



Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry

Policy questions arising from Module 6

Beyond Blue submission

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Introduction

Beyond Blue is a national, independent and bipartisan not-for-profit organisation working to promote good mental health, prevent suicide and improve the lives of individuals, families and communities affected by depression, anxiety and suicide.

Beyond Blue welcomes the opportunity to make this submission to the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry. Beyond Blue congratulates the Commission for including the impacts of industry practice on people's mental health in its hearings.

One of Beyond Blue's priorities is to reduce people's experiences of stigma and discrimination. While Australians are becoming increasingly literate about mental health conditions, there is still a level of misunderstanding associated with these conditions that can exacerbate stigma and result in discrimination. This harms individuals and our community more broadly. While public understanding of, and attitudes towards, these conditions has improved, it appears that the insurance industry's understanding and practices have largely not kept pace.

This submission has been informed by Beyond Blue's extensive work to: improve access to insurance products for people with a mental health condition; influence the industry to make changes to their policies and practices; and bring greater fairness to the insurance market.

Beyond Blue encourages Australians impacted by potential insurance discrimination to contact Beyond Blue to share their stories, and we have been contacted by several hundred people since 2013. Beyond Blue has also commissioned two consumer surveys to better understand the prevalence and types of issues people experience.

Submission 'in a nutshell'

People with a mental health condition should have **fair access to insurance products**, to enable them to protect themselves and their families against financial stress and uncertainty.

Empirical evidence and anecdotal reports demonstrate that many people with mental health conditions experience significant difficulties in obtaining and claiming on different types of insurance products, compared to the rest of the population. These difficulties occur across the general and life insurance industries for products such as travel insurance, income protection, total and permanent disability (TPD) and life insurance.

These experiences can infringe on a person's access to insurance products, but more importantly, they create a ripple effect of reinforcing self and community stigma. One of the negative consequences of stigma and discrimination is that it may prevent people from seeking professional treatment and support for their mental health issues.

Considerable effort, time and resources have been invested by Beyond Blue and others in attempting to resolve the issue through discussion and in via numerous committee and working group structures over the years. While undoubtedly mental health is now firmly on the agenda for the industry, and there are signals of change, this has not yet resulted in any large-scale, systemic improvements.

While these problems persist in the insurance industry, they exist in direct conflict with public expectation and the policies and practices of government and others, which emphasise prevention and early treatment of mental health conditions to ensure better health outcomes for all Australians.

Response to Policy Questions

1. Is the current regulatory regime adequate to minimise consumer detriment? If the current regulatory regime is not adequate to achieve that purpose, what should be changed?

Beyond Blue believes the current regulatory regime is failing to adequately protect the rights and interests of consumers of insurance products who have past or current experience of a mental health condition or poor mental health. Although a number of regulatory protections are ostensibly in place to ensure people with a mental health condition have fair access to insurance products, the experiences of the hundreds of people who have contacted Beyond Blue paint a starkly different picture.

Refusal of coverage, broad and blanket exclusions and unreasonably high premiums are common experiences. Even if their application is accepted, people can still face considerable burdens and delays when making a claim, usually when they are most vulnerable. This can cause considerable stress, and many people give up battling a process that they report is having a detrimental impact on their mental health. This infringes on consumers' fair and equitable access to insurance products, to enable them to protect themselves and their families against financial stress and uncertainty. Having a claim denied or delayed can have a significant negative impact, both financially and emotionally, during times of need and vulnerability, such as illness or death. Further evidence of the detriment experienced by people with a mental health condition is provided in Appendix 1.

People report poor experiences with many different insurers across the general and life insurance industries for products such as income protection, total and permanent disability (TPD), life insurance and travel insurance, indicating that this is a systemic issue.

The current legal and regulatory regime has been limited in its ability to prevent detriment to insurance consumers who have experienced a mental health condition due to the:

- a) Complexity of the regulatory regime and complaints and dispute resolution systems
- b) Lack of transparency of insurers' decisions
- c) Reliance on enforcement through individual disputes and complaints
- d) Failure of self-regulation to ensure that people with a mental health condition have fair access to insurance products.

a) Complexity of the regulatory regime and complaints and dispute resolution systems

The legal, regulatory and policy context relating to insurance is complex, with several different statutory agencies, industry associations and complaints bodies involved. In addition to industry legislation such as the *Insurance Contracts Act 1984* and regulatory bodies like the Australian Securities and Investments Commission (ASIC) and the Australian Prudential Regulation Authority; Commonwealth, State and Territory-based anti-discrimination legislation also includes provisions that are specific to insurers.

Under section 46 of the *Disability Discrimination Act 1992* (DDA), it is not unlawful for insurers to discriminate against a person on the grounds of their disability (including mental health conditions) whether by refusing to offer the person a product, or in respect to the terms or conditions on which the product is offered or may be obtained, where:

- The discrimination is based on actuarial or statistical data on which it is reasonable for the insurer to rely; and
- The discrimination is reasonable, having regard to the data and other relevant factors; or
- If no such actuarial or statistical data is available and cannot reasonably be obtained, the discrimination is reasonable having regard to any other relevant factors.

The Australian Human Rights Commission (AHRC) has the authority to investigate and conciliate complaints of alleged discrimination under the DDA. The AHRC also issue guidelines to assist persons and organisations to understand their rights and comply with their responsibilities under the DDA and accompanying Standards. The AHRC has issued *Guidelines for Providers of Insurance and Superannuation*,¹ which sets out the AHRC's views and relevant case law to assist insurers to comply with the DDA. However, the Guidelines are not regulations and are not binding on insurers.

There are a number of avenues in which complaints and appeals of insurers' decisions can be made. The first option for redress is through the financial service providers' Internal Dispute Resolution (IDR) process. While a proportion of complaints are resolved through IDR, many people have described dealing with the insurance industry's IDR processes as a battle and have reported that it is rare that an insurer will overturn a decision already made. The issues concerning IDR are reflected in the first TAL case study examined at the Commission's Round 6 hearings, where TAL accepted that their IDR team repeated and reiterated the claims team's decision, rather than seriously engaged with the complaint.² TAL accepted that there wasn't much point to the IDR process for the insured.³

If a customer is not satisfied with the outcome of the IDR process, they can then lodge a dispute with an External Dispute Resolution (EDR) scheme. Depending on the nature of the complaint, relevant law and jurisdiction, a person who feels they have been unfairly treated as a result of their mental health condition is expected to navigate a complex EDR system comprising of multiple organisations. This currently includes the AHRC, State and Territory based human rights, anti-discrimination or equal opportunity bodies, the Financial Ombudsman Service (FOS) and Superannuation Complaints Tribunal (SCT).

