beyondblue
Depression. Anxiety.

28 July 2017

ASIC Enforcement Review
Financial System Division
The Treasury
Langton Crescent
PARKES ACT 2600

Dear Ms Mills,

beyondblue welcomes the opportunity to make a submission to The Treasury Australian Securities and Investment Commission Enforcement Review Consultation: *Industry Codes in the Financial Sector*. *beyondblue* comments on the poor experiences of actual and potential discrimination against people who have either a past or current mental health condition by the insurance industry when trying to access or claim on travel insurance and life insurance policies. These ongoing issues could be mitigated by strengthening the current law and regulatory frameworks and their enforcement.

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

More needs to be done to protect consumers of insurance products, particularly, in relation to discrimination against people with mental health conditions who are applying for, or claiming on, insurance policies. The introduction of a co-regulatory model for financial sector industry codes is one measure *beyondblue* supports strongly to increase consumer protections and hold the insurance industry accountable for their policies and processes.

I hope the attached submission will be of assistance in the consultation process. If you would like to discuss any of the issues raised in the submission, please contact me on georgie.harman@beyondblue.org.au or call 03 9810 6100.

Yours sincerely

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About *beyondblue*

beyondblue is committed to supporting all people in Australia to achieve their best possible mental health. As a national organisation, we have a range of integrated initiatives to prevent depression, anxiety and suicide and to assist people who experience these conditions by increasing knowledge, decreasing stigma and discrimination, encouraging people to seek support early and improving their ability to get the right services and supports at the right time.

One of *beyondblue's* major goals is to reduce people's experiences of stigma and discrimination. While Australians have an increased understanding of anxiety and depression, there are still pockets of confusion and misunderstanding associated with these conditions that leads to prejudice and discrimination. This harms individuals and our community.

Since our inception in 2000, *beyondblue* in partnership with other organisations such as Mental Health Australia and community legal centres has worked to address unfair and discriminatory practices by the insurance industry for people with mental health conditions when accessing insurance products.

beyondblue welcomes the opportunity to make a submission to The Treasury Australian Securities and Investment Commission Enforcement Review Consultation: *Industry Codes in the Financial Sector*. This submission focuses on the poor treatment of people who have either a past or current mental health condition by the insurance industry when trying to access or claim on travel insurance and life insurance policies including life, income protection and total and permanent disability policies.

This submission describes why the current legal and regulatory framework including industry codes are not providing consumers, especially those with mental health conditions, the protections needed to prevent discriminatory policies or practices by the insurance industry. Overall, *beyondblue* supports the introduction of a co-regulatory model for financial sector industry codes to increase consumer protections and hold the insurance industry accountable for their policies and processes.

beyondblue's recommendations

- For consultation questions 3, 5, 7, 8 & 9 – *beyondblue* will not provide recommendations.

- For consultation questions 1, 2, 4, 6, 10 & 11 – *beyondblue's* recommendations are provided below.

Consultation Questions

1. Would a requirement to subscribe to an ASIC approved industry codes result in improved outcomes for consumers?

6. Will ensuring enforceability provisions of codes meet a minimum standard improve consumer outcomes?

- *beyondblue* supports the introduction of a co-regulatory model for the development, enforcement and monitoring of financial sector industry codes as the current legal and regulatory frameworks are not mitigating the impact of potential or actual discriminatory treatment of people with mental health conditions. The requirement for industry participants to subscribe to an Australian Securities and Investment Commission (ASIC) approved code, and in the event of non-compliance with the code, an individual customer would be entitled to seek appropriate redress is a stronger customer protection provision than the current regulatory models in place.

- *beyondblue* supports the introduction of a co-regulatory model that defines a minimum standard for the financial sector to incorporate during the development, implementation and reporting of industry codes. A minimum standard could support the development of a more even playing field for participants to implement, comply and report against their industry code. A minimum standard could also allow for industry innovation and leadership enabling participants to rise above the minimum standard to increase competitiveness within their industry.

- *beyondblue* recommends a review of the ASIC *Regulatory Guide 183: Approval of financial services sector code of conduct*. For future iterations of the Regulatory Guide 183 *beyondblue* recommends the inclusion of:
    - A minimum level of customer service and product accessibility a person can expect from Australian financial sector participants including product design, sales, claims and disputes;
    - Development of benchmarks for minimum standard reporting based on Regulatory Guide 183 requirements;
    - A framework the for the development of an industry code 'implementation guide' to support the interpretation and incorporate of a code across a sector;
    - The inclusion of a mental health condition section. This section could support the application and enforcement of Section 46 of the Disability Discrimination Act 1992.

