



# Parliamentary Joint Committee on Corporations and Financial Services

## ***beyondblue* Submission**

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# Parliamentary Joint Committee on Corporations and Financial Services Inquiry

## Summary of key points:

Insurance discrimination among people with a mental health condition appears to be a common problem.

Under section 46 of the *Disability Discrimination Act 1992 (Cth)*, 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. Insurance 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.

A 'one-size-fits all' approach conflates mental health symptoms with mental health conditions and lumps all mental health conditions together as a homogenous group.

As a result, everyone with a mental health condition is seen as high risk and/or uninsurable.

However in reality each mental health condition is different in its prevalence and prognosis, and each individual experience is different. Each condition needs to be assessed independently and on the basis of diagnosis and prognosis, not just symptoms.

Three out of four mental health conditions have their first onset before the age of 25.<sup>1</sup> Although the majority of people will recover and stay well, insurance industry practices may deem a person as high risk for the rest of their lives.

## Introduction

*beyondblue* welcomes the opportunity to make this submission to the Parliamentary Joint Committee on Corporations and Financial Services Inquiry.

This submission will provide:

- an overview of the public mental health context;
- an outline of the issues relating to mental health conditions and insurance discrimination, including personal experiences;
- an overview of efforts to improve insurance access for people with a mental health condition;
- a summary of the legal, regulatory and policy context; and
- proposed solutions and recommendations.

***beyondblue* is committed to supporting all people in Australia to achieve their best possible mental health.** As a national population mental health organisation, we have a range of integrated initiatives to prevent depression, anxiety and suicide and to assist people who experience these conditions by raising awareness, increasing knowledge, decreasing stigma and discrimination, encouraging people to seek help early and improving their ability to get the right services and supports at the right time. *beyondblue* has the support of the Commonwealth and every State and Territory government in Australia, philanthropy and public donations.

One of *beyondblue's* major goals 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 confusion and misunderstanding associated with these conditions that leads to stigma and discrimination. This harms individuals and our community.

Like physical health conditions, mental health conditions have a range of characteristics unique to each individual. They can be recognised and treated. Most people with a mental health condition will recover and stay well. Some may experience intermittent relapses. Some may experience more persistent difficulties. Individual differences must be expected and understood.

**While public understanding of and attitudes towards these conditions has improved, it would appear that insurers' understanding has not.** The one-size-fits all approach taken by the insurance industry is outdated. Blanket exclusions for people affected by a mental health condition appear to lack any justification. Risk assessment practices are not based on specific disorders, or overestimate their severity, or underestimate the possibility of recovery.

Such potential and actual discrimination is unfair and harmful. It occurs across the spectrum of the life insurance market, including direct insurance, group insurance and retail advised insurance. In addition to infringing on people's access to insurance products, it creates a ripple effect of reinforcing self and community stigma. This approach runs contrary to the Australian Government and all State and Territory Government's mental health plans, policies and reform commitments which emphasise the need to tackle stigma to reduce the prevalence and the impact of mental health conditions on individuals, society and the economy. **If mental health conditions are stigmatised in any way, people may be less likely to seek help and/or have less capacity to participate fully, with significant productivity, participation and social impacts.**

In recognition of the importance of this issue, *beyondblue* and Mental Health Australia undertook a study into insurance discrimination in 2010. The report highlighted the difficulties people with a mental health condition have in obtaining travel, life, total and permanent disability and income-protection insurance. To shed further light on this issue, since 2013 *beyondblue* has called for people to share their stories of unfair treatment or discrimination for mental health reasons. We have received hundreds of stories telling us about seemingly arbitrary decisions around access as well as obfuscation and lack of transparency in the management of claims. We have included details from some these first-hand accounts in this submission.

*beyondblue* has worked with the insurance industry since 2002 in good faith to tell them what we have been hearing and encouraging them to change the way they deal with people who live with a mental health condition. Sadly, this has made very little difference.

Despite all efforts over many years we continue to hear negative experiences of the insurance industry from everyday Australians affected by depression and anxiety. And we continue to hear the same, often contradictory, reasons from the industry in reply. On the one hand we are told that mental health conditions are too common and they are too expensive to insure<sup>2</sup> and on the other hand we are told the industry does not have enough data to inform its product development and decision making processes.<sup>3</sup> It is time for a fresh approach.

If the data is not there – we need to find it or create it. If the data is there it needs to be used in accordance with the requirements of the Commonwealth *Disability Discrimination Act 1992* (DDA) and relevant State and Territory legislation, so that insurers judge cases on facts, rather than myths or opinions. We also need to simplify, streamline and tighten up the complaints mechanisms and enforcement of regulations and legislation. Accordingly, *beyondblue* would like to make the following recommendations:

1. Insurance providers need to remove blanket mental health exclusions in all insurance products as a priority, as these clauses treat all mental health conditions as if they were the same and treat all people with a mental health condition as homogenous and high risk.
2. Commission an independent study that collates and analyses the most contemporary mental health prevalence, prognosis and pricing statistical and actuarial data to produce a robust model that Australian insurers can use to enable an evidenced-based approach to assessing risk and decisions on insurance applications and claims.
3. Require insurers to implement assessment practices and develop insurance products which are informed by the findings of this statistical and actuarial study, and in keeping with the *Disability Discrimination Act*. (Recommendations 2 and 3 could be undertaken concurrently).

4. Insurers need to undertake a more granular risk assessment of people who disclose a current or past mental health condition that takes into consideration individual circumstances that are likely to influence their risk profile, including the full range of relevant risk and protective factors that impact on functioning and outcomes.
5. Update the Australian Human Rights Commission's *Guidelines for Providers of Insurance and Superannuation*, and consider measures to increase enforceability of the Guidelines. This update should clarify what constitutes 'other relevant factors' upon which insurers can rely to decline insurance or impose particular terms and conditions, to ensure that insurers are required to use a fair and balanced approach to risk assessment.
6. Ensure that industry and discrimination guidelines and Codes of Practice require insurers to notify applicants/policy holders in writing when insurance coverage is declined or a claim is refused for mental health reasons, and provide clear reasons for this, including a summary of the actuarial and statistical data and other relevant factors relied upon by the insurer to make the decision.
7. Streamline complaints mechanisms to enable a 'no wrong door' joint approach to investigating complaints that involves the cooperation of relevant bodies such as the Australian Human Rights Commission, Financial Ombudsman Service, Superannuation Complaints Tribunal and State or Territory-based human rights, anti-discrimination and equal opportunity bodies.
8. Reduce the timeframe for internal dispute resolution through the development and implementation 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.
9. Mandate public reporting of insurance complaints for both internal and external dispute resolution processes through either reporting to a relevant body or providing a public report. Public reporting information made available should include: a) how the complaint was addressed, or inversely why it was not; b) clear reasons for this, including a summary of the actuarial and statistical data and other relevant factors relied upon by the insurer or resolution body to make the decision; c) where the complaint was referred; and d) the outcome of the complaint including adherence to timeframes for resolution.
10. Consider and act upon *beyondblue's* recommendations provided to the Australian Government Treasury in response to an issues paper - *Review of the financial system external dispute resolution framework*<sup>A</sup>.
11. Enhance enforcement of the *Disability Discrimination Act 1992 (Cth)* by giving an independent body the power to proactively conduct random audits of decisions 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, rather than only investigating complaints.
12. Require insurers to report annually to an independent body instances of reliance on the exemption in the *Disability Discrimination Act 1992 (Cth)* relating to insurance discrimination, as well as the evidence/data relied on to justify this discrimination.

