National Injury Insurance Scheme (Queensland) Bill 2016

Explanatory Notes

Short title

The short title of the Bill is the *National Injury Insurance Scheme (Queensland) Bill 2016*.

Policy objectives and the reasons for them

Queensland's compulsory third party "CTP" insurance scheme is a common law 'fault' based scheme. Where fault of a person other than the insured person can be established, the injured person may seek to claim a once-off lump sum from the CTP insurer. Where the injured person is at fault, or where no fault can be established, an injured person will not be able to successfully claim against a CTP insurer.

In 2011, the Productivity Commission recommended a National Injury Insurance Scheme ("NIIS") alongside the National Disability Insurance Scheme ("NDIS"). The NIIS is intended to meet the lifetime care and support needs of people who sustain serious personal injury in Queensland, in a motor vehicle accident, regardless of fault.

Under the May 2013 *Heads of Agreement between the Commonwealth and Queensland Governments on the NDIS*, Queensland is required to implement a NIIS for motor vehicle accidents, or, from 1 July 2016, meet 100 per cent of the costs of participants who enter the NDIS because a NIIS has not been implemented.

The purpose of this Bill is to ensure that certain people who suffer particular serious personal injuries as a result of a motor vehicle accident in Queensland, receive necessary and reasonable treatment, care and support, regardless of fault.

Where fault of a person other than the insured person can be established, certain participants are able to elect to opt out of the National Injury Insurance Scheme, Queensland ("NIIS(Q)") and obtain payment of treatment, care and support damages from the National Injury Insurance Agency, Queensland ("NIIA(Q))", with the CTP insurer making payments for all other heads of damage.

Participants who cannot, or choose not to, opt out of the NIIS(Q) will continue to receive their treatment, care and support services co-ordinated through NIIS(Q).

Achievement of policy objectives

The Bill achieves this by establishing the National Injury Insurance Scheme Fund, Queensland ("NIIS(Q) Fund") to be used for the purposes of the NIIS(Q) which is to be administered by NIIA(Q). The Bill facilitates the implementation of the NIIS(Q) through appropriate transitional provisions and consequential amendments to the *Motor Accident Insurance Act 1994* and *Civil Liability Act 2003.*

Alternative ways of achieving policy objectives

Implementation of the NIIS(Q) can only be effected by legislation.

Estimated cost for government implementation

Funding has been provided by the Motor Accident Insurance Commission ("MAIC") to establish the requirements to implement the NIIS(Q). This funding has been focussed on public awareness campaign, consultation with experts to develop policy and the legislation. Additional costs will be incurred by MAIC extending current MAIC technology and developing business processes, communication and training programs for NIIS(Q) implementation.

Future operational costs of the NIIA(Q) will be funded through the NIIS(Q) Fund. The costs of administering the NIIS(Q) and of the NIIA(Q) performing its functions are to be paid from the NIIS(Q) Fund. These costs will include staffing, information technology costs and professional advice fees.

Consistency with fundamental legislative principles

The Bill is generally consistent with fundamental legislative principles. Potential breaches of fundamental legislative principles are addressed below.

Legislation authorises the amendment of an Act only by another Act – *Legislative Standards Act 1992*, section 4(4)(c).

Clause 12 Persons eligible to participate in scheme

Clause 12 of the Bill infringes the fundamental legislative principle which provides that a Bill should only authorise the amendment of an Act by another Act. Clause 12(1)(b) provides that a person is eligible to participate in the NIIS(Q) if their injury meets the eligibility criteria prescribed by regulation. The eligibility criteria apply to serious personal injuries as defined in the Act.

The Minimum Benchmarks require the scheme to apply to 5 categories of catastrophic injury, being:

- spinal cord injury;
- severe traumatic brain injury;
- multiple or high level limb amputations;

- severe burns; and
- blindness.

The Minimum Benchmarks contain a fairly detailed definition for each of these injury categories. However, the experience to date of some other jurisdictions suggests that there is some benefit in adopting even more detailed definitions to reduce uncertainty about eligibility.

For example, it is proposed to expand the injury coverage to include people who sustain permanent brachial plexus injuries resulting in an impairment equivalent to multiple shoulder disarticulation amputations. Therefore, a person who sustains nerve damage resulting in a complete lack of mobility in their arms will qualify in this injury category when they may otherwise have been required to amputate their arms in order to gain access to the scheme.

A review of the legislation in other jurisdictions shows a similar drafting approach has been taken. The primary legislation of other jurisdictions either does not define the injury categories or contain broad definitions. All other jurisdictions have either separate guidelines or regulations which contain detailed specifications about the injury categories. The advantage of this is that a more detailed explanation of the injury categories can be given in order to provide greater certainty for people in relation to whether they meet the eligibility criteria.

Legislation does not adversely affect rights and liberties, or impose obligations, retrospectively - *Legislative Standards Act 1992*, section 4(3)(g).

Clause 96 Payment of unearned insurer's premiums

Clause 96 of the Bill infringes the fundamental legislative principle which provides that legislation should not adversely affect rights and liberties, or impose obligations, retrospectively.

From 1 July 2015 to the commencement of the NIIS(Q) Levy, insurers will receive premiums for risks that will be covered and funded by the NIIS (Q) and not be covered or funded by the insurers.

Clause 96 has retrospective operation to enable the Treasurer to decide an amount that is repayable by a licensed insurer. The Treasurer will decide the amount based on actuarial advice and the amount is limited to the amount that the insurer's liability is reduced for damages for the treatment, care and support after the commencement of the NIIS(Q).

The ability of the Treasurer to recover this payment is justified to avoid this windfall to insurers and to enable the net amount paid by motorists to be reduced in proportion to the amount recovered.

A review of the legislation in other jurisdictions shows a similar clause was provided in the legislation to recover premium.

Legislation does not have sufficient regard to the rights and liberties of individuals.

Clause 18 When person other than injured person may make application

Clause 18 of the Bill infringes the fundamental legislative principle which provides that legislation should have sufficient regard to the rights and liberties of individuals, for example obtaining consent of an individual.

Under clause 18, an insurer is able to make an application on behalf of a seriously injured person, without the person's consent, to be accepted as a participant into the NIIS(Q) Fund.

