

Model Designs

Citizens' Jury for ACT CTP Scheme

March 2018

9 March 2018

Members of the Citizens Jury
c/o democracyCo
c/o Chief Minister, Treasury and Economic Development Directorate
ACT Government
GPO Box 158
Canberra ACT 2601

Dear Jurors

Model Designs

It has been my pleasure to be responsible for developing four possible models for a reformed CTP scheme for your consideration at your meeting on March 24 and 25, 2018.

I wish to acknowledge and thank all the members of the Stakeholder Reference Group for their active participation and critique during the development process.

Best wishes for your deliberations. I look forward to joining you at the meeting and answering any questions you may have.

Yours sincerely

A handwritten signature in black ink, appearing to be "Geoff Atkins", with a long horizontal flourish extending to the right.

Geoff Atkins
Fellow of the Institute of Actuaries of Australia

Sydney

Tel +61 2 8252 3300
Level 7, 68 Harrington Street
The Rocks, NSW 2000

Finity Consulting Pty Limited

Melbourne

Tel +61 3 8080 0900
Level 3, 30 Collins Street
Melbourne, VIC 3000

ABN 89 111 470 270

Auckland

Tel +64 9 306 7700
Level 5, 79 Queen Street
Auckland 1010

finity.com.au / finityconsulting.co.nz

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1 Introduction

1.1 The Citizens Jury

In 2017 the ACT government commenced a ‘deliberative democracy’ process to consider the CTP scheme in the ACT.

Part of that process was to convene a citizens jury and, on 29 October 2017 the jury issued its report setting out the objectives it had agreed for a reformed scheme.

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.

The activities of the jury and the overall deliberative democracy process are available at www.yoursay.act.gov.au. We understand that this report will be published on that website.

1.2 Outline of this Report

Section 2 summarises the four models and their key elements. Section 3 sets out in detail the entitlement to make a claim and the benefits available to an injured person under each model.

Section 4 deals with the support available to injured people and the processes for resolving disputes. Section 5 deals briefly with premiums and scheme costs, and Section 6 covers some other issues about the coverage provided by the CTP scheme.

1.3 Terminology

Where possible in the report we have tried to limit the amount of jargon and to use words and labels consistent with those in the jury report. There is a glossary of terms and abbreviations in Appendix A.

2 The Models

There are four proposed models: A, B, C and D.

Each model is structured and defined by:

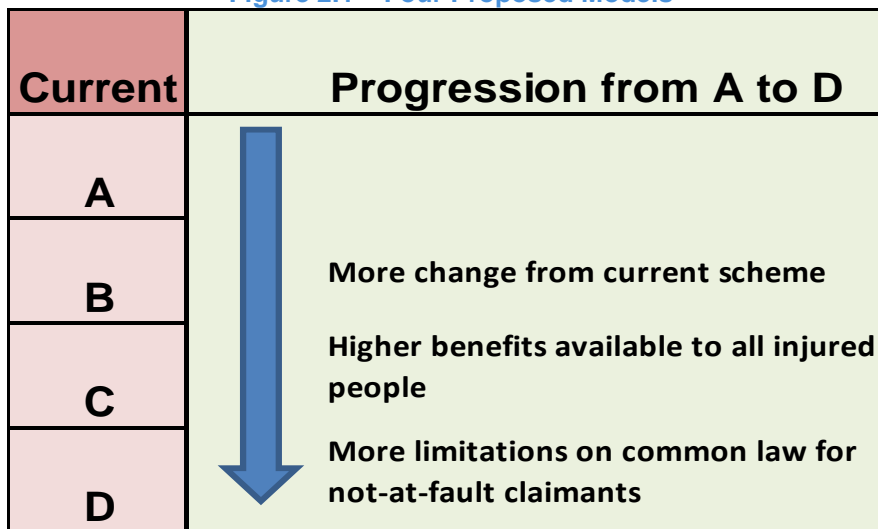
1. Benefits which are available to injured people regardless of fault – the ‘defined benefits’
2. Benefits which are available via common law (legal action) for injured people who are not-at-fault.

The key differences between the models are the level of defined benefits (this increases on a spectrum from A to D). As the defined benefits increase, there is greater limitation on the benefits available at common law for not-at-fault claimants, generating overall reductions in the estimated premium required to fund the scheme.

In the current scheme:

- There is an early payment available for up to \$5,000 in medical costs
- Not-at-fault claimants have unrestricted access to common law, and there are no limits on the compensation they may receive apart from those in the Civil Liability law that applies to all personal injury claims in the ACT.

Figure 2.1 – Four Proposed Models



2.1 Understanding the Models

This section sets out some background information relating to the proposed models. It discusses the payment types and some other key features.

2.1.1 Treatment

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”.

2.1.2 Domestic Care

This benefit relates to payment for domestic care – assistance with bathing, housework etc. Scheme payments (if eligible):

- Provide reimbursement for commercial care (“paid care”)
- Compensate for care provided on an unpaid basis (generally family) and/or for care that the injured person can no longer provide to others (“gratuitous care”).

2.1.3 Income Replacement

This payment type compensates an injured individual for lost income when they are unable to work:

- In the defined benefits context, it compensates for actual (past) lost earnings.
- Under common law there may also be compensation for expected **future** lost earnings, termed “loss of earning capacity”. This will generally include an additional allowance for lost superannuation.

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.

2.1.4 Quality of Life (QoL)

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”.

The methods used to assess QoL payments (whether in defined benefits or common law) are discussed in Section 3.7.

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.

2.1.5 Death

Payments may include reimbursement of funeral costs, and additional payments for individuals who were financially dependent on the claimant.

2.1.6 Thresholds

It is common for schemes to have ‘thresholds’ which apply to restrict access to some benefit types, or to limit the duration of payments; this draws a line between ‘more serious’ claims and other claims. For example:

- There may be a threshold for access to QoL payments
- Access to long term income replacement may be subject to a threshold.

Introducing thresholds limits total scheme costs, while shifting the balance of scheme payments towards the more seriously injured.

Thresholds will often be defined as a minimum Whole Person Impairment (WPI) or Injury Scale Value (ISV); see Section 3.7.

2.1.7 Indexation of Amounts

There are many dollar figures quoted in this report, such as for maximum weekly benefits or QoL payments. In each of the models, dollar amounts will be increased each year based on Average Weekly Earnings. This indexation maintains the level of benefits in real terms.

2.1.8 Information and Guidance

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.

2.1.9 Legal Support

Many injured people will need support in making their claims. Under all four proposed models, support from a legal adviser is available to all. There are no new regulations regarding legal costs in the common law part of the system.

One area which is discussed is solicitor-client fees; under the current common law arrangements, these fees – payable by claimants to their solicitors – are paid from the settlement amount. Disclosure to the claimant and the regulator of these fees and their makeup will be required under each of the proposed models.

2.1.10 Dispute Resolution

The proposal is that, if the injured person and the insurer cannot reach a negotiated agreement, disputes would be resolved as follows:

- Defined benefits – primarily under the jurisdiction of the Magistrates Court, with the possible use of ACAT for low value disputes
- Common law – via the courts, as happens now.

2.1.11 Determining Fault

It is proposed that two changes will be made to the current scheme (in all models):

- That common law benefits would be available to people injured in so-called ‘blameless accidents’ (see Section 3.1.1)

- That no ‘contributory negligence’ deductions would be made for children under age 16 (see 3.1.2).

