Mental Health Australia

mhaustralia.org

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

## SUBMISSION BY MENTAL HEALTH AUSTRALIA

October 2018

Mentally healthy people,
Mentally healthy communities

# Background

Mental Health Australia is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector and committed to achieving better mental health for all Australians. Our members include national organisations representing consumers, carers, special needs groups, clinical service providers, public and private mental health service providers, researchers and state/territory community mental health peak bodies.

Mental Health Australia has been working in partnership for some years with beyondblue and the Public Interest Advocacy Centre (PIAC) to draw attention to the issues people with mental illness face accessing the insurance market on fair terms. We welcome the opportunity the Royal Commission's Round 6 hearings provide to raise policy issues of long-standing concern, and propose some solutions for the Commission's deliberation.

Mental Health Australia in particular commends PIAC's submission to the Commission from April 2018, which provides a comprehensive account of the range of barriers PIAC's clients with mental health issues have faced in pursuing their legal rights with insurers. That submission also sets out a number of legal and regulatory solutions which Mental Health Australia supports.

# Response to specific questions

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

Laws are currently in effect which in theory provide some protection for consumers with prior or current mental health conditions who cannot access the insurance market on fair terms. One of the most important elements of the current regulatory regime is section 46 of the *Disability Discrimination Act 1992* (Cth) (DDA). A discussion of the DDA's more significant aspects is set out under Question 19.

Mental Health Australia is concerned that:

- These laws are not sufficiently enforced, breaches are not monitored or reported in any systematic way, and there is no way of knowing where breaches go unreported
- The onus is on individual consumers to pursue their rights under law through processes that can be time-consuming, confusing and adversarial, adding a significant financial and emotional burden through taking such action
- It is unclear to consumers how they should seek redress for their particular problem, with different external dispute resolution avenues available and different laws applicable depending on individual circumstances
- For many years there has been insufficient incentive for insurers to change their own practices to reflect their obligations under law.

People with mental health issues encounter problems in relation to life insurance, TPD insurance, income protection and travel insurance. In broad terms, some of the problems consumers experience include:

- Insurers unreasonably limiting or denying cover following disclosure of a past or current mental health condition
- Insurers underwriting policies in ways which do not reflect a contemporary understanding of mental health
- Insurers confusing the signs and symptoms of mental illness with diagnosable conditions, imputing a mental illness from treatment sought, conflating a previous illness with a current condition, and otherwise misinterpreting medical or other evidence
- Insurers unreasonably cancelling policies for alleged non-disclosure of past mental health conditions
- Internal dispute resolution processes that are slow, not transparent and that can exacerbate a mental health issue, thereby undermining natural justice

- Claims handling staff taking an overly adversarial approach to external dispute resolution processes.

The extent of consumer detriment associated with these problems is significant: we suggest the numbers of people affected in some way would dwarf the complaints statistics through internal and external dispute resolution mechanisms. This is because a great many people who are currently insured may not be aware that their policies are subject to blanket exclusion clauses covering all mental health conditions.

The implications of this are important, particularly in the life insurance sector. In one part of the market, many Australians without a history of mental illness are not insured in the case of a mental health claim, but are under the impression that they are covered, unless they have read their product disclosure statements in detail (something we know happens rarely). Only those who ultimately go on to make a mental health claim will then discover they are not covered, with all the financial and other consequences that entails.

In another part of the market, a different group of Australians are insured in the case of a mental health claim – whether they have a history of mental illness or not.

The first group hold a retail or direct life, TPD or income protection policy, or a group insurance policy underwritten with extra cover. The second group hold default group insurance offered under employer superannuation policies, since these policies are not underwritten and are not subject to such exclusion clauses.

In Mental Health Australia's view, the ability to access insurance cover for mental health-related claims should not depend on an individual's or their employer's choice of superannuation fund, or whether they happen to work in an occupation or for an employer that provides access to default group insurance. This has never been an acceptable arrangement for those individuals who remain without cover and it does not represent good public policy.

