



**Submission to the Parliamentary Joint  
Committee on Corporations and Financial  
Services: Inquiry into the Life Insurance  
Industry**

**18 November 2016**



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# 1 Introduction

The Public Interest Advocacy Centre (**PIAC**) is aware that people living with, or who have experienced mental illness in the past, find it substantially more difficult than others to access many forms of insurance, including life insurance.

Given that one in five Australians will be affected by mental illness in any 12-month period and 45% of Australians will experience a mental illness at some time in their life,<sup>1</sup> it is a matter of broad public interest to ensure that the insurance market is designing, pricing and offering policies, as well as assessing claims on existing policies, in a manner that is founded on robust evidence and contemporary understandings of mental illness.

Since 2012, PIAC has been providing legal advice and representation to people who have experienced discrimination, or otherwise been treated unfairly, by general and life insurance providers on the basis of a mental health condition. PIAC has identified systemic problems with industry practices that are failing to protect vulnerable consumers from unlawful disability discrimination or other forms of unlawful or unfair behaviour.

## 1.1 Terms of Reference

PIAC welcomes this opportunity to address the terms of reference referred to the Parliamentary Joint Committee on Corporations and Financial Services (the **Committee**) for report by 30 June 2017 as part of its inquiry into the Life Insurance Industry (the **Inquiry**), namely:

- a. the need for further reform and improved oversight of the life insurance industry;
- b. assessment of relative benefits and risks to consumers of the different elements of the life insurance market, being direct insurance, group insurance and retail advised insurance;
- c. whether entities are engaging in unethical practices to avoid meeting claims;
- d. the sales practices of life insurers and brokers, including the use of Approved Products Lists;
- e. the effectiveness of internal dispute resolution in life insurance;
- f. the role of the Australian Securities and Investments Commission and the Australian Prudential Regulation Authority in reform and oversight of the industry; and
- g. any related matters.

PIAC would also welcome the opportunity to speak with the Committee about this submission and our casework in further detail.

## 2 The Public Interest Advocacy Centre

PIAC is an independent, non-profit law and policy organisation that works for a fair, just and democratic society, empowering citizens, consumers and communities by taking strategic action on public interest issues. PIAC identifies public interest issues and, where possible and appropriate, works co-operatively with other organisations to advocate for individuals and groups affected. PIAC seeks to:

- expose and redress unjust or unsafe practices, deficient laws or policies;

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<sup>1</sup> 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>.

- promote accountable, transparent and responsive government;
- encourage, influence and inform public debate on issues affecting legal and democratic rights;
- promote the development of law that reflects the public interest;
- develop and assist community organisations with a public interest focus to pursue the interests of the communities they represent;
- develop models to respond to unmet legal need; and
- maintain an effective and sustainable organisation.

Established in July 1982 as an initiative of the (then) Law Foundation of New South Wales, with support from the NSW Legal Aid Commission, PIAC was the first, and remains the only broadly based public interest legal centre in Australia. Financial support for PIAC comes primarily from the NSW Public Purpose Fund and the Commonwealth and State Community Legal Services Program. PIAC also receives funding from NSW Trade and Investment for its work on energy and water, and from Allens for its Indigenous Justice Program. PIAC also generates income from project and case grants, seminars, consultancy fees, donations and recovery of costs in legal actions.

## 2.1 PIAC's work on disability discrimination & insurance

In 2012, Mental Health Australia (then the Mental Health Council of Australia) (**MHA**) and *beyondblue* approached PIAC detailing concerns concerning levels of apparent unlawful discrimination on the ground of mental health in the insurance industry, in particular with regard to the provision of general (particularly, travel) and life insurance products (including income protection, trauma and total and permanent disability insurance).

Since then, PIAC has provided advice and legal representation in both state and federal jurisdictions to individuals across the country who believe general or life insurance services providers (**life insurance providers**) have discriminated against them because of a mental health condition or purported mental health condition or avoided a policy under the *Insurance Contracts Act 1984* (Cth) (**ICA**) because of non-disclosure of a purported mental health condition.

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

- Senate Legal and Constitutional Affairs Committee inquiry into the Exposure Draft of the Human Rights and Anti-discrimination Bill 2012 that reported on 21 February 2013.<sup>2</sup>
- Australian Law Reform Commission's inquiry into Equality, Capacity and Disability in Commonwealth Laws that reported on 24 November 2014.<sup>3</sup>
- The now lapsed Senate Standing Committee on Economics Inquiry into the Scrutiny of Financial Advice, for which submissions closed on 15 April 2016.<sup>4</sup>

<sup>2</sup> Public Interest Advocacy Centre, Submission No 421, Senate Legal and Constitutional Affairs Committee, *Exposure Draft of Human Rights and Anti-Discrimination Bill 2012* (21 December 2012) available <http://www.piac.asn.au/publication/2013/01/aligning-pieces>.

<sup>3</sup> Public Interest Advocacy Centre, Submission No 41, Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (20 January 2014) available <http://www.piac.asn.au/publication/2014/01/equality-law-people-disability>.

