

# AIA Australia submission to the Parliamentary Joint Committee on Corporations and Financial Services inquiry into the options for greater involvement by private sector life insurers in worker rehabilitation



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## Executive Summary

Allowing private sector life insurers to have greater involvement in worker rehabilitation will help create a more complete system for supporting those who have an injury or illness that is impacting their ability to work. Specifically, allowing life insurers to fund medical treatment and medical expenses for eligible claimants under a continuous disability policy will help to minimise existing gaps in our income support and healthcare system that may restrict or prevent effective return to work. The proposed changes are intended to complement, not replace, existing income support and healthcare systems.

Allowing life insurers to fund medical treatment and medical expenses will deliver Shared Value. That is, it will create benefits for individuals and their families, Government and society, and life insurers. It is a win-win-win solution.

## Benefits for individuals

Individuals will benefit by being able to access more avenues to support them in returning to wellness. This will enable them to return to work earlier, which we know can help to promote recovery. As a result, these individuals will be in a better financial position in the longer term. When we conducted joint research with Sunsuper in 2015, we found that 22% of TPD claimants had returned to work (19% in full time work, and 3% in part time work) following payment of their claim. A further 14% were actively seeking employment.

Consumers want support to return to work, and many consumers are using benefits that are intended as income support to fund medical treatment/expenses. 31% of all claimants had spent some of their benefit on medical treatment. 66% of all claimants wanted assistance in finding a job and 69% wanted assistance in retraining/up-skilling. Swiss Re's Rehabilitation Watch found that across the industry over 80% of claimants who were identified as suitable for rehabilitation intervention opted to participate.<sup>1</sup> Allowing life insurers to fund medical treatment/expenses would enable them to better meet evolving customer needs and expectations.

## Benefits for Government and society

Government and society will benefit through a reduced impact of absenteeism and presenteeism, as well as reduced expenditure on social security and healthcare. In Australia, approximately 43.9 days are lost on average per employee due to ill-health related to absenteeism or presenteeism.<sup>2</sup> 786,000 Australians who were unable to work due to ill health, injury or disability received income support from a commonwealth, state, territory or private source in the 2015/16 financial year.<sup>3</sup> A total of \$18.5 billion was spent on income support for these people through these avenues, \$8.6 billion (46%) coming from social security – largely through the disability support pension. In 2014-15, health expenditure totalled \$161.6 billion, with \$108.2 billion (67%) funded by Australia's various levels of government.<sup>4</sup>

Collaboration between corporates, Government and other stakeholders is critical as Australia seeks to address the economic and fiscal challenges of an ageing population. As our working population continues to age, we can expect costs to increase. For example, our ageing population is predicted to result in health expenditure increasing from 6.5% to 10.8% of GDP over the next 50 years.<sup>5</sup> The more that we can solve through cooperation between the private sector and Government, then the better we can allocate the available resources of Government.

## Benefits for life insurers

Life insurers benefit by being able to better respond to customer needs by supporting and assisting them through their return to work, rather than simply paying and closing claims. Based on experience from investing in occupational rehabilitation and associated programs, these changes are expected to deliver a positive return on investment through improved claims experience. For example, Swiss Re's Rehabilitation Watch 2016 found that for every \$1 spent on rehabilitation services, insurers saved \$25 on income protection claims costs.

Allowing life insurers to fund medical expenses and treatment will further encourage innovation in product design and definitions that embrace mechanisms to support recovery, and deliver improved outcomes for consumers by better responding to their needs and expectations. The savings can also be used to minimise future premium increases.

In the group insurance context, we partnered with Sunsuper to introduce 'TPD Assist', a benefit design that provides members with time and support to recover and re-enter the workforce by: removing waiting periods for claims, focusing on early intervention and occupational rehabilitation, and structuring the benefit payment in six equal annual payments over

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<sup>1</sup> Swiss Re Rehabilitation Watch 2016

<sup>2</sup> Australia's Healthiest Workplace Survey by AIA Vitality – 2017 Country Health Report for Australia

<sup>3</sup> The Cross Sector Project – Mapping Australian Systems of Income Support for People with Health-Related Work Incapacity Final Report (January 2018)

<sup>4</sup> The Future of Workers' Compensation by Lisa Simpson (2017)

<sup>5</sup> The Future of Workers' Compensation by Lisa Simpson (2017)

five years. This focus on recovery and return to work helped reduce premiums by \$36 million per year, a 30% reduction in premium fees compared with the previous Total and Permanent Disablement offering.<sup>6</sup>

## The solution

To allow life insurers to fund medical treatment and medical expenses, amendments will need to be made to the Life Insurance Act 1995 (Cth), Private Health Insurance Act 2007 (Cth), Private Health Insurance (Health Insurance Business) Rules 2017, Health Insurance Act 1973 (Cth), Superannuation Industry (Supervision) Act 1993 (Cth) and the Superannuation Industry (Supervision) Regulations 1994. These legislative changes should be supplemented by principles that protect consumer interests and provide guidance and clarity. These principles should be included in regulations or otherwise included in the Financial Services Council Life Insurance Code of Practice.

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<sup>6</sup> <https://investmentmagazine.com.au/2016/08/sunsuper-saves-36-million-with-tpd-assist/>

## Why does the current system need change?

Allowing life insurers to fund medical treatment and expenses will help create a more efficient and effective system of income support. This in turn supports people with illness and injury and assists them to return to wellness and work. The inability for customers to afford the right treatment when it is needed is often a barrier in their recovery.

The current framework of healthcare, rehabilitation, employment and disability support, and income support systems is complex and fragmented. Life insurers, Government and other stakeholders within this landscape need to identify and action opportunities to make this system more complete and help people to remain in employment and/or return to work after a period of work incapacity. We know that employment is a determinant of health and that poor health is a major contributor to loss of work capacity and unemployment. We also know that re-engagement in work after a period of injury or illness can promote recovery.

