Chapter 3

Key issues

Introduction

3.1 This chapter covers the key issues raised in evidence to the committee. The first section examines the rationale underpinning the proposal put forward by the Financial Services Council (FSC) for life insurers to have an expanded role in worker rehabilitation, including:

- the benefits of early intervention;
- the effect on the life insurance industry; and
- the effect on government and the broader economy.

3.2 The second section looks at some of the key concerns that submitters and witnesses expressed about the proposal, including:

- the culture of the life insurance industry;
- potential conflicts of interest and power imbalances;
- the interaction of a risk-rated product, namely life insurance, in a health sector that currently uses a community-rated system premised on universal equity of access, namely Medicare and private health insurance;
- the proposal by the FSC and life insurers that payments to the insured under the proposed new scheme would be at the discretion of life insurers and would be outside contract provisions;
- the interaction of the proposal with workers compensation schemes; and
- whether the proposal should proceed prior to implementation of all recommendations from the committee's report into the life insurance industry.

3.3 This is followed by responses from life insurers to some of the issues raised by submitters and witnesses. Some possible alternatives to the FSC proposal are then considered.

3.4 The chapter concludes with the committee's view and recommendations.

The rationale for the proposal

3.5 The proposal for life insurers to have an expanded role in worker rehabilitation received general support from life insurers, with some noting the importance of safeguards.[1]

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1 See, for example, Financial Services Council, *Submission 1.1*, pp. 2–3; ClearView, *Submission 2*, p. 2; Australian Super, *Submission 6*, p. 3; MLC Life Insurance (MLC), *Submission 12*, p. 11; MetLife, *Submission 13*, pp. 6–7; Allianz Australia, *Submission 14*, p. 5; Cbus, *Submission 17*, p. 2; AIA, *Submission 20*, pp. 2–3.

3.6 Further to the discussion in Chapter 2, which relates to how the proposal would operate, this section examines the rationale supporting the proposal as presented in evidence to the committee.

The benefits of early intervention

3.7 There was general consensus amongst submitters and witnesses that early intervention can be beneficial for worker rehabilitation.[2]

3.8 Early intervention was described as beneficial for a variety of reasons. Most clearly, the receipt of early medical treatment helps people return to good health faster. In addition, an injured person who is not working may be at risk of developing a secondary mental health condition due to being unable to participate in work.[3] Moreover, it was submitted that as the length of an injured person's absence from work increases, the likelihood that they will return to work declines significantly, while their medical expenses increase.[4]

3.9 Indeed, evidence indicated that returning to work itself can also benefit a person's wellbeing.[5] As beyondblue explained, employment and financial security support good mental health:

> Evidence shows that good quality employment can improve mental health and reduce the risk of depression. There is also strong evidence that being out of work negatively impacts on health. People who are unemployed for more than 12 weeks are between four and ten more times likely to experience depression or anxiety, and unemployment is also linked with increased rates of suicide.[6]

3.10 Some submitters noted that any return to work should be conducted appropriately. For example, the Australian Manufacturing Workers' Union submitted that returning to work can be beneficial if the work is 'good'—that is, the work 'is safe, is healthy, is without risk of either further injuring or impeding the process of recovery and is individualised to the workers injury/illness and circumstances'.[7]

3.11 In addition, Ms Kim Shaw, National Head of Superannuation and Insurance Claims at Maurice Blackburn Lawyers (Maurice Blackburn), noted that it can be damaging for an injured person to return to work prematurely. She said that return to

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2 See, for example, Financial Services Council, *Submission 1.1*, pp. 9–11; beyondblue, *Submission 3*, p. 1; Australian Council of Trade Unions (ACTU), *Submission 8*, p. 11; Australian Prudential Regulation Authority (APRA), *Submission 10*, p. 2; Ms Kim Shaw, National Head, Superannuation and Insurance Claims, Maurice Blackburn Lawyers (Maurice Blackburn), *Committee Hansard*, 19 June 2018, p. 13; Ms Penny Shakespeare, Acting Deputy Secretary, Department of Health, *Committee Hansard*, 19 June 2018, p. 31.

3 beyondblue, *Submission 3*, p. 2; AIA, *Submission 20*, pp. 4–5.

4 Financial Services Council, *Submission 1.1*, p. 8; APRA, *Submission 10*, p. 2.

5 See, for example, Australian Super, *Submission 6*, p. 1; Maurice Blackburn, *Submission 7*, p. 4.

6 beyondblue, *Submission 3*, p. 1.

7 Australian Manufacturing Workers' Union, *Submission 15*, p. 2.

work 'has got to be individualised and guided by expert and treating doctor medical opinion'.[8]

The coverage gap and the proposal

3.12 As outlined in Chapter 2, the committee heard that some Australians are less able to access these early intervention benefits due to gaps in their health cover. Some life insurers emphasised this as part of the reasoning for the FSC's proposal.

3.13 For instance, AIA detailed how these coverage gaps can occur. AIA gave the example of a policyholder who would benefit from ongoing psychological support, but highlighted that Medicare generally covers only ten sessions with a psychiatrist.[9] AIA also noted that some consumers are currently using benefits provided by life insurers, and intended as income support payments, to fund medical treatment.[10]

3.14 MLC Life Insurance (MLC) explained that the proposal would benefit the people who fall into these gaps in cover, and provided anonymised examples of customers who it said would have benefited had life insurers been able to act as proposed.[11] MLC also made the following point:

> In order for non-health early intervention services 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 MLC Life Insurance to encounter customers who are unable to access the necessary healthcare service. It is customers in this category who we want to be in a position to assist by acting as a supplementary funder of medical treatment.[12]

3.15 The FSC also argued that the proposal would help realise the benefits of early intervention and return to work. For instance, the FSC stated that implementing its proposal would enable injured workers to return to work five weeks earlier than they otherwise would.[13] In addition, Mr Allan Hansall, Director of Policy and Global Markets at the FSC, stated that the proposal would enable early intervention and thereby support a person's general wellbeing:

> It is broadly acknowledged that most people want to be productive and contribute to society through work, social interactions and related activities. Our proposal means that people can reclaim the normalcy of their day to day lives, including routine and non-routine activities, faster.[14]

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8 Ms Shaw, Maurice Blackburn, *Committee Hansard*, 19 June 2018, p. 15.

9 AIA, *Submission 20*, p. 7; also see Mr Patrick O'Connor, Private Capacity, *Committee Hansard*, 19 June 2018, pp. 2–3.

10 AIA, *Submission 20*, p. 2.

11 MLC, *Submission 12*, pp. 13–14.

12 MLC, *Submission 12*, p. 12.

13 Financial Services Council, *Submission 1.1*, p. 2.

14 Mr Allan Hansall, Director of Policy and Global Markets, Financial Services Council, *Committee Hansard*, 19 June 2018, p. 25.

Effect on the life insurance industry

3.16 The FSC and other life insurers acknowledged that the proposal would benefit life insurers by saving them money. As Mr Hansall of the FSC stated:

> If an early intervention payment is made and that results in someone returning to work or coming off claim more quickly, then the claim that you would have had without the early intervention payment would have been much larger than the final result you receive with the early intervention payment.[15]

3.17 A number of submitters cited research by Swiss Re, which found that for every dollar spent on rehabilitation services, insurers saved 25 dollars on the costs of income protection claims.[16]

3.18 As noted in Chapter 2, the Australian Prudential Regulation Authority (APRA) indicated that life insurers' continuous disability products have been loss-making for various reasons.[17] Noting this, APRA has placed pressure on life insurers to shift towards more prudentially sound pricing and benefit design. As Mr Geoff Summerhayes of APRA stated:

> That has forced insurers to think about: what ways can the competitive nature of the product be maintained and for the product to be profitable going forward? Early intervention is one such dimension of that.[18]

3.19 Mr Summerhayes further explained the importance of this issue:

> Insurers are now repricing this product up, so that it is profitable, and that's putting it out of the reach, in some cases, of consumers. It's in everybody's interests to make sure that, from APRA's view, the benefit is able to be offered in an accessible way for policyholders.[19]

3.20 In APRA's view, the proposal has some merit and does not raise prudential concerns, although the government would need to exercise caution to ensure that there are no unintended consequences.[20] Subject to careful design, APRA stated that the proposal may improve the sustainability of the life insurance industry. This could in turn help keep premiums affordable for customers.[21] However, any changes should

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15 Mr Hansall, Financial Services Council, *Committee Hansard*, 19 June 2018, p. 27.

16 Financial Services Council, *Submission 1.1*, p. 10; APRA, *Submission 10*, p. 3; AIA, *Submission 20*, p. 2.

17 APRA, *Submission 10*, p. 2.

18 Mr Geoff Summerhayes, APRA Member, APRA, *Committee Hansard*, 19 June 2018, p. 35.

19 Mr Summerhayes, APRA, *Committee Hansard*, 19 June 2018, p. 35.

20 Mr Summerhayes, APRA, *Committee Hansard*, 19 June 2018, pp. 30–31.

21 APRA, *Submission 10*, pp. 2–3.

ensure that consumers are not disadvantaged and that any possible conflict of interest is managed.[22]

3.21 Some submitters argued that by saving insurers' money, the proposal would also benefit consumers by encouraging more affordable premiums.[23] As Mr Hansall of the FSC stated, the proposal is beneficial because 'it reduces cost to the risk pool, which will be transferred to all customers through cheaper insurance'.[24]

3.22 Mr Patrick O'Connor also stated that the proposal would put downward pressure on premiums. He drew particular attention to the rising claims costs for life insurers relating to mental health conditions, and said that 'if early intervention resources help [life insurers] find ways to get people back to work quicker then that's a win-win'.[25]

3.23 ClearView presented the proposal as supporting a shift in the life insurance industry. It was submitted that 'the future of the industry will be about the life insurer helping the policyholder deal with and overcome the impact of the event or condition'. ClearView suggested that income protection policyholders would benefit if life insurers transitioned from:

> …a construct focused on policyholder entitlement to income payments to one in which the primary objective is returning the policyholder to health and to work (albeit that income support during the time off work will continue be a core part of this).[26]

3.24 MLC noted that insurers other than private health insurers are already able to provide medical rehabilitation services. This includes, for example, compulsory third party motor vehicle insurers. MLC stated that there are clear parallels between that sector and the life insurance industry, and that '[t]here seems no good reason why one sector should be able to support its customers accessing rehabilitative medical treatment while the other is restricted from doing so.' MLC submitted that:

> The result of this inconsistency is life insurance customers being exposed to lesser quality health and insurance outcomes. It seems a perverse and prejudicial outcome for holders of life insurance policies that in the event of disabling injury or illness they should have lesser access to assistance from their insurer compared to third party or workers compensation insurance schemes.[27]

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22 APRA, *Submission 10*, p. 3; see also Mr Summerhayes, APRA, *Committee Hansard*, 19 June 2018, pp. 35–36.

