INSURANCE CONTRACT LAW REFORM

Bell Gully submission to the Ministry of Business, Innovation, and Employment on the draft Insurance Contracts Bill

Introduction

Bell Gully welcomes the opportunity to comment on the Ministry of Business, Innovation, and Employment's (MBIE) draft Insurance Contracts Bill (Bill).

The Bill will bring about significant changes in the law of insurance in New Zealand. Many of those changes are welcome; they will consolidate and clarify a number of outdated statutes, and modernise important principles. However, other changes are potentially problematic. They have the potential to create significant uncertainty, to the detriment of both insurers and insureds.

We recognise that the Government has already made decisions on most of the key policy issues, and as a result the scope of this consultation is largely directed towards assessing whether the proposed drafting of the Bill achieves its intended effect and is workable in practice. As a result, we generally do not comment on the policy behind the reforms, where that has already been decided. Instead, we address the drafting, and workability of the Bill, as well as any remaining policy questions.

Executive summary

1. We summarise our submission below. The remaining sections of the submission address each matter in more detail and, where relevant, make specific drafting suggestions.

Duties of disclosure (questions 2 and 5)

2. The non-consumer duty of disclosure is largely the same as that which applies under the current law, and we do not have detailed comments on it. We expect that issues are likely to arise in relation to, for example, the detailed sections dealing with what insurers and policyholders know or ought to know, but those issues are likely to need to be worked through the Courts on a case by case basis.

3. The new duty on consumers not to make a misrepresentation is a fundamental shift in the duty that applies at common law, and puts insurers at a disadvantage when compared to contracting parties more generally. This is because as a matter of general contract law, a person can be liable for an innocent misrepresentation, but as a matter of insurance contract law, a person cannot be liable for such a misrepresentation. We remain concerned about this inconsistency.

4. We consider that there are also ambiguities and gaps in the drafting of the clauses, which are likely to create additional uncertainty. We suggest that a broader range of matters should be taken into account when assessing whether a policyholder has taken reasonable care not to make a misrepresentation, and that the Bill should more directly address the relevance of silence in assessing whether a misrepresentation has been made.

Remedies for non-life policies (questions 3, 6, and 39)

5. The remedial provisions for breach of the duties of disclosure are central to the Bill. They place insurers at a disadvantage when compared to the general law relating to misrepresentations (e.g., the Bill excludes any damages remedy), which is of particular concern given that the new duty already tips the balance significantly in favour of consumer policyholders.

6. The Bill provides that an insurer's remedy, if it would have entered into the policy on different terms had it known the truth, is to deduct from a claim by the policyholder the difference in premium that the insurer would have charged in the counterfactual (e.g., if the insurer would have charged $1,000 more in premiums had it known the truth, it can deduct $1,000 from the payout for a claim under the policy). In our view, the Bill should be consistent with the United Kingdom legislation, and instead allow a proportionate reduction in premium (e.g., if the insurer would have charged a 10% higher premium, it should be able to deduct 10% from the claim). Alternatively, if the right is limited to the difference in premium, the insurer should also be able to exercise this right regardless of whether the policyholder makes a claim under the policy; otherwise the insurer has no remedy if the policyholder does not make a claim.

Insurers' duty to inform (question 8)

7. The Bill provides that an insurer has no remedy for a policyholder's breach of the duty of disclosure if the insurer breached its own duty to inform. There is an exception if the policyholder knowingly breached their duty.

8. We consider that an insurer should also have a remedy if the policyholder commits a reckless breach of duty. There is no good policy reason for distinguishing between deliberate and reckless breaches in this context, and the Bill does not otherwise distinguish between deliberate and reckless breaches when providing for the remedies that apply.

Duty of utmost good faith (question 9)

9. The Bill codifies the duty of utmost good faith. We consider that the drafting is more likely to confuse than to clarify the existing common law position. We submit that it should be removed or, if that is not possible given the direction from Cabinet, it should be amended to make it clear that it is confirming that the common law duty continues to apply, and that it is not creating any greater or broader duty.

