Australian Government
National Mental Health Commission

TRIM reference: D18-2927854

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

Dear Commissioner Hayne,

Thank you for the opportunity to outline the views of the National Mental Health Commission (NMHC) in relation to Round 6 (Insurance) of the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (the FSRC).

The NMHC's purpose is to provide insight, advice and evidence on ways to continuously improve Australia's mental health and suicide prevention systems and to act as a catalyst for change to achieve those improvements. The NMHC also has a mandate to work across all areas that promote mental health, including education, housing, employment, human services and social support.

There is a large number of people in Australia with a current or previous experience of a mental illness. Mental illness will affect one in five people in any 12 months, and almost 50 per cent of people over a lifetime. The NMHC believes that change is needed to achieve more equitable access to, and experience with, insurance products and processes for people with lived experience of mental illness. The FSRC provides an important opportunity to consider this matter and whether existing insurance products and practices in relation to mental illness align with community standards.

The NMHC notes that insurance in relation to mental health conditions was raised in the FSRC's Life Insurance Background Paper and continued to be a common theme throughout the Round 6 hearings. This submission therefore addresses both the FSRC's Terms of Reference and pertinent policy questions arising from the FSRC's examination of insurance in its Module 6.

Thank you for considering the issues and recommendations contained in the submission.
Please contact Ms Emily Clay, Director, Mental Health Reform, on [redacted] should you have any questions arising from the attached.

Yours sincerely

[redacted]

Maureen Lewis
Interim Chief Executive Officer
National Mental Health Commission

25 October 2018

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

National Mental Health Commission

October 2018

Introduction

About the National Mental Health Commission

The National Mental Health Commission (NMHC) provides cross-sectoral leadership on policy, programs, services and systems that support better mental health and social and emotional wellbeing in Australia. There are three main strands to the NMHC's work: monitoring and reporting on Australia's mental health and suicide prevention systems; providing independent advice to government and the community; and acting as a catalyst for change.

The NMHC's Contributing Life Framework acknowledges that a fulfilling life requires more than just access to health care services. It means that people with experience of mental illness can expect the same rights, opportunities, physical and mental health outcomes as the wider community.

Mental illness in the context of general and life insurance.

Mental illness is prevalent in our community. It is estimated that almost half the population between 16 and 85 will experience a common mental illness at some point in their lifetime, with 1 in 5 people experiencing a common mental illness each year.[1] Further, 3,128 people died from intentional self-harm in Australia in 2017.[2] Given these statistics, a large number of individuals are likely to be impacted by the practices of life and general insurance companies with respect to underwriting and claims related to mental illness, suicide or a suicide attempt.

However, the NMHC is aware of a number of issues in relation to insurance and mental illness, especially in the context of seeking early diagnosis and treatment. Consistent with insurance principles, a key policy aim is to encourage people to seek help for mental health concerns as early as possible. For the vast majority of conditions, there are effective treatments and services that can support people through recovery and enable them to continue to live full, healthy and contributing lives. However, discussing mental distress with a trusted GP, or seeking treatment from a mental health practitioner has been used in some cases by insurers to deny a claim. This practice can discourage help seeking behaviour by people at the time which it would be most helpful.

Further, current insurance industry practices frequently deny or limit access to insurance for people affected by, and claims in relation to, mental illness and suicide, which also limits the data available to insurers to appropriately design and price their products. Some people have reported that claims lodgement and assessment processes have caused distress and contributed to their experience of mental illness. Such approaches fail to align with the concept of recovery in mental health and trauma-informed care. Risk assessments and actuarial calculations would be more accurate and equitable if they took into account the effects of early intervention and treatment for mental health conditions, and the likely capacity for an insured person to return to their normal pattern of life, given the right supports being available at the right time.

