12 November 2017

Dr Patrick Hodder
Committee Secretary
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Parliament House
CANBERRA ACT 2600

Delivered by email: corporations.joint@aph.gov.au

Dear Dr Hodder

Regulatory constraints on Life insurers to provide early intervention to support consumers

I write to you on behalf of the Financial Services Council (FSC) to bring your attention to our submission on current regulatory constraints on life insurers' ability to provide early rehabilitation benefits and medical expenses.

This potential improvement in the NPV of an insurance policy over its life would incentivise life insurers to invest in more active rehabilitation strategies which would unlock positive externalities. It would also lead to better social outcomes for individuals. For government, higher return to work rates will reduce the fiscal costs of the Disability Support Pension and the National Insurance Disability Scheme. By definition, higher return to work rates will translate into higher workforce participation which is a key government objective at a time when the population is aging and the Australian workforce is shrinking.

The FSC has over 100 members representing Australia's retail and wholesale funds management businesses, superannuation funds, life insurers, financial advisory networks and licensed trustee companies. The industry is responsible for investing more than $2.7 trillion on behalf of 14 million Australians. The pool of funds under management is larger than Australia's GDP and the capitalisation of the Australian Securities Exchange and is the fourth largest pool of managed funds in the world.

The life insurance industry paid claims of approximately $9.1 billion to Australian households for personal death and disability risk insurance products in 2016. Our life insurance members of the life insurance industry as measured by our membership's proportion of in-force annual premiums.

Please find our submission enclosed. We look forward to discussing the contents with you. I can be contacted on .

Yours faithfully

JESSE KRNCEVIC

Senior Policy Manager

Executive summary

The Commonwealth Government has clearly articulated that boosting workforce participation is a key priority for both economic and social reasons. For example, in the 2014-15 Budget Speech, the Treasurer the Hon. J. B. Hockey MP noted:

> *"I say to the Australian people, to build a workforce for the future, those who can work, should work. The benefits of work go far beyond your weekly pay packet. Work gives people a sense of self, and work helps to build a sense of community."*

The longer an individual is away from work can significantly reduce their likelihood of returning to work which can result in a negative effect on the individual and their family. This is because the longer a person is away from work the higher the likelihood of poorer physical and mental health culminating in more permanent disability, removing them from the workforce. For example, 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.

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, only viewing this type of insurance as providing income protection ignores the wider benefits that this insurance could provide to consumers, society and public finances.

Current legislative arrangements prevent life insurers from offering targeted rehabilitation benefits in certain circumstances, even when they are considered by the insurer to be relevant, appropriate and necessary to rehabilitate the claimant under a continuous disability policy. Specifically, life insurers wish to make targeted rehabilitation payments for medical treatment or therapy that they determine to be relevant, appropriate and necessary to return the claimant to work.

If these restrictions were removed, as proposed by this submission, life insurers would be able to use more effective early claim intervention practices through offering rehabilitation benefits. This would increase an injured person's probability of successful rehabilitation relative to the status quo.

The benefits of higher return to work rates that would eventuate from a targeted adjustment to legislative settings to allow life insurers more flexibility with respect to making rehabilitation payments would promote a more sustainable life insurance industry. Increased return to work rates would translate to a lower claims cost for a disability income protection policy on a net present value (NPV) basis and would allow insurers to have more stable premiums on products.

This potential improvement in the NPV of an insurance policy over its life would incentivise life insurers to invest in more active rehabilitation strategies which would unlock positive externalities. For individuals, higher return to work rates leads to a better outcome on a NPV of lifetime income basis. For government, higher return to work rates will reduce the fiscal costs of the Disability Support Pension and the National Insurance Disability Scheme. By definition, higher return to work rates will translate into higher workforce participation which is a key government objective at a time when the population is aging and the Australian workforce is shrinking.

In our view there is a strong public policy case for making legislative amendment to allow life insurers to offer targeted rehabilitation benefits to rehabilitate the claimant in order to get them back to work under a continuous disability policy.

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.

