Comments upon the DRAFT INSURANCE CONTRACTS BILL from the questions in the **Consultation Paper - Exposure draft Insurance Contracts Bill**

Overview

The most obvious changes needed are;

- In a similar fashion to that previously illustrated by the Real Estate Industry, the Insurance Industry cannot be relied upon to act as it's own regulator. The Insurance Industry Council of NZ is much more of a PR organisation to present insurers in the best light, and examples of any previous disciplinary actions are paltry at best.
- There has been hundreds of thousands of dollars and hours wasted in legal action and in Court, arguing over what a Policy means by its wording. Words such as "reasonable". This leaves the Policy Response open to widespread abuse by the insurer. All the Court Cases (especially the Canterbury Earthquake List) should be traversed to isolate those words that have wasted Court time. The Courts are already overloaded, and some cases I have read have involved days in Court for an insurer to argue over $12,000. An example is CEIT-0047-2019. This is vexatious to say the least. The insurers currently use the threat of Court expenses to cajole claimants into accepting much-reduced offers!
- It is abundantly clear that Insurers have no business performing, commissioning, or initiating and managing assessment programs. I believe, in the USA a separate professional body with ethical standards, answerable to regulatory conditions rather than Insurers or Homeowners, is trusted for all assessments. If one thing became clear from the Canterbury Earthquake Sequence (CES) and subsequent fallout, it was that the Insurers underquoted damage repairs. This created an environment of dangerous works, cowboy operators, shoddy workmanship, repairs that subsequently failed, and many thousands of wasted hours for homeowners to prove what was practical, achievable and met the Policy document.
- EQC and private insurers throughout the 11 years since the initial Canterbury earthquakes have treated the Limitations period differently. Effectively many homeowners had consumed 2/3 to ¾ of the Limitations Act period, of 6 years, before the private insurer had even engaged with them over the claim. The date of the Limitations period should never be able to commence until the private insurer has made a settlement offer that is at least within a specified tolerance of the final settlement. In the CES, many insurers merely delayed long enough to force the homeowners to argue in Court over clearly deficient settlements, rather than engage in any negotiations. This likely lowered the settlement costs for insurers, as people did not wish to go to Court, but resulted in thousands of poor settlements and consequent claims later.

Suggestions are;
- An equal onus on the insurer to illustrate any section of the Policy that could have a material effect on the Policy Response. This should not require a Court Case to solve.
- A defined penalty for errors in judgment made by the insurer. For example a magnitude of error should never be beyond whet the commonly accepted contingency percentage in common use, such as 20%. If the insurer can double an offer without further investigation by themselves (or even with investigation) then their original investigation has a margin of error of 100%, which is clearly fraudulent when the insurer has the ability to affect a person's life savings, asset-base, retirement, living conditions, health, etc. The insurer has either failed in their Duty of Good Faith by misrepresenting the repair value, or they have fraudulently altered the final scope to omit or reduce the full cost the Policy makes them liable for. This was shown in Court in the case of Southern Response, and there is nothing to indicate any other insurer operates differently.
- It has become abundantly clear, that the insurers have no business providing the assessments. Thousands of builders, Council Consent Officers and homeowners in Canterbury will attest, that the scopes provided by insurers are very poor, impractical, result in substandard work and are generally found lacking full details when reviewed. The insurers are not only using their commercial influence to tailor the responses by their "experts", but the mere existence of an "insurance expert" exposes the reality that the 'expert' in the name is due to the ability to provide a professional looking report that travels as close as possible to illegality without breaking the law. This is mainly done by simply leaving out details that should be examined or by using opinions and assumptions to arrive at what are presented as solid facts.

  It is "what the insurers do not say' where the obfuscation mainly lies. Often their engineers are working outside the Engineering NZ Code of Practice for Certified Professional Engineers, but unless challenged, this has no consequence.
- Using the Canterbury Earthquakes as an example, the insurers have created a deficiency of billions of dollars in the correct repairs to restore people's homes to, (at the least), the condition before the earthquakes. This has been highlighted by the liability created by Southern Response – but don't for a minute assume that all claims specialists are not tarred with the same brush. Even the moniker CIP (Certified Insurance Professional) means nothing to a claimant, as all the duties imposed are to protect the insurer. An insurer I spoke with, was not prepared to confirm, that no staff I was dealing with, had a criminal record. From the examples exposed in Court, it would appear a criminal record would almost be a pre-requisite.

  All insurance staff that have ANY input into deciding a claim scope or value, should have imposed upon them the same requirements for background checks as any other person handling a persons financial affairs. Their decisions can destroy lives, yet they work towards bonuses to reduce claim costs.

