Insurance Council of Australia

26 November 2025
Council of Financial Regulators

By email

Dear Mr Healey,

Law reform priorities and regulator coordination

The Insurance Council of Australia (Insurance Council) welcomes the opportunity to collaborate on behalf of our members with the Council of Financial Regulators (CFR) on prioritising areas for law reform and streamlining regulation to increase productivity.

The Insurance Council is the representative body of the general insurance industry in Australia. Our members represent approximately 85 percent of total premium income written by private sector general insurers. Insurance Council members, both insurers and reinsurers, are a significant part of the financial services system.

An effective regulatory regime makes Australia an attractive place to invest and do business. Insurers support regulation that is proportionate, effective, and focused on outcomes. Our goal is not less regulation, but better regulation—rules that safeguard customers without unnecessary complexity or cost. In November 2025, the Insurance Council published the report "The Cost of Regulatory Burden" (Report), which outlined how inefficient regulation can impact productivity in our sector.

Our analysis has found that compliance is costing insurers (and therefore customers) somewhere between $2.5 and $3.5 billion annually, which is equivalent to 4-6% of gross written premium. The regulatory quagmire that has evolved over time in response to market events has led to over 300 regulatory instruments entailing more than 30,000 obligations that are enforced by 25 different regulators.

We welcome the work of the CFR in developing a roadmap for better regulation in financial services and would like to put forward the following priority areas:

1. Streamlined Reporting and Coordination

As found in our Report, governance obligations and reporting is one of the largest cost drivers for insurers, with clustered deadlines, disproportionate reporting thresholds and frequent ad hoc requests from different bodies which divert resources from other business operations and duplicate effort. Reporting also requires specialised IT programs that enable data extraction, breach triggers and other capabilities that support insurers to meet mandated reporting requirements. The Report outlines one example where insurers must traverse four different regulatory instruments to manage potential data breaches, which involves different threshold triggers, timelines and processes (see page 18 of the Report).

We recommend all reporting requirements be reviewed to remove duplication, ensure digital capability and proportionality. The Government should work towards building a "single touch" reporting system — built on standardised data definitions and an API-driven gateway. This would enable a "report once,

use many times" model. Given APRA's role as the national statistical agency for the financial services sector, this may be an appropriate regulator to fulfil this function.

As a shorter term priority, the Government should improve the coordination of data requests. Attachment A to this letter provides more detailed case studies about data requests from various regulators. The Insurance Council sees the Regulatory Initiatives Grid (RIG) as an available tool that could create transparency and improve coordination of requests across regulators. However, to achieve this the RIG must be mandated, capture the full range of regulators and be updated frequently (more than twice a year). Recommendations on how to better coordinate data requests are outlined in Attachment A.

2. Proportionate Regulation based on Risk

The Report found that 66 per cent of insurance obligations are prescriptive, leaving little room for regulated entities to apply a risk-based compliance approach. Moving to principles-based, proportionate regulation would allow flexibility, encourage innovation, and allow scaling of obligations to the size and risk profile of specific insurers. This approach aligns with international best practice and would ensure regulation delivers meaningful outcomes for customers.

Regulations introduced following the findings from the Hayne Royal Commission play a critical role in protecting consumers from harm and ensuring industry integrity. Since the implementation of these reforms the operational realities of these regulations have led to unnecessary operational fiction and, in some cases unintended consumer impacts. We recommend the Government undertake a thorough post implementation review of regulations introduced following the Hayne Royal Commission to ensure proportionality and the desired consumer outcome is being achieved.

Some examples which are scoped out in more detail in the Report include:

Deferred Sales Model: The Deferred Sales Model mandates a four-day pause between the sale of a primary product or service and the sale of associated add-on insurance. It was designed to address pressure selling and provide customers with time to make an informed decision. However, it assumes that all customers are unable to make informed decisions about appropriate cover. In cases where they are informed, they will be prohibited from buying that product for four days if the insurer has a distribution arrangement with the seller of the principal product. Customers will also be prevented from buying cover by approaching the insurer with the distribution relationship directly. Customers may not be covered for the deferral period or may be forced to purchase an insurance product not best suited to their needs. An example may be home and contents insurance that may be required for a home loan.

