ASIC
Australian Securities & Investments Commission

Navigating the storm: ASIC's review of home insurance claims

Report 768 | August 2023

About this report

This report outlines ASIC's work to better understand the consumer experience in home insurance claims since 1 January 2022, when claims handling and settling became a regulated financial service. It summarises our key observations on how insurers are meeting their obligations and highlights areas for improvement.

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About ASIC regulatory documents

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Examples in this report are purely for illustration; they are not exhaustive and are not intended to impose or imply particular rules or requirements.

Executive summary

ASIC's review of home insurance claims

For consumers in the unfortunate situation of needing to claim on their insurance policy, timely and fair claims handling is crucial. This report shows that claims handling generally is under strain—while there are some aspects outside insurers' direct control, there are many aspects where insurers can and should improve their claims handling practices.

Since 1 January 2022, insurers who provide claims handling and settling services have been obligated under their Australian financial services (AFS) licence to provide those services efficiently, honestly and fairly. Insurers handling claims were already obliged to act consistently with the duty of utmost good faith.

Recent law reform was intended to lift claims handling standards and enhance ASIC's ability to act where obligations are breached.

Note: See s912A of the *Corporations Act 2001* (Corporations Act) and s13 of the *Insurance Contracts Act 1984*. For relevant regulatory obligations, see Information Sheet 253 *Claims handling and settling: How to comply with your* AFS licence obligations (INFO 253). For industry standards subscribing insurers must meet, see the General Insurance Code of Practice (Code).

In June 2022, ASIC commenced a review to better understand the consumer experience in home insurance claims, and assess the current state of claims handling from the start of the new regime and how this compares to insurers' regulatory obligations.

We observed both good and poor practices across all six insurers participating in our review, with areas for improvement identified in relation to communication, project management, recognition of expressions of dissatisfaction, treatment of vulnerable consumers and resourcing.

Insurers must meet their obligations across *all* claims—for this reason, our latest review encompasses both severe weather event and non-severe weather event (other) claims.

Why we reviewed home insurance claims

ASIC reviewed home insurance claims to assess claims handling conduct relative to insurers' obligations. In June and July 2022, we met with the Insurance Council of Australia (ICA) and the following six insurers participating in this review:

- AAI Limited (Suncorp) (AAI)
- Allianz Australia Insurance Limited (Allianz)
- Auto & General Insurance Company Ltd (A&G)
- Insurance Australia Group (IAG), which includes Insurance Australia Limited and Insurance Manufacturers of Australia Pty Limited
- QBE Insurance (Australia) Limited (QBE), and
- Youi Pty Ltd (Youi).

All six insurers are subscribers to the Code and comprised 63% of the general insurance market in Australia, by annual gross written premiums as at March 2022.

Note: See Australian Prudential Regulation Authority (APRA), Quarterly general insurance institution-level statistics database, September 2017 to March 2023 (issued 25 May 2023).

At the time, insurers were facing pressures due to severe weather events, including CAT221. As at May 2023, insurers had incurred $5.87 billion in total insured losses across more than 241,000 claims arising from CAT221. This is the costliest insurance event on record in Australia. ASIC is aware that severe weather events test an insurer's ability to manage claims.

Note: 'CAT221' as declared by the ICA on 26 and 28 February 2022 refers to the February–March 2022 floods in Queensland and NSW. These figures are sourced from the ICA's Data hub.

What we did in our review

Claims handling covers a broad range of activities in the process from an inquiry to lodgement, assessment, a decision and fulfilment of a claim. Our review focused on three areas, designed to capture a broad range of consumer experiences: see Figure 1.

Figure 1: Three complementary areas covered by ASIC's review

00101
11001
01100

We reviewed **quantitative data** (up to 46 datapoints) from participating insurers for 218,256 home insurance claims (building and/or contents) lodged between 1 January and 31 March 2022.

We requested **150 claims files** (25 files per participating insurer) from those claims lodged between 1 January and 31 March 2022 for a targeted review to gain deeper insights into the claims life cycle and identify frictions in the claims handling process that can lead to consumer harm.

We commissioned **qualitative consumer research** (not limited to participating insurers) involving 40 consumer interviews and 25 case studies across Australia to capture consumers' attitudes to the claims process, their personal situation, and their experience with their insurer.

Note: See Appendix 1 for full details of the methodology of our review. This targeted approach, including sampling a small number of claims files, is non-representative, meaning our qualitative observations do not reflect any sense of proportionality across insurers or industry. In this report, we identify the source attributable to our observations by referencing the complementary areas covered by ASIC's review.

In November 2022, we sent a letter to general insurers setting out ASIC's expectations that insurers be prepared, proactive, transparent, consumer-centric, and responsive in meeting their claims handling obligations. This letter also set out our expectation that insurers review whether they are allocating adequate resourcing to claims handling.

As a follow-up to the November 2022 letter and an insurance roundtable with the Australian Financial Complaints Authority (AFCA) in May 2023, we wrote to large general insurers seeking further information on resourcing efforts to deal with significant issues and delays with claims handling and dispute resolution.

The responses to our letter showed an overall increase in the resourcing of claims handling, albeit with a significantly increased reliance on temporary staff. Importantly, they also revealed under-resourcing of dispute resolution by general insurers. ASIC requests that insurers further analyse the resourcing of claims handling as soon as practicable and immediately address under-resourcing of dispute resolution. See Table 1 on page 8 for the metrics that insurers should track.

Snapshot of insurers' claims data

This snapshot is based on data provided by the six participating insurers for the **218,256 home insurance claims** lodged between January and March 2022, and includes data on the progress of those claims up to September 2022.

We collected data for claims lodged in relation to several severe weather events. Most claims lodged for severe weather events were due to the February–March 2022 floods in Queensland and New South Wales (CAT221). Other severe weather events resulting in claims in our collection included the October 2021 severe storm in South Australia and Victoria, and the Mansfield earthquake of September 2021.

Because each insurer provided their data to ASIC at different times, this snapshot is point-in-time only and does not account for claims handling actions outside of the sampling window. As a result, this data underestimates complaints, Code breaches, and overall rates of claims decided, receiving first repairs and cash settlements.

Claims lodged and outcomes

Data on 218,256 claims lodged was provided by all six insurers:

- **57%** were building claims, **22%** contents claims and **21%** building and contents claims
- **43%** of claims related to severe weather events and **57%** to other events, and
- **76%** of claims were reported as accepted or partially accepted, **8%** declined, **12%** withdrawn and **4%** not yet subject to a decision.

Vulnerability, complaints and Code breaches

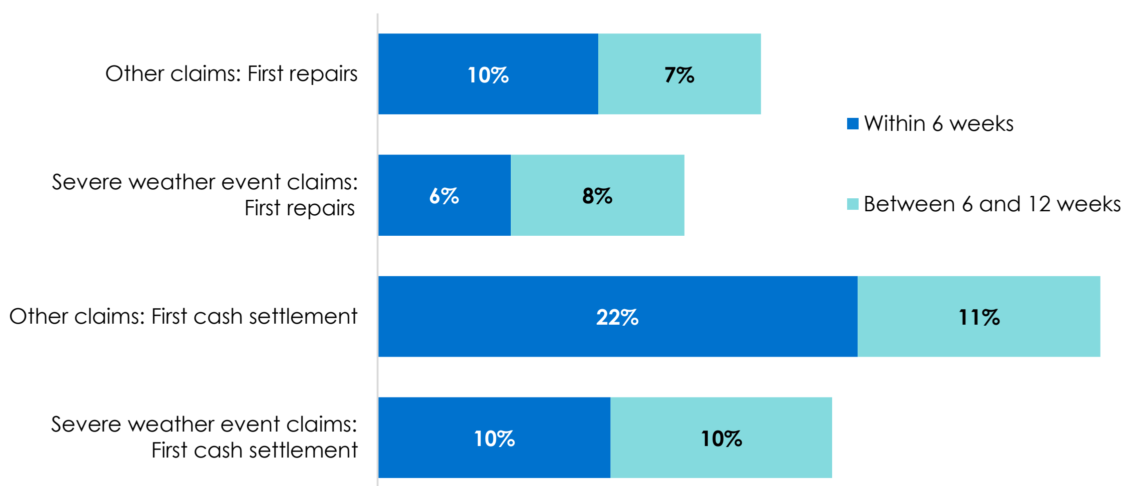
Data on vulnerable consumers, complaints and Code breaches was provided by five insurers:

- **3,639 (2%)** consumers were identified as vulnerable
- **23,759 (11%)** claims had at least one consumer complaint, and
- **21,550 (11%)** claims had at least one potential or actual Code breach.

Repairs and cash settlements

Four insurers provided data on the claims that received a first repair or first cash settlement. We then measured how many occurred within 6 and 12 weeks after claim lodgement: see Figure 2.

Figure 2: Percentage of severe weather event claims and other claims first serviced after lodgement



Note: See Table 2 for the data underlying this figure (accessible version).

Key observations from our review

Improving the claims handling experience

Insurers' obligations when handling and settling claims efficiently, honestly and fairly are set out in Table 4 of INFO 253. Generally, insurers need to act:

- in a timely way
- in the least onerous and intrusive way possible
- fairly and transparently, and
- in a way that supports consumers, particularly those who are experiencing vulnerability or financial hardship.

The timeframes for handling claims set out in the Code are useful and explicit indicators of what industry considers to be appropriate standards. Although not mandatory, subscribing to and complying with the Code is a strong indicator of an insurer's commitment to standards that complement the regulatory obligations. The General Insurance Code Governance Committee (Code Governance Committee) is responsible for monitoring and enforcing the Code.

