Mental health and Life Insurance

Insights, research and perspectives from industry experience.

Prepared by TAL Health Services, July 2020

TAL / Insuring This Australian Life

Message from our CEO

For over 150 years, TAL has been helping Australians protect what matters most in their lives and this is reflected in our Purpose to help Australians live a life filled with choices, options and freedoms, no matter what happens. The life insurance industry's first purpose is to help and support Australians when they need us most; providing valuable financial assistance in times of illness or injury, and providing the necessary support to empower customers to get back to their best possible state of health and wellbeing.

Together with our partners, TAL has an important role to provide support to our customers in their most difficult times, however our opportunity lies beyond the premiums we collect and the claims we pay, to make a greater contribution to the health, wellbeing and livelihoods of our customers and their families.

Our way of life offers greater choices, opportunity and flexibility than ever before enabled by work, technology, our global marketplace and more. However, this modern life for all of its complexities and joy, also brings with it challenges for our community and it's clear among those complexities there is now a pressing issue, the mental health of Australians. This is especially true given the current COVID-19 pandemic.

Our holistic approach to health

TAL takes a holistic view of health which brings together physical, financial and mental wellbeing of our customers. And while physical health and financial wellbeing remain important objectives for individuals, the importance of maintaining mental health has become a priority for us all. This is evidenced by the Australian Government's response to the current pandemic of additional investment and support for the mental health of Australians. (54)

For our customers, supporting them through mental health challenges is one of the most important things we can do and is also one of the most significant causes for a life insurance claim. TAL is focused on leading the industry for our customers in identifying, preventing and supporting Australians with mental health conditions as well as ensuring that we can continue to provide sustainable life insurance products into the future. We believe it's essential to have the right skills and expertise to inform our product development and practices, to reflect evolving clinical best-practice, and to offer our customers the very best support we can.

Leading the industry on mental health

TAL was the first insurer to introduce a dedicated Head of Mental Health to deliver and embed our mental health strategy across our people, our partners and customers, and for the benefit of the wider Australian community. To help TAL drive positive change across our product, underwriting and claims processes, we established a Mental Health Action Group that brings together leading external mental health experts, including those with lived mental health conditions.

We recognise mental illness is a complex area, and we don't have all the answers. We have partnered with trusted voices like the University of Sydney Brain and Mind Centre to stimulate and challenge our thinking, and to allow us to explore alternative risk predictors of mental health conditions. In addition, our work with SuperFriend ensures that we're using evidence-informed solutions in managing the wellbeing of our customers and our people.

Building a sustainable future

In recent years, the life insurance industry has been challenged to ensure the products we provide remain sustainable, accessible and affordable for our customers. This is an important objective for the communities of the future that we serve. TAL is committed to playing our part, and stepping up to the challenge of helping Australians lead their healthiest lives, physically and mentally.

In this paper we discuss the impact of mental health conditions on the life insurance industry, within Australia and also look globally for insight. Our paper aims to stimulate discussion about a pressing issue: the mental health of our community and the implications for the life insurance industry.

To truly examine this issue, we take a whole of environment approach and outline multiple factors that need to be taken into consideration. From terminology, diagnosis and treatment, to the way we are designing products, addressing support or delivering prevention initiatives.

Most importantly, our aim is to be a valuable contributor to the community and wider stakeholder discussions on better mental health, mental health policy, support and reform.

In this spirit, I am delighted to share with you the insights and research we have gathered to further the conversation. By working together, and taking a holistic approach to mental health, I am confident we will be well placed to support our customers in living the life they love, now and well into future.

Brett Clark
TAL Group CEO and Managing Director

Contents

Insights

The life insurance industry in Australia and internationally, has experienced a significant increase in the volume of mental health related claims. This experience, has required life insurers to listen and learn more about the complex area of mental health. Importantly, the actual experience of life insurers in receiving and managing these claims has shone a light on a number of systemic issues including classification of conditions, health system structures, support networks available and the ongoing stigma related to mental health condition disclosure.

As a result, for both the broader community and the life insurance industry, it is clear that a number of changes are required in relation to the capability, culture and processes of organisations in serving, supporting and engaging with individuals who are experiencing mental health conditions. Our insights in relation to these matters are summarised here and addressed in more detail throughout the paper.

Some of the work has already begun, but an enterprise approach will need to be considered to ensure insurers are both aware and prepared for changes in regulation, ongoing reduction in stigma regarding metal health conditions and changes to mental health funding models. Engagement with the community and customers regarding their expectations is key in supporting sustainable change.

Insights summary

Consistency of mental health terminology would assist with improved data analytics, reporting and customer communications.

Mental health conditions have as much of an evidenced based approach to diagnosis, treatment and coding as do physical conditions. Limited objective investigations remain a problem in reducing self-reported symptoms and functionality.

Detailed Australian data for mental health conditions, generally more than 10 years' old, is not available or difficult to access.

Discussions regarding a perceived rise in mental health conditions have been ongoing for the past two decades.

Available data indicates that the prevalence of mental health conditions is stable in Australia, but the use of mental health services, including disability support pensions is significantly increasing.

Funding for mental health conditions is limited in an outpatient setting for both government and private health care funding, resulting in an increased requirement to self-report a greater severity of any mental health condition to access inpatient funding, which is mostly fully covered by public and private healthcare funding.

Availability of specialised mental health services in Australia is stretched, particularly in non-metro areas.

There are no known global life insurance responses to increases in mental health condition claims that have had any significant effect, other than significant product restructure, notable severity-based products with objective criteria, including for mental health conditions.

Predictive factors for mental health conditions are well described.

Mental health conditions are associated with an increased morbidity of other conditions, especially cardiovascular risk.

Greater oversight of regulators and mental health advocacy groups will have impact on available options for any changes to insurers' approach to customers with mental health conditions.

Insurers need a seat at the table when it comes to engaging with industry and government bodies regarding mental health policy and reform.

Mental health conditions

Mental health conditions have a high profile both in the community as well as in the life insurance industry.

Community concerns about mental health include ongoing stigma around disclosure of mental health problems and associated conditions. There is also a perceived lack of access to life insurance cover and distrust when attempting to claim.

The Life insurance industry has been challenged by the growth in mental health conditions and claims, and there is a greater need than ever before to ensure that the products we provide remain sustainable, accessible and affordable for customers.

This whitepaper has been written to examine the scope of mental health conditions, and cover diagnosis, treatment, and predictive factors. It also explores current data relating to mental health incidence at a national level, detailing current industry disability claims experience across retail and group channels. For the purposes of this whitepaper, direct insurance business has been excluded.

For this whitepaper, the term mental health condition will be used to encompass both a mental health illness and a mental health problem. This term is most appropriate because most customers and insurers currently do not distinguish between these two definitions in social forums, product definitions, underwriting assessment or claims management. The term disorder will be used where referencing DSM-V or ICD-10 diagnosed conditions.

> For this whitepaper, the term mental health condition will be used to encompass both a mental health illness and a mental health problem.

Terminology

The World Health Organisation mental health definition

"A state of wellbeing in which every individual can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."

All the aspects of this definition are essential when evaluating whether any illness or problem is affecting mental health.

The Australian Government Department of Health mental illness definition

"A mental illness is a health problem that significantly affects how a person feels, thinks, behaves, and interacts with other people. It is diagnosed according to standardised criteria. The term mental disorder is also used to refer to these health problems."

Importantly with this definition, there is a requirement for a formal diagnosis.

The Australian Government Department of Health continues the definition for a mental health problem

"A mental health problem also interferes with how a person thinks, feels, and behaves, but to a lesser extent than a mental illness."

For a mental health problem, a formal diagnosis is not required, but it's recognised that there can be an impact on daily functioning.

Getting the terminology right around mental health is important to ensure collective understanding and accurate data collection.

Diagnosis

People might often perceive mental health conditions as not having quality clinical research or evidence based medicine to support diagnosis and treatment. This is mostly due to the symptoms being self-reported by the individual based on their emotions, thoughts and behaviours. However, this area of medicine is supported by evidenced based diagnosis and treatment, just like physical conditions are.

There are two main clinical methodologies used for the classification of mental health illnesses (not problems):

DSM-V (Diagnostic and Statistical Manual of Mental Disorders – the 5th version updated in 2013)

DSM-V is both a classification and diagnostic tool developed and maintained by the American Psychiatric Association. It is utilised globally by psychiatrists to determine, not only the diagnosis of a mental health illness (referred to as disorders in DSM-V) but also the severity. DSM-V utilises both biological and psychosocial factors in diagnosing and determining severity. Both elements are important for determining treatment regimes, which are governed by strict protocols and methodologies, depending on the multi-factorial features that the patient may have. DSM-V has groupings of various disorders detailed in chapters including schizophrenia and other psychotic, bipolar, depressive, anxiety and many other disorders.

ICD-10 (International Statistical Classification of Diseases and Related Health Problems)

ICD-10 is a list of medical classifications endorsed by the World Health Organisation (WHO). It is a globally recognised standard classification tool for epidemiology, health management, and clinical use. The WHO endorsed the 10th edition in 1990 with the updated ICD-11 being presented to the World Health Assembly in May 2019.

ICD-10 codes do not indicate severity or consider psychosocial factors as does DSM-V and are therefore not routinely used as a diagnostic tool.

ICD-10 is structured in coding blocks with sub codes for each condition group.

The block covering mental and behavioural disorders is F00-F99. Some sub code examples are:

- F20-F29 – schizophrenia and delusional disorders
- F30-F39 – mood affective disorders, e.g. bipolar, depression
- F40-F48 – neurotic, stress related and somatoform disorders e.g. anxiety, OCD
- F50-F59 – physiological disturbances and physical factors, e.g. eating disorders
- F60-F69 – adult personality and behavioural disorders

There isn't always consistency between ICD-10 classification and DSM-V diagnostic groups, e.g. bipolar disorder has its own grouping in DSM-V however, it falls under mood affective disorders in ICD-10. This can lead to confusion if both classification systems are used together. Generally, though, ICD-10 codes will be used for condition epidemiology, classification and health payments and DSM-V for diagnosis.

Investigations

Important in the overall diagnosis of any mental health condition is the evaluation of the impact and severity of the condition. Objective measurements are limited for mental health conditions.

A neuropsychometric assessment is the main investigative technique when evaluating cognitive impairment due to a mental health condition. Although **neuropsychometric testing** does involve some self-reporting, this is limited in testing. Furthermore, the testing structure includes inbuilt tests that evaluate malingering and testing bias.

Most of the various battery of tests used in neuropsychometric testing are evidence based (1, 2). In general practice, outside of formalised neuropsychometric testing, there are multiple **scoring systems** used to evaluate the severity of symptoms; most of these are self-reported, e.g. PHQ9, K10, DAS, GAF, etc. Self-reporting means there is a reduced ability of objective measures to confirm the validity of the results, which can be a cause for concern for both customers and insurers.

These scoring systems do however prove to be useful in determining the need for and the type of treatment. They also assist with the monitoring response to any deployed treatment regime.

