Department of Customer Service

Compulsory Third Party Insurance

Issues Paper

July 2026

NSW GOVERNMENT

Acknowledgement of Country

The NSW Department of Customer Service acknowledges, respects and values Aboriginal peoples as the Traditional Custodians of the lands on which we live, walk and work. We pay our respects to Elders past and present. We recognise and remain committed to honouring Aboriginal and Torres Strait Islander peoples' unique cultural and spiritual relationships, and continuing connection to their lands, waters and seas. We acknowledge their history here on these lands and their rich contribution to our society.

We also acknowledge our Aboriginal and Torres Strait Islander employees who are an integral part of our diverse workforce, and recognise the knowledge embedded forever in their custodianship of Country and cultures.

Contents

Purpose

Terms of Reference

The *Motor Accident Injuries Act 2017* (the Act) establishes the Compulsory Third Party (CTP) insurance scheme in NSW. It is a mandatory insurance scheme providing benefits and support to people with injuries relating to the death of or injury to persons because of motor crashes and generally protects drivers from liability if they cause injury or death to others.

The Department of Customer Service (DCS) is leading a statutory review of the Act in line with section 11.13 of the Act. The review will assess whether the goals of the Act remain valid and whether the terms of the Act are achieving those goals. This includes considering:

a. the effectiveness of the scheme ensuring insurers are receiving a fair but not excessive profit margin
b. the general performance of insurers in the scheme
c. the timeliness of the provision of benefits to injured persons
d. the proportion of each dollar of premiums collected that directly benefits injured persons
e. whether further changes are needed to the scheme.

The review's full Terms of Reference are available at www.sira.nsw.gov.au/resources-library/motor-accident-resources/publications/sira-reports/terms-of-reference-statutory-review-of-the-motor-accident-injuries-act-2017.

Request for feedback

The consultation process is a central part of the statutory review. This paper suggests key issues for discussion and poses questions to collect information about them. The identified issues are based on previous stakeholder feedback on the scheme that has been raised through various channels including the NSW Parliament Standing Committee for Law and Justice's 2025 review of the CTP insurance scheme. Stakeholders may choose to refer to, or incorporate by reference, their submissions to the Law and Justice Review to avoid unnecessary repetition of work already done.

The suggested key issues aim to help structure any submissions that stakeholders wish to make. They are intended to be conversation-starters rather than an exhaustive list of matters to be considered. Stakeholders are encouraged to raise other issues and ideas. A complete list of questions is in Appendix A.

Stakeholders are also welcome to provide feedback on only the matters that interest them.

Submissions received in response to this issues paper will inform DCS' analysis and assist the Minister for Customer Service and Digital Government to determine whether legislative or policy changes are needed.

Input from stakeholders will inform the findings and recommendations of the statutory review. This includes if legislative or regulatory changes are needed to strengthen the operation, effectiveness, and long-term sustainability of the scheme.

How to provide input

- A written submission
    - Written submissions should be submitted to Have Your Say at www.haveyoursay.nsw.gov.au/maia-sr.
    - The deadline for submissions is **Monday 17 August 2026**.

- **Survey through Have Your Say**
    - You can complete a survey at www.haveyoursay.nsw.gov.au/maia-sr.
    - The deadline for survey responses is **Monday 17 August 2026**.
- **Targeted consultation with key stakeholders**
    - DCS is also completing targeted consultation with specific key stakeholder groups (e.g. legal, road trauma, insurance industry and medical related stakeholders) on certain technical topics to explore them in more depth.

Introduction

Background

The Act commenced on 1 December 2017, replacing the *Motor Accidents Compensation Act 1999* (the 1999 Act) for motor crashes that happened after that date. The Act aims to deliver a fair, efficient and financially sustainable system to support people injured in motor vehicle crashes. It establishes the structure of the scheme, sets out the entitlements available to injured people and defines the regulatory framework governing insurer conduct, premiums and scheme performance.

The Act seeks to ensure that people injured in motor crashes receive timely access to treatment, care, and income support, particularly during the early stages of recovery. It provides statutory benefits for injured people, regardless of fault, enabling earlier access to support to maximise return to work or other activities.

A key driver for introducing the Act was the need to ensure CTP insurance is financially sustainable and affordable. Insurance premium affordability is critical for the millions of people who buy insurance, with 6.4 million CTP insurance policies having been taken out in 2025.[1]

The Act empowers the State Insurance Regulatory Authority (SIRA) to issue guidelines, supervise insurer conduct and ensure fair market practices.

The Act is supported by the Motor Accident Injuries Regulation 2017 (the Regulation) and SIRA's Motor Accident Guidelines.

Other reviews

Since its commencement, the Act has been subject to regular monitoring and formal reviews. Key reviews are:

- 2021 statutory review of the Act. That review made 93 recommendations and suggestions to improve the scheme's operation. Seventy-five of these recommendations have been implemented.[2] More information about this is available at www.sira.nsw.gov.au/resources-library/motor-accident-resources/publications/sira-reports/status-on-progress-made-against-the-recommendations-and-suggestions-from-the-2021-statutory-review-of-the-motor-accident-injuries-act-2017.
- The NSW Parliament Legislative Council Standing Committee on Law and Justice's (the LJ Committee) reviews of the CTP insurance scheme in 2020-21, 2022-23 and 2025-26. The LJ Committee's most recent review started in August 2025, and a final report was released on 23 April 2026.

DCS has considered stakeholder feedback provided as a part of these reviews, as well as the final reports. Key issues have been identified and are discussed in this paper. DCS will also consider the LJ Committee's recommendations from its 2025 review when developing the statutory review's recommendations.

Reforms to the Act

Changes have been made to the CTP scheme regulatory framework since the 2021 statutory review. This includes changes implemented in the *Motor Accident Injuries Amendment Act 2022* such as:

[1] SIRA, *Policy,* CTP Open Data, accessed 5 March 2026, www.sira.nsw.gov.au/CTP-open-data.

[2] This is as of 12 March 2026.

- extending statutory benefits for people with threshold injuries, or who are at fault, from 26 weeks to 52 weeks
- removing the 20-month waiting period for lodging damages claims where whole person impairment (WPI) is less than 10%
- replacing 'minor injury' with 'threshold injury' in the Act
- removing the requirement for mandatory internal review for disputes about permanent impairment before they can progress to the Personal Injury Commission
- allowing weekly statutory payments where a claim is lodged outside 28 days in certain circumstances.

Out of scope

E-micromobility devices (e.g. e-bikes and e-scooters) are out of scope of this statutory review. The NSW Productivity and Equality Commissioner is reviewing insurance settings for e-micromobility riders, including options for rider insurance. The final report is due by 31 July 2026. The Terms of Reference are available at www.nsw.gov.au/departments-and-agencies/nsw-productivity-and-equality-commission/document-library/review-of-insurance-settings-for-e-micromobility-devices-nsw.

What the Act aims to achieve

The Act's objectives

The objectives of the Act are set out in section 1.3(2). They are to:

a) encourage early and appropriate treatment and care to achieve optimum recovery of persons from injuries sustained in motor accidents and to maximise their return to work or other activities

b) provide early and ongoing financial support for persons injured in motor accidents

c) continue to make third-party bodily insurance compulsory for all owners of motor vehicles registered in New South Wales

d) keep premiums for third-party policies affordable by ensuring that profits achieved by insurers do not exceed the amount that is sufficient to underwrite the relevant risk and by limiting benefits payable for soft tissue injuries and psychological or psychiatric injuries that are not recognised psychiatric illnesses

e) promote competition and innovation in the setting of premiums for third-party policies, and to provide the Authority with a role to ensure the sustainability and affordability of the compulsory third-party insurance scheme and fair market practices

f) deter fraud in connection with compulsory third-party insurance

g) encourage the early resolution of motor accident claims and the quick, cost effective and just resolution of disputes

h) ensure the collection and use of data to facilitate the effective management of the compulsory third-party insurance scheme.

Objectives (a), (d) and (e) are further supported in section 1.3(3) of the Act, which also acknowledges key considerations when the Act is applied and administered including:

- there is an overall aim to benefit the 'motoring public' by keeping overall scheme costs within reasonable limits to keep premiums affordable and promote the recovery of injured people
- a clear legislative intent to restrict access to non-economic loss compensation to people with serious injuries
- that insurers should account for their profit margins.

Balancing affordability with other objectives

The objectives of the scheme sometimes conflict with each other and need to be balanced against each other. Keeping CTP insurance premiums affordable is essential because generally every driver must buy it. This is particularly important in the current context where cost of living is a key concern for many people.

At the same time, the scheme needs to appropriately support people who are injured in crashes to recover, and they should be able to access benefits they are entitled to as easily as they can. Providing this support depends on the scheme remaining financially sustainable and insurers earning enough profit, so they continue to provide insurance for the sector.

Getting the balance right between these objectives is crucial to ensure people can afford CTP insurance, injured people get the care they need and the scheme continues to run smoothly for the benefit of the whole community. DCS will carefully consider the potential impact on the scheme's financial sustainability and on insurance premium affordability when assessing potential reforms to the scheme.

Overview of CTP scheme's operation

Scheme data shows that average insurance premiums in the market (including levies and GST) have reduced from $935[3] as at 30 November 2017 under the 1999 Act, to $536 as at 30 June 2025 under the current scheme.[4] The proportion of CTP insurance premium returned as benefits to people with injuries has generally been increasing since the start of the scheme as shown in Figure 1.[5]

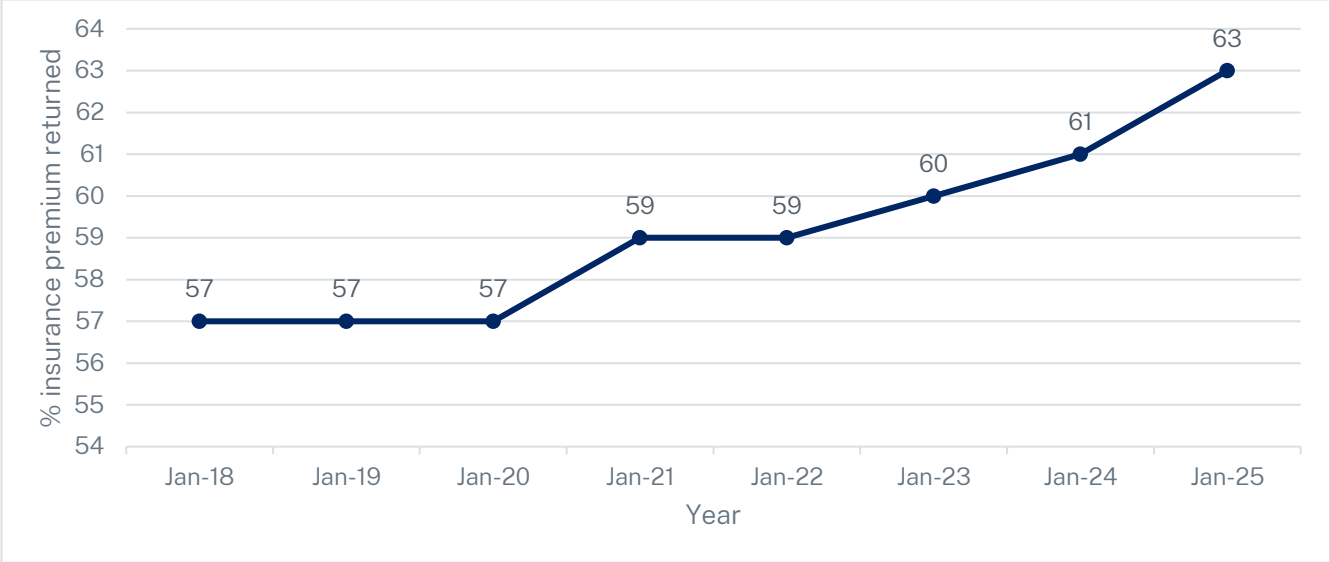

Figure 1: Percentage of CTP insurance premium amounts returned in claim benefits to injured people (excluding GST and levies) since the start of the scheme in 2017.

