



GUIDE TO THE *MOTOR ACCIDENT INJURIES BILL 2018* EXPOSURE DRAFT

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Background

Compulsory Third Party Insurance (CTP) in the ACT is currently regulated by the *Road Transport (Third-Party Insurance) Act 2008* (CTP Act) which has been in effect since 1 October 2008.

The ACT currently has an at-fault common law scheme where an injured person can sue another person for negligence and seek compensation through legal processes. The scheme does not cover accidents where fault cannot be proven. It also does not pay benefits to the person who was at fault, although most people can access up to \$5,000 for early medical expenses.

Under this scheme 'at fault' has a technical legal meaning. In many cases, momentary inattention is the cause of an accident rather than any conscious action, but the driver is still legally 'at fault'. Examples can include checking the mirror but not seeing a car in the blind spot or a sneeze that causes a driver to hit another car.

In August 2017, the ACT Government announced we would undertake a deliberative democracy process to consider with the community and other key stakeholders how to improve the scheme so it reflects the priorities of Canberrans. The Government set some criteria for this process, and committed to pursue the community's recommendations as long as these were met:

1. The CTP scheme must remain compulsory for all motorists.
2. The scheme must continue to be privately underwritten and the overall scheme design cannot raise the cost of premiums.
3. The CTP scheme in the ACT must remain community-rated.
4. The types of vehicles for which CTP must be purchased and the way premiums are calculated between vehicle types cannot change as part of this process.
5. The scheme must be workable and fit within other legal and regulatory frameworks.
6. The deliberations will not examine the established Lifetime Care and Support Scheme.

A group of 50 Canberrans, representative of the community, were randomly selected to participate in a two-part citizens' jury run by facilitators separate to Government. Their deliberations were supported by a Stakeholder Reference Group made up of legal, insurer, health care and consumer group representatives.

All Canberrans also had the opportunity to provide their views on CTP in September 2017, through surveys conducted on the ACT Government's *YourSay* website and by telephone. The survey results and feedback from these consultations were provided to the jury in the first stage of their deliberations in October 2017.

In this first stage, the jury met over two weekends to consider the question: *What should the objectives of an improved CTP scheme be to best balance the interests of all road users?*

The jury heard from a range of experts, injured people and those with experience of the current CTP scheme, to help guide their deliberations on a set of priorities for an improved CTP scheme. At the end of this process, the jury identified the following priorities:

1. Early access to medical treatment, economic support and rehabilitation services.
2. Equitable cover for all people injured in a motor vehicle accident.
3. A value for money and efficient system.

4. Promote broader knowledge of the scheme and safer driver practices.
5. Implement a support system to better navigate the claims process.
6. A system that strengthens integrity and reduces fraudulent behaviour.

The jury's priorities statement and information on the evidence they heard in developing this is available at: <https://yoursay.act.gov.au/ctp>

The jury's priorities and report were then provided to the Stakeholder Reference Group and an expert scheme designer so that they could develop a range of models for the jury's consideration.

The groups represented on the Stakeholder Reference Group were:

- ACT CTP Regulator (ACT Government)
- Justice and Community Safety Directorate (ACT Government)
- Law Society of the ACT
- ACT Bar Association
- Insurance Australia Group
- Suncorp
- Health Care Consumers Association
- John Walshe Centre for Rehabilitation Research
- Finity (scheme designer)
- EY (actuarial adviser)

Between November 2017 and March 2018, the scheme designer worked closely with the Stakeholder Reference Group to develop four workable models which aligned with the jury's priorities. These models were costed by an actuary to determine their potential impact on the premiums Canberra motorists pay.

The jury re-convened in March 2018 to consider each of the models, including receiving information from the Stakeholder Reference Group about the merits of these.

Finally, the jury chose the model that they believed to best meet the priorities they had identified in the first stage of the process. The jury's full recommendations report is available at: <https://yoursay.act.gov.au/ctp>

In line with our commitment, the Government is now pursuing the jury's recommended model by developing legislation which closely reflects this for introduction to the ACT Legislative Assembly.

Outline

The purpose of the Motor Accident Injuries Bill 2018 is to implement the model for the new motor accident injuries scheme chosen by the citizens' jury.

The bill replaces the current at-fault compensation scheme operating under *the Road Transport (Third Party Insurance Act) 2008* (CTP Act) with a new hybrid no-fault common law scheme. These types of schemes are in place in other jurisdictions. For example, both New South Wales and Victoria have hybrid no-fault common law CTP schemes. However the scheme chosen by the jury offers different coverage and benefit levels compared with these jurisdictions. The jury chose a model with coverage and benefits that best met their priorities.

A key feature of the new scheme is that it will no longer be necessary to prove another driver was at-fault in order to access benefits following injury in a motor accident.

Instead, the new scheme provides defined benefits, for treatment and care as well as income replacement, for up to five years to anyone who is injured in a motor accident. Based on actuarial modelling, this means approximately 600 more Canberrans each year will be covered by the scheme, where currently they would be unable to make a claim.

Quality of Life defined benefits to cover non-financial loss are payable to people who meet injury impairment thresholds. Additional common law benefits will also be available to people who are more seriously injured (meeting a Whole Person Impairment threshold of 10 per cent or more) and whose injury was caused by someone else's fault.

People who engage in serious criminal behaviour or put others at risk with drink and drug driving offences will be partly or totally excluded from accessing benefits under the new scheme. This is consistent with the approach taken in other parts of Australia and ensures there are strong disincentives for dangerous, criminal behaviour on our roads. It is also in the line with the model chosen by the citizen's jury that specified that there would be some exclusions for illegal behaviours.

The bill also transfers the statutory position and functions of the current CTP regulator from the CTP Act. The bill replaces the current CTP regulator with the Motor Accident Injuries Commission and establishes a position of the Motor Accident Injuries Commissioner. Licensing, enforcement and nominal defendant arrangements, including the nominal defendant fund, also continue to operate under the bill.

