Committee	House of Representatives Standing Committee on Economics
Inquiry	Inquiry into insurers' responses to 2022 major floods claims
Question No.	001-035
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Questions

Code

Alan Kirkland told the inquiry that codes 'can be useful as long as they contain provisions that do enhance consumer protection above the minimum that's required by the law, they have strong independent oversight through a code governance committee that's got appropriate representation on it and there are appropriate sanctions for breaches of the code' (Hansard, p. 6).

1. ***Does the GI Code meet the requirements of a 'useful code'? If not, why not? What measures do you think need to be taken to make it more useful?***

Industry codes of practice can play an important role in how financial products and services are regulated in Australia.

The General Insurance Code of Practice ("the GI Code") is currently being reviewed by an independent panel and the Insurance Council of Australia indicated in evidence to this Inquiry that it intends to submit the revised Code to ASIC for approval.

Given that ASIC may ultimately be required to make a decision about whether to approve the revised code under section 1101A of the Corporations Act, it may be inappropriate to comment on the merits of the current Code at this stage.

If we are ultimately required to make a decision on whether to approve the Code, our decision will be informed by the recommendations of the independent review of the Code and any relevant findings or recommendations arising from this Inquiry.

Assuming that the GI Code contains provisions that 'enhance consumer protection above the minimum required by the law':

2. ***How can such provisions deliver protection if code compliance is voluntary, non-compliance is unlikely to be detected, and there are no or only minor consequences for not complying?***

We have expressed our views on code compliance mechanisms and sanctions in ASIC Regulatory Guide 183, Approval of financial sector codes of conduct (RG 183). While RG 183 refers to the criteria we consider when deciding whether to approve a code, it also articulates ASIC's general views on effective industry codes.

In summary, these include that codes should allow the code administrator to apply appropriate remedies and sanctions for breaches of the code. Remedies should include compensation for direct financial loss or damage and the ability to make binding non-monetary orders. Sanctions can include measures such as corrective advertising notices, fines and suspension or expulsion from the industry association.

In terms of the General Insurance Code of Practice, the independent Code Governance Committee ("CGC") monitors insurers' compliance with the Code. If the CGC finds that an insurer

has breached the Code, the CGC should then make sure that the insurer addresses the cause of the problem so that other consumers are not affected in the future.

The Code Governance Committee may require insurers who have breached the Code to:

- take particular steps to rectify the breach within a set timeframe
- audit insurer compliance with the Code at the insurers' cost, and/or
- advertise to correct something that the Code Governance Committee decides needs correcting.

For significant breaches of the Code, the Code Governance Committee may impose additional sanctions including requiring insurers to compensate individuals, publish facts and/or make a community benefit payment of up to $100,000.

3. ***Are you aware of insurers ever having self-reported serious breaches of the code to the Code Governance Committee?***

Detailed questions about self-reporting of serious breaches of the Code would be best addressed to the Code Governance Committee but we are aware that some insurers have reported serious breaches of the Code to the Code Governance Committee. Insurers may also self-report these directly to ASIC where they constitute a reportable situation.

4. ***If general insurers were to register their code with ASIC, and to nominate a provision or provisions as enforceable, who decides what the penalty/consequence will be for breaches of that provision?***

In such a scenario, a breach of an enforceable code provision may attract civil penalties (including pecuniary penalties) and/or other administrative enforcement actions from ASIC, for example the issuance of an infringement notice.

A contravention of an enforceable code provisions may attract a penalty of up to 300 penalty units. A civil penalty would be determined by a Court. Administrative enforcement actions would be determined by ASIC.

5. ***What provisions of the code does ASIC believe should be enforceable provisions?***

Given that ASIC may ultimately be required to make a decision about whether to approve the revised code under section 1101A of the Corporations Act, which may or may not include proposed enforceable code provisions, it may be inappropriate to comment on the merits of enforceability of particular provisions at this stage.

The factors that ASIC must consider in relation to enforceable code provisions are included in paragraph 1.69 – 1.101 of the Explanatory Memorandum to the Financial Services Reform (Hayne Royal Commission Response) Bill 2020.