Mental health, insurance and the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry

On 10 September 2018, Counsel Assisting the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (FSRC) opened on the themes, issues and questions for consideration by the FSRC in the public hearings on life and general insurance.[3] There were five broad areas of interest to the FSRC in the public hearings in relation to mental illness and insurance:

- regulation and changes to regulatory frameworks[3]
- the Life Insurance Code of Practice[4,5]
- issues related to the *Ingram vs QBE Insurance (Australia)* case[3]
- TAL Life Insurance Company case studies[5,6,7]
- use of surveillance by insurers in relation to mental health claims. [6,7,8]

Issues relating to mental illness and insurance were also highlighted in submissions to the FSRC:

> *Common themes in the submissions addressing mental health are consumer experiences in being denied coverage or benefit on the basis of mental health exclusions, excessive premiums being charged where mental health issues are disclosed, claims of mental health conditions being exacerbated as a result of claims handling processes, and concerns over independent medical examinations as part of the claims process.*[3]

The NMHC makes this submission having regard to the wide reaching impact of the behaviour of insurers and to the following Terms of Reference for the FSRC:

(b) whether any conduct, practices, behavior or business activities by financial services entities fall below community standards and expectations;

(f) the adequacy of:

  (i) existing laws and policies of the Commonwealth; and

  (iii) forms of industry self-regulation including industry codes of conduct, to identify, regulate and address misconduct, to meet community standards and expectations to provide appropriate redress to consumers;

(g) the effectiveness and ability of regulators of financial services entities to identify and address misconduct by those entities;

(h) whether any further changes to the legal framework, financial services entities' practice or financial regulators, is necessary to minimise the likelihood of misconduct by financial services entities.

Both the specific Terms of Reference identified above and the FSRC's approach set out in the transcripts of the public hearings provide appropriate scope for the matters dealing with insurance and mental health laid out in this submission. The FSRC Policy Questions arising from Module 6 also refer to mental illness issues in insurance.

On this basis, the NMHC requests the FSRC to make 14 recommendations around actions to improve more equitable access to general and life insurance products on a basis which is sustainable for

persons experiencing mental illness, our community and the insurance industry. This submission sets out the context and rationale for these recommendations.

Summary of Recommendations

Recommendation 1 – Equitable and sustainable insurance cover for mental health conditions
1.1. Insurance product design, pricing, underwriting, limitations and exclusions should give equitable access to insurance cover to a person who experiences mental illness.
Recommendation 2 – Data Collection
2.1. An expert independent actuarial study should be commissioned to consider and report publicly on the currently available mental illness data, and its appropriateness for use in relation to insurance pricing, underwriting and claims assessment.
2.2. The Australian Prudential Regulation Authority should be directed to develop and implement, in consultation with the insurance industry, a mechanism under the Financial Sector (Collection of Data) Act 2001 (Cth) based on the current arrangements for the National Claims and Policies Database, for the collection, curation, analysis and publication of data about the incidence of mental illness as a cause of insurance claims (i.e. a new National Mental Illness Database).
Recommendation 3 – *Disability Discrimination Act 1992* (Cth)
3.1. The *Disability Discrimination Act 1992* (Cth), sections 46(1)(f)(i) and 46(2)(f)(i), should be amended to limit the exemption of superannuation and insurance products from unlawful discrimination only to the extent that the discrimination is based on credible data and independent expert professional opinion.
3.2. The *Disability Discrimination Act 1992* (Cth), section 46, should be amended to exclude the exemption of superannuation and insurance products from unlawful discrimination by reliance on or regard to 'other factors', by repealing sections 46(1)(f)(ii), 46(1)(g), 46(2)(f)(ii) and 46(2)(g).
Recommendation 4 – Medical records
4.1 Recommendations of the Parliamentary Joint Committee on Corporations and Financial Services inquiry into the life insurance industry in relation to medical records (recommendations 8.1 to 8.5, inclusive) should be adopted.
Recommendation 5 – Education and training
5.1. The training and education of sellers and claims assessors of insurance products, and the design of selling and claims management processes should be refocussed on better to assisting people who apply for, or seek to make a claim through, insurance where there are issues relating to mental illness, suicide or a suicide attempt.
5.2. The education and training standards in the Life Insurance Framework reforms should be extended to include employees, agents and suppliers to financial services entities in relation to pricing, underwriting, marketing, selling and claims assessment for mental illness and insurance contracts.
Recommendation 6 – Surveillance
6.1. There should be a prohibition on physical surveillance for a mental illness claim.
Recommendation 7 – Unfair contract terms
7.1. The *Insurance Contracts Act 1984* (Cth) should be amended to extend unfair contract terms protections regime to all insurance contracts, and to specify that the duty of utmost good faith includes a duty to be fair.