<sup>4</sup> Public Interest Advocacy Centre, Submission No. 180, Senate Standing Committee on Economics Inquiry into the Scrutiny of Financial Advice (22 April 2016) available at [http://www.piac.asn.au/sites/default/files/publications/extras/16.04.22\\_-\\_piac\\_submission\\_to\\_the\\_senate\\_standing\\_committee\\_on\\_economics\\_inquiry\\_into\\_the\\_scrutiny\\_of\\_financial\\_advice.pdf](http://www.piac.asn.au/sites/default/files/publications/extras/16.04.22_-_piac_submission_to_the_senate_standing_committee_on_economics_inquiry_into_the_scrutiny_of_financial_advice.pdf)

This submission also builds upon feedback PIAC provided in September 2016 to the Financial Services Council on its then draft Life Insurance Code of Practice.<sup>5</sup>

## 2.2 Summary of systemic problems identified through PIAC's work

PIAC has observed the following systemic problems in relation to life insurance products and mental health.

1. An applicant for insurance discloses a past or current mental health condition when applying for life insurance and the insurer:
  - a. **refuses** to offer insurance; or
  - b. offers insurance with a **broad mental health exclusion**, in circumstances where a more limited mental health exclusion would have been reasonable; or
  - c. offers insurance without a mental health exclusion but with an **unreasonably high premium**.
2. An applicant for insurance discloses **symptoms** of a mental health condition when applying for life insurance but has never been diagnosed with a mental health condition and the insurer:
  - a. **imputes** a mental health condition that is not supported by the information provided in the application or by medical practitioners; and
  - b. **refuses** to offer insurance, offers insurance with a broad mental health exclusion or offers insurance with a premium.
3. An applicant for insurance does not disclose a mental health history when applying for cover or to amend existing cover in circumstances where the non-disclosure is innocent or the insured had never been diagnosed with a mental health condition. When the insured later makes a claim on the policy, the insurer **purports to avoid** the policy for non-compliance with the insured's duty of disclosure under the ICA.

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<sup>5</sup> Letter dated 8 September 2016 from the Public Interest Advocacy Centre to Sarah Phillips, Policy Consultant, Financial Services Council, available at [http://www.piac.asn.au/sites/default/files/publications/extras/16.09.08\\_-\\_comments\\_to\\_financial\\_services\\_council.pdf](http://www.piac.asn.au/sites/default/files/publications/extras/16.09.08_-_comments_to_financial_services_council.pdf)

### 3 Summary of recommendations

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#### **Recommendation 1**

*The Financial Services Council of Australia be resourced to establish a body to develop a further iteration of Life Insurance Code of Practice that sufficiently addresses issues relating to mental health, without further delay. The body established to produce the further iteration of the Code of Practice should comprise of representatives of the key stakeholders, including life insurance providers, consumers, consumer association, Government and other community groups.*

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#### **Recommendation 2**

*The Life Insurance Code of Practice be amended to establish processes for life insurers to adhere to when considering insurance applications that reveal a mental health condition, including to require insurers to:*

- a. ensure that applications for insurance that reveal a mental health condition or symptoms of a mental health condition are not automatically declined;*
- b. refer applications for insurance that reveal a mental health condition or symptoms of a mental health condition to an appropriately qualified underwriter;*
- c. give an applicant for insurance the opportunity to either withdraw their application or provide further information, including supporting medical documents, before declining to offer insurance or offering insurance on non-standard terms;*
- d. where an insurer offers insurance on non-standard terms (for example, with a mental health exclusion or a higher premium than a standard premium), specify:*
  - i how long it is intended that the exclusion/higher premium will apply to the policy.*
  - ii the criteria the insured would be required to satisfy to have the exclusion removed or premium reduced.*
  - iii the process for removing or amending of the exclusion/premium;*
- e. develop, implement and maintain policies that reflect the above practices.*

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#### **Recommendation 3**

*The Life Insurance Code of Practice be regulated and enforceable.*

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#### **Recommendation 4**

*The insurance exemption in section 46 of the Disability Discrimination Act 1992 (Cth) (DDA) be amended to:*

- a. require insurers to provide copies of the actuarial and statistical data that they have relied on to make decisions in relation to an offer of insurance to a consumer within a reasonable time frame upon request. Wherever possible, this material should be provided to the applicant with a summary in a readily accessible and plain-language format, making reference to the specific additional risk that the applicant represents;*
- b. require an insurer to advise a consumer what relevant factors it considered, why it considers each of those factors to be relevant, and how those factors affected its decision in relation to an offer of insurance;*
- c. specify that 'other relevant factors' (consistent with the Australian Human Rights Commission guidelines and the decision of the Federal Court in Bassanelli):*
  - i means all other relevant factors, and not just the factors selected for consideration by the particular insurer or other person seeking to invoke the exemption. This includes*

- factors that reduce any risk to insurers as well as the factors that increase the risk to insurers;*
- ii. includes the factors that are relevant to the circumstances of the individual applicant; and*
  - iii. is not exhaustive and that any other factors not listed in the DDA or AHRC guidelines may be considered relevant.*