Our decision in relation to any enforceable code provisions will be informed by the recommendations of the independent review of the Code and any relevant findings or recommendations arising from this Inquiry.

ASIC's powers

6. ***Apart from broken pricing promises, have there been other instances of 'serious' failures to comply with legislative requirements in the past two years? If so, what did the case/s involve and what action did you take/are you taking?***

Enforcement outcomes within the past two years include the following matters:

- ASIC issued 38 design and distribution obligation (DDO) interim stop orders for pet insurance products issued by Hollard and Petsure via brands including Woolworths, RSPCA, Petbarn, Guide Dogs, Medibank, Bupa and HCF. These stop orders were issued due to deficiencies in the target market determinations (TMDs) for the products. Following these interim stop orders, the insurers made amendments to their TMD documents that addressed ASIC's concerns. As a result, ASIC revoked the interim stop orders on the pet insurance products and no final stop orders were made.
- ASIC cancelled the AFS licence of Assurance Cover Australia Pty Ltd, which provided cover through a discretionary mutual fund for drivers in the peer-to-peer transport industry, for not holding required professional indemnity insurance cover.
- While unsuccessful, ASIC took proceedings against Auto & General in relation to unfair contract terms in insurance contracts.

We are currently investigating a number of insurers in relation to poor claims handling practices.

Mr Kirkland told the inquiry (Hansard, p. 11) that ASIC had several investigations underway involving claims handling. He said: 'In the area of claims handling, the law is sometimes difficult for us to make out a case. Often, we'd be looking at whether we were taking action for an insurer's failure to comply with its obligation of utmost good faith under the Insurance Contracts Act or some of the provisions under the other laws that we regulate.'

This suggests that ASIC's powers to regulate the insurance industry are limited.

7. ***Are existing laws inadequate to support ASIC's regulatory role over insurers?***

The existing scope of ASIC's insurance jurisdiction is relatively new. Many of the key provisions and penalties that ASIC relies on to take enforcement action against insurers were introduced following recommendations made by the Financial Services Royal Commission. These include:

- new penalties for breach of s912A of Corporations Act and s13 of Insurance Contracts Act;
- commencement of the design and distribution obligations (DDOs);
- expansion of the unfair contract terms provisions to insurance contracts; and
- claims handling reforms.

In the past few years, ASIC has focused on bringing matters to court to test these new powers. We have expended considerable resources to identify matters which may lead to enforcement action. As a result, for example, we have tested the application of s13 to the process that an insurer needs to undertake before declining claims for fraudulent non-disclosure in a case against Zurich (23-351MR), and are currently investigating a number of insurers in relation to poor claims handling practices. Taking such matters to court helps to clarify how the relevant provisions operate.

Since the application of some of these provisions in the insurance context are relatively new and not fully tested in court, we do not currently have certainty about how they operate. However, a recent case that ASIC brought in relation to unfair contract terms in insurance contracts has highlighted that there may be difficulties in applying those provisions effectively in the insurance context (see answer to question 28).

ASIC also notes the consultation process conducted by Treasury that concluded in November 2023 on policy options to address unfair trading practices in Australia. This included consultation on several policy options that included a prohibition on unfair trading practices. If such a prohibition were introduced and covered financial services, this would improve ASIC's ability to take enforcement action in response to the issues before the Inquiry.

Mr Kirkland also said: 'If we find a case and where there's a strong basis to take action, we will do so because we think it's really important to establish the deterrent effect—to send a strong message that insurers need to treat those obligations seriously, and that includes

making sure they've got the right resources and processes to handle claims efficiently, honestly and fairly.'

8. ***Mr Kirkland's earlier statement, above, suggests that there are few cases in which the law provides ASIC with a strong basis to take action. Is this correct?***

To succeed in demonstrating a breach of a relevant provision, ASIC needs to demonstrate that the elements of the cause of action have been satisfied. This can be challenging. For instance, in the claims handling space, proving a breach of s13 or s912A requires fairly egregious misconduct. Not all delays in claims handling, for example, will constitute a breach.

