Actuaries Institute

Mental Health and Insurance

GREEN PAPER
OCTOBER 2017

About the Actuaries Institute

The Actuaries Institute is the sole professional body for Actuaries in Australia. The Institute provides expert commentary on public policy issues where there is uncertainty of future financial outcomes. Actuaries have a reputation for a high level of technical financial expertise and integrity. They apply their risk management expertise to allocate capital efficiently, identify and mitigate emerging risks and to help maintain system integrity across multiple segments of the financial and other sectors. This unrivalled expertise enables the profession to comment on a wide range of issues including general insurance, life insurance, health insurance, retirement income policy, enterprise risk management and prudential regulation and finance and investment. Our public policy principles can be viewed at:
http://actuaries.asn.au/public-policy-andmedia/public-policy/policy-principles.

This Green Paper was commissioned by the Actuaries Institute and prepared by Geoff Atkins and Sue Freeman of Finity Consulting.

The Actuaries Institute believes that mental health is an important public policy issue and one where the Institute can contribute and provide independent advice in the areas of insurance.

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John Anning – Insurance Council of Australia
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Professor Nick Glozier – University of Sydney
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Margo Lydon – Superfriend
Dr Bill Monday – Pacific Life Re
Rachel Neumann – beyondblue
Dr Doron Samuell – Psychiatrist

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Executive Summary

Mental health problems are very common in the community and attitudes to insurance needs have been changing due to greater levels of community awareness.

Why has the Actuaries Institute released this Green Paper?

This Green Paper aims to stimulate discussion about a pressing problem. The way the insurance sector and insurance products interact with people with mental health conditions is just one part of the social context of mental health. It is an aspect, though, where actuaries hope to contribute to improving outcomes and experiences for insured people and improving the way insurance products respond to their needs.

Mental health problems are very common in the community. One in five Australians will be affected by a mental health condition in any 12-month period, most commonly anxiety and depression. Mental health conditions also limit the participation of people in the workforce, which is directly relevant to insurance products.

Attitudes to mental health have been changing, with greater community awareness of mental health conditions, the need to seek treatment, and the damage caused by stigmatising those experiencing mental health conditions.

While insurance coverage is available that responds to such conditions, consumers have expressed dissatisfaction with several aspects of the insurance response to mental health conditions.

This paper explores some of the difficult problems faced by insurers as they try to balance the competing objectives of maintaining an affordable and sustainable product while meeting the expectations of their customers and the community in relation to mental health conditions.

Many insurance products respond in some way to mental health conditions of customers

Insurance offers individuals and organisations protection from potential losses, and provides some peace of mind in relation to the risks and uncertainties they face. In particular, 'disability insurance' in its various forms aims to help people through tough times, by providing financial support when illness or injury impacts their income.

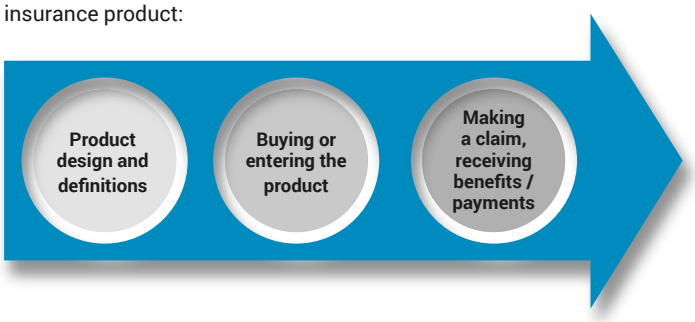
In addition to the universal protections provided by Medicare, Social Security, workers compensation insurance and CTP (motor accident injury) policies, most employed Australians have access to life insurance and disability cover, whether via their superannuation fund, purchased voluntarily or both.

Many insurers currently pay large amounts of money to people claiming for mental health conditions, and are working to improve the ways that these claims are managed.

However, the variety of different insurance products respond in different ways to mental health conditions. Difficulties can arise in many areas of the insurance process, and there are many potential opportunities for improvement.

In this paper, we draw out some of the common factors across the insurance sector and identify some areas where there might be scope for improvements that can benefit all parties.

Problems can arise at three different touch points between consumers and the insurance product:



With some insurance products, the **design and the definitions** may not always be helpful for people who suffer a mental health condition. For example, the definitions of disablement may be difficult to interpret, a travel insurance policy may exclude all claims due to mental health and workers compensation insurance may exclude some mental health conditions such as those that develop secondary to a physical injury.

For consumers **buying or entering** an insurance product that is a voluntary purchase, the insurance must operate with premium rates and other terms that are commensurate with the individual risks involved. People with past or current mental health conditions (as with other existing health conditions) may find themselves unable to get cover at all, or with high premiums and/or restrictive conditions such as exclusions from coverage. Group products usually do not have the same individual risk assessment, but the overall product still needs to balance premiums and risk levels.

When a customer needs to **make a claim**, the insurer must assess the validity of the claim according to the terms and conditions of the insurance product. Assessing claims for mental health conditions is particularly difficult for both parties and sometimes, it is argued, the claiming process could actually make the mental health condition worse. In some sectors lawyers routinely represent a person making a claim, which changes the dynamic considerably.

Assessing claims for mental health conditions is particularly difficult, and sometimes the claiming process may actually make the condition worse.

The insurance sector faces systemic difficulties in dealing with mental health coverage

Lack of relevant and appropriately collated data – a frustration for all involved, but at least it is a problem that can be tackled
Diagnosis of mental health conditions relies on subjective information and may not relate to prognosis or the impact on a person's ability to work
Reliance on self-reporting of symptoms and difficulty in validation
Severity and prospects of recovery are hard to understand, and even harder to influence
There is a high prevalence of co-morbidities, including substance abuse
The prospect of financial compensation can influence behaviour and produce worse health outcomes
The claim process itself can lead to 'secondary mental harm'
Ineffective regulatory framework, decision making and dispute resolution given the specific nature of mental health conditions

These issues are explored at some length in the paper, drawing on academic research, publications of various stakeholders and discussions with people directly involved with the sector.

How can improvements be achieved?

The problems raised by mental health conditions in the insurance sector are complex and multi-pronged. This section draws together various suggestions that have been made in conversation with stakeholders and in written material we have researched.

The nature of a 'difficult problem' is that it does not have a simple solution, and many people and organisations have already invested a lot of effort in this issue. It is the hope of the Actuaries Institute that these suggestions will stimulate further concerted and constructive actions.

1	**Product definitions**	The definitions and claim criteria in products should be continually updated to deal specifically with mental health conditions (long term products like life insurance might need regulatory change to permit this). Product descriptions that focus on wellness and recovery, and describe an active role for insurers in supporting recovery, could result in better claim outcomes.
2	**Product design**	Large lump sums are arguably not appropriate. Time-limited income streams may be better, especially if integrated with mechanisms to support recovery.
3	**Underwriting guides**	Increased investment in guidelines specifically for mental health conditions would be useful, similar to those that are used for other medical conditions. For some insurance products, in setting premiums, should insurers take into account an employer's record on mental health claims and the extent to which their culture reflects mentally healthy workplace standards?
4	**Early treatment focused on recovery**	Increased focus on insurance structures to help with early treatment and recovery, rather than getting in the way of recovery. There are opportunities for changes to the design of the system in this area, whether it involves superannuation funds, employers, treating practitioners, social supports or other pathways. Is it possible to construct and maintain a person-centred approach?
5	**Review of laws relating to mental health and insurance**	While a daunting task, a review of the many laws and regulations and anomalies between jurisdictions to give a more consistent approach to particular mental health issues may help.
6	**Data – collection, analysis and access**	Further investment in the skills and technology is needed to collect, analyse and disseminate useful data. Recent progress seems to have been slow.
7	**Specialised skills in dealing with claims**	Investment in more sophisticated claims management approaches, such as triaging techniques to improve claim outcomes for both the person on claim and insurer. SuperFriend[33] has developed a comprehensive framework for best practice management of psychological claims that can form the basis for improvements, and PIEF (the Personal Injuries Education Foundation) could also be well placed to provide programs and support across industry segments.
8	**Expert neutral evaluation**	An adversarial system of resolving disputes ('duelling doctors') seems to be especially problematic for mental health conditions. Many different insurance applications may benefit from a system of 'expert neutral evaluation', with reporting standards relating to impartiality and evidence-based opinion, early in the process.
9	**Continued education and collaboration**	Support continuing efforts to educate stakeholders and encourage active promotion of strategies that will help prevent people with mental health conditions from falling out of the workforce, improve outcomes for consumers and maintain a sustainable insurance sector.

Insurance is part of the infrastructure of our society – you don't really notice until it doesn't work. The Actuaries Institute is committed to working in the public interest to make insurance work effectively for all stakeholders and looks forward to participating in the initiatives to tackle the problems presented by mental health and insurance.

Insurance is part of the infrastructure of our society and not really noticed until it doesn't work; but problems raised by mental health conditions in the insurance sector are complex and multi-faceted.

Mental Health and insurance – why is it important?

1

- Mental health problems are common in the community.
- Attitudes to mental health are changing.
- There is dissatisfaction with the insurance response to mental health.
- Insurers face some difficult problems and real challenges to sustainability.
- Some insurance products do not deal well with mental health issues.

Half of all Australians aged over 15 will be affected by a temporary or persistent mental health condition during their lifetime.

1.1 Prevalence and impact of mental health conditions

Australia's National Mental Health Policy (2008) defines a 'mental illness' as 'A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities'.[1]

Mental health advocacy group beyondblue prefer to use the term 'mental health condition', in recognition of the diverse nature of these conditions and the fact that they impact people differently at different times.[2]

Prevalence

One in five Australians aged over 15 will be affected by a mental health condition in any 12 month period, and one in two will be affected across the span of a lifetime.[3]

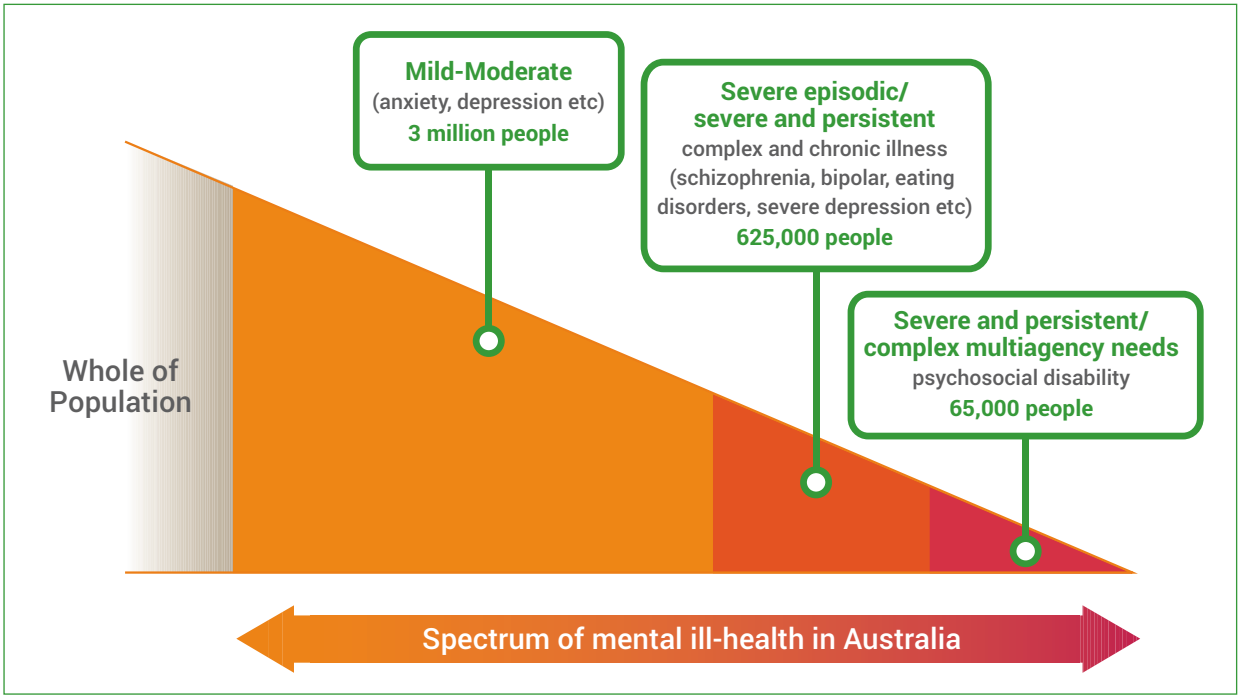
Less than half will access treatment.[4]

High-prevalence and low-prevalence conditions

The types of mental health conditions can be divided into two broad categories:

- High-prevalence conditions: such as anxiety (including phobias), depression and substance abuse disorders.
- Low-prevalence conditions: chronic and complex conditions, including some severe depression, schizophrenia, bipolar disorders and those with severe and persistent psychosocial disability.

The annual prevalence of mental ill-health in Australia (2014 estimates) is as follows[5]:



Recognising that it is a generalisation not applicable to each case, the high-prevalence disorders are often of shorter duration and more readily treatable. The low-prevalence disorders are more likely to be chronic and require ongoing treatment. The most severe are likely to be in the realm of the National Disability Insurance Scheme.

In terms of high-prevalence disorders, the 2007 National Survey of Mental Health and Wellbeing identified the most commonly experienced conditions as anxiety disorders (14% 12 month prevalence), and affective or mood disorders including depression (6.2% 12 month prevalence).[6] One in seven of the working age population reported a history of major depressive disorder; of those 21% had experienced symptoms within the past year and were receiving treatment; 17% had experienced symptoms in the past year but were not receiving treatment; and 63% considered themselves 'recovered'.[7] Workers compensation data shows 81% of the claims for mental conditions are for depression and/or anxiety.[8]

Prognosis and impact

Most people with a mental health condition will recover and stay well. For example, around half of people who experience an episode of depression will recover completely and never experience future difficulties, while the other half may experience one or more future episodes or more persistent difficulties.[9] European research in 2002 found that 50% of people diagnosed with a major depressive disorder had recovered within three months and 63% within six months, while 24% were not recovered 12 months later and 20% were not recovered at two years post diagnosis.[10] It has also been found that those whose first episode was severe, occurred during adolescence, and/or those whose symptoms did not entirely resolve with treatment are most at risk of further depressive episodes, as are those with a family history of depression.[11]

Mental illness is now the leading cause of work absence and long term work incapacity in the developed world.

