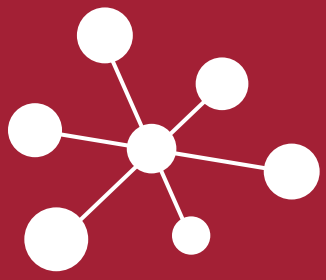

public interest
ADVOCACY CENTRE

Mental Health Discrimination in Insurance

October 2021

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About the Public Interest Advocacy Centre

The Public Interest Advocacy Centre (PIAC) is a leading social justice law and policy centre. Established in 1982, we are an independent, non-profit organisation that works with people and communities who are marginalised and facing disadvantage.

PIAC builds a fairer, stronger society by helping to change laws, policies and practices that cause injustice and inequality.

OUR WORK COMBINES:

- legal advice and representation, specialising in test cases and strategic casework;
- research, analysis and policy development; and
- advocacy for systems change and public interest outcomes.

OUR PRIORITIES INCLUDE:

- Reducing homelessness, through the Homeless Persons' Legal Service
- Access for people with disability to basic services like public transport, financial services, media and digital technologies
- Justice for First Nations people
- Access to sustainable and affordable energy and water (the Energy and Water Consumers' Advocacy Program)
- Fair use of police powers
- Rights of people in detention, including equal access to health care for asylum seekers (the Asylum Seeker Health Rights Project)
- Improving outcomes for people under the National Disability Insurance Scheme
- Truth-telling and government accountability
- Climate change and social justice.

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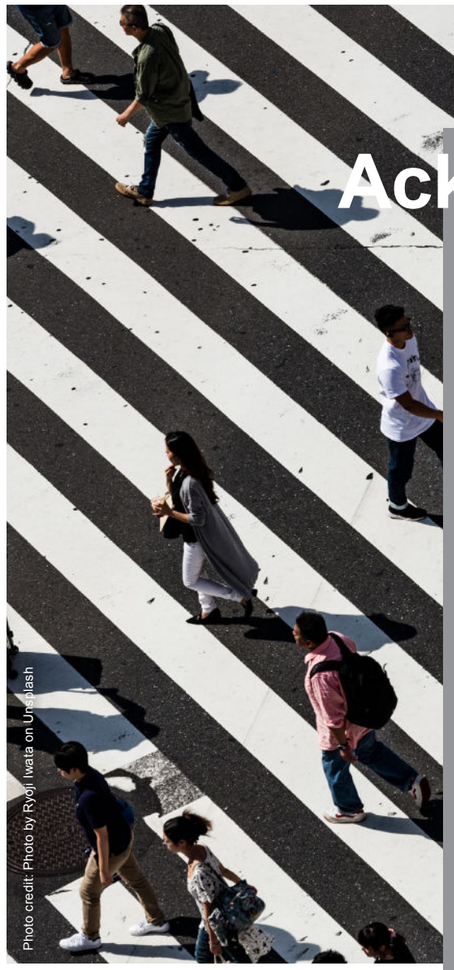

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PIAC: Mental Health Discrimination in Insurance

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PIAC would like to thank the people with lived experience of mental health conditions and health discrimination whose stories have informed this report. Each person whose experiences are related in this report are named with a pseudonym to protect their identity.

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Thank you to Michelle Cohen, Laura Lombardo, Mary Flanagan, Ellen Tilbury and the many lawyers, support staff and volunteers who have contributed to PIAC's work on this project since 2012.

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Contents

Abbreviations

ADL — Activities of Daily Living

ADW — Activities of Daily Work

AFCA — Australian Financial Complaints Authority

AFSL — Australian Financial Services Licence

AHRC — Australian Human Rights Commission

APRA — Australian Prudential Regulation Authority

ASIC — Australian Securities and Investments Commission

CGC — Code Governance Committee for the General Insurance Code of Practice

DDA — Disability Discrimination Act 1992 (Cth)

FOS — Financial Ombudsman Service

FSC — Financial Services Council

GP — General Practitioner

IC Act — Insurance Contracts Act 1984 (Cth)

Life CCC — Life Insurance Code Compliance Committee

NSW ADB — NSW Anti-Discrimination Board

PDS — Product disclosure statement

PIAC — Public Interest Advocacy Centre

PJC — Parliamentary Joint Committee on Corporations and Financial Services

RACGP — Royal Australian College of General Practitioners

TPD — Total and permanent disability/disablement

VCAT — Victorian Civil and Administrative Tribunal

VEOHRC — Victorian Equal Opportunity and Human Rights Commission

Glossary of terms

BLANKET EXCLUSION

a clause in the standard terms and conditions of an insurance policy that excludes or limits coverage for all policyholders for the stated event or condition.

BROAD MENTAL HEALTH EXCLUSION

a non-standard clause in an insurance policy issued to an individual that excludes or limits coverage for claims arising from any mental health condition.

DISABILITY

disability as a term can be used differently in different contexts and jurisdictions. The UN Convention on the Rights of Persons with Disabilities recognises that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others. This understanding distinguishes impairment (being the medical condition that leads to disability) from the result of that impairment in society.

This report refers to disability in the context of discrimination law in Australia. Both 'disability' and 'impairment' are used to describe attributes protected by anti-discrimination legislation at the Commonwealth and State and Territory level. Those definitions vary but generally have in common that disability for the purpose of discrimination law:

- may concern bodily or mental functions;
- includes a disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgment or that results in disturbed behaviour;
- includes a disability that existed in the past, that may exist in the future, or that is presumed or imputed to exist; and
- includes behaviour that is a symptom or manifestation of a disability.

DISCRIMINATION

when a person or group is treated less favourably than another person or group because of certain attributes (direct discrimination), or when an unreasonable rule or policy applies to everyone but disadvantages or is likely to disadvantage people with certain attributes (indirect discrimination).

GENERAL INSURANCE

types of insurance that are not life insurance, such as car insurance, home insurance, and travel insurance, which pay the person with the insurance policy if they suffer loss covered by the policy.

GROUP INSURANCE

an insurance policy issued to a group, typically a superannuation fund, that is available for members of the group to access.

INSURANCE POLICY

a contract that sets out the terms and conditions on which an insurance product is provided, and the premium paid by the insured person.

LIFE INSURANCE

an insurance policy that pays in the event of death, illness or disability. Different life insurance products include cover for death, total and permanent disability, trauma, and income protection.

MENTAL HEALTH CONDITION / MENTAL ILLNESS

general term for a range of illnesses or conditions that can affect a person's thinking, perceptions, mood or behaviour. These include more common conditions such as anxiety and depressive disorders, as well as less common but often more severe conditions such as schizophrenia and other forms of psychotic illness, as well as psychological conditions such as borderline personality disorder and eating disorders. Mental illnesses vary in severity and in how long they affect people.

PREMIUM LOADING

an additional premium charged by an insurer to account for increased risk in individual insurance policies.

UNDERWRITING

an insurer's process for determining whether or not to take on a risk by entering into a contract of insurance, and, if so, the terms and conditions of the insurance policy and the premium charged.

Summary of Recommendations

01.
Monitoring of General Insurance practices

The General Insurance Code of Practice should include a commitment by insurers to regularly report to the Insurance Council of Australia on the processes, procedures and policies they have implemented to ensure compliance with anti-discrimination laws and to meet their Code obligations, with reference to the 'Guide on mental health'. The Insurance Council of Australia should provide those reports to the Australian Human Rights Commission.

02.
Review of blanket mental health exclusions

ASIC should conduct a review to determine whether blanket exclusions for mental health conditions continue to be used in life insurance policies.

The Life Insurance Code of Practice should include a commitment not to design and sell products which incorporate a blanket mental health exclusion in the general terms of the policy.

03.
Claims and policy avoidance

The Life Insurance Code of Practice should include commitments as recommended by the PJC Inquiry to:

- where a pre-existing condition is to be used by an insurer as the basis for denying a claim or avoiding a contract, a direct medical connection between the prognosis of a pre-existing diagnosed condition and the claim must be established; and
- the statistical and actuarial evidence and any other material used to establish a pre-existing condition, as well as a written summary of the evidence in simple and plain language, be provided by the life insurer to the consumer/policyholder on request.

04.
Review of insurer access to clinical records

In 2023, ASIC or another appropriate body should review whether the protocols for insurer access to clinical records have resulted in more targeted requests for clinical information, and whether they give sufficient protections to people with histories that include seeking psychological treatment or counselling.

05.
TPD insurance in Superannuation

All insurers and superannuation trustees should remove ADL and other restrictive TPD definitions from insurance policies.

Photo credit: Photo by Charles Deluvio on Unsplash

Insurers should report annually, regularly review the data they rely on, and wherever possible, provide cover

06.
Life Insurance Code of Practice

The Life Insurance Code of Practice should include additional commitments to comply with anti-discrimination laws including to:

- at a minimum, design and sell products and apply their terms in compliance with the requirements of the Disability Discrimination Act 1992 and/or any relevant State or Territory anti-discrimination requirements;
- ensure decisions are evidence- based, involving relevant sources of actuarial and statistical data where this is available, and having regard to any other relevant factors including the individual circumstances of the applicant;
- regularly review and update underwriting processes and the information relied upon to make decisions to ensure these are not relying on out-of-date or irrelevant sources of information;
- not automatically decline an application where the application reveals a past or current mental health condition or symptoms of a mental health condition;
- wherever possible, provide cover to persons with a past or current mental health condition and manage risk through pricing, exclusions, limits and caps based on actuarial and statistical data and other relevant factors, rather than not provide cover at all;
- allow applicants the opportunity to withdraw their application before declining to offer insurance or offering insurance on non-standard terms;
- tell consumers, where insurance is offered on non-standard terms (for example, with a mental health exclusion or a higher premium than a standard premium):
  - how long it is intended that the exclusion/higher premium will apply to the policy;
  - how and when the insured can ask for the exclusion to be removed or premium reduced, and the criteria they would need to satisfy; and
  - to develop, implement and maintain policies that reflect the above.
- The proposed Appendix B to the Code regarding supporting customers experiencing a mental health condition should form an enforceable part of the Code and include the additional commitments outlined in these recommendations.
- Provisions of the Life Insurance Code of Practice which make commitments regarding decisions to offer or decline insurance, or to offer insurance on non-standard terms, should be made enforceable code provisions.

07.
Transparency regarding actuarial and statistical data

Insurers should be required by their respective Codes of Practice to provide, directly to an applicant or insured on request, the actuarial and statistical data and relevant factors relied on to make a decision to decline cover or offer cover on non-standard terms on the basis of disability.

The AHRC and all state-based anti-discrimination bodies should be given the power to compel insurers to provide the actuarial and statistical data and other evidence relied upon in complaints of unlawful disability discrimination.

08.
Insurance industry improves quality and use of actuarial and statistical data

The General Insurance Code of Practice and the Life Insurance Code of Practice should include a commitment by insurers to regularly review the data they rely on to make decisions to discriminate on the basis of mental health and continually seek better data to enable differentiated underwriting of particular mental health conditions.

09.
Insurers report on disability discrimination

Insurers should be required to report annually to the AHRC or another appropriate body on the number of times they have declined insurance or offered insurance on non-standard terms on the ground of disability.

10.
Improve dispute resolution processes

AFCA should request ASIC to approve a change to its Rules to enable AFCA to consider complaints regarding unlawful discrimination in relation to applications for insurance.

11.
Investigation by ASIC

ASIC should investigate, as recommended by the Productivity Commission, life insurance industry practices relating to the provision of services to those with mental health conditions. The investigation should consider discrimination in relation to mental health in the underwriting of insurance policies and adopt a model for investigation similar to that used by VEOHRC in its investigation into travel insurance.

1 Introduction

1.0 Introduction

Since 2012, PIAC's Mental Health & Insurance Project has been tackling systemic problems in the way insurers design, price and offer policies and assess claims to the detriment of people with past or current mental health conditions. These problems have arisen in both life and general insurance products such as income protection, total and permanent disability, death and travel insurance. PIAC has worked with Beyond Blue, Mental Health Australia and SANE Australia to expose these issues and advocate for change.

PIAC, together with its partners in the mental health sector, embarked upon this work having identified longstanding concerns about the barriers facing many people living with mental health conditions when accessing insurance. Beyond Blue and Mental Health Australia's research, Mental health, discrimination and insurance: A survey of consumer experiences 2011 (**Consumer Experiences Survey**) revealed experiences of discrimination when applying for insurance products and making insurance claims, including increased premiums, excessive restrictions on policies, rejection of cover and of when a history of a mental health condition was disclosed.[1]

Almost half of all adult Australians have experienced a mental health condition, and insurance is a vital service that many Australians rely upon to protect their financial security and ultimately their wellbeing. It is therefore a matter of public interest that insurance providers act fairly and without discrimination, basing their decisions on robust evidence and contemporary understandings of mental health conditions. This has been highlighted by the mental health impacts of the COVID-19 pandemic and the increase in people accessing mental health treatment.[2]

The Productivity Commission, in its recent landmark report into mental health in Australia, has recognised the important role insurance plays in supporting people with mental health conditions and in experiences of stigma and discrimination.[3] Prior to that report, several major inquiries, including the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (**Financial Services Royal Commission**), Victorian Equal Opportunity and Human Rights Commission (**VEOHRC**) Investigation into Mental Health Discrimination in Travel Insurance, and the Parliamentary Joint Committee on Corporations and Financial Services Life Insurance Industry Inquiry (**PJC Inquiry**), have prompted significant reform to the legal and regulatory framework for insurance, and to insurance industry practices. The insurance industry itself has acknowledged the need to change its approach as community attitudes to mental health change.

Notable changes include the removal of blanket exclusions from travel insurance policies and a significant reduction in their use in life insurance products like income protection, and the reform of the Insurance Contracts Act 1984 (Cth) to better protect consumers from unfair avoidance of claims by insurers. Both the general insurance and life insurance industries have introduced and updated Codes of Practice for insurers to improve their interactions with consumers, including making specific commitments to treat consumers experiencing mental health conditions fairly.

However, significant challenges remain for people living with mental health conditions, or who have experienced mental health conditions or symptoms in the past, wishing to access insurance. Those challenges include the continued likelihood of being denied cover or offered cover subject to broad exclusions for mental health, and the difficulties encountered when people try to question or challenge those decisions, as well as the absence of clear evidence to support insurer practices of discrimination.

This report outlines the progress that has been made in the areas of travel insurance and life insurance, as well as the remaining challenges, to provide an up-to-date overview of issues of mental health discrimination in insurance and options for reform. The report outlines some of the barriers and discrimination faced by those attempting to access and use insurance when they have a mental health condition or a past mental health history, drawing on case data and lived experience of PIAC's clients through case studies from PIAC's work over the past decade.

PIAC hopes the report will provide mental health sector advocates, researchers and consumer advocates with a resource to assess the current issues and continue to advocate for necessary changes to insurance industry practices.

1. 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/about-us/about-our-work/discrimination-in-insurance.

2. See, for example, ABC News, 'Mental health insurance problems to be exacerbated by COVID-19' (8 February 2021) https://www.abc.net.au/news/2021-02-08/insurance-coverage-mental-health-after-covid-19/13122144.

3. Productivity Commission, Inquiry Report: Mental Health, (Report No 95, 30 June 2020) Vol 2, 371-372, available https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume2.pdf.

Almost half of all adult Australians have experienced a mental health condition, and insurance is a vital service that many Australians rely upon

2 Background

2.1
Mental health in the community

In 2007, the Australian Bureau of Statistics reported that almost half of all adult Australians have experienced mental illness, and one in five Australians have experienced mental illness in any given year.[4] These rates, however, likely underestimate the actual prevalence of mental health conditions in Australia: some parts of the community are under-represented (for example, people who are homeless or in aged care), and people may under-report due to a reluctance to disclose or to seek treatment for mental health conditions[5]. In addition, many people experience mental ill-health without meeting the diagnostic criteria for mental illness. [6] These experiences may nonetheless affect a person's ability to access or claim on insurance products.

The ongoing COVID-19 pandemic is having widely recognised impacts on mental health and wellbeing.[7] These stem from public health measures like lockdowns and associated stressors such as remote work and schooling, loss of employment, financial hardship, and reduction in social interaction, which may contribute to or exacerbate existing mental health conditions. One indicator of this burden is the increase in demand for mental health-related services. Over 1 million mental health-related services were processed through Medicare in the four weeks to 25 April 2021, which is roughly 18% higher than in the same periods in 2019 and 2020[8]. As increasing numbers of people access mental health treatment, some for the first time, more and more people are likely to be impacted by the issues described in this report.

While awareness of mental health is increasing across the community, stigma and discrimination continues to prevent people from accessing the support and treatment they need. The acknowledgement of this by the Productivity Commission in 2020 resulted in a suite of recommendations for reform of systems to treat and support people living with mental health conditions, including the priority recommendation for the National Mental Health Commission to develop and drive a National Stigma Reduction Strategy.[9] Alongside that, the Productivity Commission recommended changes be made in the insurance sector to 'better support people to live fulfilling lives'[10].

