



Options for greater involvement by private sector life insurers in worker rehabilitation

MLC Life Insurance submission to the Parliamentary Joint Committee on Corporations and Financial Services

4 May, 2018

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Key point summary

- It is good policy for life insurers to assist claiming customers (claimants) to undergo rehabilitation and return to health so as to enable them to return to employment.
- Presently life insurers fund non-medical rehabilitation services (such as initial needs assessments, workplace assessments, functional capacity assessments, vocational assessments, work conditioning programmes and job search assistance) but are prevented by Commonwealth legislation from funding rehabilitative medical treatment. For example, life insurers cannot pay for medical services like psychiatric consultations.
- While non-medical rehabilitation services are effective for some people, in other cases the customer must first have addressed underlying health issues and be making progress on regaining their health before they can start non-medical rehabilitation.
- In some cases, where the medical treatment is not covered by Medicare but having the treatment would help a claimant return to health and work, it would benefit customers, the insurer's other policy-holders, taxpayers and the broader community if life insurers had the flexibility to be able to fund that health treatment. For example, we might continue to fund psychiatrist appointments after the Medicare funded maximum has been reached, in an effort to help a claimant regain their ability to recover.
- We do not propose for life insurers to supplant the important role played by Medicare or private health insurance in funding healthcare in Australia. Instead we recommend that life insurers be permitted to supplement these usual funding sources, only for the purposes of returning a person to employment.

Executive Summary

MLC Life Insurance welcomes the opportunity to provide a submission to the Parliamentary Joint Committee on Corporations and Financial Services inquiry into options for greater involvement by private sector life insurers in worker rehabilitation, including support after return to work. MLC Life Insurance has been a long standing advocate of life insurers being permitted to do more for our customers to help them return to health and life and we applaud the Australian Government's move in referring this important issue to the Committee.

Presently life insurers are prevented by law from funding medical treatment as part of a program of rehabilitation. MLC Life Insurance recommends these regulatory restrictions to be relaxed. Through Income Protection (IP) products (including Group Salary Continuance products) and Total and Permanent Disability (TPD) products, life insurers take on the liability associated with our customers being unable to work for health reasons, for example as in the case of individual injury or illness. Given this liability, life insurers have a strong financial motivation to support their customer's rehabilitation and return to health and paid employment.

MLC Life Insurance does not recommend supplanting existing sources of funding in the healthcare system. Australia's mixed public-private healthcare system is recognised as one of the world's best, and we support the principal of equity of access based on clinical need that underpins it. Instead, MLC Life Insurance would like to have the option to act as a "supplementary funder" of medical treatment, meaning any funding would be additive to existing health funding sources in a limited range of circumstances. This would mean that life insurers would only function as a provider of "top up" payments when two criteria are met:

1. Where it can be demonstrated that the planned medical service is reasonable and necessary to the goal of restoring the customer to health and employment.

2. Where principle healthcare funders such as Medicare and private health insurers are constrained from funding the required services due to regulation, timing of the availability of treatment (including health system capacity issues), or, in the case of private health insurance, the customer is not insured or has exhausted their benefits.

Examples of the sort of circumstances where the option of life insurer supplementary funding may be warranted as part of a program of rehabilitation include:

- Where a customer requires ongoing psychologist support but has exhausted their Medicare funded *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS* (Better Access) entitlements. In such a circumstance the life insurer should be permitted to fund the ongoing care to the same extent that Medicare normally would.
- Where a customer with private health insurance requires substantial physiotherapy to return to health and employment, but has used their maximum Medicare¹ or private health insurance physiotherapy benefits. In such a circumstance the life insurer should be permitted to fund the ongoing care to the same extent that Medicare or the private health insurer normally would.
- Where a customer and their doctor determines that a major joint replacement is required to progress a customer's return to health and employment, but the length of the public waiting list threatens a successful return to employment. In such a circumstance the life insurer should be permitted to have the option to fund the procedure or part thereof in the private healthcare system.

Customers in these circumstances either have no option to obtain the care that would benefit them, or the care is delayed past what is optimal for them. Adding to the unfortunate circumstance is that it is currently illegal for us to provide assistance by funding the medical treatment despite seeing the potential for positive outcomes. In these scenarios customer interests suffer, leaving them less likely to return to full health or employment.

Permitting a life insurer to have the option to act as a supplementary funder of medical treatment as part of a program of rehabilitation would benefit both the claimant and other customers of the insurer. Claimants would realise greater value from their insurance and have an improved chance to return to health and employment, while other customers should benefit via lower pressure on premiums.

We also believe there are clear public policy benefits associated with life insurers being permitted to fund rehabilitative medical treatment in certain circumstances, including via greater workplace participation and productivity. These benefits are explained below.

We also sound a note of caution. Any changes to current regulations would need to be carefully considered and designed so as to ensure life insurers do not exceed the sort of limited role suggested above. Discretionary powers should be left to life insurers in regards to the medical rehabilitation treatment they choose. This would ensure payments are consistent with their rehabilitation targets and strategies so as to effectively manage costs and avoid cost blowouts that would ultimately flow on to consumers and negatively impact industry sustainability.