The formation of a 'one-stop shop' Australian Financial Complaints Authority (AFCA) from 1 November 2018 (replacing FOS and SCT) is welcomed. However, this may still not deliver a one-stop shop for people whose dispute relates to their mental health condition. The AFCA rules specifically exclude complaints about underwriting or actuarial factors leading to an offer of a life insurance policy on non-standard terms, which includes where an exclusion or higher premium is applied for a specified medical condition.⁴ The AFCA rules also specifically exclude complaints about a decision to refuse to provide insurance cover, subject to certain exceptions, including where 'the decision was made indiscriminately, maliciously or on the basis of incorrect information'.

The AFCA operational guidelines outline the further considerations and discretion that AFCA can use in applying these rules. For example, before excluding complaints about the offer of a life insurance policy on non-standard terms, AFCA must be satisfied that the underwriting or actuarial factors led (that is, were relied upon in the decision) to offer a life insurance policy on nonstandard terms.⁵ It remains to be seen how AFCA will apply Rule C.1.4 in practice, including how it will interpret 'indiscriminately' and how critically it will assess the actuarial and statistical data if this is supplied by an insurer. In any case, the AFCA rules suggest that a considerable number of consumers who report issues to Beyond Blue relating to refusal of coverage, exclusions, or higher premiums, may be unable to seek assistance from the AFCA.

A person with a mental health condition or other disability who believes they have been unfairly refused life insurance or have been issued a non-standard life insurance policy, can also lodge a complaint through the AHRC under the DDA. While this may result in a positive outcome for the consumer if the matter is resolved, it does little to raise awareness and build better understanding of mental health conditions in the broader insurance industry.

This complexity makes the system difficult to navigate and deters consumers from taking action, particularly if they are currently unwell as a result of their mental health condition or feeling vulnerable and stigmatised as a consequence of their interaction with insurers.

¹ Australian Human Rights Commission (2005). *Guidelines for Providers of Insurance and Superannuation*. Accessed online 16 October 2018: <https://www.humanrights.gov.au/guidelines-providers-insurance-and-superannuation>

² Transcript Day 53, P5690.

³ Transcript Day 53, P5690.

⁴ The Australian Financial Complaints Authority (2018) AFCA Complaints Resolution Scheme Rules: Rule C.1.4. Accessed online 15 October 2018 at <https://www.afca.org.au/custom/files/docs/20180920-afca-rules.pdf>

⁵ The Australian Financial Complaints Authority (2018) AFCA Operational Guidelines to the Rules. Accessed online 15 October 2018 at <https://www.afca.org.au/custom/files/docs/20180913-afca-operational-guidelines.PDF>

Within this complex system, consumers face excessive time periods for complaints to be resolved, during which time they may remain uninsured or suffer financially. For the person who was the subject of the first TAL case study examined during the Round 6 hearings, it took three years to have her claim accepted.⁶ This is an unreasonable amount of time.

Recommendations:

1. Streamline complaints mechanisms to enable a 'no wrong door' joint approach to investigating complaints to avoid repetition and lengthy delays that may occur in seeking redress through successive or multiple agencies. This should involve the cooperation of relevant bodies such as the Australian Human Rights Commission, Australian Financial Complaints Authority and state or territory-based human rights, anti-discrimination or equal opportunity bodies. As part of this structure, a triage system should be overlaid to ensure that complaints are directed to the most suitable organisation.
2. Reduce the timeframes for IDR and EDR through the development, implementation and monitoring of clear and well-defined timeframes for a complaint to be addressed. Increase adherence to these timeframes by introducing benchmarks with penalties imposed for falling below these.
3. Mandate public reporting of complaints data for both IDR and EDR schemes. ASIC should have the power to determine the content and format of the reporting and this should include:
 - provision of a full description of how the complaint was addressed or conversely why it was not accepted and where the person was referred if needed
 - provision of a description of the outcome of the complaint, including adherence to timeframes
 - a section specifically focused on mental health related claims, which needs to include a summary of the actuarial and statistical data and other relevant factors relied upon by the insurer to make the decision
 - identification of the insurer and product type.

b) Lack of transparency of insurers' decisions

Beyond Blue has seen very little evidence of any actuarial or statistical data that is used by the insurance industry in relation to mental health. From what Beyond Blue can ascertain, discriminatory policies and practices do not appear to be supported by such data, despite the broad range of data readily available on mental health prevalence, prognosis and pricing.

However, the lack of transparency means that there is no way to critically examine whether insurers are meeting their legal obligations under the DDA, and by extension, whether the regulatory regime is adequate to minimise consumer detriment.

Ella Ingram's case against QBE Insurance⁷ in 2015 was the first test case heard by a court or tribunal in relation to insurance discrimination and mental illness in Australia. In Ella's case, the Victorian Civil and Administrative Tribunal found that QBE did not produce sufficient evidence to prove that the discrimination (in this case, issuing a travel insurance policy with a blanket mental health exclusion, and denying Ella's claim based on that exclusion) was based on actuarial or statistical data. QBE accepted that it had no actuarial data to rely on to exclude mental illness from the policy. QBE also presented a range of prevalence data, however they also acknowledged that there was a 'paucity of evidence' to show that there was a link between the statistical data and the decision to include a general exclusion for mental illness in the travel insurance policy.⁸ The finding is limited to the circumstances of Ella's case. However, being the first test-case concerning insurance discrimination on the basis of mental illness in Australia, it is one of the only examples of an insurers' data sources and the application of them being transparently and critically examined by an independent body, Court or Tribunal.

Section 75 of the *Insurance Contracts Act 1984* requires an insurer to outline in writing their reasons for refusing to enter into a contract of insurance, cancelling or not renewing a contract, or for offering insurance cover on less advantageous terms, if requested to do so in writing by the policy holder or

⁶ Transcript Day 53, P5701.

⁷ *Ingram v QBE Insurance (Australia) Ltd (Human Rights)* [2015] VCAT 1936

⁸ *Ingram v QBE Insurance (Australia) Ltd (Human Rights)* [2015] VCAT 1936

applicant. However, when an insurance application is declined or an exclusion applied, people have reported to Beyond Blue that insurers either do not provide reasons or they offer very broad or generic reasons, which do not cite particular factors that were considered relevant to the individual. When Mental Health Australia and Beyond Blue conducted a Survey of Consumer Experiences relating to insurance discrimination,⁹ we were told:

“They wouldn’t explain ... it was just ‘based on medical evidence’”

“Was told I was a risk due to ‘health problems’... did not elaborate on which ones”

Recommendation:

4. The *Insurance Contracts Act 1984* and *Disability Discrimination Act 1992* should be amended to require insurers to provide plain language written explanations when an application for insurance has been rejected or is offered on non-standard terms, or an insurance claim is denied. Insurers should also be required to provide, upon request, the actuarial and statistical data and relevant factors relied on to make a decision.¹⁰

c) Reliance on enforcement through individual disputes and complaints

Given the difficulties that people with a mental health condition report experiencing accessing insurance, we do not believe that the exemption for insurers under the DDA has operated in the spirit in which it was intended to apply. The exemptions from anti-discrimination laws in certain circumstances should not mean insurers are not accountable to justify the decisions they make under these exemptions.

