OHtax@hmtreasury.gov.uk

28 September 2023

AFM Response to HM Treasury consultation on Tax Incentives for Occupational Health

1. I am writing in response to this consultation paper, on behalf of the Association of Financial Mutuals. The objectives we seek from our response are to:

    - Comment on the proposals, and
    - Set out proposals for changes to the Benefit in Kind treatment of Health Cash Plans.

About AFM and its members

2. The Association of Financial Mutuals (AFM) represents insurance, as well as healthcare and indemnity, providers that are owned by their customers, or which are established to serve a defined community (on a not-for-profit basis). Between them, mutual insurers manage the savings, pensions, protection and healthcare needs of over 32 million people in the UK and Ireland, collect annual premium income of over £22 billion, and employ nearly 30,000 staff[1].

3. The nature of their ownership and the consequently lower prices, higher returns or better service that typically result, make mutuals accessible and attractive to consumers, and have been recognised by Parliament as worthy of continued support and promotion. In particular, FCA and PRA are required to analyse whether new rules impose any significantly different consequences for mutual businesses[2] and to take account of corporate diversity[3].

[1] ICMIF and AFM, 2022: https://financialmutuals.org/wp-content/uploads/2022/10/UK-Market-Insights-2022.pdf
[2] Financial Services Act 2012, section 138 K: http://www.legislation.gov.uk/ukpga/2012/21/section/24/enacted
[3] http://www.legislation.gov.uk/ukpga/2016/14/section/20/enacted

AFM comments on the proposals

4. We are pleased to comment on this consultation. We support all work to help people lead healthier and wealthier working lives, and indeed as a sector we are just as committed to this aim as the government. Taking action to improve the take-up of Occupational Health is a vital part of that.

5. Our response is focused on the Health Cash Plan market, as well as healthcare products offered by discretionary mutuals. This market provides low-cost solutions for employers looking to support employees with a wide range of healthcare needs, ranging from optical check-ups, to mental health support, to specialist consultations. We provide evidence in our response of the case for extending the possible changes to benefit-in-kind arrangements to include health cash plans, and we set out the benefits to employers and the NHS of doing so.

6. We have responded to the questions in the consultation below, and would welcome the opportunity to discuss further the issues raised by our response. We are happy to be included in the published list of respondents.

Yours sincerely,

Martin Shaw
Head of Policy
Association of Financial Mutuals

AFM responses to questions posed in the consultation

Question 1: Why do employers provide OH services to their employees? For example, it could be to increase workplace participation, increase workplace performance, or for the health and wellbeing of the employee.

OH services provided a valuable and tangible demonstration for employers that they support the interests of their employees. It helps attract staff, motivate them and increases their likelihood of staying.

Recent research from Medicash indicates: "employees surveyed ranked health plans and wellbeing benefits **second only to pay rises** when it comes to cost of living support from their employer"[4].

The provision of a range of services, including health cash plans and discretionary mutuals (described together as HCP in this response) also increases the productivity of the workforce, by enabling them to have treatment before they are too ill to work, or to recuperate and get back to work earlier when they are ill.

Question 2: What OH treatments are most commonly provided to employees? Have you observed any changes to this since the COVID-19 pandemic?

The research cited above mirrored similar research in 2018 by Willis Towers Watson[5], which at that time also highlighted HCP as the second most popular benefit, but at that time behind retirement planning.

Post-Covid therefore, this suggests that employees' focus has been on the here and now, rather than forward planning, but that good healthcare provision by their employers remains critical.

Amongst income protection providers, for whom AFM members account for well over half of all claims, musculoskeletal injuries are the most common cause of claim, and have increased rapidly, from around 17% of claims in 2020, to 33% in 2022[6]. By comparison, mental health claims fell to 8% of all claims.

[4] https://www.medicash.org/article/blog/health-cash-plans-the-benefit-your-employees-actually-need/#:~:text=In%20fact%2C%20employees%20surveyed%20ranked,living%20support%20from%20their%20employer.

[5] https://www.professionalpensions.com/feature/3036989/taking-responsibility-health-cash-plans-growing-popularity

[6] https://financialmutuals.org/resource/mutual-income-protection-providers-paid-out-over-50-million-in-claims-in-2022/

Question 3: What OH treatments are most effective for improving workplace participation, or effective at achieving other objectives (e.g. performance or health outcomes)?

