Dr Patrick Hodder
Committee Secretary
PO BOX 6100
Parliament House
CANBERRA ACT 2600
Delivered by email: corporations.joint@aph.gov.au

22 May 2018

Dear Dr Hodder

FSC policy on removing regulatory constraints that prevent life insurers from providing earlier intervention to support consumers

The Financial Services Council (**FSC**) has long advocated for a reform that will, with the appropriate safeguards and consents, allow life insurers to pay for the medical treatment of customers who need it to return to wellness. We are encouraged that this inquiry is looking into how this could provide better social and economic outcomes for individuals, Government and life insurers.

For Government, higher return to wellness and the increased potential for individuals to return to work will reduce the fiscal costs of the Disability Support Pension and the National Insurance Disability Scheme. Getting more people back to work will support the Government's key objective of higher workforce participation.

This FSC submission is further to the initial submission lodged on 20 April 2018.

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 $3 trillion on behalf of 14.8 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 has paid $9.5 billion to Australian households for death and disability insurance claims over the last year. Excluding employer provided sick leave, our TPD and income protection products provide one quarter of all the income support paid to around 95,000 Australians.

Please find our submission enclosed. We look forward to discussing the contents with you. I can be contacted on 02 9299 3022.

Yours faithfully

JESSE KRNCEVIC
Senior Policy Manager

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]

Personal disability income insurance protects individuals from financial losses that arise from both mental and physical disability, with wider benefits 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 provide the medical help people need to help them get back to work sooner.

Recent FSC research undertaken by Cadence Economics found that the current restrictions would apply to approximately 10,000 claimants each year in the case of musculoskeletal and mental health claims. Early intervention would be beneficial and cost effective for approximately 1,400 of those claimants.

For claimants, improved access to treatment drives higher return to work rates, and leads to better long-term outcomes. Cross jurisdictional comparison of workers compensation arrangements suggests in particular that timely intervention can drive real improvements in the number of people returning to work. In Victoria, where prescribed injury notification periods are up to 30 days after becoming aware of an injury, 37% of claims have at least six months cumulative time loss; in Queensland, this figure is 16%.[2]

For insurers, helping people return to work reduces the cost of claims and helps keep premiums affordable, providing the framework to reduce underinsurance in society.

For the 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 to work will also support the Government's key objective of higher workforce participation. Our findings show that early intervention could get people back to work five weeks earlier than otherwise, which combined with an ongoing reduction in early withdrawal from the workforce provides a $1.56 billion net present value[3] boost to GDP, along with an additional $204 million boost to Government revenue as a result of increased activity, again in net present value terms.

The available evidence presents a compelling public policy case for changing the law to allow life insurers to help claimants in this way.

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

2 Collie, A., Iles, R. and Di Donato, M.F., The Cross Sector Project: Mapping Australian Systems of Income Support for People with Health Related Work Incapacity, Insurance Work and Health Group, Faculty of Medicine Nursing and Health Services, Monash University, 2017.

3 Net present value calculated using a 7% real discount rate as per OBPR guidelines.

Under the FSC's proposed policy framework:

1. All treatment the life insurer offers to pay for would be arranged through the claimant's treating physician with the customer's consent;
2. Life insurers will not coerce or pressure customers to seek treatment or return to work;
3. 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
4. Decisions and processes relating to an offer to pay for treatment would be subject to the usual internal dispute resolution and external dispute resolution processes.

1. Introduction and Context

Continuous disability policies, such as total and permanent disability insurance, 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.

Life insurance companies routinely provide rehabilitation services to help claimants get back to wellness. However, they are not allowed to pay for medical treatment and services, even when this is clearly in the mutual interests of the individual, the Government and the insurer.

Figure 1 is a stylised claim assessment process for a continuous disability policy showing how life insurers are not allowed to pay for targeted rehabilitation benefits, even if the person's treating physician considers them relevant, appropriate and necessary to help their patient return to wellness.