It is also important to recognise the high co-morbidity of the more prevalent mental health conditions. Chronic, recurrent depression is associated in particular with anxiety and substance abuse, and also with common chronic medical conditions such as diabetes, cardiovascular disease and obesity. The prospect of full resolution of symptoms is lower, and the risk of further episodes is higher, where such co-morbidities exist.[12]

The 2011 Burden of Disease* Study[13] found that mental health conditions (including substance abuse disorders) were responsible for almost 12% of the total burden of disease in Australia, the third most burdensome disease group after cancers and cardiovascular diseases, most of the burden being non-fatal.[i]

The World Health Organisation estimates that depression will be the leading cause of disease burden globally by the year 2030.[14]

For disability insurance, the impact of a mental health condition on the ability to work is much more important than the existence of the condition. A particular condition may have no impact on one person's ability to work, while for another it may leave them totally unable to work, and for some there may be limitations requiring less work or a different job.

Mental illness is now the leading cause of work absence and long-term work incapacity in the developed world, most commonly anxiety and depression. In 2013, mental disorders surpassed musculoskeletal problems as the main cause of long term work incapacity in Australia.[15]

1.2 Changing attitudes

We have seen increasing awareness in the community of the existence and prevalence of mental illness and the importance of seeking treatment. As awareness of mental health conditions has increased, so has the understanding that ignorance and myths about mental health can lead to stigma.

Government mental health plans and initiatives are focused on the need to de-mystify mental health conditions and reduce the stigma associated with them. It is well recognised that if mental health conditions are stigmatised, people may be less likely to seek help and have less capacity to participate fully.[16] Where a mental health condition exists alongside a substance abuse problem, as is common, there may be even bigger incentives against disclosing the problem and seeking help.

One of the leading mental health advocacy groups, **beyondblue** says "to maximise their ability to proactively manage their mental health, people need to be able to engage with socially inclusive networks, and have access to social institutions which provide equitable access and a safe space for disclosure".[17]

There are alternative perspectives. Some have argued that, since the advent and aggressive marketing of anti-depressant medications (e.g. SSRIs[ii])

i Burden of disease measures the combined impact of fatal and non-fatal diseases. More than just counting overall prevalence it takes into account the severity of the disease and age at death, providing a good summary measure of the population's health. Mental illness as defined in the study includes substance abuse.

ii Selective Serotonin Reuptake Inhibitors

in the 1990's, there has been an increasing 'medicalisation of unhappiness', with increasing numbers of people seeking treatment for their experiences of stress, disappointment or isolation, and GP's increasingly tending to prescribe rather than discuss their patient's emotional symptoms. Aspects of contemporary first world society may have contributed to these trends, with declining job security, increasing work demands, increasing numbers of people experiencing relationship breakdowns, living alone or as single parents, and decreasing involvement in community and church-based activities. What may once have been regarded as normal life stresses are increasingly regarded as medical conditions, requiring treatment and, arguably, compensation.

No matter what perspective one may have on these changing attitudes, the relevance to society (and to insurance) presents challenges. How will our society evolve to respond to a future that may be increasingly demanding? Will our workplaces, institutions and communities be able to effectively build resilience and provide the necessary supports to minimise the prevalence and impact of mental health conditions? How will the insurance industry adapt to a future where periods of mental ill-health and inability to work may become the norm for its customers?

1.3 Consumer dissatisfaction

There have been many expressions of concern that people with mental health conditions are not adequately served by the insurance industry, and are unfairly discriminated against.

At the same time, there is little information or discussion about people with mental health conditions who are well served.

beyondblue has published a great deal of material that documents the concerns of consumers and other experts, and has documented some of the complaints that arise from people buying insurance products.[18] Depending on the type of product (such as death, permanent incapacity, income protection or travel insurance) people have complained that they are:

- refused cover because of their past or current mental health condition; or
- offered policies that exclude all mental health conditions, meaning that they cannot claim if any mental health condition impacts their ability to work or travel; or
- able to obtain cover only at what they regard as an unreasonably high premium.

There are also complaints that those who do obtain cover have had their claims denied for unfair reasons.

It is alleged that insurers base their decisions on incorrect assumptions, do not provide adequate reasons for their decisions, and in some cases, deal inappropriately with people requesting their services.

The insurance industry understands consumer attitudes have also changed – consumers are better educated, more articulate and more aware of their rights, and in response industry codes and standards have responded to the need for improved transparency and customer service.[19]

There are avenues for consumers to seek redress for perceived injustice. Litigation of individual claims relating to mental health conditions is not rare, spanning group insurance, individual life insurance, workers compensation and motor accidents. On the other hand, there has been relatively little litigation about people's issues with buying insurance, the travel insurance case of Ingram (see section 4.8) being a notable exception.

The number of complaints received by the Australian Human Rights Commission about discrimination on the basis of disability by superannuation or insurance providers remains very low (13 of the 1,039 complaints about disability discrimination in 2013-14, or 1%).[20]

1.4 Insurance coverage and impacts

Insurance products are essentially an undertaking to pay for losses caused by unforeseen circumstances covered under the policy definition, in exchange for payment of premiums. Insurers estimate a premium based on expected losses, so if claims increase beyond expectations this will result in increased premiums. To be sustainable, insurance products must cover risks that are 'insurable' and someone must be prepared to pay the cost. The best and most generous policy would likely be unaffordable. Insurance products need to strike a balance between meeting the needs of people who suffer the loss covered, and being affordable to those who are at risk of such losses.

Insurance products operate alongside Australia's 'disability safety net' for all citizens, including people suffering mental health conditions. Specialised treatments are available under Medicare (a GP can refer a patient to a mental health professional for assessment and development of a mental health treatment plan, as a bulk billed service) and specialised inpatient and outpatient treatment is provided at public hospitals. In addition, a basic level of income support is available through Centrelink for those temporarily or permanently unable to work due to their condition.

Insurance products that can provide protection against mental health conditions include total and permanent disablement (TPD), income protection (IP), workers compensation, motor accident insurance (CTP), private health insurance and travel insurance.

Insurance is underpinned by **risk pooling**. Insurers collect premiums from many individuals, but pay out relatively few claims because most of the pool members do not need to make claims over the same period. If this balance is somehow distorted, for example by escalating frequency or cost of claims, the viability of the insurance product may be jeopardised and consumers' access to cover may be affected.

Customer satisfaction depends on legitimate claims being paid and to do so insurers must be financially stable and solvent. If poor product pricing, underwriting or claims management affect the sustainability of an insurance fund, either premiums will subsequently rise or insurance cover will be withdrawn. If policyholders are unfairly denied payment of legitimate claims then society's confidence in the system will be undermined. Most insurers are therefore at pains to both support their clients and maintain their own viability.
The changing community attitudes and the consumer dissatisfaction described above have led to serious challenges for some parts of the insurance sector. Claims exceeded the amount expected when premium rates were set, and insurers have made substantial losses as a result. The responses are inevitable – increases in premiums (as we have seen in group TPD), restrictions in cover (as in workers compensation) or withdrawal of cover entirely from individuals or groups.

2 Many insurance products respond to mental health

2.1 Scope of insurance products and issues

Many people tend to think of insurance as a single sector, without distinguishing between the varying types of insurances available to cover mental health conditions. Just as mental health is a complex field, so does analysis and response in the insurance sector need to be sufficiently complex to deal with different products and circumstances. For each type of insurance product, the issues and concerns posed by mental health conditions are different, and require different responses.

The sectors of the insurance sector that we discuss in this paper do not cover every situation, but are the ones of most significance. There is more detailed information and discussion in the *Further Reading*. The table below outlines the key insurance products which interact with mental illness.

Sector	Product groups	Trigger for cover
Group life insurance (superannuation)	Death, TPD, IP	Any cause
Individual life insurance	Death, TPD, IP	Any cause (may have some exclusions from outset of the policy)
Workers compensation		Out of or during employment
Motor injury insurance (CTP)		Caused by a motor vehicle accident, sometimes only if the fault of another
Travel insurance		Any cause, excluding pre-existing conditions
Private health insurance (PHI)	Hospital cover General treatment cover	Private patient hospital treatment General treatment not covered by Medicare

While they are also important to society and the economy, we do not deal in the paper with the National Disability Insurance Scheme (NDIS), Medicare, social security, employment law, or a host of other issues.

Regarding the introduction of the NDIS, this is not expected to make a significant difference to the insurance sector in respect of mental health conditions. NDIS does not cover income or housing, nor does it pay lump sum benefits, so there would be no offset against insurance. Furthermore, the NDIS covers only the most serious disabilities, including congenital intellectual disabilities, and the high prevalence conditions of depression and anxiety are most unlikely to be included. Most of the mature aged people qualifying for NDIS due to a mental disability are likely to be those who sustained a traumatic brain injury, many of whom will instead be covered by the State-based National Injury Insurance Scheme (NIIS) schemes.

Touch points in the insurance process

It is worth highlighting that different issues arise at different touch points in the insurance process. The main pressure points for mental health issues arise in three places:

With some insurance products, the design and the definitions may not always be helpful for people who suffer a mental health condition.

With some insurance products, the **design and the definitions** may not always be helpful for people who suffer a mental health condition. For example, the definitions of disablement may be difficult to interpret, a travel insurance policy may exclude all claims due to mental health and workers compensation insurance may exclude some mental health conditions such as those that develop secondary to a physical injury

The design of products, and particularly the definition of the trigger for making a claim, can be problematic in all types of products. It is also argued that products that pay significant lump sums, such as Total and Permanent Disability insurance, provide perverse incentives, since they rely on a person establishing that they are permanently unable to work. These may be less appropriate for mental health conditions than income stream products, which assume that an eventual return to work may be achievable.

For consumers **buying or entering** an insurance product that is a voluntary purchase, the insurance must operate with premium rates and other terms that are commensurate with the individual risks involved. People with past or current mental health conditions (as with other existing conditions) may find themselves unable to get cover at all, or with high premiums and/or restrictive conditions such as exclusions from coverage. Group products usually do not have the same individual risk assessment, but the overall product still needs to balance premiums and risk levels.

If the insurance is ***compulsory*** (such as WC or CTP) or is provided automatically to a large group (such as group superannuation) the second part of the chain (buying or entering the product) is relatively simple. Cover is provided to everyone in the group.

If the insurance is ***voluntary*** and bought on an individual basis (such as individual TPD or IP, or travel) people with mental health conditions are more likely to experience difficulties in obtaining cover.

When a customer needs to **make a claim**, the insurer must assess the validity of the claim according to the terms and conditions of the insurance product. Assessing claims for mental health conditions is particularly difficult for both parties and sometimes, it is argued, the claiming process could actually make the mental health condition worse. In some sectors lawyers routinely represent a person making a claim, which changes the dynamic considerably.

The delays typically involved in assessing claims, and the fact that lump sum payments are often not received until a long time after the onset of disability, can also exacerbate problems with mental health conditions.
Issues with the claims process, including acceptance or rejection of claims, are the most common difficulties for people with mental health conditions across most of these insurance classes.

The next table highlights where the issues relevant to mental health are most significant for each product type. The crosses mark the touch points where difficult issues arise.

Product	Indicative Proportion of Adult Population Covered +	1 Product design and definitions	2 Buying or entering the product	3 Making a claim
Group Insurance				
TPD	40%	✗	✓	✗
IP	20%	✗	✓	✗
Individual Insurance				
TPD	10%	✗	✓	✗
IP	15%	✗	✗	✗
Workers Compensation	60%	✗	✓	✗
Motor Accident Insurance	100%	✗	✓	✗
Travel Insurance	40%	✗	✗	✗
Private Health Insurance	50%	✗	✓	✓

+ Individuals aged over 15+ Basis of the indicative proportions are given in the Further Readings

✗ = issues encountered by those with mental health conditions; ✓ = no issues encountered

2.2 Issues in the different product sectors

Superannuation and Group Insurance

Many life insurance policies offer Total Permanent Disability (TPD) cover in addition to death cover. TPD was originally designed as an advance payment of death cover, paid as a lump sum, on the grounds that if you could not work your family needed at least as much support as if you had died. Now TPD can be purchased without the corresponding death cover.

Income Protection insurance (IP) provides a regular payment if the policyholder has lost income due to illness or accident. There are many different IP policies available. Cover is generally available for up to 85% of gross salary. Cover can be time-limited, for example up to two years, or may be available up to the age of 70. There is usually a waiting period from two weeks to twenty four months before the benefits start, meaning that short term conditions often do not trigger the cover[iii] unless ancillary cover has been purchased.

iii Note that some IP is provided in products sold by general insurance companies – referred to as 'sickness and accident' and limited to benefit periods up to two years. Cover is also included in Consumer Credit Insurance which has not been specifically dealt with in this paper.

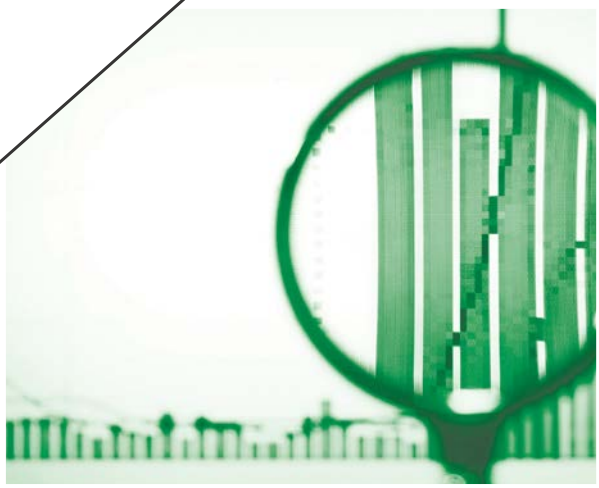
A single lump sum payment may not be the best way to support people with mental health issues.

