Financial Services Council NZ

Grow the financial confidence and wellbeing of New Zealanders

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Financial Markets Policy
Building, Resources and Markets
Ministry of Business, Innovation & Employment
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Exposure Draft Insurance Contracts Bill

This submission on the Exposure draft of the Insurance Contracts Bill Consultation Paper, 24 February 2022 (the Consultation), is from the Financial Services Council of New Zealand Incorporated (FSC).

As the voice of the sector, the FSC is a non-profit member organisation with a vision to grow the financial confidence and wellbeing of New Zealanders. FSC members commit to delivering strong consumer outcomes from a professional and sustainable financial services sector. Our 103 members manage funds of more than $95bn and pay out claims of $2.8bn per year (life and health insurance). Members include the major insurers in life, health, disability and income insurance, fund managers, KiwiSaver, and workplace savings schemes (including restricted schemes), professional service providers, and technology providers to the financial services sector.

Our submission has been developed through consultation with FSC members and represents the views of our members and our industry. We acknowledge the time and input of our members in contributing to this submission.

The FSC's guiding vision is to grow the financial confidence and wellbeing of New Zealanders and we strongly support initiatives that align with our strategic intent and deliver:

- strong and sustainable customer outcomes
- sustainability of the financial services sector
- increasing professionalism and trust of the industry.

We welcome the opportunity to provide feedback on the exposure draft of the Insurance Contracts Bill (the Bill). In July 2019, the FSC responded to the Insurance Contracts Law Review options paper, supporting its key themes to ensure that insurance remains accessible and affordable for customers and sustainable for insurers. These included the consolidation and modernisation of the legislation, disclosure of information to insurers, making it easier to read and compare policies, the continuation of an unfair contract terms (UCT) regime all whilst ensuring adequate transitional arrangements for any changes rather than retrospective application.

We reiterate our message from 2019, noting industry and the FSC research on underinsurance in New Zealand[1], that it is critical that reforms do not produce detrimental results for consumers by increasing

[1] https://blog.fsc.org.nz/research-2020-gambling-on-life

uncertainty in assessing risk thereby raising costs of providing insurance and creating unintended barriers for New Zealand consumers to obtaining insurance.

Key points for FSC submission:

- Our members support the adoption of the United Kingdom (UK) approach to consumer non-disclosure but suggest that a closer look at the drafting would be of assistance. In terms of the remedies available for careless misrepresentations, we consider the proportionate approach, as utilised in the UK, would be preferable to a straight dollar value deduction.
- We support a high threshold before a life policy can be avoided. However, if fraud is to be retained as a requirement, the Bill needs to define 'fraudulent misrepresentations' to distinguish this from 'deliberate or reckless' misrepresentations.
- We agree that the common law requirement that both parties to an insurance contract act with the utmost good faith is fundamental to the relationship between insurer and insured. However, we remain of the view that codifying this duty in statute is likely to result in uncertainty and confusion to both the industry and consumers. In addition, we are concerned that the drafting in the Bill does not accurately reflect the common law position.
- Any changes to the UCT regime must recognise the unique characteristics of insurance policies. Our members prefer Option B but have some concerns around removing the insurance specific exceptions for UCT overall.
- The provisions for interest payable on life policies should be amended so that interest does not begin to accrue until the 91st day after the death has been notified and all claim requirements have been satisfied.
- Our members are concerned that the Bill has been drafted predominantly in contemplation of fire and general insurance, and further thought is required on how it will impact on life and health insurance. There are substantial differences between the two insurance sectors. For example, in the opportunities of insurers to underwrite the risk presented by the customer, life and health insurers only have one chance to underwrite, whereas fire and general insurers can do it at each anniversary. Also, the difference in the ownership structures of the relevant policies (in the case of life and health insurance, the customer is not always the life assured). As currently drafted, the Bill does not work for life and health insurance and will result in unintended consequences for the consumers of those products.
- We support consumer insurance contracts being worded and presented in a clear, concise, and effective manner and encourage principles to that effect being included in the Bill. However, our members consider that regulations requiring insurers to publish certain information in a prescribed format or with prescriptive formatting rules, such as a specified font size, are unnecessary in circumstances where members are already part way through a programme of review and simplification.

We note we have not responded to every question at the Proposal and have removed these questions from this submission. We prefer to focus on questions of most relevance to our members and the FSC industry position.

We acknowledge and thank the team at MBIE for their engagement to date and welcome continued discussions.

I can be contacted on Privacy of natural persons Carissa Perano, Head of Regulatory Affairs, at Privacy of natural persons, to discuss any element of our submission.

