Insurance issues for people with health problems: part one

Apr 10 2008 Jonathan Goodliffe

A discussion of regulatory and other problems that arise when insurance is arranged for people who suffer or have suffered from mental health problems. This feature is published in three parts. The first part introduces the subject of mental health and insurance. It records a series of questions put to, and answers from, Toni Borneo of mental health charity Rethink. The second part will be a series of interviews with people who have had problems arranging insurance because of past or present mental health illness. The third part will consider some legal and compliance issues.

Background

Insurance may need to be arranged for the benefit of people who suffer or have suffered in the past from mental health problems. In most cases the person in question will make the arrangements him or herself. Sometimes it may be necessary for someone else (usually a relative, carer or bearer of an enduring power of attorney) to do this on their behalf. Sometimes a mental health problem may be a one-off occurrence. More often, perhaps, these problems may recur from time-to-time with more or less long periods of remission. This is not a rare phenomenon. The Rethink web site suggests the following life-time prevalence rates for three of the most common forms of mental illness:

- Depression: 16.66 per cent (five per cent for clinical depression)
- Bipolar affective disorder: One per cent (of the population that are over 18)
- Schizophrenia: One per cent

Mental health problems are also frequently co-morbid with alcohol, drug and nicotine misuse. People with mental problems may neglect their health more generally and develop physical problems as well, although many of them are able to overcome, more or less, these problems and lead normal lives. Mental illness may present problems in the insurance context for a number of reasons:

- People with past or present mental health problems may be a higher insurance risk, so insurance may be more expensive for them, or more difficult and sometimes impossible to arrange.
- These people may sometimes have cognitive or communication problems, which may affect their ability to understand what they are being sold, to get adequate professional advice and to make full health declarations.
- Many of them will be on state benefits or otherwise on low incomes, which makes them less attractive customers for insurance companies and intermediaries.
- They may be victims of unfair treatment, which has arisen from mis-selling, prejudice or ignorance (many people, for instance, believe mistakenly that schizophrenia means to have a split personality).

Public perception of how insurers treat people with mental health problems

At least two mental health charities, Rethink and Mind, provide advice on their web sites about insurance.

Toni Borneo of Rethink answered some questions which were put to her in writing, as we were not able to meet up. Rethink also put me in touch with some of its "service users" (i.e., clients) who described their difficulties (or otherwise) in arranging insurance. An interview was also organised with one other source who agreed to be interviewed. These interviews are recorded in the second part of this feature.

Questions to and answers from Toni Borneo of Rethink

Question: Please say something about Rethink's work generally.

Answer: Rethink is the leading mental health membership charity. We are experts in severe mental illness and we work towards helping everyone affected by severe mental illness to recover a better quality of life. We run 350 services across the country. We offer expert advice and support to people affected by mental illness, both service users and carers and we campaign for change nationally, through lobbying parliament and working with the media.

Q. Do you help people with addiction (e.g., alcohol or heroin) problems as well as mental health problems (or people who are co-morbid)?

A. We describe this situation, when an individual is affected both by mental illness and addiction, as a "dual-diagnosis". Rethink has services offering support to individuals with dual diagnoses, and we produce information and advice on dual diagnosis for service users and professionals.

Q. What is Rethink's perception of the problems faced by people with mental health problems (service users) in arranging financial products?

A. Rethink has recognised for a long time that financial products, and particularly insurance, can be very difficult to arrange for people affected by mental illness. Some types of insurance can be nearly impossible to obtain. If they do find appropriate cover, it is often very expensive.

A big problem with insurance for people affected by mental illness is inappropriate selling. People are often sold a blanket policy and exclusions are not mentioned. They will then find out later that there are exclusions that have not been mentioned and the policy is actually void, and was no good to them in the first place.

There is a staff training issue for insurance and other financial services — they rarely have understanding of mental health issues.

Q. What help can Rethink give service users?

A. Rethink empowers people through giving them information and advice. Insurance is covered by the Disability Discrimination Act 1995, and it is important that those affected by mental illness are aware of their legal rights.