[3] This is adjusted to 30 June 2025 for average weekly earnings with an allowance of 2% for superimposed inflation.

[4] SIRA, *2017 CTP Scheme Performance Report to 30 June 2025*, SIRA, 2025, p.1, www.sira.nsw.gov.au/__data/assets/pdf_file/0009/1386648/SIRA-2017-CTP-Performance-Report-2025.pdf

[5] SIRA, *Scheme efficiency, viability and affordability,* CTP Open Data, accessed 6 March 2026, www.sira.nsw.gov.au/CTP-open-data.

The percentage of statutory benefit claims insurers have accepted in the scheme's life has generally been increasing in small increments over the past 4 years (see Figure 2).[6] As of 11 February 2026, the overall insurer acceptance of claims rate was 96.1%.[7]

Scheme data from July 2024 to June 2025 shows that for people claiming treatment and care benefits:

- 69% accessed pre-claim treatment
- a further 21% received treatment payments within two weeks of lodging their claim.

This means 90% of people claiming treatment and care benefits accessed treatment benefits within 2 weeks of lodging their claim.[8]

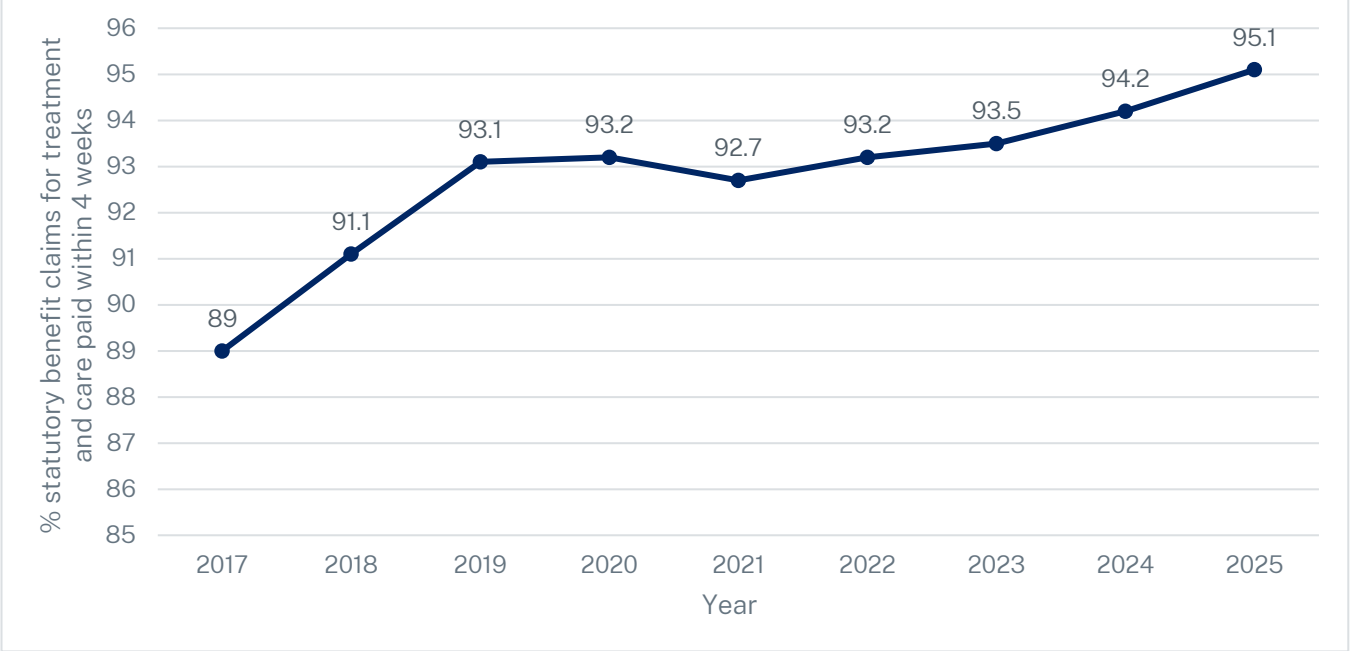

Figure 2: Percentage of statutory benefit claims for treatment and care paid within 4 weeks of claim lodgement. Includes finalised claims and claims inactive for 3 months.

The percentage of statutory benefit income support being paid to people with claims within 4 weeks of claim lodgement is much lower (see Figure 3).[9] However, weekly payments are generally only required to be paid in 10 days from an insurer accepting a claim and insurers have 28 days from a claim's lodgement to make this decision.

[6] SIRA, *Scheme effectiveness and equity,* CTP Open Data, accessed 6 March 2026, www.sira.nsw.gov.au/CTP-open-data.

[7] SIRA, *Statutory benefit claims,* CTP Open Data, accessed 11 February 2026, www.sira.nsw.gov.au/CTP-open-data.

[8] SIRA, *2017 CTP Scheme Performance Report to 30 June 2025*, SIRA, 2025, p.8, www.sira.nsw.gov.au/__data/assets/pdf_file/0009/1386648/SIRA-2017-CTP-Performance-Report-2025.pdf.

[9] SIRA, *Scheme effectiveness and equity,* CTP Open Data, accessed 6 March 2026, https://www.sira.nsw.gov.au/CTP-open-data.

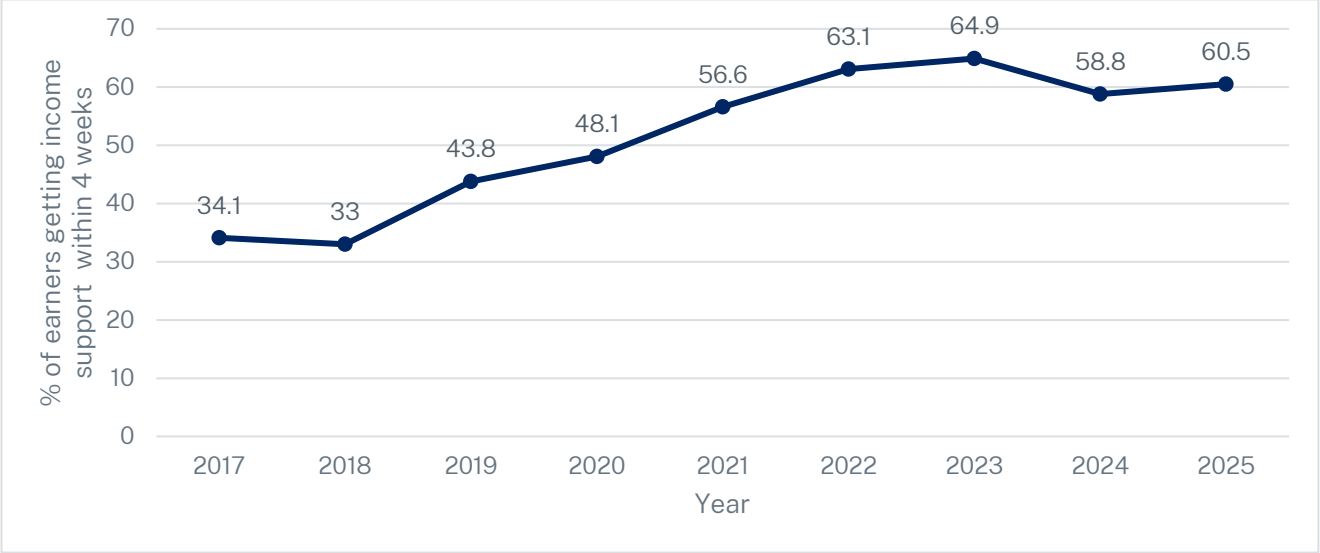

Figure 3: Percentage of earners receiving income support benefits within 4 weeks of claim lodgement.

Prior to the scheme reforms that commenced 1 April 2023, the average length of time for which a person with threshold injuries received statutory benefits was 27.78 weeks.[10] For the period 2 April 2023 to 5 March 2026, this increased to an average of 42.73 weeks.[11] Figure 4 shows the average length of time for the life of the scheme.[12]

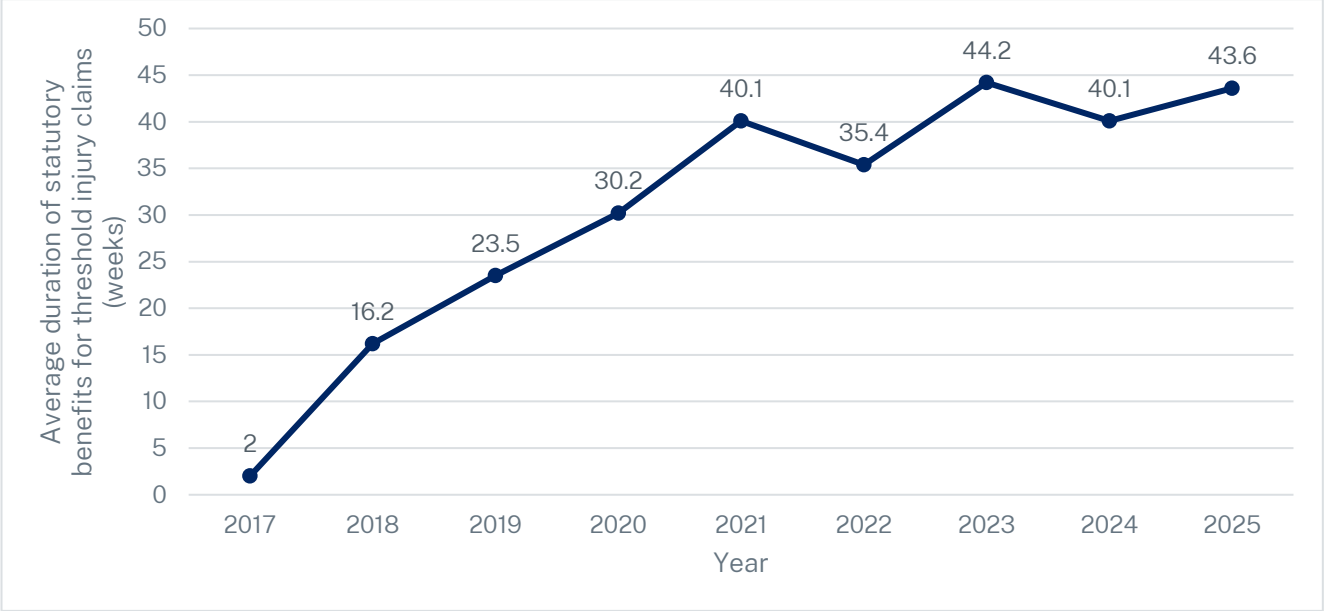

Figure 4: Average duration of statutory benefits for threshold injury claims.

[10] One of the reforms implemented was increasing the statutory benefit period for threshold injuries from 26 to 52 weeks.

[11] SIRA, *Scheme efficiency, viability and affordability*, CTP Open Data, accessed 5 March 2026, sira.nsw.gov.au/CTP-open-data.

[12] SIRA, *Scheme efficiency, viability and affordability*, CTP Open Data, accessed 6 March 2026, sira.nsw.gov.au/CTP-open-data.

Most statutory benefit claims paid under the scheme are for threshold injuries.[13] As of 9 February 2026, it was projected that 81% of the total claim benefits to be paid for the scheme would be for threshold injuries and 19% for non-threshold injuries.[14]

However, damages claim payments make up a large proportion of the total claims cost for the scheme. Scheme data has indicated such payments accounted for up to 70% of total claim costs in 2025.[15] Scheme estimates indicate the average amount of damages costs by WPI are about:

- $210,000 where WPI is less than 10%
- $610,000 where WPI is more than 10%.[16]

Since the start of the current CTP insurance scheme, SIRA has used the Transitional Excess Profits and Losses (TEPL) mechanism to recoup $542.9 million from the insurance industry. These funds have been used to reduce the cost of CTP insurance policies for motor vehicle owners in NSW.

Feedback sought

General questions

1. Do the objectives of the Act remain valid? Why or why not?
2. What are the top 3 most important things that you think may need to change in the Act (if anything) to support it to achieve and/or balance its objectives? Please explain.