Summary of benefits under the new scheme

Benefit Type	For all: Defined benefits	Common law benefits for people not-at fault
Reasonable and necessary treatment and domestic care	5 years Paid care only	Limited to the 5 years of defined benefits if Whole Person Impairment below 10 per cent No time limit if Whole Person Impairment 10 per cent or above. Paid care only.
Income replacement	5 years 95 per cent of pre-injury earnings for first 3 months then 80 per cent thereafter. Higher percentage amounts payable to people on low incomes. Maximum pre-injury weekly earnings amount of \$2,250.	Limited to the 5 years of defined benefits if Whole Person Impairment below 10 per cent No time limit if Whole Person Impairment 10 per cent or above First 12 months: as per defined benefits After 12 months: 100 per cent of loss of earning capacity (future earnings) + superannuation with a maximum pre-injury weekly earnings amount of \$4,500
Quality of life	Maximum \$350,000 Benefit based on Whole Person Impairment Threshold: No benefit if Whole Person Impairment is below 5 per cent	Maximum \$500,000 Amount based on Whole Person Impairment scale Threshold: No benefit if Whole Person Impairment below 10 per cent
Death	Funeral cost + up to \$350,000 if dependants	Funeral cost + common law damages for dependants

Summary of key provisions for new scheme

Duties and the provision of information

The bill places general duties on both insurers and applicants for defined benefits and common law damages to act in good faith and to endeavour to resolve a claim as fairly and expeditiously as possible.

Insurers must provide injured people with information to readily access and navigate through the new scheme. Information will also be provided by the Motor Accident Injuries Commission via a new website and assistance in making applications for defined benefits will be available through approved information support services.

Applications for benefits

Initial applications for defined benefits (other than funeral or death benefits) must be made within 13 weeks of a motor vehicle accident. An insurer may accept a late application, with a full and satisfactory explanation, within 2 years of an accident. The insurer with whom the application is lodged is required to provide an acknowledgement of receipt of the application with an individual claim identifier.

An insurer must then accept liability to pay defined benefits if the injury concerned occurred as a result of a motor vehicle accident. The insurer has 28 days to determine liability once they have provided a receipt notice for a complete application with all required information.

If an application is accepted, defined benefits for reasonable and necessary treatment and care and income replacement are payable for up to five years after an accident.

Pre-decision early treatment payments

An injured person will be able to receive payment for certain allowable treatments on a reimbursement basis while an insurer is determining liability for a defined benefits application, so long as the application is made within the 13 weeks from the date of the accident. This means that people who are injured are able to start accessing treatment as soon as possible to aid in their recovery.

An injured person will be able to claim reimbursement of some treatment expenses at the time of making the application, such as the cost of their appointment with their treating doctor. They will also be able to claim reimbursement for certain types of treatment such as physiotherapy (up to a specified maximum number of treatments), during the period between making an application and when an insurer makes their liability assessment. The types of treatment payable during this period, together with the specified maximum number of sessions, will be specified in guidelines. Insurers must still verify that services have been provided prior to making payments.

Once liability for an application that was lodged on time is accepted, any other treatment and care dating back to the time of the accident that is assessed as reasonable and necessary by the insurer can be reimbursed. Guidelines will provide direction on what is reasonable and necessary treatment and care.

Income replacement and treatment and care benefits

An injured person who is unable to work after an accident can also receive income replacement payments. Payments can commence from when an insurer accepts liability for their application, backdated to the time of an accident so long as the application was submitted within the required timeframe. Payments will generally be based on a person's income over the 52 weeks prior to the accident. Interim payments can also be made if an insurer is still gathering information to calculate the actual amount of a payment.

Income replacement is payable at 95 per cent of pre-injury weekly income (pre-injury weekly income capped at \$2,250 weekly) for the first 13 weeks after an accident and then 80 per cent thereafter. Income replacement payments for low income earners will be based on a higher percentage of their pre-injury weekly income.

A tailored recovery plan must be developed by an insurer for any applicant who is unable to return to their pre-injury duties and activities after 28 days from the receipt of their application. The plan will include pre-approval for treatment and care assessed as reasonable and necessary, that can then be billed by the provider directly to the insurer.

An insurer will generally rely on medical assessments carried out by a person's own doctor or health practitioner. In order to streamline the medical assessment process and limit the number of required assessments, an insurer may contact an injured person's doctor with questions, so that a medical report covers all information required by the insurer. An insurer can, however, still request an independent medical or vocational assessment if required. Guidelines will be provided to outline how and when this can happen.

An insurer can suspend income replacement payments if an injured person does not comply with a request for a medical or vocational assessment, or undertake treatment, rehabilitation or training in a recovery plan.

Quality of life benefits

Quality of life defined benefit payments are available to all injured people with a Whole Person Impairment assessment of at least five per cent. This assessment provides a medically based injury assessment on which to base a threshold. Whole Person Impairment assessments are already in use in the Comcare Workers' Compensation scheme operating in the ACT. The Motor Accident Injuries Commission will appoint a service provider with appropriate experience, to select and provide independent medical examiners to undertake these assessments. The independent medical examiner selected will depend on the injuries needing to be assessed. This ensures that the person undertaking the assessment has not been appointed by either an insurer or a legal representative. An assessment must be conducted in accordance with medical guidelines set out in a disallowable instrument. The Safe Work Australia (SWA) Guidelines for the evaluation of permanent impairment will be adopted for these purposes. These Guidelines modify some parts of *The Guides to the Evaluation of Permanent Impairment by the American Medical Association 5th edition (AMA5)*.

Six months after an accident, an insurer must give an applicant information about claiming Quality of Life payments. These payments are based on a sliding scale for a given level of impairment. A maximum cap of \$350,000 and \$500,000 applies to defined benefit and common law amounts respectively. An insurer must also provide an applicant the opportunity to request a Whole Person Impairment assessment from this point in time, if their injury has stabilised. The insurer will pay for this assessment.

Death benefits

The defined benefit scheme will cover funeral expenses of up to \$15,000 for a person who dies as a result of a motor accident. Lump sum death benefits are also payable to a deceased person's estate for their spouse and up to four children. A lump sum benefit will not be payable if the deceased person received a quality of life payment prior to their death. Applications for these benefits must be made within 13 weeks of a person's death unless the insurer accepts a full and satisfactory explanation from an applicant. An insurer may accept a late application up to 12 months after a person's death.

Common law claims

The new scheme continues to provide for common law damages for death or cases where a person is more seriously injured through someone else's fault. To access these damages a person needs a Whole Person Impairment assessment of 10 per cent or more. Applying the more extensive entitlements of common law and the resources of the court to more seriously injured people while supporting those with less serious injuries to get back to health sooner was a key factor in the scheme design chosen by the jury, including the use of thresholds.

Quality of Life damages will only be available if the injured person has not accepted a defined benefit quality of life payment. That is, a person cannot claim quality of life damages twice. To limit claims to more serious injuries, damages for loss of earnings are capped to income replacement amounts available under the defined benefit scheme for the first 12 months from an accident. Consistent with the current provisions of the *Civil Law (Wrongs) Act 2002*, the maximum amount of damages for loss of earnings is also capped at \$4,500 per week.

