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THE LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

MOTOR ACCIDENT INJURIES BILL 2019

EXPLANATORY STATEMENT

Presented By

Andrew Barr MLA

Treasurer

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This Explanatory Statement relates to the Motor Accident Injuries Bill 2019 (the Bill) as presented to the Legislative Assembly. It has been prepared in order to assist the reader of the Bill and to help inform debate on it. It does not form part of the Bill and has not been endorsed by the Assembly.

The Explanatory Statement is to be read in conjunction with the Bill. It is not, and is not meant to be, a comprehensive description of the Bill.

Background

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

The ACT CTP scheme is 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.

Between August 2017 and March 2018, the ACT Government undertook 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. In line with this commitment, the Government is now pursuing a model recommended by a citizens' jury through the Motor Accident Injuries Bill 2019.

Overview

The purpose of the Motor Accident Injuries Bill 2019 is to implement a model for the new Motor Accident Injuries Scheme, as chosen by the citizens' jury.

The Bill replaces the current at-fault compensation scheme operating under the CTP Act with a new hybrid no-fault common law scheme.

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 defined benefits following injury in a motor accident. The provision of defined benefits, for treatment and care as well as income replacement, is for up to five years. There are some exceptions and exclusions that apply to the receipt of defined benefits.

Quality of life defined benefits to cover non-economic loss are payable to people who meet injury impairment thresholds. If a person dies as a result of a motor accident, benefits are also available for dependants and to cover funeral expenses. 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.

The Bill retains the statutory position and functions of the CTP Regulator, but replaces this with the Motor Accident Injuries Commission and the position of Motor Accident Injuries Commissioner. Licensing, enforcement and nominal defendant arrangements, including the Nominal Defendant Fund, also continue to operate under the Bill.

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Summary of key provisions in the Bill

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. Assistance in making applications for defined benefits will be available through approved information support services.

Entitlements to defined benefits

The Bill 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.

There are some exclusions and limitations to entitlements to defined benefits including where an injured driver has been convicted of breaking the law.

Applications for defined 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 two years of an accident. The insurer with whom the application is lodged is required to provide an acknowledgement of receipt of the application.

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.

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. However, an insurer can 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

A quality of life benefit is a recognition payment for a person's non-economic loss as a result of a permanent impairment caused by the accident. 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. 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). Special arrangements apply to children and a person that has a significant occupational impact.

Guidelines will require that 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 $600,000 indexed 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 and permanent. The insurer will pay for this assessment. The court may also award additional quality of life damages of up to 20% of the scale if a particular injury, or a particular effect on the person's life, was not taken into account in the Whole Person Impairment assessment.

Death benefits

The defined benefit stream 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 for their spouse and up to four children of the deceased. 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. The ACT Civil and Administrative Tribunal (ACAT) is empowered to decide the disbursement of death benefits.

Future medical treatment expenses payment

The Motor Accident Injury scheme will provide for payment by an insurer to a person who requires future medical treatment expenses after the end of the defined benefit entitlement at five years. An injured person will be able to apply for this payment if they were not at fault for the motor accident; are not eligible to make a motor accident common law claim; and have continuously been in receipt of medical treatment for the two years and six months immediately prior to when an application is able to be made at four years and six months after the motor accident.

The purpose of this payment is to assist those who may still be in receipt of on-going medical treatment and there is a reasonable and necessary need for the person to receive an additional payment to cover future medical treatment. The payment is to be assessed based on the types of medical treatment the injured person has been receiving in the prior six month period, with an assessment of how long the medical treatment would be required post five years and up to 10 years. The payment is negotiated between the parties. If there is no agreement to the payment amount, then either party can apply to the ACAT for an order. Defined benefits that the injured person is entitled to are required to be continued to be paid until the end of the entitlement period and these cannot be included into the payment.

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 and external review of the insurers' decision. This body is to be the ACAT.

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 involved in the original decision. An internal review of a decision will generally be required to be completed within ten 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 ACAT of a dispute that is not resolved through internal review, or involves a decision that is exempt from internal 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 medical 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 independent medical examiner for comment. An insurer can respond by affirming or increasing the assessment, with the assessment not to increase more than the second Whole Person Impairment assessment.

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. In addition, there is also provision for an injured child who is in receipt of treatment and care defined benefits at four years and six months, and an injured adult who is in receipt of income replacement defined benefits at four years and six months and meets the significant occupational impact assessment, to access common law damages.

Heads of damages, including for future treatment and care, income replacement, paid care and quality of life, are available at common law.

The 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* (Wrongs Act), the maximum amount of damages for loss of earnings is also capped at $4,500 per week.

While damages for paid care is available, damages for gratuitous care may not be awarded at common law. This is to ensure care is provided to injured people by a properly qualified carer.

Damages for quality of life at common law is capped at $600,000, and it is a replacement for the head of damages currently known as non-economic loss. 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. The insurer is obliged to explain to the injured person the consequences of an election to accept a defined benefit quality of life payment, before they make such a decision.

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

Claims for common law damages must be lodged within five years of an accident. The claims process largely follows the Wrongs Act 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.

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 Motor Accident Injuries Commission, in its oversight of insurers, will review processes of insurers in response to complaints from injured persons, information service providers and legal representatives. This will be particularly important during the implementation of the scheme as new processes and procedures will be required by all parties in processing applications for defined benefits following a motor vehicle accident.

The Bill provides the Motor Accident Injuries Commission with the power to collect information specified in the regulation 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.

Summary of benefits under the new scheme

Benefit Type	Defined benefits: for all people	Common law: for people not-at-fault who meet threshold requirements*
Reasonable and necessary treatment and domestic care	Five years Paid care only A lump sum to cover medical treatment for up to a further five years can be payable where a person has been continuously accessing these benefits during the defined benefit period.	No time limit Paid care only.
Income replacement	Five years 95 per cent of pre-injury earnings for first three months, then 80 per cent thereafter. Higher percentage amounts payable to people on low incomes. Maximum pre-injury weekly earnings amount of $2,250.	No time limit 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 five per cent	Maximum $600,000 Amount based on Whole Person Impairment scale plus up to 20%, except for children where the amount will be Court awarded
Death	Funeral cost + up to $350,000 if dependants	Funeral cost + common law damages for dependants

* The threshold requirement is a Whole Person Impairment of at least 10 per cent. In addition, children still receiving treatment and care benefits at four years and six months; and adults still receiving income replacement benefits at four years and six months assessed with a significant occupational impact are eligible for common law.

Human Rights Implications

The purpose of a hybrid no-fault Motor Accident Injuries scheme is to extend personal injury insurance coverage to everyone injured in a motor vehicle accident, not just those who can prove fault. The scheme will extend coverage to up to approximately 40 per cent more people injured in motor vehicle accidents, including those in blameless accidents such as with wildlife. Socially, this provides more equitable and broader coverage for injured motorists.

Additionally, not-at-fault injured people will be able to access up to five years of defined benefits without having to prove fault. The 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 do this, the Bill changes the way a person receives compensation for the personal injuries suffered in a motor vehicle accident by providing benefits to any injured person, subject to certain limitations. These limitations include:

- introducing eligibility criteria for access to common law proceedings, with some restrictions on damages; and
- the receipt of defined benefits in relation to:
  - conditions affecting benefits to foreign nationals once they have returned home;
  - exceptions and exclusions of benefits for injured people charged with certain offences in relation to the accident and on conviction;
  - exclusion of benefits while the injured person is a detainee and/or young detainee; and
  - income replacement payments ending on the attainment of retirement age.

The scheme requires the submission of applications, documents and information to private entities – licensed insurers, health professionals and independent medical examiner/independent health assessor. The Bill includes robust provisions to protect the personal information of injured persons, their dependents and personal representatives.

The proposed scheme may trespass on rights previously established by law and trespass on personal rights and liberties including recognition and equality before the law; and engage the right to privacy and reputation. The latter rights are provided for by Sections 8 and 12 of the *Human Rights Act 2004* (HRA). The right to fair trial, with respect to rights and obligations, provided by Section 21 of the HRA may also be engaged.

There are offence provisions which provide for strict liability and for the evidential burden of proof, engaging the presumption of innocence provided for by Section 22 of the HRA.

In proposing the scheme, consideration has been given to any less restrictive means available to achieve its purposes while minimising the trespass on the rights previously established by law and personal rights and liberties.

Human rights issues are not addressed in individual clauses of the Bill to avoid repetition. Where human rights implications arise in a chapter, part or division, the reader is alerted to this at the beginning of the chapter, part or division and asked to refer back to this section.

Introducing eligibility criteria for access to common law proceedings

The Bill proposes to introduce eligibility criteria for access to common law proceedings to the following people who are injured and were not-at-fault for the motor accident:

- people with a whole person impairment of at least 10 per cent;
- a child who is in receipt of defined benefits at four years and six months;
- an adult who is in receipt of defined benefits at four years and six months and meets the significant occupational impact assessment; or
- a person who died as a result of a motor accident.

Whole Person Impairment is a medically based injury assessment and its application is generally well accepted and understood by medical professionals. This assessment is used by a number of schemes in Australia and around the world. Whole Person Impairment has been selected as the threshold mechanism as it provides measurable assessment criteria that will minimise inconsistent assessments for like injuries. It is an independent medical assessment, not an insurer's medical assessment. The threshold of 10 per cent or above Whole Person Impairment was selected on the basis that people with serious injuries associated with motor accidents will meet this threshold and be able to proceed to common law if they so choose. If an injured person meets the threshold and chooses to proceed to common law, the usual common law process is followed by the parties to have their matter heard.

The purpose of the limitation is to direct resources to those who are more seriously injured by someone else's negligence, by allowing the seriously injured to access damages beyond what is paid through defined benefits. A claimant is able to decide the heads of damage they may wish to claim subject to the provisions of the Bill, for example, future treatment and care and income replacement (economic loss). The quality of life damages, currently known as non-economic loss, is scaled and capped and in the case of adults will be paid based on the person's Whole Person Impairment assessment. The court may also award additional quality of life damages of up to 20% of the scale if a particular injury, or a particular effect on the person's life, was not taken into account in the Whole Person Impairment assessment. The selection of 20% as the cap for this additional quality of life damages is a material recognition of other matters not taken into account as part of the assessment. It allows for the quantum of the additional quality of life damages to increase according to the Whole Person Impairment that the person receives. In relation to children, the court will determine the quality of life amount, up to the maximum of $600,000.

An injured person will be entitled to claim for damages for future paid domestic services, but not gratuitous care that may be or has been provided, usually by family members. This is intended to allow for family members to be family members, and for injured people to receive care from qualified professionals. At common law, gratuitous care is a head of damage that may currently be claimed where care is provided by a family member on an unpaid basis. Tasmania abolished this head of damage in 1986, with Professor Harold Luntz observing the Tasmanian Motor Accidents Insurance Board provides for these needs under their no-fault scheme[1].

[1] Mendelson, Danuta (2005), Jurisprudential legerdemain: damages for gratuitous services and attendant care, Journal of law and medicine, vol. 12, no. 4, pp. 402-412, accessed through Deakin Research Online: http://dro.deakin.edu.au/eserv/DU:30002900/Mendelson-gratuitousdamages.pdf, page 4

There is a potential engagement of the right to privacy and family life on the basis this limits an injured person's choice with respect to who provides their care within their home, interfering with the privacy of his or her own home. It should be noted the injured person can still choose to have a family member provide unpaid care, however, for a common law claim the provision says this may not be included as damages. The limitation on the rights are reasonable in that the means used to impair the rights is limited only with respect to the payment. The injured person can still choose to have a family member provide unpaid care (noting the family member also has a choice) rather than a qualified, commercial service. The potential interference arises only if the injured person's care needs are met by qualified, commercial services.

A shortcoming of the current common law system is that it provides incentives for a person to avoid mitigating their injury and recovering quickly because this has a direct bearing on the damages that may be awarded. Further, research has demonstrated a link between compensation status and health outcomes. There is a direct correlation between a person's recovery and the role of compensation processes, lawyers and adversarialism in producing or perpetuating ill health among claimants[2]. The primary focus of personal injury insurance should be to provide treatment and care as quickly as possible to maximise the injured person's recovery. Defined benefits provides treatment and care without having the delay and stress of first proving some else was at-fault.

Defined benefits also provide income replacement, a head of damage that does not get paid until settlement or court order. From the acceptance of an application for defined benefits an injured person can receive income replacement, removing a burden from the injured person to manage the financial consequences of the motor accident. This also assists the recovery of the injured person, as they will not suffer the stress of having no to little income following the accident if they are unable to access leave and other sources. This may also improve their opportunities to continue to participate in the community. Defined benefits and income replacement have a generous time limit of up to five years.

A new category of disputes will arise with the introduction of defined benefits. An applicant and insurer may not agree about eligibility for, or the approved level of, defined benefits. The Bill provides for a timely and cost effective dispute resolution process to ensure rights and obligations can be considered by an independent tribunal. As part of the scheme, it is intended that an injured person can raise concerns about their application with the insurer directly or through the insurers' complaint regime. The Bill then provides for a formal process of internal review and then external review. It will be for the injured person to consider how to approach the insurer in raising their concerns, including applying in the first instance to the insurer for an internal review. If they are unsatisfied with the outcome of this review, certain insurer defined benefit matters will be able to be externally reviewed by the ACT Civil and Administrative Tribunal. The Tribunal has adopted alternative dispute resolution mechanisms as part of its current case management processes and these processes will help to facilitate the quick and just resolution of disputes so that injured persons can focus on their recovery.

[2] Grant, G. and Studdert, D. (2009). Poisoned chalice? A critical analysis of the evidence linking personal injury compensation processes with adverse health outcomes, Melbourne University Law Review, Vol. 33, 2009.

This approach has been considered against the rights of the individual and that of the broader community. On balance, it is considered the limitation to access common law is reasonable. It will allow the Magistrates Court and Supreme Court to focus on the most seriously injured, children and the family of the person who has died as a result of a motor accident. It will have a significant social impact for the community as a whole, and assist the courts to provide a just and fair adjudication over common law claims. The potential engagement of the right to privacy and family life by removing gratuitous care is considered reasonable, in that the engagement relates only to the non-payment of this head of damage at common law, and not as an interference in the choice a family may make to have care provided by a family member.

Limitations, exceptions and exclusions for the receipt of defined benefits

There are a number of limitations, exceptions and exclusions that may impact on a person's receipt of defined benefits.

The right to recognition and equality before the law is engaged by these limitations, exceptions and exclusions, as it may provide for distinction or discrimination based on certain circumstances. For more detail on the specific provisions, please refer to the relevant section of the explanatory statement.

Foreign nationals

The scheme includes provisions for the management of defined benefits for a person who does not reside in Australia but is involved in a motor accident while in the ACT. Foreign nationals are able to receive ongoing treatment, care and income replacement benefits while they stay in Australia. The quality of life defined benefit is not available. Conditions are applied to the receipt of benefits when they depart Australia, with a lump sum payable that covers future income replacement benefits and treatment and care needs if the sum is greater than $10,000. There is a minimal restriction on access to common law, provided the 10 per cent Whole Person Impairment threshold is met and a lump sum was received. There is no distinction drawn between foreign nationals, i.e. by reference to their home country, race or sex.

As foreign nationals residing outside of Australia will be outside of the jurisdiction of the scheme and insurers, it is more difficult to arrange and monitor the treatment and care of the injured person. This can cause delays in an injured person's treatment and care to the possible detriment of the person's recovery. It also places an increased burden on an insurer in navigating overseas medical and workplace arrangements, increasing the cost to the scheme where defined benefits are required to be provided overseas.

The Bill proposes a compromise by providing defined benefits while the person is residing in Australia and for future defined benefits, with a materiality threshold, to be paid as a lump sum amount. There is no less restrictive or alternative way identified, other than not providing any defined benefits for foreign nationals. Statutory motor accident compensation schemes in other jurisdictions do not pay medical expenses for services outside Australia and only pay income benefits in restricted circumstances.

Offences

Division 2.2.2 of the Bill provides for the suspension in the amount of entitlements where an offence has been committed during the motor accident. These provisions may discriminate in the way that defined benefits entitlement apply to a person that may not apply to another person. The offences only apply to those matters specified in the Bill or Regulation, and has to be relevant to charges causally connected to the motor accident.

The entitlement to all or some defined benefits is ended if the injured person is convicted of the offence. If a person is found guilty but a non-conviction order is given, this has no effect on the person's entitlement.

There are differences in which defined entitlements are ended on conviction, depending on the seriousness of the charge the person faced. For example, in relation to murder (where a motor vehicle is used as the weapon), there is no entitlement to treatment and care, income replacement or the quality of life benefit once a person is convicted. For a driving offence, generally a breach of the road transport legislation, a person's entitlement to income replacement and quality of life is ended, with the entitlement to quality of life benefits suspended if an application is made while the charge is outstanding.

The limitations on the entitlements where an offence occurs in connection with a motor accident applies one of the main objectives of the Bill, to support and promote the prevention of motor accidents and the safe driving and use of a motor vehicle. It applies a disincentive to people who engage in serious criminal behaviour or put others at risk.

The approach adopted by the Bill, in providing that the entitlement is not ended until a person is found guilty or is convicted, ensures that an injured person will still receive defined benefits until this occurs. Where the court has made a non-conviction order for the injured person in relation to the offence, the injured person's entitlement to defined benefits is not affected. It will ensure that the injured person receives treatment and care as quickly as possible after the accident. There is no requirement imposed on the injured person to pay back the benefits received if the injured person is later found guilty or convicted of an offence.

The suspension of an application for the quality of life benefit may be considered to engage the presumption of innocence that is protected by Section 22 of the HRA. However, the suspension arises only if an application for quality of life benefits is made and then applies while the charge is pending. Once the charge is resolved, the application is required to be processed by the insurer.

A further distinction included with the offences are special provisions for diplomats. As the national capital, Canberra hosts international organisations and diplomatic missions from around the world. In earlier times, immunity was provided to allow safe passage and protection from the laws of the country they were accredited to as diplomatic agents. These principles were codified in the *Vienna Convention on Diplomatic Relations* (1961), applied in Australia by the *Diplomatic Privileges and Immunities Act 1967*. By Article 31 of the convention, a diplomatic agent shall enjoy immunity from this country's criminal jurisdiction.

Provisions have been included in the bill to allow a relevant insurer to refer a person who has made a claim of immunity that prevents a charge from being finalised to the Commission for a declaration the entitlement is ended. The Commission will then decide, on the information available, whether to end the entitlement of the person.

This ensures that an independent assessment occurs rather than have the insurer make the determination. The Commission's decision will be subject to review, as a reviewable decision. The declaration made by the Commission will only be relevant to the provision of defined benefits. It does not interfere with the rights of the person that are protected under the Vienna Convention. It is required only so that for the purposes of the scheme, members of diplomatic missions and international organisations are subject to the same limitation and exclusions as non-diplomatic persons.

There is no entitlement to defined benefits where a motor accident is caused or attributable to an act that is an act of terrorism. This reflects the current CTP Act in that a CTP policy does not cover acts of terrorism. A statement of no entitlement is required to exclude this category from the provision of defined benefits. To ensure there is even treatment by insurers of a terrorist event that occurs in the ACT, the Commission is empowered to provide a notice to the insurers confirming a motor accident was a terrorist event.

There is no entitlement to income replacement or quality of life benefits if the person injured in a motor accident has the injury as a result of an intentionally self-inflicted injury. If the person dies, the estate is not entitled to quality of life and dependants are not entitled to death benefits, but will receive funeral benefits. The injured person will be entitled to treatment and care for their injuries. This ensures that the scheme is not used to obtain financial benefits for loved ones where a person intentionally injures themselves.

By providing for universal benefits to any person injured on ACT roads, limiting entitlements and reducing some benefits represents a balance between the rights of injured persons and the protection of the community.

Detainees and young detainees

An injured person who becomes a detainee or young detainee is not entitled to receive income replacement or treatment and care benefits while they are a detainee or young detainee. The limitation of this entitlement is in recognition of the services provided by Corrective Services and Justice Health while a person is under detention. The injured person is able to ask for treatment from these services for the ongoing effects of their injury from the motor accident.

To require an insurer to arrange medical treatment for a detainee or young detainee would be difficult and would interfere with security requirements. Also, a detainee or young detainee cannot work as an employee while under detention, and an insurer will not be able to assess their working capacity during this period. It is a minor restriction on the right to equality of the individual, and depending on the period of detention, may be transitory.

Before and after the person is a detainee, the insurer will be required to provide defined benefit entitlements to the injured person.

Income replacement payments ending on the attainment of retirement age

Where a person is at pension age, the income replacement payments to an injured person are switched off two years after the person attains pension age. If a person is employed at the date of the accident and they are older than pension age, income replacement benefits will be payable for a two year period from the date of the accident to provide a transitional benefit to the injured person. The pension age is as defined by Section 23 of the *Social Security Act 1991* (Cwlth). Treatment and care benefits and access to the quality of life defined benefits are not affected by this provision.

The restriction on income replacement recognises the availability of other sources of income, for example the age pension safety net for seniors that otherwise do not have replacement income through superannuation or other savings. The two year period for payments after pension age provides a reasonable proxy for a period a senior may have otherwise continued to work if an accident did not happen, i.e. a person may have intended to soon retire. It also allows for the person who turns pension age (currently 65.5, increasing to 67 by 2023) while in receipt of the income replacement benefit the time to make their application for the age pension. When providing the income replacement benefit, an insurer has regard to information from an outside source, such as an employer, regarding the income of the injured person. At this stage of a person's life, it may be difficult to obtain independent information on a person's intention regarding continuing or ceasing to work.

If the person is employed at the time of the accident and is older than the pension age, the scheme will provide income replacement for two years so that the person can transition to other income sources following the motor accident, if this is required due to an inability to work. This balances the effect of the ending of the income replacement payments on the attainment of pension age if the person is still working.

While it may be considered discrimination on the basis of age (potentially engaging the right to equality before the law), a person of pension age who is retired or is likely to be close to retirement can be presumed to have access to an alternative source of funds. Without some restriction on income replacement, some people may be in a better position with respect to income than they would have been around the time of retirement.

The provision does not impact on a person's ability to claim for loss of earnings at common law, if they are over the 10 per cent Whole Person Impairment threshold (subject to the cap provided by Section 98*, Civil Law (Wrongs) Act 2004* and first year loss of earnings under this Bill).

Submission and collection of personal information

Essential to any insurance scheme is the need for a person to provide information and the receiving entity to collect information. The *Information Privacy Act 2014*, the *Health Records (Privacy and Access) Act 1997* and the Commonwealth's *Privacy Act 1988* regulate how personal information is handled and protected, and apply to the scheme. An insurer licensed under the proposed Motor Accident Injuries scheme will be highly regulated, with statutory obligations imposed on the insurers to manage the information that is collected from and about the injured person. An insurer will be under an obligation to act in good faith in relation to the information and comply with all privacy obligations that apply.

The Bill includes a number of powers to authorise the making of an application and the provision of documents and information that concern the private life of individuals. This requires personal details, including health and financial information, to be given by consent in making an application or a claim for common law damages. This may engage the right to privacy and reputation protected by Section 12 of the HRA.

The personal and medical information is required to establish the basis of the claim on the insurance policy that is being made; to establish entitlement to benefits; and to enable services to be provided by insurers. The Bill includes safeguards for the personal information, in addition to the provisions of privacy legislation. The authority to collect and disclose information is required before an insurer can process an application. This authority can be revoked by the injured person; however, this will impact on the provision of benefits to the injured person.

Personal health information will be collected throughout the process of receiving defined benefits. This is important to enable an insurer, as part of their duties, to arrange and monitor benefits to contribute to an injured person's recovery. Without such oversight, the scheme would not provide the optimal outcomes it sets out to achieve, which will be detrimental to the community as a whole. The insurer is required to provide the personal and medical information of applicants and claimants to the Motor Accident Injuries Commission. Insurers are also required to provide the detail of their management of defined benefits, for example, decisions on benefits, payments made and other steps taken. This information is collected by the Motor Accident Injuries Commission for the purposes of monitoring the scheme.

It is noted that the consent will be required to be valid for the period of a defined benefit application. This is intended to minimise the administrative burden for applicants and insurers and to provide benefits in a timely manner. Having an ongoing consent will enable medical treatments and assessments to be arranged without the need for consent to be obtained each and every time an appointment is proposed.

Insurers may receive false claims of a motor accident injury. Insurers are obliged by the scheme to take steps to deter fraud and identify potential false claims, which requires data matching and other actions to validate information to ensure a valid application has been made. This requires the use of personal information that has been provided by injured persons for an additional purpose. This additional purpose is required by the privacy legislation to be expressly authorised and will be included in the consent authority.

Strong safeguards are in place for the handling, confidentiality, and permitted disclosures of information that the Motor Accident Injuries Commission and insurers acquire as a result of exercising functions under, or in relation, to the Bill under Chapter 7 – Information Collection and Secrecy. Offence provisions apply for a person using or divulging protected information other than in accordance with the Bill. Use of protected information also includes making a record of the information. Protected information has been used as it provides a broad meaning and means any information disclosed or obtained by a person because of the exercise of a function under the Bill by the person or someone else, and specifically includes personal health information.