2.2 The Four Models

In each of the tables that summarise the models, the middle column summarises the benefits available regardless of fault. The right-hand column outlines benefits available under common law for those who were not at fault. Those who are not at fault are entitled to both the defined benefits and the common law compensation, although there is no ‘double dipping’.

2.2.1 Model A

Model A is similar to the current scheme, but defined benefits for up to 6 months are available to all.

Table 2.1 – Model A

Benefit Type	For all: Defined benefits	Available to not-at-fault: (additional benefits via common law)
Treatment	6 months	Unlimited
Domestic care	6 months Paid care only	Unlimited Includes gratuitous care
Income replacement	6 months 95% of pre-injury earnings for first 3 months 80% thereafter Low income adjustment ¹	No time limit 100% of loss of past earnings and future earning capacity + Superannuation
Quality of life	Nil	Maximum \$500,000 Amount based on ISV ² and guidance scale
Death	Funeral cost	Funeral cost + common law for dependants

¹ Allows greater than 95%/80% for low income individuals. See Section 3.5.1.

² Injury Scale Value. See Section 3.7

During the six-month defined benefits period, the injured person can focus on recovery and determine whether someone else was at fault. If at six months the outcome in relation to determining fault is:

- **The injured person was at fault** – benefits cease.
- **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.
- **Disputed** – benefits cease and the injured person will go to common law to prove fault; if needed, they can run a separate case deciding fault before the case about payment amount.

Similar logic applies for models B to D, though they have longer defined benefit durations and there is therefore more time to determine fault.

2.2.2 Model B

Model B has more generous defined benefits (up to 12 months). The scaling of common law QoL payments would provide lower benefits than in Model A for those with relatively minor injuries, providing additional savings.

Table 2.2 – Model B

Benefit Type	For all: Defined benefits	Available to not-at-fault: (additional benefits via common law)
Treatment	12 months	Unlimited
Domestic care	12 months Paid care only	Unlimited Includes gratuitous care on the 6/6 rule ²
Income replacement	12 months 95% of pre-injury earnings for first 3 months 80% thereafter Low income adjustment ¹	No time limit First 12 months: as per defined benefits After 12 months: 100% of loss of earning capacity (future earnings) + superannuation
Quality of life	Nil	Maximum \$500,000 Amount based on ISV and guidance scale
Death	Funeral cost + \$50,000 if dependants	Funeral cost + common law for dependants

¹ Allows greater than 95%/80% for low income individuals. See Section 3.5.1.

² See Section 3.4.2.

2.2.3 Model C

The defined benefits are extended to 2 or 5 years. QoL payments are available to all, subject to a 5% WPI¹ threshold. For additional QoL compensation at common law, the QoL threshold is 10% WPI.

Table 2.3 – Model C

Benefit Type	For all: Defined benefits	Available to not-at-fault: (additional benefits via common law)
Treatment	5 years	Unlimited
Domestic care	5 years Paid care only	Unlimited But with limitations on gratuitous care – see section 3.4.2
Income replacement	2 years 95% of pre-injury earnings for first 3 months 80% thereafter Low income adjustment ¹ Extended to 5 years for WPI 10% or above	No time limit First 12 months: as per defined benefits After 12 months: 100% of loss of earning capacity (future earnings) + superannuation
Quality of life	Maximum \$350,000 Benefit based on WPI Threshold: No benefit if WPI below 5%	Maximum \$500,000 Amount based on WPI (with ranges) Threshold: no benefit if WPI below 10%
Death	Funeral cost + up to \$250,000 if dependants (\$150,000 for spouse, \$25,000 per child)	Funeral cost + common law for dependants

¹ Allows greater than 95%/80% for low income individuals. See Section 3.5.1.

¹ Whole Person Impairment – see section 3.7

2.2.4 Model D

The defined benefits are extended to 5 years. The QoL payment available to all is subject to a WPI threshold of 5%. Under common law, a 10% WPI threshold applies for access to QoL payments and for continuation of income replacement beyond 5 years. There is no common law entitlement for gratuitous care.

Table 2.4 – Model D

Benefit Type	For all: Defined benefits	Available to not-at-fault: (additional benefits via common law)
Treatment	5 years	Limited to 5 years if WPI below 10%
Domestic care	5 years Paid care only	Limited to 5 years if WPI below 10% Paid care only (no gratuitous care)
Income replacement	5 years 95% of pre-injury earnings for first 3 months 80% thereafter Low income adjustment ¹	Limited to 5 years if WPI below 10% No time limit if WPI 10% or above First 12 months: as per defined benefits After 12 months: 100% of loss of earning capacity (future earnings) + superannuation
Quality of life	Maximum \$350,000 Benefit based on WPI Threshold: No benefit if WPI below 5%	Maximum \$500,000 Amount based on WPI scale Threshold: No benefit if WPI below 10%
Death	Funeral cost + up to \$350,000 if dependants (\$190,000 for spouse, \$40,000 per child)	Funeral cost + common law for dependants

¹ Allows greater than 95%/80% for low income individuals. See Section 3.5.1.

3 Entitlements

This section steps through the components of the eligibility to claim and then each of the benefit types. It compares the four models, gives more detailed explanations and some relevant background information.

3.1 Right to Make a Claim

The current common law system is based on negligence (according to law, not community morals or ethics). In the common law system, compensation is available if an injured person can demonstrate that they have been injured because of the negligence of the driver of a motor vehicle.

If a scheme has some benefits available to all injured people (which we refer to as “available to all”):

- It will include those who were at fault (often referred to as “at fault drivers”) up to the extent of the defined benefits.
- Those who are “not-at-fault” (injured due to someone else’s negligence) also have access to the defined benefits, and can choose to go on to make a common law claim (for example if the defined benefits have not met their reasonable needs) and if the individual meets any threshold criteria.

3.1.1 ‘Blameless’ Accidents

There are occasional situations where a person is injured clearly through no fault of their own, but where they cannot demonstrate that another person was at fault. The two most common examples are:

- A medical incident (e.g. heart attack) of a driver who crashes into others – legally, that driver may not be negligent
- A kangaroo jumping out into the road which a driver cannot avoid.

Following a couple of highly publicised cases, some jurisdictions added a “blameless accident” provision to their CTP laws. These laws “deem the driver to be at fault” in the nominated situations. This means that any passengers or pedestrians are categorised as not-at-fault, but the driver themselves (the one who had the heart attack or hit the kangaroo) is not.

On the basis of the views expressed by the jury, all proposed models include a provision that in a blameless accident situation the driver is deemed to be at-fault for the purpose of others being able to make a common law claim.

3.1.2 Benefits for Minors

For young people (generally defined for this purpose as under 16) it can be harsh to allege that the child contributed to the accident by their own negligence. The proposals include a provision that contributory negligence cannot be applied in the case of a minor.

3.1.3 Other Exclusions and Limitations

Some other specific situations where benefits may be excluded or limited are set out in section 6.1, mainly related to unlawful behaviour.

3.2 Benefit Entitlements

The balance of this section covers the main types of benefits that are covered by a CTP scheme:

- Treatment (also known as “Medical”)
- Care – domestic and personal services, whether paid or unpaid (“gratuitous”)
- Income replacement
- Quality of life (compensation not linked to financial loss)
- Death.

Some of the principles and options are discussed, along with the way each of the four models deals with the type of benefit. There is more detail here than in the summaries of Section 2.

