17 August 2018

Dr Patrick Hodder
Committee Secretary
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CANBERRA ACT 2600

By email only: Corporations.Joint@aph.gov.au

Dear Dr Hodder

Parliamentary Joint Committee on Corporations and Financial Services - Options for greater involvement by private sector life insurers in worker rehabilitation – FSC response to Questions on Notice

Question 1: The committee understands that life insurers currently routinely provide rehabilitation services to help claimants get back to wellness (see Financial Services Council, Submission 1.1, p. 4).

(a) What kind of rehabilitation services do life insurers currently provide?

Currently, the rehabilitation services provided by life insurers are limited to non-medical, vocationally focused services intended to assist the customer's recovery and return to wellness. Vocational rehabilitation services can include: initial needs assessments, workplace assessment, functional capacity assessments, vocational assessments, development of graduated return to work plans, work conditioning programs, coaching for new employment, job search assistance and resume development. Other forms of rehabilitation provided by life insurers could include functional restoration programs, to rebuild a person's capacity to function socially, domestically and in the workplace, to give consumers a better chance to return to wellness.

(b) How are those rehabilitation services distinguished from the services that life insurers are seeking to be permitted to provide under the Financial Services Council's proposal?

For the sort of non-medical rehabilitation services described above to be effective, often the customer must first have addressed underlying health issues and be making progress on regaining their health. Unfortunately, for a range of reasons, it is not uncommon for life insurers to encounter customers who are unable to access the necessary medical service. It is customers in this category who life insurers want to be in a position to assist.

Current legislative restrictions prevent life insurance companies who offer continuous disability policies from paying for medical rehabilitation services that would benefit customer's and support their return to wellness and employment. The primary impediments can be found in the *Health Insurance Act 1973* and the Private Health Insurance Act 2007 and its subordinate legislation. In particular, life insurers are precluded from providing allied healthcare treatment or hospital care. These treatments include, but are not limited to, physiotherapy, mental health care, surgery, chiropractic, and osteopathy.

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(c) How are those services provided, e.g. through 'in-house staff' employed by insurers or other means?

Life insurers provide vocational rehabilitation support through:

- In-house rehabilitation teams, employed directly by life insurers, comprising expert consultants including people with qualifications and backgrounds in allied health, with previous experience delivering rehabilitation services. Their role is to look at income protection claims and determine whether the claimant (customer) may potentially benefit from support from an external provider. These benefits would not include treatment, and are vocational in nature, such as workplace assessment, development of graduated return to work plans or employment service including coaching for new employment, job seeking, resume development, interview skills etc.
- Other forms of rehabilitation provided by life insurers can include functional restoration programs, to rebuild someone's capacity to function socially, domestically and in the workplace to give customers a better chance to return to wellness.
- In-house teams can also provide coaching and support to get customers thinking about new career development. This is supported by advice to assist customers to return to employment with the same or a different employer.
- Insurers may determine that a customer would benefit from support delivered by an external provider service provider and refer the customer to the appropriate provider.

Life insurers may also refer customers to appropriate providers of community support programs available to them. For example, community walking groups, services provided by state and local government, and services provided by non-government organisations, not-for-profit groups and disease advocacy and support groups such as the Cancer Council, Stroke Foundation, Diabetes Australia etc.

(d) Why are those services not subject to the legislative restrictions that the FSC is seeking to have removed?

These services are vocational in nature and not subject to the same restrictions on funding arrangements that apply to medical rehabilitation services. In respect of the latter, life insurers are prevented by the *Private Health Insurance Act 2007,* its subordinate legislation and the *Health Insurance Act 1973* from funding services that would benefits customers.

(e) Have any life insurers ever provided any of the services that are currently prohibited by the legislation that the FSC is seeking to have relaxed?

The FSC is not aware of any of its life insurance members providing rehabilitation services in breach of legislative requirements.

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(f) Have those services already provided by life insurers led to savings to insurers in the same way that the FSC suggests will occur if its proposal is implemented?

Can the FSC provide data to demonstrate the effect?

The data provided to the Committee is only indicative of potential future benefits of early vocational intervention. It is not possible to estimate the financial benefits through reduced costs of funding treatment because no such benefits are provided in accordance with life insurer's obligations under legislation.