As a result, a number of life insurers are increasingly employing rehabilitation specialists to provide occupational or vocational rehabilitation support to the management of ongoing disability claims. These claims management specialists coordinate treatment and disability management plans and work to assist the individual claimant to either return to their prior role or facilitate the individual to find alternate employment. But insurers cannot maintain all the necessary expertise internally and need to be able to reimburse customers for these services in order to provide better outcomes for the insured.

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

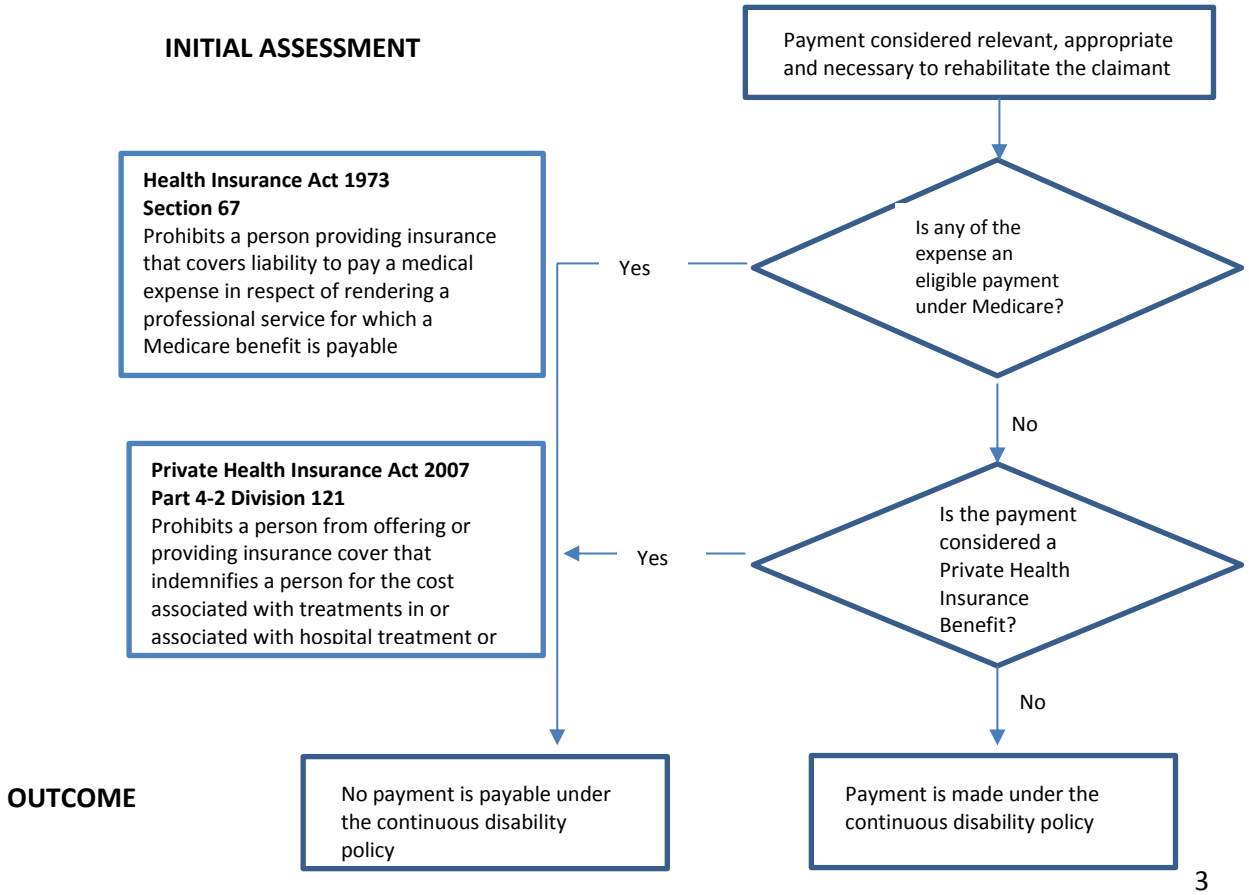
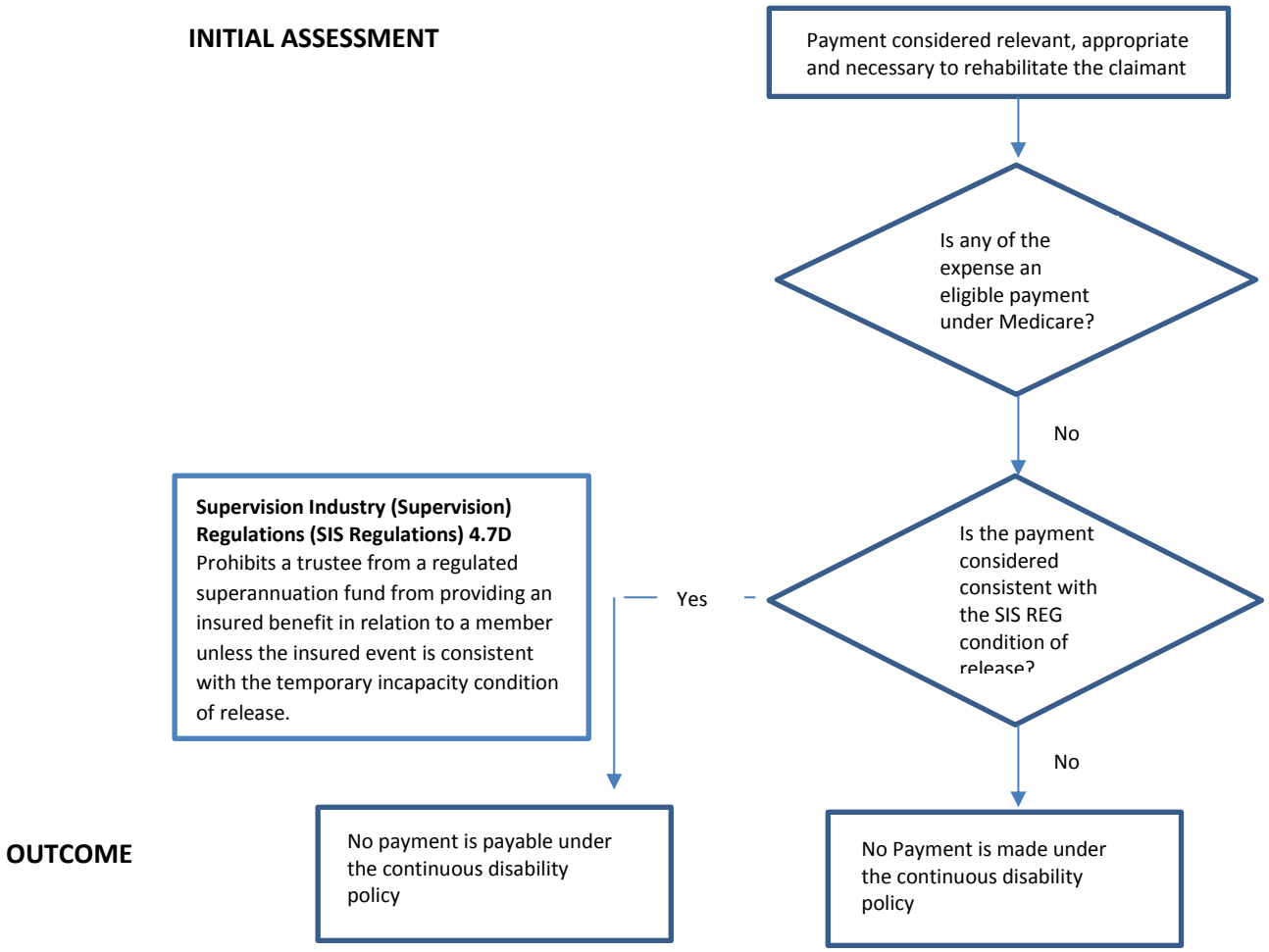