Damages can be awarded in common law to dependants of a deceased person, but will be reduced by death benefit and quality of life amounts paid under the defined benefit scheme, to remove duplication of payments.

Claims for common law damages must be lodged within five years of an accident. The claims process largely follows the *Civil Law (Wrongs) Act 2002* subject to some minor modifications set out in the bill.

Indexation

Income replacement amounts, and all threshold and capped amounts under the new scheme will be indexed in line with adjustments to Average Weekly Earnings.

Dispute resolution

The introduction of defined benefits will result in a new category of disputes, as an applicant and insurer may not agree about eligibility for, or the approved level of, defined benefits. The bill provides for timely and cost effective dispute resolution processes, with an internal review by the insurer being a prerequisite before lodging a dispute with an external dispute resolution body.

An applicant may ask an insurer to review decisions about certain defined benefit matters. Guidelines will stipulate who within an insurer can carry out an internal review and how the review is to be carried out. These guidelines will require a review to be carried out by a knowledgeable person not closely involved in the original decision. An internal review of a decision will generally be required to be completed within 10 working days from a request being made, so long as required information for the review is available.

The bill will enable an applicant to apply for an external review about certain defined benefit matters by a dispute resolution body of a defined benefit dispute that is not resolved through internal review, or involves a decision that is exempt from internal review. The Attorney General will be able to declare an entity to be responsible for carrying out external reviews, through a disallowable instrument. The Government is actively seeking feedback from stakeholders and the community on which of the ACT's legal bodies should have jurisdiction for conducting these reviews, with options including the ACT Magistrates Court and the ACT Civil and Administrative Tribunal.

Courts and tribunals have adopted alternative dispute resolution mechanisms as part of their current case management processes and these processes will also be adopted as part of any external review.

The bill also contains processes to minimise the number of possible disputes regarding Whole Person Impairment assessments. An insurer cannot dispute the initial independent impairment assessment. An injured person that does not agree with this assessment will be able to obtain their own assessment from an appropriately trained examiner in accordance with medical guidelines set out in a disallowable instrument, and submit this to an insurer for review. As part of its review, the insurer then has the option of providing this alternate assessment to the original medical examiner for comment. An insurer can respond by affirming the original assessment or increasing the

assessment, with the assessment not to increase more than the second Whole Person Impairment assessment.

Other matters

The bill will carry over provisions from the CTP Act requiring compulsory motor accident injury insurance on registration of a motor vehicle in the ACT. A Motor Accident Injuries policy will insure against liability for personal injury resulting from a motor accident, and will also provide defined benefits, on a no-fault basis, to people injured in a motor accident. The Motor Accident Injuries Commission will continue to approve premiums for policies in the scheme. A nominal defendant fund, for the payment of claims for uninsured and unidentified vehicles as well as vehicles with an unregistered vehicle permit, will also continue to operate under the new scheme.

Under the new scheme the Motor Accident Injuries Commission will continue to licence scheme insurers. The majority of the licensing provisions in the CTP Act are being carried over to the bill, with some enhancements to reflect the new scheme. The Motor Accident Injuries Commission will also continue to have a range of enforcement powers in the bill, with some provisions from the CTP Act being updated to be consistent with other ACT provisions.

The bill provides the Motor Accident Injuries Commission with the power to collect information specified in regulations from both insurers and legal practitioners, in relation to applications and claims made under the new scheme. The bill also allows for publication of statistical data based on this information, by the Motor Accident Injuries Commission.

Chapter Overview

Chapter 1 Preliminary

In part 1.1 the new Act will be named the *Motor Accident Injuries Act 2018*. The removal of the reference to Third Party Insurance in the name of the Act reflects the new scheme now covering anyone injured in a motor accident. It is intended that the Act will commence on a day fixed by the Minister by written notice. The new scheme will cover death or injury of a person that results from a motor accident that happens in the ACT on or after the day the Act commences. It includes the standard application of Chapter 2 of the *Criminal Code 2002*. It also notes that the theft, fraud and forgery chapter of the Criminal Code applies.

Part 1.1 also includes new objects to reflect the priorities of the new Motor Accident Injuries Scheme including ensuring benefits are available to support all people injured in motor accidents on a no fault basis (subject to some exclusions and limitations), encouraging early treatment and care, and providing support for people injured in motor accidents to access defined benefits under the scheme. It further includes an object to promote and encourage the early, quick, cost effective and fair resolution of disputes.

Part 1.2 set out both injury and insurance concepts used in the bill. The bill includes the concept of a relevant insurer to identify the insurer responsible for a defined benefits application or common law claim. An interstate insurer of an at-fault vehicle (the relevant insurer) is required to pay defined benefits in accordance with the bill and can enter into an arrangement with another licenced insurer or the Nominal Defendant to manage the application. While the relevant insurer is determined based on rules of fault or deemed fault, this has no impact on an injured person's entitlement to defined benefits.

Part 1.2 also places general duties on both licensed insurers and applicants for defined benefits and claimants of common law damages to act in good faith and to endeavour to resolve a claim as fairly and expeditiously as possible. If a dispute body is hearing a dispute they may take a duty of a party into consideration, and make an order in relation to that duty. Insurers will also need to comply with their duties as a condition of their licence.

Part 1.3 establishes the Motor Accident Injuries Commission, and provides for the appointment of a Motor Accident Injuries Commissioner. In line with the recommendations of the citizens' jury, the Motor Accident Injuries Commission's functions have been expanded from those of the former CTP regulator to include providing information and assistance on the new scheme and a stronger regulatory and enforcement role.

Chapters 2 & 3 Motor accident injuries - defined benefits - Matters applying to both defined benefit and common law damages

Chapter 2 establishes entitlements to defined benefits for death or injury caused by a motor vehicle accident in the ACT. These benefits are for:

- income replacement;
- treatment and care;
- loss of quality of life;
- funeral expenses and death benefits.

An application should be lodged with a relevant insurer. The relevant insurer will be an at-fault insurer, or the most at-fault insurer, for an accident. Guidelines will specify which insurer an injured person should lodge their application with if they can't work out the relevant insurer. Insurers can enter into arrangements under the industry deed to determine which vehicle is most at-fault in a multi-vehicle accident. Where only one vehicle is involved in an accident, including an accident involving a cyclist or pedestrian, the insurer of that vehicle will be deemed to be the at-fault insurer. In the case of an unregistered or unidentified vehicle that is most at-fault the relevant insurer will be the nominal defendant. Vehicles with an unregistered vehicle permit are also covered by the nominal defendant.