Insurers' obligations for handling disputes are set out in Regulatory Guide 271 *Internal dispute resolution* (RG 271).

In our review, we observed that all participating insurers can improve. Primary areas for improvement include:

- **better communications** to consumers about decisions, delays and complications
- **better project management** and oversight of third parties
- **better handling** of complaints and expressions of dissatisfaction
- **better identification and treatment** of vulnerable consumers, and
- **better resourcing** of claims handling and dispute resolution functions.

In this report, our observations track insurers' regulatory obligations across the typical stages of a claim. We also draw insurers' attention to key areas that require focused efforts to improve the consumer experience.

We observed practices across the claims process that were inefficient. For example, insurers failed to proactively project manage third parties and to communicate transparently with consumers about who would be attending their property, when and why.

We also observed that some consumers may not have been treated fairly – for example, where consumer vulnerability was not identified by insurers.

Note: In each section of this report, we have highlighted insurers' obligations under INFO 253 and the Code standards that are relevant to our review.

Frictions detract from the consumer experience

Frictions frustrate and can be harmful to consumers who may then disengage or withdraw from the claims process. Insurers must actively address frictions to ensure they are meeting their obligations and deliver quality customer service in times of need.

In our review, we observed frictions that could be addressed with sufficient resources, attention and time. If not properly addressed, these frictions may result in complaints and possibly withdrawn claims that are otherwise valid.

Poor communication is a constant source of dissatisfaction

We observed instances of good and poor communication practices by all insurers. Good communication practices sometimes helped alleviate claims handling frictions as they arose. Conversely, bad communication can exacerbate frictions felt by consumers with the claims handling process.

All insurers demonstrated they could achieve timely communications by engaging proactively and transparently with consumers and delivering key information. In our consumer research, open communication and a map of the claims process led to high consumer satisfaction. In some examples if the claim was delayed or denied, satisfaction remained high, so long as expectations were appropriately managed by insurers and third parties.

However, we also observed consistent frustration with timeliness and quality of communication with consumers feeling neglected, frustrated and overwhelmed. All insurers demonstrated instances of poor communication – for example, failing to update consumers in a timely way. This was most prevalent in building claims where we observed poor project management and a lack of oversight of third parties.

Insurers can pre-empt some frictions by ensuring that consumers understand what their policy covers, any exclusions that apply and what to expect when claiming on their policy. This extends to information in disclosure documents, websites, marketing and call scripts.

Converging forces shape the claims handling terrain

In our review, we observed the impact of external forces, such as severe weather events, and how they can affect the claims handling terrain, putting significant pressure on the resources of insurers and third parties.

A series of severe weather events in 2022 increased the number of claims received by insurers. Home insurance claims rose 25% between financial years 2020–21 and 2021–22. This caused significant delays in claims handling. In February 2023, AFCA reported that delays were the leading cause for complaints relating to CAT221. Insurers redeployed resources from other teams to accommodate the surge in CAT221 claims; however, this contributed to delays in other claims.

Note: See the annual industry data report (1 July 2021–30 June 2022) released by the Code Governance Committee, and AFCA receives over 2000 complaints in year since SEQ/NSW floods on the AFCA website.

The cumulative effect of severe weather events was compounded by ongoing challenges caused by COVID-19 and the global economic landscape, including a shortage of skilled workers (e.g. claims handling staff), supply chain issues (shortage of materials), and restricted or delayed access to parts of Australia (for assessors and tradespeople).

We observed that all participating insurers took some action to relieve pressure on consumers over the course of our review. Examples include:

- preparing for anticipated surges in claims by onboarding staff and stress-testing their disaster response teams
- providing extra amounts on top of cash settlements to account for future inflation, and
- when delays occurred, waiving excesses for some consumers.

Severe weather events are increasing in frequency and severity

Insurers should be prepared for the 'new normal' of more frequent severe weather events, starting with what is directly within their control. To meet their claims handling obligations, insurers need to:

- **minimise frictions** in the claims process
- **permanently enhance** their claims handling and dispute resolution systems, practices, resourcing, capacity and responsiveness
- **adequately prepare for disasters** by proactively uplifting resourcing rather than scaling-up resources once one has occurred, and
- **plan for repeated disaster events that overlap**, demanding significant resources to support consumers from the recovery stage through to the completion and closure of claims.

To adequately manage resourcing, insurers should also track the following metrics for full-time equivalent (FTE) staff and review these for any impact on consumer outcomes:

- the number of claims and disputes (through both internal and external dispute resolution) handled by FTE staff, and
- the proportion of temporary to permanent FTE staff.

Areas for improvement

Insurers need to handle and settle claims fairly and transparently, without undue delay and with minimum intrusion and burden. They must ensure that consumers know what to expect in the claims process and are informed about decisions in a timely way: see Table 4 of INFO 253.

As set out in the Code Governance Committee's 2022 annual industry data report, Code breaches increased by 40% on the previous year and claims handling has been the top source of Code breaches in each of the past five years.

While not all claims will be resolved quickly, they must be handled well. Insurers need to meet their regulatory obligations and community expectations.

Ongoing focused efforts by insurers on resourcing and the areas for improvement, outlined in this report, will go a long way to reducing frictions and smoothing inefficiencies within insurers' direct control that otherwise drain insurers' capacity.

Our findings on the areas for improvement informed by this review are summarised in Table 1, where we link our findings to regulatory obligations and industry standards. We have also given individual feedback to each participating insurer based on our observations in this review.

Table 1: ASIC's findings on areas for improvement of claims handling practices

Area for improvement	What insurers must do	Reference
Better communications – for transparency and timeliness	Insurers must be clear, proactive and transparent in communications to prevent or overcome confusion of consumers. Insurers should proactively inform consumers of their claim progress and decisions, outlining any further steps in the claims process.	Table 4 in INFO 253 and Pt 8 of the Code
Better project management – for minimum intrusion and burden	Insurers must maintain adequate oversight of insurer-appointed third parties and manage the claims process for consumers. This extends to notifying consumers about the purpose, order and timing of assessors and trades attending their home.	Table 4 in INFO 253 and Pt 8 of the Code
Better handling of complaints – for fairness	Insurers must adequately identify and respond to expressions of dissatisfaction and comply with their obligations for resourcing and resolving complaints. Insurers must ensure that staff are trained to detect and adequately respond to expressions of dissatisfaction at the earliest opportunity.	RG 271 and Pt 11 of the Code
Better treatment of vulnerability – for fairness	Insurers must recognise consumers experiencing vulnerability and tailor their services to consumers who are experiencing vulnerability and treat them accordingly.	Table 4 in INFO 253 and Pts 9 and 10 of the Code
Better resourcing – for timeliness and fairness	Insurers must have adequate resourcing to enable their claims handling and dispute resolution functions. This extends to ensuring that staff are properly trained and skilled to handle claims efficiently, honestly and fairly, as well as to identify expressions of dissatisfaction and vulnerability.	Tables 4 and 5 in INFO 253

Initial responses set up the claims journey

Insurers' obligations

Insurers must act in a timely way, fairly and transparently, with minimum intrusion and burden. Insurers must tailor their service to consumers who are experiencing vulnerability or financial hardship. For relevant obligations, see Table 4 of INFO 253, and paras 58–59 and 68 and Pts 9–10 of the Code.

Insurers can do better to close information gaps

Even before lodging a claim, consumers typically inquire about policy coverage, applicable exclusions, and the amount of excess payable to help them decide whether to lodge the claim.

While we observed that all insurers do well responding to inquiries, not all consumers know what to ask. Some frictions we observed could be avoided by insurers closing information gaps earlier in the process.

There was a degree of negativity and scepticism toward insurers

In our consumer research, we observed that some consumers believed insurers look for loopholes and small print to avoid paying out a claim.

Not all consumers knew who they were insured with, while some were confused by branding. For example, one consumer intended to switch insurers because they were unhappy with the service provided but had mistakenly only switched brands (and stayed with the same insurer).

Consumers tend to be confused by the claims process

In our consumer research, we observed that some consumers had pre-conceived ideas about the claims process and the impact of making a claim, for example, on future insurance premiums and the excess payable. Some consumers believed that claiming for multiple items would have a negative impact on the 'main' part of their claim. For example, one consumer opted not to claim for some items.

Note: General insurers have systemically failed to honour premium pricing discounts (e.g. 'no claim' discounts) to consumers as outlined in Report 765 *When the price is not right: Making good on insurance pricing promises*.

Few consumers understood what their policy or claim covered

In our consumer research, we observed that policy inclusions and exclusions were rarely known or completely understood, with some consumers assuming the 'basics' were covered such as flood, fire and accidental damage:

- *Building claims were less predictable and more complex than contents claims* – For example, consumers were upset to learn that building damage resulting from 'wear and tear' was not covered and were unaware of their obligations for keeping their property in 'good condition' (see Decisions need good communication).
- *Some consumers believed their claim had been partially declined only to find not all items had been claimed* – Insurers did not always communicate this effectively until a decision had been made.

Proactive, insurer-led conversations provided greater transparency

In our consumer research, we observed some insurers taking proactive steps to inform consumers about other claimable items. For example, one consumer opted not to proceed with a claim for motor burn out in their spare freezer but was pleasantly surprised to be told that food spoilage was covered without having to pay the excess.