Despite self-reported symptoms, mental health conditions have as much of an evidence based approach to diagnosis and coding as physical conditions.

Treatment

Evidence-based and consistent diagnostic criteria are important for mental health practitioners, especially psychiatrists, in order to determine the appropriate treatment regime.

Global best practice treatment protocols are available for most of the diagnostic groups in DSM-V, which can include medication, electroconvulsive therapy, transcranial magnetic stimulation, natural therapies, and counselling. Counselling or psychotherapy has many different variations depending on the type of disorder. With application of each therapy type being guided by best practice protocols.

Examples of counselling therapies:

Cognitive behavioural therapy (CBT) - attempts to alter the thoughts and behavioural patterns in an individual through awareness. Mostly used for symptoms of depression and anxiety. It can also be used for certain personality disorders.

Dialectic behavioural therapy (DBT) – a type of CBT focussed on reducing suicidal thoughts and actions. Mostly used for borderline personality disorder, bipolar disorder and certain types of post-traumatic stress disorder.

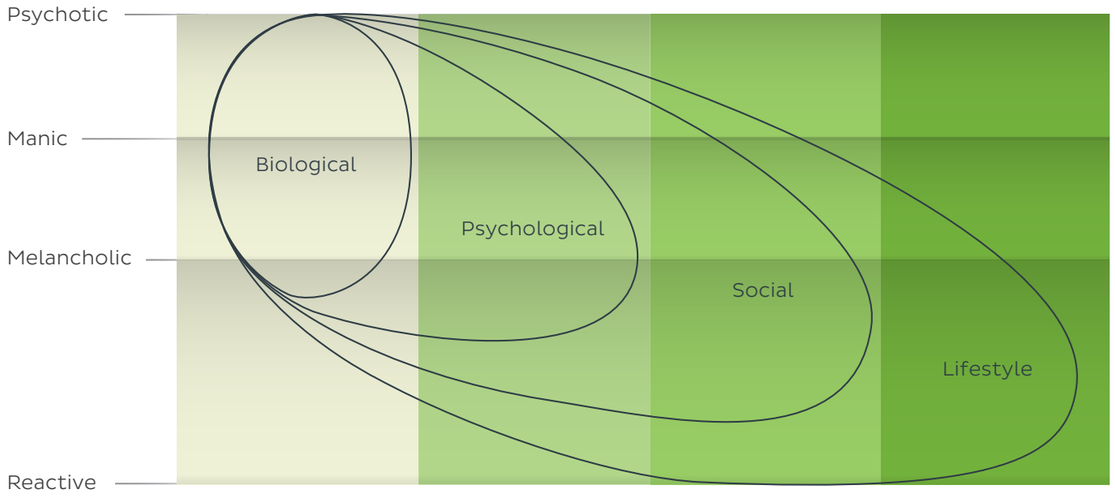
Interpersonal therapy (IPT) - focuses on interpersonal relationships and improvement of communication patterns. Mostly used for depression.

There are multiple other types of therapy that are deployed based on a specific diagnosis or cluster of symptoms in the case of a mental health problem, not yet formally diagnosed.

> There are specific treatment pathways for various mental health conditions.

Therapy for mental health conditions is holistic.

The graphic below is an excerpt from the Royal Australian College of Psychiatrists clinical practice guidelines for mood disorders (3). It details the various treatment recommendations based on the severity of the mood disorder:



Biological Treatments	Psychological Treatments	Social Treatments	Lifestyle Treatments
• Antidepressants • Antipsychotics • Mood stabilisers • Electroconvulsive therapy • Transcranial magnetic stimulation	• Brief cognitive behavioural therapy • Formal cognitive behavioural therapy • Interpersonal therapy • Mindfullness • Acceptance and commitment therapy • Schema therapy	• Family psychoeducation • Family/friends • Formal support groups • Community groups • Caregivers • Employment • Housing	• Exercise • Diet • Smoking cessation • Alcohol cessation • Ceasing drugs • Managing substance misuse • Sleep

Therapy for mental health conditions is holistic. It is based on condition type and specific patient requirements from medication, counselling to lifestyle factors.

In addition to specific treatment pathways, medical practitioners are also advised on a **holistic approach** to treatment. The focus is on using the various mental health services for a recovery model, including a culture, patient, support, workforce, and social focus (4).

It is important to understand that there is an evidence base and best practice regarding both diagnosis and treatment of mental health disorders (and in some cases mental health problems) (5, 3, 6, 7).

Generally insurers' disability products, underwriting and claims management practices do not require a formal diagnosis or treatment protocol for assessment or payment of a claim. For a claims payment there is often a greater reliance on time off work and inability to perform an occupation, rather than a formal diagnosis of the condition.

Mental health conditions in Australia

Prevalence of mental health conditions

There are many statistics available on the prevalence and incidence of mental health conditions. For this whitepaper, only those utilised or provided by the Australian Government have been used in this section. Many of the statistics relied upon by the government are over 5 years old.

The last comprehensive Australian Government survey regarding mental health disorders was performed in 2007 by the Australian Bureau of Statistics (ABS) (8). The results of this survey are still widely quoted, despite the information being over 10 years old.

Currently, there are no plans to update this survey. However, the most recent National Health Survey conducted by the ABS estimated that (9) 20.1% of Australians had a mental or behavioural condition in 2017-2018. This was an increase of 2.6% from 2014-2015 (10).

This survey was reliant on self-reported symptoms and individuals identifying as having a mental health condition, rather than an actual diagnosis. These statistics are probably most relevant for insurers given they do not require a formal diagnosis and may be obliged to pay claims based on medical reports that only include self-reported symptoms and individual identification of a mental health condition.

Additional statistics of relevance regarding mental health conditions include:

3,128

people died from intentional self-harm in 2017, an increase from 2,866 in 2016 (11).

12.1%

of the total burden of disease is made up of mental and substance abuse disorders, with those being the third highest burden of disease (12).

13.3%

of the population had at least one mental health condition and two or more physical health conditions (10).

> 45% of Australians had experienced a mental health disorder in their lifetime (8).
>
> 20% of Australians had experienced a mental health disorder the previous year (8).

Insurers often do not require a formal diagnosis for payment of disability benefits and may have priced based on formal diagnosis statistics.

Mental health condition statistics

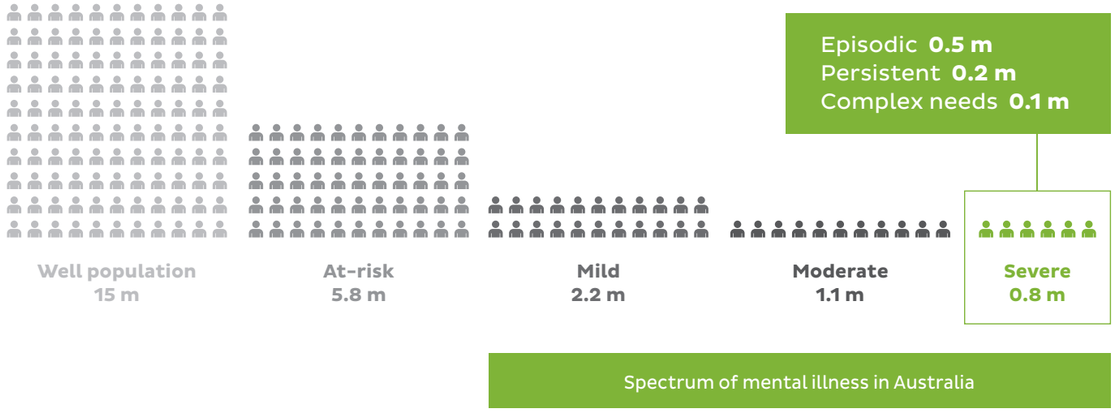
In addition to the possible gap in claims experience and pricing data due to the utilisation of formal diagnosis incidence rates vs self reported incidence, generally insurers also do not consider the impact of comorbidity between mental health and physical conditions in either underwriting or claims practices. Therefore, pricing may or may not include this either, and so is dependent on reliance or all-cause mortality and morbidity or condition incidence and/or prevalence. Comorbidity data will be dealt with in more detail later in this paper.

The following statistics are probably the most relevant for insurers given they do not require a formal diagnosis.

The **National Health Survey 2014-2015** (10) reported 17.5% of the population has a mental health condition, including both those with a diagnosis, and those self-reported. A further breakdown of condition type is noted below:

	Estimate '000	Proportion %
Alcohol and drug problems	230.9	1.0
Mood (affective) disorders		
Depression/feeling depressed	2052.2	8.9
Other mood (affective) disorders	179.5	0.8
Total mood (affective) disorders	2137.6	9.3
Anxiety related problems		
Anxiety disorders/feeling anxious, nervous or tense	2207.0	9.6
Panic disorders/panic attacks	585.7	2.5
Phobic anxiety disorders	303.6	1.3
Obsessive-compulsive disorder	267.9	1.2
Post-traumatic stress disorder	232.3	1.0
Total anxiety related disorders	2564.1	11.2
Problems of psychological development	293.8	1.3
Behavioural, cognitive and emotional problems with usual onset in childhood/adolescence	257.1	1.1
Other mental and behavioural problems	260.4	1.1
Symptoms and signs involving cognition, perceptions, emotional state and behaviour	40.3	0.2
Total mental and behavioural problems	4017.4	17.5
Total population	**22969.0**	**100.0**

The Productivity Commission Issues Paper into the Social and Economic Benefits of Improving Mental Health (Jan 2019) (13) noted the distribution of mental health conditions among the Australian Population by severity to be:



Estimated number of people (adults and children) in each group based on their mental health over the 12 months up to 31 March 2018. People were categorised as having a mental health illness) mild, moderate or severe) if they had an episode of mental illness within the 12-month period. They were categorised as being at-risk if they had emerging symptoms of a mental illness within the 12-month period, or an episode of mental illness before the 12-month period, or were children or parents of a person with mental illness.
Source: Productivity commission estimates based on prevalence rates published in the Fifth National Mental Health and Suicide Prevention Plan (COAG Health Council 2017a) and NMHC (2014a); and population statistics published by the ABS (Australian Demographic Statistics, Cat no. 3101.0).

Cost of mental health conditions in Australia

$56.7 billion per year

In 2014, The Royal Australian and New Zealand College of Psychiatrists (RANZCP) commissioned a report to review the total economic burden and cost of severe mental illness in Australia. At the time, it was estimated to be $56.7 billion per year (14). It included direct health costs, as well as indirect costs related to loss of productivity.

$4,000 per person

The National Mental Health Commission (15) estimated the cost of mental ill-health (i.e. mental health conditions) in 2016 to be about $4,000 per person.

$3,200 per employee

KPMG (16) performed a review of cost in the workplace to employers of mental conditions, estimating this to be on average $3,200 per employee.

$9 billion

During 2016-2017, the Australian Government spent about $49 per person on Medicare subsidised mental health services, $511 million on mental health subsidised prescriptions (AIHW) (17). Overall, the spending on mental health from all sources (government and non-government) was about $9 billion or $373 per person (AIHW 2015-2016) (18).

