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5 February 2016

Mr Robert Byrne
Manager, Self-insured
ReturnToWorkSA
GPO Box 2668
ADELAIDE SA 5001

Dear Rob,

Re: Proposed changes to the ReturnToWorkSA policy on self-insurance

We provide herewith our formal response to the abovenamed paper. The response is divided into 3 parts:

- Part 1 – Broad responses
- Part 2 - Responses to specific statements in the RTWSA paper
- Part 3 – Extract from actuarial advice received for the purpose of this response.

By way of general observations, the SISA Executive Committee found the paper very disappointing in terms of the proposals themselves, the quality, veracity and credibility of the justifications used to support them and the way they were articulated. This feeling is generally reflected among our members, some of who are also members of other significant business associations that may take an interest in the economic impact of the proposals.

In terms of economic impact, our early assessment of the proposals based on member input indicates that the proposals will generate significant cumulative job losses and impose major financial burdens on the affected businesses. There is even talk of options such as plant closures, offshoring and the like. To this extent we regard the proposals as not only unjustified by the paper but myopic and economically reckless from a State economic standpoint.

In addition to submitting the analysis below, we seek answers to the following questions as a part of our response:

1. SISA seeks an absolute assurance that the SIICA moneys will be kept aside as a pool for the purpose of covering any liability shortfalls in the event of a self-insurer insolvency, and not simply absorbed into the Compensation Fund (notwithstanding any legal interpretation about the maintenance of separate funds or accounts).
2. We ask that RTWSA provides us with the number and the overall cost of serious injury claims that do not have an outstanding liability as at 30 June 2015 because the claimant is deceased or the claim's remaining liability was redeemed some time earlier and that were not part of the 30 June 2015 valuation (see Part 3 for explanation).

Given that the paper is in the public domain, the affected businesses may choose to additionally express their views independently of SISA either to you or elsewhere inside or outside of RTWSA. With that said, we feel that it is inevitable that the prospect of major job losses and possibly plant closures will be taken up by the media when the issues become more broadly understood. Presumably the Corporation has a more cogent set of arguments than those presented in its paper to answer such enquiries.

We are as ever happy to enlarge on the content of this response.

Yours sincerely,

Robin Shaw
Manager

Part 1 – Broad responses

1. The overall effect of these proposals would be:
    - Increased costs for the affected companies, translating to job losses and possibly business closures
    - Expose the Corporation to significant adverse public and political opinion once the first point above becomes more broadly understood
    - Expose workers to lower standards of return to work and safety management
2. Perhaps the most telling omission is the very first one – references to 38% of the scheme being self-insured and what a high proportion that is compared to elsewhere, but not mentioning that the scheme is only exposed to half of that, (the Crown is its own insurer of last resort). This is so obvious that its omission has to be deliberate, and sets the tone for the rest of the paper.
3. The risk of catastrophic claims among self-insurers is very small, and despite the incorrect claim made in the paper, policies of reinsurance will continue in effect for events incurred during the policy period even if the self-insurer closes. Shortfalls after that will be small and can easily be covered by the SIICA funds now held by the Corporation.
4. ***SISA seeks an assurance that the SIICA moneys will be kept aside as a pool for this purpose.***
5. To remain with the actuarial element of the catastrophic injury discussion, we refer to figure 9.1 in Finity's 30 Jun 2015 report at page 76 (this being the report cited on page 4 of the RTWSA paper). The graph and the commentary that immediately follows it indicate the following:
    - For the period 1 Jul 2010 to 30 Jun 2015, the number of serious traumatic injuries each year is around 9.
    - This same period also suggests that the number of serious injuries each year is around 60.

    Assuming a population of 80 private sector self-insured employers, RTWSA's proposal to raise the minimum guarantee level to $4.5 million for every self-insured employer, is inconsistent with Finity's finding with regard to the annual frequency of these claims in the premium-paying scheme. In effect, by adopting this policy, RTWSA will have enough security to cover the full cost of 80 severe traumatic injuries (STI). Apart from being manifestly excessive, this fails to recognise that a lot of this potential exposure is insured via excess of loss policies. More importantly, the 9 new annual STI cases are expected to arise from all insured employers. The self-insured group is a very small subset of the employer base. The proposed policy thus suggests that the self-insured group will incur these types of claims at nearly 9 times the rate of premium-payers. We dispute the credibility of this assertion.

