



**Actuaries
Institute.**

12 May 2026

Mr Peter Kell
Independent Reviewer
Life Insurance Code of Practice Review
c/- Council of Australian Life Insurers

Via website: <https://lifecodereview.org.au/make-a-submission/>

Dear Mr Kell

Life Insurance Code of Practice Review – Interim Report Response

The Actuaries Institute ('the Institute') welcomes the opportunity to respond to the Life Insurance Code of Practice Review Interim Report ('Interim Report').

The Institute is the peak professional body for actuaries in Australia. Our members work in a wide range of fields including insurance, superannuation and retirement incomes, banking, enterprise risk management, data analytics and AI, climate change and sustainability, and government services.

The Institute has a longstanding commitment to contribute to public policy discussions where our members have relevant expertise. The comments made in this submission are guided by the Institute's Public Policy Principles that any policy measures or changes should promote public wellbeing, consider potential impacts on equity, be evidence-based and support effectively regulated systems.

Our submission focuses on the questions raised in the Interim Report relating to mental health, where specific feedback has been sought and where actuarial considerations are most directly engaged. We have not commented in detail on other areas covered in the Review, but recognise the importance of the Review's work including in the other key areas such as to support customers experiencing vulnerability or financial hardship, First Nations customers, claims handling and medical definitions.

More broadly, mental health and the funding of mental health care, including from insurance safety nets, remain a pressing issue for Australian society, including for the life insurance industry and its consumers. As explored in the Institute's [Mental Health and the Financial Safety Net report](#), taking a wider lens beyond life insurance reveals patterns of cost-shifting between elements of the safety net in response to financial sustainability challenges. Recent changes to some workers' compensation schemes, including increases to whole-person impairment thresholds for psychological claims, are a current example: such changes may help restore sustainability to one part of the safety net but shift reliance to others, because the underlying community need for mental health funding remains.

Mental health within life insurance is also an area where community expectations have evolved significantly and the sector has been challenged to keep pace. The Code should support the industry to respond and adapt to evolving expectations in a way that balances accessibility of insurance with equity for the insured population as a whole – considering fairness at both a macro and individual level, as set out in the Institute's [Fairness in the Life Insurance System Concept Note](#). It is crucial for the continued availability of life insurance that insurers have the ability to set this balance responsibly.

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Fairness over time in life insurance must also be considered from a sustainability perspective¹, encompassing:

- products that perform as expected by customers, with features that meet their needs without frills, reflect their insurable interests both on policy inception and subsequently, and provide more certain and readily understood outcomes;
- products that allow a pooling of similar risks which follow the principles of insurance, specifically the principles of indemnity and loss minimisation.
- prices that are stable and predictable over time, understood and consistent with underlying risk;
- product features and underwriting that promote alignment between customer and insurer through appropriate consideration of insurable interests and that incentivise customers to manage their risk profile;
- financial outcomes for insurers that ensure a sustained ability to pay claims and to continue offering valuable and affordable life insurance products to the market; and
- community confidence in the enduring value and fairness of life insurance.

Our key observations on the Reviewer's questions are as follows:

- **Question 1 (changing clause 2.1(b)):** The Institute supports, in principle, changing the current position in clause 2.1(b) to allow design features that limit mental health cover in standard form policies, subject to appropriate guardrails in the Code that build upon the law. Greater product design flexibility, alongside other levers to manage sustainability, would help insurers respond to recent mental health claim trends through means other than price alone, supporting more sustainable risk pooling and broader accessibility. Crucially, any changes made by individual life insurers would need to be consistent with anti-discrimination law and the regime prohibiting unfair contract terms in standard form contracts for life insurance consumers.
- **Question 2 (impact on consumers and insurers):** For consumers, design flexibility could moderate upward premium pressure and support affordability, but raises questions of cover adequacy and insurance responsiveness at the point of need – particularly for default-cover members in superannuation where insurance awareness is likely lower. Impacts will vary across consumer cohorts (those who never claim, those who claim due to a physical condition and those that claim due to mental ill-health), distribution channels, and over time. For individual insurers, greater design flexibility provides additional levers to manage aggregate exposure and creates space for product innovation to improve sustainability and ongoing viability.
- **Question 3 (guardrails in the Code):** The Code can play a constructive guardrail role through clarifying expectations on the data and analysis used to support product design decisions consistent with the DDA, articulating principles to ensure design features are targeted, transparent, and aligned with the underlying purpose of cover, and supporting consumer understanding both of the features themselves and of how they apply at the individual level.
- **Further observation (claims philosophy):** The Institute also draws the Reviewer's attention to claims philosophy as a further area where the Code may benefit from clearer expectations. APRA's Prudential Standard SPS 250 addresses claims philosophy for group insurance arrangements, but the Life Code contains no equivalent expectation, despite the underlying considerations being equally relevant to individual insurance.

