AFEI SUBMISSION to the INDEPENDENT REVIEW ICARE AND SICG ACT

November 2020

Introduction

The Australian Federation of Employers and Industries (AFEI) welcomes the opportunity to provide its views on the operation of the nominal insurer and the State Insurance and Care Governance Act 2015 (SICG Act) and provide insight into the matters under review from an employer perspective. These views reflect the experiences of our members and their difficulties with the scheme which they make known to us via our telephone advisory service, consulting and training services. We would be happy to discuss the issues raised with the Independent Reviewer.

In this submission we will be primarily concerned with employer interaction with icare —the nominal insurer — and its agents/subcontractors and service providers such as EML. Given the control and direction exercised by icare over these agents/subcontractors and service providers they will collectively be referred to as the *"nominal insurer".* Legislative references are to the *Workers Compensation Act 1987 (1987 Act)* Workplace Injury Management and *Workers Compensation Act 1998 (1998 Act) and the* State Insurance and Care Governance Act 2015 (SICG Act)

Workers compensation is major concern for NSW employers in terms of financial cost and management time. In spite of the much lauded average premium cost of 1.4%, for an employer managing a claim — even when not experience rated — considerable resources are expended on managing a claim with the nominal insurer. Employers want to ensure that injured workers are properly looked after and their return to work is not impeded by the nominal insurer's claims management processes. Where experience rated, there is a disproportionate cost in their premium, in addition to the time expended in attempting to get the appropriate information from the nominal insurer about the worker's condition, their treatment and capacity for return to work. This is a costly and time consuming drain on time and resources that would otherwise be spent on managing a business.

We support the principle that the workers compensation scheme should be administered in a way that is fair and equitable, underpinned by honest and transparent communication. [1] This has not been the experience for many employers, particularly since the introduction of the nominal insurer current claims management model. We support strengthening the obligation on the nominal insurer to seek information from employers, to properly consider this and to provide employers with cogent reasons for liability decisions and subsequent decisions made during the life of the claim.

[1] SIRA Standards of Practice Expectations for insurer claims administration and conduct December 2018 https://www.sira.nsw.gov.au/__data/assets/pdf_file/0005/567653/Standards-of-Practice-December-2018.pdf

LEVEL 2, 97-99 BATHURST STREET, SYDNEY NSW 2000
POSTAL PO BOX A233, SYDNEY SOUTH NSW 1235
PHONE 02 9264 2000 FAX 02 9261 1968
WEBSITE WWW.AFEI.ORG.AU

In this submission we will focus on the features of the scheme and the nominal insurer's operations which directly impact on employers, their management of claims in the workplace and the cost to their business and premiums. It is readily apparent from the material provided to the NSW Parliament Standing Committee on Law and Justice 2020 Review of the Workers Compensation Scheme[2] (*"the LC Review")* that the wasteful and unregulated expenditure by the nominal insurer has placed the scheme in jeopardy. The LC Review has raised fundamental questions about the competency of the icare board and risks to the nominal insurer's sustainability.

NSW employers fund the scheme and are liable for its debts. While most NSW employers — whose premiums are experience rated — may be unaware of the implications of this, experience rated employers are acutely aware of the cost of their claims. All NSW employers bear the major burden of the nominal insurer's mismanagement and profligate expenditure.

AFEI welcomed the initiative taken by SIRA in commissioning the 2019 independent review of the nominal insurer, the consequent DORE report, and SIRA's action on its findings. These, for the first time, provided independent confirmation that employer complaints about the nominal insurer's performance were not misplaced or ill founded.