Financial advice: Key findings from the Parliamentary inquiry into Insurers' Response to the 2022 floods emphasised the need for insurers to provide more guidance to customers regarding their sum insured and cash settlements. Financial advice limitations restrict insurers from providing this advice. The Government could look at a principles-based advice framework like that published by the Actuaries Institute in October 2025.[1] This proposed introducing risk-based tiering of different communication types: *Help, Guidance* and *Advice*. Under this framework, *Guidance* references communications that offer 'suggestions or pathways based on the consumer's general circumstances without making specific recommendations' while *Advice* references 'personalised financial

[1] Actuaries Institute. (2025). Financial Advice Reform and Help, Guidance and Advice. ALRC-FSL-Final-Report-141.pdf

recommendations provided to consumers based on a detailed analysis of their financial circumstances, goals and risk tolerance'. Using this distinction, insurers could provide *guidance* or fact-based information about their products, such as cash settlement and sum insured considerations, without it being considered *advice*.

Design and Distribution: The Design and Distribution Obligations (DDO) under Part 7.8A of the *Corporations Act 2001* require a Target Market Determination (TMD) for each product. To understand how to comply with DDO requirements, insurers must navigate legislation, ASIC Guide 274, case law and enforcement action. While intended to prevent mis-selling, the application of TMDs to simple, mass-market general insurance products has created a significant administrative impact for limited consumer benefit. For a minor formatting update to a Product Disclosure Update, an insurer must undertake a TMD review which involves:

- Formally documenting the review, assessing the change against all DDO factors
- Updating the TMD document, which requires legal and compliance sign-off
- Notifying all distributors of the updated TMD and providing new training or guidance if required
- Publishing it on the company's website.

In addition to reviewing the DDOs for proportionality, these requirements could be consolidated and better structured in regulation. This was addressed by 2024 Australian Law Reform Commission's report on financial services[2] which recommended better structuring legislation and consolidating compliance detail to make requirements clearer.

Anti-Hawking: Insurers support the objective of anti-hawking to prevent harmful, unsolicited selling, consistent with the Hayne Royal Commission's findings. However, the current prescriptive framing can also capture low risk, needs-based prompts that support better consumer outcomes and help address underinsurance. For example, when a customer contacts their insurer to update their home building policy and it becomes apparent that they have no contents cover and are unaware of that gap. Under current settings, the insurer may not be able to point out this basic protection gap unless the customer expressly asks. A proportionate approach would distinguish between the consumer risk presented by unsolicited selling from contextual engagement that seeks to benefit the consumer. Simple prompts could be permitted without breaching anti-hawking.

3. Consolidate legislation and remove duplication

The current financial services regulatory framework involves overlapping obligations enforced by multiple regulators, and ambiguous compliance processes that traverse several layers of regulation. General insurers support ASIC's regulatory simplification process started earlier this year and would like to see this undertaken across the entire financial services regulatory framework, including primary and subordinate legislation. We recommend financial services legislation be consolidated, definitions made consistent, and regulators given clearer lines of accountability. Examples of overlapping regulation that could benefit from consolidation and simplification are provided in the Report on page 20.

[2] Australian Lw Review Commission. (2023). Confronting Complexity: Reforming Corporations and Financial Services Legislation. ALRC-FSL-Final-Report-141.pdf

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This consolidation and duplication reduction process will streamline the administrative burden requiring insurers to navigate well over 300 regulatory instruments to ensure compliance. The Australian Law Reform Commission's 2023 review of financial services regulation provides a solid foundation for this process. Features of the review should include adopting long term relief orders issued by ASIC for insurers into primary legislation and embedding requirements to review legislation as regular intervals to ensure it is achieving its intended goals.