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**Recommendation 5**

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- a. Insurance companies should be required to report annually to the Australian Human Rights Commission the number of times they have declined to provide insurance or offered insurance on different terms on the ground of disability. This information should specify whether the insurer has relied on actuarial and statistical data in making their decision and the category of disability invoked by the insurance exemption. The AHRC should publish the information every year by each insurer on its website and/or in its annual report.*
- b. When a matter is before the Australian Human Rights Commission or state anti-discrimination body, insurers should be required to promptly provide the actuarial and statistical data and other relevant factors relied upon to decline coverage or refuse a claim on the ground of mental illness or another protected attribute, when requested to do so.*
- c. Insurers should be required to comply with updated insurance industry anti-discrimination guidelines that could be developed by the Australian Human Rights Commission.*
- d. The Australian Human Rights Commission or another statutory agency should be empowered to investigate and enforce breaches of the Disability Discrimination Act 1992 (Cth), including the power to audit an insurer's actuarial and statistical data.*
- e. At a minimum, the Australian Government should negotiate an agreement with insurers to require them to publish data on which decisions about insurance offerings based on disability are made.*

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**Recommendation 6**

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*Parliament should reverse the amendments to section 29 of the ICA. That provision should require an insured to prove that the insurer would have offered the insured 'a' contract of insurance not 'the' specific contract of insurance that is the subject of dispute.*

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**Recommendation 7**

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*The Life Insurance Code of Conduct be amended to:*

- a. require insurers to vary rather than avoid policies wherever reasonably possible;*
- b. include guidance notes providing examples of situations in which variation rather than avoidance of a policy is appropriate, including where the insured has made a claim on their policy for an illness or condition that is unrelated to the illness or condition that it is alleged was required to have been disclosed during the application process.*

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**Recommendation 8**

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*Each insurer be required to report publicly (eg, in its annual report) the number of policies that it avoided in the previous 12 months.*



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**Recommendation 9**

*Section 75 of the ICA be amended to require:*

- *insurers to provide written reasons when asked by an insured orally or alternatively require insurers to state in the letter declining cover that under section 75 of the ICA an insurer must provide written reasons upon written request given to the insurer;*
- *the written reasons provided by the insurer to explain the actuarial or statistical data that they have relied upon to decline cover to the applicant. The data cited and relied upon must address the specific disclosures made by the applicant.*

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**Recommendation 10**

*The ICA be amended to require insurers, within 14 days of receiving an application for review in relation to a decision not to provide insurance, to offer insurance on non-standard terms, or to avoid a policy for 'non-disclosure', to specify which documents they require to conduct the review, and to require that the documents sought are relevant to the decision/review.*

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**Recommendation 11**

*The Life Insurance Code of Conduct be amended to require insurers to:*

- provide information and undertake internal reviews within a specified time period of 60 days or less.*
- correspond directly with an applicant or insured who made their application for insurance through an insurance broker wherever the applicant or insured so wishes.*

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**Recommendation 12**

*Following internal review, applicants for insurance and insureds should be advised of all of their options for lodging a complaint (including to the Financial Ombudsman Service, the Australian Human Rights Commission) at the earliest opportunity following IDR.*

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**Recommendation 13**

*When a complaint is lodged with either FOS, the AHRC or a state anti-discrimination body, and the complaint concerns:*

- an insurance contract that has been avoided;*
- application for insurance denied or accepted on non-standard terms; or*
- an insurance claim that has been denied*

*because of a person's disability, that FOS, the AHRC or state anti-discrimination body be required to advise the complainant to seek legal advice on choice of jurisdiction and the merits of their matter before the complaint is accepted for conciliation. If the complainant is unable to obtain legal advice then FOS, the AHRC or state anti-discrimination body should provide the complainant with information regarding choice of jurisdiction before the complaint is accepted for conciliation.*

## 4 The need for further reform and improved oversight of the life insurance industry and sales practices

PIAC is concerned that insurers do not always properly assess the risk posed by individual applicants for insurance who disclose a past or current mental health issue. In our experience, it does not appear that decisions to limit or deny cover to an individual applicant because they have disclosed that they have a mental health issue are consistently based upon relevant actuarial or statistical data. Commonly, the mere disclosure that a person has a mental health condition or history will lead to an insurer limiting or denying cover, without taking into account factors particular to the individual's condition, including the relative severity or otherwise of the condition, whether a person is receiving treatment for the condition and whether or the extent to which the condition impacts on the individual's functioning.

PIAC's experience is consistent with research published by MHA and *beyondblue* in 2011 following a survey of mental health consumers' experiences in accessing or claiming upon insurance<sup>6</sup>, which reported that:

...underwriting often fails to fully consider individual circumstances, focusing on the 'illness' rather than fully considering how this fits into the bigger picture of how well a person is functioning in the various aspects of their life on a day to day basis.<sup>7</sup>

PIAC submits that the manner in which applications for life insurance that disclose a mental health condition or symptoms of a mental health condition are assessed and underwritten should be the subject of intense scrutiny and reform.

### 4.1 Underwriting of applications for insurance that disclose a past or current mental health condition

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

- a. **refuses** to offer insurance; or
- b. offers insurance with a **broad mental health exclusion**, in circumstances where a more limited mental health exclusion would have been reasonable; or
- c. offers insurance without a mental health exclusion but with an **unreasonably high premium**.

Insurers appear to be refusing insurance or offering insurance on non-standard terms based on outdated understandings of mental health conditions, which lump unrelated mental health conditions in one category, fail to recognise that mental illness occurs on a spectrum from the very mild to the very serious and can manifest and impact individuals differently depending on the nature and severity of their condition and the individual's particular circumstances.