Recommendation 8 – Insurance Industry Codes
8.1. The Insurance Council of Australia (General Insurance) and the Financial Services Council (Life Insurance) codes of practice, standards and guidelines should be amended in relation to mental illness to ensure equitable, fair and reasonable access to insurance cover to a person who experiences mental illness commensurate with the wider community.
8.2. The General Insurance Code and the Life Code should deal expressly with mental illness claims and provide standards for managing and assessing a mental illness claim in a manner which is appropriate to, and which does not aggravate, the illness.
8.3. The Insurance Council of Australia (General Insurance) and Financial Services Council (Life Insurance) codes of practice, standards and guidelines should be amended to set standards for education and training not less than those in the Life Insurance Framework reforms, and also include the concepts of recovery and trauma-informed care.
8.4. The Australian Securities and Investments Commission (ASIC) should play a role in mandating, monitoring and enforcing codes of conduct and other regulatory rules, including in relation to education and training standards around mental illness.

Insufficient data is a cause and consequence of current practices in insurance

The question of data is central to consideration of the behavior of insurers in relation to mental illness. One of the key issues is the significant limitations around the data that is available and how it is used by insurers. This has two consequences: firstly, in order for insurers to offer insurance on sustainable community terms (i.e due to the data needed for accurate underwriting), insurers often seek access to medical records that go beyond what would reasonably be expected to inform the underwriting and claims processes; and secondly, applicants and claimants are often discriminated against in accessing, or in the terms and conditions of, insurance policies, despite explicit legislative provisions against such activity.

As outlined below, the NMHC encourages the FSRC to consider the lack of evidence regarding data that would satisfy the *Disability Discrimination Act 1992* (Cth) (DDA), and to consider mechanisms that would allow lawful and more equitable access to insurance for people with experience of mental illness.

Exemptions for insurance under the Disability Discrimination Act 1992

The DDA sets the general standards and community expectations for treatment of people with a disability in many areas of public life including education, employment, housing and access to services.[9] Its provisions extend to protections for people with lived experience of mental illness, with disability defined as 'total or partial loss of the person's bodily or mental functions', including a disability that 'presently exists', 'previously existed but no longer exists', or 'may exist in the future' including behavior that is a symptom of the disability.[10] The DDA is also a manifestation of Australia's broader obligations to promote the rights of people with disability, reflected in the international conventions on Human Rights to which Australia is a signatory.

Section 46 of the DDA provides that an insurer may discriminate on the basis of a disability in the provision of, or terms and conditions of, an insurance policy, provided that:

a) the discrimination is based on actuarial or statistical data from a source on which it is reasonable to rely, and the discrimination is reasonable having regard to the data; or

b) 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.[11,12,13,14]

When making decisions around pricing, underwriting and claims processes, insurers may consider a number of characteristics of an illness or disability, including classification, diagnosis, prognosis, morbidity, mortality and treatment. For mental illnesses, these characteristics can be complex and are often not well understood. For example, there are no reliable biomarkers for mental illness and no widely accepted tool in the insurance industry for assessing severity and/or impact of a condition on a claimant's quality of life. As a result, many insurers perceive there is a high degree of subjectivity – and therefore risk – involved in relation to mental illness. [12]

To control for the impacts of the perceived risk of mental illness for a general or life insurance contract, some insurance companies will decline an application for insurance if the policy owner discloses and answers questions to the effect that the policy owner has experienced mental illness. Other insurers will require a premium loading and/or an exclusion of liability for a claim caused by mental illness.

Differential treatment in relation to insurance may be considered to not be unlawful by virtue of the s.46 DDA exemption, which recognises the additional insurance risk of some disabilities, and the need for insurers to offer products and services on sustainable and community-accessible terms. However, this exception is predicated on the threshold questions of whether data exists and is sufficiently reasonable, or alternatively whether there are other reasonable factors which would justify the departure from what otherwise are considered community expectations around fair and equitable treatment of people with disabilities.

Existence of data for purposes of s.46 DDA

The Commission would argue that data within the meaning of s.46 DDA does not currently exist, for four reasons.