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

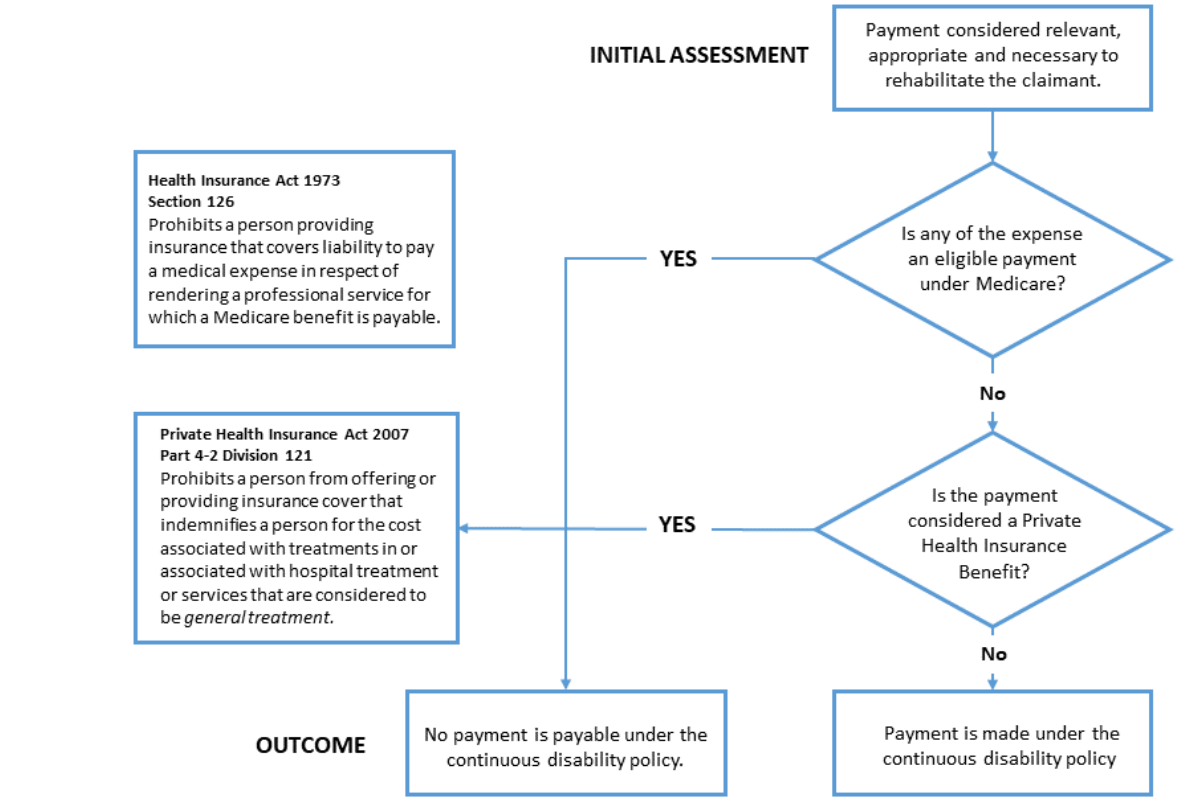
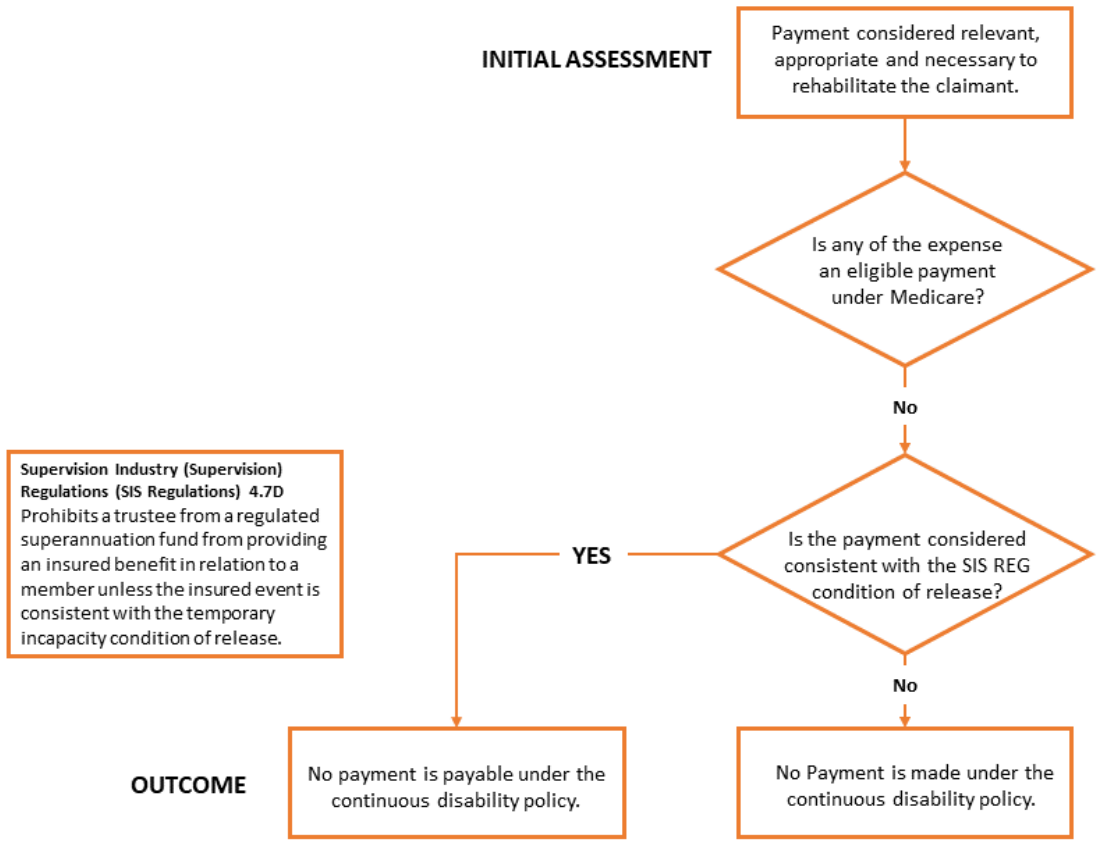