By addressing these priorities, we can create a regulatory environment that supports both consumer protection and national productivity objectives. We welcome the opportunity to work with the CFR to progress these reforms.

If you require more information please contact Brooke Noorbergen, Senior Strategic Policy Adviser at bnoorbergen@insurancecouncil.com.au.

Yours sincerely

Andrew Hall
Executive Director & CEO

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Attachment A

Coordinating Data Requests and Improving Efficiency

Insurers recognise and support the purpose and context behind data requests from regulators. There will be times when ad hoc data requests cannot be avoided, and insurers acknowledge the importance of regulators using data to discharge their roles and responsibilities.

There are however opportunities to better coordinate these requests, streamline collection processes and potentially reduce the total volume of collections undertaken in short succession (see Table 1 for the requests received between 2023 and 2025). Better coordination would have the benefits of avoiding duplication and reducing operational costs.

It is difficult to quantify the operational costs of data requests as insurers do not log hours related to specific collections. Data collection processes will vary from insurer to insurer, again making cost impacts difficult to compare across the industry. The time taken to respond to these requests also depends on the systems and processes in place and the complexity of each collection. Costs are incurred when BAU activities require system upgrades and additional costs are incurred by ad hoc requests where resources are diverted from BAU activities.

In this Attachment, we present four case studies of insurers' experience with regulator data requests. We have identified one example where insurers have had a positive experience with Government coordination. We then explore examples of where collections could better leverage established processes. Suggestions for improving processes include:

- **Defining and Standardising Data Requirements**
  Work with insurers to agree on consistent definitions and systemise easily extractable data fields which align with regulatory objectives. Using templates where possible will also standardise the format data is collected in. The Insurance Council could help facilitate this work.
- **Create a Data-Request Framework**
  Use established channels and existing reporting systems where possible to reduce manual effort and ad-hoc requests. Efficiencies may be achieved by leveraging biannual ASIC collections or annual CGC collections. APRA under the Financial Sector (Collection of Data) Act 2002 could be made the lead the data collector to establish a single platform through which data can be requested and provided.
- **Coordinate Regulators**
  Where possible, align timing and content of requests through consultation with industry and between regulators. This is an approach taken by the ACCC as part of their annual collection to monitor the cyclone reinsurance pool, which insurers have found helpful. With consent and consultation with insurers, regulators could share data, and agree on the scope of collections to avoid duplication and follow-up requests.

Critical to the success of any data sharing arrangement will be ensuring the ability of insurers to consent to the use of their data for specific purposes and allowing insurers to make updates to the data when needed.