In the alternate, if RTWSA is actually focussing on its potential exposure from *all* serious injuries (and not just STIs), then the proposal to raise the minimum guarantee level to $4.5 million also lacks credibility. In effect, by adopting this policy, RTWSA would have enough security to cover the full cost of 80 STIs, rather than 80 serious injuries. This objective is clearly unjustified, as the average cost of a serious injury is very much lower than the average cost of a serious traumatic injury according to Finity. As previously noted, the paper fails to recognise that a lot of this potential exposure is insured via EOL policies. More importantly, the 60 new annual serious injury cases are expected to arise from *all* insured employers. Again, the self-insured group is a very small subset of the employer base. The proposed policy thus suggests that the self-insured group will incur serious injury claims at a rate 33% higher than premium-payers.

6. The paper is internally contradictory. It tries to justify raising the minimum guarantee with an inexplicable assumption that the RTW Act has materially increased the risk via the serious injury provisions. These injuries have always existed, they weren't created by the new Act. But if the RTW Act increased risk, why did the Corporation's unfunded liability disappear overnight when the new Act commenced? The fact is that the new Act reduced risk making long-term benefits available only to people with 30%+ WPI.
7. The arguments about head counts are entirely without basis, and the words used have been imported from Queensland, where they were equally contrived. The Corporation wants to have a high barrier to self-insurance but won't say it.
8. Parliament moved in 2008 to remove the mandated head count from the then Act and it was not re-introduced in the 2014 Act. Instead, number of employees is one of a wide range of things to be taken into account and cannot alone be used to reject an application. The Board wants to alter the operation of the Act via a policy document, something it lacks the power to do.
9. There are other statements that are just wrong, for example the statements about reinsurance.
10. In terms of potential impact on the workforce, these changes would inflict significant extra cost on the 27 employers mentioned in the paper. If each has to shed jobs to cover the increased cost, then a large number of jobs would be lost overall. The statement at the end of the paper that there are no known effects on workers entirely lacks vision and understanding of what this paper implies.

Part 2 – Responses to specific statements

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1	2	At 38% of employee remuneration in the State, South Australia has the highest proportion of self-insurance of any jurisdiction in Australia	Half of the 38% is the Crown, which is its own insurer of last resort. So the Corporation is on contingent risk for only 19%; less than NSW and Comcare. The omission of this key piece of information brings the credibility and motivation of the entire paper into question
2	2	Only New South Wales (at 20%) and Comcare (at 24.2%) are close to having a similar concentration of self-insurance	Those schemes measure their self-insurance proportions differently – by a straight count of employers. If remuneration were the common measure, these figures would be higher. This is therefore a misleading statement
3	3	The scheme has changed and the obligations bestowed on compensating authorities are more significant than ever before.	How have the obligations changed? Self-insurers have *always* been focused on return to work and high service standards and their history of superior performance is evidence of that. Statement flies in the face of reality.
4	3	The Board is also concerned about the size and capability of some self-insured businesses to deliver on their increased responsibilities.	Why? What increased responsibilities (see above and below)?
5	3	Areas of increased responsibility on compensating authorities include: • The serious injury claim provisions including service and liability implications as well as not being able to commutate future care and support needs • The requirement to comply with the service standards set out in Schedule 5 and the requirements placed on insurers in section 13 of the Act	The new Act does not create serious injuries. They have always existed. Under the 1986 Act, even the smallest of injuries could generate claims that lasted for years or in some cases decades. If anything, the 2014 Act reduces these claims to a much smaller number. Self-insurers have always delivered high standards of service, (the State Ombudsman could no doubt verify this). This is made obvious by the fact that when Schedule 5 commenced, no large changes were needed to members' systems.
6	3	The policy describes the characteristics of a business which the Board considers suitable for self-insurance and maintains a discretionary prerogative that enables the Board to exercise judgement as is intended within the wording of the statute	Important words - *within the wording of the statute* – the 'discretionary prerogative' is not universal. The Board has to obey the law just as self-insurers do. Internally contradictory. Section 129(11) does not confer a limitless authority.

