Comments on *Model Designs – citizens' jury for ACT CTP scheme, March 2018*

#	Reference	Comment
1.1	The next stage was for a nominated 'scheme design expert' (Geoff Atkins of Finity) to prepare four possible designs for the jury to consider. That work was undertaken in close consultation with the Stakeholder Reference Group and was complemented by work of Peter McCarthy (Ernst & Young) whose role was to estimate the premiums required for each model.	Not all of the comments of SRG have been incorporated into the models and there remain areas of disagreement within the SRG and with the scheme designers about the various models.
2	There is an early payment available for up to $5,000 in medical costs	The early payment by the insurer is in fact a reimbursement which is often subject to delay due to slow and/or complicated approval processes.
2.1.1	Treatment costs relate to medical, hospital and related costs such as physiotherapy. Under all of the proposed models, as in the current scheme, the treatment costs that are paid (if the injured person is eligible) are "all reasonable and necessary costs".	This is not an accurate statement. The current legislation refers to 'reasonable and appropriate'.
2.1.3	In a defined benefits scheme the rate of ~~compensation~~ is usually defined as a percentage of pre-injury earnings, and the percentage may change as the ~~duration~~ since injury increases.	In a defined benefits scheme the rate of *benefit* is usually defined as a percentage of pre-injury earnings, and the percentage may change as the *time* since injury increases.
2.1.4	This payment type compensates an injured person for non-monetary 'loss', i.e. a reduction in their quality of life (for example, due to ongoing impairment or pain). This type of payment may be termed a "permanent impairment benefit" (in a defined benefits context), or in the common law context: "non-economic loss", "general damages" or "pain and suffering".	At common law, general damages also covers *loss of enjoyment of life*.
	Limiting access to QoL payments for individuals who have suffered relatively minor injuries is the most frequently used mechanism to direct more of the scheme resources to those more seriously injured and make a scheme more affordable.	This is not an accurate statement. The models are seeking to include increasing levels of coverage for all, and this is being paid for by reducing compensation for people injured by someone else's negligence. In fact, many of those who are more seriously injured will receive less under these models.
2.1.6	Introducing thresholds ~~limits~~ total scheme costs, while shifting the balance of scheme payments towards the more seriously injured.	Thresholds in these model designs are not shifting the balance of scheme payments towards the more seriously injured. Thresholds in relation to common law claims shift the balance of scheme payments towards at-fault claimants.
	Introducing thresholds ~~limits~~ total scheme costs, while shifting the balance of scheme payments towards the more seriously injured.	See comments made above.
2.1.8	It is proposed that under each of the proposed models, better information about an individual's entitlement to claim, the claim process, and benefit entitlements, will be available to all injured people.	How, by whom and at what cost?
2.1.9	Many injured people will need support in making their claims.	Yes, as many injured people do not feel comfortable dealing with large insurers or are not emotionally or physically well enough to do so. In many cases where injured people have an advocate to act on their behalf in dealing with insurers, they are better able to concentrate on their recovery.

2.2.1	Model A is similar to the current scheme, but defined benefits for up to 6 months are available to all.	Quality of life damages are limited by the application of the ISV scale. This is paid for by limiting quality of life damages for those injured through the negligence of others.
	The injured person was not at fault – the claimant may make a common law claim, with the insurer obliged to pay treatment costs and income replacement up to three years while the common law claim is being resolved, unless there is reasonable cause not to.	How will the insurer be obliged to make the payments? Timeliness is often an issue – how will the insurer be obliged to make payments in a timely manner? What is 'reasonable cause'? The onus should be on the insurer to show that there is 'reasonable cause' not to make payments. There is no design feature in any of the models which imposes an obligation on insurers to do anything in a way that can be enforced. This is a serious omission from the model designs.
2.2.2	**Domestic services** **Unlimited** Includes gratuitous care ~~on~~ the 6/6 rule	Domestic services are not unlimited. They are limited under the 6/6 rule.
2.2.3	The defined benefits are extended to 2 or 5 years. QoL payments are available to ~~all, subject to a~~ 5% WPI_1 threshold.	The AMA Guides clearly state that WPI percentages should not be used as a determinant of work disability. The eligibility for income replacement is a question of work disability. This measure misuses the AMA Guides.