> Insurers should provide **key information during initial inquiries** so that consumers may better understand their options: see Table 4 of INFO 253 and paras 58–59 of the Code. This may include information about their cover, what they can claim, the impact of making a claim, and a map of the claims process.
>
> Insurers should close information gaps early to avoid unmet consumer expectations later, **increasing consumer satisfaction** and reducing the likelihood of complaints, which should reduce pressures on resourcing: see Table 4 of INFO 253 and para 68 of the Code.

Insurers demonstrated positive steps at lodgement

All insurers had appropriate processes for lodging a claim

Across claims files, we observed many positive practices at lodgement:

- On the phone, insurers generally asked detailed questions to capture the extent of damage or loss being claimed.
- Online, insurers provided platforms for lodgement and progress updates, and used templates to acknowledge claims promptly.

However, insurers need to tailor responses to consumers and not sacrifice key information for expediency. For example, we observed the use of a standard email template, parts of which were not completed, resulting in invalid phone numbers being provided to consumers.

Most participants in our consumer research said they found lodging a claim to be relatively easy and straightforward. Lodgement by phone typically lasted no more than 15 minutes after call wait-times.

'It was… really smooth at the beginning, it was really easy.'

George | Building and contents, severe weather event

A dedicated claims manager was a good start to the claims process

Across some claims files, we observed the practice of having dedicated claims managers to maintain direct contact with consumers. In our research, we observed that this resulted in better management of consumer expectations and a better claims experience overall.

'Just having the one person to deal with rather than calling an info line and trying to explain this story again and again.'

Nora | Building, other event

To minimise intrusion and burden on consumers, good record-keeping is critical, particularly in the absence of a dedicated claims manager. It prevents consumers from having to re-tell their story (feeling frustrated) or having to ask for an update (feeling neglected).

Consumers had realistic expectations of insurers' service levels

Most consumers recognised the scale of severe weather events (even those lodging unrelated claims) and were understanding of delays and shortages in supply of materials and trades.

'I understood that they couldn't come out straight away… a lot of people… needed more assistance than me.'

Juan | Building and contents, severe weather event

But even the most patient consumers had their limits

There came a point where poor communication, excessive wait times and mediocre subcontractors led to immense frustration. Even the more understanding consumers felt they had paid their premiums and deserved to be treated efficiently and fairly.

'I understand there were people worse off than me… but my home's been affected as well and I'm paying for a service.'

Dawn | Building, severe weather event

> Insurers should have **adequate systems** to ensure facts and information about claims are recorded and accessible by all relevant insurer staff, to avoid consumers having to re-tell their story. Good practice is to have **dedicated claims managers** for each claimant: see Table 4 of INFO 253.

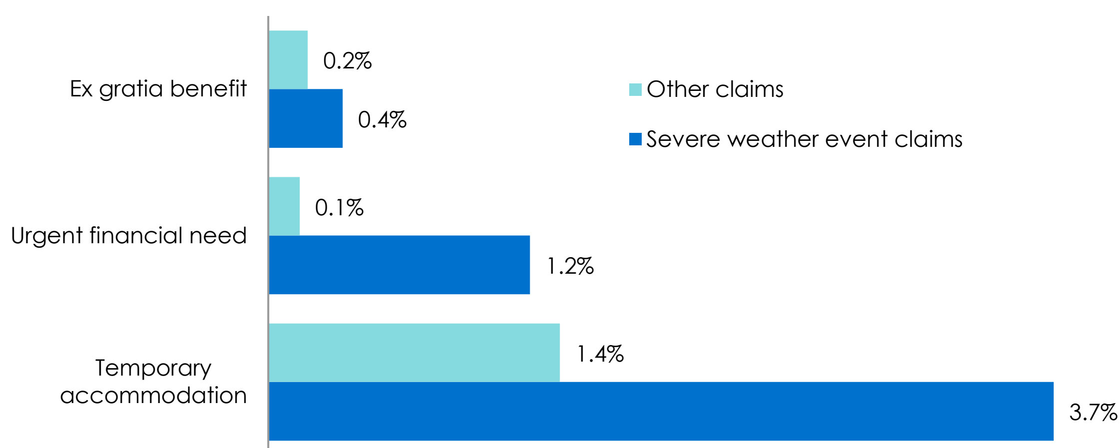
Insurers provided urgent assistance to consumers

Consumers may enter the claims process experiencing trauma, hardship and/or vulnerability. Insurers can offer early support including emergency funds for food or clothing and temporary accommodation.

From our data collection:

- five insurers provided 514 consumers with **ex gratia benefits** (1.9 times more often for severe weather event claims than for other claims)
- four insurers identified 1,145 consumers as in **urgent financial need** (8.3 times more often for severe weather event claims than for other claims), and
- six insurers provided 5,214 consumers with **temporary accommodation** (2.7 times more often for severe weather event claims than for other claims): see Figure 3.

Figure 3: Percentage of claims involving urgent assistance



Note: Certain data could not easily be extracted by some insurers and we did not ask those insurers to produce this data manually. Some data was provided with 'best endeavours'. Insurers also arranged make-safe repairs that were not discernible from repairs in general. See Table 3 for the data underlying this figure (accessible version).

Arranging temporary accommodation proved to be challenging

After severe weather events, finding accommodation was difficult due to high demand and the scarcity of available properties. We observed most insurers offered accommodation after establishing that a home was uninhabitable (e.g. due to mould or no water supply).

We also observed some creativity by insurers to overcome challenges. For example, one insurer provided a temporary accommodation benefit upfront to buy a caravan which was moved onto the consumer's property while the building was being assessed and repaired.

A lack of insurer oversight can sink critical arrangements

Across claims files, we observed that, for at least five of the six insurers, the handling of temporary accommodation appeared to be a manual exercise. In some instances, insurers did not proactively manage approved temporary accommodation, resulting in unnecessary stress for consumers. For example, one consumer contacted the insurer multiple times seeking an extension to the already-approved accommodation.

> 'We are in an Airbnb, [the booking company] needs an extension… I've just rang them and they've got nothing and we have to be out of here tomorrow so we'll be homeless.'
>
> **Sarah** | Building, severe weather event

> Insurers should have **appropriate systems to track and monitor temporary accommodation bookings and payments**. Where manual processes exist, insurers must ensure that staff are adequately trained and equipped to proactively manage these benefits: see Table 4 of INFO 253 and Pts 9–10 of the Code.

Poor triaging can set back a claim

Insurers need to handle and settle claims in a way that supports consumers, particularly those experiencing vulnerability or financial hardship. A person's vulnerability may come from a range of factors: see Table 4 of INFO 253 and Pt 9 of the Code. It may also be experienced as a result of (or be intensified by) severe weather events.

All insurers maintain special teams to manage complex claims

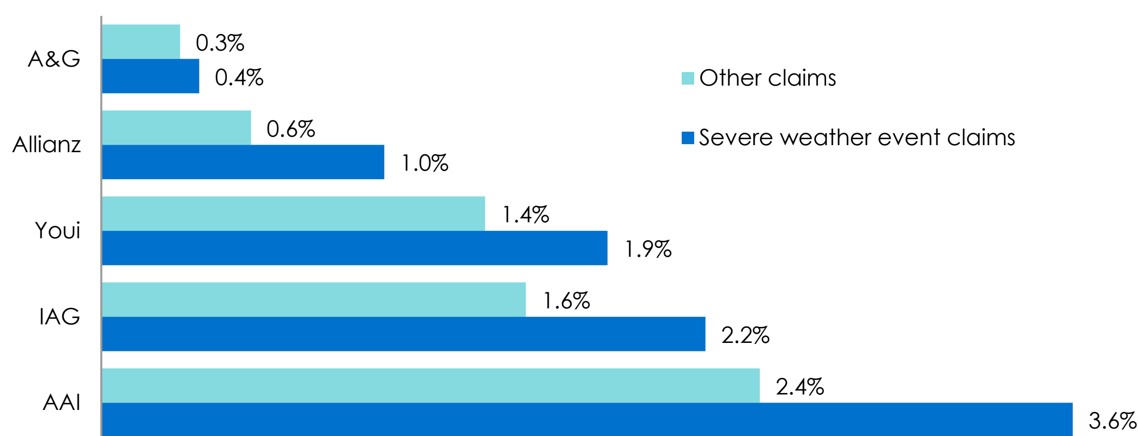
Across claims files, we observed that all six insurers had designated teams to manage claims of greater complexity or vulnerability – for example, 'High Care', 'Case Managed' and 'CAT Team' claim management streams ('CAT' representing a specialised team to deal with catastrophes).

But we have some reservations about identifying vulnerability

From our data collection, insurers identified vulnerability in no more than 3% of their claims. However, 43% of all claims involved severe weather events such as CAT221. Severe weather events cause, or contribute to, a high percentage of consumers experiencing vulnerability, albeit temporarily. This large disparity suggests under-identification of vulnerable consumers.

All five insurers that produced relevant data identified a higher percentage of vulnerable consumers with severe weather event claims compared to other claims: see Figure 4.

Figure 4: Percentage of claims involving vulnerable consumers



Note: QBE identifies and triages claims based on vulnerability, but this information was stored in unstructured data and could not be easily extracted for our review. Allianz's systems only record vulnerability while a claim is live and do not store the data once a claim is closed. We did not ask insurers to do a manual review to produce this data. QBE has since upgraded system functionality (as part of broader work to support Code requirements and guidance in INFO 253) to be able to provide this data in the future. See Table 4 for the data underlying this figure (accessible version).