Section 4 deals with the claiming process, support and advice, resolution of disputes, legal fees and other scheme costs.

3.3 Treatment Costs

Treatment costs include ambulance, hospital, doctors, specialists, surgery, allied health (sometimes subject to limits), pharmaceuticals, aids and appliances.

Table 3.1 – Treatment Costs by Model

	Model A	Model B	Model C	Model D
Available to all	6 months	1 year	5 years	5 years
Not-at-fault	Unlimited	Unlimited	Unlimited	Limited to 5 years if WPI below 10%

All models provide defined benefits to all injured persons for treatment that is “reasonable and necessary” for a condition arising from the accident.

The Clinical Framework for the Delivery of Health Services (as modified for the ACT) will be used. This framework is supported by the ACT Government and is based on five principles:

- (i) Measure and demonstrate the effectiveness of treatment
- (i) Adopt a biopsychosocial approach (which considers biological, psychological, and social factors and their interactions in understanding an injury’s impacts).
- (ii) Empower the injured person to manage their injury
- (iii) Implement goals focused on optimising function, participation and return to work
- (iv) Base treatment on the best available research.

The treatment section will include an obligation on the insurer to support rehabilitation, and an obligation on the injured person to participate in reasonable treatment and recovery programs.

3.3.1 Deferred or Delayed Surgery

The time limits on treatment in the defined benefits for Model A and Model B may give rise to anomalies around coverage for surgery costs:

- If surgery is needed it often takes some time before doctors reach a decision about the need for and type of surgery
- Even if surgery has been recommended, it may take some months between the decision and the actual surgery.

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.

The proposed way of dealing with this in models A and B is to make insurers liable for 'reasonable and necessary' surgery that is identified as being likely to take place within two years of the end of treatment entitlements and which, at time of surgery, is 'reasonable and necessary'. This provides injured people and their medical providers with the option of delaying surgery and determining whether it is reasonable and necessary following injury stabilisation.

3.3.2 Home and Vehicle Modifications

In Models A and B, the defined benefit entitlements would not include home or vehicle modifications. These major costs would be available only for not-at-fault claimants as part of the common law payment. In Models C and D the defined benefits would extend to modifications carried out during the defined benefits period that will have a long term benefit.

3.3.3 Focus on Health and Recovery

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.

3.4 Costs of Care

This benefit type refers to domestic help and personal care that is not provided by a health practitioner. This may be assistance with personal care, housework, shopping, gardening, childcare and the like. It may be help in keeping connections with society. It may include **services for the injured person** and also substitution for services previously provided **by the injured person**.

There are two types of gratuitous care payments – see Table 3.2.

Table 3.2 – Gratuitous Care Payments

Nature of care	Known as...	Comments
Care provided by family to injured person	GvK Griffiths v Kirkemeyer	In either case, the 6/6 rule (threshold) may apply – no compensation is paid unless care is needed for at least 6 hours per week for at least 6 months.
Loss of injured person's capacity to provide care to family	SvG Sullivan v Gordon	

Table 3.3 – Care Costs by Model

	Model A	Model B	Model C	Model D
Available to all: paid care only	6 months	1 year	5 years	5 years
Not-at-fault:	Unlimited	6/6 rule applies to gratuitous care	Limits on gratuitous care: 6/6 rule Minimum wage GvK only	Paid care only Limited to 5 years if WPI <10%

3.4.1 Available to All – Paid Care

The defined benefits will include provision for providing care services to the injured person (e.g. morning assistance with showering and dressing) and to substitute for care they can no longer provide to others (e.g. cooking, school pick-ups). The compensation is only for paid care by an external provider – there is no payment for gratuitous care.

In this area, it is a challenge to find a balance in the legislative provisions that will meet legitimate claimant needs but is not open to rorting. One option is to rely on assessment of “reasonable and necessary” as the control mechanism. Another option is to use some form of secondary legislation or guidelines to prescribe limits. This will need to be considered during drafting of the legislation.

3.4.2 Common Law – Gratuitous Care

The term “gratuitous care” refers to care provided either to or by the injured person on an unpaid basis, usually involving family members.

The first category of gratuitous care is that **provided to the injured person** after the injury (referred to legally as Griffiths v Kirkemeyer² or GvK). Under common law it is compensated at a commercial rate (about \$40 per hour). It is often subject to a threshold that “care is needed for at least six hour per week and for a period of at least six months”, commonly referred to as the “6/6 rule”. Gratuitous care awards can sometimes be very large and are often in the form of a ‘buffer’ (see Section 5.5 for a discussion of buffers and scheme sustainability).

The second category of gratuitous care is for loss of the capacity of the injured person to **provide care to others**, such as children, grandchildren or an elderly parent. It is referred to legally as Sullivan v Gordon³ or SvG and is less common than GvK.

² The name refers to the case that provided the legal precedent to pay for this type of care.

³ Again after the precedent-setting case.

The approach to gratuitous care costs in the common law provisions of the models are:

- Model A: no change from current scheme – only affected by limits in the Civil Liability law
- Model B applies the 6/6 rule for GvK and SvG
- Model C applies the 6/6 rule for GvK based on the minimum wage (roughly \$20 per hour, lower than the commercial rate), and has no cover for SvG
- Model D does not include compensation for gratuitous care, but covers paid care for up to 5 years if WPI is less than 10%. If WPI is 10% or more, the common law settlement may include an amount for continuation of paid care in the future.

3.4.3 Balance between Paid and Unpaid Care

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. They were developed in a time when it was routine for 'care' to be provided by family members on an unpaid basis. Payment for commercial care was unusual.

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 NIS 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 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.

3.5 Income Replacement

This payment type compensates claimants for income lost due to not being able to work as a result of their injury. The rate of payment is defined as a percentage of pre-injury earnings (or pre-injury earning capacity); the pre-injury earnings used in the calculations are subject to caps.

Table 3.4 – Income Replacement by Model

		Model A	Model B	Model C	Model D
Available to all: Lost earnings	Duration	6 months	12 months	2 years 5 years if WPI 10%+	5 years
	% of pre-injury earnings	95% first 3 months, then 80% Low income adjustment	95% first 3 months, then 80% Low income adjustment	95% first 3 months, then 80% Low income adjustment	95% first 3 months, then 80% Low income adjustment
	Max weekly income replaced	\$2,250	\$2,250	\$2,250	\$2,250
Not-at-fault: Includes loss of future earning capacity	Duration	No time limit	No time limit	No time limit	Defined benefits only if WPI below 10% No limit if WPI 10%+
	% of pre-injury earnings	100% + super	Defined benefits first 12 months (no super), 100% + super thereafter	Defined benefits first 12 months (no super), 100% + super thereafter	Defined benefits first 12 months (no super), 100% + super thereafter
	Max weekly income replaced	\$4,500	\$4,500	\$4,500	\$4,500

3.5.1 Percentages and Step-Downs

The most common income replacement level used in Australia is 80%, with some schemes having a higher percentage initially and reducing over time. The four proposed models all use the following structure in the defined benefits cover:

- 95% for the first 3 months
- 80% after that.

There is also a “low income adjustment” whereby a rate higher than 95%/80% of pre-injury earnings will apply for low income earners. The adjustment proposed is as follows:

- Weekly income \$800 to \$1,000 gross – 95% throughout
- Weekly income under \$800 gross – 100% throughout.