- First, the mental illness exclusion has been a term of general insurance policies and life insurance policies for a long time. There is no reliable record of claim denials or withdrawals on the basis of the mental illness exclusion. It is therefore reasonable to consider that there is no credible claims data about the impact of mental illness claims on the relevant insurance products.
- Second, the insurer data exemption in s.46 DDA has been raised as a defence by the insurer in four cases: *QBE v Bassanelli*[15]; *Ingram v QBE*[16]; *FOS Determination 428120*; and *FOS Determination 509552*.[17] In each case, the court or tribunal has found that the evidence, based on prevalence and incidence data provided by the insurer, did not constitute data within the meaning of the s.46 DDA. [10,18]
- Third, the insurance industry has not argued or demonstrated that there is information which would constitute data within the meaning of s.46 DDA[19,20] despite awareness of the importance of data on mental illness to improve industry capability in dealing with mental illness at every point in the life cycle of an insurance contract. Of the available data sets, there is data about the prevalence of mental illness in the community, including the insured population, and there is some data about the incidence, experience and claim cost of mental illness in the insured population.[10,12,17] However, data in mental health is often outdated and does not go to the level of specificity required to make actuarial assessments around risk and pricing.
- Fourth, there are two major papers on the subject that support the absence of qualifying data. The first, the Australian Centre for Financial Studies Paper (ACFS Paper), surveyed the publicly available material and found the material did not constitute data within the meaning of s.46 DDA. Nor was this argued or demonstrated in the second paper, the Actuaries Institute Mental Health and Insurance Green Paper (AI Green Paper), which is consistent with the view that data available to the insurance industry does not constitute data within the meaning of s.46 DDA.[12] It should also be noted that the Department of Health's National Mental Health Policy 2008 states that greater understanding of the prevalence and incidence data for mental illness is required for a range of purposes.[21]

On the basis that data within the meaning of s.46 DDA does not currently exist, current insurance industry practices mean that there is likely to be a high incidence of non-compliance with the DDA. Further, industry practice of excluding policies and claims on policies on the basis of mental illness is preventing the accumulation of credible data on which further refinements to pricing and policies

could be made. The NMHC would encourage insurers to re-consider this practice as soon as possible, and to take steps to improve compliance with the DDA.

Other mitigations for these data issues for consideration by the FSRC include an actuarial study around mental illness information, and an expansion of the National Claims and Policies database, as detailed below.

Actuarial study

More comprehensive, timely and accurate data about mental health, suicide and (importantly) recovery could help insurers to make decisions and implement policies that are evidence-based and reliable to the standard required by the DDA. This in turn would be reflected in coverage and claims outcomes that are more in line with community expectations.

An expert independent actuarial study should be commissioned to consider and report publicly on the currently available mental illness data, and its appropriateness for use in relation to insurance pricing, underwriting and claims assessment. This study should also consider the concept of recovery which is integral to contemporary mental health practice.[22] An understanding by insurers of recovery following an experience of mental illness and the lower insurance risk presented by an individual accessing mental health services or other supports should also be explored.

Expansion of the National Claims and Policies Database

The National Claims and Policies Database (NCPD) is currently maintained by the Australian Prudential Regulation Authority (APRA), the national curator of financial services statistics.[23] The NCPD holds information about public and products liability and professional indemnity insurance, with the aim of helping make these products more affordable and available. However, the NCPD is limited to certain (there are exclusions) policies, and it does not include any life insurance data or financial service statistics.

Substantial risk and claims data is collected in the NCPD, including the class of business covered by the policy, the policy basis, its current status, the dates of loss and report, the jurisdiction of the claim, the nature of the loss and details of the likely case estimate. APRA's publications that deal with economic and financial statistics, including life insurance statistics, use these data sets and provide commentary on industry wide performance and performance by product type. However, neither the data nor the commentary deal with experience, incidence or claim cost of any cause of claim. The same is true of APRA's general insurance data and commentaries. APRA has also commented that there are gaps in the data necessary for group life insurance because of the inadequacy of data and of data quality supplied by superannuation fund trustees.[17]

Expansion of the data collected and shared with APRA to incorporate mental illness would enable greater insight into the performance of insurers in handling claims. Currently there are no regulatory mechanisms that compel insurers to use consistent definitions or to collect and share data.[12] Some support by insurers has already been expressed for an industry wide database relating to life insurance, which has been echoed by the Financial Services Council (FSC).[24] Work by APRA and the Australian Securities and Investments Commission (ASIC) is also underway to collect and publish comprehensive and reliable life insurance claims information.[25]

The NMHC therefore recommends that:

a) the NCPD legislative framework and practices should be adapted to include mental illness insurance data;

b) APRA should review, adapt and amend the reporting standards, specifications and fields, through stakeholder consultation, to ensure best practice insurance data collection;

c) APRA should carry out the same role for the mental illness insurance data that it does for the NCPD;

d) the use and dissemination of mental illness insurance data in the NCPD should be on the widest public access basis; and

e) the data checking and validation processes for the currently available mental illness data and the proposed expansion of the NCPD to include mental illness data should consider inputs from life insurance industry expertise, mental health consumers and carers, as well as data specialists in the fields of mental health and suicide prevention and mental health professionals.