PIAC has observed instances of insurance providers:

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<sup>6</sup> Mental Health Council of Australia and *beyondblue*, *Mental Health Discrimination and Insurance: A Survey of Consumer Experiences 2011* (2011) available <https://www.beyondblue.org.au/docs/default-source/default-document-library/bw0129-report-mental-health-discrimination-and-insurance.pdf?sfvrsn=2>

<sup>7</sup> Mental Health Council of Australia and *beyondblue*, above 21, 9.

- declining applications for life insurance following disclosure of a mental health history at the application stage. A number of our clients have had applications for insurance declined during a telephone call with the insurer, suggesting to PIAC that some insurers have internal documents that direct their call centre operators to decline an application following disclosure of a mental health issue. Similarly, clients who have applied for insurance online have had their application automatically declined during the online process or by email within a matter of days of making the application, suggesting that online applications are programmed to automatically decline applications that disclose a mental health issue;
- failing to ask further questions or obtaining further medical information to better understand the applicant's mental health history before deciding the application;
- failing to properly consider the applicant's mental health history and the risk posed to the insurer before deciding the application, for example, by failing to take into account the time that has elapsed since diagnosis or symptoms, the absence of any recurring mental health episodes or hospitalisations, the applicant's compliance with treatment and the applicant's employment history, amongst other things;
- offering a policy with a broad, blanket mental health exclusion that lumps all mental illness together and that is not commensurate with the risk posed by the applicant's medical history.

#### **4.2 Underwriting of applications that disclose a past or current symptoms of a mental health condition**

PIAC has also advised and/or represented individuals who have disclosed symptoms of a mental health condition when applying for life insurance but have never been diagnosed with a mental health condition and the insurer:

- a. **imputes** a mental health condition that is not supported by the information provided in the application or by medical practitioners; or
- b. **refuses** to offer insurance, offers insurance with a broad mental health exclusion or offers insurance with a premium.

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

PIAC has observed instances of insurance providers:

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

- offering a policy with a broad mental health exclusion following disclosure of symptoms of a mental health condition in the absence of any diagnosis of a mental health condition.

The Financial Services Council recently released a Life Insurance Industry Code of Practice<sup>8</sup> (**Life Insurance Code of Practice**). The code refers to FSC Standard 21 on Mental Health Education and Training for insurers but does not address nor establish a process for life insurers to adhere to when assessing applications or claims that reveal a mental health condition (despite recommendations made by PIAC and other organisations who commented on the draft code). The code should be amended to provide guidance to insurers on the assessment of applications for insurance where an applicant or insured has disclosed a mental health history. In providing such guidance, the code should aim to facilitate compliance with the ICA and anti-discrimination legislation by requiring life insurance providers to take particular steps in response to applications for insurance, where the applicant discloses a mental health condition.

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### **Recommendation 1**

*The Financial Services Council of Australia be resourced to establish a body to develop a further iteration of Life Insurance Code of Practice that sufficiently addresses issues relating to mental health, without further delay. The body established to produce the further iteration of the Code of Practice should comprise of representatives of the key stakeholders, including life insurance providers, consumers, consumer association, Government and other community groups.*

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### **Recommendation 2**

*The Life Insurance Code of Practice be amended to establish processes for life insurers to adhere to when considering insurance applications that reveal a mental health condition, including to require insurers to:*

- a. *ensure that applications for insurance that reveal a mental health condition or symptoms of a mental health condition are not automatically declined;*
- b. *refer applications for insurance that reveal a mental health condition or symptoms of a mental health condition to an appropriately qualified underwriter;*
- c. *give an applicant for insurance the opportunity to either withdraw their application or provide further information, including supporting medical documents, before declining to offer insurance or offering insurance on non-standard terms;*
- d. *where an insurer offers insurance on non-standard terms (for example, with a mental health exclusion or a higher premium than a standard premium), specify:*
  - i *how long it is intended that the exclusion/higher premium will apply to the policy.*
  - ii *the criteria the insured would be required to satisfy to have the exclusion removed or premium reduced.*
  - iii *the process for removing or amending of the exclusion/premium;*
- e. *develop, implement and maintain policies that reflect the above practices.*

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### **Recommendation 3**

*The Life Insurance Code of Practice be regulated and enforceable.*

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<sup>8</sup> Financial Services Council, Life Insurance Code of Practice,  
[http://www.fsc.org.au/downloads/file/policy/LifeInsuranceCodeofPractice\\_FINAL.pdf](http://www.fsc.org.au/downloads/file/policy/LifeInsuranceCodeofPractice_FINAL.pdf)

### 4.3 Non-compliance with disability discrimination laws

Federal and state disability discrimination laws prohibit insurers from discriminating against a person on the basis of their mental health condition, including past, present, future and imputed mental health conditions unless the discrimination is:

- a. based on actuarial or statistical data that is reasonable for the insurance provider to rely on; and
- b. the discrimination is reasonable having regard to that data and all 'other relevant factors'.<sup>9</sup>

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

(collectively, the **insurance exemption**).

It is not known what, if any, actuarial and statistical data insurance companies rely on to assess the insurance risks of people experiencing mental illness. In PIAC's experience, insurers protect this information on the basis of it being commercial in confidence. Where we have been provided access to data, that data is generally in the form of general medical literature, which is not always up-to-date or relevant to the insured's particular circumstances.