Yours sincerely

Richard Klipin
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Your name and organisation

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Part 1: Preliminary Provisions

1. Do you have any feedback on Part 1 of the Bill?

As noted above, our members consider it important for MBIE to understand that there are substantial differences between life and health insurance and fire and general insurance (including liability insurance). Given that our members are life and health insurers, this is the focus of our submission, however we consider Part 1 needs to recognise the various types of insurance contracts, namely, fire and general insurance contracts, life insurance contracts, disability (trauma cover) and income insurance contracts and health insurance contracts (private medical cover).

Part 2: Disclosure duties and duty of utmost good faith

2. Do you have any feedback on the Bill's provisions in relation to the duty for consumers to take reasonable care not to make a misrepresentation, including the matters that may be taken into account to determine whether a consumer policyholder has taken reasonable care not to make a misrepresentation?

We understand that the duty to take reasonable care will effectively mean that policyholders are to take reasonable care not to make a misrepresentation. We agree that the questions asked of consumers should be specific and limited to what a reasonable person could be expected to know.

Life and health insurers only have one opportunity to underwrite the risk that a customer presents, namely at the time of application. To avoid life and health insurers setting blanket exclusions for prior existing conditions and moving away from individualised underwriting (which will have adverse consequences for the consumer as the cover available to them will be limited), insurers need to be comfortable that they can establish with at least some degree of certainty whether a consumer has taken reasonable care or not.

However, clause 14 does fail to acknowledge that, in the context of life and health insurance policies, the policyholder and the life assured may be different people. There is often the situation where the wife (W) will take out a life policy on the life of her husband (H). In this scenario, W is the policyholder and H is the life assured. Clause 14 only requires W to take reasonable care not to make a misrepresentation, but it is the health information of H that the insurer is concerned about.

Life and health insurers in particular, may need to ask additional questions to obtain the kind of detailed information required for assessing risk under the new disclosure regime. There is a risk that asking those additional questions will increase the length of time required to complete the underwriting process and clash with the need for clear and concise documents. It will be a tricky balance for insurers to get all the information they need whilst keeping various policy documentation and material 'concise'. In addition, the need to "get it right" at the outset will have a flow on effect on the medical profession, who are already struggling to provide information to insurers in a timely manner.

There is a positive duty on a consumer to answer questions truthfully and accurately. However, clause 17 provides that a failure to answer or providing an incomplete answer is not a misrepresentation. A failure to answer is essentially a misrepresentation by omission. This conflicts with the notion that a consumer policyholder must take reasonable care. In essence, the onus is being placed entirely on insurers to check and review. We are concerned that this clause sends the wrong message to consumers and leaves insurers

in a difficult position. Insurers may need to choose between spending time and resources following up incomplete answers or taking the risk of non-disclosure of a material fact, which will ultimately lead to increased insurance costs. Clause 17 should simply be included as one of the 'matters to be taken into account' in clause 15 (1). Reference should also be made to 'failing to provide an answer to a question' rather than 'failing to answer a question' which is ambiguous.

We also have some concerns around the use of the words "reasonable care" and how policyholders will interpret what is required of them. Under the current law, disclosure is assessed from the insurer's perspective, namely whether a material fact was disclosed to the insurer, and did it influence the insurer's decision to enter the policy. The Bill introduces the concept of reasonable care which denotes an objective test which a consumer is unlikely to appreciate or understand. This issue could be addressed by way of regulations, for example, prescribed wording which all insurers could use in policies to explain what 'reasonable care' means. However, such 'safe harbour' wording would need to be closely aligned with the wording in the legislation and subject to industry consultation before its implementation.

The insurer must consider certain subjective matters specific to the consumer. Clause 16 of the Bill requires insurers to consider "particular characteristics". It will be more difficult to assess reasonable care if the policyholder does not speak English or suffers from a disability, if they engage solely via a digital platform or if they dealt with an intermediary and did not have direct contact with the insurer. The presumptions in the Bill do not necessarily assist in these scenarios.

The Bill should also take into account the extent to which such matters will be separately dealt with as a result of changes being introduced by the Financial Markets (Conduct of Institutions) Amendment Bill (CoFI Bill). Fair conduct principles introduced via the CoFI Bill will effectively require that the characteristics and circumstances of policyholders will be fully considered by insurers (particularly at the time the policy is entered into). This includes requirements to pay due regard to consumers' interests, act in good faith, and assist consumers to make informed decisions. Insurers must also consider the potential for consumers to be in vulnerable circumstances. Fair conduct programmes will ensure policyholders are treated fairly and are fully informed. We are concerned that insurers may face a double jeopardy in this area if no attempt is made to at least recognise the two sets of regulatory obligations insurers will be endeavouring to discharge.