*beyondblue* is a national, independent, not-for-profit organisation working to promote good mental health and prevent suicide. Our vision is that all people in Australia achieve their best possible mental health. We create change to protect everyone's mental health and improve the lives of individuals, families and communities affected by depression, anxiety and suicide.

This submission has been informed by *beyondblue's* extensive work to improve access to insurance 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. *beyondblue* would also like to acknowledge the collaborative work we have undertaken with Mental Health Australia, the Public Interest Advocacy Centre and Victoria Legal Aid.

***beyondblue* is keen to work in collaboration with government to ensure that insurers do not unfairly discriminate on mental health grounds and apply sound, effective and proportionate judgement to individual insurance policy applications and claims, based on robust, contemporary statistical and actuarial data.**

## The facts about mental health conditions

### Summary of key points:

Mental health conditions are a range of clinically diagnosable conditions. As a group, mental health conditions are relatively common, however the prevalence rates for each specific condition is much lower.

A wealth of data exists on major conditions such as depression and anxiety, demonstrating that the severity of a condition can vary from mild, moderate to severe and that each condition also has its own typical age of onset, age and gender distribution and clinical course. It is therefore important to recognise that each condition is different and each individual's experience of a condition is different.

Effective treatments exist for the majority of mental health conditions and remission and recovery are the norm, although some people may experience relapses of their condition, or persistent symptoms.

Australian government policy emphasises the need for a joint whole-of-government and whole-of-community approach that requires every individual, group, organisation and community to assure the rights of people with mental health conditions and to enable them to participate meaningfully in society.

Tackling stigma and discrimination is a major emphasis of whole of government mental health policy.

### Definitions

**The World Health Organization defines mental health as more than the absence of mental disorders but as:**

*"a state of well-being in which an individual realises his or her own abilities, can cope with the normal stressors of life, can work productively and is able to make a contribution to his or her community".<sup>5</sup>*

Australia's National Mental Health Policy 2008 defines a mental illness in the following way:

*"A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD)".<sup>6</sup>*

While the DSM V and ICD-10 list numerous mental illnesses, the specific conditions that are of most public health significance in Australia include depression, anxiety, substance use disorders and psychotic disorders.<sup>7</sup>

The terms mental health conditions, mental disorders and mental illness are often used interchangeably. Based on feedback provided to us by people affected by depression and/or anxiety *beyondblue* prefers the term **mental health conditions** and uses this term throughout the submission to refer to mental illness.

### Prevalence

As a group, mental health conditions are relatively common. The 2007 National Survey of Mental Health and Wellbeing found that in the year prior to the survey around 1 in 5 Australians aged 16-85 had experienced a mental health condition at some point. The survey also found that over their lifetime, around 45 per cent of Australians reported that they had experienced some sort of mental health condition.<sup>8</sup>

However, when looking at specific conditions in isolation, the prevalence rates are substantially lower. For example, the 2007 National Survey of Mental Health and Wellbeing found the following 12 month and lifetime prevalence rates:

- Depressive episodes 4.1% 12 month prevalence, 11.6% lifetime prevalence
- Dysthymia 1.3% month prevalence, 1.9% lifetime prevalence
- Bipolar affective disorder 1.8% 12 month prevalence, 2.9% lifetime prevalence
- Panic disorder 2.6% 12 month prevalence, 5.2% lifetime prevalence
- Agoraphobia 2.8% 12 month prevalence, 6% lifetime prevalence
- Social phobia 4.7% 12 month prevalence, 10.6% lifetime prevalence
- Generalised anxiety disorder 2.7% 12 month prevalence, 5.9% lifetime prevalence.

It is also important to note that each condition demonstrates its own unique pattern of symptoms, age of onset, gender and age distribution and prognosis.

#### Case study:

A woman was badly bullied during her school years and as a result experienced depression, anxiety and an eating disorder. She was often unable to attend school, and began self-harming and attempted to take her life on a couple of occasions. She was prescribed anti-depressants at 14 and was eventually referred to a child and adolescent mental health service where she was able to receive the support that she needed to recover. She is now 25 and fully recovered.

In 2014 the woman applied for life insurance through her superannuation fund, using their online application form. As required, she disclosed her history and a couple of weeks later received a letter stating that all cover had been denied because of the depression, anxiety and eating disorder that she had experienced in the past. At no point was she contacted to provide further information or a doctor's report. Having experienced the stigma of mental illness for years as a teenager, the woman was not prepared to accept this decision, and contacted the insurer to question it. She was told that she presented an unacceptable risk, and would probably never get insurance through a super fund. In further contact with the company, she was told that online applications were dealt with using an automated system, and disclosures such as hers would lead to automatic refusal of cover.

The woman contacted *beyondblue*. She shared that "it disturbs me greatly to think about the number of people who would have received letters like mine and consequently have no insurance due to the discriminatory attitude of the company. Having worked very hard to survive and recover from my illness, encountering this situation so many years on is a real blow and I very much hope that the incidence of this can be dramatically reduced or eradicated in the very near future."

## Prognosis

Illness severity, and the impact on symptoms on daily functioning, varies widely from person-to-person and can range from mild, moderate to severe.<sup>9</sup> In addition, **each mental health condition demonstrates its own patterns of remission, relapse or persistence.**<sup>10</sup> For example, around half of people who experience an episode of depression will experience a single episode, recover completely and never experience future difficulties, while the other half may experience one or more future episodes or more persistent difficulties.<sup>11</sup> It is widely recognised that heterogeneity is very common in mood and anxiety conditions<sup>12</sup> and everyone's experience is therefore different and depends on a range of individual risk and protective factors, including access to appropriate treatment. Over the last two decades a large number of studies have been undertaken to map the epidemiology of particular mental health conditions to better understand their causes, likelihood, natural history and consequences. As a result, there is a substantial body of information that could be used by the insurance industry to guide their practices and policy development.

## Treatment

Effective treatments are available for mental health conditions, such as depression and anxiety. Mental health treatment needs vary for each condition across a wide spectrum of illness severity. This ranges from easy-to-access information, self-help programs, peer support, brief interventions from a trained professional, online e-mental health programs or general practitioner care, right through to comprehensive multi-disciplinary care provided by primary care providers, mental health specialists and psychosocial disability support agencies. **An individualised approach to assessment and treatment is required.**<sup>13</sup>

It is important to note that the treatment a person receives is often dictated by affordability, availability and personal preference and is not necessarily a reflection of the 'severity' of a person's condition, nor the likelihood of recovery. For example, a referral to a psychiatrist may occur because a GP is unsure of the diagnosis or management, rather than because the person is seriously unwell. Furthermore, seeing a psychologist, is not synonymous with having a mental health condition, since people may seek psychological advice for a range of reasons including relationship counselling.

## Government Policy

Mental health is one of Australia's national health priority areas. Governments make a substantial investment in mental health each year, including around \$10 billion from the Commonwealth Government alone.<sup>14</sup> Australia's National Mental Health Policies, National Mental Health Plans and the consultation draft of the 5<sup>th</sup> Mental Health Plan stress the importance of making mental health 'everyone's business' through a whole-of-government and whole-of-community approach. Crucially, **Australia's Mental Health Policy highlights the need to assure the rights of people with mental health conditions and to enable them to participate meaningfully in society**<sup>15</sup> and emphasises the importance of tackling stigma and discrimination.<sup>16</sup>

## The legal and regulatory context

### Summary of key points:

Insurance is an important protection against illness, injury and other unexpected events that can cause financial stress. Insurance providers play a crucial role in assisting every Australian to manage these risks, and are required to work within a legislative and regulatory framework, focused on industry sustainability and consumer protections.