\$1,000 per week is about two-thirds of average full-time earnings in the ACT, while \$800 is approximately the minimum wage for a full-time worker.

3.5.2 Time Limits

Time limits for payment of income replacement payments run from the date of accident. Those who apply for defined benefits within 3 months are entitled to all income lost from the date of the accident.

Those who apply after this time will only be entitled to income loss from the date of their application, unless there is a reasonable justification. Benefits will cease at the defined time limit, or six months after retirement age (as per the age pension rules) if earlier.

3.5.3 Reimbursement of Sick Leave

Many injured people will have sick leave from their employment. If an injured person chooses, the insurer can be asked to reimburse the employer for any sick leave payments (up to the eligible defined benefit amounts). This enables people to reinstate any sick leave entitlement that may have been used, and allows employers to recover the cost of sick leave payments if the CTP insurance would otherwise have paid the amount.

3.5.4 Common Law ‘Top-Up’ Payments

Claimants with a common law entitlement (not-at-fault claimants) would have a claim for ‘topping up’ the 95% or 80% defined benefit to 100% income replacement, plus superannuation where this applies.

Without other measures, the top-up would apply even for very short term claims with just days or weeks of income loss paid.

In order to limit these top-up claims to only more serious injuries, there will be a modification to common law for models B, C and D stating that for the first 12 months after the accident the entitlement to loss of earnings is limited to the defined benefit amount, with no superannuation allowance. An individual with income replacement paid for less than 12 months would receive just the defined benefits in respect of those 12 months, while a person whose income loss extends beyond 12 months would receive 100% plus superannuation from year 2 onwards (paid on a net of tax basis).

3.5.5 Defining ‘Earnings’

The scheme needs to define ‘pre-injury earnings’ for those who were in work, and to define ‘pre-injury earning capacity’ for those that were not in work, but could have been or would be in future.

For defined benefits, the proposal is:

- For those in regular employment, the average gross earnings over the previous 12 months (or shorter period if employed for less than 12 months), including regular overtime and shift allowances
- For those in irregular employment, the expected average gross earnings over the next 12 months having regard to the previous pattern of employment and earnings
- For self-employed, the average income is taken from the most recent annual tax return; for directors of family-owned companies the business tax returns will be used.
- For students, the award rate for the job they are most likely to be qualified for on completion of their current course of study, starting from the time when they would have joined the workforce.

For common law, the existing legal approaches and rules would apply. It is possible that during drafting there might need to be some modifications to avoid anomalies.

3.5.6 Maximum Weekly Amount

For defined benefits, the maximum gross earnings taken into account is proposed as \$2,250 per week (1.5 times AWE). The maximum benefit paid after the first 3 months would be 80% of this amount, or \$1,800 per week.

For common law the maximum benefit is specified as “to ignore any gross earnings or earning capacity in excess of a maximum amount”. This maximum is \$4,500 gross per week (3 times AWE Adult Total Earnings for the ACT). This is the same limit as that currently in the Civil Law (Wrongs) Act.

3.5.7 Partial Income and Earning Capacity

If an injured person is working (or is able to work) in a reduced capacity, all models would calculate the defined benefit as 95%/80% of the difference between pre-injury earnings and the earnings that the person is (or is capable of) receiving. That is, if actual earnings are A and pre-injury earnings are P, the benefit is 95% or 80% of (P minus A).

In considering whether a person is able to work at full or reduced capacity, the relevant reference is employment to which the person is “reasonably suited by education, training and experience”. Other aspects of the definition such as age, residence or the availability of work will need further consideration during drafting.

3.5.8 Capacity to Work

Defined benefits for income replacement are based on the injured person’s **capacity to work**, whether or not they are actually working:

- A person who is off work because their injury prevents them from working is entitled to income replacement
- An individual who could work but isn’t working is not entitled to income replacement.

The rules and procedures for making this decision are important and can be difficult in practice.

Each of the models will have the same set of rules regarding capacity to work, with the detail left to the drafting stage. The dispute resolution procedures (see Section 4.6) will need particular consideration of this type of dispute. One point to note is that if an insurer makes an evidence-based decision that a person has capacity to work, it may stop payment of income replacement. If subsequently the injured person successfully challenges that decision, they would get ‘back-pay’.

3.5.9 Income Tax

It is likely that an insurer will need to deduct PAYG tax instalments from defined benefits and remit separately to the ATO. All defined benefits are worked out on a gross-of-tax basis but paid net of this withheld tax.

All common law benefits are paid on an after-tax basis as at present.

3.5.10 Superannuation

In defined benefits contexts, income replacement is generally paid without superannuation. We understand that this is for practical purposes rather than a matter of principle.

3.6 Quality of Life (QoL) Compensation

This payment type represents monetary compensation that is not related to a direct financial loss. In the defined benefits context it is usually referred to as a “permanent impairment” benefit. In common law it is referred to as “general damages”, “pain and suffering”, or “non-economic loss”.

Table 3.5 – Quality of Life Compensation by Model

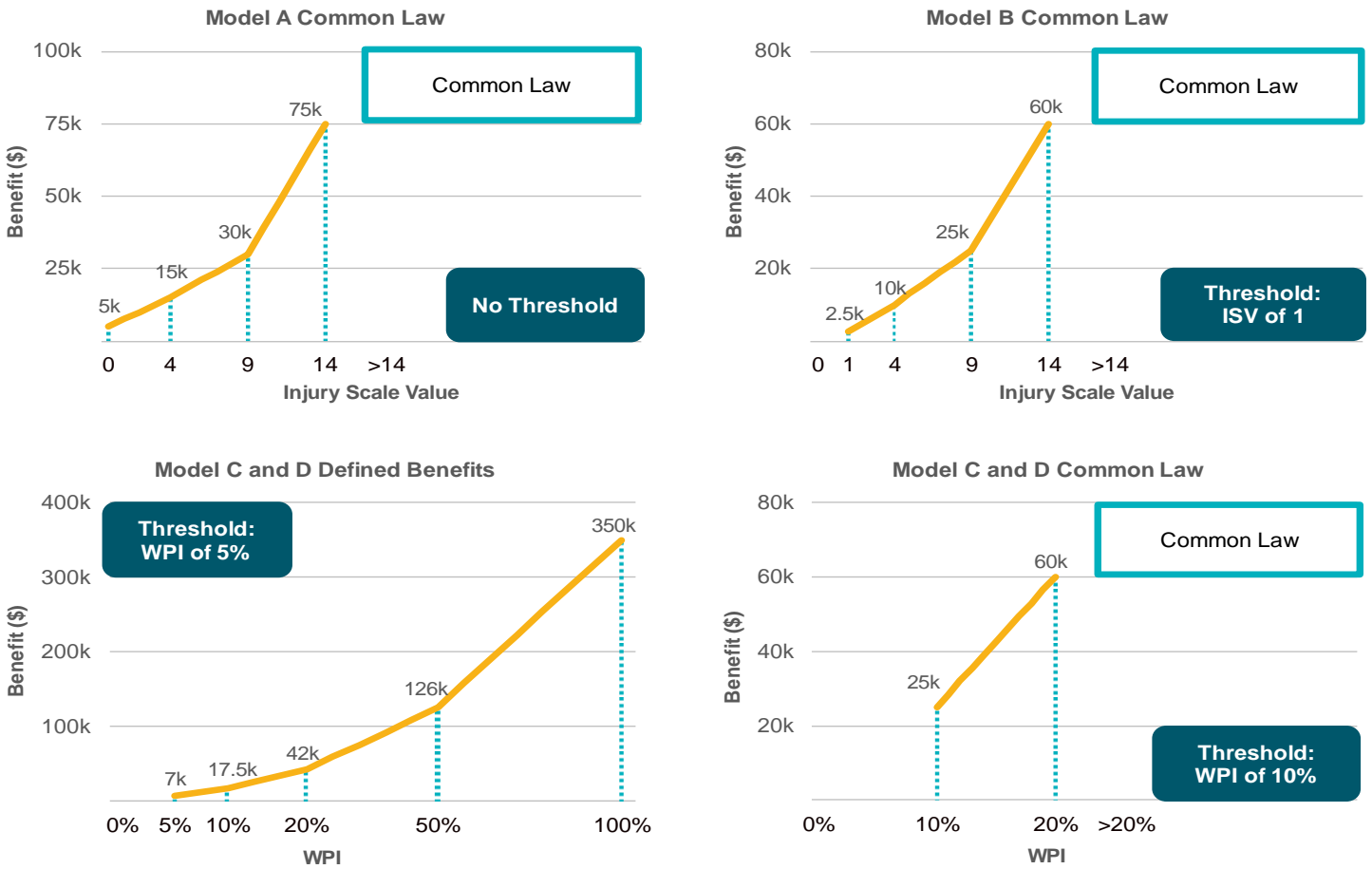
		Model A	Model B	Model C	Model D
Available to all	Threshold	n/a	n/a	WPI 5%	WPI 5%
	Maximum	n/a	n/a	\$350,000	\$350,000
	Calculation of amount	n/a	n/a	WPI scale	WPI scale
Not-at-fault	Threshold	None	None	WPI 10%	WPI 10%
	Maximum	\$500,000	\$500,000	\$500,000	\$500,000
	Calculation of amount	ISV + guidance	ISV + guidance	WPI + ranges	WPI scale