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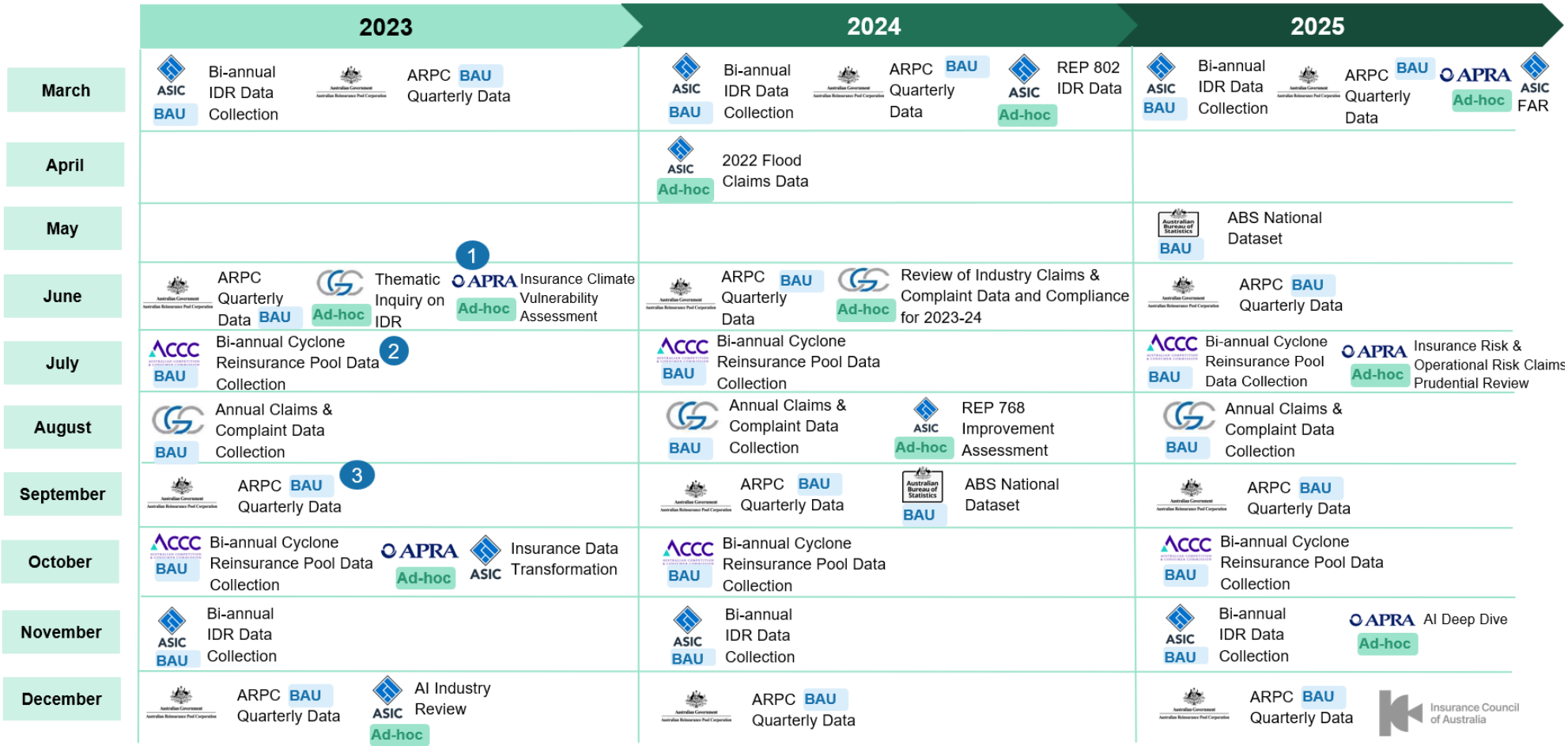
Table 1: Data Collections between 2023-2025



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Case Study 1: Positive Collaboration between APRA and Insurers

In July 2023, APRA commenced the Insurance Climate Vulnerability Assessment (ICVA)[3], a scenario analysis of home and contents insurance affordability for non-strata, residential properties in Australia under two possible climate scenarios to 2050. This required ad-hoc policy, premium and affordability data from the five largest general insurers in Australia by market share - IAG, Suncorp, Allianz, QBE and Hollard - by the first half of 2025, providing insurers with sufficient lead time to prepare.

Smaller insurers were not invited to participate in this assessment. This targeted approach recognised the limited access to resources by small insurers, without significantly disadvantaging their industry contribution or the representative value of the data collected.

In designing the ICVA, APRA consulted participating insurers to define the scope of data request and obtain feedback on areas such as the design and the data submission template. Insurers reported the following benefits of this process:

- Uniformity in data requests enabled standardised submissions through established systems and processes, thereby reducing operational burden and inconsistencies and errors via established controls.
- Collaborative approach to defining the data requirements enabled APRA to achieve its aims in the most efficient manner for the industry. The industry could also advise on the best available data to meet the regulator's objectives.
- Advance notice for insurers enabled them to plan and deploy staff and resources efficiently without significantly impacting core insurance functions or customer-facing efforts.

There is an opportunity for regulatory bodies to emulate this consultative approach when ad-hoc data requests are required. A further enhancement could involve APRA collaborating with other regulators to establish data-sharing agreements, enabling APRA to centrally collect standardised data on behalf of multiple regulators. Insurers would need to consent to the use of their data for purposes outside of the original intent of collection.