[13] Threshold injuries include soft tissue injuries and psychological or psychiatric injuries that are not recognised psychiatric illnesses.

[14] SIRA, *Scheme effectiveness and equity*, CTP Open Data, accessed 11 March 2026, sira.nsw.gov.au/CTP-open-data.

[15] SIRA, *Submission to the 2025 Review of the Compulsory Third Party insurance scheme*, 2025, p.18, https://www.parliament.nsw.gov.au/lcdocs/submissions/92379/0013%20State%20Insurance%20Regulatory%20Authority%20(SIRA).pdf.

[16] Ernst & Young, *2017 CTP Scheme Quarterly Actuarial Monitoring – 31 December 2025 data*, 2026, p.6, www.sira.nsw.gov.au/__data/assets/pdf_file/0020/1400276/NSW-CTP-2017-Scheme-Quarterly-Actuarial-Monitoring-31-December-2025.pdf.

Scheme sustainability

Legislative overview

As most people who own a motor vehicle in NSW must have CTP insurance, premium affordability and financial sustainability are fundamental to the operation of the CTP insurance scheme. This is shown in the Act's objectives to:

- keep premiums affordable by ensuring insurers' profits do not exceed what is needed to underwrite the relevant risk and by limiting benefits for certain injury types
- provide SIRA with a role to ensure the scheme's sustainability and affordability, as well as fair market practices.

Division 2.3 of the Act sets out how insurance premiums are to be determined, monitored and adjusted. It allows:

- the Motor Accident Guidelines (the Guidelines) to set how insurers determine premiums
- requires insurers to file its proposed premiums with SIRA and disclose profit margins
- SIRA to reject an insurer's filed premium if it considers the premium to be excessive, inadequate or not complying with the Guidelines
- the supporting regulations to impose risk equalisation arrangements to redistribute risk across insurers to keep the insurance market stable and to stop premiums from becoming unfair just because some insurers have riskier customers than others
- SIRA to adjust premiums or fund levies to address excess profits or losses that insurers experience.

The Act also manages scheme costs by limiting access to scheme benefits using mechanisms such as the 'threshold injury' definition. This is discussed in the 'Eligibility criteria and scheme coverage' section of this paper.

Premium affordability and scheme costs

As previously indicated, since the start of the scheme in 2017, insurance premiums have decreased from an average of $935 to $536.[17] The affordability of CTP insurance has also improved, with premiums decreasing from 37% of average weekly earnings in 2017[18] to 23% as of 30 June 2025.[19]

However, scheme data indicates the scheme is experiencing more claims and higher associated costs. For example:

[17] SIRA, *2017 CTP Scheme Performance Report to 30 June 2025*, SIRA, 2025, p.1, https://www.sira.nsw.gov.au/__data/assets/pdf_file/0009/1386648/SIRA-2017-CTP-Performance-Report-2025.pdf.

[18] This was under the old CTP insurance scheme that the *Motor Accidents Compensation Act 1999* set up.

[19] SIRA, *2017 CTP Scheme Performance Report to 30 June 2025*, SIRA, 2025, p.22, https://www.sira.nsw.gov.au/__data/assets/pdf_file/0009/1386648/SIRA-2017-CTP-Performance-Report-2025.pdf.

- the December 2025 Scheme Quarterly Actuarial Monitoring report indicates average statutory benefit claim sizes are higher for more recent accident quarters than previous quarters at the same stage of the claim[20]
- recent average premium increases have exceeded inflation for the first time in the 2017 CTP Scheme.[21]

Higher scheme costs would put pressure on premium affordability. DCS will need to consider this issue carefully when making any recommendations to change the scheme.

Reviewing available stakeholder feedback also highlights some key issues relating to scheme sustainability and scheme costs.

- **Excess profit and loss mechanism**

  Section 2.25 of the Act provides an excess profit and loss mechanism (EPL) that allows SIRA to review insurers' premium income to determine if premiums and fund levies should be adjusted to avoid or minimise excess profits or losses. This section is not implemented yet. Instead, Schedule 4 of the Act has a transitional excess profit and loss mechanism (TEPL), which is supported by the Motor Accident Guidelines - Transitional excess profits and transitional excess losses.

  Like EPL, TEPL gives SIRA the power to control how much profit insurers earn and return any excess profit to policyholders through lower premiums. However, how it does this is different from EPL. Table 1 sets out the key differences between EPL and TEPL.

  TEPL was not designed to operate on a permanent basis. While the Act provides for EPL as the ongoing mechanism, EPL has not yet been implemented. In addition to this public consultation, SIRA and DCS are conducting technical workshops on this issue with key stakeholders including insurers to better understand the issue and how excess profits and losses could be permanently managed in the CTP insurance scheme.

Table 1: Comparison between TEPL and EPL frameworks

Comparison	TEPL	EPL
1. **Profit regulation and excess profit and loss thresholds**	Regulates industry-wide profitability against fixed excess profit and loss thresholds SIRA determines. Transitional excess profit and loss thresholds are relative to the benchmark profit margin of 8%. Transitional excess profit threshold is 2% + the benchmark = 10%. Transitional excess loss threshold is the benchmark – 5% = 3%.	Regulates individual insurer profit margins against insurers' filed profits. Excess profit and loss thresholds move as they are relative to the average filed profit margin of insurers. Excess profit threshold is taken to be 2% + average filed profits. Excess loss threshold is taken to be the average filed profits – 5%.
2. **Reference for adjustments**	Adjustments to avoid or minimise transitional excess profits and losses	Adjustments to avoid or minimise excess profits and

[20] Ernst & Young, *2017 CTP Scheme Quarterly Actuarial Monitoring – 31 December 2025 data*, 2026, p.4, www.sira.nsw.gov.au/__data/assets/pdf_file/0020/1400276/NSW-CTP-2017-Scheme-Quarterly-Actuarial-Monitoring-31-December-2025.pdf.

[21] SIRA, *Submission to the 2025 Review of the Compulsory Third Party insurance scheme*, 2025, p.18, https://www.parliament.nsw.gov.au/lcdocs/submissions/92379/0013%20State%20Insurance%20Regulatory%20Authority%20(SIRA).pdf.

to avoid or minimise excess profits and losses	may bring the industry-wide profit margin back towards the transitional excess profit and loss range of 3% to 10%.	losses may bring individual insurer profits back towards their individual filed profit margins.
3. Timing of profit reviews	Balanced timing of profit reviews and regulation enabling SIRA to equally act on excess profits and excess losses.	Asymmetrical timing of profit reviews where excess losses must occur for at least 2 consecutive years before SIRA may conduct a profit review.
4. Profit criteria	Assesses underwriting profits only.	Assesses 'realised' profits and 'realised' underwriting profits.

- **Discount rate**

  Section 4.9 of the Act provides that an award of damages for future economic loss is subject to a discount rate to reflect the assumption that a person will be able to invest the payment in the coming years and so their payment should be reduced to reflect the 'present value'. The discount rate is currently 5%.

  Some stakeholder feedback is the discount rate should be lower. Recommendation 18 of the 2021 statutory review was for the Minister to consider making the discount rate lower than 5%. However, the recommendation was not implemented as it would impact the financial sustainability of the scheme and the existing discount rate was considered appropriate.

  Additionally, interjurisdictional comparison indicates that no other Australian state or territory legislates a discount rate of less than 5% for their CTP schemes. The workers compensation regulatory framework also has a discount rate of 5%.

  DCS does not propose to consider changes to the discount rate as part of this review given the affordability pressures and discount rate's alignment with other CTP and workers compensation schemes.

- **Insurer claim handling expenses**

  Schedule 1E of the Guidelines sets out SIRA's assumptions about what an average insurance premium should cost, based on information it has and projections it makes. Insurers must benchmark their premiums against these cost assumptions. Currently, Schedule 1E provides that claims-handling expenses are to be 8% of the risk premium. Note that this increased from 7.5% from 15 January 2023.

  There is some stakeholder feedback that insurers' claims handling expenses have gone up due to factors such as implementing legislative changes and introducing the customer service rating.

Feedback sought

General question

3. What other issues (if any) should the statutory review consider relating to premium affordability and financial sustainability? Please explain. Note other relevant issues such as eligibility criteria are discussed in other parts of this paper.

Specific questions

4. When should the transitional excess profit and loss mechanism in Schedule 4 of the Act end? Please explain.
5. What should replace the transitional excess profit and loss mechanism in Schedule 4 of the Act? Please explain.

6. Do you think the current assessment of claims handling expenses as part of Schedule 1E of the Guidelines is sufficient? Why or why not?

Eligibility criteria and scheme coverage

Legislative overview

The Act aims to provide early and appropriate treatment and care, as well as financial support, for people injured in motor crashes. It does this by generally providing at least 52 weeks of statutory benefits to cover:

- a percentage of pre-accident weekly earnings if a person needs time off work to recover
- reasonable and necessary treatment and care expenses
- paid domestic and personal care services a person needs while they recover.

However, the Act also aims to keep premiums affordable by limiting benefits payable for soft tissue injuries and psychological or psychiatric injuries that are not recognised psychiatric illnesses. There is also a clear legislative intent to limit access to non-economic loss to more serious and permanent injuries.

To balance these competing goals, the Act sets eligibility criteria to limit access to statutory benefits and awards of damages for non-economic and past and future economic loss for people with temporary, or less severe, injuries.

Key eligibility criteria are if:

- an injury is a threshold or non-threshold injury
- a person has suffered permanent impairment that is more or less than 10%.

Divisions 3.3 and 3.4 of the Act set out when people with injuries are entitled to statutory benefits including weekly payments for loss of earnings and for treatment and care. Sections 3.11(1)(b) and 3.28 of the Act limit these benefits to 52 weeks for people with 'threshold injuries'.

Section 4.4 of the Act provides that people with 'threshold injuries' cannot access payments for damages for non-economic and/or future and past economic loss.

Section 4.11 of the Act provides that damages for non-economic loss is only to be awarded if there is a degree of permanent impairment of more than 10%. Permanent impairment is generally referred to as 'whole person impairment' (WPI).

Table 2 summarises the statutory benefits and damages a person can access depending on their injury type and if they contributed to the crash occurring.

Table 2: Statutory benefits and damages entitlements based on injury type and fault status

Benefits and damages type	At fault claims	Not at fault claims		
		Threshold injuries	Non-threshold WPI ≤ 10%	Non-threshold WPI > 10%
Statutory benefit - weekly payments for loss of earnings	Up to 52 weeks	Up to 52 weeks	Up to 104 or 156 weeks[22]	Up to 104 or 260 weeks[23]
Damages for economic loss	No	No	Yes	Yes

[22] Up to 104 weeks unless there is a claim for damages still to be decided, which means it is up to 156 weeks.

[23] Up to 104 weeks unless there is a claim for damages still to be decided, which means it is up to 260 weeks.

Damages for non-economic loss (e.g. suffering)	No	No	No	Yes
Treatment and care benefits	Up to 52 weeks	Up to 52 weeks	CTP Care after 5 years	CTP Care after 5 years
Funeral expenses	Yes	N/A	Yes	Yes

Threshold injury definition

People with 'threshold injuries' cannot access payments for damages for non-economic and/or past and future economic loss. This mechanism ensures such payments are reserved for people with more serious and long-term injuries.

Section 1.6(1) of the Act sets out that a threshold injury is:

- a soft tissue injury
- a psychological or psychiatric injury that is not a recognised psychiatric illness.

Section 1.6(4) of the Act allows the Regulation to exclude or include specified injuries as a threshold injury. Section 4(2) of the Regulation provides that acute stress disorder and adjustment disorder are threshold injuries.

Clause 5.11 of the Guidelines require assessments of psychological or psychiatric injury to be made using the *Diagnostic & Statistical Manual of Mental Disorders* (fifth edition), published by the American Psychiatric Association.

