Insurance insights

THE MECHANICS OF MOTOR INJURY SCHEMES

Design considerations for personal injury insurance schemes for motorists

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Chris McHugh
Executive General Manager
Statutory Portfolio
Commercial Insurance
Suncorp

One Company
Many Brands

SUNCORP GROUP

Summary

Australia has more than 16 million motor vehicles that travel over 225 billion kilometres every year. For many people, motorised travel is the most dangerous activity they undertake in their daily lives.

As motor vehicles have proliferated over the past 100 years, mandatory insurance schemes have been created to protect the wellbeing of people who are injured in motor accidents and the assets of the driver responsible.

Designing these insurance schemes to maximise their efficiency and effectiveness is an ongoing challenge for the state and territory governments that administer them.

There are a number of competing interests and inherent tensions within each scheme.

Balancing affordability with the level of benefits, ensuring entitlements are consistently delivered equitably and minimising the cost of achieving positive health outcomes are but a few of the considerations.

Further, the financial sustainability of a scheme is impacted by several factors including the volatility of claims costs as well as external market components such as investment returns from premiums invested in government bonds.

This paper considers the various elements of motor accident insurance schemes and how scheme design can promote efficiency whilst delivering on the core objective of providing care and rehabilitation for motor accident victims.

Particular focus is placed on the New South Wales (NSW) experience, but the issues raised are equally applicable to other jurisdictions and other classes of personal injury insurance such as Workers Compensation.

Background

As soon as motor vehicles arrived in Australia they began causing injuries to people.

In the first half of the 20th century, the only option for many people who suffered injuries from a car accident was to pursue the driver at fault for common law damages[1] through common law legal proceedings.

The situation prior to the establishment of a mandatory scheme had considerable shortcomings.

An injured person had to successfully establish in court that the driver had been negligent in order to be compensated.

An uninsured driver could be devastated financially, and if they had limited personal wealth then the injured party would be inadequately compensated, despite having achieved a win in the courtroom.

This led Australian State and Territory Governments to create personal injury schemes to provide care and compensation for injured people in a comprehensive manner.

In NSW, the first compulsory third party (CTP) insurance legislation was established in 1942[2], requiring drivers to be covered by an insurance policy from a private provider or from the Government Insurance Office.[3]

As has been the case in other States and Territories, in the subsequent decades the NSW scheme has been repeatedly reformed in an effort to moderate the various tensions and competing interests that are impacted by the scheme's design.

1 Common law damages refers to monetary compensation that is awarded by a court in a civil action to an individual who has been injured through the negligence of another party. It typically involves calculating figures for various 'heads of damage' including past and future economic loss, past and future medical expense and care, and non-economic loss (also referred to as 'pain and suffering').

2 This was considerably later than the introduction of the Workers Compensation scheme in NSW in 1926.

3 It stated *"An Act to require that owners and drivers of motor vehicles shall be insured against liability in respect of the death of or bodily injury to persons caused by or arising out of the use of motor vehicles..."*. Throughout Australia a CTP policy forms a mandatory component of completing the registration of a vehicle.

Pricing

Affordability vs level of benefits

At the most basic level there is a trade-off between affordability and the level of benefits provided to those who have sustained injuries.

The designers of a personal injury insurance scheme – and the policy holders who participate in it – must determine what level of benefits they want a scheme to provide the injured.

The higher the level of benefits, the higher the premium rates must be to fund the entitlement. This is a constant tension to be addressed when designing a scheme.

Ultimately a scheme designer must determine how much money will be available to fund all the expenses of the scheme.

It must also answer the question of who should pay what.

Community vs risk rating

Personal injury motor insurance is mandatory in Australia. It is therefore necessary to ensure that it is reasonably affordable.

The risk that different drivers and vehicles will have an accident that results in injury varies considerably across the community.

Therefore, affordability is achieved by having low-risk motorists subsidise high-risk motorists.[4]

This cross-subsidisation in the insurance underwriting process is referred to as 'community rating'.

Alternatively, an underwriter (public or private) can set a premium rate for an individual policy that matches the *specific* risk of that policy holder.

This is referred to as 'risk rating'.

