue and in protecting the rights of consumers. This has perhaps encouraged some claims to be made that perhaps may not otherwise have been lodged. This additional claims activity is driving up the size of IBNR claims reserves and hence costs, and may result in a higher level of underlying claims.
- Also some claims are now being made as lawyers are interpreting the TPD definition in ways not previously intended. While some of these claims may be valid under a strict legal interpretation, they may not match the intention behind the cover. This indicates that the wording of the cover should be tightened to match the need underlying the

intention of the product. Definition wording should also be updated to reflect the current environment. A change to an income style benefit, which is better for claimants' recovery and return to work, is also less attractive for lawyers to pursue as a revenue source.

- Trustees can also help spread the message to claimants that making a claim is straightforward and can be made without legal assistance, and approaching the insurer should be the first step in the claims process.

7.3 Rigorous claims assessment

Recommendation:

- We recommend that disablement is defined by an objective measure, in terms of what the claimant is able to do, with a clear disablement threshold. An objective definition is easier to apply and enforce. Look to what we can learn from the permanent impairment definitions from injury schemes such as from AMA Guides and FIM scores.
- We recommend that the TPD definition defines suitable employment along the same lines as for Workers Compensation. We recommend a standardised approach to determining work capacity, to provide greater certainty to all parties.

Other learnings:

- When schemes have become (or are becoming) unsustainable, changes need to be made. For injury schemes, benefit creep is an ongoing process, and as a result, benefit definitions need revisiting on a regular basis to keep up. TPD insurers have recognised this as an industry wide issue, and it is sensible at this point to take up the opportunity for an industry wide solution.
- It is a sensible cost minimisation strategy to make sure that no unnecessary claim payments are being made, and that claim benefits and expenses are paid only according to internal practice guidelines.
- Making the claims payment process as easy as possible for a claimant reduces any need to involve a lawyer up front to help submit the claim.

7.4 Comprehensive data

Recommendations:

- We recommend that additional data is routinely collected by insurers, so they can understand the potential causes of clusters of claims – including potential increases in litigation and potential fraudulent activity.
- We recommend that freeform data relating to legal involvement in claims and relating to medical providers is captured in a way suitable for analysis, so that a greater understanding of claims data is achieved, both for the last three years and going forward.

Other learnings:

- Having industry group TPD experience data open to the market would be useful for benchmarking at a detailed level.

7.5 Reserving adequacy and its impact on pricing.

Recommendations:

- Reserving can generally be improved by using better data and by monitoring the drivers such as rates of return to work, health outcomes of claimants, relationships between AALs and claim rates, causes of claim (e.g. mental health claims versus musculoskeletal claims), claims with legal involvement and data mining for any sign of fraudulent clusters of claims.

Other learnings:

- Where data is available use an approach which analyses more segmented data.
- Recognise that current methodologies may not recognise step changes in the data.

8. Acknowledgements

The authors would like to thank Jennifer Dang and our other research assistants for their help with this paper. We would also like to thank all those who provided input and peer review. However, we accept all errors and omissions are our own.

Appendix A: Group TPD Insurance vs. Injury scheme cover

TPD insurance

TPD insurance provides a lump sum payment on the insured satisfying the definition of total and permanent disability. Although there are often multiple parts to a TPD definition, the most common definition in group insurance involves the insured not having been at work for at least three months (until recently, six months) and in the opinion of the insurer, after considering medical and other evidence, **unlikely ever** to be able to engage in their own occupation, or in any occupation that they are **reasonably suited** by education, training or experience. Note that all TPD benefits provided through superannuation must satisfy the Superannuation Industry (Supervision) Act 1993 conditions of release[34]

"a member … is taken to be suffering permanent incapacity if a trustee of the fund is reasonably satisfied that the member's ill-health (whether physical or mental) makes it unlikely that the member will engage in gainful employment for which the member is reasonably qualified by education, training or experience"

Other parts of a TPD definition may cover TPD being achieved by loss of limbs or sight, or by satisfying an "Activities of Daily Living" (ADL) definition. As it is rare for any claims to be paid under these definitions, and they are unlikely to be under the direct influence of the claimant, they are not considered further here.

For group TPD insurance (which generally is provided by corporate and industry superannuation funds[35]) the premiums relate to the number of members of the group, usually varying only be age, sex and occupation grouping, not the underlying risk factors of individual members, at least up to the automatic acceptance level (AAL) of cover. If any members choose to take out cover above this automatic acceptance level, they will be subject to some level of underwriting, and an additional premium would be required. Cover is often unit rated, based on age/sex/occupation characteristics and the experience of the group.

When it comes to claim time, members have an unlimited time to lodge a claim, as long as they satisfy the definition of disability. This makes it difficult to assess the ultimate experience of the group.

Injury scheme cover

An injury scheme provides bodily injury cover, that is a sum of money (compensation payment) if a policyholder is injured in a way that falls under the terms of the scheme. Typical injury scheme products are Workers Compensation insurance and Compulsory Third Party (CTP) insurance, as well as certain liability insurance policies. For each of these products, the benefit provided (the sum insured) is not fixed. Although the schemes specify a maximum sum insured that could be paid out, the actual benefit paid relates to the size of the loss incurred on the occurrence of the event leading to the claim. This is determined from the degree of impairment incurred, as well as any additional costs for rehabilitation, pain and suffering and economic loss. Assessment of the degree of impairment under both Workers Compensation schemes and CTP varies amongst schemes and is commonly measured as a percentage of the whole person using the guide "American Medical Association Guides to the

[34] Superannuation Industry (Supervision) Regulations 1994 - 1.03C

[35] Ordinary group lump sum risk business is about 7% of the total.

Evaluation of Permanent Impairment" (AMA Guide). Generally a minimum degree of impairment is required before compensation is made to the claimant for permanent impairment, and this minimum varies between States.

Group TPD vs. Injury scheme cover

For TPD insurance, the insurer has no obligation to pay for any rehabilitation expenses, or to attempt any rehabilitation. The insurer may choose to do so, if by doing so they may avoid the necessity of having to make a TPD payout. However, due to the benefit design, most claims are not notified to the insurer until a substantial time period has passed, as there is usually a three or six month waiting period in which the claimant must be off work, before a benefit could be paid. Often the notification delay is even longer, perhaps due to low awareness of default TPD benefits. As any rehabilitation is most effective in the early months of the claim, usually it is too late for the insurer to attempt any rehabilitation by the time they find out about a TPD claim. No amounts are paid for any pain or suffering, or for economic loss – the TPD benefit is an agree value benefit, with the basis fixed at the outset (though often varying as the age of the member changes).

The key features of group TPD insurance and typical injury scheme insurance are shown in Table 7 below.

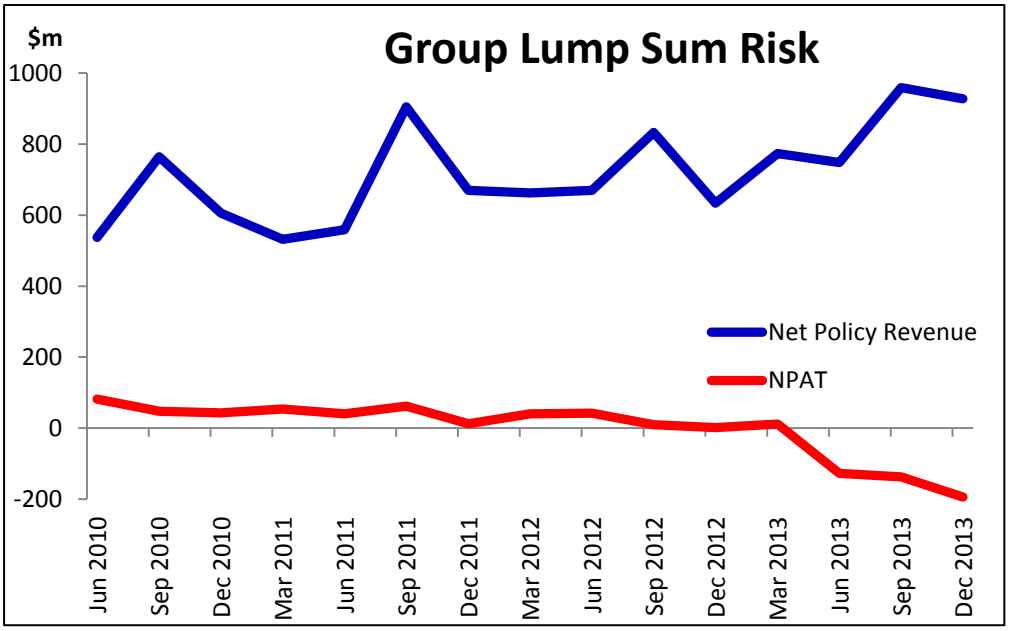
Table 7 – Comparison of key features of TPD insurance and injury schemes

	TPD Insurance	Injury Schemes
Sum Insured	Fixed for each member – determined when the policy is taken out	Varies – depends on the amount of loss incurred at the time of claim
Premium	All of the same age and sex and membership category pay the same premium rate, up to the AAL	Premium can also vary by other risk factors for CTP, WC and PL.
Benefit	The benefit paid is the sum insured	The benefit paid depends on the extent of injury and loss
Definition	Definition is subject to interpretation and judgement	Definition has less interpretation and judgement
Time limitation on claim	Unlimited – claims can be made at any time after a claim – even 20 years later	Limited. Actual limits vary by product and state of Australia. Limits for CTP and WC schemes around Australia are one year or less and generally three years for NSW public liability.
Claim process	Notify insurer, complete claim form, claim assessed	CTP – notify insurer of at-fault vehicle, complete claim form, claim assessed Workers Compensation – notify employer, complete claim form, claim assessed

Appendix B: Group TPD market – current state of play

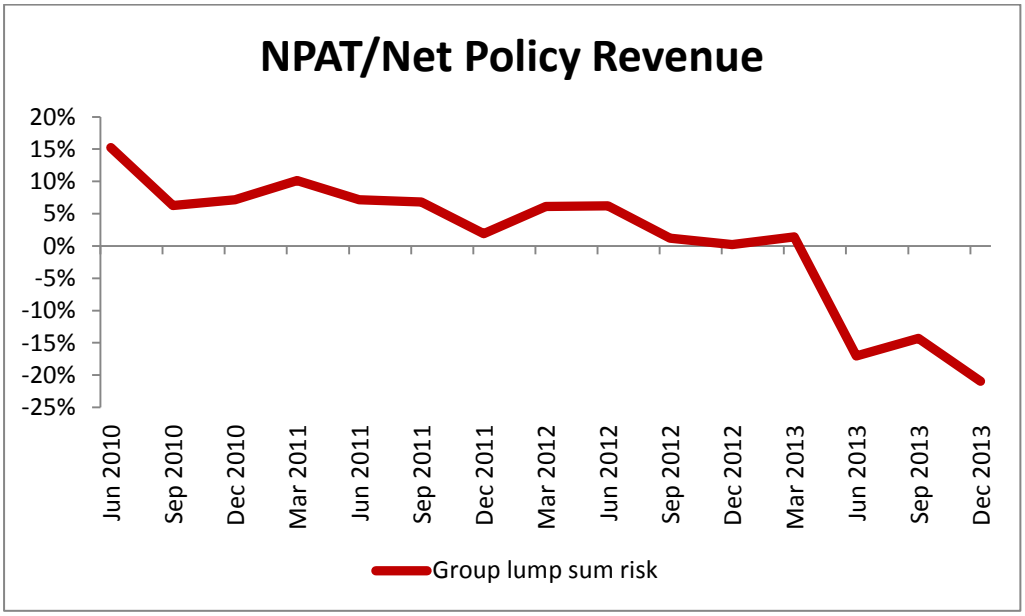
As shown in Figure 4 and Figure 5 below, group lump sum risk insurance has declined in profitability over the last few years, with large industry wide losses totalling $448m over 2013. All of the major group writers have been affected. Premiums have risen substantially[36] in the last two quarters of 2013, as insurers have moved to reflect the deteriorating experience emerging. However, as claims experience will take a number of years to emerge, it is likely that heavy claims costs will continue in the short term, dampening profitability.