The submission following addresses selected terms of reference. We would be pleased to expand on our thinking, as desired by the Committee.

¹ Ordinarily Medicare does not fund physiotherapy at all, but may fund up to five services annually where a patient has a chronic medical condition and their GP has specified physiotherapy as part of a Chronic Disease Management Plan.

About MLC Life Insurance

MLC Life Insurance, which traces its origins back to 1886, insures more than 1.5 million customers and is still fulfilling its original goal: “to bring the security and protection of life assurance within the reach of every man, woman and child”.

On 3 October 2016 National Australia Bank Limited (NAB) completed its sale of 80% of its interest in MLC Limited (MLC Life Insurance) to the Nippon Life Insurance Company (Nippon Life). This has led to the creation of a specialised life insurance business, MLC Life Insurance, where Nippon Life has a majority 80% holding, while NAB retains 20%.

With a market share of approximately 11%, we are Australia’s third largest life insurer. Traditionally our focus has been on the retail market segment where policies are sold via financial advisers, but our involvement in the insurance in superannuation market is growing. Our group insurance income premium is approaching \$600m, equal to a market share of approximately 8%². We are seeking to grow our presence in this market, particularly in the important industry superannuation fund segment, to which we are bringing new innovation and competition.

Regardless of channel, our products play an important role in protecting our customers, their families and businesses against the adverse financial impacts of premature death, illness, injury or disability. In the financial year to 31 December 2017, we paid nearly \$1b in claims for our customers and their families, in doing so reducing or removing the need for people to rely on government and taxpayer support to manage their financial needs and responsibilities.

With the strong backing of Nippon Life, MLC Life Insurance is now poised to deliver even better value for its customers. This strategic partnership is enabling us to invest significant capital (in the order of \$400 million) to simplify and improve the customer, member, trustee, adviser, banker and employee experience with the aim of ensuring our insurance products are easy, simple to understand and administer. Digital channels and data analytics form a key part of our strategy. We are investing to simplify our back-office systems, including sales, servicing, underwriting and claims, to make it easier and faster for our stakeholders.

² NMG Consulting, *Group Channel Risk Distribution Monitor*, March 2018

a. The interaction of Income Protection (IP) insurance and Total and Permanent Disability (TPD) insurance with State, Territory, and Commonwealth legislative and regulatory frameworks including Medicare, government employment schemes, workers compensation arrangements, national injury insurance schemes, the National Disability Insurance Scheme, and private health insurance.

In the Australian healthcare system the right to fund medical treatment is reserved for comparably few institutional entities. Outside of state and federal governments, private health insurers and certain other non-government sources such as workers compensation insurers and motor vehicle third-party insurers are permitted to directly pay for medical services. While life insurers deal with the consequences of injury and ill health, they are not considered a part of the healthcare funding system and are prohibited from paying directly for rehabilitative medical services.

The restrictions preventing life insurers from funding medical treatment as part of a program of rehabilitation exist primarily in Commonwealth health sector legislation, including:

- the *Health Insurance Act 1973*
- the *Private Health Insurance Act 2007*
- the *Private Health Insurance (Prudential Supervision) Act 2015*.

Taken together, these Acts and their subordinate rules and regulations combine to restrict life insurers from funding the sort of medical treatment that might form part a program of rehabilitation that it may wish to provide. Some key aspects of these restrictions are called out below.

Health legislation impediments to life insurers funding rehabilitative treatment

Three pieces of health sector legislation combine to restrict life insurers from funding medical treatment as part of a program of rehabilitation.

Health Insurance Act 1973

Section 126 of the *Health Insurance Act 1973* prohibits:

- any entity from forming a contract of insurance that may pay a benefit towards medical services delivered outside of hospital where a Medicare benefit is payable
- any entity other than a private health insurer from forming a contract of insurance that may pay a benefit towards health services delivered inside of hospital where a Medicare benefit is payable.

Note the usage of the word “payable”, which is important as it excludes the possibility of a life insurer agreeing with a customer to pay the full cost of a healthcare service even when the customer does not claim a Medicare benefit.

Private Health Insurance Act 2007

Under the *Private Health Insurance Act 2007* (PHI Act) most medical services, including services that would be required as part of a program of rehabilitation, are considered to be either *hospital treatment* or *general treatment*. *Hospital treatment* is defined in section 121-5 as any treatment that is intended to manage a disease, injury or condition and is provided at or by a hospital. *General treatment* is treatment defined in section 121-10 as any treatment that is intended to manage or prevent a disease, injury or condition and is provided out of hospital, i.e. in a primary or community care setting.

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Having defined most medical treatment that would form part of rehabilitation treatment as either *hospital treatment* or *general treatment*, at section 121-1 the PHI Act defines the business of insuring either *hospital treatment* or *general treatment* as being *health insurance business*.