Furthermore it is a condition of a Motor Accident Injuries insurer's licence under Clause 347 of the Bill that a licensed insurer adopts measures to ensure that a person that has been or is employed by the insurer does not disclose protected information unless it is in accordance with the Bill or another Territory law.

Strict liability and evidential burden

Extensive enforcement and compliance powers have been included in the Bill, based on standard statute book provisions included in other Acts that require regulatory oversight of a scheme. For example, authorised persons may apply for a search warrant and have limited seizure powers. There are four offences (out of 24 offences, mainly for licensing and enforcement) in the Bill that provide for strict liability. Three of these offences are found in the enforcement provisions and do not exceed 50 penalty units. One strict liability offence is located in Part 6.9, and obliges an insurer to provide information and assistance to the nominal defendant.

There are provisions that provide a defence for an offence which places an evidential burden on the person. These defences are generally found in the licensing provisions. The defence requires the production of proof the information could not be provided. It requires the insurer to point to evidence (ie. on the evidentiary evidence) as to why they were not able to comply with the requirement. Given this is within the insurers knowledge, the limitation is considered reasonable.

One other offence provision, clause 286, provides a reasonable grounds defence in relation to the offence of using an uninsured motor vehicle on road or road related area. This is information that the defendant would have within their knowledge with respect to the registration status of the motor vehicle.

Strict liability offences and evidential burdens are considered to engage the presumption of innocence because the burden of proof is shifted to the defendant in that the person may have to raise a defence to prove their innocence. Generally the principle is that a defendant is not obligated to offer a defence. It is for the prosecution to prove, beyond a reasonable doubt, the person is guilty. With a strict liability offence, unlike a fault element offence, the prosecution is only required to prove that a person had committed the physical element of the offence. For an evidential burden, the defendant has to present or point to evidence that suggests a reasonable possibility for that defence. The prosecution then has the burden of disproving the defence beyond reasonable doubt.

The incorporation of strict liability offences has been carefully considered during the Bill's development. Generally, strict liability offences arise in a regulatory context where for reasons such as consumer protection and public safety, the public interest in ensuring that regulatory schemes are observed, requires the sanction of criminal penalties. In particular, where a defendant can reasonably be expected, because of his or her professional involvement, to know what the requirements of the law are, the mental, or fault, element can justifiably be excluded. The Criminal Code defences apply to strict liability offences, including mistake of fact.

Conclusion

This part has identified that the proposed scheme may trespass on rights previously established by law and trespass on personal rights and liberties including recognition and equality before the law; engage the right to privacy and reputation; engage the right to fair trial, with respect to rights and obligations; and engages the presumption of innocence.

In proposing the scheme, consideration has been given to the less restrictive means available to achieve the scheme's purposes while minimising the trespass on the rights previously established by law and personal rights and liberties. The major purpose of the Bill is to provide treatment and care and a financial assistance safety net for an injured person so they can focus on their recovery. To achieve this it requires a balance be struck between the provision of up to five years of defined benefits, with some certain, clearly identified, limitations, exceptions and exclusions. The limits on the identified rights are reasonable and justifiable in a free and democratic society for the following reasons:

- a reasonable and objective criteria has been used in cases of discrimination by using the least restrictive means to achieve the purpose;
- supports and promotes the prevention of motor accidents and the safe use of motor vehicles;
- supports a regulatory scheme that provides for personal injury insurance by limiting the scope of discretion and possible unequal treatment when an insurer provides defined benefits; and
- supports a positive social impact on the community by providing benefits as early as possible, hence allowing community members to support themselves and their family, and continue to make a contribution to society.

Clause Notes

Chapter 1 – Preliminary

This Chapter will deal with preliminary matters in relation to the Act, including important concepts used in the Act. The Chapter will also establish the Motor Accident Injuries (MAI) Commission.

Part 1.1: Preliminary

Clause 1: Name of the Act

This clause provides that the Act will be named the *Motor Accident Injuries Act 2019*. The non-inclusion of a reference to Third Party Insurance in the name of the Act reflects the new scheme covering anyone injured in a motor accident.

Clause 2: Commencement

This clause provides that the Act will commence on a day fixed by the Minister by written notice. If the Act has not commenced within 12 months, it will commence on the first day after that period. This extended commencement clause is to allow for implementation of the scheme by government and licensed insurers.

Clause 3: Dictionary

This clause provides that the Dictionary at the end of the Act forms part of the Act. The dictionary contains the definitions of terms used throughout the Bill, and refers to the *Road Transport (General) Act 1999* which contains definitions and other provisions relevant to this Bill. Other terms defined in the *Legislation Act 2001* apply.

Clause 4: Notes

This clause provides that a note included in the Act is explanatory and not part of the Act.

Clause 5: Offences against Act – application of Criminal Code etc

This clause will apply other legislation to offences under the Act including Chapter 2 of the *Criminal Code 2002*. These include offences of providing false and misleading information, fraud and forgery.

Clause 6: Objects of Act

This clause sets out the main objects of the Act 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 just resolution of disputes.

Clause 7: Application of Act

This clause provides that the Act 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 and involves at least one motor vehicle that has Motor Accident Injuries cover at the time of the Act. A motor vehicle will be taken to have Motor Accident Injuries cover if:

- there was an Motor Accident Injuries policy in place for the vehicle; or
- the vehicle was owned by the Territory or Commonwealth; or
- was insured under a compulsory third party policy in another jurisdiction; or
- there is, or there is deemed to be, a right of action against the Nominal Defendant.

Part 1.2: Important Concepts

This part set outs out both injury and insurance concepts used in the Bill.

Division 1.2.1: Injury concepts

Clause 8: Meaning of *person injured in a motor accident*

This is an individual that sustains a personal injury as a result of a motor accident.

Clause 9: Meaning of *personal injury*

This is a bodily injury of a person including, a psychological or psychiatric injury and damage to aids such as spectacles, wheelchairs, and prosthetic devices. It also includes the death of a person.

Clause 10: Meaning of *motor accident*

This is an incident involving the use or operation of a motor vehicle that causes injury to a person and happens if someone is driving a motor vehicle, or someone or something collides with a motor vehicle, or someone takes action to avoid colliding with a motor vehicle, or a motor vehicle runs out of control.

Clause 11: Meaning of *use* motor vehicle

The meaning of use a motor vehicle includes drive, park, or stop the motor vehicle on a road or road related area; maintain the vehicle; using a trailer while attached to the vehicle; or a tow truck towing or carrying an uninsured motor vehicle. It also includes a trailer towed by a motor vehicle becoming detached from a vehicle and running out of control.

Clauses 12 and 13: Meaning of *permanent impairment* and *whole person impairment* (or *WPI*)

A permanent impairment is a loss, loss of use, or damage or malfunction, of part of a person's body, a bodily systems or functions, or a part of a bodily system or functions.

A Whole Person Impairment is the permanent impairment of a person resulting from an injury sustained as a result of a motor accident. A Whole Person Impairment is expressed as a whole number percentage.

Clause 14: Meaning of *independent medical examiner* (or *IME*)

An Independent Medical Examiner is a doctor, who under, an arrangement with an authorised IME provider, conducts medical examinations for Whole Person Impairment assessments, and Significant Occupational Impact assessments.

Clause 15: Authorisation of IME providers

The Motor Accident Injuries Commission must authorise Independent Medical Examiner providers for the purposes of the Bill. The Motor Accident Injuries Commission may only authorise an entity as an Independent Medical Examiner provider. To qualify for authorisation, the Commission must be satisfied that the entity has expertise in arranging medical examinations for Whole Person Impairment assessments, and Significant Occupational Impact assessments and meets the criteria specified in the Motor Accident Injuries Guidelines. The entity must also enter into a Deed of Services with the Commission. The *Legislation Act 2001* provides that an entity includes an unincorporated body and a person (including a person occupying a position).

The Motor Accident Injuries Commission may make Motor Accident Injuries Guidelines regarding the criteria for authorising an Independent Medical Examiner provider, operational requirements to be imposed and fees that may be charged for Whole Person Impairment assessments and Significant Occupational Impact assessments. Guidelines are a disallowable instrument.

Division 1.2.2: Insurance concepts

Clause 16: Meaning of *nominal defendant*

This clause provides that the Nominal Defendant is the ACT Insurance Authority (ACTIA).

Division 1.2.3: Indexation concepts

This division will insert indexation concepts so specified amounts in the Bill are indexed in line with adjustments to Average Weekly Earnings.

Clause 17: Meaning of *average weekly earnings* (or *AWE*)

This means the series of Average Weekly Earnings (or AWE) issued by the Australian Statistician, as prescribed by regulation. The regulation making power will enable a given AWE series to be prescribed that is appropriate for indexing amounts in the ACT and for this to be changed if the Australian Statistician discontinues publishing an AWE series.

Clause 18: Meaning of *AWE indexed* for amount

The clause will provide for the indexing of an amount under the Bill. An amount will be Average Weekly Earnings (or AWE) indexed by adjusting the amount in line with adjustments to AWE, on an indexation day. A regulation will be made to prescribe an indexation day for each AWE indexed amount. All indexed amounts will be rounded to the nearest $10.

If a negative adjustment occurs for an AWE series, for a given indexation day, no reductions in an AWE indexed amount will be made. The AWE indexed amount will then only be increased on a subsequent indexation day, if a negative adjustment, has been fully offset by adjustments to AWE.

Clause 19: Indexation of defined benefits and quality of life damages

For each indexation day the Motor Accident Injuries Commission will publish a declaration detailing the Average Weekly Earnings (or AWE) indexation factor to be worked out in the way prescribed by regulation for amounts as indexed. The indexed amount will apply to any defined benefit payments based on the amount, payable from the indexation day. The declaration is a notifiable instrument. A regulation will be made to prescribe the method for determining an AWE indexation factor for an amount.

Division 1.2.4: Duties in relation to motor accidents

Clause 20: Duty to act in good faith – applicants, claimants and insurers

This clause will place 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 court is hearing a dispute, involving an insurer and an applicant or claimant, they may take a duty of a party into account, and make an order in relation to that duty. Insurers will also need to comply with their duties in this clause as a condition of their licence.

Clause 21: Obligation to cooperate with MAI insurer – responsible person and driver

This clause inserts an offence for a driver or responsible person that does not fully comply with any reasonable request by a Motor Accident Injuries insurer to provide information in relation to a defined benefit application of common law claim resulting from a motor accident. The offence has a maximum penalty of 20 units. The offence will not apply if the person has a reasonable excuse for not complying with a request.

Part 1.3: Motor accident injuries commission

This part establishes the Motor Accident Injuries Commission, the successor to the CTP Regulator, established under Part 1.3 of the CTP Act. Consequential amendments in Schedule 2 will deal with the transfer of the statutory position and functions of the current CTP Regulator to the Motor Accident Injuries Commission.

Clauses 22 to 24: Motor Accident Injuries Commission and Commissioner

These clauses will establish the Motor Accident Injuries Commission. The Motor Accident Injuries Commission will constitute the Motor Accident Injuries Commissioner and the staff of the Motor Accident Injuries Commission. By Clause 22, the Minister will appoint a public servant as the Motor Accident Injuries Commissioner, for a term not longer than five years.

Clause 25: Functions of MAI commission

This clause sets out the functions of the Motor Accident Injuries Commission. In line with the recommendations of the citizens' jury, the Motor Accident Injuries Commission's functions has been expanded from those of the CTP Regulator to include facilitating the provision of information about the new scheme and a stronger regulatory role, including monitoring insurer's compliance with their obligations in the Act.

Clause 26: Functions of MAI commissioner

This clause gives the Motor Accident Injuries Commissioner functions under the Bill or another Territory Law, this includes the powers necessary and convenient to exercise a function (per Section 196, *Legislation Act 2001*).

Clauses 27 to 29: Staff of the commission

These clauses will enable the Motor Accident Injuries Commission to employ public servants or to engage consultants or contractors, as staff of the Motor Accident Injuries Commission. These clauses are required to enable the Motor Accident Injuries Commission to have the necessary resources, including consultants, in carrying out the work of the Motor Accident Injuries Commission.

Clause 30: Delegation by MAI commission

This clause will enable the Motor Accident Injuries Commission to delegate functions to the Motor Accident Injuries Commissioner, staff of the Motor Accident Injuries Commission, to a public employee or another person prescribed by regulation. A delegate may then sub-delegate, to a public employee or another person prescribed by regulation, if the sub-delegation is authorised by the Motor Accident Injuries Commission. The express authority to sub-delegate is necessary to displace the effect of Section 231(2) of the Legislation Act. Unless expressly provided for in an Act, a delegate may not sub-delegate functions.

Clause 31: Delegation by MAI commissioner

This clause will enable the Motor Accident Injuries Commissioner to delegate functions to staff of the Motor Accident Injuries Commission, to a public employee or another person prescribed by regulation.

Clause 32: MAI commission arrangements for staff and facilities

This clause will enable the Motor Accident Injuries Commission to arrange with the Head of Service to use the services of a public servant or Territory facilities. It is a standard provision for Territory authorities.

Chapter 2 – Motor accident injuries – defined benefits

Part 2.1: Interpretation – ch 2

This part provides for the terms that are used for Chapter 2 of the Bill. All of the terms are new, as they relate to the provision of defined benefits in the ACT.

Clause 33: Meaning of *defined benefits*

This clause will define the types of defined benefits available under the scheme. Each are provided for in relevant sections of the chapter. These will be:

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

Clause 34: Meaning of *relevant insurer* for motor accident

This clause will define the concept of a relevant insurer. The relevant insurer for a motor accident that involves a single vehicle accident will be the insurer of that vehicle. This includes where an application is being made for an accident involving a cyclist or pedestrian.

For a multiple vehicle accident, this will be the insurer of the motor vehicle that is most at-fault. Generally, the relevant insurer will be an at-fault insurer, or the most at-fault insurer for an accident. If an injured person cannot work out who they should lodge their application with, the guidelines will outline which insurer to lodge an application with.

Insurers and the nominal defendant may enter into an arrangement to determine the most at-fault motor vehicle.

Clause 35: Meaning of *full and satisfactory explanation* by applicant – ch 2

This clause provides for what must be provided when a full and satisfactory explanation is required to be given by an applicant where there has been a delay in the making of an application. It provides examples of what may be considered a full and satisfactory explanation, including that there was a lack of awareness an application could be made.

An explanation is not a satisfactory explanation unless a reasonable person in the position of the application would have been justified in experiencing the same delay.

Clause 36: Meaning of *person who died as a result of a motor accident*

This clause has been inserted to provide clarification for when a person is considered to have died as a result of a motor accident. The provision is most relevant for the death defined benefit, as this is payable if person dies as a result of motor accident within two years after the date of the motor accident occurring from the injuries they sustained.

Clause 37: Meaning of *private medical examiner* – ch 2

This clause provides the definition of a Private Medical Examiner as a doctor who meets the requirements under the Whole Person Impairment assessment guidelines to conduct Whole Person Impairment assessments; and has qualifications or experience relevant to the nature of the injured person's injuries.

Part 2.2: Defined benefits – entitlement

Division 2.2.1: Entitlement to defined benefits

Clause 38: Person injured in motor accident entitled to defined benefits

This clause provides for any person who is injured in a motor accident in the ACT to have defined benefits paid under this chapter. This establishes the basis for defined benefits to be paid on a no-fault basis; that is the person does not need to prove a person was at-fault in order to obtain defined benefits. The types of defined benefits include treatment and care, and income replacement.

Clause 39: Defined benefits payable by relevant insurer

This clause provides for defined benefits to be payable by the relevant insurer. The relevant insurer concept has been introduced to clarify which third party insurer is liable for defined benefits. Under an at-fault scheme, the insurer that is liable is the insurer for the at-fault vehicle. Under a no-fault scheme this rule requires elucidation, which is provided for by Clause 32.

Clause 40: Payment of defined benefits by interstate relevant insurer

This clause provides for defined benefits to be payable by an interstate relevant insurer. An interstate insurer is not an insurer for the ACT scheme. As such, provision needs to be made for an interstate insurer to pay defined benefits.

Some schemes are not established to provide defined benefits or some interstate insurers may not wish to manage all of the claim themselves. The clause proposes that an interstate insurer may enter into an arrangement with the ACT Nominal Defendant to manage the claim on their behalf. The clause provides the Nominal Defendant with the necessary authority under an arrangement, including the authority to make decisions on an application for defined benefits and recover its costs. The clause also provides that the Nominal Defendant is the relevant insurer if an interstate insurer is unable to provide defined benefits to an at-fault driver.

Division 2.2.2: Limitations and exceptions to entitlement

There are human rights implications. Please see the human rights discussion above.

Clause 41: Meaning of *driving offence*

This clause provides for the meaning of driving offence, which is used in Division 2.2.2, *Limitations and exceptions to entitlement*. It provides for the offences under the *Crimes Act 1900*; *Criminal Code 2002, Road Transport (Alcohol and Drugs) Act 1977*; and the *Road Transport (Safety and Traffic Management) Act 1999* that apply as limitations or exclusions to the receipt of defined benefits. A provision may also be prescribed by regulation to be a driving offence. Any offence that is prescribed must be associated with a motor vehicle.

Clause 42: Definitions – div 2.2.2

This clause provides definitions for terms used in this division.

This clause provides that the level for the concentration of alcohol in blood or breath is defined under the *Road Transport (Alcohol and Drugs) Act 1977*. It applies to offences that require a certain level of intoxication.

The definition for a *non-conviction order* applies the definition of the *Crimes (Sentencing) Act 2005*.

The definition of *outstanding f*or a charge applies the definition of the Bail Act 1992.

Clause 43: Entitlement limited – uninsured motor vehicle

This clause provides the limitations for when a person may not be entitled to defined benefits if the vehicle they are driving is involved in a motor accident as defined under Clause 10. The provision also applies to the responsible person for the vehicle at the time of the accident. A responsible person is defined under Sections 10 and 11 of the *Road Transport (General) Act 1999* and includes for an unregistered vehicle the person/s last recorded as a registered operator of the vehicle. A responsible person is included because the offence is about an uninsured vehicle.

Income replacement benefits may be payable if more than one vehicle was involved in the accident and the other vehicle was responsible for the accident. For an uninsured motor accident there must be fault by the other driver for the entitlement to claim income replacement benefits to operate. However, if a registered vehicle is not-at-fault in a collision with an uninsured motor vehicle the driver and persons are entitled to eligible benefits under the scheme – subject to any other limitations.

A person will be entitled to income replacement benefits if only one vehicle was involved and it is a no-fault accident as defined under Clause 251. This would mean that even though the vehicle was unregistered if the driver or responsible person were injured as a result of a motor accident collision with a kangaroo, then they would be entitled to income replacement benefits under the scheme. A responsible person for, or driver of, an uninsured vehicle is prevented from being entitled to quality of life benefit only if the other vehicle was an at-fault for the motor accident.

If the driver of the vehicle believes on reasonable grounds that the vehicle was insured and the responsible person gave permission to drive the vehicle, then the driver would be entitled to income replacement benefits. However, if the responsible person was also in the vehicle when the motor accident occurred they would not be eligible for income replacement benefits as they are expected to know that the vehicle was not registered.

Clause 44: Entitlement limited – single driving offence

This clause limits the entitlement of a person to claim benefits if the person is charged and subsequently convicted of a single driving offence in relation to the motor vehicle accident. This clause does not apply to driving offences that may have occurred that were not related to the specific accident in which the entitlements are claimed.

The ability of a person injured in a motor accident who has been charged with a single driving offence to receive a quality of life payment is suspended while the charge has not been finalised. Once a person is convicted or found guilty of the driving offence, or if a declaration has been issued by the Motor Accident Injuries Commission to a person entitled to immunity under the *Diplomatic Privileges and Immunities Act 1967* (Cwlth), the injured person is not entitled to income replacement benefits or quality of life benefits. An injured person's entitlements do not end if the court makes a non-conviction order for the injured person in relation to the driving offence.

The Motor Accident Injuries Commission, on request of a relevant insurer, may declare that a person who has diplomatic immunity should not receive income replacement benefits or quality of life benefits. The Commission must before making any such declaration consider the police accident report and any other evidence provided by the police. This clause has been inserted to ensure that a person who would otherwise have been charged, convicted or found guilty of an offence, but for the diplomatic immunity, should not be placed in a better position than any other person who is a resident of Australia. Accordingly, a diplomat who has immunity should not also be allowed to benefit from their own wrongful behaviour.

In the interests of fairness and to minimise the negative impact on the injured person, the relevant insurer is prohibited from recovering any amount of defined benefits that were received by the injured person prior to being convicted or found guilty of the offence; or prior to the Motor Accident Injuries Commission making a declaration. Further, a decision by the Motor Accident Injuries Commission to issue a declaration is a reviewable decision under Chapter 10 and Schedule 1 to the Bill.

Clause 45: No entitlement – multiple driving offences

This clause will apply to a person injured in a motor accident that is charged with two or more driving offences in relation to the motor accident.

The clause provides for suspension of the quality of life payment and the process for a diplomatic immunity declaration by the Motor Accident Injuries Commission. An insurer is also prohibited from recovering any amount of defined benefits that were received by the injured person prior to being convicted or found guilty of the offence; or prior to the Motor Accident Injuries Commission making a declaration. An injured person's entitlements also do not end if the court makes a non-conviction order for the injured person in relation to 1 or more driving offences. The Commission's declaration is a reviewable decision.

Clause 46: Entitlement limited– injuries self-inflicted

This clause provides a person that intentionally caused self-inflicted injury as a result of the motor accident is not entitled to quality of life benefits or income replacement benefits. It applies the legal doctrine that no one shall be allowed to profit by his/her own wrong; a wrongdoer should not be enabled by law to take any advantage from his/her actions. However, before a relevant insurer denies benefits due to self-inflicted injuries, there must be sufficient evidence to support this conclusion.

The estate of a person who dies from self-inflicted injuries as a result of a motor accident may claim funeral benefits but will not be entitled to quality of life. A dependant of the person is not entitled to death benefits.

Clause 47: Entitlement limited – detainees and young detainees

This clause provides an injured person is not entitled to income replacement benefits or treatment and care benefits when the person injured in the motor accident is a detainee or young detainee. The intention of this clause recognises that an injured person will not be able to work while in detention and necessary treatment and care will be a matter for the relevant custodial facility.

A note has been included regarding treatment and care under the *Lifetime Care and Support (Catastrophic Injuries) Act 2014*. Under that Act, a person with a workplace injury is eligible to participate in the Lifetime Care and Support Scheme even though they are imprisoned.

Clause 48: No entitlement – serious offences

This clause will apply to a person injured in a motor accident if they are charged with a serious offence in relation to that motor accident. A serious offence is defined and includes offences in the *Crimes Act 1900*, *Road Transport (Alcohol and Drugs) Act 1977*, and *Road Transport (Safety and Traffic Management) Act 1999.*

The clause provides for suspension of the quality of life payment and the process for a diplomatic immunity declaration by the Motor Accident Injuries Commission. Due to the severity of the serious offences category, once the injured person is convicted or found guilty of the serious offence, or if a declaration has been issued by the MAI Commission to a person entitled to immunity under the *Diplomatic Privileges and Immunities Act 1967* (Cwlth), the injured person has no entitlement to income replacement, treatment and care and quality of life benefits. An injured person's

entitlements do not end if the court makes a non-conviction order for the injured person in relation to the serious offence.

An insurer is prohibited from recovering any amount of defined benefits that were received by the injured person prior to being convicted or found guilty of the offence; or prior to the Motor Accident Injuries Commission making a declaration. The Commission's declaration is a reviewable decision.

The Executive may make a regulation in relation to other offences that may be included in the future. This provision has been inserted to provide flexibility in updating references to legislation as offences are updated and amended. It is intended the regulation will relate only to offences relevant to the purposes of the serious offences provision. The addition of new offences will be subject to scrutiny by the Legislative Assembly through the regulation being tabled.

Clause 49: No entitlement – act of terrorism

This clause provides no entitlement to a person if the motor accident is caused by, or attributable to, an act of terrorism. The Motor Accident Injuries Commission will advise a relevant insurer when a motor vehicle involved in an accident was caused or attributable to an act of terrorism.

Clause 50: Entitlement limited – workers compensation applicant

This clause will limit entitlements to defined benefits under Chapter 2 of the Bill, if a person injured in a motor accident has an application accepted under a workers compensation scheme. A work related motor accident means the person could be eligible for statutory benefits or damages under their employer's workers' compensation scheme and under this scheme for defined benefits.

The clause recognises that a person that is entitled to defined benefits under Chapter 2 may make an application for compensation under their employers' worker compensation scheme. Where liability for a person's application is accepted by a workers compensation scheme the person will no longer be entitled to income replacement, treatment and care and quality of life defined benefits.

The person's entitlement will be revived if they withdraw their workers compensation application within 13 weeks after the date of a motor accident, or if their workers compensation application is denied. This time period aligns with the initial application period to apply for defined benefits under Chapter 2. It will also ensure that a worker that receives initial treatment and care benefits and income replacement benefits, under a workers compensation scheme, has sufficient time to make an informed decision about their preferred compensation scheme.

Defined benefits are not payable for any benefits paid and not recovered under the workers compensation scheme prior to a workers compensation application being withdrawn or being denied. This will prevent a person double dipping between two compensation schemes.

The clause will only apply to a person's entitlements to defined benefits under Chapter 2, and will not prevent a person that claims statutory benefits under a workers compensation scheme from then making a common law claim under Chapter 5, if there was a motor accident while at work.