In models A and B, the defined benefits (available to all) do not include QoL compensation, while the common law is modified by requiring use of the ISV and having dollar ranges for ISV up to about 20 (see 3.7.2).

In models C and D there is some QoL compensation available for all people with a sufficiently serious permanent impairment (WPI 5% or higher). The defined benefit is a maximum of \$350,000 with the actual amount based on a scale using the WPI. Those people with a common law entitlement who have WPI of 10% or more are entitled to higher amounts.

Figure 3.1 summarises the QoL compensation scales under each model, both for defined benefits and common law.

Figure 3.1 – QoL Benefits



3.6.1 Interaction of Defined Benefits and Common Law

In models C and D, QoL compensation is available to all. For those who were not at fault there is also access to QoL under common law.

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. The proposed rules are:

- Any injured person may claim the defined benefit QoL compensation and receive an assessment from the insurer
- If a person who is not-at-fault accepts the defined benefits QoL amount, they automatically relinquish any right to QoL compensation at common law.

3.7 Severity of Injury

Each of the proposed models uses a measure of ‘injury severity’ to restrict access to certain benefits and/or define the payment amount. The two measures used to do this are (models C and D) Whole Person Impairment (WPI) and (models A and B) Injury Scale Value (ISV), which are outlined at a high level here. For the jury meeting we propose to give some examples of where sample injuries fit on WPI and ISV.

3.7.1 Whole Person Impairment (WPI)

WPI is widely used in Australia in workers compensation and CTP:

- Thresholds which allow access to specific benefit types (notably QoL) or to higher levels of payment (e.g. longer term income replacement) are commonly defined as a minimum WPI score
- The level of QoL compensation is sometimes defined using a scale which is based on WPI (e.g. WPI of 12% gives you \$14,000; WPI of 38% gives you \$186,000, etc). Usually, the QoL amount increases more steeply at higher WPI values.

WPI is a measure of an injured person’s level of permanent impairment as the result of their injury. A person’s WPI is determined by a medical practitioner using a very detailed and specific medical guide.

The assessment is usually based on one of the recent editions of the American Medical Association Guides to the Evaluation of Permanent Impairment (AMA Guides). The two editions commonly used are AMA4 and AMA5; they are mostly consistent but have some important differences in respect of neck and back injuries. All Australian jurisdictions that use WPI also apply modifications to the AMA Guides.

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.

The proposed instrument for applying WPI in the ACT CTP context is the (Australian) National Guideline, developed for workers compensation purposes and now adopted in several jurisdictions. The WPI Guideline is based on AMA5 with modifications covering:

- Psychological injuries
- Pain
- Hearing loss
- Loss of vision
- Elements of the assessment of spinal injuries of low to moderate severity
- Consideration of the ‘impact of life’, mainly based on Activities of Daily Living (ADL).

Why use WPI?

One advantage of WPI is that its use is common, and its application is generally well accepted and understood. There is a large workforce of doctors familiar with and competent to make the assessments, in all parts of Australia.

Using a WPI-based scale with ranges rather than a defined score for each injury can allow for the impact of the injury on an individual claimant’s circumstances.

3.7.2 Injury Scale Value (ISV)

The ISV is used in Queensland in personal injury cases (CTP, workers compensation and public liability). It is a measure of the “level of adverse impact” of injury on an individual, and is used to determine the level of QoL compensation.

The ISV rules identify 162 different injury definitions. For each injury there is a **range** of ISV scores (such as 0-2, 3-7 or 16-30).

An injured person's actual ISV is determined by the court; it is not a medical determination. However medical assessment will be an important input, and in particular the individual's WPI is a consideration.

The injured person is assigned an ISV which is a whole number between 0 and 100. In Queensland there is then a scale which 'converts' the ISV to a QoL damages amount. The QoL amount increases more steeply at higher ISVs. In practice, the actual ISV can be the subject of negotiation/argument as part of a court case.

Why use ISV?

The advantage of the ISV is that it provides a way to combine a medical assessment of the injury (e.g. WPI) with an allowance for the adverse impact of the injury on an individual person's life.

The ISV process requires a certain amount of professional support in establishing the necessary regulation, keeping the regulation up to date and training.

3.8 Benefits on Death

If a person's death is caused by the negligence of another person, the entitlement to damages is governed by Part 3.2 sections 25 to 31 of the Civil Law (Wrongs) Act. There will be no change to these provisions.

The proposal is to introduce death benefits that are available in respect of all victims:

- Funeral – reasonable costs to a maximum of \$15,000
- A lump sum payment if the deceased person has dependants:
 - ▶ \$50,000 in Model B
 - ▶ Up to \$250,000 in Model C (\$150,000 for spouse, \$25,000 per child up to 4 children)
 - ▶ Up to \$350,000 in Model D (\$190,000 for spouse, \$40,000 per child up to 4 children).

Any lump sum will be paid to the estate.

4 Support and Dispute Resolution

The jury put a high priority on providing support for injured people in navigating the system. This links to dispute resolution processes that are needed for defined benefit and common law aspects of the scheme, and both support and dispute resolution are covered in this section. It also deals with medical determinations and disputes.

The proposals in this section are the same for each of the four models, although the emphasis on different parts will vary.

4.1 Dispute Resolution in the New Scheme

The introduction of defined benefits will result in a new category of disputes, as a claimant and the insurer may not agree about eligibility for, or level of, defined benefits. Examples of the types of disputes include:

- Reasonable and necessary treatment and care
- Whether a person is fit to return to work
- Disputes around quantum of weekly income benefits
- The degree of permanent impairment of the injured person (for some of the models).