Relevant to section 121 of the PHI Act is the subordinate legislation the *Private Health Insurance (Health Insurance Business) Rules 2017* (the Rules). The Rules are referred to in section 121 of the PHI Act at multiple places and serve the purpose of giving a full and authoritative description of the concepts referred to in it, and as a guide for their practical application. Sections 15 and 16 of the Rules list a number of types of insurance that should not be considered *health insurance business*, including in section 16 which makes it clear that the sort of insurance cover provided by a life insurer is not considered to be *health insurance business*.

Private Health Insurance (Prudential Supervision) Act 2015

Section 10 of the *Private Health Insurance (Prudential Supervision) Act 2015* makes it an offence for a person to carry on health insurance business if that person is not registered with APRA as a private health insurer. The APRA *Private Health Insurance (Registration) Rules 2017 (No 2)* goes on to describe the criteria an entity must demonstrate in order to be registered as a private health insurer.

Reforming health sector legislation to permit payment for rehabilitation healthcare services

In terms of reforming the above mentioned legislation so as to permit life insurers the option of funding rehabilitation related medical treatment, MLC Life Insurance recommends a limited approach that considers amendments to the *Health Insurance Act 1973* and the Rules only.

Health Insurance Act 1973 reform

Our proposal is for life insurers to be considered as a supplementary funder of medical treatment, where any funding provided is voluntary rather than contractually obliged. We consider section 126 of the *Health Insurance Act 1973* may need amendment.

Amendment to this Act appears to be necessary even if life insurers do not contract liability to fund medical services within their insurance contracts. This is because other insurance policy documents, for example Product Disclosure Statements or group insurance tender documents, will likely refer to the option for insurers to fund rehabilitative medical treatment, and these may be legally interpreted as constituting an agreement between the life insurer and the policy holder. This may be the case regardless of whether the policy holder is an individual with a retail life insurance policy, or a superannuation trustee or employer under a group insurance arrangement.

For this reason we consider section 126 of the *Health Insurance Act 1973* needs to be amended in some limited way. The goal should be to permit life insurers to form contracts of insurance or agreements that allow life insurers the option of paying a benefit towards rehabilitation medical treatment for which a Medicare benefit is payable. Section 126 already contains sub-sections that describe circumstances where the section does not apply, for example 126-5a and 126-6, suggesting that adding additional exclusions is feasible and consistent with the operation of the section.

Private Health Insurance (Health Insurance Business) Rules 2017 reform

In regards to the PHI Act, MLC Life Insurance does not suggest change is required to the Act itself but only to its subordinate legislation. As noted above, via the *Private Health Insurance (Health Insurance Business) Rules 2017*, the PHI Act already permits certain types of insurance business to occur without being considered *health insurance business*³. We therefore suggest that amending the Rules to permit life insurers to fund rehabilitation related medical treatment is not only possible but is also consistent with the intent of

³ In the case of workers compensation and compulsory third party insurance, it is section 121-25 of the PHI Act itself which excludes these insurances as being *health insurance business*.

the Rules and the PHI Act. There are a number of ways that this could be done, depending on the range of medical services it is considered desirable for life insurers to fund. Three options are considered below:

1. Section 121-10 (2) of the PHI Act authorises the Rules to exclude certain treatments from being considered *general treatment* and therefore *health insurance business*. The relevant section of the rules is section 11, which could be amended to exclude as *general treatment* those services which form a part of a life insurer (as defined in section 16 of the rules) authorised *Return to Employment Plan*⁴. This option would permit life insurers to fund medical treatment related to rehabilitation that is delivered in a primary or community care setting, but not in a hospital.
2. Similarly to option one, section 121-15 (4) of the PHI Act authorises the Rules to exclude certain treatments from being considered *hospital treatment* and therefore *health insurance business*. Section 8 of the Rules could be amended to exclude as *hospital treatment* those healthcare services which form a part of a life insurer (as defined in section 16 of the rules) authorised *Return to Employment Plan*. This option would permit life insurers to have the ability to fund medical treatment related to rehabilitation that is delivered in a hospital setting.
3. A third option would be to combine option one with option two. This option would permit life insurers the most flexibility to cover medical treatment considered necessary to the rehabilitation of a customer.

Ensuring transparent and equitable access to life insurer funded rehabilitation services

MLC Life Insurance acknowledges that permitting life insurers to the option fund rehabilitation related medical treatment requires some form of regulation in order to ensure it remains limited to employment related rehabilitation only. As noted we propose that life insurers serve only as a provider of supplementary “top up” funding when two criteria are met:

1. Where it can be demonstrated that the planned medical treatment is *reasonable* and *necessary* to the goal of rehabilitating the customer to health and employment.
2. Where principal healthcare funders such as Medicare and private health insurers are constrained from funding the required services. This constraint may be due to regulation, timing of the availability of treatment (including health system capacity issues), or, in the case of private health insurance, the customer is not insured or has exhausted their benefits.