Clauses 15 to 17 of the Bill should be redrafted to comprehensively and consistently set out the matters to be taken into account in assessing whether the consumer has fulfilled their disclosure duty in one overarching provision, we suggest in line with the approach in the equivalent test under UK legislation[2]. One option is for clauses 16 and 17 to be moved into clause 15, 'matters to be taken into account'. It would also be helpful for the Bill to further clarify how to assess deliberate or reckless actions and what "particular characteristics" might be relevant in different circumstances.

3. Do you have any feedback on the Bill's provisions in relation to remedies for breach of the consumer duty?

We support the introduction of a range of remedies for breach of the consumer duty of disclosure. However, we note the remedies set out in the Bill differ from current practice.

[2] Section 3, Reasonable care, Consumer Insurance (Disclosure and Representations) Act 2012

Requiring insurers to establish that a policyholder has failed to take reasonable care, before any remedies are available to it, may create a scenario where policyholders withhold information so their premiums are less, but accepting that if they need to claim, they can pay the increased premium at claim time. This assumes that insurers are unlikely to be able to establish that a policyholder failed to take reasonable care or withheld information deliberately. This practice will impact on the premium pool available to insurers. It will also result in increased premiums, making the product more expensive for consumers.

We agree with the remedies proposed under scenario 1 and 2 for deliberate and reckless misrepresentations, however under scenario 2, all premiums must be returned the customer. There are costs associated with issuing a policy or reviewing a claim, such as the cost of obtaining a customer's medical records from a third party, the cost of the underwriter to review the medical information (which may span over at least a five year period and can be several pages in length), and the time spent by the policy team or the claims team in reviewing the relevant forms and corresponding with the consumer. We suggest that all premiums are to be returned to the policyholder, subject to the reasonable actual costs and expenses incurred by the insurer in administering the policy and assessing the application or the claim. This could be calculated on an individual contract but be limited to a set percentage.

We are concerned that the remedy for insurers in scenario 3 and under clause 5 of Schedule 2 of the Bill is not sufficiently flexible enough to deal with the common situations that arise, particularly in the life and health insurance industry. Careless misrepresentations or non-disclosure are a common occurrence, for example, where a policyholder misunderstood what a question was asking or wrongly decided a particular fact was not relevant. Insurers regularly use discretion to ensure the outcome is fair in the circumstances. This would be constrained by the current formulation and may lead to worse outcomes for policyholders. For life cover, utilising a remedy that alters the terms of the cover and thereby ensures that the insurance contract continues is a better outcome for consumers than to cancel the cover.

It is worth noting that misrepresentations or instances of non-disclosure are not only discovered at claim time. Indeed, it is not uncommon for our members to discover these when the customer requests an increase in cover or a review of their current terms. An example of this is where customers fail to disclose a medical condition (such as rheumatoid arthritis) at the time they apply for Life and Trauma cover and the omission is not discovered until they apply to increase their cover. In that situation, it is not appropriate to deduct premium, not least because there is no payment from which to deduct. Instead, the insurer would apply retrospective terms, along with loading on both covers. The available remedies need to be sufficiently flexible to allow insurers to choose an appropriate outcome, including those that do not necessarily have a monetary value.

The Consultation notes that the 'deduction of premium' approach puts the parties back in the position they would have been absent the misrepresentation, but that is not necessarily the case. If a policyholder carelessly answered 'no' to a question, but full disclosure would have led to a 100% loading (but no other altered terms), it is not correct to assume the policyholder would have entered the policy and paid the extra premium. In our members' experience, policyholders are usually not prepared to accept significant premium loadings. It is more common for the parties to negotiate different terms, perhaps a reduction of the sum insured or an endorsement for a particular condition. Applying this example to scenario 3, the insurer can only deduct the additional premium, and only if there is a claim. It does not have the option to apply a reduced sum insured or an endorsement as it would have only altered the premium.

Unintended consequences

If the proposed approach in clause 5 of Schedule 2 is progressed, we have concerns that there may be unintended consequences. Firstly, the remedy could have a disproportionate effect for some policies, depending on the amount of cover and length of time the policy was in force. For example, if a policy exists for some time (which is the case for many life and disability policies), the difference in premium has the potential to be significant and out of proportion to the sum insured. By contrast, in the case of a claim for total loss of a million dollar house, where the policy commenced relatively recently, the difference in premium would be insignificant compared to the amount payable under the claim.

As noted above the premium offset approach more equitably puts the parties back in the position they would have been but for the misrepresentation, but this does not take into account the increased risk of the pool making a loss under this approach. The inability to recover premiums unless there is a claim to offset against could result in increased pricing. Insurers will need to assess the risk of careless misrepresentation across all policyholders against the ability to recover premium from those who make a claim, together with any other remedies available. If there is no claim, a customer who made a misrepresentation resulting in a lower premium, would otherwise end up better off under the proposed legislation than a customer who provided proper disclosure and charged the correct premium from the outset.