A relevant insurer will be liable to pay defined benefits under the scheme. Arrangements for sharing the management and liability for defined benefits by insurers will be dealt with through the insurance industry deed.

Exemptions and exclusions

There will be certain exceptions and limitations to entitlements for defined benefits. A person who is convicted of a serious offence at the time of the accident will not be entitled to defined benefits. Treatment and care expenses, and income replacement, will still be payable while charges are pending. Examples of serious offences include:

- a high-level drink driving offence of a blood alcohol concentration level of 0.15g or more;
- aggravated furious, reckless or dangerous driving;
- causing the death of a person by using a motor vehicle.

Those convicted of a lower category driving offence will be entitled to treatment and care, but not income replacement (other than when charges are pending) and Quality of Life benefits. Examples of these types of offences are:

- a mid-range drink driving offence of a blood alcohol concentration level of between 0.08g and 0.15g;
- recklessly inflicting grievous bodily harm;
- driving while disqualified.

A 25 per cent reduction will be made to income replacement and Quality of Life benefits for people convicted of a low-level drink driving offence or that receive, and do not successfully challenge, certain infringement notices. Examples of these infringements are:

- not obeying the speed limit;
- not wearing a seatbelt;
- using a mobile phone.

If the coroner finds a person who died in an accident engaged in elements of conduct for a serious offence, then the estate of that person will not be entitled to death benefits. Funeral expenses can still be paid in these circumstances.

Other jurisdictions also have various exclusions for these types of offences. The exclusions reflect offences and infringements set out in the *Crimes Act 1900*, the *Criminal Code 2002*, the *Road Transport (Alcohol and Drugs) Act 1977*, the *Road Transport (Safety and Traffic Management) Act 1999*, the *Road Transport (Driver Licensing) Act 1999*, the *Road Transport (Driver Licensing) Regulation 2000* and the *Road Transport (Road Rules) Regulation 2017*.

Income replacement and Quality of Life benefits will generally not be payable to the injured driver or owner of an unregistered vehicle. Some exceptions will apply if the driver was not at-fault, did not know the vehicle was uninsured, or was involved in a blameless accident (e.g. collision with an animal). A person whose injuries are self-inflicted will only be entitled to treatment and care benefits; funeral benefits can be paid in the event of their death. Entitlements to treatment and care expenses will be restricted for people in custody and there will be no entitlement to defined benefits for accidents caused by acts of terrorism. A person who is a foreign national will not be entitled to defined benefits to the extent their injuries are covered by insurance they hold for their stay.

Information and support for applicants by insurers

The guidelines will make provision for information and support to be provided by insurers to applicants for defined benefits. Information and support will be required to be provided to applicants on their first contact with an insurer, on receipt of an application, on acceptance of liability for an application, and six months after an accident when a person may be eligible for a Quality of Life payment. An insurer will also be able to directly contact an applicant (whether or not an applicant has legal representation) to give the applicant information or to discuss the applicant's defined benefits including their treatment and care needs. It is intended that information will be given simultaneously to the applicant and their representative (if there is one) to expedite the person receiving their entitlements.

Application for defined benefits

An injured person seeking defined benefits payments for treatment and care and income replacement needs to make an initial application within 13 weeks of an accident. Late applications may be accepted up to two years after an accident if a full and satisfactory explanation is given. An example of a full and satisfactory explanation would be if a person injured in a motor accident becomes aware of their injury sometime after this takes place.

Details of the form and content of an application, and the manner an application can be made, will be set out in guidelines.

An application will need to include a signed authority to disclose personal health information so this information can be dealt with by the insurer and exchanged between them and an injured person's treating health service providers, members of their treating team, or an independent medical examiner. The authority will be given for the purposes of processing, assessing or otherwise managing a person's application and ongoing entitlement for defined benefits. An applicant will be able to withdraw this authority, but a withdrawal will delay the payment of defined benefits.

The guidelines will require that, at a minimum, an application contain information about the time, date, location, circumstances and vehicles involved in an accident and also include:

- notification of the details to the police (AFP Crash report) or police accident report; and
- a medical report certifying the injuries are consistent with a motor vehicle accident.

Guidelines will also require an insurer to pay for an initial medical consultation, and up to two allied health services, provided prior to making an application. Receipts or invoices for these services will be able to be submitted with an initial application.

Applications for defined benefits should be lodged with a relevant insurer. Guidelines will give insurers three business days to acknowledge receipt of a complete application. Applicants will also be given an individual claim identifier. An insurer then has up to 28 days to accept or deny liability for the application.

Certain allowable treatment expenses will be approved for reimbursement from receipt of an application irrespective of whether an insurer has made a decision to accept liability for an application (see the treatment and care benefits section below). Arrangements will also be put in place to transfer an application to a different insurer where it is determined that the other insurer is the relevant insurer for an application. An insurer that provides a receipt notice, and then does not accept liability for a valid application, will have a right of recovery for these expenses from the relevant insurer but not directly from the applicant.

The requirements for applications for funeral and death benefits will be set out separately in guidelines and will be subject to different timeframes. To receive Quality of Life benefits, an initial applicant for defined benefits will also need to apply to their insurer for a Whole Person Impairment assessment once their injury has stabilised.

Income replacement benefits

These payments compensate people for income lost through being unable to work, or through working at a reduced capacity, because of their injury.

To be entitled to payments a person needs to show they had a connection with the workforce at the time of the accident. Eligible people include those in paid work and those who have worked at least 260 hours in the last year, as well as people that would join or return to the workforce at a later date, including full-time students over 15 years of age. In this case, payments will not start until the date a person was anticipated to join or return to the workforce.

Payments will generally be based on a person's pre-injury income, being their average weekly income during the 52 weeks prior to an accident. A shorter income period may apply for people who have a significant change in circumstances, such as starting a new job, or moving from part-time to full-time work during the period. Special rules will apply for calculating weekly income for people joining or returning to the workforce.

An employee's income will include all amounts of income from employment other than compulsory superannuation contributions, or one-off amounts payable on termination of employment. A self-employed person's income will be the net income they derive from carrying on a business to the extent the income is attributed to personal services the person provides to that business. A person will be able to combine income received from multiple employers, or self-employment arrangements.

An injured person with a recent work history will be able to start to receive payments from the time an insurer accepts liability for their application. If an insurer is still gathering information to calculate the actual amount of a payment, the insurer may make interim income payments, covering up to the first 13 weeks after an accident so long as the application was made within 13 weeks of the accident. Regulations will set the minimum amount of an interim payment as a prescribed percentage of the pre-injury weekly income cap (\$2,250).