Figure 2 is a stylised claim assessment process for a continuous disability policy showing how superannuation trustees are not allowed to release funds to pay for targeted rehabilitation benefits, even if the life insurer offer to pay for treatment that the person's treating physician considers to be relevant, appropriate and necessary to help their patient return to wellness.

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 person receiving the treatment.

This is a perverse outcome for the individual. Providing flexibility around circumstances in which life insurers can choose to pay for 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 and where it is clearly in the mutual interests of both the life insurer and the claimant.

2. Recommendation

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

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. 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 relaxed, 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 through a claimant's treating physician where 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 to be made if this submission is accepted and implemented.

3. Supporting Evidence

Details of legislative restrictions and required changes

Life Insurance

Life insurers are regulated by APRA under the Life Act. Section 234 of the Life Act 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 of the Life Act 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, 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 PHI 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 superannuation 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 dependents or Loss Prevention and Recovery (**LPR**).

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

SIS 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 of SIS Regulations). 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.

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.

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]

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

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 Net Present Value (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.

Early intervention is critical in return to work outcomes

Collie et al. undertook a comprehensive assessment of data in relation to compensation policies and return to work effectiveness based on the Australian workers' compensation system.[5]

This study produced a set of recovery curves, showing at the national level, for those who have at least two weeks off work, 78.4 per cent are still off work at four weeks. At three months, this figure falls to 40.7 per cent. The figures are then 25.5, 15.5 and 8.1 per cent respectively at six months, one year and two years.

Importantly, the figures show considerable differences across jurisdictions. For example, injured Victorian workers had 88 per cent greater odds of receiving income replacement at four weeks compared to injured NSW workers. In discussions with industry experts, a key reason identified for relatively worse return to work effects in Victoria was the relatively large waiting times to report workers' compensation incidents in that State relative to other jurisdictions.

In 2016, Swiss Re conducted a survey of ten insurance companies for claims received and managed over 2015-16 and for 2014 with a focus on the role of rehabilitation services in assisting customers return to health and work.[6] Some of the key findings of that report are that:

- Over the two survey periods, in-house rehabilitation teams have grown by 173 per cent and that claims assessors had become increasingly involved in assisting customers access support and assistance to return to health and work.

- Customer participation in in-house rehabilitation services increased from an average of 6.1 per cent per participating insurer in 2014 to 31.3 per cent in 2016. The increase in

5 Collie, A., Iles, R. and Di Donato, M.F., The Cross Sector Project: Mapping Australian Systems of Income Support for People with Health Related Work Incapacity, Insurance Work and Health Group, Faculty of Medicine Nursing and Health Services, Monash University, 2017.

6 Swiss Re, Rehabilitation Watch - Australia, 2016.

participation for customers in external rehabilitation services rose over this period from 5.8 per cent to 17.9 per cent.