Finally, there is a risk this approach does not provide sufficient incentive to take care when answering questions, as the cost of making a misrepresentation could be minimal in many cases. Depending on claims experience over time, this may also have implications for pricing.

Suggested approach

We are of the view that a proportionate remedy as utilised in the UK would be preferable to a straight dollar value deduction. Licensed insurers are required to carry on business in a prudent manner, which includes balancing risk and costs to ensure that the business is sufficiently funded. Under the pro-rata method there is a greater incentive on the policyholder to provide accurate disclosures to the questions the insurer asks. Schedule 1(5) of the Insurance Act 2015 (UK) provides for deduction of the percentage difference between the premium that would have been charged and the premium that was in fact charged. This approach would provide insurers with a better range of remedies (at least in monetary terms), whilst at the same time providing a better disincentive for consumers to answer evasively or incompletely. This approach would also provide flexibility for insurers to be more generous should they wish to. Life and health insurers may utilise other remedies such as a reduction of the sum assured, which will need to be considered.

A further approach could be for the Bill to clarify that in respect of scenario 3 the insurer may reduce the claim payment but is not under an obligation to. If it wishes, it can pay out the full value of the claim and if no claim is payable, the insurer is entitled to seek repayment from the policyholder of the additional premiums that would have been charged had the misrepresentation not been made.

We note in relation to Group Policies that clause 21 describes the parties to a contract as “Person A” and “Person B”. It appears that “Person A” is often a company or other entity. Perhaps the drafting could be clarified to reflect this common scenario.

4. Do you have any feedback on the Bill's provisions on remedies for breach of the consumer duty in relation to life insurance policies where the misrepresentation was not fraudulent and more than three years ago?

We consider it is appropriate for the Bill to retain the special provisions in relation to life policies. However, we consider that it would be appropriate to extend the three year period to five years. Our members have noted that on numerous occasions claims where a misrepresentation has occurred have been just outside the three year period. Given the difficulty involved in proving fraud, this seems to result in unjust outcomes for insurers and other policyholders who ultimately bear the cost for fraudulent activity through increased premiums.

The original policy justification for the three year rule seems to have grown out of the idea that the person who enters into the policy, such as a life insurance policy (and who makes the representations) is not the same person as the beneficiary of the policy, and therefore avoidance will affect innocent parties. In the past, there may also have been difficulties with obtaining and preserving evidence over a long period of time or in circumstances where the proposer has died. However, these policy considerations do not provide specific justification for a three year period (as opposed to five year period for example). In our view, the timeframe for the higher standard should better reflect the average duration for which a life policy must be paid in order to collect enough premium to make the pricing/pooling effect equitable for all customers. This period is generally recognised to be eight years. We consider that increasing the time during which a life insurer may utilise remedies for misrepresentation from three years to five years strikes a good balance between insurer and customer interests.

Whilst the Bill essentially carries over the misstatement provisions from s 4(1) of the Insurance Law Reform Act 1977, it has not adopted the corresponding definition of a fraudulent statement from that Act. The Bill contains no definition of fraudulent, and it is not clear whether the common law test for fraud applies or how to distinguish between a fraudulent or deliberate misrepresentation (which would allow the life insurer to avoid the policy) and a reckless one without intent. In that case, as currently drafted in the Bill the life insurer cannot avoid the policy unless the misrepresentation was made within the specified three year period. For certainty, it would be helpful if fraudulently was defined in the Bill. We consider that the term was appropriately defined in section 4 of the 1977 Act, which defined it as:

> *a statement is made fraudulently if the person making it makes it—*
> *(a) knowing it is incorrect; or*
> *(b) without belief in its correctness; or*
> *(c) recklessly, without caring whether it is correct or not.*

In addition, it appears that the definition of 'life policy' in the Bill also captures disability and income insurance contracts. For example, an income protection policy comes within the definition of s84(1)(d) of the Insurance Prudential Supervision Act 2010. If disability and income insurance contracts are caught by the definition of 'life policy', this will have significant consequences for life and health insurers as for it to have any remedies available for misrepresentation, it has the added burden of establishing that the misrepresentation was fraudulent or within the three year period on which the insurer sought to avoid the contract. In turn, this will have unintended consequences for consumers as insurance will become more expensive as the risk presented to insurers is greater.

Proportionate remedies should be included for misrepresentations that are not fraudulent irrespective of when the misrepresentation is discovered. This is consistent with the common law remedies that are presently available to insurers for non-fraudulent non-disclosure more than three years on. In the absence of remedies for non-fraudulent misrepresentations more than three years ago, a customer making a misrepresentation (and securing cover or better terms or premiums as a result) could end up in a better position under the legislation than a customer who provides proper disclosure. A person could also be incentivised by the legislation either not to disclose matters that were unlikely to be identified within a few years or deterred from correcting any misrepresentations they had made.