From an insurers point of view, although worker's compensation data may be included in the burden of disease and economic reports, the impact and contribution by life insurance appears to be a silent witness.

Mental health condition services

> In Australia, the funding and regulation of mental health services is split between state and territory. This leads to fractured services, given that roles are not always clear (17, 18).

1. The main government funded services

- **Medicare** – Mental Health Care Plan (MHCP) which provides 10 sessions per year funded by Medicare. Access to a MHCP is only through a general practitioner (GP) and may be used for GP or registered relevant allied medical professional counselling, e.g. psychologist. The 10 session limit may be inadequate in many of the more severe or chronic mental health conditions. Access to the MHCP does not require a formal DSM-V diagnosis and referral can be based on the GP stating 'depression' or 'anxiety', which are terms indicating symptoms more than a formal diagnosis.

This is relevant to life insurance as both in underwriting and claims practices, use of a MHCP is often aligned with severity of a condition. This may not be the case where access to MHCP has been provided to provide subsidisation for an acute grief reaction or relationship counselling.

- **Pharmaceutical Benefits Scheme (PBS)** – most of the routinely used drugs prescribed for mental health conditions are subsidised by PBS.
- **Primary Health Networks (PHN's)** – there is provision of coordinated services and stepped care through a PHN Primary Mental Health Care Flexible Funding Pool. This may be unknown to a person with a severe mental health illness resulting in non-adherence to required treatment obligations either prior to or post hospitalisation.
- **Veteran's Mental Health Service**

2. The state and territory government services

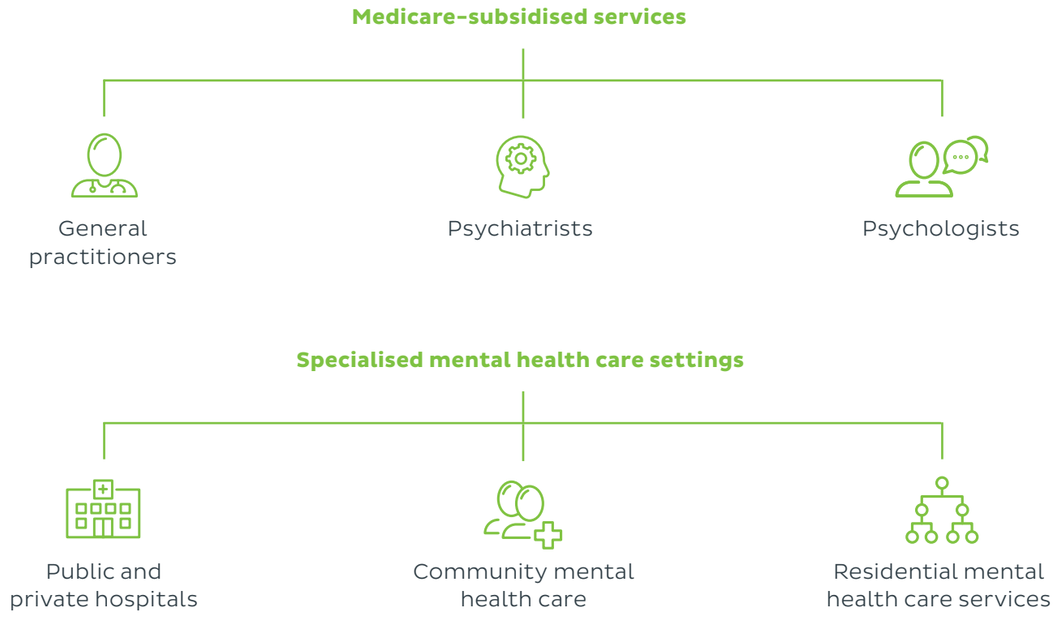
- Management and administration of public hospitals.
- Funding and management of community mental health services.

3. Shared responsibilities

- The Fifth National Mental Health and Suicide Prevention Plan.
- Funding of public hospitals.
- Registration and accreditation of mental health professionals through the Australian Health Practitioner Regulation Agency.
- National Disability Insurance Scheme – availability of services only to those with a 'significant and enduring primary psychosocial disability'.
- National Partnership Agreement (in development) focused on suicide prevention.

An overview of the Australian health care system

(Mental Health Services: In brief 2018: AIHW) (17):



Life insurers do not currently provide any guidance on subsidised services available for mental health conditions, including the NDIS because generally most life insurers operate independently to the health community.

The Productivity Commission Draft Report into Mental Health issued in October 2019 (19) indicates a need for coordination between psychosocial supports, housing services, the justice system, workplaces, and social security. It also highlights the need to find more effective ways to assist those with mental health conditions.

Mental health condition resources

The registered health community generally manages mental health conditions. The first point of contact is generally through GP's with onward referral to psychiatrists, psychologists, or psychotherapists where required. Mental health nurses are now playing a more significant role: not just providing services in hospital settings, but in prevention and take-up of services through the Primary Healthcare Network (PHN).

The number of trained mental health care workers and dedicated hospital beds for mental health are underwhelming, as noted in the table below (17):

Resource	2016 estimation
Psychiatrists	3,244 or 13 FTE per 100,000 population
Mental health nurses	21,558 or 85.1 FTE per 100,000 population 6.8% of all nurses
Registered psychologists	24,522 or 88.1 FTE per 100,000 population
Public hospital dedicated beds	7,058 (5,360 acute, 1,698 non-acute)
Private hospital dedicated beds	2,754
Residential services	2,383

In 2015-2016, it is estimated 12.4% of GP encounters involved the management of mental health conditions (17).

GP's prescribed 93% of all mental health condition prescriptions (17).

Availability of specialised mental health condition services in Australia is stretched, particularly in non-metro areas.

Mental health condition service usage

The report by the AIHW 'Mental Health Services: in brief 2018' (17) covers the use of the various mental health services tracked by the government. There's been a noticeable increase in the use of nearly all services during 2016-2017.

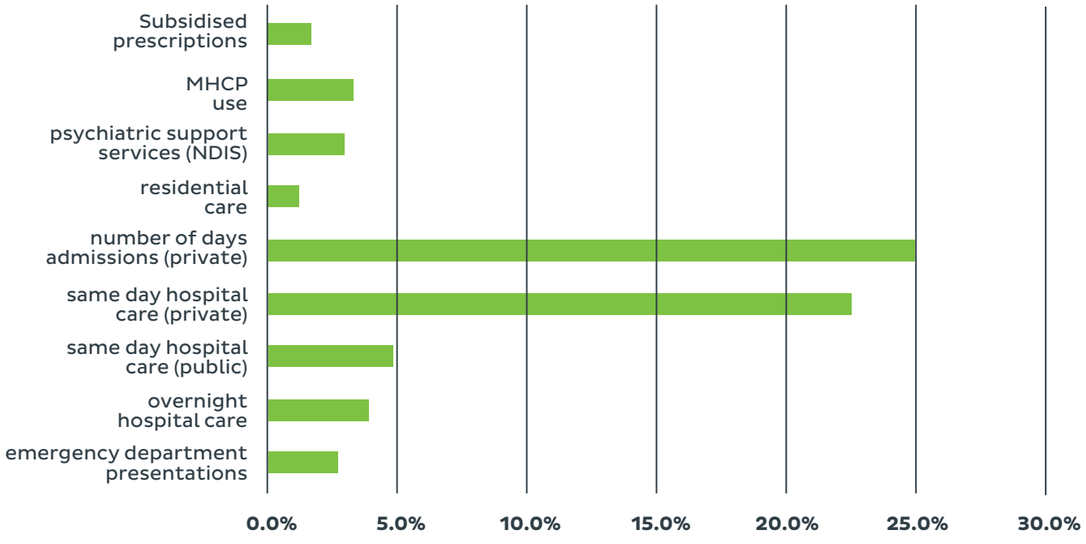
- 276,954 presentations to emergency departments.
- 2.4 million people received Medicare subsidised mental health services.
- 4.05 million people received mental health related prescriptions.
- 100,939 people received psychiatric disability support services.
- 351,239 sessions were delivered using the MHCP.

The graph below shows the percentage increase in mental health service use over the period 2012-2017 (20, 17). The NDIS increase is a year on year increase. Same day admission in public hospitals for non-mental health related conditions also showed a similar increase of 4.3%.

Most concerning is the increased rate of private hospital admissions combined with a lengthened rate of duration of stay. This may indicate more facilities being made available by private hospital groups (notably Ramsay Healthcare and HealthScope).

Generally, to get optimal funding for mental health conditions, hospitalisation is an option for many patients with more severe conditions. This increase in admission and duration of stay will be a concern for private health insurance providers.

Mental health service usage increase 2012-2017 (20, 17)

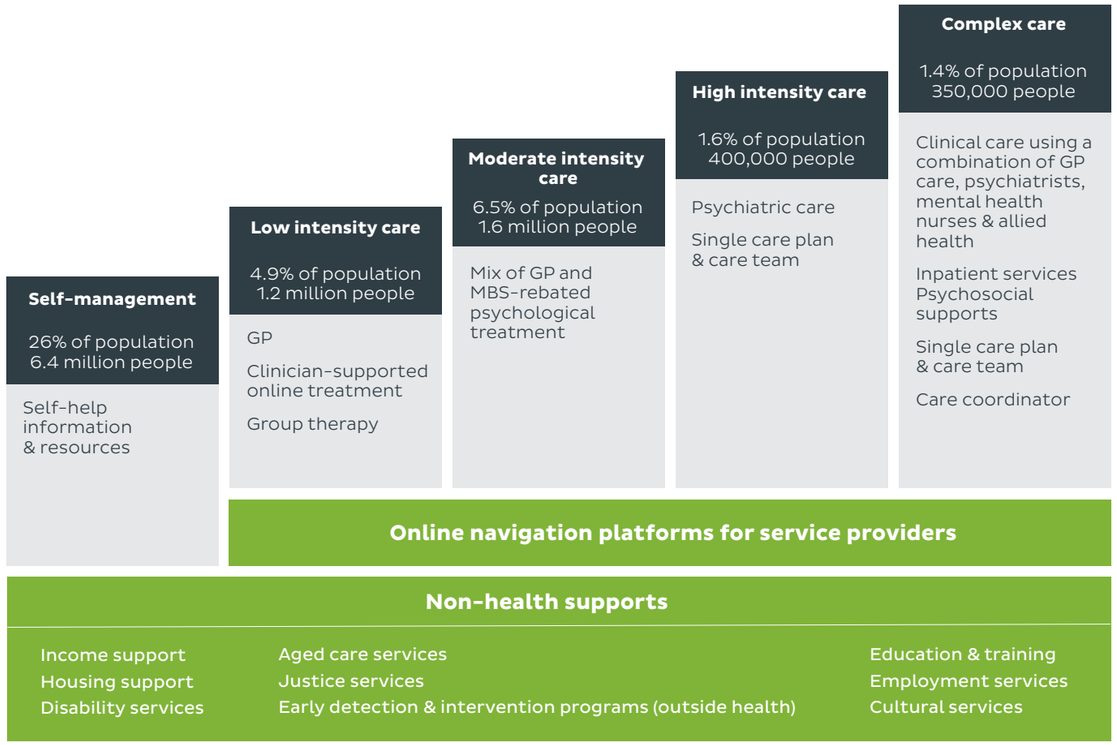


Life insurers do not currently engage with private health insurers regarding a combined claims management approach to align and optimise improved outcomes for customers.

