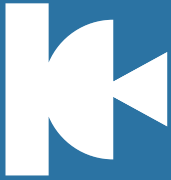

Guide on mental health

To support the Insurance Council of Australia's General Insurance Code of Practice

Insurance Council of Australia

About this guide

1. This guide is for organisations that agree to be bound by the General Insurance Code of Practice (the Code). The Code requires them to have internal processes and training to understand and support customers and others who are experiencing vulnerability — including people with a mental health condition.

2. The Code contains mandatory obligations for insurers in relation to customers with a mental health condition:

   a. at a minimum, insurers will design and sell their products and apply their terms in compliance with the requirements of the *Disability Discrimination Act 1992* (the DDA) and/or any relevant State or Territory anti-discrimination requirements;

   b. insurers will treat people with any past or current mental health condition fairly;

   c. insurers will only ask relevant questions when deciding whether to provide cover for a pre-existing mental health condition; and

   d. if cover for that condition can not be provided, insurers will tell the person about their right to ask for the information relied on when assessing the application. If a person asks for that information then insurers will provide it.

3. This guide has been developed to highlight best practices insurers should consider in meeting these Code requirements.

4. This guide does not bind insurers. Nor does it have legal force. Complying with the guide is voluntary. Even so, the Insurance Council of Australia — having developed the document with input from member companies and other stakeholders — encourages insurers to use the document to help develop internal processes, procedures and policies.

5. At least every three years, or as part of a Code review, the Insurance Council of Australia will review and revise this guideline, incorporating feedback from consumer and industry representatives, relevant regulators and other stakeholders.

Background

6. 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.[1] Australia's *National Mental Health Policy* defines a mental illness as 'a clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities'.[2]

7. Consumers with a past or current mental health condition have at times experienced challenges in accessing some general insurance products. Some products provide limited underwriting for mental health conditions. Some products also include blanket mental health exclusions that exclude claims arising from a mental health condition.

8. While it is unlawful under the DDA to discriminate against a person because of a disability, including a psychiatric or psychological disability, there is a partial exemption for insurance providers. This exemption recognises that some discrimination is necessary in the insurance business. The exemption is contained in section 46 of the DDA, and is excerpted below:

   a. *the discrimination:*

      i. *is based upon actuarial or statistical data on which it is reasonable for the first-mentioned person to rely; and*

      ii. *is reasonable having regard to the matter of the data and other relevant factors; or*

   b. *in a case where no such actuarial or statistical data is available and cannot reasonably be obtained - the discrimination is reasonable having regard to any other relevant factors.*

1 Australian Bureau of Statistics (2008), National Survey of Mental Health and Wellbeing: Summary of Results, 4326.0, Canberra
2 Commonwealth Department of Health and Aged Care (2008), National Mental Health Policy

9. Notwithstanding this exemption, there is a broader objective to promote the rights of people with a disability to participate equally in all areas of life under the DDA, Australia's *National Mental Health Policy* and international conventions of which Australia is a signatory.[3] Insurance products and underwriting practices must evolve to better meet the needs of consumers with past or current mental health conditions.

3 Including the United Nation's Universal Declaration of Human Rights (10 December 1948)

Overview: Principles

10. The following four best practice principles are discussed below:

Principle 1

At a minimum, insurers will design and sell their products and apply their terms in compliance with the requirements of the DDA and/or any relevant State or Territory anti-discrimination requirements.

Principle 2

Insurers will treat people with any past or current mental health condition fairly.

Principle 3

Insurers will only ask relevant questions when deciding whether to provide cover for a pre-existing mental health condition, and provide reasons when cover is not offered.

Principle 4

Insurers will appropriately train their employees, distributors and service suppliers working with consumers with mental health conditions.

Principle 1

At a minimum, insurers will design and sell their products and apply their terms in compliance with the requirements of the DDA and/or any relevant State or Territory anti-discrimination requirements.

11. Where possible, insurers should provide cover to persons with a past or current mental health condition and manage risk through policy pricing, exclusions, limits and caps based on actuarial and statistical data and other relevant factors, rather than not provide cover at all. The availability of insurance for persons with a past or current mental health condition should take account of the affordability of that insurance.

12. As with all health conditions, when setting premiums for products that cover mental health conditions or for individual cover for a person with a past or current mental health condition, the pricing of the offered products or cover should reflect the risk. Where exclusions and limits are applied, the pricing of the offered products should reflect the value of the cover provided.