The ability of an insurer to make such application is justified in that on the basis that a person will receive lifetime care and support under the NIIS(Q). This will provide certainty and early access to rehabilitation and services that might otherwise be delayed. Acceptance by the NIIA(Q) of a person as a participant into the scheme will relieve the insurer from direct liability for the payment for treatment and care, and is consistent with NIIS(Q) Levy and CTP premium distribution. It is important that the CTP insurer and the NIIS(Q) understand the status of a participant, this will assist with the provision of treatment, care and support services, respective liabilities of parties and the resolution of a CTP claim.

A review of the legislation in other jurisdictions shows a similar approach has been taken.

Clause 42 Liability of agency to contribute towards damages; and Clause 43 Application to court for order

Clause 42 and clause 43 infringe the fundamental legislative principle which provides that legislation should have sufficient regard to the rights and liberties of individuals, for example common law rights.

Under the current CTP scheme, an injured person has a right to claim common law damages for hospital, medical and other treatment and care. Under clause 42, if a person is a participant in the NIIS(Q), the NIIA(Q) is not liable to contribute to the claim for treatment, care and support damages where a participant is guilty of contributory negligence of more than 25%, or where the person has indicated they do not wish to preserve their right to receive damages, or where a Court prevents a participant from receiving a lump sum. Under clause 43, the NIIA(Q) may make an application to the Court preventing the participant from receiving a lump sum, where the individual's ability to manage a lump sum will compromise the participant's recovery or future health and wellbeing or at the discretion of the Court.

The removal of the right to claim common law damages in these restricted circumstances is justified on the basis that a person will receive lifetime care and support under the NIIS(Q). This will provide certainty and early access to rehabilitation and a CTP claimant no longer carries the risk that a lump sum may not last their lifetime either due to underestimation of future costs, mismanagement of funds or payment of legal costs. A participant may still claim common law damages for other categories of loss and damage where they can assert fault against other owner or driver of a motor vehicle (i.e. for non-economic loss and economic loss).

Clause 22 Deciding application; Clause 31 Deciding service request; Clause 37 Deciding payment request; Clause 46 Decision about review

Clauses 22, 31, 37 and 46 of the Bill infringe the fundamental legislative principle which provides that legislation should have sufficient regard to the rights and liberties of individuals.

It is the role of the NIIA(Q) to consider, review and decide on applications and service and funding requests. These decisions will have a significant impact on a person's quality of life and the care and support that they will receive.

To balance this administrative power of the NIIA(Q), internal review and external review mechanisms are provided for and detailed in chapter 6 of the Bill. Internal reviews are to be carried out by the NIIA(Q), external reviews carried out by a medical tribunal or QCAT with appeals to the Courts from QCAT.

Clause 130 Information to be given to the commission

Clause 130 of the Bill infringes the fundamental legislative principle which provides that legislation should have sufficient regard to the rights and liberties of individuals, in that personal information of a participant will be given to the Motor Accident Insurance Commission.

This provision of information is justified on the basis that, for the scheme to operate effectively and efficiently, it will be necessary for the NIIA(Q) to provide information to the Commission. The information provided will be restricted to information relevant to the performance of the Commission's functions. Such a clause is warranted to ensure that applications to enter the scheme can be assessed quickly and efficiently and to ensure that there are no gaps or duplication of services between the NIIA(Q) and the Commission.
A review of the legislation shows this approach is consistent with the approach taken in other jurisdictions.

Clause 131 Agency may give personal information to particular entities

Clause 131 of the Bill infringes the fundamental legislative principle which provides that legislation should have sufficient regard to the rights and liberties of individuals, in that personal information of a participant will be given to third parties.

This provision of information is justified on the basis that the participant or their litigation guardian will provide consent to access personal and private information. Further, information is restricted to information about services provided under the scheme to the participant, if the giving of the information may help in the provision of the services. Such a clause is warranted to ensure that applications to enter the scheme can be assessed quickly and efficiently and to ensure that the NIIA(Q) is able to access all relevant information. Delays in assessing information may result in a lack of funds being made available for treatment, care and support services.

A review of the legislation shows this approach is consistent with the approach taken in other jurisdictions.

Consultation

On 11 November 2015, the Legislative Assembly made a referral to the Communities, Disability Services and Domestic and Family Violence Prevention Committee to inquire and report on the most suitable model for implementing the NIIS. Responsibility for the inquiry was transferred to the Education, Tourism, Innovation and Small Business Committee (the Committee) from 18 February 2016. The original reporting date of 7 March 2016 was extended with the report tabled in Parliament on 21 March 2016. The terms of reference for the Committee's inquiry included investigation of both a no-fault lifetime care and a hybrid model. The Committee was unable to reach a majority decision about which model is the most suitable for the implementation of a NIIS in Queensland. The Committee unanimously agreed to seven recommendations regarding scheme design; including interaction with NDIS and other NIIS streams, affordability and funding, suitable accommodation, review mechanisms, parliamentary oversight, patient-centred care and choice and use of dividends.

The first recommendation, that the NIIS be a platform to accommodate other accident types, is most consistent with a no-fault model. As part of the inquiry the Parliamentary Committee considered twenty -six written submissions, ten supplementary submissions and held a number of public hearings. Disability and community services organisations, medical profession, legal profession, actuarial peak body, motoring organisations, insurers and their peak bodies and individuals provided submissions and attended at public hearings during the inquiry. No submissions opposed the introduction of a NIIS. The importance of retaining existing common law rights and lump sum payments providing for freedom, choice and autonomy were provided in support of the hybrid model.

Certainty, timeliness and quality of care and support, equity of treatment, focus on recovery and rehabilitation leading to better recovery and health outcomes were cited in support of the no-fault model. Broadly, the submissions from insurers, disability groups and community service organisations supported a no-fault model. Submissions from the legal industry supported a hybrid model. A number of submissions did not comment on a model but professed broad support for the introduction of a NIIS.

Consistency with legislation of other jurisdictions

As outlined above, in May 2013, the Queensland Government signed a Heads of Agreement with the Commonwealth Government agreeing to, inter alia, consider the feasibility of extending Queensland's CTP scheme to comply with agreed Minimum Benchmarks for meeting the needs of people catastrophically injured in Queensland motor vehicle accidents from 1 July 2016.

All jurisdictions except Queensland and Western Australia satisfy the Minimum Benchmarks. The purpose of the Bill is to implement, at the very least, these Minimum Benchmarks and provide a supporting administrative framework.