The Productivity Commission Draft Report into Mental Health indicates the following usage in the stepped model of care: (19)

Stepped model of care

Estimated number of people requiring each level of care.
The life insurance industry may be paying out claims to all levels of care given the lack of requirement for formal diagnosis or treatment plan and often a one size fits all claims assessment model is provided.



The report also noted:

- There are approximately 3,400 non acute mental health beds in the public sector, half the estimated number required.
- There is a significant gap in services between those with mild to moderate symptoms and those with more severe mental health conditions requiring specialist treatment and hospitalisation.

The number of psychiatrists for Australia's population is at the low end compared to other developed countries.

Mental health conditions – the global experience

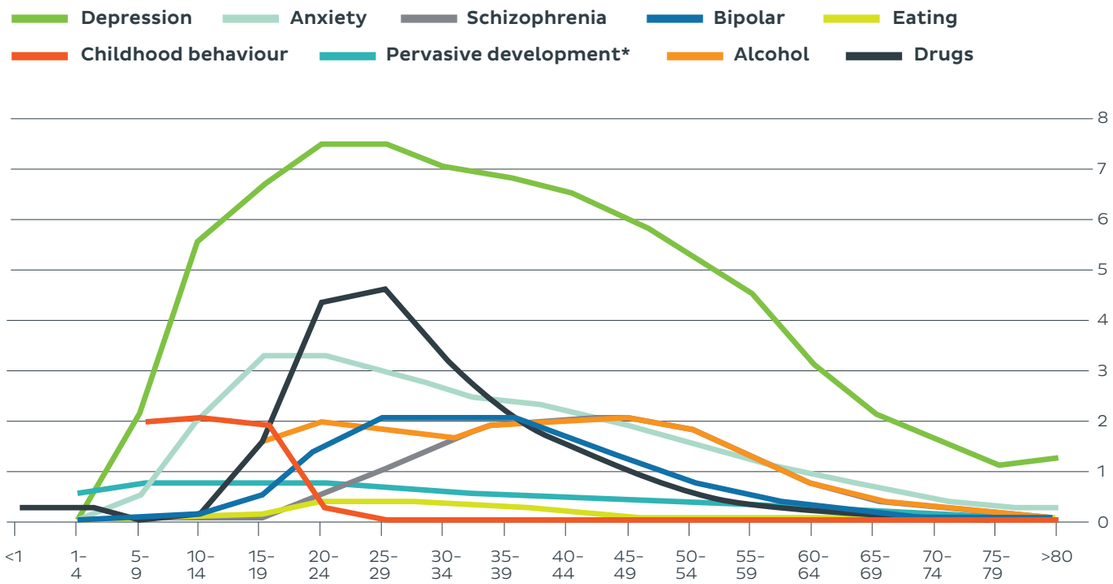
Prevalence of mental health conditions globally

The data covering the prevalence or incidences of mental health at a global, national or life insurance level are difficult to find. This is due in part to how the data is gathered. Most data may rely on a formal diagnosis, but some are focused on service usage, which again may be dependent on adherence to accepted treatment regimes. Most data will not provide insights beyond aggregated mental health conditions as very few provide insights at a diagnostic level.

Below is a global burden of mental health disorders in 2010, published in The Lancet in 2013 (21).

Global burden of mental and substance disorders

Disability-adjusted life years by age group, 2010, m

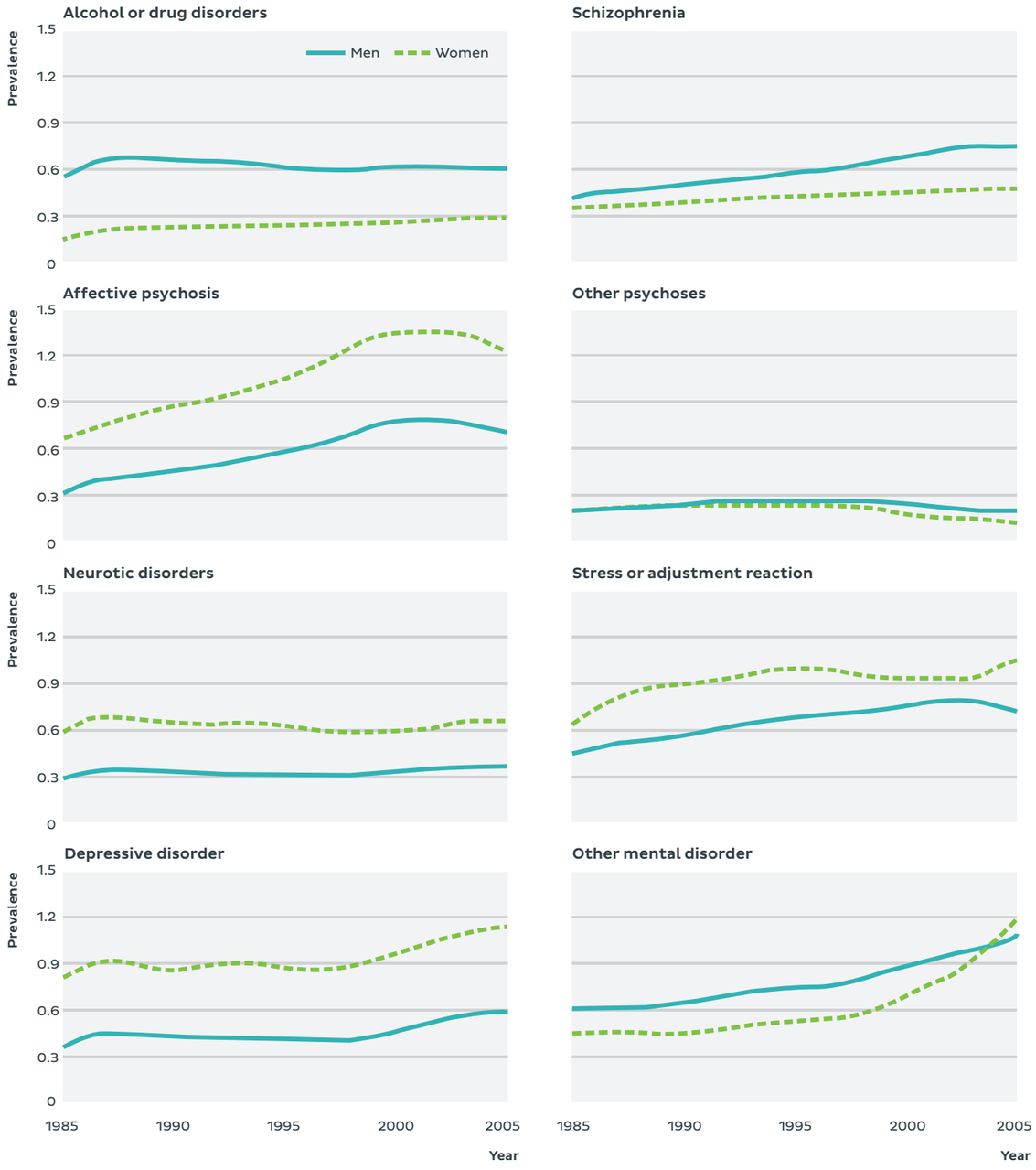


* Including autism and Aspergers syndrome

Source: H. A. Whiteford et. al. "Global burden of disease attribution to mental and substance use disorder", The Lancet, August 2013

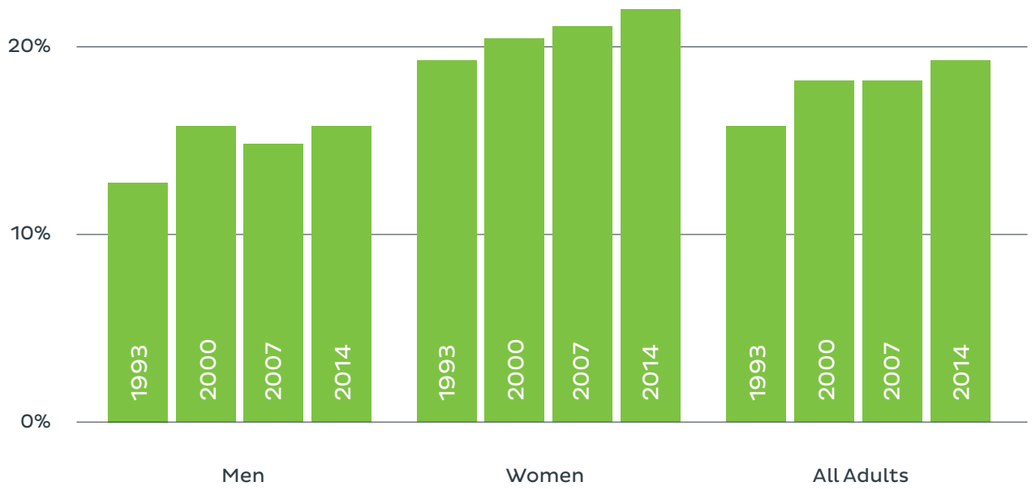
The World Health Organisation (WHO) has noted in 2001 that 1 in 4 people suffer from a mental health condition (22). However, they have not published any data showing a global increase in prevalence or disease burden. The figure above appears to be the last global burden study at a diagnostic level and does not show any change from prior years.

The graphs below, taken from a study in Western Australia in 2013 (BMJ 2013; 346) (23), shows prevalence based on contact with mental health services in women 15 years and older. These graphs show a slight increase in the prevalence of depression and other mental disorders, but this type of evidenced based data is difficult to source in Australia questioning whether there is a true increase in mental health conditions.



The UK performed a survey in 2014, which showed that the prevalence of common mental health conditions had increased from 1993 to 2014 (24).

