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THE BIG TICKET CHANGES IN THE NEW MOTOR ACCIDENT INJURIES ACT 2017

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The *Motor Accident Injuries Act 2017* (MAIA) sets up an entirely new system for claims relating to persons injured in motor vehicle accidents in NSW, differing in many respects from the previous *Motor Accidents Compensation Act* (MACA). It establishes a hybrid scheme of compulsory third-party insurance, which provides for statutory benefits for injured road users regardless of fault for a specified period, and modified common law damages for persons with injuries other than 'minor injuries' where fault is established.

We have summarised some of the biggest changes to claims arising from the *Motor Accident Injuries Act* (MAIA), *Motor Accidents Guidelines* (MAG), and *Motor Accident Injuries Regulations* (MAIR). View the MAIA & MACA Comparison Table.

STATUTORY BENEFITS NOW AVAILABLE FOR AT FAULT DRIVERS FOR UP TO SIX MONTHS

Under MACA, at fault drivers could claim a maximum of $5,000 for lost earnings and treatment under the Accident Notification Form (Part 3.2, MACA).

The MAIA introduces statutory benefits for loss of income, treatment expenses, and paid care for all claimants, regardless of fault for up to 26 weeks (Part 3, MAIA), for an uncapped sum, unless the claimant has been charged with or convicted of a serious driving offence related to the accident (s3.37 MAIA). After 26 weeks, a claimant is not entitled to statutory benefits if the motor accident was caused wholly or by the fault of the claimant, or *'mostly'* by the fault of the claimant, defined as contributory negligence of the claimant of greater than 61% (s3.11(2) MAIA).

However, a determination made by an insurer or the Dispute Resolution Service in connection with statutory benefits as to the fault of the owner or driver, or on contributory negligence, is not binding on a Court in assessing damages (s3.44, MAIA)

INTRODUCTION OF 'MINOR INJURY' LIMITATIONS

Where the claimant's only injury or injuries are soft tissue or 'minor psychological or psychiatric' injury, they will be entitled to statutory benefits for up to six months only (s3.11, 3.28 MAIA).*

An injury to a spinal nerve root that manifests in neurological signs (other than radiculopathy) is included as 'soft tissue injury' (MAIR, 4). 'Minor psychological or psychiatric injury is a psychological/psychiatric injury that is not a recognised psychiatric illness (s1.6(3) MAIA), and includes acute stress disorder and adjustment disorder (MAIR, 4(2)).

No damages may be awarded to a claimant if the only injuries arising from the motor accident were minor injuries (s4.4 MAIA). There is therefore no entitlement to non-economic loss, even if the injured person's permanent impairment is greater than 10%, if they have suffered 'minor injuries' only.

An exception to this rule: treatment and care after the 26 weeks **will be authorised by an insurer where it meets certain criteria as set out in the MAG, 5.16, including where treatment and care will improve the recovery of the claimant.*

NO ENTITLEMENT TO GRATUITOUS CARE TO THE CLAIMANT OR THEIR DEPENDANTS

The MAIA removes entitlement to *Griffiths v Kirkemeyer* damages, as either a statutory benefit (s3.25 MAIA), or common law damages (s4.3 MAIA). However, the cost incurred by a claimant in employing someone to provide attendant care services to the claimant, or to their dependants, is recoverable as paid care.

MODIFIED COMMON LAW DAMAGES

Common law damages are now limited under s4.3 MAIA to:

1. Damages for economic loss (loss of earning capacity; costs relating to accommodation or travel; financial management of damages; reimbursement for income tax paid or payable on statutory benefits); and
2. Damages for non-economic loss, if the injured person's degree of permanent impairment is greater than 10% (s4.11 MAIA) where the claimant's injuries were not 'minor injuries'.

A claim for damages cannot be made before 20 months of the date of accident, and cannot be settled within two years of the date of accident, unless permanent impairment is greater

than 10% (s6.14(1) MAIA). No claim for damages can be settled unless the claimant has legal representation or the settlement is approved by the Dispute Resolution Service (s6.23 MAIA).

EXPANSION OF WHAT CAN BE REFERRED FOR MEDICAL ASSESSMENT

The following can now be the subject of medical assessment (Schedule 2, MAIA):

1. Degree of impairment of an injured person's earning capacity.
2. Degree of permanent impairment.
3. Whether treatment and care is reasonable and necessary, and related to the accident.
4. Whether treatment and care will improve the recovery of an injured person.
5. Whether any injury is a 'minor injury'.

Any medical assessment may be referred for further assessment on one occasion only (s7.24(3) MAIA).

WORKERS COMPENSATION BENEFITS ARE PRIORITISED OVER CTP BENEFITS

The CTP insurer can refuse payment of statutory benefits on the grounds that workers compensation is payable, and can require a claimant to make a claim for workers compensation if they consider, on reasonable grounds, that such a claim is reasonable (s3.35 MAIA).