5. Do you have any feedback on the Bill's provisions in relation to the disclosure duty for non-consumers?

There will be some difficulties for insurers in determining how to apply disclosure duties where a policy has both consumer and non-consumer components, or where the policyholder does not neatly fall in either category. It would be helpful for detailed guidance to be developed as to the expected application in such situations, in consultation with industry.

6. Do you have any feedback on the Bill's provisions in relation to remedies for breach of the non-consumer duty?

The matters raised under Question 3 above also apply to remedies for breach of the non-consumer duty. We consider the Bill should allow insurers to apply a proportionate remedy.

7. Do you have any feedback on the provisions in relation to the insurer's duties to inform policyholders of the disclosure duties, and insurer access to third party information, including how the duties apply for variations of insurance contracts?

Duty of disclosure

We support a positive duty for insurers to inform policyholders of their disclosure duties. We understand compliance with that duty to be more about the act of informing, rather than the words used to describe the disclosure duty or access to third party records. It would be helpful to receive clarification as to whether compliance with this requirement is likely to hinge on how insurers describe the duty when they inform their customers. Alternatively, the insurer's duties to inform could be enhanced from the use of prescribed wording as a 'safe harbour' that insurers could rely on. Such standardised wording would allow insurers to more seamlessly meet their duty to inform policyholders and removes doubt as to whether the policyholder was properly informed. As noted in response to Question 2, any 'safe harbour' wording would need to be closely aligned with the wording in the legislation and subject to thorough industry consultation.

In our view, the provisions in clauses 55 and 57 should make clear that failure by an intermediary to pass on the insurer's documentation or adequately explain the duty does not constitute a breach by the insurer. Alternatively, the duty could be amended so that the insurer has a requirement to take 'all reasonable steps' to inform policyholders of their disclosure duties.

Access to third party records

We support openness and transparency and therefore agree with a requirement to inform consumer policyholders about access to third party information and how that information may be used. However,

insurers will need to ascertain how this obligation interacts with their existing obligations under the Privacy Act 2020.

We also seek clarification on the words "the extent to which" in relation to accessing third party records. Is this a reference to the frequency of access, or the identity or date of access? Does informing a broker discharge this duty? Depending on the scope, this could have the effect of increasing notices to customers and brokers, which may delay binding of policies and inadvertently drive prices up.

8. Do you have any feedback on the consequences in the Bill if an insurer breaches duties to inform policyholders of the disclosure duties, and insurer access to third party information?

We consider that the consequences for failure to comply with this duty as drafted are not proportionate to the harm that a consumer policyholder might actually suffer. The current proposed response, which could include licence actions under the Financial Markets Conduct Act 2013 (FMCA), seems disproportionate to the harm suffered by the policyholder and unduly punitive. In many cases, there will not be any harm resulting from the failure to meet this requirement. We suggest this mechanism is amended so that it better reflects the harm that has been caused. For example, an insurer will be unable to apply a remedy for misrepresentation if the policyholder can establish a link between the misrepresentation and the insurer's breach. As noted in response to Questions 2 and 7, 'safe harbour' wording might also assist here.

In addition, the duty to inform policyholders about their disclosure duty and access to third party information should not have the same consequences, as their effect on the insured is entirely different. In the case of the duty to inform policyholders about access to third party information, a breach of this requirement may also be a breach of the Privacy Act 2020. Accordingly, an insurer may end up being the subject of a complaint to the Privacy Commissioner as well as subject to civil liability under the FMCA.

9. Do you have any feedback on how the Bill codifies the duty of utmost good faith?

Our members agree that the common law requirement that both parties to an insurance contract must act with the utmost good faith is a fundamental and important principle of insurance law. However, we do not agree with codifying this in legislation, as we consider this will create considerable confusion and uncertainty with little benefit for consumers or the industry. It is unlikely to raise consumer awareness or improve understanding, particularly in circumstances where there are already changes being made to the consumer disclosure duty. Given that anyone reading the clause would need to undertake further research to find out more (given the very concise nature of the provision), we query what purpose is served by including it at all.

Whilst the Consultation states that the Bill codifies the duty of utmost good faith in a way that reflects the common law position in New Zealand, clause 59 only states "A contract of insurance is a contract based on the utmost good faith". The clause does not use the word 'duty' other than in the headings, nor does it describe the scope of the duty. As a result, we do not consider that clause 59 properly reflects the current common law position. Indeed, the wording of the clause may give the impression that the drafters intended the duty to be construed differently to how the New Zealand Courts have done so to date.