We also see regulation as supporting the application of this concept by ensuring that rehabilitation treatment decisions are made in a consistent, transparent and equitable manner across the entire life insurance industry.

Our view is that such objectives are best achieved via industry self-regulation. We note the Financial Services Council has proposed five key principles that should apply to rehabilitation services funded by life insurers⁵. We support these principles, which are reproduced below:

1. Customers and/or their treating physician would be required to provide consent for any early intervention payments.

⁴ The concept of a *Return to Employment Plan* is explained on page 8.

⁵ See Submission 1 to the Parliamentary Joint Committee on Corporations and Financial Services inquiry into Options for greater involvement by private sector life insurers in worker rehabilitation authored by the Financial Services Council; page 1; located at https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/Rehabilitation/Submissions

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2. Any early intervention treatment the life insurer offers to pay for, should be arranged through the customer and their treating physician(s).
3. Life insurers will not coerce or pressure customers to seek treatment or return to work.
4. Life insurers will not stop Income Protection (IP) or Total and Permanent Disability (TPD) insurance payments merely because a customer refuses any treatment that is offered.
5. Decisions and processes relating to the offer and grant of early intervention payments would be subject to the usual internal dispute resolution and external dispute resolution processes.

Furthermore, as noted above, we believe that in order for funding for medical treatment to be permitted an insurer must form a well-founded view that the treatment is *reasonable* and *necessary* to the rehabilitation of the customer. We also recommend there to be a consistent cross-industry approach to this formation. We propose that *reasonable* and *necessary* be determined and documented via the creation of an outcomes focused *Return to Employment Plan*. The *Return to Employment Plan* would be jointly prepared by the customer, their insurer, their doctor(s) and, where appropriate, their employer.

The requirements of a *Return to Employment Plan* could be fully expressed in the Life Insurance Code of Practice and/or in the Rules, similar to the way that a chronic disease management program is described in section 12 of the Rules. In summary a *Return to Employment Plan* should describe the specific rehabilitation goals agreed between the parties and the steps necessary to achieve them, including the commitments of each party. It should also explicitly require its planners to consider and incorporate health services funded by Medicare and private health insurers, before authorising supplementary funding by the life insurer.

The customer's progress to the goals specified on the *Return to Employment Plan* should be closely monitored. Once the goals are achieved the plan can then be iterated with new goals and further supports, with the process continuing until full or optimal recovery is achieved.

Life insurers should have the same capability as adjacent insurance sectors

Outside of the information provided above, MLC Life Insurance does not have any specific knowledge around the regulatory frameworks attaching to the other types of insurance referred to in question a of the inquiry terms of reference. However, we do note that insurers in adjacent sectors which play a similar role to life insurance are already permitted to pay for medical treatment.

Injury compensation insurers such as state and federal run workers compensation and compulsory third party (CTP) motor vehicle insurers are permitted to pay service providers directly for medical treatment. Data for FY16 demonstrates these insurance schemes as spending \$2.7 billion directly purchasing medical treatment for their customers⁶. Similar carve outs from health funding policy and regulation that enables workers compensation and CTP insurers to directly fund healthcare services should be applied to life insurers.

The medical treatment funded by workers compensation and CTP insurers are comprehensive. Benefits cover not just the immediate outpatient and inpatient medical services needed in response to accident or injury, but also services related to rehabilitation and return to work. Both types of insurance also pay income protection benefits when warranted. Like life insurers, workers compensation and CTP insurers seek to work with their customer to create a good health outcome that enables them to resume their lives, including their employment.

With such clear parallels between the two sectors this inconsistency is obvious. There seems no good reason why one sector should be able to support its customers accessing rehabilitative medical treatment while the

⁶ Australian Institute of Health and Welfare, *Health expenditure Australia 2014–16*, 2017, p. 40

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other is restricted from doing so. The result of this inconsistency is life insurance customers being exposed to lesser quality health and insurance outcomes. It seems a perverse and prejudicial outcome for holders of life insurance policies that in the event of disabling injury or illness they should have lesser access to assistance from their insurer compared to third party or workers compensation insurance schemes.

b. the interaction of IP and TPD insurance products with social security benefits in the context of the Life Insurance Act 1995, Health Insurance Act 1973 and Private Health Insurance (Prudential Supervision) Act 2015.

MLC Life Insurance encounters customers who are claiming TPD and who are also in receipt of social security benefits. Because TPD benefits are not assessed as income for Centrelink purposes, a benefit has no impact on eligibility for social security benefits or the quantum paid. This contrasts with IP benefits, which are assessed as income for Centrelink purposes, and therefore may impact on an individual's eligibility for social security benefits and the sum received.