Figure 4: Group lump sum risk Net Policy Revenue and Net Profit After Tax.



Source: APRA Quarterly Life Insurance Performance Statistics December 2013

Figure 5: Group lump sum risk Net Profit After Tax as a percentage of Net Policy Revenue.

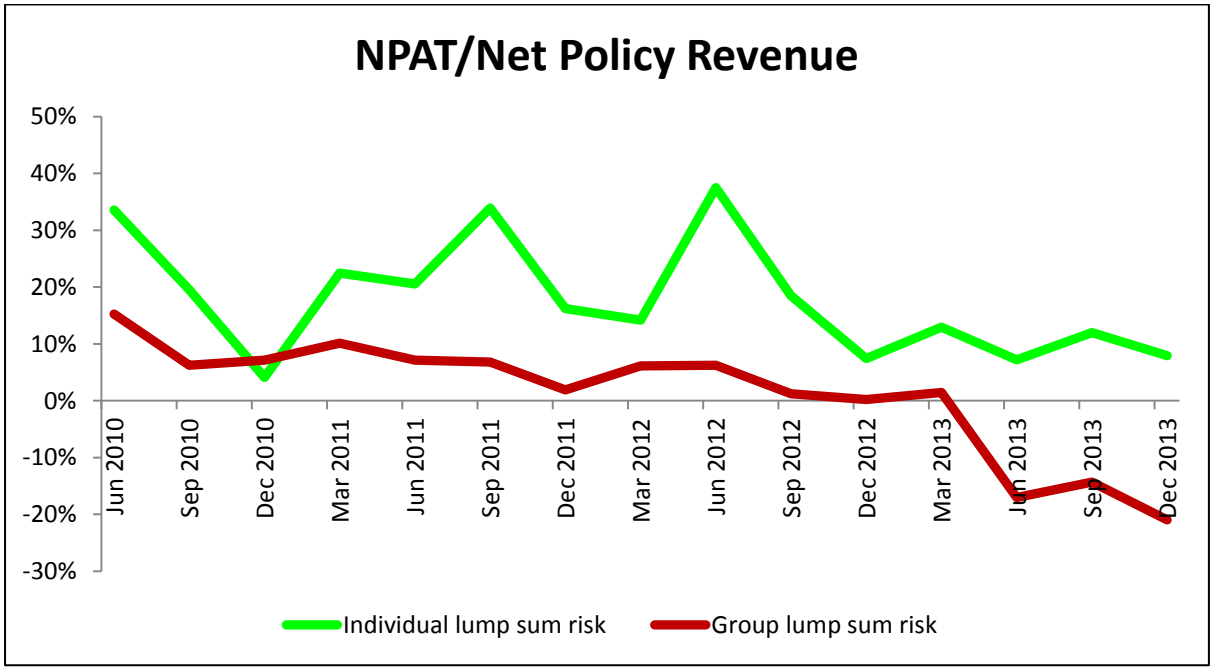


Source: APRA Quarterly Life Insurance Performance Statistics December 2013

[36] Price rises of 20% to 100% have been seen during 2013.

The Individual TPD market has not experienced the same level of losses as the group market, with average profit for the industry over 2013 at around 10%. This can be seen in the graph below. Note however, that the individual lump sum risk business shown will also contain trauma, as well as death and TPD, while there will be very little trauma cover as part of the group lump sum risk figures, as trauma is does not satisfy the conditions of release under SIS legislation, so is not part of any superannuation cover.

Figure 6: Individual and Group Lump Sum Risk Net Profit After Tax as a percentage of Net Policy Revenue.



Source: APRA Quarterly Life Insurance Performance Statistics December 2013

The reasons for the more favourable results for individual business are that retail products are not subject to the same degree of anti-selection, and are more likely to involve underwritten products. In addition, while there has been an increase in awareness of the level of cover held in group schemes, those with retail cover would have experienced no change in this regard.

Injury Schemes Seminar*

Balancing Outcomes

10–12 November 2013
Sheraton Mirage Gold Coast

* Formerly the Accident Compensation Seminar

Actuaries Institute

Sustainability of Common Law

Prepared by Geoff Atkins

Presented to the Actuaries Institute
Injury Schemes Seminar
10 – 12 November 2013
Gold Coast

Institute of Actuaries of Australia
ABN 69 000 423 656
Level 7, 4 Martin Place, Sydney NSW Australia 2000
t +61 (0) 2 9233 3466 **f** +61 (0) 2 9233 3446
e actuaries@actuaries.asn.au **w** www.actuaries.asn.au

"The reports of my death have been greatly exaggerated." Mark Twain

Abstract

Common law access and design has remained a controversial issue for nearly thirty years, as many schemes have been reviewed, reformed, reviewed again. One expert recently gave the somewhat depressing pronouncement that you just had to change a scheme every five years.

In the last five years I count four significant changes to common law entitlements in our workers compensation and motor accident schemes. Between 1985 and 1990 I count ten.

Sustainability has become a key word in all scheme objectives. With all the changes and variations, what can we say about sustainability in relation to common law?

Summary of Lessons

1. All but one jurisdiction in Australia has limited common law since 1985, some of them several times.
2. Six schemes have abolished common law access, and three had it reintroduced within three years following a change of government.
3. When scheme costs (hence premiums) are rising there is pressure for reform, and common law is most often the first target.
4. Restricting common law access to those with serious injuries is by far the most common response, and is now the norm.
5. The threshold for defining serious injury becomes the most important decision, and threshold erosion has often led to further need for reform.
6. With one exception, all the thresholds currently in use are based on Whole Person Impairment using AMA Guides – evidence that this is the most sustainable approach
7. There is one notable exception to lesson 6. In Victoria a narrative threshold has been used since 1989 (motor) and 1999 (workers) without change.
8. Other forms of limitation, such as elections, excluding heads of damage and limiting quantum, are not the most important factors in sustainability.
9. Effective litigation procedures and legal cost rules are very important, and this area can use more work.

Where to next?

15 years ago I predicted the gradual removal of common law from our injury schemes. As the quote at the start highlights, I was wrong.

Common law, limited to serious injuries and with a range of measures on quantum and process, appears to be favoured by most of our jurisdictions. The most recent example of this is QLD workers, where the government announced a change to common law access based on new serious injury thresholds just days prior to

finalising this paper. Our challenge is to manage the sustainability of this structure, with effective design, monitoring, management and interventions.

Acknowledgments

Special thanks to Kylie Hogan, who really did all the hard work (and most of the creativity). Also to my colleagues Melissa Tam, Mimi Shepherd, Karen Cutter, Andrew McInerney, Estelle Pearson. Some people from injury schemes also helped me greatly – you know who you are. Sadly I cannot blame any of these people for errors, omissions and controversial views. For those the buck stops with me.

1 Introduction

1.1 Background

In 19th century British law, the only way an injured person could receive 'compensation' was through common law, which involved suing a negligent party (if any) that caused the injury.

For workers, this changed during the twenty five years leading up to 1915. English-speaking countries – including Australian states – created specific workers' compensation laws that provided compensation for work-related injuries regardless of negligence.

From this very time, the issue of the relationship between the no fault entitlements and the common law opportunity to sue for negligence became an issue. In Britain and Australian states, the two rights co-existed. In the USA, however, what is known as the 'grand bargain' resulted in a trade-off where, in exchange for introducing no fault workers compensation, the right of an employee to sue the employer for negligence was removed.

In the case of motor accidents, this history does not exist, because motoring did not exist to any extent. In the case of motor accidents, common law was the natural means of compensation. It was only between the First and Second World Wars, as motor vehicle use grew rapidly, that specific insurance laws were introduced. These laws were not responding to any inadequacies in the common law principles of compensation, only the fact that many motor vehicle owners did not have the wealth to pay and so many accident victims were unable to get any compensation.

The motor laws, therefore, were only compulsory insurance laws (hence the 'Compulsory Third Party' label), which ensured that the ability to sue for negligence would be backed up by the ability to actually get the money. These laws did not deal with the entitlements to compensation.

1.2 Australia Flirts with Universal No Fault

In 1974 New Zealand introduced perhaps the most radical reform in personal injury compensation – the ACC scheme. It entirely removed common law actions for personal injury and, forty years later, the nation shows no desire to return to common law.

While much has been said about this fascinating scheme, the only point I wish to make in this paper is one that many people do not remember, and which relates to Australia.

In 1974 and 1975 Australia came 'that close' to adopting its own version of the ACC at a national level, following a report by Sir Owen Woodhouse and a Law

Reform Commission inquiry. If it were not for the sudden end to the reforming government of Gough Whitlam, we might be in a very different space today.

