Australian royal commission reveals predatory practices of insurance companies

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Hearings at the ongoing Royal Commission into financial services have revealed that some of Australia's largest insurance companies routinely use aggressive tactics to sell products to people who do not require them, do everything they can to avoid paying claims, and operate with impunity in the increasingly unregulated sector.

The testimony in recent weeks follows exposures of the parasitic activities of the country's banks, which are among the most profitable in the world. Like the Royal Commission as a whole, however, the hearings on the insurance industry are an exercise in damage control.

The Commission was called by the federal Liberal-National government to assuage widespread public anger. Its aim is to present the activities of the financial institutions as the result of mistakes and isolated cases of wrongdoing. This is to obscure the fact that they result from the ever-greater dominance of the financial sector over the economy, which has been promoted by successive governments, Labor and Liberal-National alike.

The hearings have nevertheless pointed to systematic malpractice across the insurance sector. In an indication of the scale, the Commission received over 8,700 public submissions, only a fraction of which will be the subject of testimony.

Almost 10 percent of the submissions related to the rapidly growing life insurance market.

Among the most explosive revelations at this month's hearings was that AMP continued to charge at least 4,656 life insurance holders a total of $1.3 million after they had died. Company representatives acknowledged that the deductions had not ended, and up to $1 million in owed payouts had not been made, despite the fact that AMP had been notified of the deaths. The company claimed that this was the result of "systems errors."

In other cases, health risks were apparently exaggerated to justify maximum premiums. One worker was overcharged $76,700 in life insurance premiums deducted by AMP from his superannuation. When he complained the company refused to repay him.

The worker, along with many others, had been incorrectly labelled as a "smoker" when he had left one employer and moved to another. If they did not reaffirm that they were "non-smokers," AMP's systems automatically assumed that customers who changed employers were now "smokers." This resulted in premiums of at least $1,000 more per month.

The hearings also heard testimony that major funds sought to avoid paying out when their clients suffered life threatening illnesses.

In one instance, TAL Life Limited, one of the country's largest providers of life insurance, terminated $5,000 per month payments to a customer who had been diagnosed with cervical cancer five months before.

After the woman's cancer diagnosis in late 2013 the company had apparently sought to find grounds for withholding payments. Its investigators found that the woman had sought professional help for depression, between 2007 and 2009, and used the fact that she had not declared this on her application as grounds for cancelling her coverage. The woman was compelled to take action through the Financial Services Ombudsman to seek recompense.

Testimony also documented an aggressive sales culture driven by commissions. According to senior counsel assisting Rowena Orr, ten of the largest life insurance companies had paid $6 billion to financial

advisers in commissions over a five-year period. In comments to the press, former employees stated that they could make up to $8,000 per week on their base salary in commissions.

This has included cold-calling the vulnerable and the poor. In a particularly egregious case in 2016, a Freedom Insurance representative sold a policy over the phone to a 26-year-old man with Down syndrome. During the call, the man was clearly unaware of what he was agreeing to. When his father complained, Freedom Insurance initially refused to cancel the policy before subsequently issuing an apology.

It emerged at the hearing that the sales representative had been the subject of multiple complaints for predatory calls. He had, however, been praised by managers for the volume of his sales. An April 2016 email from his team leader congratulated the representative for "smashing over 200 lives and earning amazing commissions."

ClearView Wealth acknowledged that it may have breached anti-hawking provisions in federal legislation over 300,000 times by trying to sell life insurance through cold calls.

The company's chief actuary and risk officer Gregory Martin acknowledged that poor people had been targeted. When asked about the precise demographic, however, he stated, "I'd emphasise lower, not lowest. After all, there was no point selling to customers who couldn't afford the product or were too poor."

Among the litany of issues covered at the hearings, it has again been underscored that the largest insurers seek to avoid payouts after natural disasters. In one case, Suncorp offered a couple with home insurance just $30,000 after their property was inundated by flooding in the Hunter Valley in 2015. The damage cost them $744,000.

After Victoria's 2015 Christmas Day bushfires, Suncorp and its subsidiaries offered cash payments to insured customers hit by the disaster that were hundreds of thousands of dollars below the value of what they had lost. The company was fined just $43,200 for misleading advertising, well below the possible sanction of $7.2 million contained in legislation.

Throughout the hearings, it has been clear that regulation is largely for appearances. Rules are rarely enforced, and breaches infrequently penalised with more than a slap on the wrist.

Orr stated last week, for instance, that general insurance companies had breached their own self-regulations over 31,000 times without penalty. The industry lobby group, the Insurance Council of Australia, responded by declaring that this was because they were more concerned with "customer remediation" than with "punishing" constituent companies. In other words, nothing is done to prevent the same practices being repeated.

The parasitic activities of the insurance companies are the direct result of the economic deregulation carried out by the Labor governments of prime ministers Bob Hawke and Paul Keating, in office from 1983–1996.

Responding to the globalisation of production, Labor junked previous regulations on the money markets and sold off the Commonwealth Bank of Australia. This was part of a broader program, aimed at attracting international investment and removing any barriers to maximum profit-accumulation by the largest financial operators.

A 2004 study by Deakin University academic Monica Keneley noted that in the life insurance sector this was accompanied by a decline in earlier mutual funds that were less profitable, and an increase in the direct involvement of the banks. In 1980 there had been no bank-owned life insurance companies. In 1990 banks controlled 9 percent of the market, while in 2000 the figure was 44 percent.

The banks' turn to life insurance was part of a diversification of their operations that included the provision of speculative financial services and exorbitant housing loans. As a result of this—and the fact that they have been effectively propped-up by successive governments, including during the 2008 financial crisis—the profits of the four largest banks have risen almost six-fold from $5.4 billion to just under $30 billion over the past two decades.