4. 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

5. Productivity Commission, Inquiry Report: Mental Health, (Report No 95, 30 June 2020) Vol 2, 110-11, available https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume2.pdf

6. Ibid 111.

7. National Mental Health Commission, National Mental Health and Wellbeing Pandemic Response Plan (Report, May 2020) available https://www.mentalhealthcommission.gov.au/getmedia/1b7405ce-5d1a-44fc-b1e9-c00204614cb5/National-Mental-Health-and-Wellbeing-Pandemic-Response-Plan

8. Australian Institute of Health and Welfare, Mental Health Services in Australia (July 2021) available https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/covid-19-impact-on-mental-health.

9. Productivity Commission, Inquiry Report: Mental Health, above n 3, 354.

10. Ibid.

2.2
Experiences of discrimination in insurance

Unfortunately, people living with mental health conditions, or who have experienced a mental health condition or symptoms of a mental health condition in the past, continue to find it more difficult than others to access many forms of insurance. In 2011, Beyond Blue and Mental Health Australia published research based on the results of a survey examining the experiences of Australians living with a mental health condition, their friends and families when applying for insurance. The Consumer Experiences Survey revealed that people living with mental health conditions experience significant difficulty and discrimination when applying for insurance products and making claims against their policies. It noted that Australians with experience of mental health conditions often face increased premiums, excessive restrictions on their policies and outright rejection of their applications and claims when a history of mental illness is disclosed.[11]

Since that time, Beyond Blue, Mental Health Australia and other organisations including PIAC have continued to advocate for change to policies and practices in the insurance and financial planning sectors regarding mental health. The experiences of PIAC's clients reflect many of the findings of the Consumer Experiences Survey.

11. Mental Health Council of Australia and beyondblue, Mental Health Discrimination and Insurance: A Survey of Consumer Experiences 2011, above n 1, 4.

Case study 1

Jessica was diagnosed with bipolar disorder ten years prior. Jessica's condition was well managed with medication. She was never hospitalised and had never taken time off work because of her condition. Jessica applied for increased income protection and Total and Permanent Disability (TPD) insurance through their superannuation provider. The application was denied. Jessica then applied for a standalone income protection policy with a different insurer and the application was again declined. Jessica then applied to increase her 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 Jessica before declining the application. None of the insurers considered the option of providing cover on non-standard terms taking into account Jessica's pre-existing bipolar disorder.

Case study 2

Suzanne 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. Her husband flew to Thailand to accompany her on the journey home. She was subsequently diagnosed with bi-polar disorder and received medical treatment in Australia.

Upon return to Australia, Suzanne 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 she 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.

Photo credit: Photo by Kevin Turcios on Unsplash

National Stigma Report Card 2020

In 2020, SANE Australia published the National Stigma Report Card which reported on the results of the Our Turn to Speak survey of the experiences of stigma and discrimination of 1,912 people living with complex mental health issues.[12] This included a survey of respondents regarding their experiences with financial services and insurance. The National Stigma Report Card indicates that stigma and discrimination in the insurance sector remains a significant issue.

Of the survey participants, 140 people identified financial and insurance services as one of up to three life domains that had been most affected by stigma and discrimination[13]. Fifty-eight percent of participants who selected financial and insurance services as one of their most affected life domains during the last 12 months indicated 'frequent' or 'very frequent' experiences of stigma and discrimination in this aspect of their lives.[14] Almost 90% of participants agreed they had been treated unfairly by insurance providers when applying for insurance products.[15] It is of particular concern that 77.7% of participants who had used (or tried to use) insurance services agreed that they had been unfairly denied access to insurance products because of stigma about mental health issues.[16]

Participants' comments identified income protection, life insurance, total and permanent disability insurance, travel insurance, and health insurance as products to which they had been denied access. Participants explained that they were more likely to be approved for such insurance products if they did not disclose their experiences of complex mental health issues. On participant from Victoria remarked: 'I had car accident which all my mental and physical injuries are covered for lifetime and yet I was declined income protection because I admitted to diagnosis of PTSD'[17]. Another from South Australia stated: 'I am not able to receive travel insurance unless I exclude my mental health condition. I am not able to receive, Income Protection, or Life insurance due to my mental health condition.'[18]

12. Christopher Groot et al, Report on Findings from the Our Turn to Speak Survey: Understanding the Impact of Stigma and Discrimination on People Living With Complex Mental Health Issues (Report, 12 October 2020) available https://nationalstigmareportcard.com.au/national-stigma-report-card/the-report.

13. Ibid 243.

14. Ibid.

15. Ibid 244.

16. Ibid 244.

2.3 Role of insurance

Insurance gives people a way to financially protect themselves against a range of unexpected events that can result in financial hardship and emotional stress. Many people have insurance products such as life insurance, income protection insurance, and temporary or permanent disability insurance through their superannuation funds or directly from insurers, as well as workers' compensation, private health insurance and travel insurance.[17]

Broadly, contracts for insurance are either a policy of:

- general insurance, which covers short-term risks (such as car and vehicle insurance, home and contents, travel and credit card); or
- life insurance, which covers the long-term life risk of the insured (such as income protection and health insurance).

In any of these insurance products, an insurer estimates the liability of a consumer for a particular loss. The insurer then sets an amount or range of cover it is prepared to indemnify, considers what premium to apply to provide the indemnity and, finally, offers a consumer an insurance contract or policy based on these variables.[20] Insurers manage risk through product design and through underwriting – making an assessment of the likelihood of a risk occurring, often using actuarial and statistical data. This information can inform the premium price they are willing to charge when selling a policy, and also rules about what they will and won't cover, often expressed as 'exclusions'.

Insurance companies also use reinsurance, which allows the insurer to write insurance policies with consumers, but relieve itself of some of the risk associated with those policies by obtaining insurance for its own liability with another entity (the reinsurer).[21] Reinsurers may have underwriting requirements that insurers incorporate into their underwriting of policies for consumers.

17. Ibid 233.

18. Ibid 242.

19. Productivity Commission, Inquiry Report: Mental Health, above n 3, 371-372.

20. Victorian Equal Opportunity & Human Rights Commission (VEOHRC), Fair-minded cover: Investigation into Discrimination in the Travel Insurance Industry (Report, June 2019), 42, available https://www.humanrights.vic.gov.au/static/ae2f408a6338e52807f9aa499f359eb1/Resource-Fair_minded_cover-Full_report.pdf.

21. Financial Services Royal Commission, Background Paper 26: Some features of the general and life insurance industries (2018), 16-17, available: https://financialservices.royalcommission.gov.au/publications/Documents/some-features-of-the-general-and-life-insurance-industries-background-paper-26.pdf.

2.3
Role of insurance cont...

Insurance sectors which most commonly interact with a person's experience of mental health conditions include:

- Group life insurance through superannuation – products include death cover, total and permanent disability (TPD) cover and income protection cover;
- Individual life insurance – products include death cover, TPD cover, income protection cover, trauma and critical illness;
- Workers compensation;
- Motor injury insurance;
- Travel insurance; and
- Private health insurance.[22]
- 'Life insurance' is used to describe several types of products including:
- Term life insurance, also known as life cover or death cover – this pays a set amount of money to nominated beneficiaries when the insured person dies.
- Trauma cover, also known as critical illness insurance – this pays a set amount on the diagnosis of a specified illness or injury such as cancer, heart attack or stroke.
- TPD insurance – provides cover when the insured becomes totally and permanently disabled and is unable to work again (either in their own occupation or in any occupation, depending on the terms of the insurance policy).
- Income protection insurance – this replaces the income lost through the insured's inability to work due to injury or sickness.[23]

Most insurers providing insurance to individual consumers are members of an industry representative body–for general insurance this is the Insurance Council of Australia (ICA), and for life insurance this is the Financial Services Council (FSC). These industry bodies create and maintain industry codes of practice for each group of insurers, which are outlined in part 3.

This report considers travel insurance and life insurance, both of which are important to many Australians for protecting themselves from future risk. For example, Australians held 22 million life insurance policies (including life, income protection, TPD and trauma cover) in 2015: 14 million of these were group policies (like those through superannuation), 4 million were retail policies, and 3.9 million were direct policies. [24] Those figures do not account for people who hold multiple overlapping policies, so the total number of people covered is significantly lower, [25] but remains a large proportion of the Australian population.

22. Actuaries Institute, Mental Health and Insurance Green Paper, (October 2017, Institute of Actuaries of Australia) 13 available https://www.actuaries.asn.au/public-policy-and-media/thought-leadership/green-papers/mental-health-and-insurance.

23. Financial Services Royal Commission, Background Paper 26, above n 21, 13 available https://financialservices.royalcommission.gov.au/publications/Documents/some-features-of-the-general-and-life-insurance-industries-background-paper-26.pdf.

24. Australian Securities and Investments Commission, Life Insurance Claims: An Industry Review (Rep 498, October 2016) available https://asic.gov.au/media/4042220/rep498-published-12-october-2016a.pdf, 35.

25. TAL, 'How Many Australians Have Life Insurance?' (Website, 21 January 2019) available https://www.tal.com.au/slice-of-life-blog/how-many-australians-have-life-insurance.

26. Mental Health Council of Australia and beyondblue, Mental Health Discrimination and Insurance: A Survey of Consumer Experiences 2011, above n 1, 8.

As acknowledged in the Consumer Experiences Survey, and in many investigations into these issues since, there is no doubt that mental health presents significant challenges for the insurance industry.[26] In the case of life insurance, data from the FSC showed that in 2019, mental illness was the highest cause of TPD claims and third highest cause for income protection claims. [27] Furthermore, disability income claim benefits paid for mental illness have doubled in the five years to 2020, making up 11% of claims. [28] The life insurance industry is grappling with the future design of these products to ensure they are sustainable in the long term.[29]

The Actuaries Institute identifies several reasons for insurer difficulties in responding to mental health conditions, including a lack of available data about mental health condition prevalence, profiles and insurance claims, subjective nature of diagnosis which does not relate to prognosis or ability to work, difficulties in understanding severity, appropriate treatment and prospects of recovery, the potential to produce worse outcomes through the prospect of financial compensation, or through harm from the claims process itself, and problems with the regulatory framework.[30]

Both the general and life insurance industries engage with mental health issues and experts. The FSC, for example, convenes a twice-yearly mental health roundtable with its members and mental health experts and advocates, and the ICA convenes an anti-discrimination working group. Notwithstanding the increasing attention paid by the insurance industry to mental health, there remain some fundamental problems with the practices of insurers which this report aims to outline.

27. Financial Services Council, 'Data Reveals the Mental Health Burden Shared across the Nation' (Media release, 30 July 2020) available https://fsc.org.au/resources/2050-fsc-media-release-data-reveals-the-mental-health-burden-shared-across-the-nation-1/file.

28. Financial Services Council, 'New KPMG/FSC Study Reveals Large Rise in Life Insurance Claims Payouts' (Media release, 23 June 2020) available https://fsc.org.au/resources/2031-fsc-media-release-new-kpmg-fsc-study-reveals-large-rise-in-life-insurance-claims-paid/file.

29. Actuaries Institute, Individual Disability Income Insurance in Australia, (2021) https://www.actuaries.asn.au/practice-area/life-insurance/individual-disability-income-insurance-in-australia.

30. Actuaries Institute, Mental Health and Insurance Green Paper, above n 22, 25.

11%

of disability income claim benefits were paid for mental illness

2.4
PIAC Mental Health and Insurance Project

PIAC developed its mental health and insurance project in partnership with Beyond Blue and Mental Health Australia, to address the concerns described in the Consumer Experiences Survey. Throughout the project, PIAC continued to engage with a mental health and insurance working group including representatives from Beyond Blue, Mental Health Australia, and SANE Australia.

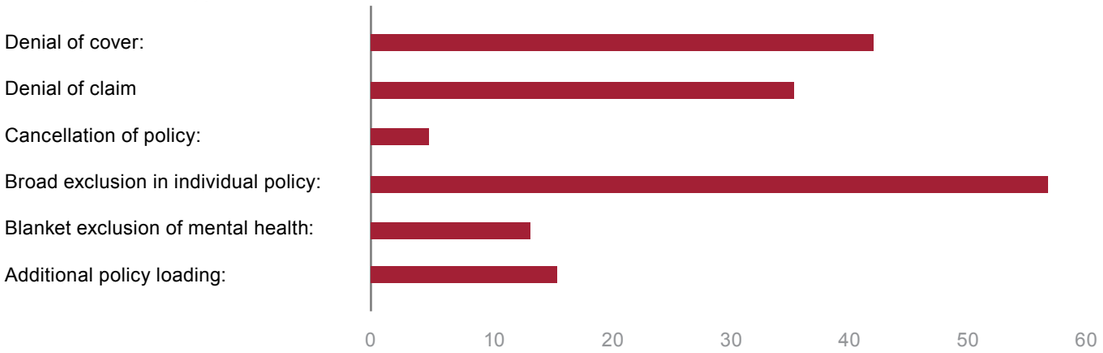
From 2012 to 2021, PIAC provided legal information, advice or representation to approximately 180 clients who contacted or were referred to PIAC in relation to a concern or dispute regarding an insurance decision connected with their mental health. Approximately 10% of those clients had experienced an issue with a travel insurance product, and the remaining clients had experienced an issue with a life insurance product, save for a few clients who called regarding mortgage insurance, or employment related insurance with which PIAC was not able to assist.

PIAC provided assistance to clients across Australia – the majority of inquiries came from clients in Victoria (36%) and NSW (31%), but clients also contacted PIAC from all States and Territories. In relation to travel insurance, PIAC received inquiries concerning at least nine different insurance providers. For life insurance related concerns, PIAC received inquiries relating to nearly 40 service providers including insurers and superannuation providers. As may be expected, the major life insurers including TAL Life, Zurich Australia, OnePath Life, CommInsure, AMP Life, and AIA Australia were the most common insurers with whom clients had insurance.

Clients who contacted PIAC regarding life insurance products often had several types of insurance cover, but the largest number of inquiries concerned some form of income protection insurance. This is perhaps reflective of the value and importance of having sufficient income protection cover, when the ability to work is disrupted. Many clients also had concerns about TPD cover, life (death) cover, and several clients were concerned with trauma and critical illness cover. The following chart lists the main problem types encountered by our clients (some clients had more than one problem), which included:

- having an application for insurance cover declined;
- insurance cover being limited by a blanket mental health exclusion applicable to all policies;
- insurance cover being limited by a broad exclusion for mental health for the individual insured;
- insurers charging an additional policy loading due to a mental health condition; and
- insurers cancelling (avoiding) a policy and/or denying a claim because of an alleged failure to disclose a mental health condition.

PIAC Cases:
Client problem types



The types of assistance PIAC provided included:

- Requesting further information and/or explanations from insurers regarding a decision;
- Seeking internal review through the insurer's internal dispute resolution processes;
- Representing clients in dispute resolution through the Financial Ombudsman Service (FOS) which later became the Australian Financial Complaints Authority (AFCA); and
- Representing clients in complaints of unlawful discrimination in State and Commonwealth jurisdictions including the Australian Human Rights Commission (AHRC), Victorian Equal Opportunity and Human Rights Commission (VEOHRC) and Victorian Civil and Administrative Tribunal (VCAT), NSW Anti-Discrimination Board (NSW ADB) and Tasmanian Anti-Discrimination Tribunal.

Accompanying our advice and casework, PIAC undertook extensive advocacy within and outside of the insurance sector to draw attention to systemic issues, and has provided detailed submissions and case studies to several key inquiries examining the conduct and practices of insurers, including:

- 2016/2017 Parliamentary Joint Committee on Corporations and Financial Services Inquiry into Life Insurance;
- 2017/2018 VEOHRC Inquiry into Travel Insurance;
- 2018 Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (Financial Services Royal Commission); and
- 2020 Productivity Commission Inquiry into Mental Health.

This report draws from PIAC's research, casework and engagement with the insurance sector over those years. The report uses de-identified case studies and examples drawn from the experiences of our clients to illustrate the issues observed.

31. Public Interest Advocacy Centre, Submission to the Parliamentary Joint Committee on Corporations and Financial Services: Inquiry into the Life Insurance Industry (18 November 2016) available https://piac.asn.au/2017/01/18/submission-to-the-parliamentary-joint-committee-on-corporations-and-financial-services-inquiry-into-the-life-insurance-industry/.

32. Public Interest Advocacy Centre, Submission to the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, (26 April 2018) available https://piac.asn.au/2018/04/26/submission-to-the-royal-commission-into-misconduct-in-the-banking-superannuation-and-financial-services-industry/.

33. Public Interest Advocacy Centre, Submission to the Productivity Commission Inquiry into Mental Health (23 January 2020) available https://piac.asn.au/2020/01/23/mental-health-and-insurance-submission-to-the-productivity-commission-inquiry-into-mental-health/.