Third party claims (question 16)

10. We support the repeal of section 9 of the Law Reform Act 1936, and the creation of a new right of action for third parties. The existing position is inconsistent with overseas jurisdictions and puts overseas insurers at a competitive advantage to New Zealand insurers, because the Courts have held that section 9 does not apply to overseas insurers. We consider that the drafting of some of the provisions could be clarified to better effect the intention of the reform.

Unfair contract terms (questions 31 and 32)

11. We consider that the insurance-specific exceptions to the unfair contract terms (**UCT**) provisions in the Fair Trading Act 1986 (**FTA**) should remain. The evidence base for change is weak, and MBIE's own assessment of the proposed options for reform is that they are no better than the status quo.

12. There will also be significant costs and disadvantages arising from any change, particularly if exclusion clauses are brought within the regime. This could create significant uncertainty for insurers, which is likely to increase premiums and result in cover being withdrawn from the market. These consequences are ultimately to the detriment of policyholders.

13. If the Bill is required to amend the existing regime, we submit that Option B should be adopted (i.e., it should be clarified that the main subject matter exception covers the subject of the insurance, the sum insured, excesses and deductibles, and exclusions/limitations of liability).

Definitions of intermediaries (questions 1 and 24)

14. We submit that the overlapping definitions of "specified intermediary" (clause 5), "broker" (clause 95(1)), and "insurance intermediary" (clause 95(1)) are confusing. If possible, they should be consolidated.

Regulations as to form and content of policies (questions 34-36)

15. We consider that the proposed regulation-making powers relating to the form and content of policies are overly-prescriptive, and we expect that they will create major difficulties and costs for insurers to implement, for little (if any) benefit. We submit that they should be recast at a higher level of generality.

Consumer duty of disclosure (question 2)

16. As initial context to our comments on the consumer duty of disclosure, we note that the Bill puts consumer policyholders in a significantly better position than consumers who enter into other contracts, and prejudices insurers when compared to other contracting parties:

    (a) Under the general law, parties (including consumers) can be liable for innocent or non-negligent misrepresentations (e.g., sections 35 and 37 of the Contract and Commercial Law Act 2017 (**CCLA**), section 9 of the FTA).

    (b) In contrast, the duty in clause 14 only requires a consumer to take reasonable care not to make a misrepresentation to the insurer. Providing false or incorrect information to the insurer is not a breach of the duty as long as the consumer is sufficiently careful when making that misrepresentation. This is inconsistent with, and more favourable than, the general law. We submit that it is an over-correction to the existing law.

    (c) As a practical matter, the nature of the duty may make it difficult for insurers to enforce. They will be required to prove not only that false or incorrect information was provided by the insured (which is all that is required under the general law), but also that the consumer failed to take reasonable care in providing that information. An insurer will be required to investigate an insured's actions, review what the consumer did and compare that against the standard of a reasonable consumer, and seek to prove that the consumer was unreasonable if there is a dispute. This is likely to give rise to additional costs for insurers, which will ultimately be passed on to consumers.

17. This context makes it even more important to ensure that the Bill provides certainty to policyholders and insureds in relation to the scope of the new duty. We consider that there is a potential for ambiguity in the way clauses 14-17 interrelate, and they should be clarified:

   (a) While clause 15 is intended to set out a non-exhaustive list of factors to take into account when assessing whether the policyholder took reasonable care, that is done by way of a sub-clause stating that the duty is not limited by the factors set out (clause 15(3)), rather than more directly stating that the relevant circumstances are not exhaustive.

   (b) Clause 16 appears to place a greater emphasis on the characteristics of the policyholder than other factors (it "must" be considered when other factors "may" be considered). It is not clear that this is necessary or appropriate. If the policyholder's circumstances are relevant in any particular case, they will be taken into account, and there is therefore no clear benefit to making this a mandatory consideration over and above the other relevant factors.