2.2.3 2.2.4	For additional QoL compensation at common law, the QoL threshold is 10% WPI. The threshold for at fault claimants is 5% WPI.	It is not acceptable that a higher threshold is applied to negligently injured people than to those at fault. There is no basis in principle but is an artificial barrier imposed to discourage common law.
2.2.4	There is no common law entitlement for gratuitous care.	This is an equity issue as most gratuitous care is provided by women. The High Court in Griffiths v Kerkemeyer in 1977 recognised that the negligent person (or their insurer) was being subsidised by carers of the injured person and awarded compensation.
3.3	The treatment section will include an obligation on the insurer to support rehabilitation	How will the obligation be imposed and enforced? The scheme design does not provide for the enforcement of the obligations of the insurer.
3.3.1	This anomaly needs to be dealt with, and it is also important to avoid incentives for surgery that is premature, unnecessary or of marginal benefit.	No evidence has been provided for the proposition that surgery that is unnecessary or of marginal benefit is actually being performed.
3.3.3	The jury put high priority on the scheme providing the best possible support for recovery and return to health. The features of the scheme design supporting this objective are: • Obligations on insurers to provide and fund services that support this objective • Adoption of the Clinical Framework for the Delivery of Health Services (as modified for the ACT) • Use of medical specialists, relatively early in the life of the claim, with an obligation to evaluate and guide treatments • The requirement for an injured person to mitigate their situation and participate in efforts to optimise their recovery • A 'moratorium' period of 6 months before common law claims can be negotiated or commenced, the intention being to give 'clear air' for the recovery focus. More detail is in sections 4.7 and 4.8.	"Obligations on insurers to provide and fund services that support this objective" – again, there is nothing in the models that compels the insurers to do so. "Use of medical specialists, relatively early in the life of the claim, with an obligation to evaluate and guide treatments" - where is this obligation found in the models? "A 'moratorium' period of 6 months before common law claims can be negotiated or commenced, the intention being to give 'clear air' for the recovery focus" – in practice, this happens now.

3.4.2	Gratuitous care awards can sometimes be very large and are often in the form of a 'buffer' …	It is appropriate that gratuitous care awards be large in the case of profoundly injured people who require a large amount of care.
3.4.3	As the common law has developed by new case law (and noting that both GvK and SvG are only a few decades old), these types of payment have been somewhat controversial	*Griffiths v Kerkemeyer* is a 1977 case. The High Court subsequently confirmed the principle in *Van Gervan v Fenton* (1992) and other cases. Some parties do not like the principle but it is not legally controversial.
	As defined benefit schemes have evolved, the view has shifted towards a preference for use of paid care. The thinking is that if the care is reasonable and necessary then it should be provided and paid for as needed. The NDIS and all the NIIS schemes operate on this basis – the only care paid for is commercial care, with no payment for care provided by family members or friends.	The use of only paid care in the NDIS and NIIS scheme is not so far operating successfully. There is some conjecture as to whether paid care will ever completely replace gratuitous care in practice. To remove the acknowledgement of gratuitous care does not guarantee that it will be replaced by paid care.
	The rationale for the increasing restrictions on gratuitous care under common law in moving from Model A through to Model D is that the better the paid care provided by the defined benefits, the less need there is for common law damages.	Refer to our comments above.
3.5.8	One point to note is that if an insurer makes an evidence-based decision that a person has capacity to work, …	What does this mean and how will it operate? The model designs do not suggest how the insurers' decision can be contested by the injured person cheaply and promptly. The onus should be on the insurer to establish that the injured person has the capacity to work before they can suspend income replacement.
3.6.1	Part of the intention of the defined benefit design is that some people who would be entitled to make a common law claim will be satisfied to accept the defined benefit amount rather than go through the common law process.	This is not a principled method of scheme design. It is an attempt to manipulate claimants into accepting less than they are entitled to by right.
