Executive summary

The longer an individual spends away from work, the greater likelihood of them never returning to work. This is because the longer a person is away from work the higher the likelihood that their physical and mental health will deteriorate, with the possibility of this culminating in a permanent disability which removes them from the workforce altogether. According to the Australasian Faculty of Occupational and Environmental Medicine, if a person is off work for 70 days their probability of returning to work reduces to 35 per cent.[1]

Private personal disability income insurance is a means for individuals to protect themselves from economic losses that arise from both mental and physical disability. However, viewing this type of insurance as only providing income protection benefits ignores the wider benefits this insurance provides to consumers, society and public spending.

Current legislation prevents life insurers from paying for medical treatment or therapy that could help claimants return to work. If these restrictions were removed, as proposed in this submission, life insurers would be able to help to provide the medical help people need to help them get back to work sooner. **A recent FSC life insurer member survey found up to 12,000 claimants a year could be helped if these restrictions be removed.**

For claimants, higher return to work rates lead to better long-term outcomes. **For insurers**, helping people return to work reduces the cost of claims and helps keep premiums affordable. **For Government**, higher return to work rates will reduce the cost of the Disability Support Pension and the National Insurance Disability Scheme. Getting more people back work will also support the Government's key objective of higher workforce participation.

There is a compelling public policy case for changing the law to allow life insurers to help claimants in this way.

Under the FSC's proposed policy framework:

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

1 The Australasian Faculty of Occupational & Environmental Medicine – Australian and New Zealand Consensus Statement on the Health Benefits of Work -- 2011

1. Introduction and Context

Continuous disability policies, such as total and permanent disability insurance (TDP), income protection insurance for temporary incapacity and trauma or critical illness benefits for specified illnesses, conditions or injuries, usually offer ancillary benefits such as:

- benefits to cover the cost of professional nursing care for an agreed period;
- (unqualified) rehabilitation expenses;
- rehabilitation benefits with an occupational or vocational focus to assist the insured return to gainful employment or fund reasonable and necessary workplace modification expenses.

Due to the overall operation of life insurance regulation, rehabilitation services are precluded from including the funding for medical treatment and services to support early return to work, which is an optimal outcome for the individual, the Government and the insurer.

Figure 1 demonstrates a stylised claim assessment process which means life insurers are unable to offer targeted rehabilitation benefits that they considered to be relevant, appropriate and necessary to rehabilitate the claimant in order to get them back to work under a continuous disability policy.

Figure 1 - Stylised Claim Assessment Process for Direct and Retail Life Insurance

