Options paper

Insurance Contract Law Review

April 2019

newzealand.govt.nz

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How to have your say

The Ministry of Business, Innovation and Employment (MBIE) seeks written submissions on the questions raised in this document by **Friday 28 June 2019**.

Your submission may respond to any or all of the questions. Where possible, please include evidence to support your views, for example references to independent research, facts and figures, or relevant examples.

Submissions process

Please make your submission through the online portal at ***mbie.govt.nz/insurance-contracts***. The portal helps us to collate submissions and ensure that your views are fully considered.

If you are preparing a comprehensive submission in collaboration with others, you may wish to first prepare answers to each question in Microsoft Word or similar. That is because the online portal does not save progress if you exit the browser.

If you are unable to access or use the online portal, please either:

- contact us at ***insurancereview@mbie.govt.nz*** to make other arrangements for us to receive your electronic submission; or

- mail your submission to:

  Financial Markets Policy
  Building, Resources and Markets
  Ministry of Business, Innovation & Employment
  PO Box 1473

  Wellington 6140
  New Zealand

Please direct any questions that you have in relation to the submissions process to ***insurancereview@mbie.govt.nz***.

Use of information

The information provided in submissions will be used to inform MBIE's policy development process, and will inform advice to Ministers on the options for the Insurance Contract Law Review. We may contact submitters directly if we require clarification of any matters in submissions.

Release of information

MBIE intends to upload PDF copies of submissions received to MBIE's website at ***www.mbie.govt.nz***. MBIE will consider you to have consented to uploading by making a submission, unless you clearly specify otherwise in your submission.

If your submission contains any information that is confidential or you otherwise wish us not to publish, please indicate this in the submission, clearly identifying the confidential information. Please also provide us with a separate PDF version excluding the relevant information for publication on our website.

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List of Acronyms

MBIE	Ministry of Business, Innovation and Employment
UCT	Unfair contract term
FMA	Financial Markets Authority
ICNZ	Insurance Council of New Zealand
IFSO	Insurance and Financial Services Ombudsman
ACC	Accident Compensation Corporation

Foreword

Insurance plays an important role in the lives of New Zealanders, helping us cope with unforeseen life events and providing businesses with greater certainty. A well-functioning insurance system is integral to ensuring insurance continues to serve all New Zealanders.

I have heard from stakeholders throughout this review that there are significant problems with New Zealand's insurance contract law. This paper sets out some options for reforming New Zealand's insurance contract law. It should be read with the paper proposing options for reforming the rules governing the conduct of financial institutions, which is also currently being consulted on.

At the moment, individuals must tell insurers everything that could affect their decision to offer insurance or how much they charge in premiums. The review has found that people often do not understand the kind of information that must be disclosed and that the consequences for not disclosing the information can be very harsh. This paper proposes options to change the rules about disclosure to better reflect the information known by consumers and businesses.

Unfair contract terms are prohibited under the Fair Trading Act. However, there are exceptions for certain core insurance terms. I am concerned that this arrangement does not protect consumers from genuinely unfair terms, and this paper proposes some options to remedy this.

The paper also sets out some options aimed at making contracts fairer and clearer, and proposes a range of miscellaneous changes to insurance contract law. While some of these changes are technical in nature, they are important to ensure that the insurance system functions more efficiently.

I am looking forward to an open and transparent discussion with stakeholders on these options, so that we can move forward with the best possible package of options for reform.

If everything goes according to plan I will be working towards introducing legislation in the current Parliamentary term.

Hon Kris Faafoi

Minister of Commerce and Consumer Affairs

1 Introduction

- The Ministry of Business, Innovation and Employment (MBIE) is reviewing New Zealand's insurance contract law. The terms of reference for the review are available at ***mbie.govt.nz/insurance-contracts***.

1. This options paper describes problems with insurance contract law, possible options for solving them, and the costs and benefits of those options.

2. The issues paper that was published earlier in MBIE's review included a discussion of conduct in the insurance industry. In parallel with this options paper, MBIE is consulting on options for a new conduct regime, available at ***mbie.govt.nz/financial-conduct***. Accordingly, this options paper does not cover options for a conduct regime.

3. We are seeking feedback on the drawbacks and benefits of the various options to inform our recommendations to the Minister. We are also seeking feedback on whether there are options that we have not yet identified that would be more effective in solving the current problems.

4. We have not expressly identified preferred options, and if we express a leaning towards an option, we are still open to feedback on what may and may not work in practice and how effective any given option is likely to be.

5. We have included suggested questions throughout the document. While we seek answers to these questions, we also welcome any other relevant information that you wish to provide. All paragraphs are numbered for ease of reference.

Next steps

6. Submissions on this paper close on **Friday 28 June 2019**. Following that, we will review submissions and make recommendations to the Minister, with a view to introducing legislation to Parliament in mid-2020.

2 Objectives of the review

7. We consulted on the objectives for the review, and have developed the following revised objectives:

   a. **Objective 1:** Participants in the insurance market are well informed and able to transact with confidence at all points in the lifecycle of an insurance policy

   b. **Objective 2:** Interactions in the insurance market are fair, efficient and transparent at all points in the lifecycle of an insurance policy

   c. **Objective 3:** Barriers to insurers participating in the insurance market are minimised

   d. **Objective 4:** Consumers' interests are recognised and protected when participating in the insurance market

8. As compared to the draft objectives set out in the issues paper, **Objective 1** has been amended to cover the need for insureds and insurers to be well-informed. This reflects that both parties have information needs and will be able to make better decisions as a result. We do not think that the objective needs to specifically address the fact that insureds can know more about their risk than insurers – there are information asymmetries in each side of the relationship.

9. **Objective 2** has been widened slightly to cover "interactions in the insurance market" instead of "interactions between insurers and insureds". This reflects the fact that some of the options described in this paper relate to other interactions in the insurance market, such as the interactions between brokers and insureds.

10. The new **objective 3** is aimed at ensuring that New Zealand remains an attractive place in which to provide insurance. New Zealand has high natural hazard risks, and therefore carries a high level of risk for insurers. We are mindful of the need to maintain a deep market for the provision of insurance in New Zealand.

11. While objectives 1-3 relate to ensuring a well-functioning market for insurance in New Zealand, the new **objective 4** explicitly recognises the need to protect consumer interests.

12. We have used the revised objectives to prepare the criteria that will be used to choose between options.

1	*What is your feedback regarding the objectives for the review?*

3 Duties to disclose information

Status quo

13. An insured, when entering into a contract of insurance, must disclose information that would influence the judgment of a prudent underwriter in setting the premium or deciding whether to take on the risk of providing insurance ("material facts"). Answering an insurer's questions does not relieve a consumer of the duty to disclose other material facts.

14. If an insured does not disclose all material facts ('non-disclosure'), the insurer is entitled to avoid the contract and refuse all claims under it, even if:

    - there is no connection between the facts that were not disclosed and the claim.
    - disclosure of the relevant facts would not have made them decline cover.

15. Insureds also have a duty not to misrepresent material facts. If an insured mispresents material facts, the insurer is entitled to cancel the contract.

Problem definition

Consumers don't understand what needs to be disclosed

16. The problem with the current situation is that an ordinary consumer cannot reasonably be expected to know what an insurer might consider material, and therefore what facts must be disclosed. For example, consumers usually know that they must disclose official medical diagnoses, but not necessarily signs or symptoms which have not been diagnosed.