To prove a breach of s13, ASIC will need to show that the insurer failed to act with utmost good faith towards an individual policyholder. This involves looking at the specific circumstances of individual claims, and showing that the insurer's conduct in those circumstances fell below standards of commercial decency and fairness. The case law on s13 suggests that this would require significant failures on the part of the insurer. While some poor claims handling practices may fail to meet community expectations, this does not necessarily mean that they would constitute misconduct in breach of s13.

To prove a breach of s912A, ASIC generally needs to show that the conduct is systemic, i.e. caused by the insurer's policies and procedures. The case law on s912A more broadly indicates that the provision does not require perfection on the part of the insurer. Isolated examples of poor claims handling conduct would unlikely, by themselves, indicate the types of systemic failures that are required to prove a s912A case.

The inquiry has been provided with a number of examples of insurers not handling claims in an honest, fair and efficient way, as required under the Corporations Act and the terms of their licence.

9. ***Why haven't these insurers been prosecuted? Why haven't they lost their financial services licences?***

ASIC is reviewing case studies from the Inquiry and monitoring reports of misconduct concerning poor claims handling practices. We currently also have a number of claims handling matters under investigation.

In our recent experience, there are certain challenges associated with finding claims handling matters suitable for enforcement action. For example:

- Claims handling cases often arise in the context of critical events such as natural disasters. Deeper investigation may uncover delays or errors that were caused by a range of factors, not all of which are attributable to the insurer; and
- Reports received by ASIC may lack documentary evidence. Matters which initially look promising can lack evidence of misconduct once initial inquiries have been made.

IDR report

ASIC is investigating insurers' IDR processes (Hansard, p. 3).

10. ***When do you expect to publish this report?***

We expect to publish this report in Quarter 4 of the 2024 calendar year.

11. ***What do you hope to achieve by publishing the report?***

The primary objective of the report is to reduce the risk of consumer harm arising from non-compliance with specific enforceable paragraphs of RG 271. These enforceable paragraphs cover a range of requirements, including in relation to IDR timeframes (271.56, 271.64-271.66, 271.71, 271.75,

271.163), what an IDR response must contain (271.53-271.54), links between the IDR process and AFCA (271.111-271.112) and resourcing (271.142-271.143).

In addition to publishing a report we will also provide individualised feedback to insurers participating in the review, identifying practices that do not meet the requirements of RG 271. Where we identify failures to comply with enforceable requirements, we will consider appropriate regulatory responses, including enforcement action.

Data

12. ***What key information do you need from insurers, that you are not getting now, or not getting consistently, that would help you better regulate insurers?***

As part of the APRA & ASIC Joint 'General Insurance Discussion Paper - Insurance Data Transformation', we have flagged the following key focus areas, with related proposed use cases:

Focus Area	ASIC Use Case
Products	Analysing whether products are designed to meet consumer needs and respond to availability and affordability issues.
Sales & Retention	Analysing whether products are sold fairly and appropriately and meeting consumers' expectations
Claims Outcomes	Analysing whether claims are handled fairly and reasonably
Catastrophe Events	Analysing consumer outcomes following a catastrophe event and identifying any areas of concern.

Further information on the proposed data dictionary included in the discussion paper is available here: Appendix - General Insurance Discussion Paper Insurance Data Transformation | APRA

13. ***Should/could insurers adopt standardised claims-handling documents/systems to capture the information you seek?***

ASIC is agnostic on the systems and processes used by insurers to provide required data, so long as they provide data in the prescribed, standardised format.

14. ***Should the provision of such information be mandated under insurers' licence provisions? Or legislated?***

ASIC is open to various mechanisms for the provision of such data. In relation to prudentially regulated entities such as general insurers, APRA is able to collect data under its reporting standards per Section 13 of the Financial Sector (Collection of Data) Act 2001.

This approach allows sharing of information with APRA and ASIC and reduces the regulatory burden of providing information separately to agencies.

If ASIC wished to collect data from non-prudentially-regulated entities such as businesses providing claims handling services, this would generally only be possible by issuing a notice to each business, as described in our oral evidence to the Inquiry. If ASIC had a general power to require the provision of data by financial services businesses on a recurrent basis it would improve our ability to monitor claims handling practices.