In preparing the Bill, the following legislation from other jurisdictions was considered:

- NSW: *Motor Accidents (Lifetime Care and Support) Act 2006*
- South Australia: *Motor Vehicle Accidents (Lifetime Support Scheme) Act 2013*
- Victoria: *Transport Accident Act 1986*
- Northern Territory: *Motor Accidents (Compensation) Commission Act 2014*
- Tasmania: *Motor Accidents (Liabilities and Compensation) Act 1973*
- ACT: *Lifetime Care and Support (Catastrophic Injuries) Act 2014*
- Cth: *National Disability Insurance Scheme Act 2013*
- WA: the proposed Motor Vehicle (Catastrophic Injuries) Bill 2016, introduced to the Legislative Assembly on 24 February 2016.

Notes on provisions

Chapter 1 Preliminary

Part 1 Introduction

Clause 1 states that, when enacted, the Bill will be cited as the *National Injury Insurance Scheme (Queensland) Act* 2016.

Clause 2 provides for the commencement of the Act:

- Chapter 4, part 2 and chapter 10, part 1 and 2, division 2, subdivision 3 commence on a day to be fixed by proclamation.
- The remaining provisions of this Act commence on 1 July 2016.

Part 2 Purpose and application

Clause 3 details that the main purpose of the Act is to ensure that persons who suffer particular serious personal injuries as a result of a motor accident in Queensland receive necessary and reasonable treatment, care and support, regardless of fault.

The Act establishes an agency, NIIA(Q) to administer the scheme. The scheme will assess the treatment, care and support needed by participants; make payments in relation to the treatment, care and support of the participants; and establish the NIIS(Q) Fund (the "fund").

Clause 4 limits the application of the Act to a serious personal injury caused by, through or in connection with a prescribed vehicle if the injury is a result of:

- the driving of the prescribed vehicle; or
- a collision, or action taken to avoid a collision, with the prescribed vehicle; or
- the prescribed vehicle running out of control; or
- a defect in the prescribed vehicle causing loss of control of the vehicle while the vehicle is being driven.

In addition, the motor accident resulting in the injury must happen in Queensland, on or after 1 July 2016.

The Act will not apply to a serious personal injury caused by, through or in connection with:

- an uninsured motor vehicle, other than a prescribed vehicle listed below, unless the motor accident resulting in the injury happens on a road or public place; or
- any of the following prescribed vehicles, unless the motor accident resulting in the injury happens on a road –
  - a tractor, backhoe, bulldozer, end-loader, forklift, industrial crane or hoist, or other mobile machinery;
  - an agricultural machine;

  - a motor vehicle adapted to run on rail or tram tracks;
  - an amphibious vehicle;
  - a motor vehicle prescribed by regulation; or
- a prescribed vehicle that is being used for the actual doing of an act or making of a threat that is an act of terrorism.

Essentially, the Act is intended to apply to the same types of accidents as are covered by the *Motor Accident Insurance Act 1994*. The differences in drafting reflect the fact that the *Motor Accident Insurance Act 1994* applies to motor vehicles required to be registered in Queensland whereas the Act needs to apply to a broader range of vehicles (for example, interstate vehicles which are being driven in Queensland).

Clause 5 states that the Bill binds the State and, as far as the legislative power of the Parliament permits, the Commonwealth and the other States. Nothing in the Bill makes the Crown in any capacity liable to be prosecuted for an offence.

Part 3 Interpretation

Clause 6 states that schedule 1 provides definitions for certain words used in the Act.

Clause 7 defines the term prescribed vehicle. The term is intended to cover motor vehicles and trailers that are currently covered by a CTP insurance policy, whether such policy is issued in Queensland or interstate (noting that such policy could specifically apply to it, or extend to apply to it, depending on the circumstances); motor vehicles and trailers that a self-insurer is the registered owner of or the insurer for; and motor vehicles and trailers that are covered by a nominal defendant scheme if they are involved in an incident in Queensland resulting in personal injury.

Essentially, the Act is intended to apply to the same types of vehicles as are covered by Part 4 of the *Motor Accident Insurance Act 1994*.

Clause 8 defines 'treatment, care and support needs' for the scheme.

Clause 9 defines 'excluded treatment, care and support' for the scheme. Such treatment, care and support is not required to be funded by the scheme. The clause also identifies treatment, care and support that must be provided by a registered provider.

Clause 10 states when a motor vehicle accident claim against an insurer is finalised.

Clause 11 clarifies the meaning of references in the Act to particular terms, such as the applicant; the injured person; the serious personal injury; the participant's injury; and the participant (in the context of a service request, a payment request and the giving of a notice or other document).

Chapter 2 National injury insurance scheme, Queensland

Part 1 Preliminary

Clause 12 provides that a person is eligible to participate in the scheme if the person has suffered a serious personal injury to which the Act applies and which meets the eligibility criteria prescribed by Regulation.

A person is not eligible to participate in the scheme in relation to a serious personal injury if the person has been awarded damages, under a final judgment of a court or a binding settlement, in relation to the person's treatment, care and support needs as a result of the injury and the damages were paid other than by way of a payment by the agency under section 44(3)(a), or, if the person was suffering from a pre-existing injury or condition and the motor accident does not permanently increase the person's extent of disability.

Clause 13 provides that the agency may decide to accept a person into the scheme if they suffer a serious personal injury prescribed by regulation but are not eligible to participate in the scheme in relation to the injury. In this situation, the period of participation in the scheme will be agreed between the injured person and the agency and could potentially relate to, for example, a fixed period of time, or, the remainder of a person's life.

If the person is accepted as a participant in the scheme, the person must pay to the agency a contribution towards the person's treatment, care and support needs. This contribution will be used to fund the person's future treatment, care and support.

If the contribution is not paid within 28 days after the person is accepted as a participant, the person stops being a participant and is taken to have never been a participant.

Part 4, division 4; part 5; and section 52 do not apply to a person who buys into the scheme.

Clause 14 provides that a person is a participant in the scheme if the agency accepts the person as a participant in the under section 13 or section 22.

A participant is a lifetime participant if the agency accepts the person as a participant for the rest of the person's life under section 22(3) or section 46(4).

A participant is an interim participant if the agency accepts the person, under section 22(1)(a), as a participant in the scheme for the participant period.