1.3 What are the Motivations for Changing a Scheme?

Many of the reports and inquiries into compensation schemes are full of ideological debate about common law and the no fault alternatives. This paper proposes that, in this context at least, economics trumps ideology:

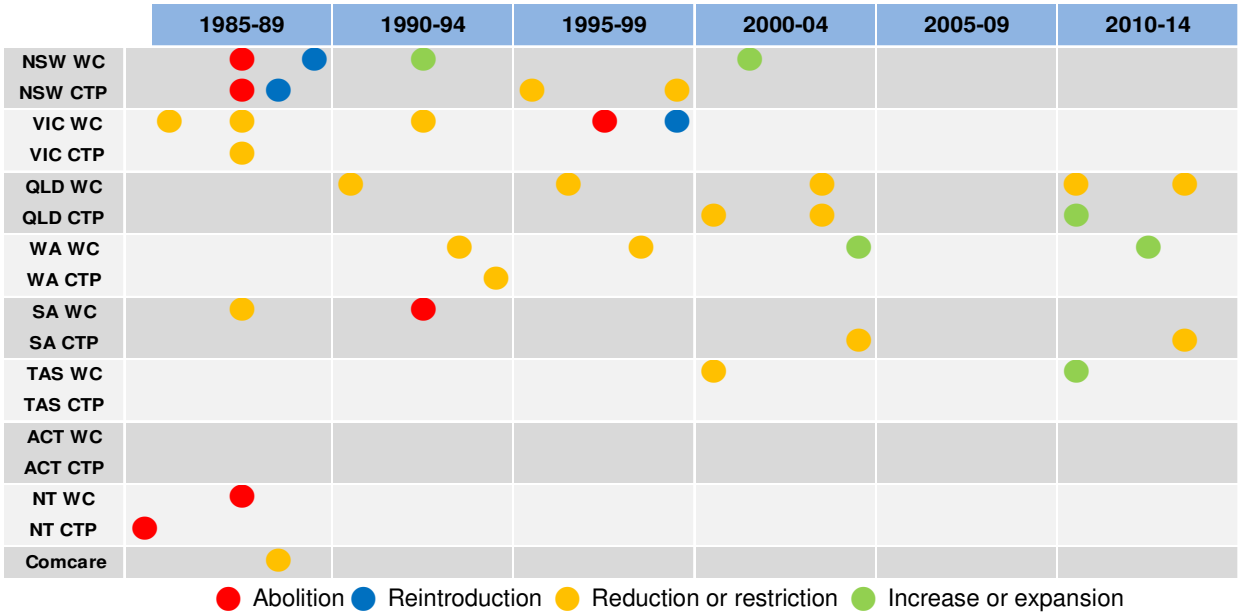
- The fundamental sustainability equation is to balance the competing interests of injured people and premium payers
- Anxiety rises when premiums rise and interest groups advocate for change
- Reform motivation is mainly to reduce scheme cost, and hence premiums
- If premiums are reasonably stable, there is little impetus for reform, although recently a stable but high premium has been enough to generate action based on 'state competitiveness'. The actuarial discipline of 'full funding' also has a role to play here.
- The main criterion for judging sustainability is therefore whether the cost of the scheme (not just the cost of common law) is increasing to a painful level.

While there are legitimate and interesting policy issues, the remainder of this paper deals with the economic side of the equation – just another example of the control that the 'dismal science' has over our lives.

2 The Last Thirty Years in Australia

From around 1985, the growing cost of workers compensation and CTP schemes in several states led to radical and controversial reforms[1]. Common law entitlements were an important, but far from the only, aspect of the reforms that were hotly debated and, in some states, resulted in seismic changes.

In a brave (but possibly futile) attempt to capture the 'big picture', the chart below summarises the changes to common law entitlements for workers compensation and motor accidents schemes. There is so much information there, and so many variations, that it is very difficult to see any themes.



Some observations that can be drawn from this chart are:

- The pace of change has slowed a lot since the turn of the century.
- NSW and Victoria were the most active from 1985, but have been very stable since 2000[2].
- The amount of change diminishes with the size of the jurisdiction.
- Only the ACT (arguably the most consistently left wing government in the country) has not made any changes to common law entitlements, although it has been tried several times. The most recent attempt was in 2010 and we understand they are still considering introducing changes to the workers scheme.
- From a visual perspective, the most sustainable changes have been NT, Comcare and Victoria Motor (the TAC), to be discussed later.
- There have been more changes for workers than CTP. Common law is more accepted in CTP, for the historical reasons outlined in section 1.1.

- All the expansions or increase in entitlements have occurred post 2004[3].

1.4 How can we categorise the common law changes?

The main purpose of this paper is to examine the types of modifications that are made to common law entitlements, and to see what lessons can be learned about sustainability. The modifications have been categorised into:

1. **Abolition (A)** – total replacement by no fault entitlements
2. **Reintroduction (R)** – the reversal of an earlier abolition
3. **Serious injury limitation (S)** – allowing common law access only for 'more serious injuries'; this approach comes down to 'thresholds'
4. **Heads of Damage limitation (H)** – permitting common law damages only in respect of certain heads of damage, with others either abolished or restricted to the no fault part of the scheme
5. **Quantum restrictions (Q)** – includes caps, discount rates and earnings limits
6. **Elections (E)** – requiring an injured person to make choices between no fault and common law entitlements, usually by a particular time
7. **Legal process and costs (L) –** restricting the normal litigation process in some way, including controls on legal costs for claimant's representatives, compulsory settlement conferences, compulsory arbitration/mediation, tribunals prior to court, etc.

The next chart aims to show the various scheme changes in more detail by labelling them with the type of common law modification.

	1985-89	1990-94	1995-99	2000-04	2005-09	2010-14
NSW WC	A RSQE	S		SEH		
NSW CTP	A RQ		Q QS			
VIC WC	H Q	SQ	A RSQ			
VIC CTP	SQ					
QLD WC		E	QL	E		L SLH
QLD CTP				L Q		Q
WA WC		SQL	SQE	SQE		L
WA CTP		Q				
SA WC	H	A				
SA CTP				Q		SQL
TAS WC				S		S
TAS CTP						
ACT WC						
ACT CTP						
NT WC	A					
NT CTP	A					
Comcare	H					

We discuss each of these controls, with examples, in the following section.

2 Controls

2.1 Abolition

The most obvious way to reduce costs associated with common law is to remove access entirely. Different schemes have attempted this with varying degrees of success, although abolition seems to have a degree of permanence in four schemes:

- Comcare since 1988 - while common law is theoretically still available, there was effective abolition for new injuries due to low capped amounts that heavily disincentivise this pathway
- Northern Territory CTP since 1979 (residents only);
- Northern Territory workers' compensation since 1987; and
- South Australian workers' compensation since 1992.

Both NSW schemes and Victoria workers compensation experienced abolition followed soon after by reintroduction.

The learning is that abolition of common law rights has been rare and sometimes not sustainable.

2.2 Reintroduction

There are three examples of abolition followed soon after by reintroduction (albeit with modifications). In each case the reintroduction followed a change of government, but of different political persuasions:

- **NSW CTP and Workers Compensation** – abolished by Labor in 1987 and reintroduced with retrospective application by the Coalition. The CTP scheme is the only scheme that has shifted underwriting from the public to the private sector in the last 30 years.
- **Victoria Workers Compensation** – abolished by Coalition in 1997, reintroduced by Labor in 2000.

We learn that in each case that saw the reintroduction of common law, the government of the day was still very keen to keep premium costs low. As a consequence there was a lot of focus on other control measures at the time.

2.3 "Serious Injury" Limitation

In 1987 Victoria introduced the TAC, a no-fault monopoly CTP scheme with limited common law rights. Awards under common law for economic (earnings) and non-economic (general damages) loss were restricted to serious injury, defined in the act as:

a) A permanent impairment of 30% or greater
b) Serious long-term impairment or loss of a body function
c) Permanent serious disfigurement, such as scarring
d) Severe long-term mental or severe long-term behavioural disturbance or disorder
e) Loss of a foetus.

The most important part of this definition is leg (b), referred to as the narrative test. This (and to some extent (c) and (d)) are where most cases are decided and in each case there is no quantitative test.

It is notable that no changes have been made to theTAC serious injury definition in more than 25 years. It also lasted after its introduction to the workers compensation scheme in 2000. The reasons for this sustainability, when other verbal and monetary thresholds have failed, warrants serious consideration, but is not tackled in this paper. Is it strategic and effective management by the schemes? Did the specific wording in the Act help (there is quite a bit)? Is there something in the state culture and in particular the legal system that 'holds the line'? [4]

WorkSafe Tasmania followed a similar path to Victoria with its 2000 amendments that restricted common law access to those with WPI of 30% or more. These changes were made in response to rising costs (Safe Work Australia, 2013). In 2009, Tasmania revised the common law threshold to WPI of 20% or more, as a result of the Clayton report into fairness and equity of the current benefits, and comparability with other jurisdictions.

The Western Australian WorkCover scheme has had an interesting journey in finding a suitable definition for serious injury. The following table shows the issues that faced the WA government and subsequent reforms to common law access.

	1993	1999	2004
Problem	Rising costs	Low pecuniary loss threshold	Impairment assessments highly variable and difficult for conditions not stabilised within 6 months
Reform	Access based on either: • 30+% impairment • Pecuniary loss threshold Impariment based on WorkCover Guides WA	• Capped damages for 16-29% impairment • No capping for 30+% impairment • Election made within 6 months of first payment Impariment based on WorkCover Guides WA, AMA Guides and Schedule 2 of the Act	• AMA guidelines for WPI assessments • Capped damages for 15-24% WPI • No capping for 25+% WPI • Election made within 12 months of termination, with possible extensions
Impact	Small	Initial claims reductions	Reasonably stable at present

While there have been small refinements to common law access in the 2010 amendments, the serious injury threshold has remained relatively unchanged. The experience in WA illustrates the importance of getting the serious injury definition right and how access via second gateways can affect the desired result.

A summary of the various types of thresholds for serious injury access is as follows:

Type of Threshold	Example	Sustainable?
Narrative	'Serious long term impairment'	No, with the notable exception of Victoria
Monetary	Medical costs over $5,000 General damages, if awarded, would be over $30,000	No
Non-economic loss	More than 10% of a 'most extreme case'	No
Impairment	% loss of function (table of maims approach)	No
Whole person impairment	AMA Guides	Yes

The assessment of sustainability is based on the past experiences in Australia (and to a lesser extent USA). The evidence is not spelt out in the paper.

2.3.1 The Rise and Rise of AMA Guides

The use of AMA Guides to Permanent Impairment has become widespread due to the consistency of assessments between assessors and over time.

It is widely accepted that use of AMA Guides for determining compensation can be 'unfair' in that it is at best a crude representation of the impact of the aftermath of injury on an individual. Nevertheless, as a threshold mechanism, the benefits in objectivity outweigh the disadvantages.

The noteworthy Victorian serious injury threshold is the only one in Australia not currently using AMA Guides as its principal mechanism.

It is usual for the AMA Guides to be varied or supplemented in one way or another, eg for hearing loss, psychological injury, loss of foetus or sexual organs. One crucial issue is the combination of physical and psychological impairments, especially if the latter develops after the injury (secondary psych, functional overlay or compensation syndrome).[5]

2.3.2 Lessons

The definition and implementation of the serious injury threshold is the most important factor in sustainability of modified common law.

Erosion of thresholds has been a major cause of unsustainability, and in many schemes (e.g. NSW CTP, WA workers) has led to multiple reforms.

Experience is showing that a threshold based on permanent impairment using AMA Guides appears to the be most likely to be sustainable.

2.4 Heads of Damage Limitation

Claims costs in a common law scheme can be reduced by abolishing access to different heads of damages. Under the SRC Act 1988, Comcare abolished all the monetary loss heads of damage and capped damages under non-economic loss. This is similar to the restrictions put in place in the South Australian workers compensation scheme in 1987, prior to full abolition in 1992. Victoria workers compensation also had this approach between 1992 and 1997.

Other examples where certain heads of damage are excluded from common law and limited to the no fault scheme are:

- Victorian motor accidents and workers, where only loss of earning capacity and general damages are allowed
- Queensland workers compensation, where no damages for gratuitous care are available

- There are other examples of minor amendments to legislation to remove the effect of unwanted precedents (eg. following the Theiring case in NSW, amendments were made to the CTP legislation to stop LTCS claimants claiming gratuitous care through the CTP scheme).

