IAG submission

to the

Ministry of Business, Innovation and Employment

on the

Issues Paper: Review of Insurance Contract Law

13 July 2018

Contents

1. Introduction

1.1 This submission is a response by IAG New Zealand Ltd (IAG) to the Ministry of Business, Innovation and Employment (MBIE) on the Issues Paper: Review of Insurance Contract Law (the Paper).

1.2 Our intent in this submission is to provide context and more information on each topic and our view on if and how the topic should be taken forward in the review. We have been selective in our response and support the submission of the Insurance Council of New Zealand in relation to:

- Third party access to liability insurance monies
- Exclusions that have no causal link to loss

1.3 Many of the topics are large and worthy of a significant amount of contextual information. We have limited the content of this submission to that which we think is most relevant. We welcome any request for further information.

1.4 We have limited our comments to general insurance.

1.5 IAG is New Zealand's leading general insurer. We insure more than 1.5 million New Zealanders and protect over $650 billion of commercial and domestic assets across New Zealand. We receive over 650,000 claims a year and pay $1.365b in settling them.

1.6 This submission holds commercially sensitive information. While IAG is happy to appear on any public list of submitters, we ask that the certain contents of our submission remain confidential under Section 9(2)(b)(ii) of the Official Information Act 1982 and would be happy to provide a redacted copy for publication purposes.

1.7 We would welcome the opportunity to continue discussing these topics with the review team.

1.8 IAG's contacts for matters relating to this submission are:

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2. Some important context

2.1 Confident, fair, and efficient transactions between insurers and their customers are a key feature of a healthy insurance market. But we cannot achieve this in a bubble. Many vital factors influence if and how these outcomes occur. It is important that the review reflect this.

2.2 The review currently focuses on the insurance contract and the interaction between consumers and insurers. But consumers and insurers are not the only actors to consider. And the outcomes from their interactions are not the only ones to consider. The review must take a wider perspective in deciding on reforms.

2.3 The review should also take care not redesign the system for the exceptions, but for the normal day-to-day activity. The exceptions are important, and the system must accommodate them, but they should not gain a prominence in the design that is out of step with or out of proportion to their presence in the market.

2.4 In this section we set out some important context. We will reference elements of it throughout our submission.

Start with remembering what insurance is (and isn't)

2.5 Insurance is the way that we, as individuals or businesses, can swap the risk of suffering a large loss for the certainty of paying a small cost. It does this by sharing amongst the many the losses that come to the few. Often called 'pooling'.

2.6 To understand how insurance does this, its easiest to think of it as a pot of money with some rules of access attached. Everyone that wants to receive help from this 'pot', the insured, pays money in and those who suffer a loss get money paid out to them.

2.7 The insurer owns the pot and so makes its rules and looks after the money coming in and going out. These rules control what losses the pot will pay for and are set out in a document called a 'policy'. The insurer also has responsibilities as a custodian. It must make sure that there is always enough money in the pot and that anything paid out is within the rules.

2.8 The insureds also have responsibilities. They must accurately describe the risk to be insured, pay into the pot the amount asked, and then do their best to reduce what the pot needs to pay out. As the pot is there for everyone, these are responsibilities insureds have to the other insureds, not to the insurer.

2.9 If everyone meets their responsibilities, then the insureds continue to get money to pay for their losses and the insurer gets to take money out of the pot to cover its costs and keep a little for itself and its investors. If they don't meet their responsibilities the insured may have to pay more or receive less, and the insurer may not make any money.

2.10 From this we can see that insurance exists on two levels. One is commercial and individualistic. Insurers contracting with insureds to indemnify their financial loss. The other is social and collective. Still a contract of sorts, but one in which the ideas of solidarity and responsibility prevail. Insurers and insureds doing the right thing for the benefit of all.

2.11 Consumers increasingly see insurance through the narrow commercial view. Some see it as a necessary burden to be meet with least effort and cost. Others like buying a utility, an unthinking task. But many still see it through an emotional view, as a safety net and a promise to be there for them. Most consumers do not view it as a social contract with each other. This change is due to many factors. Changes in societal norms, social and economic outcomes, customer expectations, and insurance practices all contribute.

2.12 It is essential that the review doesn't just see insurance in a narrow commercial or transactional way. It must not lose sight of the social contract between insureds or, for example, fail to see that conduct is both how insurers treat the insured (and vice versa) and how the insureds treat each other. If it does, then we will lose something important. Where the insured once policed themselves, the insurer as custodian and keeper of the rules will take on a greater role.

The role that insurance plays

2.13 Insurance certainly helps those who have suffered a loss by replacing the risk of ongoing hardship with the prospect of a swift and more certain recovery. Doing this brings wider benefits for the individual and, importantly, for the economy and society. How?

2.14 Insurance promotes investment and trade by unlocking capital and enabling confident investment in assets and commercial exchange. It mobilises precautionary saving into more productive pursuits, helps the flow of credit and protects trade, and brings depth and stability to capital markets.

2.15 Insurance helps smooth financial shocks by accelerating post-loss recovery, getting people and businesses back on their feet sooner. This reduces the call on the public purse via grants and demands on social programmes.

2.16 Insurance improves risk management by improving risk awareness and decision making by signalling, through underwriting and pricing, where risk lives and the nature of that risk. It also can encourage and incentivise societal preferences for behaviours and activities that reduce undesirable outcomes.

2.17 Insurance fosters a sense of certainty by meeting peoples' basic need for security, contributes to their overall feeling of wellbeing, offers independence, and enhances self-reliance.

2.18 And insurance creates economic activity by employing people and fostering the wide range of professions and trades needed to run their businesses and to settle customers' claims. As a profit-seeking and highly competitive industry, insurers also look to grow and become more efficient, which has positive knock on effects in other parts of the economy.

2.19 Why is this important to the review? Because insurance is not just about individual transactions. Insurance underpins our way of life and the wealth and wellbeing of the country.

The prerequisites for a healthy insurance market

2.20 Now, insurance only works, and customers and the country only get the benefit of insurance if people buy it. The more people who take part the better it works – especially if they live in various places and face different risks. This diversity helps to ensure not everyone will be seeking money from the 'pot' at the same time.

2.21 But for people to buy insurance, it must have four essential characteristics. And we're not talking about product features, or slick brands. To ensure as many people and business benefit from insurance as is possible it must be:

- Available. We don't get all these individual and collective benefits if it isn't available.
- Affordable. We don't get these benefits if people can't afford to buy it
- Relevant. People need to know that insurance will respond to the losses they expect to suffer (and those they don't)
- Reliable. People need know that the policy does what it 'says on the tin' (or in the contract); that it pays when they suffer a loss that is within the 'rules'

2.22 But these things don't just occur. The needs of investors, reinsurers, customers, and regulators must be carefully balanced.

2.23 Start with investors. Insurance is a business and so needs capital to exist. Indeed, the Reserve Bank has detailed rules for how much capital insurers must hold. But there is one simple point. More capital equals more insurance (and vice versa). Getting this capital requires investors to be confident that their money is safe and getting them the right return.

2.24 But investors aren't the only people investing in insurers. Reinsurers provide insurance to insurers, to protect them against the possibility of having to cover a large loss, typically from natural disasters or the loss of high value assets. Like investors, reinsurers want to be confident that they can make the right return on the reinsurance they provide.

2.25 New Zealand is profoundly reliant on the confidence of reinsurers to be able to offer the (unique) ground-up cover for earthquakes. Our high exposure to natural hazards adds volatility and therefore requires New Zealand to engage in good risk management to ensure that we continue to secure the cover provided by reinsurers. A loss of reinsurer confidence would have massive consequences for New Zealand's resilience to earthquakes. Over time this will also increasingly become the case for large scale storms and floods.

2.26 To maintain the uptake of insurance Consumers and business owners must be confident that they can obtain cover at an acceptable price and that insurers will fulfil the contractual entitlement within the insurance contract. If consumers and business owners are unwilling or unable to take part in the insurance market, this exposes them to the risk of significant loss and the Government to increased welfare and reconstruction costs.

2.27 Regulators must calibrate their policies and interventions to minimise distortions and facilitate confidence in the market. They need to guard against altering the market so that it becomes less attractive to one or more participants: insurers, reinsurers, investors, or policyholders.

2.28 Lastly insurers need to be disciplined in executing their core insurance and actuarial processes to maintain the viability of the insurance scheme. They must be able to balance the demands of investors, reinsurers, regulators, and customers. This is essential to ensuring the ongoing functioning of the insurance market.

2.29 It requires investment in high levels of customer service, technology, and large complex claims management supply chains. Bringing all this together requires insurers to attract, develop, and retain skilled professionals to operate their businesses. Inevitably this also requires a degree of scale, diversity, and sophistication that is hard to maintain in New Zealand given that it is by world standards a very small market.

New Zealand's unique challenge

2.30 New Zealand is a high-risk county. New Zealand sits just below the 'roaring forties' and atop the collision zone of two major tectonic plates. These shape our dramatic and beautiful landscapes. They also create the natural hazards that imperil our homes, businesses, and livelihoods.

2.31 Each year we feel the jolt of over 150 earthquakes; are battered by storms and tornadoes; inundated by floods and tides; see our coastlines erode and our hills slip; and face the threat of eruptions and tsunamis.