Most working people have insurance for death and often TPD provided through their superannuation fund, with no individual underwriting and a simple employment test to qualify for cover at commencement. In fact, approximately 70% of people with some life insurance cover obtained it this way.[21] The cover through superannuation has been expanding in recent years to provide some income protection cover. A minority of employed people, particularly those on low incomes, may not be in a superannuation fund or may opt out of insurance cover.

The products provided via a superannuation fund typically have a standard amount of cover for everyone, regardless of their individual risk factors or health condition. The premium, usually classified by age (and sometimes by gender, occupation or employer) is calculated based on the risk profile of the whole group.

If someone with a group policy wants to increase the level of cover from the standard policy, though, the insurer will then take current and previous health and other individual risk factors into account in deciding whether and on what terms to offer cover for the increased amount. The situation then becomes similar to that for individual life insurance, as discussed below. This is not a universal rule, and many superannuation funds, particularly industry funds and public sector funds, allow people to obtain increased levels of TPD cover without assessing risk factors.[22]

Many of the challenges discussed for the following individual products are also applicable to the group products, including challenges with definitions, appropriate benefit structures and delays in notification and claims processing. Group insurers also face a unique set of challenges.



In the year to March 2014, group insurers experienced a major increase in TPD claims. In this period Group Lump Sum made a loss of almost $500m (after tax), or 15% of their net annual net written premium. Mental health claims were a part, but by no means all, of the trend.[23]

Trustees of superannuation funds have also faced financial and operational challenges. As insurance costs increase, how do trustees balance their obligations to members regarding retirement incomes against the benefits of a level of insurance?

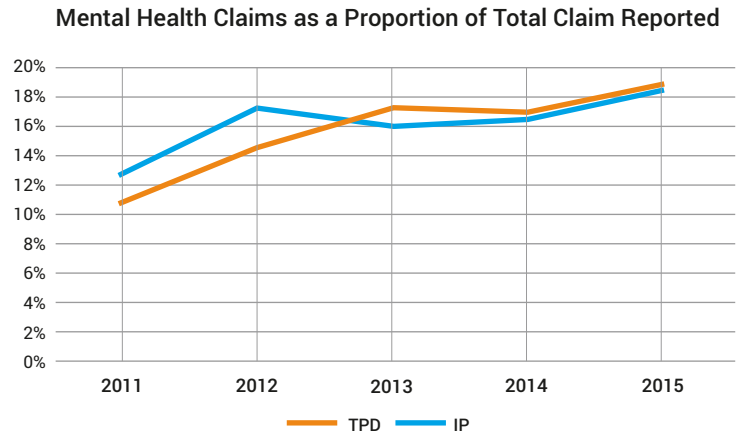
When a TPD claim arises, trustees often find themselves in an awkward situation. Under most trust deeds it is their responsibility to determine the benefit paid to a member, but in practice if the insurance claim is not paid by the insurer, the fund cannot pay the benefit. Many argue that fund trustees are faced with an inherent conflict of interest in that they have an obligation to act in the best interests of members but need to support and accept the decisions of insurers.

In 2014 a major provider of group TPD insurance surveyed people who had received a TPD payment, and found that 23% of those who had claimed for a mental health condition had returned to the workforce after receiving their payment, most of them to a different type of job, and a further 12% were actively seeking work. 47% of those who had returned to work had undertaken training, and 65% reported that they would have liked assistance to return to the workforce.[24]

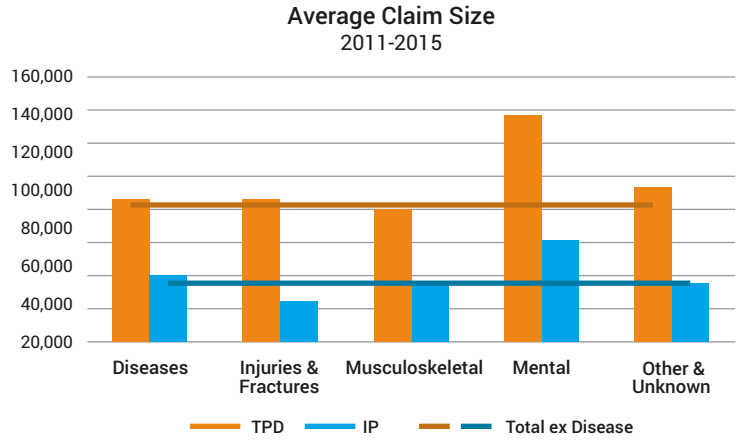
Whilst this survey is only the experience of one superannuation fund, it indicates that TPD payments are sometimes made to people who actually do have the capacity to work. Such people may be better served by an income stream product together with assistance in returning to work.

In recognition of the fact that a single lump sum payment may not be the best way to support people, many group insurers are adopting strategies to help people claiming to return to the workforce. Some engage with employers and workers compensation insurers to obtain earliest possible notification of a potential claim, and work together to support the person's recovery. Some also offer alternative product designs for TPD insurance, paying benefits by annual instalments and focusing on providing vocational support when appropriate. Such policies, which may be offered as a default or as an opt-in policy carrying a lower premium, may be a better way of meeting the needs of those unable to return to their former work roles due to a mental health condition.

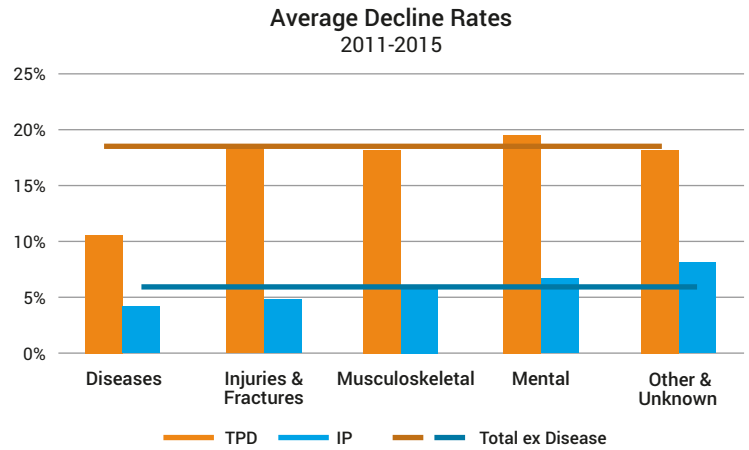
One major group insurer was able to provide data, on a confidential basis, on all TPD and IP claims in its group business, showing paid and declined claims separately and with claims coded by cause.
This data was used to form the following observations*



The proportion of mental health claims reported to the insurer has increased steadily between 2011 and 2015. Claims relating to mental health represent **19% by number** of all claims reported in 2015 for both IP and TPD. Mental health claims represent 26% of the total cost of claims, with the average size being significantly greater than other causes of claim.



Mental health claims are much larger than other claim types. For TPD the average amount paid for mental health claims is almost 65% higher than the other claim types. Likewise in IP, mental health claims are 70% larger than other claim types. The higher claims cost could be due to differences in occupation, age profile and (for IP) duration of the claim.



There is little difference between the rate of decline for mental health claims and claims arising from injuries and musculoskeletal diseases. For all of these groups the denial rate is nearly twice as high as for other diseases. The decline rate for IP claims is much lower than TPD claims. This is likely due to IP being an income stream where payments may initially be commenced and later ceased.

75% of mental health claims reported for TPD, and 85% for IP, related to the high prevalence conditions discussed in Section 1.1. The most common causes are depression and Post Traumatic Stress Disorder. For the low prevalence conditions the most common were bipolar disorder and schizophrenia.

* The observations relate solely to the experience of the insurer. It may not be reflective of the entire group industry. The observations rely on the accuracy and consistency of the insurers coding of claims and has not allowed for any changes in business mix or claims development.

Individual TPD and IP insurance

On the individual side, TPD cover is not purchased to the same extent as Income Protection. Some of the key challenges in this sector include the following.

At design stage – for both TPD and IP there are different definitions of 'disablement' in the various products. The products are long term and there are legal restrictions (intended to protect policy holders) on changing the wordings and many definitions have been in the policies for many years.

Claims are frequently not notified until the condition has been present for some time, so the insurer's ability to initiate early intervention strategies to support recovery is often limited or non-existent.

It has also been argued that the lump sum payment typically provided by TPD products may be less appropriate for mental health conditions than income stream products. The lump sum relies on a person establishing that they are permanently unable to work, whereas income streams can assume that an eventual return to work may be achievable. One person may have had six months off work but with recovery and treatment be able to start a new job, resulting in no TPD entitlement. Another person with an equivalent condition but without such motivation may get the full amount of a TPD lump sum.

The delays typically involved in receiving lump sum payouts can also exacerbate problems with mental health conditions.

The methods and standards for determining claim acceptance are not always fully specified in the policies, leading to disputes among medical experts and often involving lawyers and litigation. Claims may also be denied for non-disclosure of prior mental health conditions at the time the policy was taken out (a key requirement underlying purchase of all individual insurance), and there are inconsistencies across the sector as to how this is used in practice.

Workers compensation insurance

Workers compensation covers all employees, but not self-employed people. Each jurisdiction has its own scheme with its own legislation and lots of different detailed provisions.

To be eligible for workers compensation an injury (mental health conditions are usually defined as an 'injury') must arise 'out of or during employment'. Initial benefits do not depend on the injury being the 'fault' of any party, while sometimes there are further entitlements available under common law if the employer was negligent.

The prevalence of mental injuries in workers compensation is greater in public sector employees than in private sector.[25] While the difference is empirically clear, and various suggestions have been made about the reasons, there may be scope for useful research in understanding the differences.

Claims for mental conditions arising during employment have been a growing phenomenon for many years and there have been two common responses in the various laws:

- Workers compensation is not available if the mental condition was the result of 'reasonable management action' as defined.

- In some jurisdictions, compensation is only available for 'primary' psychological injuries, not for psychological conditions that develop secondary to physical injuries.
- For eligibility to lump sum benefits, any impairment arising from a physical injury cannot be combined with impairment arising from a mental injury. In other words, only the more serious of the two can be counted. Sometimes the threshold for a lump sum benefit is higher for mental injuries than for physical injuries.

Importantly, it has been noted that in workers compensation, legislative changes aimed at excluding or restricting claims for mental health related conditions have typically failed to result in long term cost savings, often resulting in an upsurge in claims for non-specific musculo-skeletal injuries with underlying psychological features.[26]

The evaluation of permanent impairment is a key feature of most workers compensation schemes, and is used as a threshold test for claims that extend for a lengthy period or for access to greater benefits. Physical injuries are usually assessed based on the AMA Guides,[iv] a very detailed specification based on medical criteria. The AMA Guides are regarded as unsuitable for mental injuries and most schemes have a substitute guide for mental injuries.

There are two main versions of the mental injury guides – PIRS (used in NSW and other States) and GEPIC (used in Victoria) – *see page 28 for more details*.

The legislative purpose of the evaluation in workers compensation (based on impairment) is different from that in TPD and IP products. In workers compensation, a significant emphasis is placed on ability to work, but impairment assessment is used separately as an indicator of permanent problems likely to give rise to future disabilities, and accordingly gives access to greater benefits for those that exceed the threshold. For TPD the relevant criterion to access any benefit is the inability to work in future. To our knowledge there has been no serious consideration given to the potential for these assessment guides to be used in TPD or IP products.

Motor Accident Insurance (CTP)

Each state and territory has laws providing compulsory insurance for injuries in motor accidents. Like workers compensation there are very different laws in different jurisdictions. Some provide benefits to all injured people regardless of fault; in others benefits are limited to those who can demonstrate that their injuries arose from someone else's negligence; and some schemes have a combination of these.

Cover relating to mental health conditions arises in two different situations:

- Primary – where the mental injury is a direct result of the accident (e.g. Post Traumatic Stress Disorder (PTSD) or 'nervous shock' of a witness or close relative).
- Secondary – where the mental health condition arises later as a consequence of other injuries suffered in the accident.

The motor accident insurers have always struggled with secondary mental injuries in particular, due to many of the issues discussed in the next section.

Physical injuries are usually assessed based on detailed AMA Guides – but these are regarded as unsuitable for evaluation of mental injuries.

iv The American Medical Associations' Guides to the Evaluation of Permanent Impairment (AMA Guides) provide a comprehensive methodology for evaluating the functional impairment to all body systems, resulting in a 'percentage whole person impairment' score. Many jurisdictions use either the 4th edition (1993) or fifth edition (2000), usually with some modifications. However the section of the AMA Guides that relates to 'Mental and Behavioural Disorders' does not provide a definitive methodology to obtain a numerical score or percentage impairment.

Travel insurance

Travel insurance covers medical treatment outside Australia, trip cancellation and a range of other accidental losses. It is mostly bought by individuals to cover a specific trip. The unit cost of a travel policy is small (of the order of $100) and so the economics of the product do not allow for extensive assessment of individual risks or tailoring of the cover.

The way that travel insurers respond to the variation in health risks of those buying the product is typically to exclude medical treatment or cancellation costs arising from a pre-existing health condition. The insurer will not know what conditions may have existed at the time a product was taken out, but has the opportunity to obtain relevant evidence when a claim is made.

Mental health conditions are dealt with differently from other medical conditions in the majority of travel insurance policies in that there is usually a complete exclusion of claims arising from any mental health condition.

The well-publicised case of Ingram v QBE in the Victorian AAT found that QBE had breached anti-discrimination legislation by the way it had included a mental health exclusion in its product.[27] See section 4.8.

As an example of an alternative approach, one insurer offers a travel policy that covers mental health claims but excludes claims for 'disinclination to travel' due to a mental health condition including 'nervousness, anxiety, depression, or stress-related disorders'.[28]

Private Health Insurance (PHI)

About half of Australians buy PHI for hospital cover. A mental health condition is one of only a very few conditions that, by law, cannot be excluded from a PHI policy. Claims arise mainly from low-prevalence conditions in private psychiatric hospitals.

Hospital policies cover the cost of hospital accommodation (overnight or day only) and a proportion of the medical fees while admitted to hospital. Extras policies may cover part of the cost of psychology services or counselling outside of hospital, but not psychiatry or other Medicare-funded services.