Another alternative in a 'common law only' scheme is to restrict access to certain heads of damage to those meeting a serious injury test:

- in NSW CTP only claimants who exceed a 10% WPI threshold are able to claim damages for non-economic loss, with other heads available to all
- The 2013 changes to the South Australian CTP scheme introduced a number of 'injury severity points' before the claimant is able to access future economic loss (7 points), non-economic loss (10 points) and gratuitous care (10 points).

It is the author's view that restrictions based on limiting certain heads of damage are relatively ineffective, firstly because the other costs are often met through another mechanism, and secondly because of the common law's adaptability (e.g. the use of medical or care buffers to substitute for general damages).

2.5 Quantum Restrictions

NSW CTP has introduced a variety of caps to reduce common law claims cost. These include:

- A ceiling on weekly earnings for any calculation of past and future benefits
- A cap on damages for non-economic loss
- Limitation on damages under attendant care services, and a minimum requirement (six hours per week for at least six months).

Even with these caps in place, there are still issues surrounding the sustainability of this fault based system (as indicated by the proposed reforms that were subsequently withdrawal).

The Queensland CTP scheme, throught the Civil Liability Act, introduced measures in 2003 to reduce the level of general damages. Queensland introduced an Injury Scale Value (ISV), a number between 0 and 100, reflecting the severity of the injury. The ISV score then translates directly into a general damages amount. These provisions severely curtailed the level of general damages that could be awarded at the lower end of the scale. However, any gains made were eroded over the first few years following the introduction of the CLA, with significant increases in awards for economic loss offsetting the reductions in general damages for low severity claims.

The South Australian CTP scheme changes introduced in 2013 have picked up elements of both the NSW and Queensland schemes –

- A ceiling on pre-injury earnings for any calculation of past and future economic loss benefits
- Introduction of a point scale similar to the Queensland ISV scale, with points determining quantum of non-economis loss
- A minimum requirement (six hours per week for at least six months) to qualify for gratuitous care services.

Another way to limit the entitlements paid under common law is to specify a fixed discount rate for damages paid under pecuniary heads of damage. All things being equal, the higher the discount rate, the lower the benefit paid. For younger claimants with a large proportion of damages paid as economic loss, this decrease can be significant. Most jurisdiction use a fixed 5% discount rate, and following tort reforms in civil liability it is now well entrenched.

It is the author's view that while quantum restrictions may assist in sustainability they will not be sufficient alone to achieve the goal. It is a little bit like the balloon that you squeeze in one part and bulges out somewhere else.

2.6 Elections

In an attempt to discourage smaller or frivolous claims, some schemes require claimants to make an irrevocable election to pursue common law damages. Examples include:

- QLD workers has had a form of irrevocable election since 1990. In the 1996 reforms this election was removed for those workers with a serious injury (i.e. greater than a 20% work-related impairment).
- WA workers introduced an irrevocable election in the 1999 amendments and the worker was required to elect within 6 months of the date of first compensation payment. In 2004 this was adjusted so that:
    - Statutory payments are stepped down in the 6 months after election
    - The worker has 12 months from the date of first weekly payment to elect, with a provision to extend for a further 12 months if the injury has not stabilised.

In the author's view the use of elections is not particularly helpful in sustainability. It entrenches serious legal involvement early in the life of claims and exacerbates the adversarial nature of claim resolution.

2.7 Legal Process and Costs

The QLD workers' compensation scheme has attempted to reduce common law claims costs in many ways, including restrictions on legal proceedings. The WorkCover Queensland Act 1996 introduced a pre-proceedings process for

common law claims. This was done in an attempt to promote early settlement of claims and minimise legal costs (Q-COMP, 2013). The 2009 amendments introduced stricter rules for claiming under common law and in particular -

- Increased obligations on parties to participate meaningfully in pre-court processes, and
- Allowed courts to penalise claimants whose claims are dismissed (Queensland Parliament, 2013).

While it is still early days, WorkCover QLD is predicting a small decline in claims costs as a result of these changes.

Queensland also has a comprehensive structure of legal processes and costs that applies to civil liability and CTP claims – the 'PIPA' (Personal Injuries Proceedings Act 2002). The process requirements involve pre-litigation protocols, full exchange of evidence, compulsory conferences and mandatory final offers. The PIPA restrictions on legal fees are as follows –

- no legal costs can be awarded unless damages exceed $30,000
- a maximum of $2,500 of plaintiff legal costs is recoverable for awards of between $30,000 and $50,000
- full recovery is only possible if damages exceed $50,000.

These thresholds were fixed from when PIPA came in until 1 July 2010 when there was a one-off inflationary catch-up of 17%, and the thresholds have been indexed annually since then.

The effectiveness of these thresholds is debatable – rather than being effective in reducing legal costs, it is argued that the thresholds set a 'target' for plaintiff lawyers, contributing to superimposed inflation.

The 2013 amendments to the SA CTP scheme also include legal cost restrictions –

- no legal costs can be awarded unless damages exceed $25,000
- for awards of between $25,000 and $100,000 the Magistrates Scale of Costs must be used
- full recovery is only possible if damages exceed $100,000.

Of course, these legal cost restrictions in both Queensland and SA impact on amounts that can be reimbursed as part of the claim settlement – there is nothing that stops plaintiff lawyers charging their clients a different amount in solicitor-client costs including no-win-no-fee uplifts.

The NSW CTP scheme also has a schedule of maximum costs recoverable. Even so, the non-judicial dispute system (CARS) has become more legalistic with legal representation (including barristers) now much more frequent.

2.7.1 Alternative dispute resolution

Some of the changes described above could be characterised as alternative dispute resolution (ADR) systems. By its very nature common law is a court-directed process, so ADR only has a place prior to court, and either with specific legislation or as part of court rules.

Both NSW jurisdictions (workers and motor accidents) have gone down this path with specialist tribunals, and Victoria has established protocols for considering the serious injury threshold prior to litigation.

While Australia has used ADR and non-judicial (administrative) tribunals for several decades there is not the same degree of cultural development and understanding of behaviours that exists in our court systems.

It is the author's view that modifications based on legal processes and costs have an important place in making common law sustainable. They are, however, complex in their own right and perhaps outside the core competence of many scheme designers (including actuaries).

3 Other Considerations

3.1 How do no fault and common law interact?

Our first thought tends to be that no fault and common law are alternatives – you have one or the other. As an example, for motor accidents NZ has no fault and QLD has common law.

In reality, life is not so simple. The interaction between common law and no fault, when mixed together in a scheme, is a complex cocktail, and vitally important to sustainability.

For about eighty years, our workers compensation schemes were a combination of no fault and common law, with the common law option being an extra available to an injured worker if negligence could be proven. Motor accidents, on the other hand, were common law only – no negligence meant no compensation.

Given that the basis of workers compensation is a no fault entitlement, every scheme (other than ACT) now has either no common law or restricted to 'serious injury' in one way or another. The sustainability issues have tended to arise when common law is:

- Seen as a 'risk free option' to increase compensation; or
- Blurred with redemptions, permanent impairment lump sums and pain and suffering entitlements.

Workers compensation schemes in QLD and WA are subtly different in that the statutory benefit regime is intended to be time-limited, and the structural design is for common law to be available in cases of negligence for workers who have or will reach the end of the statutory entitlements. This interaction means that restrictions on common law have often been accompanied by extensions to statutory benefits.

In motor accident schemes, there are some more interesting examples:

- The 1970/80s Victorian structure with the Motor Accidents Board (no fault) and the State Insurance Office (common law) suffered badly from the 'free option' problem and from lack of co-ordinated management.
- The Tasmanian MAIB scheme has had no fault benefits since 1973 and unrestricted common law in addition seems to have survived very well – is this because of a different litigation environment and culture in Tasmania? Or is the scheme design and management different?
- In NT, the scheme was essentially split into two. Residents have no fault entitlements without common law. Non-residents have common law only.

- In NSW (and also in SA from 1 July 2014) the 'lifetime care' scheme is no fault for catastrophically injured, while the CTP scheme for others is modified common law. The catastrophic injury schemes with lifetime no fault entitlements are likely to become the norm following NDIS/NIIS.

3.2 The relevance of scheme culture

Culture, simply described as 'the way we do things around here', can be a powerful force in a complex system involving people who work in that system all the time. Very few of these people base their actions on legislation, but rather on what they learned on the job. Changing legislation alone will not change these ingrained behaviours without a range of other forces at work.

For example, when common law was abolished (NSW and SA for example), legal activity switched almost seamlessly to redemptions and impairment lump sums (especially pain and suffering awards which existed then) in a fashion almost indistinguishable from common law, except that a workers compensation tribunal heard the matters rather than a court. In fact, the members and registrars of the tribunals typically came from courts and, not surprisingly, ran things in the way they had learned.

Culture can often be a force of inertia. Even though changes may be made to common law entitlements, outcomes can often move less than expected due to the culture. One example is 'buffers' (we have economic loss, medical and care buffers!) replacing the general damages for less serious claims after a threshold is introduced. To put it simply, lawyers and judges have an expectation about what an injury is 'worth' and follow that expectation. The Queensland CTP experience with economic loss following restrictions on general damages is a case in point.

Sometimes a cultural 'tipping point' seems to be reached – when behaviours do change, they are inclined to change more than expected and rapidly. This might occur when all the participants come to think that 'OK, this is all over and I need to get a different job.' Jeff Kennett's legislation to replace WorkCare by WorkCover in 1992 is a great example. Claims dried up several weeks before the legislation changed, and subsequently, the claims experience for claims that (under the law) continued to enjoy the more generous aspects of the WorkCare laws became very similar to those under the new (more restrictive) laws.

The lessons are:

- Minor changes to rules are unlikely to achieve much if they don't involve change in process.
- Major changes can achieve more than expected if accompanied by forces to change scheme culture.

- Any plan for changes should be accompanied by a careful assessment of how 'the system' (as opposed to the law) works and considering if and how scheme culture may be changed.

3.3 The Honeymoon

It is important to take a medium term (five to seven year) perspective in assessing sustainability following a modification to common law.

There are numerous examples of a 'honeymoon period' after a change when claim numbers and costs fall materially, often below the level anticipated. All seems to be going well, then three, maybe five, maybe seven years later the costs start to grow back towards (sometimes past) the pre-reform levels.

A rather cynical way this is sometimes expressed by the hard-bitten is that 'the lawyers are clever and persistent, and sooner or later they will work out how to fiddle the system'.

The relevance for this paper is the timeframes involved. Scheme reforms usually occur following a period of crisis (or at least high stress). For two or three years all seems well. Those involved 'declare success'. People change, the quality of leadership drops, oversight slackens and a sense of complacency and comfort prevails. As a consequence, trends are missed, corrective actions are delayed, and new reforms become necessary.

The lesson is that the institutions involved must make and stick to a plan for monitoring and management that lasts at least five years, and is itself sustainable.[6]

4 Any Lessons from the US?

The history of compensation schemes in the US has had a different trajectory from that in Australia. Workers' compensation has always had the 'grand bargain' resulting in no common law.