A key principle is equity of access, including for people who experience a disability, such as a mental health condition.

Ostensibly, a number of protections are in place to ensure people with a mental health condition have access to insurance products.

Under section 46 of the Disability Discrimination Act, 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 or if no such data is available, or other relevant factors. In essence, while the *Disability Discrimination Act 1992* (DDA) provides some exemptions in regards to who can be excluded from access to insurance or have conditions imposed, these exemptions are meant to be the exception and not the rule.

The Australian Human Rights Commission has produced Guidelines for Insurance and Superannuation Providers to guide them in applying the DDA including the interpretation of other relevant factors. In addition, insurers are required to provide training to staff on issues of disability and mental health.

The General Insurance Code of Practice, a self-regulatory code that binds all general insurers who are signatories to it, sets out the standards that general insurers must meet when providing services to their customers, such as being open, fair and honest.

The Financial Services Council, issues standards which are compulsory for all full FSC members. This includes FSC Standard No. 21: Mental Health Education Program and Training in August 2013, which is intended to ensure insurance staff and representatives receive an appropriate level of education and training in relation to mental health awareness.

In October 2016, the FSC launched the life insurance industry's first-ever industry-led consumer Code of Practice for the Life Insurance sector. The Code doesn't not include up-to-date information or understanding of mental health.

The Insurance Contracts Act 1984 (ICA) 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 applicant

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 regulation and general consumer protections, there are specific legislative protections for people with a disability, including people who live with a mental health condition.



## Disability Discrimination Act 1992 (Commonwealth)

At present, the insurance industry is permitted to discriminate against a person with a disability, where certain conditions are satisfied. The relevant legislation governing this area is the Commonwealth *Disability Discrimination Act 1992* (DDA), as well as State and Territory-based anti-discrimination legislation. The DDA aims, as far as possible, to promote the rights of people with a disability, to participate equally in all areas of life. It does this by making it unlawful to discriminate against a person with a disability (including people with a mental health condition), subject to a number of exceptions intended to balance the rights of people with disabilities with those of other persons.<sup>17</sup>

Under section 46 of the 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 DDA also contains a more general exception to unlawful discrimination on the basis of unjustifiable hardship, which allows a provider of insurance or superannuation to discriminate against a person with a disability if they can show that providing cover, or otherwise avoiding the discrimination, would cause them unjustifiable hardship. The burden of proving that something would impose unjustifiable hardship rests with the provider of insurance or superannuation.

While these caveats exist, **the legislation emphasises the need to start from the perspective that a person with a disability, including a mental health disability, should be regarded and treated as equal under the law and with equal rights to the rest of the community.** In essence, discriminatory treatment should be the exception and not the norm.

## The Australian Human Rights Commission

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*.<sup>18</sup> Although the Guidelines are not regulations and are not binding, they usefully set out the AHRC's views and relevant case law to assist insurers to comply with the DDA, make decisions in individual cases and develop broader policies and procedures.

The DDA emphasises that any decision to refuse to offer insurance and superannuation or to adjust a product's terms and conditions, can only be justified if it is made on the basis of reliable data or if such data is not available on 'other relevant factors'. **While the meaning of 'other relevant factors' is open to interpretation, the AHRC's Guidelines provide some examples about what constitutes a 'relevant factor' including:**

- medical opinion;
- opinions from other professional groups;
- actuarial advice or opinion;
- relevant information about the individual seeking insurance, such as individual medical records and work history;
- commercial judgement.

Also of relevance to mental health and insurance discrimination, the Guidelines note that:

- A decision will not always be accepted as reasonable simply because it is based on actuarial or statistical data. The data must be reasonable to rely on, and the decision itself must be reasonable.
- Insurers should consider relevant factors that increase **or reduce the risk** associated with mental illness. For example, whether the applicant is receiving support and effective treatment for their illness so as to reduce risks associated with the condition.
- Insurers should be careful to avoid assumptions that people with disabilities, or people with the same general type of disability, will always present the same risks.
- Insurers should seek to ensure good communication with people who are insured or are seeking insurance, so that information is brought out which might reduce or eliminate the need for a negative decision.
- Manuals should be based on relevant actuarial or statistical data or medical opinion and updated as necessary to take into account advances in medical knowledge, rehabilitation and treatment, technology or other areas that affect the level of risk or loss associated with a particular disability.
- The practice of other insurers in the industry, and other relevant commercial practice including by reinsurers, may be taken into account in deciding what is reasonable. However it is not reasonable to refuse to insure a person with a disability simply because of historical practice, however widespread, or to rely on inaccurate assumptions about people with a disability.
- It would be prudent, before declining to offer insurance to a person with a disability, to consider whether risks can be managed by restricting the cover, using an exclusions clause, applying a premium loading, or some other means.
- Even if providing insurance or superannuation to a person with a disability might involve some costs and effort, it will not necessarily amount to unjustifiable hardship.

### **The Insurance Contracts Act 1984 (Commonwealth)**

The *Insurance Contracts Act 1984* (ICA) sets out relevant law governing insurance contracts in Australia, and aims to strike a fair balance between the interests of the insurer and the insured. Section 13 of the ICA requires each party to act towards the other party with the utmost good faith.

Section 75 of the ICA 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 applicant. If the reasons, or one of the reasons, concerns the state of health of the policy holder/applicant, the written reasons may be provided to a medical practitioner on behalf of the policy holder/applicant.

The Australian Securities and Investment Commission (ASIC) is responsible for the general administration of the ICA. The Financial Ombudsman Service (FOS) provides dispute resolution services between consumers and financial service providers, including insurers.

### **Industry standards and codes of practice**

In 2014, the *General Insurance Code of Practice*,<sup>19</sup> a self-regulatory code that binds all general insurers who are signatories to it came into effect. The Code of Practice sets out the standards that general insurers must meet when providing services to their customers, such as being open, fair and honest. The ICA has previously indicated that the Code of Practice is not an appropriate place to address anti-discrimination issues in detail, however it recognised that that it may be appropriate to have an overarching principle in the Code committing Code participants to working to satisfy the general insurance needs of the whole community regardless of financial situation, age or disability.<sup>20</sup>

The Financial Services Council (FSC), the industry association for the financial services sector, including the life insurance industry, issues standards which are compulsory for all full FSC members. This includes *FSC Standard No. 1: Code of Ethics and Code of Conduct*, which sets out ethical principles to guide decision making, and specific rules regarding certain conduct. The FSC also issued *FSC Standard No. 21: Mental Health Education Program and Training* in August 2013. The purpose of this Standard is to ensure insurance staff and representatives receive an appropriate level of education and training in relation to mental health awareness.

In October 2016, the FSC launched the life insurance industry's first-ever industry-led consumer Code of Practice for the Life Insurance sector.<sup>21</sup> *beyondblue*<sup>22</sup> and other consumer health organisations provided feedback to the Financial Services Council before the Code's release stating the importance of addressing mental health and improving access to insurance products for customers with mental health conditions. This request was met with a press release stating this issue of a mental-health specific standard will be addressed in the next iteration of the Code in 18 months' time.