3 Legal and Regulatory Context

3.1 Discrimination law

The Disability Discrimination Act 1992 (Cth) (DDA) makes it unlawful to discriminate on the basis of disability in several areas of life, including the provision of goods and services.[34] Disability is defined broadly in the DDA and includes 'a disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgment or that results in disturbed behaviour'.[35] It also covers current, past and future disability. The definition also includes a disability that is imputed to a person, which would seem likely to capture discrimination on the basis of a symptom of a mental health condition, even where there is no diagnosis.

There is a general defence to a claim of discrimination of 'unjustifiable hardship'.[36] It is not unlawful to discriminate on the ground of a disability if avoiding the discrimination would impose an unjustifiable hardship on the respondent, taking into account all relevant circumstances.

There is also a specific exception for insurers and superannuation providers in section 46 (Insurance Exception), which allows insurers to discriminate by refusing to offer insurance, or in respect of the terms or conditions on which the insurance is offered, where the discrimination is:

a. based upon actuarial or statistical data on which it is reasonable for the first-mentioned person to rely; and
b. reasonable having regard to the matter of the data and other relevant factors; or
c. in a case where no such actuarial or statistical data is available and cannot reasonably be obtained—the discrimination is reasonable having regard to any other relevant factors.

State and Territory anti-discrimination legislation generally includes equivalent provisions both for unjustifiable hardship and the Insurance Exception, and a summary of the relevant provisions in each jurisdiction, and the complaints and enforcement mechanisms available is provided in Appendix 1.

AHRC Guidelines

The Australian Human Rights Commission (AHRC) has several functions relating to the DDA, including to promote understanding, acceptance and compliance with the DDA, as well as to investigate and conciliate complaints of unlawful disability discrimination. Under section 67(k) of the DDA, the AHRC has the power to make guidelines to assist better understanding of rights and obligations under the DDA. These guidelines are not regulations and are not legally binding. They provide the AHRC's views on the interpretation of the DDA and information on how it has been applied.

In 2016, the AHRC issued updated 'Guidelines for Providers of Insurance and Superannuation under the Disability Discrimination Act 1992 (Cth)' (AHRC Guidelines).[37] The AHRC Guidelines provide guidance for insurers on what type of actuarial or statistical data is reasonable for insurers to rely upon, what is meant by 'other relevant factors', and when it will be 'reasonable' to discriminate.

According the AHRC Guidelines, actuarial or statistical data which may be reasonable for insurers to rely upon includes:

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.

'Other relevant factors' may include:

a. medical opinions;
b. relevant information about the particular individual seeking insurance such as:
   - the type of disability;
   - the severity of the disability;
   - the functional impact of the disability;
   - treatment plans; and
   - 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.

The AHRC identifies matters that can be taken into account in determining whether the discrimination is 'reasonable' as including:

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.

Importantly, the AHRC Guidelines indicate 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.

The AHRC Guidelines emphasise the importance of supporting any assumptions underpinning the decision to discriminate with reasonable evidence.

34. Disability Discrimination Act 1992 (Cth) s 24.

35. Disability Discrimination Act 1992 (Cth) s 4, definition of 'disability'.

36. Disability Discrimination Act 1992 (Cth) s 29A, s 11.

37. Australian Human Rights Commission, Guidelines for Providers of Insurance and Superannuation under the Disability Discrimination Act 1992 (Cth), available https://humanrights.gov.au/our-work/disability-rights/guidelines-providers-insurance-and-superannuation-under-disability.

Case Law

Discrimination laws are generally administered by the AHRC and the equivalent State and Territory anti-discrimination bodies, all of which use conciliation as the primary dispute resolution mechanism. Because of the high rate of successful conciliation of individual complaints, there has been limited consideration given to these provisions in the courts. This also reflects the fact that it is difficult for people to pursue discrimination claims through to a court or tribunal decision if they are not resolved by conciliation. The few decisions that have considered these provisions are detailed opposite.

In addition to these decisions, there was at least one determination of the Financial Ombudsman Service Australia (FOS) which also found a blanket exclusion for mental illness in a travel insurance policy did not satisfy the insurance exception. FOS found that the only data provided by the insurer was not sufficiently specific to the illness suffered by the applicant, and the insurer had failed to provide an assessment of the insurance risk. In those circumstances, it was not reasonable for the insurer to rely on the data.[38]

Further, some of the anti-discrimination commissions, including the AHRC, NSW ADB and Queensland Human Rights Commission, publish case summaries which provide examples of complaints made about disability discrimination in insurance decisions. While these confirm that the issue is the subject of complaint, they do not clarify the law or provide any binding guidance on how it should operate.[39]

In summary, State and Federal anti-discrimination laws require insurance policies, terms and practices to be based on evidence, expert advice and prudent analysis, and permit discrimination that is reasonably justified on the basis of such evidence, advice and analysis.

The AHRC Guidelines and the case law provide several important principles, including:

- Insurers must actively consider the evidence available to them to determine whether discrimination is reasonable;
- Insurers cannot apply broad formulaic approaches to determining whether discrimination is reasonable – individual circumstances must be considered; and
- Insurers need to be able to identify the data they rely on to support their assessment of risk and, when relying on data, the data must be in existence at the time, be up to date and relevant to the circumstances of the individual.

In PIAC's experience, insurers have not demonstrated that they are complying with the requirements of anti-discrimination law in their use of blanket exclusions, or in their decisions to decline cover or use broad mental health exclusions for applicants disclosing current or past mental health conditions. The issues are discussed in more detail below. The potential impact of these practices include people avoiding necessary treatment in order to meet insurers' requirements, choosing or being forced to go without insurance where they would prefer to purchase cover, or not disclosing mental health concerns to their GPs so as not to affect access to insurance.[40]

38. FOS Determination 428120, 31 March 2017, available https://service02.afca.org.au/CaseFiles/FOSSIC/428120.pdf https://service02.afca.org.au/CaseFiles/FOSSIC/428120.pdf.

39. These can be found https://humanrights.gov.au/our-work/disability-rights/disability-complaint-outcomes, https://antidiscrimination.nsw.gov.au/anti-discrimination-nsw/complaints/complaint-case-studies/disability-discrimination-.html, https://www.qhrc.qld.gov.au/resources/case-studies/impairment.

40. As noted by the Productivity Commission in Productivity Commission 2020, Inquiry Report: Mental Health, above n 3, 374.

QBE Travel Insurance v Bassanelli [2004] FCA 396

QBE refused to provide Ms Bassanelli with travel insurance on grounds of a pre-existing disability of metastatic breast cancer. QBE agreed that the refusal of the insurance policy could be considered discriminatory but relied upon the exception in s 46 of the DDA. QBE accepted there was no actuarial or statistical data relied upon or available when it made the decision not to issue the policy to Ms Bassanelli, but argued the discrimination was reasonable having regard to 'any other relevant factors'.

The Federal Court found that QBE should have sought further medical information and not assessed Ms Bassanelli's situation based solely on its general experience regarding pre-existing medical conditions. The Court found QBE could not rely on the defence that the discrimination was reasonable without first seeking out relevant actuarial and statistical data. Nor could QBE choose what material should be used for the purpose of determining the reasonableness of the discrimination. Instead, it must consider 'any matter which is rationally capable of bearing upon whether the discrimination is reasonable.' Justice Mansfield said 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 (Human Rights) [2015] VCAT 193 (Ingram v QBE)

The Victorian Civil and Administrative Tribunal (VCAT) found QBE 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 then denying her claim based on that clause. 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.

VCAT found that QBE could not prove 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 it relied on contemporaneous actuarial data at the time it decided to incorporate the mental health exclusion into the policy. The Tribunal also held that QBE failed to prove that removing the exclusion would result in a price increase or financial loss.

Opinion re: Elizabeth Kors and AMP Society [1998] QADT 23

The Queensland Anti-discrimination Tribunal considered the insurance exception in the context of a refusal by the respondent insurer to offer insurance based on a medical condition, namely a history of reactive and endogenous depression. Ms Kors had applied for a life insurance policy from AMP to cover a loan of $20,000. AMP obtained authority to examine Ms Kors' medical records and contacted her general practitioner, who gave details of her condition. AMP claimed that there had been no discrimination, and if there had been, it was based on actuarial and statistical data which would satisfy the exemption.

The Tribunal found that the data used by AMP was insufficient to satisfy the exemption. The report relied on was not Australian and AMP had not demonstrated why there was no Australian data. AMP had also not established why the data was relevant and applicable to a person in the position of Ms Kors.

3.2 Insurance Contracts Act

Insurance in Australia is also regulated by the Insurance Contracts Act 1984 (Cth) (IC Act). The IC Act sets out, among many other things, duties of the insured person in relation to disclosure of relevant information when obtaining insurance, and options available to an insurer if those duties are breached, including cancelling a contract. These provisions have recently been substantially amended, following recommendations of the Financial Services Royal Commission (2021 Amendments).[41]

Prior to the Financial Services Royal Commission, PIAC had advised and represented a number of clients who 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. In those cases, the insurer alleged the person had failed to disclose a relevant prior mental health condition or mental health related medical interaction. When the insured later made a claim on the policy (whether or not the claim was connected to mental health), the insurer cancelled the policy for non-compliance with the insured's duty of disclosure under section 29 of the IC Act. PIAC identified several concerns with insurer practices in relation to this which are outlined further in part 5.3.

The newly amended provisions regarding the duty of disclosure and the ability of an insurer to avoid an insurance contract are outlined below, as well as the duty of utmost good faith which is implied into all insurance contracts.

Duty of an insured person to take reasonable care not to make a misrepresentation: s 20B

The 2021 Amendments to the IC Act substantially modify an insured person's duty of disclosure in relation to consumer insurance contracts. In agreeing with recommendation 4.5 of the Financial Services Royal Commission, the Government considered that the previous duty did not adequately protect consumers where they inadvertently failed to disclose past circumstances or where the insurer failed to ask the right questions.[42]

Before the amendments, the duty of disclosure varied depending on whether an insurance contract was an eligible or non-eligible contract. For eligible contracts, which included travel insurance, the duty was limited to requiring an insured person to respond to the specific questions asked by the insurer. However, the duty of disclosure for non-eligible contracts, which included life insurance contracts, required an insured person to disclose all matters they knew to be relevant and all matters a reasonable person could be expected to know would be relevant when entering into the contract.

Replacing the previous list of 'eligible contracts', the new category of consumer insurance contracts covers any insurance obtained 'wholly or predominantly for the personal, domestic or household purposes of the insured' (s 11AB). This includes life insurance. The new section 20B imposes a more limited duty on an insured person to take reasonable care not to make a misrepresentation to the insurer on entering into a consumer insurance contract.[43]

What constitutes reasonable care must be determined with regard to all relevant circumstances, which could include: the type of insurance and its target market; the explanatory material provided by the insurer; how clear and specific the insurer's questions are; how clearly and specifically the insurer communicated the importance of the questions; and, whether the contract was a new contract or was being renewed or varied.

Under s 20B(4), an insurer must respond to the particular characteristics of the insured person of which the insurer was or should have been aware. The insurer may therefore need to ask for more information or provide assistance to the insured person. [44] An insured person would not necessarily breach the duty by failing to answer a question or by giving an obviously incomplete or irrelevant answer to a question. [45] However, consistent with the previous law, fraudulently making a misrepresentation would breach the duty.[46]

The remedies available to an insurer under the IC Act still apply, which may include rejecting a claim, reducing a payout, increasing a premium or avoiding the contract. For these remedies to arise in consumer insurance contracts, an insured person must have made a misrepresentation in breach of the duty to take reasonable care not to make a misrepresentation (a 'relevant failure').[47]

Insurer avoidance of life insurance contracts: s 29

The 2021 Amendments also limit the circumstances in which an insurer can avoid a life insurance contract where an insured person made a non-fraudulent misrepresentation or non-disclosure. This implements recommendation 4.6 of the Financial Services Royal Commission, considering the previous regime's unfair weighting in favour of insurers.[48] Inserted in 2013, the previous section 29(3) granted life insurers a broad power to avoid a contract within three years if the insured person either failed to comply with their duty of disclosure when entering into the contract or made a misrepresentation before entering into the contract.

The new section 29(3) first requires a 'relevant failure' in relation to a life insurance contract, which arises where an insured person makes a misrepresentation that breaches the duty to take reasonable care not to make a misrepresentation. If this relevant failure is not fraudulent, the insurer may avoid the contract within three years only if, had the relevant failure not occurred, they would not have entered into the contracts on any terms. The intended effect of this provision is to place the insurer in a position similar to the one they would have been in if the insured had not made the relevant failure. If the insurer would have offered the product on different terms or a different premium, for example, the insurer would instead only have the right to vary the contract, not to avoid it.[49] However, s 29(2) retains the insurer's power to avoid a life insurance contract if the relevant failure was fraudulent.

The changes to these provisions came about following the Financial Services Royal Commission's consideration of cases in which insurer's had unfairly used their ability to avoid a contract, including in the case of PIAC's client discussed in Case study 3.

The duty of the utmost good faith: s 13

Section 13 of the IC Act implies a duty of the utmost good faith into every insurance contract. This duty applies to both the insurer and insured, in respect of any matter arising under or in relation to it. For insurers, this requires acting 'consistently with commercial standards of decency and fairness, with due regard to the interests of the insured'. [50] An insurer who fails to comply with the duty may be subject to civil penalties under s 13(2A), introduced in March 2019.[51]

41. Financial Sector Reform (Hayne Royal Commission Response) Act 2020 (Cth) sch 2.

42. Explanatory Memorandum, Financial Sector Reform (Hayne Royal Commission Response) Act 2020 (Cth) 41.

43. Insurance Contracts Act 1984 (Cth) s 20B.

Case study 3: Australian Securities and Investments Commission (ASIC) v TAL

In this case, the insured had made a claim on her income protection policy with TAL following a diagnosis of cervical cancer in late 2013. After initially paying the claim, TAL obtained the insured's medical records and argued that she had failed to comply with her duty of disclosure in relation to appointments with a psychologist three years earlier. During the initial application process, the insured had answered no to TAL's question whether she had ever received medical treatment for a mental health condition.

TAL avoided the policy under s 29(3) of the IC Act and stopped paying the claim on the basis of this alleged non-disclosure. The insured argued that she had never been diagnosed with a mental health condition, nor had symptoms of a mental health condition, and answered the questions truthfully. The psychologist appointments were initially to discuss the breakdown of a relationship and then, seeing that the counselling had been effective, undertaking further counselling to discuss issues she had experienced historically with her family. TAL 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.

PIAC assisted the insured in challenging TAL's decision, lodging a dispute with the Financial Ombudsman Service in 2014. TAL and the insured settled the dispute on confidential terms.

PIAC brought the case to the attention of the Financial Services Royal Commission and the Commission considered it alongside two other income protection claims handled by TAL around the same time. The Final Report addressed acknowledgments by TAL of its own misconduct, for example in telling the insured that she herself had breached the duty of utmost good faith.[52] It found TAL's conduct fell short of community standards by failing to afford policyholders an opportunity to address TAL before avoiding their policies, and by failing to communicate in a sensitive and empathetic way. Inadequate training and oversight of case managers, and the culture at TAL at the time, were identified as some of the causes of the misconduct.

ASIC commenced proceedings against TAL on referral from the Royal Commission, seeking declarations that TAL had engaged in misleading or deceptive conduct and had breached the duty of the utmost good faith. In the Federal Court, Allsop CJ determined that misleading or deceptive conduct as claimed by ASIC was not established, because of how ASIC had amended its argument.[53] However, his Honour found multiple interrelated breaches of the duty of the utmost good faith, especially in TAL failing to tell the insured it was considering her medical history and failing to give her an opportunity to address TAL's concerns or provide more information.[54] In addition, TAL had failed to comply with this duty by telling the insured that she had breached the duty of utmost good faith, and by threatening to recover $24,000 in payments made to her.[55]

Allsop CJ's judgment stressed that the propriety of TAL's conduct should be determined with recognition that the insured was not just an abstract 'contracting party', but a person to whom an income protection policy was important, and that such policies 'are very important to the economic and human wellbeing of people'[56]

Photo credit: Photo by Rob Curran on Unsplash

The application of the duty to act with the utmost good faith in ASIC v TAL indicates some progress towards insurer accountability for 'arbitrary, capricious and unreasonable conduct' which results in unfairness that falls short of 'community expectations of fairness and decency'.[57] PIAC hopes this will encourage insurers to examine and improve their practices to ensure people are treated fairly, and that ASIC will take a more active role in enforcing these standards in the future.

44. Explanatory Memorandum, Financial Sector Reform (Hayne Royal Commission Response) Act 2020 (Cth) 49.

45. Insurance Contracts Act 1984 (Cth) s 20B(5).

46. Ibid s 20B(6).

47. Ibid s 27AA(1)(a).

48. Explanatory Memorandum, Financial Sector Reform (Hayne Royal Commission Response) Act 2020 (Cth) 39.

49. See ibid 45; Insurance Contracts Act 1984 (Cth) s 29(4)–(8).

50. CGU Insurance Ltd v AMP Financial Planning Pty Ltd (2007) 235 CLR 1, 12 [15] (Gleeson CJ and Crennan J).

51. Treasury Laws Amendment (Strengthening Corporate and Financial Sector Penalties) Act 2019 (Cth) sch 4.

52. Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (Final Report, February 2019) vol 2, 344–5.

