Response to Questions Taken on Notice by the Australian Council of Trade Unions

PARLIAMENTARY JOINT COMMITTEE ON CORPORATIONS AND FINANCIAL SERVICES

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

Hearing, Tuesday 19 June 2018

Question 1, Hansard p5.

Question:

The Honourable Mr Keogh asked about the differences that we see between the life insurers and workers' compensation insurers in terms of conflict of interest.

Response:

Private life insurers are companies with duties to act in the best interests of shareholders. Hence, they have an overriding objective to maximise profit. WorkCover insurance, on the other hand, is provided under statutory benefit schemes. The objectives of these schemes include reducing the incidence of injury in the workplace and rehabilitating injured workers and providing a system that is fair and affordable. Profit plays no part and minimising cost does not override public interest objectives. For example, the objectives of the NSW workers' compensation scheme are set out in section 3 of the *Workplace Injury Management and Workers Compensation Act 1998 (NSW)* as follows:

> **3 System objectives**
>
> The purpose of this Act is to establish a workplace injury management and workers compensation system with the following objectives:
>
> (a) to assist in securing the health, safety and welfare of workers and in particular preventing work-related injury,
> (b) to provide:
> - prompt treatment of injuries, and
> - effective and proactive management of injuries, and
> - necessary medical and vocational rehabilitation following injuries,
>
> in order to assist injured workers and to promote their return to work as soon as possible,
> (c) to provide injured workers and their dependants with income support during incapacity, payment for permanent impairment or death, and payment for reasonable treatment and other related expenses,
> (d) to be fair, affordable, and financially viable,
> (e) to ensure contributions by employers are commensurate with the risks faced, taking into account strategies and performance in injury prevention, injury management, and return to work,
> (f) to deliver the above objectives efficiently and effectively.

Self-evidently, there is an accountability mechanism in relation to the way in which statutory schemes balance the various public interest matters from time to time, given that the architects of statutory schemes (and any amendments thereto) are democratically elected. Further, there is established convention for there to be tripartite stakeholder consultation in relation to the revision and management of statutory schemes.

In order to avoid a conflict of interest, the doctor or decision maker deciding what treatment is appropriate needs to be free from influence or financial incentive from the entity paying for that treatment. However, the FSC proposal provides inadequate protection against these being conflated. The conflict of interest would be most acute if claimants were urged to see life insurers' own doctors. In any event, the level of community trust in the life insurance industry is too low at present for the community to have any faith that life insurers would use their influence at the early intervention stage in claimants' best interest rather than abuse it in

the interests of life insurers' bottom line. This abuse could take the form of pressuring claimants to return to work early or using information gathered at the intervention stage to minimise or deny TPD or ongoing income protection claims.

Question 2, Hansard p10

Question:

The Honourable Mr Keogh asked whether we agree that to the extent a worker might have dual insurance coverage, as long as one of the insurers is paying within statutory time frames, delays by another insurer that might also be able to assist are mitigated.

Response:

We agree that to the extent that a worker is covered by, for example, both workers' compensation weekly payments and private income protection insurance payments as a result of the worker paying an additional premium, compliance by the workers' compensation insurer with statutory timeframes would help *mitigate* the *financial hardship* experienced through delay or refusal of a private claim. There would however be no mitigation of the actual *loss*, because properly understood (and subject to exclusions in the policy itself) the private benefit is separate and additional to other entitlements at law. It is unreasonable to set off a separate statutory benefit which has been received against the value of the unpaid private benefit and thereby assert that the loss is less than the whole of the value of the benefit due under the private policy.

Question 3, Hansard p12

Question:

The Honourable Mr Van Manen asked about any work we have done on the interaction between the various bits of insurance cover, including statutory workers' compensation, individual private insurance cover, income protection and TPD cover.

Response:

We note that common law rights of subrogation and insurance policy terms invariably prevent 'double dipping'. There will be overlap of the two insurers where, for example, an injured worker has a statutory entitlement to weekly payments as well as a top up from an Income Protection policy. We note that in such circumstances, the proposed assessment map in AIA's submission[1] would enable the life insurer to assess function and recovery, as it is a continuing disability benefit. This may require the worker to adhere to the rehabilitation requirements of both insurers, which may or may not be in line with treatments proposed by the worker's own treating physicians, and creates a very burdensome position for the injured worker.