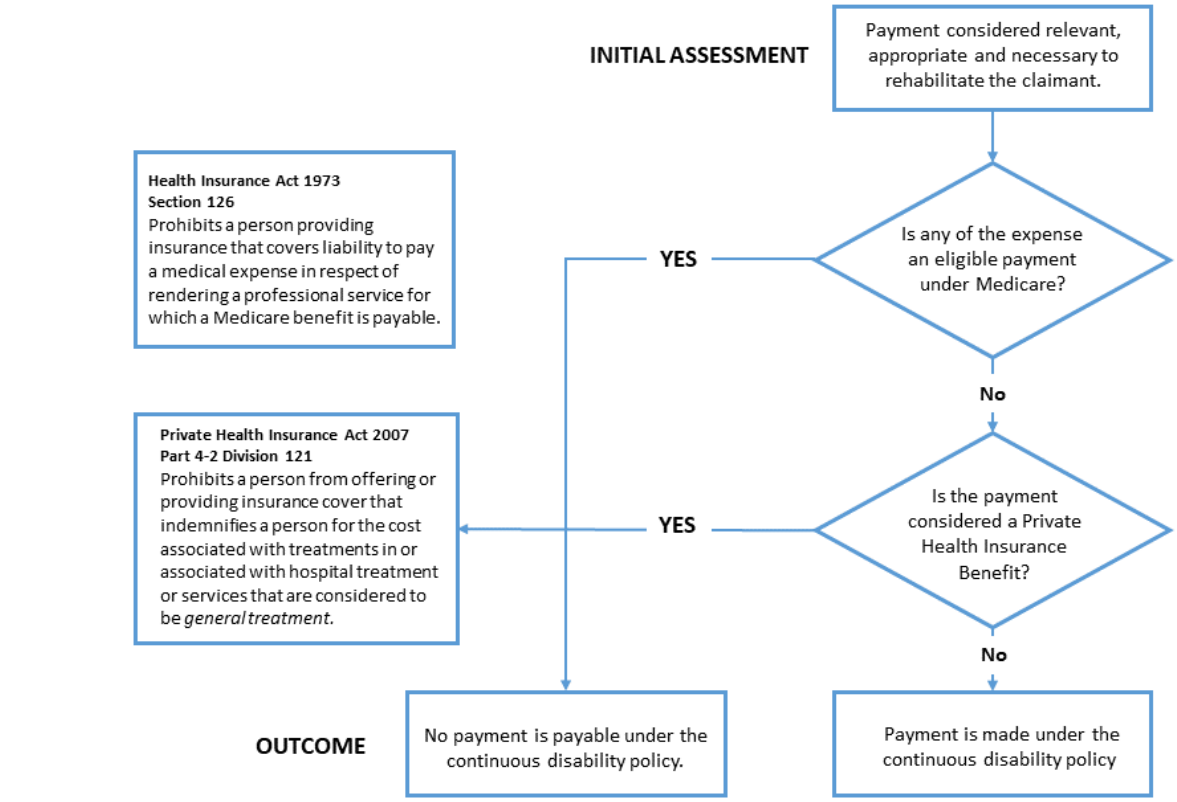
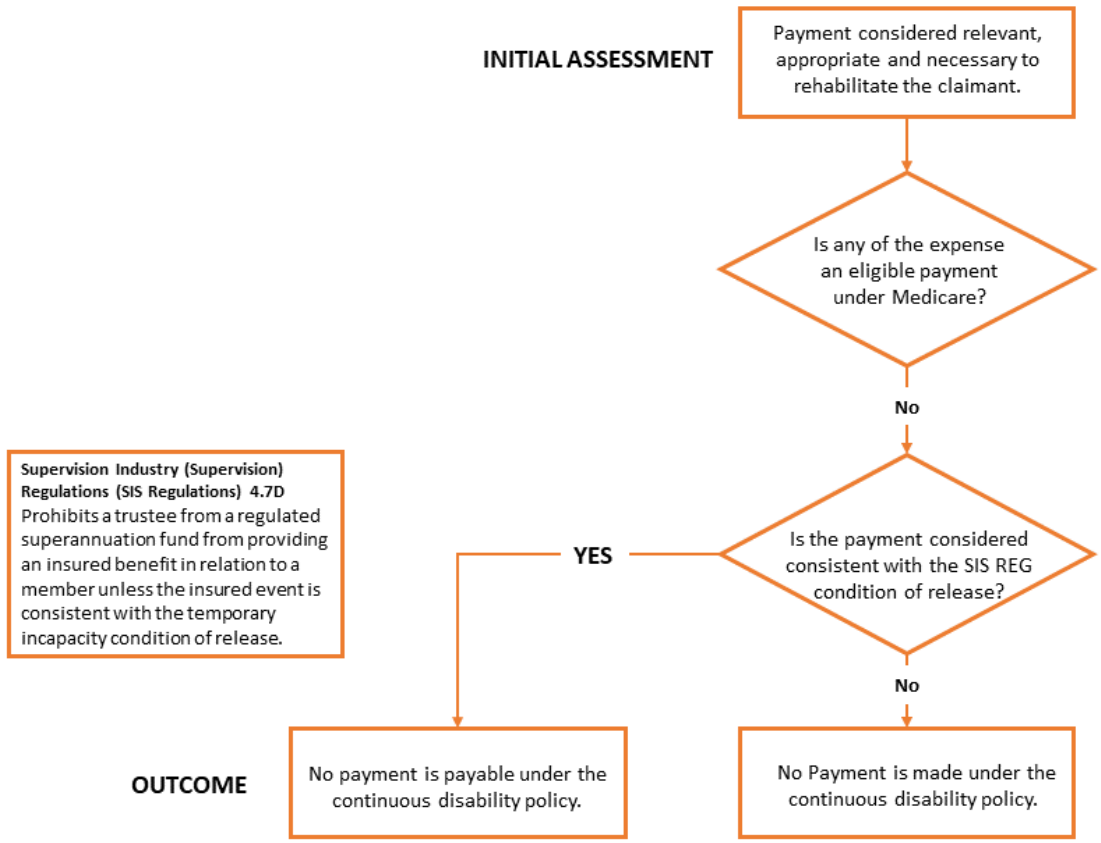


Figure 2 demonstrates a stylised claim assessment process which means trustees are unable to release funds from the insurer to offer early intervention in the form of targeted rehabilitation benefits that the insurer considered to be relevant, appropriate and necessary to rehabilitate the claimant in order to get them back to work under a continuous disability policy.

Figure 2 - Stylised Claim Assessment Process for Group Insurance in Superannuation



The *Life Insurance Act 1995* (**Life Act**), *Private Health Insurance Act 2007* (**PHI Act**), *Private Health Insurance* (Health Insurance Business) *Rules 2013* (PHI Business Rules), *Health Insurance Act 1973* (**Health Insurance Act**) and *Superannuation Industry (Supervision) Regulations 1994* (Cth) (**SIS Regulations**) interact in such a way that life insurers are not permitted to provide a benefit to a claimant under a continuous disability policy for treatment costs where either a corresponding Medicare benefit is payable or where the treatment is a hospital treatment or general treatment (and is not otherwise excluded from the concept of a health insurance business).