'Hybrid rating' is where there is a combination – a degree of community rating and a degree of risk rating.

In many schemes throughout Australia, community rating is adopted; all motorists of a certain vehicle class will pay the same amount for their insurance regardless of their individual risk profile.

That means that risk rating factors such as the age of the driver, their driving record, the age of the vehicle and where it is located are not considered when setting the price.

This is described as full community rating within a vehicle class.[5]

In NSW, hybrid rating exists. Insurers are permitted to raise the premium for higher-risk drivers and lower the premium for lower-risk drivers, in accordance with a formula and a set range designed to reward safer drivers whilst still ensuring affordability is maintained.

The pricing formula mandated by the NSW Regulator allows a variance of some hundreds of dollars between the lowest and highest premiums for a particular vehicle class.

To illustrate, an insurer may offer their lowest-risk customer a price of $520, but charge their highest-risk customer $762.

The regulated pricing formula enforces a restrictive range for insurers, meaning that if an insurer wishes to reduce their lowest price to attract low-risk customers, they are required to also reduce their maximum price, which will attract more high-risk customers.

As insurers are forbidden from refusing to offer cover to a customer, this formula ensures that the mix of high-risk and low-risk customers is well distributed between insurers.

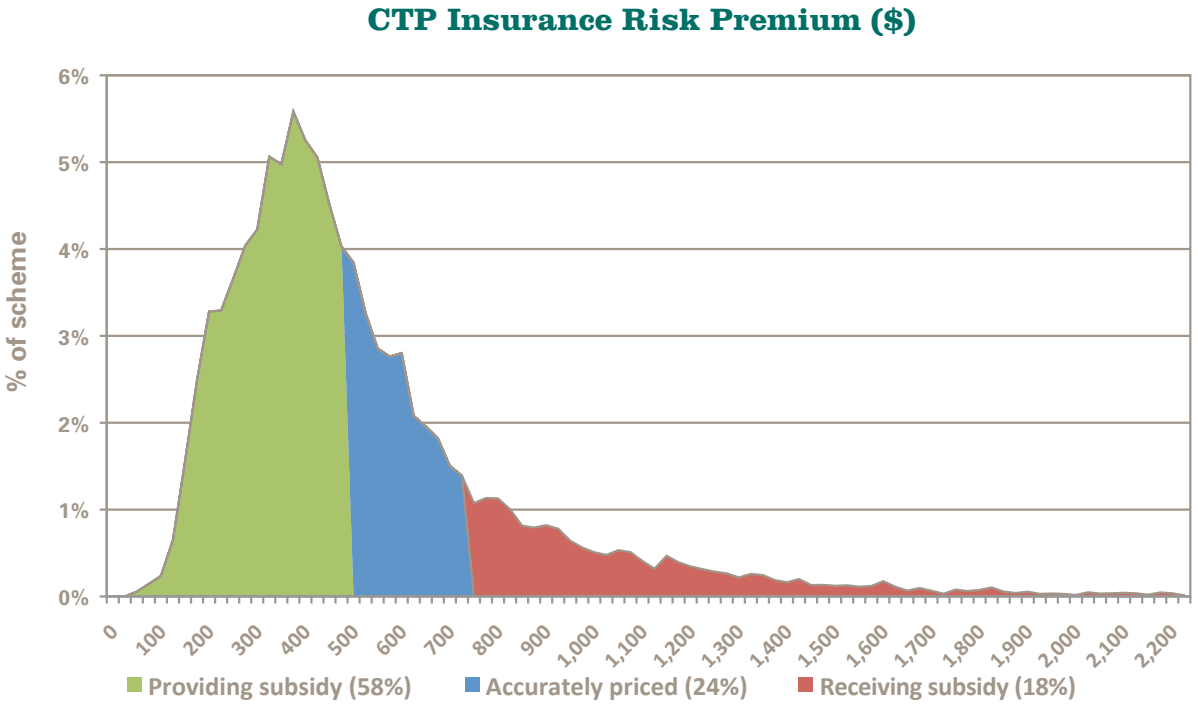
The impact of community rating on affordability is best understood by considering what price an insurer would charge if there was full risk rating.