While the life insurance market is complex and evolving, and not all policies on the market include blanket exclusion clauses, for a long time there has been sufficient consumer detriment to warrant further regulatory action.

Indeed, Mental Health Australia has been working for many years to seek changes that would improve access to the insurance market for people with mental health issues. We have been involved in various formal and informal processes over the life of several governments, notably including:

- Participating in a working group of the Insurance Reform Advisory Group, set up by the Rudd Government
- Giving evidence to the Senate Standing Committee on Legal and Constitutional Affairs as it considered the consolidation of Australia's human rights and discrimination legislation
- Giving evidence to the Joint Parliamentary Committee on Corporations and Financial Services as part of its Inquiry into Life Insurance
- Assisting the Australian Human Rights Commission as it considered the redrafting of its *Guidelines for Providers of Insurance and Superannuation under the Disability Discrimination Act* 1992 (Cth)

- Providing information and/or making submissions to the Australian Law Reform Commission, the Australian Competition and Consumer Commission, Treasury and the Australian Securities and Investments Commission
- Participating in a great many discussions with industry representatives, government officials and parliamentarians.

Throughout this work, Mental Health Australia's arguments have almost always been well received, but none of these processes led to concrete change. We believe that is because none of them were dedicated solely to finding a set of solutions to the problems people with mental health issues face in relation to insurance; instead they had a broader purpose, with the issues described above ultimately getting lost in other agendas, however well-intentioned.

Bearing that history in mind, Mental Health Australia suggests that one option open to the Royal Commission is to recommend a further dedicated process to consider how these issues are to be further advanced, noting the Commission could not give them a full airing given its time limitations and ambitious scope of work. Such a process could explore:

- Any progress following the recommendations specifically relating to mental health from the recent *Inquiry into the Life Insurance* Industry by the Parliamentary Joint Committee on Corporations and Financial Services
- Further examination of issues of underwriting, data and actuarial practice. As explained under Q19, these issues must be addressed if we are to see more accurate risk assessment and fairer treatment with respect to people with mental illness. This could involve the possibility of independently assessing the data currently held by insurers and re-insurers, to identify what data is and is not available to support particular underwriting practices, and a possible role for the Australian Government Actuary, recognising sensitivities regarding proprietary data
- Measures to increase the transparency of industry practice in relation to the issues outlined above, both for individuals affected and for the broader community
- The current and prospective role of independent agencies (the Australian Human Rights Commission, the new Australian Financial Complaints Authority, the Australian Securities and Exchange Commission and the Australian Competition and Consumer Commission) in investigating systemic issues and individual complaints, including issues and complaints relating to underwriting and actuarial practice. The role of the Australian Financial Complaints Authority in relation to investigating complaints about insurance offered on 'non-standard terms' is uncertain at this stage, making it difficult for consumers to know how to pursue their rights through external dispute resolution means through the new consolidated body
- Standardisation of particular terms and concepts that have historically proved problematic (see Q6), and examination of whether the questionnaires insurers use at the time of application are fit for purpose
- Consideration of the role of Codes of Practice in improving practices across the industry, including whether and how these should be binding, and what other mechanisms might be available.

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

The following products should not be sold:

- Life insurance, TPD insurance, income protection and travel insurance policies with blanket exclusion clauses for all mental health conditions, including exclusion clauses which refer to the signs and symptoms of mental health conditions (such as 'stress' or 'fatigue') or behaviour (such as 'suicide attempt')
- Life insurance, TPD insurance, income protection and travel insurance policies which automatically decline cover for applicants who disclose a history of mental illness. Instead applicants should be referred to an appropriately qualified underwriter who can obtain further information relevant to the application for insurance
- Life insurance, TPD insurance, income protection and travel insurance policies which impose general exclusion clauses for all mental health conditions where someone discloses a history of mental illness. Instead the exclusion clause should be as narrow as possible and relate to the pre-existing condition only, unless the insurer can conclusively demonstrate that there is an increased risk of the applicant making a claim for other conditions that are also excluded from cover based on relevant and up to date actuarial or statistical data upon which it is reasonable to rely.