23 See, for example, Allianz Australia, *Submission 14*, p. 4.

24 Mr Hansall, Financial Services Council, *Committee Hansard*, 19 June 2018, p. 25.

25 Mr O'Connor, private capacity, *Committee Hansard*, 19 June 2018, p. 4.

26 ClearView, *Submission 2*, p. 2.

27 MLC, *Submission 12*, pp. 8–9.

3.25 This ties in with a point made by APRA's Mr Summerhayes, who reflected on life insurance policyholders paying premiums but being unable to receive medical rehabilitation benefits:

> To underscore all of this, the policyholder has paid premiums to the insurer over a long period of time in these cases and the policyholder is entitled to get a benefit from that premium. I think the proposal is that the current legislative arrangements are prohibitive, when the policyholder is in hospital, of getting that particular benefit from a life insurer, notwithstanding that they might be receiving other forms of benefits from other forms of insurance.[28]

3.26 The FSC identified that in some other jurisdictions, such as the United Kingdom and Canada, life insurers have fewer restrictions on paying for medical appointments.[29]

3.27 However, Dr Caroline Johnson of the Royal Australian College of General Practitioners (RACGP) raised concerns about the highly privatised insurance-led system in the United States and suggested that 'it costs more and the outcomes are worse than the system we already have. I'd be very cautious about adopting that.'[30]

Effect on the government and broader economy

3.28 Supporters of the proposal also pointed out that helping injured people back to work would benefit government and the broader economy.

3.29 Mr Hansall of the FSC stated that the proposal could save the government $1.12 billion in healthcare costs over the next two decades [equivalent to an average of $60 million a year]. He also referred to the results of modelling conducted for the FSC and some other life insurers by Cadence Economics:

> The benefit to GDP arising from there being more people in the workforce amounts to $405.7 million by 2040, or approximately $169,000 in real GDP per additional full-time-equivalent worker, according to the Cadence [Economics] estimates. Taking the projected benefits of reform to allow early intervention over this period, Australian real GDP is expected to benefit by $1.56 billion in today's dollars over the period to 2040. Under Cadence's high-side scenario, the overall benefit rises to $4.06 billion.[31]

3.30 In a similar vein, ClearView submitted that the proposal would 'create a significant public interest benefit as affected individuals will be less likely to rely upon government assistance such as the NDIS or Disability Support Pension'.[32]

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28 Mr Summerhayes, APRA, *Committee Hansard*, 19 June 2018, p. 36.

29 Financial Services Council, answers to questions on notice, 6 August 2018 (received 17 August 2018); Mr James Connors, Senior Consultant, Government and Policy, *Committee Hansard*, 21 August 2018, p. 9.

30 Dr Caroline Johnson, Royal Australian College of General Practitioners, *Committee Hansard*, 21 August 2018, p. 14.

31 Mr Hansall, Financial Services Council, *Committee Hansard*, 19 June 2018, p. 26.

32 ClearView, *Submission 2*, p. 2.

3.31 AIA drew attention to the current level of government funding for healthcare and social security in Australia. It submitted that '[t]he more that we can solve through cooperation between the private sector and government, then the better we can allocate the available resources of government.'[33]

3.32 MLC also noted that assisting injured people to return to work would benefit government because 'employed people are also far less likely to be in receipt of welfare support or have unplanned use of the healthcare system'. Moreover, from a macroeconomic perspective, 'an employed person is contributing to economic productivity of the Australian nation'.[34]

Key concerns with the proposal

3.33 Notwithstanding the benefits claimed above, a number of submitters suggested that the proposal would either not realise its purported benefits, or those benefits would be outweighed by other harms.[35]

3.34 As an example of this general sentiment, Maurice Blackburn acknowledged that the proposal may have some appeal, but made the following point:

> It would be tempting for the Committee to conclude that ANY mechanism which promotes expediency in the provision of supports aiding rehabilitation and an early return to work would be a positive thing. We argue, however, that there are countervailing dangers associated with this conclusion.[36]

3.35 A further example came from Ms Alexandra Kelly, Principal Solicitor at the Financial Rights Legal Centre (Financial Rights), who acknowledged the purported benefits and told the committee that the proposal puts her in a 'rather vexed position'. She explained:

> On the one hand, there are consumers who would be desperate for this kind of intervention. On the other hand, there are consumers where this could be quite a negative to the way that they may recover, if it's not handled properly or well.[37]

3.36 In Financial Rights' joint submission with Choice and the Consumer Action Legal Centre (Consumer Action), the three organisations acknowledged that some

33 AIA, *Submission 20*, p. 2.

34 MLC, *Submission 12*, pp. 14–15.

35 See, for example, Mr Michael Borowick, Assistant Secretary, ACTU, *Committee Hansard*, 19 June 2018, p. 8.

36 Maurice Blackburn, *Submission 7*, p. 4.

37 Ms Alexandra Kelly, Principal Solicitor, Financial Rights Legal Centre (Financial Rights), *Committee Hansard*, 19 June 2018, p. 13. See also, for example, Mr O'Connor, *Committee Hansard*, 19 June 2018, pp. 2–5.

Australians experience a gap in their coverage, but they 'are not convinced the industry proposal will lead to better consumer outcomes'.[38]

3.37 The following section outlines in greater detail some of the key concerns raised about the proposal.

The culture of the life insurance industry

3.38 One of the main concerns put to the committee related to the culture and conduct of Australia's life insurance industry. Several submitters argued that given the problems with the culture and conduct of the industry, it would be inappropriate to expand the role of the industry at this time.

3.39 Some of these concerns drew on the committee's recent inquiry into the life insurance industry. For example, the Chief Executive Officer of beyondblue, Ms Georgie Harman, noted some of the committee's findings as follows:

> [T]hat the life insurance industry has poor legal consumer protections, a poor claims handling practice, the need for a co-regulatory model for the code of practice—that is, that self-regulation isn't working and isn't preventing poor practice—the need for a specific mental health code of practice and that the industry already has too much access to personal medical information.[39]

3.40 In its submission, beyondblue stated that it is not confident that:

> …the current culture, practices and regulation of the life insurance industry support robust consumer protection to ensure that the potential benefits [of the proposal] are realised without inflicting harm.[40]

3.41 Similarly, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) had broad concerns about the industry, and recommended caution when expanding life insurers' scope.[41] The Australian Council of Trade Unions (ACTU) submitted that the life insurance industry is 'not currently competent to perform the role it proposes'.[42] Ms Kelly of Financial Rights said that 'culturally, there is still a big problem and it would need very robust monitoring if any entry into this area were being considered'.[43]

3.42 Maurice Blackburn posited that the primary function of private sector insurers is to derive a profit, and it is in life insurers' financial interest to avoid payment of claims. In Maurice Blackburn's experience, life insurers 'are willing to place pressure

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38 Choice, Financial Rights, and Consumer Action Law Centre (Consumer Action), *Submission 16*, p. 2.

39 Ms Georgie Harman, Chief Executive Officer, beyondblue, *Committee Hansard*, 19 June 2018, p. 14.

40 beyondblue, *Submission 3*, p. 3.

41 Royal Australian and New Zealand College of Psychiatrists, *Submission 9*, p. 1.

42 Mr Borowick, ACTU, *Committee Hansard*, 19 June 2018, p. 9.

43 Ms Kelly, Financial Rights, *Committee Hansard*, 19 June 2018, pp. 14–15.

on claimants to achieve this outcome.'[44] Ms Shaw of Maurice Blackburn further stated that:

> …the life insurers' seemingly altruistic desire to assist with the provision of medical treatment and rehabilitation services and the like should be treated cautiously. We say this in the context that life insurers operate in the for-profit context together with the conduct of life insurers we've seen come out in other inquiries, such as the royal commission. We submit that, on balance, it's not worth the risk.[45]

3.43 In this regard, Ms Shaw doubted that the life insurance industry's current self-regulatory approach was sufficient to protect consumers and prevent consumer harm.[46]

3.44 While Mr O'Connor expressly supported the proposal—and stated that it 'will not only improve lives, it will save lives'[47]—he also said that he does not favour the proposal being implemented before the recommendations of the committee's previous inquiry have been implemented:

> No, not with the current Life Insurance Code of Practice the way it stands and not without clear consumer protections…around the doctor having the sole point of decision-making and such that decline wouldn't then flow onto an adverse finding on the income protection claim. If we don't include those into binding ASIC-regulated rules, with serious consequences around penalties and consumer protection, we are opening up the part of the community who are the most disabled, from a mental perspective, to abuse. I would say that that is the extreme, but we need to protect for that.[48]

3.45 Mr Harman of beyondblue also drew attention to the way in which the conduct of life insurers can negatively affect people with mental health issues:

> Many people contact beyondblue to tell us of their poor experiences and significant difficulty in getting and claiming on insurance policies. Some go through the stress and rigmarole of appealing refusals and regret battling a process that exacerbates their stress, worry and vulnerability. So here is the paradox: life insurers want to move into treatment and rehabilitation yet many of their basic practices can and do negatively impact on the mental health of people and discourage people from seeking treatment.[49]

3.46 In contrast to these concerns, the FSC noted the various principles under which the proposal would operate (see also Chapter 2). As Mr Hansall stated, the

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44 Maurice Blackburn, *Submission 7*, p. 2.

45 Ms Shaw, Maurice Blackburn, *Committee Hansard*, 19 June 2018, p. 13.

46 Ms Shaw, Maurice Blackburn, *Committee Hansard*, 19 June 2018, p. 14. See also beyondblue, answers to questions on notice, 19 June 2018 (received 13 July 2018), p. 3.