The effect of clause 60 is that a consumer will only need take reasonable care not to make a misrepresentation. This is also inconsistent with the statement in the Consultation that the Bill codifies the duty of utmost good faith in a way that reflects the common law position in New Zealand.

Rather than codifying the duty, insurers could be required to notify consumers of the duty of utmost good faith during the application or commencement process (or within the policy document itself). If it is determined to include this duty in the Bill, we consider it to be preferable for Part 2 to clarify that it modifies the common law duty of disclosure, including any disclosure duty that arises from the common law duty of good faith.

10. Do you have any feedback on the Bill's provisions relating to information provided by a policyholder to a specified intermediary?

We support a requirement for an intermediary to take reasonable steps to pass on material information. However, we consider that clause 63(2) does not create a sufficient duty on 'A' (as that is defined in clause 63) to pass on all representations to the insurer. Clause 63(2) only requires 'A' to take all "reasonable steps" to pass on the information. Considering that the insurer is deemed to know any information known by a specified intermediary (in accordance with clause 20), in our view, 'A' should be required to pass on all information to the insurer (rather than just be required to take all reasonable steps).

We also have concerns around clause 63(3) of the Bill which allows an intermediary to withhold information from an insurer if they believe on reasonable grounds that the representation was a misrepresentation. Prohibiting intermediaries from passing on information known to be a misrepresentation places intermediaries in an impossible position and means insurers are deprived of information that is potentially relevant to the risk posed, namely the insured has potentially breached their duty of utmost good faith from the outset.

We suggest that clause 63(3) is amended so the relevant intermediary must provide the policyholder with an opportunity to correct the misrepresentation and, if they do not, the intermediary has a duty to take all reasonable steps to inform the insurer of the misrepresentation before the insurer enters into the contract or agrees to the variation. The clause also needs to address the potential conflict of interest between the intermediary's duty to their client and the insurer, providing statutory relief from acting in conflict with the intermediary's duty to their client if they pass on information to insurers regarding any perceived misrepresentation.

11. Do you have any other feedback on the drafting of Part 2 of the Bill?

In accordance with the commentary on the Bill, we understand that clause 21 is intended to apply, for example, to employees of an organisation. However, it could also potentially apply to the scenario described above at Question 2 where H (the husband) takes out cover for the benefit of his wife (W). This is a common set-up for life policies. For clarity, we suggest that the 'groups' that are intended to be captured by clause 21 be specified.

Part 3: Terms of insurance contracts

15. Do you have any feedback on the exclusions listed in clause 71(3), which are not subject to the rule for increased risk exclusions in clause 71(1)?

It does not appear that this section was intended to apply to life, disability, or health policies when considering the examples listed in clause 71(3). For certainty, it would be helpful to clarify what policies this was intended to apply to.

18. Do you have any comments on not carrying over section 10(1) of the ILRA 1977?

We agree with the decision not to carry over section 10(1) of the ILRA 1977.

Part 4: Payment of monies to insurance intermediaries

20. Do you consider that changes should be made to requirements for how insurance brokers must hold premium money such as restrictions on brokers' ability to invest or more stringent requirements in line with the client money and property rules in the FMC Act?

We consider that allowing brokers to hold premium for up to 50 days, essentially so that they can invest that money, is an antiquated practice that is out of step with other industries. If this period was reduced to say, a mandatory five days, there would not be any need to regulate brokers' ability to invest the money or to require it to be kept in a client trust account as they would simply have insufficient time to do so. If brokers and insurers choose to agree to longer periods for passing on premium, it would be appropriate at that point to introduce rules around where the money should be held, along with requiring intermediaries to disclose any interest they earn to both insureds and insurers.

22. Is it necessary to retain clause 102 (broker to notify insurer within 7 days if a premium has not been received by the broker), and if so, what should be the consequence for breach of clause 102?

We support retaining this clause as an incentive for brokers to communicate with insurers when no payment has been received.

23. Do you have any other feedback on Part 4 of the Bill?

We consider the terms 'insurance intermediary', 'specified intermediary' and 'broker' should be reconsidered and combined to align with the terms used in the CoFI Bill. The changes could reflect the provision of insurance advice under the FMCA which was amended with the implementation of The Financial Services Legislation Amendment Act 2019 (FSLAA). Intermediaries dealing with client money could then be brought under the client money and client property requirements contained in the FMCA if necessary.

Part 5: Contracts of life insurance

24. If you consider that change needs to be made regarding interest payable from 91st day after date of death, please provide any further reasons and provide feedback on whether interest should only begin accruing after 90 days if the insurer has been notified of the death claim and (where relevant) letters of administration or probate have been obtained.