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

From a mental health perspective, there is substantial scope for greater use of standardised definitions of key terms in insurance contracts.

There are a range of terms used by insurers, both in insurance contracts and in questionnaires asked at the application stage, that are poorly defined and do not reflect a good understanding of mental health. Some examples are provided below.

The term *episode* (as in *when was your last episode of mental illness?*) is hardly ever defined but commonly referred to by insurers. Depending on the definition, an episode of depression could range from a sleepless night (at the mild end) to a hospitalisation (at the severe end).

Insurers sometimes stipulate in contracts that a certain period elapse since someone receives *treatment* for mental illness, without defining what constitutes treatment. (Concerningly, requiring that somebody refrain from seeking treatment as a condition of receiving cover actively discourages help-seeking – something which is not in anyone's interests and works against messages all governments actively promote.)

Insurers also ask whether an individual has been *diagnosed* with a mental illness or mental health condition. While that person may well have been diagnosed with one condition or another, they may not be aware of that fact. If an insurer later uncovers a clinical diagnosis the individual remained unaware of (in clinical notes or a doctor's report), they may allege the insured party breached their duty to disclose all relevant information and seek to avoid the

policy under Section 29 of the *Insurance Contracts Act 1984* (Cth). There are also significant differences between the way clinicians use diagnostic terminology and ordinary consumers use language relating to a mental health issue, which can also lead to misunderstandings if precision in the use of terminology is needed for purposes like insurance applications.

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

The Royal Commission regards Question 19 as applying to the 'claims' practices of insurers. While the issues at stake can be understood in a narrow sense as arising from the claims process alone, there in fact are more significant issues to consider if this Question is also addressed through an underwriting lens, and with reference to the obligations of insurers under the *DDA*. The case study relating to TAL's second Insured party (Rubric 6-45) can be understood from an entirely different perspective if these obligations are considered. From this perspective, the Commission may well reach alternative conclusions, both about TAL's conduct towards the second Insured party, and about how consumers can be protected through regulatory and other means.

Section 46 of the *DDA* prohibits insurers from discriminating against someone on the basis of a disability (including a mental health condition), unless the discrimination is:

a. Based on actuarial or statistical data that is reasonable for the insurer to rely on; and

b. The discrimination is reasonable having regard to that data and all 'other relevant factors'.

If statistical or actuarial data is not available or reasonably attainable to assess the risk, an insurer may justify its discrimination by relying solely on all 'other relevant factors'.

The Australian Human Rights Commission (AHRC) has issued *Guidelines for Providers of Insurance and Superannuation under the Disability Discrimination Act* 1992 (Cth) which set out in some detail what these obligations mean in practice.

Without reproducing the AHRC's *Guidelines* here, it is worth emphasising:

- An insurer cannot rely on only those 'other relevant factors' it chooses to pay regard to; it must look at all other relevant factors. These include factors that would lower an individual's risk of claiming as well as factors that raise that risk
- An insurer should take into account the individual's particular circumstances, rather than taking a standardised approach to everyone in a certain situation (e.g. people with a history of mental illness), even where the insurer has actuarial or statistical data that would otherwise justify a standardised approach
- It is unlawful to refuse to insure a person with a disability (such as a mental illness) simply because the provider does not have any data if it would otherwise be reasonable to insure them having regard to other relevant factors
- It is unlawful to refuse to insure someone with a disability (such as a mental illness) merely because of historical practice.

Mental Health Australia is not aware of any data that would support the practice of denying a claim for a health condition based on a completely unrelated mental health condition, whether or not their mental health condition was disclosed at the time of taking out a policy. We believe that is because such data does not exist or is not for this purpose.