Legislative amendments

In addition to the above suggested actions, the NMHC suggests the FSRC consider legislative amendments and/or clarifications to the DDA.

The NMHC argues that the reference to 'reasonable' in s.46 DDA should not be measured by the usual legal test of the ordinary person, who is not qualified to assess and give an opinion about data, but should instead be limited to independent professional expert opinion. Legislative amendment or other guidance material would be helpful to clarify this point.

The NHMC also recommends the 'other relevant factors' test in sub-sections 46(1)(g) and 46(2)(g) DDA be considered for repeal. This test is arguably too vague to exclude a human right (i.e. freedom from discrimination). Further, it appears to be of limited practical use, as it has not been applied in the cases referred to above.[26]

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Recommendation 3 – *Disability Discrimination Act 1992* (Cth)
3.1. The *Disability Discrimination Act 1992* (Cth), sections 46(1)(f)(i) and 46(2)(f)(i), should be amended to limit the exemption of superannuation and insurance products from unlawful discrimination only to the extent that the discrimination is based on credible data and independent expert professional opinion.
3.2. The *Disability Discrimination Act 1992* (Cth), section 46, should be amended to exclude the exemption of superannuation and insurance products from unlawful discrimination by reliance on or regard to 'other factors', by repealing sections 46(1)(f)(ii), 46(1)(g), 46(2)(f)(ii) and 46(2)(g).

Practices of the insurance industry detrimental to the consumer

The NMHC believes that evidence raised during the Round 6 (Insurance) hearings[7,27] demonstrated insurer behaviour in relation to mental illness that clearly falls below community standards and expectations, specifically in relation to accessing medical records, consideration of pre-existing conditions and the use of surveillance.

Medical Records

The FSRC has heard evidence in relation to insurers' broad access to medical records and subsequent use of that information to deny coverage or claims. The NMHC recognises the need for insurers to collect information to inform underwriting, pricing and other activities, and that this is authorised by an insured at the time of purchase and claim, and necessary to ensure that more affordable cover is available, the risk pool is sustainable and the life insurer is able to pay claims.[13] However, it is unclear what data is being used by insurers to make underwriting decisions that include assessment of mental health information, whether such data is up to date, and if the data reflects the fact that mental illness takes many forms and affects individuals differently.

In some cases, it is questionable whether insurers are seeking access to and using information that is relevant, either at the point of purchase or at the point of claim under a policy. For example, although the industry considers blanket exclusions for pre-existing mental health conditions to be rare, the Life Insurance Background Paper produced by the FSRC identifies that having (or having had) a mental health condition may make it difficult to obtain or claim against a life insurance policy (arguably even if the claim is not relevant to that previous experience with mental illness).[13] More pertinently, the fact that a person may have seen a counsellor once, when documented in consultation notes, might be used by an insurer to deny access to insurance products, even for unrelated conditions. One case highlighted during the Round 6 hearings illustrated this practice. A client of TAL insurance, who had previously sought the services of a psychologist, was later denied a contract for insurance related to a diagnosis of cervical cancer, on the grounds that she had failed to disclose a history of mental health conditions, despite no formal diagnosis of mental illness being recorded.[7]

The NMHC is also concerned that insurers' blanket access to medical records and subsequent use for denial of coverage or claim may present a disincentive for people to seek necessary treatment for mental health conditions. The access of life insurers to full medical records and related documentation rather than targeted reports has also presented ethical dilemmas for health professionals, particularly GPs, in having to provide information to life insurers that may not be in their patients' best interest. In the case cited above regarding TAL Insurance, the insurer committed to investigating their client for

the purpose of "uncovering" further non-disclosures in her medical record to entitle it to avoid the client's policy and later to maintain the decision to avoid that policy. [7] This was later described as form of retrospective underwriting which breached community standards and expectations.[28]

An individual should not have to trade off financial stability, which could be secured through life insurance, against their mental health. Denial of coverage on the basis of treatment seeking is also counter-intuitive in the context of risk calculation by the insurer, given that early intervention and preventing exacerbation of a condition is more likely to lower the risk of a claim.

