CLAIMSHERO

Submission to the

Australian Financial Complaints Authority – Draft Approach to Insurance Claims Handling (July 2025)

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Submission to AFCA on Consultation Draft: Approach to General Insurance Claims Handling

Thank you for the opportunity to provide feedback on AFCA's draft guidance for general insurance claims handling.

Hero Group Services, trading as Claims Hero, is an insurance advocacy business that supports consumers navigating claims and complaints in the home and contents insurance sector. We operate under an Australian Financial Services Licence (AFSL) and assist clients through home insurance property claims, including internal dispute resolution processes and complaints to AFCA.

Our team works daily with vulnerable customers who are often overwhelmed by complex insurer processes, denied claims, confusing expert reports, and protracted disputes. As a result, we are uniquely placed to observe systemic issues in insurer behaviour and the real-world impact on consumers.

We welcome this consultation and fully support AFCA's intent to provide clear and structured guidance on fair claims handling practices. Based on our practical, day-to-day experience working with consumers navigating the claims and dispute process, we see a valuable opportunity to further strengthen the Draft Approach. Our suggestions are grounded in real-world examples and aim to reduce ambiguity, promote consistency in decision-making, and provide greater certainty for both consumers and insurers. In our view, clearer expectations around key claims practices will help prevent avoidable misunderstandings and reduce the number of disputes.

This submission outlines seven areas that we believe could be strengthened in the final version of AFCA's claims handling guidance. These include:

- **Cash Settlements That Reflect Real-World Costs** - Clearer guidance is needed to ensure that settlement offers are based on accurate and complete scopes, realistic pricing, and appropriate allowances. This includes aligning offers with open market costs

rather than internal pricing models or preliminary estimates. Improvements in this area would help consumers better understand and assess the fairness of their settlement.

- **Improving the Use and Transparency of Expert Reports** - Insurer-appointed reports play a central role in many claim outcomes. We propose clearer expectations around the independence of experts, disclosure of relationships, and the evidentiary standards that must be met, including written briefs. These improvements would build trust in expert findings and reduce unnecessary disagreement.
- **Reimbursing Costs Incurred by Consumers** - Consumers are sometimes required to engage their own experts when insurer reports are inadequate or disputed. Clear guidance on when reimbursement is appropriate, including how interest is applied, would help ensure fairness and reduce financial disadvantage caused by claims handling delays or errors.
- **Clarifying When Professional Support is Justified** - While AFCA is designed to be accessible without legal or professional assistance, some matters require additional support due to insurer conduct, the complexity of the claim or vulnerabilities of the complainant. We recommend clearer guidance on when reimbursement of reasonable advocacy costs is appropriate, particularly where the need for support was caused by the insurer's actions.
- **Ensuring Fair Use of Insurer Discretion** - The discretion insurers hold in managing claims decisions should be exercised fairly and consistently. Guidance that encourages consideration of the customer's individual circumstances, including vulnerability, would help reduce perceptions of unfair treatment and improve outcomes.
- **Providing Structure for Non-Financial Loss Assessments** - Many disputes arise from poor communication or claims handling delays rather than the insured event itself. A more structured approach to assessing non-financial loss would improve consistency and provide clearer expectations for both insurers and consumers.
- **Clarifying the Treatment of Financial Losses** - Some financial losses arise not from the event itself, but from the way a claim is handled. We suggest clearer guidance on when these losses should be reimbursed, with examples to show how causation and foreseeability should be applied. This would help reduce confusion and provide greater confidence in outcomes.

Collectively, these suggestions are focused on reducing subjectivity in insurance claims handling and dispute resolution. Based on our experience, uncertainty around key issues such as settlement pricing, expert evidence, reimbursement, and non-financial loss often leads both consumers and insurers to escalate complaints to AFCA for a formal determination. When the guidance leaves too much open to interpretation, parties are more likely to proceed to determination in order to test the outcome. By setting clearer expectations and improving consistency within the document it will give greater clarity to all parties involved.

We are deeply committed to improving insurance outcomes for consumers in Australia and would welcome the opportunity to further engage with AFCA on this issue

Thanks,

Luke Dugdell

Managing Director – Claims Hero

Disclaimer

This submission has been prepared by Hero Group Services Pty Ltd (trading as Claims Hero) for the purpose of providing feedback on AFCA's Draft Approach to General Insurance Claims Handling. The views expressed are based on our professional experience assisting consumers with home and contents insurance claims and disputes. They are provided in good faith to highlight systemic issues we observe in practice and to suggest improvements that may benefit both consumers and insurers. Nothing in this submission should be taken as legal advice. This document, in whole or in part, must not be reproduced, quoted, distributed, or used for any other purpose without the prior written consent of Hero Group Services Pty Ltd.

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1. Cash Settlements Must Reflect Realistic Costs

We welcome AFCA's recognition in the Draft Approach (Section 2.3) that cash settlements must reflect a fair and reasonable cost to repair or replace insured property. This acknowledgement is essential, particularly in the context of increasing reliance on cash settlements following natural disasters and in regional areas where builder availability is limited. The focus on proper scoping, inclusion of contingencies, and clarity of communication is an encouraging step towards improving consistency and fairness in claims outcomes.

To further reduce disputes and improve consistency across determinations, we recommend that AFCA expand its guidance to clearly define the characteristics of a fair cash settlement, establish when an insurer is effectively electing to cash settle, and clarify the expectations around pricing, scoping, and transparency.

From our experience assisting and talking to countless home and contents policyholders, a lack of clarity in cash settlement practices is a major driver of disputes. Inconsistencies across insurers are frequently observed, particularly in how settlement amounts are calculated and communicated. We consider that additional clarity within the Approach document would support a reduction in complaints. Some common examples we observe from insurers that lead to confusion and disputes include:

- **Redacting individual line-item costs from scopes of work or quotes** – Insurers routinely provide redacted quotes where individual line-item dollar values is blacked out. When consumers request copies without the redactions, insurers often cite privacy legislation or commercial sensitivity as the justification for not providing the dollar values, yet this lack of transparency prevents consumers from verifying whether the allowances are appropriate. It also restricts their ability to challenge errors or omissions, increasing confusion and distrust. In circumstances where insurers elect to cash settlement, a costed scope of works should be provided to the customer with individual line-item amounts. This is particularly important in cash settlements, as without line-item costings, consumers cannot assess whether the pricing reflects open market rates, placing them at risk of being underpaid and out of pocket.
- **Including provisional sums for key components of the repair scope** – In many insurance quotes, especially those prepared early in the claims process, builders include what are known as provisional sums. These quotes are often produced prior to a contractor realising that the quote may later be used for cash settlement purposes. These are estimated amounts used for parts of the job that cannot be accurately priced at the time, such as appliances, electrical work, drainage, or structural repairs. A provisional sum is essentially the builder's best guess, often based on limited site access or incomplete information. These figures are intended to be updated once more details are known. However, insurers often treat them as final amounts when making a cash settlement offer. This creates a risk for consumers, because the actual cost of completing the work may be much higher than the original estimate. If the insurer does not take steps to replace provisional sums with accurate pricing, for example by confirming electrical requirements or obtaining specialist reports, the shortfall is left to the customer. This can result in homeowners being underpaid and facing unexpected costs during an already

stressful time. Insurers should ensure provisional sums are reviewed and updated before finalising any settlement.

- **Inaccurate quotes used to prepare scopes and quotes** – In many cases, insurers rely on quotes prepared from site visits that are brief, cursory, or conducted without proper access to all affected areas. These limited assessments often lead to significant omissions in the scope of works, particularly where damage is hidden behind walls, under flooring, or in difficult-to-access spaces. Despite these limitations, insurers frequently present such quotes as accurate and complete, using them as the basis for a cash settlement decision. This creates a substantial risk of underpayment, as consumers are left to fund the cost of rectifying damage that was not identified due to the limited assessment. Insurers' use of repairers under capped or limit-based panel contracts also creates commercial pressure to quote within insurer-set thresholds, increasing the likelihood that essential items are omitted to meet internal cost constraints. Additionally, suppliers often fail to assess or disclose the likelihood of variations arising from remediation works, leaving consumers unaware of potential cost escalations until after settlement. AFCA should recognise that a rushed or partial inspection, or a quote influenced by panel pricing constraints, cannot be relied upon to produce a fair or reliable settlement figure. Insurers must ensure quotes are actionable, reflect all reasonably foreseeable costs, and include consideration of likely variations. This may require the insurer to obtain updated or specialist reports prior to finalising any cash settlement.