As s151Z recovery actions arise only where there is a liability 'to pay damages', recovery actions will therefore apply only where the claimant has a non-minor injury.

ESTABLISHMENT OF A NEW REVIEW PROCESS

Internal review

A claimant may request an insurer perform an internal review concerning:

- a merit review matter
- a medial assessment matter
- a miscellaneous claims assessment matter (s7.9(1) MAIA).

The internal review must be conducted within 14 days of such request (s7.9(4) MAIA).

Dispute Resolution Service

The MAIA authorises the establishment of a Dispute Resolution Service (DRS) (s7.9 MAIA). If a claimant is dissatisfied with an internal review outcome, or of it does not occur, a merit review

application can be made to the DRS. This application must be made within 28 days of the claimant receiving the insurer's internal review decision, or where no internal review was required, within 28 days of receipt of the reviewable decision (MAG, 7.194).

DEFINITION OF 'EARNER'

The MAIA provides a definition of requirements to be met for a claimant to be considered an 'earner' for the purpose of obtaining statutory benefits:

1. At least 15 years old; and
2. Employed: at any time in the 8 weeks preceding the motor accident; or during a period or periods equal to at least 13 weeks during the year immediately preceding the motor accident; or during a period or periods equal to at least 26 weeks during the two years immediately preceding the motor accident; and had not retired; or
3. Before the accident had entered into an arrangement (whether or not an enforceable contract) to undertake employment or commence a business, at a particular time and place.

DRS TO DETERMINE LIABILITY IN CLAIMS FOR DAMAGES

Once a claim for damages is made by a claimant, the matter can be referred for assessment to the DRS. Unlike under MACA, where an insurer denies liability under MAIA the claim will not be exempt from assessment (MAIR, 14).

An assessment on the issue of liability is not binding on any party to the assessment (s7.38(1) MAIA). An assessment on the amount of damages for liability is binding on the insurer if:

1. The insurer admits that liability under the claim, and
2. The claimant accepts that amount of damages in settlement of the claim within 21 days after the certificate of assessment.

Accordingly, where an insurer denies liability and the claim for damages is assessed by DSR, the insurer may elect not to accept the Certificate of assessment concerning liability. However, there are potential cost implications should they proceed to Court (see below).

RESTRICTIONS ON MEDICO-LEGAL EVIDENCE

Unless a health practitioner is a treating practitioner of the claimant or is 'authorised' by the MAG to give evidence, their evidence is not admissible in proceedings before a court for damages, merit reviews and medical assessment, in relation to:

1. Degree of permanent impairment.
2. Whether treatment and care is reasonable and necessary.
3. Whether treatment and care will improve their recovery.

4. The degree of impairment of earning capacity.
5. Whether an injury is a 'minor injury'.

The DRS will publish a list of authorised health practitioners on its website who are authorised to give evidence. Parties are therefore limited in using the practitioners approved on this list, as the evidence from 'unauthorised' practitioners will not be admissible.

Regulation of costs

The regulation of costs under MAIA, is more far reaching than the limitations imposed by MACA.

Claims by minors

On legal services provided on claims brought by minors, costs are regulated in line with the amount of damages recoverable (MAIR, 26):

- Damages up to $25,000: $5,000.
- Damages between $25,000 and $50,000 (with no associate's claim): $10,000.
- Damages between $50,000 and $75,000 (with no associate's claim): $15,000.
- Damages over $75,000: clause does not apply.

An associate's claim is one in which another occupant of the same vehicle as the claimant has brought a claim and retained the same law practice as the claimant. It is unclear how costs are regulated where there is a claim by an associate.

Referral to Court after Certificate of assessment

Where a *claimant* does not accept an award for damages from DRS and proceeds to Court:

1. Where the amount of Court awarded damages does not exceed the damages in the Certificate of assessment, the claimant is liable to pay costs (up to $25,000) of any party (MAIR, 30(2)).
2. Where the amount of Court awarded damages exceeds the Certificate of assessment by at least $2,000 or 20% (whichever is greater), or at least by $200,000, the insurer is liable to pay the costs incurred by any party (MAIR, 30(3)).
3. In all other cases, the insurer and claimant pay their own costs (MAIR, 30(4)).

Where an insurer does not accept an assessment amount of damages (does not admit liability), subject to any court direction, the insurer is liable to pay the claimant's costs in respect of the claim, and regulated costs do not apply to costs after the Certificate is issued (MAIR, 31).

