26 April 2018

The Honourable Kenneth Madison Hayne AC QC
Commissioner
Royal Commission into Misconduct in the
Banking, Superannuation and Financial Services Industry

By email: FSRCenquiries@royalcommission.gov.au

Dear Commissioner

Mental Health and Insurance

The Public Interest Advocacy Centre (**PIAC**) urges the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (**Commission**) to inquire into the practices of insurers in relation to people with past or current mental health conditions.

PIAC has identified systemic problems in the way insurers design, price and offer policies and assess claims for people with past or current mental health conditions. These problems arise in both general and life insurance for products such as travel, income protection, total and permanent disability and death insurance.

Insurers appear to be unreasonably denying cover and applying broad, blanket mental health exclusions that are not supported by evidence and do not reflect the risk posed by the applicant to the insurer. As a result, it is extremely difficult for individuals who:

- had a mental health condition many years ago but no longer have a mental health condition;
- have a mild mental health condition which has been well-managed for many years; or
- have never been clinically diagnosed with a mental health condition but have shown symptoms of a mental health condition,

to obtain insurance with mental health cover, or to obtain insurance at all.

PIAC suggests that these practices are unfair and discriminatory, fall well below community standards and expectations and have the potential to affect a significant proportion of the community. One in five Australians will be affected by a mental health condition in any 12-month period and 45% of Australians will experience a mental health condition at some time in their life.[1] It is therefore a matter of broad public interest that

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[1] Australian Bureau of Statistics (ABS), *National survey of mental health and wellbeing: summary of results, Australia*, 2007. ABS cat. no. 4326.0, available

insurance providers are acting in a manner that is founded on robust evidence and contemporary understandings of mental illness.

There is no doubt that the provision of mental health cover by insurers is a complex one and that insurance will not always be available to every applicant. However, the insurance industry has been extremely slow to recognise the need for reform and it is difficult for groups such as PIAC, without access to insurers' internal practices and systems, to fully expose the scale of the issue.

This submission builds on PIAC's previous submissions to the following inquiries:

- the Parliamentary Joint Committee on Corporations and Financial Services: Inquiry into the Life Insurance Industry (Report dated March 2018);[2]

- the Senate Standing Committee on Economics Inquiry into the Scrutiny of Financial Advice (Report dated 30 June 2017);[3]

- the Australian Law Reform Commission's inquiry into Equality, Capacity and Disability in Commonwealth Laws (Report dated 24 November 2014);[4] and

- the Senate Legal and Constitutional Affairs Committee inquiry into the Exposure Draft of the Human Rights and Anti-discrimination Bill 2012 (Report dated 21 February 2013).[5]

While the Report issued by the Parliamentary Joint Committee on Corporations and Financial Services in March 2018 considered some issues regarding mental health and insurance, the inquiry was limited in that:

- it considered the life insurance industry only;

- it was confined to written submissions and the answers provided to questions asked during relatively short public hearings i.e. the Committee did not compel insurers to provide information or documentary evidence; and

- it focused primarily on the claims handling process and not on the underwriting process which is a key focus of this submission.

We note that, so far, no government inquiry has conducted a thorough and comprehensive investigation into the industry wide systemic issues set out in this submission. We respectfully

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http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4326.0Main+Features12007?OpenDocument.

[2] Public Interest Advocacy Centre, Submission No 9, *Parliamentary Joint Committee on Corporations and Financial Services: Inquiry into the Life Insurance Industry* (18 November 2016): https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/LifeInsurance/Submissions

[3] Public Interest Advocacy Centre, Submission No 180, Senate Standing Committee on Economics Inquiry into the Scrutiny of Financial Advice (22 April 2016): http://www.piac.asn.au/sites/default/files/publications/extras/16.04.22_-_piac_submission_to_the_senate_standing_committee_on_economics_inquiry_into_the_scrutiny_of_financial_advice.pdf

[4] Public Interest Advocacy Centre, Submission No 41, Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (20 January 2014) available http://www.piac.asn.au/publication/2014/01/equality-law-people-disability.

[5] Public Interest Advocacy Centre, Submission No 421, Senate Legal and Constitutional Affairs Committee, *Exposure Draft of Human Rights and Anti-Discrimination Bill 2012* (21 December 2012) available http://www.piac.asn.au/publication/2013/01/aligning-pieces.

suggest that this Commission is ideally placed to inquire into these issues and to make recommendations for reform that reasonably take into account both consumer and insurer perspectives.

We submit that this investigation falls within the Commission's Terms of Reference including in particular, the Commission's authority to inquire into:

- whether any conduct, practices, behaviour or business activities by financial services entities fall below community standards and expectations; and

- the adequacy of:

    - existing laws and policies of the Commonwealth relating to the provision of […] financial services;
    - the internal systems of financial services entities; and
    - forms of industry self-regulation, including industry codes of conduct;

  to identify, regulate and address misconduct in the relevant industry, to meet community standards and expectations and to provide appropriate redress to consumers.

In the enclosed submission, we set out:

- an introduction to the issues;
- the existing legislative context and relevant case law;
- the systemic issues we have identified through our casework;
- our thoughts as to how the Commission could inquire into the issues; and
- areas of potential reform for inquiry by the Commission.

PIAC welcomes the opportunity to meet with the Commission to discuss this submission in further detail.

Yours sincerely

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public interest
ADVOCACY CENTRE

Mental Health and Insurance

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About the Public Interest Advocacy Centre

The Public Interest Advocacy Centre (**PIAC**) is an independent, non-profit legal centre based in Sydney. Established in 1982, PIAC works for a fair, just and democratic society, tackling issues that have a significant impact upon disadvantaged and marginalised people. We ensure basic rights are enjoyed across the community through legal assistance and strategic litigation, public policy development, communication and training.

Our work addresses issues such as:

- homelessness (through the Homeless Persons' Legal Service);
- access for people with disability to basic services like public transport, education and online services;
- indigenous disadvantage (through our Indigenous Justice Project and Indigenous Child Protection Project);
- discrimination against people with mental health conditions;
- access to energy and water for low-income and vulnerable consumers (the Energy and Water Consumers Advocacy Program);
- the exercise of police power;
- the rights of people in detention, including the right to proper medical care (including the Asylum Seeker Health Rights Project); and
- government accountability, including freedom of information.

PIAC's work on mental health and insurance

In 2012, Mental Health Australia and *beyondblue* approached PIAC concerned by levels of unfair and discriminatory practices in the insurance industry around mental health, in particular, with regard to the provision of general (particularly, travel) and life insurance products including income protection and total and permanent disability insurance.

Since then, PIAC has provided advice and legal representation to individuals across the country who believe general or life insurance providers have discriminated against them.

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The Public Interest Advocacy Centre office is located on the land of the Gadigal of the Eora Nation.

Contents

Introduction

1. One in five Australians will be affected by a mental health condition in any 12-month period and 45% of Australians will experience a mental health condition at some time in their life.[1] It is therefore a matter of significant public interest that insurance providers act fairly and without discrimination, basing their decisions on robust evidence and contemporary understandings of mental illness.

2. Systemic problems exist in the way insurers design, price and offer policies and assess claims for people with past or current mental health conditions. These problems arise in both general and life insurance for products such as travel, income protection, total and permanent disability and death insurance. This submission sets out the range of systemic issues that PIAC's work has revealed and provides case studies from our work.

3. In PIAC's experience, too many insurers are unreasonably denying cover and applying broad, blanket mental health exclusions that are not supported by evidence and do not reflect the risk posed by the applicant to the insurer. PIAC has also observed insurers cancelling policies and refusing to pay claims on the basis of imputed mental health conditions.

4. As a result of these practices, it can be extremely difficult for individuals with mental health conditions to obtain insurance with mental health cover, to obtain insurance at all or to have their claims paid. This includes people who:

    a. had a mental health condition many years ago but no longer have a mental health condition;

    b. have a mild mental health condition which has been well-managed for many years; or

    c. have never been clinically diagnosed with a mental health condition but have shown symptoms of a mental health condition.

5. These practices are unfair and may be discriminatory. They fall well below community standards and expectations and have the potential to affect a significant proportion of the community.

6. The provision of mental health cover by insurers is undoubtedly complex. Insurance will not always be available to every applicant. However, the insurance industry has been extremely slow to recognise the need for reform and there is a compelling case for the Commission to investigate this issue.

[1] Australian Bureau of Statistics (ABS), *National survey of mental health and wellbeing: summary of results, Australia*, 2007. ABS cat. no. 4326.0, available http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4326.0Main+Features12007?OpenDocument.

Legal context

Disability Discrimination Act 1992 (Cth)

7. The *Disability Discrimination Act 1992* (Cth) (**DDA**) prohibits insurers from discriminating against a person on the basis of mental health, including past, present, future and imputed mental health conditions, or symptoms of mental health conditions, 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'.[2]

8. If there is no statistical or actuarial data available or reasonably obtainable to assess the risk, an insurer may justify its discrimination by relying solely on all 'other relevant factors'.

9. The reference to the discrimination being 'based' on statistical or actuarial data means that the insurer must have actually based its decision on that data and the data must have been in existence at that time the decision was made.[3]

10. The anti-discrimination legislation in each State operates in similar terms.[4]

AHRC Guidelines for Providers of Insurance and Superannuation under the *Disability Discrimination Act 1992* (Cth)

11. The Australian Human Rights Commission (**AHRC**) has issued 'Guidelines for Providers of Insurance and Superannuation under the *Disability Discrimination Act 1992* (Cth)'[5] (**AHRC Guidelines**). This document sets out guidance for insurers on:

    a. what type of actuarial or statistical data is reasonable for insurers to rely upon;
    b. what is meant by 'other relevant factors'; and
    c. when it will be 'reasonable' to discriminate.