Division 2.2.3: End of entitlement to certain benefits

Clause 51: When entitlement to certain benefits ends

This clause provides certainty by providing when an entitlement to income replacement benefits or treatment and care benefits ends. These benefits will end on whichever event occurs first: death, the claim is finalised, for example settled, the person obtains a judgement or agreement for damages in relation to the injuries independently of the Act, or five years from the date of the accident. Income replacement benefits will also end on the following events: if at the date of the accident the injured person had reached pension age and was in paid work, 2 years after the date of the accident; or otherwise reaching pension age plus two years.

Part 2.3: Application for defined benefits

This part contains provisions for people to make an application to a relevant insurer for defined benefits.

Division 2.3.1: Communicating with people in relation to motor accidents

Clause 52: Information and support for potential applicants for defined benefits – MAI guidelines

This clause will enable Motor Accident Injuries guidelines to make provision for information and support that must be given by an insurer to potential applicants for defined benefits. The guidelines may also make provision for when and how an insurer may give this information.

Division 2.3.2: Application for defined benefits

Subdivision 2.3.2.1: Definitions – pt 2.3

Clause 53: Meaning of *information* – pt 2.3

This clause provides that in this part information includes a record containing information.

Clause 54: Meaning of *authority to disclose personal health information*

This clause will set out what an authority to disclose personal health information must state. It also requires an authority to be signed by or on behalf of an injured person. An application for defined benefits must be accompanied by an authority so personal health information can be dealt with by an insurer and exchanged between them and an injured person's treating health service providers, members of their treating team, a health practitioner conducting an assessment of an injured person's treatment and care needs, or an independent medical examiner.

Subdivision 2.3.2.2: Making an application for defined benefits

Clauses 55 to 57: Application for defined benefits

These clauses will enable a person to make an application for defined benefits with the relevant insurer for a motor accident. Details of the form and content of an application, and the manner an application can be made, will be set out in the Motor Accident Injuries Guidelines.

The authority will be given for the purposes of processing, assessing or otherwise managing a person's application and ongoing entitlement to defined benefits. An applicant will be able to revoke an authority while still entitled to defined benefits, but if this occurs it may delay the payment of the applicant's defined benefits, as an insurer may need to obtain individual consents to continue to manage an application.

Clauses 58 to 59: Application period

These clauses require an application for defined benefits to be made within a given application period unless a late application is accepted if a full and satisfactory explanation is given.
An application, that is not incomplete, will be made, on the date it is received by an insurer.

An injured person seeking defined benefits payments for treatment, care and income replacement needs to make an initial application to a relevant insurer within 13 weeks following the date of an accident, with late applications being able to be accepted up to two years after an accident.
For funeral and death benefits an application needs to be made within 13 weeks following the date of an injured person's death, with late applications being able to be accepted up to one year after the death.

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 an accident takes place.

An insurer may request additional information in relation to a late application and need not make a decision about accepting the application until this information is received. However, if an insurer does not respond to an explanation for a late application within 28 days, the late application will be taken as being accepted. The relevant insurer need not accept an application if it is made outside of the timeframes.

To receive quality of life benefits, an initial applicant for defined benefits will need to apply to their insurer for a Whole Person Impairment assessment once their injury has stabilised.

Clause 60: Application for defined benefits – action following receipt

This clause will set out actions an insurer must take on receiving an application, and makes provision for the Motor Accident Injuries guidelines to specify information to be included in, and the period for giving, a receipt notice, late receipt notice, or a required additional information notice.

Division 2.3.3: Payment of allowable expenses

Clauses 61 to 64: Allowable expenses

These clauses will make provision for certain allowable expenses (for treatment and care) to be automatically approved during the first four weeks from the receipt of an application and to be paid on a reimbursement basis. This will allow access to early treatment and care that may otherwise be delayed until liability for an application is accepted.

An allowable expense will only be an expense that is incurred during the initial application period, and not an expense incurred prior to the receipt of an application. Provision will be made for the Motor Accident Injuries guidelines to specify the types of treatment and care for which an allowable expense may be incurred and also include restrictions on the payment of these expenses.

Division 2.3.4: Accepting or rejecting liability for defined benefits

Clauses 65 to 68: Obligations of a relevant insurer

These clauses will deal with the timeframes for, and actions an insurer must take, in accepting or rejecting an application for defined benefits.

An insurer will have up to 28 days to accept or reject liability for an application after the date of a receipt notice is given to an applicant. A defined benefits notice, including any information required by the Motor Accident Injuries guidelines, will need to be given by a relevant insurer on acceptance of liability of an application. A relevant insurer is then liable to pay all defined benefits that an applicant is entitled to. The Motor Accident Injuries guidelines may make provision in relation to the payment of defined benefits.

If liability is not accepted because another insurer is the relevant insurer, then a transfer notice, with contact details for the other insurer will need to be given. If an application is otherwise rejected then an insurer will need to give an applicant a rejection notice including reasons for the decision and information as to how the decision may be disputed. An application will be taken to be rejected the day a relevant insurer gives a notice to an applicant.

A decision by an insurer to accept an application will not prevent an insurer from making a later decision to reject liability; however, they will only be able to recover any amounts paid from another insurer if that insurer later accepts liability for an application. An insurer will be able to recover amounts paid to an applicant on rejection of an application, if an application was based on false or misleading information, or if the applicant was never entitled to defined benefits because they were convicted of a serious or multiple driving offences when they made an application.

Division 2.3.5: Transfer of an application to another insurer

Clause 69: Transfer of application to another insurer

This clause will enable an insurer, being the first insurer, to transfer an application to another insurer because the other insurer appears to be liable for an application. A second insurer may then decide to accept liability for an application, no later than 28 days after the date of a receipt notice given to an applicant. At this point in time the first insurer must give an applicant a transfer notice. The second insurer will advise the applicant about the acceptance of liability for the application and the need for a new authority enabling the second insurer to disclose personal health information.

Clause 70: Dispute about liability for application

This clause details the process for handling an application if there is a dispute about liability for an application between two insurers. In these circumstances, the first insurer will need to notify the Motor Accident Injuries Commission of the dispute, and notify the applicant that liability for an application will not be decided until the dispute is resolved. The dispute must be dealt with in accordance with the insurance industry deed.

The first insurer will continue to be liable for the applicant's allowable expenses, and then from four weeks after a receipt notice, the applicant's treatment, care, income replacement, and any funeral benefits until the dispute is resolved. If the second insurer, is found to be liable for an application, then the first insurer may recover both allowable expenses and defined benefits already paid, and the cost of managing and disputing the application.

Division 2.3.6: Miscellaneous – pt 2.3

Clause 71: Fraudulent application or requests

This clause will enable the relevant insurer to refuse to accept liability for an application for defined benefits or reimburse or pay any treatment and care expenses, if the insurer suspects that information in an application or a request is false or misleading. If it is later established that the application or request was not false or misleading, the relevant insurer must reimburse or pay treatment and care expenses. If an insurer has not made a decision to accept or reject liability for an application, they must still pay allowable expenses. However, these expenses may be recovered from an applicant if it can then be shown that the application was based on false and misleading information.

Clause 72: Recovery of amounts paid for defined benefits

This clause will enable the relevant insurer to recover defined benefits amounts from an applicant if an insurer was not liable to pay an amount under Part 2.3. This provision will cover circumstances where there is an over payment of an amount through an error or mistake. If an insurer rejects an application because an applicant's injury was not caused by a motor accident, then the insurer may not recover any amount paid to the applicant unless the application was fraudulent or included false and misleading information.

Clause 73: Application for defined benefits –notification of application under workers compensation scheme

This clause will require a person injured in a motor accident that applies for defined benefits, to notify an insurer about details of any application for compensation under a workers compensation scheme in relation to the injury and also of the withdrawal of any workers compensation application if that withdrawal occurs with 13 weeks of the motor accident. Notices must be given to an insurer when an application for defined benefits is made, or if a workers compensation application is subsequently made or withdrawn, within three business days of the application being made or withdrawn. If an insurer receives a notice under this section they will be able to get information about the application from the workers compensation insurer.

Part 2.4: Defined benefits – income replacement payments

This part will provide for the payment of income replacement benefits to compensate people for income lost through being unable to work, or through working at a reduced capacity, because of their injury.

Division 2.4.1: Income replacement benefits – important concepts

Clause 74: Definitions – pt 2.4

This clause includes some key definitions for the part.

A fitness for work certificate will be a certificate providing evidence of a person's fitness for work provided under Clause 104.

A person will be self-employed if they derive income from labour, skills or knowledge from a business carried on by the person.

Unpaid leave, from paid work, will include unpaid parental leave, and unpaid leave for more than 52 weeks. Under this definition a person on unpaid leave will always have a right to return their paid work at the end of their unpaid leave.

Clauses 75 to 79: Key concepts

These clauses provide for key concepts used to work out entitlements to income replacement benefits for persons injured in a motor accident.

An income replacement benefit payment will be a benefit payment payable for the first payment period under Clause 96 of the Bill and for the second payment period under Clause 97 of the Bill.

To be entitled to income replacement benefits a person needs to show, at the date of an accident, they were either in paid work or capable of being in paid work at a later date. A person will be regarded as being in paid work if they are engaged in any work for remuneration or other financial benefit. This can include work as either an employee or as a self-employed individual, full or part-time work, and paid leave from work. The Motor Accident Injuries guidelines will be able to make provision as to what is, and is not, taken to be paid work.

Persons that are not in paid work on the date of an accident, such as persons that may work on a casual or seasonal basis, may still be regarded as being capable as being in paid work if they have a connection with the workforce. A person will be capable of being in paid work if they have worked at least 260 hours in the 52 weeks before the accident, or were on unpaid leave before the accident and anticipated returning to work after the accident. People receiving workers compensation or with a new work arrangement, at the date of the accident, or full-time students over 15 years of age expecting to be in the workforce on completion of their course, will also be capable of being in paid work. The Motor Accident Injuries guidelines may also make provision for matters to be taken into account in determining whether an injured person is capable, or not capable of being, in paid work.

The gross income of a person that is an employee will, subject to certain exclusions, include all before tax amounts paid that relate to their employment including, overtime, voluntary salary sacrificed amounts and statutory loss of income payments under a workers compensation scheme. Compulsory superannuation contributions and one-off amounts payable on termination of employment will be excluded from gross income.

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. The net income amount will be based on the income of the business, after expense deductions, with adjustments being made to reflect amounts of income or deductions, which do not relate to the person's provision of personal services to the business.

Clause 80: Meaning of *pre-injury income*

This clause will provide that the pre-injury income for an injured person means the persons pre-injury weekly income or pre-injury earning capacity.

Clauses 81 to 84: Pre-injury weekly income concepts

These clauses will allow for pre-injury weekly income to be worked out for injured persons that were either in paid work or have a recent history of paid work at the time of a motor accident, including persons receiving worker compensation at the time of an accident.

A person's pre-injury weekly income, will generally be worked out as their average weekly income from all paid work during the 52 weeks before an accident. Income from paid work will include statutory payments for loss of income under a workers compensation scheme. A person will be able to combine income received from multiple employers, or self-employment arrangements for the purposes of the calculation. A shorter income period may apply to people engaged in ongoing or fixed term employment who had a significant change in circumstances, such as starting a new job, or moving from part-time to full-time work during the 52 weeks before an accident.

Special rules will also apply to simplify working out pre-injury weekly income for people in casual employment, as these people may work for a number of employers over a year. If a person has worked 260 hours in the 13 weeks before an accident then their pre-injury weekly income may be based on their average weekly income from all paid work during the 13 week period. This provision will not apply to people that were engaged in ongoing or fixed term employment, or were self-employed, at the date of an accident.

The amount paid to a person hired to perform their work after an accident may also be taken into account when working out the pre-injury weekly income of a person that was self-employed at the date of an accident.

Clauses 85 to 87: Pre-injury earning capacity concepts

These clauses will allow for pre-injury earning capacity to be worked out for injured persons with an arrangement to be in paid work at a later date after a motor accident.

A person that was on unpaid leave at the time of a motor accident, pre-injury earning capacity will generally be worked out as their average weekly income from their employment in the 52 weeks prior to starting their unpaid leave. A shorter income period may apply if the person had a significant change in their circumstances during the period prior to starting their unpaid leave.

A person that has a new work arrangement to start employment or a business, on the date of, or a date after, a motor accident, pre-injury earning capacity will be the weekly amount they will be paid or are projected to derive under the arrangement. For a prospective employee this will be based on their gross income from the arrangement and for a person starting business this will be based on their net income as a self-employed person.

A full-time student's pre-injury earning capacity will be based on the weekly amount they would have received on being employed in the occupation they would be qualified for on the completion of their course of studies. In the case of a full-time student at secondary school this will be based on the weekly amount the person would have received on being employed on successful completion of their final year of secondary school. In the case of an ACT secondary student this will be on the completion of year 12.

Clause 88: Pre-injury weekly income and pre-injury earning capacity – MAI guidelines

The Motor Accident Injuries guidelines will be able to make provision in relation to matters to be taken into account when working out a person's pre-injury weekly income or pre-injury earning capacity. The guidelines will assist the insurer in working out particular circumstances, for example

the self-employed person's income from personal services; the student's likely income on completion of their studies.

The guidelines will also clarify that a person that has both pre-injury weekly income and pre-injury earning capacity will still be able receive pre-injury weekly income payments until the point in time that they can receive a higher payment based on their pre-injury earning capacity. This could include full-time students with casual jobs and also persons that were on unpaid parental leave at the time of the accident, but had some work history in the 12 months prior to the accident.

Division 2.4.2: Income replacement benefits – entitlement

Clauses 89 to 92: Entitlement

These clauses determine which people injured in a motor accident are entitled to income replacements benefits.

A person will be entitled to income replacement payments, subject to certain limitations and exclusions, if they are at least 15 years old, and either in paid work, or capable of being in paid work, on the date of the motor accident. The Motor Accident Injuries guidelines may also make provision in relation to entitlements to income replacement benefits.

A person will not be entitled to income replacement benefits upon their death. An income replacement payment may still accrue for an injured person prior to their death.

A person will also not be entitled to income replacement benefits if, when an accident happens, they have reached pension age and are not in paid work, or if they have already been paid damages for loss of income under a motor accident claim. However, if a person has reached pension age, but on the date of the motor accident was in paid work, they will be entitled to income replacement benefits for up to two years from the date of the motor accident.

Division 2.4.3: Income replacement benefits – payments

Clause 93: Definitions – Division 2.4.3

This clause will set out key definitions for working out the amount of income replacement benefits.

Payments will be worked out for a first and second payment period. The first payment period will begin on the date of the motor accident and end 13 weeks after the date of the accident. The second payment period will begin on the day after the end of the first payment and end five years after the date of the motor accident.

An injured person's pre-injury income will be their pre-injury weekly income or their pre-injury earning capacity.

The relevant insurer may need to make a decision about an injured person's post-injury earning capacity. This will be the weekly amount that a person has the capacity to earn in paid work for which they are reasonably suited because of education, training and experience based on a person's fitness for that work.

Clause 94: Meaning of *AWE adjusted* – Division 2.4.3

This clause will provide for the adjustment of an injured person's pre-injury income to reflect movements in an Average Weekly Earnings (or AWE) series. An amount of pre-injury income will be AWE adjusted in line with adjustments to AWE, on an adjustment day. A regulation will be made to prescribe an adjustment day for pre-injury income amounts. Adjusted amounts will be rounded to the nearest dollar.

If a negative adjustment occurs for an AWE series, for a given adjustment day, no reductions in an AWE adjusted amount will be made. The AWE adjustment amount will then only be increased on a subsequent adjustment day, if a negative adjustment, has been fully offset by adjustments to AWE.

Clause 95: Adjustment of pre-injury income

This clause provides for each adjustment day the Motor Accident Injuries Commission will publish a declaration detailing the Average Weekly Earnings (or AWE) adjustment factor for pre-injury income amounts to be adjusted on that day. The adjusted pre-injury income amount will be payable from the adjustment day. The declaration will be a notifiable instrument.

A regulation will be made to prescribe the method for determining an AWE adjustment factor for an amount.

Clauses 96 and 97: Amount of income replacement benefits (first and second payment periods)

These clauses set out a formula for working out the amount of income replacement benefit payments for the first and second payment periods.

(P-A) x (N)

An injured person will be entitled to an income replacement benefit, for each week, worked out by multiplying the difference between their pre-injury income (P) and their post-injury earning capacity (A) by a proportionate factor (N). All amounts of pre-injury income used in the formula will be Average Weekly Earnings (or AWE) adjusted and a person's pre-injury income will be capped at $2,250 AWE indexed.

For the first payment period a factor of 1 will apply to low income earners with pre-injury income of less than $800 AWE indexed, or a factor 0.95 if a person's pre-injury income is $800 AWE indexed or more.

For the second payment period a factor of 1 will apply if a person's pre-injury income is less than $800 AWE indexed, a factor of 0.95 will apply if a person's pre injury income is from $800 AWE indexed to $1,000 AWE indexed, and a factor of 0.8 if a person's pre-injury income is more than $1,000 AWE indexed.

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 therefore does not have any post-injury earning capacity (A).

Suzy's pre-injury weekly income, being her pre-injury income (P), will be calculated as:

$15,800 ÷ 52 = $303.85

As this income is less than $800 per week (N=1), 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.

Clause 98: Amount of income replacement benefits – injured person receiving workers compensation

This clause will reduce the amount of an income replacement benefit for an injured person, for a given week, by the amount of a weekly payment or other payment, for the loss of income that is paid from a workers compensation scheme in relation to the week.

The clause may apply where an injured person is receiving workers compensation benefits for workplace injuries, independent of injuries sustained in a motor accident.

Clause 99: Payment of increments – apprentice, trainee or young person

This clause will enable the pre-injury weekly income of apprentices, trainees and junior workers to be worked out, for any week after an accident, by taking into account any increments they may have otherwise received if they had continued in their employment if the motor accident had not happened. This will include increments based on age, and on completion of a period of service or a course of training. The provision will only apply to persons that were at least 15 years old but less than 21 years old at the time of an accident. The Motor Accident Injuries Guidelines may make provision for matters to be taken into account in determining the payment of increments.

Clause 100: Injured person's post injury earning capacity

This clause will enable the relevant insurer to make a decision about an injured person's post-injury earning capacity, including for the purpose of assessing the person's fitness for work as a result of their injury. The clause also includes matters that an insurer must have regard to when assessing a person's fitness for work. These include the nature of a person's injury, the likely process of recovery, their treatment and care needs, and any fitness for work certificates the person provides.

The Motor Accident Injuries guidelines may make provision for matters to be taken into account and procedures to be put in place when determining a person's post-injury earning capacity.

Clause 101: Income replacement payments – period payable

This clause sets out the start and end date for the period for which income replacement payments will be payable. An injured person will become entitled to be paid income replacement benefits from when the relevant insurer accepts liability for a defined benefit application.

For persons to whom clause 90(2) applies, income replacement benefits will end two years after the date of the motor accident. In any other cases, income replacement benefits will end two years after the person reaches pension age or 5 years after the date of the motor accident.

For persons that apply for defined benefits during the initial application period, and were in paid work, receiving workers compensation or were casual workers, at the date of an accident, income replacement payments will be back paid to the date of an accident. If a late application is made, and there are not exceptional circumstances justifying earlier payment, then income replacement payments, will only be back-paid for 28 days before the date of the late application. The Motor Accident Injuries guidelines may make provision for the kinds of circumstances that may be exceptional circumstances.

Where a person was anticipated to return to work from unpaid leave, or start work after full-time studies, or start a new work arrangement after the date of a motor accident, then income replacement payments will be back-paid no earlier than the anticipated start or return date. Entitlements to income replacement benefits end five years after the date of a motor accident.

Clause 102: Income replacement benefits – payable fortnightly

This clause will provide income replacement benefits will be payable to an injured person every 14 days after the start date for the person worked out under Clause 103.

Clause 103: Income replacement benefits – interim weekly payments

This clause will enable the relevant insurer to make interim income replacement payments to an injured person if the insurer has accepted liability for a defined benefit application, and has asked for additional information to work out the actual amount of a payment. An insurer may make interim weekly payments until whichever of the following happens first: they are given the additional information; 28 days after asking for the additional information; or 13 weeks after the date of an accident. An interim payment will be payable every 14 days after the start date for an injured person worked out. A start date for an injured person means the start date for the injured person, worked out under clause 101.

Regulations will set the amount of an interim payment as a prescribed percentage of the pre-injury weekly income cap ($2,250 Average Weekly Earnings indexed). An injured person will be able to request an insurer pay a lower interim amount. The Motor Accident Injuries guidelines may also make provision in relation to interim weekly payments.

Division 2.4.4: Income replacement benefits – injured person's obligations

This division sets out obligations, and consequences of not complying with those obligations, for injured persons receiving income replacement payments. 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.

Clause 104: Requirement for evidence in relation to fitness for work etc

This clause will require an injured person to provide the relevant insurer with a fitness for work certificate covering any period for which income replacement benefits are payable. A certificate may not be for a period more than 13 weeks before the date of the certificate. A person must also give a signed declaration to an insurer about any paid work undertaken since giving a relevant insurer a previous certificate. The Motor Accident Injuries guidelines may make provision for the form and content of a certificate and also who may give a certificate and the period to which a certificate may apply.

Clause 105: Suspension of benefit payments – failure to comply with request for assessment

This clause will enable the relevant insurer to suspend defined benefit payments, including treatment and care benefits, if a person does not comply with a request for a medical or vocational assessment to assess the person's fitness for work. A relevant insurer will need to give a person a suspension notice at least two weeks before a proposed suspension. The notice needs to state reasons for the decision, actions a person may take to avoid suspension, and refer to internal review rights.

Clause 106: Offence – failure to notify changed circumstances

Under this clause a person receiving income replacement payments will commit an offence if they do not notify an insurer about a change in circumstances within a prescribed period after a change happens. The offence will have a maximum penalty of 20 penalty units. A prescribed period will be 10 business days or another period prescribed by regulation. Regulations may also prescribe how a notice to an insurer must be given. A change in circumstances happens if person returns to or starts paid work, or the amount of income the person receives from work changes.

Clause 107: Notice required to reduce or stop income replacement benefit payments

Under this clause the relevant insurer will need to give adequate notice of a decision to stop or reduce a person's income replacement benefit payments because the person is no longer entitled to these benefits. A person in continuous receipt of payments for at least four weeks will need to be given at least two weeks' written notice of such a decision. A notice will need to state the date of effect and reasons for the decision, and refer to internal review rights. If a decision is not notified in accordance with the provision then a person is entitled to recover income replacement benefit payments from the relevant insurer for any period the provision was not complied with.

This provision will not apply where payments are suspended or reduced because a person fails to comply with a request for a fitness for work assessment or an assessment of a person's injuries, or if a certificate of fitness expires, or a person returns to, or earns more from work.

Division 2.4.5: Income replacement benefits – miscellaneous

Clause 108: Income replacement benefits not commutable to lump sum

This clause will prohibit the relevant insurer from extinguishing an injured person's future entitlement to income replacement benefit payments, by making a lump sum payment. This provision will not apply if a lump sum agreement between an insurer and a foreign national under Clause 181.

Clause 109: Employer reimbursement for paid leave

This clause will enable an injured person to ask a relevant 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.

Part 2.5: Defined benefits – treatment and care benefits

This part will provide for the payment of reasonable and necessary treatment and care expenses for a person injured in a motor accident.

Division 2.5.1: Preliminary

Clause 110: Meaning of *treatment and care*

This clause will provide a list of the types of treatment, care, support or aids that are considered to be treatment and care of a person injured in a motor accident. The list includes attendant care services, rehabilitation, education and vocational training, and home and transport modification. Attendant care services, for a person injured in a motor accident, will mean services that aim to give the person assistance with everyday tasks and therefore may include personal assistance, nursing, home maintenance and domestic services.

There is scope to make regulations to prescribe or exclude as treatment care, other kinds treatment, care, support or services.

Clause 111: Meaning of *rehabilitation*

This will be the process of enabling, or attempting to enable, an injured person to attain and maintain: a maximum level of independent living; and full physical, mental, social and vocational ability; and full inclusion and participation in all aspects of life.

Division 2.5.2: Treatment and care benefits – entitlement

Clause 112: Who is entitled to treatment and care benefits?

This clause sets out what treatment and care benefits, subject to certain limitations and exclusions, a person injured in a motor accident will be entitled to. A person will be entitled to benefits for treatment and care expenses, domestic services expenses and travel expenses.

Clause 113: Meaning of *treatment and care expenses* – ch 2

Treatment and care expenses will not include expenses incurred for treatment and care that was not reasonable and necessary, or did not relate to a personal injury sustained in the motor accident, or for which the injured person has not paid and is not liable to pay for. An example of expenses that a person would not pay for would be nursing or domestic care provided by a domestic partner or relative on a gratuitous basis.

Clause 114: Meaning of *domestic services expenses* – pt 2.5

Domestic services expenses will be reasonable and necessary expenses incurred by an injured person in employing another person to provide domestic services to their dependants. This will only include expenses for domestic services the person provided to their dependants prior to an accident and their dependants are not able to undertake themselves because of their age, or physical or mental incapacity. A dependant will include members of a person's immediate family and close relatives and also other persons that were a member of the persons household when an accident happened.