Currently, enforcement relies heavily on individuals pursuing a legal complaint with an EDR body, Court or Tribunal, which often places an unrealistic burden on individuals to ensure that insurers are acting in accordance with laws and regulations. A complainant-driven process can inadvertently disadvantage consumers as the process is often complicated, costly and time-consuming. Disputed claims and/or lengthy delays can be extremely stressful and, in some cases, may exacerbate a person’s mental health condition. This can place an unreasonable burden on someone who are already experiencing vulnerability due to their mental health condition.

Many people give up. Ella Ingram’s case was unique, in that she chose to pursue her dispute with QBE to a hearing for the broader public benefit, despite the toll of protracted litigation. It took almost four years for Ella, a school girl when she made her \$4,292 travel insurance claim, to find out whether QBE’s discrimination against her was unlawful. In the time that it takes to pursue a complaint, an individual may be uninsured and unprotected, or suffer financially.

If complaints are resolved, it is often through conciliation. While conciliation processes provide an opportunity for resolution of individual claims, most cases settle on a confidential basis without an admission of liability on the part of the insurer. As a result, there is little transparency or the opportunity for these cumulative experiences to influence longer-term practice change or to set firm legal precedents.

However, some models exist which can be considered to help promote more proactive enforcement. The Victorian Equal Opportunity and Human Rights Commission (VEOHRC) has the power under the *Equal Opportunity Act 2010* (Vic) to conduct investigations into any matter relating to the operation of the Act, subject to certain requirements.¹¹ Currently, VEOHRC is undertaking an investigation into potential unlawful systemic discrimination against people with mental health issues by the travel insurance industry in Victoria, which is expected to be completed later this year.

⁹ Mental Health Council of Australia and *beyondblue* (2011). *Mental health, discrimination and insurance: a survey of consumer experiences 2011*. Accessed online 31 March 2016: <https://www.beyondblue.org.au/docs/default-source/default-document-library/bw0129-report-mental-health-discrimination-and-insurance.pdf?sfvrsn=2>.

¹⁰ See Parliamentary Joint Committee on Corporations and Financial Services (2018). *Life Insurance Inquiry Final Report*, Recommendation 10.21. Accessed online 15 October 2018:

https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/LifeInsurance/Report

¹¹ *Equal Opportunity Act 2010* (Vic), Part 9

Financial institutions, including insurers, have high levels of financial literacy, in-depth product knowledge and substantial resources comparative to consumers. A fair and effective regulatory regime should serve as a mechanism to minimise the power imbalance between large financial institutions and consumers. Change is required to strengthen enforcement of existing laws and increase the accountability of insurance providers, rather than relying on individuals to make a complaint or commence legal proceedings to determine whether discrimination has occurred.

Recommendations:

5. Enhance enforcement of the *Disability Discrimination Act 1992* by giving an independent body, such as the AHRC (with additional resources commensurate with the task), the power to conduct investigations and proactively audit an insurer's actuarial and statistical data relating to refusal of insurance applications, unfavourable changes in their terms and conditions, and decisions to refuse claims relating to people with a mental health or other disability.
6. Require insurers to report annually to an independent body the number of times they have declined to provide insurance or offered insurance on non-standard terms on the ground of disability. This information should specify whether the insurer has relied on actuarial or statistical data in making their decision and the type of disability invoked by the *Disability Discrimination Act 1992* insurance exemption. This information should be published publicly and identify the insurer and product type.

d) Failure of self-regulation to ensure that people with a mental health condition have fair access to insurance products.

Beyond Blue is concerned the lack of an appropriate self-regulatory response by the general and life insurance industries – in relation to mental health – is having an ongoing negative impact on consumers who have experienced a mental health condition or poor mental health. We agree with the observations of the Parliamentary Joint Committee on Corporations and Financial Services (PJC), who noted that they were “not convinced that a self-regulatory approach is sufficient” in relation to life insurance consumers more generally.¹²

Beyond Blue supports the co-regulatory approach as recommended by the PJC (and the ASIC Enforcement Review Taskforce). At a minimum, the co-regulatory approach should require:

- Codes to be registered with ASIC
- be mandatory for all industry participants
- give Code Compliance Committees the power to determine whether breaches have occurred
- give AFCA the power to enforce compliance through determinations
- provide genuine remedies for breaches of the Code, including financial remedies, thereby creating an incentive for compliance.¹³

The PJC also recommended that ASIC be given the power to undertake enforcement action in relation to systemic or systematic breaches of codes of practice.¹⁴

In October 2016, the FSC launched the life insurance industry's first-ever industry-led consumer Code of Practice for the Life Insurance sector.¹⁵ Beyond Blue and other consumer organisations were provided with a draft Code for comment. This draft was silent on mental health and so feedback was provided to the FSC reiterating the importance of specific standards relating to mental health and the need to improve access to insurance products for customers with mental health conditions. The FSC's subsequent press release stated mental-health specific standards would be addressed in the next iteration of the Code. Beyond Blue,

¹² Parliamentary Joint Committee on Corporations and Financial Services (2018). *Life Insurance Inquiry Final Report*, page ix. Accessed online 15 October 2018: https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/LifeInsurance/Report

¹³ Parliamentary Joint Committee on Corporations and Financial Services (2018). *Life Insurance Inquiry Final Report*, page x. Accessed online 15 October 2018: https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/LifeInsurance/Report

¹⁴ Parliamentary Joint Committee on Corporations and Financial Services (2018). *Life Insurance Inquiry Final Report*, Recommendation 4.2. Accessed online 15 October 2018:

https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/LifeInsurance/Report

¹⁵ Financial Service Council (2016). Media Release - Life Insurance Code of Practice. Accessed online on 15 October 2018 at <https://www.fsc.org.au/resources/resource-detail/?documentid=35dc353e-30a7-e611-80c9-00155d252c17>

Mental Health Australia and the Public Interest Advocacy Centre jointly expressed disappointment and frustration at the continuing deferral.¹⁶

During the Round 6 hearings, the FSC stated:

“I think the first version of the code was done without a lot of extensive consultation with the life – the mental health community. I think our view at the time was that we wanted to get the code out quite quickly, and more complex areas would be – would be attended to in the second version of the code, and that has certainly been the case.”¹⁷

It is true that mental health stakeholders were not consulted meaningfully about the first release of the Code of Practice, however this fails to recognise the extensive efforts of Beyond Blue and other organisations over a decade to provide advice to and work collaboratively with the insurance industry to encourage a change to policies and practices. From 2003 - 2011, Beyond Blue and other mental health stakeholders and health professional associations were engaged in a Memorandum of Understanding with the Investment and Financial Services Association (now known as the FSC) and the life insurance sector.