- There had been significant improvements in the timeliness of offering and receiving rehabilitation services. For example, the time from claim notification to referral to an external rehabilitation provider reduced by 119 days on average.
- Return to work rates had improved from 54.37 per cent in 2014 to 58.62 per cent in 2016 (which compares with a return to work rate of those in the workers' compensation system which was unchanged over that period).
- Rehabilitation yielded a positive return for insurers (whether provided by in-house or external rehabilitation providers) with an estimate that for every $1 spent on rehabilitation services, insurers saved $25 on IP claims costs.

Recent FSC research on Early Intervention

The FSC supported by two of its members (BT and MetLife) recently commissioned Cadence Economics to conduct economic modelling to quantify the impact of removing the restrictions preventing life insurers from providing early intervention.

Estimated benefits of reform

Based on the information gathered, and through a targeted consultation process, the estimated benefits of report presented in the research were based on:

- An assumed pool of those who would benefit from early intervention of 1,379 persons out of the estimated total of 10.1 million TPD and IP policy holders in Australia. Of the total 10,118 persons there are an estimated 1,379 for who early intervention would be beneficial and cost effective.
- An estimated reduction in return to work times of 5 weeks, down from 18 weeks to 13 weeks, and prevent 8 per cent of injuries from transitioning to total permanent disability.

The economic modelling undertaken is based on scenarios of economic conditions with and without early intervention provided by insurers. Under the scenario where early intervention is allowed, there are two main impacts on the overall economy. First, there is an effective increase in labour supply as those on IP return to work faster, and a number of people do not go on to TPD. Based on the analysis undertaken, for that cohort of persons injured in 2019 this increases the effective workforce by 110 full time equivalent (FTE) employees in 2019, 120 FTE in 2020, with a long run reduction of 109 FTE transitioning to total permanent disability. This pattern repeats each year, and importantly there is a corresponding increase in the pool of persons who are directed away from total permanent disability.

Second, there is an improvement in the government budget position resulting from the direct spending on health services for those effected persons. The reduced cost to government is estimated to be $18.9 million in the first year but increases over time as the benefits cumulate over an increasing number of people. By 2040 it is estimated that total government expenditure will be $252.3 million lower in real terms (2017-18 dollars).

Taking the projected benefits of reform over the period 2019 to 2040, Australian real gross domestic product (GDP) is projected to increase by $1.56 billion in net present value (NPV) terms in 2017-18

dollars. National welfare, measured by gross national income (GNI) is projected to be $1.42 billion in NPV terms.

In absolute terms at 2040 the GDP impact is estimated to be $405.7 million, representing approximately $169,000 in GDP per additional full time equivalent worker in the labour force.

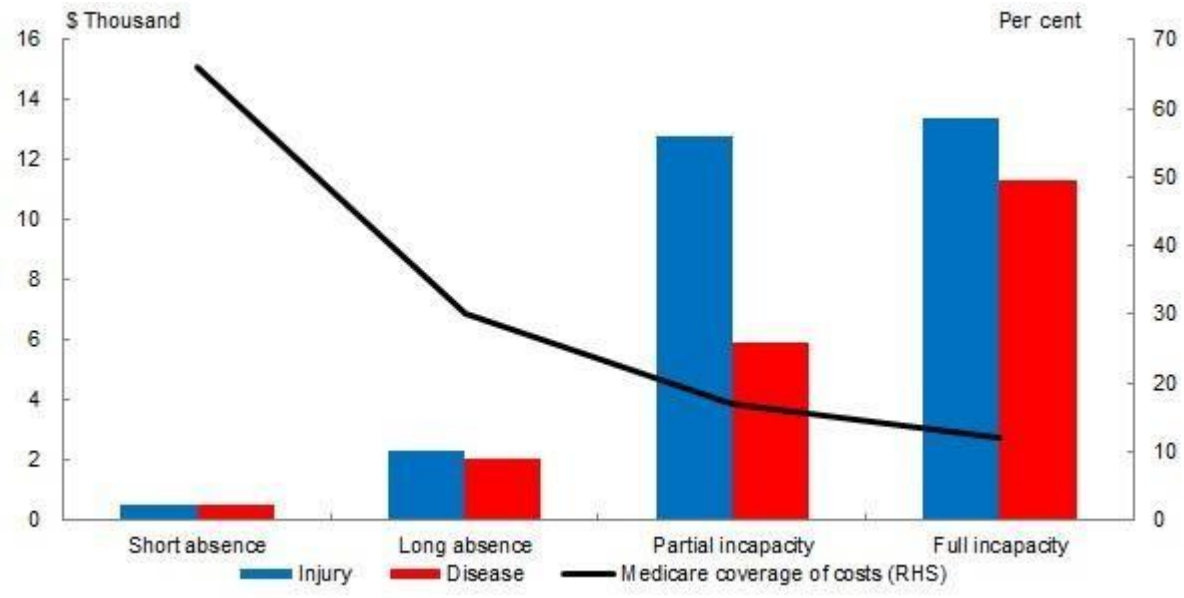
Over the period, the government is estimated to save $1.12 billion in net present value terms as a result of reduced spending on health.