As illustrated in the following graph, rather than a $242 differential, the lowest-risk driver could expect to pay less than $100, whilst high-risk drivers would pay several thousand dollars.

Approximately 0.5% of drivers (the highest risk) would pay between $2500 and $5000 for one year of cover.

4 Low risk vehicle owners pay more than their individual risk profile would require and high risk vehicle owners pay less than their risk profile would require.

5 There are several classes of motor vehicles for the purpose of setting premiums. Class 1 refers to private passenger vehicles and constitutes approximately 75% of all registered vehicles.



This graph displays an example of the risk rating of a personal injury motor portfolio. The accurately priced (red) section is the premium range that an insurer is permitted to charge (being a hybrid pricing scheme). Those drivers risk rated above or below this range are receiving subsidy or providing subsidy respectively.

Expecting a 17 year old driver with an older, low-value vehicle to pay several thousand dollars each year for their personal injury motor insurance is unrealistic.

It would inevitably lead to higher numbers of people being uninsured, which is counter to the important objective of maximising levels of coverage in order to facilitate the economic activity and social benefits that insurance provides.

The argument for hybrid rating is that it maintains affordability while providing drivers with some incentive to drive safely and purchase a safer vehicle.

It is also fairer than full community rating because it reduces the degree to which safe drivers are subsidising dangerous ones.

Whilst a degree of correlation between levels of risk and premium is appropriate, the existence of a degree of community rating is always necessary to ensure insurance is affordable and its benefits are available to the whole community.

Coverage

At-fault vs no-fault

In simple terms, a 'no-fault' motor injury scheme provides cover for everyone injured by a motor vehicle accident.

In an 'at-fault' scheme, injuries to the at-fault driver are not covered by the compulsory personal injury insurance policy attached to their vehicle – an important fact that many people are unaware of when they pay their premium.

In an at-fault scheme, if two cars collide and the driver of car A is deemed to be at-fault, then their compulsory personal injury insurance will cover the driver of car B and the passengers in both cars.

But the driver of car A will find themselves without cover for the injuries they sustain.

At-fault schemes lead to significant numbers [6] of injured drivers being without cover because the only way a driver can be covered is if *another* driver is deemed to have caused the accident.

If someone collides with a kangaroo, the kangaroo may have caused the accident but as the marsupial is not an insured driver, by default the person is deemed at-fault and is therefore without cover.

People do not drive with the intent of causing an accident.

Whist a minority of injured drivers cause accidents due to their own irresponsible behaviour, the majority of drivers make small errors of judgment or are simply victims of a combination of events; people make mistakes and accidents happen.

Unfortunately, thousands of Australian families know from firsthand experience the devastating impact of being injured in a car accident without cover for the injuries suffered.

This is most acute for those with serious and catastrophic injuries.[7]

No-fault coverage brings a financial cost to the scheme, but eliminating the tragic circumstances that can befall injured drivers who are without cover provides a profound social benefit.

A further benefit of no fault schemes is that they can speed up the rehabilitation process by avoiding the delays associated with determining who is at fault; these delays routinely produce worse health outcomes and higher costs.

First party vs third party

The implementation of a no-fault scheme allows a scheme to be 'first party' rather than 'third party'.

If two cars collide under a third party scheme, a determination is made as to which driver is at fault and that driver's third party insurer will manage the claims of all injured people in both cars.[8]

The result is that these injured people have no ability to choose the insurer that manages their claim, as it's a purchase decision that has been made by the at-fault driver.[9]

For the injured people, it's luck-of-the-draw as to who manages their rehabilitation and provides compensation through the insurance claim.

The at-fault driver may well have chosen a particular CTP insurer because they were the cheapest, not because they are known to provide the best claims service.

In a first party no-fault scheme, when two cars collide the insurer of car A manages the claims of everyone in car A, whist the insurer of car B will manage the claims of everyone in car B.[10]

A first party scheme means that policy holders know that if they are involved in an accident, whether they are at fault or not the CTP insurer *they* have chosen will manage the claims for their injuries and the injuries of everyone in their vehicle.

This allows insurers in a first party scheme to market themselves to customers on the basis of their brand reputation and claims management expertise.