3.7.1	The WPI assesses impairment as a percentage. For example a WPI of 23% means that the person is "23% impaired" compared to a healthy person.	This is not an accurate statement. The AMA Guides state: "The whole person impairment percentages listed in the *Guides* estimate the impact of the impairment on the individual's overall ability to perform activities of daily living, *excluding work*." This means that "an individual who receives a 30% WPI … is considered from a clinical standpoint to have a 30% reduction in general functioning as represented by a decrease in ability to perform activities of daily living…. A 30% impairment rating does not correspond to a 30% reduction in work capability." (page 4/5)
4.2	Advocacy – support and advice in obtaining evidence, dealing with the insurer and in lower level disputes (but not necessarily legal advice)	If advice is provided by or under the supervision of a legal practitioner, it is legal advice, by law.
4.4	The support might include assistance with completing documentation, explaining next steps, organising evidence and the like. It does not extend to 'legal representation' of the person so that, for example, the insurer and the injured person will deal directly with each other, not solely via the law firm.	If the 'support' listed is provided by a legal practitioner, it is legal advice. There is a disparity in experience and relative power in this relationship. Not all injured people wish to deal directly with the insurer.
	Only a solicitor (or their delegate) would be entitled to payment and only in specified circumstances.	If the 'circumstances' cause a solicitor to be engaged by a claimant and the solicitor performs work, they are entitled to payment. Any system that tries to prevent claimants having appropriate legal assistance causes

		an imbalance of power in favour of insurance companies.
4.5	The proposal is that there be a deadline of three months from the accident date to lodge a claim for defined benefits, with late claims being accepted only if there is a full and satisfactory explanation	In a situation where the general public will have imperfect knowledge of entitlements and procedures, 'I didn't know' should be a full and satisfactory explanation. In any event, the phrase imposes an unnecessarily onerous test.
4.5.1	The insurer will establish a claim file and advise the claim number which can then be used for medical and care providers to bill directly in permitted circumstances	No design features cause the insurer to comply with hopeful statements.
	The insurer will advise the claimant about the circumstances in which treatment and care would need to be pre-approved and an agreed timeframe before another review of treatment progress and plans. Insurers will be encouraged to be reasonable about pre-approval.	No design features cause the insurer to comply with hopeful statements.
	If an insurer is billed for a service that is not within their pre-approved boundaries, they will advise the claimant and the practitioner immediately.	No design features cause the insurer to comply with hopeful statements.
	Regarding income support, insurers will have a service standard regarding the time to obtain and assess information and (if agreed) to commence payments. Insurers will be encouraged to make interim payments if they are satisfied that there is a loss of income entitlement but do not know the amount (e.g. pay 75% of the amount requested until evidence is obtained).	No design features cause the insurer to comply with hopeful statements.
4.5.2	The normal standard should be that an insurer makes such a decision within three months of the claim being reported.	No design features cause the insurer to comply with hopeful statements.
4.6.2	Development of the details of the dispute process will need to incorporate practical provisions for decision-making on medical disputes.	The detail will be an important element in determining how well any scheme works.
4.7.2	IMEs can be automatically accredited if they are accredited in NSW, and potentially for other jurisdictions	This is a significant element of the scheme that is central to its practical function, the details of which are not known.
	Details of the system and mechanisms will need to be worked out at a later date, alongside the development of the Magistrates Court procedures.	This is a significant element of the scheme that is central to its practical function, the details of which are not known.
4.8.1	Any negotiations, including during internal review, are informal and 'without prejudice'. An insurer may offer a 'closed period' or 'partial' settlement in limited circumstances. If a claimant accepts such an offer they may not subsequently dispute the resolution unless their circumstances have changed significantly after the offer was made.	Redeeming defined benefits is inconsistent with the scheme design rationale expressed at 6.3. That a claimant may not 'subsequently dispute the resolution' should not be the case without the claimant receiving competent advice.
4.8.2	There will be a moratorium period of 6 months before common law negotiations can commence. The purpose of the moratorium period is to allow 'clear air' for a focus on health and recovery without complicating the situation by also dealing with a potential future claim.	This is a restatement of the current system and not a new measure – it is very rare for common law negotiations to commence before 6 months have passed. Common law negotiations do not create 'unclear air'.