- **Using "liability quotes" created specifically for cash settlement purposes** – In some cases, insurers arrange for quotes to be prepared solely for the purpose of offering a cash settlement, with no intention for the builder to carry out the repairs. These are often referred to as liability quotes. Because the builder knows they will not be completing the work, these quotes are typically prepared quickly and may lack detail. They may also use lower pricing for certain items compared to quotes intended for actual repair. We have identified multiple examples where the cost of key items is noticeably reduced in liability quotes. Despite this, insurers often present them as accurate and final when making a settlement offer. This creates a risk that the homeowner will receive less than the true cost of reinstating their home. Insurers should ensure that liability quotes are not used in a way that unfairly reduces the scope or pricing of works. If a quote is produced solely for cash settlement, insurers must verify that all pricing and assumptions reflect the true market cost of completing the repairs at the property, including any local/location related costs. AFCA should make it clear that quoting practices must not result in underpayment simply because a quote was labelled or intended as a liability assessment.

- **Failing to Confirm Actionability** – In many cases, there is a significant delay between when a quote is obtained and when the insurer makes a settlement offer. Quotes may be provided weeks or even months earlier, during which time material costs, labour rates, or builder availability may have changed. If the insurer does not check with the builder or assessor to confirm that the quoted works are still viable and accurately priced at the time of settlement, the consumer may be left with a shortfall. This is especially concerning in a changing market, where price increases or supply issues are common. When quotes are used without revalidation, there is a real risk that the cash settlement will be too low to complete the necessary repairs. Insurers should always confirm that a quote remains current and actionable before using it as the basis for a settlement offer. AFCA should make clear that failing to do so is not consistent with fair claims handling.

- **Failing to clearly advise consumers that the insurer has elected to cash settle** – Insurers frequently fail to inform customers that they have formally elected to cash settle the claim, and they often do not explain what this means for the customer's rights and responsibilities. As a result, many consumers do not realise they are entitled to seek independent quotes, challenge the insurer's scope of works, or raise concerns through the internal dispute resolution process. This lack of transparency leaves policyholders at a disadvantage and contributes to an imbalance in knowledge and power between the insurer and the customer. Far too often, insurers present their builder's quote as the reasonable cost of repairs, without acknowledging that this cost has been calculated within the insurer's internal pricing framework. In reality, these quotes rarely reflect the true 'reasonable' cost that a consumer would face when arranging repairs independently in the open market. Without clear communication, consumers are more likely to accept underpriced settlements without understanding their options or whether the offer is sufficient. AFCA should reinforce that insurers must clearly communicate their election to cash settle and explain its implications in plain, accessible language, including the customer's right to test the insurer's assessment against real-world market rates.

- **Proposing settlements based on incomplete or preliminary quotes** – It is common for insurers to rely on quotes that are not complete or are only intended for initial assessment purposes. Some of these quotes include notes recommending further investigation, such as engineering advice, asbestos or mould testing, or structural drying after water damage. Despite these clear warnings, insurers often treat these quotes as final and use them to make a settlement offer. Consumers are rarely told that important work has been left out of the quote, and many only discover this after trying to arrange the repairs themselves. This leads to unexpected out-of-pocket costs. Where a quote is incomplete or flags the need for additional reports, the insurer should not treat it as the final basis for settlement. AFCA should confirm that doing so is not consistent with the insurer's duty of utmost good faith.

- **Rejecting consumer quotes based only on panel rate comparisons** – When customers provide their own quotes for repair work, insurers often reject them as being too expensive. However, in many cases, the insurer is comparing those quotes only to its internal panel rates, which are usually discounted and not available to the public. Once an insurer chooses to cash settle, the customer is responsible for managing their own repairs and will usually have to pay normal retail market prices. These may include higher labour costs, regional differences, or extra charges for difficult access. Comparing these market rates only to the insurer's internal pricing results in unfair pressure to accept a lower offer. AFCA should clarify that a fair test is whether the customer's quote reflects what someone in their position would reasonably be expected to pay in the open market, not what the insurer could pay through its private arrangements as these will often always result in the customer's private quote appearing excessive.

- **Misleading consumers about contingency allowances/ entitlements** – Insurers often tell customers that contingency costs are not covered under their policy, or that these costs are already included within a builder's margin or an event loading. While policies may not explicitly mention contingency allowances, AFCA determinations have consistently recognised that they can be necessary to ensure a customer receives a settlement sufficient to complete the repairs. Contingencies account for unforeseen issues such as hidden structural damage, asbestos, or access complications that

cannot be priced at the time of quoting. Despite this, insurers rarely inform customers that contingency allowances can be reviewed or awarded as part of a complaint or AFCA process. As a result, many consumers accept underpriced settlements without understanding they are entitled to request these additional costs. AFCA should clarify that reasonable contingency allowances may be required for a fair outcome and insurers should not mislead consumers about their entitlement to this.

- **Cash Settlements Driven by Manufactured 'Maintenance' Issues** - We have observed a trend after natural disasters where the high demand on insurers' national builder panels exceeds the capacity of those contractors to carry out all required repairs. In these circumstances, panel builders often identify supposed maintenance issues as a reason they cannot warrant the repairs, which in turn triggers the insurer to pursue a cash settlement instead. In our assessment, this practice reflects a systemic issue whereby contractors, unwilling to concede to their insurer clients that they lack the operational capacity to discharge their contractual obligations, instead shift the consequences of this shortfall onto consumers. This results in delays, unnecessary disputes, and adverse outcomes that disproportionately affect vulnerable policyholders. These will often involve sections of the property un-related to the claimed damage. This practice unfairly transfers the problem to consumers, who are then left with lower cash settlements that do not reflect the true cost of reinstatement in the open market. It is compounded by the fact that customers are often told they must spend thousands of dollars on unnecessary maintenance works, or risk having their policy cancelled by the insurer under duty of disclosure maintenance letter or good condition letters.

  We note from our experience that the type and nature of maintenance issues raised after natural disasters are markedly different, with vague and unsubstantiated claims often being presented as maintenance concerns, including items such as blocked gutters, minor roof wear, and general property ageing that are unrelated to the event. In many cases these matters are not an actual barrier to undertaking repairs, and instead result in maintenance repair requests that are either unnecessary or presented as opportunities for property improvement. These are often used to state that works cannot be warranted, and therefore claims must be cash settled. Some common examples include:

  - **Roof painting or recoating** – presented as a maintenance requirement, yet no Australian Standard requires it. There is no evidence that the absence of coating contributed to the loss, and the issues only arose during heavy rain associated with the storm, not in ordinary weather conditions.
  - **Full gutter replacement or upgrades** – often recommended without reference to any Australian Standard to show gutter sizing is inadequate. There is no evidence that the gutters failed under normal conditions, and the issues only emerged during extreme rainfall events.
  - **Replacement of undamaged tiles, sheeting, or flashing** – flagged due to age or appearance, despite no Australian Standard requiring replacement of materials that remain fit for purpose. There is no evidence of long-term ingress or failure under ordinary rain, with issues only appearing in the context of the storm.
  - **Installation of modern ventilation or drainage systems** – suggested on the basis of current codes and standards that did not apply at the time of construction. There is no evidence that the absence of such systems

contributed to the claimed damage, and the property had functioned without issue in normal conditions for decades.

- **Missing weep holes in tiled roofs** – identified as a defect despite no Australian Standard requiring their installation. No evidence shows their absence caused the claimed damage, and addressing it would require unnecessary cost unrelated to the event.
- **Rendering or re-cladding of walls** – raised despite no Australian Standard requiring it for cosmetic wear. There is no evidence that superficial deterioration contributed to the loss, and overlooking the fact that the claimed damage arose directly from the event itself.
- **Complete repainting of external or internal surfaces** – framed as maintenance, but paint deterioration is not regulated by Australian Standards, nor is there evidence it contributed to the loss. The issues are cosmetic and unrelated to storm or water ingress.
- **Window or door upgrades** – recommended for leaks observed during the event, but no Australian Standard requires replacement of compliant older designs. The issues were caused by the severity of the storm, not defective construction, and the suggestion amounts to an upgrade rather than maintenance.
- **"Environmental mould"** – mould is identified as a supposed environmental or pre-existing mould, without scientific testing to confirm the mould is unrelated to the event. The conclusion is based on unsupported assumptions, and the allegation shifts responsibility for storm-related damage onto the consumer without proper basis.

The unnecessary identification or mischaracterisation of legitimate storm or water damage as "maintenance" or "pre-existing" has severe and far-reaching consequences for consumers. It is one of the most common and harmful practices we observe, and in our view should be central point of claims handling failures in the Draft Approach document. Too often, no make safe works are carried out, leaving properties exposed and causing damage to worsen over time. Families are then forced to live in unsafe conditions, where mould proliferates, structural integrity deteriorates, and serious health risks emerge.