The prevalence of common mental health problems has risen since 1993 in the UK



Patterns around the world

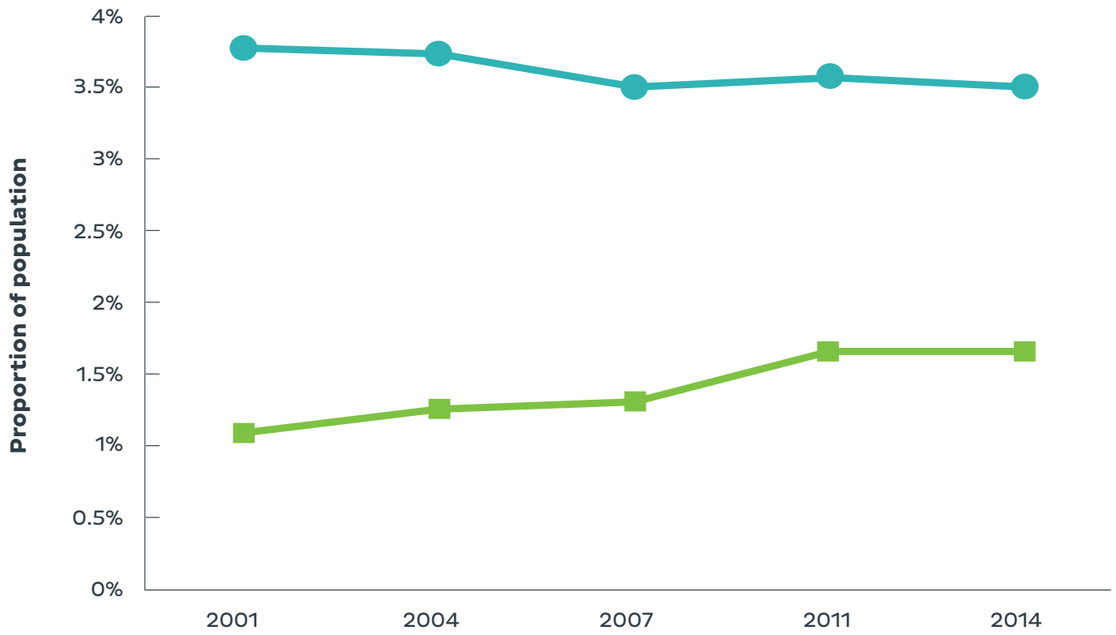
Overall global statistics looking at mental health conditions vary with regard to their value and detail. Some other countries, such as Canada show similar patterns to the UK and Australia. It's important to note that many countries and the WHO started to research mental health conditions with more intensity from the late 1990s to the early 2000s.

In Australia, The Department of Health produced a paper in 2009 (25) about the magnitude of the mental health problem. This was based on the statistics reported in the National Survey of Mental Health and Wellbeing in 2007. It's of significance given that the problem, regarding a rise in mental health conditions, has been a discussion point for the Australian, as well as other governments, for more than a decade.

Life insurers have been concerned by the potential increase in mental health conditions and have more recently looked for ways to ensure product accessibility and premium sustainability for customers (refer Mental Health and Insurance Green Paper by the Actuaries Institute 2017 (26).

An article in the Medical Journal Australia (MJA) in 2017 (27) noted that although the prevalence of common mental health disorders doesn't appear to be rising in Australia, there does appear to be a corresponding increase in the costs and level of disability associated with these conditions.

Proportion of working age Australians receiving disability support pensions (DSPs), 2001–2014; age standardised



Population receiving DSP for non-psychiatric/ psychological problems

Population receiving DSP for psychiatric/ psychological problems

The cost of mental health conditions in Australia is rising despite the prevalence appearing to be stable.

Global life insurance responses

United Kingdom

In 2017, claims for mental health conditions were the most common cause for claiming under income protection policies. The Association of British Insurers (ABI) provides guidance to customers on how to access insurance as well as high level best practice claims guidance (28). This guidance is provided by case studies, and it's not known if this has had an impact on risk assessment or claims assessment practices. The Australian Financial Services Council (FSC) Life Code of Practice appears to be following this practice in version 2.

In the early 2000s, UNUM, one of the UK's largest insurers, implemented an alternative underwriting strategy for mental health conditions. This strategy utilised certain psychosocial factors as key risk factors. This methodology was closed about five years after launch due to significant adverse claims experience. All information regarding the methodology, experience and learnings have been buried. No presentations or insights are available even from those involved in the project.

In 2018, UNUM launched its 'Mental Health Pathway'. It's an initiative aimed at early intervention in its group business rather than on an underwriting solution (29). Product definitions did not appear to be altered during the underwriting project.

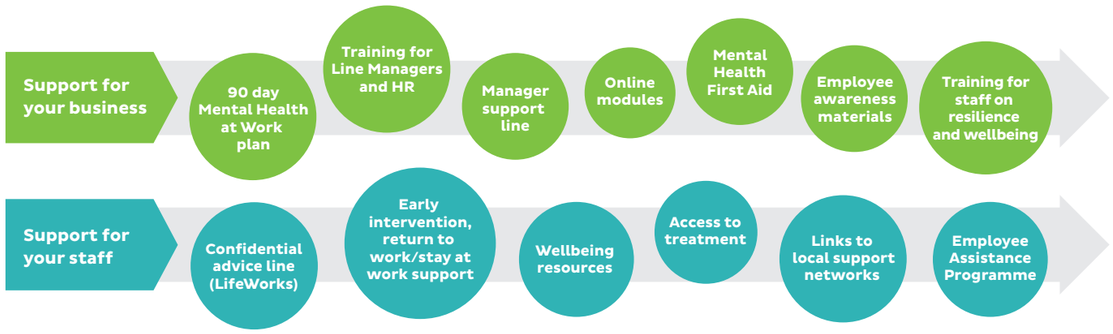
UNUM Mental Health Pathway

Stress and mental health problems are a growing concern in the workplace. In 2016/2017 stress, anxiety and depression accounted for 49% of all working days lost[1], so it's important to know when and how to best support your employees and your business.

Step 1: Email pathway@unum.co.uk or get in touch with your existing Unum Claims or Rehab contact.

Step 2: One of our trained health professionals will contact you within 48 hours to assess your needs.

Step 3: From a rich and vast range of high quality services, we'll create a 'pathway' that's appropriate for you.



This pathway is endorsed by Unum's Chief Medical Officer, Dr. Syed Zakir Abbas. It draws upon the Workplace Core Mental Health Standards recommended in the Thriving at Work review.

1. HSE - Work-related stress, depression or anxiety stats in GB. 2017

South Africa

In South Africa, life insurers noticed an increase in disability claims for mental health conditions in the early 1990s. The increase led to them producing a guideline in 1995 for the management of claims on psychiatric grounds, in conjunction with South African official psychiatric bodies (30).

The consultation between these groups initially resulted in improved disability claims experience for mental health conditions. It also improved the overall management of disability claims for mental health conditions by both the psychiatric profession and life insurers. The guideline also resulted in some substantial changes to product definitions. Examples included reduced income protection payout percentages after two years for mental health conditions, set criteria to meet a claim for TPD, and some life insurers implementing blanket mental health exclusions.

More recently, South African mental health advocacy groups have begun challenging the blanket mental health exclusions. The best practice guideline was recently updated in 2017 (30) to try to address some of the current case management issues for disability products. In the mid 2000s, most insurers moved to severity-based style products with set objective criteria for access to claim, including for mental health conditions. The claims experience for these severity-based products appears to be sustainable and within pricing expectations.

Other Global Trends

The Global insurance trends analysis performed by EY in 2018 (31) identifies critical impediments for the global life insurance industry.

1. Continued regulatory pressure that impedes growth.
2. Competition from alternative products affecting the demand for savings and wealth products – technology is key in this enabling new products, channels, and services.
3. Maturing guaranteed back book impacting margins and capital.
4. Structural decline in key markets due to falling populations and stagnant incomes.

There is no mention of a significant rise in mental health conditions, leading to a watch on adverse claims experience in other global life insurance reports for 2017/2018 (A Vision for European Life insurance: McKinsey 2018 (32); Global Insurance Industry Insights McKinsey 2017 (33). However, the Swiss Re Institute (34) indicated that although there may be a current increase in claim notifications, this may not be a new trend for the industry globally.

There are no known global life insurance responses to increases in mental health condition claims that have had any significant effect other than product restructure, notably severity based products with objective criteria.

Mental health conditions insights

Predictive factors

The ability to predict who is susceptible to a mental health condition as well as estimations of the potential duration of any mental health condition and how it will affect someone's ability to work, is important for life insurers.

In individual policies, understanding these evidence based, non-clinical factors could assist in a more advanced methodology for risk assessment beyond rating on a pure diagnostic and treatment basis once the diagnosis has been made. That is, the ability to understand who might need to claim for a mental health condition prior to a formal diagnosis being made.

In addition to underwriting, the ability to predict susceptibility to mental health conditions has an impact on many areas of the customer journey including the ability to deploy primary and secondary prevention programs as well as assist in targeted support structures once the condition is formally diagnosed.

Predictors for other conditions are better understood due to the direct correlation, for example, a family history of raised cholesterol and the risk of a heart attack at a young age. For mental health conditions, however, these factors are not as obvious due to multi-factorial inputs into mental health and wellbeing.

Contributing factors to mental health and wellbeing (37)

Risk factors for mental health

A recent paper has explored the predictors of mental health conditions in the working population (35).

The predictive factors are based on gender and age. They are then ranked according to importance and clustered to indicate a low, medium or high risk for the propensity of an onset of a mental health condition. Some examples of the predictors found include:

- Satisfaction with the number of hours worked
- Satisfaction with overall health
- More than four drinks per week
- Dissatisfaction with Partner
- Being pushed around
- Having control at work
- History of common mental health conditions
- Presence of a confidant

The Australian Government recognised in a published monograph on the Department of Health website as early as 2006 (36) that risk factors for a mental health condition are multi-factorial. These factors include social status, income, physical environment, education and educational settings, working conditions, social environments, families, biology and genetics, personal health practices, coping skills, sport and recreation, availability for opportunities and access to health care services.

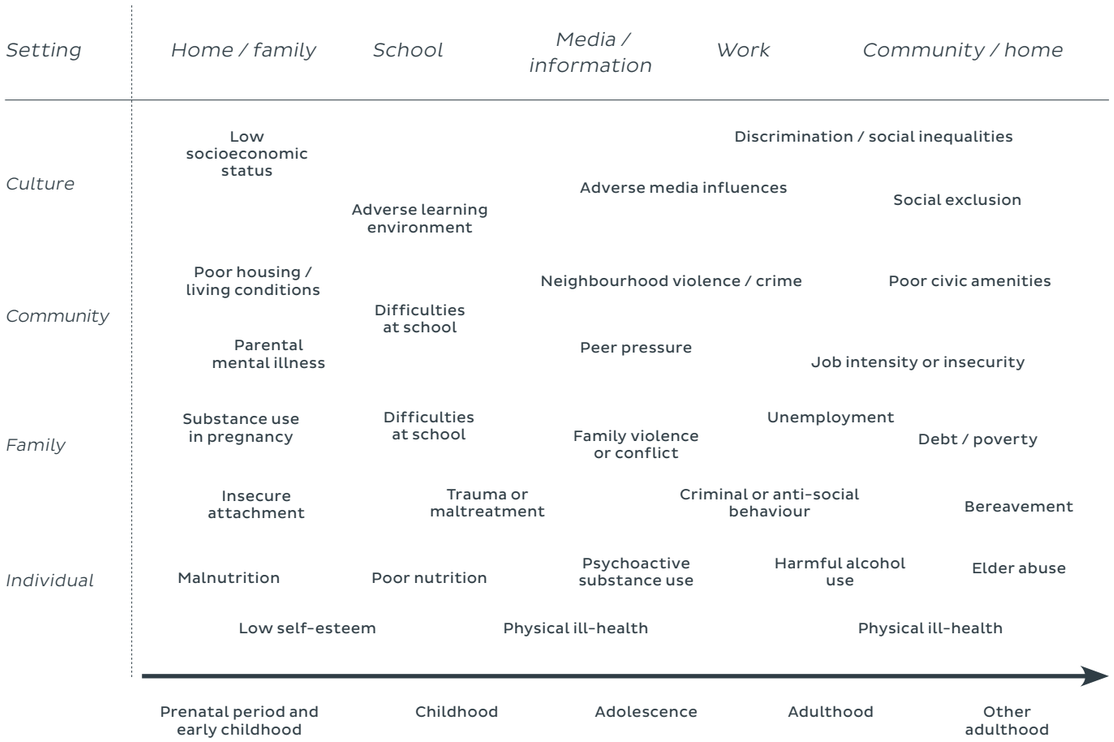
These predictive factors were noted as being both risks and protective factors for mental health conditions. As noted previously, DSM-V includes many of these factors in determining both diagnosis and severity of the condition.