  It should be illegal to offer a bonus to any staff, contractor, expert or decision

maker that rewards any effort to "trim" costs from those assessed by experts from either claimant or insurer.
- The time scale to solve claims is disproportionate to the decisions that need to be made in many cases. To be still trying to get a settlement for what is a simple house built on flat land (no matter the quality), a decade after the event is not only unprofessional, but illustrates a total lack of ability to do a correct analysis. I believe a penalty of $100,000 per year should be imposed from the date of the fist event. The first $100,000 is for emergency repairs, the cost of revised living conditions and the cost of independent experts to do assessments. The remaining $100,000 per year is effectively a penalty for delaying accurate assessment and continues to account for the varied costs of living with damaged property. This figure could be 10% of the Full Replacement value, retrospectively adjusted upwards should the final value of repairs exceed the first estimate, with no provision to claw back or reduce the annual amount. It is after all an incentive for action.

RESPONSES TO FEEDBACK QUESTIONS

1 Feedback Part One

It must be an independent body that regulates the insurer. Clearly the ICNZ is not able to perform this in a balanced and fair way that sets any precedent for retaining this duty in the future.

The practices of insurers have often been shown to be totally unreasonable, specious, vexatious and even fraudulent, yet the insurer is simply able to avoid a precedent being set in law, by settling out of Court. They can then repeat the same misdemeanours ad infinitum with increasing ability to evade detection. Just as it is said that many prisoners learn the craft of crime while in prison, insurers avoiding detection, or bullying claimants into acceptance are merely adding to their knowledge of how to repeat the same breaches to the Duty of Good Faith in the future.

2 Feedback Part Two

An insurer should not have carte blanche access to medical records. There are instances of people having unrelated or recovered conditions publically presented to merely cause embarrassment, encourage the claimant to give up, encourage the claimant to accept a lesser offer or to increase the stress the claimant is exposed to. Medical experts unrelated to the parties should privately argue medical conditions. A panel could be required to provide a majority vote like a jury and to make a statement of what may and may not have a material affect on the claim. The claimant must have an opportunity to have their own medical expert or Dr make a presentation in discussion of the summary of facts from the panel.

The purpose of the question must be defined. For example is the existence of a previous AIDS test an admission of unsafe practices or simply a test that a person agreed to have to prove no existence of disease. In other words, it is unfair to make assumptions. Is a driver unsafe, because multiple times they have loaned their vehicle, the alternate driver has caused or sustained damage? I remember

the case of a body-builder who was declined health insurance because his BMI related to obese rather than allow for 'very fit and heavily muscled' — a clear instance of false assumptions.

For example a clause that may say 'I give my GP authority to forward my medical records' is a breach of privacy, and the insurer should make reasonable requests such as current, long term or repeating illnesses that are relative to the current claim, or relative to conditions that would make a material difference to the premium.

If risk can be argued at an unknown future date, then all questions must be asked at the inception of the insurance. The risk assessment should be completed, accepted and noted at the outset of insurance, not argued on previously unconceived points 30 years later. For example historical damage should be itemised by the insurer and have the ability to be revised when or if corrected at a later date, in order to be completely removed from the historical damage list.

For example in my own experience upon purchase of a house, an agent from the insurer came to look at and measure the property before the company accepted the long term risk. At this point the homeowner possibly knows less about the building than an experienced person who has an assessment duty. Any questions should be raised at this point, for possible later clarification. For example it is pointless saying "sloping floors" if this is not quantified. To use a metaphor, this would allow an insurer to avoid accident damage to a vehicle "because there was previously one or several small dents in the vehicle or panel as a whole".

This would be inherently simple for a building. It could include a checklist such as drainage, floor levels, operative windows and doors, cracks in structural components, itemised construction materials, stability in traffic conditions, etc. All items can be contested and repaired for removal from the list of pre-existing conditions.

A Policyholder cannot be expected to know what information is material. Is it the thickness of the plasterboard, the age of the log-burner, previous repairs, previous alterations, reglazing a window or the Building Code in force when the building was built. An insurer needs to itemise what affects the cover and premium OR as people expect, average the risk across all Policies, so everyone pays the same.

Clause 14 using the word 'reasonable' but having an effective meaning is not sufficient to avoid lengthy challenges. If it <u>effectively</u> means something, then <u>say</u> that.