2.32 Earthquakes are the most devastating shocks we face from nature. Their impacts can have profound consequences for communities. Canterbury and Kaikoura attest to that. But a major earthquake or volcanic eruption could affect the entire country's prosperity and wellbeing

2.33 But it is the smaller shocks, the floods, storms, droughts, landslips, and fires, that are most common. And while smaller than earthquakes and eruptions, they often have just as great an impact for those affected. And then there are the slow disasters of coastal erosion and inundation from the sea.

2.34 None of these shocks are static. The ceaseless tectonic forces below our country add pressure to our fault lines that must eventually release. The warming climate will cause extreme weather to occur more often and with greater force. And our oceans are rising.

2.35 According to Lloyds[1], New Zealand has the 3rd highest level of natural risk in the world surpassed only by Chile and Bangladesh. As such it needs a high-capacity, high-functioning insurance industry.

2.36 That occurs now, in part, because we can attract a large amount of reinsurance, indeed the nature of our risks, particularly the Wellington earthquake risk, are a significant determining factor in IAG's reinsurance programme and we are the 3rd largest purchaser of reinsurance world-wide.

2.37 And it is our earthquake risk that makes us so different from the countries we most often compare ourselves to. For instance, the materiality of the age and construction type of a house in Essex, where the greatest natural risk might be a storm is completely different to its significance in Wellington.

2.38 The nature of New Zealand's natural disaster risks cannot be disregarded in a consideration of any reforms.

Sustainability of the insurance market

2.39 It is vital that the regime can evolve in response to changing circumstances, trends, threats, dependencies, opportunities, and innovations emerging in the industry and related markets, regimes, and jurisdictions.

2.40 To this end we see several critical issues and trends that should be actively considered, as these will increasingly affect the general insurance industry over the coming years and decades. These include:

- The physical, economic, and social impacts of climate change
- Underinsurance and the future insurability of high-risk locations
- The ability of the industry to meet the needs of customers in the face of new and emerging risks, like cyber-attacks and security breaches
- The impacts of technical disruption on insured risks and service delivery.

2.41 We acknowledge that some of these factors are outside the scope of the review. While that may mean the review cannot consider how changes to insurance contracts might address these issues, it should not prevent consideration of how contracts might need to evolve in the face of them.

[1] *Lloyds Global Underinsurance Report*, Centre for Economics and Business Research Ltd, 2012

3. Summary of positions and recommendations

Objectives

3.1 We believe that the two existing objectives of the review are too narrow and recommend that they are replaced with the following. That the review looks to:

- Maintain the attractiveness and capacity of the insurance market
- Support elevated levels of participation and confidence
- Support innovation and competition
- Support effective risk management

Disclosure and remedies for non-disclosure

3.2 We agree that the current test for determining what information is 'material', being the 'prudent underwriter' test, could be reformed. We recommend that it takes into account the circumstances of the customer and their sophistication in dealing with general insurance. We don't see value in creating different tests for different types of customers or policies.

3.3 We agree that a proportional response is best when responding to non-disclosure where the risk remains insurable within the insurer's underwriting practices.

3.4 We also consider that the duty and the remedies should be reviewed together. It seems to us that a more workable framework would be:

- The duty is to disclose all information which, a customer acting reasonably, ought to know is relevant to understanding the 'risk' to be covered and the insurers decision to insure the customer.
- The remedy for deliberate non-disclose of relevant information or the provision of information the customer knew to be false, should include avoidance.
- The remedy for careless non-disclosure should be either cancellation or retrospective adjustments of policy terms (e.g scope of cover, levels of excesses and premiums).
- The remedy for material non-disclosure without a breach of the duty, should be retrospective adjustments to policy terms.
- There should be an overriding duty to act reasonably in the exercise of these remedies

Conduct and supervision

3.5 In response to the Canterbury earthquakes the financial, reputational and moral interest of IAG was and still is the fast and full settlement of claims. We did not set out to:

- delay the settlement of our customers' claims
- deprioritise complex claims
- pressure customers to settle their claims

3.6 We recommend that the review allow for a separate round of consultation on any conduct issues raised through submissions to the issues paper. This will ensure that these issues are properly aired and evidenced before options for reform are developed and consulted on.

Unfair contract terms exceptions

3.7 The review must recognise the unique nature of insurance contracts and the role they have in managing New Zealand unique risk landscape. The review must take care to distinguish between contract terms that are in and of themselves unfair, and rare or unique circumstances that create an outcome that can be perceived as unfair.

3.8 We believe that the current unfair contract provisions are necessary and recommend that they be kept and included in a new Insurance Contracts Act.

Comparing and changing policies and providers

3.9 We agree that some consumers find it difficult to compare products. We want to see customers make informed and considered choice but recognise that achieving this is a complex task due to the many attitudinal, behavioural, and structural influences at play.

3.10 We are open to consider ways to help customers compare product and providers, and so make good decisions. We would not recommend the use of comparison sites as a means to achieve this.

Responsibility for intermediaries' actions

3.11 We believe that insurance brokers should be fully accountable for their actions and recommend that the review consider making insurance brokers the agent of the insured. This should include review of the Insurance Intermediaries Act 1994 (IIA) and the need to review or revoke relevant sections, including sections 4, 5, 8, 9 and 11.

Deferral of payments / investment of money

3.12 We recommend insurance intermediaries hold money in trust for the intended recipient of the monies.

- In the case of premiums collected but not yet paid to the insurer, the money would be held in trust for the insurer. The investment income on this money would go to the insurer as the insurer is on risk from the commencement of the insurance cover and the client is receiving the benefit of that insurance cover.

- In the case of a refund on premium, the money would be held in trust for the customer and it would follow that the investment income on this money should go to the customer.

3.13 We further recommend that s.8(2) of the IIA be amended to require the broker to pay the premium to the Insurer on the earlier date of:

- 7 days after receiving the premium from the client, and

- 20 days from the end of the month that the insurance contract cover commences

3.14 Obligations for record keeping, restrictions on the use of client money, and a penalty regime should also apply. We would see this achieved by drawing on sections 431ZZb-431ZZG of the Financial Services Legislation Amendment Bill (FSLAB).

Other matters

3.15 We recommend that the review consider the role of 'claims advocates' and 'public adjusters' as intermediaries, and whether basic consumer protections are needed to protect consumer interests and we invite MBIE to consult with consumer groups and industry stakeholders further on this topic.

4. Objectives

4.1 The Paper proposes that the review have two objectives. The first that "Insurers and insureds can transact with confidence at all points in the lifecycle of an insurance policy". The second that "Interactions between insurers and insureds are fair, efficient and transparent at all points in the lifecycle of an insurance policy".

4.2 We believe that these objectives are too narrow. We acknowledge the focus on conduct in this review. But we must achieve good conduct alongside the broader needs of insurance in New Zealand.

Key outcomes

4.3 IAG believes that New Zealand's insurance market must have five vital characteristics to effectively meet the current and future needs of customers, being:

- We have enough scale, capability, and connectivity, so that consumers can access the insurance they need
- We have the support of reinsurers, so customers can access insurance for our large commercial and natural hazard risks
- Our insurers are innovative and competitive, so that consumers can access products and services that evolve to meet their changing needs
- The market is efficient and effective in transferring risk, so that customers are confident that insurance is good value for money and continue to buy it
- The market and its insurers are stable, so that consumers can be confident that their insurer is able to meet their claims

4.4 We recognise that not all of these would be within the scope of an Insurance Contracts Act. Insurer stability for example is the remit of the Insurance (Supervision) Act 2010 and the Reserve Bank of New Zealand. Competition is the remit of the Companies Act 1993 and the Commerce Commission. Despite that, the operation of insurance contracts effects each of these characteristics which requires consideration by this review.

Recommendation

4.5 We recommend that the two existing objectives are replaced with the following. That the review looks to:

- Maintain the attractiveness and capacity of the insurance market

- Support elevated levels of participation and confidence
- Support innovation and competition
- Support effective risk management

Attractiveness and capacity

4.6 A vital prerequisite for a healthy insurance market is that it can take on all but the most extreme risks of individuals, households, and businesses. This requires:

- Individuals and institutions that are prepared to invest in New Zealand's insurers over other investment opportunities in New Zealand and other countries. Without this investment we would not have an insurance market.
- Reinsurers that are prepared to underwrite New Zealand's insurers. Without this support we would not have insurance for high value assets or large events like earthquakes.
- Insurers that are confident they can generate a return that covers their costs, meets their commitments to investors and reinsurers, and allows them to reinvest in their businesses. If insurers can't do this, they will exit the market.

4.7 Including in the review an objective to 'maintain the attractiveness and capacity of the insurance market' would mean that it will:

- Acknowledge the importance of making commercial returns
- Safeguard contractual certainty
- Support market growth and efficiency

Participation and confidence

4.8 New Zealand has an enviably high proportion of people and businesses that buy insurance compared to other countries – especially when it comes to insuring homes. Less so businesses. Maintaining this high participation requires:

- Consumers that see insurance as being relevant to their needs. Without this, customers will look to other ways to protect themselves or choose not to.
- Consumers who are confident that insurers will act fairly and transparently in meeting the terms of the insurance contracts. If people do not trust their insurer, the social contract that underpins insurance will fall away (see above).
- Insurance that is affordable and good value for money. If people cannot afford the cost of insurance, they will either forgo it or not buy enough.