The *Health Insurance Act 1973* and *Private Health Insurance (Prudential Supervision) Act 2015* do not regulate social security benefits so IP and TPD insurance related benefits would not appear to have any implications for social security benefits via these acts. We note that IP and TPD insurance related benefits do not impact eligibility for an individual to access Medicare or private health insurer funded services, although an IP benefit may impact on eligibility for the private health insurance rebate.

c. how benefits available under continuous disability policies, such as TPD, could be utilised to provide assistance and incentives to people returning to work, such as covering the cost of professional nursing care and other rehabilitation related expenses, including:

- i. whether there are any legal impediments to this; and**
- ii. whether there are any identifiable limits to this, for example with respect to cover arrangements for small business employees and the self-employed.**

MLC Life Insurance contends there is a strong case for regulatory restrictions preventing life insurers from funding medical treatment as part of a program of rehabilitation to be relaxed in certain circumstances. Through Income Protection (IP) products and Total and Permanent Disability (TPD) products, life insurers contract with customers to take on liability for the risk of a customer being unable to work for health reasons, such as in the case of individual injury or illness. The acceptance of this liability means that in the event of an IP or TPD claim due to injury or ill health, life insurers have a strong financial motivation to support their customer's rehabilitation and return to health and paid employment. Not being permitted to have the option to directly fund rehabilitative medical treatment constrains a life insurer's ability to achieve this goal and leads towards a poor outcome for the customer.

MLC Life Insurance does not advocate displacing the existing sources of funding in the healthcare system. Australia's mixed public-private healthcare system is recognised as one of the world's best, and we support the principal of equity of access based on clinical need that underpins it. Instead, MLC Life Insurance would like to be able to supplement existing funding sources in a very limited range of circumstances with the aim of improving rehabilitation outcomes. Performed effectively, such an approach would benefit both the claiming customer and other customers of the insurer. Furthermore, we believe there are clear public policy benefits associated with life insurers being permitted to fund rehabilitation related medical treatment in certain circumstances.

Our existing early intervention approach to claims management

MLC Life Insurance is a strong supporter of the health benefits of work and already takes an active role in helping our customers return to employment following illness or injury. Since 2016 MLC Life Insurance has adopted an "early intervention" approach to claims management. This approach essentially shifts our customer support and rehabilitation efforts from occurring after the acceptance of an insurance claim, to one where the support is provided up-front, prior to our contractual obligations actually commencing. For example, in the case of an IP claim we instigate support before the usual 30-90 day waiting period is served. This means we provide support and well before a decision is made on whether the claim is a payable against the terms of the policy.

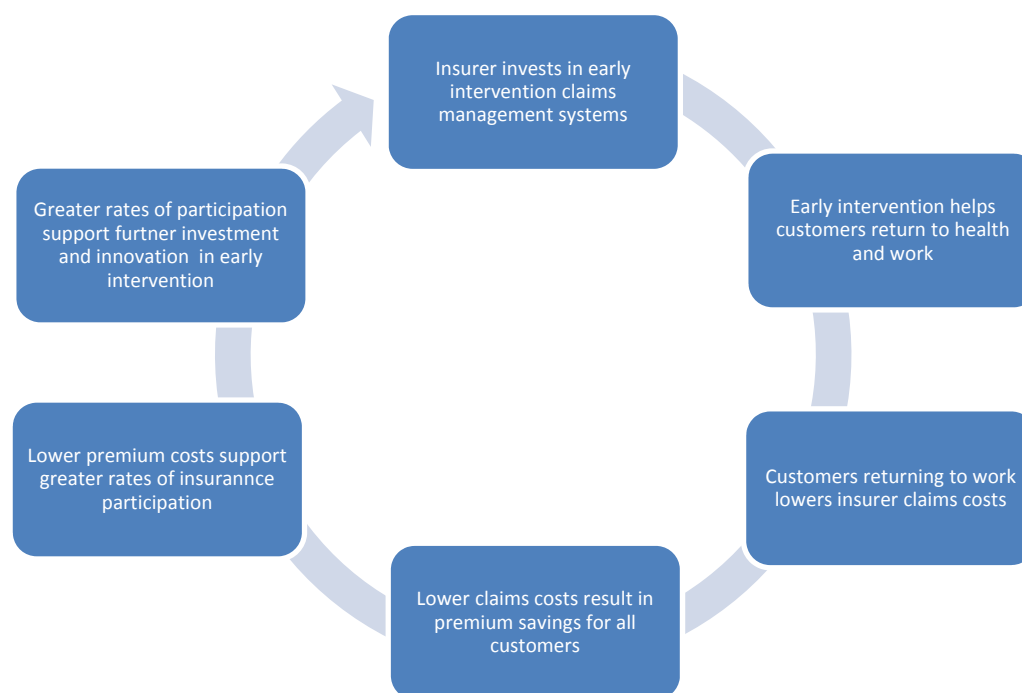
The rationale for this change in our claims management approach is the compelling evidence demonstrating that the longer a customer is away from their work and usual routines of life, the more likely the customer is to become permanently dislocated, including being permanently unable to work. The evidence shows that if a person is off work for:

- 20 days the chance of ever getting back to work is 70%
- 45 days the chance of ever getting back to work is 50%

- 70 days the chance of ever getting back to work is 35%⁷.