We consider HCP are a key element of the treatment solutions available in the workplace, and for convenience provided an overview of how they work:

Health cash plans allow an individual to claim money back, up to set limits, towards the cost of their and their family's essential healthcare, as well as providing access to valuable health and wellbeing services. They are policies designed for people who are happy to continue using the NHS, along with some complementary health treatments. This is distinct therefore from private medical insurance, which is designed to provide access to private diagnosis and treatment. Health cash plans meet the FCA definitions (in its PERG rulebook) for an insurance policy, which indicate that the normal characteristics of an insurance contract are:

1. in consideration of one or more payments;
2. to pay money or provide a corresponding benefit (including in some cases services to be paid for by the provider) to a 'recipient';
3. in response to a defined event the occurrence of which is uncertain (either as to when it will occur or as to whether it will occur at all) and adverse to the interests of the recipient.

Generally, the premium is fixed at the same level for all policyholders, regardless of their age or the number of claims that they make, and there is no need for a medical examination. Children under 18 are usually covered for free.

There is usually a fixed annual limit for claiming in each benefit category and you can claim as often as you need to until you have reached your limit. Claims are made after the customer has paid for the treatment or service; the most common ones being:

Dentist: including check-ups and dental treatments, or seeing a hygienist

- **Optician:** Eye tests and prescription glasses or (often) contact lenses
- **Chiropody:** Foot treatment and advice
- **Physiotherapy:** Sometimes coupled with osteopathy
- **Maternity payments:** Cash, paid when a child is born
- **Complementary health:** Osteopathy, chiropractic, homeopathy and acupuncture by a registered practitioner
- **Hospital in-patient:** Cash paid for each night spent in hospital
- **Hospital parental stay:** Cash paid when a parent spends the night in hospital with an ill child.
- **Special consultation:** Repayment of fees paid towards a consultant physician or surgeon.
- **Personal accident, death and funeral benefits:** Cash paid out in the event of accident or death.
- **NHS (and private) prescriptions:** Some policies pay back on the cost of a limited number of prescriptions.
- **Health screening:** the policy may pay for an annual health screening.
- **Others:** Surgical or hearing aids, redundancy payouts, mental health counselling, day surgery, recuperation grants, occupational therapy, diet advice, paternity grants, adoption grants, infertility grants. Many providers have helplines for a range of subjects.

A healthcare product provided by a discretionary mutual is provided on a not-for-profit basis, with no exclusions and no medical history required, with premiums from less than £13 per month[7].

Question 4: How much do employers typically spend on OH services? Does the existence of the £500 cap on recommended medical treatment influence the amount that employers are likely to spend on OH services?

We don't have data on this.

In respect of HCPs, the cost for an employer is typically around £10 per month. Beyond that, the provider accepts costs up to prescribed limit, and therefore the £500 cap is not relevant.

Question 5: To what extent does the tax treatment of OH services affect the decisions employers make on whether to provide OH services and what to provide as a part of them? For example, would an employer be more likely to offer a treatment that is exempt than one that is not, and to what extent is that decision influenced by the tax treatment?

Most HCP is sold today to employer schemes, as opposed to individuals. Given the appeal of the product to employees, we find employers are naturally attracted to the product, particularly as products start at around £10 a month.

However, the burden in having to manage paperwork for P11Ds, for products that cost less than £200 a year, is excessive for some employers. Despite the rapid increase in insurance premium tax, and rising claims costs in recent years, the product pricing remains low; yet there has been an unavoidable increases in price to employers, and extra administration creates a barrier to some firms.

Question 6: Small and Medium Enterprises are significantly less likely to offer OH services. Why is this? Are there other characteristics of employers that tend them towards offering less or more OH services?

As highlighted in our response above, we consider the OH market, and HCP in particular, is constrained by the current Benefit in Kind arrangements, which discourage many employers from arranging a scheme. SMEs, who are the main target market for HCPs would be much more likely to act, if the P11D exemption was raised, from £50 currently to, say, £150.

