Berrill & Watson
SUPERANNUATION & INSURANCE LAWYERS

ACN: 613 000 936
info@berrillwatson.com.au
www.berrillwatson.com.au
Our Ref: 3271
15 May 2026

Mr Peter Kell
Independent Reviewer

Dear Mr Kell,

SUPPLEMENTARY SUBMISSION LIFE INSURANCE CODE OF PRACTICE INDEPENDENT REVIEW

1. Who We Are

Berrill & Watson Lawyers is a consumer insurance, superannuation and financial services law firm. We act for thousands of claimants, who are often vulnerable people, in claims involving life insurance products.

We have seen thousands of real-world insurance disputes. We have seen instances where insurers have done an outstanding job. Equally, we have seen some of the very worst examples of claims management.

The fact that there have been examples of poor claims management speaks to the importance of the Life Insurance Code of Practice (LICOP), and why it is an important part of the life insurance infrastructure, particularly for vulnerable Australians.

We welcome the opportunity to respond to the Interim Report. We have limited our comments to certain parts of your interim report.

2. Mental Health

Before responding to any of the questions which you have asked in relation to the interim report, we feel it is important to recognise an issue which is a significant tension in the current life insurance environment. The issue is that of how the industry is dealing with mental health claims. The issue manifests in a number of different ways including claims, underwriting, product design and how the industry deals with and interacts with people affected by mental health conditions recognising that sometimes those interactions can significantly exacerbate the condition that the person is suffering which is a poor outcome both for the consumer and the insurer.

It is noted that CALI is seeking changes to the code in relation to the DDA and product design to assist them in handling what is frequently described as a mental health crisis in life insurance. If indeed there is a crisis in relation to mental health in life insurance, it would be important for CALI to actively work with the consumer movement to make appropriate changes to ensure sustainability is maintained without unnecessarily diminution of consumer rights and entitlements.

A significant challenge in this regard, is that CALI's submission refers to various statistics that we understand are held by CALI in relation to the prevalence of mental health claims and the claims experience of the industry. Regrettably, that data has not been made publicly available. It is respectfully submitted that the production of that data would be a helpful first step in enabling the broader consumer movement to understand the issues

facing the industry and the magnitude of any such issues. A simple example which is mentioned elsewhere in this submission is that it is unclear how the data relied upon by CALI defines a “mental health claim”. There are many instances where mental health is a secondary rather than primary claim. If a claim is made based upon a neurological or physical injury and the person also experiences mental health issues, such a claim should not be classified as a “mental health claim”. It can readily be seen that understanding the definition of a “mental health claim” and whether insurers across the industry are recording the data consistently, is critical to understanding the issue and prevalence of mental health claims.

Plainly, if the claims experience in respect of claims where the primary claimed condition is physical, has deteriorated in a similar fashion to mental health claims, then there are broader issues in relation to product design and underwriting that need to be considered.

Berrill & Watson encourage transparency and believe that it would be very useful for the mental health claims data to be made public so that the consumer movement can understand the issues and magnitude of the issues.

3. Our Position on Clause 2.1(b): Retain the Prohibition

The Reviewer has correctly identified the nature of the current commitment in clause 2.1(b): it represents a commitment by insurers to go beyond the minimum requirements of the Disability Discrimination Act (DDA) and not include blanket mental health exclusions in new standard form policies. That is the right reading, and it is also the right policy outcome. We support retaining clause 2.1(b) unchanged. Indeed, and for the avoidance of any doubt, the LICOP does not obviate the need to comply with the law. Plainly, the only value in having the commitment in the Code in relation to the DDA is if the commitment achieves something that exceeds the obligations under the law.

CALI’s supplementary submission asks the Reviewer to remove this prohibition and replace it with a DDA compliance standard, on the basis that the industry cannot sustainably manage rising mental health claims without the ability to introduce blanket or standardised limitations in product design. A minimum requirement of such a request would be to produce the data that is relied upon to make such a request.

Importantly, what CALI has said in their submission is worthy of consideration and highlights some of the challenging issues faced now both by consumers and industry in terms of managing the rise in mental health claims. Dealing with such a challenge will require industry and consumers alike to work together to achieve appropriate balance to ensure that insurers remain able to sustainably provide insurance products to the market and to ensure that consumers rights and entitlements are not unreasonably eroded. Berrill & Watson are always prepared in good faith to engage with industry in dealing with issues in relation to life insurance and the rights of consumers.

The industry is facing genuine challenges with mental health claims. Premium increases, product redesigns, and APRA’s public commentary point to real pressures. We acknowledge that. CALI has been doing genuine work on a framework to improve consistency in underwriting and claims decision-making for mental health conditions. These projects, if properly implemented, have the potential to improve outcomes for claimants while giving insurers a more coherent decision-making framework.