Statistics from adjacent insurance sectors underline the benefits of taking action early. WorkSafe Victoria cites interventions within eight weeks of an injury as leading to a 66% likelihood of returning to work. Where intervention does not occur until after eight 8 weeks, Worksafe Victoria found the likelihood of returning to work decreases significantly, to just 14%. Overseas research is similarly compelling: research undertaken in the United Kingdom has found that employees utilise early intervention services have an average absence period 16.6% shorter compared to those who do not. This translates to a reduction of more than a year (60 weeks) in the average seven-year duration of a long-term absence⁸.

From an insurer point of view, when performed effectively early intervention results in decreased overall claims costs. But, importantly, in achieving this goal early intervention also creates system wide efficiencies that directly benefit current and future customers, as depicted in the diagram below:



Effectiveness of early intervention presently restricted

Presently the restriction on life insurers having the option to pay for rehabilitative medical treatment means MLC Life Insurance early intervention programs are limited to paying for non-medical services. Non-medical early intervention services include services such as initial needs assessments, workplace assessments, functional capacity assessments, vocational assessments, work conditioning programmes and job search assistance.

In order for non-health early intervention services to be effective, often the customer must first have addressed underlying health issues and be making progress on regaining their health. Unfortunately, for a range of reasons it is not uncommon for MLC Life Insurance to encounter customers who are unable to access the necessary healthcare service. It is customers in this category who we want to be in a position to assist by acting as a supplementary funder of medical treatment.

Presently we have customers on claim whose best chance of returning to full health is via timely access to medical treatment. Unfortunately, for various reasons, many customers are unable to access the needed

⁷ Australasian Faculty of Occupational and Environmental Medicine, *Realising the Health Benefits of Work*, 2011, p. 12,

⁸ Centre for Economics and Business Research, *The Benefits of Early Intervention and Rehabilitation*, 2015, p. 7

treatment. This places their chances of returning to health and employment at risk. Common reasons for this include:

- **The customer is awaiting Medicare-funded surgery in a public hospital.** Depending on the surgical speciality, the wait to access a public hospital can be quite long. In fact surgical waiting times on their own surpassing the optimum return to work timelines set out by authorities such as the *Australasian Faculty of Occupational and Environmental Medicine* (AFOEM). For example the median waiting time orthopaedic surgery is 69 days, while for ophthalmological procedures the median waiting time is 73 days⁹. Each of these is well outside the optimum return to work window outlined by AFOEM.
- **The customer has exhausted their Medicare-funded services and cannot afford to pay privately for the service.** For example, the Medicare funded “Better Access” mental health program part funds a maximum of ten psychologist services per calendar year. Any additional care must be paid for entirely by the patient. This can serve as a disincentive to completing treatment. Even where patients are able to access treatment we often see a reticence to access the entitlement as quickly as is clinically optimal.
- **The customer cannot afford to access an allied health services not covered by Medicare and does not have private health insurance or adequate private health insurance.** Under normal circumstances Medicare does not fund allied health services such as physiotherapy, occupational therapy or remedial massage. Often these types of services are integral to rehabilitation and return to work care plans¹⁰, so if customers cannot afford to access them their rehabilitation is set back.

Customers in these circumstances either have no option to obtain the care that would benefit them, or the care is delayed past what is optimum. Adding to the unfortunate circumstance is that we are unable to provide assistance by funding the medical treatment despite seeing the potential for positive outcomes. The end result for customers in these scenarios is often a poor one, leaving them less likely to return to full health or employment. Contained in the boxes below are brief case studies taken from MLC Life Insurance claims records, illustrating the real life impacts associated with the restrictions on life insurers paying for medical treatment.

Case Study 1: Preventing the development of chronic pain

Mr B was a self-employed plumber, aged 43, and married with two children age six and 12. While working, he fell off a ladder breaking both feet. He underwent surgery; however, multiple operations were not successful in providing relief from chronic pain caused by the injury.

MLC Life Insurance identified that Mr B’s condition made him a good candidate for a multidisciplinary intervention via a pain clinic. Such an approach could have supported him to manage his pain with a reduced need for reliance on opioid analgesics, and is associated with an improved quality of life and improved likelihood of a returning to work.

Unfortunately Mr B could not afford the pain clinic and MLC Life Insurance is not permitted to fund the treatment. His pain management plan was instead based around heavy doses of opioid analgesics which were only partly effective and brought side-effects. He had trouble sleeping and became depressed and despairing of his future. With the passage of time Mr B has been found to be permanently disabled and assessed as unlikely to ever be able to return to work.

⁹ Australian Institute of Health and Welfare, *Elective surgery waiting times 2016–17: Australian hospital statistics*, 2017, p. 28

¹⁰ It is possible for Medicare to fund allied health services if the patient has a chronic medical condition and their GP has provided a Chronic Disease Management service, however even in these circumstances access is limited to a maximum of five services per calendar year.