4.9 Including in the review an objective to 'support elevated levels of participation and confidence' would mean that it will:

- Promote consumers interests
- Enhance insurer conduct
- Support market growth and efficiency

Innovation and competition

4.10 The insurance industry is in a phase of significant innovation and disruption, with incumbents and new 'insure-tech' market entrants bringing customer centred solutions to market. This requires:

- Insurers that are looking to the future and can invest in modernising and developing existing and or bringing new products and services to New Zealand
- A market that is open to new entrants and disruptors, and that encourages incumbents to invest in the future
- Insurers that are profitable and able to invest in new products and services

4.11 Including in the review an objective to 'support innovation and competition' would mean that it will:

- Accommodate and enable advances in risks and markets and technologies
- Reduce barriers to competition
- Support improved customer experience and accessibility
- Acknowledge the importance of making commercial returns

Effective risk management

4.12 Insurance has a key role in helping New Zealand manage risk and remove the financial strain on individuals, households, businesses, and government following a loss. This is especially important given New Zealand's high exposure to natural hazards and the growing impacts of climate change on many of them. This requires:

- Insurers to accurately select and price risks so that they have the resources to meet the terms of the policy
- The legal framework does not force insurers to lock in cover for undisclosed and unacceptable risks and moral hazards
- Insurers to manage the rules of the policy, fulfilling their custodian role

- Customers to meet their obligations to other customers and to the insurer
- Insurers to signal to consumers and businesses their preference for risk through pricing and underwriting decisions, so that they can make more informed risk decisions.

4.13 Including in the review an objective to 'support effective risk management' would mean that it will:

- Promote the importance of core insurance disciplines, including: underwriting and pricing; actuarial; capital and reinsurance
- Promote investor and reinsurer confidence in the market
- Promote consumer interests

4.14 A number of these objects and their benefits overlap and compete. We think that is ok. It is important that both the goals and the trade-offs are clear and considered when developing changes to policy.

5. Disclosure and remedies for non-disclosure

5.1 The Paper asks whether consumers are aware of the duty of disclosure and understand what information they must disclose, and whether the consequences for failing to disclose this information are proportionate.

5.2 In this section we present information on the occurrence of and our response to misstatement and non-disclosure by customers and recommend how the review should take this topic forward.

Customer understanding

5.3 We inform our customers of their duty to disclose material information at the time they take out their policy. We also include details of their duty in our consumer policy documents.

5.4 We have not directly tested with our customers their understanding of their duty to disclose material information or their understanding of what material information they need to provide. The best evidence we have is data on the number of times we uncover material information when managing a claim that we did not know when the customer took out the policy.

5.5 Information uncovered typically relates to moral or physical risk factors that we cannot be expected to know, information that is used in deciding whether to offer insurance and on what terms, and so make it fair for the wider customer base. For example, information about:

- The customer (e.g. their criminal convictions, their illicit or risky behaviours)
- Their insurance history (e.g. earlier claims, claims declines, or policy cancellations)
- The property insured (e.g. maintenance, age, modifications, how it's used)
- The risks its exposed to (e.g. locations, physical hazards)

5.6 When we become aware of this information, the person managing the claim refers the customer's policy or polices to a specialist team to consider what action if any to take. Further information on how we undertake this process can be made available to the review on request.

5.7 Table 1 shows that in the 12 months to 31 May 2018 we referred 1,639 concerns about customers' non-disclosure to our specialist team to conduct a 'prudent underwriter test' to decide our response. This equates to about 1:200 customers who lodge a claim have not told us something that is sufficiently important to warrant a review of their policy.

5.8 We think that this supports the view that while some consumers do not always understand what information we need, the vast majority do. This is not surprising given the clear requests for information we give when customers take out their policies and the warnings given about the potential consequences of non-disclosure.

5.9 But as we shall see in the next section, much of the missing information is not material and does not impact the customers' insurance. However, a sizeable proportion is material and should have been disclosed when taking out the policy.

Table 1. Referral of policies for prudent underwriter test
(12 months to 31 May 2018)

Product	# of policies	# of Claims	# referred	% of policies	% of claims
Home	834,883	60,873	245	0.03%	0.40%
Contents	805,473	88,219	214	0.03%	0.24%
Motor	1,555,498	194,342	1,180	0.08%	0.61%
Total	**3,195,854**	**343,434**	**1,639**	**0.05%**	**0.48%**

Note that due to time constraints in preparing this submission we have had to limit the data in the tables in this section to IAG's direct consumer brands (AMI, State, Lantern, and NAC) and our bank partnerships (ASB, BNZ, Westpac, and Co-operative Bank). We believe this represent most of our actions in relation to non-disclosure.

5.10 It is worth noting that during the same period there were another 6,461 claims that led to the discovery of new information about the risk or the customer that lead to a 'post-claim review' of their policy. These were not cases of non-disclosure and did not affect the customers' claims. In some instances, these reviews did result in policy cancellation.

5.11 We note that international practice varies. The UK has abolished the duty, Australia uses a reasonable person test, while the Canadian States, Singapore and Hong Kong all retain the duty.

5.12 New Zealand insurers generally use 'all-risks' general insurance policies, meaning that all risks are covered except those specifically excluded. Other jurisdictions use 'specified risk' policies, meaning the consumer is covered only for the risks listed in the policy document. This, and the nature of New Zealand's risks (mentioned above), makes having all material information vital to the insurer's ability to assess the risks it is taking on and price them correctly.

A proportionate response

5.13 The law currently gives us four choices when we discover material non-disclosure. We can:

- use the legal remedy and avoid the contract from inception and recover claims already paid out
- decline the claim and use our contractual remedy to cancel the policy through written notice to the customer
- keep the policy in place and adjust the underwriting by changing the premium or increasing the excess, with consequential affects for the claim
- keep the policy in place and otherwise do nothing at all.

5.14 When we discover that a customer has unwittingly or mistakenly withheld information from us we respond in a reasonable way. We are committed to do this because we think it is the right thing to do and because we have signed up to do so through the Fair Insurance Code. Deliberately withheld and deliberately inaccurate information triggers a different response.

5.15 Table 2 shows that 32% of time we simply adjust our records to include the extra information or we do nothing. We mostly adjust the customer's policy having gone through the process of underwriting the policy again by taking the extra information into account (59%). We rarely cancel or avoid a policy (9%).

Table 2. Actions taken following prudent underwriter test
(12 months to 31 May 2018)

Action	#	% of completed
We added terms to the customer's policy	636	39%
We took no action	457	28%
We increased the customer's excess	327	20%
We cancelled the customer's policy or policies	151	9%
We updated the customer or policy details	68	4%
Total	**1,639**	

5.16 Table 3 shows the policies which we cancelled or declared void as a proportion of the policies that were open during the same period. In total we cancelled or declared void 342 policies in the 12 months to 31 May 2018, equating to close to 1:20,000 policies.

Table 3. Cancelation of policies following prudent underwriter test
(12 months to 31 May 2018)

Product	# of policies	# referred	# cancelled	% of policies
Home	834,883	245	16	0.002%
Contents	805,473	214	23	0.003%
Motor	1,555,498	1,180	115	0.07%

Total	**3,195,854**	**1,639**	**154**	**0.005%**

* Note: the total cancelled differs from that in table 2 as one referral can result in the cancellation of multiple policies

5.17 We only cancel or avoid policies for good reasons. Reasons that we think are reasonable, backed by our underwriting criteria, and that support our obligation to enforce the rules we have set for our policies and to protect the interests our all our customers.

5.18 Table 4 shows the reasons we cancel or avoid policies. In all cases that relate to disclosure, it is reasonable to expect that the customer would have known to give us the missing information.

Table 4. Reasons for the cancellation / avoidance of policies following prudent underwriter test (12 months to 31 May 2018)

Reason	#	%
The customer did not tell us about their criminal convictions	32	21%
The customer did not tell us about how they used their vehicle	27	18%
The customer committed fraud	20	13%
The customer did not have an insurable interest	16	10%
The customer did not tell us about their claims history	13	8%
The customer did not tell us about modifications to their vehicle	10	6%
The customer did not tell us their home was vacant	9	6%
The customer did not tell us about an earlier cancellation of a policy	7	5%
The customer did not accurately describe the risk	6	4%
Other	14	9%
Total *	154	

* Note: the total differs from that in table 1 as one referral can result in the cancellation of multiple policies

5.19 Of these the overwhelming majority are cancellations. Avoidance is used only in situations of blatantly fraudulent or dishonest non-disclosure or the provision of knowingly false information.

5.20 We think that these numbers show that the material information customers fail to give us is, from the perspective of a reasonable person, obviously needed to properly underwrite their policy. This is the case even if the reasonable person test is contextualised to the specific circumstances of the individual customer, what we told them about this duty when they took out the policy, and the clear warnings given to them about the consequences of non-disclosure.

Recommendation

5.21 We agree that the current test for determining what information is 'material', being the 'prudent underwriter' test, could be reformed. We recommend that it takes into account the circumstances of the customer and their sophistication in dealing with general insurance. We don't see value in creating different tests for different types of customers or policies.

5.22 As evidenced by our current practice, we agree that proportional response is best when responding to non-disclosure where the risk remains insurable within the particular insurer's underwriting practices.

5.23 We also consider that the duty and the remedies should be reviewed together. It seems to us that a more workable frame work would be:

- The duty is to disclose all information which, a customer acting reasonably, ought to know is relevant to understanding the 'risk' to be covered and the insurer's decision to insure the customer.
- The remedy for deliberate non-disclose of relevant information or the provision of information the customer knew to be false, should include avoidance.
- The remedy for careless non-disclosure should be either cancellation or retrospective adjustments of policy terms (e.g. scope of cover, levels of excesses and premiums).
- The remedy for material non -disclosure without a breach of the duty, should be retrospective adjustments to policy terms.
- There should be an overriding duty to act reasonably in the exercise of these remedies

6. Conduct and supervision

6.1 The Paper raises concerns about the conduct of insurers, particularly in relation to sales and claims management.

6.2 In this section we present our perspectives on some of the issues raised. We focus on the management of Canterbury earthquake claims and sales practices. We conclude with our recommendation for how the review should take this topic forward.