The problem with the CALI proposal is not that it identifies a real issue. The problem is that blanket exclusions are the wrong response to it, and the data case for them has not been made.

4. What Does 'Mental Health Claim' Mean?

CALI's supplementary submission relies heavily on industry data to make the case for reform. It reports that mental health is now the driver for approximately one in three TPD claims and one in four income protection claims, with life insurers paying out $1.2 billion more in mental health claims than five years ago.

Before any conclusions are drawn from these numbers, industry needs to be clear as to what the data shows. For example, what is a "mental health claim"? Is it a claim in which mental health exists as any part of a claim (i.e. as a secondary condition)? Or is a mental health claim classified only as a claim in which a mental health condition is the primary claimed condition. This one question is an important one and would potentially dramatically affect the data.

In our experience, many claims that are recorded or classified as mental health claims involve a claimant whose primary disabling condition is a physical one i.e. chronic pain, musculoskeletal injury, autoimmune disease, with a secondary mental health component such as depression, anxiety or an adjustment disorder. This is clinically common and not surprising: serious physical illness and chronic pain frequently give rise to secondary psychological conditions. The two are often inseparable.

But whether a claim appears in the mental health column in CALI's data, or in the musculoskeletal or neurological column, may depend on how the insurer has categorised it, and whether that categorisation reflects the primary or predominant disabling condition, or merely the presence of any mental health condition anywhere in the file.

This matters enormously for the policy debate. Zurich's own data, cited in submissions to this review, indicates that almost half of all its TPD claims that mention mental health do so as a secondary issue alongside a primary physical condition. If this pattern is replicated across the industry, and there is no good reason to assume it isn't, then the statistics CALI relies on overstate the extent to which mental health is the driver, rather than a component, of claims. That is, is the rise in claims specific to mental health, or is there a rise in claims across the board.

Until disaggregated data is available, the statistical case for removing the Code prohibition has simply not been made out. APRA's own quarterly life insurance performance statistics do not attribute loss results to particular categories of claim. At least at present, the causal link between mental health and the industries claims experience is an assertion that the consumer movement is not able to properly understand in the absence of data.

This is not a minor point. Blanket mental health exclusions in standard form contracts would lead to many disputes. Those disputes will invariably be that insurers will allege that a claim is "in part" contributed to by a mental health condition and seek to rely upon an exclusion. As we have stated above, given the prevalence of mental health conditions as secondary conditions this could lead to many disputes. The industry itself will bear the cost of that disputation. Before the Code is changed in a way that triggers this consequence, the evidential basis for doing so needs to be much clearer than it currently is.

5. The DDA Does Not Fill the Gap

CALI's position is, in effect, that removing the Code prohibition is acceptable because the DDA continues to protect consumers from unlawful discrimination. We respectfully disagree with CALI's position. In our view, the way in which the DDA operates in practice creates significant challenges for consumers.

Where a consumer believes that they have been subjected to unlawful discrimination pursuant to the DDA, their rights exist by way of an application via the Australian Human Rights Commission and/or via the Federal Circuit Court or the Federal Court. The cost associated with such proceedings are prohibitive, particularly when one considers the likely benefit amount that is in dispute.

Of course, it is important to note that a person trying to navigate this complex matrix is suffering from a mental health condition that is so severe that they are unable to work. Some people have the benefit of legal representation that may assist them to achieve a just outcome, but the purpose of the LICOP is to provide a set of standards that consumers can rely upon in dealing with a life insurer and the LICOP should provide solutions to genuine consumer issues.

6. Clause 8.10

The LICOP is designed to be a set of standards that consumers can rely upon, and which the industry agrees to be bound by. It is our view that there is no reason why the standards that industry agree to should not also apply in the event that a consumer issues a court proceeding in relation to their entitlements.

In addition to the above, and in the context of a breach of the DDA, the fact that clause 8.10 operates so as to exclude the operation of the Code if a court proceeding is issued, presents a real challenge to the overall operation of the consumers rights. That is, the code assists a consumer in a pre-litigation dispute resolution context where the DDA is essentially unenforceable. If a consumer issues a court proceeding in relation to a breach of the DDA, they won't be able to rely upon the protections provided in the code. For consistency and clarity it is in our view more suitable that the standards that are agreed to continue to apply, even if litigation is commenced.

7. Actuarial Data Transparency

Even for the minority of consumers who could navigate the DDA pathway, there is a further problem. The s.46 exemption requires the insurer to demonstrate that any discriminatory treatment is based on actuarial or statistical data on which it is reasonable to rely and is reasonable having regard to the data and other relevant factors.