The importance of the multiple predictive psychosocial factors, as well as biological factors to the risk of a mental health condition, is further supported by the WHO (37). They detail individual attributes and behaviours, social and economic circumstances, and environmental factors as all having a role in contributing to both adverse and protective factors for mental health and wellbeing.

Risk factors for mental health conditions are multi-factorial.

Schematic overview of the risks to mental health over the life course

(Adopted from: Foresight project, 2008; Kieling et al, 2011; Fisher et al, 2011)



There are multiple other sources and publications confirming these predictive factors. They include the fact that genetic variations may be passed on by those who have attention deficit disorder, bipolar disorder, major depression, and schizophrenia. These mental health conditions are not yet linked to single causative genes and cannot be used for risk assessment purposes.

Most insurers do not currently use a multi-factorial risk assessment including psychosocial factors in predicting the risk of a mental health condition, given it is not only the prediction of the condition that is required for disability benefits, but also the risk of taking time off work and the duration of this action. The current underwriting practice is confined to those with either a diagnosed mental health condition or to those displaying clear symptoms of a mental health condition (38).

Absenteeism and illness duration

Published studies predicting the duration of an income protection claim, absenteeism from work or chronicity of the condition leading to a lump sum disability claim are limited. An extensive desktop research paper by KPMG, commissioned by the FSC (38) has noted the lack of these types of studies indicating an opportunity to map the duration and severity of conditions against the many known predictive factors.

The Cost of Workplace Stress in Australia

Medibank Private produced a report in 2016 'The Cost of Workplace Stress in Australia' (39). Below, details the costs in 2016.

	Stress related presenteeism	Stress related absenteeism	Total
Total cost to economy	$9.69b	$5.12b	$14.81b
Direct cost to employers	$6.63b	$3.48b	$10.11b
Labour productivity loss	0.89%	0.47%	1.36%
Days lost per worker per year	2.1	1.1	3.2

According to the KPMG report of 2018 'Investing to Save' (16), mental health conditions cost employers on average $3,200 per employee in absenteeism and presenteeism. This can increase up to $5,600 for those with severe mental health conditions.

One recent published paper looking at the predictive risk factors for duration of sick leave in Japan (40) showed a strong correlation with increased length of sick leave and the number of previous sick leave episodes, the diagnosis, and employment level. **This study could potentially indicate that the same factors that are used to predict the onset of a mental health condition may also be valuable in predicting the duration of time off work.**

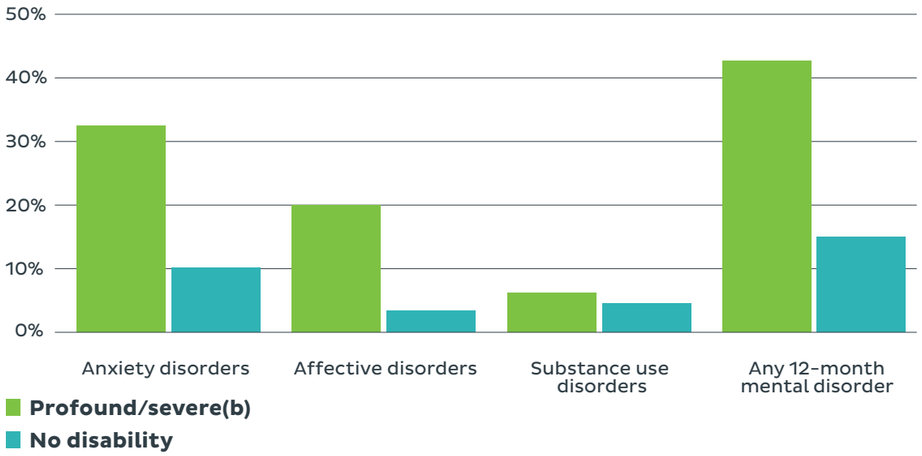
> Mental health conditions cost employers on average $3,200 per employee (16).

Studies predicting mental health conditions leading to time off work and the duration of this absence are not readily available in life insurance.

The 2007 National Survey of Mental Health and Wellbeing (8) noted that 43% of those who had a mental health condition in the previous 12 months had profound or severe core activity limitation.

The following chart shows the degree of core activity limitation by those with a mental health condition.

12-month Mental Disorders(a), by Disability status



(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview. A person may have more than one mental disorder.
(b) Core-activity limitation. See Disability status in the Glossary.

In Australia, Professor Alex Collie, the Director of the Insurance Work and Health Research Group, Monash University has produced a paper and guideline for General Practitioners (GP's) on the health benefits of returning to work for those patients with mental health conditions. The paper highlights the benefits, especially considering the additional element of compensation through WorkCover (5).

Other studies have confirmed the importance of a healthy work environment on mental health. They also show the impact of unhealthy workplaces as a predictor of mental health conditions (41). Beneficially, they reveal which empirically supported interventions workplaces can use to prevent mental health conditions and facilitate the recovery of employees diagnosed with depression or anxiety (42).

The Australian Life Insurance industry has recognised the importance of certain psychosocial factors in claims management to improve return to health outcomes and claims recurrence, but there is still opportunity to improve this approach for the benefit of both customers and life insurers.

Research indicates the importance of a healthy work environment on mental health.

Comorbidities

The Australian Health Policy Collaboration issued a policy issue paper in 2018: Australia's Mental and Physical Health Tracker (43), which had the following observations:

> People with severe mental health conditions have a life expectancy 10-15 years less than those without.

More than 75% of this excess mortality was due to chronic physical health conditions, notably cardiovascular conditions, and cancer. It is further noted that although mortality rates have improved for these two conditions in the general population, for those with severe mental health conditions, mortality rates have worsened.

Morbidity statistics for Australia are overall increased across all conditions measured for those with mental health conditions. This is attributed to multiple factors, including side effects of diagnosis and medication, increased anxiety, poor eating habits, poor lifestyle choices, and physical inactivity.

Increased morbidity in those with mental health conditions

Condition	All males	Males with a mental health condition	All females	Females with a mental health condition
Circulatory system	17.9%	27.3%	18.6%	26.3%
Diabetes mellitus	5.7%	9.9%	4.65%	6.7%
Back problems	16.2%	28.2%	16.2%	27.2%
Arthritis	12.3%	20.5%	18.35%	26.7%
Asthma	9.8%	14.6%	11.8%	20.1%
COPD	2.6%	6.7%	2.6%	5.1%
Cancer	1.7%	3.1%	1.5%	1.8%
High cholesterol	33.1%	36.4%	33.6%	41.4%
High blood pressure	24.4%	25.1%	21.7%	21.7%

People with mental health conditions are likely to make adverse lifestyle choices:

Factor	All males	Males with a mental health condition	All females	Females with a mental health condition
Smoking	16.9%	23.4%	12.1%	20%
High alcohol intake	25.9%	29.9%	9.4%	10.3%
Physical inactivity	53.1%	59.3%	60.3%	65.1%
Obesity	28.4%	33.2%	27.4%	31.3%

In an article published in the Medical Journal of Australia in 2013 (44), John Tiller noted that comorbid depression and anxiety occur in 25% of general practice patients.

85%

85% of patients with depression have anxiety.

90%

90% of patients with generalised anxiety have depression.

Both anxiety and depression are associated with a substance abuse disorder. The Mental Health Commission of NSW noted in an evidence guide in 2016 that the life expectancy of people experiencing severe mental illness is reduced by 15-20 years. Cancer and cardiovascular disease are the leading causes. A holistic, coordinated approach is required to address both mental and physical wellbeing in treating those with severe mental health conditions (45).

Furthermore, the National Health Survey in 2014 (46) found that:

13.3%

13.3% of the population had at least one mental health condition and two or more physical health conditions.

2.5%

2.5% of the population had at least a mental health condition and only one co-existing physical health condition.

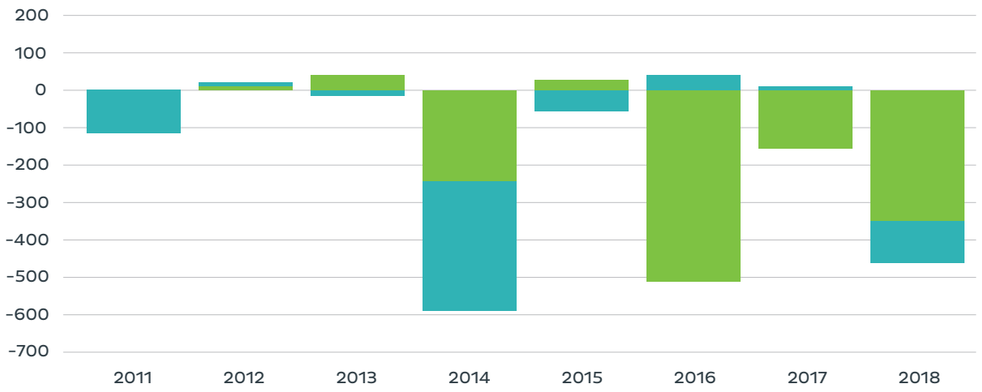
The most likely physical health problems were long and short sightedness, back problems, arthritis, hayfever, and allergic rhinitis. In addition, those with a mental health condition were twice as likely to report also having diabetes mellitus and three times more likely to have chronic obstructive pulmonary disease.

The comorbidity of mental health conditions with other conditions is significant. Life insurers need to take this into account in design of support and prevention programs.

Australian life insurance industry experience of mental health conditions

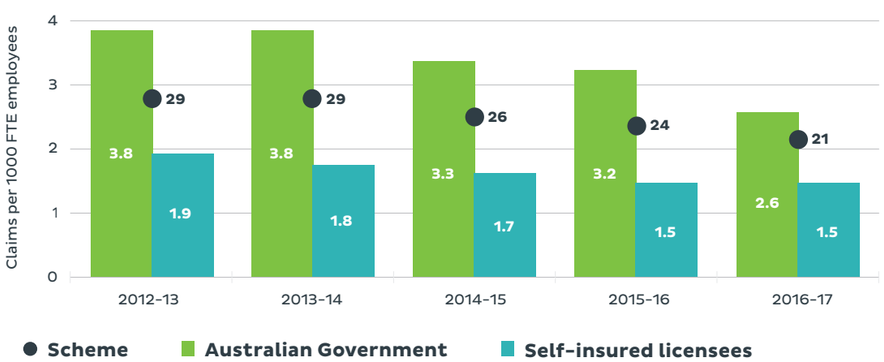
Aggregate life insurance data regarding mental health claims across all channels is complex and challenging to obtain (47). APRA's letter to all life insurers and friendly societies dated 2 May 2019 (48) addresses their concerns regarding the ongoing sustainability of income protection products given the deteriorating experience. APRA's challenge to the industry is to address core issues and implement changes necessary to meet the long-term interests of customers.