53. ASIC v TAL [2021] FCA 193, [117]–[119].

54. Ibid [197]–[199].

55. Ibid [201]–[204].

56. Ibid [64].

57. Ibid [173].

this falls short of community expectations of fairness and decency

3.3
ICA General Insurance Code of Practice

The ICA General Insurance Code of Practice applies to its members and covers a range of types of insurance including travel, home, motor vehicle, personal property and others. It is a voluntary code that sets out standards that general insurers commit to meet when providing services to their customers, covering the different stages of the insurance relationship, from buying insurance to making a claim, providing options to those experiencing financial hardship, and the process for making a complaint.

The Code is monitored and enforced by an independent Code Governance Committee (CGC) which can investigate breaches, propose corrective measures, and impose sanctions on members for breaches of the Code.[58] The CGC can also report significant breaches of misconduct to ASIC.[59] Anyone can report an alleged breach of the Code to the CGC but the CGC does not consider or try to resolve individual disputes. Instead, consumers can complain directly to an insurer about a breach of the Code and, if they are not satisfied with the outcome, take their complaint to AFCA.

In 2017-2018, the ICA reviewed the General Insurance Code of Practice. The ICA sought input from stakeholders, including consumer and mental health advocates through its Anti-discrimination Working Group. PIAC participated in this review process and encouraged the ICA to strengthen the commitments made by insurers to treat consumers with a mental health condition or history fairly.[60] VEOHRC also made several recommendations regarding the Code in its investigation into travel insurance, outlined further in part 4.2.

The new Code was finalised in 2020, and came into effect on 1 July 2021.[61] It includes the following provisions specifically relating to mental health:

> *104. When developing our internal processes and procedures we will take into account those who have a past or current mental health condition by doing the following:*
>
> *a. at a minimum, we will design and sell our products and apply their terms in compliance with the requirements of the Disability Discrimination Act 1992 and/or any relevant State or Territory anti-discrimination requirements;*
>
> *b. we will treat people with any past or current mental health condition fairly;*
>
> *c. we will only ask relevant questions when deciding whether to provide cover for a pre-existing mental health condition;*
>
> *d. if we cannot provide you with cover for that condition we will tell you about your right to ask us for the information relied on when assessing your application. If you ask for that information, then we will give it to you as set out in part 12 of the Code.*

we hope to motivate general insurers to proactively address discriminatory practices

The Code also contains a supplementary 'Guide on mental health' which sets out further best practice guidance for insurers on how to meet those commitments contained in the Code.[62] This includes principles consistent with anti-discrimination law, including:

- Where possible, managing 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.
- Exclusions for pre-existing mental health conditions should only apply where there is evidence that an applicant has an existing mental health condition, or is at risk of a recurrence of a past mental health condition, and the covered event relates to the pre-existing condition.
- Insurers must keep records of data relied on, and continuously seek to obtain better data to ensure exclusions are as narrow as possible.

It is unfortunate that the ICA fell short of making the 'Guide on mental health' binding as part of the Code (as VEOHRC and PIAC had recommended). Nevertheless, the inclusion of these provisions in the Code represents a small positive step from general insurance providers towards a commitment to treat people who experience or have experienced mental health conditions fairly.

The enforcement and sanctions provisions of the Code have also been enhanced, so that:

- it is clear that anyone can report alleged breaches to the CGC at any time;
- the CGC can impose additional sanctions for significant breaches of the Code which may include compensating an individual for direct financial loss; and
- the CGC can publish deidentified decisions regarding breaches.[63]

PIAC hopes these improvements to the Code motivate general insurers to proactively address discriminatory practices towards people with experience of a mental health condition.

58. Insurance Council of Australia, General Insurance Code of Practice 2021, cl 169, available https://insurancecouncil.com.au/wp-content/uploads/2020/01/ICA007_COP_Report_2021-Updates_2.1_LR.pdf.

59. Insurance Council of Australia, General Insurance Code of Practice 2021, cl 176, available https://insurancecouncil.com.au/wp-content/uploads/2020/01/ICA007_COP_Report_2021-Updates_2.1_LR.pdf.

60. See ICA consideration of input in Insurance Council of Australia, Final Report, Review of the General Insurance Code of Practice, (June 2018) available https://insurancecouncil.com.au/wp-content/uploads/2021/07/250618_ICA-Code-Review_Final-Report_Clean.pdf.

61. Insurance Council of Australia, General Insurance Code of Practice 2021, available https://insurancecouncil.com.au/wp-content/uploads/2020/01/ICA007_COP_Report_2021-Updates_2.1_LR.pdf.

62. Insurance Council of Australia, Guide on mental health, 1 July 2021, available at https://insurancecouncil.com.au/wp-content/uploads/2020/01/2021_07_REPORT_Mental_Health.pdf.

63. ICA Code, above n 58, clauses 164, 169, 174.

3.4 FSC Life Insurance Code of Practice

The Life Insurance Code of Practice was adopted by members of the FSC in 2017.[64] Like the General Insurance Code of Practice, it is voluntary and has limited options for enforcement. The Life Insurance Code Compliance Committee (Life CCC) independently monitors the Code and compliance, and breaches can be reported to the Life CCC by consumers. Consumers otherwise do not have a right to a remedy for a breach of the Code, although they can raise alleged breaches as part of a complaint to AFCA.

PIAC participated in consultations for the development of the Code and made submissions to the FSC about its content.[65] Importantly, the Code includes the following commitment:

> *5.17 Our decisions on applications for insurance will comply with the requirements of anti-discrimination law. Our decisions will be evidence- based, involving relevant sources of information where this is available, and having regard to any other relevant factors where no data is available and cannot reasonably be obtained. We will regularly review our underwriting decision-making processes to ensure we are not relying on out-of-date or irrelevant sources of information.*

This commitment reflects the requirements of anti-discrimination law outlined in part 3.1, insofar as it refers to basing decisions on relevant sources of information and having regard to other relevant factors, as well as committing to regularly review processes and information. The inclusion of this commitment reminds insurers, and indicates to consumers, that insurers have specific obligations under anti-discrimination laws with which they should actively comply.

The Code is currently undergoing a review and PIAC has again been involved in the consultation process. We have significant concerns about the direction of the review and the apparent intention to remove the clear commitment in [5.17]. These concerns are set out further below in part 5.6.

64. FSC, Life Insurance Code of Practice, available https://fsc.org.au/resources/1695-life-insurance-code-of-practice-with-appendix.

65. Public Interest Advocacy Centre, Feedback on the draft Life Insurance Code of Practice (8 September 2016) available https://fsc.org.au/web-page-resources/life-insurance/1594-cop-resource-ps-public-interest-advocacy-centre.

3.5 Australian Financial Complaints Authority (AFCA)

As outlined in part 3.1, discrimination laws including those applicable to insurance are administered and enforced by the AHRC and the respective State and Territory based bodies. Other consumer complaints regarding insurance can be made to the Australian Financial Complaints Authority (AFCA). AFCA is the dispute resolution scheme for financial services, and replaced the Financial Ombudsman Service (FOS), the Credit and Investments Ombudsman and the Superannuation Complaints Tribunal in November 2018.

AFCA is an independent body, funded by membership levies, user charges and complaint fees from member financial firms. It is free to use for consumers to make a complaint. AFCA's role is to assist consumers to resolve their complaints by agreement with financial firms or, if a complaint does not resolve between the parties, to decide on an appropriate outcome. Decisions are binding on the financial firm and AFCA can award compensation.

AFCA can consider complaints regarding both general insurance and life insurance. The types of complaints it can consider are outlined in its Rules and Operational Guidelines.[65] AFCA's Rules limit its ability to consider complaints relating to discrimination on the basis of mental health in decisions about whether to offer insurance and on what terms. In particular:

- Rule C.1.4(b) of AFCA's Rules (current at 13 January 2021) provides that AFCA must exclude 'a complaint about underwriting or actuarial factors leading to an offer of a Life Insurance Policy on non-standard terms.'
- Rule C.1.4(d) provides that AFCA cannot consider complaints about decisions to refuse cover unless the decision is made indiscriminately, maliciously or on the basis of incorrect information.

That is, AFCA can consider the insurer's decision-making process and address errors made in that process, but cannot consider whether the underwriting guidelines leading to the decision are fair or reasonable. AFCA has applied these rules to decline to make findings in published decisions.[67] PIAC has also provided advice to several clients who have made complaints to AFCA about a decision to decline cover or offer insurance with a mental health exclusion, and AFCA has (after some period of investigation) determined it does not have jurisdiction to consider that decision.

This split dispute resolution system can be confusing for people who wish to complain about unfair treatment on the basis of a mental health disclosure, particularly as insurers often provide information about a person's right to complain to AFCA but not about their rights to complain under disability discrimination legislation.

66. AFCA Complaint Resolution Scheme Rules (13 January 2021) available https://www.afca.org.au/about-afca/rules-and-guidelines.

67. For example, AFCA cited the exclusion from the Rules of a complaint about underwriting or actuarial factors in deciding not to compel an insurer to remove exclusions in AFCA Determination 747242, 23 February 2021.

3.6
ASIC and APRA

The Australian Investments and Securities Commission (ASIC) and Australian Prudential Regulatory Authority (APRA) regulate the insurance industry in Australia. General insurers are regulated by the Insurance Act 1973 (Cth) and life insurers by the Life Insurance Act 1995 (Cth), each of which gives responsibilities to APRA and ASIC.

APRA is the prudential regulator, and is responsible for licensing and regulatory oversight of financial entities to protect the interests of depositors, insurance policyholders and superannuation fund members.[68] APRA supervises general insurance, life insurance and reinsurance companies and monitors insurer compliance with prudential and reporting standards and practice guides.

ASIC regulates the conduct of insurers and other financial services organisations or professionals who deal in and advise on insurance. ASIC's role is to ensure that insurers and insurance brokers:

- offer insurance efficiently, honestly and fairly
- employ qualified staff who are trained to perform their role
- use advertising to inform consumers, rather than to mislead them
- give consumers the proper product disclosures and do so at the right time
- promptly report any significant breach of a financial services law
- handle any complaints properly including by accepting the decisions of the Australian Financial Complaints Authority.[69]

ASIC also has regulatory responsibility for ensuring Australian Financial Service Licence (AFSL) holders comply with their licence conditions, including the requirement to comply with financial services laws. Financial services laws as defined in the Corporations Act 2001 (Cth) (section 761A) includes any other Commonwealth, State or Territory legislation that covers conduct relating to the provision of financial services, in so far as it relates to that conduct. The DDA (and equivalent State legislation) covers conduct relating to the provision of life insurance insofar as it prohibits discrimination on the ground of disability in the provision of that service (section 24), subject to a specific partial exemption for provision of insurance (section 46), and to that extent can be considered a financial services law. However, to date ASIC has not played an active role in considering or enforcing discrimination laws against insurers.

ASIC also has the ability to approve codes of conduct that relate to the activities of AFSL licensees under s1101A of the Corporations Act, if approval of the relevant code is sought by the code owner. Prior to 2000, neither the General Insurance Code of Practice nor the Life Insurance Code of Practice were approved by ASIC. The new General Insurance Code of Practice outlined in part 3.3 has now been approved by ASIC. PIAC understands that FSC will also seek ASIC approval of the new Life Insurance Code of Practice (discussed in part 3.4).

68. ASIC, The ASIC – APRA relationship (Website, 30 March 2021) https://asic.gov.au/about-asic/what-we-do/our-role/other-regulators-and-organisations/the-asic-apra-relationship/.

69. ASIC, Insurance (Website, 26 July 2021) https://asic.gov.au/for-consumers/insurance/.

Photo credit: Photo by Ryoji Iwata on Unsplash

4 Travel Insurance and blanket mental health exclusions

4.1
Blanket exclusions in travel insurance policies

Prior to 2019, PIAC advised and represented a number of clients who had travel 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 to exclude claims on the basis of mental illness.

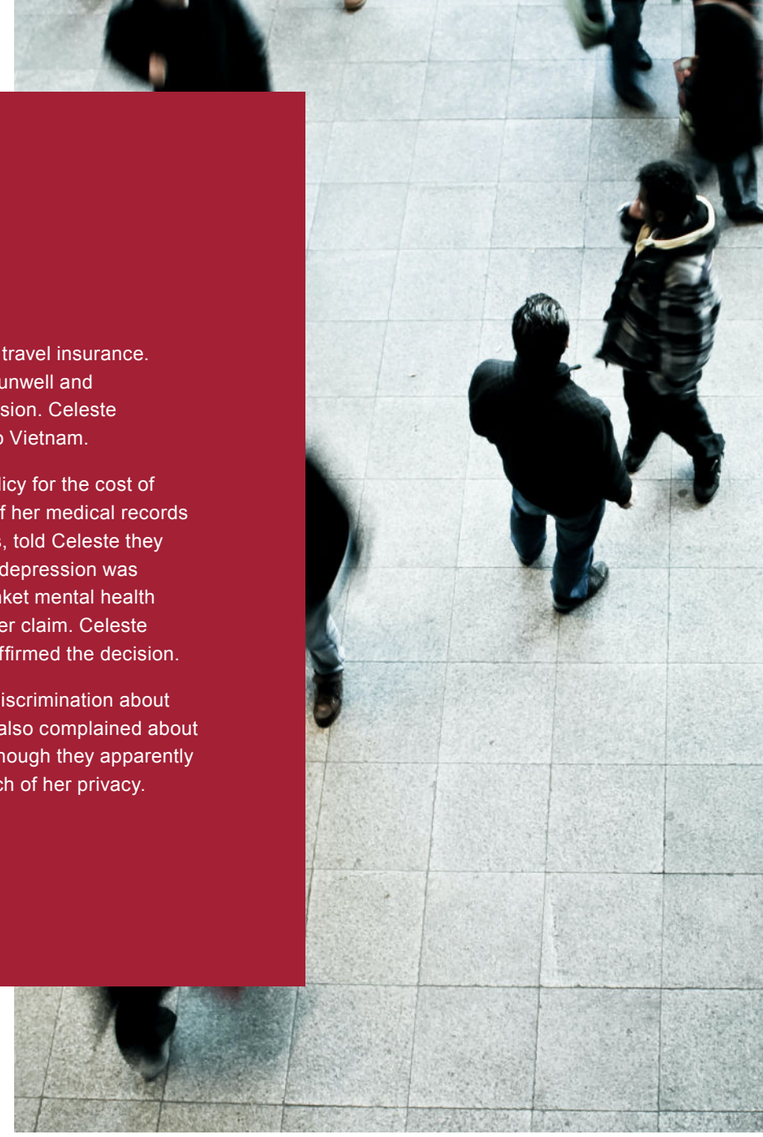
Insurers have relied on these exclusions to refuse to pay claims in circumstances where the insured had no history of a mental health condition when applying for insurance but developed a mental health condition after purchasing the policy.

> ***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*

As required by 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 is likely to be unlawful.

PIAC identified the practice of using blanket mental health exclusions in travel insurance as problematic from the outset of our project, for reasons including:

- It was not clear such exclusions were supported by relevant actuarial and statistical data – insurers are not transparent about the data they rely on and it was not clear that insurers in fact had any data to quantify the risk of insuring for mental health conditions.
- It was not clear that products which are designed to include blanket mental health exclusions could 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.
- People were often not aware that a blanket mental health exclusion applied to their policy before they purchased the product and only became aware of the exclusion at claim time, as exclusions were often buried in a dense and lengthy PDS.



Case study 4:

Celeste booked a trip to Vietnam and purchased travel insurance. Several months before the trip, Celeste became unwell and was subsequently diagnosed with clinical depression. Celeste was admitted to hospital and cancelled her trip to Vietnam.

Celeste made a claim on her travel insurance policy for the cost of the cancelled trip. Her insurer asked for copies of her medical records from her doctors and, after reviewing the records, told Celeste they would not pay her claim. The insurer agreed her depression was not a pre-existing condition but relied on the blanket mental health exclusion in the travel insurance policy to deny her claim. Celeste requested an internal review, and the insurer reaffirmed the decision.

Celeste made a complaint of unlawful disability discrimination about the blanket mental health exclusion clause. She also complained about the insurer reviewing her medical records even though they apparently always intended to rely on the exclusion, in breach of her privacy.

When PIAC commenced its work on mental health and insurance, blanket mental health exclusions were common in the Australian travel insurance market. Following the decision of VCAT in 2015 in the Ingram v QBE case (see the case study provided above), and the subsequent inquiry of the Victorian Equal Opportunity and Human Rights Commission, most major insurers in the travel insurance market have removed these exclusions from their policies.