12. The AHRC Guidelines state that actuarial or statistical data which is reasonable for insurers to rely upon includes:

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[2] Section 46 of the *Disability Discrimination Act 1992* (Cth) (**DDA**). Similar provisions can be found in state anti-discrimination legislation. For example, see *Anti-Discrimination Act 1977* (NSW) s 49QX and *Equal Opportunity Act 2010* (Vic) s 47X which each provide a similar exemption for insurers in the area of disability discrimination.

[3] *Ingram v QBE Insurance (Australia) Ltd (Human Rights)* [2015] VCAT 193, para 117.

[4] Section 49QX of the *Anti-Discrimination Act 1977* (NSW); s 47X of the *Equal Opportunity Act 2010* (Vic), s 28 of the *Discrimination Act 1991* (ACT); s 49 of the *Anti-Discrimination Act 1992* (NT); ss 74, 75 of the *Anti-Discrimination Act 1991* (QLD); s 34 of the *Equal Opportunity Act 1984* (SA); s 44 of the *Anti-Discrimination Act 1998* (TAS); s 66T of the *Equal Opportunity Act 1984* (WA).

[5] https://www.humanrights.gov.au/sites/default/files/AHRC_DDA_Guidelines_Insurance_Superannuation2016.pdf

a. complete and up-to-date underwriting manuals;
b. local data such as relevant domestic population or insurance studies;
c. relevant international population or medical studies; and
d. the claims experience of the insurer or other insurance companies which is up to date, directly applicable to the particular situation and of a sufficient sample size.

13. The AHRC Guidelines state that 'other relevant factors' include:

    a. medical opinions

    b. relevant information about the particular individual seeking insurance such as:

        i. the type of disability;
        ii. the severity of the disability;
        iii. the functional impact of the disability;
        iv. treatment plans; and
        v. employment records;

    c. opinions from other professional groups;

    d. actuarial advice or opinion;

    e. practice of others in the insurance industry; and

    f. commercial judgment.

14. Matters that can be taken into account in determining whether the discrimination is 'reasonable' include:

    a. practical and business considerations;
    b. whether less discriminatory options were available;
    c. the individual's particular circumstances;
    d. all other relevant factors of the particular case; and
    e. the objects of the DDA, especially the object of eliminating disability discrimination as far as possible.

15. The AHRC Guidelines note that it would be unlawful under the DDA for insurers to:

    a. refuse to insure a person with a disability simply because the provider does not have any data if it would otherwise be reasonable to provide insurance having regard to other relevant factors;

    b. refuse to insure a person with a disability merely because of historical practice;

    c. base decisions about insurance or superannuation on inaccurate assumptions or stereotypes of people with disability;

d. impute a disability merely from the fact that a person has consulted with a medical practitioner;

e. impute a disability merely from the fact that a person has failed to disclose to an insurer that they consulted with a medical practitioner; and

f. impute a disability from information disclosed by a person if the person has not disclosed that they have a disability and the imputation is not supported by medical opinion.

Case law

QBE Travel Insurance v Bassanelli [2004] FCA 396

16. The Federal Court decision in *QBE Travel Insurance v Bassanelli* [2004] FCA 396 articulates some of the principles underpinning this area of discrimination law. The case concerned the refusal to provide travel insurance on grounds of a pre-existing disability of metastatic breast cancer. In its submissions, QBE agreed that the refusal of the policy of insurance could be considered discriminatory and also accepted that there was no actuarial or statistical data relied upon or available when it made the decision not to issue the policy to Ms Bassanelli. However, it submitted that the discrimination was reasonable having regard to 'any other relevant factors'.

17. Mansfield J found in favour of Ms Bassanelli and held as follows at [85]:

> *I consider the appellant applied a* ***decision-making process which was too formulaic or which tended to stereotype the respondent by reference to her disability.*** *Such grouping of individuals, whether by race or disability, without proper regard to an individual's circumstances or to the characteristics that they possess, may cause distress or hurt. This case provides an illustration.* ***Legislation such as the DD Act is aimed to reduce or prevent such harm****. Section 46 of the DD Act recognises that there are circumstances in which discrimination by reason of disability may be justified (or, at least, not be unlawful).* ***It requires that the particular circumstances of an individual who is discriminated against be addressed, but not in a formulaic way.*** *Even if the exemption pathway provided by s 46(1)(f) is utilised, the reference to 'any other relevant factors' confirms that legislative intention.* [emphasis added]

Ingram v QBE Insurance (Australia) Ltd [2015] VCAT 193

18. In *Ingram v QBE Insurance (Australia) Ltd* [2015] VCAT 193, the Victorian Civil and Administrative Tribunal decided that QBE unlawfully discriminated against Ms Ingram under the *Equal Opportunity Act 2010* (Vic) by including a clause excluding all mental illness related claims in the travel insurance policy it issued to her, and when it declined to indemnify her claim by relying on that clause.

19. Ms Ingram had developed severe depression after she purchased the policy, which prevented her from travelling and gave rise to her claim. She had no prior history of mental illness. The Tribunal decided that QBE could not rely on the statutory exceptions to excuse the

discrimination, as QBE did not prove that the discrimination was based on reasonable actuarial or statistical data, or that it would have suffered unjustifiable hardship if it had not included the mental illness exclusion in the policy. Crucially, QBE did not produce any evidence to prove that at the time it decided to incorporate the mental health exclusion into the policy, it relied on contemporaneous actuarial data. The Tribunal also held that QBE failed to prove that removing the exclusion would result in a price increase or financial loss.

FOS Case No. 428120

20. In a decision made by the Financial Ombudsman Service (**FOS**) in March 2017 (Case No. 428128), FOS found that an insurer unlawfully discriminated against a man by including a broad mental health exclusion in his travel insurance policy and by refusing to pay his travel insurance claim on the basis of the exclusion.[6] The applicant had no prior history of mental illness but during his overseas trip, he suffered a manic episode resulting in hospitalisation. He lodged a claim on the travel insurance policy which was denied by the insurer relying on a clause in the policy which excluded claims arising from or in any way related to depression, anxiety, stress, mental or nervous conditions. The FOS panel found that the blanket exclusion was discriminatory and held that the insurer could not rely on s46 of the DDA. The panel held that it was not reasonable for the insurer to rely upon the actuarial and statistical data it referred to because:

    a. the insurer was unable to provide its own actuarial data specific to the applicant's risk category;

    b. the general statistical data submitted did not refer to or assess the risk undertaken by the insurer associated with first presentation mental illness;

    c. the insurer was unable to present any data it relied upon when it first introduced the exclusion to the policy; and

    d. the data provided was not accompanied by any evidence that the insurer actually relied upon it to introduce and maintain the exclusion.

Insurance Contracts Act 1984 (Cth)

21. Under section 21(1) of the *Insurance Contracts Act 1984* (Cth) (**ICA**), an insured person has a duty of dislcosure to the insurer before the relevant contract of insurance is entered into.

22. Pursuant to s 29 of the ICA, an insurer may cancel a life insurance contract if an insured person does not comply with their duty of disclosure or makes a misrepresentation to the insurer. If the non-disclosure or misrepresentation was fraudulent, the insurer can cancel the policy at any time[7] or if the non-disclosure or misrepresentation was not fraudulent, the insurer can cancel the policy within the first three years of the contract.[8]

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[6] https://forms.fos.org.au/DapWeb/CaseFiles/FOSSIC/428120.pdf
[7] ICA s 29(2).
[8] ICA s 29(3).

23. Applying to contracts for life insurance entered into, and in some cases varied, from 28 June 2014, s 29 of the ICA was amended to expand the remedies available to insurers where an insured has not complied with their duty of disclosure.[9] The purpose of the amendments was largely to introduce more flexible remedies for insurers to better cater for the strong market emergence of non-traditional life insurance (i.e., products that do not have a surrender value and do not provide cover on death – in other words, products such as income protection insurance, total and permanent disability insurance).[10]

24. Prior to the amendments, consumers had greater protection from cancellation based on innocent non-disclosures because to cancel a policy an insurer would have needed to show that it would not have been prepared to enter into *a* contract of life insurance on *any terms* if the duty of disclosure had been complied with.[11] Currently, an insurer can cancel a policy if it can show it would not have been prepared to enter into the same contract of life insurance.

25. Section 13(1) of the ICA provides that an insurance contract is one based on utmost good faith and the parties to the contract both have an implied duty to act towards each other with the utmost good faith.

[9] The amending Act was the *Insurance Contract Amendment Act 2013* (Cth).

[10] The reasons for the amendments to the remedies available to insurers are discussed in the Explanatory Memorandum, Insurance Contract Amendment Bill 2013 (Cth) at [1.113] – [1.119] and [2.117] – [2.122]. The Explanatory Memorandum notes that many of the amendments adopt the recommendations made by the Review Panel commissioned by the Australian Government in 2003 to review the ICA.

[11] ICA s 29(3) as then applicable.