Clause 115: Meaning of *travel expenses* – pt 2.5

Travel expenses will be reasonable and necessary travel and accommodation expenses incurred by a person and an accompanying parent or other carer so an injured person can undergo treatment and care.

Clauses 116 and 117: No entitlement to treatment and care benefits – allowable expenses and damages already paid

Theses clauses will exclude entitlement to treatment and care benefits for expenses that have already been paid for by an insurer.

Clause 118: No entitlement to treatment and care benefits – LTCS scheme participant

This clause provides a person that is a participant in the Lifetime Care and Support Scheme (LTCS) is not entitled to treatment and care benefits from the Motor Accident Injuries scheme. Treatment and care benefits are paid by the LTCS.

Clause 119: Treatment and care benefits not payable in certain circumstances

This clause provides the relevant insurer will not have to pay treatment and care benefits to a person if the insurer has already paid their provider for treatment and care they have received under a direct billing arrangement or if the injured person receives ambulance transport they are not liable to pay for. Insurers may enter into direct billing arrangements with an injured person's treatment or care provider so an injured person does not need to pay for and then seek reimbursement for approved treatment or care expenses. The provision will prevent an injured person double dipping in circumstances where treatment or care has already been paid for under such an arrangement.

Clause 120: Deciding whether treatment and care is reasonable and necessary

This clause will require the relevant insurer, in deciding whether treatment and care is reasonable and necessary, to consider whether the treatment and care is:

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

An insurer must also consider the appropriateness of a provider of the treatment and care. An appropriate provider will include a qualified medical or allied health provider or a bona fide service provider. An insurer will also consider the Motor Accident Injuries guidelines for treatment and care benefits.

Division 2.5.3: Treatment and care benefits – assessment

Clause 121: Assessment of an injured person's injuries

The clause will enable the relevant insurer to require a person to attend a health practitioner to assess the person's needs for treatment and care. This could include a medical or vocational assessment. An injured person must comply with any reasonable request made by an insurer in relation to an assessment. If an injured person fails to comply with a reasonable request without reasonable excuse then an insurer may suspend the person's treatment and care and income replacement benefits until the person complies with the request. The Motor Accident Injuries guidelines may make provision for the conduct of assessments and the suspension of treatment and care benefits under this provision.

Division 2.5.4: Treatment and care benefits – recovery plans

Clauses 122 to 127: Recovery plans

Theses clauses will require tailored recovery plans to manage and coordinate the delivery of medical treatment, rehabilitation and training services to be put in place by the relevant insurer for injured persons with ongoing incapacity.

A recovery 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 for defined benefits. An injured person and their treating doctor must be given a draft plan and allowed a reasonable opportunity to consider the draft. The final version of the 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 time period will apply if a person was hospitalised after an accident, or if permitted in the Motor Accident Injuries guidelines. It is proposed that the Motor Accident Injuries guidelines will allow for a longer time period where medical information is still being gathered for the plan.

A recovery plan will state the treatment and care approved by the insurer as reasonable and necessary treatment and care for the person. The plan will also include a statement that a person's entitlements to treatments and care benefits, and income replacement benefits, will be suspended if they unreasonably fail to undergo the treatment and care in the recovery plan.

The Motor Accident Injuries guidelines may make provision for matters in relation to a recovery plan. It is proposed that 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 recovery plan must be reviewed at least at 13 week intervals by the insurer, or if there is a material change in a person's condition, circumstances or treatment outcomes. An injured person must also tell an insurer, as soon as practicable if they are unable to comply with a recovery plan. In these circumstances they may also ask for a new recovery plan.

Division 2.5.5: Treatment and care benefits – payment

Clause 128: Treatment and care benefits – period payable

This clause sets out the start and end date for the period for which treatment and care benefits will be payable. An injured person will become entitled to be paid treatment and care benefits from when the relevant insurer accepts liability for a defined benefit application.

If an insurer accepts an application for defined benefits within the initial application period, then treatment and care benefits will be back-paid to the date of the motor accident. In the case of a late application, they will only be back-paid to 13 weeks prior to the date of an application unless exceptional circumstances justify the payment of expenses from the date of the accident. The Motor Accident Injuries guidelines may make provision for the kinds of circumstances that may be exceptional circumstances. Entitlements to treatment and care benefits end five years after the date of the motor accident.

Clause 129: Payment of treatment and care benefits

This clause will require the payment of treatment and care expenses, domestic service expenses and travel expenses for an injured person entitled to treatment and care benefits. The Motor Accident Injuries guidelines may make provision for verifying that treatment and care, domestic services expenses and travel expenses were incurred including that any treatment and care was given, and the injury for which treatment was given resulted from the motor accident. The Motor Accident Injuries guidelines may also make provision for when a payment of treatment and care benefits may be made before an expense is incurred. Treatment and care expenses are expenses incurred that are either approved by the insurer or set out in a person's treatment and recovery plan.

Clause 130: Treatment and care benefits not commutable to lump sum

This clause will prohibit the relevant insurer from extinguishing an injured person's future entitlements to treatment and care benefit payments by making a lump sum payment. This provision will not apply if a lump sum payment is agreed between an insurer and a foreign national under Clause 181 of the Act.

Clause 131: Treatment and care benefits – MAI guidelines

This clause will enable the Motor Accident Injuries guidelines to make provision for matters in relation to treatment and care benefits.

These guidelines may stipulate what constitutes reasonable and necessary treatment and care, amounts and limits on benefits payable, and the evidence required to verify treatment and care needs and costs. The guidelines will apply to all treatment and care received by an injured person including for domestic services provided to an injured person's dependants, and for travel to undergo treatment and care.

The guidelines may also cover information that a health practitioner may ask an injured person or relevant insurer for in relation to an assessment of a person's treatment and care needs under Clause 121 of the Bill or the circumstances that an insurer may ask for a medical assessment for a person.

The guidelines may also set out arrangements for paying treatment and care expenses provided in a public hospital, by an ambulance service or through a provider that bulk bills for a service. The principles to be followed by health practitioners in relation to the provision treatment and care may also be included the guidelines.

Part 2.6: Defined benefits – quality of life benefits

Division 2.6.1: Quality of life benefits – entitlement

Clause 132: Who is entitled to quality of life benefits?

This clause provides for when there is an entitlement to a quality of life benefit. An injured person is not eligible to a quality of life benefit unless the injury from the accident has been assessed as at least five per cent Whole Person Impairment. The meaning of permanent impairment and Whole Person Impairment are defined under Clauses 12 and 13 to this Bill.

Whole Person Impairment is a scale and its application is generally well accepted and understood by medical professionals and is used by a number of schemes in Australia and around the world. The Whole Person Impairment has been selected as it provides measurable assessment criteria that will minimise inconsistent assessments for like injuries and has been adopted as the general assessment criteria applied to workers compensation injuries. For the purposes of this Bill the Safe Work Australia template *Guidelines for the Evaluation of Permanent Impairment*, modifying the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, Fifth Edition (AMA 5), apply for all Whole Person Impairment purposes.

Subclause 132(2) provides that the quality of life benefits is subject to other relevant provisions of the Bill.

Clause 133: WPI taken to be 10% in certain circumstances

This clause provides a distinction in relation to children with respect to the Whole Person Impairment threshold of 10 per cent. It provides that if at the time of sustaining an injury in a motor vehicle accident the person was a child and at four years and six months after the day of the accident the person is in receipt of treatment and care and meets the requirement of the regulation for treatment and care, the child can be taken to have a Whole Person Impairment of 10 per cent. A child for this purpose is under the age of 18 years of age.

A child may choose to make a quality of life benefit application, and therefore obtain a Whole Person Impairment assessment for that purpose. Where a WPI assessment is carried out in relation to a child, the assessment may increase but not reduce, the injured person's assessed WPI. Where the requirements of the regulation are not met, the final offer provisions of a WPI between 5 and 9 per cent apply.

This provision recognises that due to variances that apply to a child as they develop, it may not be possible to assess their Whole Person Impairment because injuries do not stabilise in time for the assessment under the Act.

Clause 134: No entitlement to quality of life benefits – foreign national living outside Australia

This clause provides that a person injured in a motor accident is not entitled to quality of life benefits if the injured person is a foreign national living permanently outside Australia.

Clauses 135 and 136: No entitlement to quality of life benefits – benefits and damages already paid

These clauses make it clear that an injured person is only entitled to one quality of life payment. If the quality of life benefit has been paid there is no entitlement to a further quality of life benefit. If a person receives a quality of life benefit, they are not entitled to quality of life damages in a proceeding for a motor accident claim.

Division 2.6.2: Quality of life benefits – application

Clause 137: Quality of life benefits application

This clause provides that to make an application for a quality of life benefit the injured person must have received a receipt notice or a late receipt notice issued under Clause 60. This means that an injured person is not able to proceed immediately to a notice of claim without first having received defined benefits for a minimum of 26 weeks. An upper limit of four years and six months is provided to minimise the risk that a quality of life Whole Person Impairment assessment cannot be arranged before the limitation period to commence a proceeding expires. Special provisions apply to an assessment at the four years and six months from the date of the accident – see Clause 141.

Clause 138: Insurer believes injuries stable and permanent impairment

This clause provides that the relevant insurer must make an appointment with an Authorised Independent Medical Examiner Provider for a Whole Person Impairment assessment on receiving a quality of life application from the injured person. An Authorised Independent Medical Examiner Provider is an entity authorised under Clause 15 by the Motor Accident Injuries Commission for the purpose of arranging medical examinations for Whole Person Impairment assessments. The relevant insurer is only required to make the appointment if two preconditions are met namely, the insurer reasonably believes the person's injuries have stabilised and those injuries are likely to result in a permanent impairment. If either of these preconditions are not met then Clauses 140 and 141 apply for the arranging of an appointment with an Authorised Independent Medical Examiner Provider.

Clause 139: Insurer believes injuries stable but no permanent impairment

This clause provides for an assessment to occur where a relevant insurer considers the injuries stable but no permanent impairment. The insurer is under an obligation to provide a written notice regarding their conclusion, including the reasons for the belief. There must be sufficient evidence, including medical evidence, to support the decision. The Motor Accident Injuries guidelines may specify the qualifications required for person making the decision.

In providing the notice, the relevant insurer must outline the basis for the belief the person is stabilised but not permanently impaired and advise the injured person they will not refer the person for a Whole Person Impairment assessment unless the person confirms the request and pays an excess to the insurer.

If the injured person advises the insurer that they still wish to proceed to have a Whole Person Impairment assessment undertaken and pay the excess payment, the insurer must arrange for an assessment to be undertaken with an Authorised Independent Medical Examiner Provider. The insurer may not refuse to make the arrangements on behalf of the injured person.

On receiving a Whole Person Impairment report, if the injured person's Whole Person Impairment is greater than zero per cent, then the insurer must reimburse the person the excess payment. The excess payment will be set as the higher amount of $500 Average Weekly Earnings (AWE) indexed, or one quarter of the fee payable for the Whole Person Impairment assessment. The meaning of AWE indexed is specified in Clause 16 of the Bill.

Clause 140: Insurer believes injuries not stabilised – up to 4 years 6 months after motor accident

This clause provides the mechanism for when an insurer reasonably believes that the person's injuries have not stabilised and an injured person has made an application for quality of life benefits up to four years and six months. As noted for Clause 139, the qualifications of the person making the decision may be specified in the Motor Accident Injuries guidelines.

The notice must outline the insurer's belief that the injuries have not stabilised and the recommendation that the Whole Person Impairment assessment be delayed until stabilisation occurs. The notice must also advise the injured person that they may still request a Whole Person Impairment assessment be undertaken at the time; however if the assessment proceeds and the assessment indicates that the person's injuries have not stabilised, then the insurer will not be required to pay for any further Whole Person Impairment assessments. If the injured person still requests that an assessment be undertaken at that point in time the insurer must arrange with an Authorised Independent Medical Examiner Provider for a Whole Person Impairment assessment to be conducted. The insurer may not refuse to make the arrangements on behalf of the injured person.

Clause 141: WPI assessment 4 years 6 months after motor accident

This clause provides for those very rare circumstances where the relevant insurer has previously received a quality of life benefits application under clause 138 (insurer believes injuries stable and permanent impairment) or clause 140 from a person injured in the accident and the person has not had a Whole Person Impairment assessment in relation to the injuries or the Whole Person Impairment assessment has confirmed that the person's injuries have not stabilised at four years and six months after the motor accident.

At four years and six months from the motor accident the insurer may also receive a quality of life benefits application from a person injured in the accident who is receiving income replacement benefits, or, would have been eligible to receive income replacement benefits under circumstances specified in a Regulation; if the injured person believes that the injuries may have a significant occupational impact on their ability to undertake employment. Under these circumstances a person may not have had a Whole Person Impairment assessment or such assessment has indicated that the person's injuries were not stabilised.

If either of the above situation arises, the insurer must refer the injured person, to an authorised Independent Medical Examiner provider for a Whole Person Impairment assessment. If at the time the Whole Person Impairment assessment is undertaken the person's injuries have not stabilised, then assessment must estimate the person's Whole Person Impairment. The estimate is then taken to be the person's Whole Person Impairment for the purpose of a quality of life defined benefit or meeting the threshold to proceed to make a claim at common law.

If an injured person refuses to have a Whole Person Impairment assessment, the person's quality of life benefits application is taken to have been finally dealt with.

Division 2.6.3: Quality of life benefits – WPI assessment

There are human rights implications. Please see the human rights discussion above.

Clause 142: Meaning of *WPI assessment*

This clause clarifies what is meant by a Whole Person Impairment assessment. A Whole Person Impairment assessment, of a person injured in a motor accident, means an assessment to evaluate and report on the person's injuries to determine the person's Whole Person Impairment as a result of the injuries. Permanent impairment and Whole Person Impairment are defined under Clauses 12 and 13 of the Bill respectively. This clause should be read in-conjunction with Clause 143.

Clause 143: Meaning of *WPI report*

This clause clarifies what is meant by a Whole Person Impairment report. A Whole Person Impairment report is a written report, by an Independent Medical Examiner or Private Medical Examiner, of and injured person's Whole Person Impairment assessment which states the assessment of the injured person's Whole Person Impairment and complies with the Whole Person Impairment Assessment Guidelines made under Clause 145 of this Bill.

Clause 144: Meaning of *private medical examiner* – div 2.6.3

This clause provides the definition of a Private Medical Examiner as a doctor who meets the requirements under the Whole Person Impairment assessment guidelines to conduct Whole Person Impairment assessments; and has qualifications or experience relevant to the nature of the injured person's injuries.

Clause 145: WPI assessment guidelines

This clause provides that the Motor Accident Injuries Commission must make guidelines (Whole Person Impairment Assessment Guidelines) for a Whole Person Impairment assessment of a person injured in a motor accident. The powers introduced in this clause have been conferred on the Motor Accident Injuries Commission due to the operational nature of the provisions and the need to have clear administrative arrangements in place for assessing a person's injury. The intention is to apply the Safe Work Australia template *Guidelines for the Evaluation of Permanent Impairment* based on the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, Fifth Edition (AMA5) as modified.

In making the Whole Person Impairment Assessment Guidelines, the statutory instrument may apply, adopt or incorporate a law of another jurisdiction or an instrument as in force from time to time. Subsection 47(6) of the *Legislation Act 2001* does not apply in relation a law or instrument applied, adopted or incorporated for instruments determined under Clause 146.

The instrument to be made under subclause 145(2) will apply the Safe Work Australia Template of this guide as modified by 4th edition of the New South Wales Compensation Guidelines for the Evaluation of permanent Impairment. The Guidelines refer to the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, Fifth Edition (AMA5 Guide). The AMA5 Guide is subject to copyright restrictions, requiring the disapplication of subsection 47(6).

It is not the intention to limit the community's knowledge of material that is copyright. The instrument that is determined under clause 145(2) will clearly indicate the details of the applicable guide and where accessible, make reference to the website or other means of accessing the document.

Clause 146: Arrangement of WPI assessment

This clause provides for when an injured person is referred to an Authorised Independent Medical Examiner Provider. It will be for the Independent Medical Examiner Provider to arrange the necessary Independent Medical Examiner(s) to carry out a Whole Person Impairment assessment of the injured person.

The Motor Accident Injuries Guidelines may make provisions for arranging a Whole Person Impairment assessment of an injured person, including the matters of selecting an Independent Medical Examiner provider, the time when assessments must be arranged and payments for assessments. As these are procedural and operational matters such arrangements are not matters that should be included in the Whole Person Impairment Assessment Guidelines.

Clause 147: WPI assessment – provision of information

This clause applies if an authorised Independent Medical Examiner provider arranges for an Independent Medical Examiner to carry out a Whole Person Impairment assessment of an injured person. The injured person must give the all information in the person's possession that is relevant to the Whole Person Impairment assessment and any other information the examiner reasonably requires for the assessment.

The Motor Accident Injuries Guidelines, in relation to the procedures for arranging Whole Person Impairment assessments, will provide the notification requirements for the type of information that will need to be provided to the Authorised Independent Medical Examiner Provider and Independent Medical Examiner.

The relevant insurer must give the Independent Medical Examiner and Authorised Independent Medical Examiner Provider all information in the insurer's possession that is relevant to the Whole Person Impairment assessment for the injured person and any other information the examiner reasonably requires for the assessment. Insurers will need to ensure that any requests for further information must be reasonable and have the necessary nexus between the injured person and their injury and the requirement for the information.

Information to be given to the Authorised Independent Medical Examiner Provider and Independent Medical Examiner must be provided at least 10 days before the appointment and if either the insurer or injured person fails to provide the information that was reasonably required, the examiner may refuse to conduct the Whole Person Impairment assessment.

Clause 148: WPI assessment – WPI assessment guidelines

This clause provides assessments must be conducted in accordance with the Whole Person Impairment Assessment Guidelines. The Framework also limits who may undertake Whole Person Impairment assessments to an Independent Medical Examiner who must be trained in accordance with any requirements specified under the Whole Person Impairment Assessment Guidelines and the examiner can only be selected by an Authorised Independent Medical Examiner Provider to conduct the Whole Person Impairment assessments.

An injured person may arrange a Private Medical Examiner to conduct a Whole Person Impairment assessment. An injured person is not authorised to choose a Private Medical Examiner when a Whole Person Impairment assessment is to be undertaken. The selection by an injured person of a Private Medical Examiner can only occur where the person elects to have a second Whole Person Impairment assessment undertaken as a result of the injured person disagreeing with a Whole Person Impairment assessment conducted by an Independent Medical Examiner. The only exception to this rule is where an injured person makes an election under Clause 150, where both a physical injury and psychological injury are to have Whole Person Impairment assessments undertaken.

Clause 149: WPI assessment – both physical and psychological injuries

This clause clarifies that where an injured person sustains both a physical and psychological injury resulting from the motor accident that a quality of life benefit is only payable for one of the injuries. This means where two Whole Person Impairment assessments have occurred, one for physical and one for psychological injury, the injured person will have to choose which of the assessments to put forward for the quality of life benefit.

A psychological injury is defined as:

> (i) a psychological or psychiatric disorder, including the physiological effect of a psychological or psychiatric disorder on the nervous system that results directly from a motor accident; and
>
> (ii) diagnosed by a psychiatrist or clinical psychologist.

Where a psychological or psychiatric disorder results from the physical injuries caused by the accident, this is not included in the definition of psychological injury. This means that if a person suffers from depression and/or anxiety as a result of pain caused by the injuries then this psychological component is attributed to the initial physical injuries and forms part of the overall Whole Person Impairment assessment for the physical injury. This is consistent with the Safe Work Australia template *Guidelines for the Evaluation of Permanent Impairment* based on the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, Fifth Edition (AMA5) as modified:

"for WPI assessments where applicable, impairments arising from primary psychological and psychiatric injuries are to be assessed separately from the degree of impairment that results from any physical injuries arising out of the same incident. The results of the two assessments cannot be combined".

The injured person must make an election in writing concerning which kind of injury the relevant insurer should arrange the Whole Person Impairment assessment for, noting that the insurer is only liable to pay for one Whole Person Impairment assessment unless it is a multiple body system that is affected. The injured person may arrange to have a Private Medical Examiner assess the other injury under Clause 150. The assessment by the Private Medical Examiner is intended to ensure a person is not limited in making the election from having the other injury assessed.

Clause 150: WPI assessment – multiple body systems affected

This clause provides clarification that if an injured person has injuries to more than one body system, a Whole Person Impairment assessment may be made of each affected system and that there may be a need that each Whole Person Impairment assessment be conducted by a different Independent Medical Examiner. The Whole Person Impairment assessments may be combined in accordance with the Whole Person Impairment assessment guidelines to decide the injured person's Whole Person Impairment.

Where the limitation applies for both physical and psychological injuries, the Independent Medical Examiner must only assess the injury that the injured person has nominated under this clause.

Clause 151: WPI report to be prepared

This clause provides the necessary arrangements for a Whole Person Impairment report to be prepared by the assessing Independent Medical Examiner is to be provided to the Authorised Independent Medical Examiner Provider. The Whole Person Impairment Assessment Guidelines may specify the requirements for the report including timeframes for when a report must be provided.

Clause 152: WPI less than 5%

This clause provides the notification requirements required to be undertaken by the relevant insurer when a Whole Person Impairment is less than five per cent. An injured person does not qualify for a quality of life benefit if the person's Whole Person Impairment is assessed at below five per cent.

The relevant insurer must give an injured person a written notice, and a copy or the Whole Person Impairment report within 14 days of receiving a Whole Person Impairment report from the Authorised Independent Medical Examiner Provider. The notice must tell the injured person that they have 26 week after receiving the notice to provide written advice to the insurer on whether they accept or disagree with the report.

The insurer must advise that if the injured person disagrees with the Whole Person Impairment report they may have a second Whole Person Impairment assessment conducted at their own expense and give the insurer the second Whole Person Impairment report. This clause is not to be construed as requiring the injured person to give the second Whole Person Impairment report to the insurer, as whether it is given to the insurer is a decision of the injured person.

Notwithstanding that there is no obligation to give the report, if the person does not give the insurer the second Whole Person Impairment report within 26 weeks then the person is considered to have accepted the first report and the person's application for quality of life benefits is taken to be finalised.

Clause 153: WPI 5% to 9%

This clause provides the quality of life benefits offer and notification requirements required to be undertaken by the relevant insurer when a Whole Person Impairment is at least five per cent but not more than nine per cent.

The relevant insurer must give an injured person a written notice and a copy or the Whole Person Impairment report within 14 days of receiving a Whole Person Impairment report from the Authorised Independent Medical Examiner Provider. The notice must offer the injured person the amount of quality of life benefits payable for their Whole Person Impairment, based on the Whole Person Impairment report, as specified under Clause 164 of this Bill. The notice must include the injured person has 26 weeks after receiving the notice to provide written advice whether they accept or disagree with the report. Also, the notice must explain the process for obtaining the second Whole Person Impairment report.

If the injured person does not give the insurer a second Whole Person Impairment report within 26 weeks then the person is considered to have accepted the offer. Likewise, if the person accepts (or is taken to accept) the offer, the person's application for quality of life benefits is taken to be finalised; and the amount payable under Clause 164 of this Bill must be paid by the relevant insurer.

Clause 154: WPI 10% or more – injured person not entitled to make motor accident claim

This clause applies where an injured person's Whole Person Impairment is at least 10 per cent or more but the injured person is not entitled to make a common claim. This arises where the person was at-fault for the motor accident, or in a no-fault motor accident, their act or omission caused the accident.

The relevant insurer must give an injured person a written notice and a copy or the Whole Person Impairment report within 14 days of receiving a Whole Person Impairment report from the Authorised Independent Medical Examiner Provider. The notice must offer the injured person the amount of quality of life benefits payable for their Whole Person Impairment, based on the Whole Person Impairment report, as specified under Clause 164 of this Bill. The notice must tell the injured person that they have 26 week after receiving the notice to provide written advice to the insurer on whether they accept or disagree with the report and the process for obtaining a second report.

If the injured person does not give the insurer a second Whole Person Impairment report within 26 weeks then the person is considered to have accepted the offer. Likewise, if the person accepts (or is taken to accept) the offer, the person's application for quality of life benefits is taken to be finalised; and the amount payable under Clause 164 of this Bill must be paid by the relevant insurer.

Clause 155: WPI 10% or more – injured person entitled to make motor accident claim

This clause applies where an injured person's Whole Person Impairment is at least 10 per cent or more and the injured person is entitled to make a common law claim.

The relevant insurer must give an injured person a written notice and a copy or the Whole Person Impairment report within 14 days of receiving a Whole Person Impairment report from the Authorised Independent Medical Examiner Provider. The notice must offer the injured person the amount of quality of life benefits payable for their Whole Person Impairment, based on the Whole Person Impairment report, as specified under Clause 164 of this Bill.

The notice must explain that the injured person is entitled to make a motor accident claim and the consequence of accepting a quality of life benefit is that they will forgo the right to a common law claim for quality of life damages.

The notice must tell the injured person that they have until the due date after receiving the notice to provide written advice to the insurer on whether they accept or disagree with the report. The due date is specified under the clause as the later of five years after the date of the accident and 26 weeks after the person receives the notice.