Motor accident insurance, on the other hand, moved from the 'pure common law' model long before it did in Australia. Academic and policy argument for no fault motor insurance ran hot from the 1920s to the 1940s, but it was not until 1970 when the first no fault motor law was introduced in Massachusetts. Approximately 25 states introduced various versions of no fault and hybrid motor bodily injury insurance over the next 10 years.

In the US, no fault motor is currently out of favour because it is more expensive, with premiums higher than in tort systems (Anderson, Heaton, & Carroll, 2010). There are two main factors, apart from the obvious one of covering more injured people:

- Lifetime medical costs cannot be managed; and
- Most schemes are really hybrids with common law and other options that result in 'the worst of both worlds'.

The Rand research concludes that no fault laws do not lead to more accidents or a higher propensity to claim. On the other hand, no fault does give rise to more utilisation of medical services, higher fee rates for medical services and overall a much higher cost of medical treatment.

The cost pressures are worse in the larger, less conservative states such as California and New York.

5 Lessons for Sustainability

The common law system of injury compensation has not been sustainable in Australia over the last 30 years[7]. Almost all workers' compensation and motor accident schemes have moved away from a 'pure common law' structure since the 1980s. In the broader civil liability system of personal injury compensation, tort reforms in 2003 and 2004 also made many modifications to common law.

Nearly all common law modifications have incorporated, in one way or another, modifications that restrict common law entitlements to more seriously injured people. The serious injury modification that has proved to be most sustainable is to use a threshold based on permanent impairment (using AMA Guides, often with some supplementary rules).

Trying to summarise the lessons learned by thinking about the history and analysis in this paper:

1. All but one jurisdiction in Australia has limited common law since 1985, some of them several times.
2. Six schemes have abolished common law access, and three had it reintroduced within three years following a change of government.
3. When scheme costs (hence premiums) are rising there is pressure for reform, and common law is most often the first target.
4. Restricting common law access to those with serious injuries is by far the most common response, and is now the norm.
5. The threshold for defining serious injury becomes the most important decision, and threshold erosion has often led to further need for reform.
6. With one exception, all the thresholds currently in use are based on Whole Person Impairment using AMA Guides – evidence that this is the most sustainable approach.
7. There is one notable exception to lesson 6. In Victoria a narrative threshold has been used since 1989 (motor) and 1999 (workers) without change.
8. Other forms of limitation, such as excluding heads of damage and limiting quantum, are not the most important factors in sustainability.
9. Effective litigation procedures and legal cost rules are very important, and this area can use more work.

6 A recipe for sustainable common law

Many jurisdictions seem committed to keeping common law as part of their scheme design, albeit for more serious injuries only.

In this context, the author's recipe for sustainable common law can be summarised as follows:

1. Take care of the catastrophically injured with lifetime no fault benefits – the NIIS recipe
2. Provide time-limited statutory benefits on a no fault basis
3. Provide common law access for those:
    a) That can demonstrate negligence by an employer or third party, and
    b) That meet a threshold based on AMA Guides, following medical stabilisation with a maximum period of three years
4. A preliminary process for access to common law involving grant by the insurer (or if necessary independent medical assessment) of impairment and/or a court hearing on negligence
5. Case managed litigation in the intermediate court system, with a specialist case management track but without specialist courts
6. Economic loss based on earnings capped at a low multiple of AWE and a 5% discount rate
7. Non-economic loss based on a modest maximum amount with a narrative approach within the maximum
8. Medical, care and the like subject to the same provisions as civil liability
9. Clarity that 'buffers' in medical, care or economic loss are not to form part of damages, with non-economic loss covering the relevant possibilities.
10. Event based legal costs rules until the court hearing stage
11. Statutory restrictions on solicitor-client costs and no-win-no-fee uplifts
12. A scheme regulator responsible for ensuring efficiency and stability of the common law process as well as the no fault part of the scheme.

This recipe should not be taken to mean that the author supports common law over no fault. Having once predicted the gradual demise of common law compensation, and having been proven wrong, it aims to be a constructive contribution to sustainability which is, after all, a goal of all injury compensation schemes.

End Notes

1 There were three States that introduced no fault for motor accidents as far back as 1973 when the previuos cost crisis took place – Victoria, Tasmania and NT, with only NT abolishing common law.

2 Even the major NSW@ reforms of 2012 did not change common law.

3 With one exception – NSW WC 1992

4 At the 8th Accident Compensation seminar Evans and Atkins presented a case study on the workers' compensation part of this reform. Part of that paper is reproduced in Appendix C.

5 One lawyer was heard to remark "Anybody who survives three years in this system would go crazy"

6 It makes one think of the infamous movie…"just when you thought it was safe to go back in the water…"

7 The problems may actually go back 40 years to around 1973, but with most reforms starting in the next cyclical crisis in the mid 1980s.

A Current Scheme Controls

This appendix contains only the briefest of summaries of the various cost control modifications to common law. For accuracy and detail please refer to the excellent Safe Work Australia scheme comparison for workers compensation, or to scheme websites or legislation.

Key
GD General Damages (Pain and Suffering/ Non-Economic Loss)
LOE Loss of Earnings (Economic Loss)
WPI Whole Person Impairment
DPI Degree of Permanent Impairment
NEL Non-Economic Loss
EL Economic Loss

A.1 Table of serious injury thresholds

Workers Compensation

State	Serious Injury Definition	Year of Effect
NSW	At least 15% WPI	2012
VIC	Narrative test (deeming if at least 30% WPI)	1999
QLD	At least 5% DPI	2013
WA	At least 15% WPI	2004
TAS	At least 20% WPI	2010
Comcare	Must have successful permanent impairment claim	1988

Motor Accidents

State	Serious Injury Definition	Year of Effect
NSW	At least WPI of 10% for NEL access	1999
VIC	Narrative test (deeming if at least 30% WPI)	1987
QLD	No threshold	Always
WA	GD threshold of $18k (inflated annually) no threshold for LOE	1994
SA	At least ISV of 7 for EL and at least ISV of 10 for NEL and GvK. Provision for exceptional cases	2013
TAS	No restrictions	Always

A.2 Table of heads of damage exclusions

Workers Compensation

State	Heads of Damage	Year of Effect
NSW	LOE only	2001
VIC	LOE and GD only	1999
QLD	No gratuitous services	2013
WA	No exclusions	Always
TAS	No exclusions	Always
Comcare	GD Only	1988

Motor Accidents

State	Heads of Damage	Year of Effect
NSW	NEL if <10% WPI	1999
VIC	LOE and GD only in CL	1987
QLD	No exclusions	Always
WA	No exclusions	Always
SA	EL if ISV <= 7, NEL and GvK if ISV <= 10	2013
TAS	No exclusions	Always

A.3 Table of Quantum Limitations

Workers Compensation

State	Quantum Limitations	Year of Effect
NSW	Unlimited access to LOE	1989
VIC	Capped for GD and LOE	1999
QLD	Capped GD and LOE earnings limit	2003
WA	Caps when WPI less than 25%, unlimited otherwise	2004
TAS	Unlimited	Always
Comcare	Capped GD (no access to LOE)	1988

Motor Accidents

State	Quantum Limiitations	Year of Effect
NSW	Capped for GD and LOE, attendant care	1999
VIC	Capped for GD and LOE	1987
QLD	Capped for LOE, gratuitous services	2000
WA	Capped for GD	1994
SA	Capped for GD and LOE	2013
TAS	None	Always

B References

ACT Government Treasury. (2013). *Compulsory Third Party Insurance*. Retrieved September 6, 2013, from ACT Government Treasury: http://apps.treasury.act.gov.au/compulsorytpi

Anderson, J. M., Heaton, P., & Carroll, S. J. (2010). *The U.S. Experience with No-Fault Automobile Insurance: A Retrospective.* Santa Monica, CA: RAND Corporation.

Evans, J., & Atkins, G. (2000). *Serious Injury Common Law - A Scheme Reform Case Study.* The Institute of Actuaries of Australia.

Finance and Administration Committee. (2013). *Inquiry into the Operation of Queensland's Workers' Compensation Scheme (Report No.28).* Brisbane: Queensland Parliament. Retrieved from http://www.parliament.qld.gov.au/documents/committees/FAC/2012/OpQldWorkersComp/rpt-028-23May2013.pdf

Guthrie, R. (2006). *The 2004 Changes to Common Law Procedures Under The Workers Compensation and Injury Management Act 1981 (WA).* School of Business Law & Taxation Working Paper Series, Curtin University of Technology, School of Business Law.

Motor Accident Commission South Australia. (2013). *Reforms to CTP*. Retrieved September 6, 2013, from Motor Accident Commission South Australia: http://www.mac.sa.gov.au/motor_injury_insurance/reforms_to_ctp

Motor Accidents Authority. (2013). *Scheme History*. Retrieved September 4, 2013, from Motor Accidents Authority: http://www.maa.nsw.gov.au/default.aspx?MenuID=134

Motor Accidents Insurance Board. (2013). *History of MAIB*. Retrieved September 6, 2013, from Motor Accidents Insurance Board: http://www.maib.tas.gov.au/index.php/history-of-maib

Pearson, D. D., McCarthy, B., & Guthrie, R. (2000). *Report of the Review of the Western Australian Workers' Compensation System.* Perth: WorkCover WA. Retrieved from http://www.workcover.wa.gov.au/NR/rdonlyres/B89DB1BC-91FA-40A4-B2F7-8EC121EA5C35/0/Publication__Legislative_Review__Pearson_Review_2000.pdf

Pearson, E., & Atkins, G. (1991). *Common Law and Accident Compensation.* The Institute of Actuaries of Australia.

Purse, K. (2005, August). The Evolution of Workers' Compensation Policy in Australia. *Health Sociology Review, 14*(1), 8-20.

Q-COMP. (2013). *Scheme History*. Retrieved September 4, 2013, from Q-COMP: http://www.qcomp.com.au/about-us/about-workers'-compensation/scheme-history.aspx

Queensland Parliament. (2013). *Operation of Queensland's Workers' Compensation Scheme*. Retrieved October 2, 2013, from Queensland Parliament: http://www.parliament.qld.gov.au/work-of-committees/committees/FAC/inquiries/current-inquiries/OpQldWorkersComp

Queensland Parliament. (2013). *Workers' Compensation and Rehabilitation and Other Legislation Amendment Bill 2013 Explanatory Notes*. Retrieved October 23, 2013, from Queensland Parliament: https://www.legislation.qld.gov.au/Bills/54PDF/2013/WorkersCompRehabAmdBill13E.pdf

Robinson, M. A. (1987). *Accident Compensation in Australia - No-Fault Schemes.* Sydney: Legal Books Pty Ltd. Retrieved from http://www.robinson.com.au/monoartpapers/monographs/Accident%20Compensation%20in%20Australia-No-Fault%20Schemes-book.pdf

Safe Work Australia. (2013). *Comparison of Workers' Compensation Arrangements in Australia and New Zealand.* Retrieved from Safe Work Australia:

http://www.safeworkaustralia.gov.au/sites/SWA/about/Publications/Documents/782/ComparisonWorkersCompensationArrangements2013.pdf

Transport Accident Commission. (2003). *Australian CTP Scheme Comparison Table.* Retrieved from Government Prices Oversight Commission: http://www.gpoc.tas.gov.au/domino/gpoc.nsf/LookupFiles/R_MAIB_FirstSubmision2003_Append%20C.pdf/$file/R_MAIB_FirstSubmision2003_Append%20C.pdf

Transport Accident Commission. (2013). *History of the TAC*. Retrieved September 4, 2013, from Transport Accident Commission: http://www.tac.vic.gov.au/about-the-tac/our-organisation/what-we-do/history-of-the-tac

Whittle, D., & Atkins, G. (1998). *The Role of Common Law in Workers' Compensation in Australia.* The Institute of Actuaries of Australia.