   (c) Clause 17 notes that failure to answer a question, or giving an obviously incomplete or irrelevant answer, is not necessarily a misrepresentation. This may create more confusion than it prevents, because it addresses the relevance of silence only partially, and only in the negative (i.e., it does not state that silence can amount to a misrepresentation). The closest parallel to clause 17 in the UK legislation positively states that silence can amount to a misrepresentation: "A failure by the consumer to comply with the insurer's request to confirm or amend particulars previously given is capable of being a misrepresentation for the purposes of this Act (whether or not it could be apart from this subsection)" (section 2(3) of the Consumer Insurance (Disclosure and Representations) Act 2012)). In our view, clause 17 should be redrafted along similar lines.

18. We would therefore suggest that clauses 15-17 be amended as follows:

15 Matters that may be taken into account

(1) The ~~following~~ matters that may be taken into account in determining whether the policyholder has taken reasonable care not to make a misrepresentation include:

   (a) the type of consumer insurance contract in question, and its target market:

   (b) explanatory material or publicity produced or authorised by the insurer:

   (c) how clear, and how specific, any questions asked by the insurer of the policyholder were:

   (d) how clearly the insurer communicated to the policyholder the importance of answering those questions and the possible consequences of failing to do so:

   (e) any particular characteristics or circumstances of the policyholder of which the insurer was aware, or ought reasonably to have been aware:

   (f) whether the policyholder received assistance or guidance in connection with a representation from a person referred to in subsection (2) (whether or not the person is an agent of the policyholder or the insurer):

   (g) whether the duty applies in relation to—

      (i) a new contract that has the effect of operating as a renewal of a preceding contract; or

      (ii) a new contract that does not have that effect; or

      (iii) a variation or extension of an existing contract; or

      (iv) a reinstatement of a previous contract of insurance.

(2) For the purposes of subsection (1)(e), the persons are—

   (a) a financial advice provider (within the meaning of section 6 of the FMCA); or

   (b) a non-financial not-for-profit organisation (within the meaning of clause 13 of Schedule 5 of the FMCA); or

   (c) a lawyer (within the meaning of section 6 of the Lawyers and Conveyancers Act 2006).

~~(3) This section does not limit section 14(2).~~

~~**16 Particular characteristics or circumstances of policyholder**~~

~~Any particular characteristics or circumstances of the policyholder of which the insurer was aware, or ought reasonably to have been aware, must be had regard to in determining whether a policyholder has taken reasonable care not to make a misrepresentation.~~

16 Failure to answer or obviously incomplete or irrelevant answer ~~is not~~ may constitute a misrepresentation

~~The policyholder must not be taken to have made a misrepresentation merely because the policyholder—~~

For the avoidance of doubt, the following acts or omissions are capable of constituting a misrepresentation under section 14:

(a) ~~failed~~ failing to answer a question; or

(b) ~~gave~~ giving an ~~obviously~~ incomplete or irrelevant answer to a question.

Remedies for non-life policies (questions 3, 6, and 39)

19. The Bill codifies the remedies of breach of the duty of disclosure by consumers and non-consumers (clauses 26(3) and 51(3)). These remedies are central to the Bill.

20. The remedies provided under the Bill put insurers in a worse position than general contracting parties; under the general law, victims of a misrepresentation can seek damages under section 35 of the CCLA (Part 1 of Schedule 5 to the Bill), or section 43 of the FTA (if the misrepresentor is not a consumer). The Bill excludes these remedies, which is of particular concern given that the new consumer duty already tips the balance significantly in favour of consumer policyholders.

21. This is less likely to be an issue if the breach is deliberate or reckless, because the insurer is entitled to retain any premiums it has been paid (clauses 2(1) and 7 of schedule 2 of the Bill). However, in a serious case where the insurer would not have entered into the contract had it known the truth, it is not entitled to any compensation at all, regardless whether it has suffered loss as a result. That is odd in itself, but it could also give rise to perverse outcomes.

    (a) For example, consider a situation in which the insurer pays out on a single claim progressively over time (e.g., for defence costs under a liability policy), or a policyholder makes two claims under a policy in the same policy period. After having paid out under the policy, the insurer discovers that the policyholder made a material misrepresentation in breach of their duty. The misrepresentation was sufficiently serious that, had the insurer known the truth, it would not have entered into the policy. In these circumstances, the insurer appears to have no right under Schedule 2 of the Bill to recover the amounts it has already paid out – its rights would be limited to declining the any further cover, or the second claim, as the case may be. Even then, it would have to return all premiums it was paid under the policy, such that a policyholder has received cover for free. That could result in a serious injustice for the insurer.