Unlike offers under Clauses 152 to 154 the period of time is not limited to being accepted within 26 weeks for two reasons. Firstly the injured person has a right to make a claim for damages at common law. Secondly, the person may institute proceedings to claim damages at common law but for whatever reason do not proceed, and therefore may return within the five years to accept the defined benefits quality of life payment.

The insurer must advise that if the injured person disagrees with the Whole Person Impairment report they may have a second Whole Person Impairment assessment conducted at their own cost and may give the insurer the second Whole Person Impairment report. It is the decision of the injured person whether to provide the second report to the insurer.

If the injured person accepts the offer in writing, the person's application for quality of life benefits is taken to be finalised; and the amount payable under Clause 164 of this Bill must be paid by the relevant insurer.

If the injured person does not notify the insurer whether they accept or disagree with the offer and give the insurer a second Whole Person Impairment report within the due date, the person's application for quality of life benefits is taken to be finalised; and the entitlement to a quality of life payment ends at the end of the five year period.

Clause 156: Second WPI report

This clause provides the ability for an injured person to be able to seek an alternative Whole Person Impairment assessment if they have notified the relevant insurer that they disagree with the first Whole Person Impairment report under Clauses 152 to 155. The injured person is able to arrange a Private Medical Examiner of their own choice in accordance with Clause 144.

The assessment must be conducted in accordance with the Whole Person Impairment Assessment Guidelines and a Whole Person Impairment report must be prepared and given to the person. There is no mandated requirement that the injured person give a copy of the second Whole Person Impairment report to the relevant insurer.

The Motor Accident Injuries Guidelines may include matters relevant to the insurer's responsibilities concerning the second Whole Person Impairment report and time limits that may apply in responding to the injured person.

Clause 157: Second WPI report – original WPI may be affirmed or increased

This clause provides that when the relevant insurer receives a second Whole Person Impairment report and the assessment of Whole Person Impairment is higher than the original report, the insurer may provide a copy of the second Whole Person Impairment report to the original Independent Medical Examiner Provider and request that arrangements be made to review the first Whole Person Impairment report. The exchange of this information will be provided for by the existing authority given by the injured person.

To expedite matters the Motor Accident Injuries guidelines may provide time limits for the giving of the second Whole Person Impairment report to the original independent medical examiner, if this is what the insurer chooses to do. The Independent Medical Examiner will be obligated to respond to the second Whole Person Impairment report by either affirming the original assessment or increasing the injured person's Whole Person Impairment. The original Independent Medical Examiner provider must provide the relevant insurer with a written notice advising of whether the Whole Person Impairment assessment has been affirmed or increased.

If the Independent Medical Examiner increases the injured person's Whole Person Impairment assessment the relevant insurer is bound by that increase. This means that under no circumstance can the insurer rely on the injured person's original Whole Person Impairment assessment in any subsequent quality of life payment negotiations if the Independent Medical Examiner has increased the assessment. A Final Offer must then be made on the increased Whole Person Impairment, in accordance with Clause 158.

Clause 158: Final offer WPI

This clause applies if the relevant insurer receives a second Whole Person Impairment report from the injured person and requires the insurer to make a decision in relation to a final offer Whole Person Impairment.

The insurer's final offer must not be less than the original report if it has not been reviewed by the Independent Medical Examiner, or if reviewed it must be not less than the notice affirming or increasing the Whole Person Impairment. The final offer must not exceed the injured person's assessment in the second Whole Person Impairment report.

Clause 160 will allow the relevant insurer to negotiate between the first Whole Person Impairment report or if a review was requested by the insurer the notice of affirmation or increase from the IME provider, and the second Whole Person Impairment report. For example, if the notice states a Whole Person Impairment of six per cent and the second Whole Person Impairment report gives a score of eight per cent – the insurer could make an offer of seven per cent. The intent of this provision is to provide the necessary safety net for the injured person as to the minimum amount they will be entitled to.

Clause 159: Final offer WPI less than 5%

This clause provides that where the relevant insurer decides an injured person's final offer Whole Person Impairment is less than five per cent, the relevant insurer must give a written notice to the injured person within the stated time. The stated time is 14 days after the insurer has received a notice of affirmation or increase from the Authorised Independent Medical Examiner Provider or if the second Whole Person Impairment report was not referred back to the Authorised Independent Medical Examiner Provider then 28 days.

The written notice must tell the injured person what the final offer is, that they are not entitled to a quality of life benefit, and how the injured person may apply for an external review of the final offer Whole Person Impairment decision. Final offer Whole Person Impairment decisions are an externally reviewable matter under Clause 189.

Clause 160: Final offer WPI 5% to 9%

This clause provides that once the relevant insurer has decided a final offer Whole Person Impairment under Clause 158 and it is at least five per cent but not more than nine per cent, the insurer must give the injured person a written notice within the stated time. The stated time is 14 days after the insurer has received a notice of affirmation or increase from the Authorised Independent Medical Examiner Provider; or if the second Whole Person Impairment report was not referred back to the Authorised Independent Medical Examiner Provider then 28 days.

If a review has occurred in relation to the first Whole Person Impairment report the insurer must provide the injured person with a copy of the notice of affirmation or increase. The relevant insurer is to tell the injured person what the final offer Whole Person Impairment is and how they may apply for an external review if the person does not agree with the final offer Whole Person Impairment decision. Final offer Whole Person Impairment decisions are an externally reviewable matter under Clause 189.

The notice must offer the injured person the amount of quality of life benefits payable for their Whole Person Impairment, based on the final offer Whole Person Impairment, as specified under Clause 164. The notice must also tell the injured person they have 28 days after receiving the notice to provide written advice to the insurer on whether they accept the offer or have applied for external review of the final offer Whole Person Impairment decision.

If there is no advice from the injured person to the relevant insurer within the 28 days, the offer will be deemed to have been accepted. If the person accepts, or is deemed to accept, then the application is taken to be finalised and the amount payable under Clause 164 is to be paid by the relevant insurer.

Clause 161: Final offer WPI 10% or more – injured person not entitled to make motor accident claim

This clause applies if the relevant insurer has decided an injured person's final offer is at least 10 per cent Whole Person Impairment but the person is not able to apply for common law damages.

The insurer must provide the injured person with a written notice within the stated time. The stated time is 14 days after the insurer has received a notice of affirmation or increase from the Authorised Independent Medical Examiner Provider or if the second Whole Person Impairment report was not referred back to the Authorised Independent Medical Examiner Provider then 28 days.

If a review has occurred in relation to the first Whole Person Impairment report the insurer must provide the injured person with a copy of the notice of affirmation or increase. The relevant insurer is to tell the injured person what the final offer Whole Person Impairment is and how they may apply for an external review if the person does not agree with the final offer Whole Person Impairment decision. Final offer Whole Person Impairment decisions are an externally reviewable matter under Clause 189.

The notice must offer the injured person the amount of quality of life benefits payable for their Whole Person Impairment, based on the final offer Whole Person Impairment, as specified under Clause 164 of this Bill. The notice must also tell the injured person that they have 28 days after receiving the notice to provide written advice to the insurer on whether they accept the offer or have applied for external review of the final offer Whole Person Impairment decision.

If there is no advice from the injured person to the relevant insurer within the 28 days, the offer will be deemed to have been accepted. If the person accepts, or is deemed to accept, then the application is taken to be finalised and the amount payable under Clause 165 is to be paid by the relevant insurer.

Clause 162: Final offer WPI 10% or more – injured person entitled to make motor accident claim

This clause applies if the relevant insurer has decided an injured person's final offer is at least 10 per cent and the person is able to apply for common law damages. The insurer must provide the injured person with a written notice within the stated time. The stated time is 14 days after the insurer has received a notice of affirmation or increase from the Authorised Independent Medical Examiner Provider or if the second Whole Person Impairment report was not referred back to the Authorised Independent Medical Examiner Provider then 28 days.

If a review has occurred in relation to the first Whole Person Impairment report the insurer must provide the injured person with a copy of the notice of affirmation or increase. The relevant insurer is to tell the injured person what the final offer Whole Person Impairment is and how they may apply for an external review if person does not agree with the final offer Whole Person Impairment decision. Final offer Whole Person Impairment decisions are an externally reviewable matter under Clause 189.

The notice must offer the injured person the amount of quality of life benefits payable for their Whole Person Impairment, based on the final offer Whole Person Impairment, as specified under Clause 164. The notice must explain that the injured person is entitled to make a motor accident claim and the consequence of accepting a quality of life benefit is that they will forgo the right to quality of life damages at common law. This clause should be read in-conjunction with Clauses 135 and 136 of this Bill which prohibits been paid twice or receiving a 'top-up' of a quality of life payment.

The notice must tell the injured person that they have until the due date after receiving the notice to provide written advice to the insurer on whether they accept or disagree with the report. The due date is specified under as the later of five years after the date of the accident and 26 weeks after the person receives the notice. Firstly the injured person has a right to make a claim for damages at common law. Secondly, the person may institute proceedings to claim damages at common law but for whatever reason do not proceed, and therefore may return within the five years to accept the defined benefits quality of life payment.

If the injured person accepts the offer in writing, the person's application for quality of life benefits is taken to be finalised; and the amount payable under Clause 164 of this Bill must be paid by the relevant insurer.

If the injured person does not notify the insurer by the due date, the person's application for quality of life benefits is taken to be finalised; and the entitlement to a quality of life payment ends.

Clause 163: WPI assessment – relevant insurer to pay

This clause provides that the relevant insurer is liable for Whole Person Impairment assessments unless specifically excluded under Part 2.6.

The insurer is only liable for one Whole Person Impairment assessment for an injured person unless there are injuries to more than one body system. There is an exception to this rule under Clause 151, if the injured person has injuries to more than one body system then the relevant insurer is only required to pay for one Whole Person Impairment assessment for each affected body system.

Division 2.6.4: Quality of life benefits – amount payable

Clause 164: Amount of quality of life benefits payable

This clause will specify the scaled formula for the amount of a quality of life benefits payment. A maximum payment of $350,000 is payable to a person with a Whole Person Impairment percentage at 100, which must be calculated at the date of the Whole Person Impairment report or the date of the notice of affirmation or increase under Clause 157. It is intended that this date is determined by the date the Whole Person Impairment report is signed, or if the Whole Person Impairment report has been affirmed or increased, then the date of notice of affirmation, not the date that the insurer or injured person receives the report. If there are two reports and the insurer does not refer the report back to the Independent Medical Examiner, it is the date of the first report.

The provisions for amounts Average Weekly Earnings indexed are specified at Clauses 17 and 18.

Part 2.7: Defined benefits – death benefits

This part will provide for the payment of death benefits for the dependants of a person that dies in motor accident. The benefits are intended to assist households that may have been financially dependent on the deceased.

Division 2.7.1: Preliminary

Clause 165: Meaning of *dependant* – Part 2.7

This clause will define persons that are dependants of a person who has died as a result of a motor accident. A dependant will be a dependent child of the person, or a domestic partner of the person, or a dependent former domestic partner of the person, when the person died.

A dependent former domestic partner is a former domestic partner who was financially dependent on the person when they died.

A dependent child will include a biological, unborn or adopted child of a deceased person. It will also include a grandchild or step child, living with the deceased as a member of their family. A dependent child will need to be a person under 18 years, or under 25 years enrolled in full-time study, or someone with a disability who was financially dependent on the deceased.

Division 2.7.2: Death benefits – entitlement

Clauses 166 to 170: Death benefits – entitlement

These clauses determine the circumstances that a dependant of a person that dies as a result of a motor accident will be entitled to a death benefit.

A dependant of a person who dies as a result of a motor accident will be entitled to death benefits, subject to certain limitations and exclusions, if the person dies within two years after the accident. A dependant will not be entitled to death benefits if the dead person had already received quality of life benefits or quality of life damages in relation to the motor accident.

A dependant will not be entitled to death benefits where the death of a foreign national happens outside of Australia. Where the death occurs in Australia, benefits are not payable (foreign national or otherwise) if the coroner establishes that the deceased person engaged in conduct in relation to the motor accident, which included the physical elements of two or more driving offences or a serious offence.

A dependant will also not be entitled to death benefits if the death benefits (other than funeral expenses) are paid under a workers compensation scheme. An insurer will be able to recover death benefits paid under this part, if death benefits are also paid under a workers compensation claim.

Division 2.7.3: Death benefits – amount payable

Clause 171: Amount of death benefits payable

This clause will set out the amounts of death benefits payable to dependants of a person that dies as a result of a motor accident. An amount of $190,000 is payable if a deceased had a domestic partner or a dependent former domestic partner at the date of the accident. An amount of $40,000 is payable if the deceased had one dependent child at the date of an accident. The amount is increased by $40,000 for each further dependent child of the deceased at the date of an accident up to a maximum amount of $160,000 if the deceased had four or more dependent children. All amounts payable will be indexed annually in line with upward movements in Average Weekly Earnings.

Clause 172: Death benefits – income replacement benefits and treatment and care benefits still payable

This clause will clarify that income replacement benefits, and treatment and care benefits are still payable to a deceased person's estate for entitlements that accrued prior to a person's death.
A relevant insurer cannot recover any income replacement or treatment and care benefits that were paid to a person from their estate.

Division 2.7.4: Death benefits – payment

Clause 173: Payment of death benefits – application to ACAT

This clause provides that on receiving an application for death benefits the relevant insurer must make an application to the ACT Civil and Administrative Tribunal (ACAT) for the disbursement of death benefits. This application may only be made following receipt of an application to a relevant insurer made by a dependant, a dependant's guardian or personal representative of the person who died as a result of the accident. The relevant insurer must make application within five days of accepting liability or 28 days after an insurer gives notice to a dependant for additional information, whichever is the later.

The Motor Accident Injuries Guidelines may provide for the procedures to the undertaken when processing an application and the information to be given to the ACAT (under Clause 58).

Clause 174: Payment of death benefits – ACAT orders

This clause provides that on receiving an application ACT Civil and Administrative Tribunal (ACAT) must decide whether to make an order for payment of death benefits. If an order is made, the distribution to each dependant will be as ACAT considers appropriate and may include any other matter ACAT considers relevant for the making the order, within the maximum amount of defined benefits.

Part 2.8: Defined benefits – funeral benefits

This part will provide an entitlement to defined benefits for funeral expenses of a person that dies as a result of a motor accident.

Clause 175: Who is entitled to funeral benefits?

This clause will provide that a person who has paid for, or is liable to pay for the funeral expenses of a person that dies as a result of a motor accident will be entitled to funeral benefits, with exceptions for a motor accident caused by, or attributable to, an act of terrorism; for funeral expenses paid under a workers compensation scheme or where the death of a foreign national occurs overseas.

Funeral expenses will include the cost of transporting a person's body to a place outside the ACT or outside Australia.

Clause 176: No entitlement to funeral benefits – death of foreign national outside Australia

This clause provides there is no entitlement to funeral benefits in relation to a foreign national that dies outside of Australia.

Clause 177: No entitlement to funeral benefits – funeral expenses paid under workers compensation scheme

This clause provides that a person who has, or is liable to pay funeral expenses, for a person that dies as a result of a motor accident, is not entitled to funeral benefits, if funeral expenses in relation to the person are paid under a workers compensation scheme. If funeral expenses are paid under a workers compensation scheme an insurer will be able to recover the lesser of the amounts of funeral benefits paid under this part and the amount of funeral expenses paid under a workers compensation scheme.

Clause 178: Funeral benefits – maximum amount payable

This clause will cap the maximum amount payable for funeral expenses to $15,000. This amount will be indexed annually in line with upward movements in the Average Weekly Earnings.

Clause 179: Funeral benefits – MAI guidelines

The Motor Accident Injuries guidelines may make provision for the kinds of expenses that may be included as funeral benefits.

Part 2.9: Defined benefits – Australians living overseas and foreign nationals

This part will contain provisions to streamline the administration by an insurer making defined benefit payments to Australian's living overseas and to foreign nationals that have departed Australia.

Clause 180: Periodic payment of defined benefits – Australians living overseas

This clause will require Australians that are living overseas permanently or for an extended period, or intend to live outside Australia for a given eligibility period, to receive income replacement and treatment and care benefits through a periodic payment. These payments can only be deposited into an Australian bank account. The Motor Accident Injuries guidelines will make provision for the period a person must live outside Australia to be eligible for periodic payments, and the amount and of frequency of periodic payments. These periodic payments cannot to be commuted to a lumpsum.

Clause 181: Lump sum payment of certain defined benefits – foreign nationals

This clause will enable an insurer to make a lump sum agreement with a foreign national to pay the foreign national's expected future entitlements to defined benefits as a lump sum amount, if the person intends to leave Australia permanently. A foreign national is a person who is a not an Australian citizen or permanent resident.

A foreign national must advise an insurer of their intent to leave Australia permanently, and then may apply for a lump sum payment prior to their permanent departure from Australia. The insurer must continue to pay the injured person the defined benefits to which the person is entitled until the day the person leaves Australia permanently. Once an insurer has received a notification/application for a lump sum, the insurer must calculate the amount of the lump sum payable to the person and notify the injured person, in writing, about the amount calculated.

If the lump sum calculated by the insurer is less than $10,000 the injured person is not entitled to a lump sum payment. If the amount is $10,000 or more, the insurer must pay the injured person the lump sum payment.

A foreign national's entitlements to defined benefits under Chapter 2 will end when they are paid a lump sum, or when they leave Australia permanently and the injured person has not notified the insurer they intend to leave Australia permanently, or does not apply for a lump sum, or the lump sum payment is calculated at less than $10,000.

The Motor Accident Injuries guidelines will make provision for determining the eligibility of a foreign national to apply for a lump sum, the amount of lump sum payable and how the amount is calculated. If a foreign national makes a motor accident claim, the amount of a lump sum must be taken into account in assessing damages.

Part 2.10: Defined benefits – dispute resolution

Division 2.10.1: Preliminary

Clause 182: Definitions – Part 2.10

This clause provides definitions for insurer and internal review notice as used in this part.

Division 2.10.2: Internal review of insurer's decisions

Clause 183: Definitions – Division 2.10.2

This clause provides specific definitions for Division 2.10.2 in relation to what is an internally reviewable decision and internal review. An internally reviewable decision is a decision of an insurer that has been specified by regulation as a decision that can be internally reviewed.

Clause 184: Internal review – application

This clause provides how an application for internal review may be made and who may apply to an insurer for internal review of an internally reviewable decision the insurer has made about an application for defined benefits. An applicant for defined benefits includes a person injured in the motor accident and the person who paid or is liable to pay for funeral expenses; if an applicant has a legal disability, the applicant's guardian; if an applicant has died and the dependant has a legal disability then the dependant's guardian; or a personal representative of a person who has died as a result of a motor accident.

The application for internal review is to be made within 28 days after the date of the internally reviewable decision or if the insurer has not made the internally reviewable decision within the time required – the end of the time required for the decision. A late application may be made if the applicant satisfies the insurer that they have a full and satisfactory explanation for the delay, and the Motor Accident Injuries Guidelines provide for a late application to be made within a longer period, and the late application is within the longer period.

What is meant by a full and satisfactory explanation is provided for in the clause.

Clause 185: Conduct of internal review – MAI guidelines

This clause provides that the Motor Accident Injuries guidelines may make provision for the internal review of internally reviewable decisions, including applications for internal review. An application for internal review, and the conduct of the review must comply with the Motor Accident Injuries guidelines.

Clause 186: Internal review – application does not stay decision

This clause provides that a request for internal review of an internally reviewable decision does not operate to stay the decision or otherwise prevent action being taken based on the decision.

Clause 187: Internal review – information to be considered

This clause requires the applicant to give the insurer the information the insurer requests and reasonably requires for the internal review. The internal review may consider information that was not provided before the decision being reviewed was made.

Clause 188: Internal review – decision

This clause provides the process in which an internal review decision must be made. The insurer is required within 10 business days after receiving an application for internal review of an internally reviewable decision, to either affirm, amend or set aside the decision and make a substituted decision and give the applicant written notice of the decision. The written notice of the decision will include the reasons for the decision and information about how the applicant may apply for external review of the decision. The period of 10 business days may be extended in particular circumstances, as required by the Motor Accident Injuries guidelines. A regulation may be made for this clause. There are also notice requirements.

Division 2.10.3: ACAT review of insurer's decisions

Clause 189: Meaning of *ACAT reviewable decision*

An ACT Civil and Administrative Tribunal (ACAT) reviewable decision is a decision made by an insurer that has been specified in a regulation as being a decision that can go to ACAT for review. This may include insurer's decisions that have not previously had an internal review process undertaken,

Clause 190: ACAT review – application

This clause provides for the people that may apply for an ACAT external review of an insurer's decision, on a question of law or fact. The requirements for making an application to ACAT need to comply with Section 10 of the *ACT Civil and Administrative Tribunal Act 2008.*

Clause 190 provides the procedural requirements in relation to timing events for an applicant for ACAT external review. An applicant has 28 days after an internal review notice is given to the applicant, if no internal review notice is issued then 28 days from the applicant becoming aware of the decision, or if a regulation provides for a different time to make the application then that time.

Clause 191: Time for making application when no decision made under s 188

Clause 191 provides for time to make an application if an insurer was required to make a decision on an internally reviewable matter and has failed to make a decision, then the applicant has 28 days from the time the insurer was required to make the decision to make an application to ACAT.

Clause 192: External review – ACAT to notify insurer etc

Once an applicant has lodged an application to have an insurer's decision reviewed in ACAT, ACAT must advise the insurer in writing. The insurer in this clause can be a relevant insurer or an insurer of a motor vehicle involved in an accident.

Clause 193: External review – application does not stay decision

This clause will make it clear that when a person applies to have a decision externally reviewed by ACAT this does not stop the action as a result of the decision from going ahead. However, under Section 53 of the *ACT Civil and Administrative Tribunal Act 2008*, the ACAT may on application by the applicant make an interim order which does not allow the insurer's decision to proceed until ACAT has finalised the application.

Clause 194: External review – decision

In deciding an application ACAT must either affirm, amend or set aside the decision and: substitute another decision in its place; or remit the matter back to the insurer. As the application is not a merit review, only a review on questions of law and fact, ACAT can only consider information that was available to the insurer. However, ACAT may give permission for a person involved in the external review to present information that was not reasonably available at the time the insurer made the decision. This may apply in the circumstances where a person has had a medical examination conducted however, the report was not available before the decision was made.

A regulation may prescribe conditions for allowing additional information or evidence that can be provided to ACAT. This provision has been inserted to provide ACAT with sufficient flexibility and the ability to respond to circumstances that arise as external review processes are formalised by the ACAT.

Clause 195: External review – costs of proceedings

ACAT will be provided the power to order costs for the proceedings in an external review. Under Section 48 of the *ACT Civil and Administrative Tribunal Act 2008*, parties to an application must bear their own costs unless the Act or another territory law provides or on the order of the tribunal.

The provision has been inserted to provide the ACAT with the flexibility to order costs, especially if there are costs incurred by a party in proceeding with an external review. A regulation may be prescribed and provide where an order for costs is being considered, what may be considered to be a disbursement and the maximum amount that can be awarded for particular costs or if costs should be awarded overall for the external review.

Clause 196: External review – effect of decision

If ACAT makes a decision and issues an order under Clause 194 the decision must be taken as a decision of the person who made the externally reviewable decision and takes effect on the day the order is made, or on a date that ACAT provides that the decision should be valid from. If ACAT provides that a defined benefit must be paid to an applicant then the insurer must pay the amount.

Clause 197: External review – time for appeal

An application to appeal an ACAT decision must be made within 28 days after the day ACAT gives a notice on its decision. Appeal requirements, other than timing, for ACAT are provided in the *ACT Civil and Administrative Tribunal Act 2008*.

Clause 198: No monetary limit on jurisdiction of ACAT

The ACAT is not limited in the monetary value that applies to a matter being considered by ACAT except for any limitation imposed by a regulation made under Clause 196 or other provisions in the Bill that limit the amount that is payable for a defined benefit, for example a quality of life payment has a maximum payout of $350,000.

Clause 199: Inconsistency between Act and ACAT Act, pt 4A

This clause has been inserted to make it clear that the Bill will take precedence over the administrative review arrangements under Part 4A of *ACT Civil and Administrative Tribunal Act 2008*.

Part 2.11: Defined benefits – miscellaneous

Clause 200: Legal costs and fees payable by applicants and insurers

This clause will provide for the regulation of legal costs and fees payable by individuals and insurers regarding defined benefits (including disputes). Lawyers will only be entitled to charge or recover legal costs or fees that are prescribed.

This provision is intended to ensure legal costs and fees are appropriate within the Motor Accident Injuries scheme, and will not prevent an individual from obtaining a lawyer's services.

Clause 201: Defined benefits information service

This clause will give the Motor Accident Injuries Commission the power to approve an entity other than an individual to provide a defined benefits information service. An individual is excluded given the multi-faceted information needs of injured persons.

The defined benefits information service will be a service that can help a person to understand what they may apply for under the Motor Accident Injuries scheme. It is intended the service will ensure applicants receive improved information on how to access defined benefits and proceed with a motor accident claim than under the CTP scheme. Lawyers are not prevented by this clause from providing information about the Motor Accident Injuries scheme.

Guidelines will make provision for approving an information service provider, including the required qualifications, duration and conditions of approval, and the information services to be provided.

Chapter 3 – Motor accident injuries – significant occupational impact

This chapter provides for the process for an injured person to undergo a significant occupational impact assessment.