In practice, obtaining that data is extremely difficult. In our experience, compulsory discovery produces materials that post-date the discriminatory conduct, with no documented link from published actuarial studies to the specific underwriting guideline that produced the exclusion.

The case of *Ingram v QBE Insurance (Australia) Limited* [2015] VCAT 1936 illustrates the point. When required to produce the actuarial data it claimed underlay its mental illness exclusion, QBE could not do so. The relevant materials were either non-existent or not relevant to the conduct. The proceeding took years.

The Code should require insurers to proactively disclose the actuarial and statistical data underpinning their underwriting decisions, in a form that a consumer can actually understand. Recommendation 2 of the Interim Report moves in the right direction.

We would go further: the Code should require insurers to maintain and annually review the actuarial and statistical data they rely on for underwriting decisions affecting mental health conditions, and to make that data available in plain English when they make

adverse underwriting decisions. An insurer that cannot produce the data on which it claims its discrimination is based should not be able to rely on the s.46 exemption.

8. CALI's Mental Health Framework: The right response to the problem

One aspect of CALI's recent work that we believe deserves explicit acknowledgment in this submission is the industry's development of a framework aimed at improving consistency in claims assessment for mental health conditions. Done properly, a framework that gives claims assessors clear, evidence-based guidance on how to assess individual mental health claims would address the legitimate problem of inconsistency in claim outcomes.

9. Responses to the Reviewer's Questions

Question 1: Should clause 2.1(b) be changed to allow limitations on cover for mental health in standard form policies?

No. The statistical case has not been made out, in part because the data has not been disaggregated to show how many claims involve mental health as the primary disabling condition rather than a secondary one. The DDA does not provide an adequate substitute for the Code prohibition. Blanket exclusions will generate concurrent cause disputes that are expensive for both sides and will fall hardest on claimants whose primary condition is physical. Clause 2.1(b) should be retained.

Question 2: The impact of the proposed approach on consumers and insurers

On consumers, the harm would be significant and would extend well beyond claimants with a primary mental health condition. Any claimant with a concurrent mental health component which, on the available data, accounts for a substantial proportion of all TPD claimants faces the risk that an exclusion is invoked to defeat an otherwise valid claim.

On insurers, the short-term reduction in liability would likely be offset by the cost and complexity of concurrent cause disputation, and by significant damage to public trust in the industry at a time when that trust is already under scrutiny.

Questions 3(a)–3(d):

If, contrary to our primary position, the Reviewer is minded to allow some form of standardised product design features, any such approach must at a minimum:

- require insurers to maintain and make available the actuarial and statistical data underpinning any standardised limitation, updated on at least an annual basis;
- prohibit the use of concurrent cause language ('wholly or in part', 'directly or indirectly', 'to any extent') that would defeat claims where mental health is a secondary condition;
- require genuine individual assessment before any limitation is applied; and
- explicitly require CALI to develop the AHRC guidelines on section 46 into an accessible member standard, as the Commission has long recommended.

We note that CALI has to date not adopted any member standard or guidance document specifically addressing what actuarial and statistical data life insurers must collect, document, and maintain to satisfy the section 46 exemption. This is a gap that predates

the current review by many years. Addressing it should be a Code requirement regardless of the outcome on clause 2.1(b).

10. Code Enforceability

We strongly support the Reviewer's Recommendation 71 that the Code be incorporated into new consumer contracts so that its commitments are contractually enforceable.

A consumer whose insurer breaches a contractually incorporated Code commitment has a real cause of action in a court, with access to genuine remedies. Without contractual incorporation, a Code breach produces, at best, a regulatory response that is of limited direct value to the affected consumer. The Banking Code and Customer Owned Banking Code are already contractually incorporated. The Insurance Council of Australia has committed to contractual enforceability for the General Insurance Code. Life insurance is the outlier without principled justification.

The Hayne Royal Commission said it plainly: if industry codes are to be more than public relations, the promises must be kept, and they must be enforceable by those to whom they are made – the customer. We agree.

We also support Recommendation 66, enabling the LCCC to name non-compliant insurers in inquiry reports. The current position where insurers can breach the Code without being publicly identified removes a significant incentive for compliance. Public accountability is a simple and effective tool, and it has been standard regulatory practice in the financial services sector for years.

We are happy to discuss any of these issues further with the Review.

In the meantime, if you have any questions about this, please contact Paul Watson on (07) 3013 4300.

Yours sincerely,

Paul Watson
Principal
Berrill & Watson Lawyers