



Patron: His Excellency General the Honourable
Sir Peter Cosgrove AK MC (Retd)

7 March 2017

Committee Secretary
Senate Economics Legislation Committee
PO Box 6100
Parliament House
CANBERRA ACT 2600

Dear Committee Secretary

beyondblue welcomes the opportunity to make a submission to the Senate Economics References Committee in response to the *Inquiry into consumer protection in the banking, insurance and financial sector*.

beyondblue comments on the treatment and discrimination of people who have either a past or current mental health condition by the insurance industry when trying to access or claim on travel insurance and general insurance policies including life, income protection and total and permanent disability policies. We believe that discrimination within the insurance industry demonstrates failures in the current law and regulatory framework; the enforcement of the existing laws; and the significant personal and social impacts arising from these consumer protection failures.

In 2010, *beyondblue* and Mental Health Australia undertook a study into mental health, insurance and discrimination – *a Survey of Consumer Experiences*¹. This survey found that nearly half of the people with an existing mental health condition experienced some form of difficulty accessing or claiming on insurance. More recently, the *Australian Securities Investment Commission* released *Report 498: Life Insurance claims: An industry review*² which found that policy holders with a mental health condition faced a challenging burden to establish their condition to make a valid claim.

More needs to be done to protect consumer's rights within the insurance sector particularly, in relation to discrimination against people with mental health conditions who are applying for, or claiming on, insurance policies.

¹ 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>

² Australian Government Minister for Financial Services and Revenue The Hon Kelly O'Dwyer (2016). Release of ASIC report on claims handling in the life insurance industry. Accessed online on 7 March 2017 at <http://kmo.ministers.treasury.gov.au/media-release/092-2016/>

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I hope the attached submission will be of assistance in the Inquiry. If you would like to discuss any of the issues raised in the submission, please contact me on [REDACTED]
[REDACTED]

Yours sincerely

[REDACTED]

Georgie Harman
Chief Executive Officer
beyondblue

***beyondblue's* submission: Inquiry into consumer protection in the banking, insurance and financial sector**

About *beyondblue*

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.

For the past 15 years, *beyondblue* has been working to reduce discrimination by the insurance industry for people with mental health conditions when accessing insurance products.

In November 2016, *beyondblue* provided a comprehensive submission to the **Parliamentary Joint Committee on Corporations and Financial Services Inquiry** detailing the issue of insurance discrimination for people with mental health conditions and providing recommendations for change. ***beyondblue* recommends consideration of this submission to support the recommendations provided below.** This submission is enclosed and can also be retrieved from here:

[http://www.apf.gov.au/Parliamentary Business/Committees/Joint/Corporations and Financial Services/LifeInsurance/Submissions](http://www.apf.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/LifeInsurance/Submissions)

Terms of Reference a) Failures in the current laws and regulatory framework, and their enforcement

For further detail on this section, please refer to the Parliamentary Joint Committee on Corporations and Financial Services Inquiry – Legal and Regulatory Context pg.8.

People with a mental health condition are entitled to fair and equitable access to insurance products, to enable them to protect themselves and their families against financial stress and uncertainty. Despite this, 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.

The legal, regulatory and policy context relating to the insurance sector is complex with several different statutory agencies, industry associations, legislations and complaints bodies involved including 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.

Australian Human Rights Commission - developed a *Guidelines for Insurance and Superannuation Providers (2016)* to guide them in applying the DDA including the interpretation of other relevant factors³.

Financial Services Ombudsman and the Superannuation Complaints Tribunal - manage consumer complaints in relation to insurance.

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 by policy holder in writing.

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 honest⁴.

Financial Services Council (FSC) - 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.

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 health⁵.

However, even with all these codes, guidelines and regulatory bodies in place, *beyondblue* still regularly hears of stories of discrimination by the insurance industry against people with mental conditions when accessing insurance products. The current co-regulatory framework, which is reliant on industry compliance with standards and codes of conduct monitored and enforced by statutory bodies is not working.

Commonwealth Disability Discrimination Act 1992

At present, the insurance industry is permitted to discriminate against a person with a disability, where certain conditions are satisfied. Under section 46 of the Disability Discrimination Act 1992 (Cth) (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 or if no such data is available, or 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.

³ Australian Human Rights Commission (2005). *Guidelines for Providers of Insurance and Superannuation*. Accessed online 7 March 2017: <https://www.humanrights.gov.au/guidelines-providers-insurance-and-superannuation>

⁴ Insurance Council of Australia (2014). *General Insurance Code of Practice*. Accessed online 7 March 2017: <http://codeofpractice.com.au/>

⁵ Financial Service Council (2016). *Media Release - Code of Practice Life Insurance*. Accessed online on 7 March 2017 at http://www.fsc.org.au/downloads/file/MediaReleaseFile/2016_1110_MediaRelease_LifeInsuranceCodeofPractice_final.pdf

It is understood by *beyondblue* that the **insurance industry treats all mental health conditions as a single group, rather than treating each mental health condition (depression, anxiety, bi-polar etc.) as a unique diagnosis with relevant prevalence rates and prognostic characteristics**. From parts of the insurance industry, *beyondblue* has heard that they are using mental health related actuarial and statistical data as part of their product development, underwriting and claims processes, although it has not been released and shared on the public record to date. Other parts of the industry declare that robust data is not available and that other relevant information must be relied upon to make decisions. By treating all mental health conditions as a homogeneous group without adjustment for diagnosis, prognosis, risk and protective factors and individual variation, it is like treating all chronic physical conditions – heart disease, cancer, diabetes and arthritis – as a single group of conditions and making decisions relating to insurance accordingly.