	By the end of the negotiating period each party is obliged to make an offer of settlement that is open for at least one month. If agreement is not reached either party may initiate a common law claim with the Magistrates Court.	The references to 'each' and 'either' party in this context do not make any sense.

4.9.2	In respect of **defined benefits** the proposal is as follows: (i) A law firm will receive a fixed fee to provide the initial support and advocacy service described in Section 4.4	This is an attempt to restrict the amount and quality of advice that a claimant can receive and favours the insurance companies.
	If a claimant uses assistance from a law firm with a defined benefit dispute, the law firm will receive a reasonable fee for a dispute that goes beyond internal review. There will be a maximum over the life of a claim. The details for determining this 'reasonable fee' will need to be worked out once other details of the mechanism have been drafted and fleshed out with the Magistrates Court.	There are two sides to any dispute. Limiting representation on one side (the claimant) favours the other side (the insurance company).
4.10	Disclosure by insurers of their relevant finances, both in terms of annual totals and on a per-claim basis through the claims register (with enhanced data collection if needed) Disclosure by claimant representatives of their costs, showing separately the party-party and solicitor-client costs and the breakdown of each.	We agree that transparency for the entire system is important and support meaningful disclosure. In order to accurately achieve the objective of this measure (ie: to monitor where costs lie in the system), disclosure of costs should separately and meaningfully (with explanation if required) identify: • solicitor client costs • investigation costs (including medical fees and charges) • court costs, fees and charges, including fees for mandatory conciliation • government fees, charges and levies • disbursements • GST • insurer expenses (including a breakdown of costs such as claims management, acquisition and reinsurance expenses) • insurer profits (including a notation as to how a 'reasonable profit' is determined) • insurer legal fees.
5.5	Buffer" is the term used for an amount of damages that is not worked out on any specific numerical basis but is a 'just in case' amount. For example a person with a recovered knee injury might be awarded a lump sum of $20,000 for future treatment by way of a buffer, in case the knee deteriorates in later life and needs to be replaced.	A buffer is awarded when the amount, usually for a future contingency, is not capable of exact calculation. It is based on a best estimate, is not a gift and is awarded for real needs.
	It is common, after scheme reform that tightens rules about QoL damages, for Courts to be more liberal in awarding buffers – say, for future economic loss, future medical costs, and future care. This is the phenomenon where "you squeeze the balloon and it bulges out somewhere else".	Much is made of this. There are many unintended consequences of scheme design in a vacuum - this may be one. It is not necessarily the most important unintended consequence.
	Sometimes reform legislation includes specific provisions intended to control the emergence of buffers, but these are generally limited in their success. It is proposed that Models C and D will include legislative provisions to discourage buffers despite their limited success elsewhere.	If legislative reform in relation to buffers in other jurisdictions has not been successful, it is unrealistic to expect that the same legislative reform will be successful in the ACT.
6.3	In practice the use of commutations has, in many schemes, become the 'norm' and defeated some of the goals of defined benefits arrangements whereby payments are provided as the need arises.	4.8.1 and 6.3.2 are inconsistent with this statement.
6.3.2	While the legal effect of an expedited finalisation may be similar to a commutation, the concept and application is different because the amounts involved	4.8.1 and 6.3 are inconsistent with this statement.

	are relatively small and there is no negotiation based on perceived probabilities of potential outcomes	
6.4	The jury established an objective to minimise fraud, and the potential for fraud, in the scheme. Insurers and the regulator have a joint responsibility to detect fraud, deter recurrence and, if thought fit, work with the police. This activity will be included in the remit of the regulator and can take advantage of work already done in NSW.	There is no evidence of this type of fraud currently occurring in the ACT.
	In terms of fraud prevention, there are several aspects of the scheme design that are intended to make fraud more difficult and less attractive. These include: Earlier reporting of claims in order to access defined benefits The need to determine eligibility for defined benefits early makes it more likely that investigations and enquiries will identify possible fraud The restrictions on a lump sum claim for loss of earnings The threshold (depending on the model) for lump sum QoL compensation.	None of the measures listed are relevant to fraud prevention.