C Serious Injury Common Law A Scheme Reform Case Study

Serious Injury Common Law
A Scheme Reform Case Study

Authors: Julie Evans & Geoff Atkins

For presentation to
the Institute of Actuaries of Australia
8th Accident Compensation Seminar

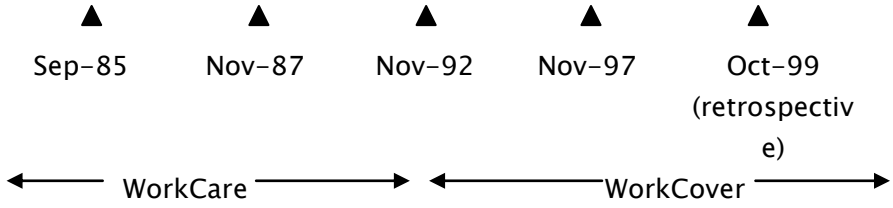
November 2000

② Background

2.1 Common Law in Victoria Workers' Compensation

Workers' compensation insurance in Victoria was underwritten in the private sector until September of 1985. At that time the private system was replaced by a public sector monopoly insurer, WorkCare. Since 1985 common law access and benefits have undergone a series of changes, as shown in the following diagram.

ACCESS	no restriction	no restriction	serious injury[11]; minimum award threshold	no access	serious injury[1]
ECONOMIC LOSS	nil	nil	capped	nil	capped
NON-ECONOMIC LOSS	unlimited	capped	capped	nil	capped



Between 1985 and 1992 common law damages were available for non-economic loss only (general damages or pain and suffering). Experience showed increasing utilisation of the benefit and high legal costs relative to the damages paid.

2.2 Serious Injury Threshold

In an attempt to reduce the cost of the scheme, a "serious injury" threshold was introduced from 1 December 1992 to restrict access to common law benefits. The definition of serious injury in S135A(19) used a "narrative" test that defined serious injury as:

[1] Definition of serious injury threshold differs between November 1992 – November 1997 and October 1999 onwards.

"(a) serious long-term impairment or loss of a body function; or
(b) permanent serious disfigurement; or
(c) severe long-term mental or severe long-term behavioural disturbance or disorder; or
(d) loss of a foetus".

Under S135A(3), an injury was *deemed* to be serious if it involved 30% or greater whole person impairment (WPI) assessed using the AMA 2nd edition[2] guide.

This definition was taken from the Transport Accident Act 1986. The threshold had proved to be reasonably successful at containing the number of successful common law claims in the transport accident environment.

As part of the Working Party's development and investigation of options for the restoration of access to common law in 2000, the serious injury definition was reviewed.

2.3 Striking a Balance

The deliberations of the Working Party, and ultimately the decision of the Government, involved striking a balance between competing goals:

- adequacy of benefits to the seriously injured
- a competitive premium
- achievement (or maintenance) of full funding of the Scheme.

To this end the Working Party developed a number of different options for the restoration "package" which varied according to, for example:

- restoration date (the degree of retrospectivity)
- access points to common law (the degree of severity)
- other benefit changes.

In this paper we discuss the option selected by Government. Details of all options examined can be found in the report of the Working Party (refer to the Reference Section of this paper for further information).

[2] American Medical Association Guides to the Evaluation of Permanent Impairment (2nd edition).

2.4 Selected Option

The Government decided to restore common law access using a modified serious injury threshold. The changes were made retrospective to the date that the new Labor Government was sworn in - 20 October 1999.

Under the option selected by the Government, eligibility to receive common law benefits is dependent on claimants satisfying a serious injury test. The revised serious injury definition is shown below. The original definition (1992 to 1997) is also shown.

	Access post 20/10/99	Access 1992 - 1997
Narrative	*S134AB(37)*	
	(a) permanent serious impairment or loss of a body function; or	(a) serious long-term impairment or loss of a body function; or
	(b) permanent serious disfigurement; or	(b) permanent serious disfigurement; or
	(c) permanent severe mental or permanent severe behavioural disturbance or disorder; or	(c) severe long-term mental or severe long-term behavioural disturbance or disorder; or
	(d) loss of a foetus	(d) loss of a foetus
Impairment	*S134AB(15)* 30% WPI under AMA 4th edition	30% WPI under AMA 2nd edition

As the comparison above shows, the new narrative definition is similar to that used previously. Changes were made to parts (a) and (c) of the narrative definition, with references to "long-term" replaced by "permanent". With regards the impairment test, the WPI assessment was changed from 2nd edition to 4th edition of the AMA Guides.

In addition, guidance is provided in the legislation to interpretation of the narrative. Broadly this guidance is provided as follows:

- *S134AB(19)(a)* - the Court must be "satisfied on the balance of probabilities that the injury is a serious injury."
- *S134AB(38)(b)* - the terms "serious" and "severe" refer to the consequences to the worker in terms of pain and suffering or loss of earning capacity
- *S134AB(38)(c)* - the consequences must be judged as "being more than significant or marked, and as being at least very considerable"

- *S134AB(38)(e)* - to satisfy the hurdle regarding consequences to the injured worker in terms of loss of earning capacity, the loss must continue permanently and be 40% of gross income or more
- *S134AB(38)(h)* - psychological or psychiatric consequences of the injury are not to be taken into account other than in testing the severity of injury under paragraph (c) of the narrative test
- *S134AB(38)(k)* - the monetary thresholds and statutory maxima which apply to damages are to be disregarded in the assessment of whether an injury satisfies the definition of serious injury.

A number of other Scheme changes were made at the time that access to common law was restored. These changes are not considered significant in terms of the discussion in this paper.

2.5 Implementation of Selected Option

With the restoration of access to common law the Victorian WorkCover Authority (VWA) faces the challenges of risk management including:

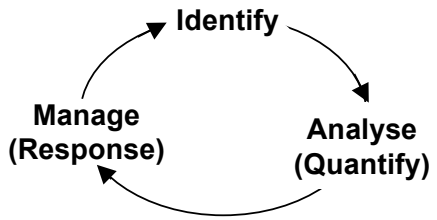
- early identification of claims with common law potential, with a view to early intervention and management
- monitoring experience so as to provide early warning signals of adverse trends and experience
- establishing and implementing controls to ensure application of the legislation in a manner which is consistent with its intent
- management of the scheme so as to ensure stability over time, which is the key to a sustainable scheme.

5 Risk Management

The concept of risk management was introduced when the Government and several stakeholders said they wanted a *sustainable* solution.

To be *sustainable* the common law experience would need to be reasonably stable over time and acceptably close to the allowance in the premium rates.

The simple risk management model can be expressed as follows:



5.1 Risk Identification and Analysis

The single most critical risk identified was the *serious injury gateway* – whether this would be stable over time or subject to erosion.

Analysis of this risk looking historically was controversial. In our view the quantitative and qualitative evidence for gateway erosion was compelling (see for example the graph in 3.2), although not everyone accepted even that. More importantly the drivers of that erosion were unclear – was it:

- the inherent nature of a common law process
- poorly drafted legislation
- poor management by WorkCover and its service providers (claims agents and legal firms)
- some bias or flaw in the County Court/Appeals Court system
- simply more and more claimants becoming aware of their rights, or
- a combination of any or all of the above.

Had there been greater clarity on the factors contributing to this risk, the responses to manage the risk may well have been more focused.

Nevertheless a range of risk management measures were adopted (or recommended for adoption in future), as described in the remainder of this section:

- codify the legal principles
- rely more on medical impairment for the gateway
- a more "objective" test of serious economic loss
- strategic management by the VWA.

5.2 Codify the Case Law

Some lawyers argued that once an adequate body of case law was established, the legal determination of gateway issues would be stable. The history from 1992 to 1999 did not, however, seem to support this proposition. The evolution of case law did seem to have a "ratchet" process – circumstances that would not previously pass the gateway would be tested in a hard-fought case. If that case was won (especially in the appeal court) those circumstances would from then on be accepted as serious injury.

The response tried in the Act was to "codify" the key elements of the case law. The argument is that by writing these critical issues into the legislation the gradual extension of the case law would be stopped.

Examples of this process are listed in Section 2.4 of the paper.

Time will tell, of course, whether this approach is effective.

5.3 Greater Reliance on Medical Impairment

In the first few years after 1992 it was common for claimants to obtain an AMA 2nd edition impairment assessment before deciding whether to pursue common law.

As the narrative test became better established, use of impairment assessments became less common with arguments being built mainly around showing "serious economic detriment". Many of the sample claimants that had impairments appearing to be around or over 30% were still granted serious injury certificates based on the narrative.

In the belief that a medical assessment of impairment would bring greater objectivity and clarity to the process, the new rules require a claimant to have an

impairment assessment before pursuing common law (even if common law is under the narrative).

The impairment assessment will, if there is a dispute, be determined by the Medical Panels.

5.4 More Objective Test for Economic Loss

The main focus of the narrative test of "serious injury" had evolved to be economic detriment. It remained a judgement to be made by the Court as to whether any particular case was "serious". In one of the high profile cases the Court granted serious injury based mainly (it appeared) on the inability to work overtime and lack of flexibility to change jobs.

The approach adopted in the new legislation was to specify that to be "serious", the loss of earnings or earning capacity needs to be at least 40% of pre-injury earnings.

Additional guidance is given to the periods before and after injury to be considered and how to allow for special cases such as apprentices.

5.5 Strategic Management by the VWA

Many observers had been critical of the management of common law by the Victorian WorkCover Authority in the years prior to 1999.

The restoration of common law was accompanied by management recommendations including:

- VWA introduce measures to constrain legal costs, and establish ongoing monitoring systems to allow an evaluation of these emerging costs
- VWA put in place a robust claims management system which could include an increased role for agents
- VWA, together with major stakeholders, establish an education program for the restoration of common law.

These and other recommendations are encapsulated in the phrase "strategic management" by which we mean management with a focus on the outcomes for the whole system. This requires a significant mindshift from the traditional approach to litigation where each case is handled on its own merits.

The VWA needs to exact an active influence on progress of the common law stream and needs to be particularly strong in its monitoring function.

NATIONAL COMPETITION POLICY
LEGISLATIVE REVIEWS

WORKSHOP ON STATUTORY MONOPOLY
CTP ARRANGEMENTS

Understanding Scheme Failures

Presented on 24 July 1998

by Geoff Atkins

Table of Contents

I. Introduction

A case study approach was adopted for this session. Five case studies of compulsory third party ("CTP") scheme failure (or at least crisis) were identified, with brief descriptions of:

- the scenario before the crisis
- what happened in the crisis
- the consequences
- lessons to be learned

The analysis of each case is intended to describe the dynamics of the situation, rather than provide a detailed history of what occurred.