We note the SIRA 21 Point Action Plan and the measures undertaken to date — the *21 Point Action Plan Update* from SIRA produced for the LC Review dated 3 August 2020.[3] While some seven of the actions required of the nominal insurer have been completed, 14 remain ongoing. From our members' perspective, little in the nominal insurer's practices has changed. It would also appear from SIRA statements during the LC Review that it too is unsatisfied with the progress made by the nominal insurer in remedying issues identified in the Dore report and the action plan. However, SIRA is limited by is legislated powers to ensure remedies are taken; this will be discussed further in this submission.

icare Culture

The fundamental absence of balance and discipline within icare leads to excess. It encourages delayed or non return to work. It encourages claimant exaggeration and insufficient examination of liability for claims. As observed in the *EY Nominal insurer 2020 Quarter 1 claims file review* SIRA July 2020:

> "*when reaching liability decisions there appeared to be an inadequate understanding of the facts of an injury that would enable an informed liability decision to be made".* [4]

[2] 2020 Review of the Workers Compensation Scheme https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-details.aspx?pk=2589

[3] https://www.parliament.nsw.gov.au/lcdocs/other/13515/Tabled%20document%20-%2021%20Point%20Action%20Plan%20update.PDF

[4] SIRA Nominal Insurer 2020 Quarter 1 Claims file review https://www.sira.nsw.gov.au/__data/assets/pdf_file/0004/876568/EY-Report-Nominal-Insurer-2020-Quarter-1-claims-file-review.pdf

Laxity at any level of the scheme has encouraged deterioration elsewhere — as exemplified in the notable deterioration in return to work rates. Some argue this points to the need for premium increases to shore up the gap between average and break even or target premium. That is not the answer. The answer lies in a system that is balanced and disciplined at every level and these have not been features of the nominal insurer's culture and operations.

Claims Management

In our members' experience, the nominal insurer's automated claims management arrangements have resulted in even less employer involvement, with the now almost universal acceptance of claims based solely on the treating doctor's certification and automatic processing thorough the computerised triage platform. Claims are now routinely accepted:

- without any information sought from the employer as to work relatedness or the circumstances surrounding the alleged injury or illness;
- where there is factual evidence presented by the employer that there was no workplace incident or injury and no reported workplace incident or reported injury;
- where workers refuse to sign statutory declarations that they are not receiving wages income while in receipt of compensation payments;
- where the claim should have been declined in accordance with section 11A of the 1987 Act;
- where the insurer instigated investigation report recommends that the claim be denied;
- where the insurer rules that the claim is a frank injury despite medical evidence that the injury is a recurrence of a pre - existing injury;
- where an IME or IMC report which is unfavourable to the worker's claim is rejected in favour of the treating doctor's view.

This outcome is the direct result of the nominal insurer having too wide a discretion in its approach to claims management, without adequate accountability. This needs to be rectified.

Automated processing and an absence of a dedicated case manager has entrenched this policy of low barrier to entry. At one stage it appears that the EML contract with icare allocated 90 claims per case manager — the apparent target is 65 with 35 for higher support claims but the target rate is still uncertain.[5] This has an adverse effect on the quality of claims management, led by the *Guidewire* automated process driven approach rather than one based on professional experience and capability. It is also unsurprising given that the emphasis is on rapid through put and "*customer*" (worker) satisfaction rather than proper evaluation.

[5] NSW Parliament Standing Committee on Law and Justice Inquiry Into 2020 Review of the Workers Compensation Scheme Transcript Monday 24 August 2020 https://www.parliament.nsw.gov.au/lcdocs/transcripts/2434/Transcript%20-%2024%20%20August%202020%20-%20UNCORRECTED.pdf

Of particular concern is the high acceptance rate of psychological injury claims. It is clear that the nominal insurer is accepting unsubstantiated claims and making incorrect payments.[6] A major concern with these claims are those made in the context of managing an employee whose work performance is substandard (or in breach of their contractual obligations). We have regular calls for assistance from employers who have undertaken performance management with all due regard for procedural fairness, have retained external independent assistance for investigation or mediation, have provided all manner of support to the worker throughout and yet are faced with acceptance of a claim for a psychological disorder.

The nominal insurer's almost universal reliance on the opinion of the NTD requires close attention. Employer experience with claims management demonstrates a range of concerns arising from this continued dependency including:

- providing a diagnosis based only on what the NTD is told by an injured worker;
- unintentional or intentional restrictions on full disclosure of past work, medical and claims history, particularly given the nature of the doctor- patient relationship. As a result non workplace injuries and conditions are funded by employer workers compensation premiums;
- ready referral for surgical treatment;
- apparent excessive reliance on physiotherapy, remedial massage and other allied health treatment regimes for prolonged periods without proper evidence of medical efficacy or the matching of treatment to actual improvement ;
- reliance on pain management treatment programs with little control over cost, duration and outcome;
- little review of success of such treatment regimes leading to a greater non accountability in treating practitioners' reliance upon them;
- claims continuing indefinitely;
- doctors interposing themselves into the employment relationship and providing opinions on workplace relations, not medical opinions.