We also steer people towards companies which we know provide insurance for people with long-term conditions at a more reasonable rate.

Q. Is it feasible for even a large mental health charity to employ workers with financial skills?

A. Rethink does plan to provide money and debt advice in the future. It is a priority for us, but requires external funding.

Q. What about problems arising from non-disclosure to insurers of medical problems (according to Norwich Union depression is one of the conditions which people most often fail to disclose)?

A. There could be some more complicated issues for people who deny that they are ill. Again responsible selling is key here, and good staff training.

Q. Do people get the help they need from their doctors when completing medical declaration forms?

A. Sometimes people actually haven't been given a clear diagnosis by their doctor.

Q. Have you followed the government's policy on financial inclusion?

A. Rethink is pleased that the Treasury's policy acknowledges that financial inclusion is an important aspect of social inclusion. Individuals affected by mental illness, whether service users or carers, often have low incomes and experience barriers to accessing financial services that can lead to exclusion from social participation. The government recognises that vulnerable people are often exploited financially by having to pay the highest costs for financial services. We welcome the Treasury's policies but will have to wait to see if good intentions bring real change for financially excluded people.

Q. Have service users also encountered problems in making claims when they are able to arrange financial products?

A. Again, it is often the case that service users discover that their policy is invalid because of an exclusion that has not been properly explained to them.

Q. People with mental health problems are often on state benefits. How do they get advice on how such benefits may be affected when they buy financial products?

A. Rethink's advice team can often signpost people to various sources of information, including money advisers who are experts in welfare rights. In the future we hope to offer our own money advice services.

Q. When service users do manage to arrange insurance is their premium rating loaded? Is it your impression that the loading is fair?

A. We have heard about people being asked to pay very high premiums because of mental illness, especially when it comes to travel insurance. We know that insurers have to balance risks but we believe that sometimes premiums are inflated to a level that cannot be justified.

Anti-discrimination legislation makes it clear that higher premiums can only be justified where there is evidence that risks are higher as a direct result of an existing health condition. This should be properly investigated, not merely assumed. It is important to look at the individual. Many people manage their illness very successfully. There are examples of good practice out there. Rethink directs people to companies that offer reasonably priced and clearly explained policies for people affected by mental illness.

Q. Anything else?

A. It is worth pointing out that Rethink rarely has enquiries about motor insurance — the Driver and Vehicle Licensing Agency rules ensure that this is a clear and straightforward process. Toni Borneo's comments were put to the Association of British Insurers and it was invited to respond, but it did not.

- ***Jonathan Goodliffe*** *is a solicitor who specialises in insurance regulation. His research paper "Insurance: solving some alcohol problems and causing others" (PDF) is published by the Institute of Alcohol Studies.*

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Insurance issues for people with mental health problems: part two

Apr 11 2008 Jonathan Goodliffe

A discussion of regulatory and other problems that arise when insurance is arranged for people who suffer or have suffered from mental health problems.

Part one of this feature introduced the topic and recorded a series of questions put to and answers from Toni Borneo of mental health charity Rethink. This part records a number of interviews with people who have had problems arranging insurance because of past or present mental health illness. The third part will consider some legal and compliance issues.

Interviews

The names of the people interviewed have been changed to preserve anonymity. Basic information about the mental conditions which they describe may be found on, for instance, the Royal College of Psychiatrists' web site.

Rachel: problems with travel and life insurance

Rachel, 52, has suffered from bipolar affective disorder since she was 15. She has attempted suicide and has overdosed on anti-depressants and anti-psychotics. She was last in hospital two years ago following a bipolar "mixed episode".

She was formerly a care support worker. She retired two years ago and now does voluntary work for Rethink.

She married about 20 years ago. She and her husband could not, because of her condition, arrange a mortgage endowment policy to pay out on her life as well as on that of her husband.

Rachel has never had any problem in arranging motor insurance.

Six years ago she could not get travel insurance at all.

Two years ago, for a trip to Australia, she was quoted premiums for travel insurance which were loaded between £200 to £500. A company that specialises in arranging travel insurance to cover "pre-existing conditions", which the Bipolar Organisation (formerly the Manic Depression Fellowship) had recommended, quoted the £500 loading. Rachel considered this to be very unreasonable and ended up taking out travel insurance which excluded cover for her existing condition.