If an application is lodged within 13 weeks of an accident, payments can be backdated to the time of the accident. If a late application is accepted, payments will only be backdated four weeks prior to the application, other than in exceptional circumstances. Payments can be made for up to five years after an accident.

For the first 13 weeks (first payment period) payments will be made at 95 percent of pre-injury weekly income (pre-injury weekly income is capped at \$2,250) and then 80 percent thereafter (second payment period with the pre-injury weekly income cap still applying). A low income adjustment will apply, with people who had pre-injury weekly income below \$800 receiving full income replacement, and those with weekly income from \$800 to \$1,000 receiving 95 per cent replacement. Payments, thresholds and caps will be indexed in line with adjustments to Average Weekly Earnings on a biannual basis. Apprentices, trainees and junior workers will also receive adjustments to their payments for increments they may have otherwise received.

Ongoing payments will be subject to an injured person providing a fitness for work certificate. The amount of a person's pre-injury weekly income will be reduced to the extent that a person receives earnings from any work, or has the capacity to work after an accident. Insurers will be required to follow guidelines when making decisions to stop or reduce payments based on a person's capacity to work. A person that has been in continuous receipt of payments for at least four weeks will be given at least two weeks' notice of such a decision. An insurer can also suspend payments if a person does not comply with a request for a medical or vocational assessment, or undertake the treatment outlined in a recovery plan. A person will also cease to be entitled to payments once they reach age pension age plus six months.

An injured person may ask an insurer to reimburse their employer for the cost of any paid leave taken as a result of the person's injury, in lieu of receiving income payments.

Example 1

Suzy was hit by a car while riding her bicycle on David Street, Turner on 2nd November 2019. She suffered a fractured collar bone, concussion and lacerations to her face and limbs. At the time of the accident Suzy was 19 and in her first year of full-time university studies. She was working casually as a barista at a coffee shop, and also had recently worked as a football referee.

Suzy lodges an application for personal injury benefits with the car's Motor Accident Injuries insurer on 16 November 2019.

Suzy's treating doctor provides her with a certificate stating that she is unfit to work as a barista for eight weeks following the accident. Suzy downloads electronic payslips from her two employers showing she worked a total of 620 hours during the 52 weeks prior to the accident, and received gross income of \$15,800. She provides these documents to the insurer with her application.

The insurer forms the view that given the nature of Suzy's injuries, she does not have any capacity to undertake any other type of work during the eight weeks following the accident.

Suzy's average weekly income will be calculated as:

$$\$15,800 \div 52 = \$303.85$$

As this income is less than \$800 per week, Suzy will be entitled to full income replacement payments of \$303.85 per week for at least eight weeks following the accident. These will be back-paid to Suzy from the date of the accident.

As Suzy has a recent work history, it does not matter that she was also a full-time student at the time of the accident, or that she earns her income on a casual basis.

Treatment and care benefits

Certain treatment expenses (allowable expenses) will be automatically approved during the first four weeks from the receipt of an application and will be paid on a reimbursement basis. This will ensure access to early treatment and care is not delayed. Under the guidelines allowable expenses are likely to include:

- up to four services from a general practitioner; and
- up to eight allied health services where a doctor's referral has been provided.

Once liability for an application is accepted, an injured person will be entitled to defined benefits for their reasonable and necessary treatment and care needs, including for paid domestic services and care. An injured person will also be entitled to benefits to pay for domestic services if they can no longer provide to a child or other dependant who was in their care before the accident.

Treatment and care expenses will not be payable to participants in the Lifetime Care and Support (Catastrophic Injuries) Scheme.

In assessing whether an application for treatment and care is reasonable and necessary, an insurer will be required to consider whether the treatment and care is:

- directly related to a person's injury;
- cost effective;
- appropriate for the injury; and
- will benefit the person.

Treatment and care must also be provided by an appropriately qualified professional or a bona fide service provider.

Guidelines will stipulate what constitutes reasonable and necessary care, amounts and limits on benefits payable, and the evidence required to verify treatment and care needs and costs.

When acknowledging liability for an application insurers must provide information about the procedure for approval and payment of treatment and care expenses. If an application is received within 13 weeks of an accident, reasonable and necessary treatment and care expenses not already paid will be back-paid to the time of the accident. For late applications, expenses will be back-paid to 13 weeks from the date of receipt of an application unless exceptional circumstances apply.

A tailored recovery plan to manage and coordinate the delivery of medical treatment, rehabilitation and training services will be required for people with ongoing incapacity. Guidelines will set out how a plan is developed and what needs to be included in a plan, and an injured person's obligations under a plan.

A plan must be developed for any applicant who is unable to resume their pre-injury duties and activities within 28 days from receipt of their application. These plans will be reviewed at 13 week intervals by the insurer. Treatment and care in this plan will be pre-approved as reasonable and necessary treatment and care and providers will be able to bill an insurer directly. A plan will generally need to be given to an injured person and their doctor within 28 days after the receipt of an injured person's application for defined benefits. A longer period will apply if a person was hospitalised after an accident, or medical information is still being gathered for the plan.

An insurer will generally rely on medical assessments carried out by a person's own doctor or health practitioner when preparing a recovery plan or making decisions about their liability to pay benefits. This will minimise stress on an injured person and avoid the cost of multiple assessments.

An insurer may contact a person's doctor so that a medical report can cover specific information required by the insurer. They can also request an independent medical or vocational assessment. Guidelines will stipulate how and when this can happen.

Treatment and care expenses will generally be payable in arrears and cannot be commuted to a lump sum. All expenses will need to be verified in accordance with guidelines. Expenses can be paid for up to five years after an accident.

Funeral and death benefits

If someone dies as a result of injuries from a motor vehicle accident within two years of this accident, a lump sum benefit will be payable to the deceased person's estate for their spouse and up to four children at the time of the accident. The amounts payable are \$190,000 for a spouse and \$40,000 for each child, and will be indexed annually.

A spouse can include a person in a domestic partnership at the time of an accident, or a former domestic partner if that former partner was financially dependent on the deceased at the time of the accident. The definition of a child will include all children of the deceased including adopted children and other non-biological children. A child will include any person under 18 years, any person under 25 years enrolled in full-time study, and adult children with a permanent disability who were financially dependent on the deceased at the time of the accident.

A lump sum benefit will not be payable if the deceased person received a Quality of Life payment prior to their death.

The defined benefit scheme also covers funeral expenses of up to \$15,000 for a person who dies as a result of a motor accident. A person's personal representative, or another person liable to pay these expenses, may make an application for these benefits.