Canterbury and Kaikoura

6.3 The Paper raises several concerns about the management of Christchurch earthquake claims, being delays in settling claims, deprioritising complex claims, and pressure to settle claims. We address each of these in turn.

Delays in finalising claims

6.4 IAG did not set out to delay the settlement of our customers' claims. Our focus was always to assess and settle claims as quickly as possible. But we acknowledge that not all our customers' claims were settled as quickly as we or they would have liked.

6.5 The Canterbury earthquake sequence presented many unique challenges that extended the time taken to settle our customers' claims. It is worth understanding these when judging the response of insurers and considering what, if anything, should be done by way of reform. The challenges were:

- Number of events. Canterbury had a sequence of four major earthquakes, including:
  - M7.1 on 4 September 2010 with 20,389 aftershocks
  - M6.3 on 22 February 2011 with 15,961 aftershocks
  - M6.3 on 13 June 2011 with 12,019 aftershocks
  - M6.2 on 23 December 2011 and 10,129 aftershocks

  This had several implications. It required us to assess damage after each event. It led to a significant (and still ongoing) exercise in apportioning costs to events to manage reinsurance exposures. And most importantly, it limited the areas in which we could safely start assessment and repair work.

- Scale. The scale of the events in Canterbury were unprecedented. For IAG they resulted in just under 100,000 home and contents claims, of which 2,500 were for the total rebuild of homes (more than the 2,420 consents issued for Canterbury for the year to September 2011[2]). To compare, nationally at the same time we would typically have 70,000 claims per year of which around 50 would be rebuilds.

  This needed a significant increase to our claims management staff, which at its peak had over 300 people dedicated to Canterbury claims.

  It also led to the creation of our Project Management Office and rebuild programme. Given the scale of the disaster we recognised we could not operate a business-as-usual approach to repairing or rebuilding peoples' homes, as it would create too great a strain on the supply of builders and specialist construction experts, such as engineers and geotechnical engineers, and worst of all the emotional strain on individuals would have caused desperation and chaos.

  We therefore chose to engage the Hawkins Group to run a project management office, to co-ordinate with builders so that a workable set of systems and processes was created to facilitate the assessment of damage, offer builders to customers (which they were free to use or not), and allow for direct payments from IAG to the customers' builders. As part of this process, customers were relieved of their obligation to prove the extent of their loss to IAG and the obligation to pay and be reimbursed. Hawkins scoped the loss and then the detailed repair/rebuild design was undertaken by the customers' chosen builders, using sub contracted specialists.

- CERA zoning. The Canterbury Earthquake Recovery Authority established a system of four colour-coded zones to manage the assessment of land to decide if it was suitable to rebuilding. Owners of homes in the red zone had 12 months to decide whether to accept a Government offer to buy them out or seek settlement from their insurer and the EQC. We had to assess 2,500 red zoned properties as part of this process. Land zoned green was suitable to build or repair the home.

- Technical land categories. CERA further divided land zoned green into three technical land categories based on the level of geotechnical investigation needed and the right foundations for the house. MBIE issued guidance on how to assess and repair properties in TC2 and TC3 categories.

  The categorisation of land and development of guidance all took time for CERA and MBIE to complete. This meant we could not confidently assess or repair TC2 and TC3 homes and instead could only progress TC1 homes.

[2] Building consents by region (Annual-Sep) Table BLD116AA, Statistics New Zealand, 31 October 2017

- Geotechnical assessment. The TC2 and TC3 properties then needed geotechnical site-specific testing to determine the proper foundation solution. Insurers first tried to work with the EQC on a joint geotechnical investigation programme. This was not successful and led to IAG starting its own programme to assess around 2,000 properties. This took time to complete.

- Land damage. The EQC developed nine categories of land damage that they would compensate. Two of these were Increased Flooding Vulnerability (IFV) and Increased Liquefaction Vulnerability (ILV). Payments made to homeowners for damaged land contributed to the overall funds available to repair or rebuild the home. Insurers and EQC could not agree the methods to calculate IFV and ILV, which lead insurers to go ahead with repairs and seek recovery from the EQC. This issue is still live.

- Multi-unit buildings. Many of the residential buildings damaged were single buildings that have multiple homes. It was often the case that each suffered different levels of damage and were insured with different insurers. This created complex situations where multiple owners and insurers had to come to an agreed solution for the building. Some of these are still ongoing.

- Legal decisions. The response to Canterbury threw up many important and novel legal issues for the courts to settle so as to establish precedents that could be applied universally. The time needed to work through these cases added time to the settlement of affected claims. The key cases included:

  - *Re Earthquake Commission* [2011] on what constituted an 'event' and whether EQC was liable to pay up to the cap for each event.

  - *Turvey Trustee v Southern Response* [2012] on the meaning of 'as new' versus 'when new' in policies, and the extent of insurer's replacement obligations for functional elements and aesthetic features, particularly native timbers.

  - *Morely v EQC* [2013] on what constituted a dwelling under the EQC Act.

  - *O'loughlin v Tower Insurance* [2013] on whether the 'red zone' created a 'loss' under the policy, the use of novel repair methods, and the extent to which replacement must be identical to damaged parts.

  - *Rout v Southern Response* [2013] on what constituted an economic repair versus a total loss.

  - *East v Medical Assurance Society* [2014] on the meaning of 'as new' in the context of foundation work.

- Claim ownership. EQC was responsible for managing those repairs less than $100,000 ('under-cap') and insurers those 'over-cap'. In many instances the early assessments of claims by the EQC categorised them as under-cap, when in fact they turned out to be over-cap on final assessment.

Private insurers did not assess these claims and in many instances were not aware of their existence. As we saw more claims become 'over-cap' we worked on joint reviews with EQC to agree claim ownership. We also agreed with the EQC that where a TC3 property hit $80k on their assessment that we should take over the claim as we expected the claim would come over cap given the MBIE foundation requirements.

The impact of this is that many homeowners' claims took longer than needed to get to their insurer. Insurers are still receiving new 'over cap' claims in 2018. It meant the homeowners had to re-start their claims experience with their insurer and it caused considerable rescheduling of repair programmes.

- Apportionment. The sequence of major earthquakes resulted in multiple property assessments and the need for the EQC to apportion costs to each event to decide if the claim was under or over cap. This all took time. Insurers looked to create an agreed approach with the EQC to apportion these costs for all homes to speed up the process. The EQC did not agree to this approach, and so we had to review and agree apportionment individually each home.

- Claim complexity. Many claims were very complex to work through due to technical structural issues such as shared property, section 114 notices, retaining walls, ILV, IFV. These claims often needed significant input from external parties which placed the timeline outside of IAG's control.

- Customers readiness. Our programme of repairs and rebuilds worked on a prioritised basis, which is describe below. Customers who opted to use the programme were given a slot in the schedule to start the rebuild / repair process. Before building work could start, the customer and IAG had to agree what work was going to be done, this required decisions on the customer's part, based on recommendations by building and engineering experts. We found that many customers were not ready when their slot came up as for a variety of reasons they had not or could not make the decisions needed. This resulted in the customer losing their slot in favour of a customer who was ready, so that the programme and the broader recovery could progress.

- Customer expectations. While a sensitive subject to raise, some homeowners had unreasonable expectations of either the amount their policies entitled them to and or the proposed repair solution for their home. Many customers with homes that the experts had decided were repairable wanted a new home instead. These expectations often lengthened negotiations and led to delays.

- Advocates. Following the February 2011 earthquake there was a significant increase in the number of advocates working on behalf of claimants. We consider these advocates raised unreasonable expectations by steering customers into seeking cash settlements for sums far greater than actual repair costs, rather than actually getting their homes repaired or receiving reimbursement for actual repairs. There were also issues with opposing repair strategies and interpretation of how the insurance policy worked. This added activity and time to the settlement of these claims.

Another significant feature with some advocates, was a marketing strategy which asserted that insurers would act in bad faith and 'deny, delay and defend' all claims. This was not helpful in a community already traumatised by the earthquakes. We have also seen that some advocates took on large workloads that they could not manage. Their delays added to the time to reach settlement.

These issues are still relevant today and have led to many long and protracted disputes.

6.6 Given this set of challenges, the aftershocks and reassessments, the time required to scope and cost work and create engineering and geotechnical design solutions, construction work did not and could not realistically start until 2013 at the earliest.

6.7 It's worth noting that even outside of major disasters, a small proportion of house claims suffer delays due to differences of opinions, problems with suppliers, and administrative issues. It is reasonable to expect a large and complex event to generate a larger number of such claims.

The fallacy that insurers benefit from delays

6.8 There is a wide spread belief that insurers gained from delays in settling customers claims. The insinuation was that insurers sit on vast sums of money which they hold onto for as long as possible for the income earned from it. This is not true.

- For any 'catastrophe event', beyond a modest retention quickly exhausted, claims payments are made using funds from reinsurers. The New Zealand insurers were simply the conduit for the flow of reinsurer funds into New Zealand to pay claims.
- The longer a disaster event takes to resolve, the greater the handling costs involved in added staff, premises and other additional fixed costs and expenses.
- The additional reserving (our estimation of the total costs for settling claims) led to increased capital charges required by the Reserve Bank and its views of heightened financial volatility from outstanding claims.
- The longer that claims resolution takes, the more an insurer harms its reputation and the greater the stress levels of our frontline staff.
- Claims that progress to litigation are certainly not in insurers' interests. Insurers simply have to spend additional time and resource on lawyers to represent them and to uphold the policy rules.