One of the critical issues with the new Code of Practice is it only covers members of the FSC. This means that this 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. The Code of Practice will also have no impact on the current standard of death, total and permanent disability claims and income protection being offered inside super funds, some of which are difficult to claim.

Since the release of the Code, Kelly O'Dwyer, Assistant Treasurer of Australia/Minister for Revenue and Financial Services has stated that the FSC's Code of Practice be submitted to ASIC for approval, after which the government will give ASIC the necessary powers to enforce the Code of Practice.<sup>23</sup> However, FSC Chief Executive Ms Loane said the FSC's Code would be reviewed in 18 months "and one of the matters to be considered at this time will be code enforceability, including applying for ASIC approval."<sup>24</sup>

#### **Case study:**

A man suffered from severe depression in his early to mid 20's. Having got married at 21, with a child and a mortgage, it was a time in his life where he felt that he was unable to cope with financial stress and stress from his relationship issues, and he attempted to take his life on two occasions. During this time the man received counselling and was diagnosed with depression. From age 25 onwards, his depression began to lift. Today he is 45, has run a successful business with his new wife and has not had any symptoms of depression for 20 years. He and his wife have a house, an investment property and a child (plus another two from his first marriage) and are a very happy family. He notes that his depression has made him a very resilient person as he now deals with more day to day stresses than ever before but suffers no ill effects like he did in his early 20's.

About four years ago, he went to see his doctor when experiencing some financial stress and anxiety due to his business still being in its early stages. Because of his previous history, the doctor prescribed some anxiety medication and asked him to speak to a psychologist. However after a few sessions it was clear that he didn't need to continue treatment, as he felt that it was not the depth of depression that he had experienced before and was just part of the life experiences that ebb and flow.

As his business and assets have grown, he and his wife decided to review their life and TPD insurances to protect each other and their family in the event something unforeseen happened. The result has left him humiliated, having been advised that the underwriter will not agree to TPD cover because of his past mental health issues. He was open and honest about his past health issues as he didn't feel it would have any impact being some 20 years ago. The insurer requested his medical files from his doctor and subsequently refused TPD cover. "Having not experienced significant mental health issues since my mid 20's, I feel I have been discriminated against for what effectively feels like [it] occurred another lifetime ago"

## The reality of insurance discrimination

### Summary of key points:

Insurance discrimination among people with a mental health condition appears to be a common problem.

Discrimination takes various forms including outright rejection of cover on dubious or undocumented grounds, unreasonable terms and conditions including inflated premiums, and unfair denial or processing of claims.

Cases of discrimination appear to be driven by an under-reliance on available statistical and actuarial data and an over-reliance on opinions based on a deep misunderstanding of the nature of mental health conditions.

Policy wording commonly refers to symptoms (e.g. stress, insomnia) or risk factors (e.g. family history) as proxies for a diagnosed mental health condition. Insurers have also been known to attribute a mental health condition because someone has seen a counsellor or psychologist even if this contact was unrelated to a mental health condition (e.g. relationship counselling, career counselling).

Many people complain 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 discrimination contribute to stigma which produces considerable harm at the individual, community and economic level.

While there are some protections offered by legislation and regulation, this appears insufficient to stop legal, but potentially unethical, behaviour that does not reflect contemporary knowledge and attitudes to mental health conditions and that has impacts on some of the more vulnerable members of society.

Aggrieved consumers can make complaints through a variety of mechanisms, however, the process is complex and the burden falls on individuals to invest considerable time, money and effort into pursuing a complaint.

### The prevalence of insurance discrimination

As the preceding section demonstrates a number of safeguards are ostensibly in place to ensure that people with a mental health condition are given fair and equitable access to insurance products, to enable them to protect themselves and their families against financial stress and uncertainty. Sadly, the reality is starkly different.

Empirical evidence and anecdotal reports demonstrate that many people with a mental health condition 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.

In order to quantify the prevalence of these issues *beyondblue* and Mental Health Australia worked together to commission the *Mental Health, Discrimination and Insurance Survey of Consumer Experiences 2011*.<sup>25</sup> The survey involved 424 people living with or supporting someone with a mental health condition. **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.** Among those respondents who had applied for life and income protection insurance 80 per cent either agreed or strongly agreed that it was difficult for them to obtain insurance due to a mental health condition specifically in relation to these products.<sup>26</sup>

More recently, the Australian Securities Investment Commission released *REPORT 498: Life Insurance claims: An industry review*, which found that 6.4 percent of all life insurance complaints were related to mental health conditions experienced by the policy holder and over 85 percent of these disputes were related to claims. The majority of the mental health disputes were related to evidence, non-disclosure and other common issues such as delays in assessing claims, pre-existing condition definitions, general declined claims and the application of exclusions for suicide. This report confirmed the need for industry standards in the area of mental health to protect policy holders

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

Ella Ingram, now 21 years old, was issued with a travel insurance policy by QBE for a school study trip to New York when she was 17 years old. After commencing Year 12, prior to the departure of the school trip, Ella became unwell and was diagnosed by a psychiatrist with depression, and was subsequently voluntarily admitted to an adolescent psychiatric inpatient unit. This was the first time in her life that Ella had experienced depression. On doctors' advice, Ella decided she would be unable to go on the trip to New York, and then claimed under the policy for the cancellation costs of \$4292.

Ella's claim was refused by QBE, who relied on a general mental illness exclusion clause, which excluded coverage of any claims relating to mental illness. Ella Ingram challenged QBE's denial of the claim in the Victorian Civil and Administrative Tribunal (VCAT), and in December 2015 VCAT found in Ella's favour. VCAT found that QBE discriminated against Ella twice, firstly by issuing a policy which contained the mental illness exclusion clause, and secondly by refusing her claim based on that exclusion.

The Tribunal found that QBE did not produce sufficient evidence to prove that the discrimination was based on actuarial or statistical data. QBE accepted that it had no actuarial data on which to rely in respect of the inclusion of the mental illness exclusion in 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.<sup>27</sup>

QBE was found by the Tribunal as not being able to produce sufficient evidence that it would have suffered an unjustifiable hardship by removing the mental illness exclusion clause. The Tribunal member noted that *"There is an absence of sufficient material for me to determine that it would be an unjustifiable hardship for QBE to be unable to rely on the mental illness exclusion. The scales weigh in favour of people like Ms Ingram being able to be properly assessed on their policy claims in the same way people with physical disabilities are assessed."*<sup>28</sup>

Although the finding is limited to the circumstances of Ella's case, which concerns travel insurance, being the first test-case concerning insurance discrimination on the basis of mental illness in Australia, the case highlights critical issues in relation to broad, blanket mental health exclusions, and the importance of policy terms being informed by robust actuarial and statistical data and analysis.

## **Types of insurance discrimination**

Insurance discrimination can take many forms. Since 2013, *beyondblue* and Mental Health Australia have encouraged Australians impacted by insurance discrimination to contact *beyondblue* to share their stories.<sup>29</sup> Over this time, *beyondblue* has been contacted by several hundred people.

### **Refusal of coverage**

The *Mental Health, Insurance and Discrimination: A Survey of Consumer Experiences 2011* found that, across all insurance types, 22 per cent of respondents reported that their insurance application was declined due to a mental health condition.<sup>30</sup> This increased to 36 per cent in relation to life insurance, and 45 per cent in relation to income protection insurance.