47 Mr O'Connor, *Submission 11*, p. 1.

48 Mr O'Connor, *Submission 11*, p. 1; Mr O'Connor, *Committee Hansard*, 19 June 2018, pp. 4–5.

49 Ms Harman, beyondblue, *Committee Hansard*, 19 June 2018, p. 14.

proposal offers more choice for policyholders and requires their consent for any action under the proposal:

> Additional medical care would always be arranged through the customer's treating physician, and would be dependent on the customer's agreement and participation. No consumer will be forced to receive treatment they don't want under this proposal, or that their doctor doesn't support. Any patient that does not wish to receive treatment under the scheme will not have their income protection and TPD insurance payments stopped. Further, we would envisage that the identification of an opportunity for early intervention payments may equally be generated from the customer themselves, with the support of their medical practitioner. In other words, the customer will have ultimate choice, and they will be the ones that have the whip hand.[50]

3.47 Moreover, the FSC advised that there has been progress in relation to implementing the recommendations of the committee's previous inquiry. This includes meetings being held between the RACGP and the FSC regarding policyholders' consent.[51] However, the FSC also stated that the extent to which the committee's recommendations have been implemented should not delay the proposal:

> Many of the recommendations from the Parliamentary Joint Committee (PJC) have nothing to do with assisting consumers return to wellness through early intervention payments. We do not see how any delay to the provision of enhanced rehabilitation support for consumers can be justified because the life insurance industry has not fully completed implementing the PJC recommendations.[52]

3.48 MLC acknowledged that the committee may consider some form of regulation necessary to ensure that the 'limited mandate' being proposed for life insurers is not exceeded.[53] It submitted that this would be best achieved by industry self-regulation, noting the overarching principles of the proposal presented by the FSC, or alternatively by an addition to the Private Health Insurance (Health Insurance Business) Rules 2018.[54] Subsequently MLC accepted that 'if policymakers deem a self-regulated approach is insufficient then we could certainly live with something more regulated.'[55]

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50 Mr Hansall, Financial Services Council, *Committee Hansard*, 19 June 2018, p. 25.

51 Mr Nick Kirwan, Policy Consultant, Life Insurance, Financial Services Council, *Committee Hansard*, 19 June 2018, p. 29.

52 Financial Services Council, answers to questions on notice, 18 July 2018 (received 27 July 2018), p. 2.

53 MLC, answers to questions on notice, 18 July 2018 (received 27 July 2018), p. 2. See also MLC, *Submission 12*, pp. 7–8.

54 MLC, answers to questions on notice, 18 July 2018 (received 27 July 2018), p. 2, p. 3.

55 Mr James Connors, Senior Consultant, Government and Policy, MLC Life Insurance, *Committee Hansard*, 21 August 2018, p. 10.

3.49 AIA submitted that the legislative changes required for the proposal 'should be supplemented by principles that protect consumer interests and provide guidance and clarity. These principles should be included in regulations or otherwise included in the FSC Life Insurance Code of Practice.'[56] AIA detailed six principles that could inform supporting regulations, which it summarised as:

1. Work is good for health and business.
2. Screening: part of a strategic claims management process.
3. Claimants are supported and empowered.
4. Support the right intervention at the right time.
5. Communicate, collaborate and educate effectively.
6. Focus on outcomes.[57]

Potential conflicts of interest and power imbalance

3.50 Submitters held mixed views on the appropriateness of allowing a single organisation to offer both continuous disability insurance and provide assistance for medical rehabilitation services.

3.51 Some submitters argued that this arrangement would amount to a conflict of interest on the part of life insurers, which could lead to negative outcomes for consumers. For example, Mr Michael Borowick, Assistant Secretary at the ACTU, asserted that neither self-regulation nor amendments to external regulation would sufficiently address the issue because 'the conflict of interest is inherent and so is unresolvable'.[58]

3.52 beyondblue outlined the conflict of interest it sees in the proposal:

> A conflict of interest also arises when the person who is funding medical treatment or rehabilitation (the insurer) has a vested interest in returning a policy holder to work, potentially before they are medically and psychologically fit to do so. If this is not managed carefully, an individual could feel pressured to undertake a particular course of rehabilitation or treatment if they believe their claim benefits depend on this. They could also feel pressured to return to work earlier than is appropriate.[59]

3.53 beyondblue added that there is also a power imbalance between a policyholder and the life insurer, 'which is exacerbated by the fact that an individual who is ill or injured and unable to work is particularly vulnerable'.[60] It suggested that

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56 AIA, *Submission 20*, p. 3.

57 AIA, *Submission 20*, pp. 14–15.

58 Mr Borowick, ACTU, *Committee Hansard*, 19 June 2018, p. 9. See also Australian Manufacturing Workers' Union, *Submission 15*, p. 3.

59 beyondblue, *Submission 3*, p. 2.

60 beyondblue, *Submission 3*, p. 2. See also Choice, Financial Rights, and Consumer Action, answers to questions on notice, 18 July 2018 (received 27 July 2018), p. 4.

this power imbalance can be particularly acute in cases where the claimant has a mental health condition.[61]

3.54 beyondblue confirmed that it does not necessarily oppose life insurers funding medical rehabilitation, but it is concerned about how the administration of claims could negatively affect the mental health of consumers.[62] While it is not confident that self-regulation would adequately address the issue, it stated that its concerns:

> …may be significantly addressed through the design of a model that structurally separates payment and administration functions. For example, life insurers could contribute funds to an independent entity who would triage claims, facilitate evidence-based treatment and rehabilitation and administer the payments to policy holders.[63]

3.55 Choice, Financial Rights and Consumer Action also pointed to a conflict of interest. They were concerned that life insurers would place more emphasis on making a profit than providing assistance.[64] They stated that there should be an arms-length relationship between the payment of claims and arranging for a claimant to return to work. Otherwise, the system would:

> …exacerbate the risk of insurers positively assessing people's ability to work and forcing them into work when it is unsuitable or premature. An increase in people being pressured by insurers into returning to work when it is not appropriately is the most significant risk of the FSC's proposal. This has not been addressed by the FSC.[65]

3.56 Financial Rights stated that it already receives calls from policyholders receiving income protection payments who feel significant pressure from the insurer to return to work. Often these callers feel that rushing their return to work would worsen their condition, and callers who are involved in mental health claims can feel that the pressure itself exacerbates their mental health condition.[66]

3.57 The RACGP was concerned that the regulatory frameworks would not protect patients from inappropriate actions by life insurers:

> For me, it's really just more that that's a precedent that hasn't been tested, in my clinical experience. In an ideal world, an insurer would contact a GP and say: 'Mrs Smith hasn't been able to work because of this. What do you recommend would give her the best chance of getting back to work?' I'd make some recommendations and they'd say, 'Great, we'll pay for that, see how you go.' If that was what happened, with no questions asked and no later disadvantage to the patient in terms of accessing other insurance, like

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61 beyondblue, answers to questions on notice, 19 June 2018 (received 13 July 2018), p. 2.

62 beyondblue, answers to questions on notice, 19 June 2018 (received 13 July 2018), p. 3.

63 beyondblue, answers to questions on notice, 19 June 2018 (received 13 July 2018), pp. 3–4.

64 Choice, Financial Rights, and Consumer Action, *Submission 16*, p. 4.

65 Choice, Financial Rights, and Consumer Action, *Submission 16*, p. 2.

66 Choice, Financial Rights, and Consumer Action, *Submission 16*, p. 2. See also Mr Borowick, ACTU, *Committee Hansard*, 19 June 2018, p. 8.

> disability pensions and those kinds of things, then if the checks and balances were there and very careful, I imagine that would be something worth looking at. I'm just sceptical as to whether we have frameworks tight enough to protect patients from all the things that could go wrong there.[67]
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> …
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> I am a big advocate for those decisions being made by the patient and the family doctor in consultation with other relevant medical specialists. And then the insurance industry does have to accept some of those decisions. My current experience is that they often don't—that they often think that the GP is just blindly advocating for the patient without fulfilling that role.[68]

3.58 Furthermore, Choice, Financial Rights and Consumer Action highlighted that, under the FSC's proposal, rehabilitation payments would be discretionary and not part of contracts with customers. They suggested that this approach 'does not increase our confidence in how this scheme would operate'. They submitted that the current problem in health coverage is partly due to a lack of transparency in the private health insurance system, and 'reproducing poor transparency in life insurance will do nothing to assist consumers in making informed decisions'.[69]

3.59 The FSC confirmed that life insurers would retain the discretion about whether to pay for medical treatments:

> The medical treatment payments the reform would allow would not be offered to every customer. They would only be offered on a discretionary basis, when the treatment is cost effective for both the customer and the insurer… Provision of these payments will not appear in product disclosure statements.[70]

Interaction with policyholders' doctors

3.60 The ACTU submitted that the proposal may '[c]ompromise the independence of doctors and the voluntary nature of treatment'.[71] It stated that in order to avoid a conflict of interest:

> …the doctor or decision maker deciding what treatment is appropriate needs to be free from influence or financial incentive from the entity paying for that treatment. However, the FSC proposal provides inadequate

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67 Dr Caroline Johnson, Royal Australian College of General Practitioners, *Committee Hansard*, 21 August 2018, pp. 14–15.

68 Dr Caroline Johnson, Royal Australian College of General Practitioners, *Committee Hansard*, 21 August 2018, p. 16.

69 Choice, Financial Rights, and Consumer Action, answers to questions on notice, 18 July 2018 (received 27 July 2018), p. 3.

70 Mr Allan Hansall, Director Policy and Global Markets, Financial Services Council, *Committee Hansard*, 19 June 2018, p. 25.

71 ACTU, *Submission 8*, p. 2. See also Australian Manufacturing Workers' Union, *Submission 15*, p. 1.

> protection against these being conflated. The conflict of interest would be most acute if claimants were urged to see life insurers' own doctors.[72]

3.61 The Australian Workers' Union emphasised that the proposal may restrict the ability of an injured patient to 'exercise his or her basic right of choice of doctor/physician'. It submitted that a number of insurers' in-house rehabilitation frameworks discourage workers from choosing a doctor that the worker believes is best placed to treat them. Moreover, it said that Australian Workers' Union members 'employed in these large multinational businesses regularly report being pressured to use the company's doctors and in-house rehabilitation providers.'[73]

3.62 Choice, Financial Rights and Consumer Action were also concerned that the proposal may place pressure on claimants' doctors. They submitted that medical practitioners would be:

> …in the unenviable position of deciding between an unfunded option which they consider superior and a funded option which may not cause harm, but ultimately not lead to the best health outcomes for the individual. This is a step back in what people expect of their health services.[74]

3.63 In addition, Choice, Financial Rights and Consumer Action expressed a number of concerns regarding specific elements of the proposed system. This included criticism of the FSC's statement that the claimant's consent would be required for any early intervention payments. Instead, they argued that any early intervention treatment should be initiated by the claimant's treating physician in consultation with the claimant. They said that life insurers should not be able to initiate or suggest treatments, nor involve their own physicians, 'independent or otherwise'.[75]

3.64 Maurice Blackburn submitted that while it does not support the proposal, if it were implemented then the plans of the policyholder's treating doctor should be given preference over the plans of the life insurer's doctor. If the treating doctor does not support the insurer's doctor's plans, then those plans should not go ahead. It should also not be possible to use this inconsistency as a basis for denying a claim.[76]

3.65 AIA responded to this concern by suggesting that the industry should have some clearly defined parameters[77] and stated that:

> I think there are also concerns around whether this would affect a member who undertook a rehabilitation program, or rather refused to undertake the

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72 ACTU, answers to questions on notice, 19 June 2018 (received 18 July 2018), p. 2–3.