An agent of the insurer should be regarded as the same as the insurer if communicating with the Policy Holder directly. An agent for the Policyholder can only be expected to ask and ascertain answers to relevant questions by normal enquiry, and unless a knowledgeable person of sound mind provides the answers, these can only be answered by making relevant enquiries with family or professionals who have the answers.

Group Insurance should not introduce liability for the Group owner to accept liability for individuals. Presumably a group allows the actuary to average the risk amongst the whole population across a smaller subset, in return for obtaining a larger account or sale. If so, less information is required to alter the risk or premium.

3 *Breach of the consumer duty*

In scenario 3, page 14, there is no check or balance to ensure that what the insurer deems to have been the appropriate premium in hindsight, is appropriate or accurate, nor any possibility for the Policyholder to have made a value decision at the outset if they were given any foresight to the cost differences.

Clause 5 of schedule 2 should require the insurer to not just ask at renewal time if there have been any changes that would have a material affect, but to ask with checkboxes if repairs have been done, leaks experienced, ground slumped, damage sustained, defects noticed, or whatever it is the insurer needs to know.

4 *Breach of the consumer duty in relation to life insurance*

Regarding *Life policies,* Clauses 2(2) and 4(2) of Schedule 2; it would appear to save argument, misunderstanding and hours of legal time, if the status quo remains and the time is defined. Any form of pro-rata argument is likely to be complex.

5 *Disclosure duty for non-consumers*

Again, relevant areas to explore are required. There are things a Policyholder may never know, such as a sinkhole, some form of inspection that they have never been aware of and has never been performed. An example is, a continuity of business insurance being voided because the business opened the doors "to test" if there was any business, and essentially create the potential to not make a claim. Any action that is only revealed in hindsight, is reprehensible, if it voids a claim. It can be assumed the insurer knows what potential risks they face, therefore, they should be able to communicate these to the Policyholder to verify. Alternatively, the insurer could have a basic premium, which can be reduced by providing evidence of various risks being mitigated, such as fire warning, fire-suppression, electrical safety checks, building WOF, or any relevant checks performed and updated.

6 *Breach of the non-consumer duty*

A non-consumer product should be just as easy to follow and assess as a consumer policy. For example on the Engineering NZ website they have a short-form and a long-form contract template. The long-form makes easy reading, and total sense. The short form agreement is much more difficult to follow and is not as clear or defined. For the sake of a couple of extra pages in large print rather than fine print, there appears to be no reason to condense the agreement at all, when it is harder to follow.

7 *Insurer's duties to inform policyholders*

Likely access is far too loose for medical records. There needs to be a medical intermediary who can decide on the basis of relevance and privacy, what medical records should be accessed. Many medical notes are exceptionally inaccurate, never seen by the patient, and can be more of an opinion formed in 10 minutes rather than any form of measurement or examination. After the insurer presents the records, may be the first time the Policyholder sees them, and be so surprised as to imagine they are another person's records.
With the ACC for example, a claimant can merely ask the claim decision-maker for the qualifications in the area of medicine in question, and find there are none and that they ask you to withdraw your complaint by signing a form (a complaint that has not been made). Any comments or opinions made, that have not been co-signed or reviewed by the patient are highly questionable as any form of evidence.

Subpart 6 of Part 2 is not suitable to be provided orally. It should be in writing and signed with a copy to both parties, if it may later be used to vary a claim.

It is very important that all variations are in writing and co-signed with a copy to both parties. Automatic variations should be in-writing and if mailed out, should also be attached to the next renewal correspondence.

A variation that initiates increased access to Policyholder information should comply to the above co-signed document as well. Merely stating that the upgrade involves permission to access further information is not sufficient. Anything that will be utilized as a contract in future, needs to be written and signed, not inferred by a list of potential options or an oral statement.

Any claim being more than the annual premium should comply with the Financial Markets Conduct Act. An insurer can literally destroy a persons life savings, credit history or living conditions and cause considerable stress on a single individual by using a group of seasoned professionals to deny, delay and defend a claim.

8 *Insurer breaches duties to inform policyholders*

The penalties should be equivalent for insurers, so for example all premiums should be returned if the conditions are breached. The insurance companies have dedicated staff, computer systems, processes and experience which is all far more than a single consumer. For this reason, they should have no reason to make mistakes.

9 *Duty of utmost good faith*

Although there are no pecuniary penalties, it appears the insurers treat this as the most serious accusation of all. They will spend tens of thousands in Court to deny any breach, far beyond the value of any claim. This is disproportionate, a waste of human and capital resources and if there is any logical reason for this, perhaps other legislation needs altering. Many survey lists place insurance

companies or agents as the least trusted of all professions, so it's not as if they can lose any more trust. The insurance companies do themselves no favours by beating plaintiffs into submission with the might of access to capital and resources, especially when there is no penalty and it does not change public perception for the better.