Adjustment disorder

Adjustment disorder has been categorised as a threshold injury. This is because the condition is viewed as generally less severe and of a shorter duration than other psychological and psychiatric conditions. One of the criteria for adjustment disorder is that symptoms do not continue more than 6 months from the end of the stressor (or its consequences).

Recommendation 34 of the 2021 statutory review was to consider removing adjustment disorder from the definition of threshold injury. That review considered that where a person diagnosed with adjustment disorder has symptoms that last more than 6 months from the motor crash:

- the stressor is not only the motor crash but is, for example, the life change a person may have experienced due to the crash, or
- their diagnosis will change because they do not meet the adjustment disorder criteria.[24]

The 2021 statutory review considered that such people should not be excluded from being supported to recover. However, recommendation 34 has not been implemented because statutory benefits are now provided for 52 weeks to people with threshold injuries and it is assumed a person suffering from adjustment disorder should be provided with sufficient support to recover within this timeframe. Removing adjustment disorder from being a threshold injury would also likely increase scheme costs.

Some stakeholders continue to advocate for removing adjustment disorder from the definition of threshold injury. They consider this approach unfairly excludes people who may need support

[24] Clayton Utz, *Statutory Review of the Motor Accident Injuries Act 2017 – Report,* 2021, p.87, www.sira.nsw.gov.au/__data/assets/pdf_file/0017/1031390/Statutory-Review-of-the-Motor-Accidents-Injuries-Act-2017-Report.pdf.

because, for example, there may be a delay in the injured person experiencing adjustment disorder symptoms and their condition may continue beyond 52 weeks from when the crash happened.

Recommendation 4 of the LJ Committee's final report for its 2025 CTP insurance scheme review is also that the NSW Government consider removing adjustment disorder from the definition of threshold injury.

Definition of 'injury'

Section 1.4 of the Act defines injury to mean personal and bodily injury including:

- pre-natal injury
- psychological or psychiatric injury
- damage to artificial members, eyes or teeth, crutches or other aids or spectacle glasses.

Section 1.6(2) of the Act defines a soft tissue injury as an injury to tissue that connects, supports or surrounds other structures or organs of the body (such as muscles, tendons, ligaments, menisci, cartilage, fascia, fibrous tissues, fat, blood vessels and synovial membranes), but not an injury to nerves or a complete or partial rupture of tendons, ligaments, menisci or cartilage. Clause 4(1) of the Regulation provides that an injury to a spinal nerve root that manifests in neurological signs (other than radiculopathy) is a soft tissue injury for the purposes of the Act.

Some stakeholder feedback says there is potential to clarify the definition of injury in the Act or Regulation due to, for example, the following Court cases:

- *Allianz v Abawi* [2025] NSWCA 85 found an injury to skin that does not involve an injury to nerves is a 'soft tissue injury' for the purposes of the definition of threshold injury in section 1.6 of the Act. However, a skin injury involving nerve damage may not be a soft tissue injury and therefore may be a non-threshold injury.
- in *Mandoukos v Allianz Australia Insurance Limited* [2024] NSWCA 71, one of the judges commented that 'injury' involved some kind of harm or detriment to a claimant, whereas surgery is typically performed for a person's benefit rather than their detriment. As such, they indicated potential doubt that changes to a person's body caused by consensual surgery would be an injury under the Act.

Psychiatric injury resulting from the death or injury of a family member

There is continued advocacy for implementing recommendation 46 of the 2021 statutory review. That recommendation was to amend the Act so a psychological or psychiatric injury resulting from the death or catastrophic injury of a family member is a non-threshold injury. The reason for this recommendation was that the scheme should minimise unnecessary stress on grieving family members.

Recommendation 46 has not been implemented, although other changes to better support this group has been made following the 2021 statutory review. These include increasing the statutory benefit period from 26 to 52 weeks and SIRA implementing a trauma and grief support service for family members who lose a loved one in a crash.

Losing a loved one in a motor vehicle crash is a deeply tragic and life-altering experience that causes profound grief and disruption to affected families. Providing that psychological or psychiatric injury resulting from such situations are automatically non-threshold injuries would not align with the Act's objective of keeping premiums affordable by limiting benefits payable for psychological or psychiatric injuries that are not recognised psychiatric illnesses. As statutory benefits are payable for 52 weeks, people facing these circumstances would receive support for this time for psychological injury that are considered threshold injuries.

How people who lose a loved one in a crash are treated under the CTP scheme is discussed further in the 'Claims Process' section of this paper.

Whole Person Impairment

The Act limits award of damages for non-economic loss to people who can demonstrate a WPI of more than 10%. Section 1.7 of the Act also requires WPI to be assessed separately for psychological and physical injuries. This means psychological and physical injuries cannot be combined to result in a WPI of more than 10%.

Recommendation 36 of the 2021 statutory review was to consider the Act providing that all injured persons may claim damages if the injuries caused by the motor crash result in a degree of permanent impairment greater than 10% even if they only suffered 'minor injuries' (i.e. threshold injuries). The rationale was the scheme should give all seriously injured persons (with a degree of permanent impairment greater than 10%) a right to claim damages for ongoing pain, suffering, loss of amenities or loss of expectation of life.

Recommendation 36 was considered but not progressed. Some stakeholders continue to support implementing it.

Treatment and care definition

An injured person can receive statutory benefits for treatment and care. Section 1.4 defines treatment and care to mean, for example, medical treatment, rehabilitation, home and transport modification and attendant care services. The Regulation can exclude or include other items as treatment and care. Some of these items are further defined in the Act. For example, section 1.4 provides attendant care services mean 'services that aim to provide assistance to people with everyday tasks' such as personal assistance and domestic services.

Some court cases indicate it may be beneficial to further clarify what is or is not included as treatment and care under the Act. For example, in *Insurance Australia Limited t/as NRMA Insurance v Chowdhury* [2025] NSWSC 1392, the injured person needed help to care for his three cats. The insurer took the view that pet care services do not form part of attendant care services, so they should not be covered as treatment and care. The Court disagreed with the insurer and found that pet care services were attendant care services as taking care of pets is an ordinary household activity for which domestic assistance could be provided.

Other scheme coverage matters

Serious driving offences

Section 3.37 of the Act limits access to statutory benefits for people who are charged with or convicted of serious driving offences connected with the motor crash that caused their injury. Section 3.37(1) provides that an injured person is no longer entitled to statutory benefits if they are charged with or convicted of a serious driving offence related to the accident in which they were injured.

If the injured person is acquitted or the proceedings are discontinued, statutory benefits become payable from the date the charge was first laid.

A serious driving offence includes:

- major offences under the *Road Transport Act 2013*
- offences under sections 115 and 116(2)(a)–(e) of that Act (e.g., police pursuits, dangerous driving)
- any additional offences prescribed by regulation.

This reflects the scheme's broader objectives of accountability and holding drivers responsible for their behaviour.

A stakeholder has raised a concern about these serious driving provisions potentially excluding a person injured in a motor crash from accessing support where they are convicted of a serious driving offence that did not actually contribute to the crash. Another stakeholder does not agree that section 3.37 needs to change due to this concern.

Interstate crashes, non-citizens and carers of injured people

If a person is injured in a motor crash interstate, the laws of the State or Territory where the crash occurred determine the benefits they can access. The Act does not allow for that person to access benefits under the NSW CTP insurance scheme even if the motor vehicle involved in the crash is covered by NSW CTP insurance. The NSW scheme is intended to cover crashes that occur in NSW.

The Act also does not allow:

- non-Australian citizens or non-permanent residents of Australia to receive statutory benefits for treatment and care provided outside of Australia
- an injured person to receive weekly statutory benefit income support for periods they live overseas except in certain circumstances.

A stakeholder has raised that the scheme should expand to cover these different cohorts to ensure they can be supported to recover from their injuries. Another stakeholder has raised that carers of people with injuries should also be able to access benefits to support them (e.g. counselling services).

Any expansion of the scheme's coverage would likely increase scheme costs, scheme complexity and fraud risks and ultimately affect the affordability of premiums for the people of NSW. There would also likely be overlaps in coverage if the scheme was expanded to cover interstate crashes.

Feedback sought

General question

7. What other issues (if any) should the statutory review consider about eligibility criteria or scheme coverage? Please explain.

Specific questions

Threshold injury and other definitions

8. Do you support adjustment disorder being a 'threshold injury'? Why or why not?
9. Do you support changing the definition of 'injury' in the Act? Please explain.
    a. If yes, how would you change the definition of injury? Please explain.
10. What else should be included or excluded from the definition of treatment and care? Please explain.

Scheme coverage

11. Would you support expanding or further restricting the scheme's coverage in certain circumstances? Why or why not?
    a. If yes, please expand on what these circumstances should be and explain why.

Claims process

Legislative overview

Part 6 of the Act sets out requirements for making a claim. Part 4 of the Guidelines also places obligations on insurers when dealing with claims. Many of these requirements support the Act's objective to deter fraud as they require claims to be supported by evidence and allow insurers to verify claims.

At the same time, the Act's objectives extend beyond fraud prevention — they also include encouraging early and appropriate treatment, supporting people to return to work or usual activities, and providing early and ongoing financial support following an injury. As such, the Act and the Guidelines have measures to promote these objectives including specific duties on insurers to handle claims in a way that facilitates timely treatment and the wellbeing of people with claims.

Generally, a person who wants to make a claim for benefits under the Act will need to:

- report the crash to the police
- lodge an application with the relevant insurer up to 3 months after the crash, although to be eligible for income support from the day after the motor crash an application should be lodged within 28 days. Section 6.13 of the Act also allows for claims to be made outside of this period in certain circumstances.

A person with an injury who wants to claim weekly income support as they cannot work while they recover must provide:

- a Certificate of Fitness from a treating medical practitioner as a part of their claim application. This certificate gives insurers essential clinical information about the person's condition such as needed treatment and their ability to work or do daily activities.
- evidence about pre-accident earnings.

Insurers can also agree to pay for treatment and care for people injured in a crash once it receives notice of the injury but before a claim is made. These payments are only available up until 28 days from the motor crash.

Once an insurer receives a claim for statutory benefits, it has 4 weeks to tell the injured person if it will accept liability for paying statutory benefits for the first 52 weeks. The insurer then has 9 months to tell the injured person if it will accept liability for paying statutory benefits after this first 52 weeks.

Weekly income support payments and supported domestic services continue only if needed (e.g. injured person cannot return to work) considering all the available information including relevant medical information.

A recovery plan is generally required for injured people except in certain situations such as if they have returned to their pre-injury work. Requests for an insurer to pay treatment and care expenses must be decided as soon as possible and within 10 days from the insurer receiving the request.

People with more serious injuries and who are not mostly at fault may later pursue a damages claim. When an insurer receives a claim for damages, it is to let the person with the claim know as soon as possible if the insurer will pay damages, and at the latest, within 3 months after the claim is made.

The Act provides a dispute resolution pathway through the Personal Injury Commission (the Commission). This is discussed in the 'Dispute resolution' section of this paper.

Division 6.2 of the Act imposes duties on injured people and insurers including:

- they are both to endeavour to resolve a claim as justly and quickly as possible
- insurers are to:

  - give people with a claim information about their entitlements, rights to have a decision reviewed and written reasons for the insurer's decisions
  - promptly pay statutory benefits and damages.
- injured people are to:
  - take all reasonable steps to minimise the loss caused by their injury such as returning to work as soon as 'reasonably practicable'
  - co-operate fully with an insurer to give the insurer enough information about the claim so the insurer can assess it
  - comply with an insurer's request to undergo medical assessments as long as they are not unreasonable, unnecessarily repeated or dangerous.

Part 4 of the Guidelines imposes more obligations on insurers to ensure they:

- maintain active and transparent communication with people with claims so they and their legal representatives (if any) are fully informed
- work collaboratively with other insurers when needed
- minimise the number of medical examinations they require people with injuries to complete.