    (b) In a less serious case where, had an insurer known the truth it would have entered into the contract on different terms, it is entitled to a limited monetary remedy: the insurer is able to deduct from any claim the difference in premium that it would have charged in the counterfactual (e.g., if the insurer would have charged $1,000 more in premiums had it known the truth, it can deduct $1,000 from the payout for a claim under the policy). However, this remedy only applies if the policyholder makes a claim, leaving the insurer with no remedy if they do not . Further, unlike the UK position, the claim is only for the difference in premiums, rather than a proportionate reduction in the claim (e.g., under the UK legislation, if the insurer would have charged a 10% higher premium, it is able to deduct 10% from the claim).

22. There does not appear to be any good policy reason for putting insurers at such a disadvantage when compared to the general law, or departing from the UK approach of proportionate reductions, in the way that the Bill does. We submit that the remedies in the Bill should be amended so that:

(a) If the insurer would not have entered into the contract had it known the truth, it is entitled to keep the premiums paid (or due) up to the date of cancellation; and

(b) If the insurer would have entered into the contract on different terms, the insurer can reduce the sum paid out on any claim proportionately to the difference in premiums (as in the UK). This more equitably puts the parties back in the position they would have been absent the misrepresentation; or

(c) If the remedy remains one in which insurers can only seek the difference in premiums that would have been paid, it should be exercisable at any time after the breach of duty is discovered. There is no good reason for limiting it to when the insured makes a claim under the policy; while that is the position provided for under the UK legislation, that is because the remedy is proportionate to the claim, so it can only be quantified if and when a claim is made. That is not necessary if the remedy is just to recover the difference – it can be quantified at any time.

23. For completeness, we note that the same points can be made in relation to the remedial regime for variations of policies, and we consider that they should be amended in the same way (making necessary modifications).

Insurers' duty to inform (question 8)

24. The Bill provides that an insurer has no remedy for a breach of the duty of disclosure if the insurer breached its own duty to inform. There is an exception (i.e., the remedies will apply) if the policyholder knowingly breached their duty. We consider that an insurer should also have a remedy if the policyholder commits a reckless breach of duty.

25. There is no good policy reason for distinguishing between deliberate and reckless breaches in this context, and doing so would be inconsistent with the fact that the Bill otherwise provides the same remedies where there has been a deliberate or reckless breach. In terms of relative culpability, we consider that a reckless policyholder should not be able to benefit from a (likely) careless breach of the insurer's duty to inform.

Duty of utmost good faith (question 9)

26. The duty of utmost good faith is a fundamental and longstanding principle of insurance law.[1] It is the basis for the policyholder's duty of disclosure at common law.[2] Beyond that, however, the scope of the duty is a matter of some doubt and debate, particularly as it applies to insurers. We agree with the Consultation Paper that the Bill should leave it to the Courts to consider the scope of the duty, on a case by case basis.

27. With that in mind, we do not see a need to codify the duty of utmost good faith, and submit that clauses 59 and 60 should be removed from the Bill.

(a) The Regulatory Impact Statement says that codifying the duty is intended to address a problem that policyholders do not know about the duty.[3] However, the central application of the duty of good faith was in requiring the policyholder to make disclosure to the insurer. The Bill codifies the duty of disclosure, and thereby provides any necessary visibility of that aspect.

(b) If codifying the duty is intended to provide greater visibility for how it applies to the insurer after contract formation, that is a questionable goal because the scope of the duty is unresolved.[4] The current drafting does not contain an operative part imposing or recognising a duty (it is only referred to in the heading), and does not address the scope of the duty or remedies for its breach. Stating that there is a duty without providing any detail as to its content does not assist – and it is

1 *Carter v Boehm* (1766) 3 Burr 1905.
2 *Rozanes v Bowen* (1928) 32 Ll LR 98 at 102 per Scrutton LJ.
3 Regulatory Impact Statement at 48.
4 See, eg, *Taylor v Asteron Life Ltd* [2020] NZCA 354, [2021] 2 NZLR 561 at [105] and [109], finding that an insured's obligation not to make claims fraudulently is an implied term of insurance contracts, and is not an aspect of the wider duty of utmost good faith.

not possible on the state of the authorities at this time to comprehensively state what the duty requires.