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7	3	Requiring a business to be able to meet its liabilities in the most trying of economic circumstances minimises the risk that services provided to workers under the Act are not compromised by immediate financial pressures on a business. The risk is that a self-insured employer that is less robust and facing financial distress may seek to relieve cost pressures by cutting costs in resourcing and service provision, or even delay making payments for essential services. The smaller and less robust the business, the greater this risk is likely to be.	• What evidence is there to support this assertion? Every self-insurer knows that to act like this increases costs and liabilities. This argument has been imported from Queensland, where it is used in Parliament and elsewhere to justify the 2,000 worker limit. It is the same sort of unsubstantiated guesswork that unions put forward when opposing self-insurance. • The truth is that when a self-insurer, is under pressure, closes down or ceases to self-insure, their claims management resources are retained and work diligently until claims are resolved. • Current examples of companies under pressure – Arrowcrest Group, Holden, Toyoda Gosei – is there a suggestion that they are not diligently exercising their delegated powers or short-changing workers? • Examples of closures or cessations – AGL Torrens Island, Metro Meats, Hills, Incitec Pivot, Levi Strauss – did the Corporation suffer any losses as a result?
8	4	The Australian Prudential Regulatory Authority (APRA), has minimum capital requirements of (sic) general insurers (minimum of $5m) that protects consumers from insurer default and similar principles are applied to protect workers and the scheme.	• This is a misleadingly incomplete statement. • APRA Prudential Standard GPS 110 - Capital Adequacy states at paragraph 23: *Regardless of the outcome of the method used for determining the prescribed capital amount, a regulated institution's prescribed capital amount cannot be:* *(a) in the case of a regulated institution other than a Category D insurer or Category E insurer, less than $5 million; and* *(b) in the case of a Category D insurer or Category E insurer, less than $2 million* • APRA Prudential Standard GPS 001 – Definitions states ***Category D** insurer means an insurer incorporated in Australia that:*

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			(i) is owned by an industry or a professional association, or by the members of the industry or professional association, or a combination of both; and *(ii) only underwrites business risks of the members of the association or those who are eligible, under the articles of association or constitution of the association, to become members of the association; but* *(iii) is not a medical indemnity insurer as defined under the Medical Indemnity Act 2002.* ***Category E** insurer means an insurer incorporated in Australia that is a:* *(i) corporate captive as defined in paragraphs 2 and 3 of this Attachment; or* *(ii) partnership captive as defined in paragraph 4 of this Attachment.* • Self-insurers obviously fit much more closely into either Category D or Category E rather than with the definitions of general insurers, and therefore would be subject to a minimum capital requirement of $2 million under the APRA standards.
9	4	The current minimum level of bank guarantees is only $840,000. This is the lowest minimum in Australia and manifestly inadequate compared to the liability implications of just one catastrophic injury which has an average liability of $4.3 million but may have far higher liabilities than this	• We dispute the validity of the $4.3m figure. An experienced consulting actuary has provided an analysis based on the Corporation's own June 2015 actuarial review and an extract dealing with this particular point is at part 3. • **We ask that RTWSA provides us with the number and the overall cost of the cases that were not part of the 30 June 2015 valuation**. • There is a notable absence of historical data on the frequency of catastrophic injuries among the self-insurers and their cost. • As soon as such a claim is incurred, provided the self-insurer remains, the valuation would increase by the estimated claim

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			cost and the guarantee would increase accordingly with a 200% scaling factor, so there is no risk to the scheme. • If the self-insurer is no longer in existence, its reinsurance policy will continue to protect the scheme (and the Corporation's statement on this is wrong - see 10 below). • The SIICA exists to make up shortfalls if the self-insurer is no longer in existence – last known value at 30/6/15 $44.6 million – possibly over $50 million by now. • To argue that the scheme is under-protected from these claims is simplistic and not credible.
10	4	But reinsurance does not protect ReturnToWorkSA if the employer becomes insolvent, and will not protect ReturnToWorkSA if the serious nature of an injury does not become evident until long after a default event and when the business may no longer exist.	This is quite simply not true – a policy of reinsurance will continue to cover costs incurred during the policy period – in such a case, the Corporation can recover ongoing costs from the reinsurer. We have confirmation from a broker that the Corporation itself requires that an endorsement to this effect be placed in every reinsurance policy. As an example, in the QBE Excess of Loss Workers Compensation policy, the endorsement reads as follows: *a) In the event of the Reinsured becoming insolvent or their self-insurance licence cancelled, relinquished or revoked, any benefits shall be payable to the WorkCover Corporation of South Australia.* We admit to surprise at the Corporation's lack of understanding of basic insurance principles and its own policy on reinsurance.