The Cross Sector Project articulates that participants in this space share common objectives, to:

1. prevent illness and injury affecting work capacity;
2. reduce the severity and duration of work incapacity where it occurs;
3. improve engagement in good work; and
4. minimise the costs of work incapacity to society, workers and employers.<sup>7</sup>

While it is true that no single system acting in isolation will be able to achieve these goals, allowing life insurers to fund medical treatments will help to solve existing gaps and will encourage product innovation and collaboration across industry participants and help to address objectives 2, 3 and 4.

Currently, when an Australian suffers injury or illness they have several avenues through which they can access treatment. The majority will start by seeking diagnosis and treatment through their general practitioner, a specialist, allied health professionals, or through specialist organisations and the internet.

Some of these systems may be freely available through the public system and via Medicare. Others may be funded through private health insurance or may be funded by workers' compensation, motor vehicle accident insurance, or be self-funded. Though there are a myriad of options for funding treatment, gaps remain and opportunities for more effective treatment are available.

The following section will provide some insight into the Health Benefits of Good Work, as well as current gaps that exist in the income support and healthcare system where allowing life insurers to fund medical treatment/expenses may benefit individuals and lift this barrier to recovery and return to work.

## Health Benefits of Good Work

*"The results of worklessness are plain to see: loss of self-esteem, standing and identity within the community besides, of course, a halt to material progress, social participation and fulfilment. But that is not all. Health, both physical health and mental health, soon become impaired. And where the cause of loss of work is itself impaired health then unwarranted delay in return to work is often associated with delayed recovery"<sup>8</sup> – Dame Carol Black*

As a society, we must do as much as we can to help people who have had an injury or illness preventing them from working to recover and return to work. By allowing life insurers to fund medical treatment/expenses we can help people return to work sooner and minimise the risk of extended periods of time out of work and the negative physical and mental health consequences that this can have.

The key reasons for encouraging people to return to work are outlined in the Royal Australian College of Physicians (RACP) Consensus Statement on the Health Benefits of Good Work:

- the provision of good work is a key determinant of the health and wellbeing of employees, their families and broader society; and
- long term work absence, work disability and unemployment may have a negative impact on health and wellbeing.

<sup>7</sup> The Cross Sector Project – Mapping Australian Systems of Income support for People with Health-Related Work Incapacity (January 2018)

<sup>8</sup> <https://www.racp.edu.au/docs/default-source/advocacy-library/realising-the-health-benefits-of-work.pdf?sfvrsn=10>



The longer someone is off work, the less likely they are to ever return. 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%; and
- 70 days the chance of ever getting back to work is 35%.<sup>9</sup>

Research has shown that unemployment can have profound consequences, particularly for young people and may lead to a range of mental health concerns such as depression, anxiety and low self-esteem. These may also impact physical health through consequential negative lifestyle choices including smoking, illicit substance use and high mortality from suicide and accidents.<sup>10</sup>

Conversely, there are many observable benefits when examining the health benefits of re-employment, including:

- improvement in markers of general health and wellness, such as self-esteem, self-rated health, self-satisfaction, physical health and financial concerns;
- reduction in psychological distress and minor psychiatric morbidity;
- contribution to lower morbidity rates; and
- improved physical functioning and mental health in older workers.<sup>11</sup>

Studies have shown that the consequences of being out of work also impact the families and children of parents out of work, including poorer physical and mental health. For example, research into the impact of parental unemployment on children has found:

- children have a higher likelihood of chronic illnesses, psychosomatic symptoms and lower wellbeing in households where neither parent has worked in the previous six months;
- in households where the parents are not working, children are more likely in the future to be out of work themselves; and
- psychological distress may occur in children whose parents face increased economic pressure, sometimes resulting in withdrawal, anxiety and depression in the children.<sup>12</sup>

For these reasons, we strongly support programs and reforms that will enable us to support and assist more people in their recovery and help them return to work. Supporting people to return to work has tremendous benefits for individuals and their families' financial, physical and mental health.

Consistent with this commitment, AIA is a signatory to the RACP Health Benefits of Good Work Charter of Principles as follows:

- when practicable, we encourage and accommodate people to remain connected to the workplace while recovering from illness or injury, as this facilitates shorter recovery times and prevents unnecessary disability;
- we embrace the spirit of inclusive employment practices which helps to reduce the risk of unemployment, social and economic inequality and associated poor health outcomes;
- if injured or ill, we promote best practice rehabilitation and injury management for workers;
- where appropriate, we encourage people with chronic illness and disabilities to be accommodated in the workplace with a supportive work culture;
- we promote the mental and physical health and well-being of people by fostering a supportive working environment and good interpersonal relationships;
- we understand that good work promotes good health and increases productivity;
- we advocate for safe and healthy work practices knowing this has socioeconomic benefits for both business and the wider community; and
- we recognise that involvement in good work can promote social cohesion and increase peoples' sense of contribution to society.<sup>13</sup>

Allowing life insurers to fund medical treatment/expenses will support these principles, and help even more people realise the Health Benefits of Good Work in their recovery.

<sup>9</sup> Realising The Health Benefits Of Work – Position Statement October 2011

<sup>10</sup> Realising The Health Benefits Of Work – Position Statement October 2011

<sup>11</sup> Realising The Health Benefits Of Work – Position Statement October 2011

<sup>12</sup> Realising The Health Benefits Of Work – Position Statement October 2011

<sup>13</sup> <https://www.racp.edu.au/docs/default-source/advocacy-library/pa-health-benefits-of-work-charter-of-principles.pdf?sfvrsn=6>

## Reducing Government expenditure on health and income support

A substantial amount of health funding comes from the public purse, both as a proportion and raw figure. Government must look for opportunities for efficiency, and for the private sector to play a greater role. Of course, public healthcare is an important foundation of the Australian system and must be protected, the Australian public has indicated that it will not accept cuts to health services. However, the current trend does not appear to be sustainable in the long term. In 2014-15 the total health expenditure totalled \$161.6 billion, funded by:<sup>14</sup>

- 108.2 billion (67%) by Australia's various levels of government;
- 42.6 billion (27%) directly by the Australian population through out of pocket payments (28.6 billion or 18%) and private health insurance (\$14 billion or 9%);
- \$10.8 billion (7%) from other non-government sources. Out of this, injury compensation insurers funded \$2.8 billion of the expenditure in 2013-14 (\$1.6 billion or 1% by workers' compensation insurers and \$1.2 billion or 1% by motor vehicle third party insurers).