73 Australian Workers' Union, *Submission 18*, pp. 1–2.

74 Choice, Financial Rights, and Consumer Action, answers to questions on notice, 18 July 2018 (received 27 July 2018), p. 3.

75 Choice, Financial Rights, and Consumer Action, *Submission 16*, p. 3. See also Maurice Blackburn, *Submission 7*, p. 6.

76 Maurice Blackburn, *Submission 7*, p. 6.

77 Ms Joanne Graves, National Rehabilitation Manager, AIA Australia, *Committee Hansard*, 21 August 2018, p. 6.

> rehabilitation program and the medical treatment that was required of them, and how that would affect their benefits. At this stage, I just want to comment that, through our current process for rehabilitation, that's not the case. We have people who start a rehab program, don't finish or say, 'It's not for me, I'm not ready yet.' That does not affect or cut off their benefits. In terms of medical treatment being part of that, we believe that that's the same focus for us, as well. We would go down the path that we currently do with our rehabilitation process in that regard. I know that is a concern and an objection, but it is not something that we believe is an issue at this stage.[78]

Current in-house rehabilitation services

3.66 The FSC informed the committee that, 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.[79]

3.67 In-house rehabilitation teams are 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.[80]

Use of information gathered during early intervention

3.68 The ACTU highlighted a risk of life insurers using information gathered through early intervention to deny a larger claim under, say, income protection insurance. As Mr James Fleming, Legal and Industrial Officer at the ACTU, put it:

> …the insurer will use whatever information they can gather to increase and maximise shareholder value and reduce costs. So they will get in early and there's a likelihood that they'll use that information to surveil the worker, to get an insurer nominated medical report to minimise or deny the final

78 Ms Stephanie Phillips, Chief Group Insurance Officer, AIA Australia, *Committee Hansard*, 21 August 2018, pp 5–6.

79 Financial Services Council, answers to questions on notice, 18 July 2018 (received 17 August 2018).

80 Financial Services Council, answers to questions on notice, 18 July 2018 (received 17 August 2018).

> claim. So that's the inherent conflict of interest. They have an interest in reducing their ultimate payout, but through denying the claim or through rehabilitation interventions, and we think there's going to be a danger they're going to do the former.[81]

3.69 Maurice Blackburn was similarly concerned that life insurers would use information, 'such as completion of a particular course of rehabilitation, to argue that the claimant no longer meets the definition of [total and permanent disability]'.[82]

3.70 Likewise, Choice, Financial Rights and Consumer Action argued that a person's rejection of a life insurer's rehabilitation plan should not be used against them when assessing a claim under income protection or total and permanent disability insurance. These organisations pointed out that it was insufficient for the FSC to state that 'any patient that does not wish to receive treatment under the scheme will not have their income protection and [total and permanent disability] insurance payments stopped'. They argued that the FSC's statement was insufficient because it 'did not go as far [as] to say the claim would not be granted in the first place, simply that after payment was granted it would not subsequently be rescinded.'[83]

3.71 The RANZCP informed the committee that the existing workers compensation regime works reasonably well for people with a less serious psychiatric claim but claimants with more severe mental health conditions face massive challenges. The RANZCP added that 'Our major concerns include the practice of surveillance and adversarial behaviour by insurers. We think that the for-profit insurers would continue or extend this sort of practice to reduce the liability of their claims.'[84]

3.72 When insurance companies were asked about the concerns relating to inappropriate access to client information and surveillance they otherwise wouldn't be able to access, AIA informed the committee that life insurers already have access to that information:

> When someone puts in a claim, as rehabilitation consultants we would have access to that information already.[85]

3.73 MLC advocated that the Life Insurance Code of Practice is a good self-regulation vehicle for dealing with such matters. MLC also noted that:

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81 Mr James Fleming, Legal and Industrial Officer, ACTU, *Committee Hansard*, 19 June 2018, p. 11.

82 Maurice Blackburn, answers to questions on notice, 19 June 2018 (received 19 July 2018), p. 2; Maurice Blackburn, *Submission 7*, p. 6.

83 Choice, Financial Rights, and Consumer Action, answers to questions on notice, 18 July 2018 (received 27 July 2018), p. 3. See also Ms Kelly, Financial Rights, *Committee Hansard*, 19 June 2018, p. 15.

84 Dr Michelle Atchinson, Chair, Section of Private Practice Psychiatry, The Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, 21 August 2018, pp 12–13.

85 Ms Stephanie Phillips, Chief Group Insurance Officer, AIA Australia, *Committee Hansard*, 21 August 2018, p. 8.

> …if policy makers think that is insufficient then I think there are other avenues open to you to regulate this sort of behaviour. It is already regulated for other types of insurance, through the Private Health Insurance Act.[86]
>
> …the private health insurance business rules, for example, contain the very mechanisms we are talking about and already discuss the role life insurers play—and limit the role that life insurers play—in funding medical care.[87]

A beneficial incentive

3.74 In contrast to the above arguments positing a conflict of interest, other submitters suggested that the proposal involves a positive incentive for life insurers to assist policyholders.

3.75 MLC submitted that given the liability life insurers hold for customers who hold continuous disability insurance, the proposal would give life insurers 'a strong financial motivation to support their customer's rehabilitation and return to health and paid employment'.[88]

3.76 Mr O'Connor acknowledged the risk of a conflict of interest depending on how the proposal was regulated.[89] But he also suggested that life insurers would be incentivised to help a claimant return to work in order to avoid making larger payments down the track. Mr O'Connor noted that private health insurers do not have a similar incentive.[90]

3.77 ClearView acknowledged that it would be important to 'have provisions in place that ensure life insurance companies avoid conflicts of interest whereby they may be perceived to pressure customers to use particular service providers or undertake particular treatment'. ClearView stated that the actions of life insurers should 'work in conjunction with the treating physician to provide an inclusive holistic approach to health, wellbeing and return to work'.[91]

Interaction with Medicare and private health insurance

3.78 One of the key issues arising from the FSC proposal is the interaction between life insurance on the one hand, and Medicare and private health insurance on the other. The issues relate to the current universality of access to Medicare and private health insurance (covered in this section), and the tension that the proposal would create between the community-rated approach used by private health insurers and the risk-rated approach used by life insurers (covered in the following section).

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86 Mr James Connors, Senior Consultant, Government and Policy, MLC Life Insurance, *Committee Hansard*, 21 August 2018, p. 8.

87 Mr James Connors, Senior Consultant, Government and Policy, MLC Life Insurance, *Committee Hansard*, 21 August 2018, p. 9.

88 MLC, *Submission 12*, p. 2.

89 Mr O'Connor, *Submission 11*, p. 24.

90 Mr O'Connor, *Committee Hansard*, 19 June 2018, pp. 3–4.

91 ClearView, *Submission 2*, p. 3.

3.79 Ms Penny Shakespeare, Acting Deputy Secretary at the Department of Health, told the committee that, to her knowledge, the original rationale for prohibiting life insurers from covering payments that are covered by Medicare was 'because Medicare was designed as a system of universal access for Australians'.[92] She later explained:

> Medicare was established as a system of universal access to healthcare under section 126 of the Health Insurance Act 1973. It's not possible for general insurers to cover services that are delivered under Medicare. There are some exemptions in the legislation at the moment for workers compensation systems run by the states and territories, which tend to be no-fault schemes.[93]

3.80 Ms Shakespeare also noted that there are exemptions for private health insurers, which are also subject to regulation 'to make sure that people are not denied access to health care through private health insurance which complements Medicare'.[94]

3.81 Nonetheless, life insurers posited that the proposal intends to supplement existing systems of coverage, not supplant them. For instance, Clearview submitted that life insurers:

> …should not be in competition with either Medicare or private health insurance providers, but rather provide supplementary services that assist, improve and promote the general health and wellbeing of customers.[95]

3.82 However, other submitters took a different view about how the Australian healthcare system should operate. The ACTU was concerned that the FSC's proposal 'would not make Australia's system of social protection more universal', and that life insurers would seek to maximise profit rather than work in the best interests of the claimant.[96]

3.83 Mr Borowick of the ACTU further suggested that the proposal 'amounts to a step towards privatisation and a foothold for the life insurance industry in the primarily public health and workers compensation systems'.[97] The ACTU submitted that the FSC's proposal:

> …is the first stage towards a broader objective of expanding their market by coercively substituting public health care and employer-funded workers' compensation with individually-funded private insurance.[98]

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92 Ms Shakespeare, Department of Health, *Committee Hansard*, 19 June 2018, p. 32.

93 Ms Shakespeare, Department of Health, *Committee Hansard*, 19 June 2018, p. 30.

94 Ms Shakespeare, Department of Health, *Committee Hansard*, 19 June 2018, p. 30.

95 ClearView, *Submission 2*, p. 3.

96 ACTU, answers to questions on notice, 19 June 2018 (received 18 July 2018), p. 4.

97 Mr Borowick, ACTU, *Committee Hansard*, 19 June 2018, p. 9. See also ACTU, *Submission 8*, pp. 7–9.

98 ACTU, *Submission 8*, pp. 4–5.

3.84 Maurice Blackburn posited that life insurance is primarily a financial product. Its purpose is to provide financial protection, not to fulfil a rehabilitation or medical role. Further, it advanced that the role of a life insurer is to provide financial protection.[99] It was argued that if a person is seeking coverage for medical treatment, they can access this through private health insurance.[100]

3.85 In response, MLC stated:

> There is clearly an interaction between life insurance and workers compensation insurance, in that sometimes we share the same customer, but we don't want to push beyond our current space.[101]

3.86 Allianz argued that the concerns about workers compensation were misconceived, telling the committee that:

> On the issue around workers' compensation, I think it is a misconceived concern, to be frank. The benefits that are available under workers compensation schemes are statutory benefits. I don't know how life insurers could push into that, or at least I don't know what the incentive would be to push into that. If push into that means paying for treatment that someone would otherwise be eligible for under the statutory benefits of a workers compensation scheme, I don't see what the incentive of that would be. That would be the opposite of our objective.[102]

3.87 On a related point, a Treasury representative explained that there are currently restrictions on the types of insurance that can be provided through superannuation. He stated that the limitations reflect the objective of superannuation, and allow only death insurance, total and permanent disability insurance and income protection insurance. The representative noted that an issue to consider would be whether it should be permissible to provide medical rehabilitation services through superannuation where 'we have sort of forced people to put in [super guarantee] contributions primarily for retirement income purposes'.[103]

3.88 Private Healthcare Australia (Private Healthcare) was concerned that the proposal would allow life insurers to cover medical treatment outside the existing regulatory framework governing private health insurers. It referred to various regulations that currently apply to its industry, including the following:

- Approval of premium increases by the Federal Minister for Health.