I asked her whether she had ever gone back to the endowment provider to review the position. She had not. She finds it emotionally difficult to deal with rejection and felt discriminated against.

I also asked Rachel to look at the Financial Services Authority's "Moneymadeclear" web site to see if it made her feel more confident about arranging financial products. She responded:

"I have just had a look at the web site. I felt that I really needed a lot more concentration than I have to be able to really understand it. Concentration varies but is something that generally people with mental health problems have a problem with. There is also no advice for anyone who does have any kind of health problem that would be very useful to anyone with any medical condition."

Andrew: lots of problems but not with motor insurance

Andrew, 57, is single and has had problems with schizophrenia since he was 24. Originally, he owned a house and had job in the City. He reacted badly to injections of Depixol (a drug then more commonly used than now). He stopped taking medication, developed paranoia and delusions and lost his job. He was offered redundancy but did not spend the money on paying the mortgage so lost the house. He ended up living rough as a vagrant for five years.

His driving licence is conditional on continuing recovery from mental illness. He is currently taking the anti-psychotic drug Olanzapine.

Andrew recently bought a new Kia Picanto (current price about £6,000). He made a declaration of his condition to Norwich Union and is paying about £28 per month for "blue ribbon" insurance. He did not know if his premium was in any way loaded on account of his condition but accepted that to the extent that there was any loading it

was probably not unreasonable.

Michael: problems with motor and protection insurance

Michael is in his late fifties. He works in the City.

Michael has had episodes of depression since childhood. He developed a dependency on alcohol in his early thirties. He made a suicide attempt at the age of 36, spent 10 days in hospital and stopped drinking permanently within a few days thereafter. He had a further, less serious, breakdown from depression at the age of 49 which did not involve hospitalisation. Both episodes involved less than a month of work each.

He made two applications for motor insurance a few months after his discharge from hospital. The first was declined and the second was granted with a loaded premium. He did not consider that unreasonable, although over 20 years later these applications sometimes still have to be disclosed (less reasonably in his view) in answer to the common question on proposal forms: "Have you ever made a proposal for insurance which has been declined or granted otherwise than at a standard premium?". From time to time he sought quotes for motor insurance from other sources who failed to respond with a quote when they saw his proposal form.

From the age of about 41 onwards Michael made various applications for protection insurance to cover contributions to his private pension arrangements. Despite impressive efforts by a large insurance broker acting for him, these applications were all declined until about five years later. At this point insurance was arranged at a premium loading of 100 per cent. Michael doubts whether much actuarial analysis went into the calculation of that loading [he accepted that this may have been before the Disability Discrimination Act 1995 came into force]. He did not maintain the protection insurance for very long, concluding that it was not worth the outlay.

John: premium loading for protection insurance

John, 47, is a health and safety adviser. He has been diagnosed with bipolar affective disorder (at first schizoaffective disorder) and takes the anti-psychotic drug Olanzapine. He had his first breakdown in 1997. This followed an episode of overactivity in the course of which he had taken on a series of very ambitious projects. He became deluded and was eventually admitted to hospital. He took three months off work and was then phased back in part-time for a further three months.

He has had three breakdowns since then but they were of greatly diminishing severity.

When well into recovery he applied for a protected income plan. He could not remember the precise details but thought he was initially quoted a standard-rated premium. Then when the insurance company found out about his condition the premium was hiked by a third to a half. He protested without success through his doctor. He thought the premium loading was unreasonable since his recovery and the nature of his symptoms were not taken into account. He did not eventually accept the cover.

Richard: unable to arrange life insurance

Richard, 29, was studying for a degree in business management in July 2006 when he had a mental breakdown and was in hospital until February 2007. He had previously had breakdowns in 2000 and 2001.

Richard thought his breakdown might have been brought on by the stress of studying for his final examinations. He has since completed his degree.

He made five applications for life insurance cover in September 2007. They were all declined. One of the insurance companies suggested he apply again in 12 months time.