This restriction applies regardless of whether the Medicare or Private Health Insurance benefit is exhausted, meaning that any gap in costs after reimbursement under a private health insurance policy or receipt of a Medicare benefit will not be able to be paid by the life insurer and will need to be funded directly by the individual receiving the treatment.

This is a perverse outcome for the individual. Providing flexibility around circumstances in which life insurers may pay medical and other such treatment costs in disability insurance claims would enable life insurers to better facilitate early claims intervention. This would allow payment of medical treatment in circumstances where treatment supports an early return to work.

2. Recommendation

Regulatory Constraints on life insurers paying early intervention benefits for rehabilitation and medical expenses

Life insurers can issue life policies that provide for disability, trauma and critical illness benefits if the policies are 'continuous disability policies' as defined in the Life Act 1995. Such policies may provide benefits, for example, to cover the costs of nursing care or certain rehabilitation expenses. However, life insurers are currently prevented by other legislation from paying benefits for certain medical treatment costs.

If the legislative restrictions were removed or loosened, life insurers would be able to more effectively use early claim intervention practices to offer targeted rehabilitation benefits to consumers, including by paying some medical costs not otherwise covered by Medicare or private health insurance.

Life insurers could also provide assistance where excessive waiting times in the public health system would result in an adverse return to work outcome. The ability to provide this additional assistance could increase the likelihood of successful rehabilitation and prevent many consumers from becoming permanently disabled.

In our view there is a strong public policy case for making necessary legislative amendments to allow life insurers to offer targeted rehabilitation benefits to continuous disability policy holders.

We set out below an overview of the key legislative restrictions and suggested amendments.

3. Supporting Evidence

Details of legislative restrictions and required changes

Life Insurance

Life insurers are regulated by APRA under the Life Act. Section 234 provides that a life company must not intentionally carry on any insurance business other than life insurance business. Life insurance business is defined in section 11 as, among other things, the issuing of life policies. Life policies include disability policies that are 'continuous disability policies' as defined in section 9A of the Life Act. Life insurers may provide disability insurance that complies with this definition, and typically do so in the form of total and permanent disability insurance (TPD), income protection insurance for temporary incapacity, and trauma or critical illness benefits for specified illnesses, conditions or injuries.

Section 9A provides that a contract of insurance entered into in the course of carrying on health insurance business (as defined in in Division 121 of the PHI Act, considered below) is not a continuous disability policy. A life company therefore cannot currently provide rehabilitation benefits to the extent this would involve carrying on health insurance business.

APRA has power under section 12A of the Life Act to declare that other types of insurance business carried on by a life company are to be treated as life insurance business. However, APRA may not make such a declaration in respect of health insurance business.

Health Insurance

Section 126 of the Health Insurance Act prohibits a person from providing insurance that covers liability to pay a medical expense in respect of the rendering in Australia of a professional service for which a Medicare benefit is payable. This restriction applies regardless of whether the person's ability to claim a Medicare or private health insurance benefit for the liability is exhausted. The key exception is for complying health insurance policies entered into by a private health insurer that cover hospital treatment or hospital‑substitute treatment. No exception applies for benefits paid by life companies.

Section 10 of the Private Health Insurance (Prudential Supervision) Act 2015 (Cth) (**PHI Prudential Supervision Act**) prohibits a person from carrying on a health insurance business if the person is not a private health insurer. Health insurance business is defined in Division 121 of the PHI Act to include the business of undertaking liability by way of insurance that relates in specified ways to hospital treatment or general treatment as defined in the same Act. Again, no exception is provided for benefits provided by life companies.

Hospital treatment is defined in section 121.5 of the PHI Act as treatment (including goods and services) that is intended to manage a disease, injury or condition, and is provided either at a hospital, or with the direct involvement of a hospital. General treatment is defined in section 121.10 of the PHI Act as treatment (including goods and services) that is intended to manage or prevent a disease, injury or condition and is not a hospital treatment. This encompasses many of the services that are likely to be necessary for the management and rehabilitation of illnesses and injuries that result in disability.

A number of insurances and benefits are excluded from the definition of health insurance business by the PHI Business Rules. Relevantly, Rule 16 of the PHI Business Rules excludes death and certain disability benefits. Many of the excluded benefits satisfy the criteria for 'continuous disability policies' under the Life Act. The exclusion applies, for example, to income replacement benefits and certain lump sum benefits payable on the occurrence of events defined in the policy (such as trauma benefits).

We consider that there would be merit in expanding the exclusions from health insurance business so that life companies are also permitted to provide benefits for other types of rehabilitation expenses. This could be done by amending the PHI Business Rules so that the exclusions under rule 16 exempt benefits provided by a life company to cover medical treatment costs where the company considers, with the approval of the consumer’s physician, that the medical treatment will assist in the rehabilitation of a claimant under a policy.