6.9 The financial, reputational and moral interest of insurers was and still is the fast and full settlement of claims

Prioritising Claims

6.10 IAG did not deprioritise complex claims. By the nature, complex claims take longer to resolve, are more prone to dispute, and were often subject to many of the issues noted above.

6.11 We prioritise claims following large disasters such as Canterbury and Kaikoura. Our approach to this has evolved through the Canterbury earthquake sequence. At the start we gave priority to the worst affected, such as customers with homes that were uninhabitable, that were red or yellow stickered, or where there are other physical risks present.

6.12 Following the February earthquake, we took greater account of vulnerability. We created a vulnerability matrix and points calculator which took account of factors like: physical status of the home; illness; disability; age; pregnancy; presence of young children; finances. The more points, the greater the priority. This matrix closely matches the guidelines issued by the Human Rights Commission for the prioritisation of vulnerable customers[3].

6.13 Through our regular contact with customers we would update their vulnerability and priority for changes in their circumstances. This vulnerability rating was a key factor in scheduling our programme of repairs and rebuilds.

Settlement

6.14 We did not pressure customers to settle their claims.

6.15 Following the Darfield earthquake in September 2011, IAG decided that it would continue its practice of supporting customers through the repair or rebuild of their homes. As noted above, this led to the creation of our repair and rebuild programme.

6.16 Customers always had the choice of taking a cash settlement for the value of their loss or organising their own repair or rebuild, which we would cover. A feature of most house insurance policies at the time was that if the customer chose not to repair/rebuild, they would be entitled to receive a cash settlement for the indemnity value of their loss. If they chose to repair or rebuild, we would cover the actual costs to do so as the costs were incurred. Given this, most customers chose to be part of our repair and rebuild programme, which involved IAG paying builders directly on behalf of the customer. While this would take longer to finalise the claim, under a full replacement policy it would deliver them a new home.

[3] Best Practice Guidelines for the prioritisation of vulnerable customers, Human Rights Commission, 2016

6.17 In 2013 we agreed with our reinsurers that we could exceed the terms of the policy and offer to cash settle customers on the basis of the estimated cost to repair/replace their home. We felt that offering this to our customers would provide them greater certainty and a quicker path to move on with their lives. This also gave customers greater flexibility with how and when they spent the money. It also gave us and our reinsurers greater financial certainty. We put this offer to our customers and many took it up.

6.18 For some customers this may have meant the choice between cash settlement or, due to their low vulnerability assessment, being in the tail end of our repair and rebuild programme. We did not intend for these options and priorities to be coercive.

6.19 We also told customers that wanted to change their slot in our repair and rebuild programme that we could not guarantee them their requested date. Again, we did not intend this to be coercive. This was an unavoidable consequence of a programme involving so many moving parts. Each builder had a finite capacity for work, was often dependent on specialist sub trades and design work and could never predict with certainty when a particular repair/rebuild would be finished, thus freeing up capacity for the 'next in line'.

6.20 As the rebuild progressed and as we received new over-cap claims, cash settlement became our default approach. We continued to give the choice of cash or repair/rebuild to vulnerable customers.

Complaints

6.21 The Christchurch earthquakes generated many customer complaints. We used our existing complaints processes to manage these. We supported the development of the Residents Advisory Services and also engaged directly with Breakthrough, Fairways Mediation and Property Pathways Limited to work with customers to assist with dispute resolution.

6.22 We would be happy to share information on our complaints procedures and the above arrangements with the review.

Kaikoura

6.23 It is worth comparing the Christchurch and Kaikoura responses to understand how the broader insurance system has evolved and what this has meant for homeowners that have suffered earthquake damage.

6.24 First it is important to acknowledge that the Kaikoura event did not have the scale or rebuild complexity of Christchurch. It was a single event, rather than a sequence, and so did not have same assessment and apportionment challenges. It also resulted in far fewer claims. It did present other challenges such as geographic spread and access to some locations. Also, a higher proportion of the damage was to public assets such as roads and rail lines.

6.25 The Kaikoura event generated just under 28,000 claims for IAG, of which approximately 22,000 were under-cap EQC claims being manged under the industry memorandum of understanding. By June 2018 only 300 were still open. There are several important contributors to this outcome.

- Single assessments. Early in the response to the Kaikoura event, insurers and the EQC agreed a Memorandum of Understand which led to insurers managing all claims. This removed a lot of duplicate activity and complexity from the claims process.

- Cash Settlement. The use of cash settlement as the default method for settling claims has simplified the process.

- Sum Insured Policies. After the Christchurch events, in 2012 IAG and other insurers reverted to sum insured home policies (i.e. polices limited to a specific sum rather than open ended obligations to cover repairs costs of whatever amount). This has greatly simplified the settlement of badly damaged homes; reduced the level of disputes and presence of advocates; and provided greater certainty to homeowners.

- Capability already in place. Most insurers still had dedicated team in place to deal with earthquake claims with greater institutional knowledge and experience in how to manage claims and support affected customers.

6.26 There are still lessons arising from the Kaikoura event. The key being the need to communicate more effectively to our customers about timeframes, and how the entire claims process works.

Other issues

6.27 We expect that the submission process will uncover a variety of specific issues that homeowners have experienced in Canterbury. Issues that are beyond the ability of this submission to address. IAG would welcome the opportunity to give context and specific content in response to specific issues raised.

Sales

6.28 We don't condone or conduct pressure sales. Indeed, as part of our ongoing efforts to focus on the quality customer outcomes, we recently removed sales incentive from our sales staff.

Existing obligations for those involved in selling

6.29 It is right and proper that a minimum standard of conduct and accountability apply to selling insurance. Consumers should receive insurance products and services that are right for their needs, that accord with what they thought they were getting, and that come with easy means of redress if things go wrong.

6.30 We note that many obligations already exist in current consumer and financial markets law (see table 5) to ensure appropriate standards of conduct in selling, to provide redress to consumers, to deter poor practices, and to censure providers (and their directors) when they fail to meet these obligations.

Table 5. Current obligation supporting good sales conduct

Act	Section	
Financial Markets Conduct Act 2013 Part 2 Fair Dealing deals with the conduct of those who deal with financial products and services	s.19	Misleading or deceptive conduct generally
	s.20	Misleading conduct in relation to financial products
	s.21	Misleading conduct in relation to financial services
	s.22	False or misleading representations
	s.23	Unsubstantiated representations
Fair Trading Act 1986 Part 1 Unfair Conduct has similar provisions to the FMCA that apply more generally	s.9	Misleading or deceptive conduct generally
	s.10	Misleading conduct in relation to goods
	s.11	Misleading conduct in relation to services
	s.12a	Unsubstantiated representations
	s.13	False or misleading representations
Part 4A Consumer transactions and auctions, Subpart 2 Uninvited direct sales deals with protection for consumers in uninvited sales	s.36L	Disclosure requirements relating to uninvited direct sale agreements
	s.36M	Cancellation of uninvited direct sale agreement by consumer
	s.36N	Enforcement of uninvited direct sale agreement by supplier
	s.36O	Effect of cancellation of uninvited direct sale agreement
	s.36P	Supplier's obligations on cancellation of uninvited direct sale agreement
	s.36Q	Consumer's obligations on cancellation of uninvited direct sale agreement
	s.36R	Compensation on cancellation of uninvited direct sale agreement
Part 4A Consumer transactions and auctions, Subpart 3 Extended warranties deals with specific protections for consumers	s.36U	Disclosure requirements relating to extended warranty agreements
	s.36V	Cancellation of extended warranty agreement
Consumer Guarantees Act 1993 Part 3 Supply of Services deals with the suitability of the service and means of redress	s.28	Guarantee as to reasonable care and skill
	s.29	Guarantee as to fitness for a particular purpose
	s.32	Options of consumers where services do not comply with guarantees
Financial Service Providers Act 2008 Part 1 Registration deals with the approval of redress mechanisms for consumers	s.11	No being in business of providing financial service unless registered and member of approved dispute resolution scheme
	s.12	No holding out that in business of providing financial service unless registered and member of approved dispute resolution scheme

6.31 We believe that these existing obligations can be relied on to keep the quality and accountability of the sales by insurers. But we are open to exploring evidenced gaps found through the review.

Recommendations

6.32 The topic of conduct is vast and with a defined set of issues it is difficult to provide comments that will help advance the discussion on what, if any reform is needed.

6.33 We recommend that the review allow for a separate round of consultation on the conduct issues raised through submissions to the issues paper. This will ensure that these issues are properly aired and evidenced before options for reform are developed and consulted on.

6.34 The risk otherwise is that the reforms are based on extreme events like Canterbury and not on the day-to-day performance of the industry.

7. Unfair contract terms

7.1 The Paper asks whether the people are experiencing problems with terms in insurance contracts that might be unfair and whether the current provisions on unfair contract terms in the Fair Trading Act 1986 (FTA) are right for insurance contracts.

7.2 In this section we present the reasons why we think the current provisions on unfair contract terms should be retained and brought into an Insurance Contracts Act.

Background

7.3 The FTA prohibits the use of terms declared unfair by a court and gives guidance to the courts on which terms should not be declared unfair (section 46K). This includes terms that:

- define the main subject matter of the contract; or
- sets the upfront price payable under the contract; or
- is a term required or expressly permitted by any enactment.