Other 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).

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



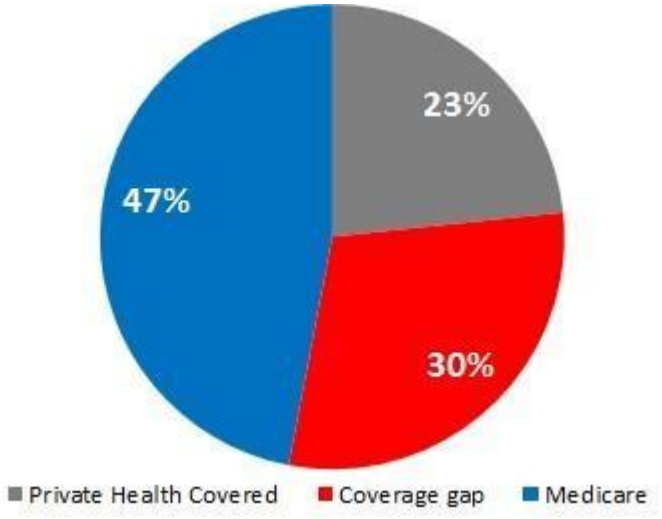
Source: Table A1.5: Parameters specific to severity and nature categories, *(SafeWork Australia, November 2015))*

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 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.[7]

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.

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

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.[8] 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.

4. Case studies that demonstrate how coverage gaps arise

Case study 1 – 46 year old Manager has complications during leg surgery and loses his job

Background

A 46 year old manager first underwent ankle surgery in June 2013, after being on a waiting list for four months. He then had to undergo a second surgery a year later after being on the waiting list for two months. His post-operative recovery and return to work was severely compromised by a diagnosis of a pulmonary embolism (blockage in one of the arteries in his lungs).

At that time, the Customer's employer was holding his position open until he was certified as fit to return to work. Unfortunately the Customer was subsequently advised that he would have to undergo a third ankle surgery which would require at least a three month wait.

The employer then advised the Customer that they were unable to hold his position open for him and his employment was terminated.

Barriers to Life Insurers' ability to assist Customer

The Customer's Life Insurer was unable to pay for the Customer's three surgeries to be had in private institutions,[9] nor any additional specialist consultation(s).[10]

8 Medicare Benefits Schedule Note A47.

9 Surgery in a private hospital is a 'hospital treatment' under the Private Health Insurance Act 2007, and undertaking liability by way of insurance for a 'hospital treatment' is to carry on a 'health insurance business' under the Private Health Insurance Act 2007 (Part 4-2 Division 121), which only a private health insurer (and not a life insurer) is able to do under the Private Health Insurance (Prudential Supervision) Act 2015 (s 10).

10 A specialist consultation is a professional service for which a Medicare benefit is likely to be payable and therefore a life insurer is unable to undertake liability by way of insurance for such expenses under the Health Insurance Act 1973 (s 126).

Benefits if barriers to assist were lifted

If the Customer's Life Insurer were able to pay for the Customer's surgery/surgeries and/or additional specialist consultations (for a second opinion or alternative treatments), the Customer would likely have had a quicker recovery from his injuries, facilitating his ability to return to work sooner which could possibly also have prevented the loss of his job.

Case study 2 – 51 year old's carpentry business fails due to extensive waiting periods in the public health system

Background

The Customer was a 51 year old carpenter who had been running his own business for 20 years. He completed most of the manual work his business required himself, but he also intermittently hired subcontractors.

The Customer was advised that he needed a knee replacement and called his Life Insurer to claim income benefits because his condition meant he was unable to work full-time. As a result of being on a waiting list for surgery for more than 18 months, the Customer had to hire more subcontractors to undertake the work he was unable to do himself. Due to building financial pressure on his business, the Customer was no longer able to fund the physiotherapy treatment which helped him to manage his pain while waiting for surgery.