Part 3.1: Significant occupational impact of injuries – important concepts

Clause 202: Meaning of significant occupational impact

This clause provides for the meaning of significant occupational impact.

An injury sustained by a person in a motor accident has a significant occupational impact on the injured person's ability to undertake employment if the person:

- is prevented from performing the work the person performed before the motor accident; or
- has reduced capacity to perform the work the person performed before the motor accident; and

the injured person is either

- unable, or has limited ability, to undertake training in another area of work; or
- cannot undertake appropriate alternative employment.

Clause 203: Meaning of independent health assessor – ch 3

This clause defines an independent health assessor to mean a health practitioner who, under an arrangement with an authorised Independent Medical Examiner provider, conducts Significant Occupational Impact assessments but does not include a health practitioner prescribed by regulation. Health practitioner is defined in the *Legislation Act 2002.*

Clause 204: Meaning of SOI assessment and SOI report

This clause defines what is meant by SOI assessment and SOI report.

Significant Occupational Impact assessment, of a person injured in a motor accident, means a health assessment to evaluate and report on whether the person's injuries have had a significant occupational impact on the person's ability to undertake employment.

Significant Occupational Impact report means a written report, by an independent medical examiner or independent health assessor of an injured person's injury that states whether the person's injury has a significant occupational impact on the injured person's ability to undertake employment and complies with the Significant Occupational Impact assessment guidelines.

Health assessment is defined under section 5 *Health Practitioner Regulation National Law*

Clause 205: SOI assessment guidelines

This clause states the Motor Accident Injuries Commission must make guidelines (Significant Occupational Impact assessment guidelines) for Significant Occupational Impact assessments.

The Significant Occupational Impact guidelines may state procedures and principles to be followed in making an SOI assessment, including assessing whether the person's injuries are likely to have a significant occupational impact on the person's ability to return to appropriate work or undertake training in another area of employment and may apply, adopt or incorporate a law of another jurisdiction or instrument as in force from time to time.

The Significant Occupational Impact assessment guidelines are a disallowable instrument.

Part 3.2: SOI assessments

Clause 206: SOI assessment 4 years and 6 months after motor accident

This clause applies if a person injured in a motor accident is receiving income replacement benefits or because of the circumstances prescribed by regulation would have been eligible to receive income replacement benefits at 4 years and 6 months from the date of the motor accident. The person's Whole Person Impairment must be assessed as below 10 per cent, and the person has not had a Significant Occupational Impact assessment in relation to the injuries caused in the accident.

The relevant insurer must refer the injured person to an authorised Independent Medical Examiner or provider for a Significant Occupational Impact assessment.

Clause 207: Arrangement of SOI assessment

This clause applies if an injured person is referred to an authorised Independent Medical Examiner provider for a Significant Occupational Impact assessment under clause 206.

The Independent Medical Examiner provider must arrange for the Significant Occupational Impact assessment to be carried out by 1 or more independent medical examiners or independent health assessors who are trained as required by the Significant Occupational Impact assessment guidelines and in accordance with the Significant Occupational Impact assessment guidelines.

The Motor Accident Injuries guidelines may make provision in relation to the procedure of arranging an SOI assessment of an injured person including selecting an Independent Medical Examiner provider, and the time within which the assessment must be arranged and arrangements for payment of the assessment.

Clause 208: Significant Occupational Impact assessment – provision of information

This clause applies if an authorised Independent Medical Examiner provider arranges for an independent medical examiner or independent health assessor to carry out an SOI assessment of an injured person.

The injured person must give the authorised Independent Medical Examiner provider and the person carrying out the assessment (the assessor) all information in the injured person's possession that is relevant to the Significant Occupational Impact assessment, and any other information the authorised Independent Medical Examiner provider or assessor reasonably requires for the assessment.

The relevant insurer for the motor accident must give the authorised Independent Medical Examiner provider and the assessor all information in the insurer's possession that is relevant to the Significant Occupational Impact assessment and a copy of any Whole Person Impairment report/s in the insurer's possession, and any other information the authorised Independent Medical Examiner provider or assessor reasonably requires for the Significant Occupational Impact assessment.

The information must be given to the authorised Independent Medical Examiner provider and the assessor at least 10 days before the day the assessor is to carry out the assessment and if the required information is not provided the Examiner and/or Assessor may refuse to undertake the assessment.

Clause 209: SOI report to be prepared

This clause states that an independent medical examiner or an independent health assessor who carries out a Significant Occupational Impact assessment of an injured person must give an SOI report about the assessment to the Independent Medical Examiner provider who arranged the assessment.

The Independent Medical Examiner must also give the report to the relevant insurer for the motor accident.

The Significant Occupational Impact assessment guidelines may make provision for the requirements for the report, including the time within which the report must be given.

Clause 210: SOI Report – injury has significant occupational impact

This clause applies if a Significant Occupational Impact report from an independent medical examiner or independent heath assessor confirms that the injured person's injury has had a significant occupational impact on the person's ability to undertake employment.

The injured person is taken to have a Whole Person Impairment of 10 per cent for this Bill, and is eligible to make a motor accident claim in relation to the motor accident. This does not prevent a person from making a quality of life benefits application.

The relevant insurer for the motor accident must, within 14 days after receiving the Significant Occupational Impact report, give the injured person a written notice including a copy of the report and the Whole Person Impairment report, if any, alongside stating that the person is taken to have a Whole Person Impairment of 10 per cent for this Bill, and they are eligible to make a motor accident claim in relation to the motor accident.

Clause 211: SOI report – no significant occupational impact

This clause applies if a Significant Occupational Impact report of an injured person confirms that the injured person's injury has not had a significant occupational impact on the person's ability to undertake employment.

The relevant insurer for the motor accident must, within 14 days after receiving the report, give the injured person a written notice including a copy of the report and stating that the person may apply to the ACAT for a review of the Significant Occupational Impact report.

Part 3.3: SOI Reports – ACAT Review

Clause 212: SOI report – no significant occupational impact – ACAT review

This clause applies if an injured person receives a notice under clause 211 in relation to a Significant Occupational Impact report, the injured person may apply to the ACAT for review of the report.

An application for review of the Significant Occupational Impact report must be made within 14 days after the day the injured person received the notice.

Clause 213: Review of the SOI report – ACAT to notify insurer

This clause applies if ACAT receives an application for review under clause 212, as soon as practicable after receiving an application for review, the ACAT must give written notice of the application to the Independent Medical Examiner provider that arranged the Significant Occupational Impact assessment to which the report relates and the relevant insurer for the motor accident.

Clause 214: Review of SOI report – IME provider to give ACAT information

This clause applies if an Independent Medical Examiner provider receives a notice under clause 213 in relation to an application for review of a Significant Occupational Impact report.

The Independent Medical Examiner provider must, within 14 days after receiving the notice, give the ACAT all information in the provider's possession that was using in carrying out the assessment to which the report relates.

Clause 215: ACAT review – decision

This clause applies when ACAT is making a decision on an application for review of a Significant Occupational Impact report of a person injured in the accident. The ACAT must, by order, either affirm the report or set aside the report and make an order confirming that the injured person's injury has had a significant occupational impact on the person's ability to undertake employment.

In making their decision, the ACAT must only consider the information that was available to the independent medical examiner or independent health assessor when the Significant Occupational Impact assessment to which the report relates was carried out.

ACAT may, on application by a party, give the party leave to present information or evidence that was not reasonably available to the independent medical examiner or independent health assessor when the assessment was carried out. For example, a medical report for an examination undertaken, but not reported on, when the assessment was carried out may be able to be presented to ACAT.

If ACAT makes an order either affirming the report or confirming the significant occupational impact, the order takes effect on the date the ACAT makes the order, unless the ACAT otherwise orders.

This clause allows that a regulation may prescribe conditions for allowing additional information or evidence to be presented to ACAT.

Clause 216: Effect of ACAT order affirming SOI report

This clause applies if the ACAT makes an order under clause 215 affirming a Significant Occupational Impact report in relation to a person injured in a motor accident.

The relevant insurer must pay the injured person the amount of quality of life benefits payable to the person under clause 164 (amount of quality of life benefits payable). Noting, the amount of quality of life benefits payable under clause 164 is dependent on the injured person's whole person impairment, as assessed under clause 141 or division 2.6.3.

Part 3.4: Significant occupational impact of injuries – miscellaneous

Clause 217: Effect of SOI assessment on motor accident claim

This clause states that despite the Limitation Act 1985, section 16AA (Motor accident claims), a person injured in a motor accident who has had a Significant Occupational Impact assessment has three months from the latest of the following dates to make a motor accident claim:

- if the injured person receives a notice under clause 210(4) (SOI report – injury has significant occupational impact) – the date of the notice
- if the ACAT makes an order under clause 215(1)(b) –
    - if no appeal from the order is made – the date the appeal period for the order ends;
    - if an appeal from the order is made – the date the appeal is finally decided.

Chapter 4 – Payment of future medical treatment expenses

Clause 218: Definitions – Chapter 4

This clause provides definitions for the chapter, *future treatment payment* defined in clause 219(2), and *medical treatment* to medical treatment prescribed by regulation. A regulation will be made providing for the type of medical treatment that would be included for the purposes of this chapter.

Clause 219: Application for future treatment payment

This clause will provide for the eligibility for a person to make an application for a payment for future medical treatment for up to five years from the date that the entitlement to defined benefits ends. To be eligible to make an application the person has to be receiving treatment and care benefits for treatment and care expenses related to medical treatment at four years and six months from the date of the accident. The medical treatment must have been received continuously for at least two years and six months preceding the four years and six months. The person must not have been the driver at fault or taken to be the driver at fault and is not entitled to make a common law motor accident claim.

The injured person has six months to make the application, from the point in time that a person is four years and six months from the date of the motor accident to the date the entitlement to defined benefits ends.

The application will be for the injured person's future medical treatment based on the approved medical treatment that the person received in the six-month period following the fourth year anniversary of the motor accident and that the relevant insurer for the motor accident has paid or agreed to pay. The application is made to the relevant insurer. Information will be provided by insurers to persons still receiving medical treatment at the relevant time explaining the process for making an application.

Clause 220: Future treatment payment – assessment and calculation

This clause outlines the process the relevant insurer is to follow on receipt of an application. The payment is to be assessed based on the types of medical treatment the injured person has been receiving in the prior six month period, with an assessment of how long the medical treatment would be required post five years and up to 10 years. The insurer is then to assess the amount payable, including any investment opportunities the injured person may have from investing the payment. The insurer is then required to provide a written notice to the injured person about the amount, how it was calculated, including information relied upon. The notice is also to include a statement that it relates to a period after the end of the defined benefit entitlement, for up to five years. The injured person may agree to the payment or enter into negotiations with the insurer for a different amount.

Clause 221: No agreement on future treatment payment – application to ACAT

This clause provides for the ACT Civil and Administrative Tribunal (ACAT) to consider an application from either the insurer or the injured person if the parties are unable to agree on the future treatment payment. The application is to be made asking ACAT to determine the future treatment payment and make an order for the payment. A guideline may be made in relation to the information that is to be given to ACAT to determine the application.

Clause 222: Decision about future treatment payment – ACAT orders

This clause provides the power for the ACAT to make a determination of the amount.

Clause 223: Future treatment payment – costs of proceedings

This clause provides that ACAT may make an order regarding the costs of a party, and may order a party to pay the other party's costs arising from an application under clause 222. Provision is being made for costs because as a result of the negotiation between the injured person and the insurer, it is expected that costs and disbursements will be incurred, for example in obtaining medical information regarding the approved medical treatment and the reasonable and necessary need for the future medical treatment.

Clause 224: Future treatment payment – no monetary limit on jurisdiction of ACAT

The ACAT is not limited in the monetary value that applies to a matter being considered by ACAT except for any limitation imposed by clause 223.

Chapter 5 – Motor accident injuries – common law damages

This chapter provides for common law damages for motor accident injuries that result in death or for persons who are more seriously injured through someone else's fault. To pursue a common law claim, a person needs to have been assessed as having a Whole Person Impairment of 10 per cent or more (this threshold is met in the case of a claim for death).

A child who was in receipt of defined benefits (treatment and care) at four years and six months may proceed to common law, as may an adult who is in receipt of income replacement at four years and six months and meets the occupational impact requirements as part of the Whole Person Impairment assessment.

A notice of claim in accordance with the Civil Law (Wrongs) Act will be required to be given to the at-fault insurer within three months that the Whole Person Impairment report is affirmed or finalised (or the estimate at four years and six months). This is to allow the person the time to make a decision about whether to accept a final offer for defined benefit quality of life from the insurer or to proceed with a common law claim. By using the notice of claim provisions, the at-fault insurer will be put on notice that a common law claim is being made and the information the claimant will rely on.

The *Limitation Act 1985* will be amended to provide for a five year limitation period for motor accidents by which proceedings are to be commenced in a court of law.

Part 5.1: Preliminary

Clause 225: Meaning of *motor accident claim*

This clause will adopt the current definition of motor accident claim at Section 77 of the CTP Act. It provides that a motor accident claim means a claim for damages for personal injury caused by a motor accident and includes, for a fatal injury, a claim by the dead person's dependents or estate.

Clause 226: Meaning of *claimant* for motor accident claim

This clause will adopt the current definition of claimant at Section 79 of the CTP Act. It provides that a claimant is a person who makes or is entitled to make a motor accident claim or in relation to rehabilitation, medical treatment or loss suffered, the injured person to who the motor accident relates. It will be noted that for Chapter 2, it is an applicant for defined benefits. The distinction is intended to facilitate clarity among all parties as to the process and stage a person may be in the scheme.

Clause 227: Meaning of *respondent* for motor accident claim – ch 5

This clause will adopt the current definition of respondent at Section 79 of the CTP Act. It provides for whom the respondent is for a motor accident claim, including a later respondent. A later respondent may be added by Section 55 of the Wrongs Act.

Clause 228: Meaning of *insured person* for motor accident claim

This clause will adopt the current definition of insured person at Section 80 of the CTP Act, updated with a reference to a Motor Accident Injuries insurer. It provides that an insured person is a person who is a Motor Accident Injuries insured person or a person whose acts and omissions the nominal defendant is liability under Clause 302.

Clause 229: Meaning of *insurer* for motor accident claim

This clause will adopt the current definition of insurer at Section 81 of the CTP Act, updated with a reference to a Motor Accident Injuries insurer.

Clause 230: Defined benefit payment etc – no effect on liability under motor accident claim

This clause reflects Section 75 of the CTP Act, which provided for no effect on liability in relation to an early payment made for the purposes of Chapter 3, early payment of treatment of motor accident injuries of the CTP Act. This clause has been updated to provide that the acceptance or deemed acceptance of liability for an application for defined benefits or the payment of defined benefits is not an admission of liability. It also does not in any way prejudice or affect a claim or proceeding arising out the motor accident.

Clauses 231 and 232: Insured person not to admit liability, settle or make payments and Power of insurer to act for insured

These two clauses will adopt Sections 82 and 83 of the CTP Act. Clause 209 restricts the insured person from acting on behalf of their insurer and admitting liability or offering to settle or make payments. Clause 210 gives authority to the insurer to act on behalf of the insured person in relation to a motor accident claim.

Clause 233: Nominal defendant may deal with motor accident claims

This clause reflects Section 83A of the CTP Act and gives authority to the nominal defendant to act where a claim is made to the nominal defendant.

Clause 234: Insurer may intervene in proceeding

This clause will insert a new provision providing that an insurer may apply to the court to be joined as a party to a proceeding brought against an insured defendant. The request to join must be to argue that in the circumstances of the case it has no obligations under the Motor Accident Injuries policy to indemnify the defendant. The clause is adopted from Section 6.18 of the *Motor Accident Injuries Act 2017* (NSW).

Clause 235: Motor accident claim – notification of application made under workers compensation scheme

This clause will require a person injured in a motor accident that makes a motor accident claim for common law damages, to notify an insurer about details of any application for compensation made under a workers' compensation scheme in relation to the injury. A notice must be given to an insurer when a motor accident claim is made. The notice will be required to include the name and address of the workers' compensation insurer, details of whether liability for the workers' compensation application has been accepted or denied and of any amounts paid under the application. If an insurer receives a notice under this section they will be able to get information about the application from the workers compensation insurer.

Part 5.2: Threshold for damages

There are human rights implications. Please see the human rights discussion.

Clause 236: Award of damages – requirements

This clause will provide that an award of damages in a motor accident claim may be made only if the injured person has made an application for quality of life benefits under Chapter 2, or has made a successful application for workers compensation benefits, or is a foreign national that has received a lump sum payment, and been assessed as having a Whole Person Impairment of at least 10 per cent as a result of the motor accident. An award of damages may also only be made where a person died as a result of the motor accident.

A person may also receive an award of damages where they are taken to have or have 10 per cent Whole Person Impairment under Clause 133 (WPI taken to be 10% in certain circumstances) and Clause 210(2) (SOI report – injury has significant occupational impact).

A successful application for workers' compensation benefits is an application that has been accepted by a relevant insurer at least 26 weeks prior to either notice of a motor accident claim being given, or a Whole Person Impairment assessment being carried out on the injured person. The 26 week waiting period will ensure that an injured person receives early treatment and care under a workers compensation scheme prior to making a claim for common law damages.

This has the effect of restricting a claim for damages by an injured person not-at-fault in a motor accident proceeding unless the person has been assessed, taken to have or have a Whole Person Impairment of at least 10 per cent. More seriously injured people (10 per cent Whole Person Impairment and above, children and adults with a significant occupational impact) will still be able to access, through a common law process, compensation for treatment and care; economic loss and quality of life, providing them with the resources needed to help them return to health. The limitation uses the means "no more than is necessary to accomplish the objective" (Privy Council in *de Freitas v Permanent Secretary of Ministry of Agriculture, Fisheries, Land and Housing* [1999] 1 AC 69 at 80).

Part 5.3: WPI assessment – claimant receiving workers compensation

Part 5.3 will enable a person that has made a successful application for workers compensation benefits to then apply to a relevant insurer for an assessment of their Whole Person Impairment, so they can then receive common law damages under the Motor Accident Injuries scheme. The part will modify the quality of life defined benefit application and assessment process in Chapter 2 so a person can receive a whole person impairment assessment, which is arranged by a relevant insurer, without having made a defined benefit application under the Act.

Clause 237: Application – pt 5.3

This clause will apply Part 5.3 to a person injured in a motor accident that makes a successful application for workers compensation benefits, and gives the relevant insurer a notice of claim for damages in relation to the injury.

Part 5.3 will not apply to a person that has already obtained a Whole Person Impairment assessment in accordance with the Motor Accident Injuries guidelines independently of the Motor Accident Injuries legislation of 10 per cent or more. This will ensure that a relevant insurer is not liable to pay for a second assessment, for a person that can already receive damages under Chapter 3.

Clause 238: WPI assessment – application and assessment

This clause will enable an injured person that Part 5.3 applies to make an application to a relevant insurer for an assessment of their Whole Person Impairment. The person must be given an acknowledgement notice acknowledging receipt of their application with the period stated in their guidelines.

The clause will modify Division 2.6.2 (quality of life benefits – application) and Division 2.6.3 (Quality of life benefits – WPI assessment) so they apply as if the application was a quality of life benefits application. Provisions which would have otherwise required the relevant insurer to offer an amount quality of life defined benefits, will not apply to the application.

Part 5.4: Damages for claims – exclusions and limitations

This part will provide for exclusions and limitations with respect to damages. The note refers the reader to the Wrongs Act, which also applies exclusions and limitations with respect to damages.

Clause 239: Quality of life damages – general

This clause will provide for the award of damages for loss of quality of life under Clause 240 and 241 for a claimant that was a child at the date of the accident. Non-economic loss damages, including pain and suffering, loss of amenities of life, loss of expectation of life and disfigurement, are replaced by quality of life damages. The quality of life damages will only be available at common law if the injured person has not accepted a defined benefit quality of life benefit (see Clause 242, quality of life damages – none if quality of life benefits received).

Clause 240: Quality of life damages – amount that may be awarded

This clause will provide for the award of damages for quality of life damages according to the assessed Whole Person Impairment percentage, commencing at $25,000 (Average Weekly Earnings or AWE indexed) at 10 per cent up to $500,000 AWE indexed at 100 per cent. A Whole Person Impairment percentage of 11 per cent to 20 per cent will be $25,000 AWE indexed, plus an amount determined for a given whole number of Whole Person Impairment provided for by a formula in Table 240 (with a separate formula applying for each range – 21 per cent to 50 per cent and 51 per cent to 99 per cent). In relation to the amount to be worked out, for each whole number of Whole Person Impairment, the Motor Accident Injuries Commission shall publish the amount each year on the indexation day by notifiable instrument.

The Court may also award an amount of additional damages where a Whole Person Impairment assessment did not take into account a particular injury, or a particular effect on the claimant's quality of life. The amount that may be awarded is up to 20% of the Whole Person Impairment amount calculated in Table 220. For example, if an injured person has an assessed Whole Person Impairment of 15 per cent, this calculates as a quality of life payment of $42,500. An additional amount of up to 20 per cent (being $8,500) can be awarded meaning the total quality of life payment can be from $42,500 to $51,000. The additional quality of life damages must not be awarded if paid under another head of damage. The maximum amount of quality of life damages that can be awarded under the clause must not exceed $600,000 AWE.

This clause does not apply to a person who was a child at the time of the accident.

Clause 241: Quality of life damages – amount that may be awarded for children

This clause provides for the amount of quality of life damages that is payable where a claimant was a child at the date of the motor accident. The maximum that may be awarded is $600,000 Average Weekly Earnings indexed. This means the payment scales for Whole Person Impairment in Clause 240 does not apply. It will be for the court to award the amount of quality of life based on the amount either agreed between the parties, or by the judge in making their determination.

Clause 242: Quality of life damages – none if quality of life benefits received

Where a person proceeds with a motor accident claim, this clause provides that quality of life damages may not be awarded if the person received quality of life benefits under Chapter 2. It is intended to ensure a person does not receive additional quality of life payment through common law.

Clause 243: Damages for loss of earnings – none in first year

This clause will provide that 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. A note also draws the reader to the current provisions of the *Civil Law (Wrongs) Act 2002*, which provides the maximum amount of damages for loss of earnings is limited to three times Average Weekly Earnings for all males total earnings.

At common law, a claimant may have a claim for 'topping up' the 95 per cent or 80 per cent income replacement defined benefit to 100 per cent, plus superannuation if applicable (note, income replacement defined benefit does not include superannuation). 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, this clause modifies common law by 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 (taxable income) in respect of those 12 months, while a person whose income loss extends beyond 12 months would receive 100 per cent plus superannuation from year two onwards (paid on a net of tax basis).

Clause 244: Recovery of defined benefits if claimant receives damages

This clause applies if a claimant receives defined benefits in relation to an injury suffered in a motor accident and is awarded damages in a motor accident claim in relation to the claimant's injuries.

The relevant insurer is entitled to deduct from the damages the lesser of the amount of any defined benefits (other than income replacement benefits received by the claimant in the first year after the motor accident) received by the person and the amount of damages awarded.

This clause also ensures that a relevant insurer is not entitled to recover any amount that has already been recovered under a provision of Part 6.10, MAI insurer and nominal defendant may recover costs incurred.

If defined benefits received by the injured person were not recovered by the relevant insurer, then this will result in a double up of benefits received by the injured person at common law.

Clause 245: Damages for compensation paid under workers compensation scheme

This provision will ensure that any award of damages in a motor accident claim will include an amount of damages equal to an amount of compensation a person has received under a workers compensation scheme, if the person being awarded the damages is liable to repay the workers compensation amount. It is intended to ensure the injured person is not worse off.

Clause 246: Gratuitous care – no damages

This clause will provide that damages for gratuitous care in the nature of treatment, care, support or services that are provided to the claimant are not available. The term 'gratuitous care' refers to care provided either to or by the injured person on an unpaid basis, usually involving family members. This is a common law head damages, commonly referred to as *Griffiths v Kirkemeyer* (or GvK damages [1977 139 CLR 161]).

The scheme during defined benefits will pay professional treatment and care for the injured person. If an injured person chooses to have a family member care for them, they may do so, however the scheme will not provide payment for this care. Similarly, under this provision, no damages may be paid for gratuitous care. The rationale is to allow family to be family and not put them in the position for caring for an injured person, when a properly qualified person can provide care.

Section 100 of the Wrongs Act, provides for damages of loss of capacity to perform domestic services. By this clause, a claimant cannot receive damages for gratuitous care. Instead, the injured person is entitled to paid care for up to five years under defined benefits and damages may be claimed for the continuation of paid care in the future, on the basis that if the care is reasonable and necessary it should be paid care.

Clauses 247 and 248: Treatment and care – damages not available for LTCS participants and damages not available for LTCS scheme foreign national participants

These two clauses reflect the policy that where a person is a participant in the Lifetime Care and Support Scheme (LTCS) they are not awarded damages for treatment and care that is provided by or will be provided for by the scheme. These clauses reflect Sections 156D and 156E of the CTP Act.

Clause 249: Wrongful death claims

This clause will provide that in the event of the death of a person from a motor accident and a wrongful death claim is brought under Chapter 3 of the Wrongs Act, that the damages must be reduced by the amount of any death benefits or quality of life benefits paid under Chapter 2 in relation to the dead person. This is to ensure that these earlier payments are taken into account by not being awarded as damages.