This will have a dramatic impact on the amount of bureaucracy in firms, and remove the need for millions of people to complete a PIID where the HCP was the only benefit listed. This in turn would reduce HMRC workload significantly, so whilst a raised exemption level would include some features that would not be

[7] There is one discretionary mutual healthcare provider currently: www.benenden.co.uk

described as serving purely an occupational health need, we consider the streamlining of HMRC workload, and the incentive for employers to act would achieve a net gain in making the policy intention a success.

Analysis by one of our members, Sovereign Health Care, in 2018, reinforced that workforce-based HCPs are most commonly held by people on low income, as the table below shows. This means the extra incentive is well-targeted, and the relatively low exemption proposed (of £100 to £150) removes the risk to Treasury that it would be extended to private medical insurance.

Sovereign Health Care policyholder breakdown

analysis by CAMEO UK Group	Policyholder Paid		Company paid	
01 - Affluent Singles & Couples in Exclusive Urban Neighbourhoods	0.50%		0.40%	
02 - Wealthy Neighbourhoods Nearing & Enjoying Retirement	2.30%		1.80%	
03 - Affluent Home Owning Couples & Families in Large Houses	10.30%		7.70%	
04 - Suburban Home Owners in Smaller Private Family Homes	13.70%		11.50%	
05 - Comfortable Mixed Tenure Neighbourhoods	12.30%		6.90%	
06 - Less Affluent Family Neighbourhoods	19.70%		13.80%	
07 - Less Affluent Singles and Students in Urban Areas	2.30%		3.90%	
08 - Poorer White & Blue Collar Workers	20.00%		19.40%	
09 - Poorer Family and Single Parent Households	10.40%		16.70%	
10 - Poorer Council Tenants Including Many Single Parents	7.80%	60.20%	16.00%	69.80%
XX - Communal Establishments in Mixed Neighbourhoods	0.10%		0.03%	
Unknown	0.70%		1.60%	

We welcomed the recent comments by the Health Secretary, on seeking support for the NHS, in reducing waiting lists, through private and third sector sources[8], and we consider our proposal to raise the P11D exemption would be consistent with that.

For example, Benenden Hospital is part of the discretionary mutual healthcare provider Benenden, and regularly works with the NHS to provide specialist care. During the pandemic, the hospital was given over to supporting the fight against Covid-19. More recently, Benenden teamed up with Channel 4 to launch a very successful "Time for a Check-In" campaign[9].

Question 7: How would any of the proposed additional treatments listed above enable you to support increased OH provision and improve workforce participation? Do you have any other comments on these proposals? If so, please comment on each in turn.

We consider that changes to the tax treatment of HCP would increase demand.

[8] https://www.theguardian.com/society/2023/aug/04/private-third-sector-nhs-waiting-lists-steve-barclay?CMP=share_btn_link

[9] https://www.channel4.com/press/news/benenden-health-teams-channel-4-encourage-brits-check-their-health-1

When the Centre for Economics and Business Research reviewed the impact of increasing levels of Insurance Premium Tax (IPT) on the take up of medical insurance, it found that for every 1% increase in IPT, 21,000 would cancel their policy, and that a third of people would consider taking out cover if these costs were reduced[10].

Research by consultancy OAC in September 2023 found that the funds paid out by HCP (and income protection policies) directly contributed to savings, by the NHS and employers. For example, in an earlier version of this report, they found that when the Children and Family Court Advisory and Support Service introduced a HCP provided by Medicash Health Benefits, they reported a 15% reduction is staff absences due to illness[11]. OAC's latest research indicates that in 2022, mutual and not-for-profit providers provided savings to the NHS and employers of £956 million[12].

Question 8: For each of the categories of treatments that are currently available, is the existing definition appropriate and does it support OH provision or does it create issues?

The definitions provide scope for a range of treatments to be adopted. We agree however that they would benefit from an expansion, in order for an employer to have broader discretion on the nature of treatment needed to support their workforce.

The expanded scope suggested would be likely to better lend itself to the range of treatments and support needed for an active workforce. This coincides with the treatments available via a HCP, as provided in response to Question 3, and lends weight to our view that enabling more employers to claim BiK reliefs for HCP costs would be a very efficient, and low-cost way of expanding OH provision.

This would also allow for welfare counselling, in relation to mental health, to be included in the BiK exemption. Currently some elements of welfare counselling are exempt, but with the significant increases in mental health issues[13], we consider this would be a very valuable addition.