There is therefore an apparent inconsistency between on one hand, the life insurance industry asking for broad information and complete medical records and, on the other hand, and better practice of using only relevant information.

The Parliamentary Joint Committee on Corporations and Financial Services inquiry into the Life Insurance Industry (the PJC inquiry) considered and made recommendations in relation to protocols and standards for accessing medical information for the purposes of insurance.[29] The PJC's recommendations 8.1 to 8.5 (extracted at Appendix A to this submission) cover: the preparation and implementation of agreed protocols for requesting and providing medical information; limitations on insurers seeking reports that go beyond the specific medical condition and that are not specifically targeted to the subject of a claim; in circumstances where a report cannot be prepared access to clinical notes is not permitted; seeking consent from the policy holder each time the insurers seeks access to medical records or intends to share them with third parties; and a revision of the Life Insurance Code of Practice to reflect the preceding recommendations. The NMHC recommends the FSRC adopt these recommendations of the PJC inquiry in relation to the use of medical records.

Pre-existing condition exclusion

Exclusion clauses are often used to exclude a pre-existing mental illness from cover. Insurers should be prevented from denying claims based on the existence of a pre-existing condition that is unrelated to the condition that is the basis for the claim. Specifically, in response to the FSRC Policy Question 20 arising from Module 6, the NMHC takes the position that life insurers seeking medical information for claims handling purposes should be required to limit the parameters of the request only to history directly relevant to the condition in the claim.

An exclusion for a mental illness where the illness first occurs during the policy period is not justifiable. There are more prevalent conditions, for example heart conditions and cancers, which are not excluded where first occurring during the policy period. The use of such exclusions is not only a breach of the DDA but also unfair, falling beneath community standards and expectations.

Physical surveillance

Data presented to Round 6 of the FSRC indicated that throughout the last five years, insurers more regularly engaged in surveillance activities in connection with mental health claims than in connection with physical health claims. On average the rate of surveillance in mental health versus physical health claims was more than double.[7] In one case, a decision was made by a case manager to hire a private investigator to make detailed observations about a claimant's behavior and daily activities without any internal approval process or safeguards against exacerbating the claimant's mental health condition, which subsequently occurred.[7]

The use of physical surveillance[30] in a mental illness claim is of little benefit for the insurer, given that the surveillance must usually be done at the time of the insured event in order to provide relevant information but it is more commonly undertaken well after that date as part of the claims assessment process. The use of physical surveillance in a mental illness claim is also damaging to the insured or claimant, as illustrated in the above case study where TAL acknowledged that such conduct in relation to claimants was likely to cause significant distress.[5,6]

Conclusion

On the basis of the practices outlined above, the NMHC submits that the FSRC should take up recommendations 8.1 to 8.5 (inclusive) of the PJC inquiry in relation to medical records. The NMHC also recommends training and education for sellers and claims assessors of insurance products, and redesign of selling and claims management processes, in order to better support people who apply for, or seek to make a claim through, insurance where there are issues relating to mental illness, suicide or a suicide attempt. The NMHC also recommends, in line with Policy Question 21, that insurers be prevented from in engaging in surveillance of an insured when they make a claim based on a mental health condition.

Recommendation 4 – Medical records
4.1 Recommendations of the Parliamentary Joint Committee on Corporations and Financial Services inquiry into the life insurance industry in relation to medical records (recommendations 8.1 to 8.5, inclusive) should be adopted.
Recommendation 5 – Education and training
5.1. The training and education of sellers and claims assessors of insurance products, and the design of selling and claims management processes should be refocussed on better to assisting people who apply for, or seek to make a claim through, insurance where there are issues relating to mental illness, suicide or a suicide attempt.
5.2. The education and training standards in the Life Insurance Framework reforms should be extended to include employees, agents and suppliers to financial services entities in relation to pricing, underwriting, marketing, selling and claims assessment for mental illness and insurance contracts.
Recommendation 6 – Surveillance
6.1. There should be a prohibition on physical surveillance for a mental illness claim.