Participation in the scheme starts on the day the person is accepted into the scheme and ends if the person dies or the person stops being a participant under this chapter or for a buy-in participant, at the end of the period mentioned in section 13(2), or in the circumstances prescribed by regulation.

Clause 15 requires the agency to consider whether treatment, care and support needs are excluded treatment, care and support and any other matters prescribed by regulation when deciding whether a person's treatment, care and support needs as a result of a serious personal injury are necessary and reasonable in the circumstances.

Part 2 Application to participate in scheme

Division 1 Making application

Clause 16 allows a person to apply to the agency for approval to participate in the scheme in relation to a serious personal injury suffered by the person as a result of a motor accident. This section imposes a one year time period for making an application, but also allows applications to be made outside that period. Where a late application is made, the section requires the agency to decide whether or not to accept the application, having regard to the matters in subsection (4). A decision not to accept a late application is a reviewable decision under the Act.

Clause 17 sets out the circumstances when an application may not be made. It also sets out when a person may make a further application for approval to participate in the scheme, in cases where either a previous application was refused or the person was previously a participant in the scheme and that participation has ended.

Clause 18 allows an application for approval to participate in the scheme to be made by a person other than the injured person. Examples of when this might occur include a parent making an application for their child, a guardian making an application on behalf of an injured person, or an insurer making an application following the making of a claim against the insurer in relation to the serious personal injury. Where an insurer is able to make the application, the application may be made without the person's consent and the insurer must give the person a copy of the application.

Clause 19 outlines the requirements for an application for approval to participate in the scheme. An application must be in the approved form; include or be accompanied by the information prescribed by regulation and, where the application is made by an injured person, state that the person authorises the agency to exchange information with entities prescribed by regulation for the purpose of the agency performing its functions under the Act. Where the injured person has made, or intends to make, a claim against an insurer in relation to the serious personal injury, the application must also contain information about the claim, or intended claim.

Clause 20 requires notice of the application to be given to the insurer by the agency if an application is made by a person, other than an insurer and states that a claim has been made against an insurer for the serious personal injury, which has not been finalised.

Clause 21 allows the agency to issue an information request to the applicant or the injured person, if the applicant is not the injured person, to seek further information needed to decide an application.

Division 2 Deciding application

Clause 22 provides that the agency must accept the injured person as a participant in the scheme in relation to the serious personal injury for the participation period (defined in Schedule 1 of the Act) if the injured person is eligible to participate in the scheme in relation to the serious personal injury.

The agency may accept the injured person as a participant in the scheme for the rest of the person's life if the agency is satisfied that the serious personal injury is likely to continue to meet the eligibility criteria for the injury after the participation period ends.

If the injured person is not eligible to participate in the scheme in relation to the serious personal injury, the agency must refuse the application.

If the injured person has received a payment from the agency under section 44(3)(a) in relation to the serious personal injury, the agency may refuse the application if the agency is not satisfied that the injured person is suffering severe financial hardship. If the agency decides to accept the injured person as a participant in the scheme, the acceptance may be subject to conditions.

The agency may extend its decision-making period (defined in Schedule 1 of the Act) by giving a notice of this to the applicant. This may be necessary, for example, in cases where the agency is obtaining information relevant to deciding the application pursuant to the authority given with the application, rather than through a formal information request.

Clause 23 sets out who the agency must give notice of a decision under section 22 to.

If the agency refuses the application, or accepts the injured person on conditions, the notice must be an information notice and the decision will be a reviewable decision.

Clause 24 provides that if the agency fails to decide the application within the decision-making period, the failure is taken to be a decision by the agency to refuse the application.

Part 3 Assessing needs

Division 1 Preparing support plans

Clause 25 provides for an assessment of each participant's needs for treatment, care and support to be carried out by the agency. The agency must assess the participant's treatment, care and support needs as a result of the participant's injury, and may also consider other treatment, care and support that is needed by the participant. It is intended that the agency will only consider other treatment, care and support needed by the participant to the extent this could impact on its assessment of the participant's treatment, care and support needs as a result of the participant's injury.

In carrying out the assessment, the agency must consult with the participant about the treatment, care and support that is necessary and reasonable as a result of the participant's injury, the participant's abilities and limitations and the participant's individual goals. The agency may also consult with any other person the agency considers appropriate.

Clause 26 provides that after carrying out the first assessment of a participant's needs for treatment, care and support needs, the agency must make a support plan for the participant. Among other things, the support plan must state any treatment, care and support needs the agency considers are necessary and reasonable in the circumstances, and any other treatment, care or support the agency considers should be funded, in whole or in part, under the scheme, having regard to the matters set out in subsection (1)(e).

Clause 27 provides that the agency may amend a participant's support plan upon carrying out a further assessment of the participant's needs for treatment, care and support.

Division 2 Service requests

Clause 28 provides that a person may make a written service request asking the agency to fund particular treatment, care or support in relation to a participant's injury for a particular period. A service request could be submitted by a participant, or a person acting for a participant. Where the participant does not make the request, the person making the request must give a copy of the request to the participant.

Clause 29 provides that the agency may make an information request to ask for further information needed to decide a service request.

Clause 30 sets out the matters that must be considered by the agency in assessing a service request. These include whether or not the requested service relates to the participant's treatment, care and support needs as a result of the participant's injury and whether the requested service is necessary or reasonable in the circumstances.

Clause 31 sets out what the agency must do after assessing a service request. The agency must decide to approve the request with or without conditions or refuse the request. Notice of the decision must be given and, if the decision is to approve the request with conditions or refuse the request, the notice given to the participant must be an information notice. Where a support plan has already been prepared for the participant, the agency must appropriately update the support plan.

Clause 32 provides that if the agency fails to decide a service request within the decision-making period, the failure is taken to be a decision by the agency to refuse the request.

Part 4 Payments

Division 1 Preliminary

Clause 33 sets out the ways in which payments may be made in relation to the treatment, care and support of participants in the scheme.

Division 2 provides for payments to be made under funding agreements to cover particular treatment, care and support expenses incurred during particular periods.

Division 3 provides for payment requests to be made for treatment, care and support expenses as the expenses are incurred.

Division 4 provides for the agency to contribute towards an insurer's liability for treatment, care and support damages on a claim in particular circumstances.