PIAC submits that there is insufficient oversight of the decisions of insurance providers. The current regulatory framework does not contain provisions to regulate compliance of insurance providers with anti-discrimination law.

#### 4.3.1 Failure to produce statistical or actuarial data and reasons relating to 'other relevant factors'

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

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

Pursuing a legal complaint is arduous, time consuming and expensive. For many of PIAC's clients, the risk of an adverse costs order dissuades them from pursuing a discrimination complaint in the federal courts even when they have a strong claim. It is not unusual for respondent insurers to retain large law firms and senior and junior counsel to represent them and costs, even on a party/party basis, can be significant. Due to the risk of an adverse costs order, many strong discrimination complaints settle on terms that may be favourable to the claimant but are far less than they ought to be under the law. Most often respondent insurers insist that any such settlement be confidential and insurers do not admit liability. The result is that the impetus for making any long-lasting change to current practice is lost and no legal precedent is made.

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<sup>9</sup> Section 46 of the *Disability Discrimination Act 1992* (Cth) (**DDA**). Similar provisions can be found in state anti-discrimination legislation. For example, see *Anti-Discrimination Act 1977* (NSW) s 49Q; and *Equal Opportunity Act 2010* (Vic) s 47; which each provide a similar exemption for insurers in the area of disability discrimination.

If an applicant has applied for insurance through an insurance broker, the insurer will generally decline to communicate with the applicant directly. This lack of transparency can at times operate to reinforce discrimination against people with mental illness and limits the ability of applicants to seek review of an insurer's decision to decline an application or to offer insurance on non-standard terms.

Insurers who purport to rely on the insurance exemption should be required by disability discrimination law to provide copies of the actual actuarial and statistical data relied on without the insured needing to first lodge a formal legal complaint.

Where copies of the actuarial or statistical data relied on are provided by the insurance company to an individual, the data should be accompanied by a plain-English summary of that material in a readily accessible format, which should make reference to the evidence of the specific additional risk that the applicant represents. Information provided to consumers by insurance companies should also include information on what steps the applicant may take if they are not satisfied with the decision.

PIAC notes that provisions reflecting this recommendation were included by the Australian Government in the Exposure Draft of the Human Rights and Anti-Discrimination Bill 2012.<sup>10</sup>

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#### **Recommendation 4**

*The insurance exemption in section 46 of the Disability Discrimination Act 1992 (Cth) (DDA) be amended to:*

- a. *require insurers to provide copies of the actuarial and statistical data that they have relied on to make decisions in relation to an offer of insurance to a consumer within a reasonable time frame upon request. Wherever possible, this material should be provided to the applicant with a summary in a readily accessible and plain-language format, making reference to the specific additional risk that the applicant represents;*
- b. *require an insurer to advise a consumer what relevant factors it considered, why it considers each of those factors to be relevant, and how those factors affected its decision in relation to an offer of insurance;*
- c. *specify that 'other relevant factors' (consistent with the Australian Human Rights Commission guidelines and the decision of the Federal Court in Bassanelli):*
  - i. *means all other relevant factors, and not just the factors selected for consideration by the particular insurer or other person seeking to invoke the exemption. This includes factors that reduce any risk to insurers as well as the factors that increase the risk to insurers;*
  - ii. *includes the factors that are relevant to the circumstances of the individual applicant; and*
  - iii. *is not exhaustive and that any other factors not listed in the DDA or AHRC guidelines may be considered relevant.*

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<sup>10</sup> See Exposure Draft Human Rights and Anti-Discrimination Bill 2012 subs 39(5)(a)(i) available [http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Legal\\_and\\_Constitutional\\_Affairs/Completed\\_inquiries/2010-13/antidiscrimination2012/info/index](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Completed_inquiries/2010-13/antidiscrimination2012/info/index)

#### 4.3.2 Reporting decisions to discriminate

To enhance accountability in relation to the operation of the insurance exemption under disability discrimination laws, insurers should be required to report annually to the AHRC instances of reliance on the insurance exemption to refuse or to offer insurance products on non-standard terms, specifying the category of disability invoked by the insurance exemption, and stating whether the insurer has relied on actuarial and statistical data to reach their decision. Where no actuarial or statistical data exists that is reasonable for the insurance provider to rely on, the provider should set out the other relevant factors on which their decisions have been based. The AHRC should publish the information every year by each insurer on its website and/or in its annual report.

This approach would ensure that consumers, the insurance sector and the AHRC (or another statutory agency) are all able to monitor the extent to which insurance products are able to accommodate people with disabilities on an equal basis and how the insurance exemption is being used over time. It may also enhance the quality of decision-making, focusing on the requirement that decisions be evidence based.

When a claim of unlawful discrimination against an insurance provider is before the AHRC or state anti-discrimination body and the complaint concerns the insurance exemption available to insurance providers, insurance providers should be required proactively to provide the actuarial and statistical data, and/or all other relevant information, relied upon to support the decision that is alleged to be discriminatory.

The AHRC or another statutory agency should be empowered to investigate and enforce breaches of the DDA, including the power to audit an insurer's actuarial and statistical data when appropriate to do so.