Systemic issues relating to provision of insurance and mental health

Insurers are unreasonably limiting and denying cover following disclosure of a past or current mental health condition in applications for life insurance

26. PIAC is concerned that insurers do not always properly assess the risk posed by individual applicants for insurance who disclose a past or current mental health condition and are, as a result, unreasonably limiting and denying cover to applicants.

27. In our experience, decisions to limit or deny cover to an individual applicant because they have disclosed that they have a mental health issue are not consistently based upon relevant actuarial or statistical data and do not otherwise appear to reflect the risk posed by the applicant.

28. The mere disclosure that a person has a mental health condition or a history of a mental health condition will commonly lead to an insurer limiting or denying cover, without taking into account factors particular to the individual's condition, including the severity of the condition, the treatment a person is receiving for the condition (indeed, that a person is receiving treatment is often taken by insurers to mean that the condition is severe) and whether or the extent to which the condition impacts on the individual's functioning.

29. PIAC's experience is consistent with research published by MHA and *beyondblue* in 2011 following a survey of mental health consumers' experiences in accessing or claiming upon insurance[12], which reported that:

> *...underwriting often fails to fully consider individual circumstances, focusing on the 'illness' rather than fully considering how this fits into the bigger picture of how well a person is functioning in the various aspects of their life on a day to day basis.*[13]

Insurers are underwriting applications for insurance that disclose a past or current mental health condition based on outdated understandings of mental health conditions and lumping all mental health conditions into one category

30. PIAC has advised and represented individuals who have disclosed a past or current mental health condition when applying for insurance, in compliance with their duty of disclosure under the ICA, and the insurer:

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[12] Mental Health Council of Australia and *beyondblue*, *Mental Health Discrimination and Insurance: A Survey of Consumer Experiences 2011* (2011) available https://www.beyondblue.org.au/docs/defaultSsource/defaultS documentSlibrary/bw0129SreportSmentalShealthSdiscriminationSandSinsurance.pdf?sfvrsn=2

[13] Mental Health Council of Australia and *beyondblue*, above 21, 9.

a. refuses to offer insurance;
b. offers insurance with an unreasonably broad mental health exclusion;
c. offers insurance without a mental health exclusion but with an unreasonably high premium loading; or
d. offers insurance with both an unreasonably broad mental health exclusion and an unreasonably high premium loading.

31. Insurers appear to be refusing insurance or offering insurance on non-standard terms based on outdated understandings of mental health conditions, lumping unrelated mental health conditions into one category, and failing to recognise that mental illness occurs on a spectrum from the very mild to the very serious and can manifest and impact individuals differently depending on the nature and severity of their condition and the individual's particular circumstances. PIAC has observed instances of insurance providers:

    a. **declining applications for insurance following disclosure of a mental health history at the application stage**. A number of our clients have had applications for insurance declined during a telephone application with the insurer, suggesting to PIAC that some insurers have internal documents or processes that direct their call centre operators to decline an application following disclosure of a mental health issue. Similarly, clients who have applied for insurance online have had their application automatically declined during the online process or by email within a matter of days of making the application, suggesting that online applications are programmed to automatically decline applications that disclose a mental health history;

    b. **failing to ask further questions or obtain further medical information** to better understand the applicant's mental health history before deciding the application;

    c. **failing to properly consider the applicant's mental health history and the risk posed to the insurer**, for example, by failing to take into account the time that has elapsed since diagnosis or symptoms, the absence of any recurring mental health episodes or hospitalisations, the applicant's compliance with treatment and the applicant's employment history, amongst other things; and

    d. **offering a policy with a broad, blanket mental health exclusion that lumps all mental illness together and that is not commensurate with the risk posed by the applicant's medical history**. For example, it is common for applicants who disclose that they experienced depression sometime in the past to have the following types of blanket exclusions placed on their policy, regardless of their individual circumstances:

        Example 1

        No claim shall be payable under this cover where that claim arises from or is contributed to by stress (including post traumatic stress), fatigue, physical symptoms of a psychiatric illness or condition, anxiety, depression, psychoneurotic, psychotic, personality, emotional or behavioural disorders, or disorders related to substance abuse or dependency (which includes alcohol, drug or chemical abuse or dependency).

Example 2

No payment will be made under this insurance for any disability contributed to or caused by any mental health disorder including, but not limited to, any anxiety state or disorder, adjustment disorder, acute stress disorder, depressive or mood disorder, personality or substance use disorder, eating disorder, suicide or self-harming behaviour or any complications arising from any of them.

Case study 1

The client was diagnosed with bipolar disorder ten years prior. The client's condition was well managed with medication. The client was never hospitalised and had never taken time off work because of their condition. They applied for increased income protection and TPD insurance through their superannuation provider. The application was denied. The client then applied for a standalone income protection policy with a different insurer and the application was again declined. The client then applied to increase their death and TPD insurance through another superannuation policy and again the application was declined.

None of the three insurers sought or obtained further information from the client before declining the application. None of the insurers considered the option of providing cover on non-standard terms taking into account the client's pre-existing bi-polar disorder.

PIAC assisted the client to file complaints against each insurer in the Australian Human Rights Commission on the basis that the refusals to provide cover constituted unlawful disability discrimination under state and federal discrimination law.

Two of the complaints settled on favourable terms to the client. One of the complaints did not settle.

Case study 2

The client experienced depression, anxiety and an eating disorder in their teenage years and experienced minor symptoms of anxiety around the time of their wedding (which was three years prior to their application for insurance). The client was provided with medication to assist them to sleep around this time.

When the client was in their mid-twenties, they applied for life and TPD insurance through their superannuation provider. The application was denied on the basis of the client's mental health history.

PIAC assisted the client to request the insurer to conduct a review of its decision to decline the client's application. The insurer then offered the client a life insurance policy with no exclusion and a TPD insurance policy with the following mental health exclusion:

No Total and Permanent Disability benefit shall be payable for any mental or nervous disease or disorder including but not limited to, anxiety, depression, stress, chronic

fatigue syndrome, post-traumatic stress disorder, exhaustion or fibromyalgia, physical complications of psychiatric disorders, drug, alcohol or substance abuse, cognitive impairment, behavioural disorders or complications thereof.

The insurer did not provide any actuarial or statistical data to show that the client's previous conditions would result in them being more likely to develop the extensive number of conditions listed in the proposed exclusion, or all other mental health conditions in the future.

PIAC assisted the client to engage in protracted negotiations in relation to the scope of the proposed mental health exclusion on their TPD policy. The insurer eventually agreed to narrow the exclusion to apply to any claims:

directly arising from or directly related to any depressive disorder, anxiety disorder or eating disorder.

Insurers are underwriting applications that disclose a past or current symptom of a mental health condition on the assumption that the applicant had or has a mental health condition

32. PIAC has advised and represented individuals who have disclosed *symptoms* of a mental health condition when applying for insurance but have never been diagnosed with a mental health condition and the insurer:

    a. imputes a mental health condition that is not supported by the information provided in the application or by medical practitioners; and

    b. refuses to offer insurance, offers insurance with a broad mental health exclusion, offers insurance with a premium loading, or offers insurance with both a broad mental health exclusion and a premium loading.

33. PIAC is concerned that some insurers are imputing a mental health condition on the basis of symptoms disclosed during the application process in the absence of a diagnosis from an appropriately qualified medical practitioner and are assessing applications for insurance in reliance on those imputed conditions.

34. PIAC has observed instances of insurance providers:

    a. **failing to properly consider the applicant's mental health history and the risk posed to the insurer by treating disclosure of minor symptoms of depression and anxiety**, for example, feeling 'low' after a relationship breakdown or feeling 'stressed' as a result of work, in the same category as people who have been diagnosed with moderate to severe depression or anxiety disorders for which they have received ongoing treatment such as counselling and/or medication and/or been hospitalised;

b. **forming conclusions about the applicant's experience of symptoms of mental illness in a manner that was inconsistent with the opinions of the medical professionals treating the insured**. PIAC has seen examples of insurers failing to accept and/or failing to take into account the evidence of a treating medical practitioner about the absence of a diagnosis or the low severity of a condition;

c. **imputing a mental health condition where there was no diagnosis of a mental illness from medical professionals and the existence of a condition is otherwise not supported by the medical evidence**. For example, we have seen an insurer rely on clinical records that show a GP discussed taking anti-depressant medication with the insured as evidence that the insured had depression;

d. **offering a policy with a broad mental health exclusion following disclosure of symptoms** of a mental health condition in the absence of any diagnosis of a mental health condition; and

e. **taking an approach that penalises and discourages people from seeking preventative, early medical assistance** to proactively manage their mental health. This also undermines government funded campaigns and programs that encourage people to take active steps to stay mentally healthy and to seek assistance to do so.

Case study 3

The client attended a counsellor on an ad hoc basis for symptoms of anxiety. The client was not provided with a diagnosis of any anxiety related disorder. The client did not take any medication and was not required to take any time off work due to their symptoms.

The client applied for life and TPD insurance. The insurer offered life insurance with no exclusions and offered TPD insurance with an exclusion which excluded claims arising from:

> *Any disability that is a result of any mental disorder including, but not limited to, anxiety, depression, stress, fatigue, post traumatic stress disorder, insomnia, exhaustion or fibromyalgia, physical complication of psychiatric disorders, drug or alcohol abuse, cognitive impairment, behavioural disorders or complications thereof.*

The client requested the insurer to change its decision to offer TPD insurance with this blanket mental health exclusion. The insurer declined this request.