7.4 In section 46L the Act says that a term is not unfair if it is "reasonably necessary in order to protect the legitimate interests of the party who would be advantaged by the term". The burden of proof falls on the party advantaged by the term. For insurance contracts the Act says the following terms are 'reasonably necessary':

- "a term that identifies the uncertain event or that otherwise specifies the subject matter insured or the risk insured against
- a term that specifies the sum or sums insured or assured
- a term that excludes or limits the liability of the insurer to indemnify the insured on the happening of certain events or on the existence of certain circumstances
- a term that describes the basis on which claims may be settled or that specifies any contributory sum due from, or amount to be borne by, an insured in the event of a claim under the contract of insurance
- a term that provides for the payment of the premium
- a term relating to the duty of utmost good faith that applies to parties to a contract of insurance
- a term specifying requirements for disclosure, or relating to the effect of non-disclosure or misrepresentation, by the insured"

7.5 When deciding if a term is unfair, the court must consider "the extent to which the term is transparent and the contract as a whole".

7.6 It is worth noting that matters listed in section 46L(4) as being 'reasonably necessary' are not 'exceptions' to the prohibition on unfair contract terms as the Paper says. The Act simply confirms that these types of insurance clauses are presumed to be 'reasonably necessary in order to protect the legitimate interest' of insurers, but still subject to the other elements of the test. Moreover, there seems to be a view that insurance contracts are not bound by the prohibition of unfair contract terms. That view is incorrect; they are bound. Indeed, the passing of the amendment Bill triggered a review of IAG's consumer policies and resulted in some changes.

7.7 For example, we reviewed a 'change in terms' clause in our policies that enables us to change the terms of the policy on notice. We determined that while there was a risk a unilateral variation clause was unfair, this term was necessary for business efficacy and was counter-balanced in most of our wordings by a right for the customer to cancel the policy with a full refund if they were not unhappy with the change in terms. However, in our AMI policies including home, contents and car policies, the customer's right to cancel mid-term incurred an administrative charge. This clause was removed from the AMI consumer policies to align it with all our other brands where customers were entitled to a full refund without charge.

Why do we have section 46L(4)?

7.8 The insurance contract describes the risk being insured. Product development and underwriting criteria circumscribe the risks of a potential customer so that they fit within the terms of the policy and the commercial appetite of the insurer.

7.9 Clearly defining the risk covered is essential to selecting, pricing, and underwriting the risk. As noted above most cancellations occur because the insured did not describe the risk accurately. An accurate understanding of the risk is essential to our decision to offer cover and on what terms. This is especially important given New Zealand's unique levels of natural hazard risk and the importance of effective risk management (described above).

7.10 If terms used to define the risk we are insuring are open to being declared unfair and unenforceable then the entire basis of an insurance contract, being the means to describe the risks being covered, is undermined.

7.11 A loss of the ability to include, rely on or enforce such terms would remove contractual certainty. This would materially influence the willingness and confidence of investors, reinsurers, and insurers to participate in the market. The consequences of that could be extreme. It was this concern that lead to the inclusion of section 46L in the Act.

7.12 We note that the European Union exempts terms which "clearly define or circumscribe the insured risk and the insurer's liability" from its UCT regime as they "are taken into account in calculating the premium paid by the consumer".[4]

7.13 We further note that the Australian Treasury has recently released a discussion paper on extending unfair contract terms provisions to insurance contracts covered by the Australian Insurance Contracts Act.

7.14 In that paper the Treasury has modelled its proposals on the New Zealand law. It proposes that "when determining whether a term is unfair, a term will be reasonably necessary to protect the legitimate interests of an insurer if it reasonably reflects the underwriting risk accepted by the insurer in relation to the contract and it does not disproportionately or unreasonably disadvantage the insured".

Why do we have each item in 46L(4)?

7.15 Beyond this financial stability and contractual certainty argument there are reasons for each element of subsection four (see table 6). In short there are two common reasons. First, that these terms a material to describing the risk. The risk being the subject of the contract. Second, that they are material to our commercial interests as we could not circumscribe risk to fit within our commercial appetite and, in some instances, we would not be able to price for the risk.

7.16 It is important to keep in mind some practical features of general insurance. Especially in the light of other contractual terms that might be highlighted through the review.

- First, New Zealand insurers generally use 'all-risks' general insurance policies, meaning that all risks are covered except those specifically excluded. Other jurisdictions use 'specified risk' policies, meaning the consumer is covered only for the risks listed in the policy document.
- Second, we insure risks, not certainties. So insurers exclude those risks they see as too likely to occur or over which the insured has some control over the risk occurring (for example deliberate or intentional damage, or wear and tear exclusions).

[4] Council Directive 93/13 on unfair terms in consumer contracts, 5 April 1993

- Third, insurers work to a risk appetite. For IAG this starts with a decision about which jurisdictions, locations, and lines of business we will be in. This will include caps on the amount of risk we are prepared to take on. In addition, some of our reinsurance treaties prevent us from writing certain risks. This is formalised into a Business License and approved by the board and is a core Governance document. This licence along with a current view of claims experiences and real-time events is given practical effect through our standard policy wordings, underwriting criteria and delegated authorities. These are key Governance and risk management tools within our business.

- Lastly, insurers must be able to exclude certain risks or elements of risks. These include risks that are inevitable, risks that are rare, and risks with insufficient data to understand likelihood and consequence and therefore are unable to be appropriately priced.

Table 6. Need for item in 46L

Explanation	Why the explanation is necessary
A term that identifies the uncertain event or that otherwise specifies the subject matter insured or the risk insured against	Specifying the subject matter of the insurance (the property insured) is essential for contractual certainty. Specifying the uncertain events or risks insured against is also necessary for contractual certainty, as these clauses set the rules for when the insured can access cover. The ability to specify the risks covered is also critical to removing specific risks or aspects of risk that fall outside the insurers commercial appetite and allows insurers to exclude risks that cannot be priced.
A term that specifies the sum or sums insured or assured	The sum insured is a key input to the calculation of the premium. The sum insured also sets the boundaries of the insured's contractual entitlement in the event of a total loss claim.
A term that excludes or limits the liability of the insurer to indemnify the insured on the happening of certain events or on the existence of certain circumstances	Excluding or limiting liability sets the boundaries of the insured contractual entitlement. For example, insurers know that the risk of loss or damage goes up in vacant houses. IAG's home policies will therefore either exclude cover or limit cover to specified named perils only when the home is left vacant for more than a specified period. Insurers also need to manage the limits of the cover they are prepared to offer by excluding risky behaviour or activity. For example, clauses in a motor policy that exclude cover where the driver is under the influence or driving a modified vehicle that has been artificially lowered. Specifying the risk insured against is vital to determining the expected loss and therefore the calculation of the premium. Specifying the risk is also critical to removing specific risks or aspects of risk that fall outside the insurer's commercial appetite or that insurers cannot price.

Explanation	Why the explanation is necessary
A term that describes the basis on which claims may be settled or that specifies any contributory sum due from, or amount to be borne by, an insured in the event of a claim under the contract of insurance	Excesses are a common feature of insurance and are used for two reasons. First to remove small claims that would be uneconomic to service; and second to incentivise good risk behaviour by the insured. Without these the cost of insurance would go up. These terms can assist in fraud and risk management. For example, a clause that limits the insurer's liability to indemnify the insured on a 'new for old' basis limits the incentive for the insured to damage or destroy their own property in the hopes of obtaining a newer replacement, or a cash windfall.
A term that provides for the payment of the premium	It's not just a case of if the policyholder does not pay they don't get a service, its that their payment is a contribution to the expected losses of the entire portfolio. Clarifies that the premium is the upfront price for insurance contracts
A term relating to the duty of utmost good faith that applies to parties to a contract of insurance	These terms explain the common law position and makes the obligations clear to the insured. Support the pooling that underpins insurance and reflects the obligations insureds have toward each other.
A term specifying requirements for disclosure, or relating to the effect of non-disclosure or misrepresentation, by the insured	These terms make the legal obligation clear to insured The terms are vital for ensuring accurate descriptions of risk so that they can be properly circumscribed and priced for the benefit of all insureds.

Recommendation

7.17 The review must recognise the unique nature of insurance contracts and the role they have in managing New Zealand unique risk landscape. It also must take care to distinguish between contract terms that are in and of themselves unfair, and rare or unique circumstances that create an outcome that can be perceived as unfair.

7.18 We recommend that the current unfair contract provisions are necessary and that they be kept and included in a new Insurance Contracts Act.

8. Comparing and changing policies and providers

8.1 The Paper asks whether it is difficult for consumers to compare products and providers, why this is so, and what if anything should be done to make it easier.

8.2 In this section we set out some of the factors we think the review must consider in looking at consumers' and small business' decisions about products and providers and at the role of comparison sites might have. We end with our recommendation on how to progress this topic.

Making good decisions

8.3 We want our consumers to make good decisions about their insurance. They should be confident that they have selected an insurer that will look after their interests and that they have a product that will meets their needs when they come to claim.

8.4 We would like to see consumers achieve this by recognising the importance of their decisions and investing the time to get it right. We would hope that this is especially the case when insuring their home and or their tools of trade. But we know this reflects only some consumers and that there a several reasons for this.