- *beyondblue* supports the introduction of regular reporting by Code Governance Committees to an independent ASIC Monitoring Board. The reporting structure should be based on the minimum standards detailed in the ASIC Regulatory Codes 183.

- *beyondblue* recommends the public reporting on each sectors' compliance with their code based on minimum standard detailed in ASIC Regulatory Guide 183. This report would provide increased transparency on how each sector is tracking against the minimum standard.

- *beyondblue* recommends the development of more sophisticated risk profiles for each individual mental health condition and associated risk factors. To develop these profiles, evidence and data from actuarial practices, claims management, research, medicine and public health needs to be collated and analysed for insurance purposes.

- *beyondblue* recommends that the risk profiles developed need to be incorporated into underwriting practices for policy applications and claims assessment. The risk assessment protocols need to also consider individual circumstances that are likely to influence their risk profile, including the full range of relevant risk and protective factors that impact on a person's functioning and outcomes.

2. In respect of which financial sector activities should the requirement apply?

- *beyondblue* supports the implementation of a co-regulatory model for industry codes across the whole financial sector, however we strongly recommend its implementation in the insurance sector based on the long history of actual and potential discriminatory practices against people with mental health conditions and the limited modification by the insurance sector over the past decade to change practice.

4. What costs or other regulatory burden would the requirement imply for industry?

- *beyondblue* acknowledges that there could be increased costs to the financial sector initially to implement increased monitoring and reporting required by the introduction a co-regulatory model. A number of general and life insurance providers are already bound by existing codes and costs could be incurred updating internal policies and providing training to staff on the updated code and supporting policies. However, these costs would reduce post-implementation and are likely to be outweighed by the benefits of an industry-wide enforceable code, including increased standards and improved customer outcomes and confidence.

10. Should the composition of individual code monitoring bodies and arrangements for enforcement be subject to ASIC approval?

- *beyondblue* supports the recommendation for individual code monitoring bodies and arrangements for enforcement to be subject to ASIC approval because of the current non-transparent nature of existing monitoring and reporting of industry codes.

11. What characteristics should code-monitoring bodies have?

- *beyondblue* recommends that code-monitoring bodies have a mechanism for consumer peer review of all proceedings and decisions. Due to the power imbalance that could exist between monitoring committees and consumer representatives, a mechanism to protect or prevent influence of consumer representatives is required. One suggestion is the development of an independent consumer representative committee that independently peer review reports to ASIC independent monitoring body.

Section One: The problem

Insurance and mental health conditions

People with a mental health condition should have fair access to insurance products, to enable them to protect themselves and their families against financial stress and uncertainty. Empirical evidence and anecdotal reports demonstrate that many people with a mental health condition experience significant difficulties in obtaining and claiming on different types of insurance products, compared to the rest of the population. These difficulties occur across the general and life insurance industries for products such as travel insurance, income protection, total and permanent disability (TPD) and life insurance.

In 2011, *beyondblue* and Mental Health Australia undertook a study into mental health, insurance and discrimination – *Mental health, discrimination and insurance*: *Survey of consumer experiences.* The results highlighted the difficulties people with a mental health condition have in obtaining travel, life, TPD and income-protection insurance. Fifty per cent of the survey respondents either agreed or strongly agreed that it was difficult for them to obtain insurance due to a mental health condition. *beyondblue* is currently updating the findings of this survey with the results due later this year. To shed further light on this issue, in 2013 *beyondblue* has called for people to share their stories of unfair treatment or discrimination by insurers for mental health reasons. Since then, we have received hundreds of stories telling us about seemingly arbitrary decisions around access, obfuscation and lack of transparency in the management of claims.

Since *beyondblue* and Mental Health Australia conducted this survey, there have been a number of high profile cases of poor insurance practices in relation to mental health issues in the media.

In 2015, the Victorian Civil and Administrative Tribunal found that QBE (Australia) Ltd directly discriminated against Ella Ingram by providing her with a travel insurance policy that had a blanket exclusion for claims relating to all mental illnesses, then proceeded to rely on this clause to reject her claim to reimburse travel expenses of $4,292.48. Ella's case, run by Victoria Legal Aid, is an Australian-first test of discrimination by insurers on the basis of a mental illness. Ella had no pre-existing illness when she was diagnosed with major depression in February 2012. On medical advice she had to cancel an overseas school trip she had booked in late 2011. Since this case, QBE have removed the general mental health exclusion from their travel insurance policy.