4.2
VEOHRC Inquiry

VEOHRC investigated the practices of several major travel insurers for compliance with their legal obligations under the Equal Opportunity Act 2010 (Vic) during the period from 1 July 2017 to 19 April 2018. VEOHRC also considered whether all participating insurers had taken sufficient steps to comply with their 'positive duty' under the Equal Opportunity Act to eliminate discrimination, as well as the impact of travel insurance practices affecting people with a pre-existing mental health condition. VEOHRC published a report on the investigation in 2019, Fair-minded cover: Investigation into mental health discrimination in travel insurance.[70]

The 'party insurers', representing approximately 70 per cent of the travel insurance market, included World Nomads Group (WNG), Suncorp, and Allianz. Zurich also participated as a non-party insurer and QBE was considered but declined to participate in the investigation.[71]

VEOHRC took a consultative approach and organisations such as Mental Health Australia, Beyond Blue, Victoria Legal Aid, PIAC, SANE Australia, the Insurance Council of Australia, the Actuaries Institute and the Australian Human Rights Commission participated. VEOHRC also drew on the lived experience of people with mental health conditions through case studies and complaint and enquiry data. VEOHRC requested and compelled participation from insurers and information from:

- party insurers to the Investigation under section 130 of the Equal Opportunity Act;
- non-party insurers; and
- industry bodies, for example the Insurance Council of Australia and the Actuaries Institute about best practice and conduct across the industry.

VEOHRC engaged an independent actuary to analyse the data provided by the party insurers to support the consideration of whether the party insurers had sufficient actuarial or statistical data to rely on the exception to discrimination under section 47 of the Equal Opportunity Act.

Discrimination findings

VEOHRC found that the three party insurers – Allianz, Suncorp and WNG – discriminated against people with a mental health condition during the Investigation Period by issuing travel insurance policies with a blanket mental health exclusion and failing to indemnify people under those policies based on a mental health condition.[72] These insurers were unable to establish that they could rely on the data exception under the Equal Opportunity Act to lawfully discriminate.[73]

VEOHRC also found that all three party insurers failed to take sufficient steps to meet their positive duty to eliminate discrimination as far as possible under the Equal Opportunity Act.[74] Critically, these insurers were unable to demonstrate that they had adequate systems in place to consider and respond to discrimination and to educate staff about their legal obligations under anti-discrimination law.[75]

Key Lessons and Recommendations

VEOHRC's report highlighted the need for the following to drive enduring change:

- More listening to consumer experience.
- Better use and analysis of data.
- Stronger regulation.
- Better education and support.[76]

VEOHRC recommended:

1. All insurers who participated in the Investigation should develop a strategy for compliance with the Equal Opportunity Act.
2. Allianz, Suncorp and WNG should apply rigorous actuarial analysis to the policy terms they use to offer or exclude travel insurance cover to people with a mental health condition (having regard to the DDA Guidelines).
3. Allianz, Suncorp and WNG should contact claimants denied indemnity or claims based on a mental health condition during the Investigation Period to notify them about the Investigation and its outcomes.
4. All insurers who participated in the Investigation should provide their staff with regular education and training on anti-discrimination law.
5. All insurers who participated in the Investigation should develop risk profiles and appropriate coverage for different mental health conditions.
6. All insurers who participated in the Investigation should provide clear reasons to travel insurance customers for refusing to offer cover or deny indemnity based on a mental health condition.
7. The Actuaries Institute and the Insurance Council of Australia should facilitate education on anti-discrimination law for actuary members and insurers respectively.
8. The Insurance Council of Australia should incorporate its Guidance on Mental Health in its revised Code of Conduct to ensure that it is mandatory and enforceable.[77]

70. VEOHRC, Fair-minded cover: Investigation into Discrimination in the Travel Insurance Industry (Report, June 2019), available https://www.humanrights.vic.gov.au/static/ae2f408a6338e52807f9aa499f359eb1/Resource-Fair_minded_cover-Full_report.pdf.

71. Ibid 7.

72. Ibid 9.

73. Ibid.

74. Ibid 10.

75. Ibid.

Photo credit: Photo by Christina @ wocintechchat.com

Outcomes and follow-up

By the time VEOHRC had finalised its report, all party insurers had removed, or taken immediate steps to remove, blanket mental health exclusions from their travel insurance policies.[78] Party insurers also agreed to take steps to address the Commission's recommendations, including in relation to the way they offer and indemnify pre-existing mental health conditions, and the ICA and the Actuaries Institute acknowledged their role in supporting better compliance with anti-discrimination law and agreed to progress the recommendations, including supporting better industry education.[79]

In October 2020, VEOHRC sought an update on progress made towards implementing the recommendations in the Fair-minded cover report from the insurers, the Actuaries Institute and the Insurance Council of Australia. VEOHRC noted that several positive improvements had been reported by the insurers, including:[80]

- Removal of blanket mental health exclusions from travel insurance policies.
- Two of the insurers, Suncorp and nib-WNG, stated that they went a step further, and contacted claimants denied indemnity or claims based on a mental health condition during the investigation period to notify them about the investigation reopened their claims.
- Insurers had developed strategies for complying with the Equal Opportunity Act, and taken positive steps to ensure actuarial data and statistics used in their screening process and for underwriting any policy terms are current, regularly updated and consistent with medical and technological developments.
- Insurers stated they have developed (or are in the process of developing) risk profiles and coverage that they deem appropriate for different mental health conditions, meaning more people with mental health conditions can obtain appropriate coverage.
- Insurers had developed tailored education programs about anti-discrimination laws, with plans to roll them out to staff and senior leaders across the business.
- Insurers together with the ICA and Actuaries Institute were working on industry-wide efforts to combat discrimination.

76. Ibid 13.

77. Ibid 12.

78. Ibid 3.

79. Ibid.

80. VEOHRC, Mental health discrimination in the travel industry, (2021, website) https://www.humanrights.vic.gov.au/legal-and-policy/research-reviews-and-investigations/mental-health-discrimination-in-the-travel-industry/monitoring/ and implementation progress report available

4.3 Conclusions

The progress made in removing blanket mental health exclusions from travel insurance policies is very welcome and PIAC recognises improvements in recent years in the approach of general insurers and the ICA in their attitude to insuring consumers with mental health conditions. This is in no small part a consequence of the attention brought to the issue by individual complainants including Ella Ingram and PIAC's clients, as well as the work of mental health and legal advocates such as Beyond Blue, Mental Health Australia, Victoria Legal Aid and others.

PIAC is pleased to see its recommendations, as well as those of VEOHRC, reflected in the General Insurance Code of Practice, outlined in part 3.3, and recognition from insurers that blanket mental health exclusions are not good practice.

Notwithstanding the positive changes that have occurred, ongoing monitoring of compliance with disability discrimination laws, and the effectiveness of the commitments made by insurers in the General Insurance Code of Practice will be required. Travel insurance policies often continue to exclude pre-existing conditions, so it remains challenging for people experiencing mental health conditions to obtain insurance with sufficient coverage for their needs.

PIAC recommends that general insurers be required to regularly and publicly report to the Insurance Council of Australia and the Australian Human Rights Commission on their compliance with anti-discrimination laws to ensure greater accountability and transparency. This could be incorporated in the General Insurance Code of Practice with reference to the 'Guide on mental health' which is currently non-binding.

01.

Recommendation: Monitoring of General Insurance practices

The General Insurance Code of Practice should include a commitment by insurers to regularly report to the Insurance Council of Australia on the processes, procedures and policies they have implemented to ensure compliance with anti-discrimination laws and to meet their Code obligations, with reference to the 'Guide on mental health'. The Insurance Council of Australia should provide those reports to the Australian Human Rights Commission.

5 Life Insurance

5.1
Blanket exclusions in income protection policies

While insurers appear to have accepted that blanket mental health exclusions in travel insurance policies are unlawful, these continue to be a feature of life insurance product – although it appears that they are becoming less common. In PIAC's view, such clauses are inconsistent with the obligations on insurers under to discriminate only where discrimination is based on actuarial and statistical data and is reasonable having regard to that data and other relevant factors. They may therefore be unlawful.

In 2018, PIAC noted a significant number of income protection policies available to retail customers which included blanket exclusions in their PDS.[81] A review of equivalent policies conducted in August 2021 indicates that blanket exclusions have mostly been replaced with alternatives, with some exceptions. Current income protection policies offered by AAMI, ANZ, Suncorp, Insuranceline and RACQ no longer contain a blanket mental health exclusion.[82] However, policies offered by Virgin Money, Medibank and HCF contain standard policy terms which exclude benefits for mental health disorders or mental illness.[83] Several other providers no longer offer income protection products, although the previous blanket mental health exclusion may continue to apply to existing customers.

While it is encouraging to see blanket exclusions being removed from policies, PIAC does not have access to a comprehensive list of income protection and other similar products available in the market to be able to confidently say that blanket exclusions are no longer a feature of life insurance products. The Productivity Commission noted this ongoing concern and recommended that blanket mental health exclusions be the subject of further investigation by ASIC.[84] PIAC also recommends life insurers commit to eliminating blanket mental health exclusions from policies in the Life Insurance Code of Practice.

81. PIAC, Submission, above n 32, Annexure B.

82. See AAMI Income Protection https://www.aami.com.au/aami/documents/life-and-income/income-protection/aami-income-protection-pds-01042021.pdf; ANZ Ezicover Income Protection https://www.anz.com.au/content/dam/anzcomau/documents/pdf/ezicover-income-protection-pds.pdf; Suncorp Income Protection https://www.suncorp.com.au/content/dam/suncorp/insurance/suncorp-insurance/documents/life-and-income/income-protection/suncorp-income-protection-pds-policy-doc-fsg.pdf; Insuranceline income protection https://www.insuranceline.com.au/-/media/PDS/income-protection-pds-8Mar2021.ashx; RACQ Income Protection https://media.racq.com.au/-/media/racq/pdf/insurance/pds-2021/racq-income-protection-pds-v6-04_21-web.pdf?la=en&rev=b0e60e5128d64669aa2a48c9eee387e7&hash=280C27177918BF918FF00C397CA0B71C4D26A457.

83. Virgin Income Protection https://virginmoney.com.au/content/dam/virginmoney/vma-downloads/life-insurance/Virgin-Money_IP_LI_PDS_FSG.pdf?mcode=VMA002; Medibank Income Protection https://www.medibank.com.au/content/dam/retail/travel-pet-life-assets/pds/life/medibank-income-protection-pds.pdf; HCF Income Assist Inusurance https://www.hcf.com.au/pdf/brochures/Income_Assist_Insurance.pdf.

84. Productivity Commission, Inquiry Report: Mental Health, above n 3, 378.

02.
Recommendation: Review of blanket mental health exclusions

- ASIC should conduct a review to determine whether blanket exclusions for mental health conditions continue to be used in life insurance policies.
- The Life Insurance Code of Practice should include a commitment not to design and sell products which incorporate a blanket mental health exclusion in the general terms of the policy.

5.2
Declining cover and alternative terms: exclusions and increased premiums

PIAC has advised and represented people 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:

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.

PIAC's casework experience aligns with the consumer data obtained by Beyond Blue and Mental Health Australia in Mental health, discrimination and insurance: A survey of consumer experiences 2011 and, as outlined in part 2.2, the 2020 Stigma Report Card indicates these experiences continue for people experiencing mental health conditions.

In PIAC's experience, these issues arise most significantly in the life insurance market. The routine denial of cover or use of extremely broad mental health exclusions is particularly prevalent in relation to income protection and TPD insurance. This occurs for people who disclose a history of a diagnosed mental health condition, as well as people who disclose symptoms of a mental health condition but have never been diagnosed. For example, clients who have been diagnosed with mild anxiety or depression, or post-natal depression, have had mental health exclusion clauses like the following examples placed on their cover. Similar exclusions have been applied after a client disclosed only symptoms of depression or anxiety or having received counselling (and not a diagnosed condition), for example, feeling 'low' after a relationship breakdown or feeling 'stressed' as a result of work.

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.

these issues arise most significantly in the life insurance market

Case study 5:

Anika, a 28 year old woman, applied for additional income protection and TPD cover in late 2019 through her superannuation fund. In the application form she truthfully answered questions regarding having received medical advice or treatment in relation to 'Depression, anxiety, chronic tiredness or fatigue, panic attacks, post-traumatic stress, or any other behavioural, mental or nervous condition' by disclosing her visits to a psychologist in 2016-2017. She had sought counselling on the recommendation of her GP to assist her to manage stress arising from her move to a new city and working in a stressful new work environment. Anika was not diagnosed with any mental health disorder, did not require any time off work, and her stress resolved following changes made to her work situation.

After submitting her application, Anika was not asked to provide further details, nor was any information obtained from her treating medical professionals. She was offered income protection and TPD policies subject to broad mental health exclusions and was not provided with reasons for that decision. Anika felt she had been treated unfairly by the insurer and was concerned about her ability to access similar counselling in the future should she need it, in case it may impact her insurance cover.

5.2
Declining cover and alternative terms: exclusions and increased premiums cont...

This recent case study, and many other inquiries PIAC has received since, indicates that the practice of applying broad mental health exclusions to income protection and TPD policies for people with a wide range of experiences of mental health conditions continues. There are several concerns arising from these practices, including:

- a lack of transparency about actuarial and statistical data on which these decisions are based;
- outdated understandings of mental health conditions;
- grouping unrelated mental health conditions into one category; and
- failing to recognise that mental health conditions occur on a spectrum from the very mild to the very serious and can manifest and impact people differently depending on the nature and severity of their condition and the person's particular circumstances.

The mere disclosure that a person has a mental health condition or a history of a mental health condition commonly leads to an insurer limiting or denying cover, without taking into account factors particular to the person'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 person's functioning. These observations are consistent with the Consumer Experiences Survey which found:

...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.[85]

PIAC's work has exposed insurers:

a. Declining applications automatically

- A number of our clients have had applications for insurance declined during a telephone application with the insurer, suggesting 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.
- 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. Assessing applications without obtaining adequate information: Clients have been declined or offered policies subject to broad exclusions without being asked any further questions, or without insurers obtaining any 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 person's compliance with treatment and employment history, amongst other things.
- 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 more severe disorders.
- 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.
- Failing to take into account protective factors disclosed by the person which may mitigate their risk, such as their physical health and activity, behaviours such as seeking medical assistance at an early stage, and their social supports.

d. 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.

PIAC is concerned that these practices take 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. Given the significant mental health impacts of the COVID-19 pandemic, and the associated increase in access to mental health services noted in part 2.1, it is likely that more people will experience discrimination on this basis in the coming years when they seek to obtain or increase their insurance cover.

While PIAC has raised these issues with insurers and insurance industry bodies like the FSC for many years, only limited improvements appear to have been made. The introduction of, and proposed updates to, the Life Insurance Code of Practice and some of its responses to these concerns are discussed further below. Yet insurer commitments to improve their processes only go so far, and the fundamental issue with the underwriting approach that relies on broad, undifferentiated mental health exclusions remains.

85. Mental Health Council of Australia and beyondblue, Mental Health Discrimination and Insurance: A Survey of Consumer Experiences 2011, above n 1, 9.

Case study 6:

In 2019, Miriam applied for income protection and TPD cover and disclosed having recently sought counselling to assist her to manage family relationships. Her mother was very ill and her family does not live in Australia, and it was a period of significant stress for Miriam and her family. Miriam's GP recommended she speak to a psychologist, who she saw for 6 sessions under a Mental Health Care Plan.

Miriam was offered income protection and TPD cover subject to a broad mental health exclusion. She questioned the insurer but was told because she had seen a psychologist they would need to apply the exclusion and she could ask them to review it in 2 years' time.

PIAC assisted Miriam to request the insurer review its decision to apply the exclusion. In the first instance, the insurer affirmed their original decision on the basis Miriam was suffering from anxiety, despite there being no diagnosis of any mental illness. Following a second letter from PIAC, the insurer agreed to remove the exclusion.

Zurich factsheet:

Zurich, which is one of the major life insurers in the market, has published an underwriting factsheet about its approach to mental health,[86] which PIAC commends as a step towards transparency. However, it also reveals the entrenched nature of these issues. Zurich offers an acknowledgment that it must consider individual circumstances, and states that it 'won't place a mental health exclusion simply on the basis of a previous discussion with a GP or Counsellor alone'. However, where Zurich does consider there is a risk that justifies exclusion, Zurich continues to use a broad, non-differentiated, mental health exclusion which also includes 'conditions with medically unexplained symptoms' – this broad exclusion applies regardless of the risk of the individual applicant developing other mental illnesses or unexplained conditions. While Zurich attempts to explain this approach with reference to 'studies', it does not identify the actuarial or statistical data it is relying upon in support of this approach.