This is only set to grow, with healthcare expenditure in Australia expected to grow from 6.5% to 10.8% of GDP over the next 50 years due largely to ageing populations, cost of new technologies and higher public expectations.<sup>15</sup>

Allowing life insurers to fund medical treatment/expenses will provide another avenue of funding that may have positive implications for government spend on health, and out of pocket payments for Australians. By supporting people to return to work, consequential impacts of poor health on the economy can also be minimised. Approximately 43.9 days are lost on average per employee due to ill-health related to absenteeism or presenteeism.<sup>16</sup> 786,000 Australians who were unable to work due to ill health, injury or disability received income support from a commonwealth, state, territory or private source in the 2015/16 financial year.<sup>17</sup> A total of \$18.5 billion was spent on income support for these people through these avenues, \$8.6 billion (46%) coming from social security – largely through the disability support pension. If life insurers were given extra capacity to support people to return to work, this is likely to have a positive influence by reducing these impacts.

## Filling gaps in support provided by Medicare and Private Health Insurance

### Medicare

Most people can access funding for medical treatment through Medicare, and the Pharmaceutical Benefits Scheme provides funding for pharmaceutical products. However, there are often gap payments which are paid by the individuals, which may be prohibitively high. In some instances, a preferred provider or service may not be available through the public system which will also mean that treatment needs to be funded by out of pocket expenses, acting as a barrier to treatment.

For others, there may be significant waiting lists which can reduce an individual's chance of effective recovery if it means they are off work for an extended period.

This can be particularly prevalent in regional areas. On a per capita basis, AIA experiences a higher percentage of claims from rural rather than metro areas. This may reflect that Australians living in rural and remote areas tend to have lower life expectancy, higher rates of disease and injury, and poorer access to and use of health services than people living in major cities.<sup>18</sup> Sometimes these individuals need to travel long distances or relocate to attend health services or receive specialised treatment, and may otherwise rely on fly-in-fly-out or drive-in-drive-out healthcare providers with extensive wait lists that may act as a barrier to treatment, recovery and return to work.

In these instances, the ability of a life insurer to fund medical treatment/expenses if the individual was eligible under a continuous disability policy could mean that treatment can be provided in the private system, reducing the potential waiting time and enabling a claimant to recover and return to work sooner, and to begin realising the Health Benefits of Good Work. Similar advantages would flow where an individual's limited financial resources are acting as a barrier to recovery.

<sup>14</sup> The Future of Workers Compensation by Lisa Simpson (2017)

<sup>15</sup> The Future of Workers Compensation by Lisa Simpson (2017)

<sup>16</sup> Australia's Healthiest Workplace Survey by AIA Vitality – 2017 Country Health Report for Australia

<sup>17</sup> The Cross Sector Project – Mapping Australian Systems of Income Support for People with Health-Related Work Incapacity Final Report (January 2018)

<sup>18</sup> <https://www.aihw.gov.au/getmedia/6d6c9331-5abf-49ca-827b-e1df177ab0d3/ah16-5-11-rural-remote-health.pdf.aspx>

## Private Health Insurance

A significant portion of the Australian population is not covered by health insurance. 47.4% of the population has hospital treatment cover, and 55.8% have some form of general treatment cover. This means that a significant portion of the population relies on the public system and public funding for medical treatment and services.

For example, an individual and their treating doctor identify that the individual would benefit from ongoing psychological support. When referred by their GP or psychiatrist, most people would be eligible for Medicare rebates for ten sessions each calendar year under a Mental Health Treatment Plan.

If you are treated by a psychiatrist in a community health centre or a public hospital, this service is covered by Medicare. These services may have longer waiting lists than a psychiatrist in private practice, however for private practice Medicare will refund only part of the fee. When the 10 sessions have been used, the treatment would need to be funded by out of pocket expenditure by the individual. Depending on the type and level of private health insurance cover, gap payments might be covered, as might additional sessions outside the Mental Health Plan. This will not be the case in all instances. The changes to private health insurance announced in March 2018 will provide a useful safety net by allowing patients with limited mental health cover to upgrade their cover on a once-off basis to access in-hospital mental health services without serving a waiting period.<sup>19</sup> However, this type of treatment is not necessarily best suited to ongoing management that would help a person remain in work, and is more geared toward individuals who are most acutely unwell.

Life insurers being able to fund medical treatment or expenses could help people in these situations where limitations in the current system exist - for example where the individual did not have private health insurance, or where gap payments were prohibitively high in the context of the individual, or where a significant wait list existed in the public system. This is the type of role that we foresee for life insurers in the payment of medical treatment or medical expenses. It is not to replace any existing systems, but rather to supplement them and act as an additional avenue for support for people seeking to return to wellness/work.

## NDIS

The NDIS does not cover income or housing, nor does it pay lump sum benefits. From a mental health perspective, it only covers the most serious disabilities, including congenital intellectual disabilities and it is unlikely high prevalence conditions such as depression and anxiety will be included.<sup>20</sup>

75% of claims for TPD and 85% for IP relate to high prevalence conditions such as depression and anxiety.<sup>21</sup> This means a significant amount of people are unable to access support through NDIS. Removing the legislative barriers that prevent life insurers from funding medical treatment/expenses will help ensure these people can access treatment and support for their recovery.

## Filling gaps in support provided by Workers Compensation

In some respects, workers' compensation schemes can provide a model for life insurance companies to pay for medical treatments and medical expenses. This is because workers' compensation is an income support scheme, but will also usually cover medical, hospital and allied health expenses to support a return to wellness outcome.