Part 5.5: Damages independently of the Act

Clause 250: Repayment of defined benefits if person receives damages independently of the Act

This clause will enable an insurer to require the repayment of defined benefit amounts if a person obtains a judgement or agreement for damages independently of the Act. The insurer will be able to recover the lesser of the defined benefits paid to the person and the amount of independent damages.

This clause will recognise that a person could obtain damages independently of the Act, such as for a claim for negligence against an employer under a workers compensation scheme. In this case the gross amount of independent damages would include provision for defined benefits already paid for under the Act. The clause will enable these amounts to be recovered by the Motor Accident Injuries insurer, with any net damages then being paid to and retained by the injured person.

Part 5.6: No-fault motor accidents

A no-fault accident is a blameless accident that is not caused by the fault of any person. Examples of these accidents include accidents that happen through a medical incident such as a heart attack, or where wildlife crosses into the path of a motor vehicle.

This part provides for the meaning of, the presumption that applies and the process for working out the driver at-fault in a no-fault motor accident. These provisions are necessary as the scheme now provides coverage for an accident where no one is at-fault. For the purposes of a motor accident claim, fault is attributed so that a claim may proceed to court. The driver for a single vehicle accident is excluded from a common law claim. For a multiple vehicle accident, enquiry into the circumstances of the accident to find whose act or omission caused the accident will need to occur to establish the at-fault driver. The excluded driver will be able to receive defined benefits.

Part 5.7: Court proceedings on motor accident claims

Divisions 5.7.1 to 5.7.4: Court proceedings

In commencing a court proceeding, a claimant must comply with the pre-court proceedings in Chapter 5 of the Civil Law (Wrongs) Act. This part then deals with some matters for court proceedings specific to the Motor Accident Injuries Scheme. Many of the pre-court proceedings provided for in the Wrongs Act was reproduced in the CTP Act, causing confusion regarding the Act to comply with when making a claim for compensation.

Section 46 of the Civil Law (Wrongs) Act provides for the burden of proof to be on the plaintiff to prove causation. For the purposes of a blameless accident, the driver is taken to be 'at-fault' and breached their duty of care. A note to section 46 has been inserted (see Schedule 2, amendment 2.9)

The conference provisions continue to encourage the settlement of a claim before court proceedings occur (division 5.7.2). This includes a compulsory conference and the making of a mandatory final offer. Costs are required to be worked out for a mandatory final offer that is for $50,000 or less (see Clause 263). If the offer is for $50,000 or less, then it must be exclusive of any amount for costs, worked out in accordance with the regulation. If the offer is less than $30,000, costs is generally $0 unless the claimant was a child or the person held a Commonwealth concession card.

Division 5.7.4 provides for procedural provisions for claims. An action lies against the at-fault driver as the insured person. Clause 269 provides that the claimant must bring the proceeding against the insured person and the insurer as joint defendants; however, as the insurer is the indemnifier for the insured person, it is the insurer the judgement is made against. Clause 270 makes it clear that a claim can be against more than one insurer and provides for how an insurer appoints a claim manager.

Clause 271 excludes the court from summary judgement in a court proceeding where the insurer admits liability. The court can give judgement by consent. By Clause 272, an insurer is permitted to call the insured person as a witness and cross-examine them. Clause 273 sets out the principles for awarding costs for damages over $50,000. The Wrongs Act retains provisions relating to costs in personal injury matters and the Bill has provisions to regulate legal fees for defined benefits. The award of costs over $50,000 for the Bill is determined based on the mandatory final offer of the claimant or respondent.

Divisions 5.7.5: Judgement for noncompliance with time limits

Division 5.7.5 provides for judgment for noncompliance with time limits. This part reflects Part 4.10 of the CTP Act. It provides a trigger for the court to provide judgment and order costs against a party who has not complied with a time limit provided for by the Bill. The purpose of these provisions is to limit or stop either side from unduly delaying common law proceedings. The definitions for the part are provided for by Clause 274, including compliance notice, enforcing party and late party.

Clauses 276 (claimant) and 277 (respondent) provides that the enforcing party may give the late party a compliance notice to provide information or otherwise comply with the Bill, within seven days. If this timeframe is not met, the court may make orders against the non-complying party, including the damages and costs payable on the orders.

Part 5.8: Other matters

Clause 281 provides that legal costs and fees payable by claimants and insurers for motor accident claims may be prescribed by regulation. A lawyer is not entitled to be paid or to recover any legal costs for services provided other than the prescribed costs and fees. This clause mirrors clause 201 for defined benefits.

Clause 282 provides that where a payment is made by the LTCS Commissioner, to a LTCS participant, that this payment does not confirm a cause of action under Section 32 (Confirmation) of the *Limitation Act 1985.* This clause reflects Section 176A of the CTP Act.

Chapter 6 – Motor accident injuries insurance

This chapter is substantially Chapter 2 of the CTP Act. It provides for Motor Accident Injuries policies which will insure against liability for personal injury resulting from a motor accident. It also provides for Motor Accident Injuries premiums which will continue to be regulated by the Motor Accident Injuries Commission. Chapter 15 provides for some transitional matters relevant to this chapter.

This chapter also includes parts of Chapter 4 of the CTP Act related to the Nominal Defendant Fund, which will continue to operate for the payment of defined benefits and claims for uninsured, unidentified and unregistered vehicles, and recovery of costs; and includes provisions enabling the recovery of costs from an injured person by an Motor Accident Injuries scheme insurer and the nominal defendant.

Part 6.1: Important Concepts

This part provides for the definitions, including that of an insured motor vehicle is a vehicle insured under a Motor Accident Injuries policy, and a Motor Accident Injuries insured person is a person insured under a Motor Accident Injuries policy.

Clause 285 excludes the Territory and Commonwealth and territory or commonwealth authorities from the requirement to have a Motor Accident Injuries policy for owned motor vehicles, however they must provide coverage in accordance with the scheme.

Part 6.2: Compulsory motor accident injuries insurance

This clause has been moved from Part 2.1 of the CTP Act. It contains the main offence provision, making it an offence to use an uninsured vehicle on a road, with a maximum penalty of 50 penalty units. The offence does not apply if there is an unregistered vehicle permit in force, is exempt from registration or is owned by the Territory, a Territory authority, the Commonwealth, or a Commonwealth authority. The defence provides for a reasonable grounds to believe that the vehicle was an insured motor vehicle, which is an evidential burden.

Part 6.3: Motor accident injuries policies

This part specifies the details relating to Motor Accident Injuries policies - what and who are covered; what risks are, and are not, covered; licensed insurers cannot decline Motor Accident Injuries policies; licensed insurers must compensate insured people; and a policy is not affected by a change in vehicle ownership or an error.

Clause 289 will provide for Motor Accident Injuries policies that a policy includes benefits on a no-fault basis to people who sustain personal injury resulting from a motor vehicle accident. This is essentially the basis for the ACT's Motor Accident Injuries scheme to provide no-fault insurance coverage for ACT registered vehicles.

Part 6.4: Selecting an MAI insurer

This part outlines the processes for selecting an insurer for first registration; registration renewal; vehicles with trader's plates; and light rail vehicles.

These provisions are necessary to ensure competition within the ACT Motor Accident Injuries insurance market.

Part 6.5: Length of MAI policy

This part covers details relating to the length of Motor Accident Injuries policies. A Motor Accident Injuries policy comes into force when the registration or renewal takes effect, and the insurer is liable for any claims until midnight of the day the registration is renewed, or until the Motor Accident Injuries policy is cancelled. By Clause 302, a person has up to 14 days to renew their registration and thus their Motor Accident Injuries policy. If a person fails to renew their registration and the vehicle is written off during the 'grace' period, the car is not capable of reregistration and the vehicle will be an uninsured vehicle for the purposes of the Bill.

Part 6.6: Cancellation of MAI policies

This part specifies that a Motor Accident Injuries insurer cannot cancel a Motor Accident Injuries policy, and that a Motor Accident Injuries policy is cancelled if the registration of the vehicle is cancelled. This ensures an insurer is not able to avoid the liability for claims during the registration period by cancelling a policy.

Part 6.7: MAI premiums

This part provides for the Motor Accident Injuries Commission to continue to regulate Motor Accident Injuries premiums and for Motor Accident Injuries guidelines to make provision for Motor Accident Injuries policy premiums.

The provisions in this part are substantially Part 2.6 of the CTP Act; however, two significant changes have been made. Clause 318 will provide for mediation to occur if the Motor Accident Injuries Commission rejects a Motor Accident Injuries policy premium. An accredited mediator will mediate the matter and must be independent of the Motor Accident Injuries Commission and the licensed insurer, and be agreed upon by both parties. If the premium is rejected following mediation, the matter must be arbitrated (Clause 319). The Bill will no longer provide for the CTP premium board. Matters that were previously to be arbitrated by the CTP premium board will be arbitrated by the arbitrator worked out under the *Commercial Arbitration Act 2017*.

Clause 320 requires an insurer to report on profit margins on which each Motor Accident Injuries premium charged by the licensed insurer is based. This requirement has been inserted in the Bill to provide improved authority for the Motor Accident Injuries Commission to assess the profit margin and the actuarial basis on which the profit margin is worked out. Profit margin is required to be disclosed as part of the premium filing under the current CTP Act. The assessment will then be able to be compared with the reported profit margins of other privately underwritten motor accident schemes to assess the reasonableness of the margin.

Part 6.8: Nominal defendant's liabilities

This part provides that the Nominal Defendant is liable for personal injury caused by an uninsured or unidentified motor vehicle unless specific criteria are met. The Nominal Defendant is the insurer for any vehicle that has been issued an unregistered vehicle permit by the Road Transport Authority.

Part 6.9: Nominal defendant fund

This part has been moved from Part 4.10A of the CTP Act and outlines functions of the Motor Accident Injuries Commission and the nominal defendant regarding the nominal defendant fund. It requires the Motor Accident Injuries Commission to establish the nominal defendant fund, collect an amount for the fund, and determine the UVP liability contribution. This part also requires the nominal defendant to use the fund to pay certain claims, deposit certain monies into the fund, keep separate accounts within the fund to meet liabilities, and have the fund audited.

This part adds five new clauses that will provide new powers for the nominal defendant for the management of claims, including the functions of a claims manager: assessing the financial position of the fund, engaging consultants (including claims managers), delegating its functions, and requiring an insurer to give it reasonable and necessary information and assistance.

Part 6.10: MAI insurer and nominal defendant may recover costs incurred

This part has been moved from Part 4.11 of the CTP Act. This part provides for the Motor Accident Injuries insurer and/or the Nominal Defendant to recover costs incurred under certain conditions such as fraud, vehicle defects, or intentional injury. The Nominal Defendant was permitted under Section 174 of the CTP Act to recover costs from the responsible person for a vehicle, or the driver of the vehicle, any costs reasonably incurred by the Nominal Defendant. With a no-fault scheme, Clause 347 provides that recovery can only occur if the motor accident is caused by the act or omission of the responsible person or the driver. Specifically, the insurer may only recover costs in relation to a common law claim against a driver at fault if the driver was intoxicated by alcohol or drugs. The insurer may not recover costs paid in relation to a defined benefits application if the driver was using alcohol or drugs, unless fraud has taken place. If the accident is a blameless accident (no-fault accident), no recovery may occur. Clause 348 deals with other circumstances of recovery for uninsured and unidentified motor vehicles.

Chapter 7 – MAI insurer licences

This Chapter is substantially Chapter 5 of the CTP Act. There are some new provisions to clarify the licensing process and address some operational issues. Chapter 15 provides for some transitional matters relevant to this chapter. 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 analyse the net profitability of licensed insurers.

Part 7.1: MAI insurer licences – preliminary

This part provides for preliminary matters related to insurer licences. Clause 330 provides for the definitions, including that a licensed insurer is to be a corporation and that a Motor Accident Injuries insurer licence is a licence to conduct business as a Motor Accident Injuries insurer. Clause 352 inserts a term, *former licensed insurer,* as a corporation that was a licensed insurer but is no longer a licensed insurer.

This part also has two clauses to address the circumstances of a Motor Accident Injuries policy that is issued by an unlicensed insurer. Clause 353 makes it an offence for a person to issue, or purport to issue, a Motor Accident Injuries policy if they are not a licensed insurer. A person includes a corporation. In the event that an unlicensed insurer does issue a Motor Accident Injuries policy, Clause 354 specifies that Motor Accident Injuries policies issued by an unlicensed insurer are not void. Although the issue of a Motor Accident Injuries policy is tied to registration, the Clause is required in the event a person is sold a Motor Accident Injuries policy by an unlicensed insurer.

The Motor Accident Injuries Commission is required by Clause 355 to keep a register of all Motor Accident Injuries insurer licences issued or refused, specific licence details, and anything prescribed by regulation or considered appropriate by the Motor Accident Injuries Commission. The provision has been moved to this part from Part 5.6 of the CTP Act.

Part 7.2: MAI insurer licences – insurance industry deed

The Insurance Industry Deed is an important part of the licensing scheme. It is an agreement between the Commission, nominal defendant and licensed insurers that regulates the conduct of licensed insurers and the Motor Accident Injuries insurance scheme (Clause 356). It has been located with the licensing provisions having previously been located in Part 1.2 of the CTP Act. Clause 357 outlines what may be included in the deed, including managing applications for defined benefits, disclosure requirements, apportionment of liability, and anything else prescribed by regulation.

The Motor Accident Injuries Commission intends for the Insurance Industry Deed to be a key tool in the management of the scheme. Similarly to the current deed, members of the public will be able to see what is included in the deed, as a disallowable instrument (this will be provided for by regulation).

Part 7.3: MAI insurer licences – issue

This part provides for the eligibility for a corporation to be approved for a Motor Accident Injuries insurer licence (Clause 358); the process for application (Clause 359) and the decision by the Motor Accident Injuries Commission on the application (Clause 360). Licences take effect on the day stated in licence and will remain in force until cancelled (Clause 361).

Part 7.4 MAI insurer licences – conditions

This part provides for the conditions in relation to Motor Accident Injuries insurer licences. Clause 362 provides the clause of the Bill as conditions relevant to Motor Accident Injuries insurer licences. Clauses 363 to 373 are statutory conditions that apply to all licences. The conditions have a particular focus on compliance with the conduct of the insurer and its employees to enable the objects of the Bill to be realised. Conditions include such matters as: compliance with Motor Accident Injuries Guidelines; prompt management of applications; early treatment and care; resolution of claims; compliance with ACT Civil and Administrative Tribunal (ACAT) orders; having processes in place for protected information; proving information the Motor Accident Injuries Commission; dealing with complaints; conduct and practices of the insurer; measures and policies required for staff of an insurer; and compliance with Motor Accident Injuries Commission conditions.

Clause 374 provides the Motor Accident Injuries Commission with the power to apply individual conditions on a Motor Accident Injuries insurer's licence when the licence is issued, by amending the licence, or by revoking a condition; and the application or withdrawal of a condition is a reviewable decision under Chapter 10 and Schedule 1 to the Bill. Any condition which provides a competitive advantage to another licensed insurer, or requires a licensed insurer to obtain a share of the insurance market is not valid under Clause 375 of the Bill.

A contravention of a licence condition is an offence provision see Clause 376. Clause 385 provides that a contravention of a licence condition does not affect a Motor Accident Injuries policy. A contravention of licence can occur by an unlicensed person if such conduct would be a contravention of licence condition relating to a motor accident if the person was licensed. This clause is an offence provision which attracts applies a maximum penalty of 100 penalty units.

Part 7.5: MAI insurer licences – suspension

This part has been updated to provide the Motor Accident Injuries Commission with the ability to manage a suspended licensee and their policies.

The grounds for licence suspension can be for contraventions such as breaching the Act, a Motor Accident Injuries insurer licence condition, or the insurance industry deed. Clause 359 also specifies that if a breach can be rectified within 21 days of occurring, the Motor Accident Injuries Commission must wait until this time has elapsed. Other grounds are provided for in Clause 360. A licence is suspended under Clause 382 by issuing the licensed insurer a suspension notice, which states the suspension date and the grounds for suspension. A licence suspension can be ended under Clause 383 by the Motor Accident Injuries Commission if it believes the insurer can now comply with the licence conditions. It is an offence under Clause 384 to issue a Motor Accident Injuries policy while suspended.

The following clauses (385 and 386) provide for the continuation of the liability of a suspended licensee for the policies they have issued and outlines a process for the selection of a Motor Accident Injuries insurer during the period the licence of an insurer is suspended. They are new for this scheme. By Clause 386, the Road Transport Authority is authorised to allocate all Motor Accident Injuries policies of the suspended insurer to the remaining licensed insurers following consultation with specified parties. The clause also provides the mechanism for the Motor Accident Injuries Commission to consult with other insurers to assume the policies that have been issued by the suspended insurer, and to provide for these policies to be allocated.

Part 7.6: MAI insurer licences – occupational discipline

This part provides for an insurer to be referred to the ACT Civil and Administrative Tribunal (ACAT) for occupational discipline. The Motor Accident Injuries Commission may apply to the ACAT to make an occupational discipline order against a licensed insurer, instead of prosecuting them under the Bill (Clause 388). The grounds for occupational discipline are set out in Clause 389 and are wide-ranging, including contravening the Insurance Industry Deed. The remaining clauses deal with the Motor Accident Injuries Commission making the application, and the orders that may be made by the ACAT particular to this Act. The ACAT's legislation provides for other occupational discipline orders that the ACAT may make.

Part 7.7: MAI insurer licences – cancellation

This part provides for the cancellation of a Motor Accident Injuries insurer licence. The provisions are similar to Part 5.5 of the CTP Act; however, the part has been updated and clarified. For example, Clause 392 provides a clearer process for a proposed licence cancellation. A decision to cancel requires notice to be given to an insurer outlining the grounds for cancellation and the insurer given the opportunity to respond. If the decision is made to proceed to cancel, the decision is a reviewable decision.

Part 7.8: MAI insurer licences – transfer

The part provides for the transfer of a Motor Accident Injuries insurer licence. The part has been updated and clarified from the provisions contained in Part 5.6 of the CTP Act. The part in the CTP Act deals only with the transfer of CTP policies, with the transfer of a licence in another part (Part 5.2, Section 192).

With this Bill, all the provisions relating to transfers are in one part. Clause 395 provides that a licensed insurer may, with the approval of the Motor Accident Injuries Commission, transfer their licence to another insurer. Separate provision is made for the transfer of policies (see Clause 396). As policies are tied to motor vehicle registrations, a process needs to be undertaken with the Road Transport Authority to transfer the policies of the outgoing licensee.

Part 7.9: MAI insurer licences – supervision

This part adopts provisions in Part 5.7 of the CTP Act and provides for the supervision of licensed insurers by the Motor Accident Injuries Commission. Two sections of the CTP Act, Sections 216 and 217, which relate to a licensed insurer advising the CTP Regulator on their market share will be moved to the regulation and the Motor Accident Injuries Commission will report on market share for Motor Accident Injuries policies.

A business plan is required as part of the first issue of the licence. It is a requirement that licensed insurers have a business plan (Clause 398), comply with the plan (Clause 399) and undertake a yearly review of the plan or when directed by the Motor Accident Injuries Commission (Clause 379). Motor Accident Injuries guidelines may be made in relation to business plans (Clause 401).

Reinsurance is an important feature of insurance - essentially insurance for insurance companies. It allows an insurer a way of transferring some of the financial risk an insurer assumes when underwriting policies to another entity. It is important for Regulators to be aware of the arrangements a licensed insurer has in place, and by Clause 402 a licensed insurer is required to give this information to the Motor Accident Injuries Commission, noting that the licensed insurer must also disclose the terms of approval by the Australian Prudential Regulation Authority (APRA).

The Motor Accident Injuries Commission will be empowered by Clause 404 to arrange for the audit of accounting records and compliance with the Motor Accident Injuries guidelines. It is an offence if a licensed insurer does not co-operate with the appointed auditor (Clause 405). The Motor Accident Injuries Commission may, separately, carry out an audit of an insurer's profitability. The findings of the audit are required to be reported in confidence to the APRA (Clause 406). By Clauses 407 and 408 the Motor Accident Injuries Commission may prepare for the Minister an analysis and report of a licensed insurer's net profitability based on information that is provided by the insurers to the Motor Accident Injuries Commission, including an audit conducted under Clause 404. It is an offence for an insurer not to keep accounts (Clause 403).

Clauses 410 to 411 will make provision for the protection of Motor Accident Injuries policies where this may be in the interests of the policy-holder due to the insurer not being able to meet liabilities or acting in a prejudicial manner. This requires the Supreme Court to make an order and it is an offence to contravene the Court's order.

It is offence for an insurer to fail to tell the Motor Accident Injuries Commission about grounds for suspension (Clause 413) or of a decrease (or likely decrease) in the issued capital of the insurer (Clause 414). An insurer must tell the Motor Accident Injuries Commission of a bidder's statement or target statement (Clause 415).

Clause 416 will make it clear that only the Motor Accident Injuries Commission may commence proceedings against a licensed insurer.

Part 7.10: MAI insurer licences – insolvent insurers

There are human rights implications. Please refer to the human rights discussion.

This part provides for the management of insolvent insurers. If a Motor Accident Injuries insurer is insolvent, the Nominal Defendant will become the insurer and may recover costs. The Nominal Defendant is given authority to borrow and to take or intervene in legal proceedings.

Clauses 422 and 421 are offences in relation to the actions of the liquidator that may be appointed. The first relates to a liquidator failing to give information to the nominal defendant and the second relates to the liquidator failing to allow the inspection of documents within a 45 day period. The offences do not apply if the liquidator takes certain action before the 45 day period expires. This is an evidentiary provision and would require a defendant, if desired, to raise evidence to disprove the evidence. However, if the defendant chooses to do so it would only be to the evidential burden. This means that the defendant would only have to point to evidence that suggests a reasonable possibility that action was taken by the liquidator, something within their knowledge.

Part 7.11: MAI insurer licences – miscellaneous

Clause 428 provides that an insurer has an obligation to deter fraudulent applications or claims made against the scheme.

Clause 429 is a new clause to permit the relevant insurer for a motor accident to contact certain people under specific circumstances regarding certain matters. The Clause has been included to provide legislative authority for the contact insurers have with applicants and claimants, whether or not they have legal representation. If a person is legally represented, the relevant insurer may still copy information to the lawyer but the primary contact insurers will have is with applicants and claimants.

Chapter 8 – Enforcement

There are human rights implications. Please refer to the human rights discussion.

This Chapter is substantially Chapter 6 (Enforcement) of the CTP Act. The Motor Accident Injuries Commission will continue to have a range of enforcement powers with the Bill, with some provisions from the CTP Act being updated to reflect provisions in other ACT legislation and to improve the conduct of investigations. The definitions are provided for in Part 8.1.

For this Chapter, the following offences are strict liability:

- Clause 432 (Identity cards)
- Clause 438 (Power to seize things)
- Clause 439 (Power to require name and address).

The penalties for strict liability offences contained in this Chapter do not exceed more than 50 penalty units and do not propose a term of imprisonment. The mistake of fact defence expressly applies to strict liability as do other defences in Part 2.3 of the *Criminal Code 2002*.

Part 8.2: Enforcement – authorised people

This part has been added to provide that the Motor Accident Injuries Commission rather than the Road Transport Authority appoints authorised officers to undertake enforcement activities. The powers included in the Bill are the standard provisions in the ACT statute book for the appointment of public servants as authorised officers.

This part also specifies the details of an authorised officer's powers. The powers included in the Bill are the standard provisions in the ACT statute book for exercising entry to premises. One change from the search powers in the CTP Act (Section 253) is to make the search powers more relevant to an insurance scheme. Section 253 in the CTP Act included powers to take measurements and conduct tests or take samples. Clause 437 makes it clearer an authorised officer may examine anything and take copies of or extracts of documents required for the purpose of investigating a matter.

Part 8.3: Enforcement – search warrants

This part covers details relating to the obtaining of search warrants and their execution by authorised officers. The powers included in the Bill are the standard provisions in the ACT statute book. A search warrant may be obtained from a magistrate to enter and search premises for a particular thing or activity connected to an offence against the Act.

Part 8.4: Enforcement – return and forfeiture of things seized

This part specifies the details related to returning and forfeiting items seized under Clause 425, power to seize thing. The provisions for the return and forfeiture of things in the Bill are now the standard provisions in the ACT statute book. For example, Clause 449, return of seized thin, and Clause 451, return of seized thing – extension of time, are not currently provisions in the CTP Act.

Part 8.5: Enforcement – miscellaneous

This Part outlines other matters related to enforcement and are standard provisions in the ACT statute book.

Chapter 9 – Information collection and secrecy

There are human right implications. Please refer to the human rights discussion.

Clause 458: Meaning of *publish* – ch 7

This clause provides the definition for publish for Chapter 7 of the Bill to make it clear that information can be disseminated orally, by visual means, in writing, electronically, or in another way.

Clause 459: Licensed insurers must give information to MAI commission

This clause will place a positive obligation on an insurer to provide business and financial information regarding the licensed insurer, or a corporation that is a related body corporate of the licensed insurer, to the Motor Accident Injuries Commission if so requested. A related body corporate is determined under Section 9 of the Dictionary to the *Corporations Act 2001*.