Division 2 Funding agreements

Clause 34 provides that the agency may enter into a funding agreement with a person that provides for the agency to pay to the person an amount to cover particular expenses to be incurred by the person, during a stated period, for the treatment, care or support of a participant. Particular requirements for funding agreements may be specified in a regulation.

Division 3 Payment requests

Clause 35 provides that a participant in the scheme may, by a payment request, ask the agency to pay all or part of the amount of the expense. Payment requests can not be made if the person has entered into a funding agreement with the agency, the funding agreement relates to the particular treatment, care or support to which the payment request relates, and the expense was incurred during the period covered by the funding agreement.

Clause 36 provides that the agency may make an information request to ask for further information needed to decide a payment request from the person who made the request or the participant.

Clause 37 requires the agency to decide to approve the payment request or refuse the payment request within the decision-making period.

Payment requests must be approved if they relate to the period in which the participant is a participant in the scheme and also relate to an approved service (defined in Schedule 1 of the Act).

However, the agency is not liable to pay a part of the requested amount that exceeds:

- if the requested amount relates to treatment, care or support provided within Australia – the amount prescribed by regulation for the treatment, care or support;
- if the requested amount relates to treatment, care or support provided outside Australia – the average cost of providing the treatment, care or support in Queensland.

If a payment request relates to excluded treatment, care and support, the agency is also not required to pay the requested amount, unless the excluded treatment, care and support is specifically stated to be an approved service in either a support plan or a service request approval.

Clause 38 provides that if a payment request is refused, the agency must give the person who made the payment request or the participant, if the person who made the payment request is not the participant, notice of the decision.

The notice given to the participant must be an information notice.

Clause 39 provides that if the agency fails to decide the payment request within the decision-making period, the failure is taken to be a decision by the agency to refuse the request.

Division 4 Contribution by agency

Clause 40 provides that this division applies in relation to a lifetime participant if a claim has been made against an insurer for the participant's injury.

Clause 41 provides that the participant must give notice to the agency and the insurer stating whether the participant wants to preserve any right the participant may have to be awarded treatment, care and support damages under a final judgement of a court or a binding settlement.

The giving of such a notice does not oblige the participant to take the final assessed treatment, care and support damages, in the form of a lump sum. It operates to create this as a possible method of the participant receiving those damages.

A notice given by a person with a 'legal disability' is not effective until it has been sanctioned by the court.

Clause 42 provides that if the participant gives a notice under section 41 indicating that the participant wishes to preserve any right the participant may have to be awarded treatment, care and support damages under a final judgement of a court or a binding settlement, the agency is liable to contribute towards the insurer's liability, if any, on the claim for treatment, care and support damages.

Subsection (2) sets out the circumstances in which the agency stops being liable to contribute.

Clause 43 allows the agency to make an application to the court for an order preventing the participant from being awarded treatment, care and support damages under a final judgement of a court or a binding settlement. Such application can be made whether or not the participant has given a notice under section 41(1).

In deciding whether to make the order, the court must consider the participant's ability to manage an award of treatment, care and support damages in a way that will not compromise the participant's prospects of improvement or rehabilitation or their future health and well-being. The court may also consider any other matter it considers relevant.

If the court makes the order, a participant is either (i) prevented from giving a notice preserving the right to be awarded damages; or (ii) if a notice has already been given, the notice is taken not to have been made.

Clause 44 provides a process for the participant to notify the agency and the insurer of the participant's final decision about whether the participant intends to accept an awarded treatment, care and support damages under a final judgement of a court or a biding settlement, and confirms when the damages are required to be paid and who is liable to pay them. This section does not displace any additional requirements that may apply to the process, for example the need for the payment to be sanctioned by the Public Trustee or a court. Where a participant chooses not to accept the awarded treatment, care and support damages, they will remain a participant in the scheme for the rest of their lifetime and have their treatment, care and support needs met through the scheme.

Part 5 Reviewing participation

Clause 45 provides that the agency may review the participation of an interim participant at any time during the participation period. At least 1 review must be carried out before the end of the participation period.

Clause 46 sets out the agency's obligations after carrying out the review. The agency must make a decision about whether or not the participant is still eligible to participate in the scheme. If the participant is still eligible to participate in the scheme, the agency must decide whether it is satisfied that the participant's injury is likely to continue to meet the eligibility criteria for the injury after the participation period. The agency's decisions will determine whether a decision is made for the participant to be accepted into the scheme for the rest of the person's life, or for the participant to continue as an interim participant, or for the participant to stop being a participant.

Clause 47 requires the agency to give notice of its decision to the participant and, in appropriate cases, the insurer. In cases where the participant is not accepted as a participant in the scheme for the rest of the person's life, the decision will be a reviewable decision.

Clause 48 provides that if the agency does not review an interim participant's participation or make a decision about a review, before the end of the participation period, the agency is taken to have decided that the participant is no longer eligible in the scheme and the participant stops being a participant at the end of the participation period.

Part 6 Participants absent from Australia

Clause 49 provides that this part of the Act applies to a participant in the scheme if they leave Australia and expenses are, or are likely to be, incurred by or for the participant for the participant's treatment, care or support while overseas, and the agency did not take that into consideration when deciding the approved services for the participant.

Clause 50 requires the participant to notify the agency at least 1 month before leaving Australia, where the participant has not previously requested the agency to consider a service request for treatment, care and support to be provided outside of Australia. The notice received from the participant must include details of any treatment, care and support to be provided outside of Australia that the participant wants the agency to fund.

Clause 51 provides that to the extent a support plan or service request approval relates to the period the participant is, or intends to be absent from Australia, the agency may review the plan of approval and make any amendments to the plan or approval that the agency considers appropriate.

Clause 52 provides that a participant's participation in the scheme may be suspended if the agency is satisfied that the participant has left Australia for more than 3 consecutive months and either the participant has not made a claim against an insurer or the insurer has denied liability on the claim or has been held by a court not to be liable for the participant's injury.

Part 7 Miscellaneous

Clause 53 provides that, if a person makes a claim in relation to a serious personal injury, the person must give the agency notice saying that the person has made the claim and the insurer against which the claim has been made.

Clause 54 provides that without limiting the *Electronic Transactions (Queensland) Act 2001*, a person is taken to have complied with the requirements for making an application if the person gives the information required on the approved form by a method acceptable by the agency and gives the agency any information that must accompany the application.