Why consumers and small businesses look for insurance

8.5 Consider how consumers and small businesses come to the insurance market either for the first time or on later occasions. Our research and experience tell us that:

- Consumers first buy general insurance in life stages. It typically starts when they get their first car (motor insurance), then when they move out of home (contents), and finally when buying their first home (house).
- Consumers tend to stick with their existing insurer when changing their car or moving to a new house. It is typically far easier and less time consuming as their existing insurer has their details and claims history. Our research shows that 62% of consumers would sacrifice ease over value when getting general insurance.
- Consumers typically enter the market again or 'shop around' because they have a poor claims experience with their current insurer or receive a significant increase in their premium.

8.6 This suggests that consumers are not actively looking for better deals. Indeed, our research shows that 62% of consumers want to 'set and forget' their insurance. This ambivalence most often falls away when they claim on their insurance. But given the low frequency of claims, the quality of claims practices, and the absence of significant premium increases over recent years, it is no wonder that the level of switching in general insurance is low.

8.7 Small businesses tend to behave in much the same way as consumers, only with more heightened extremes. This is because insurance protects not just assets, but their livelihood.

- Small businesses don't have a single defining moment or reason why they come to the insurance market. It could be a requirement of the industry, a demand from a client, experience (if the owner has previously been in business), they have suffered a loss they weren't insured for, or a wide range of other 'lightbulb moments'.

- Like consumers the default behaviour of small businesses is to stay with their current insurer as insurance is not high on their list of priorities, and due to low engagement, few want, or see the need, to engage with their policy at the point of renewal.

- There are more reasons why small business come back into the market. Like consumers this is often because of a poor claims experience or a sharp rise in premiums. But it might also be because they need to reduce their expenses, there has been a change in the business circumstances; they have bought a significant asset, or because of an external influence such as a broker.

How consumers and small businesses look for insurance

8.8 When consumers and small businesses are looking for a new insurance policy they bring to that task a variety of preferences and perspectives that shape their decision making. These will often vary through the life stages and because of the trigger that lead them to enter the market. Drawing on research from the past few years these factors include:

- How people see insurance. At one end of a spectrum some people see insurance as a financial transaction to protect their investments and financially support their way of life. At the other end some see it as an emotional investment, there to support them and their family in their time of need and to avoid being a burden on others.

- Involvement in the category. People tend to be involved or not. 49% agree that they regularly review their insurance, 25% do not. 62% agree that they want to set and forget their insurance, but 22% say they don't.

- Level of insurance. 65% agree that they want to be fully insured; 33% agree that they want to have as little insurance as they can get away with

- Brand preference**.** Most people tend to have 2-3 insurance brands in mind before making their choice.

- Channel preference. Most people have a preferred way to deal with an insurance company. Some prefer to approach the company directly either face-to-face, on the phone or on-line. Others prefer to use an intermediary such as their bank or an insurance broker.

- Outcomes sought. People typically fall in into one of three camps when asked what is most important in selecting an insurer. Some primarily focus on selecting an insurer that promptly pays all claims, others an insurer that is fair and honest in their dealings, and others on an insurer that offers the lowest price.

- Involvement in the purchase process. At one end of the spectrum some people are heavily involved in the process and work through the detail of their needs and options. At the other end some people want others to guided them through the process and recommend a provider and product. This could be an insurance intermediary or friends and family. 63% agree that they like to invest their time and energy in the decision.

8.9 Once again small businesses show similar but more extreme traits.

- How they see insurance. Some small businesses see insurance as important for reducing the anxiety they feel about running a business. It helps protect not just assets, but their livelihood. For others is a negative businesses expense (almost like a tax) that's a necessity to run a business but not something from which immediate benefit is gained or income is derived.

- Involvement in the category. Small business owners are ignorant about insurance and most want to engage with insurance as little as possible. It's just another of many important tasks that they face every day. And compared to the other worries that keep them up at night insurance sits far down the queue.

- Channel preferences. Small businesses have most of the channel options consumer do but have a stronger preference for brokers. Brokers are seen to provide greater ease, empathy, expertise and value for money.

- Outcomes sought. When purchasing insurance products, small business owners are fundamentally seeking a sense of security. Their primary desire is for their chosen provider to show an understanding of their needs, which they perceive to be complex and individual.

- Involvement in the purchase process. Small business owners tend show one of three distinct buyer behaviours: they outsource the job to a broker, with many going with the brokers recommendation; they get it over and done with quickly as they have simple insurance needs; or they want to consider, compare and customise their options to ensure the best insurance cover for their specific needs is chosen.

8.10 This tells us the we have everything from engaged customers who like to be involved and be fully insured, through to those that are disengaged and will get away with as little insurance a possible. And then there are some who want to be well insured and do nothing to get there and others who are engaged but still get it wrong.

8.11 Against this backdrop there is only so much insurers or other actors can do to help customers to engage and make informed and considered choices. It requires customers to invest the time and the effort to make it happen.

The critical role of trust

8.12 Trust is a foundational element of the insurance industry and can be seen at work throughout a customer's relationship with an insurer. Some of this trust includes:

- Trusted sources of information. People tend to build their perception of insurers from a variety of sources, using different sources to support different attributes. Importantly people understand the likely claims experience by asking friends and family, from the media, or through their own experience.
- Trusted sources of advice. When choosing their insurer, people mostly rely on the advice of their friends and family. When they use a broker, many rely on the broker to decide or help them to decide on the best product and provider.
- Trusted to be fair. Consumers tend to stay with their insurer when they are treated fairly during a claim or look for another insurer when they are not.

8.13 This tells us that personal experience or the experience of others are key to determining if and how long a customer will have a relationship with an insurer.

8.14 What all this tells us is that, while some customers are motivated by price, for most consumers and small businesses there are many more factors that come ahead of price in their decisions. Enabling them to make better decisions is a complex and multifaceted problem that needs a variety of solutions.

Important characteristics, challenges, and trends

8.15 Against this backdrop of decision making, it is essential to bear in mind several factors about general insurance products that influence customers' need for and ability to compare products and providers and the risk of switching. This includes:

- Price equals cover. This is dangerous for consumers, because price is a function of cover and cheaper insurance typically means less cover or can mean less certainty of meeting claims. To date insurers have competed on product and service quality, not price, for this very reason.

- General insurance is an 'all perils' product. General insurance products typically work on the basis that the insured is covered for anything that causes damage to their property except those risks that are specifically excluded either in part or full. Life and health insurance typically do the reverse, the insured is only covered for those risks that are specified. General insurance in Australia works in the same way, they have more specified risk policies that all-risks. This makes is difficult to compare cover at a headline level, as the differences in cover are in the exceptions and the detail of how they are applied.

- General insurance uses a mix of market and specified value. Home and contents insurance mostly uses a value specified by the insured (often called the 'sum insured') as the basis for the policy. In comparison, motor insurance mostly uses the market value of the vehicle. This requires consumers to think differently about each of their policies.

  Although outside the scope of this review, we believe there is often more financial risk to the insured from underinsuring their home by getting their sum insured wrong than in selecting the wrong product or provider.

- Limited down side to switching. General insurance does not use the concept of an exclusion for a pre-existing condition that are a mainstay in health and life insurance products. A general insurer will ask about an insured's previous claims history to ascertain the moral hazard of a customer and whether there is any pre-existing damage that has yet to be repaired but a customer can reasonably be expected to have full knowledge of their previous claims and the state of their property. In the case of unrepaired pre-existing damage, a general insurer may add a note to the policy to record for clarity that such pre-existing damage existed prior to the policy inception but this will generally not otherwise prevent or limit cover available to the customer in the future (this will depend on the extent of pre-existing damage). We do look at claims history which for some customers can be a barrier to obtaining insurance.

  By contrast, with health and life insurance people may not know that they have an underlying pre-existing medical condition at the time they look to purchase insurance. If they switch insurance providers, they run the risk that develop a condition which will not be covered as it relates to an unknown pre-existing condition.

- Risk-based pricing. Fully reflecting risk in the price paid for insurance has been a feature of business and motor vehicle polies for years. General insures are already moving to take the next step in the use of risk-based pricing. This will see the cost of natural hazards more accurately reflected in peoples' house insurance premiums. This is due to increased knowledge about current risks and the expectation that climate change will worsen future risks. This will make insurance less affordable (again outside the scope of this review) and lead homeowners to seek lower cost options. This pressure will increase as the impacts of climate change affect flood and inundation prone locations.

- Digital. Insurers are increasingly investing in their digital capability to make the experience of buying insurance faster, easier, and cheaper. This includes:

- Investments in digital solutions, like sum insured calculators and quote and buy solutions, to support consumer decisions and experiences. For example, it is now possible to get a quote for motor vehicle insurance in less than 5 minutes.

- Investment in proprietary and third-party data to support underwriting and pricing. As the scope, availability and quality of this data improves consumers will move from providing data to verifying data to ultimately having little or no engagement at all. This is still some ways off.

- Product design. Insurers continue to modernise their products including increasing use of modular designs to enable lower cost development and more customisation by consumers. It allows customers to understand the costs and benefits of different combinations of cover. While still in its infancy, this will grow over time to create a more fluid set of products for consumers to choose from.

- Regulation. The Financial Services Legislation Amendment Bill introduces a duty to put customers interest first when giving financial advice. Improved disclosure and conduct obligations will support this. Combined this will help ensure a better matching of customers to products and providers. We acknowledge that this only applies to advice and not all sales.

8.16 This tells us that there are many competing influences to navigate before deciding if and how to improve consumers' ability to compare products and providers. Some will make it easier to compare and switch, while others add complexity to the task. Some heighten the importance of getting it right, while others reduce the risk of getting it wrong.