(c) The Fair Insurance Code 2020 is likely to be more practically useful to a consumer policyholder than clauses 59 and 60. It already sets out how insurers will treat claims, and is expressed in plain English.

(d) The wording of clause 60 could also preclude future development of the duty of good faith, because it is too broad. It states that the duty of good faith imposes no other duty "in relation to the disclosure of a matter to the insurer or a representation". It appears that this wording is intended to ensure only that there are no duties of disclosure prior to policy inception or variation other than those set out in clauses 14 and 31 the Bill. However, the wording is broader than that. The drafting could, on its face, exclude the operation of the duty of utmost good faith in relation to, for example, representations made during the policy period.[5]

28. If, given decisions made by the Government, the Bill is required to include provisions on the duty of utmost good faith, we submit that clauses 59 and 60 should be amended as follows to address the issues identified above:

59 Duty of utmost good faith

(1) The common law duty of utmost good faith between insurer and policyholder continues to apply.

(2) For the avoidance of doubt, this section does not impose on a policyholder, before the contract of insurance is entered into or varied, any duty in addition to:

(a) the duty to take reasonable care not to make a misrepresentation (in the case of a consumer insurance contract) under section *[…]*; or

(b) the duty of fair presentation of risk (in the case of a non-consumer insurance contract) under section *[…]*.

Third party claims (question 16)

29. The new third party claims provisions would repeal section 9 of the Law Reform Act 1936 and create a new right of action against insurers in certain specified circumstances involving (in broad terms) insolvency or the policyholder is deceased. These provisions respond to the Supreme Court's decision in *Steigrad*,[6] which held that the section 9 charge applies to the whole liability policy, including any entitlement to defence costs.

30. Under the current law, the insured cannot access the policy for defence costs while defending the third party's claim, because the charge preserves all of the funds available under the policy until the third party's claim is determined. If the third party's claim against the insured is successful, the third party can access the funds available under the policy directly, in priority to the insured. If the third party's claim is not successful, the insured can then (and only then) access the policy to pay for his or her defence costs. This is usually dealt with by entering into a separate, ring-fenced policy for defence costs.

31. The insurance market adapted to the decision in *Steigrad* by introducing split policies, which separately cover liability and defence costs, to preserve policyholders' ability to seek cover for their defence costs. However, the legal position is inconsistent with overseas jurisdictions. It also puts overseas insurers at a competitive advantage to New Zealand insurers because section 9 does not generally apply to overseas

[5] The Court of Appeal has said held that there is an implied term to the effect that the insured must act honestly in connection with the making of a claim and if the insured fails to do so, and dishonestly makes a claim that is false in some material respect, the whole of the fraudulent claim will be disallowed. The Court held that this obligation is not based on the duty of utmost good faith (*Taylor v Asteron Life Ltd* [2020] NZCA 354, [2021] 2 NZLR 561 at [105] and [109]).

[6] *BFSL 2007 Ltd v Steigrad* [2013] NZSC 156, [2014] 1 NZLR 304.

insurers. We therefore support the repeal of section 9, and the creation of the new third party right of action.

32. We consider that the drafting of some of the provisions could be clarified to better effect the intention of the reform.

33. Clause 85 requires the claimant to obtain the leave of the Court to bring a claim under subpart 4, but it is not said how or when the claimant should seek leave. Section 5 of the Civil Liability (Third Party Claims Against Insurers) Act 2017 (NSW), on which this clause is based, does set out such detail:

> **5 Leave to proceed**
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> (1) Proceedings may not be brought, or continued, against an insurer under section 4 except by leave of the court in which the proceedings are to be, or have been, commenced.
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> (2) An application for leave may be made before or after proceedings under section 4 have been commenced.
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> (3) Subject to subsection (4), the court may grant or refuse the claimant's application for leave.
>
> (4) Leave must be refused if the insurer can establish that it is entitled to disclaim liability under the contract of insurance or under any Act or law.