Chapter 3 National Injury Insurance Agency, Queensland

Part 1 Establishment, functions and powers

Division 1 Establishment of agency

Clause 55 establishes the National Injury Insurance Agency, Queensland.

Clause 56 sets out the legal status of the agency as a body corporate.

Clause 57 provides that the agency represents the State and has the status, privileges and immunities of the State.

Division 2 Functions and powers

Clause 58 sets out the agency's main functions.

Clause 59 sets out the general principles that the agency must have regard to in performing its functions.

Clause 60 provides that the agency may enter into an agreement with a support entity that provides for the agency to perform a function of the entity under a care and support scheme law.

Clause 61 provides that the agency has all the powers of an individual.

Clause 62 provides that the agency may perform its functions, or exercise its powers, inside or outside Queensland, including outside Australia.

Division 3 Administration

Clause 63 permits the agency to employ staff that it considers appropriate to perform its functions. Staff are employed under this Act and not the *Public Service Act 2008*.

Clause 64 sets out the entities/person to which the agency may delegate its functions or powers to.

Clause 65 provides that the agency may establish 1 or more advisory committees to advise the agency on its performance. The matters the advisory committee may advise on are to be decided by the agency, with the approval of the Minister.

Part 2 Board

Division 1 Establishment, functions and membership

Clause 66 provides for the establishment of the board as the governing body of the agency.

Clause 67 provides for the functions of the board.

Clause 68 provides for the appointment of board members by the Governor in Council.

Clause 69 provides for the appointment of a chairperson of the board and a deputy chairperson of the board by the Governor in Council.

Clause 70 provides for the term of appointment for board members.

Clause 71 provides for the disqualification from membership of the agency's board.

Clause 72 provides for the conditions of appointment for board members.

Clause 73 provides the situations in which a board member's office becomes vacant.

Division 2 Administration

Clause 74 provides that the board may conduct its business, including its meetings, in the way it considers appropriate.

Clause 75 sets out the time and place of board meetings.

Clause 76 provides that a quorum for a meeting of the board is a majority of the board's members for the time being.

Clause 77 sets out who is to preside at meetings.

Clause 78 sets out the conduct of meetings.

Clause 79 provides that the board must keep minutes of its meetings.

Division 3 Duty of members

Clause 80 provides that a board member has a duty to disclose a conflict of interest to a meeting of the board.

Part 3 Chief executive officer

Clause 81 provides that the agency must have a chief executive officer. The chief executive officer is to be appointed by the board with the prior written approval of the Treasurer.

Clause 82 sets out the terms of appointment of the chief executive officer.

Clause 83 provides that the chief executive officer holds office on the terms of appointment decided by the board for matters not provided for under this Act or stated in the chief executive officer's contract of employment. The chief executive officer is appointed under this Act and not under the *Public Service Act 2008.*

Clause 84 provides that the chief executive officer is responsible for ensuring the efficient and effective administration and operation of the agency in accordance with the board's priorities.

Part 4 Reporting and accountability

Division 1 Application of financial Acts

Clause 85 provides that the agency is a statutory body under the *Financial Accountability Act 2009* and a statutory body under the *Statutory Bodies Financial Arrangements Act 1982*.

The *Statutory Bodies Financial Arrangements Act 1982,* part 2B sets out the way in which the agency's powers under this Act are affected by the *Statutory Bodies Financial Arrangements Act 1982*.

Division 2 Reporting generally

Clause 86 provides that the board must give the Treasurer quarterly reports about the agency's financial position and performance.

Clause 87 provides that the board must immediately inform the Treasurer if an issue arises that may significantly affect the agency's financial position or the ability of the agency to perform its functions.

Clause 88 provides that the Treasurer may act for the purpose of monitoring, assessing or reporting on the agency's performance of its functions.

Division 3 Annual reports

Clause 89 sets out the information to be included in the agency's annual report under the *Financial Accountability Act 2009.*

Division 4 Strategic and operational plans

Clause 90 provides that if something is required to be done under this division, and the same thing, or something to the same effect is required to be done under the *Financial Accountability Act 2009*, compliance with this division is sufficient compliance with the *Financial Accountability Act 2009*. Otherwise, the requirements under this division are in addition to the requirements under the *Financial Accountability Act 2009.*

Clause 91 provides that before 31 March each year, the board must prepare, and give to the Treasurer for agreement, a draft strategic plan and a draft operational plan for the next financial year.

Clause 92 provides that the board may modify the agency's strategic plan or operational plan only with the written agreement of the Treasurer.

Chapter 4 Funding of scheme

Part 1 National injury insurance scheme fund, Queensland

Clause 93 establishes a fund called the national injury insurance scheme fund, Queensland. The fund consists of:

- the amounts received by the agency by way of the levy;
- the amounts received, or recovered, by the agency in connection with the scheme;
- income derived from the investment of the fund;
- an amount transferred to the fund under section 95; and
- an amount paid to the agency under section 96(2).

The following amounts are to be paid from the fund:

- the costs of administering the scheme, including payments made under chapter 2, part 4;
- the costs of managing the fund;
- the costs of the agency in performing its functions;
- the amount that must be paid under section 94;
- amounts to reimburse the Commonwealth for expenses incurred by the Commonwealth under the *National Disability Insurance Scheme Act 2013* (Cwth), to the extent those relate to serious personal injuries suffered in Queensland motor accidents.

Clause 94 provides that an amount decided by the Treasurer must be paid from the fund for each financial year to:

- the department in which the *Fire and Emergency Services Act 1990* is administered*;* and
- the department in which the *Hospital and Health Boards Act 2011* is administered; and

- the department in which the *Ambulance Service Act 1991* is administered; and
- any other government entity that is responsible for providing public hospital services and emergency services.

The amount decided by the Treasurer must cover a reasonable proportion of the estimated cost of providing public hospital services and emergency services for the financial year in which the amount is paid, taking into account the number of people who are injured in motor accidents and make use of public hospital services and emergency services as a result of their injuries and are participants in the scheme.

It is the intent of this bill at the time of drafting that public hospital services will include, but not be limited to, all admitted and non-admitted public hospital services provided in a hospital, outpatient and community setting.

Clause 95 provides the Treasurer with power to transfer an amount from the nominal defendant fund under the Insurance Act to the fund.