Richard thought the attitude of the insurance companies was unreasonable as his condition had improved since leaving hospital and he had not at any point attempted to harm himself.

Rex: getting advice on how annuities and insurance affect benefits entitlement

Rex has a brother, Gordon, aged 60, who has suffered from schizophrenia since his early twenties. Gordon was the beneficiary under a protective trust of which Rex was a trustee. His mother created it 17 years ago. In 1996 Rex took the view that the assets of the trust were too low to make it viable and arranged for it to be terminated. This had to be done in a way which was not only effective in tax terms but also with a view to minimising the impact on Gordon's entitlement to state benefits.

Neither the independent financial adviser nor the solicitor who acted were able to advise on benefits issues, so Rex had to work his way through the regulations with the help of the Mitcham Citizens Advice Bureau. In the end the assets of the trust were used to purchase an annuity and a single premium insurance bond for Gordon. Single premium insurance bonds and the capital value of annuities do not count towards the calculation of capital for most benefits purposes.

Rex found the IFA generally unhelpful. Constant reminders had to be sent to him to complete matters. In particular, it was nearly a year after he had received instructions that the IFA eventually forwarded the bond that

he had been asked to take out. This was in marked contrast to Rex's personal experience in dealing with product providers and intermediaries in relation to his own investments.

Rex added that several years earlier arranging for a building society account to be opened for Gordon had been a challenging task as Gordon did not have a passport or a driving licence. Different personnel in the building society had different views as to what other documents that verify identity complied with their know-your-customer requirements. The process of opening the account took several months.

- ***Jonathan Goodliffe*** *is a solicitor who specialises in insurance regulation. His research paper "Insurance: solving some alcohol problems and causing others" (PDF) is published by the Institute of Alcohol Studies.*

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Insurance issues for people with mental health problems: part three

Apr 16 2008 Jonathan Goodliffe

A discussion of regulatory and other problems that arise when insurance is arranged for people who suffer or have suffered from mental health problems.

Part one of this feature described the issues and covered a series of questions put to and answers from Toni Borneo of mental health charity Rethink. Part two recorded a series of interviews with people who have had problems arranging insurance because of past or present mental health illness. This part considers some legal and compliance issues. The views expressed in this part are those of the author and are not necessarily shared by Rethink.

Disability Discrimination Act 1995 and 'unfair underwriting'

An insurer's refusal to offer cover or to offer it otherwise than on onerous terms does not engage the Financial Services Authority's regulatory objectives. In general, an insurer is under no legal duty to offer insurance for any specific risk. The Disability Discrimination Act 1995 in effect introduced an exception to this rule. It makes it unlawful to discriminate against disabled people in a number of areas. These include employment and the provision of goods, facilities and services such as insurance.

When the DDA was brought into force it was, however, recognised that there are circumstances where insurers might be justified in offering less favourable terms to disabled people. The Disability Discrimination (Services and Premises) Regulations 1996 set out the circumstances where insurers can do this. "Disability" in this context covers mental impairment but not alcohol or drug dependency.

The Association of British Insurers' "An Insurer's Guide to the Disability Discrimination Act 1995" (PDF) contains guidance on how to achieve compliance with the DDA and the regulations. The DDA and the regulations do not, for instance, prevent an insurer from loading the premium on a life insurance contract taken out by someone with a history of mental illness. Regulation two of the regulations provides that:

> "Where, for a reason which relates to the disabled person's disability, a provider of services treats a disabled person less favourably than he treats or would treat others to whom that reason does not or would not apply, that treatment shall be taken to be justified for the purposes of section 20 of the Act in the circumstances specified in paragraph (2).
>
> (2) The circumstances referred to in paragraph (1) are that the less favourable treatment is—
>
> (a) in connection with insurance business carried on by the provider of services;
> (b) based upon information (for example, actuarial or statistical data or a medical report) which is relevant to the assessment of the risk to be insured and is from a source on which it is reasonable to rely; and
> (c) reasonable having regard to the information relied upon and any other relevant factors."