34. The Consultation Paper states at page 23 that the Bill does not allow for leave to be sought after proceedings have been commenced (as in section 5(2) above) because that would be unusual under New Zealand procedure, and so it is unnecessary to provide for that eventuality. We disagree:

    (a) We expect that the most efficient way to proceed in a third party claim will be to file a notice of proceeding, statement of claim, and interlocutory application for leave to file against the insurer. This would allow the proceeding to be treated as a standard claim for relief.

    (b) This course of action would arguably be prevented by the current wording of clause 85, which provides: "a proceeding may only be brought by a claimant against an insurer under this subpart with the leave of the court". A proceeding is commenced when the statement of claim is filed,[7] so clause 85 could be read as preventing the filing of a statement of claim until after leave has been granted.

    (c) The alternative could be to file an originating application for leave to bring the proceeding, but this would appear to require an amendment to Part 20 of the District Court Rules, and Part 18 of the High Court Rules, to confirm that such a proceeding can be commenced by originating application. That is not currently provided for in Schedule 5 of the Bill.

35. We submit that it would be helpful for the wording of section 5 of the Civil Liability (Third Party Claims Against Insurers) Act 2017 (NSW) to be carried over into clause 85. This would clarify that it is permissible to file a proceeding without leave, but the proceeding will not be permitted to continue unless leave is sought and granted, which we consider to be an important clarification as to the procedure to be followed. It may also avoid unnecessary delay in circumstances where the claimant inadvertently omits to seek leave in advance; that could be remedied simply by filing the application, rather than having to file an application and then, if successful, re-file the proceeding.

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[7] District Court Rule 5.28; High Court Rule 5.25.

36. Clause 87(1) provides that the insurer may rely on any defences that the specified policyholder has. Clause 87(2) appears to be intended to prevent an insurer from relying on a defence created (perhaps cynically) by the specified policyholder after the event that gave rise to the liability:

> **87 Defences generally**
>
> (1) The insurer is entitled to rely on any defence or any other matter in answer to the proceeding under this subpart or in reduction of its liability to the claimant—
>
> (a) that the insurer would have been entitled to rely on in a claim made by the specified policyholder under the contract of insurance; or
>
> (b) that the specified policyholder would have been entitled to rely on in a proceeding brought by the claimant against the specified policyholder in respect of the liability.
>
> (2) Despite subsection (1) and section 86, the insurer is not entitled to rely on a defence arising from an act or omission by the specified policyholder that occurred after the event that gave rise to the liability (for example, a defence based on the specified policyholder failing to comply with a condition to provide information or assistance to the insurer).

37. We consider that subclause (2) is worded too broadly. For example, on its face, it would prevent an insurer relying on a defence that the specified policyholder made payment to the claimant in discharge of the claim, because that would be "an act or omission by the specified policyholder that occurred after the event that gave rise to the liability". The example included within subclause (2) suggests that this is not what was intended, and we would be surprised if that was the intention.

38. As a matter of policy, we submit that the insurer should not be required to indemnify the third party claimant in circumstances where it would not be required to indemnify the policyholder (e.g., because the policyholder had failed to pay their premiums).

39. We note that there is no equivalent to subclause (2) in the Civil Liability (Third Party Claims Against Insurers) Act 2017 (NSW) nor the Third Parties (Rights against Insurers) Act 2010 (UK), and submit that it should be removed from the Bill. Alternatively, the subsection should be limited to circumstances in which the policyholder has taken an action or omitted to do something with the intention of defeating the third party claim.

40. Clause 89 contains a typographical error. In the following passage, the underlined word should be added: " … does not prevent the claimant from recovering an amount for the damages, compensation, or costs under <u>this</u> subpart …".

Unfair contract terms (questions 31 and 32)

41. The Bill would remove the current insurance-specific exceptions to the unfair contract terms regime (**UCT**) from section 46L of the FTA.

42. The Consultation Paper notes, however, that "final policy decisions have not yet been made in this area" (page 33). We submit that the current exceptions should be retained.