Clause 96 provides for the recovery of 'unearned premiums' from insurers. From 1 July 2015 to the commencement of the fund levy, insurers will have been collecting premiums in relation to risks covered and funded by the scheme. This provision facilitates the recovery of this one-off windfall sum from the insurers.

Part 2 Fund levy

Clause 97 provides that at least 5 months before the end of each financial year, the agency must calculate, based on actuarial advice, the amount required to be contributed to the fund for the next financial year.

Clause 98 provides that at least 4 months before the end of each financial year, the commission must give the Treasurer a written recommendation about the amount of the levy for the next financial year. The commission may, at any time, recommend to the Treasurer a special increase in the levy.

Clause 99 provides that the levy for a financial year is the amount fixed by regulation for the financial year. If a regulation fixing the levy for a financial year is not made at least 3 months before the start of the financial year, the levy last fixed continues until a regulation made for the financial year commences.

Part 3 Recovery of amounts

Clause 100 provides that the agency may recover, as a debt, from a person who defrauds, or attempts to defraud, the agency in relation to a participant in the scheme any costs reasonably incurred by the agency because of the fraud.

Clause 101 provides that if an insurer has a right of recovery against a person under section 58 of the Insurance Act or the nominal defendant has a right of recovery against a person under section 60 of the Insurance Act, the agency may exercise the same right of recovery against the person as the insurer or nominal defendant may exercise for the present value of the agency's treatment, care and support liabilities in relation to a participant in the scheme.

Clause 102 provides that if a participant's injury was caused, wholly or partly, by a wrongful act or omission of the owner or driver of a prescribed vehicle, other than the participant and the vehicle was covered by a CTP insurance policy under the law of another State, the agency may recover, as a debt, from the insurer in respect of the CTP insurance policy the present value of the agency's treatment, care and support liabilities for the participant. This applies only to the extent the owner or driver of the prescribed vehicle is liable for the injury.

Chapter 5 Role of the commission

Clause 103 sets out the commission's functions in relation to the scheme, which include:

- monitoring the operation of the scheme;
- conducting research and collecting statistics about the scheme;
- making recommendations to the Treasurer about changes to the scheme; and
- making recommendations to the Treasurer under section 98 about the levy.

Clause 104 sets out the information to be included in the commission's annual report under the *Financial Accountability Act 2009.*

Chapter 6 Reviews

Part 1 Internal review

Clause 105 provides that a person may not apply to QCAT for review of a decision unless the person has applied for an internal review of the decision under this part.

Clause 106 sets out who may apply to the agency for an internal review.

Clause 107 sets out the requirements for making an internal review application.

Clause 108 allows the agency to request the applicant or another affected person for the application to provide further information for the purposes of an internal review.

Clause 109 sets out the requirements for an internal review.

Clause 110 sets out the requirements for giving notice of an internal review decision.

Clause 111 sets out when a person may request a decision notice.

Part 2 External reviews

Division 1 Review by medical tribunal

Subdivision 1 Referral to medical tribunal

Clause 112 sets out the circumstances in which an internal review decision about a 'medical matter' may be referred to a medical tribunal.

Clause 113 provides that if the agency receives a request to refer a medical matter to a medical tribunal, the agency must refer the matter.

Clause 114 provides that a medical tribunal deciding a medical matter referred to it must not be constituted by a person who is an employee of the agency or an insurer.

Clause 115 sets out the power of a medical tribunal, which has had a medical matter referred to it, to carry out or arrange a personal examination of the injured person.

Subdivision 2 Proceedings of medical tribunal

Clause 116 provides that this subdivision applies to a proceeding of a medical tribunal for a medical matter referred to the tribunal under section 113. Chapter 11 part 4 of the Workers' Compensation Act does not apply.

Clause 117 allows a medical tribunal to request further information from the person who made the referral request, the agency or another affected person for the request.

Clause 118 provides for the exchange of relevant documents when a medical matter has been referred to the medical tribunal.

Clause 119 gives the injured person a right to appear and be heard before a medical tribunal.

Clause 120 sets out how new medical information is to be treated.

Clause 121 sets out the record keeping requirements of a medical tribunal.

Clause 122 allows a medical tribunal to defer its decision on a referred matter.

Clause 123 provides that the decision of a medical tribunal on a medical matter referred to it is final and is not reviewable by QCAT.

Clause 124 provides how the decisions of a medical tribunal are to be given.

Clause 125 provides that a member of a medical tribunal does not incur civil liability for an act done or omission made under the Bill.

Subdivision 3 Reviewing internal review decision

Clause 126 provides that the agency must review the internal review decision within 14 days after receiving notice of a medical tribunal's decision. If the internal review decision is inconsistent with the medical tribunal's decision, the agency must make a new internal review decision.

Division 2 External review by QCAT

Clause 127 sets out who may apply to QCAT for an external review.

Clause 128 provides that QCAT may receive in evidence transcripts from other relevant proceedings or adopt decisions of other relevant proceedings.

Clause 129 provides that, where a medical matter has been referred to a medical tribunal, QCAT must not make a decision in the proceeding until the medical tribunal makes a decision on the medical matter.

Chapter 7 Information exchange

Clause 130 sets out when information must be given by the agency to the commission.

Clause 131 provides that the agency may give personal information about a participant in the scheme to an entity that provides services under the scheme to the participant, if the giving of the information may assist in providing the services.

Chapter 8 Miscellaneous

Part 1 Offences, evidence and proceedings

Clause 132 provides that a person must not in any way defraud the agency or deliberately mislead the agency or connive at conduct by another that defrauds or misleads.

Clause 133 provides that a person must not, in relation to the administration of the Act, give the agency information the person knows is false or misleading.

Clause 134 provides that an offence against this Act is a summary offence.

Clause 135 provides that in a complaint starting a proceeding for an offence against this Act, a statement that the matter of the complaint came to the complainant's knowledge on a stated day is evidence the matter came to the complainant's knowledge on that day.

Part 2 Other provisions

Clause 136 provides that the Treasurer may give written direction to the agency or the board about the performance of their functions or powers.

Clause 137 allows the Treasurer to direct the agency or the commission to prepare a report in relation to alternative service delivery.

Clause 138 allows the Treasurer to refer a matter about the operation of the scheme to the parliamentary committee.

Clause 139 provides that the board may approve forms for use under the Act.

Clause 140 provides that the Governor in Council may make regulations under the Act.