General insurer performance when assessing claims

Some stakeholder feedback indicates dissatisfaction with insurers' processing of claims including concerns that insurers:

- obtain medical assessments from biased medical practitioners to deny claims unfairly
- do not comply with the Guidelines' requirement that insurers should deal with people with claims' treating medical practitioner first before requiring a medical examination
- are resistant to overturning claim decisions during the internal review process
- pressure people with injuries to return to work before they are ready.

Scheme data provides some indication that insurers are assessing claims as required. For example, in the 2025 calendar year:

- 96.7% of claims were accepted for statutory benefits[25]
- 95.1% of statutory benefits claims had treatment and care paid for within 4 weeks of claim lodgement [26]
- 98.3% of insurers' internal review were determined within statutory timeframes.[27]

Scheme data also shows:

- of the 8352 internal reviews applied for in 2025, insurers' review of their initial claim decision led to the decision being overturned in favour of claimants in 20.64% of reviews[28]
- while the majority of respondents to SIRA's CTP closed claims survey indicated they had an extremely positive or positive overall claims experience, a substantial proportion of respondents indicated they had an extremely negative or negative overall claims experience – between 33%

[25] SIRA, *Statutory benefit claims,* CTP Open Data, accessed 4 March 2026, sira.nsw.gov.au/CTP-open-data

[26] SIRA, *Scheme equity and effectiveness,* CTP Open Data, accessed 4 March 2026, sira.nsw.gov.au/CTP-open-data.

[27] SIRA, *Internal review,* CTP Open Data, accessed 4 March 2026, sira.nsw.gov.au/CTP-open-data.

[28] SIRA, *Internal review,* CTP Open Data, accessed 11 March 2026, sira.nsw.gov.au/CTP-open-data.

and 37% for the June 2024, November 2024 and May 2025 periods.[29] It should be noted respondents' views may also reflect the overall difficulty and stress associated with recovering from injuries sustained in a motor crash, rather than the claims process alone, as well as interactions with other involved parties (e.g. medical practitioners) and not only insurers.

The statutory review will consider if there are opportunities to improve insurers' claims handling.

A stakeholder has also suggested requiring the Guidelines to set a timeframe for when an insurer must calculate pre-accident average weekly earnings. There is no set timeframe for this calculation although section 3.6(5) of the Act provides if a weekly payment of statutory benefits is payable, but more information is needed to determine the payment amount, interim payments are to be made as allowed under the Guidelines.

Medical examinations and assessments

Insurers can ask a person with a claim to attend a medical examination. They may do this to help them determine aspects of the claim such as verifying the injury diagnosis, assessing WPI and determining if a proposed treatment is reasonable and necessary.

Role of treating practitioners

If claiming weekly income support, an injured person's treating medical practitioner will generally be responsible for providing Certificates of Fitness to demonstrate to insurers that the weekly payment should continue. Section 3.15(3)(b) of the Act sets out that such certificates can be provided for a period of up to 28 days. However, section 3.15(4) provides a certificate can cover more than 28 days if the medical practitioner gives special reasons for the longer period and the insurer accepts those reasons.

The Guidelines set out requirements around when an insurer can have a person with a claim undergo more medical examinations:

- clause 4.155 requires insurers to work with treating medical practitioners to resolve an issue before they make a person undergo another medical examination
- clause 4.157 provides the insurer's request to undergo a medical examination must be followed unless it is unreasonable, unnecessarily repetitious or dangerous
- clause 4.157 provides an insurer's request for another medical examination is generally reasonable if:
  - the treating practitioner has not responded to a request for information from the insurer
  - information provided by the treating practitioner to the insurer is inadequate
  - the insurer's communication with the treating practitioner cannot resolve a dispute.

Some stakeholder feedback suggests the Act should give an injured person's treating medical practitioner a larger role and more power to decide treatment. While insurers are required to work with an injured person's treating practitioner, they are also able to obtain opinions from their own medical practitioners. Stakeholder feedback may be due to negative experiences where, for example, treating practitioners' advice may have been seen as having been disregarded.

Recommendation 6 of the 2021 statutory review was to provide that a treating practitioner's recommended treatment or care is presumed to be reasonable and necessary, and related to the injury resulting from the motor accident. The review considered the treating medical practitioner is generally the best person to decide an injured person's treatment and care and injured people should be able to choose if they accept the recommended treatments. Recommendation 6 has not been implemented.

[29] SIRA, *Customer experience,* CTP Open Data, accessed 18 February 2026, sira.nsw.gov.au/CTP-open-data.

Joint medico-legal assessments

When a person makes a claim for damages, medico-legal assessments are used to provide a report on their injuries that is used to assess their claim. It usually covers matters such as the cause of injury and the injured person's WPI, long-term earning capacity, and long-term care and domestic assistance needs. Generally, only authorised medical practitioners complete such assessments.

Some stakeholder feedback indicates concerns about delays in determining claims and unnecessary stress on injured people who may be subject to multiple medico-legal examinations during the claims process. Encouraging the use of joint medico-legal assessments, where an insurer and injured person jointly agree to use one medico-legal examiner for the claim, has been recommended as an avenue that could address some of these issues.

The 2021 statutory review made recommendations to encourage the use of joint medico-legal assessments. For example, recommendation 29 was for SIRA to consult to determine changes to the scheme that directly facilitate and incentivise the use of joint medico-legal assessments in relation to claims for damages, as well as a program of data collection to assess the efficacy of the changes. To implement this recommendation, clause 8.7 of the Guidelines requires parties to a dispute (e.g. insurers) to 'use their best endeavours to agree to a joint medical or other health related assessment, taking into account the individual circumstances of the injured person…' SIRA also published a guidance note[30] to assist parties to comply.

Authorised health practitioners regime

When a medical opinion is to be used in Court or other formal dispute resolution processes, only the following health practitioners can give evidence:

- a treating health practitioner, or
- a practitioner authorised under the Guidelines.

Part 8 of the Guidelines sets out the criteria for how health practitioners can be authorised by SIRA. This includes that they are to complete at least two hours of continuing professional development relating to medico-legal practice during the 3-year authorisation period and maintain appropriate and secure record management systems. A stakeholder has raised concerns that some of these requirements are unnecessary as health practitioners (e.g. psychologists) must already meet high professional standards. As such, they are disincentivised from participating in providing medico-legal assessments.

Section 8.4 of the Act provides for maximum fees that may be charged by health practitioners for medico-legal services. Schedule 2 of the Regulation sets out what these fees are.

Many stakeholders have raised that the maximum fees for authorised health practitioners are insufficient, resulting in practitioners not wanting to provide medico-legal services for people with claims. This means parties may wait for extended periods of time and claims may take longer to resolve.

A stakeholder has also raised that the maximum fees may impact the quality of the reports from authorised health practitioners as higher quality practitioners are not attracted to provide services under the scheme. Another stakeholder has indicated that some authorised health practitioners may have limited experience completing CTP scheme assessments and this can have negative impacts such as poor customer experience.

Authorised health practitioners play an important role in the scheme to support good decision-making and outcomes for people with injuries. However, any increases in costs to the scheme will

[30] See SIRA, *Guidance to Joint Medical or Other Health-Related Assessments in the CTP Scheme,* SIRA, 2025, accessed 3 March 2026, www.sira.nsw.gov.au/resources-library/motor-accident-resources/publications/for-professionals/guidance-to-joint-medical-or-other-health-related-assessments-in-the-ctp-scheme.

need to be carefully considered as scheme financial sustainability is crucial to support affordable premiums.

DCS will also consider the *Health Provider Regulation Implementation Roadmap,*[31] which has been developed from a SIRA-commissioned independent review of how SIRA regulates health providers in NSW personal injury schemes. This roadmap has actions about how to improve the regulation of health providers including how SIRA sets fees under the CTP scheme.

Complexity of psychological/psychiatric injury assessment

Many stakeholders indicate handling psychological and psychiatric injuries under the Act could be improved as such injuries are complex and can be more expensive to resolve. Some stakeholder groups consider the Act does not properly recognise psychological harm and the system and process can contribute to secondary psychological harm for people with claims.

The Guidelines require the Permanent Impairment Rating Scale (PIRS) to be used to measure the degree of functional impairment caused by a psychiatric condition. PIRS evaluates behaviour and functioning across six categories – self care and personal hygiene, social functioning, social and recreational activities, travel, concentration persistence and pace, and employability.

Customisation for those who lose a loved one in a crash

There is strong stakeholder sentiment that people who lose a loved one in a motor crash should be treated differently under the Act as they experience intense grief and trauma that the CTP scheme's requirements make worse.

The Act provides for the payment of reasonable funeral expenses when a person dies because of a motor crash, regardless of who was at fault. These benefits cover the reasonable cost of the funeral and transport costs (where needed). The *Compensation to Relatives Act 1897* allows dependents of a person who dies in a car crash to claim compensation for financial losses and lost services.

Apart from these rights, a person who loses a loved one in a crash would only be entitled to statutory benefits or award of damages under the Act if they suffer an injury because of the motor crash such as a psychological injury. They would also generally need to complete the same claims process as other people with claims.

Steps have been taken to better support this group including:

- establishing a trauma support service
- engaging specialist staff to support impacted family members through the claims process
- Guidelines requiring insurers dealing with claims involving the death of a person to be managed in a proactive, respectful and sensitive manner
- SIRA facilitating 'trauma-informed care' education sessions with insurers to assist in improving case manager capability in managing claims related to a death
- improving the SIRA website for better access and navigation to timely information and support for families.

Potential options that have been suggested to improve the claims process for this group include:

- entitling them to full support without having to prove their 'injury'
- making the process easier by, for example:

[31] Dawson, Sue, March 2026, www.sira.nsw.gov.au/__data/assets/pdf_file/0006/1408182/Health-provider-regulation-roadmap.pdf.

  - not requiring them to complete unnecessary Certificates of Fitness
  - introducing umbrella documents for a family claim
  - a single point of contact throughout the claims process
- removing or strictly limiting the application of contributory negligence in their cases
- having more targeted support for affected children, young people and retirees.

Implementing any presumption about an injury would be a significant change in the CTP scheme's design as three objectives of the Act are to encourage early and appropriate treatment and care, provide early and ongoing financial support for injured persons, and keep insurance premiums affordable.

There are likely improvements that could be made to customise the claims process for this specific group. Note stakeholder feedback to change the threshold injury definition for people who lose a loved one has been discussed in the 'Eligibility criteria and scheme coverage' section of this paper.

Simplification of claims process

Some stakeholder feedback indicates the claims journey (including treatment and care experience) could be simplified or improved so the customer experience is better for people with claims. For example:

- simplifying how pre-accident weekly earnings are calculated especially for self-employed people
- having more prescriptive communication requirements that insurers are to give information to treating practitioners such as advice about injury classifications (e.g. threshold vs non-threshold) and expected claim duration
- having automatic approval of six physiotherapy sessions for people with certain types of injuries to reduce treatment delays
- not requiring families who receive no-fault funeral benefits under the CTP insurance scheme to have to repay amounts where they subsequently receive damages claims under the Compensation to Relatives Act and the person who died was found to have been partly at fault.

SIRA completed a review of the weekly payments framework in October 2025 in response to recommendations of the 2021 statutory review.[32] Its review indicated the framework is operating relatively well but improvements could be made to support customer understanding of entitlements and claims handling. To address these findings, SIRA is progressing further work to improve customer support.

Some stakeholders also advocate for recommendation 39 of the 2021 statutory review to be implemented. Recommendation 39 was to change the Act so that where an insurer changes its mind about an injury being a non-threshold injury, and more than 18 months have passed since the motor crash, the insurer must refer the matter to the Commission for medical assessment and keep paying statutory benefits until the matter is assessed. This recommendation has not been implemented because the Act allows the Guidelines to address assessments of whether an injury is a threshold injury and the 20-month waiting period for lodging damages claims has been removed.

[32] Clayton Utz recommendation 14 and Deloitte recommendations 33 and 39. See Clayton Utz, *Statutory Review of the Motor Accident Injuries Act 2017 – Report,* 2021, www.sira.nsw.gov.au/__data/assets/pdf_file/0017/1031390/Statutory-Review-of-the-Motor-Accidents-Injuries-Act-2017-Report.pdf.