Following this, Beyond Blue participated in the Mental Health Insurance Working Group between November 2011 and November 2012. The Working Group was established by the Insurance Reform Advisory Group, a forum convened by Commonwealth Government Treasury. The membership consisted of representatives from Government, the FSC, life and general insurance, superannuation and mental health sectors, and people with a mental health condition and their families and carers.

Considerable effort, time and resources have been invested by Beyond Blue and others in attempting to resolve the issue through discussion. This has not resulted in any significant systemic improvements for people with a mental health condition, leading Beyond Blue to question the commitment of the insurance industry to take real action to address this widespread and long-standing issue.

Although the FSC have stated that mental health will be addressed in the next iteration of the Code, two years on, a proposal of what will be included in the revised Code of Practice has not been provided. At the Round 6 hearings, an FSC document in relation to the scope of Code 2.0 changes was examined.¹⁸ At the time this document was written, the only agreed scope in relation to mental health was to include examples of good mental health questions in underwriting. Several other items relevant to mental health, taken from the recommendations of the Life Insurance Inquiry Final Report,¹⁹ are marked as ‘still for consideration’.

In June 2018, the Insurance Council of Australia (ICA) released the final report of the Review of the General Insurance Code of Practice.²⁰ The new version of the Code of Practice includes Draft Guidance on Mental Health, which will be attached as an appendix to the main Code. However, these best practice ‘aspirational’ principles are voluntary and do not impose any binding obligations on insurers. The lack of enforceability of guidance documents annexed to the Code was raised during the Round 6 hearings in relation to the best practice product design and distribution guidance that have been developed for add-on insurance sold through car dealers.²¹

While Beyond Blue broadly supports the content of the guidance document, we have serious doubts about the ability of non-binding principles to influence practice change within the General Insurance industry in relation to mental health. Beyond Blue’s submission to the ICA Code of Practice Review recommended that the revised Code establish a set of mandatory standards relating to mental health that insurers commit to uphold, to meet the Code’s objective of promoting consumer trust and confidence in the insurance

¹⁶ Beyond Blue, Mental Health Australia and Public Interest Advisory Centre (2016). Media release. Accessed online on 15 October 2018 at <https://www.beyondblue.org.au/docs/default-source/media-release-pdf/response-to-fsc-insurance-code-of-conduct.pdf?sfvrsn=4>

¹⁷ Transcript Day 59, P6447

¹⁸ Transcript Day 59, P6448.

¹⁹ Parliamentary Joint Committee on Corporations and Financial Services (2018). *Life Insurance Inquiry Final Report*. Accessed online 15 October 2018: https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/LifeInsurance/Report

²⁰ Insurance Council of Australia (2018) *Review of the General Insurance Code of Practice – Final Report*. Accessed online on 15 October 2018 at http://codeofpracticereview.com.au/assets/Final%20Report/250618_ICA%20Code%20Review_Final%20Report.pdf.

²¹ Transcript Day 59, P6406.

industry.²² In the Final Report, the ICA recommended that the guidance remain as non-binding best-practice principles. The ICA expressed the view that “as the market continues to make improvements in the underwriting of mental health conditions, the ICA will reconsider the feasibility of binding minimum standards.”²³

However, as a self-regulatory instrument, it could be argued that the Code should start with the establishment of minimum binding standards, and then as the market develops it sets more aspirational best-practice principles for insurers to benchmark their performance against and continually improve.

Given the long-standing issues that people with mental health conditions have experienced in relation to accessing and claiming on travel insurance, Beyond Blue is very concerned that consumers will continue to suffer detriment, with no assurances about when the industry will improve its underwriting of mental health conditions.

Recommendations:

7. A co-regulatory approach be adopted across the life and general insurance industries, as outlined by the Parliamentary Joint Committee on Corporations and Financial Services, and the ASIC Enforcement Review Taskforce.
8. Under the co-regulatory approach, that ASIC be given the power to undertake enforcement action in relation to systemic or systematic breaches of codes of practice, as recommended by the Parliamentary Joint Committee on Corporations and Financial Services.
9. The FSC and mental health stakeholders collaborate to develop a new mandatory and enforceable Code of Practice, or dedicated part of its existing Code of Practice, specifically in relation to mental health. If the FSC and mental health stakeholders have not agreed to mental health standards within six months, the Parliamentary Joint Committee recommendations specifically relating to mental health (see its Recommendation 10.7²⁴) should be enacted as part of a co-regulatory model.

A. Product Design

2. Are there particular products – like accidental death and accidental injury products – which should not be sold?

There are insurance policies for sale in the Australian market that contain blanket exclusions of any claims relating to any type of mental health condition, whether pre-existing or not. Mental health conditions are not homogenous and differ in their prevalence, severity, duration and prognosis. Blanket exclusions suggest all conditions are the same and paint everyone as high risk and uninsurable. This demonstrates a fundamental misunderstanding or ignorance about mental health conditions.

Blanket mental health exclusions can generally be found in travel or income protection insurance policies. Although many travel insurers have removed blanket mental health exclusions from their products within the last 18 months, other travel insurance policies containing these exclusions continue to be sold to consumers. In its previous submission to the Royal Commission, the Public Interest Advocacy Centre has provided examples of travel insurance and income protection policies with blanket mental health exclusions, as at 19 April 2018.²⁵

²² Beyond Blue (2018) Submission to the ICA Code of Practice Review. Accessed 16 October 2018:

<http://www.codeofpracticereview.com.au/submissions>

²³ Insurance Council of Australia (2018) Review of the General Insurance Code of Practice – Final Report, page 29. Accessed online on 15 October 2018 at http://codeofpracticereview.com.au/assets/Final%20Report/250618_ICA%20Code%20Review_Final%20Report.pdf.