The insurer is to give the Motor Accident Injuries Commission information and documents for periodic returns as prescribed by Regulation; information concerning claims; information in relation to applications for defined benefits and other information that is relevant to the administration of the Act; as prescribed by regulation and in accordance with written notice issued by the Motor Accident Injuries Commission. An extended meaning is given to what is considered to be a document and includes a return or account given under the *Corporations Act 2001* (Cwlth), *Insurance Act 1973* (Cwlth) and the *Financial Sector (Collection of Data) Act 2001* (Cwlth), and a copy of, or extract from, a document.

The Motor Accident Injuries Commission may request the inspection of a documents kept by the insurer or body related body corporate of the insurer. A regulation may prescribe the time which a document or periodic return must be provided to the Motor Accident Injuries Commission under and what other information the licensed insurer must give the Motor Accident Injuries Commission. Clause 459 does not limit any other provision in relation to the obtaining information or how that information is obtained by the Motor Accident Injuries Commission.

A licensed insurer under Clause 459 includes a former licensed insurer. Clause 459 should be read in-conjunction with Clause 461 which provides the procedural requirements for how the Motor Accident Injuries Commission is to make a request to an insurer. Offence provisions apply to an insurer that fails to comply with Clause 459 under the offence provisions at Clause 462.

Clause 460: Licensed insurer to provide investment details

This clause provides a licensed insurer may be requested to provide the Motor Accident Injuries Commission with how the insurer's funds are invested. Funds also includes third-party. This clause should be read in-conjunction with Clause 659 which provides the procedural requirements for how the Motor Accident Injuries Commission is to make a request to an insurer.

Failure of the insurer to comply with a request for investment information, or failure to provide the information within the specified time, is an offence provision. The maximum penalty prescribed is 100 penalty units.

Clause 461: How MAI commission is to make request

This clause provides the procedural requirements that the Motor Accident Injuries Commission must follow when making a request to a licensed insurer for information or documents. A request must be in writing and state how and when the request may be complied with. A certificate of correctness may be required, which is a certificate which certifies the correctness of the information, document, copy or extract by a registered tax agent, registered company auditor or an actuary approved by the Motor Accident Injuries Commission. A registered company auditor takes its meaning form Section 9 of the *Corporations Act 2001*.

Clause 462: Offences – insurer to give periodic returns, documents and information

Clause 462 creates two offence provisions in relation to compliance with Clause 459 which requires information to be given to the Motor Accident Injuries Commission. If an insurer fails to give the Motor Accident Injuries Commission information, periodic return or document under Clause 459 then the licensed insurer will commit an offence.

If the insurer fails to give the information, periodic return, or document in the way or times stated in the Regulation or under a Clause 461 request for information then the insurer is guilty of an offence. Both offences have a maximum penalty of 100 penalty units prescribed.

A defence, with an evidential burden, applies, that is for the insurer to prove that it was not within their power to comply with a request or requirement under Clause 459. The giving of information is purely within the control of the insurer, and it is reasonable the insurer will be able to prove why they were not able to comply with a request or the requirement.

Clause 463: MAI commission may disclose information to licensed insurers etc

The Motor Accident Injuries Commission may exchange information of that has been disclosed to or obtained by the Motor Accident Injuries Commission exercising their functions to an information sharing entity. However, the information can only be disclosed if the information is relevant to the exercise of the functions of the information sharing entity; and such disclosure is appropriate. Disclosure would be appropriate for the purpose of detection or investigating fraud in relation to a motor accident or an application for defined benefits.

An information sharing entity is a licensed insurer, Nominal Defendant, Road Transport Authority (RTA), the ACT Civil and Administrative Tribunal (ACAT) and a person approved in writing by the Motor Accident Injuries Commission. Importantly, each of the entities identified have specific prescribed functions under the Bill, for example, the RTA issues and collect premiums, ACAT is the jurisdictional body to hear disputes and other matters conferred under the Bill, and the Nominal Defendant is the default insurer when a vehicle may not have insurance (i.e. unregistered motor vehicle). A person approved in writing caters for those situations where the Motor Accident Injuries Commission may need to authorise a person for a specific purpose or period, for example a police officer conducting an investigation.

Clause 464: MAI commission – disclosure of information relating to complaints

This clause provides the necessary framework to enable the exchange of some or all of the information provided as part of a complaint to the relevant insurer. A complaint does not need to be lodged by an injured person but may be made by a personal representative or guardian. The Commission will only provide the insurer with the information necessary to deal with a complaint. To ensure fairness to all parties involved, and to minimise those occurrences where complaints are used to subvert other mandated processes, the Motor Accident Injuries Commission is prohibited from disclosing any other further information concerning the complaint until all inquiries are completed.

Once the Motor Accident Injuries Commission has competed its inquiries into the compliant the Commission must provide the relevant insurer and the complainant with a written notice of its findings. The contents of the notice may include some or all of the information included with the complaint and any response by the relevant insurer. However, inclusion of information which may disclose confidential information about the relevant insurer's business operations or may prejudice and investigation into the motor vehicle accident or application for defined benefits or motor accident claim is prohibited. However, this prohibition is subject to the Commission having reasonable grounds to believe the information may disclose the insurer's operations or prejudice and investigation. Information in the notice must not include information that is prescribed by regulation as being a prohibited disclosure.

The Motor Accident Injuries Commission may make Motor Accident Injuries Guidelines regarding the handling of complaints.

Clause 465: Licensed insurer may disclose information to another licensed insurer

This clause provides the provisions concerning the disclosure of information about an application for defined benefits to another licensed insurer and have been inserted to cater for those circumstances where it is discovered that another licensed insurer is responsible for the application or claim in relation to a motor vehicle accident.

To minimise the interference with a person's private life, personal health information can only be provided to the new insurer if the injured person has provided an authority to transfer personal health information. The authority applies only to the transfer of the application. This information needs to be disclosed to determine entitlements to benefits for injured persons as there is a fundamental requirement to have factual evidence, such as those provided through personal health information, which can be assessed by objective standards to minimise fraud and dishonesty. This approach also minimises inequitable outcomes that could occur if evidence in support of injuries and required costs for benefits was not supplied.

An additional measure is included to protect the disclosure of an injured person's personal health information by providing that that a regulation may prescribe conditions in relation to the disclosure. This will allow for any procedural gaps that result in unauthorised disclosure of such information to be promptly dealt with.

Clause 466: Lawyers etc must give information to MAI commission

This clause provides that a regulation may require lawyers and other service providers to give information to the Motor Accident Injuries Commission in relation to applications for defined benefits and motor accident claims. The procedural aspects may be specified in the regulation and may include such matters as amounts paid to, and costs/disbursements paid by applicants and claimants, and when such payments were made or received.

The Motor Accident Injuries Commission may publish statistical data based on the information, or may be required by the Minister to do so.

Clause 467: Information about certain offences

The clause provides that the Motor Accident Injuries Commission may request that a court provide information and evidentiary certificates in relation to a person that was injured in a motor accident. The information required has a specific causal link to Division 2.2.2 of the Bill in relation to limitations and exceptions to a person's entitlement as a result of a motor accident. As a person's entitlement to a defined benefit cannot be extinguished or reduced until an person is convicted or for found guilty of a specified offence under Division 2.2.2 of the Bill the relevant the information must be provided to the relevant insurer to enable action to occur. The Motor Accident Injuries Commission obtains this information on behalf of the relevant insurer from the court.

Clause 468: MAI commission may disclose information to LTCS commissioner

This clause provides that the Motor Accident Injuries Commission may disclose information to the LTCS Commissioner. The LTCS Commissioner is appointed under the *Lifetime Care and Support (Catastrophic Injuries) Act 2014*. The information that can be disclosed must relate to motor accident claims under the Bill, application for defined benefits, payments made to or on behalf of a person who is a participant in the LCTS scheme, and treatment and care needs for a person who is a participant in the LTCS scheme in relation to a motor accident injury.

Clause 469: MAI injury register

This clause provides as part of the requirements of the scheme the Motor Accident Injuries Commission must keep a register of motor accident claims and applications for defined benefits under Clause 469(1). The register will contain information provided to insurers under the Act, and information provided by the LTCS Commissioner under the *Lifetime Care and Support (Catastrophic Injuries) Act 2014*, that the Commission considers necessary to be included in the register. Information that would affect an insurer's competitiveness must not be disclosed in a form that would allow the insurer to be identified.

The injury register facilitates the commission exercising its functions, and ensures the information is recorded in one register. The commission may only approve a person to access the register if it is for a legitimate purpose and the person has appropriate safeguards in place to protect the information. There is no authority under this provision for information collected in the Motor Accident Injuries Register to be released. Strong safeguards are in place for the handling, confidentiality, and permitted disclosures of information that the Motor Accident Injuries Commission and insurers acquire as a result of exercising functions under, or in relation, to the Bill.

Offence provisions apply at Clause 473 for a person using or divulging protected information other than in accordance with the Bill. Use of protected information also includes making a record of the information. Protected information has been used as it provides a broad meaning and means any information disclosed or obtained by a person because of the exercise of a function under the Bill by the person or someone else, and specifically includes personal health information. The maximum penalty that can be applied is 50 penalty units, imprisonment for six months, or both.

Clause 470: Publication of information – licensed insurers

This clause provides the Motor Accident Injuries Commission may publish information relating to the licensed insurer's obligations under the Bill and matters relevant to the performance of the insurer's business and financial affairs relevant to the motor accident injuries scheme. It is not specific personal or personal health information of an injured person, and the licensed insurer is a corporate entity.

The Commission must not publish any information that the Commission is satisfied would disclose personal information or a trade secret not known by other insurers. Further, the Motor Accident Injuries Commission must not publish information about a licensed insurer's profitability or profit margins in relation to the motor accident injuries insurance scheme if such information would identify the licensed insurer or allow the insurer's identity to be ascertained from that information.

Clause 471: Publication of net profit analysis of licensed insurer

This clause provides that the Minister may publish a net profit analysis prepared by the Motor Accident Injuries Commission under Clause 407 of the Bill. However, the net profit analysis or part of the analysis may only be published if it does not identify a licensed insurer or allow a licensed insurer to be identified.

Clause 472: Summary of report about insurers may be made public

This clause provides that the Minister may publish a summary of a report prepared by the Motor Accident Injuries Commission under Clause 409 relating to the level of compliance of a licensed insurer, complaints received and relevant matters relating to insures. The summary may only be published if it does not identify a licensed insurer or allow a licensed insurer to be identified.

Clause 473: Offences – use or divulge protected information

This clause has been inserted in the Bill due to the personal information and personal health information that is collected under the Bill. The offence provisions provide that if a person uses or, divulges protected information, and they are reckless to whether the information is protected, and the information could be divulged to someone else, will be guilty of an offence. Divulge incudes communicate and publish. The maximum penalty that can be applied is 50 penalty units, imprisonment for six months, or both.

Subclause 473(3) provides the authority for when information can be used or divulged. Specifically information can be used or divulged if:

(i) under the Act or another law of the Territory;
(ii) exercising a function under the Act or another law of the Territory;
(iii) in accordance with the Insurance Industry Deed;

(iv) for the purpose of Court proceedings, Court includes a tribunal, authority or person having power to require the production of documents or the answering of questions, see Subclause 473(5);
(v) in accordance with a person's consent;
(vi) an insurer to another insurer in accordance with the Insurance Industry Deed.

There is an evidential burden to the offences by providing when disclosure or use of protected information will be considered to be authorised. The giving of evidence on whether the use or disclosure of the information was authorised is purely within the control of the person, and it is reasonable the person will be able prove why their actions were authorised.

Chapter 10 – Notification and review of MAI commission reviewable decisions

This chapter provides for reviewable decisions that are currently in the *Road Transport (General) Act 1999.* It was considered more appropriate to include these provisions in the Bill.

Clause 474: Definitions – ch 10

This clause defines essential terms used in this chapter.

Clause 475: Internal review notices

This clause requires the Motor Accident Injuries commission to give an internal review notice to an entity mentioned in Schedule 1, Column 4 where the Motor Accident Injuries Commission makes a Motor Accident Injuries Commission reviewable decision.

Clause 476: Applications for internal review

This clause lists the people that apply to the Motor Accident Injuries Commission for review of a Motor Accident Injuries commission reviewable decision. The application must be in writing and state the applicant's name and address and set out the applicant's reasons for making the application.

The application must be given to the Motor Accident Injuries Commission within 28 days after the applicant is given the internal review notice for the decision, or any longer period allowed by the Motor Accident Injuries commission before or after the end of the 28 day period.

Clause 477: Applications not stay MAI commission reviewable decisions

This clause provides that the making of an application for review of a Motor Accident Injuries Commission reviewable decision does not affect the operation of the decision.

Clause 478: MAI commission reviewer

This clause provides that the Motor Accident Injuries Commission must arrange for a person (the Motor Accident Injuries Commission reviewer) who did not make the Motor Accident Injuries Commission reviewable decision to review the decision.

Clause 479: Review by MAI commission reviewer

This clause provides that the Motor Accident Injuries Commission reviewer must, within 28 days after the day the Motor Accident Injuries Commission receives the application for review of the Motor Accident Injuries Commission reviewable decision either confirm, amend, or set aside the decision and substitute the reviewer's own decision.

If a decision is not amended or set aside within the 28 day period, the decision is taken to have been confirmed by the Motor Accident Injuries Commission reviewer.

Clause 480: Reviewable decision notices

This clause provides that if a Motor Accident Injuries Commission reviewer makes an externally reviewable decision, the Motor Accident Injuries Commission reviewer must give a reviewable decision notice to each person affected by the decision.

This clause notes that the Motor Accident Injuries Commission must also take reasonable steps to give an reviewable decision notice to any other person whose interests are affected by the decision (as per *ACT Civil and Administrative Tribunal Act 2008,* Section 67B).

Clause 481: Applications for external review

This clause provides that the following people may apply to ACAT for review of an externally reviewable decision:

- a person to whom a reviewable decision notice is required to be given in relation to the decision;
- any other person whose interests are affected by the decision.

Chapter 11 – Miscellaneous

Clause 482: Offences – referral fees

Clause 482 will prohibit payments by a lawyer, or their related entity, for referrals of defined benefit applications or damages claims for legal representation. A lawyer will commit an offence if the lawyer, or a related entity, gives consideration for a referral for legal representation. The maximum penalty will be 200 penalty units.

Similarly, a lawyer will commit an offence, if the lawyer, or their related entity, receives consideration for referring a claimant being represented by the lawyer to a service provider. The maximum penalty will be 200 penalty units.

Consideration is defined as including a fee or other financial benefit but does not include hospitality that is reasonable in the circumstances. What is reasonable in the circumstances will be based on the facts. Reasonable in the circumstances may be the provision of refreshments or light meals in a professional setting or hospitality in a private home; what is not be reasonable is sport or other entertainment tickets, or a paid vacation in return for the referrals.

The offences 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. They will also assist in deterring claims farming practices that involve members of the public receiving cold calls or social media prompts, seeking personal details regarding possible involvement in motor accidents. These details are then sold, for a commission, to legal firms and other service providers. This would be considered a referral and therefore in breach of this clause.

The offence provisions are necessary so the prohibition on referral fees is not circumvented through arrangements with related entities that fall outside of professional conduct rules.

Clause 483: Extraterritorial operation

Clause 483 provides for the extraterritorial operation of the Bill and provides for the intention of the Assembly for the provisions of the Bill to apply outside the ACT and Australia, and for the recovery of any damages above the defined benefits that would have been payable and other thresholds in the Bill. This clause is currently Section 177 of the CTP Act, which was inserted to address a House of Lords case where a non-resident was injured in Australia who then recovered damages under the more favourable jurisdiction of his home country.

Clauses 484 to 485: MAI guidelines and forms

Clause 484 will provide for the Motor Accident Injuries Commission to create legally binding Motor Accident Injuries guidelines (disallowable instruments) about matters specified in the Bill. This Clause is moved from Chapter 5 (Licensing of insurers) of the CTP Act. The Motor Accident Injuries guidelines may provide for what information is to be included in forms that the Bill requires, and where they can be accessed (Clause 485).

Clauses 486 to 488: Fees and levy

Clauses 486 to 488 will provide that the Motor Accident Injuries Commission may determine fees for this Bill, the Minister must determine a motor accident levy to fund the Motor Accident Injuries Commission's functions, and the Motor Accident Injuries Commission must refund a portion of the levy paid if a person cancels their motor vehicle registration. These determinations are disallowable instruments and were previously provided for under Section 96 of the *Road Transport (General) Act 1999*.

Clause 489: Regulation-making power

Clause 489 contains the regulation making power of the Executive, including the power to create offences and fix maximum penalties of not more than 20 penalty units.

Clause 490: Review of operation of Act

Clause 490 provides for the Minister to review the Motor Accident Injuries scheme as soon as practicable after the end of every third year of its operation and present a report of the review to the Legislative Assembly. The review will be required to include the proportion of premiums used to pay defined benefits, including treatment and care for injured people; the number of disputes occurring and their outcomes; time taken to resolve claims and average claims outcomes, including the degree of severity of personal injury. The review is not limited in what may be included and is to cover each three year period of the scheme.

Chapter 15 – Transitional

This Chapter will provide for the transitional arrangements to enable the seamless transition from the *Road Transport (Third-Party Insurance) Act 2008* to the Motor Accident Injuries scheme. Clause 600 provides the definitions for the Chapter and refers to the *Road Transport (Third-Party Insurance) Act 2008* as the repealed Act. The Motor Accident Injury Commission will be able to deal with the amounts paid for premiums under the repealed Act if there is a reduction in premiums amounts that may apply once the commencement of the Motor Accident Injury Act occurs under clause 601. Clause 604 provides that a CTP policy that applies under the repeal Act will be taken to be a premium under the Motor Accident Injuries scheme.

Clauses 602 and clause 603 provide an accident that occurred under the repealed Act or a claim for damages that is still proceeding when the Motor Accident Injuries scheme begins will still be dealt with under the repealed Act. Section 84 of the *Legislation Act 2001* provides explicit arrangements that existing rights and liabilities under the repealed Act will continue to apply.

Clause 605 to clause 610 provide for the operational mechanisms for the Motor Accident Injuries scheme by providing that licensed insurers, former insurers, powers that may be exercised by the CTP regulator and the nominal defendant, and the nominal defendant fund are automatically transitioned from the repealed Act to the Motor Accident Injuries scheme. Clause 608 specifically allows for a regulation to prescribe information that a licensed insurer must give the MAI Commission when exercising the functions of the CTP Regulator under the repealed CTP Act, section 269.

Clause 611 provides the Motor Accident Injuries Commission will be able to do a single annual report for the CTP regulator on the operation of the repealed Act and the new Commission for the financial year when CTP regulator finishes operating and is replaced by the Commission.

Clause 612 enables the Executive to make regulations dealing with transitional matters. The clause contains two different regulation making powers. Subclause (1) enables the making of a regulation to deal with any transitional matter that arises as a result of the enactment of the Bill. However, the scope of the regulation must be confined to the same sphere of operation as the Act, be strictly ancillary to the operation of the Act and not widen the Act's purpose. Subclause (2) enables the making of a regulation that modifies the Act. A regulation under this clause may only modify chapter 15 of the Act, and only if the Executive is of the opinion that the chapter does not adequately or appropriately deal with a transitional issue. A provision of this kind is an important mechanism for achieving the proper objectives, managing the effective operation, and eliminating transitional issues in the application of the Act in unforeseen circumstances by allowing for the flexible and responsive (but limited) modification by regulation. Subclause (3) gives a regulation under subclause (2) full effect according to its terms.

A provision of chapter 15 modified by regulation will operate in the same way (in relation to another provision of the Act or any other territory law) as if it were amended by the Act, and in accordance with established principles of statutory interpretation. The section is not expressed, and does not intend, to authorise the making of a regulation limiting future enactments of the Legislative Assembly. Also, any modification by regulation of chapter 15 of the Act has no ongoing effect after the expiry of that chapter.

Clause 613 provides that the chapter will expire five years from the day the Act commences. This reflects the long-tail nature of insurance schemes and defined benefits being available for five years.

Chapter 16 – Repeals and consequential amendments

Clause 613 and 614: Legislation amended-sch 2 and Legislation repealed

Clause 613 will provide for consequential amendments outlined in Schedule 2. Clause 614 provides for the legislation that will be repealed on commencement of the *Motor Accident Injuries Act 2019.*

Schedule 1 – MAI Commission reviewable decisions

This schedule provides for all the reviewable decisions of the MAI commission.

Schedule 2 – Consequential amendments

The amendments outlined in Schedule 2 are consequential amendments necessary to amend references to the CTP Act being replaced by the *Motor Accident Injuries Act 2019.*

Part 2.1 ACT Civil and Administrative Tribunal Act 2008

This part will amend provisions of the *ACT Civil and Administrative Tribunal Act 2008* as a consequence of the conferral of jurisdiction on the ACAT for the purposes of dealing with external review matters under this Bill.

Part 2.2 Civil Law (Wrongs) Act 2002

This part will amend references to the *Road Transport (Third-Party Insurance) Act 2008* to the Motor Accident Injuries Act 2019. It also provides for amendments as motor accident claims will be required to be notice of claims under this Act.

A note is to be added into section 46 which states that for the purposes of making a claim for a no-fault motor accident, under Clause 253, in the case of a single vehicle accident, the driver of the motor vehicle is taken to be the driver at fault and to have breached their duty of care to an injured person, and in the case of a multiple vehicle accident, the driver of the motor vehicle whose act or omission caused the accident is taken to be the driver at fault and to have breached their duty of care to an injured person.

A new section 51(3A) will be inserted stating the time limits a notice must be given within 3 months of the latest of the stated time limits.

Section 51A is to be inserted to provide for the requirement for a respondent to a notice of claim to identify and notify others of the notice of claim. By section 56, which is to be amended to make it clear for a motor accident claim the process of deciding a claims manager if there is two or more respondents.

Provisions that were in the *Road Transport (Third-Party Insurance) Act 2008* regarding surveillance films as part of reports have been included at relevant sections in the Civil Law (Wrongs) Act.

Part 2.3 Emergencies Act 2004

This part will amend the reference to the *Road Transport (Third-Party Insurance) Act 2008* to the Motor Accident Injuries Act 2019.

Part 2.4 Heavy Vehicle National Law (ACT) Act 2013

This part will amend the reference to the *Road Transport (Third-Party Insurance) Act 2008* to the Motor Accident Injuries Act 2019.

Part 2.5 Lifetime Care and Support (Catastrophic Injuries) Act 2014

This part will amend references to the *Road Transport (Third-Party Insurance) Act 2008* to the Motor Accident Injuries Act 2019. The amendments also adopt the new terminology for MAI cover, MAI policy, definition of insurer, MAI Commission with new definitions inserted to be consistent with the Motor Accident Injuries Act 2019.

Part 2.6 Limitation Act 1985

This part will insert a new limitation period for motor accident claims. A five year limit on commencing a motor accident claim is provided for by new section 16AA. Minor changes have been made to section 16B, section 30A and section 36.

Part 2.7 Road Transport (Alcohol and Drugs) Act 1977

This part will amend the reference to the *Road Transport (Third-Party Insurance) Act 2008* to the Motor Accident Injuries Act 2019.

Part 2.8 Road Transport (Driver Licensing) Act 1999

This part will amend the reference to the *Road Transport (Third-Party Insurance) Act 2008* to the Motor Accident Injuries Act 2019.

Part 2.9 Road Transport (General) Act 1999

This part will amend references to the *Road Transport (Third-Party Insurance) Act 2008* to the Motor Accident Injuries Act 2019 and adopt new terminology for insurer licence register and the Motor Accident Injuries Commissioner.

Part 2.10 Road Transport (General) Regulation 2000

This part will amend the reference to the *Road Transport (Third-Party Insurance) Act 2008* to the Motor Accident Injuries Act 2019.

Part 2.11 Road Transport (Offences) Regulation 2005

This part will amend references to the *Road Transport (Third-Party Insurance) Act 2008* to the Motor Accident Injuries Act 2019 and insert new offences under the Bill.

Part 2.12 Road Transport (Public Passenger Services) Act 2001

This part will amend the reference to the *Road Transport (Third-Party Insurance) Act 2008* to the Motor Accident Injuries Act 2019.

Part 2.13 Road Transport (Public Passenger Services) Regulation 2002

This part will amend definitions of ambulance, bus, motorcycle and public vehicle from the *Road Transport (Third-Party Insurance) Act 2008* to the Motor Accident Injuries Act 2019.

Part 2.14 Road Transport (Safety and Traffic Management) Act 1999

This part will amend the reference to the *Road Transport (Third-Party Insurance) Act 2008* to the Motor Accident Injuries Act 2019.

Part 2.15 Road Transport (Vehicle Registration) Act 1999

This part will amend the references to the *Road Transport (Third-Party Insurance) Act 2008* to the Motor Accident Injuries Act 2019.

Part 2.16 Road Transport (Vehicle Registration) Regulation 2000

This part will amend the references to the *Road Transport (Third-Party Insurance) Act 2008* to the Motor Accident Injuries Act 2019 and adopt the new terminology for motor accident injury policies from CTP policy.

Dictionary

This provides for terms defined in the Bill and terms that are defined in other legislation, including the *Legislation Act 2001*.