Superannuation

Life insurance is commonly held through superannuation funds. The lives insured under a policy are the members of the fund. If a member dies or is disabled within the meaning of the policy, the life company will pay the benefit under the policy to the trustee. The trustee will in turn pay that benefit to the member or the member's dependants or Loss Prevention and Recovery (**LPR**).

There are restrictions in the SIS Regulations which could prevent rehabilitation benefits from being provided under policies issued to superannuation fund trustees for the benefit of members.

Regulation 4.07D provides that a trustee of a regulated superannuation fund must not provide an insured benefit in relation to a member of the fund unless the insured event is consistent with a condition of release specified in the SIS Regulations. One of the specified conditions of release is temporary incapacity (item 109 of Schedule 1). A benefit can be cashed under this condition of release only as:

> A non-commutable income stream cashed from the regulated superannuation fund for
> (a) the purpose of continuing (in whole or part) the gain or reward which the member was receiving before the temporary incapacity; and
> (b) a period not exceeding the period of incapacity from employment of the kind engaged in immediately before the temporary incapacity.

This would prevent the provision of rehabilitation benefits unless the purpose of the benefit is to continue the member's pre-disablement income. It would not otherwise permit the cashing of benefits for medical treatment or other rehabilitation.

In order to allow trustees of superannuation funds to provide an insured benefit to members who pay for rehabilitation, the condition of release in item 109 would need to be amended to insert a second limb, so that it provides as follows:

> ***Amounts to cover the cost of medical treatment to assist in the rehabilitation of the member.***

A trustee of a superannuation fund is subject to a covenant under section 52(7)(c) which requires it to 'only offer or acquire insurance of a particular kind, or at a particular level, if the cost of the insurance does not inappropriately erode the retirement income of beneficiaries'. In order to allow a complying superannuation fund to deduct premiums it pays for insurance policies that provide benefits as suggested above, section 295-460 of the Income Tax Assessment Act 1997 (Cth) would need to be amended to include rehabilitation benefits in addition to income streams payable in the event of a member's temporary disablement.

Two prevalent examples will enable us to illustrate the types of issues that lead to an insurance coverage gap for individuals.

Physical injury - impact of waiting times for elective surgery when a private health insurance benefit is unavailable

An individual without private health insurance physically injures themselves and requires surgery before they can return to work. This means they are placed on a public hospital waiting list to receive their elective surgery.

In 2014-15, 50 per cent of all patients were admitted for elective surgery after 36 days. 90 per cent of all patients were admitted within 253 days, while 10 per cent of patients waited longer than these times.[2]

An individual with a continuous disability policy would benefit if their insurer determined that given the waiting period and type of injury it would be relevant, appropriate and necessary from a claims

2 Australian Institute of Health and Welfare - Admitted patient care 2014–15: Australian hospital statistics.

perspective to pay for the individual to receive the treatment in a private hospital. Unfortunately they cannot. As the waiting period for surgery in a public hospital is extended the likelihood of returning to work diminishes and the system prevents actions aimed at reducing this waiting period by life insurers.

Mental health – impact of a Medicare benefit running out for mental health care management strategies

An individual has suffered a mental health issue that has seen them exit the workforce. They have qualified for an income payment under their continuous disability insurance. They have no private health insurance.

At the onset of their mental health issue they received therapy via an allied health professional and were reimbursed via Medicare.[3] However, the number of individual allied mental health services for which a person can receive a Medicare rebate is 10 services per calendar year. The individual cannot afford to continue the therapy without a rebate.

The individual and allied health professional are of the view that the therapy was yielding positive results and was likely to assist this individual to return to work. The life insurer agrees that continued therapy is a relevant, appropriate and necessary from a claims perspective as it would assist the individual return to work. However, they are unable to make any payments either in full or partially due to the current legislative arrangements, to the detriment of the individual's rehabilitation progress.

Illustrative example of how a coverage gap arises

Case study

The Customer is a 43 year old software engineer who developed depression and anxiety as a result of workplace bullying. The Customer had lodged a workers' compensation claim which was in the process of being disputed. The Customer had exhausted all of her annual leave and sick leave entitlements and was not receiving any further benefits from her Workers Compensation Insurer.

The Customer reported that she has been attending sessions with a psychologist that had been originally funded by her Workers Compensation insurer but this had stopped after the Workers Compensation claim was declined. Due to financial constraints, she had not been able to attend any further psychological sessions or afford her anti-depressant medication.

If the life insurer was legally permitted to, it could have funded the psychological sessions and medication when the Workers Compensation insurer funding ceased, thereby, increasing the likelihood that the Customer was able to recover and return to work.

3 Medicare Benefits Schedule Note A47.