Figure 2 demonstrates a stylised claim assessment process which means trustees are unable to release funds from the insurer to offer early intervention in the form of targeted rehabilitation benefits that the insurer considered to be relevant, appropriate and necessary to rehabilitate the claimant in 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*, *Private Health Insurance Act 2007*, *Private Health Insurance (Health Insurance Business) Rules 2013, Health Insurance Act 1973* and S*uperannuation Industry (Supervision) Regulations 1994 (Cth)* 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 paid.

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 and aids the 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 Insurance Act 1995 (Cth) (Life Act). 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, private health insurance or where excessive waiting times in the public health system would result in an adverse return to work outcome. This could increase the likelihood of successful rehabilitation and prevent many consumers from becoming permanently disabled.

The benefits of higher rehabilitation rates would also promote a more sustainable life insurance industry with lower claims costs on a net present value (NPV) basis and would allow insurers to charge more stable premiums. This would create incentives for life insurers to invest in more active rehabilitation strategies. Higher rehabilitation and return to work rates would benefit the individuals themselves as well as the community, and would reduce demand for of the Disability Support Pension and the National Disability Insurance Scheme, and could result in higher workforce participation.

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 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 Private Health Insurance Act 2007 (Cth) (**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 1973 (Cth) (**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 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 Private Health Insurance (Health Insurance Business) Rules 2017 (Cth) (**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 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 Superannuation Industry (Supervision) Regulations 1994 (Cth) (**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 a 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. One possible way to do this would be to amend the cashing restriction in item 109 to insert a second limb so that it provides as follows:

> 1. 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; or
> 2. 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'. While there is some uncertainty about what precisely this obligation means, if allowing insurers and trustees to provide a broader range of rehabilitation benefits results in lower premiums over the long term, this would have the additional benefit of allowing trustees to provide insurance cover to superannuation members in a way that is less likely to inappropriately erode retirement benefits.

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.

The economic and social benefits of increasing rehabilitation rates

Being off work can significantly reduce the likelihood of an injured person returning to work. Research has shown that people who do not work are at risk of poorer physical and mental health. They are more likely to be socially isolated and experience low self-confidence. They are at a greater risk of suicide and death. All of these factors have flow on effects to society, impacting families and communities.

If a person is off work for:

- 20 days, the chance of ever getting back to work is 70 per cent;
- 45 days, the chance of ever getting back to work is 50 per cent;
- 70 days, the chance of ever getting back to work is 35 per cent.[4]

The benefits of higher return to work rates that would eventuate from a targeted adjustment to legislative settings to allow life insurers more flexibility with respect to making rehabilitation payments would promote a more sustainable life insurance industry.

Increased return to work rates would translate to a lower claims cost for a disability income protection policy on a net present value basis and would allow insurers to have more stable premiums on products.

This potential improvement in the NPV of an insurance policy over its life would incentivise life insurers to invest in more active rehabilitation strategies which would unlock positive externalities.

For individuals, higher return to work rates leads to a better outcome on a NPV of lifetime income basis. It would also lead to better social outcomes for individuals.

For government, higher return to work rates will reduce the fiscal costs of the Disability Support Pension and the National Insurance Disability Scheme. By definition, higher return to work rates will translate into higher workforce participation which is a key government objective at a time when the population is aging and the Australian workforce is shrinking.