15. ***What is the state of play with the Insurance Data Transformation Project? When is 'enhanced data collection' likely to start? What information do you hope to get from it that you don't get now?***

The joint discussion paper was published on 12 October 2023, with consultation submissions received up to 22 December 2023.

APRA and ASIC are now reviewing the submissions and considering next steps, which includes timing of the enhanced data collection. Within the consultation paper, we also sought industry views on appropriate timelines, noting the required investment, preference for a pilot approach, and competing data investment requirements (e.g. the introduction of Prudential Standard CPS 230 Operational Risk Management).

Further information on the data to be received under the project is outlined in our response to Q12.

> Insurers are now required to report standardised IDR data to ASIC, and ASIC has power to publish this data and name individual firms.

16.When will you start receiving this standardised data?

ASIC started receiving IDR data from insurers in September 2023. This first batch involved the collection of IDR data for the period 1 January 2023 to 30 June 2023. Insurers are now required to report their IDR data every 6 months thereafter.

17. Will you name individual firms?

The IDR data reporting reforms provide that ASIC may publish the IDR data at the aggregate or firm level.

> ASIC has previously consulted with industry and consumer groups to gather detailed submissions on publication of the IDR data. We have not yet made a decision on whether to name individual firms.

Systemic issues

In the 2022-23 financial year, AFCA reported 17 systemic issues (SI) to ASIC (ASIC submission, p. 6). 'ASIC took further action in relation to 11 of the notifications received in the 2022-23 financial year.'

18. Do you mean that you took action in 11 of the 17 SI that AFCA referred to you?

In the 2022–23 financial year AFCA reported 105 systemic issues (SI) to ASIC—including 17 that related to general insurance (see paragraphs 13-17 of ASIC's submission to the Inquiry).

All 105 AFCA notifications received by ASIC are assessed by our Misconduct and Breach Reporting team. ASIC took further action in relation to 11 of the total notifications received in the 2022–23 financial year and merged two notifications with existing matters. The remaining matters form valuable intelligence that informs ASIC's regulatory decision making.

19. If so, what actions did you take in these cases?

Of the 13 systemic issue matters that were reported in 2022-23 that ASIC took further action on:

- 5 matters were investigated and subsequently closed (e.g. due to insufficient evidence of misconduct or systemic breaches, or the issue was resolved);
- 3 matters are subject to ongoing investigation (e.g. breaches of general conduct obligations, insurance contracts act, licence cancellation, unlicensed advice);
- 3 matters were investigated and resulted in negotiated outcomes; and
- 2 matters are currently subject to ongoing surveillance in relation to a current project (a remediation process or thematic review).

The above matters cover a broad range of conduct and are not limited to general insurance.

20. You have investigations underway in relation to 2022 flood claims. Are these investigations separate to the 'action' mentioned above? If not: how many investigations?

Systemic issues notifications from AFCA are not ASIC's only source of information about misconduct. We receive information about misconduct in a number of ways, including reports of misconduct from members of the public and consumer groups, and reportable situations lodged by insurers. We are also proactively monitoring case studies from the Inquiry.

While we cannot comment on individual investigations, we currently have several underway which relate to different types of claims (including flood claims) and are assessing other instances of potential misconduct to determine if they are appropriate for investigation.

21. What systemic issue or issues are involved?

ASIC's investigations are ongoing. ASIC is unable to provide further information at this stage as disclosure of that information may prejudice those investigations.

22. What enforcement options are open to you in relation to these cases?

In relation to claims handling matters, the main provisions that ASIC may rely on are s13 of the Insurance Contracts Act and s912A of the Corporations Act. We may seek penalties under each of those provisions.

AFCA must report certain matters to you 'such as serious contraventions, failures to give effect to determinations and systemic issues' (submission, p. 6).

23. Does 'contraventions' refer to contraventions of the General Insurance Code of Practice or something else?

'Contraventions' in this context refers to serious contraventions of financial services and credit laws.

We expect AFCA to report a serious contravention of the Code if it would be a breach of a financial services law (e.g. an insurer's general obligations as a financial services licensee to act efficiently, honestly and fairly).