Example — taking account of individual circumstances on an income protection policy

The ABI's guidance contains practical advice for insurers on how to respond to some of the issues described above. It contains, for instance, the following case study:

> "A man aged 38 sends you an application form for life cover and income protection. He has answered 'yes' to a question that asks whether the applicant has ever had any form of mental or stress related illness that involved treatment and/or resulted in time off work.
>
> However, you find out from his GP that he had been suffering from anxiety related symptoms that started about seven years ago. At the time, he had two weeks off work but had no prior history of anxiety. He was prescribed Seroxat [an anti-depressant] and was referred to a Community Psychiatric Nurse. Over the next two years, the anxiety was gradually resolved and the treatment stopped. Since then, he has been symptom free for the last five years.
>
> In the circumstances of the case, you accept the life cover and income protection on standard terms with no extra premium."

No cases on 'unfair underwriting'

There do not seem to have been any judgments in the courts which concern claims under the DDA with regard to "unfair underwriting". The Equality and Human Rights Commission enforces the DDA.

There is no reference to "unfair underwriting claims" on the Financial Ombudsman Service's web site, although claims under the DDA against insurers may come within FOS jurisdiction, even when the victim of discrimination is only a "potential customer" because he does not end up with any insurance (DISP 2.4.8R). Emma Parker of the FOS commented to me:

> "We have not seen many (I am not aware of any) complaints about this yet. Insurance complaints continue, in the main, to be triggered when a claim is turned down — payment protection insurance being the current notable exception — rather than about the sales process. As you indicate, disputes of this nature can be referred to us. We would want to be satisfied that any decision by the underwriters complied with the Disability Discrimination Act 1995 and was justifiable and fair — and not based on stereotypes or generalisations."

It is perhaps not surprising that such claims have not materialised. People with a record of mental health problems are doubtless even less equipped than the average policyholder to pursue a claim against an insurance company. Moreover, what may appear at first blush to amount to an unfairly loaded premium rating may ultimately prove to be justifiable.

Alternatively, the loading may arise because either the proposer or the intermediary acting for him has not adequately presented the positive aspects of the proposer's recovery as a counterbalance to the negative record of his illness. There may be a case for insurers to cue proposers for this kind of material by asking questions such as: "Is there anything else you wish to say in support of your application?"

In any event where a complaint is made to the FOS that arises from the DDA it will often be appropriate to join both the insurer and the intermediary as respondents.

Travel insurance is a product which Rethink specifically identifies as problematical. An insurer might argue, however, that it is primarily for the government to negotiate reciprocal agreements (such as those which apply within the European Economic Area) with other countries so that insurance does not have to cover the full cost of medical care for UK tourists in those countries.

Motor insurance

Toni Borneo pointed out that to arrange motor insurance does not usually give rise to undue difficulties for people with a record of mental health problems. Michael was the only person interviewed in the second part of this feature who was initially declined motor insurance. His experience dates back to the mid-1980s. Since then most motor insurers are content to leave health issues to the Driver and Vehicle Licensing Agency. This seems to work well for policyholders. It is perhaps questionable whether it works so well for the victims of motorists who are unfit to drive.

Specialist providers

There are a number of firms that specialise in providing insurance for people with medical problems. Partnership Assurance, for example, is a life assurer. It claims in relation to its protection products that:

> "Our experience of underwriting impaired lives allows us to provide cover for people with severe medical conditions who may previously have been considered uninsurable, while continuing to benefit those whose medical condition is considered moderate."

Partnership Assurance and some other firms also take medical problems into account in underwriting annuities on more favourable terms than would be available to someone in normal health.

Free Spirit is a trading name for PJ Hayman & Company Limited, which is an appointed representative of Crispin Speers & Partners Limited, an insurance and reinsurance broker. Free Spirit describes itself as a "travel insurance solution for people with pre-existing medical conditions" and claims that:

> "Many Travel Insurers will not provide cover for pre-existing medical conditions and those that do may impose terms that are either onerous or unacceptable. We have designed Free Spirit to solve this problem, and in the vast majority of cases we are able to provide cover for pre-existing medical conditions."