43. First, there is no good evidence that any problem exists in relation to the existing UCT regime as it relates to insurance policies. The Regulatory Impact Statement acknowledges at page 3 that:

> The evidence base for the problem of unfair contract terms in insurance is weakest, because it is largely based on anecdotal evidence of contract terms which may or may not be unfair in the circumstances in question.

44. The anecdotes referred to in the Regulatory Impact Statement include situations that are plainly justifiable and not unfair: "requiring preapproval before incurring healthcare costs", an insured being required to follow "the defence recommendations of the insurer's lawyer" under a liability policy, and exclusions for pre-existing conditions (pages 29-30). The suggestion that such terms may or may not be unfair in the circumstances also ignores the intended scope of the UCT regime. It does not apply on a case by case

basis. It addresses terms in standard form contracts that are unfair in themselves, not because they are unfair depending on how they are applied (otherwise there would be no justification for preventing any reliance on the term pursuant to section 26A of the FTA).

45. Second, MBIE acknowledges that neither of the proposed options is likely to result in any net improvements. The Regulatory Impact Statement assesses both of the options on which MBIE is consulting as “about the same as doing nothing/the status quo” (page 36). This further emphasises that there is no good reason to change the existing regime.

46. Third, the existing regime is justified. The terms that are currently carved out were considered by Parliament to be critical to insurers’ assessment of risk and reflect the unique nature of the operation of insurance contracts.

47. Insurance contracts differ from other types of contracts in that, in order to operate, insurers need to have a clear understanding of the extent of risk they are taking on. Insurers attempt to define the parameters of risk, and price them accordingly, through the terms of the insurance contract. Such terms include exclusions, which may be used to ensure that insurance is only covering unforeseen claims, and ensure that all consumers in the pool are treated equally. Premiums are then priced based on these factors.

48. It is important to understand that the insurance contract is the product itself, and so differs from other types of products. Insurance policies can be contrasted with, by way of example, gym memberships (where use of the gym is the product, and the contract simply sets the terms relating to the product) and phone networks (which the particular phone and use of the network is the product, and the contract again simply sets the terms). The terms of an insurance policy are integral to the very product itself.

49. Fourth, changing the existing regime and opening up insurance policies (particularly exclusion clauses) to challenge is likely to result in very significant uncertainty about the enforceability of insurance policies, which will ultimately be to the detriment of policyholders. Exclusion clauses are fundamental to the operation of an insurance policy because they are critical to determining the scope of the risk that is covered. Insurers use standardised policy wordings that contain standardised exclusion clauses, which are often mandated by their reinsurers; any uncertainty in relation to any individual exclusion clause would have systemic effects in terms of the cover that insurers are willing to offer, and/or the price at which it will be offered.

50. It is no answer to say, as the Consultation Paper does (at pages 32-33), that insurers will be able to rely on the general exceptions of the insurance-specific exceptions.

(a) The Regulatory Impact Statement says that exclusion clauses do not fall under a general exception, and it is not appropriate for there to be an exception for them, because they should be able to be justified as being in the insurer’s legitimate interest (page 31).

(b) There may be other standard policy terms that arguably do not define the main subject matter of an insurance contract per se and so do not automatically fall under the general UCT exceptions, but which are central to an insurer’s ability to assess the risk, accurately price it, manage the risk over the life of the contract, and efficiently settle any claims. As noted above, if insurers are unable to accurately price risk, they may cease to offer cover or increase premiums to cover the risk that they may not be entitled to rely on the terms of cover.

(c) The uncertainty as to whether the general exceptions apply will be magnified because, if the terms of an insurance policy were to be challenged as unfair, the onus would be on the insurer to prove that the terms were reasonably necessary in order to protect their legitimate interests (section 46L(3) of the FTA), rather than the Commerce Commission or Financial Markets Authority proving that they are not.[8] That is a complete reversal of the existing position, without any justification. There is no evidence that insurers have adopted inappropriate exclusions – and if they had, this

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8 The Consultation Paper states at 335 the Financial Markets Authority will be given the power to enforce the UCT regime.

would be easy to determine, because all of the policy wordings for the major New Zealand insurers are publicly available on their websites.