24. What consequences do insurers face for 'serious contraventions'?

ASIC assesses all AFCA notifications, and carefully selects matters for further formal investigation and enforcement action based on our strategic priorities.

ASIC may consider taking three broad types of enforcement action in the case of serious contraventions by insurers:

- We will generally consider pursuing criminal proceedings for offences involving serious misconduct that is dishonest, intentional or highly reckless.
- We may consider pursuing civil penalty proceedings for contraventions of civil penalty provisions and seek a civil pecuniary penalty. Courts can also make compensation orders to compensate consumers and require the wrongdoer to establish a compliance, education or training program.
- We may consider taking administrative action such as:
    - suspending, cancelling or varying an AFS licence
    - issuing a product intervention order or stop order
    - issuing a public warning notice or infringement notice
    - accepting a court enforceable undertaking from the insurer

In some instances, it is more efficient and effective to address matters using other regulatory tools, such as engagement with stakeholders, surveillance, guidance and/or education.

25. What are the consequences for insurers who fail to give effect to AFCA determinations?

Failure to give effect to an AFCA determination is a breach of REG 7.6.03C of the *Corporations Regulations*, which requires licensees to take reasonable steps to cooperate with AFCA in resolving any complaint, including by giving effect to any determination made by AFCA in relation to the complaint.

There are a range of actions available to ASIC where an entity has failed to co-operate with AFCA, such as:

- civil penalty proceedings;
- injunctive relief;
- compensation orders;
- administrative action; and
- negotiating compliance outcomes.

ASIC told the inquiry that insurers need to make sure they have adequate numbers of staff to live up to their legislative requirements. (Hansard, p. 11).

26. What legislative requirements do you refer to?

The claims handling obligations that insurers must meet are the same as the general obligations of all AFS licensees under s912A of the Corporations Act.

Under s912A(1)(d) AFS licensees must have available adequate resources (including financial, technological and human resources) to provide the financial services covered by the licence and to carry out supervisory arrangements. However subsection 4 of s912A specifically carves out APRA-regulated entities such insurers from the obligations under s912A(1)(d).

This leaves other obligations under s912A, such as (1)(a) which provides that "a financial services licensee must do all things necessary to ensure that the financial services covered by the licence are provided efficiently, honestly and fairly" and (1)(e) which provides that a "financial services licensee must maintain the competence to provide those financial services". In ASIC's view, these obligations can encompass adequacy of resourcing.

A court would ultimately determine on a case-by-case basis if an insurer has breached its obligations under the Act, including whether their staffing was adequate to meet their obligation to provide claims handling services efficiently, honestly and fairly.

27. ASIC has said that many insurers had inadequate staff numbers in claims handling and IDR. Has legal action (e.g. under the Corporations Act or otherwise) been taken against them? If not, why not?

At paragraph 54 of our submission to this inquiry, we found that in response to increasing claim volumes the insurance industry had increased their total full-time equivalent claims handling staff, however they relied on increasing their temporary, rather than full-time, claims handling staff to meet surges in claims due to ICA declared events.

At paragraph 55 of our submission to this inquiry we found that the increase in IDR resourcing in 2022 did not keep pace with the increase in IDR cases in 2022, and that there was a risk that the increase in resources would not keep pace with the increase in complaints in 2023 also.

ASIC has not commenced proceedings against any insurer regarding their resourcing of their claims handling or dispute resolution functions. ASIC's regulatory toolkit includes a range of tools for addressing conduct – such as engagement with stakeholders, surveillance, guidance and education, as well as enforcement action.

In the case of insurer resourcing, we have chosen to publish REP 768 with a concurrent media release 23-221MR, gather further data from insurers on levels or resourcing, and publicly highlight the need to improve resourcing in a public speech made by former ASIC Deputy Chair Karen Chester to industry

on 12 October 2023. Adequacy of resourcing has been a consistent theme in our direct engagement with insurers and with the Insurance Council of Australia. We reserve the right to take further action.

Policy exclusions

AFCA and the Code Governance Committee both report a concerning trend in claim denials based on 'maintenance' and 'wear and tear' exclusions that rely on 'poor quality' expert reports that are often overturned when reviewed.