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99 Maurice Blackburn, *Submission 7*, p. 2.

100 Ms Shaw, Maurice Blackburn, *Committee Hansard*, 19 June 2018, p. 13.

101 Mr James Connors, Senior Consultant, Government and Policy, MLC Life Insurance, *Committee Hansard*, 21 August 2018, p. 5.

102 Mr Nicholas Scofield, Chief Corporate Officer, Allianz Australia, *Committee Hansard*, 21 August 2018, p. 6.

103 Mr Ian Beckett, Principal Adviser, Retirement Income Policy Division, Treasury, *Committee Hansard*, 19 June 2018, p. 35.

- A requirement to offer 'complying health insurance products' as defined in the PHI [Private Health Insurance] Act 2007.
- A requirement that the insurance must be community-rated, which prevents private health insurers from setting premiums based on a person's risk profile, or from otherwise discriminating between people on the basis of their health or any other reason described in the PHI Act 2007.
- A requirement to pay minimum benefits for certain treatment.
- Requirements relating to waiting periods, portability and information provision.
- Oversight by the Department of Health, Private Health Insurance Ombudsman and prudential oversight by the Australian Prudential Regulation Authority (APRA).[104]

3.89 Ms Shakespeare from the Department of Health similarly drew attention to the wide range of regulations that apply to private health insurers, and said that, when comparing life insurance with private health insurance, 'you'd probably need to look at the whole regulatory framework'.[105]

Risk rated versus community rated insurance

3.90 The Deputy Chief Executive Officer of Private Healthcare, Mr Steven Fanner, emphasised in particular the community rating used by private health insurers, as opposed to the risk rating used by life insurers:

> Community rating means that every customer who purchases a particular insurance policy pays the same premium regardless of their risk profile. Private health insurance is also subject to open enrolment, which means that an insurer must accept anyone who applies and allow every policyholder to renew their cover indefinitely.[106]

3.91 Mr Fanner further explained the rationale behind community rating:

> [S]preading the cost of claims over the entire pool of insured people allows more Australians to contribute towards their own healthcare costs which in turn reduces the cost to government. Community rating is possible because of the parallel mandatory framework of risk equalisation, which transfers funds from insurers with lower claims risk to those with higher claims risk based on the age profile of the fund's policyholders.[107]

3.92 The Department of Health also highlighted that private health insurance is community rated, not risk rated, which means it is 'to some extent consistent with the legislative arrangements for Medicare in terms of ensuring that there is equitable

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104 Private Healthcare Australia (Private Healthcare), *Submission 4*, p. 2.

105 Ms Shakespeare, Department of Health, *Committee Hansard*, 19 June 2018, p. 37.

106 Mr Steven Fanner, Chief Executive Officer, Private Healthcare, *Committee Hansard*, 19 June 2018, p. 19.

107 Mr Fanner, Private Healthcare, *Committee Hansard*, 19 June 2018, p. 19.

access to health services'.[108] Ms Shakespeare told the committee that if the same sorts of services were covered by one industry which is community rated and another which is risk rated, then there would be:

> …very different outcomes in terms of coverage, benefits and costs of premiums. It's very difficult, I suppose, to imagine the two operating in the same space.[109]

3.93 The Department of Health noted that the proposal is inconsistent with the existing provisions of the *Health Insurance Act 1973*, and would put services covered under the expanded life insurance arrangements outside the regulatory protections of the private health insurance legislative framework set out in the *Private Health Insurance Act 2007*. Under this Act, the community rating ensures that private health insurers do not discriminate against people based on personal attributes such as age, health risk or use of health services.[110] The Department of Health also noted that while it is responsible for administering the relevant legislation, it has not specifically examined whether life insurers have complied with the relevant legislative restrictions.[111]

3.94 The Department of Health also noted that if the FSC proposal was to be implemented, the same consumer protections that apply to private hospital insurance under the community rating provisions of the *Private Health Insurance Act 2007* may need to be considered if a level playing field between insurers is to be established.[112]

3.95 The RACGP informed the committee that it supports equity of access to general practice services for all people, regardless of income or ability to afford life insurance. The RACGP suggested that measures will need to be developed to ensure that the involvement of private insurers in worker rehabilitation doesn't create a two-tiered primary care system. Rather, it would have to complement and create efficiencies in the current system.[113]

3.96 The FSC indicated that it would support the removal of any restrictions on private health insurers from providing medical rehabilitation services.[114] However the Department of Health raised further concerns, informing the committee that:

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108 Ms Shakespeare, Department of Health, *Committee Hansard*, 19 June 2018, p. 30.

109 Ms Shakespeare, Department of Health, *Committee Hansard*, 19 June 2018, p. 36.

110 Department of Health, answers to questions on notice, 19 June 2018 (received 17 August 2018).

111 Department of Health, answers to questions on notice, 19 June 2018 (received 17 August 2018).

112 Department of Health, answers to questions on notice, 19 June 2018 (received 17 August 2018).

113 Dr Caroline Johnson, Royal Australian College of General Practitioners, *Committee Hansard*, 21 August 2018, p. 12.

114 Financial Services Council, answers to questions on notice, 6 August 2018 (received 17 August 2018).

> …this question relates to the general prohibition on any insurance arrangement providing benefits for professional services for which a Medicare benefit is payable (under Section 126 of the Health Insurance Act 1973 (HIA)). Under subsection 126 (5A) of the HIA this prohibition does not apply to private health insurance in respect of cover for hospital treatment and hospital-substitute treatment. Removal of this prohibition would enable private health insurers to cover Medicare eligible services that are not hospital treatments. This would raise fundamental issues about the operation of universal access to health care through Medicare.[115]
>
> Subsection 126 (5A) is designed to ensure that people are not given preferential access to primary medical care because they hold private health insurance or other forms of insurance.[116]

3.97 Mr Fanner told the committee that while the proposal has merit, Private Healthcare would not support the proposal unless its concerns were addressed. This includes the risk that allowing life insurers to cover medical treatment outside the existing regulatory framework 'could undermine the model of community rating and risk equalisation designed to facilitate equity of access to private healthcare'.[117]

3.98 Separately, Private Healthcare also raised risks in relation to 'double dipping'. It submitted that, currently, 'private health insurers rely on members to disclose whether they have received compensation from another source for an injury or condition'. If the proposal were implemented, Private Healthcare suggested that enabling life insurers and private health insurers to share information, subject to the member's consent, 'would enhance transparency of funding and help to prevent cost shifting and double dipping'.[118]

3.99 It was also suggested that the proposal may increase premiums for private health insurance.[119] Private Healthcare explained how this may occur:

> If life insurers are given the unilateral ability to shift rehabilitation care into the community, and health funds are not given the same concession, it is likely that lower risk members might shift from health funds to life products. This would be exacerbated by the ability of life insurers to risk rate and attract low risk members. Such a shift will put upward pressure on health fund premiums as the funds will be left with higher claimers, and also be locked in to a more expensive hospital-based model of care.[120]

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115 Department of Health, answers to questions on notice, 19 June 2018 (received 17 August 2018).

116 Department of Health, answers to questions on notice, 19 June 2018 (received 17 August 2018).

117 Mr Fanner, Private Healthcare, *Committee Hansard*, 19 June 2018, p. 19.

118 Private Healthcare, *Submission 4*, p. 3; also see Mr Fanner, Private Healthcare, *Committee Hansard*, 19 June 2018, pp. 19–20.

119 Mr Fanner, Private Healthcare, *Committee Hansard*, 19 June 2018, pp. 20–23.

120 Private Healthcare, answers to questions on notice, 18 July 2018 (received 27 July 2018), pp. 2–3.

Discretionary nature of payments for life insurers

3.100 When questioned on the difficulties arising from life insurance being risk rated and health services being community rated, the FSC replied with the following statement:

> 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.[121]

3.101 Choice, Financial Rights and Consumer Action also highlighted that, under the FSC's proposal, rehabilitation payments would be discretionary and not part of contracts with customers.[122]

3.102 The FSC confirmed this discretion, stating:

> The medical treatment payments would not be offered to every customer. They would only be offered on a discretionary basis, when the treatment is cost effective for both the customer and the insurer… Provision of these payments will not appear in product disclosure statements.[123]

3.103 The FSC proposed that:

> 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).[124]

Committee view—discretionary rehabilitation medical treatment

3.104 The committee has particular concerns about the FSC's answer regarding the provision of discretionary rehabilitation medical treatment. In the committee's view, a system that operates at the discretion of life insurers would appear to provide even less equity of access than a risk-rated system. A risk-rated insurance system at least has identifiable processes that can be held to account by dispute resolution systems, regulators and the courts. The FSC's discretionary proposal, however, has no equity of access and no accountability.

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121 Financial Service Council, answers to questions on notice, 6 August 2018 (received 17 August 2018).

122 Choice, Financial Rights, and Consumer Action, answers to questions on notice, 18 July 2018 (received 27 July 2018), p. 3.

123 Mr Allan Hansall, Director Policy and Global Markets, Financial Services Council, Committee Hansard, 19 June 2018, p. 25.

124 Financial Service Council, answers to questions on notice, 6 August 2018 (received 17 August 2018)

3.105 The committee also has concerns about AIA's suggestion that the current prohibition on life insurance in the health sector is a legislative anomaly.[125] Rather, the evidence from the Department of Health indicates that the difference between risk-rated and community-rated insurance stems from the fact that Medicare was designed as a system of universal access for Australians.

3.106 In this regard, the committee considers that the FSC's proposal has not understood and addressed the issues identified by the Department of Health regarding the community-rated nature of health insurance.

3.107 The committee also notes that the FSC and life insurers have argued that they already provide non-medical rehabilitation services on a similar discretionary basis.[126]

3.108 Rather than reassuring the committee, this raises further concerns about the operations of life insurers. The committee sets out some of its concerns and associated questions in relation to the proposed rehabilitation payments below:

- Why are these rehabilitation payments proposed to be outside contracts and product disclosure statements?
- Is it within the code of practice for the proposed rehabilitation payments to not be included in contracts and product disclosure statements?
- Does the current legal framework allow for these proposed rehabilitation payments to not be included in contracts and product disclosure statements?
- What consumer protections are removed by the proposed rehabilitation payments being outside the contract and the product disclosure statements?
- If rehabilitation payments are outside the contract and product disclosure statements:
    - What dispute resolution arrangements will apply?
    - How will consumers take life insurers to court to seek redress when life insurers behave in ways that are harmful to consumers?
    - How will ASIC investigate claims handling?