In March 2016, ABC Four Corners program and Fairfax Media publications published the story of Matthew Attwater, a Commonwealth Bank employee who developed a major depressive disorder and then struggled to claim on his life insurance policies alongside other cases of poor customer service by CommInsure. Matthew Attwater was told by his employer, the Commonwealth Bank, that he was permanently unfit for work when he developed a major depressive disorder after a distressing event, and was "medically retired" from his job as a customer services representative at the bank. The bank commissioned a psychiatric report on Mr Attwater which found he was not fit for work. But when he lodged his claim for Total and Permanent Disability, CommInsure relied on a phrase from the same psychiatrist to argue that he was indeed fit for work. It took three years for CommInsure to settle Mr Attwater's claim.

After this Four Corners report, the Government commissioned the Australian Securities Investment Commission to review claim handling practices across the life insurance industry. In October 2016, ASIC released its *REPORT 498: Life Insurance claims: An industry review* which found that even though 90 percent of claims are paid out by the life insurance industry, that policy holders with a mental health condition face a challenging burden to establish their condition which entitles them to make a valid claim and confirmed the need for industry standards in the area of mental health to protect policy holders. Within the same report they also state that:

> *"For consumers, the intrinsic value of an insurance product is in the ability to make a successful claim when an insured event occurs. Not being able to successfully claim on life insurance in these circumstances can be financially devastating for the consumer and/or their family".*

For mental health claim disputes, the report identified several areas for concern including the evidence required to substantiate a claim, issues of non-disclosure and issues such as delays in assessing claims, pre-existing condition definitions, general declined claims and the application of exclusions for suicide.

Recently, there has also been media coverage of insurance claim issues relating mental health involving to Workers Compensation Schemes and Veteran Affairs Programs in Australia.

Types of problems experienced

Refusal of coverage

The *Mental Health, Insurance and Discrimination: A Survey of Consumer Experiences 2011* found that, across all insurance types, 22 per cent of respondents reported that their insurance application was declined due to a mental health condition. This increased to 36 per cent in relation to life insurance, and 45 per cent in relation to income protection insurance. Some respondents stated they had been declined insurance because of a mental health condition that had occurred many years ago, and had been treated and/or resolved, yet was still taken into account.

Outright refusal of coverage has a significant impact on an individual, as it leaves them unable to protect themselves and their families against uncertainty and financial stress during times of serious need, such as severe illness and death.

Policy exclusions

The *Mental Health, Insurance and Discrimination: A Survey of Consumer Experiences 2011* found that 25 per cent of those obtaining life insurance received an exclusion relating to mental health conditions while 34 per cent received an exclusion on their income protection insurance. Across all insurance types, 24 per cent of people received an insurance product with exclusions relating specifically to mental health conditions. While some change in terms and conditions may be reasonable for people who report an existing mental health condition, in many instances people are offered policies with broad, blanket exclusions on claims relating to all mental health conditions, even if unrelated to their specific condition.

Of greater concern, mental health condition exclusions can sometimes be applied simply because a person reports symptoms that may or may not be associated with a mental health condition (e.g. stress, insomnia) or even risk factors for a mental health condition (e.g. family history) despite the person not having been diagnosed with a mental health condition. Insurers also have been known to determine that a person has a mental health condition if they state they have seen a counsellor or psychologist even if this contact was unrelated to a mental health condition (e.g. relationship counselling, career counselling) or even if the psychologist/counsellor did not think the person had a mental health condition.

In 2016, Ginger Gorman, an award winning Australian journalist, reported her own potential discrimination by her insurance company for both her life and income protection insurance because she sought psychological support after being made redundant from her job at the ABC and for having received treatment five years earlier for postnatal depression.

Making a claim
Among the respondents in the *Mental Health, Insurance and Discrimination: A Survey of Consumer Experiences 2011* who had made a claim against their insurance, 41 per cent had their claim accepted without any problems, 13 per cent said they had problems getting their claim accepted and 12 per cent had their claim partly declined due to a history of a mental health condition. Of particular concern, some people described experiencing a prolonged claims process that sometimes spanned a number of years.

In some cases claims are declined because the mental health condition is considered to have been 'pre-existing', even when there was no evidence for this, while in other cases the reverse happens with other respondents stating they had their diagnosis questioned by the insurer or the specialist chosen by the insurer. Disputed claims and/or lengthy delays can be extremely stressful and in some case may exacerbate a person's mental health condition. Respondents in the *Survey of Consumer Experiences* spoke of the increased stress that the claims process inflicted, particularly the impact of prolonged processes with extensive evidence required, and examinations undertaken by unfamiliar medical professionals working for insurers.