Avenues to improve standards in the insurance industry

Key mechanisms that form part of the current regulatory regime for insurers are legislative protections and industry codes of conduct, in particular, the General Insurance Code of Practice and the Life Insurance Code of Practice. There are relatively straight forward improvements to each of these that could substantively improve interactions with insurance and insurers for people with experience of mental illness.

Legislative protections against unfair contract terms

In relation to legislative protections, the NMHC supports the extension of the scope of unfair contract terms (UCT) protections to insurance, as identified at Policy Question 29 and detailed in the 2018 proposals paper published by the Treasury.[31] Reforms to the *Insurance Contracts Act 1984* (Cth) (IC Act) to allow the UCT laws to apply to insurance would go some way to balancing the inherently

asymmetrical relationship of someone with a mental health condition dealing with a large powerful insurer. For example, the IC Act does not currently address potential unfairness in the context of insurance contracts, particularly denial of claims based on exclusions that may not have been fully understood by the insured at the time they made a claim.[27]

The Life Insurance Code of Practice

The FSC Life Insurance Code of Practice (the Life Code) came into effect for all life insurers from 1 July 2017. The Life Code sections do not deal specifically with the collection, use, disclosure or dissemination of mental illness data, but instead provides that:

> *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.* [19]

The Life Code contains sections about a life insurance company providing assistance in the application or claims process for a person with unique need but it does not provide for standards in relation to mental illness and policy application, underwriting, pre-existing conditions, exclusions[2] or claims.[3,4]

During the course of Round 6 of the FSRC hearings, the FSC indicated that there would be 'far more granularity' in the next iteration of the Life Code in relation to mental health.[3] Of note, one of the key items being considered by the FSC for inclusion in the next iteration is that insurers are to:

> *Ensure that applications for insurance that reveal a mental health condition or symptoms of a mental health condition are not automatically declined.*

Although the FSC could not confirm this would definitely be reflected in the next iteration of the Life Code, it was indicated that it was 'highly likely'.[3]

The NMHC strongly supports revisions to the Life Code, as well as to other relevant standards and guidelines[32,33], to ensure equitable, fair and reasonable access to insurance cover for people with experience of mental illness. The NMHC also advocates that all employees who deal with mental health conditions should have a good understanding of the concept of recovery and trauma-informed care. Education in these practices and philosophy could be embedded within industry codes of practices and relevant training materials.

The General Insurance Code of Practice

The General Insurance Code of Practice 2014 (the GI Code), which took effect on 1 July 2014, refers to mental illness in the context of a factor supporting an application for Financial Hardship to provide relief where a person owes money to an insurer. The position of a person who experiences mental illness is an issue that has been identified as an issue for further consideration and development for the GI Code.[34,35]

In June 2018, the final report of a review by the Insurance Council of Australia (ICA) recommended that the GI Code be amended to include a new principles-based section on consumers experiencing vulnerability. The proposed section would include: acknowledging and accommodating their diverse

needs; staff training to help and engage with them with respect and compassion; assistance with those who have trouble meeting identification requirements; and standards for the use of interpreters.

The ICA also proposed that the GI Code should be accompanied by best practice guidance on mental health, and put forward a Draft Guidance document to this effect.[30] The Draft Guidance incorporates best-practice approaches to prevalence data and to claims experience (incidence) data in relation to mental health conditions.[10,17] It also outlines that: product design should consider the needs of a person who experiences mental illness; pricing should reflect the risk; insurers should move away from blanket exclusions for mental health conditions; mental health conditions should be categorised according to current commonly accepted professional standards; insurers should comply with the DDA; and employees, and distributors and service suppliers should be trained and supported in their work with a consumer with a mental health condition.

Changes in industry practice along the lines promoted in the Draft Guidance would directly address many of the difficulties and complaints reported by people with mental illness in relation to their dealings with insurance products and processes. It is critical that these changes are agreed and implemented as soon as possible.

Education and training

In order to make a practical difference within a reasonable timeframe, any changes to industry codes of conduct must be supported by appropriate education and training, consistent with the Life Insurance Framework reform requirements for education and training.[12] The NMHC recommends that such training be designed, delivered and evaluated in partnership with people with lived experience of mental illness and also involve appropriately qualified and experienced health professionals.