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.

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.<sup>31</sup> The following are actual experiences that people have shared with *beyondblue* about being refused coverage due to their mental health condition or history:

*When my husband recently rang around for life insurance for both of us, he was fine but they got to me and stated that I could only be offered accident insurance due to having seen a doctor for depression. We tried several different companies, all with the same outcome. - Personal experience shared with beyondblue*

*I have had depression since a teenager (I am now 41). I take medication to regulate my condition and have had several episodes of severe depression in my life, however on a daily basis I'm able to work full-time in government, study for my Masters, and I just purchased my first home! I applied for Income Protection insurance through my superannuation company. I was directed online to the Insurers website where I filled out an application form. I truthfully advised that I had experienced depression in the last three years but less than three instances. Apart from an unlucky bout of pneumonia in 2012 I have had no other health problems. My online application was instantly declined. - Personal experience shared with beyondblue*

*I was diagnosed with Depression/ Anxiety when I was 18. My condition has been under control and well managed since the age of 23 through medication and under the care of my GP. I recently applied for income protection insurance through my superannuation provider and received written notification that my application was being refused because of my history of depression/ anxiety. Initially I felt ashamed but now it makes me angry. - Personal experience shared with beyondblue*

*First diagnosed with major depression and generalised anxiety disorder at age 16. Have been taking medication and seeing a psychiatrist on and off ever since. I completed an undergraduate degree and then a medical degree without taking any time off due to mental health. I also have never been admitted to hospital for mental health reasons. However, I was entirely refused income protection insurance. It had taken me 5 years to work up the courage to apply again. It is only now that I am self-employed and have two small children to support that I really must have income protection insurance. I am frightened that I will be refused outright again. - Personal experience shared with beyondblue.*

*A few years ago I had some mild panic attacks, in order to prevent them from happening again, this year I saw a psychologist to try and resolve the underlying issues. I still work full time in a high-intensity industry with no additional difficulty and never required medications. When answering an online questionnaire/application for income protection insurance, I was given a list of details to fill out after answering that I had experienced mental illness. I then described in detail that I had sought medical advice purely for referral to a psychologist to prevent recurrence of the condition, which I have since attended 2-3 sessions. I was then told that I needed a medical exam with a nurse, and after having all my results fall within normal limits, I was sent a letter saying that my application was refused and that I should try again in 6 months. - Personal experience shared with beyondblue.*

## Policy exclusions

The *Mental Health, Insurance and Discrimination: A Survey of Consumer Experiences 2011* 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.<sup>32</sup>

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.** This is akin to someone with a history of gastroesophageal reflux problems being excluded from cover for bowel cancer on the basis they are both gastrointestinal disorders.

While some people may experience more than one mental health condition at the same time or at another time in their life, this is definitely not invariable. The 2007 National Survey of Mental Health and Wellbeing found that only one in four people who had experienced a mental health condition in the past 12 months

had experienced more than one class of mental disorder – 75 per cent had not. Not all mental illnesses are the same, and in most cases a more limited exclusion would be appropriate.

As one respondent in the *Survey of Consumer Experiences* suggested:

*“I don’t trust insurance companies to not connect unrelated events to a mental illness.”*

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**. This approach would be akin to someone being given an exclusion for brain cancer on the basis of reporting a history of migraine headaches or a family history of migraine headaches.

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.

#### **Case study:**

A woman applied for income protection and total and permanent disability insurance through her superannuation. She ticked a box on the questionnaire to say that she had visited a counsellor in the past. She was referred to the counsellor by her GP, during a very challenging time in her life – her husband was dying after an eight-month stay in hospital, and she was working full-time and taking care of her four children. She sought out the counsellor to deal with what she thought would be the normal stressors of someone in her situation. Grief is a normal part of life, and she saw the counsellor to prevent the anxiety and grief from overtaking her. She continued to work and take care of her family.

The insurer offered a policy with an exclusion for any claims relating to mental illness. Yet she does not have any pre-existing condition – no diagnosis of depression or anxiety. Even after she complained about this and obtained a letter from her GP and counsellor to support her, these were disregarded and the exclusion clause was still put in place.

#### **Case study:**

A woman was diagnosed as an adult with Post-Traumatic Stress Disorder (PTSD) as a result of negative childhood experiences. Following consultation with her GP, she was given a mental health plan, and has seen a psychologist for the past two years. She expressed that she is functioning well, highlighting that her PTSD has not led to her taking any days off work.

She applied for life insurance, total and permanent disability insurance and income insurance. Her applications were accepted with the policy exclusion that any claim that involved a mental health issue would not be covered. She felt that even though she was taking positive steps to manage her mental health, the insurance company made a generalised assumption that the treatment and management of mental health conditions is the same for all individuals, and did not properly consider her personal experience or individual circumstances.

### **Paying increased premiums**

The *Mental Health, Insurance and Discrimination: A Survey of Consumer Experiences 2011* found that across all insurance types, 14 per cent of people received their insurance products with increased premiums because of their mental health condition. Sixteen per cent of people reported they had received income protection insurance with an increased premium, and 24 per cent reported an increased premium in relation to life insurance.<sup>33</sup>

*beyondblue* acknowledges the need for insurers to set premiums that reflect the level of risk that an individual presents to an insurer. However, the personal stories which are shared with *beyondblue* 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:

*"I was outraged at the premium I was asked to pay. For income protection insurance I was asked to pay 200% of the premium I would have paid had I not had a mental illness"* – Respondent to Survey of Consumer Experiences

beyondblue also regularly hears from people who have both a broad mental health exclusion, and increased premium loading applied to their policy:

*"Only one insurer would offer me TPD insurance. Mental health exclusion and 50% medical loading due to 'medical history'. So I am in fact being charged extra for the very conditions that are excluded from my cover. And yet I must consider myself lucky to even have the cover as this insurance company was the only one (out of about seven or eight) who offered me any cover at all. I can understand either medical loading or exclusions, but both?"* – Personal experience shared with beyondblue.

### Problems when making a claim

Among the respondents in the *Mental Health, Insurance and Discrimination: A Survey of Consumer Experiences 2011* 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.<sup>34</sup> Of particular concern, some people described experiencing a **prolonged claims process that sometimes spanned a number of years**.

*"The claim was accepted after about 5 years – they lost the original claim, then lost the next one, then delayed whilst sending me to a lot of specialists at my cost. Whenever the specialist reported in my favour they would send me to another at my cost. I never recovered the cost of specialists."* – Respondent to Survey of Consumer Experiences

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, while in other cases the reverse happens with other 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 case may exacerbate a person's mental health condition. Respondents in the *Survey of Consumer Experiences* 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.<sup>35</sup>

More recently, the Australian Securities Investment Commission 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**.<sup>48</sup> Within the same report they also state that:

*"For consumers, the intrinsic value of an insurance product is in the ability to make a successful claim when an insured event occurs. Not being able to successfully claim on life insurance in these circumstances can be financially devastating for the consumer and/or their family".*

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.<sup>48</sup>

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 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. This demonstrates unfair insurance practices that aim to find any excuse to not pay out a claim.
- **Insurers 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 cover.