²⁴ Parliamentary Joint Committee on Corporations and Financial Services. (2018). Life Insurance Industry report. Accessed online 28 March 2018: https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/LifeInsurance/Report

²⁵ Public Interest Advocacy Centre (2018) Mental Health and Insurance: Submission to the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry. Accessed online 16 October 2018 at <https://www.piac.asn.au/wp-content/uploads/2018/04/18.04.26-RC-submission-FINAL-.pdf>

As no actuarial or statistical data has been produced to support the inclusion of blanket mental health exclusions, as required by the *Disability Discrimination Act*, Beyond Blue recommends their removal from insurance policies.

Recommendation:

10. Products containing blanket mental health exclusions should not be sold.

B. Disclosure

6. Is there scope for insurers to make greater use of standardised definitions of key terms in insurance contracts?

Beyond Blue believes there is scope for greater use of standardised medical definitions to be used in insurance contracts, specifically in relation to mental health conditions.

Currently, policy wording commonly refers to extremely common symptoms that may or may not be associated with a mental health condition (e.g. stress, insomnia) or risk factors (e.g. family history).

Insurers have also been known to attribute a mental health condition to a person because they have seen a counsellor or psychologist – even if this contact was unrelated to a mental health condition (e.g. relationship counselling, career counselling) and the counsellor or psychologist’s professional opinion is that the person does not have a diagnosable mental health condition. During examination of the first TAL case study during the Round 6 hearings, the Commission heard evidence that TAL sought records from an insured person’s visits to a psychologist under her workplace Employee Assistance Program, despite these visits being related to seeking information about her rights at work as a carer for her partner, and not related to seeking treatment for her own mental health.²⁶

Imprecise and unjustifiably broad policy wording can result in a person being offered a policy with a broad mental health exclusion, despite them not having a pre-existing mental health condition. It can also result in an insurer avoiding a policy and denying a claim due to alleged non-disclosure of a pre-existing mental health condition, despite the claimant being unaware of any pre-existing mental health condition to disclose (as demonstrated in the second TAL case study examined during the Round 6 hearings).

Further, policy wording often treats mental health conditions as one homogenous group, rather than be specifically tailored to individual clinically diagnosable conditions (e.g. depression, anxiety, bipolar disorder). This can result in people who disclose a pre-existing mental health condition being offered policies with broad exclusions of any claims relating to any type of mental health condition, even if unrelated to their actual diagnosed condition. As previously noted, mental health conditions are not homogenous and differ in their prevalence, severity, duration and prognosis.

Standard mental health definitions should be used by insurers which are limited in their scope to actual, diagnosed conditions, consistent with currently accepted medical knowledge and classification systems, such as the Diagnostic and Statistical Manual of Mental Disorders. This would deliver greater certainty and fairer outcomes to consumers.

Recommendation:

11. Insurers should use standard mental health definitions which are limited in their scope to actual, diagnosed conditions, consistent with currently accepted medical knowledge and classification systems, such as the Diagnostic and Statistical Manual of Mental Disorders. Mental health definitions should not refer to commonly experienced symptoms, such as stress or insomnia.

²⁶ Transcript Day 53, P5687.

E. Claims Handling

19. Should life insurers be prevented from denying claims based on the existence of a pre-existing condition that is unrelated to the condition that is the basis for the claim?

Currently, insurers are able to cancel policies and therefore deny claims when the insurer determines that the consumer did not comply with their duty of disclosure.²⁷ This includes alleged non-disclosure of a pre-existing condition, even if unrelated to the claimed condition. This approach appears to be operating particularly harshly for people who may have previously experienced a mental health condition, or even where they may not have not been diagnosed with a mental health condition, but they have sought support to protect their mental health and prevent the potential onset of a diagnosable mental health condition (e.g. from a relationship counsellor).

The second TAL case study examined during the Round 6 hearings, where a woman was denied a claim for cervical cancer because TAL assessed that she had failed to disclose a prior history of depression, demonstrates the significant impact that this can have on an individual when they are already experiencing a period of great stress and vulnerability.

In October 2016, ASIC released *REPORT 498: Life Insurance claims: An industry review*²⁸. One area of concern highlighted by ASIC for mental health claims disputes was issues of alleged non-disclosure of pre-existing mental health conditions. The proportion of disputes about a claim being declined for non-disclosure was substantially higher for mental health claims than the proportion of disputes about non-disclosure across all claims (15 per cent of all disputes about mental health claims compared to five per cent of all claims related disputes). ASIC highlighted three particular areas of concern:

- An insurer may investigate a lengthy period of the policy holder's life as part of assessing whether there was a pre-existing condition. Some complaints received were about insurers examining policy holder's medical history as far back at 20 years. Examples were found where an insurer considered a 'pre-existing condition' to include a matter as simple as a comment to a GP or a visit to a counsellor both in the absence of any diagnosis, resulting in an unrelated mental health claim being declined many years later. Seemingly, this demonstrates unfair insurance practices that aim to find any reason to not pay out a claim.
- Insurers appear to have avoided paying on policies due to non-disclosure of mental health conditions even though the mental health condition did not cause or contribute to the claim.
- Due to a combination of both points above, policy holders showed reluctance in seeking help for mental health conditions, even in the absence of a diagnosis, or to support recovery or prevent relapse because they were aware of the impact it may have on their ability to access life insurance.

When insurers are deciding whether to cancel a policy and deny a claim, they are undertaking a retrospective assessment of the policy that they would have offered at the time of application, had the duty of disclosure been complied with. This points to a larger issue about how insurers underwrite mental health at the application stage. From the many personal stories Beyond Blue has received about refused applications, mental health exclusions and higher premiums, this is certainly an issue that is equally as important to consumers as the issues experienced at claims time.

There appears to be contradictory messages from the insurance industry about how the disclosure of mental health conditions is treated at the application stage. In giving evidence to the Life Insurance Inquiry conducted by the Parliamentary Joint Committee on Corporations and Financial Services, the FSC said that it was not aware of its members denying complete insurance coverage due to a pre-existing mental health condition.²⁹ It is difficult to reconcile this statement with the actions of TAL in two case studies examined at the Round 6 hearings. In the first case study, TAL cancelled the insured's policy, saying that they would not

²⁷ *Insurance Contracts Act 1984* (Cth), s29.

²⁸ Australian Securities and Investments Commission (2016). Report 498. Life insurance claims: an industry review. Accessed online 16 October 2018 <http://download.asic.gov.au/media/4042220/rep498-published-12-october-2016a.pdf>

²⁹ Financial Services Council (2017). Supplementary Submission to the Parliamentary Joint Committee on Corporations and Financial Services - Inquiry into the Life Insurance Industry (Submission 26.1, page 5). Accessed online 16 October 2018: https://www.afp.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/LifeInsurance/Submissions

have offered an income protection policy on any terms if the insured had disclosed her history of anxiety or stress in her application.³⁰ In the second case study, TAL cancelled the insured's policy, saying that they would not have offered an income protection policy on any terms if the insured had disclosed her history of depression (combined with the application of a cervical spine exclusion).³¹ The above statements from the FSC are also at odds with the many experiences of refused coverage that consumers have shared with Beyond Blue.