Further, once a claim is accepted, the nominal insurer is permissive of repeated worker non-compliance with their injury management plan and return to work obligations. This extends to allowing workers to routinely seek no change/downgraded certificates from their treating doctor or to change their treating doctor in order to obtain a work capacity certificate which certifies them as unfit (or partially fit), and thus rendering them compliant and entitled to continued payments (and back payments).

[6] Synapse report: https://www.parliament.nsw.gov.au/lcdocs/other/13628/AQON%20-%20SIRA%20board%20%20-%2024%20August%202020%20hearing.pdf
Total Incorrect Payments $9,812,778.86 (33%)

This is symptomatic of the nominal insurer's process driven, rather than outcome driven, driven approach to claims management. The scheme measures its performance in metrics, ticking boxes at designated milestones in the claim history, and is entirely concerned with timeframes, delivery of treatments in conformity with the injury management plan, rather than a proper evaluation of the claim, its progress and effectiveness. Unsurprisingly, aggregated return to work rates have declined despite all the "reforms", massive expenditure and "*customer*" experience.[7]

The 1987 Act S 192A — *Claims administration manual* (1)(d) provides that SIRA (now the "Authority" referred to) is required to promote, as far as practicable, the proper investigation of liability for claims. While publishing claims management standards in an attempt to address this requirement, in practice these are ignored as the nominal insurer follows its own procedures and employers are deliberately frozen out of the triage process and subsequent aspects of claims management. One icare executive even acknowledged that the strategy of excluding employers because it made claims management too adversarial had "*perhaps gone too far*".[8]

Imbalance in nominal insurer assisting employers to meet obligations – stringent employer return to work obligations

Once a liability decision has been made, employers are not provided with detailed reasons for the decision and avenues for review if the employer does not agree with the decision. On the other hand, when liability is declined and a section 78 dispute notice is issued to a worker, they are provided with extensive detail outlining the evidence relied upon and reason for the decision to decline liability. They are also provided with a number of avenues for the decision to be reviewed.

S 46 of the 1998 Act sets out the employer's injury management plan obligations:

> *(1) The employer must participate and co-operate in the establishment of an injury management plan required to be established for an injured worker.*
>
> *(2) The employer must comply with obligations imposed on the employer by or under an injury management plan for an injured worker.*
>
> *(3) This section does not apply when the employer is a self-insurer.*

This requisite employer participation usually amounts to merely forwarding the employer the plan already agreed by the nominal insurer and the worker. For injury management plans to be workable and effective, the nominal insurer should be fully informed by the employer as to the alternative work available at the pre injury workplace (or at other locations of that employer) and to actually take this into account, and make these known to the treating doctor — the doctor will not usually communicate with the employer directly.

[7] No amount of PR speak on the part of ICNSW will convince employers they are its customers or clients. They are compelled to participate in a compulsory regulated compensation scheme.

[8] LC Review https://www.parliament.nsw.gov.au/lcdocs/transcripts/2434/Transcript%20-%2024%20%20August%202020%20-%20UNCORRECTED.pdf

S 270 1998 Act *Obligations of worker to provide authorisations and medical evidence* requires workers to authorise release of information from the service provider to the insurer, including to employers. S 47(5) of the 1998 Act provides that

> *(5) The worker must authorise the worker's nominated treating doctor to provide relevant information to the insurer or the employer for the purposes of an injury management plan for the worker.*

Despite these provisions the nominal insurer typically claims compliance with privacy legislation as the basis for withholding claimant information from employers. It is frequently reported to us that the nominal insurer cites "privacy reasons" for inaction in claims management, particularly as a reason for not undertaking an investigation or making further inquiries of the worker about the circumstances of the claim, even where it is reasonable to assume these may have an adverse impact on the effectiveness of an injury management plan.