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11	4	ReturnToWorkSA acknowledges that this is a significant increase in the minimum guarantee, but one which is proportionate to the level of risk associated with becoming an insurer under the *Return to Work Act 2014*.	See item 5 – this seems to suggest that the Corporation believes that the RTW Act has increased this risk in some way. If anything it has decreased it by limiting long-term costs and liabilities to 30%+ WPI claims. If this is not the case, why did the Corporation's unfunded liability vanish as soon as the Act commenced? Is there a suggestion that the Act has reduced the risk for the Corporation but increased it for self-insurers? If this is the case, how? Also contradicts item 11.
12	4	The amount of guarantee required will be lowered from 200% of the outstanding claims liability (OCL) to 150% of the OCL on account of the greater certainty in valuing the liabilities of larger portfolios of risk and the introduction of the clearer boundaries for income support and medical expenses for the non-serious injury claims.	This is saying is that the RTW Act lowered liability and risk. Runs counter to item 10 – it cannot be both.
13	4	The scaling factor of 200% dealt with the high uncertainty of liability that existed in the workers rehabilitation and compensation scheme.	Not true. The 200% was based on an actuarial assessment originally done by David Finniss of Tillinghast in the 1990s that projected the cost of claims if a self-insurer no longer offered employment to injured workers. It was an insolvency risk issue, not legislative.
14	5	ReturnToWorkSA is aware that increasing the minimum guarantee from $840,000 to $4.5m increases costs and adversely impacts the balance sheets to varying degrees for more than half of the currently self-insured employers.	Why is there no mention of the availability of insurance bonds as an alternate form of security? This is unlikely to be as high-impact if the Corporation would increase its acceptance of bonds.
15	5	Allowing businesses to stay self-insured on this basis has allowed for exceptions to be viewed as examples of why comparatively small employers can self-insure (because the downside risk has not materialised), and distorted the broader scheme structure implications of such small employers being perceived as suitable for self-insurance. If the going concern prospects of a business rely on being self-insured it suggests the business viability is marginal and it is not a business suitable for self-insuring.	Difficult to decode this statement. 'Distorted the broader scheme structure'…how?
16	5	If the going concern prospects of a business rely on being self-insured it suggests the business viability is marginal and it is not a	In other words, the Corporation is saying it will, as a matter of policy, close businesses down.

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		business suitable for self-insuring. The policy makes clear that a reliance on self-insurance to remain viable will not be considered a reason for allowing a business on to continue to be self-insured if it is not otherwise considered suitable by the ReturnToWorkSA Board.	
17	5	The money collected in previous years remains able to be used in the case of insolvency where bank guarantees may be insufficient. However the historical contributions by self-insurers under such a scheme are not a reason to allow businesses which are financially unsuitable to be an insurer to self-insure.	The Corporation wants to increase minimum guarantees due to a non-existent increased risk, while acknowledging the existence of around $50 million of self-insurer contributions as a back-up in case of shortfalls. Does not make any sense at all. **What will be the true fate of the SIICA funds?**
18	5	The basis for requiring a business to be of sufficient size to self-insure includes ensuring it is able to continuously employ sufficient expertise within the business to responsibly exercise delegations and manage claims in a way that is consistent with the requirements of the Act.	This is almost word for word out of the Queensland Parliamentary Hansard from a few years ago. It is a theory that is entirely without foundation and there is history to show that the reverse is true – companies under stress will seek to improve performance, not make it worse. See item 7.
19	5	The self-insured business is responsible for the reasonable exercise of powers. If the business is so small as to not be able to justify the employment of expertise within the business with a comprehensive understanding of the responsibilities of a self-insurer, then it is ill-equipped to self-insure.	Section 134(7) provides the Corporation with the power to withdraw delegated powers if a self-insurer exercises them unreasonably. Note, however, that this has *never occurred*. Not a credible statement.
20	6	The reasons outlined above which relate to the size of the employer are highly relevant to understanding if a business is suitable for self-insurance.	This makes no sense at all. A business can be high value and high profit but small in size through highly efficient methods – automation etc. Again, this statement has no basis in reality.
21	6	The use of a range suggests that there may be some employers that, by virtue of other features of their business and the industry they work in, might be considered suitable at 500 employees where as others might be unsuitable at a higher number. Jurisdictions with prescribed minimum numbers of employees required to be able to self-insure include Queensland (2000), New South Wales (500) and the Commonwealth (Comcare) (500).	• How could such a judgement be made? Based on what reasoning? This is unsustainable and suggests that the Board believes it has unfettered powers. • Other jurisdictions use head counts as a barrier to self-insurance, pure and simple. The fact that they do it does not make it right.