## Demonstrating a connection with work

Workers' compensation is a compulsory system and consequently has broad coverage. It is also 'no fault', however the test for payment requires that the employee is disabled or injured *in connection with work*. This means that the injured person must be able to demonstrate that the injury or disability arose 'out of or in the course of employment'. This will not be true in all cases. For example, workers' compensation accounted for 156,000 (19.8%) of the 786,000 people who were unable to work due to ill health, injury or disability and received income support in 2015/16.

Eligibility rules differ depending on the relevant workers compensation scheme. Due to escalating costs, the tests have become stricter – for example, by requiring that the employment must have been a significant, material, substantial or the major contributing factor to the injury.

<sup>19</sup> <http://www.health.gov.au/internet/main/publishing.nsf/Content/MC18-001267-PHI-Premium-Increases-2018>

<sup>20</sup> Actuaries Institute Mental Health and Insurance Green Paper (October 2017)

<sup>21</sup> Actuaries Institute Mental Health and Insurance Green Paper (October 2017)



## Mental Health

Eligibility tests may create significant challenges for certain individuals. For a psychological injury or mental health condition it may be very difficult to determine whether it is attributable to employment conditions or other causes. Some schemes also exclude mental ill health where it develops secondary to a physical injury.<sup>22</sup> Workers' compensation is also not available if the mental health condition was the result of 'reasonable management action' (for example, appraisal of the worker's performance based on reasonable grounds and delivered in a reasonable manner).<sup>23</sup> This presents challenges for individuals claiming for mental ill health through workers' compensation. It also presents a societal challenge as to the best way to support these individuals through our income support and healthcare system.

The scale of this challenge is significant. One in five Australians aged over 15 will be affected by a mental health condition in any 12-month period, and one in two will be affected across the span of a life time.<sup>24</sup> Mental illness is now the leading cause of work absence and long-term work incapacity in the developed world, most commonly anxiety and depression. Mental ill health represents about 12% of the total disease burden, the third largest group after cancer and cardiovascular diseases. The World Health Organisation estimates that depression will be the leading cause of disease burden by the year 2030.<sup>25</sup>

We also know that many (63%) Australians suffering from mental health conditions believe that the current mental health system is complex and too confusing- one third felt frustrated trying to navigate the healthcare system, and seven in ten who sought help said it was a negative experience.<sup>26</sup> Most tellingly, 72% were concerned about the cost of treatment, 48% were concerned about long wait times and 43% indicated they had considered giving up treatment.<sup>27</sup> This demonstrates that there is a need that could be filled by life insurers being able to fund medical treatment and expenses.

Part of the challenge arises from the very nature of mental ill health claims. For most physical injuries and illness there are objective tests and indicators that enable diagnosis and certainly it is more straightforward to determine whether a physical injury occurred during the course of work. Mental health diagnoses, in contrast, are often subjective, with diverse symptoms and diagnoses. Quite often a diagnosis is based on descriptions which vary greatly, and 'may not link strongly to any specific neurobiological or environmental risk factors' making it difficult to establish the causal link between the illness and employment. This may be compounded by the fact that psychiatrists often disagree on the applicable diagnosis, and people may vary in the way they describe their own symptoms.<sup>28</sup>

These challenges in assessing mental ill health claims are not limited to workers' compensation, however, the additional requirement to establish a causal link with the employment has led to a lower proportion of mental health claims being supported. Mental ill health represents about 12% of the disease burden, and represents a similar proportion of claims for AIA. Some life insurers report a higher prevalence rate, at 19% of claims by count, and 26% of claims by cost.<sup>29</sup> For life insurers, there is also minimal difference between the rate of decline for mental ill health claims and claims arising from injuries and musculoskeletal diseases.<sup>30</sup> In contrast, the proportion of claims for mental ill health in workers' compensation is 6%. The highest level of dispute arising in most workers compensation schemes is for mental ill health due to this challenge. Queensland workers' compensation schemes rejected 65% of psychological claims in 2014/15, of which 96.8% were due to the injury arising out of reasonable management actions.<sup>31</sup> This is not a criticism of the workers' compensation system, but rather an illustration that there are many individuals who would subsequently transition to life insurance claims where the additional medical treatment support is not available.

In 2014, a major provider of TPD insurance surveyed people who had received a TPD payment and found that 23% of those who had claimed for mental ill health had returned to the workforce after receiving their payment, and a further 12% were actively seeking work. 47% of those who had returned to work had undertaken training and 65% reported that they would have liked assistance to return to the workforce.<sup>32</sup> This shows that certain claimants may be better served by

<sup>22</sup> Actuaries Institute Mental Health and Insurance Green Paper (October 2017)

<sup>23</sup> Actuaries Institute Mental Health and Insurance Green Paper (October 2017) see also: <http://www1.worksafe.vic.gov.au/vwa/claimsmanual/Content/2WorkersAndInjuries/2%201%202%201%20Mental%20injury.htm>

<sup>24</sup> Actuaries Institute Mental Health and Insurance Green Paper (October 2017)

<sup>25</sup> Actuaries Institute Mental Health and Insurance Green Paper (October 2017). n.b. 'disease burden' is the impact of a health problem as measured by financial cost, mortality, morbidity, or other indicators.

<sup>26</sup> <https://www.mlcinsurance.com.au/about-us/media/australian-mental-health-system-too-complex-research-reveals>

<sup>27</sup> <https://www.mlcinsurance.com.au/about-us/media/australian-mental-health-system-too-complex-research-reveals>

<sup>28</sup> Actuaries Institute Mental Health and Insurance Green Paper (October 2017)

<sup>29</sup> Actuaries Institute Mental Health and Insurance Green Paper (October 2017)

<sup>30</sup> Actuaries Institute Mental Health and Insurance Green Paper (October 2017)

<sup>31</sup> The Future of Workers Compensation by Lisa Simpson (2017)

<sup>32</sup> Actuaries Institute Mental Health and Insurance Green Paper (October 2017)

income stream style products, together with assistance returning to wellness and work, including the payment of medical treatment/expenses such as ongoing psychological support.