By the time the Customer was able to receive claim payments for his bilateral knee replacement, he was in severe financial difficulty and his business was no longer running. His disappointment was further reinforced when he realised the amount of his benefit payments could only afford to cover debts he had incurred, and not the physiotherapy he needed to recover from the knee replacement. Unfortunately his business did not recover from the events.

Barriers to Life Insurers' ability to assist Customer

The Life Insurer was unable to pay for:

1. a work assessment under the supervision of his physiotherapist or a qualified occupational therapist for the purposes of managing his medical condition while in his workplace;[11]
2. physiotherapy to manage the customer's condition;[12] and/or
3. private surgery to avoid public waiting list times.[13]

11 A work assessment (or aspects of a work assessment) would likely be considered 'general treatment' or 'hospital treatment' under the Private Health Insurance Act 2007 by virtue of how and why the assessment was commissioned (as part of a treatment plan to ameliorate the customer's symptoms and/or prevent deterioration of his condition or the onset of other conditions) or who the assessment was performed by (a health professional). Undertaking liability by way of insurance for 'general treatment' or 'hospital treatment' costs is to carry on a 'health insurance business' under the Private Health Insurance Act 2007 (Part 4-2 Division 121), which only a private health insurer (and not a life insurer) is able to do under the Private Health Insurance (Prudential Supervision) Act 2015 (s 10).

12 Depending on how the service is dispensed, physiotherapy provided in respect of the management of a diagnosed condition is likely to be a 'hospital treatment' or 'general treatment' under the Private Health Insurance Act 2007, and undertaking liability by way of insurance for either of these things is to carry on a 'health insurance business' under the Private Health Insurance Act 2007 (Part 4-2 Division 121), which only a private health insurer (and not a life insurer) is able to do under the Private Health Insurance (Prudential Supervision) Act 2015 (s 10). In certain cases, physiotherapy could also be a service for which a Medicare benefit is payable, and a life insurer is unable to undertake liability by way of insurance for such expenses under the Health Insurance Act 1973 (s 126).

13 See note 2, above.

Benefits if barriers to assist were lifted

If the barriers outlined above were removed, the Life Insurer would have had multiple options to provide assistance, including paying for the Customer's work assessment, physiotherapy and/or even funding the Customer's knee surgery. One or a combination of these could have meant the Customer was able to be more actively involved in his business and thereby reduce his outgoings on replacement staff, and/or avoided lengthy surgery waiting times in the public sector. In this Customer's case, the interventions suggested may well have saved the Customer's business.

Case study 3 – 49 year old self-employed CEO of manufacturing business files for bankruptcy due to severe mental illness

Background

The Customer was 49 years old and the self-employed CEO of a manufacturing business. He held this position for 20 years and was responsible for 40 staff members. The Customer had suffered from depression for many years and had previously consulted with a psychologist in 2013.

In late 2014, the Customer was experiencing financial difficulty which was causing him stress and anxiety. At that stage, the Customer's symptoms of depression had started to worsen and he subsequently consulted his GP. The Customer's GP referred the Customer to a psychiatrist for treatment (fortnightly sessions which cost $200.00 per consultation). The psychiatrist recommended Cognitive Behavioural Treatment (CBT) and a mental health care plan.

Due to financial stress, the Customer could not afford to attend the regular consultations or pay for the required medication. The Customer's private health insurance had lapsed.

When the Customer lodged his claim for income benefits in late 2015, he advised the Life Insurer that he had filed for bankruptcy. The Customer also 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 during the claims process, which resulted in a complex claim which included various barriers to the Customer's recovery and his ability to return to work.

Barriers to Life Insurers' ability to assist Customer

The Life Insurer was unable to pay for the Customer's psychiatric services.[14]

Benefits if barriers to assist were lifted

14 Psychiatric services may be either a) a professional service for which a Medicare benefit is payable, and a life insurer is unable to undertake liability by way of insurance for such expenses under the Health Insurance Act 1973 (s 126); or b) when provided in respect of the prevention or management of a diagnosed condition, depending on how the services are dispensed, either a 'hospital treatment' or 'general treatment' under the Private Health Insurance Act 2007. Undertaking liability by way of insurance for either of these things is to carry on a 'health insurance business' under the Private Health Insurance Act 2007 (Part 4-2 Division 121), which only a private health insurer (and not a life insurer) is able to do under the Private Health Insurance (Prudential Supervision) Act 2015 (s 10).