(d) The argument that insurers should be able to rely on general exceptions cuts both ways. If that argument is correct, then it undermines the rationale for reform, because little will change. As explained above, we do not agree with that assessment, but it highlights that the assumptions underpinning the argument for reform do not justify it.

51. If, notwithstanding the above, the Bill is required to amend the existing regime, we submit that Option B should be adopted (i.e., it should be clarified that the main subject matter exception covers the subject of the insurance, the sum insured, excesses and deductibles, and exclusions/limitations of liability). Most crucially, Option B would continue to disapply the UCT regime to exclusion clauses.

Definition of intermediaries (questions 1 and 24)

52. The definitions of "specified intermediary" (clause 5), "broker" (clause 95(1)), and "insurance intermediary" (clause 95(1)) overlap in a way that we consider is likely to give rise to unnecessary confusion, and it is not clear that there need to be three separate definitions.

53. The definition of "specified intermediary" is as follows:

> **specified intermediary**, in relation to a contract of insurance,—
>
> (a) means a person entitled to receive from the insurer commission or other valuable consideration in consideration for the person's arranging, negotiating, soliciting, or procuring the contract of insurance between a person other than that person and the insurer; but
>
> (b) does not include an employee of the insurer.

54. The term is used in the Bill only in relation to the duties of disclosure.

55. The definition of "broker" is:

> **broker**, in relation to an insurer, means a person—
>
> (a) who carries on the business of arranging contracts of insurance (whether or not the business is the person's principal business or is carried on in connection with any other business); and
>
> (b) who is not the employee of the insurer; and
>
> (c) who is not appointed under a signed agreement as the agent for the insurer for the purposes of receiving—
>
> (i) money due to the insurer from the policyholder; and
>
> (ii) money due to the policyholder from the insurer.

56. There is a significant degree of overlap between these two definitions. They both apply to people who arrange contracts of insurance but who are not employees of the insurer. However, different terms are used to describe the business of arranging insurance. The definition of "specified intermediary" would appear to capture a person who has only a one-off involvement in the inception of a single policy (because they need only be entitled to commission in relation to the policy), potentially unlike a "broker", who must carry on the business of arranging insurance contracts (which could imply ongoing activities). It is not clear whether this is intentional.

57. The definition of "insurance intermediary" is as follows:

> **insurance intermediary**—
>
> (a) means a person—

(i) who for reward arranges contracts of insurance in New Zealand or elsewhere; and

(ii) who does so as the employee of or agent for 1 or more insurers or as the agent for the policyholder; and

(b) includes a broker.

58. This definition uses a different description again to refer to the business of arranging contracts of insurance. It is not clear whether this is intended to distinguish the nature of an insurance intermediary's business from a specified intermediary or a broker, but given that the definition expressly includes brokers, there must be at least some overlap in the nature of their respective businesses.

59. We submit that it would aid in understanding the Bill if the definitions could either be consolidated (for example combining "specified intermediary" and "broker"), or the reasons for the differences in the definitions be more clearly indicated.

Regulations as to form and content of policies (questions 34-36)

60. The Bill would amend the Financial Markets Conduct Act 2013 to create a new power for the Governor-General to issue regulations mandating the form and presentation of insurance contracts.

61. The proposed form of the power allows for very prescriptive regulations: for example, specifying what explanatory materials is required to be contained within a contract of insurance, how long particular sections of the policy can be, and what font size has to be used.

62. We note the comment in the Consultation Paper (page 36) that "there is presently no intention to make regulations that contain detailed requirements of how each aspect of an insurance contract is to be presented … or prescribe standard forms". With that being the case, we submit that any regulation-making power should be framed at a higher level of generality. We query the need for more specific regulation on font size (for example).

63. In our experience, regulations of this kind can be unworkable in practice, unless a particular form is provided (e.g., numerous parties have been prosecuted for failure to comply with the prescriptive requirements for extended warranties under 36U of the FTA, which require a lot of information to be contained on the front page of the agreement, but for which there is no specified form). The compliance costs associated with such changes are also likely to be significant.

For more information

Privacy of natural persons