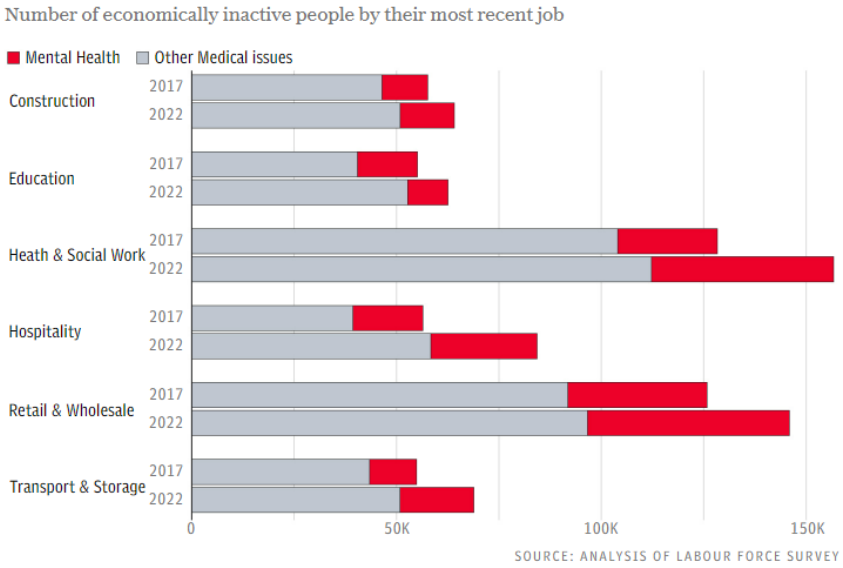
[10] http://www.independent.co.uk/news/business/news/health-insurance-premium-tax-pushed-200000-private-cover-nhs-bupa-research-a8055286.html

[11] https://financialmutuals.org/wp-content/uploads/2022/11/OAC-Report-The-benefits-to-the-welfare-state-of-mutuality-2.pdf

[12] oac-limitedmutualityhealth-and-wellbeing-in-the-ukv10-2.pdf

[13] https://www.theguardian.com/society/2023/sep/27/policy-must-tackle-root-causes-of-englands-record-mental-ill-health-says-report

This is reflected in the chart below, which is sourced from a survey by ONS referenced in the accompanying DWP consultation[14]. Long-term sickness in the UK has grown 26% in the last decade, and stood at 2.6 million at the date of the survey. The chart also demonstrates the rapid rise in economic inactivity caused by mental illness.



Question 9: Are there are other costs that should be in scope, and how would they help achieve our goal of improved OH provision and greater labour market participation?

We are not aware of any.

Question 10: Do you have any views on the drawbacks of expanding BiK reliefs?

We consider the benefits of expand BiK reliefs considerably outweigh the costs. This is because currently employers face significant bureaucracy and costs complying with BiK requirements, given that for millions of employees the only items included on disclosures will relate to low value OH support. We also consider that there are material benefits for government in reducing the volume of BiK statements it receives.

An expansion in the adopt of OH support from employers will also result in greater productivity, lower absenteeism, reduced employee turnover, and lower NHS costs. These will far exceed the costs or drawbacks quoted.

Question 11: Do you see a case for any of the above costs being in scope of additional tax relief under the BiK exemption? If so, please discuss why, and how

14 https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/economicinactivity/datasets/economicinactivitybyreasonseasonallyadjustedinac01sa

this would help achieve the government's objective of increasing employer provision of OH services and labour market participation.

Most of our comments in this response have been given over to an assessment of why we consider Health Cash Plans, provided by friendly societies and not-for-profit healthcare providers, should be included within the changes to tax incentives proposed. We do not consider this should extend to Private Medical Insurance (PMI), as that provides a different level of cover for specific diagnoses, as opposed to the everyday health needs provided by HCP.

HCP is designed to meet out of pocket expenses for essential healthcare. Where individuals purchase cover, that may include other family members. For employer-funded arrangements however, which are in the scope of BiK, the provision tends for be for the employee only, so we do not see any contradiction with the proposed out of scope items.

Question 12: Are there alternative tax incentives that you think would be more effective in incentivising employers to invest in OH services for employees? If so, please explain why.