6 In South Australia the at-fault scheme resulted in approximately 40% of catastrophically injured motor accident victims being left without compensation. South Australia introduced a new no-fault Lifetime Support Scheme for people catastrophically injured in motor accidents, effective 1 July 2014.

7 The NSW scheme provides no-fault coverage for those with catastrophic injuries through the Lifetime Care and Support scheme. Less severe injuries are covered for drivers at fault up to a maximum value of $5000.

8 If it is an at-fault scheme, the at-fault driver's injuries will not be covered.

9 This is distinct difference to most other forms of insurance such as property and motor vehicle insurance where the customer's claim is managed by their own insurer. A good reputation for claims management is a key selling point for an insurer of these classes of insurance.

10 A cost sharing arrangement between insurers transfers the majority of the cost to the insurer of the at-fault driver. This process does not involve the policy holders and those involved in the crash. Similar cost sharing between insurers currently occurs within the NSW CTP scheme and in relation to motor vehicle repairs.

Claims

Defined benefits vs common law

Perhaps the most debated aspect of personal injury insurance scheme design is the amount of care and financial compensation provided to injured people, and the manner in which it is determined.

A 'defined benefits'[11] scheme seeks to reduce the degree of uncertainty around claims costs by having a schedule of prescribed financial compensation amounts that will be paid, depending on the type and severity of the injury.

For example, in addition to having medical expenses, lost income and out-of-pocket expenses covered by the insurer, someone who lost sight in their left eye would be given a defined amount for non-economic loss, also known as 'pain and suffering'.

The same amount would generally be paid to all people who lose sight in their left eye.

A scheme that relies on common law to determine financial compensation involves a process of negotiation or arbitration to define a lump sum figure based on the individual circumstances of each case.

Lawyers tend to have a greater involvement in common law schemes as there is greater scope to argue for higher levels of financial compensation, particularly by pointing to legal precedents in other cases involving similar injuries.

The advantage for injured motorists in a common law scheme is that they may be awarded more money.

A feature of common law schemes is that people with minor injuries who present a persuasive case can be awarded disproportionally large amounts, which results in higher premiums.

For example, in the Australian Capital Territory (ACT)[12] someone with a non-severe whiplash injury[13] who suffers approximately $20,000 in lost income and medical costs, may be awarded in the order of $60,000 for pain and suffering.

The benefit is that an injured person in the ACT can receive substantial financial compensation for any pain and suffering they may have experienced.

The cost is that people in the ACT pay more for their CTP insurance.

11 Defined benefits structures can be based on a combination of factors including severity of injury, limits on the duration of payments, caps on wages payable and defined payment amounts for certain prescribed injuries.
12 The ACT CTP scheme allows unrestricted common law claims for all injuries to people not deemed at-fault who suffer injuries as a result of a motor vehicle accident.
13 An injury from which they can be expected to fully recover.

Whole person impairment thresholds

In an attempt to reduce large compensation payments for minor injuries, many personal injury schemes[14] have introduced thresholds that must be reached before certain benefits can be awarded.

Typically, a whole person impairment (WPI)[15] threshold is applied to access financial compensation for pain and suffering, which restricts these payments to those people who have the most severe injuries.

The degree of whole person impairment is determined by a process of medical assessment, although this can be an issue of contention as the conclusions of different medical experts can vary.

Prompted by escalating claims costs and rising premiums, in 1999 the NSW CTP scheme introduced a 10% whole person impairment threshold for non-economic loss.[16]

To illustrate, a fractured sternum is unlikely reach the 10% threshold, but a fractured pelvis almost certainly would.

Injured people who do not reach the 10% threshold are still able to claim for all other heads-of-damage (past and future economic loss, past and future care and out of pocket expenses), but not for pain and suffering.

Apart from directly containing claims costs by removing pain and suffering compensation for non-severe injuries, an important consequence of having whole person impairment thresholds is the impact on premium volatility.

Payouts for non-economic loss common law claims can be substantial and can change significantly over a short period of time as new legal precedents are set.

This uncertainly is a risk factor that underwriters must include in their calculations when setting the premium based on expectations of future claims costs.