Consumers are also denied clarity about their rights, as insurers rarely explain that dismissing damage as "maintenance" amounts to a partial declinature of the claim. Without this transparency, policyholders are not informed of their right to dispute the decision. At the same time, they are pushed into spending thousands of dollars either acting on unsolicited advice from contractors or commissioning independent experts to disprove claims that are vague, unsubstantiated, and unrelated to any Australian Standard. When it inevitably becomes clear that the expenditure was unnecessary, insurers routinely refuse to reimburse those costs. Many are then steered into cash settlements that fall well short of restoring their homes, leaving them to fund the balance themselves.

The human consequences are equally serious. Families experience emotional harm, distress, and uncertainty, compounded by the stress of living in deteriorating conditions. Relationships often break down under the strain of ongoing disputes, and trust in the insurer erodes rapidly when consumers feel they are being blamed or misled. The result is an escalation of complaints and disputes with AFCA and regulators, further prolonging resolution and compounding the harm.

Finally, it must be recognised that many consumers already face financial hardship following a natural disaster or general property damage claim. Asking them to spend thousands of dollars unnecessarily, simply to contest or disprove baseless "maintenance" allegations, places an unfair and disproportionate burden on policyholders at their most vulnerable time.

A particularly troubling practice we observe with certain insurers is the use of so-called "good condition" requirements to pressure customers into cash settling their claims. Insurers often create the illusion that they will complete the repair works if the property is first brought up to these requirements, which can involve tens of thousands of dollars in supposed "maintenance" or "defect" costs. Knowing that few customers can afford such expenses, insurers effectively push them into electing a cash settlement. Most insurance policies contain a term stating that if a customer elects to cash settle, the insurer will only pay what it would have cost them to complete the works using their own panel of builders. This is a critical detail, because insurers operate at heavily discounted commercial rates that consumers cannot access. It amounts to an inherent acknowledgement by insurers that customers will be unable to have the same works completed for the settlement amount. When consumers are placed in this position, they often feel they have no choice but to request a cash settlement. The insurer then relies on the policy term to limit the payout to what it would have cost them through their own builder panel, even though it is clear they are not actually able or willing to undertake the works. We see this scenario play out repeatedly, right through to AFCA determinations, with certain insurers using this approach as a routine practice to reduce payouts. This is, in effect, an extortionary practice. Rather than coercing customers into making the election, insurers should acknowledge that they themselves are electing to cash settle because they cannot warrant the repairs without demanding the customer spend tens of thousands of dollars first. In those circumstances, fairness requires that the insurer pay the consumer the true cost of completing the works at market rates, not their internal discounted rate.

This is why insurers and AFCA should require that any maintenance issue is directly linked to an applicable Australian Standard, clearly explains how it is contributing to the loss, and sets out explicit actions required to address it. Otherwise, there is a real risk of lazy identification of supposed issues with little concern for accuracy or fairness. Insurers should also ensure their providers are educated on the consequences of non-compliance and the serious impact such practices can have on vulnerable customers.

AFCA should make clear that contractors using maintenance identification due to capacity constraints to justify cash settlements is not acceptable, as it increases the burden on consumers and undermines fair claims handling. To resolve this, insurers or their panel builders should be upfront if they are choosing to cash settle due to capacity limitations, or otherwise critically review whether the identified maintenance issues are legitimate, necessary, and based on objective standards. This issue is being compounded as the insurance market increasingly relies on a smaller pool of large panel of national contractors. Insurers should review their panel arrangements and business continuity practices to ensure this practice does not occur. This requires a strategic review of their approach to cost management and a careful assessment of how those practices impact customers. Claims and dispute resolution teams should actively monitor their panels for evidence of this behaviour, particularly in the aftermath of natural disasters, and ensure they are not issuing duty of disclosure letters or coercing

customers into cash settlements on that basis. This is where insurers could engage more transparently with the insured to explore practical options for resolution that take into account the customer's interests. For example, they could offer alternative panel builders, support the use of a private builder, or facilitate the separation of claim and non-claim works where appropriate. While not ideal, and not something we would advocate as a regular practice, insurers could also consider discussing the option of undertaking the works without offering a lifetime warranty if that would enable the repairs to be completed rather than forcing a cash settlement.

These issues are routinely identified in AFCA disputes and contribute significantly to the volume of home insurance claims that proceed to formal determination. A lack of clarity around insurer quotes, policy entitlements, and the cash settlement process leaves consumers unable to assess whether the offer is fair or sufficient. This creates confusion, erodes trust, and leads to unnecessary follow-up queries and complaints that could be avoided with clearer upfront guidance.

Practical Improvement Opportunities

To ensure fairness and consistency, we recommend AFCA update the Draft Approach to include the following:

1. **Model definition:**

   While Section 2.3 already sets out principles for fair cash settlements, there remains significant uncertainty in how these principles are applied. To increase clarity and reduce subjectivity in determinations, Section 2.3 should be updated to include explicit references that fair cash settlements must:

   - Include an itemised and costed scope of works with individual line items disclosed (no redactions except for Privacy Act requirements i.e. individuals names etc).
   - Incorporate a reasonable contingency allowance to cover transferred risk and unforeseen issues.
   - Benchmark pricing against open market rates, not insurer panel or bulk-discounted rates.
   - Replace provisional sums with confirmed costs prior to final settlement.
   - Be supported by quotes that are current and actionable at the time of settlement.
   - Be based on thorough inspections that identify concealed or inaccessible damage, not rushed or cursory site visits.
   - Not rely on quotes prepared solely for liability or settlement purposes unless those quotes reflect genuine market rates for actual reinstatement.
   - Be accompanied by clear written notice when the insurer elects to cash settle, with plain language explaining the implications for the consumer's rights (including their ability to obtain independent quotes, challenge the scope, or raise a dispute).
   - If variations arise after a cash settlement, AFCA should clearly outline expectations that insurers are required to assess and pay these additional costs without delay or placing unnecessary burdens on the consumer. This includes accepting reasonable evidence such as a builder's quote and accompanying report that explains the nature of the variation and how it relates to the insured damage. Insurers should not impose onerous requirements or shift the evidentiary burden unfairly onto the policyholder.

2. **Maintenance issues:**

AFCA should clarify in Section 2.3 that contractor capacity constraints or inflated maintenance objections cannot be used to justify cash settlements. Where capacity is the true reason, insurers (or their builders) should be upfront. Importantly, any identified maintenance issues must:

- Be demonstrably linked to the claimed damage, not to unrelated property issues. The insurer should also clearly explain why the maintenance issues impact the warrantability of the works.
- Be supported by proper evidence, such as inspection data, photographs, or specialist reports.
- Be reasonable having regard to the age, condition, and nature of the property insured, and not apply standards that did not apply to the home at construction.
- Be clearly linked to an applicable Australian Standard or recognised code of practice, rather than arbitrary or subjective contractor preferences.
- Ensure that property improvements are clearly identified as such (for example, installation of gutter guards) and are not misclassified as maintenance issues and used to cash settle claims.
- Not rely on assumptions when listing maintenance issues and require that any issues are actually proved by evidence.
- Not rely on opinions from individuals who are unqualified to assess the issue (including internal assessors lacking relevant expertise).

If AFCA identify that an insurer or their builder has relied on any of these approach or tactics that repairs should be completed by another panel builder and a warranty provided.

3. **Transparency obligations:**

AFCA should update Section 2.3 to ensure guidance is clear that the expectation is that insurers to provide consumers with full disclosure of all scopes, quotes, reports, and correspondence in their position when cash settling a claim (i.e. not just information the relied upon). Practices inconsistent with utmost good faith include:

- Insurers must clearly advise customers when they have elected to cash settle a claim, and make clear that if the insurer requires the customer to undertake any works before repairs can commence, then in circumstances where the customer cannot reasonably perform those works, the insurer is taken to have elected to cash settle.
- Insurers should not rely on policy terms that limit cash settlements where the evidence shows they would have been unable to warrant the repairs, even if the customer has elected to cash settle. Such terms should also not apply where there has been a breakdown in the relationship that was materially caused by the insurer or its contractors.
- Redacting costings from scopes or quotes.
- Using outdated quotes without revalidation.

- Proposing settlements based on incomplete or preliminary quotes that flag the need for further investigation (e.g. asbestos, mould, engineering).
- Rejecting consumer quotes solely because they exceed panel rates, without testing them against real-world market costs.
- Withholding information that may suggest increased costs or liability.
- Misleading consumers about their entitlement to contingency allowances.
- Insurers should advise consumers that settlement offers based on insurer-prepared quotes may not reflect actual market costs, and that customers should obtain independent quotes to properly assess fairness.