The same dispute resolution process is currently proposed for each of the models, with a focus on a timely process. It is proposed that defined benefit disputes will be dealt with primarily under the jurisdiction of the Magistrates Court. The Chief Magistrate's role in managing the business of the court would not change. The Chief Magistrate may wish to direct the registrar of the Magistrates Court to take on the central role in case management of disputes – referring parties to alternative dispute resolution, where appropriate.

The use of the ACT Civil and Administrative Tribunal (ACAT) for low value disputes is a possibility which will be considered in the broader context of bedding down processes for managing disputes, recognising that this potentially provides faster resolution for low value disputes.

Common law disputes would continue to go through the courts in the normal way, according to the size of the claim and jurisdictional limits.

4.2 Aspects of Support

We think of the support for injured people in three categories, although there is overlap between them:

- (i) Information – both general and personalised information to assist an injured person and their family in understanding and navigating the system
- (ii) Advocacy – support and advice in obtaining evidence, dealing with the insurer and in lower level disputes (but not necessarily legal advice)
- (iii) Representation – legal representation of an injured person in respect of a claim, and particularly a dispute over a claim.

4.3 Providing Information

It will be a function of the regulator, with assistance from insurers, to provide multiple sources of information that will enable injured people to begin to access the scheme at the earliest opportunity. This may include:

- System-triggered contacts after a first responder (ambulance or police) has responded to an accident
- Agreement with hospitals to provide information to patients on discharge, whether from ED or admissions, and during the delivery of any pastoral care or social worker support
- Information available from GPs and physiotherapists – including the possibility of automatic reminders in practice management software (such as Medical Director) for the practitioner to pass on this information, where a consultation relates to a motor vehicle accident.

The initial notification of a claim can be on-line (including by App as insurers develop their technology) or by telephone, as well as on paper.

As well as initial information, there needs to be follow-up personalised information (such as a help-line) that can give relevant information to the individual, taking into account what is known about their claim and the activities to date. ‘What happens next, and what do I do?’

Insurers will have an obligation to support claimants in this way, but as noted below there will be some people who will not feel confident trusting the insurer to do the right thing by them.

4.4 Support with Advocacy

Having considered the options available for navigating the system and support in relevant parts of the process, we are proposing that (apart from insurers) law firms be the main providers of this service.

A fee will be paid to the law firm by the insurer for this activity.

The support might include assistance with completing documentation, explaining next steps, organising evidence and the like. It does not extend at this point 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.

Options considered but not proposed were for the regulator to provide this service, to create a new specialised entity or to use existing community-based services.

The regulator currently receives, and will in future receive, complaints from time to time. The role of the regulator is to be helpful with such complaints, confirm that correct processes have been followed and accurate information supplied. This also gives the regulator some visibility of the day-to-day operational performance of insurers. Handling of complaints by the regulator is not a formal conciliation service and the regulator has no role as a decision-maker.

The scheme will explicitly allow an injured person to have support from anybody at, for example, a medical examination or a dispute conference. This could be family, a friend, a not-for-profit help service, a lawyer or other support person. Only a solicitor (or their delegate) would be entitled to payment and only in specified circumstances.

The process during any dispute resolution is covered below in Section 4.6.

4.5 Process of Making a CTP Claim

A claim for defined benefits can be initiated with a relatively small amount of information. This encourages early reporting and early response by the insurer, even though it implies that there will be further information needed later in the process.

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. Benefits for income loss will only commence from the date one month prior to the claim being notified to the insurer.

4.5.1 Early Treatment and Care

If a claim is made for defined benefits, the claimant must provide claim information and a medical report from the initial treating practitioner. The insurer will pay a standard fee for such a report.

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.

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.

If an insurer is billed for a service that is not within the pre-approved boundaries, it will advise the claimant and the practitioner immediately.

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).

4.5.2 Denying a Claim Outright

There can be several reasons for an insurer to deny a claim outright, even for defined benefits. For example, the insurer may suspect fraud – the accident did not occur, the claimant was not in the accident, the claimant was not injured, any injury was not caused by the accident – or the insurer may not be the insurer.

The normal standard should be that an insurer makes such a decision within three months of the claim being reported. If after that time the insurer has not made a decision, the claimant or the insurer may lodge a dispute.

4.5.3 Fault and Negligence

If at any time a claimant chooses to pursue a common law claim, they will notify the insurer by way of a secondary claim form. The insurer should normally decide on negligence within three months of receiving that claim. The insurer may reserve its position on contributory negligence until evidence is received.

If, after six months, the insurer has not accepted common law liability (i.e. negligence of another) the claimant may lodge a dispute.

Note that this provision only deals with whether there was negligence. Other aspects of a common law claim, particularly quantum, are dealt with in Section 4.8.

4.6 Disputes about Defined Benefits

Both legal and medical skills are needed for an effective dispute assessment process, and lawyers or doctors may be directly involved as decision-makers or provide expert reports from which others make decisions.

The regulator can play a role in trying to improve consistency of approach and greater efficiency, by publishing de-identified dispute decisions and producing guidance notes for certain medical or other disputes in defined benefit claims.

4.6.1 Internal Review by Insurer

It is now common practice to require ‘internal review’ by an insurer if a decision is disputed. The review must be undertaken by a knowledgeable and authorised person not closely involved with the original decision. There may be more specific procedural and communication requirements, such as timetables and advice on further appeal rights.

A requirement for internal review is included in all four models for defined benefits.

4.6.2 Medical Disputes

In CTP the majority of disputes involve (at least to some degree) medical issues. The types of questions that need to be dealt with include:

- Does the person have an injury?
- Was the injury caused by the motor accident?
- What symptoms and consequences continue, at any point in time?
- Is particular treatment or care reasonable and necessary?
- What is the influence of pre-existing, co-morbid and subsequently occurring conditions, including substance abuse (legal and illegal)?
- What is the appropriate determination of severity of injury, permanent impairment or impact on quality of life?
- To what extent does the injury impair a person’s capacity for work?

At present if there is a dispute of this nature, it is dealt with in the legal system either by negotiation between insurer and solicitor or, if it escalates, by the Court. It is an adversarial process, with each party obtaining its own expert evidence and then providing that evidence for decision-making. This process is known colloquially as ‘duelling doctors’.

Most compensation schemes now have an alternative process for medical disputes, whether it is an ‘independent medical examiner’ a ‘medical panel’ or some other variant.

Development of the details of the dispute process will need to incorporate practical provisions for decision-making on medical disputes.

4.7 Dispute Resolution in the Magistrates Court

As discussed in Section 4.1, it is proposed that defined benefit disputes will be dealt with primarily under the jurisdiction of the Magistrates Court. The Chief Magistrate's role in managing the business of the court would not change. The Chief Magistrate may wish to direct the registrar of the Magistrates Court to take on the central role in case management of disputes, referring parties to alternative dispute resolution, where appropriate.

We also note that the Magistrates Court deals with workers compensation disputes, including defined benefits, and there may be opportunities to improve and leverage this part of the system as well.

It is hoped that the Chief Magistrate can develop a system for managing CTP disputes that allows prompt referral to relevant experts for appropriate and quick decisions.

If there is a common law dispute, the matter would move from one part of the law to the other; the reports of any expert(s) can be used for the common law dispute and the same procedures should be available to the Registrar for suitable cases. The decision-making would, however, be subject to the relevant civil law provisions relating to personal injury cases.