Despite the scheme focus on protection of worker privacy, there is no reference to employer, or other workers' privacy. We are aware of instances where investigation reports including statements made by other workers have been provided to claimant workers by the insurer (as required by s 73 1998 Act) and the worker has given these to third parties, including other workers. Consequently the personal information of workers, and the employer, in these reports has been improperly released by the worker under privacy legislation and in breach of s 243 of the 1998 Act. These reports have even been utilised in other litigation instigated by the worker.

No equivalent standard for workers in actual return to work

Despite the legislated obligation for workers to make reasonable attempts to return to work[9], if a worker does not want to do the work which is offered, their refusal is readily accepted by the nominal insurer. The general practice within the nominal insurer, despite the legislated requirements [10] is to support the worker's non return to work. A common situation is a labourer who will not undertake clerical duties. Employers regularly confront situations where they have work available within the usual workplace (or other convenient location) which fits the worker's medically assessed capacity but which are deemed unsuitable by employees. This is routinely unchallenged by the nominal insurer. Section 48A of the 1998 Act is invoked rarely (if ever in our member's experience).

Independent medical examinations

Under s 119 of the 1998 Act an employer may direct a worker to an IME in accordance with the guidelines. Yet the claims administration guidelines, in their current iteration as SIRA Standards and Guides, make no reference to IMEs. The right of an employer to utilise an IME should be observed as an integral part of the claims management process. Further, the nominal insurer should not interfere with an employer's right to obtain a medical opinion on a worker's fitness for work; employers must meet their work health and safety duties at all times and must have confidence in the diagnosis of the worker's capacity.

[9] S48 1998 Act

[10] 1987 Act 32 A Definitions *suitable employment*

Factual investigations

Along with the reduced use of IMEs and IMCs, and its preference for using non transparent internal reviews and medical panels, the nominal insurer seems deliberately resistant to undertaking factual investigations.

Unlike privately underwritten schemes, the nominal insurer appears to see little need to avoid non-work related, exaggerated or even fraudulent claims. This is a significant concern given that the nominal insurer does not test claims rigorously from the outset, as demonstrated by the Dore report and the EY review. It has been our member's common experience that even where a factual investigation does not find circumstances warranting an acceptance of liability, the claim is accepted. Further, employers are not provided with any detail of the factual investigation, at best they are provided with a summary outline of conclusions, and only after they have requested this information.

"Detached" workers

A disturbing practice by the nominal insurer is to notify employers that the worker is to be *"detached"* from their employment. This is done with apparent disregard for the fact that the contractual relationship between the worker and the employer remains intact, the worker has not resigned, and the employer retains all their obligations to the worker under employment legislation and the terms of the employment contract.

None of this is made known to the employer. To the contrary, the impression is conveyed that the worker is now to be "*taken care of"* by the nominal insurer, who will no longer provide the employer with any information about the claim and its management. The employer is left exposed to the vagaries of the claims management process, from which they are now entirely isolated. Usually they do not understand that they must continue to accrue legislated benefits for the worker (annual leave, etc.) and meet other contractual and legislative obligations, along with the burden of claims experience costs where they are experience rated.

This has resulted in dispute and unfair dismissal claims[11] all of which add to the time and resources an employer has to devote to mismanaged nominal insurer claims.

Avenues for employer complaint or dispute

The ***Workers Compensation Legislation Amendment Act 2018*** restored the jurisdiction of the Workers Compensation Commission to determine all disputes, including the review of work capacity decisions — effectively creating a streamlined 'One-stop Shop' for dispute resolution for workers. Amongst other beneficial changes for workers, it provided the Commission with the power to determine permanent impairment disputes without referring the worker to an Approved Medical Specialist (AMS).

[11] See for example WenfuYang v Comfort Management Pty Ltd 24 August 2018 FWC (U2018/4121).While in this case the employer was not found to have unfairly dismissed the "detached" worker, they were subject to court proceedings and the need to respond with attendant time and expenditure. Other employers in this situation have resorted to out of court settlements even before conciliation. The nominal insurer plays no part in these proceedings, despite being the instigator.