ASIC REP 768 recommends that insurers 'ensure that overly broad and open-ended obligations do not amount to unfair contract terms'.

According to the evidence, the way that some of these exclusions are being applied suggests they amount to unfair contract terms.

28. Has ASIC taken, or is ASIC considering, legal action against insurers for applying these terms unfairly? If not, why not?

Since the unfair contract term protections were extended to insurance contracts, ASIC has undertaken a targeted review of potential unfair terms in insurance contracts. Following the review, ASIC commenced a number of investigations.

ASIC ran our first case alleging an unfair contract term in an insurance contract against Auto & General (24-057MR). We argued that a term which required consumers to notify the insurer of any changes to their home and contents was unfair. ASIC took on this case because we believed the term was unfair as it imposed an unclear obligation on the customer regarding what they needed to disclose to the insurer, and suggested that the insurer had a broader right to refuse or reduce the amount payable under claims than was available under the Insurance Contracts Act. In that case, Justice Jackman found that the term was not unfair.

ASIC is considering the implications of his Honour's decision. Following the decision, ASIC would need to consider the impact of other laws, including the Insurance Contracts Act, when assessing whether a particular term in an insurance contract is unfair. The impact of this case is that an insurer is able to have a term in their contract that would be unfair if not for the operation of other laws. However, consumers are unlikely to be familiar with other laws that impact their rights under their insurance contracts. This will likely make it harder for consumers to understand their rights and therefore to know when those rights have been breached. This will also significantly limit the circumstances in which ASIC can take unfair contract terms enforcement action within the insurance space, including in relation to maintenance exclusions, and wear and tear exclusions.

Cash settlements

29. Given the problems identified with cash settlements, should wording in the cash settlement fact sheet about seeking independent advice be made more emphatic? For example, rather than the 'policyholder should consider obtaining legal advice….' should it say that 'ASIC recommends that policyholders/you get independent legal or financial advice on the amount offered to ensure it will cover the actual cost of repairing damage', etc.

ASIC supports any steps that make consumers more informed about decisions they make in relation to their insurance claims.

In ASIC's view, insurers should not offer cash settlements in ways that would require independent financial and/or legal advice in every cash settlement situation. Steps insurers could take to minimise the amount of independent financial and/or legal advice consumers need include:

- only offering cash settlements to consumers who are suitable to receive them or where no other fulfilment is available.

- proactively and transparently communicating the detail of the cash settlement through whatever medium the consumer prefers. Cash settlement details should include what is being cash settled, for how much and why, and what remains outstanding under the claim.

Name of 'cash settlement fact sheets'

> ***Allianz says cash settlement fact sheets should be renamed because they imply that the sum offered is a final, settlement payment. Yet these fact sheets are used when temporary emergency payments are provided, which confuses many consumers, who worry that the sum presented is what the insurer is offering to settle their claim. See comments below.***
>
> ***Nicholas Scofield (9 February hearing Hansard report, p. 26):***
>
> ***We found a lot of confusion with people when we gave them a $5,000 emergency payment, or just small amounts of payment. For example, when we settle their contents before the building and we give them something called a 'settlement sheet', they are thinking, 'Is this it?'—when, in fact, we may give people multiple cash settlement fact sheets over the course of their claim as we pay various losses in cash.***

30. Should these forms be named differently – for example, a 'cash payment fact sheet' or 'cash payment information'?

We support any changes to the cash settlement fact sheet that improves consumer understanding of the cash settlement process.

ASIC has begun reviewing the cash settlement fact sheet relief instrument ahead of its expiry in 2025. This relief allows insurers to give emergency payments to consumers in certain circumstances without first giving them a cash settlement fact sheet. This review may provide insights into how consumers are understanding cash settlement fact sheets. We will also consider any relevant findings or recommendations of the Inquiry as part of this review.

31. Do regulators know what percentage of approved claims involve cash settlements?

We do not currently receive any claims data that would address this question.

32. If known, has the percentage of total claims that involve cash settlements increased in the past five years?

We do not currently receive any claims data that would address this question.