17. Consumers have a range of understandings about whether their duty is limited to answering questions asked by insurers. In a 2018 Colmar Brunton survey commissioned by MBIE, 51% of respondents thought they need to tell the insurer everything that might affect their insurer's decision, even if the insurer doesn't specifically ask for it. Another 24% thought that they need to tell the insurer everything relevant that they can remember, while 18% thought that they only need to answer the insurer's questions.

18. A common assumption of consumers is that if the insurer needs information (e.g. medical records or claims history), the insurer will get it from a third party. Of respondents to the Colmar Brunton survey who had life, health or income protection insurance, 45% said they thought their insurer checked their medical records before agreeing to give them insurance. Often this is incorrect– while a consumer may have given permission for their insurer to access the consumer's records, the insurer usually only does so after the consumer has made a claim.

Consumers may not be aware of the duty of disclosure

19. Insurers do not have a legal duty to bring the duty of disclosure to the attention of consumers. If consumers are not aware that they have a duty to disclose and they fail to make complete disclosure, the consumer may not be covered for a loss for which they thought they were covered.

20. Insurers submitted that consumers are aware of the duty and its consequences and said they made efforts to make their customers aware. Other submitters, such as financial advisers, dispute resolution schemes and law firms noted that despite disclosure being signposted in insurance policy documents, consumers still do not necessarily understand the duty and its implications. This is also evidenced by the number of disputes relating to non-disclosure taken to dispute resolution schemes: the Insurance and Financial Services Ombudsman Scheme said in its submission that of the 4,500 complaints it has investigated since 2000, there were 750 complaints related to non-disclosure (17%)[1]; the Banking Ombudsman said in its submission that in the last five years, it had 52 disputes related to non-disclosure, out of 120 insurance-related disputes (43%).[2]

Disclosure problems in relation to businesses

21. We have not received much evidence to suggest that the same problems identified with non-disclosure for consumers are also prevalent for businesses (of any size). An insurer that primarily provides commercial insurance estimated that it has avoided fewer than 10 policies in the last decade for non-disclosure, across 30,000 policies. Most of its business customers are advised by brokers and are well-informed. Another submitter with experience handling commercial insurance claims said that it was not aware of large or mid-sized businesses having policies avoided based on non-disclosure.[3]

22. Submitters generally thought that non-disclosure is more of an issue for consumers and that disclosure expectations for businesses should be higher than those for consumers.

23. However, many submitters noted that small businesses are similar to consumers in their knowledge and resources and should be treated similarly. The Insurance Council of New Zealand (ICNZ) pointed out that small businesses are currently covered by the Fair Insurance Code and have recourse to dispute resolution schemes.

24. Submitters argued that large businesses should be treated differently because they have greater resources and bargaining power. Large businesses often have sophisticated record-keeping systems, in-house legal teams and brokers when they interact with insurers. ICNZ submitted that while what would be material to a prudent underwriter is not something all consumers can be expected to understand, it is not an unreasonable expectation for businesses working through brokers.

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[1] Submission – Insurance and Financial Services Ombudsman Scheme
[2] Submission – Banking Ombudsman Scheme
[3] Submission – Assure Legal

25. Despite the lack of evidence that the current laws are resulting in negative outcomes for businesses, arguably the expectation that any insured should know what a prudent underwriter would consider to be material is unreasonable. Notably, Australia and the UK have both reformed the law of disclosure as it relates to businesses, not just consumers. In the UK, it was suggested that the law no longer reflected commercial practices in relation to business insurance, that the duty was poorly understood by businesses and allowed insurers to play a passive role when obtaining information to underwrite risk.[4]

Consequences for insurers

26. Poor quality information resulting from consumers' lack of understanding about what to disclose can have negative consequences for insurers. This includes being unable to properly price and manage risk, damage to relationships and reputations with customers and the public, and administrative and legal costs. It can also affect the functioning of insurance markets.

27. Low consumer confidence in insurance markets can also lead to a decrease in insurance sales, which is not only to the detriment of insurers but can also lead to consumer under-insurance, leaving them without adequate cover for loss.

Problems with legal remedies for non-disclosure

28. If an insured fails to disclose material facts, the insurer is entitled to avoid the policy and refuse claims. This can be a disproportionate response with serious consequences for the insured. Apart from the insured's immediate loss, it can impact their ability to obtain cover in the future if they have a history of having a previous contract avoided. That aside, the effect of avoidance is to require the insured to repay any claims paid by the insurer between the date of the policy and the avoidance.

29. Insurers told us that they do not strictly apply the legal remedy of avoidance to all non-disclosures and instead respond reasonably on a case-by-case basis. They said that it would be counterproductive for them to develop a reputation for claims avoidance. One insurer said that in a third of its responses to non-disclosure, it does nothing and less than 10% of the time cancels or avoids the policy.

30. Insurers said they consider a range of factors when responding to a non-disclosure, including how the new information would have affected their decision to insure and on what terms, whether the information may have been disclosed but not captured by the insurer or broker, the conditions of the insurer's reinsurance, the claim amount and the interests of other policyholders.

31. However, other submitters suggested that non-disclosures are not always dealt with reasonably, as evidenced by the number of disputes about non-disclosure. The Banking Ombudsman Scheme said that it frequently sees disputes about banks declining claims due

[4] *Impact Assessment: Insurance Contract Law: Updating the Marine Insurance Act 1906,* Law Commission (26 August 2014): ***https://www.parliament.uk/documents/impact-assessments/IA14-19A.pdf***.

to non-disclosure, mostly to do with pre-existing health conditions.[5] The Insurance and Financial Services Ombudsman (IFSO) commented that in its experience, insurers tend to avoid policies and decline claims based on non-disclosure. About 10% of the claims received by IFSO relate to non-disclosure.[6] The results of our Colmar Brunton survey found that of respondents who had a claim denied or reduced, 15% said the reason was that they hadn't told the insurer information that the insurer thought they should have.

32. Submitters gave examples of where non-disclosures had resulted in disproportionate consequences. Some examples are:

- An income protection claim was declined when an insured had to leave work for cancer treatment because she had not disclosed psychological problems experienced as a teenager.
- An insurer avoided a claim for a heart attack because the insured didn't disclose a sore hip.
- A life insurance policy was avoided when a wife tried to claim after her husband was killed by a drunk driver, because her husband had not disclosed a former bankruptcy.

Criteria

33. MBIE has identified the following criteria for determining options to address the problems described above:

a. Insurers have confidence that they can effectively measure and price risk

b. Insureds understand clearly what information they need to disclose

c. The option does not unduly limit innovation in the provision of insurance

d. Remedies are proportionate to materiality

e. Costs are minimised.

Options in relation to disclosure by consumers

Option 1: Duty to take reasonable care not to make a misrepresentation

34. This option would abolish the duty of disclosure for consumer insureds and replace it with a duty to take reasonable care not to make a misrepresentation. Insurers would have to identify, through questions, the information they need to underwrite the risk. Consumers must answer truthfully and as accurately as is reasonable.

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[5] Submission – Banking Ombudsman Scheme

[6] Submission – Insurance and Financial Services Ombudsman

35. Whether or not a consumer has taken reasonable care would take into account factors such as how clear and specific the insurer's questions were and whether an agent was acting for the consumer.