Cases of discrimination appear to be driven by **an under-reliance on available statistical and actuarial data and an over-reliance on views of the nature of mental health conditions**, often based on deeply flawed understanding of these 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. Evidence suggests insurers may also attribute a mental health condition to someone who has seen a counsellor or psychologist, even if this contact was unrelated to a mental health condition (e.g. relationship counselling, career counselling).

When an application for insurance is declined, people have reported to *beyondblue* 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 *beyondblue* conducted a Survey of Consumer Experiences relating to insurance discrimination, 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”

The Insurance Contracts Act 1984 aims to strike a fair balance between the interests of the insurer and the insured. Section 13 requires each party to act towards the other party with the utmost good faith. *beyondblue* believes by not providing clear reasoning to a consumer in relation to their application denial, this is not acting in good faith nor is it providing the actuarial or statistical data need to justify their decision as required by the Disability Discrimination Act 1992.

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 Schedule (MBS), Pharmaceutical Benefits Scheme (PBS), Australian Institute of Health and Welfare (AIHW), Independent Hospital Pricing Authority (IHPA) 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.

Terms of Reference b) the impact of misconduct in the sector on consumers; and f) the social impacts of consumer protection failures in the sector

beyondblue and Mental Health Australia undertook a study into mental health, insurance and discrimination in 2010 – the *Survey of Consumer Experiences*⁶. 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. This demonstrates that **the failings of the insurance industry is having a significant impact on a large number of consumers**. To shed further light on this issue, since 2013 *beyondblue* has called for people to share their stories of unfair treatment or discrimination by insurers for mental health reasons. **We have received hundreds of stories telling us about seemingly arbitrary decisions around access, obfuscation and lack of transparency in the management of claims.**

Recently Ginger Gorman, an award winning Australian journalist, reported on her own discrimination by her insurance company [for both her life and income protection insurance](#) because she sought psychological support after being made redundant from her job as a journalist at the ABC and for having received treatment five years earlier for postnatal depression. She was discriminated against because she acted to protect her health.

The 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. Some survey respondents indicated that **insurance companies appeared to automatically categorise mental health conditions as high risk regardless of the person's individual circumstances**. Insurers made broad assumptions about a person's ability to maintain employment and their general level of functioning, which in turn had negative implications for their application. 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.

"... 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

The flow on effects of this discrimination contributes to stigma, which produces considerable harm at the individual, community and economic level. 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. 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.

⁶ 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>

“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.

It could also 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.

Dispute resolution

Many people described 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. 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

Disputed claims and/or lengthy delays can be **extremely stressful and in some cases 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. The issues in relation to claiming were recently exposed in a joint Fairfax-Four Corners investigation, which highlighted evidence that insurers (in this case CommInsure) are unfairly denying people coverage or rejecting and/or delaying claims, often based on weak diagnoses and outdated attitudes about mental illness.

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

Ingram v QBE Insurance (Australia) Ltd (Human Rights) [2015] VCAT 1936⁷

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.

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."

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.

⁷ QBE comment VCAT ruling. Accessed 6 March 2017: <https://www.qbe.com.au/about/contact-alerts/media-centre/press-releases/qbe-comment-vcat-ruling>

beyondblue's recommendations to improve consumer protection within the insurance sector

Product development

- Insurers must **remove blanket mental health exclusions in all insurance products** as a priority. 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; they are unfair and discriminatory.
- Insurers must **develop products and underwrite policies using the most contemporary mental health prevalence, prognosis and pricing data as well as using actuarial policy and claims data** to assess risk and make decisions about insurance applications and claims, keeping in alignment with the Disability Discrimination Act 1992.
- **Insurers must collect and use robust actuarial data involving mental health related policy applications, claims, disputes and underwriting processes**; the data must be collected in a usable and systematic format for future product development and policy underwriting. Evidence of this data must be regulated by an independent body.
- Insurers must **adopt standardised definitions** used across the insurance industry for disability insurance policies including mental health.

Consumer product sales

- Insurers need to undertake a more **individualised risk assessment of people who disclose a current or past mental health condition**. This assessment needs to consider individual circumstances that are likely to influence their risk profile, including the full range of relevant risk and protective factors that impact on a person's functioning and outcomes.
- Insurers need to make decisions to provide cover on the basis of **actual diagnosed conditions, not symptoms, or risk factors for conditions**.
- Insurers need to provide **simple short form product disclosure statements** to consumers in replacement of the current lengthy and confusing product disclosure statements.

Claims management

- **Mandate the implementation of industry and discrimination guidelines and Codes of Practice**, which 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.
- **Mandate public reporting of insurance complaints** for both internal and external dispute resolution processes through either reporting to a relevant body or providing a publically available report quarterly. 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.

- Undertake an **in-depth follow-up investigation** into the high rates of mental health claims disputes highlighted in their *Australian Securities and Investment (ASIC) Commission Report 498 Life Insurance Claims: An industry review*.
- A regulatory body needs to have increased powers to pursue civil charges against insurers **for breaches of good faith duties**. Currently ASIC does not have the regulatory remit to address 'unethical' practices across the financial services sector unless practices are unlawful.

Dispute resolution

- Implement an external dispute resolution system that **puts consumers' needs at its centre**, including those with a mental health condition.
- 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.
- **Reduce the timeframe for internal dispute resolution** through the development and implementation of clear and well-defined timeframes for a complaint to be addressed (30 – 45 days instead of 60 - 90 days). Increase adherence to these timeframes by **introducing benchmarks with penalties imposed for falling below these**.
- Implement *beyondblue's* [issues paper](#) and [interim report](#) recommendations from the Australian Treasury External Dispute Resolution and Complaints Framework consultation process to reduce the complexity and consumer confusion for people with mental health conditions seeking redress.