For their part, when asked to provide data, insurers typically claim that their data is commercially sensitive, so it is impossible to test whether insurers (or their re-insurers) do possess relevant data, and whether they are applying it reasonably to the circumstances of people with mental health conditions.

Where data might exist in this area, in Mental Health Australia's view it would apply only in limited circumstances (i.e. studies linking the risk of specific physical health conditions to specific mental health disorders). In practice, insurers apply general exclusion clauses which cover a range of mental health disorders, as reflected in the question TAL asked the second Insured in its 26 September 2013 telephone call:

> *Have you ever had or received medical advice or treatment for any of the following… depression, anxiety, panic attacks, stress, psychosis, schizophrenia, bipolar disorder, attempted suicide, chronic fatigue, post-natal depression, or any other mental or nervous condition?* (WIT.0001.0141.0001, Rubric 6-45, p.16, paragraph 42).

These 'catch-all' questions are reflected in policy wording that is commonplace across the life insurance industry.

In Mental Health Australia's view, it is inconceivable how data could exist which would definitively link:

a) the presence, prior diagnosis of, or past treatment for, each and every one of these mental health conditions, signs and symptoms and behaviours (since not all of the items listed are disorders *per se*), with

b) an increased risk of every other one of the same mental health conditions, signs and symptoms and behaviours in the same list, and/or

c) an increased risk of developing a range of physical health conditions, to the point of making someone with the presence, prior diagnosis of, or past treatment for, any mental health condition effectively uninsurable.

Under Section 46 of the *DDA*, such data would need to exist in order to justify the automatic refusal to provide cover to someone with a mental health condition.

If insurers do not possess such data, their only option (as set out under the *DDA* and the AHRC's *Guidelines*) would be to consider 'other relevant factors', before making a decision about whether to provide an individual with cover. Because such factors must include the individual's circumstances, the insurer's standard practice cannot (if it adheres to the *DDA*) be to deny cover to someone with a history of mental illness. This would remain the case whether the insurer discovers information about the mental illness at the time of application for insurance, or at the time of claim.

Of course there are circumstances in which an insurer may consider 'other relevant factors', including an individual's personal circumstances, and decide that they present an uninsurable risk. They may also decide that a premium loading or a narrow exclusion be applied to the policy in response to the information uncovered. Through such a process, an insurer acting in good faith would thereby discriminate fairly between people presenting at different levels along a continuum of risk.

However, Mental Health Australia believes that many people with a mild mental illness (with a correspondingly mild impact on their lives and their employability) are being assessed by insurers as presenting the same risk of making a life insurance or income protection claim as people with severe and enduring mental illness – and are as a result either being excluded from all cover associated with any mental illness, regardless of whether it is related to the original condition, or (worse) being refused cover altogether.

With just under one in two Australians experiencing the symptoms of mental illness at some point in their lives, but only 2-3 per cent having a severe mental illness, the size of the population where better decisions are needed about presenting risk is substantial. In not applying more granular underwriting criteria for people with mental illness, Mental Health Australia questions whether the behaviour of insurers is consistent with both the letter and the intent of the *DDA*, as explained in the AHRC's *Guidelines*.

Turning to the case study example of TAL's second Insured party, TAL concedes that some of its conduct fell below community standards and expectations in relation to the Insured (e.g. 'Some of the communication… was not of the standard that TAL would expect… there was [not] sufficient empathy'). (WIT.0001.0141.0001, Rubric 6-45, p.28, paragraph 108.)

Despite these admissions, TAL contends that it would still have declined to provide cover to the Insured altogether had it known about her mental health history at the time of application:

> *Clinical notes indicate that the insured had pre-existing depressing in 2007, 2008, 2009. Based on the medical evidence obtained underwriting would have declined cover due to the prior history of depression…*
>
> *TAL would not have entered into a policy on any terms therefore the recommendation is to maintain the decision to avoid the policy based on the remedy 29(3) of the insurance contracts act.* (WIT.0001.0141.0001, Rubric 6-45, p.25-6, paragraph 93.)
>
> *As to the decision itself, I believe that the appropriate decision was made.* (WIT.0001.0141.0001, Rubric 6-45, p.8, paragraph 112.)