Option 2: Duty to disclose what a reasonable person would know to be relevant

36. The duty would be to disclose information that the consumer knows, and that a reasonable person in the circumstances could be expected to know, to be a relevant matter to the insurer in making a decision to accept the risk. Whether a reasonable person would know the information to be relevant would take into account the type of insurance product and the target market for the insurance.

Option 3: Require life and health insurers to use medical records to underwrite

37. The duty would remain similar to the status quo. However, there would be an obligation on life and health insurers to seek permission to access consumer medical records and use these records to underwrite the risk. This would only address non-disclosure in relation to personal insurance products like health, income protection, life and trauma insurance.

Table 1: Costs and benefits of consumer disclosure options

Option	Benefits	Costs
Option 1 consumer disclosure: duty to take reasonable care not to make a misrepresentation	• Consumers do not have to understand what an insurer would consider to be relevant to underwriting risk. Consumers clearly understand what they need to disclose, as they only have to answer questions truthfully. • Likely to reduce the number of disputed claims which cause delays and expense to both parties • It is only in unusual circumstances that a consumer risk would exhibit non-standard features that could not be picked up by express questions.	• If insurers have to draft and ask questions to obtain all the information they need, this may take more time and resources and could raise the costs of insurance. However, drafting questions would likely only incur one-off costs. • Compliance costs for insurers could raise premiums for consumers. • Even with very specific questions, insurers may not be able to identify all the information they need. This may impact insurers' certainty of the risk. • Consumers may have to invest more time and resources in responding to longer and more complex questionnaires.
Option 2 consumer disclosure: duty to disclose what a reasonable person would know to be relevant	• Retains an active duty on consumers to identify the information that insurers will need. Gives insurers more confidence that they can measure and price risk, because it makes it more likely that adequate information will be disclosed to the insurer. • May slightly reduce the number of disputed claims which cause delays and expense to both parties.	• Less favourable to consumers than Option 1, as the consumer is still required to identify information that a reasonable person would expect an insurer to consider to be relevant. The move to a "prudent insured" test does have more reasonable expectations of the insured's understanding than the status quo. • There may still be some uncertainty as to what must be disclosed. Specifically, what a reasonable person in the circumstances could be expected to know to be relevant may be debatable (unlike Option 1, which doesn't require such a test), and the extent to which the insured's own personal understanding is to be taken into account

		would have to be determined.
Option 3 consumer disclosure: require life and health insurers to use medical records to underwrite	• Would relieve consumers of the duty to disclose in relation to matters which the insurer obtained elsewhere. Insurers could not use a consumer’s non-disclosure of a medical issue as a reason for declining a claim.	• Could add significant compliance costs to insurers. Many insurers do not access medical records at contract formation because of the costs of doing so for every application. • If a non-disclosed issue was not in a consumer’s medical records, the same issues with non-disclosure could still persist as under the status quo. • Would not address non-disclosure problems in relation to general insurance. While problems with non-disclosure are higher in life and health than for general insurance (such as house or car), we are also aware of non-disclosure having disproportionate consequences in general insurance. • This option could be extended to a general requirement to access relevant third party records, but this could create confusion about what matters the consumer must disclose and what the insurer will access elsewhere

2	*What is your feedback in relation to the options for disclosure by consumers? In particular: Do you agree with the costs and benefits of the options? Do you have any estimates of the size of those costs and benefits? Are there other impacts that are not identified? Are there other options that should be considered? Which option (including the status quo) do you prefer and why?*

Design options for all consumer disclosure options

Design option 1: Requirement to inform consumers of the duty to disclose

38. As a design option that would apply to all of the consumer disclosure options above, there could be a statutory requirement that insurers must warn insureds of the duty in writing before a contract is entered into. We seek feedback on whether this would improve consumer understanding of disclosure.

3	*Should insurers be required to warn consumers of the duty to disclose? Why/why not? Should insurers be required to warn all insureds of the duty to disclose, including businesses?*

Design option 2: Disclosure of the use of third party information

39. Many consumers assume their insurer accesses their medical records (or other third party records, such as their claims history with another insurer) at contract formation. This is often not the case. While a consumer may have given permission for the insurer to access their records, the insurer usually only does so after the consumer has made a claim, so they can check whether anything was not disclosed.

40. As a design option that would apply to all of the consumer disclosure options above, there could be a statutory requirement that insurers inform the consumer about whether and when they will access third party records, and state whether this relieves the insured of

the duty to disclose particular matters. If the insurer intends to rely on such information as part of pre-contractual disclosure, this should be declared and the consumer's duty to disclose in relation to those matters waived.

4	*Should insurers have to tell consumers what third party information they will access, when they will access it and if they will use it to underwrite the policy?*

Options in relation to disclosure by businesses

Option 1: Duty to disclose what a reasonable person would know to be relevant

41. Under this option, businesses would be required to disclose what a reasonable person would know to be a material fact, taking into account the circumstances and characteristics of the insured.

42. The option reflects consumer disclosure Option 2. In practice, a higher standard would apply for businesses because they can be expected to have a higher level of knowledge and resources, and because they are more likely to use brokers.

Option 2: Duty to make fair presentation of risk

43. The option would be modelled on the UK's Insurance Act 2015. The option would require businesses to disclose every material circumstance which they know or ought to know, or if they are unable to, to make disclosures that gives the insurer sufficient information to put a prudent insurer on notice that it should ask further questions to reveal those material circumstances. A material circumstance is one which would influence the judgment of a prudent insurer in determining whether to take the risk, and on what terms.

44. Under this option, an insured in a business context would be presumed to know or ought to know:

- if the insured is an individual, the information known to (or deliberately ignored by) the individual or the individuals responsible for the insured's insurance
- if the insured is a corporate, the information known to (or deliberately ignored by) the senior management of the insured or the individuals responsible for the insured's insurance
- information that should have been reasonably revealed by a reasonable search of information available to the insured.

Option 3: Duty to take reasonable care not to make a misrepresentation

45. This option would be the same as consumer disclosure Option 1. It would replace the duty to disclose with a duty to take reasonable care not to make a misrepresentation.

Table 2: Costs and benefits of business disclosure options

Option	Benefits	Costs
Option 1 business disclosure: duty to disclose what a reasonable person would know to be relevant	• Improves businesses' understanding of what to disclose compared to the status quo. Would not require businesses to know what a prudent insurer would consider to be material to assessing the risk. Arguably large businesses with legal teams and brokers could be expected to have the knowledge of a prudent insurer, but this may not be appropriate for all businesses on the whole. • Provides flexibility to take into account the circumstances of the business, its size, nature and resources in any assessment of whether the duty of disclosure has been fulfilled. The option therefore builds in reasonable expectations of the insured's knowledge and understanding. • Retains an active duty on businesses to disclose material facts accurately. • It supports the ability of insurers to measure and price risk.	• Requires some assessment on the part of the business to identify what information is likely to be relevant. However, arguably businesses, particularly those using brokers, are likely to have greater knowledge of this and it may be appropriate to apply a higher standard of expectation for businesses than consumers. • May introduce some uncertainty if it is left up to regulator guidance or court decisions to determine the standard of reasonableness.
Option 2 business disclosure: duty to make fair presentation of risk	• Encourages active participation on the part of insureds and insurers to volunteer and seek information respectively. • Supports insurers to measure and price risk. • Makes the duty slightly clearer, by clarifying what an insured is presumed to know. • Minimises compliance costs for insurers because businesses would be more likely to provide relevant information. • Reduces the number of disputed claims due to non-disclosure, to the extent that they exist.	• The difference between this and Option 1 above is that the test depends on what the particular insured knew or ought to have known, and does not require consideration of what a hypothetical reasonable person in the circumstances ought to have known. This requires businesses to know what a material circumstance is (and therefore what would influence the judgment of a prudent insurer in determining whether to take on the risk and on what terms).
Option 3 business disclosure: duty to take reasonable care not to make a misrepresentation	• Businesses would be relieved of the duty to proactively volunteer information about the nature of their risks, as the onus would be on the insurer to identify appropriate questions. Businesses would clearly understand what information to disclose.	• Could be inappropriate for many businesses with complex and unique risks. Unless an insurance product specifically caters to the unique risks of a business in a particular sector, and the insurer is a specialist in that area, it could be difficult for insurers to ensure they ask the necessary questions to obtain the information they need to assess and price the risk. This is particularly the case where large businesses negotiate the terms of an insurance agreement to cater to very specific risks. • This would likely add significant costs for insurers, if they have to draft complex questionnaires for businesses of which they may have little expert knowledge. The costs are potentially disproportionate to the size of the potential problem, if any.