In early 2016 in a joint Fairfax-Four Corners investigation questioned the practices of insurers (in this case CommInsure) are unfairly denying people coverage or rejecting and/or delaying claims, often based on flimsy diagnoses and outdated beliefs about mental illness.<sup>36</sup>

### Complaints and dispute resolution

There are a number of avenues in which complaints and appeals of insurers' decisions can be made. Many complaints are resolved through conciliation. While conciliation processes provide an opportunity for satisfactory resolution for the individual, **most cases settle on a confidential basis without an admission of liability on the part of the insurer.** As a result, the opportunity to set firm legal precedents, or to influence longer-term practice change, has been considerably constrained.

**The problem with the current approach is that the burden falls on individuals to invest considerable time, money and effort into pursuing a complaint.** A complainant-driven process, as is articulated in the *Disability Discrimination Act 1992 (Cth)*, can inadvertently disadvantage complainants as the process is often considered complicated and intimidating to individuals. This places an unreasonable burden on ordinary people who have been or suspect that they have been unlawfully discriminated by an insurer. Pursuing a complaint is incredibly time consuming, and the costs of bringing proceedings in a Court or Tribunal are often prohibitive for an individual. Pursuing a complaint can also be very stressful and be detrimental to a person's mental health.

Many people have described to *beyondblue* that dealing with the insurance industry's internal dispute resolution processes as a battle. Case studies have also reported that it is rare that an insurer will overturn a decision already made. These case study reports are supported by the recent Australian Securities Investment Commission REPORT 498 which found less than two per cent of disputed claims are resolved through internal dispute resolution.<sup>48</sup> Of particular concern, some people described experiencing a prolonged claims process that sometimes spanned a number of years.

[Ella Ingram's case against QBE](#)<sup>37</sup> was the first test case heard by a court or tribunal in relation to insurance discrimination and mental illness in Australia. Ella Ingram's case was unique, in that she chose to pursue her dispute with QBE to hearing for the broader public benefit despite the toll of protracted litigation. It took almost four years for Ella 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.

### Interactions with insurance providers

Consumer experiences that are reported to *beyondblue* suggest that dismissive and/or obstructive conduct within the insurance industry is common, and is particularly concerning given the negative impact that this can have on vulnerable people. In the *Mental Health, Insurance and Discrimination: A Survey of Consumer Experiences 2011* some 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.<sup>38</sup>

*“... I decided not to take up the product for the time being, because I felt discriminated against and deeply affected by the stigma and shame the whole process (answering the questions etc.) made me feel.”* - Respondent to Survey of Consumer Experiences

While there are some protections offered by legislation and regulation, this appears insufficient to stop behaviour that is legal, but potentially unethical. This has impacts on some of the more vulnerable members of the community.

## The impact of insurance discrimination

The negative impact of stigma and discrimination reaches further than the individuals who have directly experienced it and can affect others even if people don't experience it personally. When people with a mental health condition hear about others' experiences of discrimination – whether in relation to insurance or other matters – they begin to anticipate discrimination and may stop themselves from doing things due to the unfavourable treatment and discrimination that they anticipate experiencing. One of the major negative consequences of discrimination is that it may prevent people seeking treatment and support from a health professional for their mental health condition. It can also lead to non-disclosure of pre-existing conditions for fear of being rejected or having to pay increased premiums. Non-disclosure generally causes problems when a person is most vulnerable during the claims process.

While some insurance companies allow people with a mental health condition to purchase cover if they have not sought treatment for a given time period, this can actually serve as a disincentive for people to implement self-management and/or report mental health problems to a health professional and seek treatment. Policies and practices such as these conflict with the broad range of government policies which emphasise prevention and early treatment of mental health problems.

*“It is unfortunate that doing something to improve your health, i.e. a short voluntary admission to prevent illness by changing medication, means that you are punished by becoming ineligible for important things like insurance. This is a definitely a disincentive to seek treatment.”* – Respondent to Survey of Consumer Experiences.

*“A number of years back my long standing income protection insurer refused to increase my cover because I had a history of depression. To this day my income protection cover remains probably 15 years out of date because I had been advised by financial advisors not to give up what insurance cover I already had because I would not get cover with anyone else. What's more, despite being stable on treatment for a number of years, I was additionally told my only hope would be to come off medication and stay well for a few years - how helpful and potentially dangerous is that advice to a chronically depressed person.”* – Personal experience shared with *beyondblue*

*“My husband and I bought a house together and wanted to get (life, income protection and total and permanent disability) insurance as you do. We went through the questions with a bank rep, when along came the question ‘have you been on any long term medications in the past 5 years?’ to which I have, and when I informed them it was my antidepressants, my application was immediately rejected for all insurance, with no other products for policies available, even with increased premiums. How does this make you want to seek help for your conditions or even tell them the truth if you are going to be discriminated against?”* - Personal experience shared with *beyondblue*

If people do seek support and treatment they may do so later than they otherwise would, potentially requiring more intensive psychotherapy and/or medication usage than would have been otherwise needed.

It could be argued therefore that insurance discrimination runs directly counter to the Australian Government's, and each State and Territories government's emphasis on and considerable investment in mental health early intervention services, stigma reduction and mental health promotion more broadly.

## **beyondblue's efforts to improve insurance access in Australia**

### **Summary of key points:**

*beyondblue* and Mental Health Australia (formerly the Mental Health Council of Australia) have been concerned about insurance discrimination for over a decade.

During this period, the two organisations have tried to work in collaboration with key stakeholders, including representatives of the insurance industry, through regular discussions, correspondence and meetings.

To date, these efforts have had a limited impact on insurers' approaches to cover and claims assessment for people with a mental health condition. People continue to contact us to share their stories.

The issue of insurance discrimination among people with a mental health condition is not a new one. In 1993 the first *National Inquiry into the Human Rights of People Living with a Mental Illness* noted that "the question must be asked whether, in light of contemporary expert medical opinion, and the well-established success rates of treatment for mental illness, the insurance industry remains unjustifiably cautious – to the point of discrimination in its assessments of risk in this area".<sup>39</sup> Unfortunately, 23 years on, little has changed to improve access to insurance for people who live with or have previously experienced a mental health condition.

*beyondblue* has worked in collaboration with Mental Health Australia (MHA) for over a decade to improve insurance outcomes for people who have experienced a mental health condition. This has included extensive efforts over a period of 10 years to meet and work with the insurance industry to encourage them to change their policies and practices to improve access to insurance for people who have experienced a mental health condition. The following section outlines some of the actions taken by *beyondblue* and MHA.

### **MoU with health professional associations and life insurance sector**

From 2003 - 2011, *beyondblue* and MHA were engaged in a Memorandum of Understanding (MoU) with health professional associations, such as the Australian Medical Association (AMA) and the life insurance sector. The key objectives of the most recent MoU, which expired in February 2011, were to improve:

- access to information and education about mental illness and insurance processes for people with a mental illness, mental health professionals and insurance and financial planning sector staff
- complaints resolution for people who live with or support someone with a mental illness
- underwriting and claims practices for people with a mental illness.

The notable outcome of this MoU was the development of the '*Mental health and life insurance: what you need to know*' guides which provide people with information about the impact of having a mental health condition on insurance applications, how risk is assessed, and rights and responsibilities when making an application.

*beyondblue* acknowledge and welcome the work of SuperFriend. SuperFriend is a nationwide health promotion foundation that works in collaboration with industry superannuation funds, group life insurers and the mental health sector to facilitate initiatives for members of these funds. In 2015, SuperFriend published a best practice framework to support their members manage claims related to mental health.