13. Exclusions for pre-existing mental health conditions should only apply where there is evidence that an applicant has an existing mental health condition, or is at risk of a recurrence of a past mental health condition, and the covered event relates to the pre-existing mental illness.

14. Where a consumer makes a claim against an existing policy, the claim should not be denied on the basis of a pre-existing mental health condition where the covered event does not relate to the pre-existing mental health condition.

15. Where insurers rely on the exemption contained in section 46 of the DDA or a similar exemption in any relevant State or Territory legislation, they must keep accurate records of the actuarial or statistical data and/or other relevant factors they have relied upon to do so.

16. Insurers should continually seek to obtain better data to enable any exclusions to be narrowly designed. Any application of blanket exclusions of mental health conditions or broad categories of mental

health conditions must be based on statistical or actuarial data or other relevant factors.

17. When designing products, insurers should seek to co-design with consumers.

18. The insurance industry should work collaboratively with stakeholders such as consumers, mental health professionals and consumer advocates to improve the provision of products and services to consumers with a past or current mental health condition.

19. Insurers should cooperate with the Insurance Council of Australia in ongoing statistical research endeavours to get a better understanding of mental health conditions and proactively improve the availability of clinical data and claims experience data.

Principle 2
Insurers will treat people with any past or current mental health condition fairly.

20. Insurers and their distributors and service suppliers should adopt a respectful and positive approach towards consumers with a past or current mental health condition in their sales and claims processes. Insurers should develop and implement policies and procedures that support this approach.

21. Where an insurer is aware that a customer has a past or current mental health condition, it should determine whether they are a consumer experiencing vulnerability under the Code and treat them accordingly.

22. Through each stage of the life cycle for relevant insurance products, mental health conditions should be treated in the same way as any other medical condition and have regard to available prognostic data and documented rates of prevalence, morbidity and mortality.

23. Mental health conditions should be categorised according to current commonly accepted professional standards.[4]

24. Claims involving mental health conditions should be processed sensitively having regard to the consumer's ongoing medical treatment needs using the least intrusive methods of investigation in accordance with the Claims Investigation Standards in the Code.

Principle 3
Insurers will only ask relevant questions when deciding whether to provide cover for a pre-existing mental health condition. If cover for that condition can not be provided, insurers will tell the person of their right to ask for the information relied on when assessing the application. If a person asks for that information then insurers will provide it.

25. At the point of sale, insurers should act in a transparent manner in determining the risk of applicants with a past or current mental health condition.

26. Insurers should ensure that questions asked at application for insurance:

a. are simple, clear and specific;

b. only ask questions that are relevant to the insurer's underwriting guidelines or its risk assessment of the applicant;

c. do not ask questions requiring knowledge which the applicant could not reasonably be expected to possess;

d. are accompanied by examples of the type of information that is sought where appropriate; and

e. provide sufficient opportunity for an applicant to provide more detailed answers.

27. When determining an individual's risk profile based on their past or current mental health condition, insurers should, where possible, take into account factors which may reduce a person's risk such as treatment plans and prescribed medication to give a holistic view.

4 As at May 2017, commonly accepted professional standards include International Classification of Disease (ICD) or Diagnostic and Statistics Manual (DSM) systems.

28. If an application for insurance includes underwriting questions about medical history, insurers should not automatically decline an application where an applicant discloses a past or current mental health condition but rather should obtain further information from the applicant to assist in the assessment of their application.

29. Where cover is not offered or is provided on terms deviating from the standard policy, insurers should provide the applicant with a statement of written reasons in plain language, explaining why they cannot offer insurance or why they have offered cover on non-standard terms. Insurers should provide applicants with the opportunity to discuss this with them further to get an understanding of the underwriting criteria, and reapply if their circumstances change.

Principle 4
Insurers will appropriately train employees, distributors and service suppliers working with consumers with mental health conditions

30. Training should increase awareness and understanding of common causes, signs and symptoms of mental health conditions in the community.

31. Training should develop communication skills for interacting with consumers who have, or show signs of having, a mental health condition.

32. Training should cover the requirements of section 46 of the DDA and any relevant State or Territory anti-discrimination legislation.

33. Training programs should be reviewed regularly and — at a minimum every three years — by insurers to ensure the programs are effective in achieving the objectives listed above. Insurers should include information on the outcome of any review as part of their annual reporting to the Code Governance Committee.

Insurance Council of Australia

The Insurance Council of Australia is the representative body of the general insurance industry in Australia. Its members represent about 95 per cent of total premium income written by private sector general insurers.

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Published 1 July, 2021

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