We note that the courts' interpretation of the common law duty of utmost good faith has already evolved since the Government made decisions on changes to insurance contract law in November 2019. See *Southern Response Earthquake Services Ltd v Dodds* [2020] NZCA 395 and *Taylor v Asteron Life Ltd* [2020] NZCA 354.

10 *Information provided by a policyholder to a specified intermediary*

In reality the application document, should cover all the needs for information required. Boxes can be ticked for yes/no/uncertain to allow follow-up if required. Why should an agent have any more onus than the individual? Yes they may be more *au fait* than a consumer, but the application form should include the same things whether an agent is asking or a consumer is filling out a form. If there is a liability, then it should go to the agent, as they are trained in the requirements and relevant laws.

If information is not sought in the application, there should be no reason for an agent to add anything from casual conversation unless it can be applied to one of the questions asked whilst with the applicant.

11 *Any other feedback on the drafting of Part 2 of the Bill*

Insurers **must** be answerable to an independent regulatory body. They have proved over and over that they cannot reliably regulate themselves.
It is idiocy that the insurers waste so much Court time arguing over defined areas of their own Policy contracts. All terms should be obvious and not require interpretation in Court. For example whether *reasonable* means one of the following;
-available as of the current date
- in use within this country
- at a cost within a set degree of the insurers own verified estimate for exactly the same products
- verified by people that will make-good the claim that the solution is practical, economical and achievable
- signed off by the relevant authority as meeting regulations, ready to proceed.

It is NOT suitable for an insurer to make estimates based on a best case scenario, or merely a note that says a professional 'would' sign it off, especially when insufficient detail is given for a relevant authority to actually make that determination.

Part 3 of the Bill relates to the terms of insurance contracts

12 *Claims-made policies*

I do not have experience in this area, but reading the section, it would seem reasonable providing and dependant upon receiving the 14 day written advice after the Policy Term. This leaves another 46 days for the insured to notify potential counter-claimants, to check any agreements in progress, and to notify the insurer of a **potential** counter-claimant.

13 *Insurers should be required to notify policyholders*

Absolutely.

14 *Other comments*

It must be remembered that the insurer has computer systems to deal with processes such as renewals, whereas the insured often relies on status quo unless notified otherwise. The insured has many other aspects of business to consider, apart from a Policy, and I imagine, that if a potential claimant existed, that particular job would in all likelihood be already very demanding to manage.

15 *Feedback on the exclusions listed in clause 71(3)*

Exclusions need to be the same for all Insurers, so regulatory control is more favourable. Perhaps the Policyholders could request extensions for various things, if required.
"Commercial Use" is not well defined, and if the increased risk is due to more time/distance on the road, raising the risk, this should be quantified against the normal mileage a driver or vehicle (or both) clock up.
A detrimental case could be where a small operator uses their private vehicle to deliver some product, due to any one of; i) the work vehicle being elsewhere, having maintenance, requiring a check, ii) the delivery being on the driver's way home or elsewhere, iii) the private vehicle having a larger or specific size/height cargo trunk, or iv) any other reason where it was rational for the sake of expediency to use a private vehicle. Possibly the vehicle normally only transports the driver, but on an occasion it becomes expedient to carry some goods — this should not exclude a claim.

If more mileage per annum created more risk, then the criteria should be based on mileage rather than purpose. So if a commercial vehicle generally did 50,000 kilometres a year, then create a defining distance for which a different policy is required rather than a loose definition that can be argued in Court such as "Commercial".

The original intention of insurance was to spread the risk across all Policyholders, not to create so many exclusions that no one really knew what they were covered for.

Geographical limitations should be obvious such as a geographical barrier and be notified fully in writing. For example a 4WD vehicle can drive many places where

a road does not exist, but should this mean it becomes uninsured when it leaves the tarmac?

Age and experience are a rudimentary divider. As we well know, some extremely experienced pilots still crash. Often the cause is a variety of factors that combine to elevate the risk, and many not under the control of the pilot. These are accidents and unexpected events, which is why people take out insurance in the first place. Even a vehicle with no WOF may still be totally safe and the lack of a WOF a complete oversight. Any exclusion should be wholly relatable to the accident, pre-defined and easily pre-judged, otherwise the Policy just becomes clever legalise designed to escape liability in situations not expected by the Policyholder.