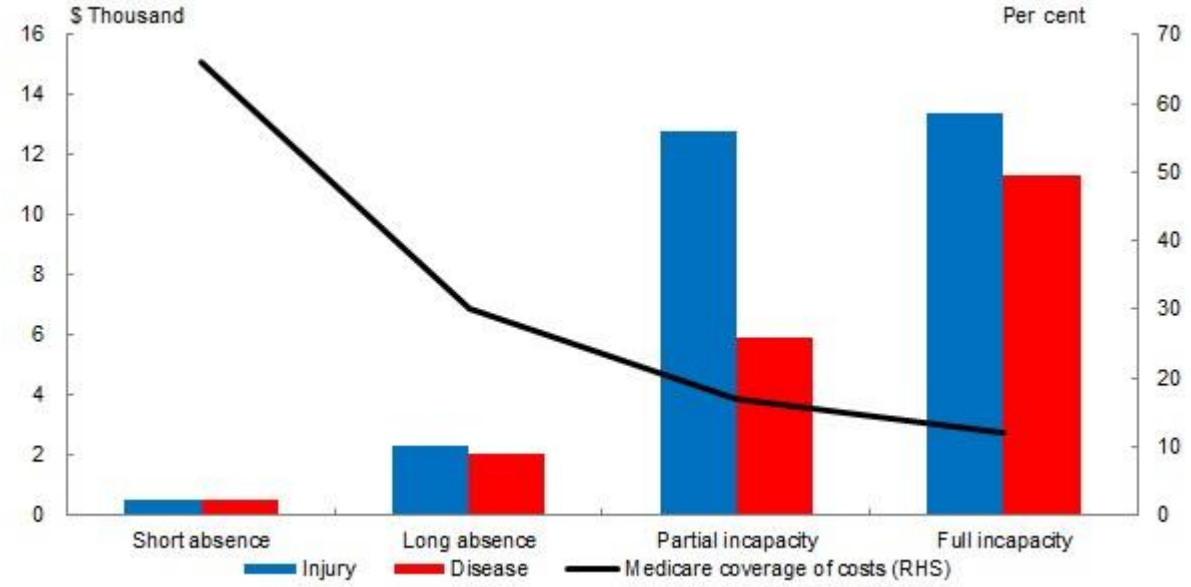
Supporting Data

Data and commentary in the report, *The Cost of Work-related Injury and Illness for Australian Employers, Workers and the Community: 2012–13 (SafeWork Australia, November 2015),* provides a useful benchmark of the cost impact of funding medical expenses in a personal injury jurisdiction.

Drilling down to medical costs incurred for work-related injuries and illnesses, SafeWork Australia's report highlights the exponential increases in medical costs with increasing absence duration (Figure 2).

[4] Realising the Health Benefits of Work. Position statement of the Australasian Faculty of Occupational and Environmental Medicine.

Figure 2: Medical expense and Medicare coverage against absence/incapacity status

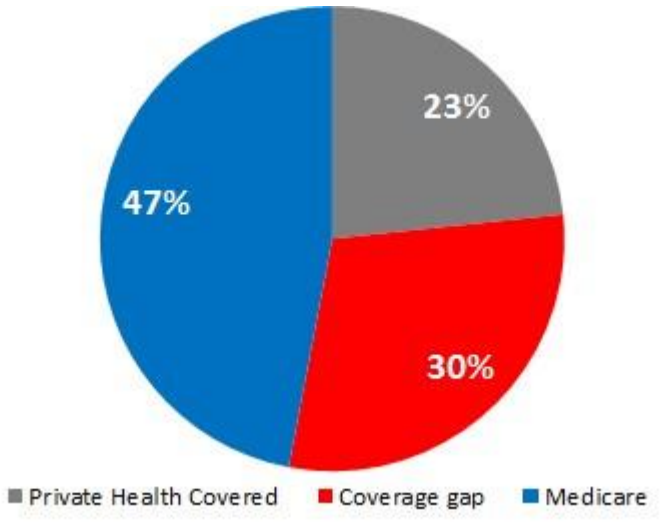


Source: Table A1.5: Parameters specific to severity and nature categories, *(SafeWork Australia, November 2015))*

The right hand axis of Figure 2 also shows the percentage of medical expenses that are covered by Medicare. The data shows that the coverage percentages reduce with the length of absence duration – it is assumed that this is due to exceeding the threshold of services covered by Medicare (as an example – psychological treatment – 10 sessions covered by a GP Mental Health Treatment Plan).

Data shows that 47 per cent of the total medical costs results from Medicare covered services, with the remaining 53 per cent of costs available to be covered by private health insurance (Figure 3). For those without Private Health Insurance a significant cost gap would arise once the threshold of services covered by Medicare is reached. Of the 53 per cent of medical costs that are available for cover by PHI, the data suggests that this cover is only accessed by 44 per cent of injured/ill workers.

Figure 3 Medicare/Private Health split



Source: SafeWork Australia, November 2015

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 in order 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 in within 253 days, while 10 per cent of patients waited longer than these times.[5]

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 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.[6] 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.

[5] Australian Institute of Health and Welfare - Admitted patient care 2014–15: Australian hospital statistics

4. Illustrative examples of how a coverage gap arises

Case study 1

A 46 year old manager first underwent ankle surgery in June 2013, for which he was on a waiting list for four months and a second surgery a year later where he was on another waiting list for two months. His post-operative recovery and return to work was severely compromised by a diagnosis of pulmonary embolism.