This a huge opportunity for life insurers to help support individuals with a mental health condition that is preventing them from working. Mental ill-health is estimated to cost the economy \$60 billion a year, and it is estimated that realistic improvements in mental ill-health rates could improve workforce participation rates by 30%.<sup>33</sup> Median time lost for a mental health claims was about 10 times that of all claims in Australia in 2009-10 in the workers compensation system.<sup>34</sup> This is troubling when we consider that the longer someone is off work, the less likely they are to return. Removing the barriers that prevent life insurers from funding medical treatment/expenses will ensure that people suffering from mental health conditions will have another avenue of support.

## Aging population

When we consider age, over the last 37 years the proportion of employed persons aged 55 and over has increased from 11% to 18%.<sup>35</sup> As for mental ill health claims, it can be difficult to determine what is just the impacts of aging, and an injury related to working. While the workers compensation scheme will inevitably cover some of these costs that are not strictly work related, the rising number of older workers will need support that will not be provided through the workers' compensation system. This challenge will only increase, with those born in 2012 having a life expectancy of 92-94 years and with young workers looking at a reality where they will be retiring in their 80s.<sup>36</sup> Though there are challenges with older workers in achieving positive return to work outcomes, the ability to provide both vocational and medical support will allow more opportunities to help older people back into work and prevent flows into the disability support pension and Newstart.<sup>37</sup>

## Self-employed people

Often self-employed people are not covered by workers' compensation, with about 10% of working Australians being self-employed.<sup>38</sup> The self-employed on average tend to be older than employees. Around 20% of the self-employed are aged 60 years and over, compared with 9% of the overall workforce.<sup>39</sup> Life insurance is critical for the self-employed, however, while life insurance – particularly IP – will provide income support, these individuals cannot currently be offered the same level of support that can be offered to employed persons through workers compensation. This is a concerning when we think that a self-employed person is more vulnerable to suffering of their business the longer that they are off work, and thus could benefit substantially by having the support of a life insurer with respect to medical treatment and expenses.

<sup>33</sup> Investing to Save – The Economic Benefits for Australia of Investment in Mental Health Reform (May 2018)

<sup>34</sup> Actuaries Institute Mental Health and Insurance Green Paper (October 2017)

<sup>35</sup> The Future of Workers Compensation by Lisa Simpson (2017)

<sup>36</sup> The Future of Workers Compensation by Lisa Simpson (2017)

<sup>37</sup> The Future of Workers Compensation by Lisa Simpson (2017)

<sup>38</sup> ASFA Super and the self-employed (May 2016)

<sup>39</sup> ASFA Super and the self-employed (May 2016)

## What are the current barriers that prevent life insurers from funding medical treatment or medical expenses?

Life insurers are limited in their ability to help people to return to wellness and work. Currently, life insurers can provide rehabilitation that has an occupational or vocational focus. Some policies also include a nursing care benefit, typically where a person is confined to bed and needs to be under the care of a registered nurse. However, life insurers are prevented from providing targeted benefits that may otherwise be insured by a private health insurer as health insurance business, or, are covered by Medicare.

The following section will outline how the current legislation operates in a manner that prevents life insurers from funding medical treatment or expenses. The relevant pieces of legislation include:

- Life Insurance Act 1995 (Cth)
- Private Health Insurance Act 2007 (Cth)
- Private Health Insurance (Health Insurance Business) Rules 2017
- Health Insurance Act 1973 (Cth)
- Superannuation Industry (Supervision) Act 1993 (Cth); and,
- Superannuation Industry (Supervision) Regulations 1994.

### The Life Insurance Act 1995 (Cth)

The Life Insurance Act sets out the legislative requirements for carrying on a life insurance business, permits life insurers to engage in life insurance business, and defines what constitutes life insurance business.

A company that wishes to issue a life policy or undertake liability under a life policy must apply for registration with the Australian Prudential Regulation Authority (APRA). Subject to satisfying the registration requirements, APRA will register the company as a life company.<sup>40</sup>

Life companies are permitted to engage in life insurance business, and must not intentionally carry on any insurance business other than life insurance business.<sup>41</sup> Life insurance business is defined under the Life Insurance Act to include 'the issuing of life policies', and 'the undertaking of liability under life policies'.<sup>42</sup>

Life policy is also defined under the Life Insurance Act and includes 'a continuous disability policy'.<sup>43</sup> Continuous disability policies come in a variety of structures and are more commonly referred to as Total and Permanent Disability insurance (TPD), Income Protection insurance (IP), and Trauma or Critical Illness benefits. These products must comply with the definition of continuous disability policy, being a contract of insurance:

- a) that is, by its terms, to be of more than three years' duration; and
- b) under which a benefit is payable in the event of:
  - i. the death, by accident or by some other cause stated in the contract, of the person whose life is insured (the *insured*); or
  - ii. injury to, or disability of, the insured as a result of accident or sickness; or
  - iii. the insured being found to have a stated condition or disease.<sup>44</sup>

A contract of insurance entered into in the course of carrying on a health insurance business is not a continuous disability policy.<sup>45</sup> Further, though a life insurer may request APRA to make a declaration that certain business is 'life insurance business', they are unable to do so for anything that is considered carrying on a 'health insurance business'.<sup>46</sup> Each benefit under a policy of insurance issued by a life insurer must satisfy the requirements of a 'life policy' under the Life Insurance Act.

This means that a life insurer is only able to provide benefits under a life policy for medical treatment or medical expenses, provided that the policy conforms to the definition of 'life policy' and where said benefits do not constitute 'carrying on a health insurance business'. Therefore, we must examine what constitutes a health insurance business.

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<sup>40</sup> Life Insurance Act sections 234, 17, 20, 21

<sup>41</sup> Life Insurance Act sections 234, 17, 20, 21

<sup>42</sup> Life Insurance Act section 11

<sup>43</sup> Life Insurance Act section 9

<sup>44</sup> Life Insurance Act section 9A

<sup>45</sup> Life Insurance Act section 9A

<sup>46</sup> Life Insurance Act sections 12A, 12B

## The Health Insurance Act 1973 (Cth), Private Health Insurance Act 2007 (Cth) and Private Health Insurance (Health Insurance Business) Rules 2017

The Health Insurance Act prohibits a person from making a contract of insurance with another person that contains a provision purporting to accept liability to pay medical expenses in respect of a professional service for which a Medicare benefit is payable.<sup>47</sup> The only avenue for life insurers to fund medical treatment or expenses would be where no Medicare benefit is payable, or where there is a relevant exemption from this prohibition.