Zurich also states:

> *In 2016 Zurich considered insurance cover for over 8000 Australians who had experienced a history of a mental health condition, and less than 4% of those customers were declined cover due to their mental health condition. Of the policies offered to customers providing life and trauma cover, less than 5% of policies had a premium loading, and of those providing Total and Permanent Disablement (TPD) and Income Protection cover only 30% of policies included a mental health exclusion.*[87]

Zurich's figures there demonstrate that mental health exclusions are affecting significant numbers of people. Insurers are not required to report on this information, so these are the only figures PIAC has seen regarding the proportion of people affected. In PIAC's view, insurers should be required to regularly report on the number of policies declined or offered subject to a premium loading or mental health exclusion, as discussed further in part 6.1.

Insurers should also improve their approach to underwriting life insurance for people who have experienced a mental health condition, or symptoms of a mental health condition, by adopting policies and practices which:

a. always consider individual circumstances and do not automatically decline cover or impose a broad mental health exclusion where the application reveals a past or current mental health condition or symptoms of a mental health condition;
b. 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;
c. develop underwriting practices which differentiate between particular mental health conditions; and
d. if an exclusion is required, wherever possible, apply an exclusion which is tailored to the risk of the applicant.

In PIAC's view, these steps are necessary to avoid unlawful discrimination. PIAC would like to see these principles reflected in the Life Insurance Code of Practice, outlined in further detail below, as well as additional mechanisms for enforcement of the Code to provide an accessible remedy for consumers concerned about unfair practices.

86. Zurich, Mental Health Frequently Asked Questions (Underwriting Information Factsheet, 17 August 2018), available https://www.zurich.com.au/content/dam/au-documents/advisers/life-insurance/marketing/mental-health-faq.pdf.

87. Ibid 3.

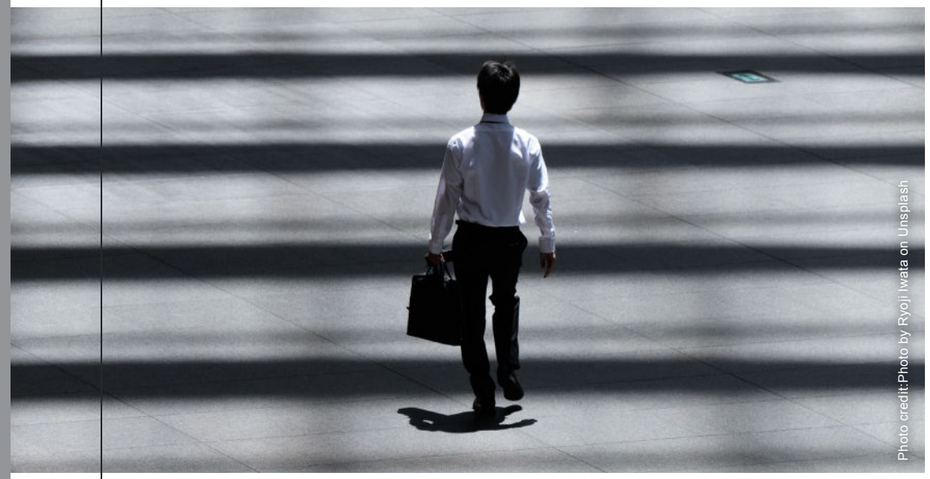


Photo credit:Photo by Ryoji Iwata on Unsplash

5.3
Claims handling and avoiding policies

Prior to the Financial Services Royal Commission, PIAC advised and represented a number of clients who had their life insurance policies cancelled by insurers for their purported failure to disclose a prior mental health condition at the time they applied for cover or to amend existing cover. Often, the non-compliance was innocent, or the insured did not know, and could not reasonably have known, that prior medical interactions would have been relevant to an insurer's decision to offer a policy. When the insured later made a claim on the policy (whether or not the claim was connected to mental health), the insurer cancelled the policy for non-compliance with the insured's duty of disclosure under s 29 of the IC Act.

PIAC raised several issues related to this with the Financial Services Royal Commission, including:

- Difficulties with application forms, which include questionnaires regarding an applicant's medical history and often ask broad, unclear and open-ended questions which are misunderstood by applicants.
- Insurers obtaining access to an insured's complete medical history and relying on matters 'discovered' during the review of the insured's medical records to allege that the insured has breached their duty of disclosure.
- Insurers drawing conclusions from medical records which are inconsistent with the insured's own experience, or with opinions from the insured's treating medical practitioners.
- Insurers using mental health related alleged non-disclosures to deny claims unrelated to mental health.

In PIAC's view insurers have unfairly and unnecessarily cancelled insurance policies to avoid paying legitimate, reasonable claims, potentially in breach of their duty of good faith as required by section 13 of the IC Act. PIAC observed the unfair operation of section 29 of the IC Act and that decisions to cancel contracts of insurance can operate harshly on people who reasonably believe that they are protected by insurance. We noted that people are faced with cancellation of their policy at a time where they are particularly vulnerable.

The Financial Services Royal Commission considered these issues with reference to case studies, including that of PIAC's client outlined above (Case Study 3), and recommended several changes to the legislation and to insurance Codes of Practice to address the issues identified. This included changing the duty of disclosure for consumer insurance contracts to a duty to take reasonable care not to make a misrepresentation, and limiting the ability of insurers to completely avoid a contract of insurance. The changes to the IC Act recommended by the Financial Services Royal Commission have now been implemented and are outlined in part 3.2.

PIAC hopes these changes will improve both the application and claims process for consumers

PIAC hopes these changes will improve both the application and claims process for consumers. In addition to the legislative changes, the current draft of the revised Life Insurance Code of Practice contains commitments from insurers to:[88]

- explain the duty to take reasonable care not to make a misrepresentation and the consequences of not taking reasonable care;
- ensure a person is not required to have specialist knowledge to answer questions;
- ensure questions are asked in plain language;
- before making a decision to cancel or vary a contract, give consumers a chance to explain; and
- if deciding to cancel or vary a contract, explain the decision in writing and tell consumers how to dispute the decision.

Some of the concerns noted above may remain an issue for consumers who took out a policy prior to the legislative amendments, and will still be subject to the previous law. In those cases, PIAC hopes that insurers will act consistently with their utmost duty of good faith and will not seek to unfairly avoid insurance contracts on the basis of alleged mental health non-disclosures. PIAC also considers the Life Insurance Code of Practice should include the additional commitments recommended by the PJC Inquiry to establish a connection between a pre-existing condition relied on to deny a claim or avoid a policy and the claim, and to provide more detailed information regarding the basis of a decision to deny or avoid.

It will also be important that the operation of the recent reforms and consumers' experiences of the claims processes since their introduction continue to be monitored.

88. FSC, Life Insurance Code of Practice Consultation draft (18 August 2021), 11-12, available https://fsc.org.au/resources/2247-fsc-life-insurance-code-of-practice-2-0-final-consultation-version/file.

03.
Recommendation: Claims and policy avoidance

The Life Insurance Code of Practice should include commitments as recommended by the PJC Inquiry to:

- where a pre-existing condition is to be used by an insurer as the basis for denying a claim or avoiding a contract, a direct medical connection between the prognosis of a pre-existing diagnosed condition and the claim must be established; and
- the statistical and actuarial evidence and any other material used to establish a pre-existing condition, as well as a written summary of the evidence in simple and plain language, be provided by the life insurer to the consumer/policyholder on request.

5.4
Access to medical records

Insurer access to the medical records of an insured person has raised ongoing concerns for consumers, particularly in relation to mental health. While some access to clinical information is necessary for insurers to understand and categorise risk for a person, the issue of insurers seeking broad access to an applicant's or claimant's medical information and records has been a key concern of consumers. This was noted by the PJC Inquiry:

The committee is also very concerned about evidence provided that patients are reluctant to seek necessary treatment, particularly for mental ill health, due to concerns over life insurers having access to their full medical record and then using such information to limit or deny coverage or a claim.

The committee is firmly of the view that life insurers should only have access to targeted medical information. The committee is therefore recommending that the Financial Services Council and the Royal Australian College of General Practitioners collaborate to prepare and implement agreed protocols and standards for:

- requesting and providing relevant medical information only, not complete medical files;
- uniform authorisation forms for access to medical information;
- appropriate storage of medical information; and
- real-time disclosure to consumer about the progress of their claim, including requests for medical records.[89]
- The Productivity Commission also noted concerns about insurers conducting 'fishing expeditions' for reasons to deny claims, as well as:
- the risk that GPs may not fully document a patient's condition in their consultation notes because of concerns about how an insurer might use or misinterpret certain information;
- the risk that a patient may not fully disclose symptoms – or may avoid seeking treatment altogether – for fear of how an insurer might use that information; and
- the fact that, while consultation notes may include a diagnosis, they may not include a prognosis that takes into account treatment options and behaviour changes.[90]

The concerns raised in those reports are consistent with experiences reported by PIAC's clients – clients are often shocked at the request from insurers to provide consent to access all their clinical records and often ask for advice about whether they need to give this consent. Case study 3 demonstrates that insurers have used medical records to identify reasons to avoid policies, even where those records are unrelated to the condition the subject of a claim. As recently as 2020, PIAC assisted a client who had claimed on TPD and income protection policies because of a condition affecting one of his hands and, upon review of his prior medical history, the insurer alleged non-disclosure of past treatment for PTSD as one basis for avoiding his policies.

PIAC is also aware of concerns that parents may be wary of obtaining mental health treatment for their children or having such treatment documented because of fears of future discrimination by insurers. The law does not restrict an insurer's ability to seek access to childhood health records and PIAC has assisted clients whose childhood health records have been considered by insurers in the context of an application for insurance or assessment of a claim. Medical practitioners have expressed concerns about this open-ended access to medical records, and instances of discrimination arising from open-ended access to medical records have been reported.[91]

The FSC and the Royal Australian College of General Practitioners (RACGP) have now agreed to a standard consent form, FSC Standard 26, which must be adopted by all FSC members, and which aims to 'ensure that, when obtaining information from health practitioners about customers, FSC Members use a standardised consent wording developed in agreement with the RACGP as well as a process to inform customers as to when this consent will be used'.[92] The Standard provides wording to be used by insurers, including:

We, [The Insurer], collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

The form then includes two separate authorities to be signed, one consenting to release of information excluding consultation notes, and the second consenting to release of consultation notes as well. The form explains that the second authority will only be used to request consultation notes if the insurer has asked the GP to provide a report and the GP has not done so or the report is incomplete or inaccurate.93 The form does not appear to suggest any limitation to the time period for which insurers can request records.

The standard form has been available since July 2019, but FSC members were only required to adopt it by July 2021. As it has only been operating for a short period, there is not yet evidence of its uptake or success in addressing these concerns. The Productivity Commission recommends this be reviewed within 2 years of the protocols commencing operation.[94] PIAC agrees with that recommendation, but considers ASIC may be a more appropriate body than the Australian Law Reform Commission (which was suggested by the Productivity Commission) to conduct that review.

89. Parliamentary Joint Committee on Corporations and Financial Services, Life Insurance Industry (March 2018), p xi.

90. Productivity Commission, Inquiry Report: Mental Health, above n 3, 377.

91. See ABC News, 'Doctors resisting health records being sent to insurance companies' (8 September 2017) https://www.abc.net.au/news/2017-09-08/doctors-resisting-health-records-being-sent-to-insurance-compan/8887374 and ABC News, 'Insurers gaining 'open-ended access' to medical records slammed as 'unfair privacy breach'' (24 January 2019) https://www.abc.net.au/news/2019-01-24/medical-records-handed-to-insurance-companies-over-mental-health/10720024.

92. FSC Standard No. 26, Consent for Accessing Health Information (27 July 2021) available https://fsc.org.au/resources/2233-standard-26-consent-for-accessing-health-information-1/file.

93. Explained under 'Authority 2 explanatory notes', FSC Standard No. 26, ibid.

94. Productivity Commission, Inquiry Report: Mental Health, above n 3, 378.

04.
Recommendation:
Review of insurer access to clinical records

In 2023, ASIC or another appropriate body should review whether the protocols for insurer access to clinical records have resulted in more targeted requests for clinical information, and whether they give sufficient protections to people with histories that include seeking psychological treatment or counselling.

5.5
TPD insurance in superannuation – restrictive definitions

Total and Permanent Disability (TPD) insurance provides financial support to those who can never work again due to disability. It is commonly available to people through their superannuation fund. Around 10 million Australians have TPD insurance cover bundled with their super – funds are legally required to provide insurance to those over 25 with a default MySuper account with at least $6,000, unless the person opts out.[95]

Super Consumers Australia have reported on the significant discrimination that results from the use of restrictive eligibility conditions and definitions in many of these TPD products.

Most TPD policies consider a person eligible to claim if they become disabled and are unlikely to return to work in any occupation for which they are suitably qualified. However, under many default policies, people who do not meet certain employment criteria, including those who may be unemployed, in part-time or casual work at the time of becoming injured or ill, must pass an Activities of Daily Living (ADL) or Activities of Daily Work (ADW) test. These tests usually require a person to show they cannot do at least two of a list of five physical activities, such as walking, talking, feeding themselves, using the bathroom and dressing, in order to be classified as permanently disabled.[96]

The result of such restrictive criteria is to leave many people who are unable to work due to mental illness ineligible to claim under their TPD policy.

In 2020, Super Consumers analysed policies of Australia's largest super funds. They found that 94% of the 32 policies they considered contained terms that required unemployed people or people working limited hours to claim under restrictive definitions of TPD.[97]

ASIC has also drawn attention to these problematic definitions. In ASIC's Report 633 Holes in the safety net: a review of TPD insurance claims, it found that ADL type definitions have a much higher declined claims rate than a standard TPD definition on average (60% compared with 12%), rising to 77% for mental health claims.[98]

Policyholders whose employment status limits them to claiming under a restrictive TPD definition pay the same premiums as all other policyholders, although the policy is of little value to them as they are unlikely to successfully claim. Super Consumers Australia, the Financial Rights Legal Centre and others have called for such restrictive definitions to be prohibited. PIAC agrees with that recommendation.

95. Super Consumers Australia, Campaign: remove junk insurance from super (Website, 2021) https://www.superconsumers.com.au/campaigns-junk-insurance.

96. Ibid.

97. Super Consumers Australia, Restrictive definitions in default TPD insurance policies (Blog, 8 July 2020) https://superblog.netlify.app/2020/07/08/tpd/#the-prevalence-of-restrictive-tpd-definitions-in-2020.

98. ASIC, Report 633 Holes in the safety net: a review of TPD insurance claims (October 2019) available https://asic.gov.au/regulatory-resources/find-a-document/reports/rep-633-holes-in-the-safety-net-a-review-of-tpd-insurance-claims/.

05.
Recommendation:
TPD insurance in Superannuation

All insurers and superannuation trustees should remove ADL and other restrictive TPD definitions from insurance policies.

5.6
Life Insurance Code of Practice

As noted above, the FSC Life Industry Code of Practice is currently undergoing a review. The FSC has said it has attempted to incorporate recommendations of the PJC Inquiry regarding mental health, among other improvements responding to feedback from various stakeholders.[99] A revised draft of the Code has recently been released for further consultation.

It proposes removing the current commitment in [5.17], which states:

Our decisions on applications for insurance will comply with the requirements of anti-discrimination law. Our decisions will be evidence- based, involving relevant sources of information where this is available, and having regard to any other relevant factors where no data is available and cannot reasonably be obtained. We will regularly review our underwriting decision-making processes to ensure we are not relying on out-of-date or irrelevant sources of information.

Instead, the Code would include the following: [100]

> *4.18 If you tell us about a diagnosed mental health condition or symptoms of a mental health condition you have or have had, we will:*
>
> a. allow you the opportunity to provide information about the history, severity or type of condition before making our decision about whether to insure you and, if so, the terms we offer you, and
>
> b. take into account your circumstances such as the history, severity or type of condition, when deciding whether we can offer you cover. If we do not offer you cover, or we offer you alternative terms, we will explain to you why in line with clause 4.26.

The revised draft Code also includes an appendix outlining provisions of the Code that may be relevant to a person experiencing a mental health condition, although it contains no further commitments and is said not to form part of the Code. The appendix refers to provisions regarding taking extra care to support vulnerable customers, outlined in part 6 of the draft Code, as well as commitments to restrict the use of surveillance when investigating claims (including to stop surveillance if evidence from a doctor or psychologist shows it is negatively affecting health). While this appendix collates many of the provisions of the Code which may be relevant to a person experiencing a mental health condition, its purpose is ambiguous, and it does not provide any further information about how insurers might implement the commitments they have made (unlike, for example, the 'Guide on mental health' provided by the ICA with the General Insurance Code of Practice). At a minimum, PIAC considers the appendix should form an enforceable part of the Code.