Key challenges for SMEs are the simplicity of any tax incentives, the ease of obtaining them, and the absolute value of those arrangements.

Question 13: Are there particular tax incentives that would be better suited to helping small and/or medium sized businesses invest in OH services?

As the consultation paper observes, take-up of OH is particularly weak by small businesses: only 18% provide cover, compared to 49% for medium-sized businesses.

We agree that it would be worth exploring a super-deduction of OH costs from business taxes, to encourage greater take-up.

Question 14: To what extent would tax incentives be more effective in increasing employer investment in OH, compared to legal measures to provide OH, which could vary by the size of the business?

We have lobbied in the past for HCP to be exempt from tax. When the government raised the rate of Insurance Premium Tax (IPT), AFM members were unable to absorb all the costs, and the price of HCP rose for many employers. We saw feedback that this was unwelcome and caused businesses to reconsider the benefit.

We therefore consider that demand for OH services and HCP is elastic and would respond to new tax incentives.

Currently long-term life and income protection policies are exempt from IPT, and extending that arrangement to HCP, or including in BiK arrangements, would not therefore create a precedent.

Question 15: Do you have any comments on the government's expectations regarding Exchequer impacts?

We are unable to comment on all the OH proposals included in the consultation. With regards to HCP though, were these excluded from BiK assessments, we predict the Exchequer impact would be modest. This is because the value of most employer-funded HCP is around £100, and therefore the reduction in tax recovered would be low, particularly as employees tend to be on lower income and therefore subject to 0% or 20% tax.

Question 16: Would businesses seek to increase their overall investment into OH, if the exemptions from BiK rules were expanded in line with the suggestions in the chapter "Scope"? If so, to what extent?

See answer to Q19 below.

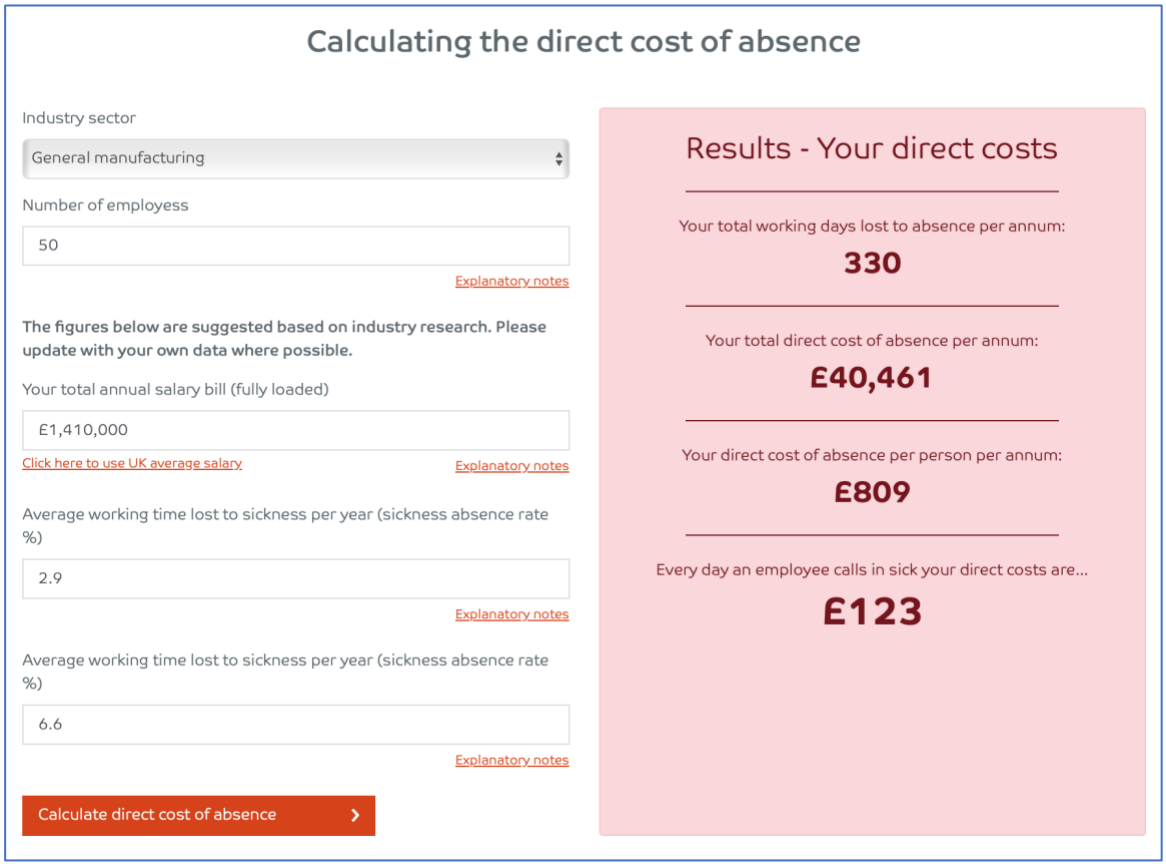
Question 17: Do you have any comments on the government's assessment that tax incentives would positively impact the health of employees and lead to both fewer employees leaving the workforce and encouraging those currently employed to return to the workforce?