The information we have is specific to the benefits life insurers receive from providing early vocational rehabilitation support (not treatment). For every dollar spent on rehabilitation services, life insurers saved an average $25 in claims reserve.[1]

Question 2: The committee understands that, under the FSC's proposal, life insurers would provide assistance to policyholders for rehabilitation medical treatment on a discretionary basis.

(a) Which customers would be considered for this assistance? For instance, would the customer need to hold a continuous disability insurance policy?

The customers considered for this assistance would typically be those making a claim under their disability cover whose doctor believes that their patient would benefit from some form of medical intervention which they are not currently able to get – for example, because they are on a long waiting list or they do not have private health insurance. In such cases, life insurers would consider whether it would make financial sense to pay for the intervention.

Industry guidance and standards could be developed to govern the expanded provision of discretionary rehabilitation medical treatment, for example through the Life Insurance Code of Practice which is monitored by an independent Life Code Compliance Committee. The Life Code Compliance Committee is an independent body administered by the Financial Ombudsman Service (soon to be the Australian Financial Complaints Authority).

(b) Would any cohorts of customers be more or less likely to receive assistance than others, including on the basis of what insurance policy they hold or their employment status prior to their injury?

See answer provided to question 2(a).

(c) What factors would life insurers consider when deciding whether to offer rehabilitation assistance?

See answer provided to question 2(a).

[1] Swiss Re – Rehabilitation Watch (2016) – Australia – p.24-25.

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Additionally, the FSC notes that existing regulatory frameworks, which apply to state based compensation schemes, would be useful in guiding future development of clearly defined and appropriate criteria.

FSC also recommends for customers to have engaged with their own treating doctor in respect of their rehabilitation. This will allow the life insurer to support a rehabilitation plan that is developed by the customer and their doctor, based on the customer's goals, and that draws on existing medical services, before requiring input from their insurer.

(d) What consultations has the FSC had with the Department of Health regarding its proposal?

The FSC has met with the Department of Health to discuss the FSC's early intervention proposal.

(e) Are there any precedents from other jurisdictions for what the FSC is proposing?

Yes, some comparable international markets have the capability to pay for early intervention for allied health services and hospital services on a discretionary basis.

In the United Kingdom, for example, insurers have no restrictions on paying for any forms of help to get their customers back to wellness and work, and frequently do so.

(f) Should the restrictions also be removed from health insurers?

The FSC supports greater and more affordable access to services which would assist its customers in returning to health. If there are legislative restrictions that prevent Private Health Insurers from supporting people from returning to wellness and employment, we would support the removal of these restrictions.

(g) How does the FSC propose to resolve the issue raised by the Department of Health that health insurance is community rated and life insurance is risk rated?

The FSC believes that many of these issues are resolved by ensuring that life insurance funding of medical rehabilitation services is strictly discretionary. By making it discretionary, life insurers would be prevented from writing contracts of insurance that are similar to, or have a similar effect as, a private health insurance contract. Community rating issues are therefore avoided.

(h) Would it provide a better outcome for consumers if the FSC worked with the life industry to ensure that claims for income protection were paid promptly so consumers could pay for their rehabilitation services as needed from their income protection insurance payments, without being subject to the 'discretion' of life insurers?

The FSC Life Insurance Code of Practice already has strict minimum service standards for claims payments and decision timeframes.

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Income protection is normally restricted to paying percentage of the customer's pre-disability earnings. This means that consumers will not have excess income even though their claim has been paid promptly.

This in turn means that if the customer did not have enough money to pay for their treatment before the onset of the disability, they are very unlikely to suddenly acquire that money after the onset of the disability.

In addition to the above, income protection policies generally have waiting periods of between 30 and 90 days before a benefit is be payable. Experience shows that the earlier people get help to return to wellness, the more likely it is to be successful.[2] This is why life insurers often provide non-medical rehabilitation services before claim payments start. If an insurer agrees to fund rehabilitation during the customer's waiting period, and this is not successful, the terms of the income protection policy would still apply as usual.

(i) What groups is the FSC including in its definition of 'worker' in its proposal, e.g. employees, contractors, self-employed, people temporarily away from work to study or to undertake parenting duties?

The FSC considers for the purpose of its proposed model that beneficiaries of continuous disability policies could benefit from more affordable and accessible (allied health services and hospital services) rehabilitation services without the need for defining the nature of their work.

[2] The Australian Faculty of Occupational and Environmental Medicine (2011), Realising the Health Benefits of Work: A Position Statement, p.12.

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