Some consumers were flagged and treated by insurers as 'vulnerable'

Across claims files, we observed insurers responding to vulnerability by:

› increasing contact with consumers – for example, one insurer flagged a vulnerable consumer undergoing cancer treatment for fortnightly contact (and did so, as shown through good record-keeping), and

› referring vulnerable consumers to external support services (e.g. counselling), making emergency payments for essentials and waiving the excess.

Not all consumers flagged as ‘vulnerable’ were treated accordingly

Across claims files, we observed that some consumers identified as vulnerable were subject to a breakdown in communication, which led to a poor claims experience overall. For example, one insurer arranged temporary accommodation for a consumer, after their property was deemed uninhabitable with mould due to flood damage. At the time, the consumer made it known that some family members required special medical care. The insurer noted the vulnerability, but failed to appropriately communicate and manage expectations, leading to complaints (including about delays).

> ‘I recall a phone conversation with you at about week 5 after the flood, where I said that I could see us living on concrete floors in winter, you replied, “No, no, that won’t happen!” Well, here we are.’
>
> **Jack** | Building and contents, severe weather event

Some consumers were not flagged as ‘vulnerable’, but likely should have been, and as a result were not treated appropriately by insurers

Across claims files, we observed that some claims were not triaged despite indicators of complexity or vulnerability. Proper triaging may have provided a better claims experience for those consumers.

In one instance, a consumer made a claim for damage to their carpet, due to blood stains from an accident. During a call, the consumer raised concerns with the insurer about delays and said the blood stains were causing them significant distress. They also spoke of self-harm.

It does not appear that the insurer identified the consumer as vulnerable or treated the consumer or the claim any differently. In our review of the claim file, we found no documentation that captured the consumer’s distressed state or explicit comments made during the call.

Insurers need to consider the full scope of consumer vulnerability

In our data collection, one insurer flagged all consumers identified as vulnerable as also being in financial hardship, suggesting the insurer may not understand the full scope of vulnerability in para 92 of the Code.

We also observed that one insurer took approximately 40 days to approve a consumer’s financial hardship application. The consumer had emphasised several vulnerabilities, including having a permanent disability, ‘practically no savings’ and relying on social security benefits.

> Insurers must **tailor their services to consumers who are experiencing vulnerability**, by first identifying the vulnerability and then treating consumers accordingly. This includes **ensuring that insurer representatives are appropriately trained** to identify if a consumer is experiencing vulnerability, and not relying on consumers to self-identify this. While insurers are not responsible for resolving vulnerabilities, if they fail to tailor their claims handling, they may not provide a fair service: see Table 4 of INFO 253 and Pts 9–10 of the Code.
>
> Insurers may need to **enhance systems and processes** to facilitate default flagging of vulnerability. For example, a default flag for elderly consumers or those living in remote or disaster-affected areas may improve insurers’ ability to identify vulnerability and respond more appropriately: see Table 4 of INFO 253 and Pt 9 of the Code.

Assessing a claim is often complex

Insurers' obligations

Insurers must act in a timely way, fairly and transparently, with minimum intrusion and burden. Insurers must ensure consumers know what to expect (including assessment reports) and maintain sufficient oversight of insurer-appointed third parties. For relevant obligations, see Table 4 of INFO 253 and paras 61 and 67–75 of the Code.

Well-handled claims stood out as having highly efficient and streamlined assessment processes

The contents claims assessment process was relatively easy

In our consumer research, we observed that for contents claims:

- there were no or fewer third parties for consumers to deal with
- the cause and extent of loss was seldom contested by insurers, and
- the assessment was less subjective than building claims since it rarely relied on an assessor to determine the cause of loss.

'I was surprised, I thought it was going to take longer… the whole claim went through in a couple of days.'

Andrew | Contents, other event

'None of the numbers were contested. I was really impressed because I couldn't find the exact model.'

Joseph | Contents, other event

However, our consumer research also revealed that it could be onerous for consumers to audit all damaged items and provide photos, receipts (if possible), and quotes for comparable items. For example, one consumer who had trouble finding a quote for a traditional, older-style lounge was frustrated that the insurer would not accept quotes for a similar lounge.

'We have had these lounges for many years. It is nearly impossible to find the exact same type online.'

Ali | Building and contents, severe weather event

The building claims assessment process was typically more complex

In our review of claims files, we observed that at least one assessor was required to attend the property for most building-related claims. At times insurer-appointed assessors and trades were the same person and, in some cases, they could do minor repairs during the assessment.

‘The assessor went up… he had the silicon gun and he said… “I’ve glued him up for you. No worries”.’

Caterina | Building, other event

We note that CAT221 resulted in a shortage of assessors, limited access to property, and delays, which affected both severe weather event claims and other claims.

‘[The assessor said]… I was probably about 800th on the list.’

Matilda | Building and contents, severe weather event

As complexity scaled up, so did confusion

Across claims files, we observed a correlation between the number of assessors and experts involved in a claim and the overall complexity and duration of the claims process.

Transparent communication is central to a positive claims experience

In our research, we observed that positive consumer experiences were driven by transparent communication and efficient project management by insurers.

Consumers understood that assessors were not always able to provide a decision immediately, but they appreciated open communication from assessors and insurers, and receiving the assessment report for transparency.

‘It was very smooth, the communication was great. You weren’t blindsided by someone popping up at the door. They advised you that a person from this company was coming at this time.’

Nora | Building, other event

‘The transparent scope of works… just gives comfort. You know, what you are paying for is what was proposed.’

Sachin | Building, other event

A lack of transparency creates a negative claims experience

Conversely, our research revealed that:

- a lack of communication by insurers left consumers confused about *who* was attending their property, *when*, and *why*, and
- some consumers felt assessments were inaccurate, unfair, or costed for a ‘quick fix’.

‘I still don’t understand why three assessors were sent out to do the same job. I don’t think there was any communication that our property had already been assessed.’

Oliver | Building, severe weather event

‘They didn’t really look at the deck properly… they didn’t check the joists, that was my biggest concern about the deck, and they were going “Oh, that’s just wear and tear”.’

Matilda | Building and contents, severe weather event

In our research, we observed that consumers became frustrated when assessors’ reports were not provided in a timely way, and even more so when asked to supply further information. This led to some consumers feeling helpless, seemingly excluded from the assessment process.

‘I didn’t get anything back from them from the inspection so how can I supply more [information]?’

Chen | Building, severe weather event

Certain behaviour can erode consumers’ trust

Trust and respect are also essential for a positive claims experience

The involvement of insurer-appointed third parties can contribute to frictions in the claims process.

Across claims files and consumer research, we observed this to include:

- delays with no warning or explanation
- rushed or incomplete assessments
- misleading comments from assessors about the likely outcome
- delays in report submission
- underquoted costs of repairs, and
- a failure to involve consumers in the process.

Frictions can overflow and impact the claims journey

In one claim file, we observed a negative claims experience that was unnecessarily delayed and subject to multiple complaints due to:

- poor customer service from the insurer – for example, long wait times, multiple claims managers and a failure to respond, and
- poor quality of work from the assessor.

In this instance, the consumer disagreed with the initial assessment, finding that it did not include some repair items. The insurer arranged a re-assessment by a different assessor who found that the initial assessment required ‘a complete overhaul’.

In our consumer research, we observed an example of a negative claims experience in which the consumer encountered frictions throughout various stages of the claims process. Frictions observed in this claim included:

- the insurer not organising repairs for a damaged roof, resulting in the consumer having to arrange this independently
- delays in the assessor attending the property
- the assessor agreeing to repairs without authority from the insurer, and
- the insurer only offering a cash settlement to the consumer and not to repair the roof, as preferred by the consumer.

At the end of the claim, the consumer ultimately accepted a cash settlement of their claim. While they did not agree with the cash settlement amount, they did not lodge a complaint.

> Insurers must **maintain adequate oversight of third parties**, including assessors, and this extends to notifying consumers about the order and timing of attendance at their home: see Table 4 of INFO 253 and paras 72–73 of the Code.
>
> For transparency and fairness, insurers must maintain **clear and transparent communication** across the entire claims process to prevent or overcome confusion that consumers may experience, particularly in complex claims. Insurers should also **proactively share assessment reports** with consumers as they become available.
>
> Proactively sharing reports with consumers would assist insurers in meeting their obligations under the Code to **respond to routine inquiries** from consumers about claims within 10 business days: see Table 4 of INFO 253 and paras 61 and 67–75 of the Code.

Decisions need good communication

Insurers' obligations

Insurers must act in a timely way, fairly and transparently, and include consumers in the claims process. Insurers must have adequate systems and records to regularly monitor compliance with key timeframes set out in the Code. For relevant obligations, see Table 4 of INFO 253 and paras 64, 70–71, 76–78 and 81–84 of the Code.

Insurers need to better communicate decisions

Across claims files, we did not observe any instances where insurers were deliberately dishonest, but insurers can improve efficiency and transparency in how decisions are recorded and communicated.

It wasn't always clear when a decision was made or communicated

In our review of claims files, it was sometimes difficult to determine when the actual claim decision was *made*. We observed that claims were often *assessed* and then either *fulfilled* (partially or fully) or *declined* without the insurer communicating to the consumer what had actually been approved or declined.

One consumer claimed for roof repairs and internal damage due to a hailstorm. After the claim was assessed, the insurer told the consumer the claim for internal damage would be accepted if issues of roof maintenance were addressed.

The insurer should have explicitly said that the claim for roof damage had been denied and explain why (i.e. that it was excluded due to maintenance issues). The insurer also should have provided details of their internal dispute resolution (IDR) process and provided AFCA's contact details to the consumer when the decision was made. We did not observe evidence of this in our review of the claim file.