4. **Systemic response:**

   Where AFCA identifies recurring behaviours such as reliance on poor quality quotes, use of unsubstantiated maintenance objections, or systematic rejection of consumer quotes based on panel rates, AFCA should:

   - Treat these practices as breaches of claims handling obligations under the Insurance Contracts Act and AFCA's fairness principles.
   - Award higher non-financial loss where consumers have been forced into unnecessary complaint processes or delays, particularly where the insurer knew or ought to have known the issue was systemic or recurring.
   - Refer identified patterns of conduct for systemic reporting and ensure these are reflected in publicly available determinations to drive industry-wide correction.

   By embedding these requirements, AFCA can significantly reduce disputes by increasing clarity for consumers and insurers, restore consumer confidence, and ensure that cash settlements deliver the protection policyholders reasonably expect.

Unintended Consequences

While Section 2.3 of the Draft Approach acknowledges that cash settlements must be fair and reasonable, the current wording leaves too much room for subjective interpretation. This subjectivity is a key driver of disputes, as both insurers and consumers interpret "fairness" differently. As a result, AFCA is repeatedly required to determine the same issues.

Updating Section 2.3 to include explicit guidance on recurring issues would significantly reduce disputes and improve consistency across determinations. Clearer standards would limit subjectivity, create greater predictability in outcomes, and reduce the incentive for either consumers or insurers to test the same issues at determination. It would also empower Case Managers to rely on the Approach document earlier in the process to provide certainty to both parties, preventing unnecessary escalation and ensuring complaints are resolved more efficiently.

2. Expert Reports and Independence

We welcome AFCA's acknowledgement in the Draft Approach (Section 2.4) that the quality and independence of expert evidence must be carefully evaluated. This recognition is critical given the widespread concerns about the impartiality of insurer-appointed reports and the weight they carry in determining outcomes. In our experience, many reports used to deny claims would not withstand adversarial scrutiny, yet they are routinely relied upon by insurers in the claims process. This creates an uneven playing field where consumers are placed at a significant disadvantage unless they incur the cost of sourcing their own competing evidence.

While the Draft Approach touches on issues of independence and plausibility, greater clarity and specificity are needed to reduce disputes and ensure consistency across determinations. Expert reports must demonstrate the qualifications of the author, the relevance of their expertise, and the reasonableness of their assumptions. They must also address the correct question: causation. Too often, reports focus on the condition of a property without addressing whether the insured event was the proximate cause of the loss, which is the issue that determines coverage.

The insurance industry frequently refers to their appointed engineers, assessors, and building consultants as "independent experts." However, transparency and fairness require that this description is accurate. Where experts are under contract with an insurer, are part of a panel arrangement that guarantees repeat work, or otherwise maintain commercial ties, their independence is compromised in both appearance and substance. In these circumstances, it is misleading to present them as independent without disclosing the relationship. A striking example is where a loss adjuster has appointed an expert firm they own or have a financial interest in, without advising the customer. This type of undisclosed arrangement creates an obvious conflict of interest that undermines confidence in the claims process and may amount to a breach of the insurer's duty of utmost good faith.

AFCA's Approach should therefore make clear that insurers must disclose any contractual, financial, or repeat-appointment relationships with their appointed experts, including ownership or affiliation links through loss adjusters. Full disclosure would enable consumers and AFCA to properly assess the weight of evidence presented, ensuring that reports are not unfairly relied upon where independence is only nominal. Embedding this requirement would help restore trust in the process, reduce disputes, and hold insurers accountable to higher standards of transparency and fairness.

AFCA should also make clear that repeated reliance on experts whose opinions have previously been criticised in determinations undermines fair outcomes and may justify higher awards of non-financial loss.

From our experience, common examples that contribute to unnecessary disputes include:

- **Experts presented as independent when they are not** – Insurers frequently describe their appointed engineers, assessors, and consultants as independent, even when these individuals or firms are under contract, operate within panel arrangements, or receive the bulk of their work from insurers. In some cases, we have seen loss adjusters appoint expert firms they own or have a financial interest in, without disclosing this to the consumer. This lack of transparency creates the false impression of impartiality and undermines trust in the claims process. Insurers should disclose any contractual, financial, or repeat-appointment relationships with experts and clearly identify potential conflicts of interest to ensure that evidence is weighed appropriately.

- **Reliance on assumptions instead of evidence** – Expert reports are often used to decline or reduce claims based on unproven assumptions. For example, insurers may assert maintenance issues such as rising damp or drainage defects without supplying inspection data, testing results, or specialist reports. These assumptions are then used as the basis for exclusions or liability reductions. Such practices leave consumers unfairly disadvantaged, as they cannot meaningfully challenge unsupported conclusions. Insurers should ensure all expert findings are evidence-based and supported by data or testing before relying on them in claim decisions.
- **Unclear or inadequate briefs to experts** – Many disputes arise because experts are instructed without a clear brief. As a result, reports sometimes answer the wrong question, such as commenting on the general condition of a property rather than addressing causation of specific damage. This wastes time, creates confusion, and often creates unnecessary disputes. Insurers should provide precise written instructions that define the scope of the expert's task and ensure reports address the central issues relevant to coverage and liability. Any issues addressed outside of the scope should be removed from the expert report.
- **Repeated reliance on experts whose opinions have been rejected** – It is not uncommon for insurers to continue appointing providers whose reports have been rejected in multiple AFCA determinations. For example, we have seen cases where experts consistently use an opinion that has routinely been rejected by AFCA, but insurers continue to use that expert and do not provide the feedback that the opinion has been rejected. Persisting with such providers without correcting the Draft Approach signals systemic issues within insurer practices and places complainants at risk of repeated unfair treatment. Insurers should stop appointing experts whose work has been found unreliable in past disputes until performance improvement occurs. Insurer should also proactively remediate customers who were impacted.
- **Failing to acknowledge influence over providers** – Insurers often appear oblivious to the influence they exert on experts, even indirectly. Panel arrangements, guaranteed work volumes, or close financial ties can create subtle pressure on providers to align findings with insurer expectations. This is particularly true when insurers are requesting a third party to review consumer reports and quotes. This undermines independence and fairness. Insurers should actively recognise this influence, manage conflicts transparently, and ensure that expert evidence is produced free from perceived or actual bias.
- **Continuing to rely on reports with known errors** – Even when consumers or AFCA point out clear errors or omissions in reports, insurers frequently continue to rely on those documents throughout the dispute resolution process. This behaviour prolongs disputes and damages confidence in fair claims handling. Insurers should withdraw or amend reports once flaws are identified and ensure they do not continue to rely on incorrect information to support a claim decision. AFCA should also recognise that continued reliance on conflicted or flawed expert reports imposes unnecessary cost and delay on consumers, and may amount to a breach of utmost good faith. Where such practices are repeated, they should be treated as systemic conduct warranting regulatory attention.
- **Cherry-picking favourable findings** – Insurers sometimes rely only on parts of an expert report that support their position, while ignoring sections that may contradict it. This selective use of evidence undermines the duty of utmost good faith and creates unfair outcomes for policyholders. Insurers should consider expert reports in their entirety,

clearly address conflicting findings, and document how they were resolved rather than disregarding inconvenient evidence.

- **Discounting consumer-provided evidence** – A recurring issue is the dismissal of expert reports obtained by consumers on the grounds that they were not prepared by insurer-appointed providers. In many cases, consumer evidence is sidelined regardless of its quality, leaving complainants disadvantaged. Insurers should properly consider consumer evidence on its merits and provide clear reasons where they disagree, rather than dismissing it outright because it was obtained independently. The use of conflicted or inadequate reports by insurers often compels consumers to commission their own expert evidence, leading to unnecessary cost, delay, and stress. This practice creates a substantial barrier to fair outcomes and limits access to justice, especially for vulnerable consumers who may lack the resources or support to challenge flawed insurer assessments.