There are two exemptions from this prohibition, relevantly for our purposes is the exemption for contracts of insurance entered into by a private health insurer in so far as the contract is a complying health insurance policy that covers hospital treatment or hospital-substitute treatment.<sup>48</sup> However, life insurers are not private health insurers and therefore cannot carry on a health insurance business.<sup>49</sup>

Payment for medical expenses or treatment under a continuous disability policy would constitute carrying on a health insurance business. This is because a health insurance business is defined as the business of undertaking by liability, by way of insurance, that relates to hospital treatment or general treatment.

Hospital treatment is defined as treatment that:

- Is intended to manage a disease, injury or condition;
- Is provided to a person by a person who is authorised by a hospital to provide the treatment under the management or control of such a person; and
- Is either provided at a hospital or arranged with direct involvement of a hospital.<sup>50</sup>

Treatment includes a reference to any combination of accommodation, nursing, medical, surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or other services or goods intended to manage a disease, injury or condition.<sup>51</sup>

This already broad concept of hospital treatment is expanded by any treatments specified in the Health Insurance Business Rules.<sup>52</sup>

General treatment is defined in equally broad terms, as treatment that is:

- Intended to manage or prevent a disease, injury or condition; and
- Is not hospital treatment.<sup>53</sup>

Further context is again provided by the Health Insurance Business Rules.<sup>54</sup>

The above leaves little scope for life insurers to fund medical treatment or medical expenses under a continuous disability policy.

There are, however, carve outs for specific types of insurance that are excluded from the concept of health insurance business, meaning that you are not required to be a health insurer. These include:

- liability insurance, such as CTP and worker's compensation;
- accident and sickness insurance providing periodic or lump sum payments on the happening of a personal accident, disease or sickness provided that cover is not referable to the provision of treatment or treatment expenses; and
- specified insurance providing cover for death benefits, terminal illness, total and permanent disability, income protection.<sup>55</sup>

These exemptions do not cover the types of benefits that a life insurer may wish to provide to support treatment that would help a claimant return to work under a continuous disability policy.

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<sup>47</sup> Health Insurance Act section 126

<sup>48</sup> Health Insurance Act section 126

<sup>49</sup> Private Health Insurance (Prudential Supervision) Act section 10

<sup>50</sup> Private Health Insurance Act section 121.5

<sup>51</sup> Private Health Insurance Act section 121.5

<sup>52</sup> Private Health Insurance (Health Insurance Business) Rules section 8

<sup>53</sup> Private Health Insurance Act section 121.10

<sup>54</sup> Private Health Insurance (Health Insurance Business) Rules sections 9 - 10

<sup>55</sup> Private Health Insurance (Health Insurance Business) Rules section 11

## The Superannuation Industry (Supervision) Act 1993 (Cth) and Superannuation Industry (Supervision) Regulations 1994

The majority of cover for death, total and permanent disability and income protection is insured via superannuation funds. For full benefit of this reform to be realised, changes will need to ensure that can be paid through insurance in superannuation.

Currently, there are a number of barriers to offering the proposed benefits in conjunction with a life policy that is held through superannuation. These include:

- the sole purpose test that limits the use of superannuation funds for prescribed or approved retirement of retirement related purposes;
- insurance operating standards that limit the type of insurance that can be offered in super; and
- cashing restrictions on the nature and value of benefits released to members.

Without changes to these restrictions, were life insurers able to make the payments, they would be made into the superannuation account but then could not be released to the insured.



## What is the solution to these challenges?

### Changes to existing legislation

In order to allow life insurers to fund medical treatment or medical expenses, the following legislative changes would need to be made.

#### Life Insurance Act 1995 (Cth)

The concept of a continuous disability policy would need to be expanded to include the costs of medical treatment and expenses that are reasonably necessary to assist an insured return to wellness and work after suffering an injury, illness or disability that is covered by the policy. This would require changes to section 9A of the Life Insurance Act.

#### The Health Insurance Act 1973 (Cth), Private Health Insurance Act 2007 (Cth) and Private Health Insurance (Health Insurance Business) Rules 2017

The Private Health Insurance Act allows for exclusions to the concept of health insurance business under the Health Insurance Business Rules. This would need to be amended to include payment of medical treatment and expenses provided in conjunction with a continuous disability policy to improve function and recovery.

In addition, a further exemption would need to be included in section 126 of the Health Insurance Act so that payment for medical treatment and expenses where a Medicare benefit is not prohibited where payable where the payment is made under a continuous disability policy to improve function and recovery.

#### The Superannuation Industry (Supervision) Act 1993 (Cth) and Superannuation Industry (Supervision) Regulations 1994

Benefits provided through superannuation must be consistent with the sole purpose test, this could be achieved by amendment of section 62 of the Superannuation (Supervision) Act 1993. Alternately, APRA could make a declaration that this is an approved ancillary purpose.

The benefits would also need to be capable of being provided in conjunction with a condition of release specified in the insurance operating standard in SIS Ref 4.07D. This may require amendment in order to allow these types of benefits, or the existing condition for release may be considered sufficient in conjunction with a change to the cashing restriction.

Benefits can be released if they meet a relevant cashing restriction, currently the cashing restriction for benefits paid in relation to temporary incapacity of a member is a replacement income stream only. This would need to be amended to allow for the release of benefits for the payment of medical treatment and expenses on behalf of the member.

### Additional regulations to support

This legislative solution would need to be supported by appropriate regulations that provide further clarity and guidance.