While PIAC welcomes the ongoing recognition of the need to take special care in handling mental health issues, PIAC is concerned that the Code does not sufficiently address the concerns outlined in this report. PIAC strongly opposes the FSC's intention to remove the clear commitment in the existing Code to comply with anti-discrimination laws, ensure

5.6
Life Insurance Code of Practice cont...

decisions are evidence-based, and review and update underwriting decision-making processes. Including these commitments in the Code:

- assists consumers to understand that insurers are required to comply with anti-discrimination laws;
- reminds insurers what those laws require of them in terms of their decision-making and internal processes; and
- provides an additional mechanism for accountability where compliance with the Code is monitored and Code breaches can be raised, for example, in complaints to AFCA.
- PIAC considers that, at a minimum, the Code should include commitments similar to those made by general insurers in clause 104 of the ICA Code (see 3.3 above) to comply with relevant anti-discrimination laws. In addition, PIAC considers the Code should include clear commitments to:
- not automatically decline an application where the application reveals a past or current mental health condition or symptoms of a mental health condition;
- allow applicants the opportunity to withdraw their application before declining to offer insurance or offering insurance on non-standard terms, as the stigma of having an application declined (and potentially having to disclose that again in the future) is something that clients have raised with PIAC as a significant concern;
- 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; and
- tell consumers, where insurance is offered on non-standard terms (for example, with a mental health exclusion or a higher premium than a standard premium):
  - how long it is intended that the exclusion/higher premium will apply to the policy
  - how and when the insured can ask for the exclusion to be removed or premium reduced, and the criteria they would need to satisfy.

These recommendations are consistent with those made by the PJC Report.[101] PIAC will reiterate these concerns in its response to the FSC consultation on the final draft Code.

The other major challenge in relation to the Life Insurance Code of Practice is its enforceability. Currently, the Code only creates legal rights between the entities bound by the Code and the FSC. The Life Insurance Code Compliance Committee (Life CCC) independently monitors the Code and compliance, and breaches can be reported to the Life CCC by consumers, but consumers themselves cannot take action to obtain a remedy for a breach of the Code (although they could raise the alleged breaches as part of a complaint to AFCA). The Financial Services Royal Commission recommended that the provisions of the Code that 'govern the terms of the contract made or to be made between the insurer and the policyholder' be made 'enforceable code provisions'.[102] A breach of one of those provisions would then be considered a breach of law and could be enforced by consumers through existing complaints and legal processes. The provisions of the Code which are proposed to be 'enforceable' in this way have not yet been nominated by the FSC. PIAC considers that the Code commitments regarding decision-making in relation to offering insurance, or the terms of insurance offered, are provisions that govern the terms of the contract and should be made enforceable so that consumers have the ability to directly enforce those terms.

99. See, for example, FSC, FSC Code of Practice 2.0 Review of Consultation Feedback (November 2020), 23.

100. Financial Services Council, Life Insurance Code of Practice Consultation draft (18 August 2021) available https://fsc.org.au/resources/2247-fsc-life-insurance-code-of-practice-2-0-final-consultation-version/file

101. Parliamentary Joint Committee on Corporations and Financial Services, Life Insurance Industry (March 2018), Recommendation 10.7.

102. Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (Final Report, February 2019) vol 1, Recommendation 4.9, 316.

06.
Recommendation: Life Insurance Code of Practice

The Life Insurance Code of Practice should include additional commitments to comply with anti-discrimination laws including to:

- at a minimum, design and sell products and apply their terms in compliance with the requirements of the Disability Discrimination Act 1992 and/or any relevant State or Territory anti-discrimination requirements;
- ensure decisions are evidence- based, involving relevant sources of actuarial and statistical data where this is available, and having regard to any other relevant factors including the individual circumstances of the applicant;
- regularly review and update underwriting processes and the information relied upon to make decisions to ensure these are not relying on out-of-date or irrelevant sources of information;
- not automatically decline an application where the application reveals a past or current mental health condition or symptoms of a mental health condition;
- wherever possible, provide cover to persons with a past or current mental health condition and manage risk through pricing, exclusions, limits and caps based on actuarial and statistical data and other relevant factors, rather than not provide cover at all;
- allow applicants the opportunity to withdraw their application before declining to offer insurance or offering insurance on non-standard terms;
- tell consumers, where insurance is offered on non-standard terms (for example, with a mental health exclusion or a higher premium than a standard premium):
  - how long it is intended that the exclusion/higher premium will apply to the policy;
  - how and when the insured can ask for the exclusion to be removed or premium reduced, and the criteria they would need to satisfy; and
  - to develop, implement and maintain policies that reflect the above.
- The proposed Appendix B to the Code regarding supporting customers experiencing a mental health condition should form an enforceable part of the Code and include the additional commitments outlined in these recommendations.
- Provisions of the Life Insurance Code of Practice which make commitments regarding decisions to offer or decline insurance, or to offer insurance on non-standard terms, should be made enforceable code provisions.

6 Ongoing concerns

6.1
Absence of clear and accessible evidence

Data is at the centre of the insurance exceptions under the DDA and equivalent anti-discrimination legislation. These allow insurers to lawfully discriminate if the discrimination is based on actuarial or statistical data and other relevant factors.[103] However, it is extremely difficult for consumers or observers to know whether insurers have relevant data and, if they do, whether it justifies their discriminatory decisions. In PIAC's experience, consumers cannot easily access the data relied upon by insurers in decisions that affect them because insurers rarely provide such data outside court processes.

This means that for many people the only way to test whether an insurer has satisfied the insurance exemption in the DDA is to pursue a legal complaint at a court or tribunal, and seek access to the actuarial and statistical data and any other evidence relied upon in making the decision. This places an unrealistic and unfair burden on vulnerable people who suspect an insurer has unlawfully discriminated against them.

Insurers should be more transparent about the data they use to make discriminatory decisions, ideally by providing that data to the extent possible in plain language to people. PIAC's engagement with insurers in various contexts indicates they are reluctant to provide detail regarding the data they have relied on. PIAC also understands that often data is held by reinsurers who provide insurers with underwriting manuals but are not willing to disclose the data informing those manuals to consumers.

Recognising that commercial imperatives may make companies reluctant to disclose this information, the AHRC and state-based anti-discrimination bodies could be given the power to compel insurers to provide the data relied upon where a person complains of discrimination. This would allow them to access such data for the purposes of investigation and further provision could be made for the provision of this information to complainants subject to strict confidentiality. The NSW and Tasmanian legislation does already require insurers to disclose the source of their data and the other relevant factors relied upon if requested by the Tribunal.[104] This could be adopted in other jurisdictions.

103. VEOHRC, Fair-minded cover: Investigation into Discrimination in the Travel Insurance Industry, above n 20, 8.

104. Anti-Discrimination Act 1977 (NSW), s 49Q; Anti-Discrimination Act 1998 (Tas), s 44(2).

07.
Recommendation:
Transparency regarding actuarial and statistical data

Insurers should be required by their respective Codes of Practice to provide, directly to an applicant or insured on request, the actuarial and statistical data and relevant factors relied on to make a decision to decline cover or offer cover on non-standard terms on the basis of disability.

The AHRC and all state-based anti-discrimination bodies should be given the power to compel insurers to provide the actuarial and statistical data and other evidence relied upon in complaints of unlawful disability discrimination.

Quality and use of data

PIAC has long held concerns about the quality of data relied upon by insurers, and VEOHRC's investigation into travel insurance revealed concerning practices related to data, including the use of outdated or irrelevant data and insufficient analysis of data.[105]

VEOHRC noted that in order to rely on the data exception, insurers must use appropriate data that is up-to-date and relevant.[106] Notwithstanding limitations in existing data identified by insurance industry bodies and the Actuaries Institute, VEOHRC observed that quality, accessible data about mental health conditions, their prevalence, severity and treatment, continues to increase, including through the collection of data by insurers themselves, and that it is critical that insurers regularly review the data they rely on.[107] This growth in data also means that insurers should be able to consider and adjust insurance policies for particular mental health conditions, like they do with different physical conditions.

The Actuaries Institute, in considering challenges for the industry in relation to the use of data in respect of mental health conditions, identified the 'great assistance' that comprehensive and medically validated underwriting guides specific for Australian practice would provide to underwriting those with mental health conditions, as well as opportunities for better using existing data.[108] PIAC considers that up to date and specific medical information and data about different mental health conditions is required to ensure underwriting is accurate and reasonable.

The FSC has recently made some efforts to improve the collection and analysis of claims data from its members, commissioning KPMG to assemble and analyse data from the retail life insurance industry from 2007-2019 regarding mental health claims.[109] Findings from that research have been published and provide some insights into the likelihood of a person making multiple claims. Claims data provides only one piece of the puzzle, and the KMPG research identified additional data that could be collected to improve analysis, including more detailed claims data to enable a consideration of particular mental health conditions, as well as detailed underwriting data to provide insights into the impacts of underwriting mental health.[110]

105. Ibid 13.

106. Ibid 14.

08.
Recommendation:
Insurance industry improves quality and use of actuarial and statistical data

The General Insurance Code of Practice and the Life Insurance Code of Practice should include a commitment by insurers to regularly review the data they rely on to make decisions to discriminate on the basis of mental health and continually seek better data to enable differentiated underwriting of particular mental health conditions.

6.1
Absence of clear and accessible evidence cont...

Discrimination data reporting

Since 2018, life insurers have collected and published data in the aggregate, available via the Australian Prudential Regulation Authority (APRA), in relation to claims and disputes.[111] This includes claims admittance, denial and withdrawal rates by category of cover and distribution channel, claims frequency and claims paid ratios, and claims processing duration. Disputes data includes dispute lodgement ratios, dispute outcomes by cover type, and dispute processing duration. This data can assist to identify systemic issues in the industry, and provides some transparency of industry performance on its key commitments to consumers regarding claim and dispute handling. It also provides valuable information for regulators like ASIC and APRA.

However, this data collection does not include any data regarding applications for insurance and underwriting outcomes, which would provide greater transparency regarding insurer practices.

For example, insurance companies could be required to report annually to an appropriate regulator (the AHRC, ASIC or APRA) 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 data could then be published by the relevant regulator on its website and/or by insurers in their annual report. The Zurich 'factsheet' information noted above indicates insurers have this information available and could report on it if required.

People often purchase insurance, particularly life insurance products, through financial advisors or planners rather than from insurers directly. There is also no data to quantify how many people are dissuaded from applying for insurance, or decide to withdraw an application for insurance to avoid having a record of being declined, on advice from their advisor that an insurer is likely to decline an application or only offer cover subject to a mental health exclusion or premium loading. Financial planners may be another source of data regarding the prevalence of this type of discrimination, although PIAC has not explored the feasibility of collecting that data.

107. Ibid 131.

108. Actuaries Institute, Mental Health and Insurance Green Paper, (October 2017, Institute of Actuaries of Australia) 36-37.

109. KPMG Financial Services Consulting, Mental Health Analysis Summary Report (June 2021) available https://www.fsc.org.au/resources/2235-fsc-kpmg-mental-health-analysis-summary-report-june-2021.

110. Ibid, 21.

111. APRA, Biannual Life insurance claims and disputes statistics (2021, Website) https://www.apra.gov.au/life-insurance-claims-and-disputes-statistics.

09.
Recommendation: Insurers report on disability discrimination

Insurers should be required to report annually to the AHRC or another appropriate body on the number of times they have declined insurance or offered insurance on non-standard terms on the ground of disability.

6.2 Discriminatory decisions are hard to challenge

While PIAC's casework experience demonstrates that the issues outlined above affect many people, it also demonstrates that it is difficult for people to seek review and redress of an insurer's decision without legal assistance. This is partly due to inadequacies in the communication by insurers of the options available to people for review of their decisions. It is also due to the lack of transparency and information imbalance between the insured and the insurer.

Internal dispute resolution

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 IC Act.

PIAC recommends this to clients as a first step in resolving their complaint, but also has concerns about the effectiveness of this in practice as, for many clients:

a. insurers are reluctant to articulate precisely why an application was rejected. Even after a formal request for reasons, 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; and
c. insurers sometimes only provide written reasons to the applicant/insured/s medical practitioner.

If the applicant is still unhappy with an insurer's decision, or if an insured person is unhappy with a decision, they may seek an internal review of that decision. In our submission to the Financial Services Royal Commission, PIAC noted the internal dispute resolution mechanisms were rarely effective in resolving disputes and observed:

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 sometimes ask for medical health records spanning most or all of the applicant's life as part of the internal review process, which can be time consuming and costly for an applicant for insurance and cause further delays;
e. the prospect of obtaining an improved outcome following internal review is low, however, it increases where an applicant has engaged legal representatives.

Since the Financial Services Royal Commission, PIAC has observed some improvement in insurer responses to requests by clients for reasons, and some improvements in the time frames within which insurers respond to complaints. The introduction of the Life Insurance Code of Practice in 2017 may have contributed to this–it commits insurers to respond to complaints in writing within 45 days where possible, and if longer, to provide reasons for the delay and tell consumers of their right to complain to AFCA.[112]

The revised draft of the Code proposes to improve those commitments further, so insurers are required to respond to the complaint within 30 calendar days, and include specific information including reasons, summary of information relied on, that the complainant can ask for copies of documents, and how to make a complaint to an External Dispute Resolution Body if they are not satisfied.[113]

The revised draft Code also includes the following provisions which provide some greater commitments to provide reasons to consumers at the outset:

4.26 If we offer you alternative terms, we will explain in plain language:

a. the alternative terms
b. that if you agree to buy the policy, we will take this as your agreement to the alternative terms
c. that you can ask us to review any alternative terms we offer now or in the future if circumstances change, and how to do so, and
d. the elements in clause 4.29.

4.29 If we do not offer you insurance, we will explain to you in plain language:

a. the reasons for our decision
b. that you can ask us for the information about you that we relied on to make this decision
c. that you can contact us if you think the information we relied on is incorrect or out of date
d. that you can ask us to review our decision or give us extra information to consider, and
e. our Complaints process.

The General Insurance Code of Practice contains similar commitments.[114]

This is an improvement on consumers having to rely only on section 75 of the IC Act, but does not promise to provide the level of detail in responses that would enable a person to understand whether the insurer's decision was reasonable. While PIAC hopes these changes will improve the experience for consumers, PIAC remains concerned that internal review processes have limited utility in addressing the causes of discrimination and consumer dissatisfaction.

External complaints and litigation

People 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 IC Act 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 AFCA or the AHRC, or the anti-discrimination agency in their State or Territory. Following internal dispute resolution, the insurer will usually only advise the consumer of their right to lodge a complaint with AFCA, despite AFCA's limited ability to consider discrimination complaints as outlined in part 3.5.

112. FSC Life Insurance Code of Practice, 9.12 and 9.13.

113. Financial Services Council, Life Insurance Code of Practice Consultation draft (18 August 2021) available https://fsc.org.au/resources/2247-fsc-life-insurance-code-of-practice-2-0-final-consultation-version/file, 7.12.

114. Insurance Council of Australia, General Insurance Code of Practice, clause 47 available https://insurancecode.org.au/resources/general-insurance-code-of-practice-2020/.

6.2
Discriminatory decisions are hard to challenge cont...

Clients are often unaware of this split dispute resolution system, and can be prejudiced from enforcing their rights as a result. A person generally cannot lodge complaints in both AFCA and the AHRC or State anti-discrimination commission at the same time, so must choose one or the other. Time limits can then create difficulties if the person finds they need to go to the other jurisdiction only after already pursuing a complaint in the first jurisdiction. The AHRC can decide not to accept a complaint made more than 6 months after the alleged discrimination, and the State and Territory anti-discrimination commissions generally have a 12 month time limit. While these time limits may be extended, if a person is outside of time it can create additional stress and uncertainty.

While both AFCA and anti-discrimination dispute resolution mechanisms are designed to be accessible to consumers, the complexities outlined above mean many people require legal assistance to access those mechanisms. Legal assistance is also often required to persuade an insurer to provide all of the material relied on by the insurer, and often that material, for example, underwriting guidelines and medical journal articles, requires expert analysis by lawyers, actuaries and medical experts in the field of psychiatry, which it is difficult for people to obtain alone.

While legal assistance is often required, it is rarely available to people who seek to question an insurer's decision to decline their policy or offer a policy on non-standard terms. PIAC has provided assistance and representation to many people, but there are few other services which provide this specialised advice. Private lawyers are often available to represent people who have an existing policy and have had claims denied, and can often act on a 'no win, no fee' basis in those matters, but as there is likely to be little immediate financial return from a discrimination complaint about an underwriting decision (apart from the longer term financial benefits of a suitable policy), affordable representation is often not available.

Beyond the complaint and conciliation process offered by anti-discrimination commissions, the barriers to accessing tribunals and courts are even higher. Pursuing a legal complaint is arduous, time consuming and expensive. For many of PIAC's clients, the risk of a substantial costs order against them if they are unsuccessful dissuades them from pursuing a discrimination complaint in the federal courts even when they have a strong claim.

PIAC continues to advocate for change to the costs regime in the federal courts for discrimination cases, as this is a barrier faced by clients in discrimination matters generally. It is not unusual for respondent insurers to retain large law firms and senior and junior counsel to represent them, meaning costs can be significant. While State administrative tribunals generally involve a lower risk of being ordered to pay costs, some risk remains and must be balanced against the amount of compensation a person might receive. In discrimination cases, this is often minimal. 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 would be awarded if the matter was successful at hearing.