¹ As adapted from the [Life Insurance Sustainability Guide: A framework for managing life insurance products for the long-term alignment of all system participants](#) (Actuaries Institute, August 2025). The 1st and 3rd bullet points no longer refer to the past. The 2nd bullet point has been added to elevate insurance principles. The 4th bullet point makes clearer that principle of customer and insurer alignment in managing the risk of loss. The 5th bullet point now also includes the objective of offering 'affordable' life insurance products and the references to 'life insurance' in the 5th and 6th bullet points have been amended from 'disability insurance',

To assist the Reviewer's consideration of the issues raised in this submission, we draw attention to a small number of additional Institute publications that may be of value – in particular, the Life Insurance Sustainability Guide (August 2025), referenced in footnote 1 below, and [Disability Insurance in Australia: Findings and Recommended Actions \(September 2024\)](#) prepared by the Actuaries Institute Disability Insurance Taskforce Task Force.

The attachment sets out our specific responses to each of the Interim Report's questions on mental health. If you would like to discuss any aspect of this submission, please contact the Institute via (02) 9239 6100 or public_policy@actuaries.asn.au.

Yours sincerely,

(Signed)

Elayne Grace

CEO

Attachment

Question 1 – Changing Clause 2.1(b)

Would it be appropriate to change the current position set out in clause 2.1(b) to allow limitations on cover for mental health in standard form policies (consistent with the DDA) in light of the trends for mental health claims?

Clause 2.1(b) requires insurers to design new products that do not incorporate a blanket exclusion specific to mental health, consistent with their obligations under the Disability Discrimination Act 1992 (DDA) and equivalent State and Territory laws.

The Institute supports, in principle, changing this position in the Code, subject to appropriate guardrails (discussed in our response to Question 3). Product design, pricing for uncertainty, claims management and underwriting practices are all key drivers of life insurer portfolio sustainability. Greater product design flexibility – alongside other levers identified in the [Institute's Life Insurance Sustainability Guide](#) – would help insurers respond to recent mental health claim trends through means other than price alone, supporting more sustainable risk pooling and broader accessibility.

Our supporting reasoning, in summary:

- **Pooling sustainability and cover accessibility.**
 - Risk pooling is fundamental to all insurance: premiums must reflect the underlying risk profile of the pool to remain sustainable. Mental health claim incidence and duration have risen materially in recent years, and pricing has been the predominant lever used to respond. Used in isolation, premium increases are a blunt instrument – with mental health claim costs spread across the pool, affordability consequences fall on all members, not just those who claim.
 - As with any other condition, some mental health claims under TPD insurance paid as a lump sum may exceed the actual financial loss incurred. Product design flexibility offers a more targeted alternative – one that can better support consumers experiencing mental ill-health while preserving affordable and appropriate cover for the broader pool.
- **A workers' compensation parallel.** Recent workers' compensation reforms in Victoria and New South Wales – including increases to whole-person impairment thresholds for psychological claims – illustrate that, despite being contentious, governments have considered such changes necessary to restore financial sustainability.
- **Adherence to the law.** Any changes made by insurers would still need to be consistent with federal and state discrimination law and with the unfair contract terms regime applying to standard form consumer contracts. Design features developed within those constraints would support better alignment of price and risk while maintaining cover availability.
- **Implementation considerations from prior actuarial work.** The Institute's earlier Disability Insurance Task Force (DITF) work considered, but did not recommend, options including products that excluded mental health cover entirely or that offered mental health cover only on an opt-in basis. Three points from that work warrant ongoing consideration.
 - Products framed as excluding mental health altogether (or as offering mental health cover only as an option) could attract considerable societal criticism, even where legally permissible under the DDA.
 - The idea of offering mental health cover as an option was considered more palatable.
 - Mental health conditions also frequently arise in connection with a physical condition that initially gave rise to a disability income claim, which raises practical questions about how

benefits should be managed where mental health issues subsequently become the dominant cause of incapacity.

These considerations reinforce the case for carefully designed Code guardrails (discussed in Question 3) and for industry guidance on claims management implications as part of any changes from the current position.

Question 2 – Impact on Consumers and Insurers

The impact the industry's proposed approach may have on consumers and insurers.

For people living with mental illness, life insurance can be one of the few financial buffers available during periods when they are least able to work and most vulnerable. Consumer and mental health advocacy groups have rightly raised concerns that any reduction in mental health cover – even where framed as a design choice rather than a blanket exclusion – risks leaving people without meaningful protection at exactly the moment they need it most. The Institute takes these concerns seriously.