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			• In 2008, Parliament acknowledged that head counts give no assurance of the ongoing viability of a business and removed the mandate from the WRCA. The current Government and Parliament reinforced this by not including a mandated head count in the RTW Act. The Board is seemingly seeking to defy the will of the Parliament by administratively re-imposing a hard barrier. • Employee number is now one of a broad range of matters that must be taken into account – if an employer complies with all other criteria, the number of employees cannot be used on its own to refuse an application. If necessary we are willing to test this in a court. • Enron collapsed suddenly with 20,000 employees. There is a multitude of small and family businesses in SA employing fewer than 10 that have been successful for generations. Head counts are nothing more than an artificial barrier to self-insurance.
22	7	ReturnToWorkSA is of the view that these changes are essential to providing for an affordable and sustainable scheme that is able to deliver its objectives for all employers and workers in South Australia.	It's impossible to know how any of this would make the scheme more affordable or sustainable. It ignores the fact that self-insurance generally holds a higher average risk due to the nature of the industries covered – bringing some back to the premium pool might put upward pressure on the average premium rate.
23	7	There are no known or expected adverse impacts on workers associated with the proposed change in policy.	Demonstrably untrue. Self-insurers have been acknowledged as superior performers in both safety and return to work. The SA Parliamentary Hansard can provide plenty of evidence for it. This proposed policy will impose the following on affected workers: • Job losses due to increased employer costs – especially the case in the not-for-profit sector (aged care etc) where there is no way to absorb increases. Based on the words at item 15

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			above, they might even force the closure or offshoring of some businesses. • Less efficient and effective management of claims and RTW • Lower standards of WHS

Part 3 - Extract from actuarial advice to SISA by a Fellow of the Institute of Actuaries of Australia

In the left column on page 4 of RTWSA's paper it is stated that the average cost of a catastrophic injury that is insured by RTWSA is $4.3 million. I do not understand why this statistic has been presented as justification for raising the minimum financial guarantee amount to $4.5 million.

Finity estimated RTWSA's outstanding claims liability as at 30 Jun 2015. Its report on its valuation of this liability is dated August 2015. On pages 73 and 74 of this report it is stated that the serious injuries included in the valuation can be subdivided into three subgroups.

The first subgroup is referred to therein as severe traumatic injuries. Finity states that these claims are managed internally by RTWSA. It also states that these claimants require significant levels of care and support or else have other special needs. From this subgroup there are 118 active at 30 Jun 2015 (see page 78 of the report). The average cost of each such claim is $4.3 million (see page 82 of the report). These claims are not necessarily the catastrophic claims that RTWSA refers to on page 4 of its paper.

The second subgroup consists of other claims that have a WPI assessment of at least 30% or are claims that have not yet had a WPI assessment of 30% or more but may do so at some point in future (these claims are managed by one of RTWSA's claim agents). The latter were in fact identified by RTWSA and notified to Finity (page 75 of the report states that there are 327 of these claims). From this subgroup there are 448 active at 30 Jun 2015 (based on table 9.3 on page 75 of the report and the number in subgroup 1). The average cost of each such claim is $1.1 million (see page 87 of the report).

The third subgroup consists of serious injury claims that, as at 30 Jun 2015, have not been identified as being such claims but will end up being so categorised. In this subgroup there are 109 as at 30 Jun 2015 (based on table 9.3 on page 75 of the report). The average assumed cost of each such claim is $1.3 million (see page 87 of the report).

Finity valued 675 serious injury claims as at 30 Jun 2015, (being the aggregate of 118, 448 and 109). Their overall cost, in "2015 dollars", is $1,141.9 million, (being the aggregate of 118 lots of $4.3 million, 448 lots of $1.1 million and 109 lots of $1.3 million). This suggests the average cost of these 675 claims is $1.7 million - $1,141.9 million divided by 675.

I believe it is unconscionable for RTWSA to focus solely on the cost of the severe traumatic injuries (which may not necessarily be "catastrophic" injuries), rather than the cost of all of the serious injuries. It is clearly unrealistic and inappropriate to require each self-insured employer to provide sufficient funding to cover such uncommon extreme claims, more so if the group of self-insured employers has never incurred such injuries. I believe it is more realistic for RTWSA to argue for funding to cover a serious injury whose maximum cost is $1.7 million (not $4.5 million).

The $1.7 million number is too high for this purpose, as it is only based on the claims that have an outstanding liability as at 30 June 2015. A significant number of serious injury claims do not have an outstanding liability as at 30 Jun 2015, as the claimant is deceased or

the claim's remaining liability was redeemed some time earlier. There may be up to 151 such claims (refer to table 9.3 on page 75 of the report). The report does not indicate the overall cost of these extra cases. However, given the time that they were active or the fact that future income maintenance was redeemed, their average cost is likely to be significantly below $1.1 million. If these extra cases are taken into account, the average cost of all serious injuries could well be significantly below $1.5 million. **To establish the actual position, RTWSA should be asked to advise the number and the overall cost of the cases that were not part of the 30 Jun 2015 valuation**.