While insurers cannot exclude mental health cover, they can offer partial or restricted cover, with partial benefits for a limitation period of up to two years, or where the benefit is only sufficient to cover treatment as a private patient in a public hospital.

PHI is community rated, meaning that insurers cannot set premiums based on age or health status, cannot decline cover, cannot put special conditions or exclusions on an individual policy and policyholders can change insurers without having to re-serve waiting periods. This highly regulated community rating system has a major impact on market and insurer dynamics, usually not understood by consumers. Some of the consequences are:

a) The 'top cover' policies in the market include mental health cover without restricted benefits or benefit limitation periods, but lower cost policies usually have some or all of the restrictions outlined above.
b) The community rating rules make it difficult for an insurer to offer better benefits than its competitors for mental health conditions. Because many of the conditions are chronic or recurring, insurers with more generous inpatient psychiatric benefits often see clusters of transfers from other insurers, based on particular hospitals or practices recommending to their patients that they switch.
c) People holding more basic policies (for example young adults) may be unaware that they will not be covered as they may have anticipated, should they unexpectedly require hospital treatment for mental health issues.
d) Some insurers do not provide cover for outpatient psychological therapy in their extras policies because of the possibility of attracting those with chronic mental health conditions and consequently incurring high costs from psychiatric hospital claims.

These issues with mental health conditions in PHI are just part of the current debates about affordability and value of the products. PHI currently funds more than 50% of all private hospital mental health admissions and even more of same-day admissions, with the cost growing faster than most causes of claims.

While there is a 'risk equalisation pool' in PHI to share the high cost arising from older members, it does not mitigate the anti-selection risks in relation to younger chronic mental health sufferers.

A mental health condition is one of only a very few conditions that, by law, cannot be excluded from a PHI policy.

3

Relevant knowledge about mental health conditions

- The importance of the workplace
- Poorer outcomes when mental health is involved
- Increasing ability to make risk-based forecasts

3.1 The importance of the workplace

TPD, IP and Workers Compensation are all closely related to work – the first two having claim entitlements based on the ability to work, and the latter based on injuries caused at work.

A general acceptance that 'work is good for you' and 'dislocation from the workplace is bad for you' has informed rehabilitation practice for at least the last decade, leading to concepts of partial fitness, gradual return to work, modified duties and 'stay at work' programs being written into legislation in workers compensation.

These concepts are underpinned by a 2011 position paper 'Realising the Health Benefits of Work' published by the peak body representing Occupational Physicians (AFOEM).[v] [29]

"For most people work is good for their health and their wellbeing and loss of work, whether because of impaired health or for other reasons, is generally harmful."

The position paper outlined the research and other evidence, which it described as 'unambiguous' and was a call to action for health professionals,

v The Australian Faculty of Occupational and Environmental Medicine is a division of the Royal Australian College of Physicians.

Workplaces with a strong team morale, collaborative working relationships, a focus on quality customer service and supportive management styles have the lowest workers compensation costs.

employers and governments. Recommendations spanned education, attitudes, research, policies and regulation. It was noted that the longer a person is away from the workforce, the less chance they will have of ever returning, and early intervention to plan a return to work became the accepted approach.

In 2013 AFOEM followed up with a position paper 'What is Good Work?' It recognised that in order to reap the health, social and economic benefits of work there needs to be a focus on 'good work' not just any work. There was recognition that some workplaces are not 'good for you' and returning a vulnerable person to a negative and unsupportive environment can be counterproductive.

The question of what is 'good work' is complex, and is partly specific to the individual. The domains of 'good work' are specified as:

- Engages workers.
- Engages with the community culture in which the work is performed.
- Respects fairness and procedural justice.
- Balances job demands, job control and job security.

A companion position paper in 2013 was 'Improving workforce health and workplace productivity: A virtuous cycle'.[30] This was a call to action for employers, to own some responsibility for the wellbeing of their employees and act to create mentally healthy workplaces. By 2014 a consensus statement on the health benefits of work had been signed by over 100 Australian organisations across multiple sectors, and subsequently an evidence update by AFOEM[31] marked a shift in focus towards productivity and away from disease. Research was reported covering the role of GPs, and a substantial body of work directed specifically to the appropriate management of mental health conditions.

This body of work from AFOEM has a great deal of useful input when a workplace context is relevant (as it is in most insurance segments), along with references to many other publications and research papers.

It has long been known that workplaces with a strong team morale, collaborative working relationships, a focus on quality customer service and supportive management styles have the lowest workers compensation costs, not only because of fewer claims but also because those who do experience injury return to work sooner.[32] Since 2013 the 'Mentally Healthy Workplace Alliance'[vi] has been promoting the need for employers to adopt strategies that build employee resilience, encourage awareness of mental health issues, train their managers and leaders, and embed strategies to ensure early intervention and supported recovery.

This has been well recognised by SuperFriend, established by the group superannuation insurance industry, who have identified that an integrated approach, working with employers to foster 'mentally healthy workplaces', is critical both as a preventative strategy and as a way to maximise return to work for those who have claimed.[33] Their Guidelines for organisations[34] outline the steps needed to promote positive mental health, while their annual surveys inform participating employers on their progress.[35,36] These results confirm that it is a significant challenge for insurers to engage with the workplace and for the employer to genuinely provide a supportive environment, but that progress can be made iteratively and measured against benchmarks.

3.2 Poorer recovery when mental health conditions are involved

Evidence shows that (on average) people with a mental health condition are slower to recover and return to work (if relevant)

vi Established by the National Mental Health Commission

than people without a mental health condition. For injuries and illnesses that are not caused by mental health issues, the presence of a mental health condition as a co-morbidity is a predictor of significantly worse outcomes.[37]

With income protection and TPD claims, psychological and cognitive barriers have been identified as the main factors preventing return to work.[38]

In workers compensation, mental health claims relating to work relationships or work stress (rather than a traumatic event) are 20-40% more likely to involve time off work than physical injuries, and have ten times longer off work (median time nine weeks) than other claims (median time<0.5 weeks).[39] People claiming workers compensation for a mental health condition are more likely to be certified wholly unfit, and for longer, than people with other types of conditions.[40]

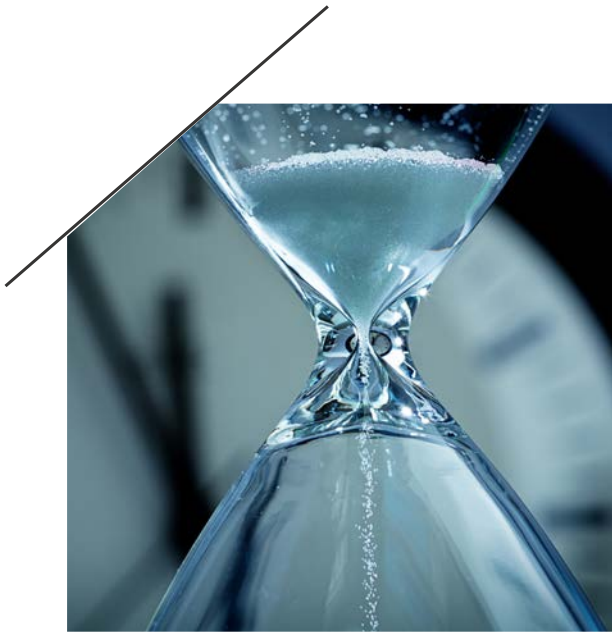
Pre-existing mental health is also an important factor. A comprehensive review of the evidence derived from 10 studies involving nearly 4,000 people across a variety of countries and compensation systems found people who claimed compensation had poorer mental health to begin with than those that did not, and while their recovery at follow up was poorer and they had more mental health complaints than those who did not claim, most (75%) of the mental health problems seen at follow up had been present at baseline.[41]

The Victorian Transport Accident Commission (TAC) surveyed people who had claimed for injuries relating to a motor vehicle accident and found that more than 50% of people reported that they had a pre-existing condition or disability at the time of their motor vehicle accident. 16% reported a pre-existing chronic mental health condition, 10% of whom also reported a chronic physical condition or chronic pain as well. The TAC research found that poorer outcomes are associated with pre-existing mental health conditions and 'mental health vulnerability', as measured by a comprehensive questionnaire incorporating measures of post-traumatic stress disorder, depression, cognition, resilience, and the person's own expectations about their recovery.[42]

Some research has focused on the role of medical professionals and opportunities for improvement.

The majority of mental health conditions are managed by a GP; only 9% of cases seen by GPs are referred to a psychiatrist.[43] The role of the GP is critical in making early determinations of an individual's capacity for work, but GPs typically have limited time to engage with their patients, and may lack specific training on the management of mental health conditions and substance abuse problems – despite their high prevalence.

It has been found that health practitioners are more likely to certify individuals with mental health conditions as being totally unfit to work than any other injury group. Fitness (or unfitness) for work is usually certified by a GP, although a treating psychiatrist may also provide an opinion on whether a patient is, or is likely to become, capable of return to work. Recent research has shown that the motivational and biopsychosocial factors influencing return to work are not well assessed, and GPs most commonly will certify people with a mental health condition unfit for work (rather than partially fit for work), with the period of unfitness being significantly longer than for other conditions.[44] It has also been found that health practitioners are more likely to perceive people with a mental health condition as having poorer outcomes than they really have.[45]



Mental health claims relating to work relationships or work stress are 20-40% more likely to involve time off work than physical injuries, and for significantly longer periods.

Many people currently do not receive evidence-based treatment,[vii] and receiving appropriate treatment is often not enough in itself to facilitate a return to work.[46] There is evidence of better outcomes for people with anxiety and depression, with less time lost from work, when traditional treatment methods are combined with service coordination involving early liaison between employers, insurers and treating practitioners, and work modifications.[47]

However, psychiatrists and clinical psychologists are typically not specifically trained in assessing work capacity, and seldom see their role as extending to liaison with a workplace. Limited understanding of mental health conditions at many workplaces compounds the problem, making many practitioners reluctant to allow an employee back to work unless they appear to be fully recovered.

Considerable investments are being made by many insurers in the triage of claims, in order to identify cases most at risk of a poor outcome, and intervening to provide additional support and/or access to evidence-based treatment strategies. However, the ability of an insurer to influence a person's choice of treatment provider and/or the treatments used is variable, and very limited in some jurisdictions such as life and TPD insurance.

3.3 The ability to make risk-based forecasts

For insurance applications, the existence of reasonable risk-based models of the occurrence and severity of mental health conditions would be a great help in designing, pricing and underwriting insurance products. There is some encouraging research under way.[48]

There are predictive algorithms in existence which have been tested on large populations of people who are psychologically well, and have been found to effectively predict the risk of a diagnosis of major depressive episode in the next 12 months.[49] The studies across six European countries were found to be at least as accurate as similar tools used to predict risk of cardiovascular disease, and led to the development of an online questionnaire ("PredictD") which can provide a risk score.[viii]

The tool looks at known predictive factors, including age, sex, education, past history of depression, family history of psychological problems, current physical and mental health (as measured by the SF12, a 12-question test), and reported difficulties at work. Interestingly, reported experience of discrimination, for whatever reason, is also a strong predictor of future mental health problems.[50]

Work has been done to develop and test a predictive algorithm using Australian data from the Household, Income and Labour Dynamics in Australia (HILDA) survey dataset of over 17,000 people. This has resulted in different predictive models for men and women, and a set of screening questions that can be used to identify people who are at highest risk of developing depression.[51]

The aim of this work is preventative – to identify people at risk early and encourage interventions that can help reduce the risk – although the potential use of such models for insurers in estimating risk is obvious, in terms of developing better product definitions and better pricing. Discussions are underway about further work to develop predictive models for people who have a current mental health condition, which may be even more useful for insurance.

The results of the Victorian Transport Accident Commission's research on claim outcomes has also suggested that an early screening process, involving four simple questions that can be asked by claims staff relatively soon after the injury, can help identify those at low, medium, high or severe risk of a poor outcome. Such screening tools can be used to identify the estimated 30 – 40% of people who make a claim who are likely to benefit from specialised intervention and assistance relating to their mental health or persistent pain.[52]

vii It has been estimated in the U.S that only a quarter of people with depression receive treatment that is consistent with accepted guidelines.

viii Available at: http://www.ucl.ac.uk/predict-depression/

4

The difficult problems – why does the insurance sector find it difficult?

There are many reasons that insurers find mental health conditions difficult to underwrite, and difficult to resolve at claim time. Advocacy groups refer to discriminatory attitudes, stigma, lack of knowledge, lack of compassion and the primacy of commercial interests. Insurers do not accept these views, but the root causes of the issues remain difficult to pin down. While there may be truth in some of these, the actuaries can make their best contribution by understanding the dynamics of the insurance life cycle and drawing out the inherent difficulties.

We use the term difficult problems, in acknowledgment of the systemic issues faced by the insurance sector when trying to maintain affordable and sustainable products that appropriately respond to mental health conditions.

Based on the research undertaken for this paper, we have tried to deconstruct the nature of the problem into the following issues.

- Lack of appropriately collated data.
- Diagnosis relies on subjective information and doesn't relate to prognosis or ability to work.
- Reliance on self-reporting and difficulty in validation.
- Severity, appropriate treatment and prospects of recovery are hard to understand, and even harder to influence.
- The high prevalence of co-morbidities (including substance abuse).
- The prospect of financial compensation can influence. behaviour and produce worse outcomes.
- The claim process itself can lead to secondary harm.
- Ineffective regulatory framework, decision making and dispute resolution, given the specific nature of mental health conditions.

With no current bio-markers for mental health conditions and severity, psychiatrists may, and often do, disagree as to the applicable diagnosis for an individual.

4.1 Lack of appropriate data

In the absence of reliable data – the problems are hard to tackle

Regardless of your place in the system, the absence of reliable and relevant data is a problem.

Data and information is required in order to appropriately design products, underwrite them, inform claims processes, provide transparency of decision-making and evaluate the performance of the product, the players and the processes.