We trust the above further information and our written submission assists. We have searched our records and have no further information to provide. Noting the Committee's appetite for

[1] See Submission no. 20 from AIA Australia, dated 18 May 2018.

further information on the interaction, we consider it incumbent upon the FSC and its members to articulate the intersection of the various national and state statutory workers compensation schemes with its proposal, and demonstrate the positive public interest outcomes, prior to any intervention by life insurers being permitted.

Question 4, Hansard p12

Question:

The Honourable Acting Chair asked: "Do organisations involved in rehabilitation services consider that there is a problem that needs addressing or is the FSC proposal a solution looking for a problem? And what alternative approaches, other than life insurance, do you believe could be used to fund rehabilitation services—that is, are new funding arrangements really needed or is the answer to the problem that exists better cooperation of existing mechanisms?"

Answer:

The ACTU considers that Australia, as a wealthy and highly developed country, should be proud of its social security and public welfare system and should always be looking to ensure that all those in need are covered and no one is left behind by progressing further towards a universal system. This includes ensuring universal social protection for those who are injured so that they can participate fully in society. The FSC's proposal would not make Australia's system of social protection more universal. Given life insurers' track record, the community cannot trust them to deliver medical and rehabilitation services with the best interest of the claimant in mind as is required rather than their bottom line. The FSC's suggested "frameworks" are insufficient and clearly provide inadequate protections for consumers.

Instead, gaps in social protection should be covered by expanding the public health and workers' compensation systems to the full extent of social need. The ACTU makes the following alternative proposals, as outlined in the attached document.

Firstly, the current cap of 10 sessions of Medicare-subsidised sessions with a psychologist[2] should be lifted and especially for those people who are prevented from attending work due to a mental health issue where a GP decides further counselling is likely to assist a person in returning to work.

Secondly, much unnecessary harm to injured workers and cost to government could be avoided by amending the life insurance industry code of practice to better ensure that life insurers make a decision on income protection insurance within a reasonable timeframe. Where claimants have provided sufficient information to establish a prima facie entitlement to a payment, claimants should be entitled to at least an interim decision and interim payments within 14 days.

Further written materials

[2]Under the Australian Government's *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS* initiative.

Attached is the written document we advised at the hearing that we would provide (see p10 of the Transcript). It is a copy of the ACTU's complete oral submissions, including case studies and more detail on the above reform proposals.

18 July 2018.

ACTU Oral Submission

To: *Joint Parliamentary Inquiry into Options for Greater Involvement by Private Sector Life Insurers in Worker Rehabilitation*

Hearing: *19 June 2018, 6pm (attendance via telephone)*

Delivered by: *Michael Borowick, Assistant Secretary and James Fleming, Legal and Industrial Officer, Australian Council of Trade Unions*

Thank you to the joint committee for the opportunity to be heard in relation to this inquiry.

We appear on behalf of the Australian Council of Trade Unions which is the peak body for working Australians.

The proposal put before this inquiry by the Financial Services Council and some of its member insurance companies may look superficially attractive. In essence, that proposal is to allow private life insurers, typically through insurance policies provided by superannuation funds, to fund rehabilitation measures for injured workers that are not otherwise supported either by Medicare, private health insurance, workers compensation or the NDIS, but which would get a worker back to work sooner or prevent permanent disability.

On the surface, this may look like a good practical solution for people who have Income Protection (IP) or Total Permanent Disability (TPD) cover via their superannuation fund but no other form of insurance or public support. You might say it seems like a possible win-win and the incentives are aligned between worker, insurers and government, in helping the worker this way towards a more rapid recovery.

However, this is not the case. None of the organisations that have submitted to this inquiry who advocate for injured workers and consumers (that is consumer rights groups, unions, Beyond Blue and a plaintiff law firm) support giving life insurers a greater role in worker rehabilitation and for good reason.

I'd like to address briefly just four of those reasons.

Firstly, there is an unresolvable conflict of interest for life insurers in making decisions about early rehabilitation, which would undermine the intended outcome of rehabilitating injured workers and assisting them back to work. Life insurers' interests are in increasing profits for shareholders and decreasing costs. We are concerned the push for these changes is motivated not by concern for injured workers but by life insurers desire to exert greater influence over treating doctors in order to pressure workers back to work or to otherwise minimise cost, and to use data gathered during the intervention phase to minimise and deny claims and to inform the design of future policy exclusions. This is not a hypothetical problem and reflects practices by life insurers that are already occurring, as highlighted by the AWU and Maurice Blackburn in their submissions.