PIAC has acted for many clients who have had life insurance cover denied or limited as described above, and has lodged disability discrimination complaints on behalf of clients in the AHRC and State-based anti-discrimination commissions. Most of those complaints have been resolved with the relevant insurer on favourable, but confidential, terms for our clients. Outcomes have included the removal or more appropriate limiting of exclusion clauses, the payment of compensation, and agreements to review the insurer's policies or procedures. While these outcomes have assisted our clients, the individual resolution of claims is not able to achieve the systemic change which is necessary to see all life insurers more fairly and lawfully offer cover to those who have experienced a mental health condition.

One way to simplify the process would be to enable AFCA to also consider complaints regarding unlawful discrimination in insurance. ASIC must approve a change to AFCA's Rules pursuant to section 1052D of the Corporations Act 2001 (Cth). This could assist people who are unhappy with an insurer's decision to deny insurance or offer insurance on non-standard terms to obtain a remedy. However, this does not address the broader issue that individual dispute resolution is not effective at addressing underlying practices of insurers that result in these decisions. That requires stronger regulation, which is considered further below.

10.
Recommendation: Improve dispute resolution processes

AFCA should request ASIC to approve a change to its Rules to enable AFCA to consider complaints regarding unlawful discrimination in relation to applications for insurance.

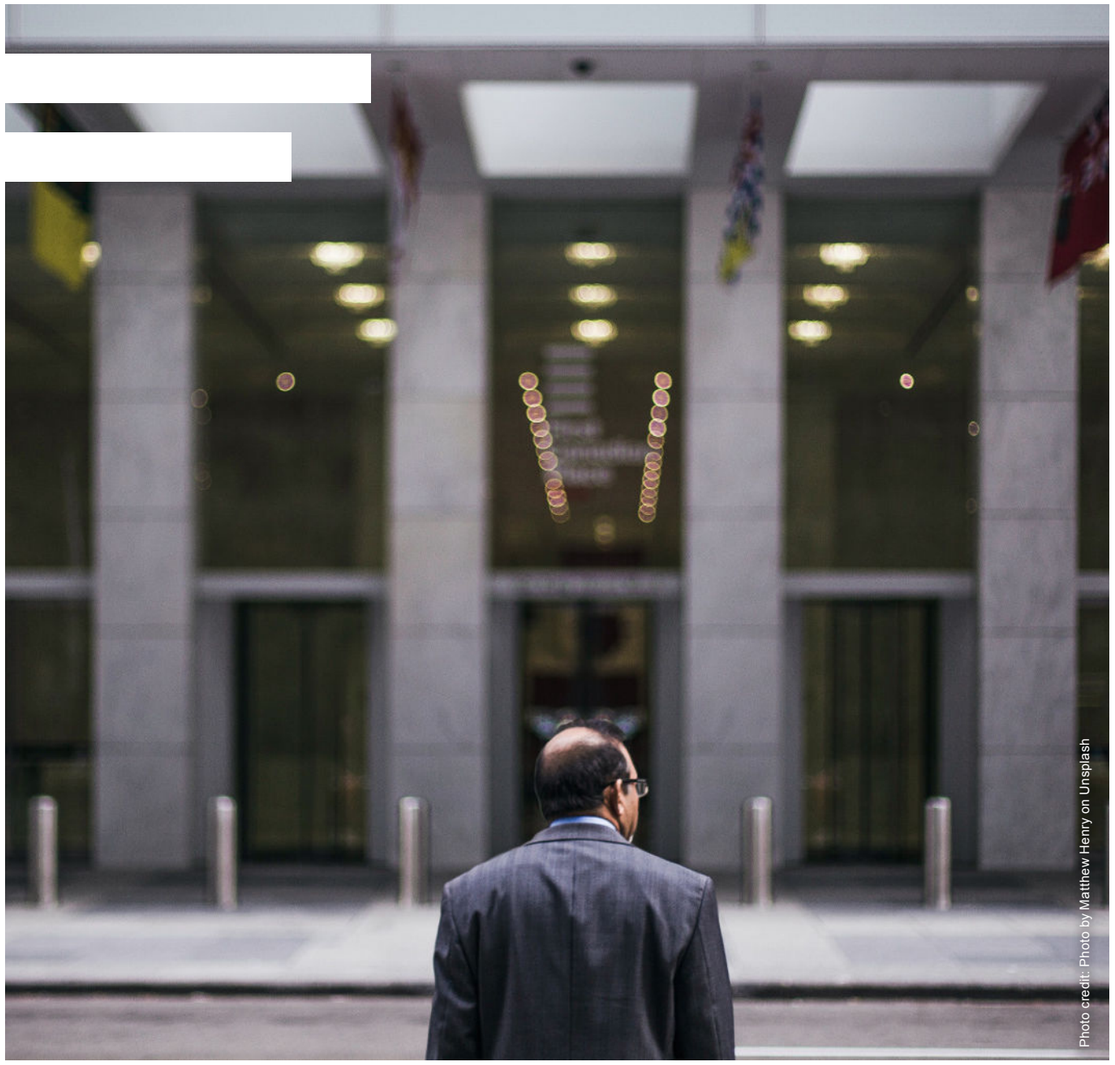


Photo credit: Photo by Matthew Henry on Unsplash

7 Path forward

7.0
Path forward

PIAC considers that the key lessons identified by VEOHRC in its landmark inquiry into travel insurance apply equally to the broader life insurance industry, and are the principles which should be adopted to drive enduring change. There is a need:

- to listen to consumer experience
- for better use and analysis of data
- for stronger regulation
- for better education and support

PIAC's recommendations in this report are directed at improving the experience of consumers with these principles in mind. The current legal framework which relies on people bringing complaints is not working adequately and has not seen sufficient timely or widespread change to the practices of insurers to address the experiences of discrimination outlined in this report. PIAC suggests two options for achieving the change that is required to end discrimination by insurers against people with mental health conditions.

The first is for ASIC to take up the recommendation of the Productivity Commission to review industry Codes of Practice and standards. PIAC has engaged with ASIC on these issues over the course of our work, and has strongly encouraged ASIC to undertake such an inquiry. ASIC has existing powers as the regulator of financial service providers, including insurers. ASIC has conducted several previous investigations on related topics, including Report 498, Life insurance claims: An industry review, released in October 2016, and Report 633 Holes in the safety net: a review of TPD insurance claims, released in October 2019.

The VEOHRC investigation outlined in part 4.2 provides an excellent model for the conduct of such an investigation – involving people with experience of mental illness, and possessing sufficient authority to compel insurers to provide the information necessary.

The other option may be to empower the AHRC to investigate systemic discrimination in the insurance industry. The AHRC has the power to inquire into, and attempt to conciliate, individual complaints of unlawful discrimination. 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.

Part 9 of the Equal Opportunity Act 2010 (VIC) empowers VEOHRC to conduct investigations into any matter relating to the operation of the Act where the matter is serious, affects many people, and contraventions are suspected to be widespread. VEOHRC exercised this power in its investigation into travel insurance. While VEOHRC may also have the power to conduct further investigations into insurance, such investigations take significant resources and are not confined to the Victorian market, such that it would be more appropriate for a national body like the AHRC to conduct this type of inquiry.

The AHRC could be provided with similar powers to conduct investigations into suspected breaches of the DDA, although this may require legislative change. 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. In order for such powers to be effective, the AHRC would also need to be adequately resourced to undertake such an inquiry. Given that ASIC has existing powers that could be used for this purpose, it may be the preferable option.

11.
Recommendation: Investigation by ASIC

ASIC should investigate, as recommended by the Productivity Commission, life insurance industry practices relating to the provision of services to those with mental health conditions. The investigation should consider discrimination in relation to mental health in the underwriting of insurance policies and adopt a model for investigation similar to that used by VEOHRC in its investigation into travel insurance.

An inquiry of the nature suggested would provide a starting point for stronger regulation to improve the experience of people living with mental health conditions in relation to insurance. Additional regulatory oversight should also include enforcement by ASIC of serious breaches of the law by insurers, including in relation to the duty of utmost good faith (as outlined in part 3.2) and breaches of the provisions of the General Insurance Code of Practice and the Life Insurance Code of Practice.

PIAC's recommendations in this report are directed at improving the experience of consumers

Appendix 1

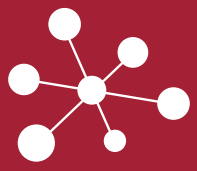
Disability discrimination laws and complaint mechanisms

Jurisdiction	Legislation	Disability Discrimination Provisions	Exceptions for Insurance	Complaints body	Time Limits and Costs	Process/ Remedies	Further appeal
Australia-wide	Disability Discrimination Act 1992 (Cth)	**Section 4:** disability definition **Section 24:** discrimination in provision of goods or services unlawful	**Section 29A:** general defence of unjustifiable hardship **Section 11:** circumstances to consider in determining unjustifiable hardship **Section 46:** exemption for insurance and superannuation providers if: **s 46(1)(f)** the discrimination (i) is based upon actuarial or statistical data on which it is reasonable for the first-mentioned person to rely; and (ii) is reasonable having regard to the matter of the data and other relevant factors; or **Or:** **s 46(1)(g)** in a case where no such actuarial or statistical data is available and cannot reasonably be obtained—the discrimination is reasonable having regard to any other relevant factors.	Australian Human Rights Commission (AHRC) Australian Human Rights Commission Act 1986 (Cth)	**6 months** No cost to lodge a complaint.	**Conciliation** -parties to come to agreement to settle the dispute – could include various outcomes such as apology, change of policy or compensation.	**Federal Court or Federal Circuit Court** If the complaint is terminated there is a right of appeal to Federal Court or Federal Circuit Court: Federal Court proceedings are subject to fees and costs orders.
NSW	Anti-Discrimination Act 1977 (NSW)	**Section 4:** disability definition **Section 49M:** discrimination in provision of goods or services unlawful	**Section 49M:** defence of unjustifiable hardship **Section 49C:** circumstances to consider in determining unjustifiable hardship **Section 49Q:** exemption for terms and conditions of superannuation or provident fund or scheme, or terms of policy of insurance where: (a) the terms or conditions— (i) are based upon actuarial or statistical data on which it is reasonable to rely, and (ii) are reasonable having regard to the data and any other relevant factors, or (b) in a case where no such actuarial or statistical data is available and cannot reasonably be obtained—the terms or conditions are reasonable having regard to any other relevant factors, and the source on which any data referred to in paragraph (a) is based is disclosed to the Tribunal, where the Tribunal so requires, and any other relevant factors to which regard has been had as referred to in paragraph (a) or (b) are disclosed to the Tribunal, where the Tribunal so requires.	Anti-Discrimination Board NSW (NSW ADB)	12 months No cost to lodge a complaint.	Conciliation	NSW Civil and Administrative Tribunal (NCAT) Generally parties bear own costs but NCAT has power to award costs.

Jurisdiction	Legislation	Disability Discrimination Provisions	Exceptions for Insurance	Complaints body	Time Limits and Costs	Process/ Remedies	Further appeal
Victoria	Equal Opportunity Act 2010 (Vic)	**Section 4:** disability definition Section 15: positive duty to take reasonable and proportionate measures to eliminate discrimination as far as possible **Section 44:** discrimination in provision of goods and services prohibited	**Section 46:** defence where adjustments to service required are not reasonable. **Section 47:** exception for insurers if: (b) the discrimination— (i) is based on actuarial or statistical data on which it is reasonable for the insurer to rely; and (ii) is reasonable having regard to that data and any other relevant factors; or (c) in a case where no such actuarial or statistical data is available and cannot reasonably be obtained, the discrimination is reasonable having regard to any other relevant factors.	Victorian Equal Opportunity and Human Rights Commission (VEOHRC) Victorian Civil and Administrative Tribunal (VCAT) A person can bring a complaint to VCAT whether or not the person has brought the dispute to VEOHRC.	**VEOHRC** – 12 months No cost to lodge a complaint. **VCAT** – 12 months No cost to lodge a complaint.	**VEOHRC** – Conciliation **VCAT** – Tribunal hearing Can order, for example, compensation and/or to stop committing contravention.	**VCAT** Generally parties bear own costs but VCAT has power to award costs.
Queensland	Anti-Discrimination Act 1991 (Qld)	**Section 4:** impairment definition **Section 67:** discrimination in supply of insurance prohibited	**Section 74:** exemption in insurance area for discrimination on basis of age or impairment if the discrimination: (a) is based on reasonable actuarial or statistical data from a source on which it is reasonable for the person to rely; and (b) is reasonable having regard to the data and any other relevant factors. **Section 75:** … if: (a) there is no reasonable actuarial or statistical data from a source on which it is reasonable for the person to rely; and (b) the discrimination is reasonable having regard to any other relevant factors.	Queensland Human Rights Commission (QHRC)	**12 months** No cost to lodge a complaint.	**Conciliation**	Queensland Civil and Administrative Tribunal (QCAT) Generally parties bear own costs but QCAT has power to award costs.
SA	Equal Opportunity Act 1984 (SA)	**Section 5:** disability definition **Section 76:** discrimination in provision of goods or services unlawful	**Section 84:** defence of unjustifiable hardship **Section 85:** exemption for insurance if: (a) the discrimination— (i) is based on actuarial or statistical data from a source on which it is reasonable to rely; and (ii) is reasonable having regard to that data and other relevant factors; or (b) if no such actuarial or statistical data is available, the discrimination is reasonable having regard to other relevant factors.	Equal Opportunity Commission South Australia	**12 months** No cost to lodge a complaint.	**Conciliation**	Equal Opportunity Tribunal South Australia Generally parties bear own costs but has power to award costs.

Jurisdiction	Legislation	Disability Discrimination Provisions	Exceptions for Insurance
WA	Equal Opportunity Act 1984 (WA)	**Section 4:** impairment definition **Section 66K(1):** discrimination in provision of goods and services unlawful	**Section 66K(2):** defence of unjustifiable hardship **Section 66T:** exemption for insurance where discrimination: (a) is based upon actuarial or statistical data from a source on which it is reasonable to rely or, where there is no such data, on such other data as may be available; and (b)is reasonable having regard to the data, if any, and other relevant factors.
Tasmania	Anti-Discrimination Act 1998 (Tas)	**Section 3:** disability definition **Section 16 and 22**: Broad prohibition on discrimination, including in provision of goods and services	**Section 48**(b): defence of unjustifiable hardship **Section 44:** exception for insurance if the discrimination: (a)is based on actuarial, statistical or other data from a reliable source; and (b) is reasonable having regard to that data and any other relevant factors. Exception only applies if insurer discloses to the Tribunal, when required to do so: (a) the sources on which the data are based; or (b) the relevant factors on which the discrimination is based.
ACT	Discrimination Act 1991 (ACT)	**Section 5AA:** disability definition **Section 20:** discrimination in provision of goods and services unlawful	**Section 53:** unjustifiable hardship **Section 28:** exception for insurance: …if the discrimination is reasonable in the circumstances, having regard to any actuarial or statistical data on which it is reasonable for the first person to rely.
Northern Territory	Anti-Discrimination Act 1996 (NT)	**Section 4:** impairment definition **Section 48:** discrimination in supply of insurance and superannuation prohibited	**Section 58** – defence if accommodating special need unreasonable **Section 49:** exemption if: (d) the discrimination is based on reasonable actuarial or statistical data from a source on which it is reasonable to rely and the discrimination is reasonable having regard to that data and other relevant factors; (e) if there is no reasonable actuarial or statistical data on which it is reasonable to rely, the discrimination is based on other data on which it is reasonable to rely and the discrimination is reasonable having regard to the data and any other relevant factors; (f) if there is no reasonable actuarial, statistical or other data on which it is reasonable to rely, the discrimination is reasonable having regard to any other relevant factors.

Complaints body	Time Limits and Costs	Process/ Remedies	Further appeal
Equal Opportunity Commission Western Australia	**12 months** No cost to lodge a complaint.	**Conciliation**	State Administrative Tribunal Western Australia Costs may be awarded.
Equal Opportunity Tasmania Office of the Anti-Discrimination Commissioner	**12 months** No cost to lodge a complaint.	**Conciliation**	Anti-Discrimination Tribunal Tasmania Generally parties bear own costs but has power to award costs.
ACT Human Rights Commission Human Rights Commission Act 2005 (ACT)	No time limit for complaints No cost to lodge a complaint.	**Conciliation**	ACT Civil and Administrative Tribunal (ACAT) Generally parties bear own costs but ACAT has power to award costs.
Northern Territory Anti-Discrimination Commission	**12 months** No cost to lodge a complaint.	**Conciliation**	Northern Territory Civil and Administrative Tribunal (NTCAT) Generally parties bear own costs but NTCAT has power to award costs.



MENTAL HEALTH DISCRIMINATION IN INSURANCE

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