Case Study 2: Duplicative Claims Data Requests

This case study shows how claims data requests during this 12-month period were often ad-hoc, duplicative, overlapping, at short-notice, and containing bespoke data fields.

[3] APRA, 'Insurance Climate Vulnerability Assessment'. https://www.apra.gov.au/insurance-climate-vulnerability-assessment.

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Table 2: Claims data requests made during 2024

Date of Request	Regulator	Ad-hoc /BAU Collection	Purpose of Request	Data Requested	Duplication Identified
April 2024	ASIC	Ad-hoc	Monitoring of outstanding Catastrophe and Significant Event claims as part of the 2022 Parliamentary Flood Inquiry.	Open claims data from the 2022 floods as of April 2024.	Refer to duplication identified in ASIC's August 2024 data request. See below.
June 2024	CGC	Ad-hoc	Review of Industry Data and Compliance for 2023-24.	All claims reported for the period of July 2023 to June 2024.	Duplication with annual claims submission in August 2024.
August 2024	ASIC	Ad-hoc	Assessment on whether insurers have implemented improvements outlined in REP 768 regarding the assessment of home insurance claims handling conduct released in August 2023.	Home insurance claims data	• Duplication with ASIC's flood claims data request in April 2024 – included similar data points but covering a wider scope (not limited to the 2022 floods). • Included detailed unstructured data points that are not readily accessible by systemised extractions.
August 2024	CGC	BAU	Annual claims submission.	Claims and complaints data points.	Coincided with ASIC's ad-hoc claims request, suggesting competing priorities within the same month.
October 2024	ACCC	BAU	Bi-annual submission for ACCC's review of the Cyclone	Policy and claim data for the review period of from 1	Some overlap with both APRA ICVA and ARPC Quarter submissions, see Figure 2.

Date of Request	Regulator	Ad-hoc /BAU Collection	Purpose of Request	Data Requested	Duplication Identified
			Reinsurance Pool covering the period from 1 January 2022 to 30 June 2026.	January 2022 to 30 June 2026.	

The experience of insurers suggests that the various types of claims data requested during 2024 can be perceived as duplicative and ad hoc collections could leverage standard processes. The volume of ad-hoc data requests during 2024 required the diversion of internal teams within insurers including legal, regulatory engagement, group analytics, pricing and operations away from BAU responsibilities. The operational burden was further exacerbated by the short intervals between requests and limited lead time. For example, during the 2022 Parliamentary Inquiry, ASIC issued a data request on 19 March 2024, with responses initially due by 9 April 2024. This deadline was subsequently extended to 30 April 2024. Managing short notice periods imposes significant demands on staffs across various business areas, potentially disrupting BAU activities (for example, core insurance functions and customer-facing activities). Some insurers reported having to return staff from leave to manage this specific request.

Suggested improvements:

In this example, the collection processes could have been improved by planning ahead and allowing insurers sufficient lead time to allocate resources effectively. Such forward planning helps insurers to configure systems, which would require less manual handling and streamline the collection process, while minimising the disruption to BAU activities. Regulators could have consulted with industry and across other regulators to coordinate on the timing and the content of data requests throughout this period. Regular collections could have been leveraged for ad-hoc reviews (noting that insurers would need to consent to the use of this data for other purposes).

A more consultative approach may have:

- Enabled ASIC to identify the need to expand the scope of data request in April 2024, to be utilised in the REP 768 assessment in August 2024.
- Enabled CGC to leverage the BAU submission in August 2024 for the data requested for the Review of Industry Data and Compliance initiative in June 2024.
- Enabled alignment in data scoping and definitions where possible between requests issued by multiple regulators on similar topics, reducing the number of collections for the same data type.

Case Study 3: Volume of Data Requests 2023-25

This case study illustrates the significant volume of data requests from multiple regulators between 2023 to 2025.