Transparent communication is crucial for adverse decisions

In our consumer research, participants were frustrated to discover that certain damage was not covered under their policy. Some consumers were accepting of this once their insurer pointed to the relevant terms.

> 'They drew me to a large clause in my agreement… it wasn't covered, there was nothing I could do.'
>
> **Matilda** | Building and contents, severe weather event

Our consumer research also revealed that insurers sometimes did not adequately explain why a claim had been denied. For example, in written correspondence, an insurer referred to evidence such as a builder's reports but did not explain how that evidence related to the consumer's policy and the actual claim.

'It was "You're unsuccessful at this point… it's not covered" wasn't much more of an explanation… I think they did offer to send something out and I was like, well, what's the point?'

Arnold | Building, other event

Across claims files, we observed one case where damage was clearly excluded under the standard policy terms (due to claiming damage to an unsealed driveway). The insurer did not identify and communicate this exclusion and proceeded to arrange assessments that required the consumer to attend. The consumer took time off work. The insurer then cancelled the assessor (having instead decided to investigate the circumstances of the claim) but failed to inform the consumer, resulting in unnecessary loss of wages.

'Wear and tear' and maintenance exclusions are not well understood

Damage that is 'pre-existing' or due to 'wear and tear' or a failure to maintain property in 'good condition' is generally excluded from home insurance policies, which are designed to cover damage from unforeseeable events like floods, storms, fires and other accidents.

In our consumer research, we observed that participants were generally unaware:

- if their property required maintenance
- what the obligation to *reasonably* maintain their property entailed, and
- that a claim could be denied due to the condition of their property if they failed to meet this obligation.

This led to unmet expectations and dissatisfaction when damage was found to be the result of 'wear and tear'.

Some participants said they could not easily inspect all parts of their property (and had little knowledge of the condition before claiming). Others described claims that were denied due to 'wear and tear' as a 'get out of jail' clause. They believed that insurers agreed to insure their property knowing its age, quality, and condition, but used 'wear and tear' to avoid payment.

'My roof was declined because it's my duty of care to… do the maintenance on my roof… how do I know [my tiles failed]?'

Dawn | Building, severe weather event

'I still don't know if the damage… was due to the tree branches… the [insurer] is saying it is partially due to the ageing house… I didn't really have the courage to go up on the roof so I have to take their word for it.'

Juan | Building and contents, severe weather event

Note: The expectation gap between insurers and consumers regarding maintenance is not confined to the roof. It also applies to other parts of the home that are difficult to access such as under sinks and behind refrigerators.

In our research, we observed a case where a consumer's property was affected by significant flood damage. While the insurer agreed to cover internal repairs, the restumping of the house was not covered due to 'wear and tear'. The consumer said 'wear and tear' had not been raised in a recent pre-purchase inspection report. The insurer maintained that restumping was required before the claimable repairs could be made.

Across claims files, we observed one insurer demonstrating a proactive approach to assessing pre-existing damage. During the assessment of the claimed damage, the insurer arranged for other primary areas of the consumer's property to be assessed for potential lack of maintenance. The insurer told the consumer that the purpose of this assessment was to identify any maintenance issues, so that they could be rectified before any future claim.

> Insurers should do more to explain **wear and tear and maintenance exclusions** to consumers at policy inception and renewal, in addition to a claim event. Exclusions are not well understood, increasing the potential for complaints and disputes. Insurers should **clearly set out their expectations** for consumers in terms of property maintenance. They should consider the nature of the claim and the consumer's personal circumstances (including vulnerability): see Table 4 of INFO 253.
>
> Insurers need to be careful to ensure that terms do not impose **overly broad and open-ended obligations** that amount to unfair contract terms: see Table 4 of INFO 253 and s12BF of the *Australian Securities and Investments Commission Act 2001*. ASIC will monitor this issue.
>
> If a claim is partially or fully declined, insurers need to provide **clear reasons supported by adequate evidence** in writing, with details of their IDR process and the contact details for AFCA. These reasons must clearly explain what parts of the claim have been denied, what evidence has been relied upon and how it relates to specific terms under the policy. It is unfair practice for example, to assert that claimed damage was due to 'wear and tear' or 'lack of maintenance' without explanation: see Table 4 of INFO 253 and paras 81–82 of the Code.

Insurers need to record accurate data

Adequate systems and records are crucial for meeting obligations

In our data request, we asked insurers to provide the date the claim decision was communicated. In part, this was done to better understand insurers' practices in communicating the claim decision and meeting their Code obligations. For example, the Code specifies that insurers will:

- once they have all relevant information and have completed all inquiries, decide whether to accept or deny a claim and tell the consumer of their decision within 10 business days (see para 76 of the Code), and
- make a decision on a claim within four months of receiving it unless certain circumstances apply (see para 77 of the Code).

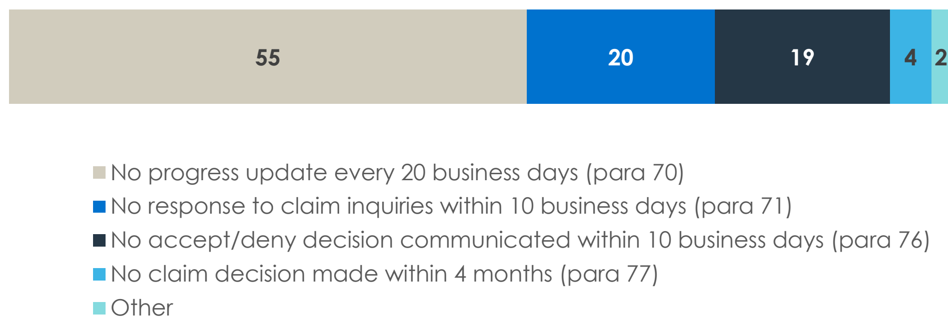
In response to our data request, none of the insurers were able to easily access and provide structured data from within their claims systems on the date the decision was communicated across all relevant claims.

Note: If insurers could not easily extract data from their systems, we did not ask them to produce this data manually. Some data was provided with 'best endeavours'.

Insurers seem to be recording Code breaches inconsistently

From our data collection, insurers reported having identified 4,318 claims subject to a breach (or potential breach) of para 76 of the Code and 1,034 claims subject to a breach (or potential breach) of para 77 of the Code: see Figure 5.

Figure 5: Type of Code breaches or potential Code breaches (%)



Note: Breaches or potential breaches that made up 1% or less of all breaches or potential breaches are bundled into 'Other'. See Table 5 for the data underlying this figure (accessible version).

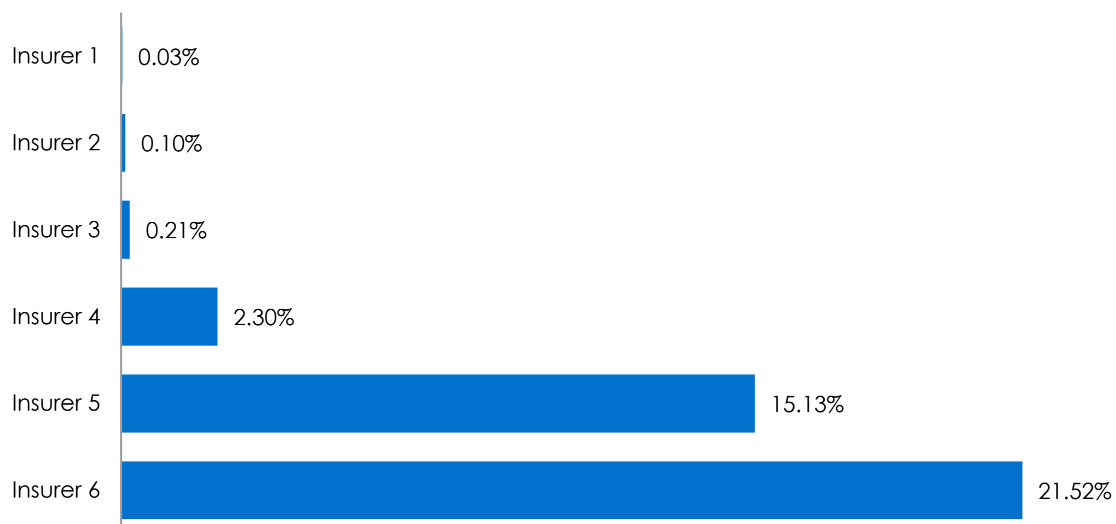
There was a significant difference in *reported* Code breaches on lodged claims across insurers: see Figure 6.

This difference could indicate a variance in:

- insurer code conduct
- internal systems for insurers recording breaches, and
- individual insurer breach reporting thresholds.

We also observed that Code breaches were more likely to occur in severe weather event claims compared to other claims.

Figure 6: Percentage of claims with a *reported* Code breach or potential Code breach



Note: Insurer 1 could not easily extract Code breach data for claims lodged within the relevant period. We did not ask them to do a manual review to produce this data. Insurer 6 provided Code breach data where *potential* breaches were identified. This could not be differentiated from confirmed breaches, so was not comparable to breaches reported by other insurers. See Table 6 for the data underlying this figure (accessible version).

Insurers need to meet the standards set in the Code

The Code Governance Committee's 2022 annual industry data report reveals that breaches of the obligation to provide a claim decision within four months (para 77 of the Code) increased from 641 breaches in the previous year to 1,063 breaches. These breaches are not specific to home insurers (or the six insurers participating in our review). However, three out of four breaches involved home or motor insurance policies.