PIAC assisted the client to send another letter to the insurer requesting it to change its decision on the basis that the insurer had failed to make inquiries into all relevant factors relating to the client's application for insurance. If the insurer continued to insist on offering a TPD policy with a mental health exclusion, we requested the insurer to indicate in writing:

- the actuarial or statistical data relied upon by the insurer to apply the mental health exclusion clause to the TPD cover offered to the client; and

- all other relevant factors considered by the insurer in making the decision to apply the mental health exclusion clause to the TPD cover offered.

After reviewing the client's medical records, the insurer reversed its decision and offered the client a TPD policy without a mental health exclusion.

Insurers are unreasonably cancelling policies for alleged non-disclosure of past mental health conditions and/or symptoms

35. PIAC has advised and represented individuals who have had their life insurance policies cancelled by insurers for their purported failure to comply with their duty of disclosure at the time they applied for cover or to amend existing cover, in circumstances where the non-compliance is innocent, or where the insured did not know, and could not reasonably have known, that their prior medical interactions would have been relevant to an insurer's decision to offer a policy. When the insured later makes a claim on the policy (whether or not the claim is connected to mental health), the insurer cancels the policy for non-compliance with the insured's duty of disclosure under s 29 of the ICA.

36. This issue is compounded by the difficulties applicants face when completing application forms. Questionnaires regarding an applicant's medical history often ask broad, unclear and open-ended questions which are misunderstood by applicants. If applicants misinterpret a question because it is vague or unclear, this gives rise to the risk that an applicant could be accused of failing to comply with their duty of disclosure or of making a misrepresentation.

37. For example, an application form might include a question asking whether an applicant "has ever been stressed". This is an extremely broad question and is liable to different interpretations by different applicants. Another example is where an applicant might disclose that they have depression and a follow up question might then ask "how many episodes of depression have you had". This question is difficult for applicants to answer as it is not always possible to categorise a person's experience of depression into one or more "episodes". There is generally no explanation of what is meant by the term "episode".

38. PIAC is concerned that insurers appear to be unfairly and unnecessarily cancelling insurance policies to avoid paying legitimate, reasonable claims. PIAC is of the view that in some circumstances this practice constitutes a breach of an insurer's duty of good faith as required by section 13 of the ICA.

39. An allegation by an insurer that the insured has not complied with their duty of disclosure generally arises after the insured has made a claim for a benefit against the policy. Often the claim that the insured is making against the policy is not related to mental health.

40. After an insured has made a claim against their policy, the insurer obtains access to and reviews the insured's medical records. PIAC has seen instances of insurers obtaining an insured's complete medical history, including from doctors that treated the insured during childhood, before deciding a claim. PIAC has found that insurers often rely on matters

'discovered' during the review of the insured's medical records to allege that the insured has breached their duty of disclosure.

41. Often the conclusions drawn by the insurer from the insured's medical records about their experiences of mental health are inconsistent with the insured's medical records and the opinions of their treating medical practitioners. For example, PIAC has represented clients where the insurer has alleged there has been a breach of the duty of disclosure because:

    a. notes taken by a psychologist during a consultation with the insured show the psychologist suspected the insured might be depressed, despite the psychologist confirming to the insurer that he had never made a diagnosis of depression nor communicated his concerns that the insured was depressed to the insured;

    b. the treating medical practitioner retrospectively diagnosed a mental health condition – i.e., the practitioner did not make this diagnosis at the time of treatment nor communicate it to the insured;

    c. the insurer interpreted an accidental overdose of pain medication to be a suicide attempt despite medical evidence from the insured's treating medical practitioners, including contemporaneous medical evidence, confirming the overdose was accidental; and

    d. the insured sought counselling from a psychologist following the breakdown of a relationship, in circumstances where there was no diagnosis of a mental health condition.

42. PIAC has represented individuals who have had a policy cancelled because the insurer has relied on medical records to impute a medical condition that either did not exist or that the insured did not know existed at the time of applying for insurance.

43. In PIAC's experience, it appears that consumers are being disadvantaged by the reforms to the remedies available to insurers under s 29 of the ICA (as set out in paragraphs 22 to 24 above), or at the very least, are not seeing any benefits flowing from the increased flexibility by the amendments to the ICA.

44. Take the following scenarios:

    The insured obtains income protection insurance. During the application process, the insured does not disclose that they attended a counsellor a number of years prior. The insured does not think the appointments with the counsellor are relevant to their insurance application because they were never diagnosed with a mental health condition. The insured subsequently becomes ill with an unrelated physical medical condition and makes a claim on their income protection policy. The insurer discovers that the insured did not disclose that they attended a counsellor and cancels the policy and stops paying the claim on the basis of the purported non-disclosure.

    Scenario A – the policy of insurance commenced prior to 28 June 2014 before the changes to s 29 of the ICA came into effect. The insured is able to prove that, according to the

insurer's underwriting guidelines, the insurer would have offered them an income protection insurance with a mental health exclusion. Because the insurer would have offered a policy of insurance, the insurer is not entitled to cancel the insured's policy and must continue to pay the insured's claim arising from their unrelated physical medical condition.

Scenario B – the policy for insurance commenced after 28 June 2014 when the changes to s 29 of the ICA came into effect. The insured is unable to prove that the insurer would have offered them the same policy had he made the alleged non-disclosure during the application process. The insurer is entitled to cancel the policy and the insured's claim is not paid.

45. As the above scenarios demonstrate, decisions to cancel contracts of insurance can operate harshly on people who reasonably believe that they are protected by insurance (and had they known they were not insured may have been able to take other steps to protect themselves financially – including approaching other insurers). Cancellation often occurs at a point in time where the insured is particularly vulnerable and has made a claim on the policy (sometimes for a condition that is not related to mental health), thereby depriving them of the benefit of the insurance.

46. However, there are other less drastic measures that an insurer may take under the ICA. Insurers are able to vary a contract of insurance *at any time*, whether the non-disclosure is fraudulent or non-fraudulent, to adjust the sum insured using a statutory formula for proportionality,[14] or to vary the terms of the contract to place the insurer in the position they would have been in if the duty of disclosure had been complied with.[15] The discretion as to whether to vary or to cancel a contract of insurance rests solely with insurers.

47. The unfairness of cancellation is particularly evident where the insurer purports to cancel a policy of insurance for non-disclosure of matters that were known to the insurer, or could reasonably have been known to an insurer, from medical information provided about the insured in respect of prior applications for insurance with the same insurer that was accepted by the insurer.

Case study 4

The insured obtained income protection insurance. During the application process, the insured did not disclose that they had seen a psychologist three years prior, initially to discuss the breakdown of a relationship and then, seeing that the counselling had been effective, undertaking further counselling to discuss issues the insured had experienced historically with their family.

The insured was subsequently diagnosed with cancer and stopped working. They made a claim on their income protection policy. The insurer initially paid the claim but, after obtaining the insured's medical records and discovering the appointments with the counsellor, the insurer argued that the insured had not complied with their duty of disclosure when answering

[14] ICA s 29(4).
[15] ICA s 29(6).

a question during the application process as to whether the insured had ever received medical treatment for a mental health condition. The insured argued that they had never been diagnosed with a mental health condition or had symptoms of a mental health condition and answered the questions asked of them during the application process truthfully. The insurer relied on clinical notes that described observations by the treating doctor that the insured had been feeling low and that they had discussed anti-depressant medication. The insurer cancelled the policy and stopped paying the claim on the basis of the non-disclosure.

PIAC assisted the insured to challenge the insurer's decision by arguing that the insured had not been diagnosed with a mental illness (which the insured's psychologist confirmed in a written report provided to the insurer) and that if the insured had made the disclosure at the time of the application, the insurer would have offered the insured a policy anyway. As a result of PIAC's assistance, the insured settled their dispute with the insurer.

Many insurance policies have blanket mental health exclusions

48. PIAC has advised and represented individuals who have had their insurance claims denied on the basis of a blanket mental health exclusion contained in a policy. These are standard exclusions contained in product disclosure statements (**PDS**) which apply to all policy holders regardless of their medical history. Insurers rely on these exclusions to refuse to pay a claim in circumstances where the insured had no history of a past or current mental health condition when applying for insurance but developed a mental health condition after purchasing the policy. Examples include the following:

    Example 1

    We will not pay under any circumstances if:

    > *[…] Your claim arises from or is in any way related to mental illness including: dementia, depression, anxiety, stress or other mental or nervous condition; or conditions that have resulted in behavioural issues; or a therapeutic or illicit drug or alcohol addiction.*

    Example 2

    We will not pay a claim arising directly or indirectly from:

    - *a mental illness condition;*

49. Blanket mental health exclusions are common in the Australian travel insurance market. While some insurers have recently taken steps to remove these exclusions from their policies[16], there are still a significant number of polices in Australia which include these

[16] See: http://www.smh.com.au/business/consumer-affairs/travel-insurance-providers-remove-mental-health-illness-exclusions-20170704-gx4514.html

exclusions. We set out in Annexure A a list of the mental health exclusions included in the travel insurance policies of many of Australia's leading travel insurance providers.

50. Blanket mental health exclusions also appear in some income protection insurance policies. These policies often involve limited individual underwriting and are purchased directly by a customer via an insurer's website, telephone sales or other branches of an insurers' partners or affiliates. We set out in Annexure B a list of some of the income protection policies in the Australian market which contain blanket mental health exclusions.