I'm going to outline some further case study examples today. Beyond Blue has spoken about the danger of incentivising insurers to push injured workers back to work before they are ready. There is a danger that if the individual refuses intervention treatment that the insurer deems reasonably necessary, the insurer could rely on this in refusing a claim on the basis of the claimant's failure to mitigate loss. Hence, the incentives are not aligned between worker and insurer in the insurers' proposal. Quite the contrary.

Secondly, the case for change has not been made out. We do not know how many people could be assisted by the insurers' proposal. Many people have death and TPD cover through their superannuation fund but many do not have income protection insurance. Presumably, insurers will only help rehabilitate those where the cost of treatment is less than the likely IP or TPD payout. Once the qualifying criteria are better known this may mean only a very small number of people are assisted by the proposal. We do not have that information but what we do know is that the Financial Services Council would have us remove the consumer protections and other safeguards inherent in the regulations that apply to the health, workers' compensation and NDIS systems and that exist for good reason. We would need to know more about the consequences on these systems. One consequence that comes to mind is that the feedback loop inherent in the workers' compensation system, whereby employers are penalised for unsafe workplaces through higher premiums as a result of claims would be broken, undermining that system.

This would create greater opportunity for less ethical and unscrupulous employers to shift the cost associated with a workplace injury from the relevant workers compensation insurer, to the injured worker and their private insurer. This risk is particularly high in circumstances where the injured worker is worried about losing their job, and the employer is pressuring them to not make a workers' compensation claim as "*it is too difficult*" and where they may be told by their employer that "*you are covered by income protection anyway*." In short, it is a further disincentive to pursue a claim through the appropriate statutory workers compensation scheme, which in the long run, prejudices the workers ongoing statutory entitlements and potential common law rights.

The third reason is that the private life insurance industry is not currently competent to perform the role it proposes. It is under scrutiny for poor practices and for failing to adequately perform its existing role in providing financial protection to consumers and to comply with its own industry code of conduct. Hence, it would be inappropriate and unconscionable at this time to consider expanding its role. Insurers' suggestions for self-regulation to replace the consumer protections they ask be rolled back must be dismissed out of hand. Amended external regulation will not suffice either as the conflict of interest is inherent and so it is unresolvable.

The fourth reason is that the proposal amounts to a step towards privatisation and a foothold for the life insurance industry in the primarily public health and workers' compensation systems. Privatisation of essential services makes them more expensive and is difficult to undo. Hence, the Committee ought to reject the insurers' proposals.

So what can be done?

Instead of giving life insurers a greater role, there needs to an expansion of the public health and workers' compensation systems to cover the known gaps. In particular, there needs to be an expansion of mental health services to the full extent of social need.

This is not only a social and moral imperative but an economic one. Spending on mental health services is productive investment with high economic returns. KPMG's recent report, *Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform,*[1] sets out some of the real savings to both government and business by investment in mental health early intervention measures, to the tune of $8.2 billion in annual savings, and up to a $10 return on every dollar invested.

Whilst any increase in public outlays is likely to be unfavourable to a government committed to cutting social spending, outlays could target first those measures that are most obviously cost neutral, at least in the medium term.

For example, the current cap of 10 sessions of Medicare-subsidised sessions with a psychologist[2] should be removed for those people who are prevented from attending work due to a mental health issue where a GP decides further counselling is likely to assist a person in returning to work.

The initial public outlay in funding extra mental health services is overwhelmingly likely to be repaid by the reduced cost of public disability support and also increased taxation revenue gained by the person's earlier return to work. This further assistance is particularly important where the initial public investment in mental health services could prevent a person from developing a long-term disability and incapacity for employment.

We could also avoid unnecessary harm to injured workers and cost to government by requiring life insurers to make a decision on income protection insurance within a reasonable timeframe. For example, where claimants have provided sufficient information to establish a prima facie entitlement to a payment, claimants should be entitled to at least an interim decision and interim payments within 14 days.

Some insurers already do the right thing and provide good faith initial payments but this is not mandatory under the code of practice. The Victorian workers' compensation system on the other hand, requires insurers to make a decision to accept or deny an initial claim within 28 days except in a narrow set of exceptional circumstances or else the claim is deemed to have been accepted. So, in that jurisdiction, initial payments tend to commence much faster.