Our comments below seek to map the range of consumer impacts, including those that cut against greater design flexibility, so that the Review can weigh them with appropriate weight alongside the financial sustainability considerations. Decisions on particular product designs are a matter for individual insurers, and insurer responses will vary – including some insurers continuing to offer standard form contracts without mental health limitations.

The pace at which impacts emerge will differ by channel: group insurance design changes can apply at the next renewal or tender, whereas retail in-force books retain unrestricted exposure on existing policies.

Impacts on consumers

Impacts can be considered through two cohorts: consumers who never claim for a mental health condition, and those who do.

It may seem counterintuitive, but consumers who never make a mental health claim are also affected by how the system is designed – primarily through what they pay. With mental health claims now accounting for around one in three TPD claims and one in four income protection claims, this cost is currently absorbed across broadly pooled standard form products. Design features that manage aggregate mental health exposure could moderate upward pressure on premiums and improve affordability. Channel dynamics differ:

- For group insurance members in superannuation, sustained premium increases will reduce retirement income for those members who do not claim (approximately 70% of members²) and may prompt trustees to reduce default cover levels, to balance cost and benefit as required under the superannuation law including consideration of members' best financial interests.
- For individual policyholders, premium pressure may lead some consumers to reduce cover or lapse policies. These consumers may not be able to obtain individually underwritten cover again, particularly where their health has deteriorated, or may only be able to do so on less favourable terms.

The stakes are highest for people who develop a mental health condition and need to make a claim. This is often a period of significant personal crisis where financial security matters enormously to recovery. Design features could limit the financial support available to the consumer at the time of need when their capacity to work has been materially affected. Features limiting cover that are too broad risk rendering cover insufficient at the time of need. When policy limitations effectively exclude

² [Group Insurance in Superannuation Public Policy Statement](#) (Actuaries Institute, August 2025).

meaningful cover, some consumers may need to seek support from other parts of the safety net or may find themselves without adequate financial support at all.

Existing individual policyholders retain their current terms under guaranteed renewability, meaning standard form changes apply only to new business, mirroring the experience with agreed-value income protection contracts. While these policyholders would continue to benefit from broader mental health coverage than would be available under new policy terms, they may face higher premiums as mental health claims costs continue to grow on their existing terms.

A change permitting limitations may also lead to greater product diversity, increasing consumer choice but also complexity for consumers and advisers comparing cover.

Impacts on insurers

Permitting design features that limit mental health cover would provide additional levers to manage aggregate exposure (which CALI has reported has grown by \$1.2 billion in mental health claim payments over five years), reduce reliance on individual underwriting and repricing, and create space for innovation in benefit structures suited to mental health and other conditions with variable recovery.

Where some insurers introduce limitations and others do not, mental health exposure may concentrate in insurers maintaining broader cover, which may in turn compel those insurers to reprice or introduce limitations of their own. The extent to which the benefits and risks above are realised will depend on how the design flexibility is exercised, reinforcing the case for the guardrails set out in our response to Question 3.

Question 3 – Guardrails in the Code

If the prohibition on blanket mental health exclusions was removed and design features in insurance policies that limit cover for mental health were permitted – parts (a) to (d) below.

Question 3(a) – DDA Consistency

How could the Code help ensure that such an approach was consistent with the requirements of the DDA?

Differential treatment of mental health may arise either through underwriting (an individual's eligibility, exclusions, or non-standard premium loadings) or through product design (where standard form contracts treat mental health conditions differently to other conditions).

A useful illustration of how the DDA already accommodates product design that treats a mental-health-related risk differently is the 13-month suicide exclusion in retail (and typically in voluntary group superannuation) death cover. The exclusion is not a blanket exclusion of mental health conditions; rather, it is a specific design feature that supports the underlying purpose of insurance – financial protection for unforeseen events – while balancing the risk that the existence of cover could be a factor in impulsive purchase decisions. The justification rests partly on qualitative reasoning about consumer outcomes and the purpose of cover, rather than purely quantitative claims data, demonstrating that 'data' for DDA purposes can take a range of forms.

The Code could assist by providing guardrails (discussed in 3(b) and providing clarity as to the type of data that can be used to support product design limitations of mental health cover more generally (not just blanket exclusions), including:

- Specify what "ideal" data might look like (e.g. data from the last 5 years, based on the Australian life insurance industry).
- Specify caution that should be applied as the available data moves further away from "ideal".
- Provide insight regarding ways in which qualitative information can be considered to be data.

- Provide insight as to whether data demonstrating that certain product designs may work well for physical health conditions but may not work well for mental health conditions from both an ability to reach a conclusion as to whether the claimant meets the claim definitions as well as whether the product design meets the needs of the claimant can be considered to be data.
- Compel the sharing of industry data for all channels in a way that allows stakeholders to understand the positions taken by companies.