Applications for funeral and death benefits must be made within 13 weeks of a person's death unless the insurer accepts a full and satisfactory explanation from an applicant. An insurer may accept a late application up to 12 months after a person's death.

Quality of Life benefits

A person will be eligible for defined benefits for the loss of Quality of Life if they receive a Whole Person Impairment assessment of five per cent or more as a result of injuries sustained in the motor vehicle accident. A higher quality of life benefit can be pursued through a common law claim, if a Whole Person Impairment assessment is 10 per cent or more.

A scaled formula is set out in the bill for calculating Quality of Life defined benefit payments. A maximum payment of \$350,000 is payable to a person with a Whole Person Impairment of 100 per cent. Each dollar amount in the scaled formula will be indexed annually in line with adjustments to Average Weekly Earnings. The Motor Accident Injuries Commission will make a notifiable instrument setting out the Quality of Life defined benefit payments for each level of Whole Person Impairment on commencement of the new scheme, and then on each subsequent indexing day. An insurer may delay paying an indexation adjustment, if an instrument is not made until after an indexing day.

Whole Person Impairment assessment

Chapter 2 deals with the process and procedures for obtaining a Whole Person Impairment assessment, for both defined benefits and common law damages.

An assessment of Whole Person Impairment will need to be provided by an independent medical examiner, selected and provided by the appointed service provider. Neither insurers nor legal representatives will play a role in selecting the medical expert to conduct an initial Whole Person Impairment assessment. The Motor Accident Injuries Commissioner will authorise service providers with appropriate expertise in arranging independent assessments. A deed of services will set out operational requirements for a service provider and will include a schedule of fees for Whole Person Impairment assessment services.

An assessment must be conducted in accordance with medical guidelines set out in a disallowable instrument. The Safe Work Australia Guidelines for the evaluation of permanent impairment will be adopted for these purposes. These national guidelines are largely based on the *American Medical Association Guides to the evaluation of Permanent Impairment* (5th Edition) (referred to as AMA5), with certain modifications for some bodily systems.

The bill includes provision for guidelines to be made for insurers to provide information to a personal injury applicant. The guidelines will require, for example, that six months after an accident an insurer must give an applicant sufficient information for them to make an informed decision about pursuing a defined benefit or common law Quality of Life payment. This will include information about the criteria for these payments and the process for applying for a Whole Person Impairment assessment.

These assessments cannot be undertaken earlier than 26 weeks from the date of the accident, and generally not later than four years and six months after an accident. Whole Person Impairment assessments can be conducted only after the injured person and the insurer agree an injury has stabilised. If an injury has not stabilised after four years and six months, a Whole Person Impairment assessment will be carried out at this time.

An insurer must arrange a Whole Person Impairment assessment, on application, if the available information indicates that a person is likely to have a permanent impairment. If an insurer does not believe a person has a permanent impairment, the applicant may still request a Whole Person Impairment assessment, but will need to pay an excess to the insurer for this cost. The proposed excess will be the greater of \$500 or 25 per cent of the cost of the assessment. The excess will be refundable if the person is assessed with a Whole Person Impairment of at least one per cent. The guidelines will stipulate how the insurer is to make a decision on whether a person has a permanent impairment.

If a Whole Person Impairment assessment is between five per cent and nine per cent, the insurer must offer the applicant a defined benefit Quality of Life payment. The applicant will have 26 weeks to accept the offer. It is open for an applicant to seek an alternative Whole Person Impairment assessment, at their own expense, and submit the assessment to the insurer for reconsideration. The insurer will have processes and strict rules they must follow if an applicant disagrees with their Whole Person Impairment assessment and during any offer process. If an applicant seeks an alternative assessment, and disagrees with the subsequent final offer by the insurer, the applicant may seek an external review of the decision.

If the Whole Person Impairment assessment is 10 per cent or more, a defined benefit offer may also be made but the insurer must inform the applicant that accepting this offer will disqualify them from accessing common law Quality of Life benefits. The same processes available to the five per cent and nine per cent Whole Person Impairment will apply to an applicant who is unable to claim common law Quality of Life benefits. If an applicant is able to proceed to common law, the applicant may accept a defined benefit Quality of Life benefits offer at any time up to the end of the defined benefit period, for example, if they were unsuccessful in their common law claim.

Example 2

Sarah was stopped at lights on Northbourne Avenue while driving her Toyota sedan and was wearing her seatbelt when she was rear-ended by another car. Sarah was taken to hospital by ambulance. As she was complaining of posterior neck pain, the ambulance officers placed a cervical collar on Sarah. At hospital, Sarah was assessed as being neurologically normal. She was discharged home with painkillers and a soft collar. She had no significant past history of neck injury.

At home Sarah persisted with normal activities, but attended a physiotherapist over a period of a couple of months, with her need for physiotherapy diminishing thereafter. She was able to continue with her normal part-time clerical work and was not required to take any time off work.

At eight months post-accident, Sarah was experiencing intermittent daily headaches and mild posterior neck pain, and stiffness in the neck. Her daily activities remained essentially uninterrupted and she had no difficulty with her personal care. Every so often (about once a week) she experienced transient pain radiating into her left arm to the left thumb and index finger. Her insurer determines that Sarah's injury has stabilised and she is likely to have a permanent impairment.

The insurer arranges an assessment through the approved service provider for an independent Whole Person Impairment assessment. Sarah receives a Whole Person Impairment classification of five per cent. The insurer pays the scheduled fee for the assessment and accompanying report. As the Whole Person Impairment assessment is five per cent, the bill specifies the quality of life payment to be \$7,000.

Sarah's insurer makes an offer of a payment of \$7,000. This offer remains open for 26 weeks from the 15 July 2020. Sarah chooses to accept the offer on 18 July 2020.

Injured people residing overseas and foreign nationals

Special provisions have been included in the bill to assist insurers with paying defined benefits to Australians living overseas and foreign nationals.

An Australian citizen or permanent resident who lives overseas, or intends to live overseas for an extended period, may receive defined benefits through a periodic payment. Guidelines will make provision for determining the period that a person must live overseas, and the amount and frequency of payments that can be made to a person.

A relevant insurer may enter into an agreement to pay defined benefits to a foreign national as a lump sum amount. Guidelines will make provision for the eligibility of a foreign national to enter into an agreement, the defined benefits that may be taken into account when calculating a lump sum payment, and procedures for paying defined benefits prior to an agreement being made.

