27 July 2018

Dr Patrick Hodder
A/g Committee Secretary
Parliamentary Joint Committee on Corporations and Financial Services
PO Box 6100
Parliament House,
Canberra, ACT, 2600

By email: corporations.joint@aph.gov.au

Dear Dr Hodder

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

Thank you for your letter dated 19 July 2018 requesting answers to two questions posed by the Parliamentary Joint Committee on Corporations and Financial Services (the Committee). We understand these questions relate to the Committee's current inquiry into options for greater involvement by private sector life insurers in worker rehabilitation. We are pleased to provide the following responses.

1. **Noting the issues raised in your submission, do you have any different views on life insurers having greater involvement in rehabilitation in the following two situations:**
    a. **Where an injury illness occurs at or due to work and people have access to relevant workers compensation and other support mechanisms; or**
    b. **Where an injury or illness is unrelated to work?**

As explained in the MLC Life Insurance submission to the inquiry (submission 12), we recommend life insurers be authorised to act as a "supplementary funder" of medical treatment. This would mean that life insurers should only fund medical treatment as part of a program of rehabilitation when two criteria are met:

1. Where it can be demonstrated that the planned medical service is reasonable and necessary to the goal of restoring the customer to health and employment.
2. Where principal healthcare funders are constrained from funding the required services due to regulation, timing of the availability of treatment (including health system capacity issues), or, in the case of private health insurance, the customer is not insured or has exhausted their benefits.

While criteria two was formed with Medicare and private health insurers in mind, it is equally applicable to workers compensation insurance.

In respect of situation a, we assume the person's access to workers compensation insurance also grants access to rehabilitation services. In this situation, our view is that rehabilitation services determined to be reasonable and necessary to the goal of restoring the customer to health and employment should only be funded by the person's life insurer if their workers compensation insurer is unable or unwilling to fund the service.

We have heard views put forward in submissions and testimony by witnesses to this inquiry stating that life insurers should not be permitted to fund rehabilitation in the circumstances imagined in situation a.

Opposition to this appears to be founded on the misapprehension that Australian life insurers seek to somehow supplant existing workers compensation insurers from their role. This is incorrect. Life insurers simply seek to be legally permitted to better support customers where their recovery is at risk due to difficulty in accessing rehabilitative medical services.

Nonetheless, we understand the Committee may form the view that some form of regulation is required to ensure life insurers do not exceed the limited mandate being requested. In our submission MLC Life Insurance described an approach that would achieve this and could work via either industry self-regulation or an addition to the *Private Health Insurance (Health Insurance Business) Rules*. For your convenience this approach is attached as an appendix to this letter.

In respect of situation b, we see helping customers who have injuries and illnesses unrelated to work as the primary beneficiaries of life insurers being permitted to fund medical treatment as part of a program of rehabilitation. People in this situation do not have the benefit of a workers compensation insurer to assist them. While Medicare and private health insurers are in place to assist these people and in general do a good job, in the course of assisting customers who make a claim with us we do encounter some who are unable to access the medical care that would assist them in returning to health and to employment. It is these people we would like to be able to assist. Indeed having paid their premiums in good faith, customers in this situation often expect their insurer to be able to assist with reasonable rehabilitation expenses and are disappointed when they are informed the law currently precludes this from occurring.

2. Do you support greater involvement by private sector life insurers in worker rehabilitation before the life insurance industry has completed actioning the recommendations of the committee's Report?

MLC Life Insurance appreciates the significant time and effort the Committee invested to produce the report deriving from its prior inquiry into the life insurance industry. This is a substantial report and along with our industry association and peers we have and will continue to approach its recommendations in good faith.

We note that of the 49 recommendations made in the report, 26 are directed at the Australian Government or industry regulators and we understand responses to these recommendations will be forthcoming. The remaining 23 recommendations are directed at industry either directly or via the Financial Services Council (FSC). Through both our own internal efforts and our participation in FSC working groups, we can assure the Committee that good progress is being made on taking action in the areas identified.

The primary beneficiary of changes that permit life insurers to fund medical services as part of a program of rehabilitation are customers who, due to no fault of their own, are unable to access the needed health services. Given this, we urge the Committee to recognise the positive benefits that will become available to life insurance claimants if present restrictions are lifted, and to recommend the necessary changes to take place as soon as possible.

Yours sincerely,

David Hackett
Chief Executive Officer
MLC Life Insurance

Appendix one: an approach to regulating life insurer involvement in medical rehabilitation

MLC Life Insurance acknowledges that permitting life insurers the option to fund rehabilitation related medical treatment requires some form of regulation in order to ensure it remains limited to employment related rehabilitation only. As noted we propose that life insurers serve only as a provider of supplementary "top up" funding when two criteria are met:

1. Where it can be demonstrated that the planned medical treatment is *reasonable* and *necessary* to the goal of rehabilitating the customer to health and employment.
2. Where principal healthcare funders such as Medicare and private health insurers are constrained from funding the required services. This constraint may be due to regulation, timing of the availability of treatment (including health system capacity issues), or, in the case of private health insurance, the customer is not insured or has exhausted their benefits.

We also see regulation as supporting the application of this concept by ensuring that rehabilitation treatment decisions are made in a consistent, transparent and equitable manner across the entire life insurance industry.

Our view is that such objectives are best achieved via industry self-regulation. We note the Financial Services Council has proposed five key principles that should apply to rehabilitation services funded by life insurers. We support these principles, which can be found in Submission 1 to this inquiry.

Furthermore we believe that in order for funding for medical treatment to be permitted an insurer must form the view the treatment is *reasonable* and *necessary* to the rehabilitation of the customer. We also recommend there to be a consistent cross-industry approach to this formation. We propose that *reasonable* and *necessary* be determined and documented by the creation of an outcomes focused *Return to Employment Plan*. The *Return to Employment Plan* would be jointly prepared and agreed by the customer, their doctor(s), their insurer, and, where appropriate, their employer.

The requirements of a *Return to Employment Plan* could be fully expressed in the Life Insurance Code of Practice, or if policy makers prefer a more regulated approach, in the *Private Health Insurance (Health Insurance Business) Rules*[1]. In summary a *Return to Employment Plan* should describe the specific rehabilitation goals agreed between the parties and the steps necessary to achieve them, including the commitments of each party. It should also explicitly require its planners to consider and incorporate health services funded by other funders (including Medicare, private health insurers and workplace compensation insurers), before authorising supplementary funding by the life insurer.

The customer's progress to the goals specified on the *Return to Employment Plan* should be closely monitored. Once the goals are achieved the plan can then be iterated with new goals and further supports, with the process continuing until full or optimal recovery is achieved.

[1] Using the *Private Health Insurance (Health Insurance Business) Rules* in this way would be a consistent extension to its current application, notably section 16, which differentiates life insurer business from Private Health Insurer business, and section 12, which defines the content of a Chronic Disease Management Program.