Practical Improvement Opportunities

To ensure fairness and consistency, we recommend AFCA update Section 2.4 to include the following:

- **Transparency of independence** – Insurers should disclose any contractual, panel, or financial relationships with their appointed experts, including ownership links through loss adjusters. Reports should not be presented as independent unless full disclosure is made. This ensures both AFCA and consumers can properly assess the weight of the evidence. When insurers knowingly rely on reports that are partial, conflicted, or previously identified as flawed, this conduct may amount to a breach of the duty of utmost good faith. Such behaviour undermines trust in the claims process and can justify higher awards for non-financial loss, as well as reimbursement of unnecessary costs the consumer was forced to incur in order to correct or challenge the insurer's position.
- **Evidence-based reporting** – Insurers should ensure that expert conclusions are supported by inspection data, testing results, or appropriately qualified specialist reports. Assumptions without evidence should not be relied upon to deny claims or reduce liability.
- **Clear expert instructions** – Insurers should provide experts with a clear written brief that sets out the scope of their task and the key issues relevant to the claim, particularly causation. Reports should not stray into irrelevant commentary, and any findings outside the scope should be disregarded.
- **Addressing repeated poor performance** – Insurers should not continue to rely on experts who consistently adopt approaches or methodologies that AFCA has previously found unreliable or inadequate. Persisting with discredited approaches, rather than improving standards or seeking alternative expertise, should be treated as a systemic issue within the insurer's claims handling framework. Such conduct undermines confidence in fair outcomes and may justify higher non-financial loss awards where it exposes consumers to repeated disadvantage.
- **Managing insurer influence** – Insurers should actively recognise and manage the influence they have over providers, particularly those under panel arrangements or

guaranteed work contracts. Processes should be put in place to protect experts from subtle or perceived pressure to align with insurer expectations.

- **Correcting identified errors** – Insurers should withdraw or amend expert reports once clear errors, omissions, or misstatements are identified. Continuing to rely on reports known to be flawed is inconsistent with utmost good faith and undermines fair dispute resolution.
- **Considering the full report** – Insurers should not cherry-pick favourable sections of expert reports while ignoring findings that contradict their position. Reports must be considered in their entirety, with conflicting conclusions addressed openly and transparently.
- **Giving proper weight to consumer evidence** – Insurers should consider consumer-appointed expert reports on their merits rather than dismissing them simply because the provider is not insurer-appointed. Where they disagree, insurers should provide detailed reasons, not blanket rejection.

Unintended Consequences

While Section 2.4 of the Draft Approach acknowledges that the quality and independence of expert evidence must be evaluated, the current wording leaves too much room for subjective interpretation. This subjectivity is a key driver of disputes, as insurers and consumers hold very different expectations about what constitutes independence, adequacy of evidence, or the proper scope of an expert report. As a result, AFCA is repeatedly required to determine the same issues about expert assumptions, conflicts of interest, and the reliability of opinions.

Updating Section 2.4 to provide clearer standards on expert independence, transparency of relationships, and evidentiary requirements would reduce unnecessary disputes and improve consistency across determinations. It would also empower Case Managers to intervene earlier in the process, pointing out when reports fail to meet minimum standards of independence or reliability, and preventing issues from escalating unnecessarily.

3. Reimbursement of Costs Incurred by Customers

We welcome AFCA's recognition in the Draft Approach (Section 2.4) that the fairness of outcomes must take into account both the conduct of the parties and the quality of the evidence relied upon. However, from the consumer's perspective, the current guidance does not go far enough in recognising the very real financial and emotional toll created when customers are forced to commission their own expert reports.

When insurer-appointed evidence is flawed, incomplete, or not independent, customers are left in an impossible position. They must either accept an unfair outcome or fund their own engineers, builders, or other specialists at significant personal expense. This often occurs while families are already under stress from living in damaged or unsafe properties, compounding the emotional and financial strain. Many customers spend months carrying the cost burden, uncertain whether their evidence will even be considered, while the insurer's position remains unchanged.

The power imbalance between insurers and consumers is precisely why the threshold for reimbursement must be low. Insurers essentially have unlimited funds to spend on expert reports, but consumers are often in financial hardship during a claim. If insurer conduct in any

way contributes to the need for a customer to obtain their own expert evidence, the costs should be reimbursed. Clear examples demonstrate this principle: where an insurer changes its decision after consumer-funded evidence is provided, where the offer amount is increased following such evidence, where the evidence resolves a complaint that the insurer previously resisted, or where the insurer withdraws or amends a flawed report once competing evidence is produced. In each of these situations, it is the insurer's conduct that triggered the customer's need to spend money, and fairness requires that those costs are repaid rather than left with the consumer.

In practice, consumers frequently see their concerns dismissed until competing evidence is produced. Only then do insurers acknowledge that their own position was unsustainable. By this stage, the customer has already borne thousands of dollars in costs, endured months of delay, and suffered prolonged uncertainty. This imbalance undermines trust, exacerbates hardship, and leaves policyholders feeling that the system is stacked against them.

The impact is particularly severe for vulnerable customers, who are often the least able to shoulder these additional costs and the most likely to suffer long-term harm when insurers fail to act fairly.

Practical Improvement Opportunities

To ensure fairness and consistency, we recommend AFCA update Section 2.4 to include the following:

- Where a customer is required to obtain their own evidence because the insurer's reports are flawed, incomplete, demonstrably biased, or because the insurer refused to acknowledge legitimate concerns, the insurer must reimburse and acknowledge those costs as part of the claim outcome.
- Where an insurer changes its approach or decision following the provision of consumer-funded evidence, reimbursement must automatically follow, as the costs were triggered by the insurer's own failure to properly assess the claim in the first instance.
- Interest should be applied from the time the customer was compelled to act, including where insurers have refused reimbursement until a later AFCA determination, to reflect the financial disadvantage and prolonged stress caused.
- Insurers must not continue to rely on reports once errors or deficiencies are identified and must either withdraw or rectify such reports to prevent unnecessary duplication of evidence.

Unintended Consequences

While Section 2.4 of the Draft Approach acknowledges that the fairness of outcomes must consider both the conduct of the parties and the quality of evidence relied upon, the current wording does not provide clear guidance on when customers should be reimbursed for the costs of expert reports. This lack of certainty leaves too much room for subjective interpretation, leading to repeated disputes about whether reimbursement is appropriate.

Without stronger guidance, insurers can continue to rely on inadequate reports without consequence, knowing that the cost of rectifying these shortcomings will fall on the consumer.

This undermines fairness, prolongs disputes, and forces AFCA to repeatedly determine the same issues about reimbursement on a case-by-case basis.

Updating Section 2.4 to set explicit expectations that reimbursement is required where insurer conduct or flawed reports trigger the need for consumer-funded evidence would reduce unnecessary disputes, prevent inconsistent outcomes, and restore balance to the process. It would also ensure that consumers are not unfairly penalised for correcting insurer failings, reinforcing the principle of utmost good faith.

4. Allowances for Professional Fees and Advocates

We note that Section 2.3 of the Draft Approach states that *"AFCA provides a free service. As such, it is not usually necessary for either party to be professionally represented. Therefore, there is no automatic right to such costs, even if the complainant is successful in their position."* We agree that in most cases consumers should not need to engage professional representation to resolve disputes through AFCA. However, in our experience the current framing underestimates the circumstances in which representation becomes unavoidable, particularly where insurer behaviour, complexity of evidence, or vulnerability makes it unrealistic for consumers to advocate effectively on their own.

While we acknowledge that some may perceive these submissions as self-serving, our experience with consumers tells a different story. It is not uncommon for people to cry on the phone when we tell them that they have a legitimate point, because they have spent months feeling ignored or dismissed by their insurer. Many say they are "exhausted" and on the verge of "giving up," demonstrating the significant mental and emotional toll of having valid concerns disregarded for extended periods. In this context, making access to reimbursement of professional advocacy difficult only entrenches the imbalance of power between insurers and consumers, leaving vulnerable people without the support they desperately need.

We respectfully note that the current wording in Section 2.3 of the Draft Approach creates ambiguity about the role AFCA plays for consumers. While we agree that AFCA is a free and accessible service and that in many cases consumers will not require representation, in complex home insurance disputes AFCA cannot fulfil the role of a paid advocate.

The statement in Section 2.3 also appears to suggest that insurers and consumers are on equal footing when engaging with AFCA, as it notes that neither party usually requires representation. In practice, this is not the case. In almost all matters before AFCA, insurers are represented by highly qualified and skilled professionals within their External Dispute Resolution (EDR) teams. These teams specialise in AFCA complaints, manage them daily, and have deep knowledge of AFCA's rules, processes, and prior determinations.

Even a standard claims manager within an insurer generally holds far more knowledge, experience and access to internal systems, supplier networks and decision-making authority than the average consumer. They are often the final decision-maker and are supported by internal legal and technical resources. Consumers, by contrast, are frequently navigating the process for the first time, often in the aftermath of significant personal loss and under considerable stress. Given this disparity, insurers should be held to a higher standard of conduct, including the providers they appoint.

This creates a structural imbalance, as insurers effectively rely on paid representation by default, while consumers typically enter the process without similar resources or expertise.