16 & 17 ***Any other feedback***

I believe guidance should be obtained by reviewing past Court Cases to see what factors, created protracted arguments in Court, for what should have been elementary and straight-forward decisions.

19 ***Any other feedback***

Arbitration should be more readily available to elicit certain facts. For example after the CES (Canterbury Earthquake Sequence), some insurers failed to agree on a single fact, because they wished to leave the entire claim open to litigation and argument. This meant a power imbalance as the insurers relied more upon legal arguments than facts, and posed the constant threat to the insured that they have given nothing and the insured will receive nothing, if the argument is taken to Court. In reality such facts as the materials of construction in a building, the extent of coverings and services incorporated are elementary and should be noted and confirmed.
It should not waste valuable Court time to determine what the existing build is constructed of, and features it contains such as ventilation, glazing, data cabling, lighting, power outlets, natural timbers and permanent materials.

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?*** *(Financial Markets Conduct Act 2013)*

It is vital that the payment to the broker is considered a payment to the insurer. The Policyholder is totally reliant upon this. After the CES I heard of one case where an investor lost insurance on 6 or more properties because the broker had not forwarded payments to the insurer. His entire portfolio was almost destroyed, because the broker had kept the premiums.
If the 50, 80 or 90 days are regarded as a form of commission that escapes other regulations, then it must be totally repealed and profit from broking should rely solely on payments returned from the insurance company. The insurance company has a larger capital base than a broker and is less likely to liquidate than a broker.

The insurance industry is repeatedly quoted as the least trustworthy, and this reputation is gained through obfuscation, omission and declining claims that an average person in the street sees to have merit. The industry relies far too heavily on their own interpretation that is at odds with common people. Insurers are commonly providing protection for assets that the Policyholder has decided, they cannot afford to risk covering themselves. So no matter the value of the asset, it represents a proportion of the insured assets that must be quickly recovered after an event. Any loss in prompt recompense, recovery or reimbursement to the Policyholder represents an added loss, previously not even imagined. Those Canterbury earthquake claimants still waiting for an honest response from the insurance company or disadvantaged by previous poorly scoped and costed repairs, over a decade after the event, are little better off than the Australian detention centre occupants who have been in limbo, fighting to get their life back, against political indifference for almost a decade. This represents a significant proportion of the lifetime of a Policyholder, despite believing they had done the responsible thing by insuring their home.

Any money held by brokers should absolutely be held in Trust accounts, with no other purpose for existence than to accumulate for perhaps a fortnightly reconciliation with the insurance company. There is no reason for a broker to be making money from Policyholder funds, a) because it adds an incentive to hold them as long as possible, b) it increases the risk of the insurance company not receiving the premiums, c) the insurer has stated that they must pay reinsurance, levies and GST from commencement of the Policy (this is likely not completely true and should be verified).
If the insurer is complaining they have fees to pay (incurring a cost) if brokers retain funds, and brokers complain they would lose some income by making more timely payments so requiring more commission, then a rebalance merely maintains a status quo of funds in and funds out, but presents the commission earned in a transparent way rather than an as investment of another party's money, as well as removing the risk of intermediary monies being lost.

21 *Do you have any feedback on the proposed penalties for non-compliance with Part 4 of the Bill ?*
Some of these transactions protect the lifetime assets of Policyholders, so the requirements for funds to be in the correct place should be exactly the same as the legal purchase of a dwelling, with or without a bank mortgage.
The penalty should reimburse the party who has suffered a loss as the result of the action or inaction.
It is unreasonable to consider the penalty should be any different from an equivalent breach by a lawyer, bank or other party regulated by the FMA.

22 *Is it necessary to retain clause 102 ?*
Surely the insurer would insist on this if the insurer is to accept the risk from the date the Policyholder made the payment. It is conceivable that funds transfers can and do go wrong from time to time and some allowance needs to be made for balancing commitment and signature, against the actual transfer of funds arriving in the correct place and being identified correctly.

24 ***Re: changes regarding interest payable from 91st day.***

It is quite conceivable that a death involves a lot of other arrangements besides a life insurance claim. The potential claimant may not even have knowledge of the Policy for quite some time. Dying intestate prior to any arrangements being made, can be very complicated, and even involve the so-called *vultures* attempting to profit from the occasion.

I believe an important duty of an Act is to reduce the need for argument in Court or elsewhere. The date of the death is immutable and eventually known to all parties. It is likely that the only persons even thinking about the interest regulation are those in the insurance industry, not the common person.