3.109 The committee also has questions about the in-house rehabilitation services that life insurers currently provide, including whether they are also outside the contract and product disclosure statements, and also at the discretion of the insurer when the insurer considers it to be in the insurer's best interest.

3.110 Following on from this, the committee would like to understand whether consumer protections and dispute resolution arrangements apply to in-house

125 Ms Stephanie Phillips, Chief Group Insurance Officer, AIA Australia, *Committee Hansard*, 21 August 2018, p. 2.

126 Financial Service Council, answers to questions on notice, 6 August 2018 (received 17 August 2018); Ms Stephanie Phillips, Chief Group Insurance Officer, AIA, *Committee Hansard*, 21 August 2018, p. 5.

rehabilitation services and, more broadly, the extent to which any other concerns with the FSC's proposal have been addressed for these non-medical services.

3.111 Finally, the committee's previous inquiry identified a raft of hidden commissions and inappropriate financial incentives in the life insurance industry that are yet to be investigated by ASIC. A question therefore arises about the extent to which inappropriate financial incentives may exist around in-house rehabilitation services and potentially lead to customers being pressured into using in-house rehabilitation services or having claims denied because they did not use in-house rehabilitation services.

3.112 In light of the above, the committee therefore considers that ASIC should undertake a thorough investigation of the use of in-house rehabilitation services in the life insurance industry to determine whether all the concerns, including inappropriate financial incentives, regarding the FSC's proposal have been resolved for the current non-medical rehabilitation services.

Recommendation 1

3.113 The committee recommends that the Australian Securities and Investments Commission undertake a thorough investigation of the use of in-house rehabilitation services in the life insurance industry to determine whether all the concerns, (including inappropriate financial incentives) regarding the Financial Services Council's proposal have been resolved for the current non-medical rehabilitation services.

3.114 The committee is also concerned more generally about the use of discretionary services in the life insurance industry that are outside contracts, disclosure and therefore relevant consumer protections. While the committee has heard about such approaches being used for non-medical rehabilitation and the FSC's proposal for medical rehabilitation, the committee is concerned about how widespread this practice is. The committee therefore recommends that the life insurance industry be required to disclose all of its discretionary, off-contract arrangements and that these arrangements be examined by ASIC.

Recommendation 2

3.115 The committee recommends that the life insurance industry be required to disclose all of its discretionary, off-contract arrangements to the Australian Securities and Investments Commission and that these arrangements be examined.

Interaction with workers compensation schemes

3.116 As noted in Chapter 2, the FSC's proposal would enable life insurers to provide medical rehabilitation assistance regardless of whether the policyholder's injury is related to work. In cases where an injury is related to work, workers compensation schemes may apply.

3.117 MLC submitted that life insurers are not seeking to supplant existing workers compensation insurers. Rather, '[l]ife 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'.[127]

3.118 In contrast, Maurice Blackburn was concerned that the proposal would inadvertently set up two systems: first, the current workers compensation scheme which is subject to various regulations; and second, a parallel scheme 'in which private sector insurers determine the worthiness of claims and the processes and conditions for [return to work]'.[128]

3.119 The ACTU also had concerns that the proposal would not operate with the kind of safeguards that apply to existing workers compensation systems. It submitted that while life insurers are motivated by profit, the objectives of workers compensation schemes:

> …include reducing the incidence of injury in the workplace and rehabilitating injured workers and providing a system that is fair and affordable. Profit plays no part and minimising cost does not override public interest objectives.[129]

3.120 The ACTU also suggested that the proposal would shift the costs of rehabilitation treatment from the employer (via workers compensation schemes) to the employee (via life insurance premiums).[130] Mr Borowick of the ACTU said that the current system, 'whereby employers are penalised for unsafe workplaces through higher premiums as a result of claims, would be broken, undermining that system'. This would create:

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

127 MLC, answers to questions on notice, 18 July 2018 (received 27 July 2018), p. 2.

128 Maurice Blackburn, *Submission 7*, p. 4.

129 ACTU, answers to questions on notice, 19 June 2018 (received 18 July 2018), p. 2.

130 ACTU, *Submission 8*, pp. 10–11.

> prejudices the workers' ongoing statutory entitlements and potential common-law rights.[131]

Whether injuries occur at work

3.121 In commenting on the differences between injuries that occur at work and those that do not, beyondblue informed the committee that the issues raised in beyondblue's previous submission apply to both, including the power imbalance between an insurer and an individual, and the potential for an individual to feel pressured to undertake a particular course of treatment or return to work earlier than is appropriate. These are significant issues which could arise for anyone with a mental health condition who makes a claim, regardless of whether their condition arose within or outside of the workplace.[132]

3.122 MLC and the FSC suggested that life insurers should only act as a supplementary funder when other sources are exhausted and that would apply regardless of whether the injury occurred at work.[133]

3.123 CHOICE, Financial Rights and Consumer Action argued against greater involvement in rehabilitation for life insurers where someone already has cover under another scheme. These organisations argued it would be inefficient, lead to duplication and increase costs without additional benefit:

> In the case of workers' compensation, there is already a sophisticated rehabilitation system with checks and balances to protect people. These protections are severely lacking from the life insurer's proposal. In these situations, it may even lead to conflicting recommendations for treatment, which would add further confusion and distress to the person subject to the claim.[134]

> More broadly, our concern with this proposal is not just that it duplicates workers compensation, but that it fails to address the root causes of rehabilitation funding shortfalls. Instead, it seeks to add a second layer of insurance, which is both lacking consumer protection and inherently conflicted.[135]

Life insurers responses to issues

3.124 The committee scheduled an additional hearing which allowed life insurers to respond to issues identified in the FSC proposals through submissions and the earlier

131 Mr Borowick, ACTU, *Committee Hansard*, 19 June 2018, p. 8.

132 Beyondblue, answers to questions on notice, 18 July 2018 (received 14 August 2018).

133 MLC, answers to questions on notice, 18 July 2018 (received 27 July 2018); FSC, answers to questions on notice, 18 July 2018 (received 27 July 2018).

134 Choice, Financial Rights, and Consumer Action, answers to questions on notice, 18 July 2018 (received 27 July 2018).

135 Choice, Financial Rights, and Consumer Action, answers to questions on notice, 18 July 2018 (received 27 July 2018).

hearing. This section summarises the responses from life insurers to questions at the hearing.

3.125 In response to concerns about the role of the patient's own treating doctor, Mr James Connors from MLC stated:

> I understand there are those concerns out there, but we are very clear—all of us—that the patient's own doctor and the patient themselves would have to be in the driver's seat of any medical rehabilitation funded with a life insurer.[136]

3.126 Likewise, AIA suggested:

> …you would need to get that consent from the doctor and the doctor would have to be part of the plan. So the individual and the doctor would have a consensus before we would go down that path.[137]

3.127 Allianz argued:

> The proposal that I think the insurers are putting is that the GP, the doctor, creates a plan, as they normally would, and, as part of that plan, various treatments and services will be included.[138]

3.128 The committee asked life insurers about the percentage of patients who might be able to utilise the FSC proposal. AIA estimated that up to 20 per cent of people on claim would benefit from additional allied health services or surgery.[139] MLC estimated that approximately 30 per cent of its customers were participating in rehabilitation at any given point in time.[140]

Committee view

3.129 The committee notes that the views expressed by MLC, namely that the patient's own doctor and the patient themselves would have control of any medical rehabilitation funded with a life insurer, does not appear, on its face, to align with the evidence provided by the FSC[141] that any payments would only occur at the discretion of the life insurance company and that they would occur outside contracts and disclosure requirements.

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136 Mr James Connors, Senior Consultant, Government and Policy, *Committee Hansard*, 21 August 2018, p. 3.

137 Ms Stephanie Phillips, Chief Group Insurance Officer, AIA Australia, *Committee Hansard*, 21 August 2018, p. 3.

138 Mr Nicholas Scofield, Chief Corporate Affairs Officer, Allianz Australia, *Committee Hansard*, 21 August 2018, p. 3.

139 Ms Joanne Graves, National Rehabilitation Manager, AIA Australia, *Committee Hansard*, 21 August 2018, p. 4.

140 Ms Amanda Ide, Head of Retail Claims, MLC Life Insurance, *Committee Hansard*, 21 August 2018, p. 4.

141 See the earlier section on the discretionary nature of payments.

Implementation of all recommendations from the committee's report into the life insurance industry

3.130 The committee explicitly sought the views of submitters and witnesses on whether the life insurance industry should be required to demonstrate that all the problems identified in the committee's recent inquiry into the life insurance industry had been addressed, prior to any consideration being given to the FSC proposal proceeding.

3.131 Views on this matter were highly polarised. The FSC and the life insurers, MLC, AIA, and Allianz, suggested the FSC proposal should proceed without waiting for the recommendations to be implemented.[142] CBUS also supported implementing the proposal without waiting for the recommendations to be actioned.[143]

3.132 The FSC claimed that:

> Many of the recommendations from the Parliamentary Joint Committee (PJC) have nothing to do with assisting consumers return to wellness through early intervention payments. We do not see how any delay to the provision of enhanced rehabilitation support for consumers can be justified because the life insurance industry has not fully completed implementing the PJC recommendations.[144]

3.133 MLC also noted that the life insurance industry is proposing to develop and update the code of conduct to address the committee's recommendations from the previous inquiry.[145]

3.134 While AIA acknowledged that trust is a concern for the life insurance industry, they argued:

> …we as an industry have to push forward, and we see this as a positive intervention in giving people the understanding that it is not just the workers comp insurer that will help them get back to work, but it's also their life insurer as well.[146]

3.135 APRA noted that there may be benefits to policy holders that are not dependent on actioning the recommendations from the committee's report on the life insurance industry.[147]

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142 FSC, answers to questions on notice, 18 July 2018 (received 27 July 2018); MLC, answers to questions on notice, 18 July 2018 (received 27 July 2018); Allianz, answers to questions on notice, 18 July 2018 (received 26 July 2018); AIA, answers to questions on notice, 18 July 2018 (received 27 August 2018).