By design, AFCA cannot bridge this imbalance by acting as an advocate for consumers. Its own Rules make this clear:

- Rule A.2.2 (page 6) requires AFCA to operate independently of financial firms, complainants, and government.
- Rule A.2.3 (page 6) requires AFCA to act impartially, ensuring fair treatment of all parties.
- Rule A.4.1 (page 9) reinforces that AFCA must provide a fair, independent, and impartial process that is transparent and accountable.

This reality means that when a consumer lodges a complaint, they face a natural imbalance of power. While AFCA provides impartial support, consumers are effectively pitted against a team of trained dispute resolution specialists working for the insurer. These teams are often subject to internal performance metrics and KPIs that can influence how complaints are handled, meaning their role is not impartial but instead driven by outcomes that align with the insurer's commercial or operational interests. This imbalance is particularly evident where the insurer's own conduct has caused or escalated the dispute , such as relying on flawed expert reports, failing to properly address valid concerns, or incorrectly denying a claim. In our experience, rather than acting as an internal check, EDR teams frequently reinforce earlier decisions, even when the underlying evidence is weak or contested. Instead of critically reassessing the matter or advocating for a fair resolution, they often present entrenched positions to AFCA. In these situations, consumers are left at a significant disadvantage and often need external support to level the playing field and reach a just outcome.

For these reasons, we submit that the relevant test for reimbursement should be whether the insurer's conduct contributed to the need for paid representation. The focus should not rest solely on the complainant's vulnerability or the technical complexity of the dispute. Rather, fairness requires asking whether the insurer's own actions created or materially contributed to the need for representation.

For example, where an insurer wrongly declines a claim that should have been paid, ignores valid evidence, or relies on flawed expert reports that cause significant stress or confusion, the consumer is often left with no choice but to seek professional assistance to navigate the process. In these circumstances, the need for representation arises directly from the insurer's conduct. But for the insurer's actions, the consumer would not have been required to engage a paid representative.

AFCA should recognise that pursuing a matter to determination has vastly different consequences for insurers and consumers. For consumers, pushing a matter to AFCA determination may mean they are risking their financial future (i.e. if their entire claim has been declined for example), while for insurers the same dispute represents little more than a rounding error on their balance sheet if they lose. This stark structural imbalance of power, coupled with widespread lack of insurance literacy, leaves many consumers overwhelmed and extremely vulnerable to pressure tactics by insurers. Too often they are told repeatedly by insurers that they are wrong, or are pushed into settling claims prematurely rather than enduring the drawn-out process to determination. The number of adverse AFCA determinations against insurers should be seen as a warning sign of the devastating impact on countless customers who lacked the resources, knowledge, or fortitude to continue their fight. This reality highlights why paid representatives are necessary. They help redress the imbalance, ensure customers' rights are properly argued, and give consumers the confidence to challenge insurer conduct. Where an

insurer's conduct has created the need for a paid representative (such as in the case of a declined claim), and the complaint is ultimately successful with the support of that representative, the insurer should be required to contribute to the professional fees. The only exception should be where there is clear evidence that the representative provided no meaningful assistance.

From our experience, when insurers' conduct contributes to the need for paid representation, the services provided by advocates or professionals often go far beyond what AFCA can offer under its impartial mandate. This is not about duplicating AFCA's role, but about addressing the imbalance created when an insurer's actions force a consumer to seek additional support. These tasks, which directly arise because of insurer behaviour, highlight the gap between AFCA's free service and the practical advocacy consumers require in complex or disputed claims. For example, representatives are frequently required to:

- **Gathering and presenting evidence** – Collecting photos, videos, timelines, policy documents, and correspondence to establish causation, coverage, and breaches of obligations.
- **Attending the property** – Inspecting damage, liaising with contractors, and documenting the scope of works in a way insurers rarely facilitate for consumers.
- **Arranging expert assessments** – Identifying, instructing, and coordinating independent engineers, builders, hydrologists, or mould specialists to provide evidence addressing causation or scope.
- **Reviewing and testing expert reports** – Asking critical questions of insurer-appointed experts and ensuring assumptions are backed by evidence, not conjecture.
- **Clarifying insurer correspondence** – Interpreting letters, scopes, and reports when they are drafted in overly technical, legalistic, or confusing language, and explaining their implications for the consumer.
- **Drafting submissions** – Preparing written arguments and responses for the customer, including submissions to the insurer, IDR, and AFCA, structured to address the key issues in dispute.
- **Emotional and practical support** – Providing sustained psychological support to policyholders dealing with prolonged stress, loss of their home, or vulnerable circumstances.
- **Assisting with contents inventories** – Helping families prepare detailed schedules of damaged or destroyed items, including proof of ownership and valuation.
- **Challenging insurer decisions** – Responding to declinatures, partial offers, or policy interpretation disputes through IDR or escalation channels before AFCA involvement.
- **Lodging and managing AFCA complaints** – Ensuring complaints are framed accurately, evidence is filed correctly, and arguments align with AFCA's jurisdiction and Approach documents.
- **Negotiating settlements** – Reviewing insurer offers and negotiating to ensure settlements reflect actual reinstatement costs in the open market, including contingencies and GST.

- **Monitoring compliance with codes and obligations** – Identifying and pressing breaches of the General Insurance Code of Practice, ASIC Act, or Privacy Act when insurers fall short of their obligations.

In some cases, consumers may simply prefer to engage a representative for support, and we acknowledge that this is a matter of personal choice. However, where representation becomes necessary because of the insurer's conduct, the payment of professional fees should not be as narrowly limited as AFCA's current Draft Approach suggests.

It is important to recognise that many consumers, particularly those in vulnerable circumstances, cannot afford to wait for the full AFCA process to be completed before resolving urgent issues such as housing, safety or financial stability. In practice, the need for professional support often arises well before AFCA reaches a decision, especially where insurers delay action, rely on flawed reports or fail to properly address valid concerns. These situations require timely and specialised assistance that most consumers are not equipped to manage on their own. While some may suggest that consumers rely on free community legal or financial services, this is neither realistic nor fair in many cases. These services are often under-resourced, face high demand and may not have the expertise to provide effective support in technical or complex insurance matters. It is unreasonable to expect vulnerable individuals to rely on overstretched community services when the need for representation has been caused by the conduct of insurers who generate substantial profits. In such circumstances, reimbursing the cost of paid representation is not a luxury but a necessary measure to ensure consumers can assert their rights and access timely, fair outcomes. Awarding reimbursement for professional fees in these circumstances should not be viewed by AFCA as a form of punishment, but rather as a necessary remedy to restore balance and fairness where insurer conduct has created the need for paid support.

Practical Improvement Opportunities

To ensure fairness and consistency, we recommend AFCA update Section 2.3 to provide clearer guidance on when reimbursement of professional fees and advocacy costs is appropriate. While AFCA is correct to note that its service is free and most consumers should not require representation, there are important circumstances where representation becomes unavoidable due to the conduct of the insurer. In those cases, fairness requires that consumers are not left bearing the financial burden of correcting insurer failings.

Specifically, Section 2.3 should make clear that:

- **Representation necessitated by insurer conduct test** – Where an insurer's handling of a claim has necessitated consumer representation (for example, declining a claim that should have been paid, failing to respond meaningfully to legitimate concerns, or relying on flawed evidence), the costs of representation should be reimbursed as part of the claim outcome, subject to the existing AFCA limits. This consideration should not be limited only to circumstances where the consumer achieves a successful outcome. The appropriate test is whether the insurer's conduct created or contributed to the need for representation in the first place.
- **Proportionality and fairness** – While reimbursement should not apply in all cases, AFCA should acknowledge that the nature of the claims, including where the insurers conduct

has contributed to the complexity (i.e. lack of make safe repairs), then paid representation for the customer to help prepare the claim is reasonable.

- **Trigger for reimbursement** – This consideration should not be limited to successful outcomes, but should focus on whether the insurer had all reasonable information available to make the correct decision and whether the claimant gave the insurer a fair opportunity to resolve the matter before engaging a paid representative or advocate.

Embedding these improvements would align Section 2.3 with AFCA's fairness mandate, reduce disputes about representation costs, and promote accountability for insurer conduct that drives the need for paid advocacy.

Unintended Consequences

While Section 2.3 of the Draft Approach rightly acknowledges that AFCA provides a free service and therefore representation is not usually necessary, the current framing risks oversimplifying the reality of claims handling disputes. By suggesting that professional representation should only be reimbursed in very narrow circumstances, AFCA may unintentionally create perverse outcomes.