If the above accountability mechanisms are not adopted by the Committee, PIAC submits that at a minimum, the Australian Government should negotiate an agreement with insurers requiring the publication of data upon which decisions about insurance offerings based on disability are made. PIAC notes that a similar recommendation was made by the Australian Law Reform Commission (ALRC) with respect to insurance offerings based on age, the ALRC having referred to an existing such agreement between insurers and the UK government.<sup>11</sup>

#### **Recommendation 5**

- a. *Insurance companies should be required to report annually to the Australian Human Rights Commission the number of times they have declined to provide insurance or offered insurance on different terms on the ground of disability. This information should specify whether the insurer has relied on actuarial and statistical data in making their decision and the category of disability invoked by the insurance exemption. The AHRC should publish the information every year by each insurer on its website and/or in its annual report.*
- b. *When a matter is before the Australian Human Rights Commission or state anti-discrimination body, insurers should be required to promptly provide the actuarial and statistical data and other relevant factors relied upon to decline coverage or refuse a claim on the ground of mental illness or another protected attribute, when requested to do so.*

<sup>11</sup> Australian Human Rights Commission, *Access All Ages – Older Workers and Commonwealth Laws*, ALRC Report 120 (30 May 2013) [6.28] – [6.37]; Recommendation 6-2, available <http://www.alrc.gov.au/publications/access-all-ages-report120/6-insurance>

- c. *Insurers should be required to comply with updated insurance industry anti-discrimination guidelines that could be developed by the Australian Human Rights Commission.*
- d. *The Australian Human Rights Commission or another statutory agency should be empowered to investigate and enforce breaches of the Disability Discrimination Act 1992 (Cth), including the power to audit an insurer's actuarial and statistical data.*

*At a minimum, the Australian Government should negotiate an agreement with insurers to require them to publish data on which decisions about insurance offerings based on disability are made.*



## 5 Whether entities are engaging in unethical practices to avoid meeting claims

PIAC has advised and/or represented individuals who have had their life insurance policies avoided (cancelled from commencement) by insurers for their purported failure to comply with their duty of disclosure at the time they applied for cover or to amend existing cover, in circumstances where the non-compliance is innocent, or where the insured did not know, and could not reasonably have known, that their prior medical interactions would have been relevant to an insurer's decision to offer a policy.

Pursuant to section 29 of the *Insurance Contract Act 1984* (Cth) (**ICA**) an insurer may cancel a contract of insurance at any time if the non-disclosure or misrepresentation was fraudulent,<sup>12</sup> or within the first three years of the contract if the non-disclosure or misrepresentation was not fraudulent.<sup>13</sup>

Applying to contracts for life insurance entered into, and in some cases varied, from 28 June 2014, the ICA was amended to expand the remedies available to insurers where an insured has not complied with their duty of disclosure.<sup>14</sup> The purpose of the amendments was largely to introduce more flexible remedies for insurers to better cater for the strong market emergence of non-traditional life insurance (ie, products that do not have a surrender value and do not provide cover on death – in other words, products such as income protection insurance, total and permanent disability insurance).<sup>15</sup>

Prior to the amendments, consumers had greater protection from cancellation based on innocent non-disclosures because to cancel a policy an insurer would have needed to show that it would not have been prepared to enter into a contract of life insurance on *any terms* if the duty of disclosure had been complied with.<sup>16</sup> Currently, an insurer can cancel a policy if it can show it would not have been prepared to enter into the same contract of life insurance.

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

### 5.1 Alleged breaches of the duty of disclosure

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

After an insured has made a claim against their policy, the insurer obtains access to and reviews the insured's medical records. PIAC has seen instances of insurers obtaining an insured's

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<sup>12</sup> ICA s 29(2).

<sup>13</sup> ICA s 29(3).

<sup>14</sup> The amending Act was the *Insurance Contract Amendment Act 2013* (Cth).

<sup>15</sup> The reasons for the amendments to the remedies available to insurers are discussed in the Explanatory Memorandum, *Insurance Contract Amendment Bill 2013* (Cth) at [1.113] – [1.119] and [2.117] – [2.122]. The Explanatory Memorandum notes that many of the amendments adopt the recommendations made by the Review Panel commissioned by the Australian Government in 2003 to review the ICA.

<sup>16</sup> ICA s 29(3) as then applicable.

complete medical history, including from doctors that treated the insured during childhood, before deciding a claim.

PIAC has found that insurers often rely on matters ‘discovered’ during the review of the insured’s medical records to allege that the insured has breached their duty of disclosure.

Often the conclusions drawn by the insurer from the insured’s medical record about their experiences of mental health are inconsistent with the insured’s medical record and the opinions of their treating medical practitioners.

For example, PIAC has represented clients where the insurer has alleged there has been a breach of the duty of disclosure because:

- notes taken by a psychologist during a consultation with the insured show the psychologist suspected the insured might be depressed, despite the psychologist confirming to the insurer that he had never made a diagnosis of depression nor communicated his concerns that the insured was depressed to the insured;
- the treating medical practitioner retrospective diagnosed a mental health condition – ie, the practitioner did not make this diagnosis at the time of treatment nor communicate it to the insured;
- the insured interpreted an accidental overdose of pain medication to be a suicide attempt despite medical evidence from the insured’s treating medical practitioners, including contemporaneous medical evidence, confirming the overdose was accidental;
- the insured sought counselling from a psychologist following the breakdown of a relationship, in circumstances where there was no diagnosis of a mental health condition.