The amendments did not provide for a legislated employers' complaint and dispute resolution pathway. The Minister announced that employers are to take their complaints about workers compensation matters to SIRA. There is no legislated mechanism for employer/insurer dispute resolution nor for employers to have any greater say in liability or claims management decisions.

Subsequently SIRA, via its website, provided contact details for employers or "*other stakeholders*" with an "*unresolved enquiry or complaint".* In our experience, this has left employers in an unchanged situation. Members continue to report a high level of disinterest on the part of the nominal insurer to concerns they raise about both liability and claims management. It seems clear that in this environment SIRA is constrained in seeking to achieve an appropriate outcome by icare's unconditional licence which prevents SIRA's effective intervention. There is a need for a more balanced and stringent review process which holds the nominal insurer accountable for the decisions it makes and gives far greater transparency about its decision making.

THE CLAIMS AGENT MODEL AND INCENTIVE STRUCTURES

The detail of the claims agent arrangements within the nominal insurer and the incentive structures have never been made known publicly. In the LC Review certain arrangements with EML were disclosed. [12]

For employers, the nominal insurer's reduction in agents/subcontactors — initially to one — said to generate efficiency and other gains for the scheme overall in fact led to a period of upheaval, confusion and delay. As employers came quickly to realise, even if other insurers remained in the scheme, in terms of claims management they were at the direction and control of icare, which set up an internal "shadow" workforce to ensure agent compliance with its directives. This was done to enable the rapid and consistent application of the Capgemini Guidewire claims processing system.

In the compulsory, monopoly insurance scheme legislated in NSW, there should be an absolute obligation on the responsible Minister and its agencies to ensure a fair, transparent and viable insurance structure is in place. The current legislative framework, in particular the provisions of the SIGC Act does not ensure this outcome.

GOVENANCE

Major change is needed as it is apparent the nominal insurer is off on a frolic of its own. SIRA with overarching responsibility needs legislative changes that will give the workers compensation system the credibility it needs so that the regulator of the scheme can do its job properly.

[12] NSW Parliament Standing Committee on Law and Justice Inquiry Into 2020 Review of the Workers Compensation Scheme Transcript Monday 24 August 2020 pages 19-22 https://www.parliament.nsw.gov.au/lcdocs/transcripts/2434/Transcript%20-%2024%20%20August%202020%20-%20UNCORRECTED.pdf

An effective regulator needs to be able to ensure that its standards, guidelines, practice notes, etc., actually deliver proper outcomes; outcomes that deal fairly with injured workers while resolutely imposing a claims management system that will actually get them back to work and not one full of pretence primarily providing a pool of money for exploitation by a wide range of service providers.

The SICG Act has been drafted in the broadest possible terms, without clear and specific obligations for SIRA or ICNSW as to the manner in which they discharge their statutory functions. The nominal insurer is not required by the SICG Act or by the 1987 Act (s 154A—154CA) to be accountable for its performance. Section 10(1)(d) of the SICG Act merely requires ICNSW to "monitor" the performance of the schemes for which it provides services. As a consequence, both bodies are able to conduct their operations without any requirement to be transparent or accountable to NSW employers who own the scheme liabilities 1987 Act 154D(4)). This needs to be remedied by legislative reform.

Nor is adequate information provided about expenditure levels on the various nominal insurer activities. For example, on service providers and benefits such as payments for risk management, educational assistance and social reform initiatives, including the activities of the icare foundation. Given the information provided to the LC Inquiry, these are both very substantial and varied.

Such expenditure as has publicly emerged includes over $8.2 million in payment for "*risk consulting services*" and some $5 million to $6 million to create an icare workspace called an imaginarium.[13] Other icare forays include funding for housing and welfare.[14] According to the icare Foundation website, over S25 million has been committed *"to support research, seed-funding, capacity building and scale-funding".* [15] While the funding comes from all of icare's insurance schemes, icare should make clear to NSW employers how much of this comes from the workers compensation fund, which has apparently had to require funding transfers from the Treasury Managed Fund.[16]

The need for great accountability and prudential oversight is addressed below in the need for review of the SIGC Act.