The greater the uncertainly, the higher the risk and the higher the premium paid by motorists.

Objectively defined rules that create certainty assist insurers when setting premium rates.

14 Examples of whole person impairments thresholds in other personal injury schemes include 15% (NSW Workers Compensation), 30% (Victorian Workers Compensation), 20% (Queensland Workers Compensation) and 15% (Western Australian Workers Compensation).
15 Each jurisdiction has its own method for determining the level of whole body impairment, meaning that threshold figures cannot be directly compared between schemes.
16 Approximately 10% of injuries in NSW are sufficiently severe to be classified as having resulted in a 10% WPI.

Lump sums vs weekly payments

When someone is injured in a car accident or at work, the financial impact is immediate in the form of medical costs and lost income from the inability to work.

Across all personal injury schemes, medical expenses and care are generally paid immediately as they are incurred.

However, for economic loss a scheme designer may elect to have economic loss (loss of income) paid in the form of weekly payments or as lump sum once a final figure has been determined.

The NSW CTP scheme pays lump sums, whilst the NSW Workers Compensation scheme makes weekly payments (referred to as 'weekly benefits') for economic loss.[17]

Because the injury has to stabilise before its full impact can be assessed, injured people will wait months or years to receive a lump sum for economic loss.

The arguments for lump sums are that they allow the claim to be finalised (which reduces ongoing administration costs) and give the injured person a substantial amount of money to manage as they see fit.

The arguments against lump sums are that people have to wait some time for their payout and it can be difficult to successfully manage this money in the long term.

Further, lump sums contain estimates of future economic loss that often include buffers for the inherent uncertainly of such speculative calculations.

The result is that some injured people are paid for an economic loss that they don't actually end up suffering, while others experience greater economic loss than they receive in their lump sum compensation.[18]

Regardless of whether or not economic loss is paid as weekly benefits or as a lump sum, the key issue for scheme designers is how to effectively provide an incentive for injured people to recover.

Disincentives to recover

There is no simple solution to the conundrum of how to provide accident victims adequate financial compensation for economic loss without providing a disincentive to recover.

If a scheme designer elects to provide weekly payments, it can expect that some people will remain on these benefits for years and even decades.

If the lump sum option is taken, the NSW CTP experience has demonstrated that this can provide an incentive for injured people to refrain from returning to work to maximise their payment for economic loss.

Economic loss often constitutes the vast majority of claims for non-severe injuries – typically 60% to 80% of the total lump sum.

To illustrate, someone with $30,000 in medical and care expenses may be paid $200,000 in economic loss – principally future economic loss as distinct from past economic loss.

If an injured person returns to work before their lump sum negotiations are finalised, they can expect the size of their lump sum to be dramatically reduced – often by more than 50%.

This provides an incentive for injured people to emphasise their incapacity and delay their return to the workforce in order to maximise their lump sum payment.

17 There are some cases in which, once the injury has stabilised, a Workers Compensation claim will be 'commuted' which involves paying a lump sum for future compensation.

18 Another factor in a system of lump sum payments is that a considerable proportion of the lump sum can ultimately be directed to an injured person's lawyer. In NSW the maximum legal costs that can be paid as part of a claim settlement are defined by a schedule approved by the Motor Accidents Authority (MAA). The official figures for legal and investigation costs do not take into account additional sums of money that are often paid to lawyers by injured people once they receive a payout. These sums can be significant, but no scheme-wide data is available as the amounts are contained in confidential agreements between a lawyer and their client. Instances of lawyers receiving $0.5m of a $1.5m payout have been reported.

The consequences of an emphasis on financial compensation rather than expediting rehabilitation can be a delayed recovery for an injured person in the short term, which can then seriously impede their long-term employment prospects.

The cumulative effect of numerous people not returning to work in a timely manner produces a material increase in costs to the scheme, and therefore higher premiums for policy holders.

Limited vs unlimited duration

An option for scheme designers who aim to contain costs and encourage injured people to make a rapid return to work is to set a maximum period of time for which compensation payments will be made. [19]

A limited timeframe is typically applied only to non-severe injuries, while those with severe disabilities as a result of their accident have no set time limit and access to compensation through common law proceedings.