Disclaimer: the views expressed are the personal views of the presenter, not necessarily those of the firm he represents or any of the clients he advises.

II. Case Study 1: New South Wales pre-1987

Scenario

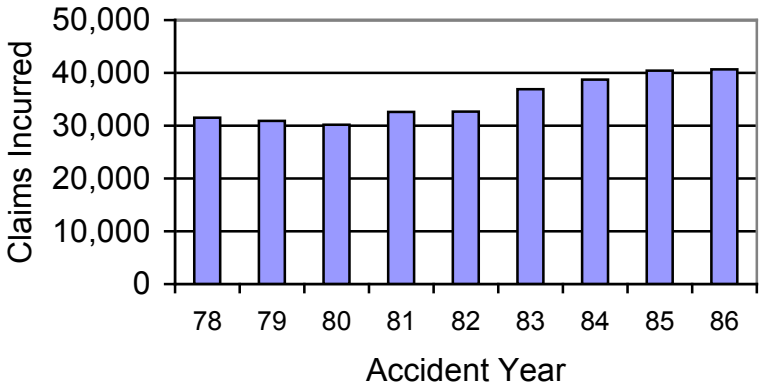
Prior to 1987, the CTP scheme in New South Wales was a government monopoly. The scheme provided benefits based on common law. There were few restrictions placed on common law benefits.

The scheme was managed by GIO, and a separate fund was established within GIO for dealing with scheme funds. CTP premiums were set by the government.

What Happened?

New South Wales experienced a rapid and serious blowout in claims, especially whiplash and minor claims. The cost of large claims also increased. This increase in claims cost was accompanied by a significant increase in frequency. For example, the number of claims grew from 30,000 in 1980 to over 40,000 in 1986. Fraud was believed to be rampant.

Table 1.1 - New South Wales
Number of Claims



In the face of increasing claims costs, GIO management was ineffective. GIO mistakenly tried the "settle quick" approach, paying whatever it took to settle the claims quickly. This fueled the increase in claims costs.

Premium increases were recommended by GIO but resisted by the government.

Consequences

Claim liabilities blew out dramatically. The scheme was unfunded by more than $2 billion. GIO management of the scheme lost credibility.

The scheme was completely reformed and replaced by TransCover in 1987. Transcover provided statutory entitlements rather than common law benefits, but the new scheme was still fault-based. TransCover was subsequently replaced by a competitive scheme in 1989.

To pay off the unfunded liability, motorists paid a $43 levy from 1989 to 1998. The levy was insufficient, however. The State budget picked up the rest of the cost.

Lessons

The common law structure proved to be unmanageable in New South Wales.

The lack of financial responsibility in pricing:

- led to the problem being ignored for too long
- ran up a huge unfunded liability
- caused the scheme to eventually be replaced

There are risks in having a single administrator responsible for a CTP scheme. GIO decisions on the approach to claim management contributed to the problem.

III. Case Study 2: Victoria pre-1986

Scenario

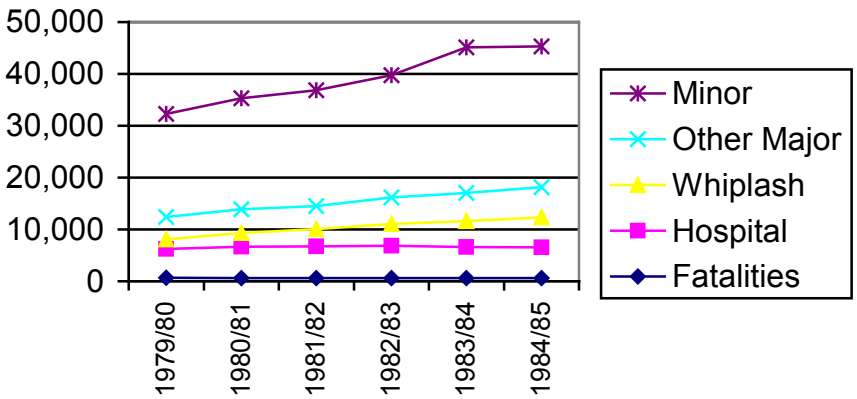
The State Insurance Office was responsible for payments litigated under common law. No fault benefits (up to $20,800 per claim) were provided by the Motor Accidents Board. CTP premiums were set by the Treasurer on advice from an independent Premiums Advisory Committee. Premiums were collected by the Road Traffic Authority at the time of vehicle registration.

The CTP scheme was an effective government monopoly, split between two agencies.

What Happened?

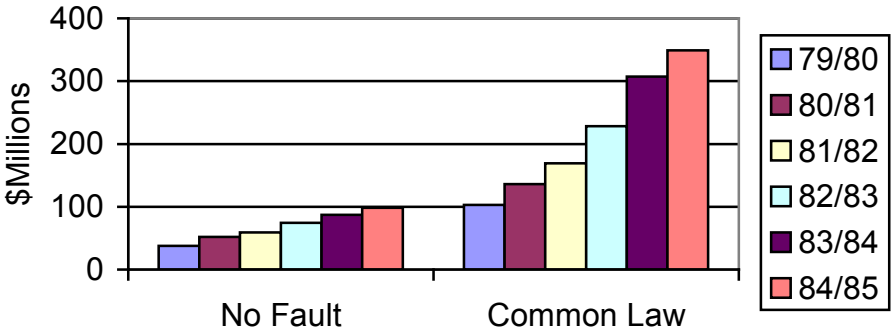
First, as can be seen in Table 2.1 below, too much money went to minor injuries.

Table 2.1 - Victoria
Claims by Injury Type



Second, the cost of claims trebled between 1980 and 1985, mainly from common law. Table 2.2 shows the increase in financial year payments over this period.

Table 2.2 - Victoria
Claim Payments



In 1986 the Premiums Advisory Committee recommended a rate increase from $181 to $500.

Why?

Several factors combined to cause the problems in Victoria. First, there was no threshold for common law claims. Smaller claims intended to be dealt with under the no fault amendments could also be pursued under common law. The government had no ability to manage adverse court decisions and the rising demand for common law.

Second, fraud was perceived to be rampant.

Third, there was poor co-ordination between the agencies.

Fourth, the recommendations of the Premiums Advisory Committee were ignored.

Consequences – Reforms

To address the lack of co-ordination between agencies, the government established a single organisation (TAC) with overall management responsibility for a new scheme on 1 December 1986.

The government abolished common law rights below a certain threshold. The benefit structure of the scheme was revised to lower the benefits provided to those with less serious injuries. These changes were intended to reduce fraud.

Premiums under the new scheme were set on a “ten year fully funded” approach. Under this approach, premiums were set high enough to pay all claims in the coming ten years, and to build up a fund sufficient to cover all outstanding liabilities at the end of the ten-year period.

Victoria set out to become a leader in accident prevention. The TAC succeeded in this regard.

Consequences – Who Paid?

The CTP scheme faced an estimated unfunded liability of $1.6 billion at 30 June 1986. This liability was primarily paid off by a 16% premium increase. The government also provided once-off support of $30 million. In the end, the liabilities as of 30 June 1986 were run off close to $1 billion.

Lessons

Prior to reform, insurers spent $0 on road safety or accident prevention; post-reform spending paid off. Victoria became a leader in accident prevention.

As in New South Wales at the same time, the government's reluctance to increase premiums exacerbated the financial crisis.

The common law benefit regime didn’t work in Victoria.

Table 5. Case Study 3: South Australia 1984-87

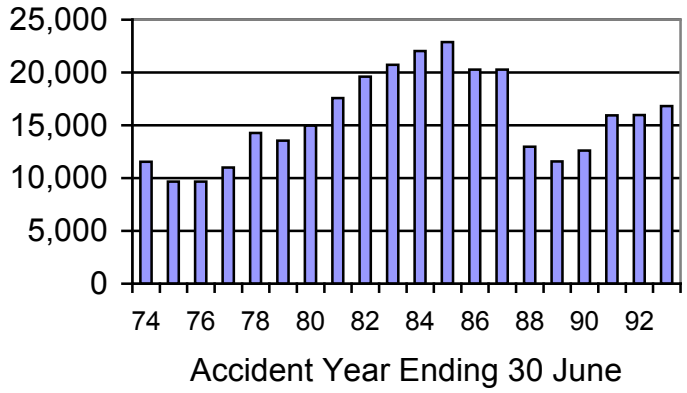
Scenario

The CTP scheme in South Australia in 1984 was a common law system underwritten by the State Government Insurance Commission. The scheme had a deficit of $30.4 million at 30 June 1985.

What Happened?

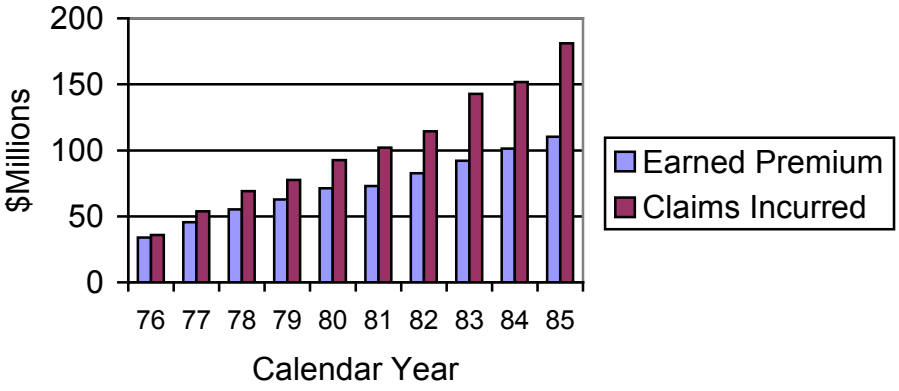
The average cost of a claim rose sharply in the ten years from 1976 to 1986. The increase can be seen in Table 3.1 below, which also shows the more recent history.

Table 3.1 - South Australia
Average Cost per Claim ($95/96)



As shown in Table 3.2, this increase in the cost per claim led to a dramatic increase in claims incurred by year.

Table 3.2 - South Australia
Premium and Claim Statistics



Factors Contributing to Fund Deterioration

The State Government Insurance Commission "had no control over the premiums, the cost of claims, or the obligation to continue as the sole insurer". The increase in average claim size was caused by changes in common law, adverse court decisions, and increasing use of solicitors.

Premiums were inadequate because of government intrusion.

Consequences

Amendments to benefit entitlements were instituted with a maximum award of $60,000 for pain and suffering, based on a points scale from 0 to 60. It placed other restrictions on circumstances in which a claim could be lodged and on the benefits payable. A premium increase was finally approved.

The fund gradually recovered, and stability of claim costs and funding returned under SGIC management.

Lessons

Unlimited common law is prone to cost blow-outs. As in previous case studies, government premium setting kept premiums too low. It is difficult to get government attention to financial soundness.

In the case of South Australia, the scheme reform took place without structural change.

Table 5. Case Study 4: Western Australia 1991-93

Scenario

Benefits under the CTP scheme were provided according to common law. The scheme was run by a government monopoly, the State Government Insurance Commission ("SGIC").