Under section 46 of the DDA, insurers bear the responsibility of proving that any discrimination on the basis of disability is substantiated by actuarial and statistical data, where that data is available. However, Beyond Blue has seen very little evidence of any actuarial or statistical data that is used by the insurance industry in relation to mental health. From what Beyond Blue can ascertain, discriminatory policies and practices do not appear to be supported by such data, despite the broad range of data readily available on mental health prevalence, prognosis and pricing.

Recommendations:

- 12.** Section 29 of the *Insurance Contracts Act* should be amended to prevent insurers from denying claims based on the existence of a pre-existing condition that is unrelated to the condition that is the basis for the claim.
- 13.** Independently examine the mental health actuarial and statistical data currently used within the insurance industry to assess risk and make decisions regarding insurance applications and claims. If this identifies issues with the data being used by the industry, an independent study should be commissioned that collates the most contemporary mental health prevalence, prognosis and pricing data to ensure insurers make evidence-based decisions in line with the requirements under the *Disability Discrimination Act*.

20. Should life insurers who seek out medical information for claims handling purposes be required to limit that information to information that is relevant to the claimed condition?

Life insurers currently have very broad access to a policy holders medical information, with an estimated 50 per cent of requests for medical information by life insurers being made for whole medical records rather than more specific medical reports.³² Such broad access is problematic, particularly in relation to mental health, as experience has shown that something as simple as a comment to a GP (e.g. the 'baby blues' after childbirth) can be used by the insurer to indicate a pre-existing mental health condition.³³ The Royal Australian College of General Practitioners (RACGP) has said that its members are concerned about life insurers misinterpreting consultation notes, noting that "consultation notes are a comprehensive written record of the conversation that have taken place, containing sensitive information to support us when providing quality of care".³⁴ Consultation notes are not created for the purpose of a life insurer to assess an individual's risk.

Life insurers' broad access to medical information is one factor that can prevent people from discussing and seeking treatment and support from a health professional for their mental health, as they are concerned how such actions will affect their life insurance applications or claims.

Beyond Blue supports the view of the Parliamentary Joint Committee on Corporations and Financial Services that life insurers should only have access to targeted medical information.³⁵ This should be limited to information that is relevant to the claimed condition. This Committee recommended that the FSC and

³⁰ Transcript, Day 53, P5689-5690.

³¹ Transcript, Day 54, P5767.

³² Parliamentary Joint Committee on Corporations and Financial Services (2018). *Life Insurance Inquiry Final Report*, page 125. Accessed online 15 October 2018: https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/LifeInsurance/Report

³³ Australian Securities and Investments Commission (2016). Report 498. Life insurance claims: an industry review. Accessed online 16 October 2018 <http://download.asic.gov.au/media/4042220/rep498-published-12-october-2016a.pdf>

³⁴ Parliamentary Joint Committee on Corporations and Financial Services (2018). *Life Insurance Inquiry Final Report*, page 127. Accessed online 15 October 2018: https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/LifeInsurance/Report

³⁵ Parliamentary Joint Committee on Corporations and Financial Services (2018). *Life Insurance Inquiry Final Report*, page 132. Accessed online 15 October 2018: https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/LifeInsurance/Report

RACGP collaborate to implement agreed protocols for requesting and providing medical information, and it is understood that this work is underway.

Recommendation:

14. Protocols developed in relation to the medical information sought by life insurers should specify that only information relevant to the claimed condition be sought by a life insurer, and that consumers are kept informed about the medical information that the insurer has requested and any third parties who the information is being shared with. These protocols must be binding and enforceable.

21. Should life insurers be prevented from engaging in surveillance of an insured who has a diagnosed mental health condition or who is making a claim based on a mental health condition? If not, are the current regulatory requirements sufficient to ensure that surveillance is only used appropriately and in circumstances where the surveillance will not cause harm to the insured? If the current regulatory requirements are not sufficient, what should be changed?

When considering whether life insurers should be permitted to conduct surveillance of policy holders who have a mental health condition, the rights, interests and impact of surveillance on the individual must be considered against the rationale for, and utility of, surveillance for the life insurer.

In the first TAL case study examined at the Round 6 hearings, evidence was given that TAL engaged a private investigator to conduct surveillance on the insured. The instructions given by TAL to the private investigator included that they ascertain the insured's current activities and the extent of her 'alleged' psychological condition.³⁶ Intrusive physical surveillance was used, and notes of the private investigator included the observation that "the claimant displayed a happy, confident, carefree demeanour as she was observed and videoed during the surveillance period showing no outward signs of her alleged psychological condition".³⁷ This statement shows a complete lack of insight or understanding about mental health conditions, suggesting that you can somehow simply tell by looking at someone whether they have a mental health condition or not, or that people with a mental health condition are expected to behave in a certain way. It is extremely concerning that TAL may have relied on such evidence to decide whether the insured had a mental health condition, despite the existence of clear contrary evidence from her GP that the insured had been diagnosed with a mental health condition that was preventing her from working.

In this case study, the insured's treating psychiatrist submitted a report to TAL noting the insured's fearfulness and anger which was directed towards the insurance processes, and that there had been a progressive deterioration in her condition over the past six years.³⁸ Whilst this opinion was in relation to the insurance process generally rather than the impact of surveillance specifically, surveillance was one of the key elements of the insured's overall claims experience.

ASIC's Report 498 noted that five per cent of the evidence-related disputes that it examined in relation to mental health allegations of surveillance practices that were seen as unfair or even caused a person's mental health condition to worsen.³⁹

The life insurance industry has argued that surveillance is a necessary part of the claims process, as it protects against false claims and insurance fraud.⁴⁰ However, Beyond Blue questions the utility of surveillance for claims involving mental health conditions. Importantly, the Actuaries Institute has observed that "in the case of a mental health condition, it is rare that it (surveillance) will produce anything meaningful to assist the insurer, while often causing significant distress to the person making a claim".⁴¹

³⁶ Transcript, Day 53, P5709.

³⁷ Transcript, Day 53, P5709.

³⁸ Transcript, Day 54, P5755.