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: see Pt 13 of the Code, in particular para 174.

The increase in Code breaches due to insurers not meeting decision-making timeframes is mirrored in complaints seen by AFCA for CAT221. In February 2023, AFCA reported that of the 2,021 complaints made to them in relation to this severe weather event, 37% were due to delays in claims handling: see AFCA receives over 2000 complaints in year since SEQ/NSW floods on the AFCA website.

> To facilitate transparency and timeliness, insurers need to **record the claim decision date and when it is communicated** in a structured way so they can give consumers clear information and regularly monitor, record and report on compliance with the Code: see Table 4 of INFO 253 and paras 76 to 78 of the Code.
>
> Insurers need to **meet the standards set by the Code**. Where breaches have occurred, insurers need to address the cause of these breaches to ensure they do not repeat: see Pt 13 of the Code.

Complexities can continue into fulfilment

Insurers' obligations

Insurers must act in a timely way, fairly and transparently, with minimum intrusion and burden. Insurers must proactively project manage claims. Insurers must resolve disputes and handle complaints objectively, fairly and in a timely manner, in accordance with maximum regulatory timeframes. For relevant obligations, see Table 4 of INFO 253, paras 64, 70–71, 76–84 and 86–87 and Pt 11 of the Code, and RG 271.

Inefficiencies continued during fulfilment of a claim

After a claim decision had been made, we observed some poor claims handling practices during the fulfilment of the claim. This was principally due to inefficient actions and processes, including:

- poor scheduling and logistics management by insurers and their third-party providers
- lack of or unclear communication with consumers, and
- significant resourcing challenges during severe weather events.

This highlights an issue with the scalability of insurers' (and their supply chains) processes and procedures as claim volumes increase, particularly during severe weather events.

Across claims files, we observed that cash settlement processes were generally appropriate. However, insurers can improve their record-keeping practices by demonstrating compliance with the requirement to provide cash settlement fact sheets to consumers. While these fact sheets appear to have been sent to consumers – with file notes to that effect – they were not always locatable on file.

In our consumer research, some participants with building claims preferred repairs over cash settlement but were not always given this option. In some cases, an unwillingness from builders to warrant repairs on older buildings meant the insurer would only offer a cash settlement.

'They said they won't warrant the roof because it's an old roof. The roof is in perfect condition… I haven't got leaks, the tiles aren't falling off. All the tiles were there till the tree came on it.'

Grayson | Building, severe weather event

Most research participants thought that the cash settlement they were offered would cover the cost of repairs. However, some consumers were concerned that rising building costs would cause them to be out of pocket. Across claims files, we observed that one insurer included an extra amount to account for potential future cost rises.

Initial make-safe repairs lay the foundation for the claims experience

In our review of claims files, we observed that when a make-safe repair was required, insurers and their appointed third parties generally appeared to carry these out quickly and without issue.

We observed one instance where an insurer approved a make-safe repair, but to be compliant, further repairs outside the scope of the policy were required. The insurer made two significant ex gratia payments to the consumer to ensure the repairs could be completed.

However, if insurers get the make-safe repair wrong, it can significantly affect the consumer. In one claim file, we observed a consumer contacted by two repairers for make-safe repairs, but neither had any information about the work. A lack of contact from the insurer led to the make-safe repairs being delayed for a long time when the consumer did not have access to drinking water at their home.

In our consumer research, we observed where one insurer failed to coordinate and communicate a make-safe repair. This led to significant delays, with the consumer arranging the make-safe repair independently without knowing if the insurer would cover it.

> 'Water was coming in and I just went "Well, if I lose the money, I lose the money". What can I do?'
>
> **Dawn** | Building, severe weather event

At times insurers displayed poor project management and oversight of third parties

Some consumers had to project manage the repair themselves

We observed through our research that very few insurers appointed an internal project manager, meaning the often-complex assessment and repair process was regularly managed by the consumer.

> 'It's given me one more thing on my plate, I just feel I paid for the [repairs]. It's like going to a restaurant and ordering a meal and then being told to cook it yourself.'
>
> **Grayson** | Building, severe weather event

Communication was often delegated to third parties (e.g. assessors and repairers) with limited coordination between them, the consumer, and the insurer. As a result, the insurer was 'out of the loop', unaware of delays and tradespeople being booked in an illogical order.

> 'I can't understand the lack of communication between the core trades and there wasn't that many of them… but me being asked technical questions and "What this guy has done?" it's like I don't know, I'm not a licensed electrician.'
>
> **Oliver** | Building, severe weather event

Some consumers lost trust in the quality and efficacy of trades

In our consumer research, we observed one claim where repairs were being made to a wall before an asbestos issue was addressed. The illogical order of trades in this case led to the consumer lodging a complaint, and ultimately settling the claim for cash.

Insurers were generally able to fulfil a cash settlement quicker than a repair. We observed consumers choosing a cash settlement to avoid delays in repairs due to limited availability of trades and materials (even though the consumer may find it difficult to arrange trades and materials themselves in a timely manner).

Not all consumer experiences we observed were poor

Insurers that were able to proactively project manage the repair and seek feedback were more likely to deliver a positive claims experience for consumers.

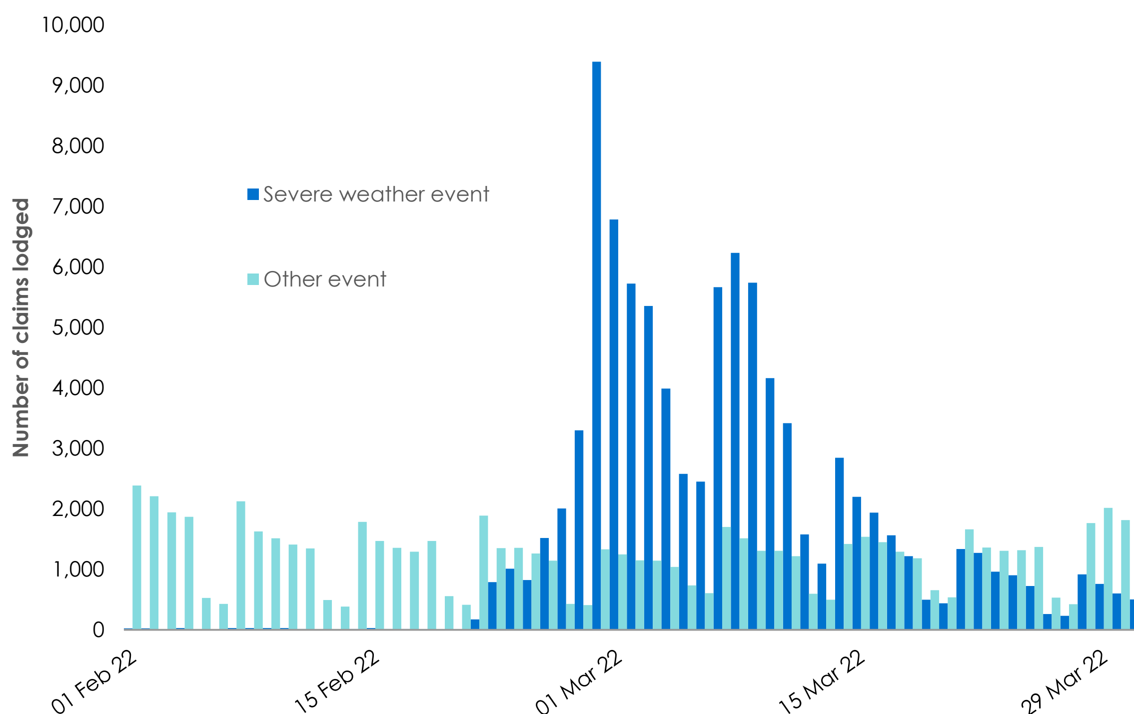
In our review of claims files, we observed online chat platforms being used to facilitate quick and seamless communications between insurers and appointed third parties. Insurers that did not make use of such platforms generally communicated by phone or email which often resulted in long wait times.

> 'After each trade [the insurer] called to make sure we were satisfied with what had been done. You know, just to make sure that the process had gone smoothly and to make sure that the repairers did what they were supposed to do.'
>
> **Nora** | Building, other event

Severe weather events affect insurers' service levels

From our data collection, the volume of claims lodged each day surged due to CAT221: see Figure 7. The volume of claims lodged due to other events remained steady throughout.

Figure 7: Number of claims lodged each day (1 February–31 March 2022)



Note: See paragraph above for a description of the trends in this figure (accessible version).

Insurers’ abilities to manage claim surges varied

Insurers’ data covered claims lodged between 1 January and 31 March 2022. The data provided visibility on insurers’ timeliness in responding to severe weather event claims and other claims, by measuring the time from lodgement until first repairs or first cash settlement. We analysed claims lodged in the three fortnights following CAT221 and then looked at insurers’ service levels 10 weeks after a claim was lodged.

Note: First repair may include make-safe repairs. Some insurers provided the date of the first repair invoice on claims files. First cash settlement may include emergency payments.

One aspect of claims handling efficiency is an insurer’s ability to service claims in a timely manner. Insurers with efficient claims handling processes will be better able to manage surges when they happen.

To benchmark individual insurer performance, for each insurer we compared the rates at which they provided repairs or cash settlements for severe weather event claims and other claims after CAT221. There was considerable variation across insurers in the rate of severe weather event claims they were able to service compared to the rate of other claims they serviced during the same period.