TAL is indeed correct that since 2013, Section 29 of the *ICA* has given insurers significant power to avoid policies where it is deemed policy holders did not make adequate disclosures at the time of application.

This provision does not however exempt insurers from Section 46 of the *DDA*, as explained above. To underscore the point, even if TAL were entitled to avoid the Insured's policy under Section 29 of the ICA, Section 46 of the DDA would still require TAL to have actuarial or statistical data that would justify such a decision – noting that TAL was suggesting it 'would not have entered into a policy on any terms'.

To the best of Mental Health Australia's knowledge, no insurer in Australia has yet been able to conclusively demonstrate they have data that would reasonably justify either imposing blanket exclusion clauses relating to all mental health conditions (or the signs and symptoms thereof) or declining cover altogether to people who disclose a prior or current mental health issue. Mental Health Australia has reached this conclusion after many years of requesting such information from insurers. It may be that re-insurers, some of whom are based overseas, hold relevant data; certainly re-insurers appear to wield significant influence over the practices of the insurers who use their underwriting manuals.

To return to the question put by the Royal Commission, insurers should be prevented from denying claims based on the existence of a pre-existing condition that is unrelated to the condition that is the basis for the claim, where there is no relevant actuarial or statistical data to rely on, and/or where there are no other relevant factors to support such practices. In fact, denying claims in this way – as well as automatically denying applications for insurance, and applying blanket exclusion clauses – where data does not exist to support those practices is already unlawful. The challenge for policy-makers, regulators and industry bodies is to ensure better adherence to law and regulation.

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

Life insurers who seek out medical information for claims handling purposes should be required to limit that information to information that is relevant to the claimed condition.

The Parliamentary Joint Standing Committee on Corporations and Financial Services considered this issue at some length as part of its recent Inquiry into Life Insurance. Mental Health Australia strongly supports the intent behind recommendations 8.1, 8.2, 8.3, 8.4 and 8.5 from the Inquiry's Final Report (reproduced below). Actions reflecting those recommendations (or similar) will promote more targeted and appropriate information-seeking by insurers, and help prevent or reduce the extent of irrelevant information provided and misinterpretations made, including the so-called 'fishing expeditions' referred to in the Round 6 hearings.

Mental health consumers report concerns about seeking help for mental health issues from their GP lest their disclosures appear in case notes and have a detrimental impact on their ability to access insurance cover or claim on their insurance in future. With long-established government policies and considerable public resources aimed at encouraging help-seeking for mental health issues, it is very unfortunate that the way insurers uncover information can in practice undermine public health outcomes in this way. Reassuring consumers about the circumstances in which their disclosures will be revealed (and not revealed) is an important consideration when designing new or alternative systems for accessing sensitive information for insurance purposes.

*Recommendation 8.1*

*The committee recommends that:*

- *the Financial Services Council and the Royal Australian College of General Practitioners collaborate to prepare and implement agreed protocols for requesting and providing medical information;*
- *the Financial Services Council develop a uniform authorisation form for access to medical information at the time of application and at the time of claim that must be used by all of its members;*
- *this uniform authorisation form explain to consumers/policyholders in clear and simple language how information will be stored and used by third parties; and*

- *a consumer/policyholder should be able to use the same uniform authorisation form between different life insurers and different life insurance products.*

*Recommendation 8.2*

*If the Financial Services Council and the Royal Australian College of General Practitioners have not agreed to protocols within six months, the committee recommends that at the time of application, life insurers must only ask a consumer's General Practitioner, or other treating doctor where relevant, for a medical report specific to the consumer's relevant medical conditions. In circumstances where such a report cannot be prepared, life insurers cannot ask for access to clinical notes regarding the consumer/policyholder.*