143 CBUS, answers to questions on notice, 6 August 2018 (received 13 August 2018).

144 FSC, answers to questions on notice, 18 July 2018 (received 27 July 2018).

145 Ms James Connors, *Committee Hansard*, 21 August 2018, p. 9.

146 Ms Stephanie Phillips, *Committee Hansard*, 21 August 2018, p. 7.

147 Australian Prudential Regulation Authority, answers to questions on notice, 18 July 2018 (received 27 July 2018).

3.136 Very different views were put forward by other submitters and witnesses. beyondblue was opposed to the FSC proposal proceeding before the recommendations from the committee's earlier report had been addressed:

> In particular, we believe that effective consumer protections, a co-regulatory approach, appropriate access to policy-holders' medical information and improved claims handling practices are fundamental components to establish before the life insurance industry expands into funding rehabilitation and medical treatment. The Committee's recent inquiry into the life insurance industry highlighted many issues across these areas, and the Committee's recommendations from this report should be implemented as a priority, prior to any legal or regulatory reform which is the subject of this inquiry.[148]

3.137 Choice, Financial Rights and Consumer Action suggested that that there are many recommendations from the committee's previous inquiry into the life insurance industry which should be of higher priority than the FSC's proposal:[149]

> Given the repeated evidence before the inquiry that the industry currently lacks adequate consumer protection in how it deals with these cases, we caution against further involvement of life insurers in rehabilitation. During claim time people are particularly vulnerable, without adequate, enforceable protections in place these people are at risk of exploitation. Currently claims handling is exempt from fundamental protections, such as the best interests duty and regulatory oversight from the Australian Securities and Investments Commission (regulation 7.1.33 of the Corporations Regulations 2001 (Cth) provides an exemption under section 766A of the Corporations Act 2001 (Cth).
>
> With so many critical questions left unanswered now is not the time to be experimenting with people's health outcomes.[150]

3.138 The ACTU were also strongly opposed to giving life insurers a greater role in worker rehabilitation before the industry has actioned the committee's recommendations, stating:

> It would be unconscionable for the Committee to recommend life insurers be given a greater role in worker rehabilitation before the industry has fully actioned the recommendations of the Committee's previous report. Given the extent of problems in the life insurance industry, any greater involvement by private sector life insurers in worker rehabilitation should not be considered at least until after ASIC has completed its first audit of 20 per cent of the life insurance adviser population, as per Recommendation

148 beyondblue, answers to questions on notice, 18 July 2018 (received 26 July 2018).

149 Choice, Financial Rights, and Consumer Action, *Submission 16*, p. 1.

150 Choice, Financial Rights, and Consumer Action, answers to questions on notice, 18 July 2018 (received 27 July 2018).

> 3.7 of the Committee's report, and only in the event that the results of that audit show that the problems identified in that report have been resolved.[151]

3.139 RANZCP and Maurice Blackburn argued that it would be appropriate for the industry first to action the recommendations of the committee's previous inquiry.[152] Maurice Blackburn also suggested waiting until the following processes had been concluded:

- the Financial Services Royal Commission; and
- the Treasury inquiry into Unfair Contract Term provisions to cover insurance contracts.[153]

3.140 RANZCP informed the committee that:

> We've seen, during the recent Royal Commission, that industry codes and self-regulation of the financial services have fallen well short of community expectations. We commend recent commitments to strengthen those codes and take regulators more seriously, but we would join with others who have given evidence to your inquiry in questioning whether the life insurance industry is prepared to take on that additional area of business.[154]
>
> …we do raise concerns about life insurers taking on a gatekeeper role for that. At a minimum, we would want a strengthened industry code and tighter guidance around good practice dealing with mental injury claimants. [155]
>
> …we welcome anything that helps people access care quickly, but we don't want that to come at a cost with an industry that has another purpose or isn't dealing with people with a mental illness very well.[156]

3.141 Mr Patrick O'Connor argued that 'the failure of the FSC self-regulation of life insurers has resulted in the monumental trust deficit with the community.'[157] Consequently, Mr O'Connor stated:

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151 ACTU, answers to questions on notice, 18 July 2018 (received 26 July 2018).

152 Royal Australian and New Zealand College of Psychiatrists, answers to questions on notice, 18 July 2018 (received 14 August 2018); Maurice Blackburn Lawyers, answers to questions on notice, 18 July 2018 (received 19 July 2018).

153 Maurice Blackburn Lawyers, answers to questions on notice, 18 July 2018 (received 19 July 2018).

154 Dr Michelle Atchinson, Chair, Section of Private Practice Psychiatry, The Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, 21 August 2018, p. 13.

155 Dr Michelle Atchinson, Chair, Section of Private Practice Psychiatry, The Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, 21 August 2018, p. 13.

156 Dr Michelle Atchinson, Chair, Section of Private Practice Psychiatry, The Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, 21 August 2018, p. 13.

157 Mr Patrick O'Connor, answers to questions on notice, 18 July 2018 (received 22 July 2018).

> Hence it is unfortunate that I can only support the proposal with additional and comprehensive claimant protection laws which need to be implemented in combination with the PJC March 2018 Life Insurance Industry report.[158]

3.142 The RACGP submitted to this committee's 2017 inquiry into the life insurance industry. During that inquiry, the RACGP raised several concerns with the practices of the life insurance industry, particularly in regard to requests for full patient records and the privacy and ethical impacts of sharing this information. RACGP stated that:

> We strongly recommend that those concerns be addressed before any options for greater involvement for private sector life insurers in worker rehabilitation are considered.[159]

> Having worked for more than 20 years with patients who have mental health issues related to claims, I have to remain sceptical that the life insurance industry would be better than any other insurance industry I've had to deal with over those years in terms of giving the GP the control. I have numerous anecdotes of difficulties in getting any type of insurance—whether it be something as simple as work cover right through to income protection, travel insurance and everything else—to actually listen to the GP's recommendations. If we could be guaranteed a GP recommendation that a person did not require any more scrutiny but just required some specific treatment options, that would be something that would be very welcome. But I remain sceptical that that's how it would play out, because that's frequently been my experience to date when dealing with insurance.[160]

Committee view

3.143 At the time of drafting this report, the government had not responded to the recommendations contained in the committee's report on the life insurance industry tabled in March 2018.

3.144 The committee's consensus report on the life insurance industry focussed on areas where substantial changes are required to ensure the life insurance industry is held to account and made recommendations in relation to:

- effective consumer protections and industry codes of practice;
- the transparency of remuneration, commissions, payments and fees;
- the provision of advice in the best interests of consumers;
- group life insurance arrangements that do not disadvantage certain groups of consumers;
- appropriate access to personal medical and genetic information; and

158 Mr Patrick O'Connor, answers to questions on notice, 18 July 2018 (received 22 July 2018).

159 Dr Caroline Johnson, Royal Australian College of General Practitioners, *Committee Hansard,* 21 August 2018, p. 12.

160 Dr Caroline Johnson, Royal Australian College of General Practitioners, *Committee Hansard,* 21 August 2018, p. 13.

- fair claims handling practices.[161]

3.145 In relation to the areas listed above, the committee is concerned that the FSC expressed the view that many of the committee's recommendations 'have nothing to do with assisting consumers return to wellness through early intervention payments'.[162]

3.146 The committee begs to differ. While it may be argued that the FSC is technically correct in a narrow sense, such comments do not reassure the committee that the life insurance industry is committed to implementing the recommendations set out in the committee's report on the life insurance industry.

3.147 When the FSC's comments are taken together with the concerns raised by other submitters and witnesses in this report, the committee is of the view that the life insurance industry should, as a priority, adequately address all the recommendations of the previous inquiry.

Recommendation 3

3.148 The committee recommends that the government and the life insurance industry implement the committee's recommendations from its report on the life insurance industry.

3.149 To be clear, the committee notes that adequately addressing all the recommendations of the previous inquiry is not the only barrier to the FSC's proposal. Even with the implementation of those recommendations, the other matters identified in this report raise such serious concerns with respect to the FSC proposal that they militate against it being considered further.

Alternatives to the proposal

3.150 As outlined in Chapter 2, one issue the proposal seeks to address is the gap in coverage that some Australians experience when seeking rehabilitation treatment. The evidence received by the committee under the terms of reference did not go into substantial detail about other ways that this problem could be addressed. However, some alternatives were raised in general terms.

3.151 An initial point related to the specificity of the FSC's proposal. Several submitters noted that, at least at the time of their submission, the FSC's proposal was not sufficiently detailed to allow for full consideration.[163] In this vein, the Australian Manufacturing Workers' Union stated:

> Whilst all of the schemes mentioned in the Terms of Reference deal with incapacity to work in some form, there is such diversity of purpose and

161 Parliamentary Joint Committee on Corporations and Financial Services, *Life Insurance Industry*, March 2018, p. ix.

162 FSC, answers to questions on notice, 18 July 2018 (received 27 July 2018).

163 See, for example, ACTU, *Submission 8*, p. 5; Australian Manufacturing Workers' Union, *Submission 15*, p. 2; Choice, Financial Rights, and Consumer Action, *Submission 16*, p. 3; Choice, Financial Rights, and Consumer Action, answers to questions on notice, 18 July 2018 (received 27 July 2018), pp. 3–4.

> administrative arrangements that a comprehensive inquiry would take considerably longer than the time allocated to this inquiry.[164]

3.152 Further, some submitters proffered certain parameters for any reform. For example, beyondblue detailed principles which it said should underpin any reforms in this area: a person-centred approach; non-coercion; privacy and confidentiality of clinical records; defined scope of insurer involvement; and effective, evidence-based treatment and support.[165]

3.153 Choice, Financial Rights and Consumer Action submitted that the fair operation of the system should not be left to life insurers to self-regulate. Rather, 'specific consumer protections should be introduced to prohibit this coercion and introduce meaningful penalties in case of breaches'.[166]

3.154 More broadly, there was some support for addressing the gap in coverage via public means, rather than via private life insurers. The ACTU argued that 'gaps in social protection should be covered by expanding the public health and workers' compensation systems to the full extent of social need.'[167] The ACTU suggested that the FSC's proposal would not adequately address the problem:

> Allowing private life insurers to offer an alternative form of private health cover is hardly a solution to the problems the FSC raise, given that they involve people who cannot afford private insurance. They are examples of people who happen to have one form of private insurance and not another and the reality of the inadequate funding of the public system. Free and universal health services are a fundamental human right and should not be left to private provision for those who can afford it.[168]

3.155 Choice, Financial Rights, and Consumer Action similarly submitted that the committee's first priority should be to consider the adequacy of government support for rehabilitation programs and Medicare programs. They stated:

> The risk of disability and its impact on employment can impact anyone; likewise the solutions to these problems need to be universal…The solution is not to add another layer of complication, but to address the lack of universality in the existing response.
>
> To that end, an industry led response will never be capable of providing a universal solution, as it relies on people purchasing individual cover. Consumers and taxpayers will be better served by different approaches that keep life insurers out of the rehabilitation space.[169]

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164 Australian Manufacturing Workers' Union, *Submission 15*, p. 2.

165 beyondblue, *Submission 3*, pp. 2–3.