Individual DII net profit/loss after tax



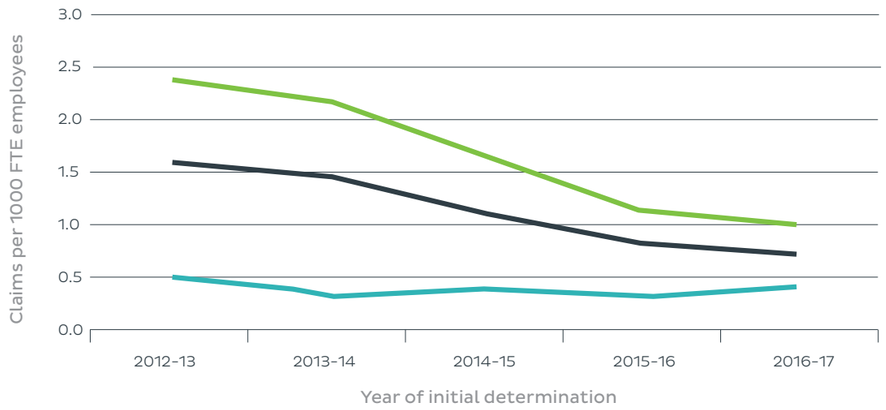
The FSC commissioned KPMG to review 30,000 income protection claims made between 2009 and 2013. The trends showed an increase in claims for mental health conditions compared with the two previous decades (49).

In comparison, Comcare scheme workers' compensation statistics, released by the Australian Government for the period 2016-2017 (50), show a decline in accepted claims for mental health conditions.

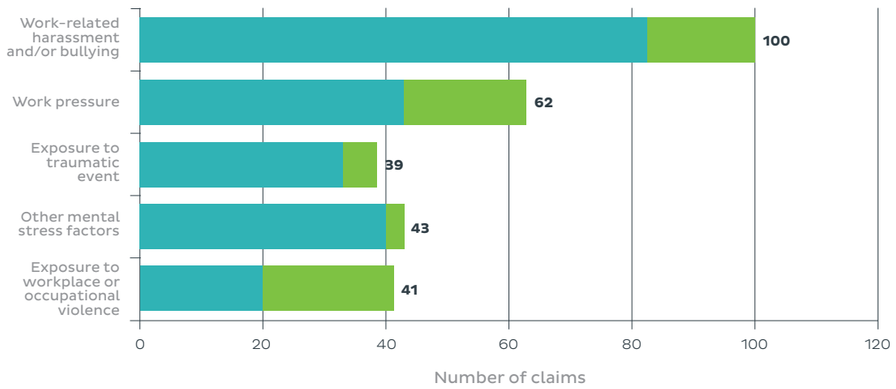


The overall incidence of mental health conditions has also decreased from the prior five-year period by 54%. Bullying continues to be the main cause of claims for mental health conditions.

Incidence of mental stress claims-scheme



Mental stress claims by mechanism of incident initially accepted in 2016-17

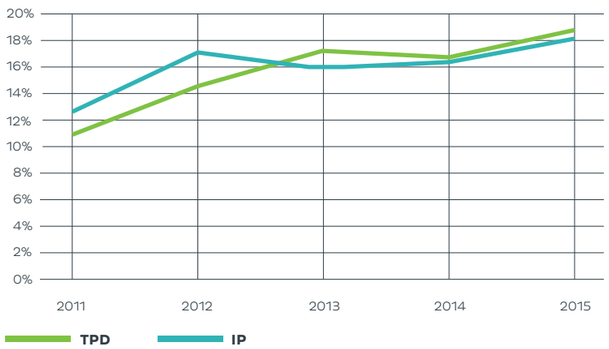


Further investigation into what mechanisms the Australian Government has put in place to have led to this overall reduction in claims for mental health conditions might be required, given that this appears to be an isolated result. Of note, this improvement is in incidence of mental health condition claims only and is not addressing duration of claim.

Although life insurance industry claims experience statistics for mental health conditions is difficult to obtain, the Actuaries Institute Green Paper of October 2017 (26): Mental Health and Insurance cited the following statistics based on one insurer:

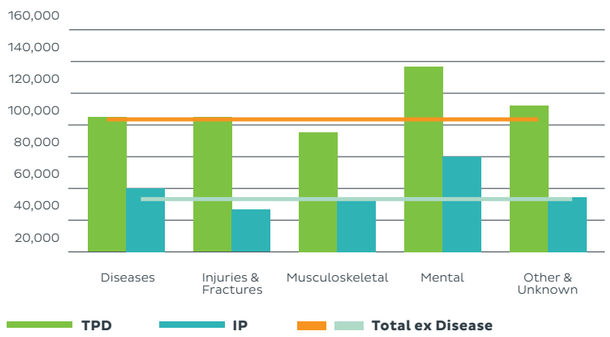
One major group insurer was able to provide data, on a confidential basis, on all TPD and IP claims in its group business, showing paid and declined claims separately and with claims coded by cause. This data was used to form the following observations*

Mental Health Claims as a Proportion of Total Claim Reported



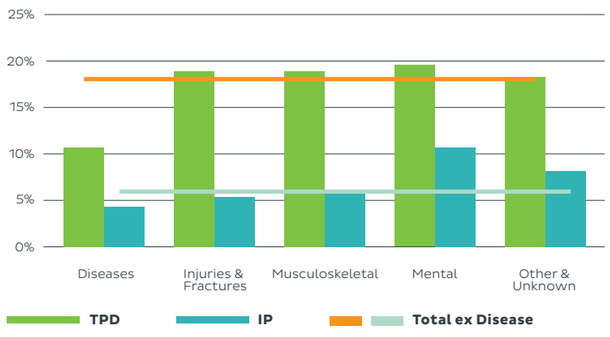
The proportion of mental health claims reported to the insurer has increased steadily between 2011 and 2015. Claims relating to mental health represent **19% by number** of all claims reported in 2015 for both IP and TPD. Mental health claims represented 26% of the total cost of claims, with the average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

Average Claim Size 2011-2015



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.

Average Decline Rates 2011-2015



There is little difference between the rate of decline for mental health claims and claims arising from injuries and musculoskeletal 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 related soley 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 changed in business mix or claims development.

While industry statistics on mental health claims are challenging to obtain, it does appear however, that the discussion regarding rising mental health condition claims has been ongoing for at least the past 10 years. It would be beneficial to understand if this is a sustained increase or part of the regular claims cycle. If there is a real increase in mental health condition claims, then multiple factors could be at play.

Factors that could be increasing mental health claims:

- Improved ability to classify secondary claims cause.
- Reduction in stigma regarding mental health conditions leading to:
  a) increased willingness to claim for a mental health condition.
  b) reclassification of claims, for example, a previous claim for chronic fatigue syndrome now being classified primarily as a mental health condition resulting in no real increase in claims incidence.

Interestingly, The Productivity Commission Draft Report into Mental Health (19) notes that 'while only around 6% of all workers compensation claims in Australia are for work-related mental health conditions, the cost of these claims are typically about three times the cost of other workers compensations claims. What's more, they involve significantly more time off work; the median time off work for mental health-related workers compensation claims is 16 weeks, compared with six weeks for other claims.

Although this experience is noted in worker's compensation, these statistics are replicated in life insurance, with an increase in duration rates for mental health conditions. The Productivity Commission notes that delays in providing treatment can delay recovery and return to work.

Mental health claims conditions industry experience

The following aggregated group data for one insurer shows all causes of claims against mental health conditions:

Measure	Commentary
TPD claim incidence number	21% of all TPD claims are for MH conditions
TPD claim payout total	26% of all TPD payments are for MH conditions
TPD claim payout average per claim	There is a 22% increase in average payout amount for MH conditions
IP claim incidence number	15% of all IP claims are for MH conditions
IP average duration	There is a 91% higher average duration for MH conditions
IP claim payout total	18% of all IP payouts are for MH conditions
IP claim payout average per claim	There is a 19% increase in payout amount per MH condition claim
IP reopen rates	There is a 52% improvement in improved reopen rates for mental health conditions

Implications for life insurers to consider

With industry concern over the premium sustainability of retail and group disability products, it is crucial to examine all the factors involved in order to ensure that customers will still be able to have ongoing accessibility to affordable life insurance products.

When looking at mental health conditions, it is clear these can affect death benefits. This is due to suicide, self-harm attempts, medication side effects as well as the known physical impacts, such as cardiovascular disease and the risks associated with more severe conditions.

Within this section, the focus will be on the disability benefits of Total & Permanent Disablement Cover (TPD) and Income Protection.

Product

Although both group and retail disability products require a medical trigger in order to claim, the main requirement for both a TPD and income protection claim involves the inability to work.

Income protection

Post suffering from a mental health condition, there is a reliance on the claimant to self-report the inability to work in one or more of their income producing duties for their own occupation (retail only) or one income producing duty of the regular occupation and not working in any capacity. The requirement to be treated by a medical practitioner may or may not form part of the disability definition. A medical doctor, however, is required to complete the income protection claim form confirming that the claimant is unable to work. There is no requirement to have a formal DSM-V or ICD-10 diagnosis, to be treated according to a recognised clinical protocol (which may require referral to a specialist) or to undergo the necessary testing in order to provide an objective measurement for the outcome of the mental health condition causing the inability to work, e.g. neuropsychometric testing confirming cognitive impairment within the PDS.

The Productivity Commission Draft Report into Mental Health (19) indicates that the assessment tools for Disability Employment Services should be reviewed with consideration given to: adding a mental health diagnostic instrument to the job seeker classification instrument and supplementing the employment services assessment with a personal and social performance measure. This is possibly an area that life insurers could monitor and align with regarding the objective measure of disability.

Total and permanent disablement

Post suffering from a mental health condition, there is a reliance on the claimant to self-report the inability to be permanently unlikely to ever engage in their own (retail only) or any occupation for which they are reasonably qualified by education, training or experience. TPD must be confirmed by a medical practitioner and to restrict unauthorised access to superannuation funds, the ATO requires two registered medical practitioners to confirm the validity that TPD criteria have been met (although most medical practitioners will be unaware of TPD policy terms and conditions). In many cases, the self-reported signs and symptoms of the mental health condition are not objectively investigated (where such testing is available) and compliance to recognised clinical treatment protocols by either the treating doctor or claimant are not required in the policy terms and conditions. Most products do not require that a claimant has a formal diagnosis or has been assessed or treated by a recognised mental health specialist, that is, a psychiatrist.