It is currently not uncommon for life insurers to take up to 8 months or more to make a decision, during which time, a claimant may be without income. The issue arises because the Life Insurance Code of Practice allows for insurers to delay whilst waiting on information and permits them to take up to 12 months in 'unexpected circumstances'. Those circumstances are defined so broadly that it is too easy for insurers to justify an unnecessarily lengthy delay. The system incentivises insurers to delay where the claimant is on social welfare benefits as under many policies these can be offset to reduce the insurers' payment liability. This delay and consequent stress and uncertainty can cause the worker to develop mental health issues, resulting in prolonged disability and in a further claim. Hence, we urge

[1] Mental Health Australian and KPMG, Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform, May 2018: https://mhaustralia.org/sites/default/files/docs/investing_to_save_may_2018_-_kpmg_mental_health_australia.pdf.

[2] Under the Australian Government's *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS* initiative.

the Committee to recommend a change to the life insurance code of practice to require timely processing of claims, and a commitment from the industry to comply.

Three case studies presented to us by Slater and Gordon Lawyers illustrate the practices of life insurers in this space. The names of the claimants have been changed to protect the identity of their clients.

Case Study #1 – John - cessation of IP payments following lump sum claim

The first concerns John, whose IP payments were stopped by the insurer after he made a lump sum TPD claim. He has also developed a further injury as a result of the insurer's delay. John, is a 47-year-old salesman, who injured his shoulder and back in a fall. He made a claim on his IP "own occupation" policy, which was admitted and paid. He paid for all treatments out of these benefits following the exhaustion of his private health entitlements. After three years, he made a claim for his TPD benefit. The insurer rejected his TPD claim and in the same letter, also rejected his IP benefits. The insurer rejected the IP claim based on an insurer nominated medical practitioner's report for the separate TPD claim. John requested reconsideration of his IP claim a month later with letters from his GP and surgeon. A further decision to reject ongoing IP payments was made 3 months later. John provided further supportive medical information including an occupation physician report. To date, he has not even had his request allocated to a case manager for review. This was 2 months ago. John has been reliant on Centrelink to support his family as he remains disabled by his injuries. He now also requires psychological treatment as a result of the lack of support and the drawn-out process of finalising his claim.

This is just another example of the life insurer being non-compliant with its own 'self-regulated' code of practice relating to the timely processing of claims. It also shows how insurers are using information gathered on one claim to deny another.

Case Study #2 – Felicity – code inadequate

The second example shows how the code itself is inadequate for ensuring the timely processing of claims. Felicity is a 42-year-old personal carer in a nursing home who suffered an injury to her neck and right arm. Since undergoing multiple surgeries, Felicity has been unable to return to work. Felicity is a single parent and is struggling financially to pay for her treatment and day-to-day living expenses. She is currently reliant on Centrelink for financial support. She lodged an income protection claim, which has been with the insurer for 8 months. A decision is yet to be made on the claim. The insurer continues to use 'outstanding information' requests as an excuse to delay a decision and payment.

Case Study #3 – Amy – delay in payment of IP

The final example concerns Amy, a 35-year-old IT consultant, who was disaffected by an insurer's delay in making a decision. Amy developed an acute psychological injury precluding her from working following bullying by her manager. Her WorkCover claim was rejected and she was given a mental health plan by her GP. She could not afford further treatment after the subsidised sessions ceased. Fortunately, she had income protection through their super, so she made a claim on the insurer, advising she was behind on her mortgage repayments. Despite acute financial hardship, the insurer delayed for over 4 months

before admitting the IP claim. Even following acceptance of the claim, payments were erratic, leading to her needing to sell her home and move to a regional town to live with her parents. She then faced further delay in accessing treatment. Two years later, her condition had not improved, and she made a claim for TPD. She remains unable to work due to her ongoing chronic psychological injury.

Assessment and payment of her income protection in a timely fashion and interim payments could have made a big difference and prevented the sale of her home. This is within the control of the life insurance industry currently. This is how insurers can and should act to prevent long-term damage: by better exercising their existing responsibilities.

In summary, for the very small number of people the insurer's proposal is likely to help, a much greater number of people are likely to be made worse off. We have outlined how the system could instead be improved to the benefit of everyone.

Thank you again for the opportunity to be heard and we would be happy to answer any questions that the committee may have.