Complaints and dispute resolution
There are a number of avenues in which complaints and appeals of insurers' decisions can be made. Many complaints are resolved through conciliation. While conciliation processes provide an opportunity for satisfactory resolution for the individual, most cases settle on a confidential basis without an admission of liability on the part of the insurer. As a result, the opportunity to set firm legal precedents, or to influence longer-term practice change, has been considerably constrained.

The problem with the current approach is that the burden falls on individuals to invest considerable time, money and effort into pursuing a complaint. A complainant-driven process, as is articulated in the *Disability Discrimination Act 1992 (Cth)*, can inadvertently disadvantage complainants as the process is often considered complicated and intimidating to individuals. This places an unreasonable burden on ordinary people who have been or suspect that they have been unlawfully discriminated by an insurer. Pursuing a complaint is incredibly time consuming, and the costs of bringing proceedings in a Court or Tribunal are often prohibitive for an individual. Pursuing a complaint can also be very stressful and be detrimental to a person's mental health.

Many people have described to *beyondblue* that dealing with the insurance industry's internal dispute resolution processes as a battle. Case studies have also reported that it is rare that an insurer will overturn a decision already made. Ella Ingram's case against QBE was the first test case heard by a court or tribunal in relation to insurance discrimination and mental illness in Australia. Ella Ingram's case was unique, in that she chose to pursue her dispute with QBE to hearing for the broader public benefit despite the toll of protracted litigation. It took almost four years for Ella to find out whether QBE's discrimination against her was unlawful. In the time that it takes to pursue a complaint, an individual may be uninsured and unprotected, or suffer financially.

Interactions with insurance providers
Consumer experiences that are reported to *beyondblue* highlight dismissive and/or obstructive attitudes by some in the insurance industry. This is particularly concerning given the negative impact that this can have on vulnerable people. In the *Mental Health, Insurance and Discrimination: A Survey of Consumer Experiences 2011* some survey several respondents mentioned the embarrassment, humiliation and insensitivity surrounding interactions with an insurance provider. Several also mentioned how their interactions with insurance providers have impacted negatively on their mental health.

The social impact

Like physical health conditions, mental health conditions have a range of characteristics unique to each individual. They can be recognised and treated. Most people with a mental health condition will recover and stay well. Some may experience intermittent relapses. Others may experience more persistent difficulties. Individual differences must be expected and understood.

The *Mental Health, Insurance and Discrimination: A Survey of Consumer Experiences 2011* found over 37 percent of survey respondents received the insurance product they most recently applied for without any exclusions or increased premiums. However, almost one-quarter (24%) of survey respondents received the insurance product with exclusions relating specifically to mental illness, and 22 percent who indicated that their insurance application was declined due to mental illness. The proportion of respondents who received their insurance products with increased premiums due to mental illness was 14 percent. Some survey respondents indicated that insurance companies appeared to automatically categorise mental health conditions as high risk regardless of the individual circumstances and made broad assumptions about their ability to maintain employment and their general level of functioning.

Risk assessment practices that overestimate a conditions severity or underestimate the possibility of recovery or that does not account for a person's individual circumstances can infringe on a person's access to insurance products but more importantly it can create a ripple effect of reinforcing self and community stigma. The negative impact of stigma and discrimination reaches further than the individuals who have directly experienced it and can affect others even if people don't experience it personally. When people with a mental health condition hear about others' experiences of discrimination – whether in relation to insurance or other matters – they begin to anticipate discrimination and may stop themselves from doing things due to the unfavourable treatment and discrimination that they anticipate experiencing. One of the major negative consequences of discrimination is that it may prevent people seeking professional treatment and support for their mental health condition. It can also lead to non-disclosure of pre-existing conditions for fear of being rejected or having to pay increased premiums. Non-disclosure generally causes problems when a person is most vulnerable during the claims process.

While some insurance companies allow people with a mental health condition to purchase cover if they have not sought treatment for a given time period, this can actually serve as a disincentive for people to implement self-management and/or report mental health problems to a health professional and seek treatment. Policies and practices such as these conflict with the broad range of government policies which emphasise prevention and early treatment of mental health conditions.