What Happened?

Between 1990 and 1993, SGIC got caught up in “WA Inc”. During that time, SGIC wrote down assets of $550 million, mostly belonging to the CTP Fund, including:

	$m
Bond Corp & Bell Group	260
Rothwells	30
Spedley	16
Property writedowns	190

By 30 June 1993 the deficit in the CTP fund was $330 million. The SGIC gained an increase in premiums of 30% in October 1991. A recommended increase of 12% in October 1992 was not approved by the Minister of Finance.

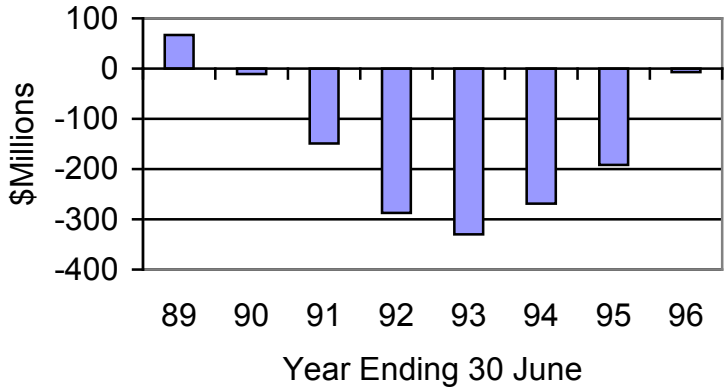
Consequences

SGIC introduced a $10,000 threshold/deductible for general damages. General damages were limited to $200,000 per claim.

A premium levy of $50 per policy from 1993-96 provided $158 million in funds. The government paid $75 million into the fund in 1996. The remaining $97 million deficit was cleared by improved investment returns. Table 4.1 below shows the annual deficit reductions.

SGIO Insurance Limited was privatised and floated publicly, although the CTP scheme remained in government ownership.

Table 4.1 - Western Australia
Reduction of Deficit



Lessons

Investment risk is material, and government funds are not immune from it.

Table 5. Case Study 5: New South Wales 1993-95

Scenario

The CTP scheme in New South Wales was privatised on 1 July 1989. Market share at that time was allocated. Price competition was introduced on 1 July 1991; insurers then had to compete for market share.

Prices fell from $350 to $200 from 1991 to 1993, due to competition and good claim experience.

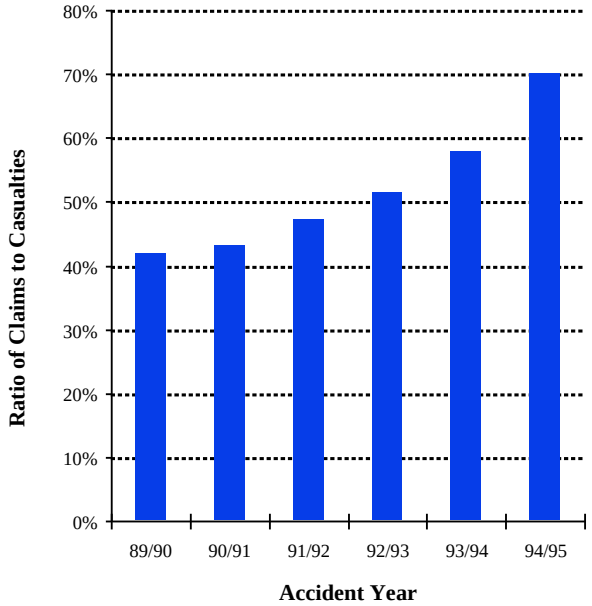
What Happened?

The number of minor injury claims increased dramatically from 1993 to 1995. Insurers made significant losses, after earlier years of very good profits.

Prices rose dramatically as well. Although prices only increased to 1991 levels, and they were not set by the government, they were politically controversial.

Table 5.1 below shows the ratio of claims to casualties. This graph demonstrates that the higher claim numbers were caused by a higher propensity to claim, not by more injuries.

Table 5.1 – New South Wales
Utilisation Rate

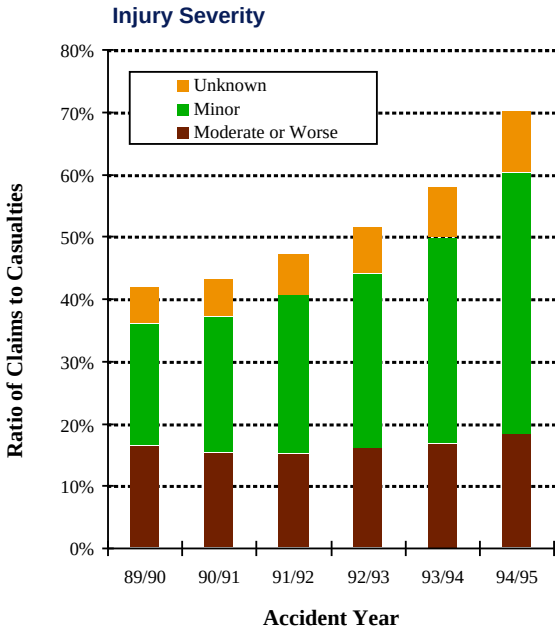


- In 1989/90 there were 42 CTP claims for every 100 injuries on the roads. By 1994/95 that figure had increased to about 70 claims per 100 injuries.
- The higher claim numbers are attributable to an increasing propensity of those injured in motor accidents to claim, not to more injuries occurring. In fact the number of injuries has fallen.

Source: Claim numbers - Tillinghast Report
Casualty data - RTA Statistics

Table 5.2 shows that the growth in claim frequency was all in minor injuries.

Table 5.2 – New South Wales
Utilisation Rate by Injury Type



- Claims are coded according to the severity of injury - minor, moderate etc., through to fatal.
- The increase in claims is attributable entirely to those who have suffered *minor injuries* in traffic accidents.
- More severely injured people (moderate or worse) are no more likely to claim than they were 6 years ago.

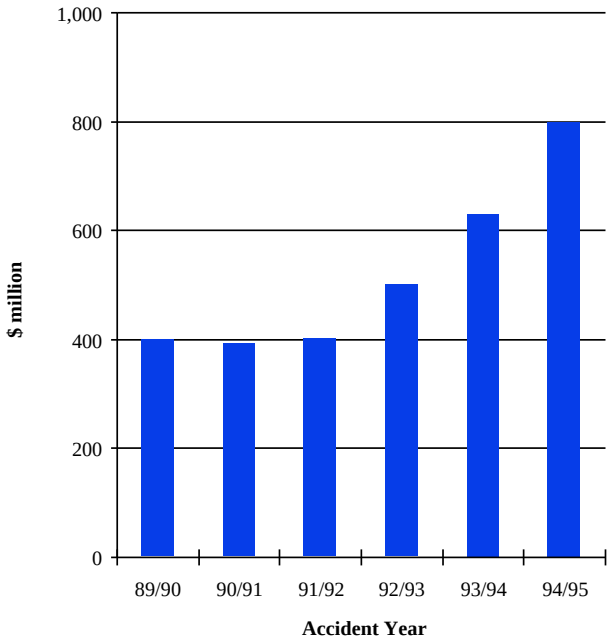
Source: Claim numbers - Tillinghast Report

Casualty data - RTA Statistics

Split by injury severity - based on Trowbridge Consulting's analysis of industry claims data provided by Price Waterhouse

Table 5.3 shows the increase in annual claims costs. Claim costs escalated rapidly from 1992/93 to 1994/95.

Table 5.3 – New South Wales
Claim Costs



- Estimated claim costs have increased considerably in recent years.
- First three years were stable before escalation started.
- 1994/95 costs are around double those for 1989/90.

Chart shows the estimated total cost of claims for the accidents occurring each year (both payments so far and estimate of payments yet to be made). Amounts are discounted to net present value in the accident year.

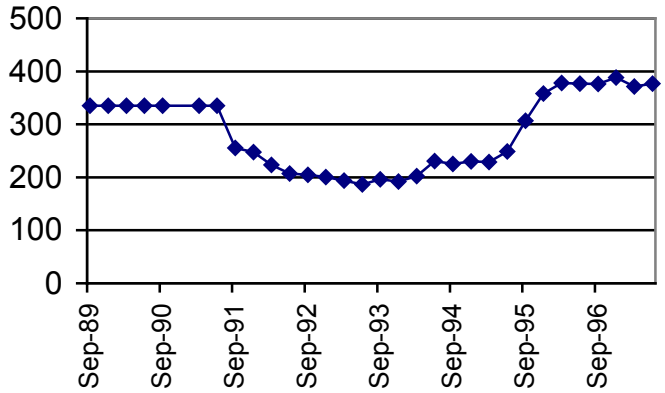
Source: Tillinghast Report for MAA "Estimation of Industry Average Pure Premium for Renewals in 1996"

Consequences

Pressure for scheme reform came from both insurers and politicians. Insurers were concerned about increasing losses, and the politicians were concerned about the rising premium level.

Further amendments to the general damages entitlements were made in 1995. The reforms stabilised premium rates. Table 5.4 shows the average premium rate from 1989 to 1997.

Table 5.4 - New South Wales
Average Premium Rate 1989-97



Lessons

The same scheme design problems can occur in a competitive scheme. The common law benefits that were a problem in New South Wales in 1987 (see Case Study 1) are still leading to instability in the losses in the state.

The insurers' ability to control prices gave them considerable power in forcing reform. In the current New South Wales scheme:

- government controls benefits through legislation
- insurers control price
- government still cares about price because insurance is compulsory

VII. Summary of Case Studies on Scheme Failure

The common law structure is difficult to manage. Strong legislative design is crucial to minimise loopholes and the ability to change legislation is needed to close them.

Problems with schemes being underfunded have arisen mainly from claim costs, although investment risk can also be a factor.

In the case studies, we consistently see a lack of responsible pricing if the scheme is Government controlled.

The community will not accept excessive premiums, whether the scheme is run by a monopoly or under competition. The reaction of the community to increasing premiums can help to force reforms.

Reductions in benefit entitlements are the ultimate (and only successful) measure to control *premiums.*

References

Motor Accidents Authority of New South Wales (1996-97), *Annual Report*.

Motor Accidents Authority of New South Wales (1997), *Whiplash and the NSW Motor Accidents Scheme*.

Motor Accident Commission of South Australia (1996-97), *Annual Report*.

New South Wales Attorney General's Department (1989), *Motor Accidents: the Act and background papers*.

New South Wales Law Reform Commission (1983), *Working Paper 1: A Transport Accidents Scheme for New South Wales*.

State Government Insurance Commission of South Australia (1985), *Compulsory Third Party Insurance Fund Enquiry*.

State Government Insurance Commission of Western Australia (1990, 1991, 1992, 1993, 1994, 1995 and 1996), *Annual Report*.

State Government Insurance Commission of Western Australia (1994), *Report on Compulsory Third Party Insurance Fund of Western Australia* by Russell Skerman, Manager.

Transport Accident Commission of Victoria (1997), *Annual Report*.

Victoria (1986), *Transport Accident Compensation Reform*.