We consider that tax incentives would materially benefit the health of employees. This is because in our experience firms are willing to consider investing in OH services, but nervous about open-ended costs. Many therefore opt for HCP solutions, where the provider collects a monthly contribution which in turn caps the outlay for the employer.

Tax incentives would act as a prompt to open a dialogue about the wider impact of staff absences. The chart below uses an absence calculator designed by Westfield Health. We've used illustrative numbers to show that with a workforce of 50, an SME might expect absence costs each year of over £40,000[15].

Tax incentives would be expected to increase the likelihood that an employer would act, and this would in turn reduce employer costs, as well as increasing the health of employees.

[15] https://www.westfieldhealth.com/business/calculator



Question 18: Do you agree that tax incentives for providing access to occupation health services will promote a stronger culture in the UK of employers taking good care of employee health?

As the research from Medicash (above) shows, there is a strong interest amongst employees in receiving OH-style benefits. SMEs and other businesses that act on this are likely to enjoy greater employee loyalty as well as lower levels of absence. We consider this will lead to a happier and more productive workforce.

Question 19: How significant could the economic benefits of greater OH provision in the UK be?

When we wrote to the then Economic Secretary, John Glen MP, in 2018, we estimated that changes to the tax treatment of HCP might increase the market by around 20%. We also calculated at the time that the net benefit from this increase- to the NHS and employers- would be £37 million a year, allowing for the loss of tax revenue balanced against the reduction in costs for the NHS and a reduction in absenteeism.

We would set a similar ambition here.

Question 20: Do you have suggestions on how the effectiveness of these changes could be monitored?

We consider it would be instructive to measure the increased take-up of OH services by employers.

In the case of AFM members, this would be correlated with the increase in the number of employees covered by HCP schemes.

Question 21: If you are an employer, what are the formal processes around spending on OH? For example, do you have an annual budget that you must work within, or is this flexible and dependent on the needs of the business and employees in that time period?

n/a

Question 22: Do you have views on how best to minimise the administrative burdens for businesses, as a result of new OH tax incentives?

As mentioned above, increasing the BiK threshold would be the optimal way of reducing administration to firms, who would be released, collectively, from producing millions of very low value BiK returns.

Question 23: Do you have views on how best to minimise the complexity associated with new OH tax incentives?

We consider a blanket approach is the most effective route to minimising complexity.

Question 24: Do you have any views on the implications of the proposal in this consultation for you, or the group or business you represent, and on anyone with a relevant protected characteristic? If so, please explain who, which groups, including those with protected characteristics, or which businesses may be impacted and how.

We do not have detailed data, but previous research indicated that holders of HCP are more likely to be on lower income, and therefore to include a higher proportion of people with protected characteristics.

Question 25: Do you have any comments on the territorial impacts?

No comment

Question 26: Do you have any comments on the impacts on HMRC and other public sector delivery organisations?

We expect a strong net gain to HMRC, by removing a significant proportion of BiK returns for individuals for whom a health cash plan, for example, is the only benefit in kind listed on their annual declaration.

Appendix: list of mutual health cash plan providers

(AFM members in blue)

Benenden Healthcare (a discretionary mutual)

BHSF

Exeter Friendly Society

Health Shield Friendly Society

HSF Health Plan

Medicash

Paycare

Simplyhealth

Sovereign Health Care

UK Healthcare

WHA Healthcare

Westfield Health

Western Provident Association