If that claim is right then it may be that other insurers are routinely infringing the DDA. In some cases it may be that it is the intermediary who is unwilling or unable to undertake the work necessary to find an insurer willing to cover the risk. This too may sometimes amount to unlawful discrimination.

Non-disclosure issues

In many cases people with mental health problems may fail to disclose that fact when applying for insurance. Toni Borneo accepted that this may be an issue and a Norwich Union study identifies depression and alcohol problems as two of the main conditions people fail to disclosure when completing insurance application forms.

The solution may consist, as Borneo suggested, partly in better training for salesmen and better designed web sites. State benefits and mental health issues do, however, seem to be covered in training syllabuses that, for instance the Chartered Insurance Institute, publish. There may also be scope for dialogue between the insurance and medical professions with a view to promoting health as well as financial awareness.

A fairer approach to claims handling will also doubtless emerge as a result of the FSA's treating customers fairly initiative, the Law Commission's project for the reform of insurance contract law and the ABI's new guidelines on non-disclosure.

A further strategy that might perhaps be calculated to encourage a higher degree of honesty on proposal forms might be to balance negative messages with positive ones. The FSA's "Moneymadeclear" web page on critical illness insurance, for instance, says that:

> "It's essential that you give full, honest answers to questions you are asked about both your own and family medical history. Giving incomplete or wrong information could invalidate your policy and any claim you make on it."

It could then go on to say words to the effect of "even if you disclose a history of medical problems critical illness insurance may still be a worthwhile investment, although you might have to pay a higher premium". Better still it could include a special page on insurance for people with physical and mental health problems, as Rachel suggested in the second part of this feature.

Nonetheless, there will doubtless still be many cases in which even the best practice will not be able to penetrate the "denial" of the customer as to his or her health issues, however, well or badly he is treated in the sales process.

Treating customers fairly

Apart from non-disclosure issues, people with past or present mental health problems are particularly vulnerable to unfair treatment. The reasons for this are identified in the first part of this feature. There is perhaps scope for this aspect of TCF to be the subject of a special study. It is indeed recognised in the FSA's Business Plan 2008/09 which states at page 28:

> "We will partner with national and local organisations to deliver financial information and guidance to consumer sectors such as ex-offenders and prisoners; those in affordable housing; those receiving cancer support; lone parents; carers; women's organisations; those with autism; and those with mental health problems."

Treating vulnerable customers fairly might sometimes mean deciding not to make a sale to them because they do not appear to understand what they are buying. On the other hand, even sophisticated customers often buy insurance without understanding the product and can be pleasantly surprised to find that they are covered against risks they had never thought about.

Benefits issues

Rex, one of the people interviewed in part two of this feature, mentioned his need to get benefits advice on behalf of his sick brother Gordon. It may be worth identifying the regulatory aspects of one of the issues which he mentioned.

People who suffer from chronic ill health, whether physical or mental, will often be in receipt of one or more state benefits. These include, for instance, disablement benefit, disability living allowance, housing benefit and sickness benefit. Each of these benefits is subject to broadly similar rules as to eligibility. These include rules as to how the applicant's other income and capital resources should be calculated to determine whether he qualifies or not.

These rules generally exclude from calculation of the applicant's capital "the surrender value of any policy of life insurance" (see for instance Regulation 17 of the Housing Benefit Regulations 2006). It may, therefore, make sense for people on the borderline of benefit entitlement to invest in a single premium insurance policy rather

than or, in addition to, an individual savings account. There are similar rules for annuities. Under Regulation 13, "the value of the right to receive any income under an annuity or the surrender value (if any) of such an annuity", is excluded from the calculation of capital, although a part of the payments from the annuity will count towards income.

This is, however, subject to Regulation 49 which provides that:

> "A claimant shall be treated as possessing capital of which he has deprived himself for the purpose of securing entitlement to housing benefit or increasing the amount of that benefit ..."

Purpose in this context means "significant operative purpose". The claimant might argue that the significant operative purpose of buying a single premium bond was to acquire an investment rather than to deprive himself of capital.

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