Question 3(b) – General Principles and Guardrails

Are there some general principles or ‘guardrails’ that should apply in the Code to ensure fair and transparent treatment of consumers experiencing mental health conditions as these design features are developed and implemented?

Code guardrails should help ensure design features are appropriately targeted, transparent, and aligned with the underlying purpose of cover. Subject to competition law, a range of options could be investigated further:

- requiring targeted rather than generic blanket exclusions (for example, specific conditions rather than the full mental health spectrum), and time-limited rather than permanent restrictions;
- promoting design features that align with the underlying purpose of insurance and avoid perverse incentives; for example, avoiding designs that may discourage return to wellness first, and then continued workforce participation, given evidence that remaining engaged in work can support recovery from mental health conditions; and
- setting tiered product structures with commonly used definitions of severity or scope of cover, supporting consumer comparability, similar in spirit to the gold/silver/bronze tiers used in private health insurance.

Question 3(c) – Consumer Understanding of Why Features Exist

Is there information that could be specified in the Code that would help ensure consumers understand why these policy features have been introduced and how they work?

The purpose of the Life Code (as set out in Section 1) at a high level relates to the insurers’ obligations to consumers when they buy policies, make claims or deal with insurers and ensures that insurers provide high standards of customer service, improve services, communicate in Plain Language and increase consumer trust and confidence in the life insurance industry.

In considering the broader objective of insurers acting to increase consumer trust and confidence in the life insurance industry, the Institute believes it may be beneficial for the Code to ensure that particular focus is given to circumstances where the product features or benefits may differ for mental health conditions relative to other conditions.

The Review may also wish to consider whether the Code, or industry initiatives sitting alongside it, could support periodic publication of aggregate, plain-English information explaining how design features that limit mental health cover operate and why, supported by data such as:

- the level and trend of mental health claims relative to other claims (ideally at an ICD-10 or ICD 11³ sub-chapter level or finer);
- the relationship between premium changes and mental health claims experience; and
- how benefit design and coverage levels (for example, TPD relative to income protection benefits) correlates with mental health claims patterns and financial needs.

³ ICD 10 and ICD 11 represents the International Classification of Diseases. A chapter level under ICD 11 would be Chapter 6: “mental, behavioural or neurodevelopmental disorders”. A sub-chapter level would be “Anxiety or fear-related disorders”.

We offer this as an option for the Reviewer's consideration.

Question 3(d) – Consumer Understanding of How Features Apply

Is there information that could be specified in the Code that would help ensure consumers understand how policy features apply to their situation?...

We agree that consumers should have a reasonable understanding of why cover has been declined, limited, or offered on non-standard terms – a principle reflected in the Code's existing commitments under section 4.25. We understand there are concerns around current practices whereby applicants typically receive a generic, high-level explanation under 4.25(a), and the actuarial, statistical or other data or evidence used to support the decision is not typically provided outside a complaints process. Greater transparency may benefit consumers, while recognising that fully individualised data disclosures carry significant cost and operational implications for the underwriting process that the Review would need to weigh.

A more proportionate path could combine:

- greater clarity in the Code on the level of detail expected under 4.25(a), so that applicants experience more consistent treatment across insurers; and
- supplementary reference to plain-English industry or population statistics that insurers could draw on to illustrate the type of information typically used in underwriting.

A complementary consideration is that consumer understanding can be improved as much by clarity on what is covered as by clarity on what is not. The Code could helpfully expect plain-English explanations of conditions covered, and standard disclosures about how mental health design features operate in practice (including the circumstances or conditions that may trigger a limitation). We note Sections 2.3 and 4.22 already require insurers to explain product features and the reasons for any alternative terms. Clarification of the level of detail expected could deliver a meaningful improvement without requiring more substantial Code change.

Further Observation – Claims Philosophy

We also draw to the Reviewer's attention one further area where the Code may benefit from clearer expectations: claims philosophy. APRA's Prudential Standard SPS 250 (Insurance in Superannuation) requires trustees to assess the claims philosophy of their group insurer when selecting and managing insurance arrangements, but the Life Code contains no equivalent expectation, despite the underlying considerations being equally relevant to individual insurance.

How an insurer interprets and applies policy terms in practice – and the culture, governance and decision-making it brings to claims assessment – is an important determinant of consumer outcomes, and one of the factors that helps explain material differences between insurers in claims admittance rates and in the pricing of group life tenders. The Reviewer may wish to consider whether the Code could helpfully set out expectations around the publication, application and oversight of insurers' claims philosophies, drawing on the principles in SPS 250 with appropriate adaptation for individual insurance.