## **5.2 Avoidance for breach of the duty of disclosure**

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

In PIAC’s experience, it appears that consumers are being disadvantaged by the reforms to the remedies available to insurers (as set out above), or at the very least, are not seeing any benefits flowing from the increased flexibility.

Take the following example, which has been anonymised and adapted from PIAC’s casework experience:

*The insured obtained income protection insurance. During the application process, the insured did not disclose that he had seen a counsellor three years prior, initially to discuss the breakdown of his marriage and then, seeing that the counselling had been effective, undertaking further counselling to discuss issues he had experienced historically with his family. Two and a half years after obtaining insurance, the insured was diagnosed with prostate cancer and stopped working. He made a claim on his income protection policy. The insurer initially paid the claim but, after obtaining the insured’s medical records and*

*discovering the appointments with the counsellor, the insurer argued that the insured had not complied with his duty of disclosure when answering the question: 'Have you ever been diagnosed with or ever had symptoms of any mental health disorder?'. The insured argued that he had never been diagnosed with a mental health condition or had symptoms of a mental health condition and answered the questions asked of him during the application process truthfully. The insurer relied on clinical notes that described observations by the treating doctor that the insured had been feeling low and that they had discussed anti-depressant medication. The insurer avoided the policy for innocent non-disclosure. In addition to ceasing to pay the claim, the insurer threatened to take steps to recover the amount of benefits that had already been paid.*

*Scenario A – if the policy for insurance commenced prior to 28 June 2014 when the changes came into effect. The insured is able to prove that, according to the insurer's underwriting guidelines, the insurer would have offered him income protection insurance with a mental health exclusion. Because the insurer would have offered 'a' policy of insurance, the insurer is not entitled to avoid the insured's policy and must continue to pay the insured's unrelated claim arising from his diagnosis with prostate cancer.*

*Scenario B – if the policy for insurance commenced after 28 June 2014. The insured is unable to prove that the insurer would have offered him the same policy had he made the alleged non-disclosure during the application process. The insurer is entitled to avoid the policy and the insured's claim is not paid.*

As the above scenarios demonstrate, decisions to avoid contracts of insurance can operate harshly on people who reasonably believe that they are protected by insurance. In most of the cases PIAC has been involved with where the insurer has alleged that the insured did not comply with their duty of disclosure, the insurer has elected to avoid the insured's policy or policies. Avoidance often occurs at a point in time where the insured is particularly vulnerable and has made a claim on the policy (often for a condition that is not related to mental health), thereby depriving them of the benefit of the insurance.

However, there are other, less drastic measures that an insurer may take under the ICA. Insurers are able to vary a contract of insurance *at any time*, whether the non-disclosure is fraudulent or non-fraudulent, to adjust the sum insured using a statutory formula for proportionality,<sup>17</sup> or to vary the terms of the contract to place the insurer in the position they would have been in if the duty of disclosure had been complied with.<sup>18</sup>

The discretion as to whether to vary or to avoid a contract of insurance rests solely with insurers. PIAC is not aware of any industry standards or best practice guidelines to assist insurers to reach fair and reasonable decisions about when to choose to vary and when to choose to cancel.

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

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<sup>17</sup> ICA s 29(4).

<sup>18</sup> ICA s 29(6).

Through PIAC's casework we have observed instances of insurance providers:

- 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 insurers rely on clinical records that show a GP discussed taking anti-depressant medication with the insured as evidence that the insured had depression;
- forming conclusions about the insured's experience of symptoms of mental illness in a manner that was inconsistent with the opinions of the medical professionals treating the insured. PIAC has seen examples of insurers failing to accept and/or failing to take into account the evidence of a treating medical practitioner about the absence of diagnosis or the low severity of a condition;
- taking an approach that penalises and discourages people from seeking preventative, early medical assistance to manage 'normal' reactions to common life situations well in advance of any diagnosis of mental illness, which undermines government-funded campaigns and programs that encourage help-seeking.

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**Recommendation 6**

*Parliament should reverse the amendments to section 29 of the ICA. That provision should require an insured to prove that the insurer would have offered the insured 'a' contract of insurance not 'the' specific contract of insurance that is the subject of dispute.*

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**Recommendation 7**

*The Life Insurance Code of Conduct be amended to:*

- require insurers to vary rather than avoid policies wherever reasonably possible;*
- include guidance notes providing examples of situations in which variation rather than avoidance of a policy is appropriate, including where the insured has made a claim on their policy for an illness or condition that is unrelated to the illness or condition that it is alleged was required to have been disclosed during the application process.*

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**Recommendation 8**

*Each insurer be required to report publicly (eg, in its annual report) the number of policies that it avoided in the previous 12 months.*

## 6 The effectiveness of internal dispute resolution in life insurance

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

The failure to provide actuarial and statistical data and written reasons can cause consumers to be confused about why their application for insurance has been declined and can also make it difficult for consumers to seek review of a decision of an insurance provider, as they do not have access to the information on which the decision was based.

### 6.1 Failure to provide written reasons

Where an insurance provider has declined to offer insurance or has offered insurance on non-standard terms, the applicant (on written request) is able to obtain written reasons for the decision pursuant.