5	*What is your feedback on the options in relation to disclosure by businesses? In particular: Should businesses have different disclosure obligations to consumers? Do you agree with the costs and benefits of the options? Do you have any estimates of the size of those costs and benefits? Are there other impacts that are not identified? Are there other options that should be considered? Which option (including the status quo) do you prefer and why?*

Design options for all business disclosure options

Design option 1: To whom should business disclosure apply?

46. If the option chosen for business disclosure differs to that for consumers, there is a question about whether small businesses should be included or excluded. Some submitters suggested that small businesses often have the same level of knowledge and resources as consumers, and should therefore be treated similarly. Some New Zealand insurers already distinguish between small and other businesses.

47. Small businesses could be defined on the basis of:

    a. **Employee count of less than 20 employees:** This is used elsewhere in New Zealand legislation, and is also used in ICNZ's Fair Insurance Code.

    b. **Business turnover:** It is more difficult to determine an appropriate business turnover threshold. Westpac defines a small business as having an annual turnover of less than $2 million. However, this may not be reflective of a business' internal resources, and could exclude small businesses in low margin but high turnover sectors. It also may not be particularly useful for complex corporate structures involving subsidiaries.

    c. **Whether a business is publicly listed or not.** This is not necessarily indicative of a firm's size or resources.

    d. **Class of policy.** Drawing a distinction based on the policy taken out, following the Australian model.

48. Another option would be to apply a test where a business would have to meet a certain number of the above criteria (e.g. at least two out of three) to be classed as small.

6	*If we have a separate duty of disclosure for businesses, should small businesses have the same duty as consumers? Why/why not? If so, how should small businesses be defined?*

Design option 2: Should businesses be able to contract out?

49. If a duty of fair presentation is adopted, there is a question of whether insurers and businesses should be permitted to modify or exclude the duty. This recognises that some businesses have significant bargaining power and may be content to agree to contracts on terms that differ from the default scheme for insurance contracts set out in the law. The parties may wish to contract out or modify the presentation regime if the risk insured is unique or particularly complex.

7	*If a duty of fair presentation of risk is adopted, should businesses be allowed to contract out of the duty? What are the costs and benefits of allowing businesses to do so? If businesses are allowed to contract out, should the duty apply to all businesses?*

Options in relation to disclosure remedies

50. The options presented below have been designed to apply to both consumers and businesses.

Option 1: Remedies based on intention and materiality

51. This option would allow insurers to avoid contracts for deliberate or reckless non-disclosure or misrepresentations that are material. A non-disclosure or misrepresentation would allow avoidance if it was objectively material and if it induced the insurer to enter into the contract on those terms. The insurer:

- may avoid the contract and reject all claims
- need not return premiums unless it would be unfair to the insured to retain them (for example, cases involving life insurance policies with an investment element, or joint policies where only one policyholder has made a misrepresentation).

52. A non-disclosure or misrepresentation would be deliberate or reckless if the insured knew the statement was false or misleading or did not care; and knew the matter was relevant to the insurer or did not care. The onus would be on the insurer to prove that it was deliberate or reckless.

53. Proportionate remedies would apply where non-disclosure or misrepresentation was not deliberate or reckless, but was both careless and induced the insurer to enter the contract on those terms. Insurers could 're-underwrite' an insurance contract upon learning of such a non-disclosure or misrepresentation, by doing what they would have done had they known of the information at the time of contract formation:

- If the insurer would not have entered the contract, they can avoid the contract and refuse all claims, but must return the premiums.
- If the insurer would have varied the terms (except those relating to premiums), the contract must be treated as if it were entered into on those terms, or the insurer can cancel the contract by giving reasonable notice.
- If the insurer would have charged higher premiums, the insurer may reduce the claim amount paid by that amount, or can cancel the contract by giving reasonable notice.

Option 2: Remedies based on intention and materiality; no avoidance for non-fraudulent material non-disclosure

54. This option would allow insurers to avoid contracts where the non-disclosure or misrepresentation was fraudulent and induced the insurer to accept the contract on those terms.

55. This option would be similar to Option 1, but the key differences would be:

a. A court (or dispute resolution scheme) could disallow avoidance (or order the insurer to pay an amount in respect of the claim), where the insurer has not suffered any significant loss; or where it would be harsh and unfair.

b. An insurer would not be allowed to avoid a contract for non-fraudulent non-disclosure, even where the insurer would not have entered the contract initially.

Option 3: Disclosure remedies based on materiality only

56. This option would create proportionate remedies based on what the insurer would have done had it known of the correct information at the time of application. These would be similar to the proportionate remedies described in other options above.

57. Insurers would have to apply these remedies regardless of the intent behind the non-disclosure or misrepresentation e.g. if a non-disclosure was deliberate but not material to the insurer and would not have altered the terms or price of the contract, the insurer would have to pay the claim.

Table 3: Costs and benefits of disclosure remedy options

Option	Benefits	Costs
Option 1 disclosure remedies: remedies based on intention and materiality	• Applying more serious consequences to deliberate or reckless non-disclosure compared to other non-disclosures would discourage fraud and carelessness, and incentivise care and accuracy when filling out applications. • Proportionate remedies that take into account whether the insurer was induced to enter the contract because of the information ensure that both parties are no better or worse off than if they had all the facts at the time of application. This helps to support an effective insurance market by ensuring predictable outcomes for both parties. For example, allowing an insurer to reduce claim amounts by the higher premiums it would have charged, means that an insured who has deliberately not disclosed something, and then does not have to pay for past actions, is not in a better position than an insured who disclosed a matter for which they were then not covered or had to pay higher premiums to obtain cover. • Proportionate remedies also mean that insureds are not unduly penalised due to innocent or non-material non-disclosures or misrepresentations.	• May add costs for insurers if they have to prove that a non-disclosure or misrepresentation was deliberate or reckless. • May involve additional re-underwriting costs as it would require insurers to make retrospective assessments of what they would have done if the insured had disclosed the information accurately. However, according to many insurers, they already use a range of proportionate remedies, which they select based on a range of factors, including what the insurer would have done had they known of the information at contract formation. ICNZ submitted that it is common practice for insurers currently to re-underwrite when responding to non-disclosures, so this would not be onerous for insurers to comply with or involve significant costs. Providing this range of remedies would codify existing (best) practice.
Option 2 disclosure remedies: remedies based on intention and materiality; no avoidance for non-fraudulent material non-disclosure	• The benefits of this option are the same as Option 1.	• The proportionate remedies for non-fraudulent disclosure do not always leave both parties in the same position as if the information had been disclosed at contract formation time. Under this option, if the insurer would have refused to enter the contract had it known the information, it cannot avoid the contract unless the non-