Feedback sought

General question

12. What other issues (if any) should the review consider about the claims process? Please explain.

Specific questions

Pre-accident average weekly earnings calculation

13. Does the process to calculate weekly average pre-accident earnings for statutory benefit income support need to be changed, including for self-employed injured people? Please explain.
14. Do you support the Guidelines setting a timeframe for when an insurer must calculate pre-accident average weekly earnings? Why or why not?

Treating medical practitioners

15. Do you think treating medical practitioners have an adequate role in the CTP insurance scheme? Please explain.

Joint medico-legal assessments

16. Do you support the use of joint medico-legal assessments? Why or why not?
17. Are there barriers to using joint medico-legal assessments and if so, what are they? Please explain.

Authorised health practitioners

18. What has been your experience accessing and engaging authorised health practitioners under the CTP scheme?
19. Do you support adjusting the fees that authorised health practitioners can be paid under the CTP scheme? Why or why not?

Psychological and psychiatric injuries

20. Does the CTP scheme support psychological and psychiatric injuries as well as it does physical injuries? Why or why not?

People who lose a loved one

21. When people lose loved ones in motor crashes, should the claims process be adapted to reflect their circumstances? Please explain.
    a. If yes, how else could the claims process better support this group of people while continuing to meet the objectives of the Act? Please explain.

Dispute resolution

Legislative overview

One of the Act's objectives is to encourage the early resolution of motor accident claims and the quick, cost effective and just resolution of disputes. Part 7 of the Act sets out the dispute resolution process. It creates a two-stage process consisting of an insurer internal review and then a determination through the Commission (an independent statutory tribunal) if needed.

A person with a claim may request an internal review within 28 days of receiving a decision. An insurer has 14 days to complete the review and let the person with a claim know the outcome. The Guidelines set out how insurers are to complete internal reviews.

If a dispute is not resolved through the internal review process, the injured person can apply to the Commission to determine the matter. Disputes about WPI do not have to be internally reviewed by insurers before progressing to the Commission.

The Commission's procedures are governed by the *Personal Injury Commission Act 2020* and its own rules and procedural directions. These are out of scope of this statutory review.

The Act sets out different streams for matters the Commission determines:

- merit reviews, which involve reviewing the correctness of insurers' decisions about matters such as the amount of statutory benefits payable as weekly payments or for funeral expenses.
- medical assessments, which involve new medical assessments and are about matters such as if an injury is a threshold injury, if treatment and care is reasonable and necessary or caused by the motor crash, and level of WPI
- miscellaneous claims assessments, which involve certain procedural, liability and compliance issues.

The Commission is also responsible for certain matters relating to settlements of claims for damages such as approving settlements where a person with a claim is not legally represented.

Figure 5 shows a high-level summary of the dispute resolution process.

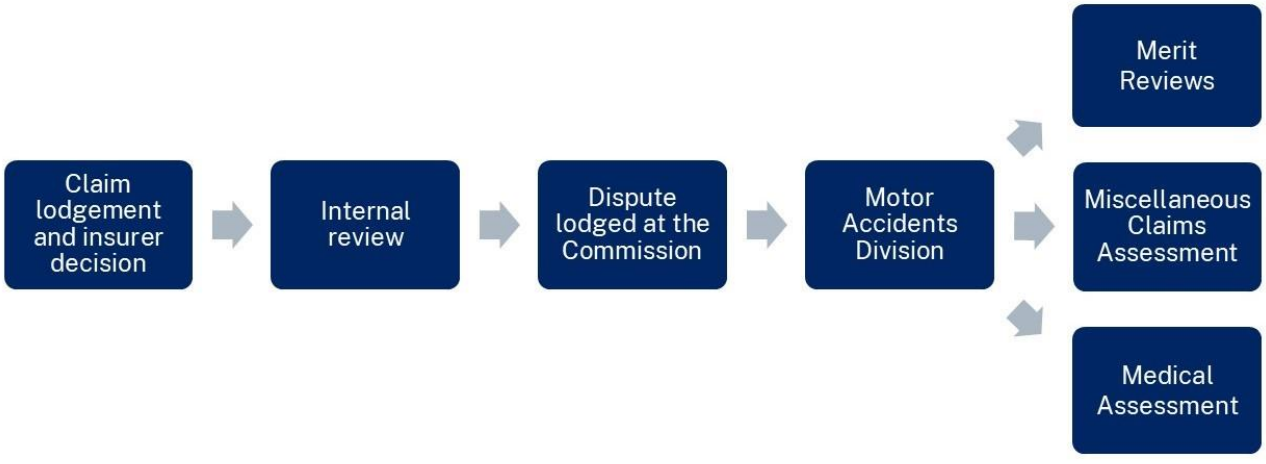

Figure 5: High-level summary of the CTP insurance scheme dispute resolution process.

Causation of injury

Section 7.20(2) of the Act requires medical assessors to decide medical assessment matters. Clause 2 of Schedule 2 of the Act provides that medical assessment matters include disputes about whether:

- treatment and care are reasonable and necessary, or relates to the injury caused by the motor accident
- the degree of permanent impairment of the injured person that has resulted from the injury caused by the motor accident
- the injury caused by the motor accident is a threshold injury.

Some stakeholders advocate for assessments about what caused an injury to be decided as legal matters instead of medical matters. They argue deciding the cause of an injury involves applying legal principles (e.g. foreseeability, scope of liability and evaluating competing facts), which courts and legal experts can do. Further, this is how such matters are dealt with under the *Workplace Injury Management and Workers Compensation Act 1998* (the Workplace Injury and Compensation Act).

Stakeholders argue that changing the dispute resolution approach for such matters would ensure the law is applied correctly, improve decision making and reduce costs. They have also raised that reducing the number of disputes needing a medical assessment would likely speed up the resolution of disputes as medical assessments can be delayed due to factors such as a shortage of available medical assessors.

Potential options stakeholders have proposed to allow causation of injury to be determined as a legal matter instead of a medical matter include:

- providing that causation of injury matters are first considered by the Commission at a hearing during conciliation, arbitration or mediation with medical matters then referred to medical assessors for consideration
- treatment and care disputes in clause 2(b) of Schedule 2 of the Act being dealt with as miscellaneous claim assessments instead of medical assessments. To ensure there is a right of appeal through the Commission (as opposed to only the Supreme Court), the Act could also allow miscellaneous claim assessment decisions by a non-Presidential Commission member to be appealed to a Presidential member.

Medical Review Panel remit

Section 7.26 of the Act allows parties to have a single medical assessor's medical assessment reviewed by a Medical Review Panel. The Commission's President is only to refer an assessment for review if they are satisfied 'there is reasonable cause to suspect that the medical assessment was incorrect in a material respect.' Such a review is to be a 'new assessment of all matters with which the medical assessment is concerned.'

Stakeholder feedback indicates this approach increases costs and extends the time to resolve disputes. It also can cause people with claims more trauma as they need to undergo new medical assessments for the same matters.

Further, the Act's approach contrasts with the approach in the Workplace Injury and Compensation Act where:

- the grounds for appeal are set (e.g. medical assessment certificate contains a demonstrable error)
- an Appeal Panel only considers matters that are alleged to be incorrect
- the Commission President can refer a matter to a medical assessor to reconsider their decision, as an alternative to an appeal.

A potential option would be to change the Act to more closely align with the Workplace Injury and Compensation Act so that Medical Review Panels only review medical assessment decisions where there is basis for review (e.g. error) and limit their review to those issues instead of completing a new assessment.

Feedback sought

General questions

22. What has your experience been with the dispute resolution process? Please provide details.
23. What other issues (if any) should the review consider about the dispute resolution pathways under the Act? Please explain.

Specific questions

Causation of injury

24. Do you support disputes about causation of injury being decided by Courts or Commission members instead of a medical assessor? Why or why not?

Medical Review Panel

25. Do you support changing the Medical Review Panels' remit under the Act so they:
    a. are not to conduct a new medical assessment?
    b. must meet more set criteria before they can review a medical assessment decision?

    Please explain your response.
26. What could be the grounds on which a medical assessment decision should be reviewable? Please explain.

Legal fees and access to legal support

Legislative overview

The Act regulates legal costs for statutory benefit claims and claims for damages. The Act provides the Regulation can set maximum costs to be paid for legal services provided to insurers and people with claims. Schedule 1 of the Regulation sets the maximum costs that can be recovered for legal services.

For statutory benefit claims, legal costs can generally only be paid once a dispute is lodged at the Commission. The maximum cost is 16 monetary units (i.e. calculated as $2031.20 for 2025-26) for certain types of disputes before the Commission, with some additional amounts available for panel reviews and appeals within the Commission. Amounts above the set maximum cannot be charged or recovered, although the Commission can approve costs above the maximum in exceptional circumstances. Unpaid legal representation can still occur at any stage in a claim.

For claims for damages, Schedule 1 of the Regulation allows for higher maximum costs to be recovered for legal services. Clause 25 of the Regulation also allows legal practitioners to enter alternative fee arrangements for damages claims above $75,000. For claimants, these legal costs are paid for from the damages amount recovered. The maximum costs recoverable in such cases is fixed at the amount paid to resolve the claim minus $75,000. Before the Act was implemented in 2017, the threshold was $50,000 under the 1999 Act.

Clause 40 of the Regulation also requires legal practitioners representing a person with a claim to give SIRA a costs breakdown for the claim. This is to allow SIRA to advise the Minister about the efficiency and effectiveness of the scheme.

Identified issues

Recommendation 30 of the 2021 statutory review was that SIRA should develop and consult on recommended changes to the legal support provisions in the Act and Regulation. SIRA completed this work in 2025 focusing on the legal fees for disputes about statutory benefits. No change was subsequently made.

Some stakeholder feedback continues to be that legal fees that can be paid under the Act are too low and limited in their availability, which means people with claims do not have access to legal support that they may need. These stakeholders:

- highlight that the scheme is complex and not being able to access legal support early or during the process may mean people injured in a motor crash end up not accessing support to which they are entitled
- advocate for the legal fees under the Act at least being aligned with those available under the Independent Legal Assistance and Review Service that is in place for workers compensation matters
- advocate for allowing legal costs to be recouped at all stages of a claim including before a claim is lodged.

In contrast, other stakeholders emphasise that increasing lawyers' involvement in the process could make it more adversarial, increase costs and delay how quickly disputes are resolved. They also indicate that current support for people with claims is adequate including SIRA's CTP Assist service, the Independent Review Office's (IRO) complaint handling and the internal review process.

Some stakeholders have also raised concerns about whether the limits in clause 25 on separate fee arrangements should apply to insurers' legal representatives. It is suggested that the current limits may, in some cases, prevent insurers' legal representatives from recovering the full costs of their

completed work. However, removing these limits for insurers may increase differences in access to legal resources between insurers and claimants. Any increase in legal costs is also likely to put upward pressure on insurance premiums.

In the second reading speech for the Act in 2017, there was a strong focus on the Act reducing costs (including legal costs) and the adversarial nature of the scheme under the 1999 Act.[33] Legal representatives provide important support for people with claims but costs to the scheme will need to be balanced so premiums remain affordable and the scheme is sustainable.

Feedback sought

General question

27. What other issues (if any) should the review consider about legal fees that can be charged or people with injuries' access to legal support? Please explain.

Specific questions

28. Where relevant, what has been your experience with legal representatives under the CTP insurance scheme? Please explain.
29. What role should legal representatives play in supporting people with injuries in the CTP insurance scheme? Please explain.
30. Apart from legal representation, what else could be used to assist people who are injured in motor crashes to understand and go through the claims and dispute resolution process? Please explain.
31. Do you support clause 25 of the Regulation not applying to fee arrangements between insurers and their legal representatives? Why or why not?

[33] Legislative Assembly, *Motor Accident Injuries Bill 2017 Second Reading,* 2017, p.2, www.parliament.nsw.gov.au/bill/files/3373/2R%20Motor.pdf.