Regulatory oversight

The content of codes of practice and the rules regulating insurance industry behaviour are determined by industry participants. A co-regulatory model would be stronger than self-regulation by requiring approval by the ASIC, mandatory participation, and enforceability of a code. The introduction of an enforceable co-regulation in appropriate parts of the financial sector could boost consumer confidence in financial services. This would also be of particular benefit for vulnerable people, including people with experience of mental illness. To this end the NMHC would support a co-regulatory approach in so far as it could provide more appropriate safeguards and transparency for people dealing with insurers in relation to mental illness, suicide attempt or suicide.

Recommendation 7 – Unfair contract terms
7.1. The *Insurance Contracts Act 1984* (Cth) should be amended to extend unfair contract terms protections regime to all insurance contracts, and to specify that the duty of utmost good faith includes a duty to be fair.
Recommendation 8 – Insurance Industry Codes
8.1. The Insurance Council of Australia (General Insurance) and the Financial Services Council (Life Insurance) codes of practice, standards and guidelines should be amended in relation to mental illness to ensure equitable, fair and reasonable access to insurance cover to a person who experiences mental illness commensurate with the wider community.
8.2. The General Insurance Code and the Life Code should deal expressly with mental illness claims and provide standards for managing and assessing a mental illness claim in a manner which is appropriate to, and which does not aggravate, the illness.

8.3. The Insurance Council of Australia (General Insurance) and Financial Services Council (Life Insurance) codes of practice, standards and guidelines should be amended to set standards for education and training not less than those in the Life Insurance Framework reforms, and also include the concepts of recovery and trauma-informed care.
8.4. The Australian Securities and Investments Commission (ASIC) should play a role in mandating, monitoring and enforcing codes of conduct and other regulatory rules, including in relation to education and training standards around mental illness.

Conclusion

The FSRC presents an opportunity to hear and progress practical responses to the many longstanding issues that people with experience of mental illness have raised around accessing insurance. Such action would be timely and appropriate in the context of broader mental health reforms and changing community attitudes around destigmatising mental illness and encouraging early treatment and access to mental health services and supports.

The FSRC's Round 6 (Insurance) hearings have brought to light cases that demonstrate industry practices that, unfortunately, are often routine in the handling of insurance contracts and claims in relation to mental health and suicide.

The NMHC encourages the FSRC to consider the issues and options presented in this submission for inclusion in its final recommendations, and to use its powers to recommend legislative and regulatory change that will positively impact on people in the community with experience of mental illness who seek fair treatment and financial security through insurance.

GLOSSARY

ACFS Paper	Ian Enright, 'Data Flows for Life Insurance – Mental Illness Disability Data', commissioned by Monash University, Australian Centre for Financial Studies' Insurance Research Program Committee, ACFS Commission Paper Series.
AIDA Paper	Lachlan Gell and Ian Enright, Conference Paper, 'Insurance Discrimination Law in Australia', presented at AIDA Conference 2014, Rome.
AI Green Paper	Actuaries Institute Mental Health and Insurance, *Green Paper*, October 2017.
APRA	Australian Prudential Regulation Authority
ASIC	Australian Securities and Investments Commission
NMHC	The National Mental Health Commission
DDA	*Disability Discrimination Act 1992* (Cth)
FOS	Financial Ombudsman Service
FSC	Financial Services Council
FSRC	Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry
GI Code	The General Insurance Code of Practice
IC Act	*Insurance Contracts Act 1984* (Cth)
ICA	Insurance Council of Australia
Life Code	Life Insurance Code of Practice
NCPD	National Claims and Policies Database
PJC inquiry	Parliamentary Joint Committee on Corporations and Financial Services – Life Insurance Industry, March 2018
UCT	Unfair contract terms

APPENDIX A: Parliamentary Joint Committee on Corporations and Financial Services – Life Insurance Industry inquiry recommendations on access to medical information

Recommendation 8.1

The committee recommends that:

c) the Financial Services Council and the Royal Australian College of General Practitioners collaborate to prepare and implement agreed protocols for requesting and providing medical information;
d) the Financial Services Council develop a uniform authorisation form for access to medical information at the time of application and at the time of claim that must be used by all of its members;
e) this uniform authorisation form explain to consumers/policyholders in clear and simple language how information will be stored and used by third parties; and
f) a consumer/policyholder should be able to use the same uniform authorisation form between different life insurers and different life insurance products.

Recommendation 8.2

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

Recommendation 8.3

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

Recommendation 8.4

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

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

Recommendation 8.5

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

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