The combination of making periodical (eg. weekly) payments available for a limited duration and delivering that compensation through weekly payments allows the scheme to cover the *actual costs* that injured people incur, as they are incurred.

This removes lump sums and the incentives they generate to emphasise incapacity or delay a return to work.[20]

The limited duration also reduces the incentive for an injured person to delay a timely return to work, due to the understanding that their weekly payments for economic loss will not continue indefinitely.

It is important that the designated timeframes are appropriate for the injuries suffered to allow people with injuries a reasonable period of time to recover before compensation ceases.

If a system of defined benefits (as distinct from common law) is also incorporated into the scheme design, there is an opportunity to significantly reduce the need for legal representation.

Friction costs

The legal profession has always played a role in determining the financial compensation paid to motor accident victims.

The fees that are paid to the lawyers, medical experts and investigators are referred to as 'friction costs'.

Schemes with lower friction costs are considered more efficient as they increase the proportion of scheme income dedicated to the provision of care and financial compensation of injured people.[21]

Reducing friction costs whilst maintaining a fair and equitable scheme requires a robust yet efficient dispute resolution mechanism.

Dispute resolution

Some disputes will inevitably arise in any claims process. Having an effective dispute resolution process reduces the need to revert to a formal legal process conducted through the courts.[22]

The challenge for scheme designers is to minimise disputes and to have them resolved in a quick, fair and efficient manner.

The benefits that injured people covered by personal injury schemes are entitled to are clearly defined by legislation and guidelines, so a primary function of dispute resolution is to ensure that the rules are being followed.

Insurers are generally required to have an independent dispute resolution process, with the claimant having the option to escalate to the regulator if they are dissatisfied with the outcome.

The more that scheme designers are able to remove uncertainty and ambiguity around entitlements, the less requirement there will be for complex dispute resolution mechanisms.

19 This might be a maximum of five years depending on the injury type and severity.
20 The removal of lump sums also reduces legal expenses (referred to as 'friction costs') that focus on the need to negotiate future economic loss and care settlement figures. 'No win no fee' legal cost structures are eliminated.
21 Other significant scheme costs are insurer profit and regulator expenses.
22 Key design features of effective dispute resolution include providing easy access for participants, being non-adversarial and having a transparent decision making process.

Conclusion

Mobility in our modern society is recognised as a right, not a privilege. This right is predominately exercised through affordable access to a motor vehicle.

Whilst the cars of the future may be too clever to crash, in the medium term Australia will have a growing number of vehicles that are still able to crash and cause people injuries.

The core purpose of a personal injury insurance scheme is to look after these injured people – a task performed most comprehensively by a no-fault scheme.

The complex task of designing a scheme involves finding a balance of risk and community rating to ensure affordability with a degree of fairness.

It requires focus on minimising the uncertainty around benefits to encourage people to recover and maximise the proportion of expenses that ultimately reach accident victims.

Defined benefits and limited compensation timeframes, combined with a dispute resolution mechanism that reduces the need for legal representation can produce efficiencies that will have a positive impact on premium rates.

A failure to promptly implement reforms as imbalances and inefficiencies arise can lead to schemes quickly becoming financially unsustainable.

The negative consequences may include ballooning insurance premiums, a declining proportion of every dollar ending up in the pocket of injured people, inadequate compensation for motorists and massive losses for underwriters.

As multi-billion dollar operations, rehabilitation of impaired and poorly designed schemes is extremely expensive.[23]

The inherent complexity of personal injury insurance schemes and the broad collection of interested stakeholders mean that implementing timely reform requires strong political leadership with a vision for the long term interests of the community.

Millions of Australians risk injury from motor accidents every year and many thousands of them are unfortunate enough to experience it.

A scheme that caters for their needs in a fair, affordable and efficient manner is a critical component of the insurance landscape.

23 At 30 June 1988 liabilities for the NSW CTP scheme stood at $3 billion of which $1.87 billion was unfunded. Representing $4.7 billion in today's terms, the NSW deficit was enormous both in percentage and absolute terms. Every NSW CTP policy had an additional $47 levy for the next 10 years to pay off the debt.

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