If a claimant has a common law claim, then defined benefit disputes may be left undecided and 'rolled into' the common law claim.

4.7.1 Appeals

A decision of the Magistrates Court (or Supreme Court) on a defined benefit or common law matter may be appealed in the same way as at present.

4.7.2 Independent Medical Examiners

Dealing with medical questions and disputes in the scheme is likely to be based around a system of Independent Medical Examiners (IMEs). IMEs are typically accredited in relevant specialties, taking a broad view of a specialty rather than a narrow one (e.g. an orthopaedic specialist not a knee specialist). IMEs may also be accredited in clinical psychology and some allied health areas such as physiotherapy.

IMEs can be automatically accredited if they are accredited in NSW, and potentially for other jurisdictions.

Details of the system and mechanisms will need to be worked out at a later date, alongside the development of the Magistrates Court procedures. The two must dovetail together.

4.8 Negotiations and Offers

4.8.1 Defined Benefits

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.

4.8.2 Common Law Negotiations

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.

If, after the moratorium period, the parties agree that an injury has stabilised sufficiently that a common law process can commence without undue waste of time and effort then, by notice and acceptance, a common law negotiation process is commenced. Failure to agree on stabilisation can be taken to dispute resolution by either party.

From that time there will be a period of six months for the parties to obtain and exchange evidence and negotiate in good faith. This negotiating period may be extended by mutual agreement for up to a further six months.

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.

4.8.3 Existing Civil Law Provisions

The *Civil Law (Wrongs) Act* contains provisions about pre-trial procedures, negotiations, offers and the like. There are corresponding provisions regarding legal costs.

Those provisions will be considered carefully during drafting, with the goal of making CTP consistent with them unless there is a good reason to deviate.

4.9 Regulation of Legal Costs

The question of regulation of legal costs is an important one for any compensation scheme, as it is with most litigation undertaken by individuals.

4.9.1 Definitions

Legal and investigation costs are incurred by both the injured person and the insurer. If the injured person has a successful claim, the insurer is obliged to pay the reasonable legal costs and disbursements of the injured person. These are referred to as ‘**party-party costs**’ and comprise (1) legal fees on a scale that includes hourly rates, and (2) disbursements that are reasonable for the claim involved. It is common for not all disbursements to be included, and for the calculated legal fees to be less than the actual hours worked at market rates.

The injured person will have a legal services agreement with their lawyer which includes, among other things, the basis of remuneration for the law firm. To the extent that the remuneration according to the contract is greater than the party-party costs, it is paid to the law firm by the injured person, and is referred to as ‘**solicitor-client costs**’. The solicitor-client costs are nearly always deducted from the settlement amount after it is received – the insurer pays to the lawyer’s trust account, the law firm takes its solicitor-client costs and pays the remainder to the injured person.

4.9.2 Proposals

Specific provisions for legal costs need to follow from other elements of the system design, rather than leading the design.

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

- (ii) 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.

For **common law** claims there is no proposal to change from the current regulation of legal fees, which in summary are:

- Party-party costs are based on a scale in the Court rules, and are agreed by negotiation between the insurer and the law firm, or failing agreement determined by the Court.
- Solicitor-client costs are based on the legal services agreement and are paid after resolution of the claim
- For claims with a settlement or award under \$50,000, the regulation limits legal fees (solicitors and barristers combined) to a cap of \$10,000 including GST. If party-party costs are less than \$10,000 the balance may be made up in solicitor-client fees.

The SRG discussed at some length the merits of, and alternatives for, regulation of legal costs. The arguments are complex, and none of the proposed models has adopted any changes to current regulations. Noting the transparency provisions (see Section 4.10), future oversight and supervision of the scheme performance may identify a need for further regulation.

4.10 Transparency of Legal and Other Costs

The objectives stated by the jury (value for money and efficiency) call for transparency about where the CTP dollar is spent.

Payment for referrals will be explicitly prohibited.

For all models the new scheme will require:

- Disclosure by insurers of their relevant finances, both in terms of annual totals and on a per-claim basis through the claims register
- Disclosure by claimant representatives of their costs, showing separately the party-party and solicitor-client costs and the breakdown of each.

The individual disclosures will be strictly confidential to the regulator, and the regulator will use aggregates and averages to fulfil its reporting functions.

5 Premiums and Scheme Costs

5.1 The Current Premium System

The amount paid by a motorist when they register their car is made up of:

- The registration fee
- The CTP premium – set by the insurer to meet its own financial obligations and profit target
- A levy to fund the regulator and the nominal defendant scheme
- A levy to fund the Lifetime Care and Support Scheme
- A levy to fund emergency recovery and Road Safety programs
- GST.

5.2 Limitations on Reform

The boundaries set by government mean that a reformed system will be competitively underwritten, community rated and with an expected premium no higher than at present. For this reason, this is a short section included only for completeness.

It is assumed that there would be no changes to registration, taxes or LTCS levy.

5.3 Road Safety Funding

The scheme objectives established by the jury put a priority on road safety (objective 4).

Road safety already benefits from a levy paid with registration. The money goes into a special trust, and the use of that money has its own governance arrangements, in which the CTP regulator plays a part.

For this reason the models do not include any specific provision relating to road safety funding. The decision about the appropriate level of funding through registration is a policy question best dealt with separately from the CTP review.

5.4 Funding Other Scheme Costs

It is reasonable for CTP premiums under a revised scheme to be the source of funding for 'external' scheme costs such as:

- The direct cost of the scheme regulator
- Additional resources needed by the Magistrates Court
- The cost of alternative dispute resolution.

5.5 Scheme Sustainability and Buffers

"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.

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”.

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.

6 Other Coverage Issues

Beyond the issues of no fault coverage there are some details that need to be determined, including:

- Blameless accidents – this was covered in Section 3.1.1
- Exclusions or limitations for illegal behaviour
- Contributory negligence
- Redemption or commutation
- Fraud minimisation.

6.1 Illegal Behaviour

6.1.1 Exclusions in No-Fault Schemes

The Australian CTP schemes that provide benefits to injured people regardless of fault (Victoria, NSW, Tasmania, NT) all have specific provisions in the law to partly or totally exclude benefits to drivers (and sometimes passengers) in the following situations.

Table 6.1 – Exclusions for Illegal Behaviour

Situation	Victoria	NSW	Tasmania	NT
Unregistered vehicle	No income replacement	Total	?	Total
Unlicensed driver	No income replacement	No exclusion	Total exclusion	Partial (b)
DUI Alcohol or drugs	Partial (a)	Partial	Partial (a)	Partial (b)
Serious driving offence	No income replacement	Total	Total exclusion	Partial (b)
During commission of a crime	No income replacement	?	Total exclusion	Total exclusion
Seatbelt or helmet	No exclusion	Partial	None	Partial (25%)

(a) Reductions to income replacement – 1/3 for low-range, 2/3 for mid-range, 100% for high-range

(b) Applies to income replacement and permanent impairment only

None of the schemes provide coverage for motor sports, and there is no plan for the ACT scheme to be any different.

The proposal is that, for all models, in respect of the benefits available to all the exclusions are:

- Exclusion of all benefits for ‘more serious’ offences (e.g. commission of a crime)
- Exclusion of income replacement and QoL only for some offences (e.g. serious driving offence)
- Partial reduction of income loss and quality of life for seatbelt, helmet and low range DUI.

