Why is it such a challenge to level up mental health insurance with the needs of the financial professional?

Kevin Rideout 4/26 "This is just my view, and everyone should do their own research, i.e., Food for thought only."

Finance companies often present themselves as sophisticated risk managers, yet many struggle to provide adequate mental health insurance for their own employees. This tension reflects not a single failing but an interaction of structural, economic, cultural, and regulatory factors that shape benefit design and decision-making. In this essay, I argue that financial institutions' difficulty in offering appropriate levels of mental health insurance stems from (a) legacy benefit structures built around acute, physical illness; (b) actuarial and underwriting practices that treat mental health as an unpredictable, high-risk cost centre; (c) cultural norms in finance that stigmatise psychological vulnerability and prioritise short-term performance; and (d) fragmented regulatory and market incentives that do little to reward sustained investment in mental health coverage. Together, these factors create a system in which mental health support is rhetorically endorsed but practically under-funded and narrowly defined.

Historically, corporate health benefits—especially in markets like Hong Kong, the UK, and the US—evolved around physical, acute conditions: inpatient stays, surgeries, and clearly diagnosable diseases. Plans were structured to cover discrete episodes with relatively predictable costs, and underwriting models were calibrated using long-standing data on physical morbidity. Mental health conditions, by contrast, often present as chronic, relapsing disorders with fluctuating severity and complex comorbidity (e.g., depression with anxiety and substance use). They require sustained outpatient care (psychotherapy, psychiatric follow-up, medication management) whose frequency and duration can vary enormously between individuals. Traditional group medical policies frequently placed low caps on outpatient psychiatric care, excluded many psychological services altogether, or treated them as "extras", reflecting an underlying assumption that mental health was peripheral rather than central to employees' overall functioning.

From an actuarial perspective, mental health conditions are often perceived as a source of "unbounded" risk. Unlike a broken bone or an appendectomy, there is no universally agreed protocol for how much therapy is "enough", and treatment response is highly heterogeneous. For insurers and corporate buyers, this introduces concerns about moral hazard (employees "over-using" therapy) and adverse selection (individuals with pre-existing conditions disproportionately seeking generous plans). Consequently, many finance firms' purchasing groups offer coverage, and they accept products with strict limits on visits, low reimbursement for psychological services, and broad

exclusions for pre-existing mental health conditions. In some cases, long-term disability policies either exclude or heavily restrict coverage for mental and nervous conditions or require a very narrow definition of “total and permanent disability” that many people with serious depression or anxiety will never meet, despite being unable to sustain high-intensity work. This actuarial conservatism is reinforced by the difficulty of quantifying the positive return on investment from more robust mental health coverage, even though research increasingly links mental health interventions to reduced absenteeism and improved productivity in financial services.

Cultural factors within finance further exacerbate under-provision. Financial institutions are characterized by high-pressure environments, long working hours, and strong norms around toughness, resilience, and “always-on” availability. Career progression often depends on perceptions of reliability under stress, rapid decision-making, and willingness to sacrifice personal life for work. Within such cultures, disclosing mental health difficulties can be perceived—explicitly or implicitly—as a sign of weakness or lack of “fit”, creating powerful disincentives for employees to use the limited benefits that do exist. This under-utilisation can perversely reinforce management’s belief that demand for mental health coverage is low or that existing provision is adequate. At the same time, leadership teams often rise from cohorts that navigated their own struggles without formal support, leading to a tacit narrative that “we managed without these benefits; why are they suddenly necessary?” In practice, this can result in symbolic initiatives—awareness campaigns, one-off talks, or basic employee assistance programs—being prioritized over costly, comprehensive insurance upgrades.

Structural features of the finance industry also influence benefit decisions. Many firms, particularly smaller asset managers, brokers, and fintechs, operate on tight margins and are acutely cost-sensitive regarding fixed overheads such as health insurance. Benefit decisions are typically made annually, framed as part of compensation cost management, and evaluated against peer practice rather than clinical need. If competitors offer only minimal mental health cover, any firm that significantly enhances its benefits risks being seen as “over-spending” or attracting higher-risk employees—despite the potential longer-term gains in retention and performance. This dynamic is reinforced within global institutions, where benefit designs are often centralized or regionally standardized. Local HR teams in financial hubs may have limited authority to deviate from group templates, even when local mental health needs and service availability warrant more comprehensive coverage.

Regulatory and legal frameworks provide, at best, partial incentives to improve mental health insurance. Anti-discrimination and disability laws may prohibit direct discrimination against employees with mental health conditions, but they do not typically mandate specific levels of mental health insurance coverage. As long as employers offer some form of group medical plan and can demonstrate a facially

neutral benefit structure, they may technically comply with legal requirements while still offering very limited practical access to meaningful mental health care. Moreover, enforcement bodies and courts often focus on workplace adjustments (e.g., flexible hours, leave) rather than on the content of insurance policies. As a result, finance companies can respond to mental health-related complaints primarily through HR and management measures—performance management, leave arrangements, or return-to-work plans—without addressing the underlying inadequacy of insurance schemes.

Another reason finance companies struggle is the disconnect between mental health benefits and the metrics that senior leadership typically monitors. Senior executives and boards are accustomed to tracking key performance indicators such as revenue, return on equity, VaR, or cost-income ratios. The benefits of robust mental health coverage—reduced presenteeism, lower error rates, fewer conduct issues, improved retention of high performers—are diffuse, lagged, and hard to attribute directly to specific benefit line items. Without clear internal data linking mental health coverage to financial outcomes, budget holders may view enhanced insurance as a discretionary cost rather than a strategic investment. External consultancy reports and academic studies do document substantial productivity losses and cost savings associated with mental health interventions in financial services. Still, these findings often fail to translate into internal business cases that resonate with CFOs and compensation committees.

Finally, there is a persistent conceptual gap in how many finance companies think about "risk" when it comes to their people. Market risk, credit risk, and operational risk are treated as core disciplines, with sophisticated models, dedicated teams, and clear governance. Human risk—particularly the risk that impaired mental health will affect decision-making, client relationships, and control effectiveness—is often managed informally or reactively. When episodes occur (a breakdown on the trading floor, a high-profile departure due to burnout, or, in the worst cases, self-harm), the organizational response may focus on the individual rather than on the underlying system of support and prevention. Without reframing mental health insurance as part of the firm's overall risk and resilience architecture, efforts to improve coverage will continue to be constrained by cost-control mindsets and short-termism.

In summary, finance companies' difficulties in offering appropriate mental health insurance arise from the intersection of legacy benefit designs focused on acute physical illness, actuarial caution around open-ended mental health costs, cultural norms that stigmatize vulnerability, cost, and competitive pressures that discourage generous coverage, limited regulatory compulsion, and a narrow conception of risk that sidelines human factors. Overcoming these barriers would require not only revising insurance contracts but also repositioning mental health as a strategic component of

performance, conduct, and risk management, backed by data that speaks in the language financial decision-makers use every day.