beyondblue
Depression. Anxiety.

15 March 2017

Manager
Financial Services Unit
Financial System Division
The Treasury
Langton Crescent
PARKES ACT 2600

RE: *beyondblue's* submission to the Australian Government Treasury *Design and Distribution Obligations and Product Intervention Power* consultation.

Dear Manager

beyondblue welcomes the opportunity to make a submission to the Australian Government Treasury's *Design and Distribution Obligations and Product Intervention Power* consultation.

Our 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.

Our recommendations focus on the critical need for the insurance industry to become much more sophisticated in their risk profiling of mental health conditions to prevent discrimination. To better inform product development and risk management, a structured and collaborative approach combining evidence, data and knowledge from actuarial practices, claims management, medicine, public health, and research is needed.

Action is needed to ensure that Australians living with either a past or current mental health condition are able to access and claim on insurance products to support themselves and their families during times of financial insecurity.

beyondblue wants to work 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

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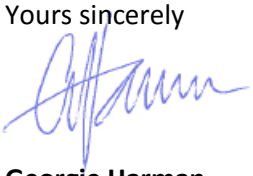
judgement to individual insurance policy applications and claims, based on robust, contemporary statistical and actuarial data.

I hope the attached submission will be of assistance. If you would like to discuss any of the issues raised in the submission, please contact me on georgie.harman@beyondblue.org.au or call 03 9810 6102.

Yours sincerely



Georgie Harman
Chief Executive Officer
beyondblue

beyondblue's recommendations for design and distribution obligations and product intervention power – insurance products & policies consultation

Design and distribution obligations

To improve product design and distribution of travel and life insurance products (including life, total and permanent disability and income protection); *beyondblue* makes the following recommendations to ensure legal, fair and ethical access to insurance products for people living with mental health conditions:

- Insurers need to develop robust and sophisticated risk profiles for each major mental health condition to inform insurance product development and risk management strategies.
- To develop robust risk profiles for mental health conditions, insurers need to combine and apply evidence, data and knowledge from actuarial practices, claim management, medicine, public health and research.
- To inform risk assessment protocols for policy applications and claims assessment, insurers should use the mental health risk profile used for product development. The risk assessment protocols need 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.
- To inform future product development, risk forecasting and risk management, insurers should be required to routinely collect actuarial data relating to policy applications (accepted or rejected) and policy claims (accepted or rejected) where a mental health condition or related risk factors was a part in the decision.
- The actuarial data collected by insurers needs to be standardised across the insurance industry and collected in a usable and systematic format.
- Standardised definitions for disability insurance policies including mental health need to be developed and adopted by the whole insurance industry.
- Insurers need to remove blanket mental health exclusions and processes that lead to the automatic inclusion of a mental health exclusion clause when a mental health condition is disclosed. 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 should be required to identify the appropriate target market for their product and carry out extensive and rigorous testing of their products for suitability, level of coverage provided and comprehension of the product features coverage provided.
- To increase consumer comprehension of insurance cover provided, legislate the implementation of simple short form product disclosure statements.

Product intervention powers

To improve product intervention powers for travel and life insurance products sold in Australia; *beyondblue* makes the following comments and recommendations:

- *beyondblue* agrees that the *Australian Securities and Investment Commission (ASIC)* should have the authority to intervene on a product or product feature on either a market wide (class) basis or an individual basis through: disclosure obligations; warning statements; advertising and marketing documents; features of the product and banning the product and distribution channels.

- *beyondblue* agrees that ASIC should have the authority to publish information on interventions that involve consumer detriment especially when it involves either a class of products, a product feature or an individual product discriminates against people with mental health conditions.

- *beyondblue* recommends the proposed design and distribution obligations and the products intervention powers recommendations should be implemented not only on retail insurance products but also on group life insurance products sold in Australia. In Australia, over 14.8 million people have a superannuation accounts which includes an opt-out system for group life insurance policies including income protection, total and permanent disability and life insurance.

- *beyondblue* recommends the 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.

- *beyondblue* recommends undertaking 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* to continue to inform product development and distribution obligation for insurers.

- *beyondblue* recommends increasing ASIC's authority to pursue civil charges against insurers for breaches of good faith and to be able to address 'unethical' practices across the insurance sector.

beyondblue' s submission: Design and Distribution Obligations and Product Intervention Power

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.

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.

For the past 16 years, *beyondblue* in partnership with other organisations such as Mental Health Australia and community legal centres, has worked to address discrimination by the insurance industry for people with mental health conditions when accessing insurance products. Potentially unlawful discrimination occurs in the form of refusal to provide insurance cover, increased premiums and delays or rejections during the claiming process. Insurance discrimination occurs across the insurance product range including travel, life, total and permanent disability and income protection insurances.

Mental health conditions

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".*[i]

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)*".[ii]

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.[iii]

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.[iv]

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.

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.[v] In addition, **each mental health condition demonstrates its own patterns of remission, relapse or persistence.**[vi] 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.[vii] It is widely recognised that heterogeneity is very common in mood and anxiety conditions[viii] 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 and support

Effective treatment and support 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, treatment and support is required**.[ix]

It is important to note that the treatment a person and support they receive 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.

Legal and regulatory context

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

At the Commonwealth level, the insurance industry is governed by two primary pieces of legislation—the *Insurance Act 1973 (Cth)* and the *Insurance Contracts Act 1984 (Cth*).

The insurance industry in Australia is regulated by a prudential regulator and a corporate regulator. The prudential regulator is the Australian Prudential Regulation Authority (APRA), which is responsible for general administration of the *Insurance Act 1973*. APRA has the authority to set prudential standards for the general insurance industry and has developed a detailed framework of prudential standards and practice guides. The corporate regulator is the Australian Securities and Investments Commission (ASIC), which is responsible for, among other things, the general administration of the *Insurance Contracts Act 1984*, monitoring and promoting market integrity and consumer protection and licensing.

The Insurance Council of Australia (ICA) is the representative body of the general insurance (not life insurance) industry in Australia. The ICA oversees the General Insurance Code of Practice—a self-regulatory code that binds all general insurers who are signatories to it. The Financial Services Council (FSC) is the industry association for the financial services sector, which includes the life insurance industry. Compliance with the FSC Code of Ethics and Code of Conduct and the FSC Code of Practice Life Insurance is compulsory for all FSC members.

Another key legislative regime with bearing on the insurance industry is the Commonwealth Australian Human Rights Commission *Disability Discrimination Act 1992 (Cth) (*DDA), under which there are a number of exemptions for insurance. 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.

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* understand the industry is 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.

Ingram v QBE Insurance (Australia) Ltd (Human Rights) [2015] VCAT 1936[1]

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.

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

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*.[x] The survey involved 424 people living with or supporting someone with a mental health condition. 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.** 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. [xi]

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.

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.

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.[xii] 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.[xiii] 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.[xiv] 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*
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> *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*
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> *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.[xv]

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.[xvi]

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.[xvii] 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.[xviii]

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**.[48] 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.[48]

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.[xix]

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**.**[48] Of particular concern, some people described experiencing a prolonged claims process that sometimes spanned a number of years.

Ella Ingram's case against QBE[xx]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.[xxi]

> *" … 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 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.

> *"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.

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.

> *"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.

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.

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 with little or no transparency on the rationale for these decisions. 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.

beyondblue understands that not every risk is insurable. What *beyondblue* wants to see is the accurate use of medical, public health, research and policy and claims actuarial data in product development and risk management for travel and life insurance products including total and permanent disability, life and income protection.

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.

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