Scheme information, compliance and enforcement

Legislative overview

Division 10.1 of the Act outlines SIRA's functions. They include:

- investigating and responding to complaints
- monitoring insurer compliance with the Act, Guidelines and *Personal Injury Commission Act 2020*
- investigating claims to detect and prosecute fraudulent claims
- monitoring the operation of the scheme, including collecting statistics and information on scheme performance
- publicising and disseminating information about the scheme.

The Division supports many objectives of the Act including deterring fraud, ensuring the collection and use of data to facilitate the effective management of the scheme, and giving SIRA a role to ensure sustainability and affordability of the scheme and fair market practices.

Transparency of scheme information

Division 10.5 provides SIRA with broad powers to collect and use data related to premiums, claims, insurer performance and service provision.

SIRA proactively publishes information about the scheme in accordance with its Regulatory Publishing Policy.[34] According to this policy, SIRA publishes scheme information only if it meets certain criteria including being in the public interest and best interest of customers.

SIRA generally publishes information about:

- the CTP scheme's performance including scheme data available on its Open Data Portal, scheme actuarial monitoring data, data about regulatory focus areas or scheme performance issues
- insurers' licences including issuing a new licence, imposition of licence conditions and suspension or cancellation of a licence
- compliance and enforcement action such as audits, investigations, reviews, prosecutions and issued improvement notices, remediation plans, letters of censure and penalty notices[35]
- volume and nature of significant matters referred to SIRA from other bodies such as legal matters, privacy or information breaches or investigations[36]
- changes to levies that impact premiums
- the outcome of premium filing assessments

[34] SIRA, *Regulatory Publishing Policy,* SIRA, 2022, accessed 3 March 2026. www.sira.nsw.gov.au/resources-library/regulation-and-fraud/regulation-of-health-and-related-services-providers/regulatory-publishing-policy

[35] For example, see SIRA quarterly regulatory updates available at SIRA, *Regulatory Activity,* SIRA, 2026, accessed 3 March 2026, www.sira.nsw.gov.au/resources-library/regulation-and-fraud/regulatory-activity.

[36] See SIRA, *Significant Matter Notification Requirements*, SIRA, 2024, www.sira.nsw.gov.au/__data/assets/pdf_file/0003/1286508/SIRA-Significant-Matter-Notification-Requirements-2024.pdf.

- TEPL assessments such as the decision to trigger the mechanism, the amount being recouped, the relevant accident years, and any adjustments from previous years
- the number of decisions in relation to Innovation Support application.[37]

SIRA generally does not publish where information is commercially sensitive or would impact market competitiveness. Section 11.2 of the Act also sets out strict confidentiality rules around 'protected information' collected in the exercise of functions under the Act.

Identified issues

Certain stakeholders have indicated the potential to improve scheme transparency by publishing additional scheme information. Some issues raised revolved around the non-disclosure of certain information, while others are criticisms of the data collection within the scheme.

Stakeholders have requested additional transparency about matters including:

- the number of claims for statutory benefits that each CTP insurer is handling
- more detailed data on the outcomes of disputes such as insurer decisions the Commission overturns broken down by dispute and/or injury type
- the calculation of premiums, including the proportion of premiums that is risk based compared to statutory charges, such as levies
- how the community risk aspect of premiums is determined
- SIRA's compliance and enforcement activities, including SIRA's response to complaints referred from the IRO
- data on claims submitted involving rideshare vehicles
- information on insurer profit and SIRA's decision-making under the TEPL mechanism, including the application of the 'innovation' exception for the cap on insurer profits.

Insurers have previously recommended that any changes to their data reporting requirements be considered carefully, considering the administrative burden on insurers of changes to data reporting.[38]

Compliance and enforcement

SIRA undertakes regulatory activities in line with its published Regulatory Framework.[39] Some stakeholder feedback is that SIRA's ability to enforce the CTP scheme's regulatory framework could be strengthened.

The Act gives SIRA powers to monitor, investigate and enforce compliance with the Act. This includes investigative powers to gather information and conduct audits. The Act also makes certain provisions offence provisions with maximum penalties ranging between 20 and 1000 penalty units.

[37] SIRA, *Regulatory Publishing Policy,* SIRA, 2022, accessed 3 March 2026, www.sira.nsw.gov.au/resources-library/regulation-and-fraud/regulation-of-health-and-related-services-providers/regulatory-publishing-policy

[38] For example, the Suncorp Submission to the 2021 Statutory Review: Clayton Utz, *Statutory Review of the Motor Accident Injuries Act 2017 – Report,* 2021, p.78, www.sira.nsw.gov.au/__data/assets/pdf_file/0017/1031390/Statutory-Review-of-the-Motor-Accidents-Injuries-Act-2017-Report.pdf.

[39] SIRA, *Regulatory Framework*, SIRA, 2025, accessed 3 March 2026, www.sira.nsw.gov.au/resources-library/law-and-policy-or-corporate/publications/siras-regulatory-framework.

Fraud

An objective of the Act under section 1.3(2(e)) is to deter fraud. As indicated previously, there are aspects of how the scheme works that support achieving this objective. For example, requiring people with claims to provide certain information before they can receive statutory benefits.

As noted above, one of SIRA's functions is to detect and prosecute fraud. Division 6.6 of the Act also sets out provisions in relation to fraudulent claims, including the insurer obligation to take all reasonable steps to deter and prevent fraud. SIRA's approach to deterring, detecting and responding to fraud is set out in its Fraud Framework.[40] For the 2024-25 financial year, SIRA received 50 fraud referrals for investigation. Of these, 2 prosecutions were finalised.[41]

It is becoming more challenging to deal with fraud because fraud schemes are becoming more complex and often involve many organisations and networks working together. SIRA's response to fraud therefore requires closer collaboration and information sharing across different government agencies, as well as navigating the broader legal landscape, which usually involves many different laws.

Five recommendations for changes to scheme implementation were made in the 2021 statutory review to better support fraud deterrence, including for SIRA to conduct a thorough investigation into the extent and nature of fraud within the scheme, monitor key metrics and implement specific fraud prevention initiatives.[42] All five recommendations have been actioned by SIRA.[43]

A stakeholder has suggested that SIRA's Fraud Framework could be expanded to create more detailed processes for information sharing, respond to possible overcharging by medical practitioners, recover insurer costs for complex fraud investigations and explore new tools to test certain claims.

Insurer misconduct

The 2021 statutory review made several recommendations in relation to insurer compliance such as recommendations 2, 3 and 32. In response, SIRA has implemented additional reporting requirements under the Guidelines, released its Regulatory Publishing Policy, and conducted risk-based compliance activities regarding specific clauses of the Guidelines.

Some stakeholders consider SIRA remains unable to address insurer non-compliance and that SIRA should be given stronger enforcement powers such as higher penalties.

Complaint handling

SIRA's functions under section 10.1 of the Act include to investigate and respond to complaints about:

- premiums for third party policies
- the market practices of licensed insurers

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[40] SIRA, *Fraud Framework,* SIRA, 2024, accessed 3 March 2026, www.sira.nsw.gov.au/resources-library/regulation-and-fraud/preventing-fraud/fraud-framework.

[41] SIRA, *2017 CTP Scheme Performance Report to 30 June 2025*, SIRA, 2025, p.20, www.sira.nsw.gov.au/__data/assets/pdf_file/0009/1386648/SIRA-2017-CTP-Performance-Report-2025.pdf.

[42] See scheme implementation recommendations/suggestions 25-29, Clayton Utz, *Statutory Review of the Motor Accident Injuries Act 2017 – Report,* 2021, p.169, www.sira.nsw.gov.au/__data/assets/pdf_file/0017/1031390/Statutory-Review-of-the-Motor-Accidents-Injuries-Act-2017-Report.pdf.

[43] SIRA, *Status on progress made against the recommendations and suggestions from the 2021 Statutory Review of the Motor Accident Injuries Act 2017,* SIRA, 2025, accessed 3 March 2026, www.sira.nsw.gov.au/resources-library/motor-accident-resources/publications/sira-reports/status-on-progress-made-against-the-recommendations-and-suggestions-from-the-2021-statutory-review-of-the-motor-accident-injuries-act-2017.

- claims handling practices of insurers.

IRO has also been set up under the *Personal Injury Commission Act 2020* to handle complaints about the CTP insurance scheme. A person with a CTP claim may make a complaint to IRO about any insurer's act or omission that affects their entitlements, rights or obligations under the Act. IRO is responsible for investigating the individual complaint.

IRO will refer relevant complaints about the scheme to SIRA for consideration and compliance action if appropriate.

For the financial year 2024-25, 740 complaints were received in relation to the scheme. Of these, 480 complaints were handled by IRO, and 260 were addressed by SIRA.[44] This is a relatively low number of complaints considering more than 15,000 claims were lodged in 2025.[45]

A stakeholder has raised concerns that issues that may warrant SIRA's regulatory action are not being referred from IRO. It recommends considering if the system is effective in dealing with both low-level complaints and broader concerns around insurer conduct.

Feedback sought

General question

32. What other matters (if any) should the review consider in relation to scheme information, compliance and enforcement? Please explain.

Specific questions

33. What other information (if any) should SIRA publish? Please explain.
34. Are there opportunities to improve SIRA's compliance and enforcement powers? Please explain.
35. Are there opportunities to improve complaints handling under the scheme? Please explain.

[44] SIRA, *2017 CTP Scheme Performance Report to 30 June 2025*, SIRA, 2025, p.27, www.sira.nsw.gov.au/__data/assets/pdf_file/0009/1386648/SIRA-2017-CTP-Performance-Report-2025.pdf.

[45] SIRA, *Claim,* CTP Open Data, accessed 4 March 2026, sira.nsw.gov.au/CTP-open-data.

Point to point industry

Legislative overview

Section 2.7 of the Act and Part 2 of the Guidelines require the full CTP insurance premium to be paid before an insurance policy can be issued. However, the Motor Accident Guidelines: Determination of Insurance Premiums for Taxis and Hire Vehicles (Point to Point Guidelines) allow different arrangements for taxis and hire vehicles including rideshare vehicles. These guidelines provide that insurers can:

- accept payment for an insurance policy's premium in instalments for taxis and hire vehicles,
- for taxis, charge insurance premiums based on the kilometres the taxi travels,
- for hire vehicles (including rideshare), charge insurance premiums based on the kilometres the vehicle's driver is paid to travel.

Taxis and rideshare vehicles fall into different CTP vehicle classes, and their premiums differ based on their risk. Clause 1.19 of the Guidelines provides insurers must classify motor vehicles in line with vehicle classifications that SIRA sets.

Identified issues

Taxis' insurance premiums are generally higher than those for standard passenger vehicles because taxis have a higher 'risk rating'. This means taxis are more likely to be involved in motor crashes or have related CTP insurance claims. For example, it has been calculated that taxis are approximately 7 times more likely to make a claim under their CTP insurance than a standard passenger vehicle.[46]

The Point to Point Guidelines were introduced to give taxis and rideshare vehicles greater flexibility in how they pay their insurance premiums. However, there are implementation challenges.

The taxi industry has also raised concerns about the affordability of CTP insurance, as well as how premiums differ between taxis and rideshare vehicles.

Recommendation 1 of the LJ Committee's final report for its 2025 CTP insurance scheme review is for SIRA to finalise changes to the appropriate guidelines within six months of the tabling of the Committee's report to group taxis and rideshare operators in a single class for CTP insurance. The LJ Committee also recommended SIRA should have regard to the models adopted in Queensland and Victoria, where all point-to-point service providers are placed within a single class for the purposes of CTP insurance.

Grouping taxis and rideshare vehicles into a single class may have impacts for insurance premiums across the scheme and for rideshare service prices.

It should be noted that the Victorian and Queensland CTP schemes significantly differ from NSW's scheme. Victoria's scheme is managed by the Victorian Government and there are no private insurers. Queensland's scheme is fault based, which means benefits are only paid to injured people who did not wholly cause the relevant motor crash.