Option	Benefits	Costs
		disclosure is fraudulent. This is different to Option 1, in which insurers can avoid the contract if they would have refused to enter the contract at formation time, even if the misrepresentation or non-disclosure was not deliberate or reckless.
Option 3: disclosure remedies based on materiality only	• This option would not require insurers to consider the "intention" of any misrepresentation. This would potentially have fewer costs for insurers if they don't have to investigate misrepresentations and/or go to court to prove intention. It would provide more certainty to insurers.	• This option would not provide a strong incentive against intentional (fraudulent or otherwise deliberate) non-disclosure or misrepresentation. For example, it would put a consumer who had deliberately concealed a medical condition they had in the past five years, knowing that or not caring if it was relevant to the insurer, in the same position as a consumer who had not known to disclose a medical symptom that occurred twenty years ago, if both non-disclosures would have made the insurer exclude certain matters from cover. While the effect on the insurer may be the same, and the loss incurred is equal, this does not necessarily incentivise consumers to disclose material facts accurately.

8	*What is your feedback in relation the disclosure remedy options? In particular: Do you agree with the costs and benefits of the options? Do you have any estimates of the size of those costs and benefits? Are there other impacts that are not identified? Are there other options that should be considered? Which option do you prefer and why?*

Design options for disclosure remedies

Design option 1: Non-disclosures and misrepresentations unrelated to claims

58. Submitters wanted to clarify the effect of a non-disclosure or misrepresentation on a claim that is unrelated to the information that was not disclosed correctly.

59. An option is that if a claim is not connected to the non-disclosure or misrepresentation, the insurer would be required to pay that claim (even if they would not have entered the contract if they had known the facts). If the insurer then wishes to cancel the policy or impose additional or different terms, they can do so using the proportionate remedies proposed in the options above.

9	*Is it fair to require insurers to pay claims that are not connected to a non-disclosure or misrepresentation, even if the insurer would not have entered into the contract had they known the facts?*

Design option 2: Non-disclosure or misrepresentation discovered without any claim

60. Another issue is where insurers discover a non-disclosure or misrepresentation where a claim has not been made. If the insurer re-underwrites the contract to apply proportionate remedies, and discovers that they would have charged a higher premium, they can charge higher premiums in the future. However, they do not have a claim that they can reduce to

take into account the difference between the actual premiums charged and the premiums they would have charged had they know the facts.

61. An option is that the insurer could either ask the insured to cover the difference between the premiums retrospectively, or offer reduced cover for the future to cover the difference in premiums.

10	*Should insurers be able to offer reduced cover or ask the insured to cover the difference in order to recoup the amount they would have charged if they had the facts? Why/why not?*

Design option 3: Clarify return of past claim money

62. Where an insurer responds to a deliberate/reckless and material non-disclosure/misrepresentation by avoiding a contract and rejecting all claims, one issue is whether the insurer should be able to recover all past claims paid out to the insured, even where the money is not easily recoverable.

63. On one hand, the insured would have benefitted from the claims as a result of a breach of their duty, so they would have benefitted unfairly. It may therefore be more 'fair' to require them to return all past claims money. On the other, if the insured has used the claim money to, for example, rebuild a house, the claim money is not easily returnable and it may be hard or 'unfair' to require them to refund the insurer.

11	*Should we clarify that where a contract has been avoided and all claims rejected, the insured is not required to refund claims money if it is not easily returnable and would hard and unfair to the insured? Why or why not?*

Design option 4: Clarify interaction with general contract law

64. It is not clear that any proposed remedies in insurance contract law override the remedies provided by the Contract and Commercial Law 2017 for misrepresentations by insureds that induce insurers to enter a contract.

65. The Contract and Commercial Law Act provides remedies where a party has been induced to enter a contract by a misrepresentation that was material to the induced party. The induced party is entitled to damages from the other party as if the misrepresentation were a term of the contract that had been breached.

66. If new remedies are adopted for the duty of fair presentation in insurance, we suggest that insurance law clarify that section 35 of the Contracts and Commercial Law Act does not apply to non-disclosure remedies in any contracts of insurance. We suggest disapplying this law to non-disclosure/misrepresentation remedies available to the insurer only, so that the insured still has rights in relation to misrepresentation by the insurer.

12	*Do you agree that section 35 the Contract and Commercial Law Act should not apply to insurance contracts? Are there any other sections of the Contract and Commercial Law Act that should not apply to insurance contracts?*

Misrepresentation provisions in the Insurance Law Reform Act 1977

67. The Insurance Law Reform Act 1977 limits the circumstances in which an insurer may avoid a life insurance policy based on a misrepresentation. The effect is that insurers cannot rely on minor, non-fraudulent misstatements to avoid a life policy. The Act also provides that for other contracts of insurance, insurers cannot avoid a policy because of a minor misstatement.

68. We are proposing to replace these provisions to bring the remedies for misrepresentation that currently exist in the Insurance Law Reform Act 1977 into line with any new remedies for an insured's failure to disclose. Submitters generally agreed that there is no reason to differentiate between the two because both have a similar effect.

13	*Do you agree with the proposed change to the misrepresentation provisions in the Insurance Law Reform Act 1977? Why/why not?*

4 Unfair contract terms

Status quo

69. The Fair Trading Act 1986 prohibits unfair contract terms (UCTs) in standard form consumer contracts. A term is “unfair” if it would cause an imbalance in the rights and obligations of the parties to the contract, is not reasonably necessary to protect the legitimate interests of the party who would benefit from the term, and would cause detriment to a party to the contract.

70. Terms that cannot be declared to be unfair (‘**generic exceptions’**) are terms that:

    a. define the main subject matter of the contract

    b. set the upfront price payable under the contract

    c. are required or expressly permitted by any enactment.

71. There are also some exceptions for insurance contract terms (“**insurance-specific exemptions**”). The following terms in insurance contracts cannot be declared to be unfair:

    - the subject or risk insured against
    - the sum insured
    - excluded/limited liability on the happening of certain events
    - the basis on which claims may be settled
    - payment of premiums
    - the duty of utmost good faith
    - requirements for disclosure.

Problem definition

72. Consumer stakeholders were concerned that the insurance-specific exceptions mean that consumers are not protected from genuinely unfair terms.

73. Some consumers commented on particular exclusions from cover in their policies that allowed insurers to avoid paying out claims. These exclusions were surprising to consumers when they found out. However, the fact that consumers were surprised about the exclusions does not necessarily mean these terms were unfair.

74. There has been no formal enforcement action on UCTs in insurance contracts which would give guidance about whether particular insurance terms would be caught by UCT provisions. The lack of enforcement action may be due in part to a general perception, including from those who might report UCTs to the Commerce Commission, that insurance

contracts are more or less exempt from the UCT provisions. In addition, the UCT provisions do not allow for self-enforcement by consumers, meaning that judgments on UCTs are dependent on the Commerce Commission taking action.[7]

Assessment of specific examples given by submitters

75. In the absence of enforcement action, MBIE has assessed examples given by submitters to form an initial view of whether particular terms are likely to be unfair. The table below assesses examples given by submitters against the criteria in the Fair Trading Act for determining whether a term is unfair.