At this point, the Customer's employer was holding his position open for him until when he would be certified as fit to return to work. Unfortunately the Customer was advised that he would have to undergo a third ankle surgery and it would be at least a three month wait.

The employer advised they were unable to hold the Customer's position open to him and his employment was terminated. If INSURER X were able to pay for surgery or pay for a specialist consult for a second opinion, the Customer would have had a quicker recovery, and may not have lost his job.

Case study 2

Customer was a 51 year old carpenter who had been running his own business for 20 years. He completed manual work himself, as well as intermittently hired subcontractors. Customer calls INSURER X to claim income benefits due to his inability to work full-time, As a result of being on a surgical waiting list for more than 18 months, he had to hire more subcontractors to undertake the work he was unable to do. Due to building financial pressures of his business, he was no longer able to fund his physiotherapy treatment that managed his pain while waiting for surgery.

By the time the Customer came onto claim for his bilateral knee replacement, he was in severe financial difficulty and his business was no longer running. His disappointment was further reinforced when his benefit payments could only afford to pay debt, rather than also the physiotherapy he needed to recover. Unfortunately his business did not recover from the events.

Had we been able to intervene earlier, ways INSURER X might have assisted to improve the customer outcome include:

- Work assessment to identify modifiable factors at work;
- Treatment to include physiotherapy or even funding the surgery (avoiding the lengthy wait lists in public sector)

Case study 3

Customer was a 49 year old a self-employed CEO of a manufacturing business for 20 years and was responsible for 40 staff members.

The Customer had suffered from depression for many years and had consulted with a Psychologist in 2013. In late 2014, the Customer's symptoms of depression had started to worsen and he consulted his GP. At this stage, the Customer was also experiencing financial difficulty that was causing him stress and anxiety. The GP referred the Customer to a Psychiatrist for treatment (fortnightly sessions at $200.00 per consultation).

The Psychiatrist also recommended Cognitive Behavioural Treatment (CBT) and a mental health care plan. Due to the financial distress, the Customer could not afford to attend regular consultations or pay for any medication and his private health insurance had lapsed.

When the Customer lodged his Income Protection claim in late 2015, the Customer advised that he had filed for bankruptcy. The Customer reported dealing with an independent consultant who was managing his financial affairs and was in the process of finalising his debtors' requirements. The Customer's mental health continued to deteriorate. This resulted in a complex Income Protection claim for a Customer with many barriers to his recovery and RTW.

For this particular Customer, his Income Protection benefit was approx. $13,000 per month. Whilst Psychiatry appointment cost approx. $200 per consultation, an investment by the Insurer to pay for up to 6 months (i.e. $2400) may have assisted the Customer with his business, thereby eliminating the need for the Customer to file for bankruptcy or require income compensation.

Case study 4

Customer is a 39 year old stockbroker who was diagnosed with lymphoma. The Customer was advised to cease work for at least six months whilst he underwent chemotherapy and was advised to rest. During this period he became severely deconditioned and was experiencing fatigue and cognitive impairment as a result of the chemotherapy. He also developed secondary depression.

There is now new research to support that exercise during and after chemotherapy treatment increases survival rates by 50%. It also reduces the impact of symptoms during treatment (e.g. nausea and fatigue) ensures he maintains his muscle mass and prevents cognitive impairment and releases endorphins to prevent and treat psychological illness.

If INSURER X engaged an exercise physiologist when the Customer was diagnosed, his quality of life could have been maintained and the after effects of cancer could have been significantly reduced.

Case study 5

The Customer is a 57 year old commercial salesman who, following a heart attack, had aortic valve replacement surgery in 2014. Post-surgery the Customer was having issues with high blood pressure which the specialist advised was due to the Customer's obesity and in turn was delaying his recovery. However the Customer was also displaying fear avoidant behaviour towards increasing his heart rate or participating in exercise (due to fear of risk).

If INSURER X could have implemented services from a dietician or nutritionist and an exercise physiologist to provide education to the Customer both prior to and post the aortic valve replacement surgery, he may have had a better chance at recovery prior to developing fear avoidant behaviour around exercise.

Case study 6

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 INSURER X was able to, we 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.