Chapter 9 Transitional provisions

Clause 141 defines the term 'insurance commissioner' for this chapter.

Clause 142 declares the insurance commissioner to be the board until it first consists of at least 4 members and sets out the insurance commissioner's functions.

Clause 143 declares the insurance commissioner to be the first chief executive officer of the agency until a chief executive officer is appointed.

Clause 144 provides for the preparation and application of the first strategic and operational plans.

Clause 145 provides a power to make a regulation to set the levy for the 2016-2017 financial year.

Chapter 10 Amendment of this Act and other legislation

Part 1 Amendment of this Act

Clause 146 provides that this part amends this Act.

Clause 147 amends the long title of the Act.

Part 2 Amendment of other legislation

Division 1 Amendment of Civil Liability Act 2003

Clause 148 provides that this division amends the *Civil Liability Act 2003.*

Clause 149 inserts a new Chapter 3, part 2A into the *Civil Liability Act 2003.*

New section 52A inserts new definitions for this part.

New section 52B applies to the awarding of damages in relation to a serious personal injury if the person suffering the injury is, or was, a participant in the scheme. A court cannot award damages in relation to a person's treatment, care and support needs for the period that the person was a participant in the scheme.

New section 52C applies to a claim for personal injury damages against an insurer. If a court awards treatment, care and support damages, in assessing such damages, the court must not take into account any contributory negligence of the person where the court decides the person is less than 25% contributorily negligent.

Clause 150 amends Schedule 2 of the *Civil Liability Act 2003* by inserting new definitions.

Division 2 Amendment of Motor Accident Insurance Act 1994

Subdivision 1 Preliminary

Clause 151 provides that this division amends the *Motor Accident Insurance Act 1994*.

Subdivision 2 Amendments commencing on 1 July 2016

Clause 152 inserts new definitions into section 4 of the *Motor Accident Insurance Act 1994.*

Clause 153 inserts a note into section 10(1) of the *Motor Accident Insurance Act 1994* which includes a reference to the functions of the insurance commission in relation to the scheme.

Clause 154 amends section 19 of the *Motor Accident Insurance Act 1994* to include a reference to the reporting requirements for the scheme.

Clause 155 amends section 28 of the *Motor Accident Insurance Act 1994* to take into account the fact that some payments from this levy will be made to the Public Safety Business Agency, which is not a department.

Clause 156 amends section 37 of the *Motor Accident Insurance Act 1994* to provide that an accident claim notice must also authorise the agency to exchange information about the claimant in particular circumstances.

Clause 157 amends section 37A of the *Motor Accident Insurance Act 1994* to provide that an insurer may ask a claimant to provide additional information for the purposes of considering whether the injury comes within the scheme or the claimant is an eligible person.

Clause 158 amends section 38 of the *Motor Accident Insurance Act 1994* to refer to the new divisions inserted in that Act.

Clause 159 amends section 39 of the *Motor Accident Insurance Act 1994* to require an insurer to confirm in its response to the claim notice whether it will meet the reasonable costs of the claimant's rehabilitation for the period the claimant is not a participant in the scheme.

Clause 160 amends section 41 of the *Motor Accident Insurance Act 1994* to require an insurer to give consideration as to whether a claimant may be eligible to participate in the scheme.

Clause 161 amends section 42 of the *Motor Accident Insurance Act 1994* to make it clear that an insurer does not have to pay the medical expenses of a claimant that is a participant in the scheme or where the claimant, or a person acting for a claimant, has received a payment under the scheme.

Clause 162 amends section 51 of the *Motor Accident Insurance Act 1994* to make it clear that an insurer does not have to provide rehabilitation services to a claimant in relation to a claimant's treatment, care and support needs if the claimant is a participant in the scheme or the claimant, or a person acting for the claimant, has received a payment under the scheme.

Clause 163 inserts a new part 4, division 8 and division 9 into the *Motor Accident Insurance Act 1994.*

New section 61A sets out the claims process under the *Motor Accident Insurance Act 1994* if the agency is liable to contribute to the claim.

New section 61B requires an insurer to give the insurance agency written notice of particular matters where a person makes a claim for a personal injury and is a participant, or has applied to be a participant, in the scheme.

Clause 164 amends section 87B of the *Motor Accident Insurance Act 1994* by inserting the "National Injury Act".

Clause 165 amends section 87G(1)(c) by inserting the "National Injury Act".

Clause 166 amends section 87I(1)(a) by inserting the "National Injury Act".

Clause 167 amends section 87L(2)(a) by inserting the "National Injury Act".

Clause 168 amends section 87P(3)(b) by inserting the "National Injury Act".

Clause 169 amends section 87Q(1) by inserting the "National Injury Act".

Clause 170 amends section 87V(1) and 4(a) and (b) by inserting the "National Injury Act".

Subdivision 3 Amendments commencing by proclamation

Clause 171 inserts a new definition of 'injury insurance scheme levy' into section 4 of the *Motor Accident Insurance Act 1994.*

Clause 172 amends section 12 of the *Motor Accident Insurance Act 1994* to:

- enable the injury insurance scheme levy to be collected as part of an insurance premium;
- enable the statutory insurance scheme levy to cover the estimated costs of the commission performing its function under the scheme; and
- clarify that the hospital and emergency services levy does not cover the costs of participants, or eligible participants, in the scheme.

Clause 173 amends section 14 of the *Motor Accident Insurance Act 1994* to refer to the insurance commission's role in making recommendations about the injury insurance scheme levy.

Clause 174 amends section 14A of the *Motor Accident Insurance Act 1994* to make it clear that the requirement to fix levies by regulation under the *Motor Accident Insurance Act 1994* does not apply to the injury insurance scheme levy.

Clause 175 amends section 15 of the *Motor Accident Insurance Act 1994* to ensure that the scheme is considered when the insurance commission undertakes its review into the affordability of CTP insurance.

Clause 176 amends section 27 of the *Motor Accident Insurance Act 1994* which deals with the disbursement of gross premiums by transport administration, to clarify its application to the injury and insurance scheme levy.

Clause 177 amends section 27A of the *Motor Accident Insurance Act 1994* which deals with the disbursement of gross premiums by insurers who receive premiums directly, to include its application to the agency.

Schedule 1 Dictionary

Schedule 1 provides a dictionary, which defines particular words used in the Bill to aid in interpretation of the legislation.