Purportedly insurers scan the death notices anyway, and quite probably know of a death before the Policyholders notify them. The 91st day is a reasonable period of time, albeit quickly consumed with probates and other legal requirements.

Insurance companies use actuaries to calculate their exposure to costs, and one of the easiest calculations to make would be the percentage of claims that are made after 90 days. It is therefore extremely easy to incorporate any extra costs for interest due, into the overall calculations.

Also as stated, the insurance company is earning interest on the monies anyway, so a favourable and eloquent alternative would be to pay interest from the date of death in all cases.

25 ***Mortgaging of life insurance policies.***

As long as legacy policies are protected, this would seem to cover the requirements. I am not *au fait* with the PP & SA 2009, but would hope that it allows for a life Policy to still be used for some form of security for say a bank loan or mortgage.

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

- The relevant requirement would seem to be *"Clause 126 provides that a life insurer must on receiving a transfer record it in a register, confirm to the person who presented the instrument that it has been registered, and retain a record of the instrument. "*

The essential thing is that previously identified difficulties in Court, or using lawyers are reduced to an absolute minimum by addressing the issues that have arisen in the past.

27 **Re:** ***section 75A of the LIA***

The changes appear to have considered and modernised the Act in the relevant areas. I believe it is important the ownership of the Policy after the insured's death should not be contestable, if the insured was a signatory.

30 ***Do you see any unintended consequences from removing these provisions from the MIA?***

I am not convinced the insurance industry should be treated to differently to any other. The more exemptions that are added, the less and less the Policyholders can ascertain the value of what they are purchasing. Insurance is supposed to spread the risk of loss, not become a complicated wager on whether there is any real benefit or value in exchange for paying a premium.

The amendment to section 40 of the MIA would appear to be sensible and consistent with other changes in Insurance Contracts Bill.

The comment below may belong elsewhere, but demonstrates examples where insurers maximise the absolute power they have in comparison to the Policyholder to divert from the intent of various regulations.
For health insurance the average Policyholder has no means to assess what their chance of suffering a particular health challenge may be, and the person selling it is not a medic presenting unbiased facts.
For a home insurance, at commencement, you will hear nothing but how it will save your bacon, should the worst happen. Yet the CES has demonstrated severe under-scoping; poor workmanship; insurance companies maximising exclusions from the Building Act, such as Section 112, which were not intended to evade major practical repairs, but to allow practical repairs to small parts of a building without requiring full compliance to all current regulations; insurance companies using "compliant" engineers to sign off substandard repairs or to avoid obtaining Building Consent, or to avoid performing the scope recommended by practical trades-people. It could even be found that insurance companies create shell companies to merely quantify the insurers nominal position, and in addition will hire tradesmen with a high likelihood of liquidation under duress, to perform works that would otherwise be considered to be illegal or not tradesman-like. Certainly industry professionals will have an intuition or experience that this does occur.

31 ***Which option do you prefer and why?***
Option A is preferred for the consumer.

The basis on which claims may be settled is a very grey area in home insurance Policies. They often state that payment will be made within 30 days of settlement, but omit to say that they will provide inaccurate reports, leave out relevant details to obscure the true loss, contract 'complicit or biased' parties to present their reports, and essentially provide the minimum of information in a presentable form, which then requires the Policyholder to spends tens or hundreds of thousands of dollars to prove the insurers report is incorrect. This is unfairly weighted in the insurers favour and is the opposite of the sentiment; "ignorance of the law does not remove the liability to comply".
Insurers should lose all rights to do the original assessment and be only allowed to review assessments done by others. It is normally what the insurer does NOT SAY, that forms the detail that creates the most significant difference in the costs of reinstating the loss.

The duty of utmost good faith must be spelled out more fully as I have seen insurers present a statement saying *[insurer] has been committed (and remains so) to resolving the plaintiffs' claim*, yet their actions demonstrate they have more commitment to obfuscation, legal action and creating expensive barriers for the claimant than to an honest resolution.
I whole-heartedly concur that the exceptions should be subject to the same level of scrutiny as any other contract. The insurer is able to argue a point about