Comparison sites

8.17 The Paper highlights comparison websites as one way to aid consumers in comparing products and providers. We note that the Productivity Commission, in their Review of the Services Sector, found that "Accurate and accessible comparison websites can help to reduce search costs and facilitate more competitive markets."

8.18 Despite that, we hold serious concerns about the unintended and negative impacts that comparison sites can have. These include:

- Not meeting conduct standards. Reviews by the FSA and ASIC have found shortcomings in the way comparison sites have been run, including:

  - Mispresenting the nature or extent of the comparison service, including market coverage and presence of advice

  - Misrepresenting the savings achieved by using the comparison service

  - Comparisons failing to be unbiased, impartial or independent given ownership or underlying commercial relationships with providers

- Failing to ensure the accuracy or quality of product information
- Failing to explain how they would use consumer data

- Not meeting consumers' needs. Research by the FSA has shown that comparison sites did not always solve consumer challenges in comparing products, including:
  - Not enough or the right type of information presented
  - The range of product features and variables
  - Not understanding why the price of products varied so much
  - Little sense among consumers that policies might differ in quality or level of cover
  - A default belief was that high-cost products are just over-priced, and the low-cost products are competitive, good value, and the best choice
  - Belief that all products presented were viable and trustworthy
- Reinforcing a price-based purchasing model. As noted above, while this may suit some consumers, it can easily leave them with less cover. Indeed, a stronger focus on price will drive insurers to offer cheaper products to compete. The simplest way to do this will be by removing cover and or increasing excesses, which has the ironic effect of increasing the cost and risk back to the consumer.
- Undermining needed profitability. As noted in the opening of this submission, it is important that insurers are profitable so that they can invest in their businesses and provide an adequate return to shareholders. There would also be downstream impacts on insurer's supply chains. Evidence from the UK shows that price-based competition made motor insurance a loss-making product for the industry.

8.19 Without seeing these concerns addressed, we believe that comparison sites will create more harm than good in the general insurance industry.

Recommendation

8.20 We agree that some consumers find it difficult to compare products. We want to see customers make informed and considered choice but recognise that achieving this is a complex task due to the many attitudinal, behavioural, and structural influences at play.

8.21 We are open to consider ways to help customers compare product and providers, and so make good decisions. We would not recommend the use of comparison sites as a means to achieve this.

9. Responsibility for intermediaries' actions

9.1 The Paper asks whether there are problems with insurers being held responsible for an intermediary's failings and if so how this could be addressed.

9.2 In this section we provide our view of the problems and our recommendation on how to progress this topic.

Current problems

9.3 It's important to note that in IAG experience the behaviours shown by New Zealand brokers market are generally customer centric, ethical and display a high level of professionalism. However, from time to time, issues do arise where a broker may fail in their duty to the insured and/or insurer, including by:

- Not giving material information to an insurer
- Not matching the clients' insurance needs with an appropriate insurance solution
- Misrepresenting the nature of the risk to be insured
- Not managing insureds' premiums per Sections 77P-77T of the Financial Advisers Act

Other changes

9.4 We note that the Financial Services Legislation Amendment Bill (FLSAB) will enhance the conduct, competency, and disclosure standards for insurance intermediaries. It seems inconsistent to raise the professional standard of insurance brokers and make them accountable for their advice, but not all aspects of their role in the transaction of insurance.

9.5 This is especially the case when we consider that the insurance broking industry has undergone significant increases in its capacity and capability over the past 20-30 years. A once fledgling industry populated by many small businesses has grown to handle nearly half the premium of the general insurance market and to be dominated by eight large international broking houses and domestic networks.

9.6 We believe that these organisations are more than capable of being held to account for their occasional failings and making proper redress to affected customers.

Consumer expectations

9.7 We also think that costumers who engage an insurance broker expect that individual or organisation to be working for them and their interests. Moreover, that they would not think it right that their broker is not held responsible for their errors and shortcomings and be required to redress any harm their failing caused.

Recommendation

9.8 We believe that insurance brokers should be fully accountable for their actions and recommend that the review consider making insurance brokers the agent of the insured. This should include a review of the Insurance Intermediaries Act 1994 and the need to review or revoke relevant sections, including sections 4, 5, 8, 9 and 11.

10. Deferral of payments / investment of money

10.1 The Paper asks whether the ability of insurance intermediaries to defer payment of premiums causes problems and if so what options MBIE should consider.

10.2 In this section we provide our view as to the problems deferring payments cause and our recommendation as to how the review should take this topic forward.

The problem

10.3 The deferral of payments and investment of money by insurance brokers is problematic for several reasons.

10.4 First, deferral by insurance brokers under s8(2) of the Insurance Intermediaries Act 1994 (the IIA) results in insurers having to pay over the GST on premium to the Inland Revenue approximately 3 weeks before the premium is received and in practice can extend to 7 weeks.

10.5 Second, deferral sees insurers incurring the cost of being 'on risk' without having received the compensating premium. These costs include the cost of administering the policy, setting aside capital, and buying reinsurance. The effect is that of having to service our product for free for almost 3 months in terms of s8(2) of the IIA and in practice that can be for up to 4 months.

10.6 Third, as noted in the Paper, insurers are financially exposed to the failure of the intermediary. With the potential of up to $500m of premiums being held by insurance brokers across the industry at any one time this a material, albeit less likely, risk.

10.7 Fourth, we suspect that consumers don't know that their insurance broker is profiting from deferring their payment. Moreover, we believe that they would not think it right that they do so. A position we would support. We note that the consumer is not at financial risk due to section 4 of the IIA.

10.8 Fifth, the IIA gives legislated support for insurance brokers, both in terms of financial gain and payment terms, which is unwarranted for a market now dominated by eight large international broking houses and domestic networks.

10.9 Lastly, it is inconsistent with other professions. To our knowledge insurance brokers are the only profession that can make personal gain from their client's money in this way.

10.10 Consider Brokers. Sections 77P-77T of the Financial Advisers Act require Brokers to pay client money into an interest-bearing trust account for the benefit of the client and to keep proper records. The Broker can only use the money as the client directs and it is not available to meet the Broker's debts.

10.11 Sections 431ZZB-431ZZG of the Financial Services Legislation Amendment Bill (FLSAB) currently before the Economic Development, Science and Innovation Select Committee keeps these requirements.

10.12 Also consider lawyers and conveyancers. Sections 110-115 of their governing Act requires them to pay client money into an interest-bearing trust account for the benefit of the client and to keep proper records. Failure to do so incurs penalties of up to $25,000. Any interest received on a client's money is either returned to the client along with the principle or applied to the relevant transaction.

10.13 Sections 122 to 125 of the Real Estate Agents Act also requires real estate agents who receive client monies to keep funds in separate trust account to be drawn on only for paying to the person so entitled and is not to be available for payment of the agent's debts.

Changes to agency

10.14 In the previous section we called for the insurance intermediary to be the agent of the insured. If this is taken forward into legislation and sections 4, 5, 8, 9 and 11 of the IAA are repealed, then the issue of deferred payments goes away. A premium would only be consider paid when the insurer receives the money.

Recommendation

10.15 Irrespective of what happens in relation to the topic of agency, we recommend that insurance intermediaries hold money in trust for the intended recipient of the monies.

- In the case of premiums collected but not yet paid to the insurer, the money would be held in trust for the insurer. The investment income on this money would go to the insurer as the insurer is on risk from the commencement of the insurance cover and the client is receiving the benefit of that insurance cover.
- In the case of a refund on premium, the money would be held in trust for the customer and it would follow that the investment income on this money should go to the customer.

10.16 We further recommend that s.8(2) of the IIA be amended to require the broker to pay the premium to the Insurer on the earlier date of:

- 7 days after receiving the premium from the client, and
- 20 days from the end of the month that the insurance contract cover commences

10.17 Obligations for record keeping, restrictions on the use of client money, and a penalty regime should also apply. We would see this achieved by drawing on sections 431ZZb-431ZZG of the FSLAB.

11. Other issues

Claims advocates and public loss adjustors

11.1 One issue we do want to highlight is the advent of 'claims advocates' and foreign based 'public loss adjusters' who came into New Zealand after the earthquakes (mentioned above in relation to Canterbury claims). We believe any reform of insurance law that has the aim of improving the position of consumers, needs to include a review of claims advocates as a category of intermediaries.

11.2 Insurance is a financial instrument that is intended to provide the insured with a sum of money necessary to put them in the position they were in before (and not to profit from) the loss caused by unintended and unexpected physical loss or damage.

11.3 Most policies will cover costs associated with professional services needed to repair or rebuild homes, such as architects and engineers. The cost of loss adjusters is met by insurers and not related to the value of the claim. as percentage of the claim.

11.4 Claims advocates and public loss adjustors are remunerated as a percentage of an insurance payout, which creates a conflict between their interests and that of the customers. They cannot serve their own interests in being paid and the customer's interest in receiving enough funds for repairs/rebuilding their home, without inflating the 'cost' to rebuild/repair to a level that covers their percentage fee plus the real cost of the rebuild/repair. This is in indirect conflict with insurers contractual obligation to their reinsurers to only pay according to what the polices entitle the customers.

11.5 If 'claims advocates' and 'public adjusters' are to become intermediaries, then basic consumer protections are needed to ensure consumer interests are not subordinated to the remuneration incentives of these intermediaries.

11.6 We invite MBIE to consult with consumer groups and industry stakeholders further on this topic.