First repairs hit bottlenecks

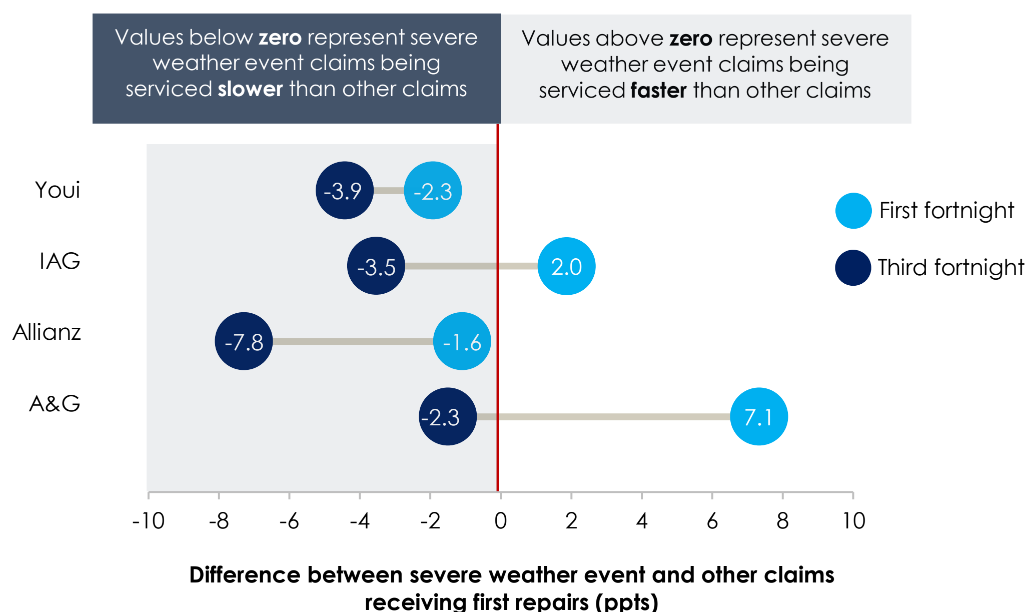
We observed a ‘bottleneck’ effect for severe weather event claims lodged in the second and third fortnights after CAT221, where severe weather event claim first repairs were being actioned slower than other claims.

Across all insurers, the rate of first repairs for severe weather event claims compared to other claims deteriorated in the third fortnight after CAT221 compared to the first fortnight: see Figure 8. That is, for all insurers the percentage point difference fell below zero or further below zero in the third fortnight relative to the first fortnight. For example, the data provided by A&G demonstrates this trend:

- For claims lodged in the first fortnight, A&G’s rate of first repairs was 7.3 percentage points (ppts) higher for severe weather event claims compared to other claims – that is, they serviced 23.1% of repairs for severe weather event claims and 15.8% of repairs for other claims.
- For claims lodged in the third fortnight, A&G’s rate of first repairs was 1.5 percentage points lower for severe weather event claims compared to other claims – that is, they serviced 15.7% of repairs for severe weather event claims and 17.2% of repairs for other claims.

We expect insurers to be prepared to better manage surges of severe weather event claims without sacrificing service levels for other claims.

Figure 8: Repair efficiency at 10 weeks for claims lodged in the first and third fortnights after CAT221



Note: QBE and AAI made best endeavours to provide the data that we requested, but this could not be easily extracted. We did not ask them to do a manual review to produce this data. The dates of the first fortnight after CAT221 were from 19 February 2022 to 4 March 2022 inclusive. The dates of the third fortnight were from 19 March 2022 to 31 March 2022 inclusive. See paragraphs above for a description of the trends in this figure (accessible version).

First cash settlements were slower to be paid

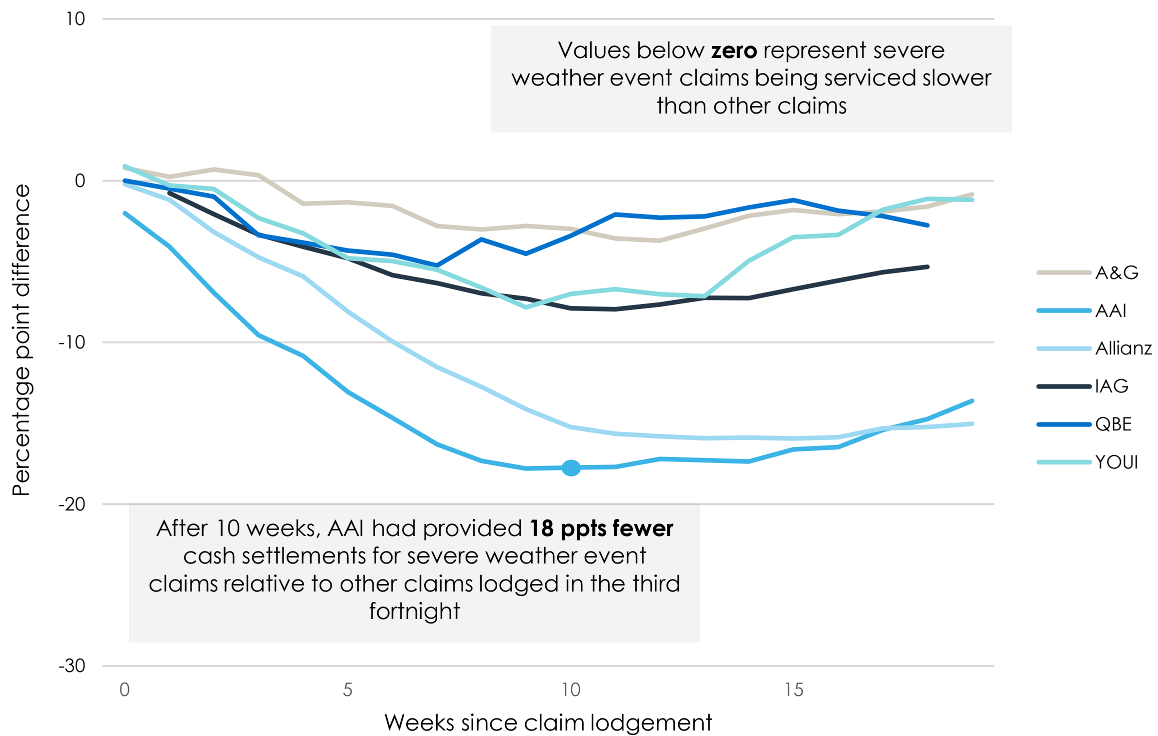
Figure 9 shows the percentage point difference between first cash settlements provided by each insurer for severe weather event claims and other claims lodged in the third fortnight after CAT221. This indicates how efficiently insurers made first cash settlement payments for severe weather event claims compared to other claims they received at the same time.

Generally, first cash settlements were paid more slowly for severe weather event claims than for other claims. As shown in Figure 9, at 10 weeks after lodgement, there was a considerable difference between the rate of cash settlements for other claims and severe weather event claims made by AAI and Allianz. This suggests they did not provide as many first cash settlements for severe weather event claims within 10 weeks of being lodged compared to the number of cash settlements they provided for other claims within 10 weeks of being lodged.

For claims lodged in the third fortnight:

- AAI's rate of cash settlements within 10 weeks of claim lodgement was 18 percentage points lower for severe weather event claims compared to other claims lodged – that is, they provided cash settlements for 36% of other claims and 18% of severe weather event claims.
- Similarly at 10 weeks, Allianz's cash settlement rate was 15 percentage points lower for severe weather event claims lodged in the third fortnight after CAT221 compared to other claims.

Figure 9: Percentage point difference between cash settlements for severe weather event claims and other claims lodged in the third fortnight after CAT221



Note: The dates of the third fortnight after CAT221 were from 19 March 2022 to 31 March 2022 inclusive. See paragraphs above for a description of the trends in this figure (accessible version).

The difference between the rate of cash settlements for severe weather event claims and other claims 10 weeks after claim lodgement could indicate that:

- insurers' capacity to assess claims and fulfil cash settlements becomes strained following severe weather events
- there is a different level of complexity for assessing severe weather event claims and other claims, and
- consumers prefer repairs for severe weather event claims compared to other claims.

A consumer's preference for their claim to be fulfilled by cash settlement as opposed to repair or replacement will depend on their own circumstances. For claims that are fulfilled by cash settlement, insurers should maintain the same levels of timeliness and efficiency for claims due to severe weather events as they do for other claims.

Converging forces impacted insurers' efficiency

We recognise insurers had to operate in difficult times. However, insurers should expect that similar circumstances will arise in the future and need to be prepared to meet their claims handling obligations. We note all insurers were operating in the same external environment and there was different performance across insurers, suggesting room for improvement.

Insurers must **maintain timeliness and efficiency during surge times** and review their operations, particularly those that lead to initial delays in servicing claims. Insurers must do so without sacrificing their ability to service claims: see Table 4 of INFO 253 and paras 70–71, 76 and 84 of the Code.

Insurers need to consider **permanently enhancing their claims handling capacity and responsiveness**. They should prepare for disasters rather than scale-up resources once they have occurred: see Table 5 of INFO 253.

Insurers must assist consumers throughout the fulfilment phase until a claim is finalised. Insurers also need to be confident in their third-party partners and **proactively project manage** the fulfilment process: see Table 4 of INFO 253 and paras 86–87 of the Code.

Like all stages, we expect **clear and transparent communication** in the fulfilment of a claim to prevent or overcome confusion that can arise, particularly in complex claims with multiple parties: see Table 4 of INFO 253 and para 70 of the Code.