³⁹ Australian Securities and Investments Commission (2016). Report 498. Life insurance claims: an industry review, page 63. Accessed online 16 October 2018 <http://download.asic.gov.au/media/4042220/rep498-published-12-october-2016a.pdf>

⁴⁰ Financial Services Council (2017). Supplementary Submission to the Parliamentary Joint Committee on Corporations and Financial Services - Inquiry into the Life Insurance Industry (Submission 26.1, page 6). Accessed online 16 October 2018: https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/LifeInsurance/Submissions

⁴¹ Actuaries Institute (2017) Mental Health and Insurance Green Paper, page 29. Accessed online 16 October 2018: <https://actuaries.asn.au/Library/Miscellaneous/2017/GPMENTALHEALTHWEBRCopy.pdf>

When balanced against the harm that this can cause for people who have a mental health condition, the justification for conducting surveillance on policy holders who have a mental health condition appears to be very weak.

Previously, there has been little public information available about the use of surveillance by insurers. The FSC had estimated that one to five per cent of claims are subject to surveillance, and that surveillance in relation to mental health is even rarer.⁴² However, evidence tendered at the Round 6 hearings about the surveillance practices of ten insurers showed that, over the past five years, surveillance activities occurred in mental health claims more than twice as frequently as in physical health claims (1.29 per cent of physical claims, and 3.9 per cent of mental health claims).⁴³

MetLife and Zurich abandoned the use of surveillance for any mental health claims from July 2016. MetLife specifically noted that their policy now states that surveillance is not to be used in the assessment of the claim where diagnosed mental illness is known to be a factor in the claim,⁴⁴ showing that it is possible for a life insurer to change their approach to claims assessment and processing.

Although the number of claims in which surveillance has been used has decreased significantly since July 2016, Beyond Blue remains concerned that surveillance of policy holders who have a mental health condition continues to be used within the life insurance industry.

Section 8.12 of the FSC Life Insurance Code of Practice sets standards in relation to the use of surveillance by insurers, including that surveillance be discontinued where there is evidence from an independent medical examiner that it is negatively impacting the claimant's recovery.⁴⁵ Whilst this clause prevents further harm being inflicted on an insurance consumer, it fails to prevent possible harm from being inflicted in the first place.

Recommendation:

15. In the absence of any discernible evidence that surveillance assists in the assessment of claims, and knowing the significant harms surveillance can cause claimants, life insurers should not be permitted to engage in surveillance of an insured person who has a diagnosed mental health condition or who is making a claim based on a mental health condition.

H. Regulation

33. Should the Life Insurance Code of Practice and the General Insurance Code of Practice apply to all insurers in respect of the relevant categories of business?

To ensure greater consumer trust, confidence and certainty, it is critical that the Life Insurance Code of Practice and General Insurance Code of Practice apply to all insurers within the relevant categories of business.

Currently, the Life Insurance Code of Practice applies only to FSC members. This means that the Code of Practice does not cover insurance products taken out through super funds, which represents more than 70 per cent of life insurance policies in Australia.⁴⁶ The Australian Institute of Superannuation Trustees, the Association of Superannuation Funds of Australia and the FSC released the Insurance in Superannuation Code of Practice in December 2017.⁴⁷ However, this Code is voluntary for industry participants. It is also confusing for consumers that two separate Codes apply to life insurance in Australia.

⁴² Financial Services Council (2017). Supplementary Submission to the Parliamentary Joint Committee on Corporations and Financial Services - Inquiry into the Life Insurance Industry (Submission 26.1, page 6). Accessed online 16 October 2018: https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/LifeInsurance/Submissions

⁴³ Transcript, Day 54, P5787.

⁴⁴ Transcript, Day 54, P5790.

⁴⁵ Financial Services Council (2016) Life Insurance Code of Practice. Accessed online 16 October 2018: <https://www.fsc.org.au/policy/life-insurance/code-of-practice/life-code-of-practice>

⁴⁶ <https://www.ricewarner.com/insurance-through-superannuation/>

⁴⁷ Australian Institute of Superannuation Trustees (2017). *Insurance in Superannuation Voluntary Code of Practice*. Retrieved from http://www.aist.asn.au/media/1099546/insurance_in_superannuation_voluntary_code.pdf

Recommendation:

16. The Life Insurance Code of Practice and General Insurance Code of Practice should apply to all insurers within the relevant category of business. These Codes of Practice must be mandatory and enforceable, and this also must capture life insurance policies issued through superannuation.

Appendix 1: An overview of insurance discrimination and mental health

Insurance and mental health conditions

People with a mental health condition should have fair access to insurance products, to enable them to protect themselves and their families against financial stress and uncertainty. Empirical evidence and anecdotal reports demonstrate that many people with mental health conditions experience significant difficulties in obtaining and claiming on different types of insurance products, compared to the rest of the population. These difficulties occur across the general and life insurance industries for products such as travel insurance, income protection, total and permanent disability (TPD) and life insurance.

Since 2013, Beyond Blue has been collecting stories from people who wish to share their experiences of unfair treatment or discrimination by insurers, such as blanket mental health exclusions or increased premiums citing mental health concerns as the basis. Many have reported that there has been little transparency around the management of claims, including seemingly arbitrary decision making-processes. These stories paint a picture of experiences with insurance companies that are distressing and discriminatory and are further supported by two community surveys in 2011 and 2017 on this topic.

In 2011, Beyond Blue and Mental Health Australia undertook the study *Mental health, discrimination and insurance: Survey of consumer experiences*. The results highlighted the difficulties people with a mental health condition have in obtaining travel, life, TPD and income-protection insurance. Fifty per cent of the survey respondents either agreed or strongly agreed that it was difficult for them to obtain insurance due to a mental health condition. Some survey respondents indicated that insurance companies appeared to automatically categorise mental health conditions as high risk regardless of individual circumstances and made broad assumptions about their ability to maintain employment and their general level of functioning.

In 2017, a further *Mental Health, Discrimination and Insurance Consumer Survey* was commissioned by Beyond Blue. The results from this survey further support the findings from the 2011 survey.

Types of problems experienced

Refusal of coverage

The *Mental Health, Discrimination and Insurance: A Survey of Consumer Experiences 2011* (Consumer Survey) found that, across all insurance types, 22 per cent of respondents reported that their insurance application was declined due to a mental health condition. Some respondents stated they had been declined insurance because of a mental health condition that had occurred many years ago, and had been treated and/or resolved, yet was still taken into account.

Similar findings appeared in the 2017 consumer survey: people who disclose a mental health condition were more likely to be rejected than people without a mental health condition for life insurance (13 per cent vs 9 per cent) and TPD (14 per cent vs 7 per cent).

Outright refusal of coverage has a significant impact on an individual, as it leaves them unable to protect themselves and their families against uncertainty and financial stress during times of serious need, such as severe illness and death.