If the barriers outlined above were to be removed, the Insurer could have undertaken to pay for psychiatric services rendered to the Customer, which may have assisted him to mitigate the deterioration of his condition, and to return to health and to work**.**

Case study 4 – 39 year old stockbroker suffers fatigue and cognitive impairment due to chemotherapy

Background

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

New research suggests 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 maintenance of muscle mass, prevents cognitive impairment and releases endorphins which can both prevent and treat psychological illness.

Barriers to Life Insurers' ability to assist Customer

The Life Insurer was unable to pay for the Customer to see an exercise physiologist.[15]

Benefits if barriers to assist were lifted

If the Life Insurer was able to engage an exercise physiologist when the Customer was first diagnosed with lymphoma, his quality of life might have been maintained through his chemotherapy treatment, and the after-effects may have been significantly reduced. This may have even prevented the onset of depression as a secondary condition.

Case study 5 – 57 year old develops high blood pressure and obesity post aortic valve replacement surgery

Background

The Customer was 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. This in turn delayed his recovery. The Customer was also displaying fear avoidant behaviour towards increasing his heart rate or participating in exercise (due to fear of the risks of engaging in this type of activity in his condition).

15 In these circumstances it is possible that the exercise physiologist services would be a service for which a Medicare benefit is payable, because the service in this case may be provided to a person who has a chronic condition being managed by a medical practitioner. If a Medicare benefit is payable, a life insurer is unable to undertake liability by way of insurance for such expenses under the Health Insurance Act 1973 (s 126). Alternatively, depending on how the treatment is dispensed, exercise physiologist services provided in respect of the management of a diagnosed condition may be either a 'hospital treatment' or 'general treatment' under the Private Health Insurance Act 2007, and undertaking liability by way of insurance for either of these things is to carry on a 'health insurance business' under the Private Health Insurance Act 2007 (Part 4-2 Division 121), which only a private health insurer (and not a life insurer) is able to do under the Private Health Insurance (Prudential Supervision) Act 2015 (s 10).

Barriers to Life Insurers' ability to assist Customer

The Life Insurer was unable to pay for the Customer to see a dietician/nutritionist[16] and/or an exercise physiologist.[17]

Benefits if barriers to assist were lifted

If the Life Insurer could have implemented services from a dietician or nutritionist and/or an exercise physiologist to provide education to the Customer both prior to and after the aortic valve replacement surgery, the Customer may have been able to avoid the secondary issue of high blood pressure and had a better chance of recovery before developing fear avoidant behaviour around exercise.

16 Under certain conditions services provided by eligible dieticians (Accredited Practicing Dieticians) treating chronic health conditions (such as cardiovascular disease) under a care plan coordinated by a general practitioner are services for which a Medicare benefit is payable, and a life insurer is unable to undertake liability by way of insurance for such expenses under the Health Insurance Act 1973 (s 126). Alternatively, depending on how the services are dispensed, dietician and nutritionist services provided in respect of the management of a diagnosed condition may be either a 'hospital treatment' or 'general treatment' under the Private Health Insurance Act 2007, and undertaking liability by way of insurance for either of these things is to carry on a 'health insurance business' under the Private Health Insurance Act 2007 (Part 4-2 Division 121), which only a private health insurer (and not a life insurer) is able to do under the Private Health Insurance (Prudential Supervision) Act 2015 (s 10).

17 In these circumstances it is possible that the exercise physiologist services would be a service for which a Medicare benefit is payable, because the service in this case may be considered to be provided to a person who has a chronic condition and complex care needs being managed by a medical practitioner. If a Medicare benefit is payable, a life insurer is unable to undertake liability by way of insurance for such expenses under the Health Insurance Act 1973 (s 126). Alternatively, depending on how the services are dispensed, exercise physiologist services provided in respect of the management of a diagnosed condition may be either a 'hospital treatment' or 'general treatment' under the Private Health Insurance Act 2007, and undertaking liability by way of insurance for either of these things is to carry on a 'health insurance business' under the Private Health Insurance Act 2007 (Part 4-2 Division 121), which only a private health insurer (and not a life insurer) is able to do under the Private Health Insurance (Prudential Supervision) Act 2015 (s 10).