We consider interest should not be payable on life policies where the delay in payment is due to matters outside the insurer's control. Interest should not begin to accrue until after the insurer has received all information reasonably required to process the claim. For example, for a life insurance policy, interest should only begin accruing from the 91st day after the insurer has been notified of the death, all claim requirements have been met and probate or letters of administration have been granted, where applicable, in the case of payments being made to the insured's estate.

Insurers want to settle life claims efficiently and in a timely matter. However, there will be situations where this is not possible. With increased delays in the New Zealand Court system due to the impact of COVID-19, it is taking longer to obtain probate or letters of administration. It is not correct to assume that the insurer is able to earn interest during this period of delay. Where a death has been notified, the insurer carries a contingent liability, and the money must be kept liquid and not invested. An insurer is unlikely to be able to earn the level of interest that it must subsequently pay out under this provision. When interest rates are high, payments of interest can be sizeable, and this can create an incentive to delay notification of a death. We consider it to be unreasonable for insurers to be put in a position where they are unable to progress a claim but must pay interest through no fault of their own.

We note that by virtue of the calculations specified in the Interest on Money Claims Act 2016, the level of interest payable to policyholders will vary over time. In addition, the rate will still be more than the rate the insurer can earn due to its prudential obligations. Accordingly, the recent low interest rate environment should not be taken into account when considering the impact of these provisions on insurers.

25. Do you have any feedback on the proposal that any mortgaging of life insurance policies under new policies be dealt with under the Personal Property and Securities Act 2009?

We do not have any objection to the mortgage of life policies being dealt with under the Personal Property and Securities Act 2009.

26. Do you have any feedback on the Bill's requirements relating to assignments and registrations generally?

The Bill does not address the situation where a joint policy owner refuses to sign the transfer. This is a common occurrence in relationship property disputes where one partner would like to transfer a joint policy into their own name. Insurers have limited options available to assist their policyholders in these circumstances. One possible solution is to allow the transfer of a policy by one joint owner when that joint owner is also the life insured.

We do not consider that there is still a need to maintain a register of assigned life insurance policies (clause 126). Technological advances mean that insurers have much better records of policy owners. When a policy

owner transfers ownership to another, insurers have processes to handle these transfers which means that a separate register is not required.

28. Do you have any other feedback on Part 5 of the Bill?

Clause 146 of the Bill currently limits benefits paid on the death of a minor to be the total of the premiums paid, plus $10,000 for historical reasons. In some of our member's experience, $10,000 is too low. We recommend that this be increased to $20,000.

Part 7: Unfair contract terms and presentation of consumer policies

31. In relation to unfair contract terms: which option do you prefer and why?

We are concerned that Option A would also create a significant level of uncertainty, particularly in subjecting exclusion clauses to the UCT regime. If insurers are unable to confidently determine the scope of their policies, it will not be possible to accurately price the risk that insurers assume under those policy terms. Therefore, it is likely that policies will be priced conservatively to account for this uncertainty, exacerbating affordability and availability issues for New Zealand consumers.

Our members prefer Option B and note that insurance contracts are not comparable to other standard form contracts. The contract itself is the product and the pricing of that product is inherently driven by the contract terms themselves. Option B strikes an appropriate balance between protecting the interests of the relevant policyholders and insurance providers. This approach would adequately protect customers from inappropriate UCT, whilst supporting the sustainable provision of insurance.

We can also foresee an issue around the threshold for "small trade contracts" in the upcoming change to the Fair Trading Act. A $250,000 limit for premium would capture a huge amount of commercial business. In our view the premium based threshold would be better set at $10,000.

We also note the Cabinet paper on the Insurance Contract Law Reforms references the Memorandum of Understanding between the FMA and the Commerce Commission (the MoU)[3] in terms of how they work together to enforce the "fair dealing" provisions. This MoU will need to be amended to encompass UCTs, to ensure that all parties are aware which entity will be responsible for taking action.

32. Do you have any feedback on the drafting of either of the options?

If Option B is adopted, we consider that it should be clarified that the premium payable is excepted as part of the 'upfront price payable under the contract'. If it is progressed as proposed, further work would also need to be undertaken to more specifically define the types of exclusion or limitation terms that would be captured. We consider that this is a matter best covered off in detailed guidance developed in close collaboration with industry.

[3] https://www.mbie.govt.nz/dmsdocument/7478-insurance-contract-law-reforms-proactiverelease-pdf at paragraph 40.

33. Do you have any comments on the obligation that consumer insurance contracts be worded and presented in a clear, concise and effective manner?