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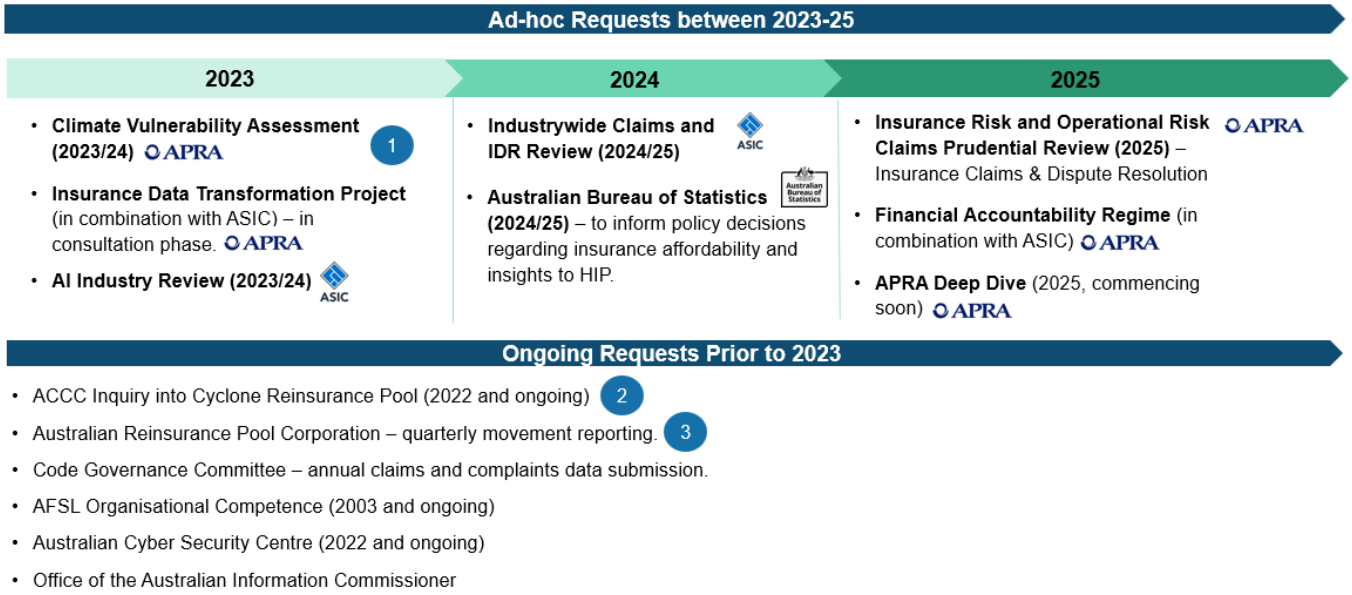
Figure 1: Volume of Data Requests from 2023-2025



The experience of insurers suggests that while there are overlaps among these data requests, the nature of overlap can vary. The overlaps are often not like-for-like, making it difficult to standardise collection processes and requiring manual handling. As an example, three data requests are selected from the figure above (APRA's ICVA, the Australian Reinsurance Pool (APRC) Corporation quarterly reporting, and the ACCC's inquiry into Cyclone Reinsurance Pool) to illustrate the nuanced nature of overlaps in greater detail.