Case Study 2: Treatment for major depression and substance use disorder

Mr P is a 52 year old debt collector who is diagnosed with depression. He has become increasingly unwell due to a substance addiction. As a consequence of the addiction his business went bankrupt and his health further deteriorated. He ceased work and claimed a benefit from MLC Life Insurance.

To try to turn around his circumstances, MLC Life Insurance engaged with Mr P's doctor to arrange for a review of his case. Mr P was referred to a psychiatrist and a psychologist. While he was motivated to attend he found the cost prohibitive. He reported he needed to wait for a particular month when his MLC Life Insurance benefit was not committed to other expenses before he could afford to attend consultations. As a result his treatment was irregular and ineffective.

Despite the fact that Mr P has a mental illness for which treatment is known and effective, a successful outcome appears out of reach for him at this stage. If MLC Life Insurance were able to support Mr P by funding appropriate treatment interventions at the appropriate recommended intervals, there would be a much improved opportunity to facilitate his recovery, long-term health outcomes and prospect of his ultimate return to work.

Case Study 3: Surgery and post-operative rehabilitation for a hip replacement

Mr M is a self-employed tradesman with a role that requires heavy manual labour. He needs a hip replacement and until he receives it he is restricted to using crutches and is in significant pain. As he is unable to afford the cost of surgery Mr M is on a public hospital waiting list with an expected 12 month waiting period. Post-operatively he is likely to require as much as six month's rehabilitation before he will be capable of resuming his usual labouring duties.

As a sole trader, Mr M's inability to perform his usual duties while awaiting surgery means his business has needed to be closed down. This is likely to impact on his ability to return to work post-operatively and is a source of anxiety for Mr M and his family.

If MLC Life Insurance were able to assist Mr M undergo surgery and rehabilitation in a timely manner we could also assist him with restructuring his business temporarily while he recovers. This approach would enable him with a clear return pathway to employment. Without this option, Mr M remains on claim with a clouded employment future.

Public benefits of life insurers paying for health services

It is not just life insurance customers that stand to gain from a reform of rules preventing life insurers from paying for rehabilitation related medical treatment. If life insurers were permitted to have the option to fund medical treatment related to rehabilitation that resulted in higher rates of customers returning to their employment, there would be a shared public benefit across the community as a whole. This benefit would accrue at multiple levels:

- At the individual level employed people are healthier, enjoy better standards of living and experience greater levels of life satisfaction¹¹.
- At the employer level, employers regain the skills, knowledge and productivity of their employees while avoiding the costs associated with recruiting and training new employees.

¹¹ Australasian Faculty of Occupational and Environmental Medicine, Realising the Health Benefits of Work, 2011, <https://www.racp.edu.au/advocacy/division-faculty-and-chapter-priorities/faculty-of-occupational-environmental-medicine/health-benefits-of-good-work>

- At the government (and taxpayer) level, employed people are also far less likely to be in receipt of welfare support or have unplanned use of the healthcare system¹².
- At the macroeconomic level, an employed person is contributing to economic productivity of the Australian nation.

There are other benefits as well: There is substantial evidence demonstrating the link between disablement and lower rates of labour force participation¹³. As Australia grapples how to respond to current and future labour market and skills challenges, we believe there is a strong public benefit to be obtained from insurers being permitted to pay for treatments that help trained and productive working age people to remain in the workforce.

Legal impediments to rehabilitation benefits, including funding medical treatment

As noted in our earlier response to question in the Terms of Reference for this inquiry, there are presently a number of legal impediments embedded in health legislation that prevent MLC Life Insurance from funding medical treatment as part of a program of rehabilitation. This is even the case where a life insurer does not contract to insure medical treatment, but only wishes to fund it on voluntary basis.

We have also considered possible impediments in financial services legislation. Section 234 of the *Life Insurance Act 1995* (Life Act) prohibits a life insurance company from carrying on any business other than *life insurance business*, which is itself defined at sections 11, 12A and 12B of the Life Act. Taken together we understand these sections permit life insurers to have the option to fund the sort of medical services that would be relevant to a program of rehabilitation. This is because the trigger for the rehabilitation need is an illness or injury for which benefits under a life policy are payable.

Confirmation of this understanding would require liaison with the industry prudential regulator the Australian Prudential Regulation Authority (APRA) to understand its position. The key question is whether the proposed rehabilitation payments as set out in this paper would be considered health insurance business. If so this would form an impediment to life insurers funding rehabilitation related medical services, but we note the reforms to health legislation we propose earlier in this submission, on pages 6 to 8, would resolve it.

We have considered other possible legal restrictions that prevent insurers from including non-medical rehabilitation benefits in some types of life insurance policies. The *Superannuation Industry (Supervision) Regulations 1994* regulation 4.07D requires for a trustee of a regulated superannuation fund to not provide an insured benefit to a member of the fund, unless the insured event is consistent with specific conditions of release. Presently the conditions of release do not permit the release of benefits for rehabilitation, whether medical or otherwise. We do not believe the superannuation restrictions will prevent the life insurer from voluntarily paying for rehabilitation medical treatment when it is fully funded by the life insurer rather than paid for by superannuation fund monies or assets. Nevertheless, this restriction will need to be considered so as to holistically ensure life insurance policies purchased via superannuation contain the same access to rehabilitation benefits as presently permitted in policies purchased via retail policies.