Table 4: Examples of potentially unfair insurance contract terms

Example of insurance contract term	Imbalance in rights/obligations?	Necessary for legitimate interests?	Would cause detriment?	Do insurance-specific exceptions apply?
Travel insurance: requiring preapproval before incurring healthcare costs	Yes – the consumer has a right to healthcare, but their right is blocked/limited.	Possibly not – being informed after costs are incurred should not prejudice the insurer or affect their decisions on whether to cover	Yes – detriment to insured if they cannot access timely healthcare.	May be excluded under s46L(d) – basis on which claims may be settled.
Insurer may make unilateral changes to a contract[8]	Yes – the insured does not have the same ability.	Possibly – depends on the nature of the change as to whether it is in legitimate interests.	Yes – an insured can lose cover they previously had, without the ability to negotiate.	May be excluded under s46L(a) – subject or risk insured against.
Income protection policies: insurer has discretion to decide whether the insured is unable to work[9]	Yes – the insurer has the ability to make decisions that affect the insured.	Possibly – the insurer can't leave it up to the insured to decide, but may also need to rely on expert opinions.	Yes – insureds may not be able to either work or obtain income protection, to their financial detriment.	May be excluded under s46L(d) – basis on which claims may be settled.
Third party claims: Insured must follow the defence recommendations of the insurer's lawyer[10]	Yes –insurer making decisions for the insured. Insurer's interests may not align with the insured	Possibly – may be necessary to ensure insurers do not pay more money than necessary.	Possibly – depending on the case.	May be excluded under s46L(d) – basis on which claims may be settled.
Car insurance: Insurer may decline a claim for an accident if they cannot contact the person at fault[11]	Yes – the consequences are borne by the insured, even though the insurer had the responsibility.	Possibly – if the insurer can't claim money from the third party.	Yes – the insured does not get their claim paid out through no fault of their own.	May be excluded under s46L(c) – limits liability of insurer on happening of certain events; or s46L(d) basis on

[7] Note that MBIE has a separate piece of work underway which is giving consideration to self-enforcement of UCT provisions for standard form contracts.
[8] Submission – Insurance and Financial Services Ombudsman
[9] Submission – Shine Lawyers (Tim Gunn)
[10] Submission – Consumer NZ
[11] Submission – Consumer NZ. This was also raised by stakeholders in the Australian review of insurance contract exemptions from UCTs: ***https://static.treasury.gov.au/uploads/sites/1/2018/06/t284394_UCT_Insurance_Contracts_Proposals_Paper_Aug.pdf***

Example of insurance contract term	Imbalance in rights/obligations?	Necessary for legitimate interests?	Would cause detriment?	Do insurance-specific exceptions apply?
				which claims may be settled.
Travel insurance: Broad exclusions for any claim related to mental health[12]	Yes – insureds may be denied claims because of actions outside of their control (e.g. if they have to cancel a trip because of a suicide of a family member). Broad exclusions may give insurers the right to interpret meaning e.g. is loss that is the result of a shooting, which was caused by mental health, covered?	Possibly – limits insurer's liability, to enable them to underwrite risk.	Yes – financial detriment and potentially detriment to mental health.	May be excluded under s46L(a) – subject or risk insured against; or s46L(c) – limits liability of insurer on happening of certain events.
Life insurance: Exclusions for any "unlawful act"[13]	Yes – if the contract has unreasonable expectations of the insured to ensure that third parties refrain from unlawful acts.	Possibly – could be necessary to protect legitimate interests in some circumstances and deter illegal activity.	Yes – detriment to beneficiaries of life insurance because of actions outside of their control.	May be excluded under s46L(c) – limits liability of insurer on happening of certain events.
Broad exclusions for pre-existing conditions (insurers can decline claims for any symptom, regardless of whether insured knew it was a symptom)[14]	Yes – unreasonable expectations of insured. Broad exclusions may give insurers the right to interpret meaning.	Possibly – limits insurer's liability, to enable them to underwrite risk.	Yes – detriment to insured if they cannot be covered for conditions that they weren't aware they had.	May be excluded under s46L(c) – limits liability of insurer on happening of certain events.

76. Our preliminary view is that some of the examples could be exempt from being declared unfair by virtue of the insurance-specific exceptions, but could otherwise meet the tests of creating imbalanced rights and obligations, being to the detriment of one party, and not being necessary to protect the legitimate interests of the party advantaged by the term (although they might also be excluded under the generic exceptions). This suggests that there is a problem with the status quo, which results in consumers being disadvantaged by genuinely unfair terms. The insurance-specific exceptions can potentially capture much of the content of an insurance contract, and thus may limit what actions can be taken against UCTs in insurance contracts. The status quo may allow genuinely unfair terms to be

[12] Submission – Financial Services Complaints Limited. This was also raised by stakeholders in the Australian review of insurance contract exemptions from UCTs: *https://static.treasury.gov.au/uploads/sites/1/2018/06/t284394_UCT_Insurance_Contracts_Proposals_Paper_Aug.pdf*

[13] Submission – Financial Advice New Zealand

[14] Submission – Insurance and Financial Services Ombudsman

included in contracts, which can affect how insurance markets fulfil their objectives of protecting consumers in the event of loss.

14	*Which of the terms in Table 4 are unfair? In your opinion, are they exempt from the unfair contract terms prohibition?*

Insurers say the current law is not a problem

77. Many submitters considered that the exceptions clarify what cannot be declared to be unfair in an insurance contract on the basis that they are needed to protect the legitimate interests of the insurer. These submitters supported retaining the status quo.

78. Without the exceptions, insurers say they would face uncertainty regarding the extent of risk they take on. For example, an insurer may include terms which exclude it from liability on the happening of certain events, and prices its premiums based on those exclusions. If a court can strike down those terms as unfair, the insurer has not factored this additional liability into its premiums. If insurers can't accurately price risk, they may cease offering cover or increase premiums.

79. Insurers argue that the generic exemptions would not provide the necessary exemptions for insurance contracts. Insurers argue that insurance contracts contain a number of terms which do not meet the generic exceptions (the main subject matter or the up-front price payable) but which are necessary for the insurer to assess and price risk. On the other hand, as the courts can already weigh the legitimate interests of the insurer in determining an unfair term, the exceptions may not be necessary.

Criteria

80. The criteria that MBIE has identified for determining options are as follows:

    a. consumers are protected from contract terms that disadvantage them and are not necessary to protect an insurer's legitimate interests.

    b. insurers have confidence that they can effectively measure and price risk.

Options in relation to unfair contract terms

Option 1: Tailor generic unfair contract terms provisions to insurance

81. This option would remove the insurance-specific exceptions, and instead tailor the generic UCT exceptions to accommodate specific features of insurance contracts. Australia is currently considering a similar proposal.[15] Under this option, the law would:

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[15] ***https://treasury.gov.au/consultation/c2018-t284394/***

- define the 'main subject matter' of an insurance contract broadly as terms that clearly define the insured risk accepted by the insurer and the insurer's liability – broad definition would mean that policy limitations and exclusions that affect the scope of cover would be considered part of the 'main subject matter' and would not be open to review
- define the 'upfront price' to include the premium and the excess payable
- consider a contract to be standard form even if the consumer can choose from various options of policy coverage
- consider a term reasonably necessary to protect the legitimate interests of an insurer if it reasonably reflects the underwriting risk accepted by the insurer and it does not disproportionately or unreasonably disadvantage the insured
- provide alternative court orders where a term is found to be unfair, instead of the term being declared void. For example, a court could make orders to prevent or redress disadvantage to third parties impacted by the term, that the declaration applies on a case-by-case basis and not automatically to all contracts, and to avoid the outcome that policyholders are not entitled to any claim as a result of the term being voided.