There are sources of data and research about the prevalence and profile of people with different mental health conditions, such as the 2007 National Survey of Mental Health and Wellbeing and many other epidemiological and clinical studies. Some are referred to in this paper, but to have a complete and informed view of all this information is a difficult task for a full-time academic, let alone for an insurer.

Even then, the nature and granularity of the data needed for insurance applications is different from that for population, public health or clinical purposes. Firstly, the 'exposure' (the number of insured people and their characteristics) needs to be recorded. There is probably a lot of relevant information that is not collected at the start of an insurance policy and can therefore never be analysed.

Secondly, the claims information needs to be available at a detailed level regarding the nature and cause of the claim and other characteristics of the individual, their history and the cover provided. There is a clear need for consistency in definition, language and data standards to improve the quality of information available across the system.

Naturally, when the insurance cover for mental health conditions is not provided (as in the case of most travel insurance products) there will not be relevant data from the insurance history. However, even when relevant data exists within insurers there are practical and commercial difficulties in turning it into a useful form.

Insurance underwriting is a competitive business and there are no institutional frameworks that compel insurers to use consistent definitions or to collect and share data.[ix]

4.2 Diagnosis and subjectivity

For most physical injuries and illnesses, there are tests and objective indicators that enable doctors and in turn insurers to have confidence in a diagnosis and a reasonable understanding of prevalence and likely outcomes.

A notable exception is soft tissue injuries such as whiplash, and motor injury insurers face many of the same difficulties with whiplash as are discussed in this paper regarding mental health conditions.[x]

The same cannot be said for mental health conditions. While mental health conditions are recognised in the international classification of diseases (the ICD-10), there are currently no reliable biomedical markers to indicate the presence or severity of most mental health conditions.

ix As an interesting example APRA (jointly with ASIC) recently published an issues paper on a data collection to assist regulators and the public assess the performance of insurers in handling claims. The proposal did not have any information on the cause of the claim.

x Insurance system responses to soft tissue injuries may in fact be a useful case study in considering improvements in handling mental health conditions.

By their very nature, the conditions are subjective, with diverse symptoms and diagnoses, and may or may not be well controlled by treatment.

A mental health condition may be diagnosed by a GP, for example, when referring someone for counselling or prescribing anti-depressants, while a psychiatrist may not agree that a recognised psychiatric condition exists.

An insurer assessing any claim must rely on the evidence available. Initially the evidence is provided by the person making the claim, including their doctors and sometimes other experts (especially if the person has legal representation from the outset). After that the insurer can (and often does) seek out its own evidence including medical examinations. The subjectivity of assessing mental health conditions and associated co-morbidities inevitably makes this a difficult task for an insurer.

Diagnosis – the DSM-5

A manual available to health care professionals to classify mental health conditions is the 5th edition of the DSM[53] (DSM-5), published in 2013.[xi] This manual of over 900 pages provides specific criteria that need to be met for a diagnosis to be made. It does not, however, aim to deal in other than a fleeting way with treatment, severity or prognosis.

It is acknowledged that current diagnoses are based largely on descriptions, which can vary from practitioner to practitioner and may change markedly over the course of illness… they often relate poorly to the actual stage of illness (and)… 'do not link strongly to any specific neurobiological or environmental risk factors, underlying pathophysiological processes, or patterns of specific treatment response'.[54]

It is generally accepted that psychiatrists may, and often do, disagree as to the applicable diagnosis for an individual. Individuals may vary in the way they describe their symptoms and their severity. Some may exaggerate, whether deliberately or unconsciously, and some may have difficulty expressing what is happening. There is heavy reliance on the presentation of the person on the day and on the clinical judgement of the diagnosing psychiatrist.

Symptoms often vary over time. Many disorders have a 'high degree of short term diagnostic instability, where symptoms that initially fit into a certain category can change within a few weeks and the original diagnosis may no longer be valid'.[55] Medical conditions rarely have this characteristic.

There are critics of the DSM. Since the first edition of the DSM in 1952, the total number of psychiatric conditions has more than tripled, from 112 in 1952 to over 370 recognised disorders now.[56] However, for the first time in its history, the number of diagnoses did not increase with the introduction of DSM-5. While it has been argued that the 5th edition lowered the diagnostic threshold for high-prevalence conditions such as depression, this has been rejected by the DSM-5 Taskforce who say that studies have indicated that there will be essentially no change in the overall rates of disorders under DSM-5.[57]

To our knowledge there is no widely accepted tool in the life insurance sector for assessing the severity of a mental health condition and/or the expected impact on a person's life. This is a critical assessment because eligibility for a claim does not depend merely on the existence of a condition but on the impact on a person's life and livelihood.

To our knowledge there is no widely accepted tool in the life insurance sector for assessing the severity of a mental health condition and/ or the expected impact on a person's life.

xi More information is in the Further Reading.

Insurers face the dilemma that some people, certified as incapacitated, may actually be capable of resuming some sort of work with the right kind of support services and interventions.

Impairment – PIRS[58] and GEPIC[59]

Severity is assessed in many workers compensation and motor accident compensation systems using the concept of 'permanent impairment'. There are two commonly used instruments – PIRS and GEPIC.[xii] The content of these two guides is quite different from each other, although they are used for essentially the same purpose. The guides must be applied by specially trained psychiatrists.

Both scales purport to measure impairment, but the PIRS classifies the level of disability.

Impairment is defined by the World Health Organisation as 'any loss or abnormality of psychological, physiological or anatomical structure or function' and is therefore different from disability or restriction of ability to perform activities, which is a consequence of an impairment.[60] Both the PIRS and the GEPIC use definitions consistent with this, and further define a 'permanent impairment', being 'an impairment that has become static or well stabilised with or without treatment and is not likely to remit despite future medical treatment'. The PIRS adopts a further definition of permanent impairment as 'an alteration to a person's health status. It is a deviation from normality in a body part or system and its functioning', which has 'been present for a period of time, is static, well stabilised and unlikely to change substantially (i.e. by more than 3%) in the next year with or without medical treatment.[61]

The impact on normal functioning is assessed across six domains, being 'Self-Care and Personal Hygiene', 'Social and Recreational Activities', 'Travel', 'Social Functioning', 'Concentration Persistence and Pace', and 'Adaptation'. A person is scored from one to five reflecting 'severity of impairment' in each domain, and the scores are combined, using a method taking median severity and total score into account, to give an overall impairment rating.

By contrast, the GEPIC classifies impairment in each of six different domains ('Intelligence', 'Thinking', 'Perception', 'Judgement', 'Affect' and 'Behaviour'). Each domain is scored into one of five classes of severity, and the median severity score is used to determine the overall impairment percentage range. Assessment of impairment to 'ability' (relating to activities of daily living) and 'potential' (relating to rehabilitation or treatment potential) are specifically excluded from GEPIC.

There are many criticisms of PIRS and GEPIC, not least of which is the absence of a sound basis in medical or scientific research, and inter-rater reliability has been questioned.[62] As with a diagnosis, the claims officer in an insurer will often find impairment reports to be subjective, inconsistent with each other, difficult to verify and amenable to coaching. On the life insurance side, these tools are not widely used.

4.3 Reliance on self-reporting

The primary source of information about a mental health condition comes from the individuals themselves. They try to explain how they feel, how their lives have changed and the impact on their functioning. There may be many influences on how a person reports on their symptoms. Some people are more articulate and insightful than others. There may be a tendency for people suffering from depression to have a very bleak outlook about their condition, and on the other hand there may be incentives for a person suffering both a mental health and a substance abuse problem to withhold details of the substance abuse. Some

xii Developed independently in Victoria (the Guide to the Evaluation of Psychiatric Impairment for Clinicians, or GEPIC) and NSW (the Psychiatric Injury Rating Scale, or PIRS). Variants are used in many jurisdictions.

insurers have suggested that it may be possible to coach someone to present with a mental health condition for a particular purpose.

Insurance systems place a heavy reliance on medical experts to validate and assess the condition of a person making a claim. A medical expert in relation to a mental health condition, however, has very little information with which to work other than what the person, or other doctors, has told them.

For a physician aiming to help a person there is normally a presumption to believe what the person says – in fact in some mental health situations 'the perception is the reality'; if that is what the person is telling me the question is "how I can help them feel better", not "are they telling me the truth?". While medical practitioners no doubt often have a feeling about the truthfulness or objectivity of a patient it is not their role to undertake a cross-examination or a forensic investigation of truthfulness.

An insurer, if it is not comfortable with the veracity of the information provided, can also try to find evidence from others who were in contact with the person at the time. Many are family members, but court judgements often find that evidence from family takes the side of the person claiming and is not reliable. Just as there are some witnesses who take the side of the person claiming, an insurer may look for evidence, witnesses and opinions to seek to disprove the person's case.

Another approach that may be used by an insurer to test the veracity of the information provided by a person making a claim is to use surveillance. Understandably, there is unease among many about the use of surveillance, but it is one of the few forms of evidence that sometimes can incontrovertibly show a person was not telling the truth. In circumstances of mental health conditions, the level of unease about surveillance is exacerbated because of how it could further harm the person's mental condition, and the effectiveness is also often lower because symptoms cannot be physically observed and because people have good and bad days. A very recent issue is that social media is sometimes a very effective method of surveillance and this also brings in concerns of privacy.

If ways can be found to get reasonably reliable validation of what a person says in self-reporting their mental health condition, many insurance issues would be resolved.

For physical injuries, surveillance is one method that can be used to test the veracity of a person making a claim's case, and in recent times this has expanded to include review of a person's social media posts. Not only is the inappropriate use of surveillance roundly criticised by many, in the case of a mental health condition it is rare that it will produce anything meaningful to assist the insurer, while often causing significant distress to the person making a claim.

4.4 Severity and prospects of recovery

- **Severity and prospects of RTW are hard to understand.**
- **Fitness for work is not well assessed and RTW is not well supported.**
- **Insurers have limited possibilities to influence outcomes.**

[Most of the relevant insurance products are based in some way on the ability of a person to work or to return to work following an illness. For this reason, we refer to Return to Work (RTW) as a key issue, while recognising that in some circumstances it is not an appropriate goal. In section 3.1 we discussed the importance of the workplace.]

As **beyondblue** points out, it is important to recognise that 'each condition is different and everyone's experience of a condition is different.... and depends on a range of individual risk and protective factors, including access to appropriate treatment'.[63]

An insurer must necessarily start with the statements of the person making a claim and the reports of their treating doctor, psychiatrists and psychologists to understand how severe an individual's mental health condition is, and whether the person is, or is likely to become, capable of working.

A person's treatment is not necessarily a reliable indicator of the severity of their condition. The treatment a person receives is 'often dictated by affordability, availability and personal preference' and is not necessarily a reflection of the 'severity' of a person's condition, or the likelihood of recovery.

As discussed in section 3.2 the majority of mental health conditions are treated by a GP, and although treatment by a psychiatrist might indicate the presence of a more significant condition, it may also occur because a GP is unsure of the diagnosis or management, rather than because the person is seriously unwell.[64]

In assessing the veracity of information and whether a person's condition satisfied the definitions for a claim, insurers will often go beyond the diagnostic categories, and use a variety of assessments and information from various health professionals, to build up an understanding of the individual's condition.

Some insurers have been requiring people claiming on income stream products for mental health conditions to complete daily activity diaries, raising concerns by some that this is unnecessarily intrusive. Submissions have been made to the Joint Parliamentary Committee Inquiry into Life

Insurance that the use of such diaries should be regulated and only used in consultation with treating health practitioners.[65]

Insurers therefore face the dilemma that people with a mental health condition will often be certified as incapacitated when this has not been assessed in detail, and with the right kind of support services and interventions it may indeed be possible to resume some sort of work, if not the pre-injury job. As has already been discussed, insurers providing TPD and income protection insurance are very reliant on the advice of the treating professionals, given their very limited opportunity to understand the situation early and provide any support to facilitate return to work.

Evidence from the workers compensation jurisdiction indicates that intervention within the first few weeks of injury or symptoms is critical to obtaining good claim outcomes.[66]

However, in TPD and IP, an insurer's ability to make early contact and ensure access to appropriate treatment and rehabilitation strategies is usually very limited, because claims are typically notified well after the conditions first manifest. Liaison between life insurers, workers compensation insurers and employers to obtain early notification of potential claims might assist in ensuring those at most risk get access to support when needed, although there are legal and practical impediments to this occurring.

4.5 The prevalence of co-morbidities and substance abuse

Chronic, recurrent depression is associated in particular with anxiety and substance abuse, and with common chronic medical conditions such as diabetes, cardiovascular disease and obesity. The prospect of a full resolution of symptoms is lower, and the risk of further episodes is higher, where such co-morbidities exist.[67]

As discussed in section 3.2 a pre-existing mental health condition is also an important factor, with claims outcomes being negatively affected by the presence of a pre-existing mental illness. Opioid medications, often prescribed for pain, can also have an adverse impact on mental health, and can be subject to abuse.

Substance abuse presents a challenge, whether it is of legal substances such as alcohol or pharmaceuticals or illicit substances such as marijuana or methamphetamines. It is highly likely that substance abuse alongside or as part of other mental health conditions is significantly under-reported.

Along with the medical and evidentiary challenges that substance abuse creates, there are also serious legal and policy issues impacting on insurance:

- How does (or should) a pre-existing substance abuse issue be considered in determining a claim for a mental health condition? Is it relevant to a causation issue (such as in workers compensation) or to non-disclosure (such as in income protection)?
- To the extent that substance abuse may be an illegal activity to what extent does that fact influence the legal and moral approach to claim entitlements?
- If the substance abuse arises after the original condition, does its outcome form part of the outcome of the condition or should the condition be assessed by attempting to exclude the impact of the substance abuse?

4.6 Financial incentive

Does the prospect of financial compensation influence outcomes?