51. As stated above, pursuant to the DDA, insurers must ensure that the decision to include a blanket mental health exclusion in a policy is based on actuarial or statistical data that is reasonable for the insurance provider to rely on and the decision is reasonable having regard to that data and other relevant factors. Otherwise the inclusion of the blanket mental health exclusion in the policy may constitute unlawful disability discrimination.

52. However, PIAC is concerned that some insurers continue to include blanket mental health exclusions in their policies in circumstances where:

    a. they may not have the statistical or actuarial data to support their decision to include the exclusion in their policy; or

    b. the statistical or actuarial data upon which they rely is out-of-date, general in nature and not directly applicable to the person or insurance product involved, based on an insufficient sample size or not directed towards insurance risk or incidence data.

53. In some cases, it is not known what, if any, actuarial or statistical data insurance companies rely upon when designing policies with blanket mental health exclusions. In PIAC's experience, insurers often protect this information by claiming it is commercial-in-confidence.

54. Moreover, because in the general insurance industry travel insurance providers have not historically covered mental illness, we understand there is no relevant pool of claims experience from which to draw. This compounds the lack of clarity regarding the basis on which travel insurance providers assess the likelihood of future claims being made.

55. It also unclear whether products which are designed to include blanket mental health exclusions can ever satisfy the exemption in s 46 of the DDA given that s 46 mandates an insurer to consider "other relevant factors" which includes relevant information about the particular applicant seeking insurance such as the type of disability they have or the functional impact of the disability. Blanket mental health exclusions preclude the consideration of these factors.

Failure to disclose blanket mental health exclusions

56. In our experience, people are generally not aware that a blanket mental health exclusion applies to their policy before they purchase a product and only become aware of the exclusion at claim time, at which point they are often shocked to discover that their claim is not covered by their policy.

57. Policy exclusions, including blanket mental health exclusions, are often buried in dense and lengthy PDSs. These documents can range between 40 to 100 pages long and are difficult documents to read even for experienced legal practitioners. Applicants are usually provided with a link to the PDS at the application stage and/or are provided with a copy of the PDS after they purchase the policy. It is not always clear to a consumer why it is important to read a PDS. Even if a consumer is well-informed and tries to read a copy of a PDS before they commence the application process, it is often difficult to find a copy of the PDS on an insurer's website. For example, the links tend to be placed at the bottom of webpages in very small text without a clear explanation as to the relevance of the PDS.

58. We submit that merely providing a person with a link to a PDS during the application process or after an insured has purchased a policy does not constitute adequate disclosure, particularly for crucial terms such as policy exclusions. We are also concerned that these practices may constitute a breach of an insurers' duty to act with the utmost good faith as required by s 13 of the ICA.

Case study 5

The insured booked a trip to Vietnam and purchased travel insurance. Approximately 10 months before the trip, the insured became unwell and was subsequently diagnosed with clinical depression. Following admission to hospital, the insured cancelled their trip to Vietnam.

The insured made a claim on their travel insurance policy for the cost of the cancelled trip. The insured gave authority for the insurer to obtain copies of the insured's medical records from their GP and their treating psychiatrist. Having reviewed the records, the insurer acknowledged that the insured's condition was not a pre-existing medical condition at the time she entered into the policy. However, the insurer nevertheless declined the claim on the basis of a blanket mental health exclusion in the travel insurance policy. The insured requested an internal review of the decision to decline to pay their claim and the insured re-affirmed the decision.

PIAC assisted the insured to request the insurer to change its decision on the basis that:

- the general mental health exclusion clause on the insured's travel insurance policy constituted unlawful disability discrimination;
- the insurer's application of the exclusion to decline the insured's claim is a breach of the terms of the policy; and
- given that the insured apparently always intended to rely on the blanket mental health exclusion in the policy to decline the insured's claim, the insurer's decision to nonetheless obtain information and documents from the insured's treating mental health professionals about their mental health condition, was a breach of the insured's privacy and a potential breach of the *Privacy Act 1988* (Cth).

The insurer subsequently agreed to pay the insured's claim. However, among other things, the insurer did not provide an adequate explanation for its discriminatory conduct or for the potential breaches of the insured's privacy.

PIAC assisted the client to file a complaint with the NSW Anti-Discrimination Board.

The matter settled on favourable terms to the insured.

Case study 6

The insured booked a trip to Thailand and purchased travel insurance. During the trip in Thailand, she experienced a sudden panic attack with symptoms of paranoia and confusion. She was admitted to hospital where she stayed for four days to support her recovery. The insured's husband flew to Thailand to accompany her on the journey home. The insured was subsequently diagnosed with bi-polar disorder and received medical treatment in Australia.

Upon return to Australia, the insured made an insurance claim for her medical expenses and unexpected travel costs. The insurer refused to pay her claim on the basis of a blanket mental health exclusion in her policy. The insurer also implied that the condition the insured experienced in Thailand was a pre-existing illness, on the basis that she had experienced post-natal depression following the birth of her first child, over 16 years earlier.

PIAC assisted the insured to seek an internal review of the insurer's decision to refuse to pay her claim on the basis that:

- the blanket mental health exclusion was likely to constitute unlawful disability discrimination under state and federal disability discrimination legislation; and
- the insured's single episode of post-natal depression 16 years prior did not fall within the definition of a "pre-existing medical condition" in the insured's product disclosure statement.

The insurer eventually paid the insured's claim.

The methods of redress for individuals against insurers are ineffective

59. It is extremely difficult for an individual who finds themselves in any of the above situations, to seek review and redress of the insurer's decision without legal assistance. This is because:

    a. the internal review process, which is itself flawed, generally results in the insurer affirming its original decision. Following the internal review process, the individual has no choice but to pursue a formal complaint or claim to an external body;

    b. the individual is often denied access to some or all of the material relied on by the insurer, thereby making it extremely difficult for the individual to address the insurer's concerns; and

    c. some of the material relied on by insurers to demonstrate that applicant for insurance poses too high a risk, for example, medical journal articles, require expert analysis by lawyers, actuaries and medical experts in the field of psychiatry. Notably, in our

experience, the data relied on by insurers is sometimes outdated and/or irrelevant and/or has been misinterpreted by the insurer.

Difficulties in obtaining written reasons

60. Where an insurance provider has declined to offer insurance or has offered insurance on non-standard terms, for example, with a mental health exclusion or a premium loading, the applicant (on written request) is able to obtain written reasons for the decision pursuant to section 75 of the ICA.

61. However, in PIAC's experience:

    a. insurers are extremely reluctant to articulate precisely why an application was rejected. Even after a formal request for reasons has been made, insurers' responses are often generic and unhelpful. For example, insurers often simply state that an application was rejected "due to your medical history" or "because of the answers you gave in your application form";

    b. where an applicant for insurance has applied for insurance through an insurance broker, the insurer will only communicate with the insurance broker, thereby reducing the applicant's ability to advocate for themselves and relying on the efficacy and expertise of the insurance broker who often has only a basic understanding of mental illness; and

    c. insurers will only provide written reasons to the applicant/insured/s medical practitioner, even if the circumstances of the case do not suggest that there is any health or safety risk if the written reasons are provided to the applicant/insured directly.

Failure to provide statistical and actuarial data

62. It is also extremely difficult for consumers to gain access to the data relied upon by insurers in decisions that affect them. Insurers rarely provide such data outside formal complaints or court processes.

63. This means that for many individuals the only way to test whether an insurer has satisfied the insurance exemption in the DDA is for an individual to pursue a legal complaint at a court or tribunal, using compulsory document production processes to access the actuarial and statistical data and other reasons for insurers decisions. This places an unrealistic and unfair burden on vulnerable individuals who suspect an insurer has unlawfully discriminated against them.

64. Pursuing a legal complaint is arduous, time consuming and expensive. For many of PIAC's clients, the risk of an adverse costs order dissuades them from pursuing a discrimination complaint in the federal courts even when they have a strong claim. It is not unusual for respondent insurers to retain large law firms and senior and junior counsel to represent them and costs, even on a party/party basis, can be significant. Due to the risk of an adverse costs order, many strong claims settle on terms that may be favourable to the claimant but are far less than they ought to be under the law. Most often respondent insurers insist that any such

settlement be confidential. The result is that the impetus for making any long-lasting change to current practice is lost and no legal precedent is made.

Ineffectiveness of internal dispute resolution mechanisms

65. Where an applicant for insurance or an insured is unhappy with an insurer's decision, they may seek an internal review of that decision. In PIAC's experience, internal dispute resolution (**IDR**) mechanisms in an insurance context are rarely effective in resolving disputes. IDR requests are sometimes ignored or 'overlooked', time frames are long, there is generally little to no contact with the consumer during this period (for example, the insurer rarely seeks further information from the consumer during this period, although it may obtain the consumer's consent to obtain further information from a third party, such as a medical practitioner), thereby limiting the consumer's ability to advocate for themselves during the IDR process. On the whole, an insurer will usually affirm its original decision following IDR. The likelihood of a different decision following IDR is only slightly increased by the involvement of a solicitor representing the consumer.