*Recommendation 8.3*

*If the Financial Services Council and the Royal Australian College of General Practitioners have not agreed to protocols within six months, the committee recommends that at the time of a consumer/policyholder making a claim, life insurers can only ask a policyholder's General Practitioner, or other treating doctor where relevant, for a medical report that is specifically targeted to the subject matter of the claim. In circumstances where such a report cannot be prepared, life insurers cannot ask for access to clinical notes regarding the consumer/policyholder.*

*Recommendation 8.4*

*If the Financial Services Council and the Royal Australian College of General Practitioners have not agreed to protocols within 6 months, the committee recommends that life insurers must obtain consent from a policyholder each time it intends to:*

- *request a policyholder's medical records, reports or other medical information from their General Practitioner or other treating doctor; and*
- *share a policyholder's information with a third party.*

*Recommendation 8.5*

*The committee recommends that the Financial Services Council, in discussion with the Royal Australian College of General Practitioners, update the Life Insurance Code of Practice and relevant Standards to reflect Recommendations 8.1, 8.2, 8.3, and 8.4.*

## 23. Should universal:

- **23.1 minimum coverage requirements; and/or**
- **23.2 key definitions; and/or**
- **23.3 key exclusions,**

**be prescribed for group life policies offered to MySuper members?**

Mental Health Australia strongly cautions against applying any universal exclusions relating to mental health conditions or claims for group life policies offered to MySuper members. The effect of this would be to:

- Create two classes of group life insurance policies, one which covers members for mental health claims and one which does not, with access to coverage skewed towards people who are more highly engaged with their superannuation but with no apparent policy rationale
- Make it extremely difficult to define how such exclusions would apply with any consistency, taking into account individual circumstances
- Raise very difficult questions regarding who would conduct assessments and how these would be conducted.

Instead, MySuper policies should operate in the same way as other group life policies which cover mental health claims: by spreading risk as widely as possible, thereby providing cover across the risk pool.

### 29. Is there any reason why unfair contract terms protections should not be applied to insurance contracts in the manner proposed in "Extending Unfair Contract Terms Protections to Insurance Contracts", published by the Australian Government in June 2018?

Mental Health Australia strongly supports the Australian Government's proposals to extend protections for unfair contract terms to insurance contracts.

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

Each of these Codes of Practice should apply to the re-insurers with whom primary insurers do business. Mental Health Australia understands that a significant amount of underwriting practice (including poor underwriting practice relating to mental health issues) can be ascribed to the requirements that re-insurers place on insurers, for instance through underwriting manuals provided by re-insurers. Re-insurers can be based overseas, making regulation a greater challenge than for primary insurers based in Australia.

### 34. Should a failure to comply with the General Insurance Code of Practice or the Life Insurance Code of Practice constitute:

- **34.1 a failure to comply with financial services laws (for the purpose of section 912A of the Corporations Act 2001 (Cth));**
- **34.2 a failure to comply with an Act (for example, the Corporations Act 2001 (Cth) or the Insurance Contracts Act 1984 (Cth))?**

Mental Health Australia does not have a view on what legal mechanisms or penalties should apply when insurers fail to meet their respective codes of practice. However, the regulatory regime to date has not been sufficient to avoid consumer detriment and we therefore argue the codes of practice ought to be binding in a way that goes beyond industry self-regulation and that involves sanction for misconduct.

From the perspective of people with mental illness accessing (or attempting to access) the insurance market on fair terms, such failures might relate to not complying with the duty to act in good faith under the *Insurance Contracts Act*. As argued above, they may also relate to breaches of the *Disability Discrimination Act* 1992 (Cth).

Mental Health Australia

Mentally healthy people,
mentally healthy communities

Mental Health Australia is the peak independent, national representative body of the mental health sector in Australia.

Mental Health Australia Ltd
9-11 Napier Close
Deakin ACT 2600
**ABN** 57 600 066 635

**P** 02 6285 3100
**F** 02 6285 2166
**E** info@mhaustralia.org
**W** mhaustralia.org