Section Two: Legal and regulatory context

The legal, regulatory and policy context relating to the insurance sector is complex with numerous different statutory agencies, industry associations, legislations and complaints bodies involved. Even with all these codes, guidelines and regulatory bodies in place, *beyondblue* still regularly hears of stories of poor consumer experiences by the insurance industry against people with mental conditions when accessing or claiming on insurance products. The current laws and regulatory frameworks, which is reliant on industry compliance with standards and codes still require further refinement to ensure people with mental health conditions are not experiencing discrimination outside of the legislation.

Current legal and regulatory codes relating to insurance and mental health:

- **Commonwealth Disability Discrimination Act 1992** and State and Territory-based anti-discrimination legislation. The Disability Discrimination Act 1992 (Cth) aims, as far as possible, to promote the rights of people with a disability, to participate equally in all areas of life.
- **Australian Human Rights Commission** developed a *Guideline for Insurance and Superannuation Providers (2016)* to support the insurance and superannuation sector apply Section 46 of the Disability Discrimination Act 1992 (Cth).
- **Insurance Contracts Act 1984** requires an insurer to outline in writing their reasons for refusing to enter into a contract of insurance, cancelling or not renewing a contract, or for offering insurance cover on less advantageous terms, if requested by policy holder in writing. Section 13 requires each party to act towards the other party with the 'utmost good faith'.
- **Industry Codes of Practice** – industry determined and monitored codes of practice to guide industry standards for customer service and protections. For example the Insurance Council of Australia General Insurance Code of Practice and the Financial Services Council Code of Practice Life Insurance.

For the remainder of this section, the submission will focus on issues arising from the insurance industry's application of Section 46 of the Disability Discrimination Act 1992 (Cth).

Commonwealth Disability Discrimination Act 1992

At present, the insurance industry is permitted to discriminate against a person with a disability, where certain conditions are satisfied. Under section 46 of the Disability Discrimination Act 1992 (Cth), it is not unlawful for insurers to discriminate against a person on the grounds of their disability (including mental health conditions) whether by refusing to offer the person a product, or in respect to the terms or conditions on which the product is offered or may be obtained, where the discrimination is based on actuarial or statistical data or if no such data is available, or other relevant factors.

The Disability Discrimination Act 1992 (Cth) also contains a more general exception to unlawful discrimination on the basis of unjustifiable hardship, which allows a provider of insurance or superannuation to discriminate against a person with a disability if they can show that providing cover, or otherwise avoiding the discrimination, would cause them unjustifiable hardship. The burden of proving that something would impose unjustifiable hardship rests with the provider of insurance or superannuation. While these caveats exist, the legislation emphasises the need to start from the perspective that a person with a disability, including a mental health disability, should be regarded and treated as equal under the law and with equal rights to the rest of the community. In essence, discriminatory treatment should be the exception and not the norm.

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

Cases of actual or potential discrimination appear to be driven by an under-reliance on available statistical and actuarial data and an over-reliance on views of the nature of mental health conditions, often based on deeply flawed understanding of these conditions. Policy wording commonly refers to symptoms (e.g. stress, insomnia) or risk factors (e.g. family history) as proxies for a diagnosed mental health condition. Evidence suggests insurers may also attribute a mental health condition to someone who has seen a counsellor or psychologist, even if this contact was unrelated to a mental health condition (e.g. relationship counselling, career counselling). When an application for insurance is declined, people have reported to *beyondblue* that insurers either do not provide reasons or they offer very broad or generic reasons, which do not cite particular factors that were considered relevant to the individual.

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

Furthermore, *beyondblue* has seen no evidence that the insurance industry is basing its decisions on readily available epidemiological data that relates to the typical trajectory of each specific mental health condition and the types of risk and protective factors, including access to effective treatment that can modify these trajectories**.** Data from the Medical Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS), Australian Institute of Health and Welfare (AIHW), Independent Hospital Pricing Authority (IHPA) and other sources that would assist in calculating the likely costs of treatment of different mental health conditions at varying severities in order to inform its risk ratings and price settings.

As noted in the consultation paper, one of the limitations of the Life Insurance Code of Practice is it only covers members of the Financial Services Council. This means that this Code of Practice does not cover insurance products taken out through superannuation funds, which represents more than 70 per cent of life insurance policies in Australia. The Code of Practice will have no impact on the current standard of death, total and permanent disability claims and income protection being offered inside superannuation funds, some of which are difficult to claim. The development of a Code of Practice for the superannuation industry through the Insurance in Superannuation Working Group should consider the issue of mental health conditions in insurance as part of their remit for the new Code as well as the other issues addressed in this section.