It is known that people who claim financial compensation under various jurisdictions, for any kind of injury or illness, have poorer health outcomes than those with similar conditions who do not make a claim.[68]

In terms of psychological outcomes, there is strong evidence that people claiming compensation have worse mental health outcomes than those who do not claim compensation.[69] Most studies (but not all) have found that victims who are involved in compensation claims had higher levels of depression, anxiety and PTSD than non-compensated victims,[70] and there is some evidence to suggest that the implications for mental health are worse when claim processes drag on for more than six months.[71]

> **"By comparing the post-injury health status of patients who claim compensation with that of patients who do not claim, more than 100 studies have concluded that recovery trajectories are worse among claimants".**[72]

One explanation is that the compensation process is a stressful experience: victims suffer from renewed distress (secondary *victimisation*) caused by the claims settlement process.[73] Another explanation is the theory that being involved in claims settlement creates an unconscious financial incentive for victims not to get better as long as the settlement lasts (*secondary gain*).

Given the subjectivity of diagnosis and symptoms, insurers are always mindful that an unscrupulous person can exaggerate their symptoms if there is the possibility of financial gain. Products that provide lump sum payments may provide more incentive for fraud or exaggeration than those that provide income streams. Given that subjective health complaints such as back pain and stress 'are very expensive and claim half or more of the funds available for sickness compensation'[74] and account for most of the rise in sickness absence and social security benefits [75] the authenticity of these claims is a real question for society, and insurers clearly have an obligation to undertake due process and defend against fraud.

It is difficult to obtain data on the levels of fraud and exaggeration that are currently being experienced and whether this is a material issue.

The issues above are not limited to insurance – it is also an issue for social welfare and other structures such as veterans' affairs.

The financial interests of the person making a claim and the insurer are at odds, although this does not always mean that there will be disputes or conflicts. The insurer wants to collect as much information as possible to inform claim decisions and help develop an appropriate return-to-work strategy. An individual, on the other hand, will often be wary of disclosing information that would jeopardise his/her entitlement to receive monetary benefits from the insurance company.

Society needs to, and broadly does, recognise this inherent feature of the system and the need for an insurer to obtain verification and make financially disciplined decisions. While it is never easy to balance the

The financial interests of the claimant and the insurer are at odds – society needs to, and broadly does, recognise the need for an insurer to obtain verification and make financially disciplined decisions.

interests of insurer and a person claiming in respect of claim investigations, a transparent approach to product definitions and claims assessment criteria, communicated in a clear way, may help reduce disputation and complaints.

4.7 Secondary harm

- **Does the claims process influence outcomes? – Secondary harm**

Insurers are dealing with an increasing number of claims made for mental health conditions, and in addition a significant proportion of people who make a claim for another reason may have, or may develop, a mental health condition as well. This could be pre-existing, or may develop as a result of their physical disability, or arise from other factors in their lives.

There is evidence to suggest that some people will develop or exacerbate mental health problems as a result of the stresses associated with the claiming process itself.[xiii] Exposure to perceived discrimination or exclusionary practices can have a negative impact on recovery. Uncertainty, lack of control, and perceptions of being devalued and misunderstood can all trigger feelings of anxiety and depression which may develop into diagnosable conditions in some people. In addition, financial insecurity and relationship difficulties (often triggered by financial stress) can exacerbate symptoms of anxiety and depression.

There is evidence to suggest that some people will develop or exacerbate mental health problems as a result of the stresses associated with the claiming process itself.

While many claims staff have received training on these issues and strive to minimise secondary harm, the delays often experienced before the outcome of a claim is known can significantly exacerbate the financial strain and associated anxiety experienced by someone unable to work because of their mental health condition.

Claimants often speak of having to repeat their story many times, sometimes to an insurer-appointed expert whom they regard as against them. There is concern that frequent repetition of the story can re-traumatise and make it more difficult to develop a positive frame of mind.[76]

Some argue that neuroplasticity may also play a part, and suggest that constant repetition of the story may change the brain such that the individual becomes more unwell regardless of their motivation or honesty.[77]

4.8 Ineffective regulatory framework

- **Fragmentation of the regulatory framework – lawful and unlawful decisions.**
- **Human Rights Commission Guidelines.**
- **Ingram v QBE.**

The laws and systems for determining claims and resolving disputes were developed for physical injuries or illnesses and now apply, with limited adaptation, to mental health conditions. It is slow and difficult to change any of those laws and systems. This would be so even if there was broad agreement that different approaches might be needed.

A fundamental example is in the way claims and disputes are usually resolved. A person making a claim obtains and provides evidence to the insurer relating to their condition and the impact it has. An insurer will conduct its own inquiries and examinations as well as assessing the information provided.

xiii For example Judges in court verdicts frequently comment that the person will be much better once the court case is over.

Often there is agreement on the outcome, in that the insurer accepts the claim, or the person making the claim accepts that they are not entitled to a claim under the relevant product.

If there is no agreement, various forms of dispute resolution exist. There are numerous forms, approaches and rules which in itself can be a problem. A common factor is that the fundamental approach, as is embedded in our system of law, is an adversarial one. Each party presents its case and the decision-maker makes a decision.

The different insurance products are governed by a wide variety of (often overlapping) laws, guidelines and regulators. See the *Further Reading* section of this paper for more details and discussion of the various components.

Codes of Conduct – FSC Standards, Codes for General Insurance (2014), Life Insurance (2016) and Private Health Insurance (2016). These are typically focused on customer service standards, transparency and ethical behaviour. The Insurance in Superannuation Working Group has recognised the need for a more comprehensive code of practice for superannuation funds, to better ensure they meet their obligations to oversee the management of insurance claims.[78]

Specific Insurance Legislation – there are many relevant Acts which govern insurance and sometimes have unexpected consequences in areas relating to mental health. Legislation includes the Life Insurance Act, the Insurance Act, the SIS Act, the Insurance Contracts Act, the Private Health Insurance Act and many aspects of the Corporations Law and Consumer Law.

Anti-discrimination legislation – Each jurisdiction has anti-discrimination laws, which are themselves complex and open to interpretation. The various anti-discrimination acts allow for insurers to discriminate on the basis of a mental health condition (or another disability), for example by refusing to offer a product, or imposing additional terms and conditions, or additional premium, only where there is reasonable evidence in support of the decision.

Specifically, the discrimination must be based on 'actuarial or statistical data on which it was reasonable to rely', and the discrimination must be 'reasonable' having regard to that data and 'other relevant factors'. If appropriate data is not available or cannot reasonably be obtained, the insurer would need to show that the discrimination is reasonable having regard to other relevant factors.[79]

Disability Discrimination Guidelines – The Australian Human Rights Commission (AHRC) has authority to investigate and conciliate complaints of alleged discrimination under the Commonwealth Disability Discrimination Act and has issued "Guidelines for Providers of Insurance and Superannuation" (updated in 2016).[80] These guidelines are not legally binding. However, they provide guidance as to when discrimination by insurance and superannuation providers may be lawful or not lawful, and set out the AHRC's expectations of insurers.

Ingram v QBE[81] – In the case of *Ingram v QBE*, the insurer needed to demonstrate the statistical or actuarial justifications for a blanket exclusion of mental health conditions in a travel policy. QBE acknowledged that there was an absence of evidence which demonstrated that it made the decision to exclude mental illnesses on the basis of contemporaneous actuarial data. However, QBE described the mental illness exclusion as general industry practice at the time.

If there is no claim resolution agreement, various forms of dispute resolution exist. There are numerous forums, approaches and rules, which in itself can be a problem.

The Tribunal (VCAT) determined that it was more likely that QBE had based its decision to exclude mental illnesses in the policy on perceptions of the prevalence of mental illness in the community and as portrayed by the media. QBE was unable to demonstrate that it would have suffered unjustifiable hardship if it had not included the mental illness exclusion in the policy issued to Ms Ingram, or to all travel insurance policies.

Dispute resolution forums – disputes about claims are heard in many different forums including specialist workers compensation and motor accident tribunals, FOS, SCT, federal and state administrative tribunals and federal and state Courts. The variation and complexity (which exists for all types of claims but is probably exacerbated for mental health conditions) is not only difficult to manage but there is undoubtedly 'forum shopping' by legal advisers. To make robust decisions at underwriting and claims time that can withstand the numerous possible legal challenges can be onerous and costly. Insurers may be inclined to pay a claim rather than resist it, and may try to avoid the problem by the kind of definitions and blanket exclusions that are the subject of much complaint. In either case, the integrity and usefulness of the insurance product is undermined, as is community confidence in insurers.

Historically the industry has been under relatively 'light touch' regulation, but the times are changing.

Clearly insurers need to discriminate between customers to appropriately price products according to risk. In a highly competitive market there is an incentive to keep premiums as low as possible while striving to keep claims costs within predicted levels. Historically the industry has been under relatively 'light touch' regulation, but the times are changing as the industry becomes more litigious and is coming under increasing scrutiny by regulators. As noted previously (section 1.3), while there are various codes of practice and standards governing underwriting and claims practices, many are not mandatory and full compliance requires investment in systems and training. A company that invests in change may be at a competitive disadvantage to other companies that do not.

4.9 Turning to possible solutions

This section of the paper has aimed to deconstruct the root causes of some of the difficulties with mental health and insurance.

The next section moves on to some suggestions about how improvements might be achieved.

5 How can improvements be achieved?

The problems raised by mental health conditions in the insurance sector are complex and multi-pronged.

There is no doubt the industry must respond to the changing needs of its customers and find ways to provide products and services that meet their needs and are sustainable. This inevitably means bringing a new focus on to mental health conditions, in product design, underwriting and claims management.

There is much known already that can be implemented in the insurance sector. Some improvements are readily achievable and others require a longer-term commitment.

This section draws together various suggestions that have been made in conversation with stakeholders and in written material we have researched.

We do not suggest that we have a roadmap for success. The nature of a 'difficult problem' is that it has no easy answer. Nevertheless, there are nine specific areas that warrant co-operative consideration and further development:

- Product definitions.
- Product design.
- Underwriting guides.
- Early treatment focused on recovery.
- Review of laws relating to mental health and insurance.
- Data - collection, analysis and access.
- Specialised skills and processes in dealing with claims.
- Expert neutral evaluation.
- Continued education and collaboration.

5.1 Product definitions

Most life insurance products (except for critical illness cover) provide cover for an outcome regardless of cause. The definitions may benefit from supplementary information relevant to mental health disorders, putting flesh on the bones of 'unable to work'.

For some products like workers compensation and motor accidents the cause is entirely relevant – e.g. whether the condition arises out of or during employment. Workers compensation laws have been changed to exclude coverage where the condition was the result of reasonable management action. Another example in workers compensation is that the severity of physical injuries and mental injuries is assessed separately and not combined.

Definitions need to be kept reasonably up to date with medical knowledge and evidence. Life insurance may need a change in the law to enable this to happen

Standardised definitions for disability insurance products, including definitions of mental health conditions, could be adopted. Consumer groups have suggested that product descriptions and communication using plain language would facilitate better understanding for customers and for people who want to make a claim. On the other hand, such an approach can stifle innovation and reduce competition in the market.

In some products, an explicit description of how pre-existing conditions and co-morbid substance abuse are treated may be helpful.

Comprehensive and medically validated guides specific for Australian practice may be of great assistance in underwriting those with mental health conditions.

Language is critical in communicating the nature and intent of the insurance product. Poor terminology, and a focus in product materials on incapacity and disability, can serve to disincentivise recovery and create negative expectations. Better expectations could be created by product descriptions that focus on wellness and recovery, and describe an active role for insurers in supporting recovery and return to productivity.

5.2 Product design

The benefits available under certain products may not be conducive to effectively dealing with mental health conditions. A large lump sum based on the inability to ever work again is probably not ideal. Better protection may be provided by an income stream, perhaps with time limits. It would be even better if the product can be integrated with mechanisms to support recovery and it might be necessary to make benefits contingent on participation in reasonable recovery efforts. The inclusion of features with partial return to work being accompanied by partial payments can be considered.

Development of a set of product design principles that support best practice, and include the possibility of co-design with consumers, would be helpful. Target markets should be identified and products tested for suitability and consumer understanding. The regulatory barriers to providing simple plain English product disclosure statements should be reviewed.

Workers compensation is often predicated on the obligation of the employer to take the worker back and the primary goal of helping the worker back to the same job or with modified duties. Often a mental health claim results from the employment situation itself and attempts to return to that job may be entirely counter-productive. Some mental health conditions might be better dealt with by a different structure of entitlements and a process on return to the workforce in a different job or with a different employer.

5.3 Underwriting Guides

Life insurance relies on extensive medical underwriting guides that have been developed over decades to help assess the risk relating to different conditions and inform decisions on the availability and terms of insurance. For example, detailed and specific information is provided on heart disease or various cancers. Reinsurers have contributed to these guides drawing from their broad experience and resources in dealing with non-standard risks.

In relation to mental health conditions, such guides are relatively basic if they are used at all. It is possible that comprehensive and medically validated guides specific for Australian practice may be of great assistance in underwriting those with mental health conditions. The guides need to deal in a relatively comprehensive way with a range of pre-existing conditions and the effect on the risk of future problems. This requires a pooling of knowledge from actuarial, epidemiological, medical and claims areas. The capability exists to develop such a guide (or more than one) but it is not clear who has the right incentive and resources to undertake the task.

The potential also exists for insurers to recognise workplaces that have a positive and supportive culture and to influence those that do not, in recognition of the fact that 'mentally healthy workplaces' have fewer claims and better RTW rates. In setting premiums, should insurers rate employers in terms of their record on mental health claims and the extent to which their culture reflects mentally healthy workplace standards?

5.4 Early treatment and recovery

An inherent problem for life insurers is that they do not know anything about the person making the claim or their condition until well after the condition has arisen and a claimant has left work. Communication tends to focus on eligibility for benefits, rather than recovery and wellness, especially if the claimant is legally represented.

Some people will recover from a set-back on their own, and are better left to do so. For many, though, suitable treatment as well as non-clinical support is beneficial. How can ways be found such that a likely mental health claim can be identified early and have the potential for treatment and support to be provided early? How can expectations be better managed so that people seeking to claim will work together with their treating doctors, employers and insurers towards the best possible outcome?

Insurers have an incentive for this to occur but rarely have the opportunity (and may not have the capability). There are opportunities for changes to the design of the system in this area, whether it involves superannuation funds, employers, treating practitioners, social supports or other pathways.