reasonableness, which is a moot over-arching escape clause with no prior description or explanation.
Reasonableness could be argued from any position to suit, but should be at least in a category of costs, tradesman-like processes, equivalent permanence, total lack of material availability (unrelated to economic or global events), safety, expedience and whether the value of the asset will been negatively impacted by arguing for a lesser reinstatement.
Option A, should incorporate provision for the annual changing of the sum-insured value and define exactly what publicly available metric is used to make this change. It should also describe the process to question this or alter it, and that process should be based on facts rather than an insurer simply declining to make an alteration. The insurer should present the metric used to make the decision, such as water levels, rock-fall danger, access difficulties, erosion or whatever is material. The decision should be backed up by Policies on other buildings and from other insurers. The risk should be spread, not pin-pointed.
Option B, creates exactly the obfuscation that insurers rely upon. It allows them to effectively make an argument to avoid any risk when it occurs, due to some ambiguous wording in the Policy. Insurers have legal experts to create a Policy giving them the maximum flexibility, while appearing to be equitable. However there is no provision for the insured to remove or alter terms or wording in the Policy at any point, effectively making the Policy contract unconscionable in some cases. The insurers would wish to retain this, not because it gives them more certainty, but because it allows more escape opportunities from liability. It is notable that insurers use every opportunity to avoid a precedent being set in Court. In addition they use the threat of Court costs to reduce any settlement amount to the Policyholder, by claiming an *out of court* or *out of Policy* settlement saves the insured the extra burden of Court costs. What they do not mention is that the settlement will be considerably less than the rightful payment a Court would award, and the insurer will pay the Court costs unless they are exonerated in Court. Certainly in the majority of arguments for earthquake repairs the insurer has been shown to be unreasonable, and the resultant expense of the argument often exceeds the cost of the reasonable repair by a significant margin.

The cost of household premiums has more than doubled in 10 years, yet the risk remains the same. This would appear to be a weighted recovery of costs incurred from major events occurring in the last decade.

32 *Feedback on drafting Option A or Option B.*
Clarity. Open-ended exceptions are not suitable in a contract situation. The terms must be understandable by the average person in the street. If an argument is going to be proffered on say 'reasonableness', the parameters should be clearly defined. The average person would imagine that descriptions such as *to the same extent and condition as when new,* does not require argument in Court, however insurers have been able to replace permanent materials with less permanent materials, reducing durability, utility and aesthetic features of a home, when this was clearly beyond the expectation 'a person in the street' would garner from the Policy wording.

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

All terms must be beyond argument, totally free of ambiguity and not use wording that implies more than what is guaranteed by the contract.
The sentences should be short and to the point and not require long explanations or the concurrent reading of other clauses to validate them.
The average person in the street should be able to fully comprehend the Policy. I believe this would mean a reading-age level of 11 years.
Because insurance is such a ubiquitous product, consumed by people of all levels of education, all Policy contracts should be subject to registration by a body that examines them for simplicity, honesty and plain-speak. Regulation should prevent the insurer suddenly expanding the number of Policy documents to overwhelm the registration system. They could perhaps be registered as a main body for house insurance and then other conditions separately registered for the different classes of policies or exemptions. There is even an argument that an insurance policy, for say a dwelling, could be a generic legal document adopted by all insurers, and only added to, by the insurers specific conditions.
To illustrate the point, hundreds, if not thousands of hours have been wasted arguing the difference between *as new* and *as when new*. This is a very basic and essential clause in a Policy that should not expose any argument whatsoever.

It would be sensible I believe, to use a series of Policyholder questions to create the information display. For example;

- What is covered? Defined area, extent or full description including materials.
- What exceptions are there?
- Will there ever be an argument over a provision or clause? Does ambiguity exist?
- What items is it prudent for me to quantify now ahead of a potential loss?
- Is it up to me to provide the assessment of the loss? Or an independent contractor?
- What must I keep the insurance company informed about? (address, repairs, specific dangers, etc)
- What expenses will be rapidly reimbursed?
- What expenses must be approved first?
- How much and which costs of the claim will be reimbursed?
- Is there a penalty for the insurer to offer less than say a 15% difference in price from the final settlement?
- What is that penalty?
- From what date does the Limitations Period commence and finish?
- Is the insurance company underwriting or part owner of any company they may use for assessment, repairs or construction?
- Does the insurer guarantee that employees are free of a criminal record or any accusation of fraud in the past? This should be mandatory to be employed in the industry.
- Is a stipend paid during the claims process until settlement to account for the loss of income, extra costs, expert fees, emergency repairs, temporary accommodation and storage and general costs of the claim?
- Are industry mediators used to determine adherence to regulations, and tradesman like repair methods, or does the insurer choose to engage lawyers

to argue points of law, rather than the necessary requirements to remediate the damage to the Policy standard (clearly defined)?

- What percentage of claims is not paid?
- What is the maximum and minimum period from claim to settlement?
- How much is the average claim?

A survey of many homeowners would create a complete list of main points.