Interactions with workers compensation schemes

The final bill will contain provisions so injured people covered under a workers compensation scheme have the choice of receiving defined benefits under either their workers compensation scheme or the new Motor Accident Injuries scheme. A person who starts to receive worker compensation benefits will also be able to switch to the new Motor Accident Injuries scheme within one month of making a workers compensation claim. A person who receives workers compensation benefits or a workers compensation settlement will also be able to receive top up benefits under a Motor Accident Injuries common law claim.

Dispute resolution

The introduction of defined benefits will result in a new category of disputes, as an applicant and insurer may not agree about entitlements to defined benefits. Part 2.10 provides for timely and cost effective dispute resolution processes, with an internal review of an insurer's decision generally being required before engaging with an external dispute resolution body.

Internal review

An insurer must review a decision relating to defined benefit entitlements, including a request for an impairment assessment, on request from an applicant. A request will generally need to be made within 28 days of an insurer making a decision, unless exceptional circumstances apply.

The review is to be carried out by a knowledgeable person not closely involved in the original decision. An applicant may provide new information to an insurer (such as an alternative medical assessment or evidence of financial dependency) that was not available at the time of a decision, for the purposes of the review. An insurer may also invite an applicant to an informal conference as part of the review. A request for internal review will not stay a decision of an insurer or otherwise prevent an insurer from acting on a decision.

Under proposed guidelines an internal review will generally need to be completed, and the applicant informed of the outcome, within ten business days of a request being received by an insurer. The guidelines will also include criteria for accepting late requests for a review, providing an extension for review and notification time frames.

External review

The bill will enable a dispute regarding certain defined benefit matters that is not resolved through internal review, or involves a decision that is exempt from internal review, to be decided by external review. The guidelines will make provision for how an application is to be made, and to limit the time a person may apply, for external review. There is no stay on a decision where an application for external review is made. An external review decision will be binding on all parties.

Power is given to the Attorney-General to make a declaration conferring jurisdiction on an external review entity. The Government is seeking input on the appropriate legal bodies to hear Motor Accident Injuries Scheme disputes, and this component to be addressed in the final bill.

Regulations will be made on the types of matters that will be covered by internal and external review processes. The following areas of the scheme have been identified as likely dispute points:

- the payment of treatment and care expenses
- a person's capacity to work after an accident
- the determination of income replacement benefits
- whether a person was a dependant of a deceased person

- liability disputes (e.g. whether an injury was caused by the motor accident), and
- disputes regarding Whole Person Impairment assessments.

Legal Costs

Regulations will be able to be made prescribing the legal costs payable by applicants and insurers for legal services relating to defined benefit applications. This provision is intended to regulate legal costs and fees so as to ensure these are appropriate within the overall scheme and will specify what legal services will be payable by the new scheme (by insurers). The regulation will not limit an applicant being able to obtaining legal assistance from a lawyer.

Information support services

As part of improving access to information about the scheme, the Motor Accident Injuries Commission may approve a body to provide information support services for applicants under the new scheme. For example, the Motor Accident Commission could approve a community legal service to provide this service but cannot approve an individual lawyer to provide services.

Guidelines will make provision for approving information support services, including the qualifications of providers, and the services to be provided. The regulations will set out a schedule of fees that insurers will be required to pay for a given service.

Chapter 3 - Motor accident injuries – common law damages

The chapter provides for common law damages for death or injury in a motor vehicle accident caused by someone else's fault.

Claims will be able to be made by people who are more seriously injured in a motor vehicle accident that are receiving, or have previously received, personal injury defined benefits. The court will determine a claim in accordance with the personal injury claims procedure in the *Civil Law (Wrongs) Act 2002*, the court procedures rules and the common law.

The bill includes specific provisions for motor vehicle accident claims. To pursue a claim through common law, a person's injury must have been caused by someone else's fault and they must have a Whole Person Impairment assessment of 10 per cent or more. In a blameless accident, the driver is deemed to be at-fault for the purpose of others being able to make a common law claim; for example where a driver suffers a medical incident or strikes wildlife. The period of time that a person can lodge a claim for common law damages has been extended to be five years from the date of an accident.

A notice of claim in accordance with the *Civil Law (Wrongs) Act 2002* will be required to be given to the at-fault insurer within three months of the Whole Person Impairment report. This is to allow the person the time to make a decision about whether to proceed with a common law claim but also allow the at-fault insurer to be put on notice that a common law claim is being made. Provision has been made for a Whole Person Impairment assessment in the event an injury has not stabilised, so that a person can have an estimate of their Whole Person Impairment at four years and six months, in order to be in the position of submitting a notice of claim and commence proceedings within the five year limitation period.

The conference provisions previously provided for in the CTP Act have been carried over to this bill, to continue to encourage the settlement of a claim before court proceedings occur. This includes the mandatory final offer process. Where damages over \$50,000 are awarded, excluding Quality of Life damages, costs may be awarded according to whether the amount was more or less than the amount of the mandatory final offer.

Caps will apply to damage amounts.

There is no cap on the amount of treatment and care expenses payable for a person under a common law claim, or limits on the amount of time that these expenses can be paid. However, no damages can be awarded for treatment, care, support or services provided to an injured person where payment has not occurred or where there is no liability to pay. For example, benefits will not be paid when domestic assistance is provided by a partner on an unpaid basis.

Damages for loss of earnings may not be awarded for the income replacement amounts paid for the first 12 months from an accident. This is because these amounts are paid under the defined benefit scheme. After the first 12 months, the maximum amount of damages for loss of earnings is capped at \$4,500 per week, in accordance with the current provisions in the *Civil Law (Wrongs) Act 2002*.

Consistent with defined benefits, non-economic loss has been replaced by Quality of Life damages. A scaled formula is set out in the bill for the purposes of calculating Quality of Life payments under common law. These amounts are more generous than amounts for an equivalent degree of impairment available under the defined benefit scheme. A maximum amount of \$500,000 is payable to a person with a Whole Person Impairment of 100 per cent. A person who has already accepted a Quality of Life defined benefit payment will be unable to then claim an equivalent payment under common law.

Damages can also be awarded in common law for dependants of a deceased person, but to remove duplication payments will be reduced by any death benefit and Quality of Life amounts paid through the defined benefit scheme.

Chapter 4 - Motor accident injuries insurance

This chapter carries over provisions from the CTP Act requiring compulsory motor accident injury insurance on registration of a motor vehicle in the ACT. A Motor Accident Injuries policy will insure against liability for personal injury resulting from a motor accident, and will also provide defined benefits, on a no-fault basis, to people injured in a motor accident.