166 Choice, Financial Rights, and Consumer Action, *Submission 16*, p. 3.

167 ACTU, answers to questions on notice, 19 June 2018 (received 18 July 2018), p. 4.

168 ACTU, *Submission 8*, p. 6.

169 Choice, Financial Rights, and Consumer Action, *Submission 16*, p. 2.

3.156 These three organisations also argued that both private health insurance and the public health system are 'uniquely adapted' to provide rehabilitation treatment. Both systems have:

> …built in protections and a foundation on universality, through the public system and the community rating in private health insurance. We agree funding shortfalls in the public system need to be addressed. We also agree that the private health insurance sector has been allowed to run riot in the offering of junk insurance policies and significant out of pocket costs. However, the solution is not to paper over these policy failures with yet another form of insurance and hope the outcomes will be different.[170]

3.157 Choice, Financial Rights and Consumer Action drew attention to the many gaps in the existing private health insurance system that stem from the proliferation of junk insurance policies and out of pocket medical costs. Noting that the Minister for Health has established an expert committee to consider many of these issues, they argued that it would be duplicative to attempt to solve them through this process.[171]

3.158 Some alternative possibilities relating to support for employers were offered by the Australian Industry Group. Its submission noted that, in the context of a skills shortage, it is beneficial for employers to have their employees return to work. The Australian Industry Group presented some ways in which life insurers could assist employers, for example, by helping them modify the workplace to assist an injured employee to return to work.[172]

Committee view

3.159 In general terms, there is merit in examining a proposal that purports to improve early intervention and rehabilitation services, and also provide potential benefits to the public and the government

3.160 The FSC first raised its proposal in evidence to the committee's recent inquiry into the life insurance industry. As the committee stated at that time, details of the proposal emerged fairly late in the inquiry into the life insurance industry and so the committee was not able to consider it in detail.

3.161 The committee has serious reservations about the way in which this proposal originated. When a policy proposal is put forward, it has typically gone through a development process and is underpinned by a substantive policy rationale and analysis prepared by the relevant government department or departments. In such a scenario, the committee and stakeholders already have a fully formed proposal to study and that serves as a basis on which to submit their views.

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170 Choice, Financial Rights, and Consumer Action, answers to questions on notice, 18 July 2018 (received 27 July 2018), p. 2.

171 Choice, Financial Rights, and Consumer Action, answers to questions on notice, 18 July 2018 (received 27 July 2018), p. 2.

172 Australian Industry Group, *Submission 19*, pp. 4–6.

3.162 By contrast, important details of the FSC proposal only emerged as this inquiry unfolded. Furthermore, in the intervening period between the committee's inquiry into the life insurance industry and this inquiry, no comprehensive cost-benefit analysis of the options for improving rehabilitation services has been done or provided by the proponents. These factors may have affected the evidence that submitters and witnesses were able to give the committee regarding the proposal. Noting these points, the committee offers its view on the proposal in general terms.

Potential benefits

3.163 It is clear that early intervention can be very beneficial for worker rehabilitation. In addition, supporting an injured person to return to work can benefit their general health and wellbeing if done appropriately. It is promising that the proposal may allow more Australians to access these benefits. It would also be positive if, as claimed, the proposal caused flow-on benefits for the broader economy and the government's budgetary position.

3.164 It was also suggested that the proposal would help address some of the prudential issues in the life insurance industry. This is certainly desirable, and the committee is encouraged by evidence from APRA indicating that the proposal may have this effect. It was further claimed that improving the sustainability of the industry would benefit policyholders by reducing their premiums. This would be a positive development and the committee notes the FSC's statement that life insurers' reduced costs would be transferred to consumers in the form of cheaper insurance. However, it is not clear to the committee how this purported reduction in insurance premiums would be guaranteed.

Concerns with the proposal

3.165 Notwithstanding the potential but uncertain benefits discussed above, the committee acknowledges that a broad range of submitters held various concerns about the proposal. These are discussed in the following subsections.

Industry culture, potential conflicts of interest, and regulatory framework

3.166 An initial concern related to alleged problems with the culture of Australia's life insurance industry. Those who held these concerns encouraged general caution in any changes that would expand the life insurance industry's scope.

3.167 Further concerns related to a potential conflict of interest and related risks with the operation of the proposed system. For example, witnesses highlighted the risk that life insurers may pressure policyholders to return to work, interfere with the advice and treatment of policyholders' doctors, or unduly use information gathered during early intervention to deny subsequent claims.

3.168 In general terms, the committee is of the view that any proposed change to the current system should operate fairly and in the interests of policyholders and the general public.

3.169 This would include, for example, ensuring that proposed payments appear in insurers' contracts with policyholders and in product disclosure statements. In keeping with this, any process should be claims-based rather than consent-based, meaning that

policyholders would be able to make claims for rehabilitation assistance in consultation with their doctor, rather than being approached by their life insurer at the insurer's discretion. In such a scenario, if a policyholder's claim for a rehabilitation payment was reasonable, then the life insurer should be required to pay that claim rather than being able to exercise discretion over how to pay a claim.

3.170 Safeguards such as these should form an integral part of any package in which life insurers provided rehabilitation assistance in order to ensure fair and equal treatment. Policyholders who need assistance should not miss out merely because they do not represent a potential financial liability for the life insurer. For example, a stay-at-home parent might not be entitled to large income protection payments, but they may benefit from rehabilitation assistance nonetheless.

3.171 The FSC has indicated that it does not wish to define what a 'worker' is, or the nature of work that would be covered by its proposal.[173] Given that the FSC is arguing for the payment of rehabilitation services to be at the discretion of life insurers, the committee is concerned that it would be open to life insurers to use a very narrow definition of work and thereby exclude large sections of the community.

Interaction with private health insurance

3.172 A further concern raised in evidence related to how life insurers would operate in the same area as private health insurers.

3.173 The committee is conscious that these two industries currently operate differently. If they were to offer the same services, they would likely need to be regulated in a similar way. This may include:

- enabling private health insurers to operate in any space in which the proposal enables life insurers to operate;
- applying to life insurers any consumer protections that currently apply to private health insurers; and
- ensuring that life insurers use the same definitions in their policies as private health insurers (following on from issues raised in the committee's previous inquiry).[174]

3.174 A related issue concerns how life insurers' risk-rated policies might operate alongside private health insurers' community-rated system. The committee considers community rating to be a key part of ensuring equal access to health cover, and it should not be unduly compromised.

3.175 Based on the evidence received during the inquiry, including from the Department of Health, it is not clear to the committee how risk-based life insurance could operate alongside community-rated private health insurance without unduly

173 Financial Services Council, answers to questions on notice, 6 August 2018 (received 17 August 2018).

174 For background on this point, see Parliamentary Joint Committee on Corporations and Financial Services, *Life Insurance Industry*, March 2018, pp. 162–167.

compromising the equality of access that underpins the community-rated system. In the committee's view, allowing life insurers to operate alongside a community-rated system would be inappropriate.

The role of group life insurance policies

3.176 The committee understands that in group life insurance, all group life policyholders already pay the same premium, which is somewhat akin to a community-rating. It could be argued, therefore, that limiting the FSC's proposal to group life insurance policyholders may mitigate some of the concerns about risk rating.

3.177 However, even such a limited approach would be problematic.

3.178 The committee notes that some group life insurance through superannuation appears to provide equity of access, as entry is not risk-rated. As such, it appears on its face to be similar to a community-rated system of insurance. It could be argued, therefore, that limiting the FSC's proposal to group life insurance policyholders may mitigate some of the concerns about risk rating.

3.179 However, from its work on the recent inquiry into life insurance, the committee also notes that:

- disability income insurance (also known as income protection insurance) is not a common feature of default group life insurance policies;
- it is unclear whether rehabilitation payments would satisfy the release conditions of trustees to make payments to superannuation members; and
- the APRA data presented to this inquiry (discussed in Chapter 2) shows that group disability income insurance is financially sustainable, whereas the risk-rated individual income disability insurance sold through the financial adviser and direct channels is financially unsustainable.[175]

3.180 In light of the above, even if the FSC proposal was a fair and workable proposition, restricting the proposal to group life insurance policyholders would be unlikely to address the life insurance industry's financial sustainability issues because those issues pertain predominantly to risk-rated individual income disability insurance sold through the financial adviser and direct channels.

3.181 With these concerns in mind, the committee considers it would be prudent for the government to commission a holistic analysis of the financial sustainability of the life insurance industry, including the reasons for the prudential issues.

Recommendation 4

3.182 The committee recommends that the government conduct a holistic analysis of the sustainability of the life insurance industry that considers all key elements of the issue, including the reasons for the prudential issues and options for reform.

175 Australia Prudential Regulation Authority, *Submission 10*, p. 2.

Conclusion

3.183 The committee notes that the FSC acknowledged that income protection policies have waiting periods of 30 to 90 days and that life insurers currently provide non-medical rehabilitation services before claims payments start.[176] Further alternatives were suggested in evidence to the committee, such as improving the operation of the existing public and private healthcare systems. These options were discussed in the main text.

3.184 The committee also notes that the Department of Health agreed with the following concerns raised by submitters and witnesses about the proposal including the need to:

- protect consumers from discrimination in access to insurance for health services;
- provide early access to appropriate health services in a way that ensures all Australians can access health services according to the urgency of that clinical need; and
- consider all funding arrangements for rehabilitation.[177]

3.185 The committee would like to see Australians have better access to medical rehabilitation services, as well as a more sustainable life insurance industry. However, the committee is concerned that the FSC proposal is not supported by a workable business case and does not provide better access to medical rehabilitation services.

3.186 Having considered the FSC's proposal, the committee makes the following points:

- Were life insurance rehabilitation to be proposed again in the future, it should be a stand-alone policy with a community-rated (not risk-rated) premium.
- The proposed payments should be included in contracts with policyholders and should appear in product disclosure statements.
- Provision of payments should be on the basis that a policyholder makes a claim to the life insurer, rather than the life insurer approaching the policyholder and seeking the policyholder's consent.
- The payment of rehabilitation claims should not be at the discretion of the life insurer; if the claim is valid, then the claim should be paid.
- Consumer protections and other regulations that currently apply to private health insurers should also apply to life insurers.

3.187 In light of the above, the committee recommends that the FSC's proposal not be proceeded with.

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176 Financial Services Council, answers to questions on notice, 6 August 2018 (received 17 August 2018).

177 Department of Health, answers to questions on notice, 6 August 2018 (17 August 2018).

Recommendation 5

3.188 The committee recommends that the government not proceed with the Financial Services Council's proposal.

The Hon Mr Michael Sukkar MP

Committee Chair