82. A variation on this option would be for the regulator to issue guidance to help define what the generic exceptions mean in the insurance context. This option would potentially provide less certainty (at least initially) than defining the exceptions in statute.

Option 2: Rely on generic unfair contract terms provisions

83. This option would remove all insurance-specific exceptions from the Fair Trading Act. The generic UCT provisions would apply to insurance contracts unconditionally.

84. A variation on this option would be to follow the UK's UCT law as it applies to insurance. The UK law provides that core terms (main subject matter and price) are exempt from being declared unfair, unless they are not transparent and/or prominent. The key difference between the UK law and relying on our generic UCT provisions is this emphasis on the transparency and prominence of terms. The UK law does not appear to have impeded the effective functioning of insurance markets or exposed insurers to significantly increased risk and uncertainty.

85. Much of the enforcement action taken by the UK regulator in relation to insurance UCTs relate to terms that are so broad that their meaning is unclear (i.e. not "transparent"), and which are therefore unfair as they leave the interpretation of the contract up to the insurer. For example, some of the potential UCTs were exclusion clauses, which were potentially unfair because they were vaguely worded, rather than just because they limit the insurer's liability.[16]

86. Currently s46L(2)(a) of the Fair Trading Act provides that in determining whether a term is unfair, the court must take into account the extent to which the term is transparent.

[16] ***https://www.fca.org.uk/firms/unfair-contract-terms/library#cp***

Without any court decisions on UCTs, it is difficult to know whether in practice this means that a core term can be considered unfair solely because it isn't transparent.

87. If we adopted similar provisions it would make it clear that terms that specify excluded or limited liability could not be assessed for unfairness, as they define the main subject matter, unless they are not prominent or transparent. This means that where a core term defining the subject matter is so broadly worded as to be vague, it can be unfair. This would address some of the possible UCT examples submitters identified, such as broadly-worded exclusions for mental health, pre-existing conditions and unlawful acts – but not all of the examples. This would encourage precision and accuracy in how insurers word their contract terms, to provide greater clarity and certainty to the benefit of both parties.

Option 3: Completely exempt insurance contracts from UCT provisions and rely on conduct regulation

88. Under this option, insurance contracts would be largely or completely exempted from the from UCT provisions in the Fair Trading Act. The costs and benefits of this option would rely on the outcome of a separate review being carried out by MBIE into the way that conduct is regulated in the insurance industry. The options paper for that review is available at ***mbie.govt.nz/financial-conduct***.

89. While we do not think this is a viable option for the reasons set out in the 'Cons' section below, we have assessed it for completeness as we anticipate this option would otherwise be raised by submitters.

Table 5: Costs and benefits of UCT options

Option	Benefits	Costs
Option 1 unfair contract terms: tailor generic contract terms provisions to insurance	• Could benefit consumers by bringing insurance contracts under the general UCT provisions for all standard form consumer contracts. This would better protect consumers from unfair insurance terms compared to the status quo. • Compared to the other options, would provide more certainty and clarity to insurers about how the generic exceptions apply to insurance contracts. In particular, insurers would have assurance that terms setting out their liability will be reasonably necessary to protect the legitimate interests of an insurer if they reasonably reflect the underwriting risk accepted by the insurer in relation to the contract. • Would improve consumer choice of fair insurance products, and help consumers to get what they think they paid for, which would in turn increase trust in the insurer-insured relationship and support the effective functioning of insurance markets.	• A broad definition of 'main subject matter' would provide less comprehensive scope for consumer protections than a narrow interpretation (which would define the 'main subject matter' as the subject insured, i.e. a house, car, etc.).
Option 2 unfair contract terms: rely on generic unfair contract terms provisions	• Would provide certainty and clarity to the regulator and consumers that insurance contracts are covered by standard protections. • Would prompt enforcement action against	• Increases uncertainty for insurers that terms they think are necessary could be challenged in a court. However, arguably many insurance-specific exceptions could be considered necessary to protect the

Option	Benefits	Costs
	potentially unfair terms in insurance contracts. • Would improve consumer choice of fair insurance products. While consumers may not automatically be aware that their contract is now fairer, they are more likely to receive cover that matches their expectations. • We would expect this option to improve consumer choice of fairer insurance products.	legitimate interests of the insurer, and therefore these terms may be exempt from being declared unfair even without the insurance-specific exceptions under the status quo. • Insurance premiums may increase to take into account the insurer's expectation of increased risk. Consumers would face increased costs, but also gain by having fairer contracts –the increase in premiums would be the price of a fairer contract.
Option 2a unfair contract terms: core terms are exempt unless not transparent and prominent	• Provides certainty to insurers that terms that specify excluded or limited liability cannot be assessed for unfairness, as they define the main subject matter. • Would encourage precision and accuracy in how insurers word their contract terms, to provide greater clarity and certainty to the benefit of both parties. • Would address some (but not all) the UCT examples, such as broadly-worded exclusions for mental health, pre-existing conditions and unlawful acts	• A broad definition of 'main subject matter' would provide less comprehensive scope for consumer protections than a narrow interpretation (i.e. defining the 'main subject matter' as the subject insured, e.g. a house or car). A broad definition means that policy limitations and exclusions affecting the scope of cover would be considered the 'main subject matter' and would not be open to review.
Option 3 unfair contract terms: completely exempt insurance contracts from UCT provisions and rely on conduct regulation	• Assuming that a conduct regime is implemented, insurance contracts would be treated in a unique context. This would acknowledge the unique nature of insurance contracts, which is all about allowing the insurer to measure and price risk.	• May not provide sufficient consumer protection, even if a conduct regime is implemented. UCT provisions protect consumers from contract terms, while conduct regulation aims to protect consumers from unfair conduct. • If consumers are not protected from insurance UCTs, insurers have little incentive to avoid using UCTs. This could reduce consumer choice in quality insurance products, which may in turn impede the effective functioning of insurance markets. • If a conduct regime was not implemented, consumers would have even less protection.

15	*What is your feedback on the UCT options? In particular: Do you agree with the costs and benefits of the options? Do you have any estimates of the size of those costs and benefits? Are there other impacts that are not identified? Are there other options that should be considered? Which option do you prefer and why?*

5 Understanding and comparing policies

Status quo

90. Currently, there is no requirement for insurers to present policy information in certain ways. Upcoming changes in the Financial Services Legislation Amendment Bill will require financial advisers, including insurance brokers, to disclose their conflicts of interest and other information about themselves in a clear, concise and effective manner, using plain language. However, these requirements will not apply to the insurance products themselves.

91. Because insurance is complex, consumers are likely to rely on insurers or intermediaries to inform them about the policies that are available and the features of those policies.

92. Current settings also allow insurers to prevent third parties from creating a comparison platform for general insurance policies.

Problem definition

93. Submissions indicated a general lack of understanding amongst consumers about their insurance. Consumers found it difficult to understand and compare insurance policies, in part due to complex language in contracts and policies.