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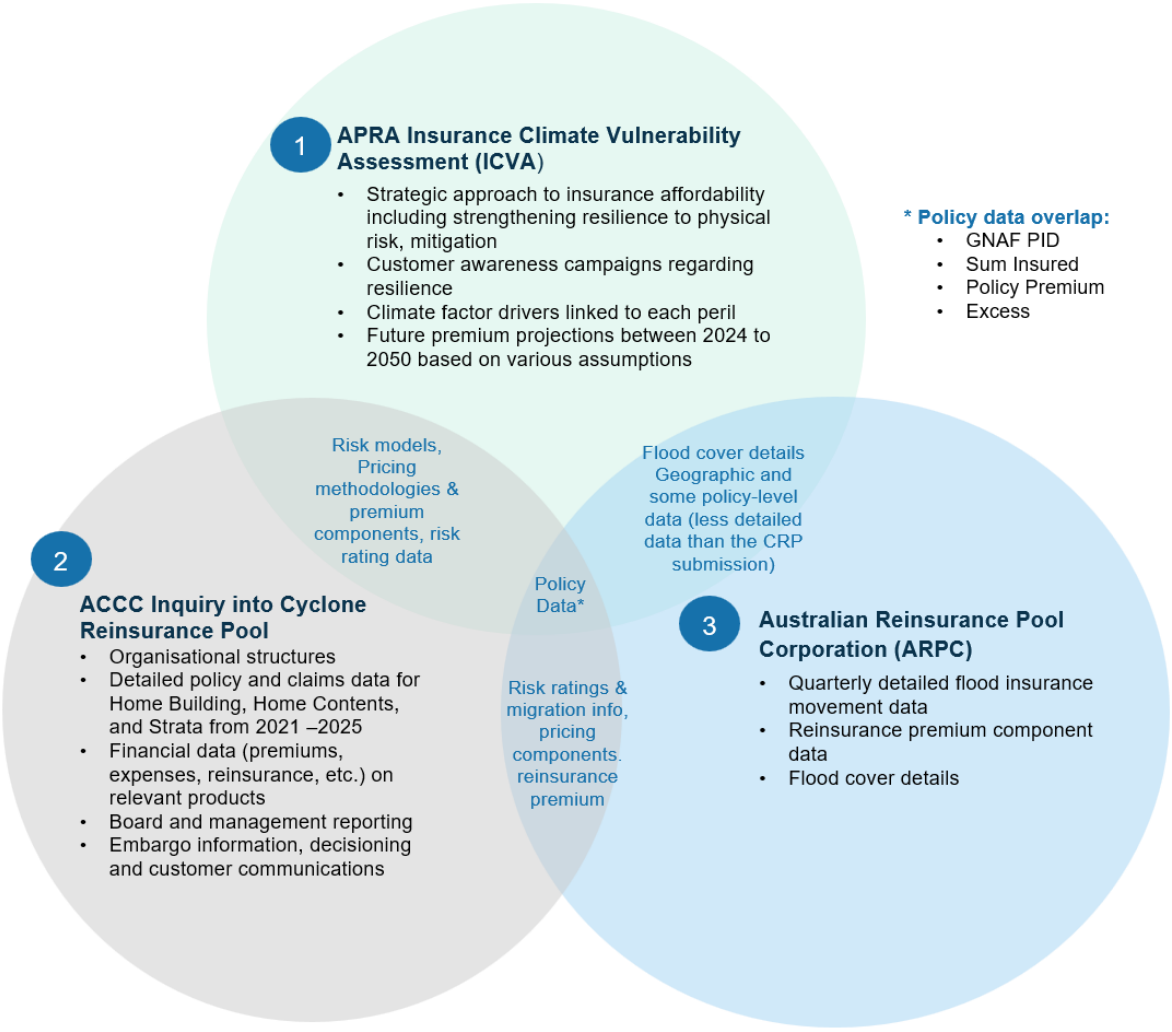
Figure 2: Illustrative Example of Overlapping Data Points



The nuanced nature of the overlap often requires insurers to address each request separately, with limited ability to leverage what was submitted in a previous data request. This often results in a resource-intensive process that significantly increases the operational complexity associated with data submissions. While insurers understand and respect that there may be cases where ad hoc, bespoke requests are unavoidable, processes have the potential to be streamlined where possible.

Suggested improvements:

Similarly to case study 2, regulators could work together to see if any parts of these collections could be consolidated. Ad hoc requests would still be issued where data cannot be used form previous collections or are not specific enough to the regulator's priorities. Data-sharing arrangements could again be used, but would need to be negotiated with insurers to ensure informed consent is provided for each use case and context.