The Motor Accident Injuries Commission will continue to regulate premiums charged by insurers for Motor Accident Injuries policies, based on compliance with premium guidelines and independent actuarial advice on whether a premium meets the fully funded test and is not excessive. Guidelines will specify how premiums are to be worked out and what additional information the Motor Accident Injuries Commission requires insurers to provide with a premium filing. The guidelines will continue to require information on claims handling expenses, interest earned on investments, inflation assumptions and return on capital. All these factors are considered by the scheme actuary when assessing premiums.

A nominal defendant fund will also continue to operate under the bill for the payment of defined benefits and claims for uninsured, unidentified vehicles and vehicles with an unregistered vehicle permit.

This chapter also includes provisions enabling the recovery of costs from an injured person, by a Motor Accident Injuries scheme insurer and the nominal defendant. These are based on existing provisions in the CTP Act for premium fraud, intentional injury and alcohol or drugs affecting a driver's ability to control a vehicle. Provision is also made for an insurer to recover costs from a manufacturer or repairer for a defective vehicle, and for the nominal defendant to recover costs from the responsible person for an uninsured or unidentified motor vehicle.

Chapter 5 – Motor Accident Injuries scheme insurer licences

Under the new scheme the Motor Accident Injuries Commission will continue to licence Motor Accident Injury scheme insurers, with insurers being required to apply for licences for the new scheme. The licencing process will be streamlined for existing licenced insurers, given the CTP regulator currently holds information in relation to those insurers. The type of information required is likely to include documents such as a new business plan covering how the insurer will meet the defined benefit requirements for the new scheme. The majority of the licensing provisions in the CTP Act are being carried over to the bill, with some enhancements for the new scheme.

The bill will impose additional conditions on an insurer’s licence, including requirements to manage applications for defined benefits in a timely and efficient manner, and to achieve the early payment of reasonable and necessary treatment and care for injured people. The scope of the insurance industry deed will also be expanded to include provisions dealing with applications for defined benefits. Improvements are also made to provisions dealing with the suspension or cancellation of an insurer’s licence, including on the transfer of a licence to another insurer. New provisions have been included that will authorise the Motor Accident Injuries Commission to report on the net profitability of licensed insurers.

Chapter 6 - Enforcement

The Motor Accident Injuries Commission will also continue to have a range of enforcement powers under the bill, with some provisions from the CTP Act being updated to reflect provisions in other ACT legislation and to remove impediments to the conduct of investigations. In particular, a provision has been included for the Motor Accident Injuries Commission to appoint a public servant as an authorised officer for the purposes of exercising enforcement powers under the bill. The CTP Act formerly gave this power to the road transport authority.

Provision is also made for these officers to be given identity cards and for these cards to be shown when an authorised officer exercises a power under the bill. The general powers of an authorised officer that enters premises also now include a specific power for an authorised officer to examine and take copies of documents relating to possible contraventions of the bill.

Chapter 7 - Information collection and secrecy

The chapter includes provisions to enable licensed insurers to share information between themselves and, in the event it is required to be given to another party – for example a health service provider. This may occur where an insurer shares liability for a claim, or another insurer is liable or potentially liable for an application. The applicant will be advised that their information may be shared. The information sharing provisions have been drafted to ensure the protections provided by the *Health Records (Privacy and Access) Act 1997* and the *Privacy Act 1988 (Cwlth)* continue to operate in relation to the information, including the giving of consent.

Chapter 8 - Miscellaneous

This chapter includes miscellaneous provisions dealing with the operation of the new scheme, including the power for the Motor Accident Injury Commission to issue scheme guidelines and also for those guidelines to make provision for making forms. The Motor Accident Injuries scheme guidelines will be a disallowable instrument under the bill and so are legally binding.

The Minister will set the motor accident levy, to fund the Motor Accident Injuries Commission's operations, and the Commission must refund a proportion of the levy on the cancellation of the registration of a motor vehicle. The chapter also includes a regulation-making power and enables the Minister to determine fees for the new scheme. A fee determination will be a disallowable instrument. The operation of the new scheme will be reviewed as soon as practicable after the end of every third year of its operation.

The bill will also repeal the CTP Act, and regulations and all other legislative instruments made under the CTP Act.

Referral fees

The bill will prohibit payments by a lawyer for referrals of applications or claims for legal representation, or for lawyers to receive payments from other service providers. A payment is defined to include any fee or financial benefit. These provisions will assist in ensuring that legal services are provided on an impartial and cost effective basis, and the selection of key service providers such as medical assessors is not compromised.

The prohibition of referral fees will assist with deterring claims farming practices that involve members of the public receiving cold calls or social media prompts, seeking personal details regarding possible involvement in car accidents. These claim farmers encourage people to make a compensation claim. They then sell these details, for a commission, to legal firms.

Schedule 1 - Consequential amendments

Schedule 1 makes a number of consequential amendments to the Civil Law (*Wrongs*) Act 2002, and other road transport legislation, to replace references to the CTP Act with references to the new Act. There are also some modifications made to the Civil Law (*Wrongs*) Act to reflect time frames for making common law claims under the new scheme and to tailor provisions so they reflect motor accident claim procedures. A new limitation period for motor accident claims has been inserted into the *Limitation Act 1985* to place a five year limit on commencing a motor accident injury claim.

Dictionary

Provides for the terms used in the bill.

Transitional provisions to be included in the bill when introduced

The final bill will contain transitional provisions between the old and new schemes. The provisions will enable the CTP Act to apply to any existing claims made under that Act as if that Act had not been repealed. A CTP policy will continue to remain in place until the earlier of the policy being replaced by a Motor Accident Injuries policy, or the ending of the grace period for the renewal of registration. If a personal injury arises out of a motor accident prior to the day the new Act comes into operation, the claim will be dealt with as if the new Act had not been enacted. A CTP policy with a duration that extends beyond the day the new scheme commences will automatically transition to a Motor Accident Injuries policy on the date the new scheme commences. Transitional provisions will enable the Motor Accident Injuries Commissioner to direct the application of any unearned premium surplus, as a result of a CTP policy transitioning to a Motor Accident Injuries policy.

The provisions will also state that the person who was, immediately before the operational day, the CTP regulator, will be taken to be appointed as the Motor Accident Injuries Commissioner. The nominal defendant will continue to have the rights and liabilities under the new scheme that it currently has under the CTP Act.

Consultation

The Justice and Community Safety Standing Committee of the ACT Legislative Assembly is conducting an inquiry into the provisions of the exposure draft of the *Motor Accident Injuries Insurance Bill 2018*.

Submissions can be lodged via the Committee's website: <https://www.parliament.act.gov.au/in-committees/standing-committees-current-assembly/standing-committee-on-justice-and-community-safety>



Andrew Barr
Treasurer

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