66. In PIAC's experience:

    a. it can take up to six months, and sometimes longer, for an insurer to consider an application for internal review on a decision;

    b. the applicant/insured is generally not consulted with as part of the internal review process;

    c. the applicant/insured often does not know why the original decision was made or have enough information about the original decision, thereby reducing their ability to effectively engage in the process;

    d. insurers will often ask for medical health records spanning most or all of the applicant's life as part of the internal review process. This can be time consuming and costly for an applicant for insurance. In addition, they often ask for these records some time into the review process (for example 1-3 months) which has the effect of significantly delaying the review process and the period of time for which the individual remains uninsured. The result of the internal review is almost always to reaffirm the original decision; and

    e. the prospect of obtaining an improved outcome following internal review is low, however it increases where an applicant has engaged legal representatives.

Lack of clarity regarding complaints process following IDR

67. Individuals who have had their contract cancelled, application for insurance denied or accepted on non-standard terms, or a claim denied because of their disability may have claims under both the ICA and the DDA (or equivalent state anti-discrimination legislation). This means that they may have grounds to lodge a complaint to more than one dispute resolution body, such as FOS or the AHRC.

68. Following IDR the insurer will usually only advise the consumer of their right to lodge a complaint with one complaints body but not all of the complaints bodies that are an option for them.

69. Further, an individual generally cannot lodge complaints in both FOS and AHRC, which means that they must elect the forum in which to make their complaint. Both bodies have the power to decline to consider a dispute that it considers has been or would be more effectively dealt with in another forum. The forum in which the complaint is lodged may impact the remedies that are available to the complainant by:

    a. preventing them from commencing a complaint in another jurisdiction if the complaint in the jurisdiction initially elected is unsuccessful; and

    b. operation of the various time limits – for example, if the period taken to resolve the complaint in the initial jurisdiction is such that the individual finds that they are then outside of the time limits within which to bring a complaint in the other jurisdiction.

Proposed inquiry by the Commission

70. The unfair and discriminatory practices set out above have a profound impact on the lives of people with a mental health condition. Individuals can find themselves in the precarious situation of not being able to secure any insurance protection for themselves or their families or a situation where the protection they are able to secure is of limited value.

71. When an insured person makes a claim on their policy, this is often one of the most stressful and uncertain times of their lives. For life insurance policies in particular (which as noted above, includes life, income protection and total and permanent disability insurance), it can lead to disastrous consequences when the financial safety net of the insurance policy the insured thought they had does not exist. This can leave people unable to provide for their own or their families' basic necessities and cause them to incur substantial debt.

72. These practices also have the perverse consequence of discouraging people from seeking professional treatment and support for their mental health condition for fear that it could negatively impact their insurance applications in the future. This undermines government funded campaigns and programs that encourage people to seek medical assistance for their mental health.

73. PIAC has advocated for change on these issues for over five years. Other mental health advocates, like Mental Health Australia and *beyondblue,* have been engaged on this issue for over a decade. So far, the insurance industry has shown itself to be unwilling to commit to meaningful change.

74. As far as PIAC is aware, we are one of the only legal organisations in Australia dedicated to exploring this issue on an ongoing basis. As a community legal centre, our resources are limited and our ability to address the systemic issues is limited to assisting clients on a case by case basis. We believe that our casework is representative of a much larger problem.

75. PIAC therefore calls upon the Commission to fully inquire into these unfair and discriminatory practices, to report on the extent of the problems and to make recommendations for reform.

76. Given the significance of mental health as a national issue and the crucial role insurance plays as a means of providing financial security, PIAC submits that the issues set out in this submission should be the subject of a dedicated topic of inquiry or case study by the Commission and should be a topic for public hearing.

77. We set out below our thoughts as to how the Commission might structure its inquiry into these issues so as to assist the Commission's consideration of this matter.

Evidence from consumers

78. PIAC suggests that the Commission should call for submissions from individuals who have experienced the issues set out above and it should actively encourage people who have experienced any of these issues to provide their story to the Commission.

79. PIAC has a small but compelling cohort of past and current clients who have experienced the issues set out in this submission. The de-identified case studies set out in paragraphs 30 to 58 of this submission represent the experiences of some of those clients. We note that a number of our clients are unlikely to voluntarily provide an identified submission to the Commission due to concerns about legal redress that might be taken against them (notwithstanding the comments made by the Commission at the public hearing on 12 February 2018).

80. The Commission might also approach mental health stakeholders such as *beyondblue*, Mental Health Australia and SANE Australia to provide information on the issues identified in this submission.

81. We then suggest that the Commission obtain statements and hear evidence from selected individuals who are representative of the particular issues identified.

Evidence from insurers

82. PIAC respectfully submits that obtaining material from insurers will be crucial to the Commission's inquiry. We set out in Annexure C a matrix that highlights the type of information the Commission could seek in order to investigate the issues we have identified.

83. It may also assist the Commission to obtain oral evidence from relevant individuals within the insurance companies with responsibility for:

    a. underwriting decisions;
    b. product design;
    c. risk management;
    d. claims handling; and
    e. dispute resolution,

    such as chief underwriters/actuaries, chief risk officers and general counsel.

Funding and support

84. There is currently no financial support available for the work consumer representatives are doing to provide the Commission with consumers' stories. This work is largely falling to already under-resourced community legal centres and not-for-profit organisations.

85. As a result, we are concerned that many consumers' stories will not be heard by the Commission and many consumers will not receive legal advice and representation they require to engage with the Commission.

86. In order to ensure fair and adequate representation for consumers, PIAC respectfully submits that the Commission should work with the Commonwealth Attorney-General to provide funding to community legal centres who are assisting people to put forward submissions to the Commission.

Proposals for reform

87. The proposals for reform will largely depend on the outcome of the Commission's investigation. Should the Commission decide to investigate this issue, PIAC will seek to make further submissions about reform needed to the industry at the appropriate time.

88. In the interim, we suggest that any proposals for reform should explore the matters listed below. These matters are focused on addressing the systemic issues we have identified in relation to mental health, however, we acknowledge that a number of these suggestions will have implications beyond mental health.

Increasing transparency and accountability to applicants for insurance who have been denied cover or offered cover on non-standard terms due to a mental health condition

89. There should be increased transparency and accountability to applicants for insurance who have been denied cover or offered cover on non-standard terms due to a mental health condition. This may be achieved by:

    a. requiring insurers to provide an applicant with plain language written reasons for the decision to decline on the basis of mental health, irrespective of whether the applicant has made a written request to the insurer for written reasons (a written request is currently required by section 75 of the ICA); and

    b. requiring insurers to provide, directly to an applicant or insured, the actuarial and statistical data and relevant factors relied on to make a decision upon request. Currently, insurers are only obliged to provide such data during a formal external dispute resolution process, where that power is exercised by the relevant forum.

Defining 'other relevant factors' in disability discrimination legislation

90. Though the AHRC Guidelines and the decision of the Federal Court in *Bassanelli* provide clear guidance on the meaning of 'other relevant factors', improved compliance with the requirements to consider other relevant factors would be achieved by amending disability discrimination legislation to expressly state that 'other relevant factors' includes but is not limited to:

    a. factors that reduce any risk to insurers as well as the factors that increase the risk to insurers; and

    b. factors that are relevant to the specific circumstances of the individual applicant.

Reversing the amendments made to section 29 of the ICA

91. PIAC submits that the amendments made to section 29 of the ICA have given insurers almost unfettered ability to cancel policies for purported non-disclosure or misrepresentation.

92. This imbalance should be corrected and the amendments made to section 29 of the ICA should be reversed.

Amending the ICA to require clear disclosure of policy exclusions

93. The ICA should be amended to require insurers to clearly inform customers of all exclusions that apply to their policy prior to the customer entering into the contract. For example, at the application stage, insurers should be required to provide customers with a complete list of the exclusions that apply to their policy and not simply provide customers with an electronic link to a copy of the PDS.

Increasing transparency and accountability to the community by requiring insurers to report annually to the AHRC

94. It is difficult to hold the industry accountable when so much of its practices are hidden from public view. Insurance companies have known for over a decade that reform is needed in the area of mental health, however, that reform has largely not occurred because the industry lacks sufficient regulatory oversight and accountability to consumers.

95. At a minimum, insurance companies should be required to report annually to the AHRC on the number of times they have declined to provide insurance or offered insurance on non-standard terms on the ground of disability. This information should specify whether the insurer has relied on actuarial or statistical data in making their decision and the type of disability invoked by the insurance exemption. The AHRC should publish the information every year by each insurer on its website and/or in its annual report.

96. Each insurer should be required to report publicly (for example, in its annual report) the number of policies that it cancelled in the previous 12 months.

Giving power to the AHRC to investigate and enforce

97. The AHRC has the power to inquire into, and attempt to conciliate, individual complaints of unlawful discrimination.[17] While this power allows people to seek redress on a case by case basis, its utility is limited in addressing systemic breaches of the DDA.

98. Part 9 of the *Equal Opportunity Act 2010* (VIC) empowers the Victorian Equal Opportunity and Human Rights Commission to conduct investigations into any matter relating to the operation of the Act if:

    a. the matter:

        i. raises an issue that is serious in nature;
        ii. relates to a class or group of persons; and
        iii. cannot reasonably be expected to be resolved by dispute resolution or by filing an application in the Victorian Civil and Administrative Tribunal; and

[17] Section 11(1)(aa) of the *Australian Human Rights Commission Act 1986* (Cth).

b. there are reasonable grounds to suspect that one or more contraventions of the Act have occurred; and

c. the investigation would advance the objectives of the Act.