We are strongly supportive of consumer policies being written and presented clearly and ensuring that consumers are assisted to understand their rights and obligations under their policies. However, we note that a statutory obligation to do so risks creating an inflexible and prescriptive situation in circumstances where attempts to use plain language in the context of a technical document such as an insurance policy can result in meaning being lost. This is particularly the case for life and health insurance where policies contain complex medical definitions, testing, criteria, and diagnoses which trigger claims coverage. In addition, there is a risk for insurers that converting these technical documents to plain language creates a mismatch with reinsurance treaties (which will retain technical language and wording), leaving a gap for insurers.

Insurance contracts, due to their nature, need to be able to use technical language where words have very specific meanings (and certainly to align with underlying reinsurance treaties). The move to plain English is a good one, but not at the cost of specificity and precision. Sometimes the best word is the technical one, such as a medical term or because there is extensive case law behind the meaning and interpretation.

In addition, many insurers have, or are working on revising their policy wordings in response to the FMA and RBNZ Life Insurer Conduct and Culture Review. It will have a large impact on the industry in terms of cost, resources, and time if insurers are required to go through this exercise again to align with a high level principle.

We suggest that this requirement is reconsidered in the broader context of industry practice and the other reforms proposed under the Bill, including the work already done by the industry as set out above. It is also important to note that in the context of life and health insurance, consumers often receive financial advice and are supported by their advisers to understand the terms of policies. We also do not consider that it is necessary to require insurers to publish certain information in a prescribed format. Insurers need to retain the flexibility to construct their own policy documents. Likewise, we are concerned that providing explanatory material at the start of each document (page 36 of the Consultation) will increase the size of the policy document, making it more difficult to navigate. Policies that are worded clearly and concisely should not need this sort of explanatory material.

To the extent that these regulations were to progress, we would endorse a less prescriptive approach. We support the intention not to provide detailed requirements on how each aspect of an insurance contract is to be presented nor the introduction of prescribed standard forms for key fact sheets or summaries.

35. Do you think regulations specifying form and presentation requirements for consumer, life and health insurance contracts (e.g., a statement on the front page that refers to where policy exclusions can be found) would be helpful? If so, please explain.

Whilst we support efforts to make policies easier for consumers to navigate, we are concerned that prescriptive requirements such as font size and layout may have the effect of making documents more difficult to navigate, particularly where documents are increasingly consumed online. It is in insurers' interests for documents to be easy to read and navigate and this is a process that is constantly being refined. Insurers need to retain the flexibility to adapt their drafting as the market changes and adapts. In the absence of an identified issue, we submit that such regulations are unnecessary.

In addition, we consider that guidance or "information sheets" are likely to add to the size of the policy without actually assisting the insured to effectively navigate the document. It is worth noting that insureds will increasingly navigate their policy electronically which may diminish the usefulness of such explanatory documents or pages, particularly if they are located in a separate document.

36. Do you think regulations specifying publication requirements for insurers would help consumers to make decisions about insurance products? If so, please explain.

We do not consider that the publication of this information would actually assist a consumer, rather such information is likely to be difficult to understand and may not provide an accurate picture of an insurer's business. Information such as the number of complaints or disputes only reflects the size of the insurer or their market share. Given the amount of information that a consumer must process, we consider that providing more information is unlikely to be helpful.

Timing and transitional arrangements

37. Do you have any initial feedback on when the Bill's provisions should come into effect?

It will require considerable time and resource to implement the changes proposed by the Bill. This needs to be considered in the context of wider industry change including the Natural Hazards Insurance Bill and the proposed New Zealand Income Insurance Scheme. Generally speaking, it would be worth aligning such large scale changes. It will also be important for all the required legislative and regulatory changes to be finalised before any transitional period begins.

We do not consider it to beneficial for either party if insurers must change their policy documents on multiple occasions over the next three to five years to respond to legislative changes. Rather it is disruptive to consumers and to the industry as a whole. Our members' preliminary view is that a period of at least two years from the date all requirements (including related Regulations and guidance) are finalised is likely to be appropriate. We strongly recommend MBIE consults further with the industry before deciding the date the provisions will come into force.

38. Do you have any feedback on the transitional provisions in Schedules 1 or 4, or other proposed transitional arrangements?

As noted in the FSC's response to the 2019 Insurance Contracts Law Review options paper, the adequacy of transitional periods, including to allow for systems changes and renewed documentation is critical.
We encourage the preparation and consultation of regulations during the progress of the Bill to ensure that insurers have adequate resources and time to prepare for the changes in the Bill.

The application of the Bill to renewals is particularly problematic, at least for the first renewal once the Bill comes into effect, with uncertainty as to the implications of that. For example, are insurers automatically in breach if they renew an existing contract without issuing a 'plain English' policy in line with the new requirements? We foresee major practical challenges with the proposed transition rules in this regard, with a need for some practical relief or carve out provided.