¹² In fact effective early intervention itself is associated with savings of up to 64% in medical costs, and up to 80% in disability benefits. The cost of rehabilitation is also lower at, up to 56 % lower when administered early. See Theodore, Mayer, Gatchel, "Cost-effectiveness of early versus delayed functional restoration for chronic disabling occupational musculoskeletal disorders", *Journal of Occupational Rehabilitation*, June 2015, Volume 25, Issue 2, pp. 303–315

¹³ Mavromaras, K; Oguzoglu, U; Black, D and Wilkins, R. *Disability and Employment in the Australian Labour Market*, Melbourne Institute of Applied Economic and Social Research, 2007

d. the current definitions, standards, and requirements claimants must meet to access services and payments, including waiting periods or prerequisites.

Notwithstanding our desire to be able to better support our customers return to health and employment through the funding of medical treatment, a number of current and past generation MLC Life Insurance products contain non-medical rehabilitation related product features. These features are termed the Rehabilitation Expense Benefit and the Rehabilitation Bonus:

- The Rehabilitation Expense Benefit is designed to assist customers with medical conditions to obtain sustainable suitable work.
- The Rehabilitation Bonus is to act as an incentive for a claimant to participate in a vocational rehabilitation program.

Depending on the product, none¹⁴, one or both of these features may be present.

By way of example, the policy definitions for our current generation on sale product, *MLC Insurance*, relating to rehabilitation and to the Rehabilitation Expense Benefit and the Rehabilitation Bonus are listed in the table below. Please note that while the definitions and the product features in previous generation products fulfil a similar role, the definitions differ slightly, and can be provided upon request.

Rehabilitation	Rehabilitation means: <ul style="list-style-type: none"> • a government approved vocational rehabilitation program; or • another rehabilitation program approved by us.
Rehabilitation Expense Benefit	<p>If the Life Insured is Disabled we will pay for rehabilitation expenses (such as the cost of a rehabilitation course or special equipment to help the Life Insured return to work) that have been approved by us up to a maximum of 12 times the Monthly Benefit.</p> <p>The Rehabilitation Expense Benefit is in addition to any other benefits we may pay.</p>
Rehabilitation Bonus	<p>If You are receiving Disability Benefits while the Life Insured is undergoing Rehabilitation, we will pay You an additional benefit for up to a maximum of 12 months.</p> <p>The additional benefit we will pay each month will be 50% of the Disability Benefit being paid.</p>

Other than the requirement noted above for a rehabilitation program to be either a government approved vocational rehabilitation program or approved by us, MLC Life Insurance applies no waiting periods or prerequisites to the provision of rehabilitation. In fact as noted earlier in this submission, we seek to engage customers in our early intervention programs prior to a claim being submitted or accepted.

¹⁴ Notable for not having rehabilitation benefits are policies owned by superannuation trustees. This is due to constraints on restrictions in the *Superannuation Industry (Supervision) Regulations 1994* which prevent rehabilitation benefits from being provided under policies issued to superannuation fund trustees. See page 15 for more information.

Current types of rehabilitation services provided by MLC Life Insurance

The table below sets out the type of rehabilitation services presently provided by MLC Life Insurance.

One-Off Assessments	Programs	Pre-vocational	Training	Other
Initial Needs Assessment	Return to Work Plan	Wellbeing/work readiness/resilience/goal setting	TAFE (public RTO)	Ergonomic equipment
Workplace Assessment	Job Search Assistance	Vocational counselling	Registered Training Organisations (RTO)- private	Gym membership
Functional Capacity Assessment	Volunteer work	Cancer wellness	University (higher education)	Vehicle modifications
Ergonomic Assessment	Work trial	Medical Case Conferencing	Community Colleges- VET	Home modifications
Driving Assessment	Work conditioning/ exercise program	Exercise program		
Vocational Assessment	Training			
Task Analysis	Executive Coaching			
Labour Market Analysis	Business coaching			

e. the consistency and transparency of IP and TPD insurance definitions, policies, and disclosure documents in the context of other rehabilitation schemes.

This question is not addressed.

f. information available to consumers about IP and TPD insurance in the context of other rehabilitation schemes.

From a clinical perspective, it is important for customers to only participate in a single program of rehabilitation at a time. Sometimes we encounter customers who are also on workers compensation and receiving rehabilitation via their workers compensation insurer. In these scenarios we do not offer rehabilitation until the first program is completed and results are known.

In some instances a workers compensation insurer will not cover the desired rehabilitation service, leading customers opting to cease their involvement in the workers compensation rehabilitation program and to move to a program offered by us.