99. The AHRC should be provided with similar powers to conduct investigations into suspected breaches of the DDA. The power should be sufficiently broad to permit the AHRC to conduct an audit of an insurer's actuarial and statistical data where it seeks to rely on s 46 of the DDA.

Ensuring greater clarity in the application process by improving questions in health questionnaires

100. Insurers should be required to improve the structure and content of the health questionnaires they use by ensuring that questions in application forms:

a. are simple, clear and specific;

b. ask only one question at a time and not bundle several questions together at once;

c. not ask questions requiring knowledge which the applicant could not reasonably be expected to possess;

d. are accompanied by examples of the type of information that is sought where possible;

e. provide sufficient opportunity for an applicant to provide more detailed answers where necessary; and

f. only ask questions that are relevant to the insurer's underwriting guidelines and its risk assessment of the applicant.

Improving Industry Codes of Practice

101. The industry Codes of Practice administered by the Insurance Council of Australia (for general insurers) (**ICOA**) and the Financial Services Council (for life insurers) (**FSC**) are currently being reviewed by the ICOA and the FSC.

102. These codes should:

a. be binding and enforceable;

b. be approved by ASIC in accordance with ASIC Regulatory Guide 183 "Approval of Financial Services Sector Codes of Conduct";

c. set out guidance about insurers' obligations under the DDA. This guidance should be drawn from the AHRC Guidelines; and

d. require insurers to:

i. ensure that applications for insurance that reveal a mental health condition or symptoms of a mental health condition are not automatically declined;

ii. refer applications for insurance that reveal a mental health condition or symptoms of a mental health condition to an appropriately qualified underwriter and obtain further information from the applicant to assist in the proper risk assessment of their application;

iii. wherever possible, provide cover to persons with a past or current mental health condition and manage risk through policy pricing, exclusions, limits and caps based on actuarial and statistical data and other relevant factors, rather than not provide cover at all;

iv. ensure that products are not designed to include blanket mental health exclusions;

v. ensure that where a policy is offered with a blanket mental health exclusion or a premium loading, that the exclusion (including the breadth of the exclusion) and the premium loading satisfy s 46 of the DDA;

vi. ensure that where a policy is offered with a blanket mental health exclusion or a premium loading, specify:

A. how long it is intended that the exclusion or higher premium will apply to the policy;

B. the criteria the insured would be required to satisfy to have the exclusion removed or premium reduced; and

C. the process for removing or amending the exclusion/premium;

vii. automatically provide applicants with detailed written reasons when they refuse to provide insurance or offer cover on non-standard terms (e.g. with an exclusion or a premium loading), which at a minimum refers to the specific grounds on which the decision was made having regard to the disclosures made during the application process and the risk according to actuarial and statistical data;

viii. ensure that claims are assessed according to current, commonly accepted professional standards and diagnoses; and

ix. provide training to staff (not just call centre operators but also underwriters and managers) on:

A. mental health conditions, the spectrum on which they can occur and their treatment;

B. the operation and requirements of s 46 of the DDA and the equivalent provisions in state and territory anti-discrimination legislation; and

C. communicating with people with mental illness.

103. The Life Insurance Code of Conduct should be amended to:

a. require insurers to vary rather than cancel policies wherever reasonably possible (consistent with the ICA); and

b. include guidance notes providing examples of situations in which variation rather than cancellation of a policy is appropriate, including where the insured has made a claim on their policy for an illness or condition that is unrelated to the illness or condition that it is alleged was required to have been disclosed during the application process.

Annexure A

Examples of travel insurance policies with blanket mental health exclusions as at 19 April 2018

(hyperlinks to relevant PDSs provided in 'Insurer' column)

Insurer	Wording of exclusion
Nomad[18]	We won't pay for costs arising in any way from: 15. Any mental illness as defined by Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), whether or not the condition arises independently or is secondary to other medical conditions, including but not limited to: dementia, depression, anxiety, stress, or other mental or nervous conditions (except claims following assault as outlined under Section 1.5 - Clinical psychology (Explorer Plan); behavioural diagnoses; a drug or alcohol addiction; eating disorders.
Allianz Australia[19]	p 40: We will not pay under any circumstances if: cl B.8: Your claim arises from or is in any way related to mental illness including: dementia, depression, anxiety, stress or other mental or nervous condition; or conditions that have resulted in behavioural issues; or a therapeutic or illicit drug or alcohol addiction.
American Express AU[20]	cl 11: We will not (under any Section) pay for claims arising directly or indirectly from: (18): Your nervous, anxiety or stress disorders resulting in a disinclination to travel or complete Your Journey.
Citibank[21]	cl 10: We will not pay (under any Section) for claims arising directly or indirectly from: (16): Your or a Travelling Companion's nervous, anxiety or stress disorders resulting in a disinclination to travel or complete Your Journey.
GIO[22]	p 52: We will not pay claims arising from:

[18] https://productsapi.worldnomads.com/v1/insuranceContract/8/pds?preferredDocumentFileType=HTML&planId=13&countryCode=AUS#exclusions

[19] https://travel.allianz.com.au/allianztravel/File/Download?docType=PDS

[20] https://www.americanexpress.com/au/content/pdf/insurance/files/travel-insurance-pds.pdf

[21] https://www.citibank.com.au/global_docs/pdf/12594_CitibankOneTrip_DL.pdf

[22] https://www.gio.com.au/documents/travel/holiday-travel/gio-holiday-travel-insurance-pds.pdf

Insurer	Wording of exclusion
	cl 6: all psychiatric, mental, nervous, emotional, personality and behavioural disorders, including but not limited to phobias, stress, anxiety and depression,
HSBC AU[23]	p 36-40: To the extent permitted by law we will not pay if: Your claim arises from or is in any way related to: • mental illness or: dementia, depression, anxiety, stress • or other mental or nervous condition; or • conditions that have resulted in behavioural issues; or • a therapeutic or illicit drug or alcohol addiction.
NAB Travel[24]	p 16-7: Excluded conditions … Part A is a list of Pre-existing Medical Conditions for which there is no cover for medical expenses, cancellation costs or additional expenses Arising from or related to these particular conditions. Pt A, cl 10: Any mental illness as defined by DSM-IV including: a) Dementia, depression, anxiety, stress or other nervous condition; or b) Behavioural diagnoses such as but not limited to autism; or c) A therapeutic or illicit drug or alcohol addiction. p 55-6: We will not pay under any circumstances if: cl 16: Your claim Arises from, is related to or associated with any Pre-existing Medical Condition, except as provided under the section "Pre-existing Medical Conditions" (pages 13 to 21) section 1.1 d (page 37) and section 4.1 e (page 41) […] cl 23: Your claim Arises from or is in any way related to depression, anxiety, stress, mental or nervous conditions.
Real Travel Insurance[25]	p 48: We will not pay for any claim or loss under any circumstances if Your claim Arises from: cl 28: or is in any way related to depression, anxiety, stress, mental or nervous conditions;

[23] https://enhance.agatravelinsurance.com.au/hsbc/File/Download?docType=PDS

[24] https://www.nab.com.au/content/dam/nabrwd/personal/insurance/documents/travel-insurance-spds-pds.pdf

[25] https://www.realinsurance.com.au/RealInsurance-Mk2/media/documents/pds/travel/real-insurance-travel-pds.pdf

Insurer	Wording of exclusion
Suncorp[26]	p 48: We will not pay claims arising from: cl 6: all psychiatric, mental, nervous, emotional, personality and behavioural disorders, including but not limited to phobias, stress, anxiety and depression,
Travel Insurance Direct[27]	p 24: We will not pay for any claim arising from or relating to the following: cl 27: Any mental illness defined by DSM IV including but not limited to dementia, depression, anxiety, stress, or other nervous condition, behavioural diagnoses such as autism, eating disorders, a drug or alcohol addiction.
Virgin Money[28]	We will not pay for: B.7 Your claim arises from or is in any way related to: • mental illness; or • dementia, depression, anxiety, stress or other mental or nervous condition; or • conditions that have resulted in behavioural issues; […]

[26] https://www.suncorp.com.au/content/dam/suncorp/insurance/suncorp-insurance/documents/travel/holiday-travel/holiday-travel-insurance-pds.pdf

[27] https://www.travelinsurancedirect.com.au/pds

[28] https://virginmoney.com.au/content/dam/virginmoney/vma-downloads/Travel-Insurance/Travel-Insurance-Product-Disclosure-Statement.pdf

Annexure B

Examples of income protection insurance policies with blanket mental health exclusions as at 19 April 2018

(hyperlinks to relevant PDSs provided in 'Insurer' column)

Insurer	Exclusion
AAMI[29]	p 20-21 6. When we will not pay - Disability Benefit: We will not pay the Disability Benefit, refund or waive any premiums under your policy if the event giving rising to the claim, directly or indirectly, is a result of: […] Any mental disorder or mental illness
ANZ[30]	p 13 We do not pay any claim arising directly or indirectly from: […] a mental illness condition
NRMA[31]	p 24: General exclusions for both Income Protection Cover and Essentials Cover – We won't pay a benefit if the claim is caused directly or indirectly by: • Any mental health disorder; including anxiety disorders, depression and stress, disorders related to fatigue, drug or alcohol abuse
Suncorp[32]	p 20: cl6 What we won't pay - Disability Benefit We will not pay the Disability Benefit, refund or waive any *premiums* under *your policy* if the event giving rise to the claim, directly or indirectly, is as a result of: […] any *mental disorder or mental illness* […]