One consequence is that insurers are encouraged to contest the legitimacy of a complainant's representative, shifting the focus away from the core issues of the dispute. Instead of engaging with whether the claim has been handled fairly, disputes can become bogged down in arguments about whether representation was justified. This creates unnecessary animosity between the parties, prolongs disputes, and causes significant and avoidable stress for consumers who are already managing the burden of loss. In our experience, this additional layer of conflict is deeply discouraging for complainants, who often feel overwhelmed and disheartened when the legitimacy of their need for support is itself turned into a point of contention.

Without recognising that insurer conduct can directly necessitate the need for representation, AFCA risks entrenching an imbalance of power. Clearer standards would reduce subjectivity, ensure consistency, and help restore consumer confidence that representation is recognised as legitimate when caused or contributed to by insurer behaviour. This would also reduce disputes over the legitimacy of representation costs, ensuring focus remains on resolving the substantive claim issues rather than side arguments.

5. Insurer must exercise discretion fairly

We welcome AFCA's recognition that insurers hold significant discretion in the way they handle claims. However, we consider the Draft Approach could add additional context around how the discretion should be exercised.

In our experience, insurer discretion is often applied inconsistently and sometimes in a way that disadvantages the consumer. For example, an insurer may choose to retain control over the repair process when it is operationally convenient, but then switch to a cash settlement approach when it is more financially beneficial to the insurer. This shift can occur without regard for whether the outcome meets the customer's needs or circumstances. Fairness requires that discretion is applied consistently and reasonably in both directions. If a customer elects to cash settle for valid reasons, such as a breakdown in the relationship caused by the insurer or its

contractors, then the insurer should not rely on policy terms to reduce the settlement amount. This is particularly important where the insurer's own conduct has contributed to the situation that led the customer to request a cash settlement. Insurers should also be transparent about why a cash settlement is being offered and avoid using vague or subjective reasons, such as broad claims of maintenance issues, which often increase stress and confusion for already vulnerable customers.

A common reason disputes arise is when an insurer says the property was not properly maintained or not in "good condition," often only after the customer has made a claim. This is usually linked to the insurer's obligation to provide a lifetime warranty for repairs. If they believe there are pre-existing defects or maintenance issues, they may decide they cannot offer that warranty and instead choose to cash settle the claim. While this can be a reasonable approach when supported by clear evidence and a logical link between the identified issues and the ability to carry out safe, warrantable repairs, too often that link is missing. In many cases we see, the insurer relies on opinions formed during brief site visits, assessments by individuals without relevant qualifications, or issues unrelated to the damaged areas. Customers are rarely given clear explanations of what was found, why it affects the ability to repair, or what steps they can take in response.

In practice, this results in vague and unsupported maintenance allegations that shift the burden onto the customer to disprove them, often at significant personal cost. Common examples include:

- Alleged maintenance issues that are not linked to any applicable Australian Standard, such as installing weep holes or gutter guard, which are typically improvements rather than required maintenance.
- Claims of non-compliance with modern building codes that did not exist at the time the property was constructed, without any explanation of how these issues contribute to the damage or affect repairability.
- Cosmetic conditions, like the need to repaint a tiled roof, being classified as maintenance concerns.
- Broad statements like "poor drainage" without identifying what specifically needs to be fixed or how it impacts the claim.
- Significant works are often recommended without a clear or justified link to the available evidence. For instance, we frequently see recommendations for full roof restorations or complete replacement of stormwater drainage systems, even when a more targeted, cost-effective repair would be appropriate. These large-scale proposals often delay progress and create unnecessary complexity, pushing consumers toward cash settlement because the proposed works become financially or practically unviable.
- Insurers or their contractors sometimes identify issues as fact without proper evidence, relying instead on assumptions. A common example is the assertion of "rising damp" without any testing or confirmation that a damp-proof course is absent or has failed. Verifying this would typically require invasive investigation such as removing floor coverings or conducting external excavations. In another case, a customer was told they may have a non-compliant cold joint, yet the insurer expected the customer to disprove the issue by undertaking destructive works, despite providing no testing or verification

themselves. This practice unfairly shifts the burden of proof and expense onto the consumer and leads to dispute. Insurers should not raise these issues, unless they are actual proven issues by qualified experts.

This creates a two-fold harm. First, the insurer refuses to carry out the repairs and offers a cash settlement instead. Second, the customer is left with the risk that their policy may be cancelled unless they disprove the alleged maintenance issues. Many feel forced to pay thousands of dollars for independent reports just to protect their insurance or avoid being labelled as having misrepresented their property. When the issues raised are not validated, or are unrelated to the loss, this approach causes significant consumer harm and is not consistent with fair claims handling. When consumers spend unnecessary funds on maintenance issues, insurers refuse to reimburse these costs.

Discretion must also be applied by prioritising the customers' needs and with utmost good faith. A customer-focused approach requires insurers to actively consider the unique circumstances of each customer, including health, financial stress, and access to housing. The insurer should focus on how they can support the customer to have repairs completed and not create unnecessary barriers. Insurers should also take greater responsibility for the repair decision-making process and not rely solely on the views of a single builder to determine whether a repair can proceed or whether a warranty can be offered. The insurer also has the option to provide the repair warranty directly, rather than relying solely on their builder to offer it. This approach would allow the insurer to prioritise the customer's interests and proceed with necessary repairs, even in situations where a builder declines to offer a warranty. Taking ownership of the warranty in this way could help avoid unnecessary cash settlements and reduce the burden placed on customers. Insurers should carefully consider how their contracting approaches, including requiring builders to provide warranties and using fixed-fee contracts, can lead to perverse outcomes for vulnerable customers, particularly in the aftermath of natural disasters when capacity is limited and repair complexity is high.

Insurers should carefully assess how their procurement models and outsourcing arrangements may be affecting their ability to deliver timely and fair repair outcomes. For instance, relying heavily on national building panels that operate under fixed-rate contracts can lead to capacity issues, especially after natural disasters, where those builders may prioritise higher-paying or less complex jobs from other insurers. This can result in significant increases in these providers identifying maintenance issues that restrict their ability to 'warrant the work', a key driver of cash settlements. To ensure fair outcomes, insurers should adopt more flexible and responsive procurement strategies that account for surge demand and regional constraints. This includes maintaining access to a broader and more diverse pool of service providers to ensure customers are not unfairly impacted by the insurer's own commercial arrangements. After catastrophic events, supporting repair capacity is especially important. Insurers should closely examine whether their internal strategies and supply constraints are contributing to an increased reliance on cash settlements during these periods. Where this occurs, it is essential that cash offers are based on realistic market rates and not influenced by internal pricing models or panel constraints. Insurers must take active steps to ensure their processes do not lead to compounding vulnerability by raising un-related and unnecessary maintenance requirements due to their own limitations.

Decisions to withhold repairs or warranties should only be made where clearly identified maintenance issues are directly related to the claimed damage and have been properly proven

to impact the ability to warrant the works. Without this level of evidence and accountability, consumers are left exposed to inconsistent outcomes and avoidable financial disadvantage.

Practical Improvement Opportunities

To ensure fairness, transparency, and consistency in decision-making, we recommend that AFCA update Section 2.3 of the Draft Approach to provide clearer guidance on how insurer discretion should be exercised in relation to cash settlements and repair decisions. While the current draft acknowledges the broad discretion available to insurers, it does not adequately address how this discretion must be applied fairly and consistently, particularly in situations where an insurer chooses to withhold repairs based on alleged maintenance issues or builder warranty concerns.

Specifically, Section 2.3 should clarify the following:

- **Constructive cash settlement test** – Where an insurer refuses to proceed with repairs unless a customer completes a list of tasks (such as maintenance or compliance upgrades), AFCA should consider the insurer to have elected to cash settle. In these circumstances, the settlement amount should reflect market rates available to the consumer and cannot be limited to internal or panel pricing. Treating these scenarios as constructive cash settlements would ensure that insurers cannot impose repair preconditions that unfairly shift cost and responsibility to the consumer.
- **Maintenance and warranty issues must be evidence-based** – AFCA should make clear that any decision to refuse repairs or offer cash settlement based on maintenance or warranty limitations must be supported by objective, independently verified evidence. This includes identifying what specific issue exists, how it relates to the claimed damage, and how it prevents the insurer or builder from carrying out safe, warrantable repairs. Vague or unsupported allegations such as “poor condition” or “non-compliance” should not justify cash settlement or reduced entitlements.
- **Transparency in discretionary decisions** – Insurers should be required to clearly advise the customer when they have elected to cash settle and explain the reasons for that decision, including whether it relates to builder availability, repair feasibility, or alleged property conditions. Customers should also be informed that they are entitled to obtain their own quotes and challenge the proposed scope. AFCA should expect insurers to provide this information as part of their duty to communicate clearly and support informed decision-making.
- **Repair decisions must prioritise the customer’s interest** – Where a builder declines to offer a warranty, insurers should not automatically default to cash settlement. AFCA should confirm that the insurer has a duty to explore alternatives, including whether it can provide the warranty directly or engage another builder willing to undertake the work. Discretionary decisions should reflect the customer's needs, not just builder preferences or internal limitations.
- **Procurement constraints do not justify shifting cost to the consumer** – AFCA should recognise that some cash settlements arise from the insurer’s own commercial limitations, such as fixed-price builder panels or regional capacity shortages. In these cases, settlement offers must still reflect fair market rates and should not be reduced due to the insurer’s internal pricing arrangements or builder availability. Consumers should

not bear the financial consequences of insurer procurement decisions. Additional allowance for project management fees or costs should be included in circumstances where customers need to undertake the repairs themselves.