AFCA penalties

33. Should the non-financial loss penalty limit (that AFCA can impose) be increased from $5,400 to better compensate consumers for the long delays they endure (often from systemic problems) and to encourage insurers to take complaints more seriously? Long delays are also occurring in non-flood related claims.

AFCA is required to make adjustments to its compensation caps and monetary limits every three years in line with CPI/ wage indexation. These caps and limits have recently increased as of 1 January 2024, see Incoming adjustments to AFCA's monetary limits and compensation caps (1 January 2024) | Australian Financial Complaints Authority (AFCA).

In addition to (or instead of) compensation for financial loss, AFCA can decide that financial firms should compensate complainants for non-financial loss. Compensation for non-financial loss is capped at:

- $6,300 per claim for complaints lodged on or after 1 January 2024.

- $5,400 per claim for complaints lodged between 1 January 2021 and 31 December 2023.

If there are multiple grounds of non-financial loss in the one complaint, AFCA can make multiple non-financial loss awards. We understand AFCA is implementing this approach for complaints against general insurers – for example delays in claims handling.

Treasury's Independent Review of AFCA in 2021 specifically considered whether compensation caps for non-financial loss should be increased (outside of the normal indexation). The Review did not support an increase in the compensation cap for non-financial loss, as there was insufficient evidence to suggest the existing cap was inadequate and AFCA decisions are not reviewable.

The Review suggested AFCA should continue to collect data on decisions to award compensation for non-financial loss to help inform future consideration of this matter.

If there is new evidence the existing non-financial loss cap is insufficient to appropriately compensate complainants for their suffering, then it may be appropriate to give further consideration to whether the cap should be increased.

34. Should the fees that insurers pay AFCA for dispute resolution be increased to encourage them to improve their handling of claims and complaints?

AFCA's current funding model is broadly based on a 'user pays' approach to fees. Heavy users pay more to account for their use of AFCA's service.

Key features of AFCA's funding model are as follows:

- Single annual registration fee ($375.55 for financial firm members)
- Complaint fees (first 5 complaints free, then scaled fees depending on when the financial firm resolves the complaint)
- User charge (see below)
- Systemic issues fees (see below)

The user charge is a fixed annual amount which is calculated at the end of the financial year, applied to members with six or more complaints. The user charge is proportionately allocated based on the number, closure point and complexity of the complaints each member closed in the relevant financial year, compared with same data for all members in the same period.

This model is intended to create incentives for firms to use internal dispute resolution to decrease complaints to AFCA. Firms can significantly reduce their fees and charges through improvements to their IDR, and by resolving complaints earlier in the EDR process.

A single fee is charged for a systemic issue investigation, irrespective of the number of related complaints. Four different charging levels can apply, reflecting the time taken to investigate the matter and the level of expertise required.

We expect that general insurers with high numbers of complaints and systemic issues in the last financial year will receive higher AFCA fees.

By way of background, AFCA recently conducted a comprehensive review of its funding arrangements, and implemented a new model from 1 July 2022. In 2021 Treasury also made recommendations that AFCA should provide greater transparency of its fees, and that the arrangements should not disincentivise firms from defending unmeritorious complaints or disadvantage small financial firms (recommendations 7 and 8 of the Review). These recommendations were implemented by AFCA in 2022.

Improving the clarity and quality of policies

Consumer and legal aid groups say insurance documents should be shorter, and use plain English and not legal jargon.

35. How could this be achieved? For example, should insurers use regulator-approved templates?

In general, ASIC agrees that insurance documents should be clear, concise, and effective to inform consumers of relevant terms/exclusions in the policy and help them make informed decisions.

We note that in 2011, the Government introduced a mandatory one-page Key Fact Sheet for home insurance which sets out the basic terms to improve consumer understanding of the policy. At the time, Treasury issued a discussion paper and sought industry feedback on the content, format, and structure of the proposed template.

Any requirement for insurers to use standard templates for insurance policies would require legislative change, so would be a matter for government. It would be important for any mandated templates to be subjected to rigorous consumer testing in order to ensure that they achieve the intended outcome of improving consumers' understanding of complex policies.