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[46] Mandy Young, evidence to Legislative Council, *Reviews of the Third Party Insurance and Lifetime Care and Support Scheme,* Parliament of New South Wales, Sydney, 8 December 2025, page 58, www.parliament.nsw.gov.au/lcdocs/transcripts/3624/Transcript%20-%20CORRECTED%20-%20LJ%20-%202025%20Reviews%20of%20the%20Third%20Party%20Insurance%20and%20Lifetime%20Care%20and%20Support%20-%208%20December%202025.pdf.

Feedback sought

General question

36. What other issues (if any) should the review consider about the point to point industry and the CTP insurance scheme? Please explain.

Specific question

37. How should point to point industry vehicles (including taxis and rideshare vehicles) be charged for insurance under the scheme? Why?

CTP care

Legislative overview

CTP Care began on 1 December 2022. Section 3.2(3) of the Act provides that people injured in a motor crash who require treatment and care statutory benefits more than 5 years after the relevant motor crash are to be transferred to CTP Care.

Section 3.45 of the Act provides that an injured person can transition to CTP Care earlier than 5 years if it becomes clear they will have long-term treatment and care needs. An 'Early by Agreement' (EBA) between CTP Care and the initial CTP insurer is used to facilitate this early transfer.

Section 10.14 of the Act establishes the Motor Accident Injuries Treatment and Care Benefits Fund that funds CTP Care. Section 10.15 sets out how these funds are to be administered.

CTP Care must comply with the Act, the Regulation and the Guidelines when handling treatment and care claims. However, it is not a licensed insurer under the Act.

SIRA's Motor Accident Guidelines: CTP Care also sets out how claims are to be transferred between an insurer and CTP Care. SIRA may also determine, for a relevant period, the maximum amounts that CTP Care may determine for claims handling expenses.

Transition and oversight of CTP Care

The number of people under CTP Care is growing with approximately 550 people added to the scheme each year.[47] As of 30 June 2025, there were a total of 1,675 CTP Care customers with 8 of them having been transferred early using an EBA.[48]

Currently, as CTP Care is not a licensed insurer under the Act, no authority including SIRA has any powers to supervise the management of claims under CTP Care.

There may also be improvements that could be made to ensure injured people transferred to CTP Care have as simple and streamlined an experience as possible. For example, one stakeholder has raised concerns about certain people with workers compensation claims having to transfer schemes three times and suggested the use of EBAs be encouraged more in these cases.

The LJ Committee also reviewed the Lifetime Care and Support Scheme in 2025 and released its final report on 23 April 2026. The Committee made recommendations relevant to CTP Care:

- Recommendation 1 is that iCare enhance their monitoring, follow up and public reporting of client satisfaction for CTP Care and Lifetime Care schemes, focusing on steps it takes to investigate and remediate causes of dissatisfaction,
- Recommendation 4 is to ensure people with non-threshold injury claims are aware of the CTP Care scheme and that they may be eligible to enter the scheme early by agreement by:

[47] iCare, *Submission to the NSW Legislative Council Standing Committee on Law and Justice ' s 2025 review of the Compulsory Third Party (CTP) insurance scheme - CTP Care*, 2025, p.4. https://www.parliament.nsw.gov.au/lcdocs/submissions/92263/0004%20Insurance%20and%20Care%20NSW%20(icare).pdf

[48] iCare, *Submission to the NSW Legislative Council Standing Committee on Law and Justice's 2025 review of the Compulsory Third Party (CTP) insurance scheme - CTP Care*, 2025, p.4. https://www.parliament.nsw.gov.au/lcdocs/submissions/92263/0004%20Insurance%20and%20Care%20NSW%20(icare).pdf

- amending the Guidelines to require insurers to advise customers with non-threshold injuries of the CTP Care scheme and the early by agreement mechanism,
- ensuring injured people receiving workers compensation due to a motor crash are advised of the CTP Care scheme and the early by agreement mechanism.

Feedback sought

General question

38. Are there any other issues about CTP Care that the statutory review should consider? Please explain what they are (if any).

Specific questions

39. Do you think there is adequate oversight of CTP Care's claims management? Please explain.
40. Should 'Early by Agreement' arrangements be used more to transfer injured people to CTP Care? Why or why not?
    a. If yes, what would support the use of these arrangements? Please explain.

Other issues

Reviewing available stakeholder feedback indicates other issues the review may need to consider.

- **'Motor crash' instead of 'motor accident'**

  Some stakeholders advocate for replacing 'motor accident' with 'motor crash' in the Act. This is because 'accident' suggests inevitability or blamelessness, which can downplay the role of human error, risk-taking or system failures that often contribute to road trauma. Using 'crash' instead treats incidents as preventable events rather than unavoidable mishaps.

- **Autonomous vehicles**

  An emerging issue that may need consideration in this review is how the CTP scheme responds to autonomous vehicles. The National Transport Commission (NTC) is developing a Commonwealth Automated Vehicle Safety Law to regulate the safety of automated vehicles.[49] However, state and territory CTP schemes will likely still need to consider how to approach automated vehicle crash injuries.

  Some stakeholders have indicated the NSW Government should proactively engage with the NTC to ensure the NSW CTP insurance scheme is considered in national policy conversations on the regulation of autonomous vehicles.

Feedback sought

41. Are there any other issues that have not been covered in this issues paper that the statutory review should consider? Please explain what they are (if any).

[49] National Transport Commission (NTC), *Automated Vehicle Program,* NTC, 2025, accessed 3 March 2026. https://www.ntc.gov.au/transport-reform/automated-vehicle-program

Appendices

Appendix A – Questions in the issues paper

What the Act aims to achieve

1. Do the objectives of the Act remain valid? Why or why not?
2. What are the top 3 most important things that you think may need to change in the Act (if anything) to support it to achieve and/or balance its objectives? Please explain.

Scheme sustainability

3. What other issues (if any) should the statutory review consider relating to premium affordability and financial sustainability? Please explain. Note other relevant issues such as eligibility criteria are discussed in other parts of this paper.
4. When should the transitional excess profit and loss mechanism in Schedule 4 of the Act end? Please explain.
5. What should replace the transitional excess profit and loss mechanism in Schedule 4 of the Act? Please explain.
6. Do you think the current assessment of claims handling expenses as part of Schedule 1E of the Guidelines is sufficient? Why or why not?

Eligibility criteria and scheme coverage

7. What other issues (if any) should the statutory review consider about eligibility criteria or scheme coverage? Please explain.

Threshold injury and other definitions

8. Do you support adjustment disorder being a 'threshold injury'? Why or why not?
9. Do you support changing the definition of 'injury' in the Act? Please explain.
    a. If yes, how would you change the definition of injury? Please explain.
10. What else should be included or excluded from the definition of treatment and care? Please explain.

Scheme coverage

11. Would you support expanding or further restricting the scheme's coverage in certain circumstances? Why or why not?
    a. If yes, please expand on what these circumstances should be and explain why.

Claims process

12. What other issues (if any) should the review consider about the claims process? Please explain.

Pre-accident average weekly earnings calculation

13. Does the process to calculate weekly average pre-accident earnings for statutory benefit income support need improving including for self-employed injured people? Please explain.
14. Do you support the Guidelines setting a timeframe for when an insurer must calculate pre-accident average weekly earnings? Why or why not?

Treating medical practitioners

15. Do you think treating medical practitioners have an adequate role in the CTP insurance scheme? Please explain.

Joint medico-legal assessments

16. Do you support the use of joint medico-legal assessments? Why or why not?
17. Are there barriers to using joint medico-legal assessments and if so, what are they? Please explain.

Authorised health practitioners

18. What has been your experience accessing and engaging authorised health practitioners under the CTP scheme?
19. Do you support adjusting the fees that authorised health practitioners can be paid under the CTP scheme? Why or why not?

Psychological and psychiatric injuries

20. Does the CTP scheme support psychological and psychiatric injuries as well as it does physical injuries? Why or why not?

People who lose a loved one

21. When people lose loved ones in motor crashes, should the claims process be adapted to reflect their circumstances? Please explain.
    a. If yes, how else could the claims process better support this group of people while continuing to meet the objectives of the Act? Please explain.

Dispute resolution

22. What has your experience been with the dispute resolution process? Please provide details.
23. What other issues (if any) should the review consider about the dispute resolution pathways under the Act? Please explain.

Causation of injury

24. Do you support disputes about causation of injury being decided by Courts or Commission members instead of a medical assessor? Why or why not?

Medical Review Panel

25. Do you support changing the Medical Review Panels' remit under the Act so they:
    a. are not to conduct a new medical assessment?
    b. must meet more set criteria before they can review a medical assessment decision?

    Please explain your response.
26. What could be the grounds on which a medical assessment decision should be reviewable? Please explain.

Legal fees and access to legal support

27. What other issues (if any) should the review consider about legal fees that can be charged or people with injuries' access to legal support? Please explain.
28. Where relevant, what has been your experience with legal representatives under the CTP insurance scheme? Please explain.
29. What role should legal representatives play in supporting people with injuries in the CTP insurance scheme? Please explain.

30. Apart from legal representation, what else could be used to assist people who are injured in motor crashes to understand and go through the claims and dispute resolution process? Please explain.
31. Do you support clause 25 of the Regulation not applying to fee arrangements between insurers and their legal representatives? Why or why not?

Scheme information, compliance and enforcement

32. What other matters (if any) should the review consider in relation to scheme information, compliance and enforcement? Please explain.
33. What other information (if any) should SIRA publish? Please explain.
34. Are there opportunities to improve SIRA's compliance and enforcement powers? Please explain.
35. Are there opportunities to improve complaints handling under the scheme? Please explain.

Point to point industry

36. What other issues (if any) should the review consider about the point to point industry and the CTP insurance scheme? Please explain.
37. How should point to point industry vehicles (including taxis and rideshare vehicles) be charged for insurance under the scheme? Why?

CTP Care

38. Are there any other issues about CTP Care that the statutory review should consider? Please explain what they are (if any).
39. Do you think there is adequate oversight of CTP Care's claims management? Please explain.
40. Should 'Early by Agreement' arrangements be used more to transfer injured people to CTP Care? Why or why not?
    a. If yes, what would support the use of these arrangements? Please explain.

Other issues

41. Are there any other issues that have not been covered in this issues paper that the statutory review should consider? Please explain what they are (if any).

Appendix B – Glossary of terms

Term	Meaning
Act	*Motor Accident Injuries Act 2017*
Commission	The Personal Injury Commission, established under the *Personal Injury Commission Act 2020*.
Compensation to Relatives Act	*Compensation to Relatives Act 1897*
CTP insurance	Compulsory Third Party insurance. CTP protects the driver of the motor vehicle from liability if they were to injure or cause the death of a person or people in a motor crash. CTP insurance is generally mandatory for all vehicles registered in NSW and is governed by the Act.
CTP Care	Manages treatment and care claims for injured people who have treatment and care needs more than five years after their crash.
DCS	Department of Customer Service
EBA	Early by Agreement arrangement that facilitates early transfer to CTP Care of injured people who will need long-term treatment and care.
EPL	Excess Profit and Loss mechanism set out in section 2.25 of the Act, which is not implemented yet.
Guidelines	Motor Accident Guidelines (Version 10.1, which commenced 12 December 2025)
IRO	Independent Review Office
LJ Committee	The Standing Committee on Law and Justice of the NSW Parliament
NTC	National Transport Commission
PIRS	Permanent Impairment Rating Scale
Point to Point Guidelines	Motor Accident Guidelines: Determination of Insurance Premiums for Taxis and Hire Vehicles
Regulation	Motor Accident Injuries Regulation 2017
Scheme	The scheme of compulsory third-party insurance and provision of benefits and support established by the Act.
SIRA	State Insurance Regulatory Authority
TEPL	Transitional Excess Profit and Loss mechanism set out in Schedule 4 of the Act.
Workplace Injury and Compensation Act	*Workplace Injury Management and Workers Compensation Act 1998*

WPI	Whole Person Impairment
1999 Act	*Motor Accidents Compensation Act 1999*

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