Premiums

We consider this to be a relevant concern of this inquiry as it relates to the funding of the scheme and its component entities. We understand that at the request of SIRA the nominal insurer will undertake a comprehensive review of the insurance premium calculation model. However the elements of this review are to be assessed against the principles of the Market Practice and Premium Guidelines (MPPGs).

[13] NSW Parliament Standing Committee on Law and Justice Inquiry Into 2020 Review of the Workers Compensation Scheme Transcript Monday 24 August 2020 and Wednesday 9 September 2020

[14] https://www.icare.nsw.gov.au/news%20and%20stories/icare%20foundation%20funding%20helps%20develop%20homeshare%20program%20in%20nsw/#gref

[15] https://www.icare.nsw.gov.au/icare-foundation/about-icare-foundation

[16] NSW Auditor General's Report Central Agencies 2019 published December 2019 https://www.audit.nsw.gov.au/our-work/reports/central-agencies-2019-0

The MPPGS are high level and aspirational and do not provide clarity or transparency for employers in premium setting. They do not set out with any specificity the measures by which SIRA will assess insurers' conformity with the guidelines. Employers have no objective or accessible means of assessing the extent to which the nominal insurer is adhering to the MPPG principles. They appear to operate primarily to ensure that as little information about the actual rationale for premium setting is released to employers.

The MPPGs are wholly inadequate in requiring the nominal insurer or SIRA to demonstrate how and why premiums have been set at the approved level. They simply set out certain actions and steps SIRA may demand of the insurer where the premium filing is found to be lacking.

The non disclosure of premium — determining information is in contrast to other workers compensation jurisdictions in a competitive market environment where the actuarial information underpinning premium determination is made publicly available.[17] Full actuarial reports are not published for this purpose. SIRA now publishes regular and detailed reports on scheme metrics (claims numbers, type, expenditure return to work, etc.) which is a great improvement on the near complete absence of data since icare became the nominal insurer.

However, both SIRA and the nominal insurer have argued commercial — in confidence reasons for the absence of meaningful data underpinning the current premium filing process under the MPPGS. We fail to see that the level of competition faced by the nominal insurer from specialised insurers is so intense that this is a valid argument. Rather, it would appear to be the means by which transparency, accountability and competition within NSW workers compensation can be minimised, while calls for full disclosure of all expenditure are resisted.

Given the overarching legislation, this outcome is not surprising.

The MPPG stated objective of ensuring insurance policies and premiums are fair affordable and commensurate with each employer's risk remains an aspirational objective. Large employers who are premium impacted (at a level determined by the nominal insurer's table of claims performance rates (CPR) used when calculating an experience-rated employer's premium) pay a multiple of actual claims costs which are in most cases in no way commensurate with the employer's risk. The MPPG are predicated on the specious proposition that premium collection is primarily based on the principle of good WHS preventative practices and timely return to work after injury resulting in reduced costs for the employer. The reality is that the nominal insurer has complete control over the claims management process and return to work, and its substandard performance has driven costs dramatically. However, despite the "no fault" nature of the scheme, the premium calculation formula completely inappropriately regards employers as entirely responsible for all injury and illness and heavily penalises experience rated employers when a claim is made.

[17] WorkCover WA 2020/21 recommended premium rates April 2020 https://www.workcover.wa.gov.au/wp-content/uploads/2020/04/WorkCover-Actuarial-Assessmees-Full-Report-2020-2021.pdf

If the nominal insurer had operated properly and effectively, scheme costs who would have been dramatically lower thus the providing the opportunity to recast the premium formula to remove the indefensible loading of experience rated employer premium charges.

There is no certainty as to what will be included in the formula or its weightings; these can be altered without explanation or justification. Employers have no way of knowing that Premium Principles are being met or that the formula meets the stated objective — to "*reward*" good performers and penalise others (we consider there are flawed assumptions in this objective — that every claim reflects a WHS failure by the employer).