The objective of these reforms is to allow life insurers to support people to return to wellness and work after experiencing a disability, and by being able to engage more effectively in early intervention we may increase the probability of a person successfully returning to work. This is the optimal outcome for the individual, society and the life insurer. It is win-win-win. It is about addressing a gap in protection for claimants where they do not have funds or access to other insurance, such as private health insurance or workers compensation that could fund treatment and support them to return to work.

Not all claims will require this type of support, nor will all claims be appropriate for this type of intervention. While life insurers are required to adhere to the duty of utmost good faith when handling a claim, we believe that the industry and consumers would benefit from further clarity and guidance on the funding of medical treatments and expenses by life insurers.

Such guidance could be contained in regulations, or perhaps included in a new iteration of the FSC Life Insurance Code of Practice – provided that it is registered with the Australian Securities and Investments Commission (ASIC) under the co-regulatory framework proposed under the ASIC Enforcement Taskforce Review, supported by the Government in their response to said review, and supported by the Parliamentary Joint Committee on Corporations and Financial Services in their final report on the life insurance industry.

The purpose of these regulations would be to ensure best outcomes for claimants and insurers.

## Guiding Principles

In 2014, AIA commissioned 'Principles of Best Practice in Occupational Rehabilitation for AIA Australia' by renowned personal injury management and rehabilitation expert Petrina Casey, in conjunction with Professor Ian Cameron. The aim of the principles-based best practice occupational rehabilitation framework was to provide an evidence-based approach to the provision of occupational rehabilitation services in the life insurance industry.

The funding of medical treatment/expenses by life insurers would sit naturally within broader rehabilitation and return to work programs. While this research is focused on occupational rehabilitation, the principles are also relevant to funding medical treatment/medical expenses, and should inform supporting regulations.

The Principles are:

1. Work is good for health and business;
2. Screening: part of a strategic claims management process;
3. Claimants are supported and empowered;
4. Support the right intervention at the right time;
5. Communicate, collaborate and educate effectively; and
6. Focus on outcomes.

The following sections provide an overview of the meaning of these principles, with additional commentary on the payment of medical treatment/expenses where relevant.

### Work is good for health and business

This is similar to the discussion above in relation to the RACP Consensus Statement on the Health Benefits of Good Work, recognising that good work can contribute to recovery. It emphasises that it is critical to work together with the individual and the employer, to educate the employer on the benefits of early return to work for the claimant and for their business. Work also needs to be done to encourage early claim notification to support early intervention, as this will be more effective.

### Screening: part of a strategic claims management process

This principle is about how the life insurer is set-up to support rehabilitation and return to work, noting that an operational model that has strong 'linkages between claims management activity and rehabilitation' is essential.

This includes having clear protocols for:

- referral to internal rehabilitation staff and for referral to external occupational rehabilitation providers; and
- clear protocols and a decision making model for assessing those who are eligible for support and assistance.

It is critical to recognise that not everyone lodging a claim will have return to work potential, nor may they be suitable to receive funding for medical treatment or services to facilitate an improvement in recovery and function.

Once a potential return to work capacity is assessed, screening will be required to identify barriers in achieving a return to work outcome to understand the type of interventions that will support the individual. This assessment must consider potential barriers across the biological, psychosocial and social domains (a biopsychosocial approach).

Research has shown the important role psychosocial factors play in recovery and claim outcomes. Factors such as motivation, attitude, perceived ability and expectations will impact recovery and return to work outcomes. Motivation is considered the biggest determinant of rehabilitation utilisation and return to work. It is not in the life insurers' interests to pressure individuals to undertake medical treatment as this will not support a sustainable return to work outcome.

These assessments should be done in conjunction with the claimant's treating practitioner and may involve detailed consideration of potential barriers such as pain, functional issues, readiness to return to work, or ongoing psychological issues, as well as incorporating best practice.

The information from this process will inform a tailored return to work strategy and plan, of which provision of medical treatment will be only one component. The information should also allow for a comprehensive understanding of barriers that can be influenced or changed, for example through motivational support, for those who have prolonged periods of work absence.

## Claimants are supported and empowered

Good return to work outcomes are more likely when individuals understand the Health Benefits of Good Work and are empowered and engaged throughout the journey. This will involve educating individuals and setting expectations around the return to work process. Empowerment is a critical factor in a successful return to work program.

As noted above, claimant motivation is the biggest determinant of rehabilitation utilisation and successful return to work. Any decisions must be made together with the claimant and their treating doctor.

## Support the right intervention at the right time

It is important that each claim is assessed on a case by case basis, and that consideration is given to the specific circumstances and expectations of the individual. This will inform the appropriate return to work pathway and interventions, such as funding medical treatment or expenses.

For example, where someone is in the acute disability phase, interventions aimed at pain relief, advice to continue to participate in everyday activities, including remaining at or returning to work, might be the most appropriate. For those in the chronic disability phase, interventions might be more intensive, for example involving specialist rehabilitation

## Communicate, collaborate and educate effectively

Working together with other stakeholders in the return to work journey is important, including where relevant the employer, doctor, healthcare providers and family. This will be particularly important in setting and aligning expectations and achieving successful return to work outcomes.

## Focus on outcomes

The aim of return to work plans has been defined as a necessary means 'to gradually increase the tolerance of an injured worker using suitable duties, or those duties suitably matched to the employee's capacity, to enable a return to pre-injury duties'. Return to work plans can also be developed to assist the claimant upgrade capacity at a new employer. Without outcome focused return to work plans, tailored to the individual's circumstances, achieving return to work outcomes may be compromised. In order to achieve optimal results, the specified return to work outcomes should be developed with, and agreed to by, the claimant.