## Mental Health Insurance Working Group

In September 2011, *beyondblue*, MHA and the Australian Human Rights Commission presented an Issues paper to the Insurance Reform Advisory Group (IRAG) convened by the Commonwealth Government Treasury. IRAG was a forum in which insurance consumer groups, insurers and other stakeholders could work with the Commonwealth Government to contribute to the fair, efficient and effective regulation of the insurance industry. As a result of the IRAG, the then Assistant Treasurer and Minister for Financial Services, and the then Minister for Mental Health established the Mental Health Insurance Working Group (MHIWG) in October 2011.

The MHIWG membership consisted of representatives from Government, the Financial Services Council, life and general insurance, superannuation and mental health sectors, and people with a mental health condition and their families and carers. Between November 2011 and April 2012 the MHIWG met four times. These meetings focused on data sources, the complaints process, and education and awareness.

At a MHIWG meeting in November 2012 *beyondblue* and MHA asked the insurance industry for a timeline for implementation of the actions described in a previously presented 'plan of action'. In December 2012, the Insurance Council of Australia and members of the insurance sector responded with a proposal for further discussions.

Considerable effort, time and meetings have been invested by *beyondblue* and MHA in attempting to resolve the issue through discussion. Disappointingly, these discussions have not resulted in any significant improvements for people with a mental health condition leading *beyondblue* to question the commitment of the insurance industry to take real action to address this widespread and long-standing issue.

## Solutions and recommendations

### Solutions and recommendations

It is clear from the quantitative and qualitative evidence that insurance discrimination is a significant problem in Australia. Moreover, the case studies which are shared with *beyondblue* cite interactions and experiences with a variety of different insurance companies.

This suggests that despite the supposed safeguards, **unethical and potentially unlawful discriminatory conduct is a systemic issue within the insurance industry**. Given this, it is *beyondblue's* view that there is a conflict and inconsistency between insurance industry practices and government legislation, policy and intent in the area of disability discrimination and mental health promotion which needs urgent attention.

***beyondblue* recognises that insurance companies need to make a profit to maintain commercial viability, but that this should not be at the expense of people living with mental health conditions – a fairer balance is required.** *beyondblue* also acknowledges that mental health conditions such as depression and anxiety are relatively common, thereby creating a need for careful risk assessment and management. In our discussions with the industry, we have been told that changes to the way mental health conditions are assessed and managed would significantly diminish insurers' profits and make them commercially unviable as a result. However, *beyondblue* is skeptical of these claims as we have not seen any evidence of relevant statistical data or actuarial modelling to support this claim. This lack of evidence was highlighted in the recent test-case of *Ingram v QBE*, where the Victorian Civil and Administrative Tribunal found that QBE had not produced sufficient evidence to demonstrate that it would experience unjustifiable hardship or increased financial losses by removing the general mental illness exclusion clause from its travel insurance policy.<sup>40</sup>

*beyondblue* therefore proposes the following solutions to reduce or prevent the problem of insurance discrimination among people affected by a mental health condition.

### Review blanket exclusions relating to mental health conditions

People who disclose a pre-existing mental health condition are often offered policies with broad, blanket exclusions of any claims relating to any type of mental health condition, even if unrelated to their current condition. **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 of mental health conditions.

Under the *Disability Discrimination Act*, insurers bear the responsibility of proving that policy clauses that discriminate on the basis of disability are substantiated by actuarial and statistical data, where that data is available. Because these broad, blanket exclusions relating to mental health conditions do not appear to be supported by available data these policy clauses should be removed by insurance providers as a priority.

### Recommendation

1. Insurance providers should remove blanket mental health exclusions in all insurance products as a priority.

### Increase the availability and use of statistical and actuarial data to inform practice and policies

*beyondblue* has seen very little evidence of any actuarial or statistical data that is used by the insurance industry in relation to mental health. On the basis of what we have heard, **it appears that the insurance industry are lumping together all mental health conditions as a group, rather than treating each mental health condition as a unique condition in its own right with a specific prevalence rate.** Furthermore, *beyondblue* has seen no evidence that the insurance industry is basing its decisions on readily available epidemiological data that relates to the typical trajectory of each specific mental health condition and the

types of risk and protective factors, including access to effective treatment that can modify these trajectories. Nor does the insurance industry appear to rely on the wealth of data from the Medical Benefits Scheme (MBS), Pharmaceutical Benefits Scheme (PBS), Australian Institute of Health and Welfare, Independent Hospital Pricing Authority and other sources that would enable it to calculate the likely costs of treatment of different mental health conditions at varying severities in order to inform its risk ratings and price settings.

This concern is supported by the findings of the Victorian and Civil Administrative Tribunal in *Ingram v QBE*, which found that QBE did not produce sufficient evidence to prove that a general mental illness exclusion clause within its travel insurance policy was based on actuarial or statistical data.<sup>41</sup> Furthermore, there appears to be an admission by the industry that they “do not have at its fingertips a large volume of data on mental health that would allow it to price mental health for risk”.<sup>42</sup>

In the apparent absence of such data or actuarial analysis within the insurance industry, **it appears that practices in relation to mental health are based on outdated and stigmatised views and myths, inaccurate stereotypes and assumptions about mental health conditions under the guise of ‘other relevant factors’.**

[I was told that] “...too many people were claiming for depression and they were not prepared to insure people with depression. They stated that people were claiming like they used to for back problems, that too many people could feign depression and make claims” - Respondent to Survey of Consumer Experiences.

Under the *Disability Discrimination Act*, insurers must use actuarial and statistical data to justify any discrimination on the basis of disability where that data is available. Some in the insurance industry claim they are using such data, although they have not been willing to put the relevant data on the public record. Others claim that robust data is not available and that they are forced to rely on other information. This latter argument is of considerable concern, since it appears to be used to justify a lack of rigour rather than to encourage efforts to correct this problem. **To the best of *beyondblue*'s knowledge, the insurance industry has done very little to obtain available data, or to invest in projects to create such data where it is not available.**

Given this lack of initiative, it is recommended that a specific independent study be commissioned to: investigate current sources of available data and the reliability and relevance of existing data for the purposes of insurance underwriting; address any data gaps through targeted projects; and translate this data into actuarial models that can produce appropriate, evidenced based calculations of risk.

## Recommendations

2. Commission an independent study that collates and analyses the most contemporary mental health prevalence, prognosis and pricing statistical and actuarial data to produce a robust model that Australian insurers can use to enable an evidenced-based approach to assessing risk and decisions on insurance applications and claims.
3. Require insurers to implement assessment practices and develop insurance products which are informed by the findings of this statistical and actuarial study, and in keeping with the *Disability Discrimination Act*. (Recommendations 2 and 3 could be undertaken concurrently).