The provision stated… *The obligation will also be a market services licensee obligation, once insurers are licensed through the Conduct of Financial Institutions regime. This would mean the FMA could use a range of tools to enforce compliance (see section 414 of the FMC Act). The legislative objectives may be supported by FMA guidance (subject to resource and funding).*
It is imperative that breaches are swiftly acted upon, published widely, and a penalty applied if the insurer fails to remedy the problem, including retrospectively to existing clients. Lack of resource and funding could potentially create a backlog of years of work, which renders the action ineffectual. The responses from the FMA must be legally binding and swift (within say 12 months).

It will be a given that insurers will spend copious amounts of money to argue anything that reduces their ability to remain ambiguous and to reduce liability for unforeseen instances. Precisely the instances that people take out insurance for! The *modus operandi* repeatedly echoed for insurance companies after the Canterbury earthquakes was "*deny, delay and defend*". We could readily add "*confuse and refuse*" to that.

34 Do you have any comments on the regulation-making powers in clause 184?

It is vital that explanatory documents are included with the Policy and not referenced as available elsewhere such as a website. All determinations on the suitability of the Policy should be available in what is put before you, before you sign, or make any agreement.
The regulation-making power will be an essential element to remove ambiguous, vexatious, unbalanced, untrue and other conditions excluded by the Court, including unconscionable contracts. Also it should allow for any and all arguments in Court to be quickly and clearly incorporated into a Policy. Rulings such as the Sleight case that defines when an insurers liability for repair costs ceases, are vital and should be clearly stated in the Policy itself. Also the common law, duty of utmost good faith, further defined by the Courts in 2020.

The suggestion of … *Regulations could require an insurer to disclose information about their business, such as claim acceptance rates, the length of time to settle claims, contract cancellations, complaints made against the insurer, and disputes the insurer is or has been involved in,* is very important for such a large financial commitment for what may be a consumers greatest asset. Paying a premium for 30 years, only to find out that the insurer will argue to the death (or bankruptcy) to avoid their liability, is totally unacceptable and must be outlawed at all costs.

What will undoubtedly help this is to remove the ICNZ from being an industry regulator, and task the government with this regulatory control. A first step to transparency and honesty by the industry is to remove their in-house regulation authority. A levy could apply to all contracts in a similar fashion to the Fire Service Levy, to ensure adequate funding and expedient rulings, further funded by penalties that deter breaches, to the largest extent conceivable.

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

Vital for transparency. An insurance company is possibly the closest most people will come to dealing with an organisation that calls them clients, but does everything possible to deny the liability they have accepted in return for the premium paid. The placement of insurers near or at the bottom of "trusted industry" lists is a visual representation of this.

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

Yes.

Insurers are a law unto themselves and statements they make are the minimum possible to placate negative PR, rather than consolidated improvements or assistance for potential or existing clients.

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

Three years would appear to be adequate, to move regulation away from the ICNZ, customize provisions to suit the Policyholders understanding, reduce the not inconsiderable time and money insurers arguments clog our Court systems with, define the commencement of Limitations Act across the board for all insurers, examine and correct existing Policy documents and give public advance notice ahead of the final law changes.

It will be rather important that the new regulators are not previously employed in any management capacity for an insurance company, as the failings are systemic, come from the top down and personnel readily move from one insurance company to another.

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

The clause relating to *Unfair contract terms* should not allow unfair terms to remain, as insurers will merely make the process, conditions or pricing of cancelling and starting a new Policy to be onerous to the extent that Policyholders will wish to avoid it. All conditions in the new Policy should overtake conditions in the old Policy, apart from the basic extent, value, term, and premium.

It is totally unacceptable for those long-term clients to be excluded from revisions to the industry. Perhaps a Policyholder could review the old and the new Policy and choose which items to delete from either, but to merely carry

over the Policies of old is unfair on the most loyal clients, who potentially have not made a claim (which in the case of a rebuilt house, ends the Policy), or taken out a new Policy.

39 ***Do you have any feedback on Schedule 5 of the Bill?***

The adoption of regulatory powers by existing bodies is required and necessary. I believe it should also become mandatory for all staff, including management to

- pass the same fit person standards as other financial institutions
- be completely free of any fraud accusations or criminal convictions
- declare any criminal record to the employer, who must divulge this to clients
- be subject to ongoing training in the law
- maintain a currency of education with a points system like many industries do
- replace in-house certifications with NZQA accredited courses
- be liable for fines and disciplinary action for vexatious and partisan behavior,

and a record of all these criteria and adherence thereto be publicly available to any person without recourse or favour.