Maximum costs of merit review, medical assessments, miscellaneous assessments

The maximum costs for legal services provided to a claimant or insurer in connection with a merit review, medical assessment, or miscellaneous assessment is $1,600, to a maximum of $6,000 per claim (MAIR, Schedule 1). Maximum costs for legal services provided for review of these, is:

1. If the Proper Officer approves the application: $1,600
2. If the Proper Officer rejects the application:
    - Applicant: $0
    - Respondent: $800

Maximum costs for advocates at court proceedings

The MAIR impose maximum recoverable costs for advocates on Court proceedings, with an amount for the fees for Senior Counsel, or more than one advocate, not allowed unless the Court so orders (MAIR, Schedule 1):

- Interlocutory court proceedings: $800
- Maximum/day for advocate (not Senior Counsel): $2,500
- Maximum/day for Senior Counsel: $3,550

Contracting out of practitioner/client costs

A legal practitioner is permitted to 'contract out' of practitioner and client costs, where the amount paid in resolution of the claim by way of settlement or an award of damages, is greater than $75,000 (MAIR, 25).

NEW KEY LIMITS

Key time limits imposed on claimant and insurer (MAIA and MAG)	
Notice required from the insurer before discontinuing or reducing weekly payments (s3.19)	When discontinuation or reduction is during the first entitle period - 2 weeks, or when the discontinuation or reduction is during the second entitlement period—4 weeks, or when the discontinuation or reduction is after the second entitlement period—8 weeks.

Key time limits imposed on claimant and insurer (MAIA and MAG)	
Rejection of a claim by insurer for damages on the ground of non-compliance with motor accident verification requirements (s6.10)	Within 2 months after receiving the claim, and within 2 mon receiving an explanation for the non-compliance, to reject t explanation.
Time for making of claims for statutory benefits (s6.13)	Within 3 months after date of motor vehicle accident to wh claim relates. Within 28 calendar days after date of motor vehicle acciden weekly payments.
Time for making of claims for damages (s6.14)	Not before 20 months after the motor accident unless injury rise to a degree of permanent impairment of greater than 1(
Notice of acceptance of liability by insurer for claim for statutory benefits (s6.19)	Within 4 weeks after a claim is made for payment of statuto benefits during the first 26 weeks post accident. Within 3 months after a claim is made for payment of statut benefits after the first 26 weeks post accident.
Notice of change in insurer's liability denial (partial or full) decision after receipt of additional information (4.31 of MAG)	As soon as possible but no later than 14 calendar days of re additional information.
If claimant fails to comply with their duty to minimise loss, insurer is authorised to suspend weekly payments in writing (4.56 of MAG)	Suspension notice giving the claimant 14 days to comply mu given.
Duty of insurer to make offer of settlement on claim for damages (s6.22)	As soon as practicable unless the insurer wholly denies liabi the claim.
Restrictions on settlement of claim for damages (s6.23)	Cannot be settled within 2 years after motor accident unles gives rise to a permanent impairment of greater than 10%.
Insurer may require claimant to commence court proceedings (s6.33)	If claimant has been entitled to commence proceedings for of at least 6 months.
Internal review of insurer's decisions (s7.9)	Insurer to notify the claimant of results of the review within after receipt of request.
Time limits for referring claims and making assessment (s7.33)	A party to a claim cannot refer a claim for assessment unde Division 7.6 more than 3 years after the motor accident unle and satisfactory explanation for the delay is provided and le granted by a claims assessor.

Key time limits imposed on claimant and insurer (MAIA and MAG)	
Internal review period by insurer	Table 7.1 of MAG Merit review matters - 14 days Medical assessment matters - 14 days 1. treatment and care, 2. degree of impairment of earning capacity) Medical assessment matters - 21 days 1. degree of impairment 2. minor injury Miscellaneous claims assessment matters - 14 days 1. all matters under Schedule 2 clause 3 other than matters (a) t below Miscellaneous claims assessment matters - 21 days 1. fault 2. person mostly at fault 3. serious driving offence exclusion 4. contributory negligence
Reply period for Merit review applications	Table 7.2 of MAG ▪ Funeral expenses - 7 days ▪ Weekly payments - 7 days ▪ Treatment and care benefits - 7 days ▪ Damages claim - 14 days ▪ Other merit review matters - 7 days
Application for a medical assessment must be made	Within 28 days of claimant receiving insurer's internal reviev decision, or Within 28 days of the due date if the insurer fails to comple notify the internal review decision.

COMMENT

With any new legislation setting out to achieve such a complete overhaul, only time will tell

how these changes will apply in practice. On the face of it, it appears there will be a number of initial challenges for all involved:

- with the increase in the types of disputes determinable by the DRS whether there will be an increase in administrative law challenges in the Supreme Court
- whether there will be inconsistent findings on liability with respect to entitlement to statutory benefits versus damages
- whether the inconsistency is addressed where claimants with permanent impairment assessments of well above 10% for 'minor injuries' have no entitlement to non-economic loss, but a claimant assessed at 11% for non-'minor injuries' is entitled to damages for non-economic loss
- whether the limitations on the use of expert opinion challenges the opinion rules of evidence under the *Evidence Act 1995* and the UCPR rules relating to expert evidence
- the impact on workers compensation insurers and s151Z recovery actions.

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