Pricing

Pricing for both income protection and TPD products is based on all cause morbidity actuarial tables as well as previous claims experience of the particular distribution channel. The overall changes to the Australian Health statistics regarding mortality or morbidity are generally not taken into account as an overlay or adjustment when pricing. It is important that actuarial tables are updated regularly and include new diagnostic and treatment regimes as well as economic factors that may impact health, particularly mental health.

Risk assessment

Individual policies that are underwritten require questions that seek to identify applicants that have either been diagnosed with a mental health condition or have symptoms that may lead to the diagnosis of this type of condition. Further reflexive questions will ask about time since last symptoms, severity, treatment, hospitalisation, time off work amongst other risk factors in order to determine the risk of a claim. The underwriter is also reliant on reinsurance manuals in order to determine an evidence-based approach to risk assessment. Feedback from mental health advocacy groups, litigation teams, and claims managers have noted areas for improvement in both the questioning and risk assessment of mental health conditions:

- The application question can be misleading in that severe conditions and symptoms are put together in one question (depression, anxiety, panic attacks, stress, psychosis, schizophrenia, bipolar disorder, chronic fatigue, post-natal depression, or any other mental or nervous condition?) resulting in applicants possibly not disclosing more minor symptoms.
- The mental health condition questionnaire focuses more on diagnosis and treatment with limited psychosocial questions. There is an opportunity to include questions regarding known risk and protective psychosocial risk factors in order to more accurately identify those at risk of time off work due to a mental health condition.
- Risk assessment is currently based on diagnosis, treatment, severity, relapse or recurrence and time since last symptoms. The inclusion of psychosocial factors may lead to a more accurate risk assessment process.

Prevention

Across the industry, there are few targeted programs aimed at prevention of mental health conditions for customers. This is an area that needs far greater investment by life insurers to reduce the impact of claims as well as contribute to improved mental health wellbeing of all insured Australians.

Claims management

There are two aspects to claims management, namely policy acceptance and claim liability.

Policy acceptance

For individually underwritten policies, a review of mental health condition disclosures can be difficult due to interpretation of the current application and mental health questionnaire. For example, a customer may not perceive that they have a mental health condition, especially considering that stress may not be considered a diagnosis or mental health condition.

Claims validity

Claims case managers assess the validity of a claim against policy terms and conditions for TPD and income protection benefits. Case management for mental health conditions can be challenging where disability product terms and conditions:

- Do not specify objective criteria.
- Do not require adherence to recognised treatment protocols.
- Allow for the ability to work for 10 hours a week and still claim for full income protection.
- Do not require specialist confirmation of TPD.
- Do not require a formal diagnosis.
- Allow for payment based on self-reported symptoms and inability to work.
- Do not require engagement with evidence-based recovery programs.
- Allow for income protection payments that may be in excess of previously earned amount (post CPI increases, agreed value).
- Reduce the ability for early intervention due to late notification, workers compensation intervention or prolonged waiting periods.

Case managers need to have a specific skill set to engage with claimants who have a mental health condition. This is particularly true with claimants who have more severe conditions where paranoia, extreme anxiety or cognitive impairment is present. Skill sets would need to include:

- Empathy and strengths-based training.
- Extended technical understanding of the various mental health conditions, including an understanding of DSM-V classifications.
- Good understanding of what support programs are relevant and when to engage the claimant regarding these.
- Base case management requirements, including financial, tax, superannuation, legal, product, underwriting, and technical process requirements.

Certain life insurance providers have specialised teams to deal with mental health condition claims. Knowing that mental health conditions can present as a secondary cause in many other physical claims, the involvement of any specific team for mental health conditions needs to be engaged at the appropriate time in many non-mental health condition claims.

Although the case management of mental health claims is key to ensuring that the claims experience is aligned to pricing assumptions, case managers can only function within the boundaries set by product terms and conditions. Also key is to ensure that customer expectations are managed with a mutual engagement in programs that support a return to health.

Combined product and claims initiatives

Sustainability of premiums based on increasing mental health claims will need to be reviewed with a dual approach, namely:

Current and legacy business where disability benefit terms and conditions cannot be changed.

The focus here needs to be:

- Early engagement, active return to health strategies, specialised mental health trained case managers.
- Added incentives for engagement in support programs and earlier return to work.
- Full engagement with all stakeholders (including employers).
- An understanding of psychosocial factors.

New product design

Alternative terms for mental health condition claims that support a return to health in a macro environment that currently nudges towards an increased severity and chronicity of condition. Factors could include:

- Duration limitation.
- Objective criteria.
- Requirement for specialist evaluation and treatment.
- Adherence to clinical diagnostic and treatment protocols.
- Capped maximum payout amounts.
- Greater shared value reward to encourage engagement of claimants in their own return to health journey.

There is an opportunity to work with other stakeholders, especially Medicare and private health insurers, given that there is currently fractured and ad hoc engagement with other key stakeholders.

Disability premium sustainability needs to address both legacy and new products.

Regulation and mental health advocacy

Actuaries Institute

In 2017, the Actuaries Institute released a paper “Mental Health and Insurance Green paper” (26) which reviewed how life insurers dealt with people with mental health conditions. The paper suggested that there was still a lot of work to do to improve public and commercial policy around insurance for those suffering with a mental health condition. The main findings include:

- The insurance sector faces ‘systemic difficulties’ dealing with mental health coverage.
- Many insurers are improving claims processing.
- Progress is hampered by insufficient data and subjective criteria for diagnosis.
- The claims process can be adversarial and in itself lead to ‘secondary mental harm’.
- There’s a bias against early intervention that can hinder a claimant’s recovery and return to work.
- Insurers face real challenges to sustainability.

Greater oversight of regulators and mental health advocacy groups will have an impact on how insurers’ approach and treat customers with mental health conditions.

The paper included 9 key recommendations which were:

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 guidelines	Increased investment in guidelines, specifically for mental health conditions, would be useful, similar to those that are used for medical conditions. For some insurance products, in setting premiums, should insurers consider 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; this could involve superannuation funds, employers, treating practitioners, social supports or other pathways. How can we construct a person-centred approach?
5. Review of laws pertaining to mental health and insurance	A review of the many laws and regulations and the 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 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 claiming and the 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 (‘dueling 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. 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.

Nearly all the recommendations made in the “Mental Health and Insurance Green paper” are consistent with the themes explored in this paper. The findings in this paper were made independently and acknowledge similar factors insurers need to address.

Parliamentary Joint Committee review of the Life Insurance Industry Report: March 2018 (51)

Recommendations from this report regarding the approach life insurers have towards mental health conditions include:

Recommendation	Item	Recommendation
10.3	10.60	In relation to definitions in life insurance policies, the life insurance industry must: clearly explain which associated conditions that may arise from the initial condition, including mental ill health, are covered by the insurance policy.
10.7	10.101	The committee recommends that after consultation with relevant medical professionals independent of the life insurance industry and mental health advocacy groups, the Financial Services Council establish a mandatory and enforceable Code of Practice for its members, or a dedicated part of its existing Code of Practice, specifically in relation to mental health life insurance claims and related issues.
	10.102	Ensure that applications for insurance that reveal a mental health condition or symptoms of a mental health condition are not automatically declined; • refer applications for insurance that reveal a mental health condition or symptoms of a mental health condition to an appropriately qualified underwriter; • where an insurer offers insurance on non-standard terms, for example, with a mental health exclusion or a higher premium than a standard premium, specify: • how long it is intended that the exclusion/higher premium will apply to the policy; • the criteria the insured would be required to satisfy to have the exclusion removed or premium reduced; • the process for removing or amending of the exclusion/premium;
	10.103	The committee recommends that consideration be given to allowing insurers to more actively promote and fund evidence-based best-practice preventative health measures targeted at promoting good mental health at a general level.
10.9	10.129	The committee recommends that the Financial Services Council and the Insurance in Superannuation Working Group consult with financial legal services and mental health advocacy groups to determine appropriate time-frames for claims decisions and that the Life Insurance Code of Practice and the Insurance in Superannuation Code of Practice be updated to reflect the outcome of such consultation.
10.10	10.130	The committee recommends that after consultation with relevant stakeholders, including medical professionals that are independent of the life insurance industry and mental health advocacy groups, the Financial Services Council and the Insurance in Superannuation Working Group mandate through the Life Insurance Code of Practice and the Insurance in Superannuation Code of Practice an upper limit on the number of medical assessments that can be requested of a policyholder and the specific circumstances in which this upper limit could be deviated from.

These recommendations include all feedback from various mental health advocacy groups and are being actioned by the Financial Services Council as incorporations in the 2nd version of the Life Code of Practice. These recommendations should be used as a minimum standard by life insurers when engaging with customers with mental health conditions.

Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry: 1 February 2019 (52)

Although mental health and the treatment of customers with mental health conditions were not specifically called out in the recommendations, the following recommendations will need to be specifically considered regarding sustainability of premiums with an increase in the mental health claims portfolio.

Recommendation 4.5

Duty to take reasonable care not to make a misrepresentation to an insurer: Part IV of the Insurance Contracts Act should be amended, for consumer insurance contracts, to replace the duty of disclosure with a duty to take reasonable care not to make a misrepresentation to an insurer (and to make any necessary consequential amendments to the remedial provisions contained in Division 3).

Recommendation 4.6

Avoidance of life insurance contracts: Section 29 (3) of the Insurance Contracts Act should be amended so that an insurer may only avoid a contract of life insurance on the basis of non-disclosure or misrepresentation if it can show that it would not have entered into a contract on any terms.

Recommendation 4.7

Application of unfair contract terms provisions to insurance contracts: The unfair contract terms provisions now set out in the ASIC Act should apply to insurance contracts regulated by the Insurance Contracts Act. The provisions should be amended to provide a definition of the 'main subject matter' of an insurance contract as the terms of the contract that describe what is being insured. The duty of utmost good faith contained in section 13 of the Insurance Contracts Act should operate independently of the unfair contract terms provisions.

Other recommendations regarding culture and governance, remuneration, claims handling and external dispute resolution will have impact, but this may have similar impact across all claims causes.

Parliamentary Joint Committee (PJC) review on options for greater involvement of life insurance in worker rehabilitation – October 2018 (53)

Following a submission by the Financial Services Council (FSC) and certain life insurance providers to obtain a review of legislation, notably PHI, preventing life insurers from paying for treatment where this will improve return to work, the PJC firmly recommended not accepting the FSC's proposal and in addition recommended that:

- ASIC undertake a full review of the use of rehabilitation services by the life insurance industry
- All discretionary, off-contract arrangements utilised by life insurers be disclosed to ASIC
- The government conduct a sustainability investigation of the life insurance industry

This finding means that where there are gaps in current funding models, for example, Medicare funding of only 10 sessions under the MHCP, life insurers cannot elect to pay for ongoing sessions, even if this will increase the likelihood of a claimant returning to health.

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