Unintended Consequences

While the Draft Approach recognises insurer discretion as part of claims handling, it should be updated to reflect the commercial reality that cash settling claims often delivers materially better financial outcomes for insurers. It enables faster claim closures, reduces ongoing claims handling, reduces reserves needed, reduces administrative claims handling expenses, eliminates exposure to variations and cost escalations during the repair process, and avoids future obligations such as providing or managing builder warranties. In surge environments or where builder availability is constrained, cash settlement is particularly attractive, allowing insurers to reduce their operational burden and shift responsibility for repair execution onto the customer. However, these benefits must be balanced against the insurer's duty to act fairly, uphold the policy promise, and prioritise the customer's interests. Where the insurer elects to transfer responsibility for repairs, it must also transfer the full financial capacity for the customer to reinstate their property. Insurers cannot have the best of both worlds, fairness demands that settlement outcomes genuinely reflect what is required to restore the customer, in line with the cover they paid for.

This creates uncertainty for consumers and undermines trust, particularly for vulnerable people who are disproportionately affected by outcomes that fail to account for their circumstances. It also risks entrenching systemic behaviours where discretion is used to minimise insurer exposure rather than balance the rights and needs of both parties. Over time, this will increase disputes, as consumers perceive discretion as arbitrary or self-serving.

6. Non-Financial Loss – Clearer Structure Needed

We welcome AFCA's existing recognition of allowances for non-financial loss. However, the current guidance lacks structure in linking insurer conduct to outcomes, leaving both insurers and consumers uncertain about when non-financial loss will be awarded and at what level.

In our experience, the greatest consumer frustration arises not simply from declined claims but from how insurers engage with them. Where poor communication, dismissiveness, or unreasonable delay forces a customer into AFCA's process, the stress and frustration are direct consequences of insurer conduct, not an inevitable part of claims handling. It should not be acceptable for consumers to bear this burden without redress.

We also see significant inconsistency in awards of non-financial loss. While each case must be assessed individually, a more structured approach would increase predictability and transparency. A matrix or indicative range of awards, tied to the severity and nature of insurer conduct, would improve consistency across determinations and reduce the likelihood of repeated disputes over the same issues.

Practical Improvement Opportunities

To ensure fairness, transparency, and consistency in decision-making, we recommend:

- AFCA Explicitly link non-financial loss to insurer conduct, making clear that poor conduct which forces a consumer into AFCA is unacceptable.
- Develop an indicative matrix or range of awards to provide consistency while allowing flexibility for exceptional circumstances.
- Recognise that repeated systemic failings or reckless disregard for fairness should justify higher awards to act as a corrective incentive.

Unintended Consequences

The Draft Approach recognises the potential for non-financial loss but provides little clarity on how insurer conduct links to such awards. Without a structured framework, outcomes remain inconsistent, subjective, and difficult for both parties to predict. This lack of structure has two key consequences:

1. Consumers are left uncertain about whether their experiences of stress, delay, or poor conduct will be recognised, which undermines confidence in the fairness of the process.
2. Insurers face unclear expectations about the potential consequences of poor conduct, which reduces the incentive to change systemic behaviours.

In our experience, this uncertainty drives many consumers to escalate to AFCA, simply to "test" whether their experience of stress or delay qualifies for non-financial loss. This adds unnecessary pressure to AFCA's caseload. By not linking conduct clearly to outcome ranges, the current guidance risks perpetuating inconsistent awards and repeated disputes about the same issues.

7. Financial Losses

We welcome AFCA's recognition that financial losses may be awarded where unreasonable insurer conduct directly causes consumer losses. However, the current test, which requires the loss to have been reasonably foreseeable at policy inception, is both unclear and impractical in the context of claims handling disputes.

From our experience, financial losses most often arise not from the insured event itself but from the insurer's conduct during the handling of the claim. For example, delays in organising repairs often force families into temporary accommodation, incurring rental expenses they would not otherwise face. Consumers are frequently required to pay for their own expert reports after insurers rely on flawed evidence, only for the insurer to later change its position. These losses may not have been foreseeable when the policy was first taken out, but they are entirely foreseeable once the insurer begins mishandling the claim.

Importantly, insurers gain access to significantly more information about the customer during the claims process than they had at policy inception. This includes knowledge of the number of occupants, presence of dependents or pets, medical conditions, financial stress, or any other vulnerabilities. Once this information is known, any unreasonable action or inaction by the insurer can knowingly increase financial harm to the customer. In such cases, those losses should be recoverable, not dismissed on the basis that they were not foreseeable at the start of the policy.

The current test is too narrow and risks denying fair compensation for genuine losses. It should be reframed to distinguish between losses that guide underwriting at inception and those that

become foreseeable once the insurer is aware of the consumer's circumstances and begins to manage the claim.

Practical Improvement Opportunities

To improve clarity and fairness, AFCA should update the Draft Approach as follows:

- Retain inception as the anchor point for underwriting risk but clarify that where losses arise directly from claims handling conduct, foreseeability should be assessed at the time of the unreasonable conduct.
- Provide worked examples of common scenarios where reimbursement is appropriate, such as:
    - Temporary accommodation costs caused by unreasonable delays.
    - Consumer-funded reports needed because insurer reports were flawed or incomplete.
    - Consumer-funded reports needed because claim was declined or otherwise reduced.
    - Increased costs, such as pet accommodation, that arise as a direct result of the insurer's mishandling of the claim or delays in progressing repairs should be recognised as recoverable losses. These expenses are often unavoidable once the insurer's conduct has disrupted the customer's living arrangements and should not be borne by the consumer.
    - Health or financial stress expenses directly tied to insurer behaviour.
    - Storage costs where delays prevent contents being reinstated.
    - Increased premium refunds where claims were unreasonably delayed causing increases in premiums, where cheaper cover would have been available had the consumer been able to switch insurers.
    - Increased travel expenses resulting from the insurer's failure to secure appropriate temporary accommodation, such as placing the customer far from work, school, or support networks, or the added costs of having to frequently relocate due to short-term or poorly coordinated accommodation approvals, should be treated as recoverable losses. These costs are a foreseeable consequence of inadequate claims planning and should not be passed onto the consumer.
- Make clear that if the insurer had all reasonable information available to make the correct decision, and failed to act fairly, reimbursement of consumer losses should ordinarily follow.
- Reduce subjectivity by stating that once causation and reasonableness are satisfied, financial loss should be awarded unless exceptional circumstances apply. Without clearer standards, the current test will continue to generate disputes, with parties needing AFCA to determine whether they were reasonable or not. More context, will reduce complaints due to improved clarify.

Unintended Consequences

The Draft Approach currently frames the test for financial loss too narrowly, with foreseeability tied primarily to policy inception. This overlooks the reality that many losses arise later and are not foreseeable, directly from unreasonable claims handling conduct, rather than the insured event itself. Without acknowledging this distinction, consumers may be unfairly denied reimbursement for genuine losses such as rental costs, storage fees, or expenses for consumer-funded reports.

This creates two perverse outcomes:

- Consumers are discouraged from pursuing reimbursement for legitimate losses, believing the test is stacked against them.
- Insurers are incentivised to argue that losses were unforeseeable at inception, even when they directly flowed from unreasonable delays or mishandling, prolonging disputes unnecessarily.

The result is greater subjectivity and inconsistency in determinations, leaving both consumers and insurers uncertain about when financial loss will be awarded. This uncertainty drives repeat disputes and undermines AFCA's ability to deliver clarity and predictability in its Approach. Providing clear guidance on the recoverability of these types of costs will inevitably lead a reduction in complaint volumes.