Further consideration will be needed at the drafting stage.

6.1.2 Exclusion for Acts of Terrorism

The current law specifies that the CTP policy does not cover injuries caused during commission of a terrorist act. This provision was introduced in most states and territories after 2001, when international reinsurance markets withdrew coverage for terrorist acts.

If the ACT government wishes to remove this exclusion, and cover injuries caused during a terrorist act, there are three main alternatives:

- (iv) Agree with insurers that they will cover terrorist acts, which in turn would require insurers to get agreement from reinsurers that relevant reinsurance will cover terrorist acts
- (iii) Request that the Australian Government and the Australian Reinsurance Pool Corporation (ARPC) agree that the ARPC will give reinsurance cover to ACT CTP insurers for claims arising from acts of terrorism
- (iv) Make the nominal defendant responsible for claims arising from acts of terrorism, with the understanding that future levies will have to be increased, possibly substantially, to pay for claims.

6.2 Contributory Negligence

Contributory negligence is a **common law** concept whereby the damages paid to a claimant may be reduced due to them contributing to the accident (or to the seriousness of their injuries) through their own legal negligence. It is usually expressed as a percentage reduction in the damages, e.g. 20% or 50%.

Note that deductions and exclusions from defined benefits for illegal activities are dealt with in Section 6.1, and would operate alongside the contributory negligence provisions.

6.2.1 Defined Benefits

To the extent that defined benefits are available to all injured people (regardless of fault), the idea of contributory negligence is meaningless. However there may still be deductions for behaviour such as not wearing a seatbelt, which is covered in Section 6.1.

6.2.2 Common Law Benefits

For common law benefits (available only to those who can prove fault by another party) the concept of contributory negligence is relevant.

Under all the proposed models extent of contributory negligence, if any, would be determined by the legal process including the Court system.

The percentage will then be applied to reduce the common law damages amount. The percentage reduction would be applied to the amount by which the common law damages exceed the defined benefits:

$$\text{Deduction} = \text{Contributory Negligence \%} \times (\text{total claim} - \text{defined benefits}).$$

As noted in Section 3.1.2, the proposals include a provision that contributory negligence cannot be applied in the case of a minor.

6.3 Redemptions or Commutations

This topic deals with the ability of an insurer and a claimant to agree to completion of a defined benefit claim by payment of an agreed lump sum (which effectively replaces all expected future payments). The two terms “redemption” and “commutation” are used interchangeably, and here we use the latter.

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.

The proposed models will generally not permit commutation of defined benefit entitlements. Of course if an injured person has a common law claim then whenever the claim is resolved it will be completed by payment of a lump sum that replaces any future defined benefits. For models C and D it is expected that many if not most common law claims would be resolved before the end of the defined benefit period.

6.3.1 Early Resolution

The jury emphasised the desire for early resolution of claims. At the very least, the design needs to minimise barriers to early resolution and, at best, may include specific provisions to encourage (or mandate) early resolution.

Most claims, other than the most minor, seem to be suited to a resolution between 12 and 24 months after the accident. Injuries have generally stabilised, employment patterns have settled and evidence is available. For most claims medical costs and income replacement should have been paid regularly along the way, and part of the design rationale is that many people will not see the need or benefit of pursuing a common law claim since their needs have been met.

6.3.2 Expedited Finalisation

There will be circumstances where an injury is stable, the course is relatively predictable and both insurer and claimant are ready to wrap up a defined benefit claim even though there is still some time to run.

While the legal effect of an expedited finalisation may be similar to a commutation, the concept and application is different because the amounts involved are relatively small and there is no negotiation based on perceived probabilities of potential outcomes.

Under all four proposed models:

- An insurer and a claimant may agree on an expedited finalisation within three months of the end of a defined benefit entitlement period.
- Neither an insurer nor a claimant has the right to **require** an expedited finalisation, and if they do not agree there is no dispute process.

6.4 Fraud Minimisation

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.

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.

A Appendix A – Glossary of Terms

AWE	Average Weekly Earnings – measured for the ACT as a whole or a subset of the working population and published by the Australian Bureau of Statistics.
Common law	The system of law developed by courts and judges. Personal injury claims at common law require proof that the injury was caused by someone else's negligence.
Common law benefits	Compensation available via the legal and court system.
Contributory negligence	Where claimants have, through their own negligence, contributed to the harm they suffered.
CTP	Compulsory Third Party Insurance
CTP benefits	Compensation that an injured person can claim under a CTP policy.
CTP insurers	Private insurance companies licensed by the ACT CTP Regulator to provide CTP insurance in the ACT. Current insurers are AAMI, GIO, APIA and NRMA.
CTP policy	Mandatory insurance paid when a vehicle is registered. It covers people (including pedestrians, passengers and cyclists) injured in an accident with a motor vehicle. Policy terms are set by legislation. Currently, the ACT policy covers those injured through someone else's negligence.
CTP premium	The amount motorists pay for CTP. Premiums are set by insurers and must be approved by the ACT CTP Regulator.
CTP Regulator	Independent office set up to regulate CTP insurance in the Territory, such as licensing insurers and reviewing CTP premium changes.
Defined benefits	Entitlements to compensate for injury defined by legislation and available outside common law (that is, it is not necessary to prove negligence of another).
Domestic care benefits	Domestic services or care benefits cover domestic help and personal care that is not provided by a health practitioner. This may include domestic help with housework, shopping, gardening and childcare. It may also include assistance with personal care, such as showering.
Gratuitous care	Refers to care provided either to or by the injured person on an unpaid basis, usually involving family members.
IME	Independent Medical Examiner. IMEs are typically accredited in relevant specialties, taking a broad view of a specialty rather than a narrow one.
Income Benefits	Benefits provided to compensate for lost income if an injured person cannot return to work or cannot work as much as a result of their injuries.
Injury Scale Value (ISV)	ISV is a measure of the 'level of adverse impact' of an injury on an individual, and is used to determine the level of quality of life compensation.
Lifetime Care and Support Scheme (LTCS)	The LTCS offers early intervention and lifetime treatment and care to eligible persons who have sustained catastrophic injuries in a motor vehicle accident in the ACT. The Scheme provides coverage on a no-fault basis. That is, not-at-fault, at-fault, single vehicle and blameless accidents are all covered.
Nominal Defendant	An entity created to provide compensation to those injured if the at-fault vehicle cannot be found or is uninsured. In the ACT it is the ACT Insurance Authority (ACTIA).
Pre-injury earnings / earnings capacity	Used to calculate the income benefits. Pre-injury earnings are the earnings the injured person made prior to the accident. Pre injury earnings capacity is the pre injury capacity of those not in work, but who could have or would have been in work in the future.

Quality of life compensation	This payment compensates an injured person for non monetary loss, such as a reduction in their quality of life due to ongoing impairment or pain. At common law, it is known as “General Damages”.
Settlement	Financial payment at common law to cover the losses arising from a personal injury claim such as motor accident injuries.
Thresholds	Minimum injury severity levels that must be met to access some benefits (in some models).
Treatment Benefits	These are benefits to cover the cost of reasonable and necessary treatment as a result of injuries sustained in a motor vehicle accident. They include things like medical costs and allied health costs.
Whole Person Impairment (WPI)	A measure of an injured person’s level of permanent impairment as a result of their injury and is based on the American Medical Association (AMA) 5 guidelines (modified).