A complaint is an opportunity to re-set the course

We observed insurers responding to complaints and dissatisfaction

Across claims files and our research, insurers responded to complaints by:

- apologising or offering compensation to consumers
- reassessing the property
- providing tailored assurances to consumers about how they might rectify similar issues in future (e.g. training staff), and
- providing a clear justification for their decision (e.g. explaining relevant policy terms) to help consumers understand the insurer's processes.

'They said "Well, this is our policy now, and can I refer you to the terms and conditions"… Okay, well it is what it is.'

Grayson | Building, severe weather event

In our review of claims files, one case involved a complaint about the denial of a claim. The insurer sent an internal assessor with other relevant third parties to the consumer's property to properly communicate and demonstrate the reason for denial. The consumer was satisfied with the explanation.

In another case, a consumer expressed dissatisfaction due to poor communication during the initial stages of the claim. In response, we observed subsequent good claims handling practices that appeared to put the claim back on course. This included:

- clear and empathetic communication from a dedicated claims manager
- proactive management of expectations, and
- a timely resolution of the claim.

Some opportunities to re-set the course were missed

Attempts to manage complaints were sometimes short-sighted

Across claims files, we observed that insurers sometimes recognised an expression of dissatisfaction as a complaint but did not always demonstrate a genuine attempt to understand and address the consumer's concerns.

In our review of a call recording, a dissatisfied consumer asked how they could speak to another staff member who would be able to answer the consumer's questions. In response, the staff member suggested to call the claims phone line again.

'Insurer: "I guess you can hang up and re-call."'

Ali | Building and contents, severe weather event

Some consumers felt they had reached a dead end

In our consumer research, some participants were left dissatisfied and unsure about their options going forward. Other than an apology, insurers expressed to consumers that little could be done to alleviate complaints about inefficiencies with the claims process.

Dissatisfied consumers were more often financially vulnerable and not in a position to fix the problem themselves, resulting in a sense of helplessness. In one case, a financially vulnerable consumer felt that their insurer was largely dismissive of their concerns.

'They said they will relook at all the information, it sounded more so like they were just trying to get me off the phone call… it was obvious they weren't going to change their mind.'

Bella | Building, severe weather event

Insurers did not always recognise expressions of dissatisfaction

In some claims files, it appeared that insurers did not always recognise an expression of dissatisfaction as a complaint. For example, one consumer lived in an evacuation centre while their insurer arranged make-safe repairs to their relocatable home. When they returned to their property for an on-site assessment, they found the home mostly demolished, causing great distress. We did not observe any record of a complaint being lodged in recognition of the consumer's extreme dissatisfaction.

Insurers should resolve more complaints through internal channels

In February 2023, AFCA reported a 65% increase in general insurance complaints (external dispute resolution) in the 2022–23 financial year compared with the same point in the 2021–22 financial year. By comparison, complaints made about banks increased by 8% from the 2021–22 financial year to the 2022–23 financial year. AFCA recognised the scale of CAT221, but expressed concerns that the volume of complaints about delays by insurers went beyond the floods.

AFCA reported that 40% of complaints involving CAT221 were resolved at the earliest stage of AFCA's process, indicating that insurers could do more to resolve claims through their IDR processes. This is below the 51% early resolution rate for all complaints to AFCA in the 2021–22 financial year,

indicating that insurers could do more to resolve claims earlier through the EDR process: see AFCA receives over 2000 complaints in year since SEQ/NSW floods on the AFCA website.

> Insurers must handle complaints objectively, fairly and in a timely manner. This extends to maintaining **adequate resourcing** within dispute resolution teams and ensuring complaints are acknowledged and resolved within maximum regulatory timeframes: see RG 271.56, RG 271.142 and RG 271.166, Table 5 of INFO 253 and para 147 of the Code.
>
> Insurers must ensure staff are adequately trained to **recognise and respond to expressions of dissatisfaction**. Failure to do so means that consumers may not be made aware of their right to have their complaint reconsidered internally, and if unresolved, externally by AFCA: see RG 271.27–RG 271.28 and para 140 of the Code.
>
> General insurers will be **required to report IDR data to ASIC** every six months on an ongoing basis from 31 August 2023: see Internal dispute resolution data reporting and *ASIC Corporations (Internal Dispute Resolution Data Reporting) Instrument 2022/205* (as amended by *ASIC Corporations (Amendment) Instrument 2023/282*). ASIC will continue to monitor this issue.

Appendix 1: Methodology

Our review employed a multi-limb approach, designed to provide a holistic view of the claim life cycle. This targeted approach minimised the burden on insurers as we assessed the efficacy of their claims handling processes at the start of the new regime.

Quantitative review of claims data

The initial stage involved a request sent to the participating insurers for data on home insurance claims (building and/or contents) lodged between 1 January 2022 and 31 March 2022. This data includes metrics across 218,256 claims lodged with six insurers up to September 2022, when it was given to ASIC. Therefore, the data did not necessarily contain details about the resolution of each claim (i.e. if the claim was unresolved at September 2022).

We utilised specific metrics to benchmark the performance of insurers, gain insights across both severe weather events and other events, highlight potential frictions and facilitate a risk analysis of claims based on indicators of claims frictions. The data request was designed to provide a selection of claims files for a targeted review.

This initial stage started with early engagement with the participating insurers, before requesting the data. We discussed claims data and systems with each participating insurer to understand how it stores and maintains claims data, and how this data can be obtained. We shared examples of the types of datapoints anticipated to be in ASIC's data request and discussed the least onerous way to obtain claims data.

Targeted review of claims files

Based on our analysis of insurers' claims data, we selected claims files to capture a broad range of consumer experiences. ASIC requested 150 claims files for a targeted review, using our compulsory information-gathering powers.

This targeted sampling of a small number of claims is non-representative (25 claims files per insurer). Therefore, our qualitative observations do not reflect any sense of proportionality across insurers or industry.

This review sought to facilitate deeper insights into claims handling practices throughout the life cycle of a claim, identify good and bad claims handling practices and areas of potential consumer harm and frictions, and capture how insurers are performing in relation to their claims handling obligations generally.

Qualitative consumer research

We commissioned a social research firm to undertake research on consumers' experience of the insurance claims handling process (not limited to the six participating insurers), covering metropolitan and regional locations across Australia.

Individual interviews were conducted with 40 respondents who made, or considered making, a home insurance claim (building and/or contents) in 2022. Of these, 25 interviews were developed into case studies to help capture the consumer perspective. Quotes taken from our consumer research and claims reviews used throughout our report have been anonymised.

Appendix 2: Accessible versions of figures

Table 2: Percentage of severe weather event claims and other claims first serviced after lodgement

Service of claim	Within 6 weeks	Between 6 and 12 weeks
Other claims: First repairs	10%	7%
Severe weather event claims: First repairs	6%	8%
Other claims: First cash settlement	22%	11%
Severe weather event claims: First cash settlement	10%	10%

Note: This is the data shown in Figure 2.

Table 3: Percentage of claims involving urgent assistance

Category	Severe weather event claims	Other claims
Ex gratia benefit	0.4%	0.2%
Urgent financial need	1.2%	0.1%
Temporary accommodation	3.7%	1.4%

Note: This is the data shown in Figure 3.

Table 4: Percentage of claims involving vulnerable consumers

Insurer	Other claims	Severe weather event claims
A&G	0.3%	0.4%
Allianz	0.6%	1.0%
Youi	1.4%	1.9%
IAG	1.6%	2.2%
AAI	2.4%	3.6%

Note: This is the data shown in Figure 4.

Table 5: Type of Code breaches or potential Code breaches (%)

Breach	Percentage
No progress update every 20 business days (para 70)	55%
No response to claim inquiries within 10 business days (para 71)	20%
No accept/deny decision communicated within 10 business days (para 76)	19%
No claim decision made within 4 months (para 77)	4%
Other	2%

Note: This is the data shown in Figure 5.

Table 6: Percentage of claims with a Code breach or potential Code breach

Insurer	Percentage of claims with a Code breach
Insurer 1	0.03%
Insurer 2	0.10%
Insurer 3	0.21%
Insurer 4	2.30%
Insurer 5	15.13%
Insurer 6	21.52%

Note: This is the data shown in Figure 6.

Key terms and related information

Key terms

AFCA	Australian Financial Complaints Authority
AFS licence	An Australian financial services licence under s913B of the Corporations Act that authorises a person who carries on a financial services business to provide financial services **Note**: This is a definition contained in s761A.
APRA	Australian Prudential Regulation Authority
CAT221	The February–March 2022 floods in Queensland and NSW (an ICA-declared catastrophe event)
Code	General Insurance Code of Practice
Code Governance Committee	General Insurance Code Governance Committee
Corporations Act	*Corporations Act 2001*, including regulations made for the purposes of the Act
FTE	Full-time equivalent
ICA	Insurance Council of Australia
IDR	Internal dispute resolution
other claims	Claims that are not severe weather claims
s766G (for example)	A section of the Corporations Act (in this example numbered 766G), unless otherwise specified

Related information

Headnotes

Building insurance, catastrophe, claims handling and settling, complaints, contents insurance, home insurance, severe weather event, vulnerable

Legislation

ASIC Corporations (Internal Dispute Resolution Data Reporting) Instrument 2022/205 (as amended by *ASIC Corporations (Amendment) Instrument 2023/282*)

Corporations Act 2001, s766G, 912A–912B

Insurance Contracts Act 1984, s13

ASIC documents

INFO 253 *Claims handling and settling: How to comply with your AFS licence obligations*

RG 271 *Internal dispute resolution*