5.5 Review of laws relating to mental health and insurance

There may be scope for improvement by reviewing in a co-ordinated way the numerous laws that influence how insurance interacts with people with a current or future mental health condition, and removing the drafting differences between jurisdictions that cause practical difficulties.

This would be a large and complex undertaking. Developing recommendations would be difficult enough but getting various governments to make the changes would be even more difficult. Perhaps with the sort of goodwill that led to the establishment of the NDIS it might be possible.

5.6 Data collection, analysis and access

The skills and technology exist to collect, analyse and disseminate helpful data relating to the many interactions between mental health and insurance. Barriers to the process include:

- The cost and effort involved, including the coding process and computer system changes.
- The absence of sufficient commitment across the sector, combined with the inability to compel submission of data.
- The length of time before sufficient data is available.

There are some existing examples of voluntary and compulsory data submission and analysis, though none is particularly helpful with respect to mental health conditions. The outcome would be better if existing data facilities could be expanded and adapted for the purpose rather than starting with new data collections, although standardised definitions and systematic collection protocols will be critical.

We also emphasise that a great deal can be achieved by a focused but limited data collection, whether it be on a sampling basis or with the co-operation of a few insurers. This step can inform the development of a more systematic approach as well as providing useful data within a short period (a few months).

Some people with a mental health condition will make a claim against more than one insurance product, e.g. workers compensation and TPD. Both at an individual claim level and at a data collection level co-operation across insurance industry sectors will produce better results.

The Actuaries Institute has frequently contributed to endeavours of this kind and stands ready to assist and advise on further initiatives.

5.7 Specialist skills and processes in dealing with claims

The skills, capabilities and attitudes of insurer staff dealing with claims are always important. It is arguably more important in dealing with mental health claims because of the potential for further harm.

For insurers, though, achieving consistent quality in this area is always a challenge. Contact is rarely face-to-face, there are no pre-existing relationships and initial trust is low.

This is an area that is seeing significant change and investment. Updated industry codes have included actions to develop staff capability. SuperFriend is one organisation that has developed training for insurance sector staff and PIEF (Personal Injury Education Foundation) is another potential venue in non-life insurance sectors.

The work undertaken by SuperFriend in the life insurance sector provides a comprehensive framework for best practice claims management specifically for claims involving mental health conditions.[33] This evidence-based resource is the first of its kind in insurance in Australia and its relevance to other insurance sectors has already been recognised. The framework is currently in use in retail, direct and group life insurance and some other jurisdictions have made use of relevant sections to inform their practices. The framework is soon to be released for use across all workers compensation insurers and scheme agents nationally.

An understanding of the dimensions of a 'mentally healthy' workplace, and liaison between claims staff and employers to help support of employees with mental health conditions, will be increasingly important and the Guidelines for employers

issued by SuperFriend[34] provides a useful resource for this work.

The recent trend in more sophisticated claims management has been towards a process of triage and directing claims to smaller specialised groups. This approach is likely to be necessary with mental health claims, and may be assisted by automated processes to help ensure that attention and expertise is directed to the claims at most risk of poor outcomes.

5.8 Expert neutral evaluation

We discussed in section 4.7 the likelihood that the claiming process is detrimental to the mental health of some people. One underlying cause is the reliance on dispute processes that are essentially adversarial in nature.

What if there was 'expert neutral evaluation' for mental health conditions right from the beginning? The person making a claim would come to the insurer with information from treating medical practitioners. The insurer would, if it is not satisfied that this information enables it to make a decision, request 'expert neutral evaluation' where one agreed expert (or expert forum) deals with the person in a non-adversarial manner, and reports in accordance with standards relating to impartiality and evidence-based opinions. One could expect that forum to deal empathetically but objectively with the person, be able to explore treatment options with treating practitioners and give a binding decision on medical aspects of the claim.

In many insurance products, a proportion of people making a claim will be represented by a lawyer from an early stage. Many lawyers advertise widely regarding personal injury and superannuation entitlements. Legal representation significantly limits any connection between the person claiming and the insurance company. As well as expert, neutral evaluation there may be other dispute resolution methods that give better outcomes than adversarial legal representation.

5.9 Continued education and collaboration

More collaboration and sharing of information is needed among the insurance industry, employers and the medical and health professions. There is increasing knowledge in this area and it is important that insurance practices stay up to date.

The same is true within the insurance sector – at present there is little cross-learning and a more collaborative approach across the sector would be beneficial.

Active promotion of strategies to:

- create more 'mentally healthy' and supportive workplaces;
- improve training of and liaison with treating practitioners;
- facilitate co-ordinated treatment plans focused on return to productivity,

will help prevent people with mental health conditions from falling out of the workforce.

The Actuaries Institute supports continuing efforts to educate relevant stakeholders and encourages further collaboration in efforts to improve outcomes for consumers and maintain a sustainable insurance sector.

Insurance is part of the infrastructure of our society – you don't really notice until it doesn't work. The Actuaries Institute is committed to working in the public interest to make insurance work effectively for all stakeholders and looks forward to participating in the initiatives to tackle the problems presented by mental health and insurance.

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With increasing knowledge in the relevant issues, more collaboration and sharing of information is needed among the insurance industry, employers and the medical and health professions.

Further Reading

A Regulatory framework – laws, guidelines and codes

B Features of relevant insurance products

This *Further Reading* contains more information on many of the topics covered in the Green Paper. The aim is to provide information of an objective nature (although some information is of an advocacy nature and identified as such), and to identify relevant further sources.

A Regulatory framework – laws, guidelines and codes

A.1 Codes of Conduct

A patchwork of laws, codes, guidelines and standards is relevant to how insurance responds to mental health.

The Life, General and Private Health Insurance industries each have a Code of Conduct. The **General Insurance Code of Practice (2014)**[1] sets out the standards general insurers must meet, such as being fair, open and honest. The **Life Insurance Code of Practice**[2] was issued by the Financial Services Council (FSC) in October 2016.

These Codes of Conduct are generally focused on improving the interactions a customer has with the insurance provider. The objectives include:

- Providing a high standard of service.
- Promoting better and more informed relationships.
- Maintaining and promoting trust and confidence in the industry.
- Providing fair and effective complaints mechanisms.
- Promoting continuous improvement in the industry.

A common feature of all codes is the requirement to provide material in 'plain language' to promote understanding. However, they vary in terms of scope, as shown in the table below, and none include specific requirements for dealing with people with mental health conditions.

Topic Covered in Code	Life	General	Private Health [3]
Product Design	✔	✘	✘
Sales Practices & Advertising	✔	✔	✘
Underwriting	✔	✘	✘
Policy Changes and Cancellation	✔	✔	✔
Requirements for Policy Documentation	✔	✘	✔
Consumers Requiring Additional support, including financial hardship	✔	✔	✘
Process for Claiming	✔	✔	✘
Complaints and Disputes – Internal & External processes	✔	✔	✔
Timelines for Claims and Disputes	✔	✔	✘
Standards for Third Parties	✔	✔	✔
Privacy Act	✔	✔	✔
Training Requirements for Employees	✔	✔	✔
Interacting with individuals with mental health concerns	✘*	✘	✘

* *In 2016 the FSC issued a standard requiring staff awareness training which was a step in this direction*

The Codes of Conduct have been criticised because they are essentially self-regulated, and do not deal with the issues or concern raised by people with mental health conditions. The exception to this is FSC Standard No. 21 which dictates that customer facing staff must receive an appropriate level of education and training in relation to 'mental health awareness', but provides little guidance in relation to the management of such claims.[4]

The Insurance Council of Australia (ICA) is currently reviewing the General Insurance Code, and its Terms of Reference specifically refer to adopting principles for working with people with a mental health condition.[5] The ICA has in the past recognised that that it may be appropriate to include an overarching principle committing participants to working to satisfy the general insurance needs of the whole community, regardless of financial situation, age or disability.

While ASIC approves the Life Insurance and General Insurance Codes, it does not currently have enforcement powers. Compliance is instead overseen by an independent (but industry appointed and funded) body which may impose sanctions on non-compliant signatories, but no further legal right or liability currently arises from non-compliance with these Codes.

The Codes do not cover all products which may be offered by a signatory. For example, the Life Insurance Code does not apply to any cover which is sold through superannuation funds, nor to annuities and investment products,[6] while the General Insurance Code excludes workers compensation, medical indemnity and CTP.

The various codes offer a great opportunity to establish and embed self-regulated improvements if the relevant bodies can agree and bring stakeholders with them.

A.2 Legislation

General and life insurers are bound by the **Insurance Contracts Act 1984** (Cwlth), which is administered by ASIC. This requires each party to act towards the other party with the utmost good faith (s.13), and to outline in writing their reasons for refusing to enter into a contract of insurance, or for offering insurance cover on less advantageous terms, if requested by the policy holder or applicant (s.75). In addition, s.54 prevents an insurer from denying a claim in full where there was an act or omission by the policy holder that constituted a breach of the policy terms, but the insurer did not suffer any prejudice as a result because there was no causal connection between the breach and the claim.

Commentators have noted that the interpretation of s.54 is broadening. In *Maxwell v Highway Hauliers*[7] the insurer was prevented from denying two claims relating to truck accidents because the drivers had not undergone a psychiatric assessment, as was required under the fleet policy. It was found that this failure had no correlation with the incidents leading to the claim. The insurer in this case had clearly assessed the risk of persons with a mental health condition driving trucks as being a greater risk than persons without a mental health condition. The insurer had actuarial and statistical data available to make this connection, so this was lawful, but that did not permit them to deny the claim on a technical breach, because there was no suggestion that mental illness had played any part in the accidents.[8]

The Financial Services Ombudsman (FOS) manages disputes and complaints relating to this Act.

The number of disputes about General Insurance received by FOS increased by 21.5% in the first quarter of 2017, to 3,291 complaints lodged, although the number that related to mental health conditions is not published.[9]

Other relevant legislation governing insurers includes:

- Insurance Act.
- Life Insurance Act.
- Private Health Insurance Act.
- Corporations Law (as it relates to financial products and services).
- Competition and Consumer Law.

A.3 Disability Discrimination Act and Associated Guidelines

Key legislation relating to discrimination is the Disability Discrimination Act of 1992 (DDA), which aims to promote the rights of people with a disability to participate equally in all areas of life, and makes it unlawful to discriminate based on disability, subject to certain exceptions. It starts from the perspective that a person with a disability should be regarded and treated as equal to the rest of the community, and discriminatory treatment should be the exception not the norm. The law provides specific exclusions for insurers that enables lawful discrimination under certain conditions, acknowledging that insurance underwriting may discriminate between customers in terms of the risk they present, to price their products appropriately and competitively. The DDA recognises that discrimination based on disability may involve refusing to offer the product, or varying the terms and conditions (including price) at which it is offered.

The issue is therefore not whether insurers can discriminate, but how they approach this and whether their assessments are fair and evidence based. 'Discrimination' in this context is therefore not a pejorative term.

Also relevant is the Equal Opportunity Act 2010 (EOA), which makes it unlawful to discriminate by refusing to provide goods or services, or in the terms of the goods and

services, but also allows an exception for insurance, allowing discrimination that is permitted under the DDA. Essentially, if the discrimination is permitted by the DDA, it is permitted under the EOA.

Section 46 of the DDA provides that discrimination in relation to provision of insurance or superannuation, by either refusing to offer a product, or in respect of the terms or conditions on which the product is offered or may be obtained, is not unlawful if:

- the discrimination is based upon actuarial or statistical data on which it is reasonable to rely; **and**
- the discrimination is reasonable having regard to the matter of the data and other relevant factors (the 'data limb'); **or**
- 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 (the 'no data limb').

In addition, under s. 29A of the DDA, it is not unlawful for an insurer to discriminate against a person with a disability if it can be shown that providing cover, or otherwise avoiding the discrimination, would cause unjustifiable hardship to the insurer. The burden of proving unjustifiable hardship rests with the insurer. s.11 of the DDA further states that 'all relevant circumstances of a particular case' are to be considered in determining whether a hardship imposed on a person is unjustifiable.

A.3.1 AHRC Guidelines for Providers of Insurance and Superannuation (2016)

The Australian Human Rights Commission investigates complaints of alleged discrimination under the Commonwealth DDA, and has recently updated its Guidelines for insurers.[10]

The number of complaints about discrimination based on disability by superannuation or insurance providers remains low. In 2013-14 the AHRC received 1,039 complaints about disability discrimination of which 13 or 1%, related to insurance and superannuation.[11] This could be interpreted as suggesting that any problems are not widespread, but it could be an indication of the potential for much greater activity in another regulatory forum.

The AHRC Guidelines confirm that insurers are expected to have a relevant evidence basis for their decisions, and that they **must** take any relevant information that is available into account. The Guidelines further note that a decision will not always be accepted as reasonable simply because it is based on actuarial or statistical data. The data must be reasonable to rely on, and the decision itself must be reasonable. It is particularly important that any assumptions which underpin the decision to discriminate are supported by reasonable evidence. This suggests that while there are population studies that provide data on the prevalence and morbidity of specific mental health conditions (such as the 2007 National Survey of Mental Health and Wellbeing), the decision as to whether an insurer has acted lawfully may turn on what assumptions the insurer has made in using that data.

The Guidelines also provide examples of what may be considered 'other relevant factors' when an insurer seeks to rely on the 'no data limb' of the Act, and makes the following observations about these factors.