## Promote individual risk assessment

Mental health conditions are influenced by a series of personal and environmental risk factors (such as life events and stressors, family history), but also protective factors (such as the support of family and friends, access to effective treatment). The Australian Human Rights Commission's *Guidelines for Providers of Insurance and Superannuation* highlight the need for underwriters and assessors to consider relevant factors that increase or reduce the risk associated with mental illness, for example, if the applicant is receiving effective treatment for their illness so as to reduce risks associated with the condition.<sup>43</sup>

*beyondblue* regularly hears stories which suggest that insurers are failing to consider individual circumstances, focusing on diagnosis (or worse still symptoms), rather than considering the type of

condition, its severity, prognosis, individual treatment plan, or how well a person is functioning in the various aspects of their life on a day to day basis. For example:

*“I don’t qualify for the income protection insurance, despite my letters explaining that my condition has never impaired my ability to work (I always worked full time) and despite a positive letter from my GP, this was still refused.”* - Respondent to Survey of Consumer Experiences

In the *Survey of Consumer Experiences*, people expressed that they were willing to accept compromise and that mental health conditions may need to be excluded from the policy if necessary - they just wanted to be treated individually.

## Recommendations

4. Require insurers to undertake individualised risk assessment of people who disclose a current or past mental health condition that takes into consideration individual circumstances that are likely to influence their risk profile, including the full range of relevant risk and protective factors that impact on outcomes.
5. Update the Australian Human Rights Commission’s *Guidelines for Providers of Insurance and Superannuation*, and consider measures to increase enforceability of the Guidelines. This update should clarify what constitutes 'other relevant factors' upon which insurers can rely to decline insurance or impose particular terms and conditions, to ensure that insurers are required to use a fair and balanced and approach to risk assessment.

## Improve transparency of decisions and complaints mechanisms

People report that insurers either do not give reasons for declined applications or they give very broad or generic reasons, which do not cite particular factors that were considered which are relevant to the individual.

*“They wouldn’t explain ... it was just ‘based on medical evidence’”* - Respondent to Survey of Consumer Experiences

*“Was told I was a risk due to ‘health problems’ did not elaborate on which ones”* - Respondent to Survey of Consumer Experiences

**Currently, there is a complex system comprising of multiple bodies who can hear complaints regarding insurance, depending on the nature of the complaint, relevant law and jurisdiction.** This includes the Australian Human Rights Commission, State and Territory based human rights, anti-discrimination or equal opportunity bodies, the Financial Ombudsman Service and Superannuation Complaints Tribunal. *beyondblue* hears stories of excessive time periods for complaints to be determined. For example, the median time from when a complaint is received to when the case is closed (determined) by the Superannuation Complaints Tribunal can exceed two years.<sup>44</sup>

The following recommendations are made to increase the transparency of insurers who seek to rely on the exemption, and provide people with a fairer and more streamlined process if they wish to make a complaint or challenge the decision of an insurer.

## Recommendations

6. Ensure that industry and discrimination guidelines and Codes of Practice require insurers to notify applicants/policy holders in writing when insurance coverage is declined or a claim is refused for mental health reasons, and provide clear reasons for this, including a summary of the actuarial and statistical data and other relevant factors relied upon by the insurer to make the decision.
7. Streamline complaints mechanisms to enable a 'no wrong door' joint approach to investigating complaints that involves the cooperation of relevant bodies such as the Australian Human Rights Commission, Financial Ombudsman Service, Superannuation Complaints Tribunal and state or territory based human rights, anti-discrimination or equal opportunity bodies.

8. Reduce the timeframe for internal dispute resolution through the development and implementation 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.
9. Mandate public reporting of insurance complaints for both internal and external dispute resolution process through either reporting to a relevant body or providing a public report. Public reporting information should include: a) how the complaint was addressed, or inversely why it was not; b) clear reasons for actions in point (a), including a summary of the actuarial and statistical data and other relevant factors relied upon by the insurer to make the decision c) where the complaint was referred; and d) describe the outcome of the complaint including adherence to timeframes for resolution.
10. Review *beyondblue* recommendations provided to the Australian Government Treasury in response to an issues paper reviewing the *financial system external dispute resolution framework*.

Given the difficulties that people with a mental health condition have experienced accessing insurance to date, we do not believe that the exemption for insurers under the *Disability Discrimination Act 1992* has operated in the spirit in which it was intended to apply. Currently the only way to test this is for an individual to pursue a legal complaint in a court or tribunal, which places an unrealistic burden on individuals who believe they have been unlawfully discriminated against by an insurer. It is imperative that insurers are held accountable for the privilege of being exempt from anti-discrimination laws.

Even in the rare case that these matters go before a court or tribunal, recent experience has demonstrated that this has not influenced the adoption of broader policy or practice change by the insurer. Although the Victorian Civil and Administrative Tribunal recently found that insurer QBE was not able to produce sufficient actuarial or statistical data to support the issuing of a policy to Ella Ingram that contained a blanket exclusion of any claims relating to mental illness,<sup>45</sup> this clause remains in place within QBE's travel insurance policy.

The new FSC Code of Practice for the Life Insurance sector does not address the issues relating to insurance access and discrimination for people with mental health conditions detailed in our submission to their draft code. A Code of Practice is already in place in relation to the general insurance industry, yet empirical evidence and anecdotal reports demonstrate that many people with a mental health condition continue to experience significant difficulties in accessing and claiming against different types of general and life insurance products. The ICA have previously indicated that the Code of Practice is not an appropriate place to address anti-discrimination issues in detail, however they recognised that that it may be appropriate to have an overarching principle in the Code committing Code participants to working to satisfy the general insurance needs of the whole community regardless of financial situation, age or disability.<sup>46</sup> This was in response to an Australian Law Reform Commission proposal to review and amend insurance industry codes to encourage insurers to consider the needs and circumstances of mature age persons.<sup>47</sup>

The following recommendations are made 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

11. Enhance enforcement of the *Disability Discrimination Act* by giving an independent body the power to proactively conduct random audits of decisions 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, rather than only investigating complaints.
12. Require insurers to report annually to an independent body instances of reliance on the exemption in the *Disability Discrimination Act* relating to insurance discrimination, as well as the evidence/data relied on to justify this discrimination.
13. The Senate Economics References Committee should review progress against its recommendations in 12 months' time



## Conclusion

This submission outlines the significant challenges and issues that people with mental health conditions experience in accessing and claiming against insurance products in Australia, compared to the rest of the population. This includes outright refusal of coverage, increased premiums or excessive exclusions on placed on policies. Furthermore, many people with a mental health condition experience difficulties in claiming against their insurance policies across the general and life insurance industries for products such as travel insurance, income protection insurance, total and permanent disability and life insurance.

The stories which are shared with *beyondblue* cite interactions and experiences with a variety of different insurance companies. This suggests that potentially discriminatory conduct is a systemic issue within the insurance industry more generally. Insurance brokers and financial planners also act as an interface for people in their access to insurance, and play a critical role in improving the quality of advice and respectful and non-stigmatising interactions with people with a mental health condition.

The issue of insurance discrimination among people with a mental health condition is a long-standing one, first highlighted in 1993 in the first National Inquiry into the Human Rights of People Living with a Mental Illness. Unfortunately, 23 years on, little has changed to improve access to insurance for people who live with a mental health condition. Although the law contains protections for people with a disability (including a mental health condition), practices appear to be skewed towards the interests of insurers, at the expense of the rights of insurance policy holders and applicants.

*beyondblue* is keen to work in collaboration with government on concrete actions for change so that insurers do not unfairly discriminate on mental health grounds, but instead apply sound, effective and proportionate judgement to individual insurance policy applications and claims, based on robust, contemporary statistical and actuarial data.

That said, we express considerable disappointment that after advocating for change for over a decade, and having received regular assurances from the insurance industry that they are working to make changes, there appears to be little to no positive changes for people and families affected by mental health conditions.

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