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Case Study 4: Complaints Data

This case study explores the complexity of bespoke data requests relating to complaints data.

Table 3: Duplicative complaint data requests made during 2023 and 2024

Date of Request	Regulator	Ad-hoc /BAU Collection	Purpose of Request	Data Requested	Duplications Identified
July 2023	CGC	Ad-hoc	Thematic inquiry on Internal Dispute Resolution (IDR).	20 specific sample complaints for insights into how insurers review and overturn claim denial decisions.	Partial duplication – similar data fields to CGC's BAU request in August 2024.
March 2024	ASIC	BAU	Bi-annual IDR data submission.	IDR complaint level data, FTE for complaints per quarter – fixed set of data fields that has been operationalised with minimal manual intervention.	Duplication with ASIC's ad-hoc request for REP 802. See below.
March 2024	ASIC	Ad-hoc	REP 802 – Cause of complaint: Complaints Handling in GI.	IDR complaint level data and the FTE for complaints per quarter.	Duplication with ASIC's BAU request – broadly follows the same format but requires detailed unstructured data points that are not readily accessible by systemised extractions.
June 2024	CGC	Ad-hoc	Review of Industry Data and Compliance for 2023-24.	Number of complaints received and resolved complaint outcomes for the period of July 2023 to June 2024.	
August 2024	CGC	BAU	CGC annual data collection.	Part of the return requires information on complaints and	

				complaints categories over the financial year.	
November 2024	ASIC	BAU	Bi-annual IDR data submission.	IDR complaint level data, FTE for complaints per quarter – fixed set of data fields that has been operationalised with minimal manual intervention.	Duplication with ASIC's ad-hoc request for REP 802.
Throughout	AFCA	Ad-hoc	Investigation into potential systemic issues	Typically complaints data points that are specific to complaints from customers.	Typically overlap with complaints data that ASIC and sometimes CGC have obtained.

The experience of insurers suggests that current ad-hoc requests often require complaints data that are not readily accessible by automated or systemised extraction due to non-standard field definitions, which can lead to subjectivity and variability across insurers. For example, during the 2022 Parliamentary Flood Inquiry, specific complaints regarding issues such as "maintenance" and "wear and tear" contained in unstructured data fields. This has resulted in insurers needing to manually review case files through extensive keyword searching, leading to a highly manual and resource-intensive process prone to inconsistencies and human errors. Thus, there is an opportunity for regulators to standardise the core complaints data fields with explicit definitions to minimise bespoke rules and manual extraction. Aligning data definitions and collection processes across regulators and industry systems facilitates automation and supports a collect-once, reuse-repeated data framework, which reduces the need for manual workarounds.

Furthermore, the insurers' experience suggests that the data dictionary provided often contains ambiguous definitions, which can lead to assumptions being made regarding the required data fields, again potentially causing inconsistencies across submissions and potentially misleading comparisons. For example, the definition of "cash settlements" does not explicitly specify whether temporary accommodation and emergency payments should be excluded. Some insurers have noted that the annual CGC submission does not apply this exclusion, whereas previous flood-related data requests have varied in their requirements. This sometimes results in the need for follow-up data requests to address any gaps where the definitions have been mis-understood.

The Australian Financial Complaints Authority (AFCA) plays a key role in the regulatory ecosystem by analysing individual consumer complaints to identify systemic issues and provide valuable regulatory intelligence to other regulators. The industry acknowledges that these requests are usually specific to cases and are inherently bespoke. However, these requests often overlap with ASIC systemic issues investigations so there may be an opportunity for ASIC intelligence to initially inform AFCA

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investigations. Again, insurers will need to consent to the sharing of any data between regulators for extended purposes.

Suggested improvements:

The case study outlines the value of consistent definitions and to clearly define and standardise data requirements ahead of issuing requests. Such standardisation reduces manual workload for insurers, and enhances inter-insurer comparability thereby making the data collected more useful to regulators.