- **Medical opinion –** it is important to recognise that medical experts and actuaries have different skill sets. There may be limits on the ability of medical experts to quantify risk. The risk of a claim being made against an insurance policy is primarily an actuarial question. Expert opinion regarding risks that pertain to a particular disability might appropriately be sourced from experts such as medical researchers who have statistical experience and academic medical qualifications.
- **Relevant information about the individual seeking insurance –** such as individual medical records and work history; taking account of the type and severity of the condition, its functional impact on the person, and treatment records. The Guidelines further state that 'the circumstances of the individual ought to have particular prominence as a 'relevant factor', and notes that 'decision-making processes which are formulaic or which tend to stereotype individuals by reference to their disability should be avoided'.
- **Opinions from other professional groups –** bearing in mind the need to consider the specific circumstances of the individual concerned, it may also be reasonable to rely on the opinion of other professionals with relevant experience, for example occupational therapists, physiotherapists, clinical psychologists or mobility trainers. Again, it is important to recognise that these professional experts have different skill sets to actuaries and there may be limits on their ability to quantify risk.
- **Actuarial advice or opinion –** it may be reasonable to rely on actuarial advice or opinion to assist in quantifying the risk of insuring someone with a particular disability if there is no other data available and the opinion is from a relevant source. Actuarial opinion may be helpful in interpreting medical studies or making allowances for differences in degree of disability between an individual applying for insurance and the study population.
- **Practice of others in the insurance industry –** it is permissible when determining whether the discrimination is reasonable to have regard to the

fact that another insurer with the same or similar knowledge was prepared to issue a policy to the person (including the terms on which they were prepared to do so).

- **Commercial judgement –** assessing the likelihood of an insurance claim can sometimes go beyond medical and statistical probability. Other relevant commercial factors may be considered so long as it is reasonable to do so. For example, there may be circumstances, such as when there is evidence that a person has made fraudulent claims in the past or where there is clear evidence that a particular mental illness creates a higher propensity for fraud, in which it is reasonable for an insurer to consider an individual's claims history or propensity or incentive to make a fraudulent claim when assessing the overall risk of insuring someone with a particular disability. This does not, however, entitle insurers to rely on untested discriminatory assumptions.

The Guidelines emphasise that insurers should consider relevant factors that increase **or reduce the risk** associated with mental illness (for example, whether the applicant is receiving support and effective treatment for their illness so as to reduce risks associated with the condition), and further state that:

- Insurers should be careful to avoid assumptions that people with disabilities, or people with the same general type of disability, will always present the same risks.
- Insurers should seek to ensure good communication with people who are insured or are seeking insurance, so that information is brought out which might reduce or eliminate the need for a negative decision.
- Manuals should be based on relevant actuarial or statistical data or medical opinion, and updated as necessary to consider advances in medical knowledge, rehabilitation and treatment, technology or other areas that affect the level of risk or loss associated with a particular disability.
- The practice of other insurers in the industry, and other relevant commercial practice including by reinsurers, may be considered in deciding what is reasonable. However, it is not reasonable to refuse to insure a person with a disability simply because of historical practice, however widespread, or to rely on inaccurate assumptions about people with a disability.
- It would be prudent, before declining to offer insurance to a person with a disability, to consider whether risks can be managed by restricting the cover, using an exclusions clause, applying a premium loading, or some other means.

The standards expected of insurers are therefore quite onerous – to justify a discriminatory decision they are expected to understand the circumstances of the individual and refer to specific actuarial and statistical evidence directly relevant to those circumstances, or if they seek to argue that such data is not readily available, cite "other relevant factors". However here they also enter a legal minefield. The relevance of the factors considered and the weight given to each can be, and often is, challenged.

With reference to s.29A of the DDA, allowing for discrimination if it can be shown that providing cover, or otherwise avoiding the discrimination, would cause unjustifiable hardship to the insurer, the Guidelines note that 'Even if providing insurance or superannuation to a person with a disability might involve some costs and effort, it will not necessarily amount to unjustifiable hardship'.

The 'relevant circumstances' that need to be considered in determining whether a hardship imposed on a person with a disability is justifiable include:

- Any benefits that might accrue to the customer with a disability or any other person (including other people with the same disability, the community generally, or even the insurer) if cover was provided.
- The effect of the disability of the person concerned (the steps required to be taken to avoid discrimination against a person will depend on the nature of the person's disability).
- Any costs or other disadvantages of providing cover, bearing in mind the financial circumstances of the insurance or superannuation provider (noting that a level of hardship that may be unjustifiable for one insurer may not be for another: 'Clearly the larger the company the more it can usually afford').
- The availability of financial and other assistance to the insurance or superannuation provider.
- The terms of any action plan developed by the insurer or superannuation provider under s.64 of the DDA that are relevant.

B Features of relevant insurance products

B.1 TPD Insurance policies (Group and Individual)

Benefit Structure	TPD insurance provides a lump sum payment if the insured person becomes totally and permanently disabled and cannot work. There is evidence that the lump sum benefit structure does not meet the needs of the person on claim. Outcomes for both the person on claim and insurers could be improved by providing greater vocational support.
Definition of a claim	Policy definitions can be very broad and are difficult to change after a policy is issued. Insurers are reliant on the diagnosis and prognosis of medical professionals, including their assessment of the individual's future work capacity. There is evidence that the TPD definitions for mental health poorly distinguish those that are truly disabled.
Underwriting process and outcomes	Rejections and premium loadings for a history of mental health have been reported for individual (retail) products. In group, given the majority is not underwritten, mental health is automatically covered. Steps are being taken to improve data collection. This is expected to enable better and more accurate underwriting practices for individual policies.
Claim Management	As TPD provides a lump sum, the claim determination is critical but otherwise there is limited claims management required. Resources may be used to validate a claim, including medical assessments, surveillance and activity diaries. There can be long delays (up to 15 months or more) between ceasing work and notification to the insurer.
Unique Experience	Australian Super, the largest industry super fund, increased premiums by 38% in 2013 and a further 35% in 2014. A recent report by Rice Warner found an average premium rise of 215% for death and TPD cover over the past 4 years, while income protection rates went up 82%.[12] These premium increases are not directly attributable to mental health, although the increase in mental health claims was a contributing factor. An analysis of pooled data from 13 super funds and 6 insurers for 2007-2011, representing close to 40% of the Australian labour force, found that approximately 15% of all claims related to mental health conditions, with considerable variation across different industries and locations. TPD claims for mental health conditions were over 25% of all TPD claims for some funds, and for income protection mental health claims were as much as 28% of all IP claims.[13]

B.2 Income protection (Group and Individual)

Benefit Structure	Income protection provides an income stream if an individual is unable to work for a period of time. The purpose of income protection insurance is to ensure people can continue paying essential expenses and maintain an existing lifestyle. Policies usually cover up to 75% of gross salary at the time of claim. Cover may be time-limited e.g. up to two years or to a certain age. Individuals can select a waiting period between 30 days and two years before a claim is paid.[14]
Definition of a claim	Policy definitions can be very broad and are difficult to change after a policy is issued. Insurers are reliant on the diagnosis and prognosis of medical professionals, including their assessment of the individual's work capacity.
Underwriting process and outcomes	There is a greater reliance on underwriting for income protection policies compared to TPD. ▶ It is less common for group insurers to provide income protection policies to their members. ▶ Compared to Death and TPD, fewer superannuation funds allow their members to obtain a higher level of income protection without underwriting.[15] Income protection presents a greater underwriting challenge for individual insurers, since it requires them to estimate the risk of a person not only becoming unwell but also having a period off work in excess of the waiting period. Rejections and premium loadings for a history of mental health have been reported in individual products.[16] Steps are being taken to improve data collection. This is expected to enable better and more accurate underwriting practices for individual policies. The 2003 FSC Underwriting Guidelines for Mental Health Conditions are applicable to FSC member policies issued outside of superannuation funds.[17]
Claim Management	Income protection requires ongoing claims management. Similar to workers compensation, the intention is to return the individual to work as soon as possible. The delay between leaving work and notification is longer than for workers compensation (on average 48 days compared to 4 days).[18] This greatly affects the return to work outcome for the individual. Resources may be used to validate a claim, including medical assessments, surveillance and activity diaries.

B.3 Death Insurance (Group and Individual)

Benefit Structure	Death Insurance provides a lump sum benefit on the death (or in some cases diagnosis of a critical illness) of the insured.
Underwriting process and outcomes	Many insurers and superfunds require an exclusion on claims arising from suicide and self-harm which occur in the first 13 months of the policy.[19] The aim of this exclusion is to protect the insurer from being selected against. After this initial waiting period, there are generally no exclusions on mental health claims
Claim Management	As death payments are a once-off lump sum, there is limited claims management required other than verification.

B.4 Travel Insurance

Benefit Structure	Travel insurance provides cover for unexpected costs of travel. In particular it provides coverage if a trip is delayed or cancelled due to illness and overseas medical costs. Travel insurance generally applies for only a short period of time and has small premiums. 'Opt-in'-product features means that individuals may not be covered if they experience an episode for the first time while traveling.
Underwriting process and outcomes	Mental illness is excluded from the majority of travel policies Where mental illness is covered there are often exclusions for a disinclination to travel, suicide and for the effects of alcohol and drugs. Due to the small premiums, it is not feasible for travel insurers to apply the same level of sophistication as life insurers when underwriting.
Claim Management	As travel payments are a once-off lump sum there is limited claims management required, except for emergency assistance which is usually part of the product offering.
Unique Experience	In the case of *Ingram v QBE* in the Victorian AAT, it was found that QBE had breached anti-discrimination legislation in how it applied a mental health exclusion in its product.[20] Following the case the Victorian Legal Aid Commission has called for insurers to disclose and explain the basis of mental illness claim denials (which they do not currently do), and consider the individual policy-holder's mental health circumstances, rather than imposing a general exclusion of all mental health related claims.[21] The ICA is currently 'discussing with members the possibility of adopting broad principles on dealing with mental health issues, and the potential for data collaboration to improve access to travel insurance for people with a mental health condition'.[22] Cover-More and QBE recently announced that they have changed products to remove the blanket exclusion.[23]

B.5 Workers Compensation & Motor Accident Compensation

Benefit Structure	Workers Compensation provides a range of benefits where an injury arises out of, or in the course of, employment Motor accident compensation provides cover where an injury arises either directly from an accident (such as Post Traumatic Stress Disorder) or indirectly due to the consequences of other injuries suffered. Benefits range from lump sum and ongoing payments (similar to TPD and income protection) to rehabilitation and medical costs. Common law claims are an important feature in many schemes.
Underwriting process and outcomes	As cover is compulsory all individuals must be provided with cover. Workers Compensation – underwriting occurs at an employer level. A higher premium may be charged to an employer which has a history of mental health claims, due to the higher costs associated with these claims. Motor Accident Compensation - there is no underwriting on the basis of the past or present health of a vehicle owner or driver.
Claim Management	Claims management is ongoing with a focus on rehabilitation. There are short delays between injury and notification, providing the scheme with the best opportunity to help achieve a successful RTW outcome. Resources may be used to validate a claim, including medical assessments and surveillance. Many claimants report high levels of stress from engaging with injury compensation schemes. Management of secondary injuries creates further difficulties for insurers. The severity of a mental injury is usually assessed using impairment guides such as PIRS and GEPIC. The eligibility of an individual to access different benefit types are dependent on the scores arising from this assessment. Schemes are reliant on the diagnosis and prognosis of medical professionals, including their assessment of the individuals work capacity.
Unique Experience	Workers Compensation – each year around 10,000 people in Australia will make a workers' compensation claim for mental stress, with more than five days lost from work.[24] In the NSW public sector, mental stress claims account for 11% of all workers compensation claims and 36% of total claims costs.[25] On average, the hours lost from work are 5.3 times higher than for physical injuries, and the average amount paid per claim for medical and rehabilitation costs is 81% higher for mental health conditions than for physical conditions.[26]

B.6 Private Health Insurance

Benefit Structure	Hospital policies cover the cost of private hospital accommodation (overnight or day only) and a proportion of the medical fees while admitted to hospital. Extras policies may cover part of the cost of psychology services or counselling outside of hospital. By regulation, all hospital policies must provide cover for psychiatric treatment. However, insurers can offer only partial or restricted cover, where the benefit is only sufficient to cover treatment as a private patient in a public hospital. The maximum waiting period for new policyholders can be no longer than two months. However, insurers can apply benefit limitation periods of up to 24 months, when only partial benefits are paid.
Underwriting process and outcomes	Health insurance is community rated. Insurers cannot decline an application for cover, and policyholders can change insurers without having to re-serve waiting periods. The current risk equalisation arrangements have limited ability to spread the costs arising from mental health-related claims. This has resulted in: ▶ Insurers avoid offering mental health-related benefits which are more generous than those offered by their competitors. ▶ Comprehensive mental health benefits are often only available on the most expensive PHI policies.
Claim Management	▶ There is limited claims management possible.
Unique Experience	▶ Private health insurance funds approximately 6% ($540 million)* of national expenditure on mental health-related services.[27] ▶ Health insurers estimate they cover 90% of day admissions for mental health care, and 50% of all mental health hospital admissions.[28]

* *Includes $408 million of PHI funding, and a further $131 million paid by health insurers but classified as Australian government funding, which represents the private health insurance premium rebate.*

B.7 Coverage of Insurance Products

The following table outlines our indicative proportion of adult population covered by each insurance product.

Benefit Structure	Indicative Proportion of Adults Covered	Explanation
Group Insurance		Approximated from a survey of 814 Australians undertaken in 2014 by CoreData Consulting.[29] The proportions have not been adjusted for any bias which may have existed from the sample.
TPD	**40%**	
IP	**20%**	
Individual Insurance		
TPD	**10%**	
IP	**15%**	
Workers Compensation	**60%**	November 2016 Australian employment to adult population ratio as estimated by the International Labour Organization.[30] This includes a proportion of Australians that are self-employed (approximately 10% of employed persons).
Motor Accident Compensation	**100%**	All Australians are covered by motor accident compensation in some form.
Travel Insurance	**40%**	Assumes that over 40% of Australians travel overseas each year and at least 90% of them take out travel insurance.[31]
Travel Insurance	**50%**	Derived from the Jun. 2016 estimate of persons insured[32] and Australian population.[33]

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The Actuaries Institute supports continuing efforts to educate relevant stakeholders and encourages further collaboration in efforts to improve outcomes for consumers and maintain a sustainable insurance sector.

Institute of Actuaries of Australia
ABN 69 000 423 6546

Level 2, 50 Carrington Street
Sydney NSW Australia 2000
t +61 (0) 2 9239 6100
f +61 (0) 2 9239 6170
e actuaries@actuaries.asn.au
w www.actuaries.asn.au