## Reasonably necessary

In developing the supporting regulations, consideration should also be given to the workers compensation concept of 'reasonably necessary'.<sup>56</sup> Life insurers would only fund medical treatment and expenses that they consider to be 'reasonably necessary', with regard to:

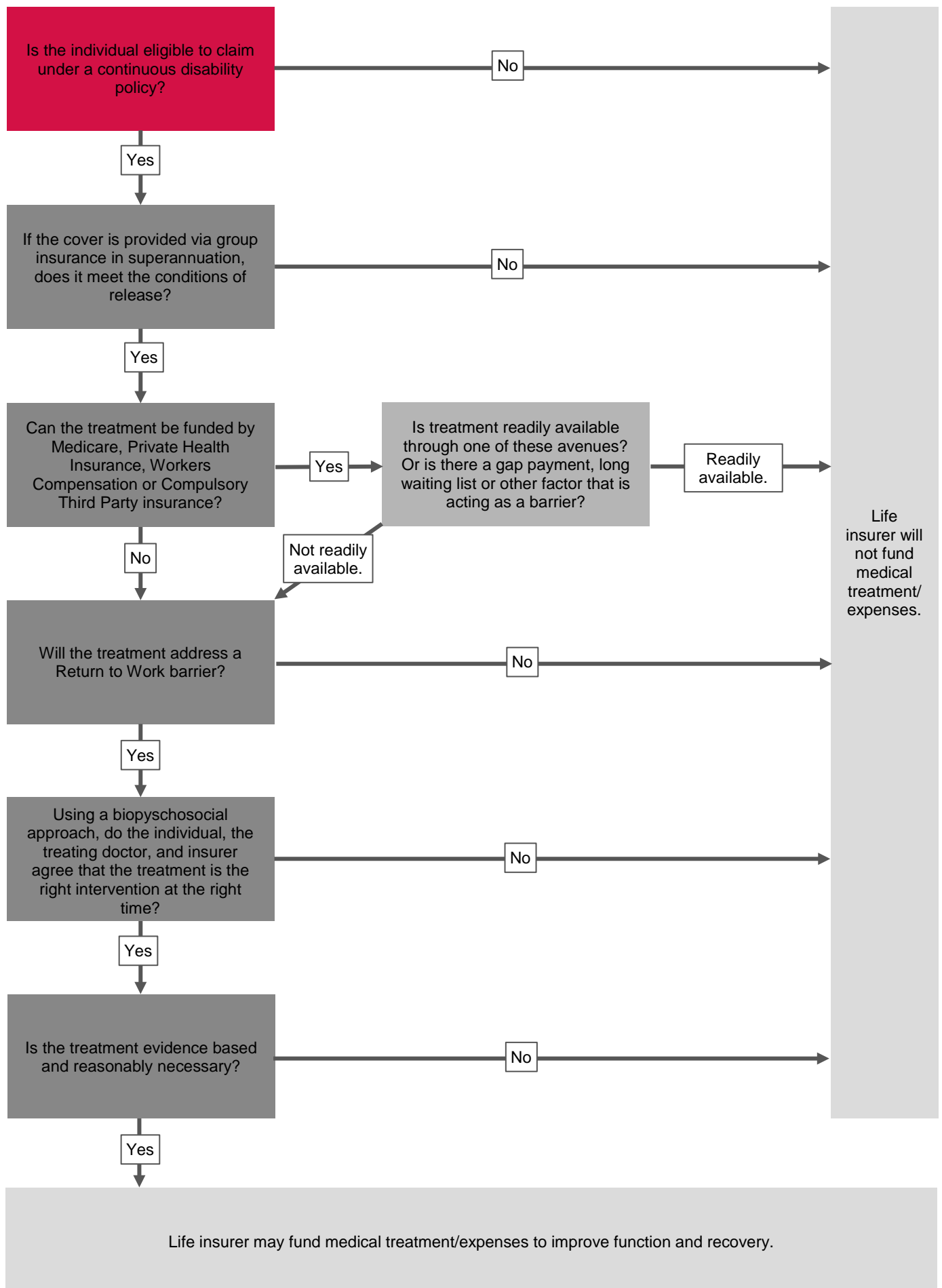
- **Injury** – is the treatment addressing a return to work barrier associated with the claimed condition?
- **Appropriateness of the treatment** – how will the treatment help the individual and their goals of return to wellness and work?
- **Cost** – is the treatment and care considered cost effective?
- **Effectiveness** – will the individual benefit from the treatment, does it have the potential to be effective for this particular individual?
- **Alternatives** – are there any alternative treatments available that may be more appropriate, effective?
- **Acceptable practice** – is the treatment considered effective and reasonable by medical experts (assessed on a case-by-case basis).

The reasonably necessary methodology would only be linked to medical treatment. This would not limit life insurers' ability to fund general wellness and work readiness services as part of an occupational rehabilitation program which may not be considered 'reasonably necessary' treatment, but might be a value adding activity for the customer as a tool to manage their condition and add structure to their day.

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<sup>56</sup> See, e.g. iCare Information Sheet W04 'What is reasonably necessary treatment and care?'

## Appendix 1 – Assessment Map



## About AIA Australia

AIA Australia Limited is an independent life insurance specialist with over 45 years of experience building real and sustainable partnerships. AIA Australia offers a range of products that protect and enhance the lives of over 4 million Australians and is a market leader in product innovation and development.

AIA Australia is the country's largest group life insurer by market share and works closely with major financial institutions and corporate partners to provide life insurance solutions. In addition, AIA Australia is the fastest growing provider of retail life insurance products sold through financial advisers. AIA Australia also works with affinity partners who distribute life insurance products.

In 2014, AIA Australia introduced 'Vitality' – the world's leading scientifically-backed health and wellness program – to Australia. AIA Vitality aims to enable real change for positive health outcomes.

In 2017, AIA Australia launched myOwn to bring together health insurance with the AIA Vitality wellness program to help its members live longer, healthier, better lives. myOwn is a joint initiative of AIA Australia, not for profit health fund GMHBA and South African financial services provider Discovery.

AIA Australia has received multiple insurance industry awards, including the ANZIIF Life Insurance Company of the Year (2017, 2015, 2013, 2012), Super Review's Best Insurer of the Year (2017, 2016, 2014, 2012, 2011), AB+F Life Insurance Product of the Year (for AIA Vitality in 2017 and 2016), ANZIIF Women's Employer of the Year (2016) and three AFA & Beddoes Institute Consumer Choice Awards (2016).