Policy exclusions

The 2011 Consumer Survey found that 25 per cent of those obtaining life insurance received an exclusion relating to mental health conditions while 34 per cent received an exclusion on their income protection insurance. Across all insurance types, 24 per cent of people received an insurance product with exclusions relating specifically to mental health conditions.

The 2017 Consumer Survey found that people with a mental health condition were more likely to have exclusions placed on their policy compared to people without a mental health condition for income

protection insurance (9 per cent people with a mental health condition vs 1 per cent without), travel insurance (5 per cent vs 2 per cent) and TPD (9 per cent vs 0 per cent).

While some change in terms and conditions may be reasonable for people who report an existing mental health condition, in many instances people are offered policies with broad, blanket exclusions on claims relating to all mental health conditions, even if unrelated to their specific condition.

Of greater concern, mental health condition exclusions can sometimes be applied simply because a person reports symptoms that may or may not be associated with a mental health condition (e.g. stress, insomnia) or even risk factors for a mental health condition (e.g. family history) despite the person not having been diagnosed with a mental health condition. Insurers also have been known to determine that a person has a mental health condition if they state they have seen a counsellor or psychologist even if this contact was unrelated to a mental health condition (e.g. relationship counselling, career counselling) or even if the psychologist/counsellor did not think the person had a mental health condition.

Paying increased premiums

The 2011 Consumer Survey found that across all insurance types, 14 per cent of people received their insurance products with increased premiums because of their mental health condition.

Beyond Blue acknowledges the need for insurers to set premiums that reflect the level of risk an individual represents to an insurer. However, the personal stories which are shared with Beyond Blue indicate that higher premiums are often unreasonable or at a level that makes the cost prohibitive for the person to take out insurance, leaving them uninsured as a result. Beyond Blue also regularly hears from people who have both a broad mental health exclusion, and increased premium loading applied to their policy.

Making a claim

Among the respondents in the 2011 Consumer Survey who had made a claim against their insurance, 41 per cent had their claim accepted without any problems, 13 per cent said they had problems getting their claim accepted and 12 per cent had their claim partly declined due to a history of a mental health condition. Of particular concern, some people described experiencing a prolonged claims process that sometimes spanned a number of years.

In some cases, claims are declined because the mental health condition is considered to have been 'pre-existing', even when there was no evidence for this. In other cases the reverse happens with respondents stating they had their diagnosis questioned by the insurer or the specialist chosen by the insurer. Disputed claims and/or lengthy delays can be extremely stressful and, in some cases, may exacerbate a person's mental health condition. Respondents to the Consumer Surveys spoke of the increased stress that the claims process inflicted, particularly the impact of prolonged processes with extensive evidence required, and examinations undertaken by unfamiliar medical professionals working for insurers.

In the 2017 Consumer Survey, 68 per cent of respondents who had a mental health condition had their claims immediately approved compared to 79 per cent amongst those who have never experienced a mental health condition. This suggests that some people with mental health conditions experience different treatment from insurance companies compared with those without mental health conditions.

Coinciding with the greater numbers of people with a mental health condition whose claims are only approved after an appeal, or not at all, claims for people with a mental health condition also take longer to process. The 2017 Consumer Survey found that only 70 per cent of people with a mental health condition had their claim processed within three months, compared to 84 per cent of people without a mental health condition.

More recently, ASIC released *REPORT 498: Life Insurance claims: An industry review*, which found that policy holders with a mental health condition face a challenging burden to establish their condition entitles them to make a valid claim.⁴⁸ Although this review focused specifically on life insurance claims, there are findings and reflections which are likely to be equally relevant for the general insurance industry.

⁴⁸ Australian Securities and Investments Commission (2016). Report 498. Life insurance claims: an industry review. Accessed online 31 October 2016 <http://download.asic.gov.au/media/4042220/rep498-published-12-october-2016a.pdf>

For mental health claim disputes, the report identified several areas for concern including the evidence required to substantiate a claim, issues of non-disclosure and issues such as delays in assessing claims, pre-existing condition definitions, general declined claims and the application of exclusions for suicide.

For disputes relating to what constitutes evidence for validating a mental health claim, dispute rates were much higher than dispute rates relating to evidence for all claims (51 per cent compared to 25 per cent). The evidence required by insurers to substantiate mental health claims included requiring policy holders to attend psychiatric assessment, complete activity diaries, submit regular progress claims forms, provide medical reports and attend interviews with private investigators, as well being subject to surveillance in some cases.

For disputes relating to alleged non-disclosure of pre-existing mental health conditions, dispute rates were much higher than disputes rates for all claims (15 per cent compared to 5 per cent).

In disputes relating to alleged non-disclosure for mental health conditions, three concerning areas emerged:

- An insurer may investigate a lengthy period of the policy holder's life as part of assessing whether there was a pre-existing condition. Some complaints received were about insurers examining policy holder's medical history as far back as 20 years. Examples were found where an insurer considered a 'pre-existing condition' to include a matter as simple as a comment to a GP or a visit to a counsellor both in the absence of any diagnosis, resulting in an unrelated mental health claim being declined many years later. This demonstrates unfair insurance practices that aim to find any reason to not pay out a claim.
- Insurers avoided paying out on policies due to non-disclosure of mental health conditions even though the mental health condition did not cause or contribute to the claim.
- Due to a combination of both points above, policy holders showed reluctance in seeking help for mental health conditions, even in the absence of a diagnosis, or to support recovery or prevent relapse because they were aware of the impact it may have on their ability to access life insurance cover.

Interactions with insurance providers

Many people say that dealing with the insurance industry is a battle which can be detrimental to their mental health, because of the stress and shame caused. The flow on effects of this contribute to stigma which produces considerable harm at the individual, community and economic level.

Consumer experiences that are reported to Beyond Blue highlight dismissive and/or obstructive attitudes by some in the insurance industry. This is particularly concerning given the negative impact that this can have on vulnerable people. In the 2011 Consumer Survey, several respondents mentioned the embarrassment, humiliation and insensitivity surrounding interactions with an insurance provider. Several also mentioned how their interactions with insurance providers have impacted negatively on their mental health.

The 2017 Consumer Survey found that because people with a mental health condition are less likely to be immediately approved, their applications are also more likely to take longer than people without a mental health condition. This was particularly an issue for income protection insurance, where only 35 per cent of people who disclosed a mental health condition had their application processed within 3 months, compared to 65 per cent of people without a mental health condition.

Furthermore, the perceived fairness of the application process was much lower for people with a mental health condition than those without, across life insurance, income protection, TPD and travel insurance. For example, 30 per cent of people with a mental health condition believed the application process for income protection insurance was unfair, compared to 8 per cent of people without a mental health condition.