In PIAC's experience:

- insurers will only provide written reasons after multiple requests and when the request for reasons is in writing (as currently required by the ICA) and even then the explanation may be put in terms that do not assist the applicant to understand the particular issue for the insurer, for example, 'based on your medical history';
- where an applicant for insurance has applied for insurance through an insurance broker, the insurer will only communicate with the insurance broker, thereby reducing the applicant's ability to advocate for themselves and relying on the efficacy and expertise of the insurance broker who often has only a basic understanding of mental illness;
- insurers will only provide written reasons to the applicant/insured/s medical practitioner, even if the circumstances of the case do not suggest that there is any health or safety risk if the written reasons are provided to the applicant/insured directly.

### ***Recommendation 9***

*Section 75 of the ICA be amended to require:*

- *insurers to provide written reasons when asked by an insured orally or alternatively require insurers to state in the letter declining cover that under section 75 of the ICA an insurer must provide written reasons upon written request given to the insurer;*
- *the written reasons provided by the insurer to explain the actuarial or statistical data that they have relied upon to decline cover to the applicant. The data cited and relied upon must address the specific disclosures made by the applicant.*

## 6.2 Ineffectiveness of internal dispute resolution

Where an applicant for insurance or an insured is unhappy with an insurer's decision, they may seek an internal review of that decision.

There are no time periods built into the ICA in relation to the time for considering and deciding an insurance application, or for undertaking an internal review of a decision on whether or not to grant insurance. Generally complaints bodies allow the insurer 90 days for IDR.

In PIAC's experience:

- it can take up to 6 months, and sometimes longer, for an insurer to review an application for internal review on a decision;
- the applicant/insured is generally not consulted with as part of the internal review process;
- 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;
- insurers will often ask for medical health records spanning most or all of the applicant's life as part of the internal review process. This can be time consuming and costly for an applicant for insurance. In addition, they often ask for these records some time into the review process (for example 1-3 months) which has the effect of significantly delaying the review process and the period of time for which the individual remains uninsured; the result of the internal review is almost always to reaffirm the original decision;
- the prospect of obtaining an improved outcome following internal review is low, however it increases where an applicant has engaged legal representatives.

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### **Recommendation 10**

*The ICA be amended to require insurers, within 14 days of receiving an application for review in relation to a decision not to provide insurance, to offer insurance on non-standard terms, or to avoid a policy for 'non-disclosure', to specify which documents they require to conduct the review, and to require that the documents sought are relevant to the decision/review.*

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### **Recommendation 11**

*The Life Insurance Code of Conduct be amended to require insurers to:*

- provide information and undertake internal reviews within a specified time period of 60 days or less.*
- correspond directly with an applicant or insured who made their application for insurance through an insurance broker wherever the applicant or insured so wishes.*

## 6.3 Clarifying the complaints process following IDR

Individuals that have had their contract avoided, application for insurance denied or accepted on non-standard terms, or a claim denied because of their disability may have claims under both the ICA and the DDA (or state anti-discrimination legislation). This means that they may have

grounds to lodge a complaint to more than once dispute resolution body, such as FOS or the AHRC.

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

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

- a. preventing them from commencing a complaint in another jurisdiction if the complaint in the jurisdiction initially elected is unsuccessful; and
- b. operation of the various time limits – eg, if the period taken to resolve the complaint in the initial jurisdiction is such that the individual finds that they are then outside of the time limits within which to bring a complaint in the other jurisdiction.

Determining the appropriate jurisdiction within which to commence a complaint can be difficult and complex, and an individual will often require legal advice regarding the merits of their claims in each jurisdiction, and on procedural matters relating to choice of jurisdiction.

As such PIAC recommends that when a complaint is lodged with either FOS, the AHRC or a state anti-discrimination body, and the complaint concerns:

- (a) an insurance contract that has been avoided;
- (b) an application for insurance denied or accepted on non-standard terms; or
- (c) a claim denied

because of a person's disability, that FOS, the AHRC or state anti-discrimination body be required to advise the complainant to seek legal advice on choice of jurisdiction and the merits of their matter before the complaint is accepted for conciliation. If the complainant is unable to obtain legal advice then FOS, the AHRC or state anti-discrimination body should provide the complainant with information on choice of jurisdiction before the complaint is accepted for conciliation.

### ***Recommendation 12***

*Following internal review, applicants for insurance and insureds should be advised of all of their options for lodging a complaint (including to the Financial Ombudsman Service, the Australian Human Rights Commission) at the earliest opportunity following IDR.*

### ***Recommendation 13***

*When a complaint is lodged with either FOS, the AHRC or a state anti-discrimination body, and the complaint concerns:*

- a. an insurance contract that has been avoided;*
- b. application for insurance denied or accepted on non-standard terms; or*
- c. an insurance claim that has been denied*

*because of a person's disability, that FOS, the AHRC or state anti-discrimination body be required to advise the complainant to seek legal advice on choice of jurisdiction and the merits of their matter before the complaint is accepted for conciliation. If the complainant is unable to obtain legal advice then FOS, the AHRC or state anti-discrimination body should provide the complainant with information regarding choice of jurisdiction before the complaint is accepted for conciliation.*