[29] https://www.aami.com.au/aami/documents/life-and-income/income-protection/pds-income-protection.pdf
[30] https://www.wealth.anz.com/content/dam/anzwealth/pdfs/insurance/ANZ-Income-Protection-Insurance-PDS.pdf
[31] https://www.nrma.com.au/sites/nrma/files/nrma/policy_booklets/income_pds_0617_all.pdf

Insurer	Exclusion
Virgin money[33]	p 13: When is a benefit not payable? No Sickness and Injury or Permanent Disability Cover Benefit will be payable for: • Any mental health disorder, including anxiety, depression, stress, adjustment disorders, eating disorders, emotional or behavioural disorders, disorders relating to fatigue including chronic fatigue syndrome, myalgia, drug or alcohol abuse, psychosomatic disorders, or any treatment complications; […]
Guardian Insurance[34]	P 12: We will not pay an Income Benefit in respect of a claim for a Disabling Sickness or Injury occurring directly or indirectly from: • a Mental Disorder or Illness; […] P 16: We will not pay a Homemaker Benefit in respect of a claim for a Sickness or Injury occurring directly or indirectly from: […] • a Mental Disorder or Illness
OnePath Easy Protect[35]	P 11: We will not pay a claim arising directly or indirectly from: • a mental illness condition; […]

[32] https://www.suncorp.com.au/content/dam/suncorp/insurance/suncorp-insurance/documents/life-and-income/income-protection/suncorp-income-protection-pds.pdf

[33] https://virginmoney.com.au/content/dam/virginmoney/vma-downloads/life-insurance/Virgin-Money_IP_LI_PDS_FSG.pdf

[34] https://www.guardianinsurance.com.au/resources/pdf/Income/guardian-income-protection-pds.pdf

[35] http://www.onepath.com.au/public/pdfs/OnePath-EasyProtect-Income-Protection-PDS.pdf

Insurer	Exclusion
Budget Direct[36]	P 7 10. We will not pay the monthly benefit if the serious illness or injury occurred directly or indirectly from; • A mental disorder, illness or condition.
Real Insurance[37]	P 11: We will not pay an Income Benefit in respect of a claim for a Disabling Sickness or Injury occurring directly or indirectly from: • a Mental Disorder or Illness; or […]
Medibank[38]	P 11: We will not pay an Income Benefit in respect of a claim for a Disability occurring directly or indirectly as a result of: • a Mental Disorder or Illness; or […]
nib[39]	P 11: […] For nib Income Protection cover and Basics cover or when making a claim for Permanent Disability Cover or Involuntary Unemployment Cover, no Benefit will be payable under this Policy if the event giving rise to the claim is caused directly or indirectly by: • Any mental health disorder, including: anxiety disorders and depression; stress or adjustment disorders; eating disorders; emotional or behavioural disorders; drug or alcohol abuse; psychosomatic disorders; or any treatment complications. […]

[36] https://secure.budgetdirect.com.au/branding/resources/BUDD/legal/income-protection/PDS.pdf?_ga=2.39282147.198680171.1521527077-833957357.1518509456&_gac=1.149087746.1521527077.EAIaIQobChMIvKWWoKH62QIVWwQqCh3aMQ_6EAAYASAAEgLQ_vD_BwE

[37] https://www.realinsurance.com.au/RealInsurance-Mk2/media/documents/pds/income/real-insurance-income-pds.pdf

[38] https://www.medibank.com.au/content/dam/retail/travel-pet-life-assets/pds/life/Medibank_Income_Protection_PDS_Dec2015_WEB.pdf

[39] https://www.nib.com.au/docs/life-insurance-income-protection-pds

Insurer	Exclusion
Insuranceline[40]	P 26: […] For your standard personal Cover on Income Protection Plus (Rate Saver and Time Saver), or when making a claim for Permanent Disability Cover, no Benefit will be payable under this Policy if the event giving rise to the claim is caused directly or indirectly by: • Any mental health disorder, including: anxiety disorders and depression; stress or adjustment disorders; eating disorders; emotional or behavioural disorders; drug or alcohol abuse; psychosomatic disorders, or any treatment complications. […]
RACQ[41]	P 18: Please read this section carefully to understand what is not covered. • Mental Illness, including any condition which is directly or indirectly contributed to, caused or aggravated by Mental Illness.

[40] https://www.insuranceline.com.au/~/media/PDS/income-protection-pds.ashx

[41] https://www.racq.com.au/insurance/learn-more-about-insurance/product-disclosure-statements#life

Annexure C

Matrix of documents relevant to particular enquiries

	Subject of enquiry	Information held by insurers
1.	To obtain statistics on the prevalence of the issues identified in this submission:	Yearly statistics (for at least the past 5 years, broken down according to the type of policy eg income protection, TPD, life, travel and by gender and age) on: • the number of applicants for insurance who have been declined cover for mental health reasons and the total proportion this represents of all applications that were declined; • the number of applicants for insurance who have been offered insurance with a mental health exclusion and/or a premium loading and the total proportion this represents of all individuals offered insurance; • the number of applications for insurance who, after being offered insurance with a mental health exclusion and/or a premium loading, accepted the offer; • the number of applicants for insurance who have disclosed a mental health condition and been offered insurance without a mental health exclusion or a premium loading and the total proportion this represents of all individuals offered insurance; • for policies with a mental health exclusion, the terms of that exclusion; and • the number of policies cancelled by an insurer on the basis of purported non-disclosure or misrepresentation of a mental health condition during the application process and the total proportion this represents of all policies cancelled on the grounds of non-disclosure or misrepresentation.

	Subject of enquiry	Information held by insurers
2.	To investigate individual refusals to provide insurance because the applicant disclosed a past or current mental health condition or symptoms of a past or current mental health condition:	• the personal and medical questionnaires completed by the applicant during the application process; • the medical documents relied on by the insurer to refuse to issue the policy; • any information and documents (in whatever form) provided by the insurer to the applicant about their application; • the underwriting procedures and guidelines relied upon by the insurer when it decided to refuse to provide insurance; and • any statistical or actuarial data or other relevant information relied upon by the insurer when it decided to refuse to provide insurance.
3.	To investigate insurance products with automatic processes to decline applications revealing a mental health condition (e.g. when an applicant applies via an online application process):	• the underwriting guidelines; • the internal policies and manuals which inform the underwriting guidelines; • the documents regarding the product's design including the design of the questions in the application process and any programmed responses to those questions; and • the internal training and other guidance material provided to customer service officers.
4.	To investigate individual insurance policies that are offered with mental health exclusions and/or premium loadings because the applicant disclosed a past or current mental health condition or symptoms of a past or current mental health condition:	• the policies and the certificates of insurance; • the personal and medical questionnaires completed by the insured person during the application process; • the medical documents relied on by the insurer to issue the policy with a blanket mental health exclusion and/or a premium loading; • any information and documents (in whatever form) provided by the insurer to the insured about the mental health exclusion and/or the premium loading;

	Subject of enquiry	Information held by insurers
		• the underwriting procedures and guidelines relied upon to determine that the mental health exclusion and/or premium loading was reasonable; and • any statistical or actuarial data or other relevant information that the insurer relied upon to determine that the mental health exclusion and/or the premium loading was reasonable.
5.	To investigate products which are designed to include blanket mental health exclusions applicable to all persons covered by the policy regardless of their past or current mental health history:	• the product disclosure statement for the policies; • any underwriting procedures and guidelines relied upon to determine that the mental health exclusion was reasonable; • any statistical or actuarial data that the insurer relied upon to determine that the mental health exclusion was reasonable; and • internal documents and communications relating to the design and approval of the product.
6.	To investigate individual policies that were cancelled because of a failure to disclose a past or current mental health condition or a misrepresentation by the insured in relation to a past or current mental health condition:	• the policies and the certificates of insurance; • the claim forms; • the personal and medical questionnaires completed by the insured person during the application process; • any medical documents relied upon by the insurer to cancel the policy; • all information and documents (in whatever form) provided by the insurer to the insured about the decision to cancel the policy; and • the insured's written reasons for the decision to cancel the policy.
7.	To investigate individual complaints by customers regarding: a. a refusal to provide insurance because of the	• the complaint file including documents which evidence: - the complaint by the customer; - communications between the insurer and the complainant during the complaint process;

	Subject of enquiry	Information held by insurers
	disclosure of a past or current mental health condition or symptoms of a past or current mental health condition; b. an offer of a policy with a blanket mental health exclusion and/or a premium loading which is placed on the policy due to the disclosure of a past or current mental health condition or symptoms of a past or current mental health condition; c. a refusal to pay a claim because of a blanket mental health exclusion on the policy; or d. a policy that has been cancelled because of a failure to disclose a past or current mental health condition or symptoms of a past or current mental health condition:	- the result of the complaint following the insurer's IDR process; and - the result of any complaint made by the complainant to the AHRC, FOS or a state anti-discrimination body. • statistics on: - complaint handling timeframes; - changes in decision by insurers following IDR; and - results in FOS, the AHRC or a state anti-discrimination body.
8.	To investigate the effectiveness of internal complaints processes:	• statistics on: - the number of complaints that proceed to external dispute resolution; - the number of complaints made to the ICA Code Governance Committee under the General Insurance Code of Practice regarding complaints handling; and - the number of complaints made to the FSC Life Code Compliance Committee under the Life Insurance Code of Practice regarding complaints handling.