In the NSW scheme premiums are a levy structured to fund a wide range of nominal insurer expenditure apart from the cost of claims and are not solely (or even primarily) a reflection of employers' safety and workers compensation performance.

Statutory review required by s 32 of the SIGC

In our view the operation of the workers compensation scheme demonstrates that the SICG Act and the related relevant provisions in the 1987 Act and the 1998 Act are in need of reform to enable a "*consistent and robust approach to the monitoring and enforcement of insurance and compensation legislation in this State".*[18]

icare has failed to hold itself accountable for its performance as the nominal insurer, which is unsurprising, given that it is not required to do so by the SICG Act or by the 1987 Act (s 154A—154CA). Section 10(1)(d) of the SICG Act merely requires icare to "monitor" the performance of the schemes for which it provides services. To date it seems that, because of icare's unconditional licence, SIRA does not have the legislative power to require icare to perform appropriately.

SIRA has stated that "*As workers compensation insurance is required by law in NSW, there is a need for transparency and accountability to the general public. A key component of competition within any market is the availability of information to consumers*."[19]

However, with the limited exception of self and specialist insurers, there is no competition for NSW employers in their choice of insurer. The NSW workers compensation scheme is a closed compulsory scheme, which, other than the claims metrics, return to work data now regularly published by SIRA on its website does not provide detailed, accurate and timely information about scheme financial operation and performance. System affordability in this data is a summary graph of overall cost of premiums as a percentage of the reported NSW wages bill and a summary chart showing percentage share of premium paid by the scheme insurers. (We are appreciative of the claims, payments and return metrics now provided by SIRA as for over five years there was a near complete absence of up to date information.)

However, available scheme affordability and viability information is confined to high level data in annual reports which are inevitably out of date, similarly delayed is the more detailed and helpful Workers Compensation System Annual Performance Review Report published by SIRA. Six monthly actuarial reports on the nominal insurer liability valuation

[18] Minister second reading speech introduction of SIGC Act

[19] SIRA MPPG Discussion Paper 2016

are now published by icare and SIRA, however, the most recent available review covered valuations as at December 2019.[20]

The legislation needs to be amended to:

- require full disclosure by the nominal insurer of all income and expenditure and a full balance sheet along with due diligence and viability of the scheme information;
- provide SIRA with specific powers of control so that it can require icare to operate according to any requirements SIRA adds to icare's licence .

The current legislation is so broadly framed that almost any activity and expenditure by the nominal insurer falls within its remit yet there are no corresponding provisions for due diligence or accountability to those who have liability for workers compensation scheme funding. The legislation provides for icare to prepare an annual statement of business intent which is to be submitted to the Minister and Treasurer each year (SICG Act s 11). This also should be made public.

Workers compensation schemes have in the past to slid into deficit when coupled with poor claims management, inadequately controlled spending, excessive staffing levels, uneconomic premium levels, unsustainable benefit levels, experimentation with untested or under performing software and a general lack of discipline in scheme management. These all play a critical part in scheme performance. As submitted above, this lack of discipline is currently seen in its adverse effects on the:

- quality of triage for new claims;
- experience of insurance staff in managing claim files;
- failure to investigate questionable claims, questionable diagnoses and over treatment;
- encouragement of lawyer involvement in the scheme process through an inappropriate funding and dispute model;
- almost total exclusion of the employer from all levels of this whole process.

The NSW workers compensation scheme has in the past experienced negative performance swings for precisely these reasons and has now declined again for a mix of similar reasons.

We need amendment of the SICG Act to provide certainty about the rigour of SIRA's power to compel icare's performance. If SIRA does not actually operate a comprehensive and effective oversight of ICNSW and the scheme, then what is its purpose?

Is SIRA's job to protect both the machinery and the benefits of the workers compensation scheme, operating with effectiveness and balance, for the benefit of workers making genuine claims and employers paying affordable premiums? If the legislation does not empower and require SIRA to command that result, it should be amended. Alternatively, start again: repeal the legislation; create new structure(s) with new rules designed for discipline and balance, and consider the possibility of privatising workers compensation insurance.

[20] https://www.icare.nsw.gov.au/about-us/annual-reports#gref