94. In addition, due to its complexity and the amount of information that must be provided to get a quote, it is often prohibitively time consuming for a customer to "shop around". Insurers also present policies in different ways so it can be difficult for a consumer to compare the information they get on a "like for like" basis. Submissions on the issues paper noted that there is a lack of reliable sources a consumer can rely on for information to compare different policies. We also have received evidence of an insurer issuing a cease-and-desist letter to an insurance comparison website.

95. In their submission the Financial Services Council acknowledged the importance of having plain English policy wordings for the purpose of comparing and changing insurance contracts. Some insurers are making steps in this direction already to design policy documents that are straightforward and clear.

Criteria

96. The criteria that MBIE has identified for determining options are as follows:

a. Insurance contracts provide certainty about the risks insured against

b. Customers have the information needed to make informed decisions about insurance.

Options in relation to understanding and comparing policies

Option 1: Require plain-language insurance policies

97. This option would require insurers to present their policies in plain language. It assumes that consumers will be more likely to engage with their policies if they are simpler and easier to understand. The result would be less jargon and legalistic language in policies.

98. At least eight submitters suggested using plain language as a tool to aid understanding. Consumers wanted contracts to be plainer, while insurers noted that they were already moving in this direction.

Option 2: Require core policy wording to be clearly defined

99. This option would require insurance contracts and policies to contain clear definitions for core policy terms. This would clarify the exact meaning of terms which could be subjective, and go some way to ensuring that legal language and jargon is understandable. This option relies on the assumption that people would read and understand their policy/contract and the definitions.

Option 3: Require a summary statement to be provided

100. A requirement to highlight core policy terms or provide a summary statement would draw consumers' attention to the key aspects of the policy in order to aid understanding of the product. This option could include a regulation making power to prescribe the form or length of the summary statement.

Option 4: Require insurers to work with third party comparison platforms

101. This option would require insurers to work with third-party comparison platforms. We are interested in suggestions for how this could be done. Some ideas are:

- Requiring insurers to work with third-party comparison websites.
- Prohibiting contractual terms that have the effect of prohibiting the use of publicly available information for price comparison purposes.
- Establish a government-run website that insurers are required to work with.

Option 5: Require insurers to disclose key information

102. This option would require insurers to disclose key information (e.g. key product features, complaints process, obligations of parties, incentives) to clients, in a clear, concise and effective manner, using plain language.

Table 6: Costs and benefits of options to help consumers understand and compare contracts

Option	Benefits	Costs
Option 1 **Require plain language insurance policies**	• Would make it easier for some consumers to understand insurance policies. • If consumers better understand their policies then they are better able to make their own decisions about financial products, and they are less likely to face unexpected at claims time	• It may be difficult to accurately translate complex terms into plain language. • There will be a cost to insurers to translate their policies/contracts into plain language • what is plain language for one person may still need explanation for others.
Option 2 **Require core policy wording to be clearly defined**	• It might make it easier for some consumers to understand insurance policies. • If consumers better understand their policies then they are better able to make their own decisions about financial products. • Fewer unexpected declines at claims time because consumers better understand the cover that their policies offer.	• There would be an initial cost for insurers. • In a legal document any word can be a key term and small wording differences can lead to very different outcomes. Therefore it may be very difficult to determine which words/phrases/terms are 'core'. • may create more confusion for consumers, as they will have to read their policies alongside the definitions.
Option 3 **Require a summary statement to be provided**	• It might make it easier for some consumers to understand insurance policies. • If consumers better understand their policies then they are better able to make their own decisions about financial products. • This option would make it easier for consumers and comparison websites to compare product features.	• It may be difficult to summarise a policy while capturing its nuances. • Consumers might rely on the summary and miss details about their policies which affect their cover. • Developing the summaries would be an added cost to financial entities • Insurance cover is complex, so the summary statement might end up nearly as long as the full policy, in which case the customer may end up with more information to try and understand policy document and possibly make policies more difficult to understand.
Option 4 **Require insurers to work with third party comparison platforms**	• Consumers would be better able to compare their insurance policies.	• Care would need to be taken in designing the requirements to ensure that commercially sensitive information is not revealed. • May be costly to establish and run.
Option 5 **Require insurers to disclose key information**	• This option may go some way towards ensuring that customers who are financially capable have access to appropriate and accessible information to help them make decisions.	• Disclosure requirements have minimal impact on consumer behaviour. The information needs to be presented in a clear, simple manner, employing lessons from behavioural science.

16	*What is your feedback on the options to help consumers understand and compare contracts? In particular: Do you agree with the costs and benefits of the options? Do you have any estimates of the size of those costs and benefits? Are there other impacts that are not identified? Are there other options that should be considered? Which options do you prefer and why?*

6 Miscellaneous issues

Insurer deemed to know matters known by its representatives

Status quo

103. Under Section 10 of the Insurance Law Reform Act 1977, an intermediary (such as an insurance broker) that receives commission from the insurer is deemed to be a representative of the insurer. The insurer is deemed to know matters known to the representative before the insurer accepts the insured's proposal.

104. For example, a consumer may disclose information to an insurance broker who receives commission from an insurer. If the broker fails to pass the relevant information onto the insurer, the insurer cannot avoid that insurance policy on the basis that the matter was not disclosed to them – because section 10 deems the insurer to have been given notice of it through the broker.

105. The provision was initially included on the basis that insurers are better placed than insureds to bear the risk of default or lack of skill by an intermediary, and on the basis that insurers should only pay commissions to those who the insurer is prepared to trust.

Problem definition

106. We have heard that it may be unreasonable that the insurer should bear the cost of an intermediary's failure to pass on information on the basis of entitlement to commission alone, particularly given:

    - Industry practice is that intermediaries are paid commission by the insurer, even if the intermediary is a broker selected by the insured to arrange insurance on behalf of the insured and is not closely controlled by the insurer. Some insurers suggest it is not appropriate for insurers to bear responsibility for failures by brokers who are acting on behalf of insureds just because a commission is payable.
    - Intermediaries may be substantial entities with professional indemnity insurance for insureds to claim against if something goes wrong. Once the new regulatory regime for financial advice is in force, many intermediaries will be required to be licensed and owe conduct and client care duties to the insured.
    - The New Zealand position is unique in common law jurisdictions, where brokers are not deemed agents of the insurer.

107. We have also heard that it is problematic that consumers may not always be aware whose agent an insurance intermediary is, and may not know that they will be responsible for an intermediary's failures if the intermediary is not entitled to commission from the insurer. However, this seems unlikely to be a major issue if in practice almost all intermediaries are paid commission by the insurer.

Criteria

108. MBIE has identified the following criteria for determining options to address the problems described above:

a. Insurers have confidence that they can effectively measure and price risk

b. Failure by intermediaries do not leave insureds without insurance cover and redress

c. Insurers do not unjustifiably bear liability for third party failures

Options in relation to miscellaneous issues

Option 1: Status quo

109. One option is to retain the status quo. Despite the problems identified above, it is arguable that as between the insured and insurer, the insurer is in a better position to decide which intermediaries to transact with and on what terms. The insurer may be able to impose contractual obligations on the intermediary e.g. require the intermediary to pass on all client information to the insurer. The insurer can also undertake checks to ascertain that an intermediary is reliable and that they are in a strong financial position and/or has professional indemnity insurance which can be claimed against in the event of misconduct.

Option 2: Provide for some intermediaries to be agents of the insured

110. Under this option, certain intermediaries such as brokers acting on behalf of insureds would no longer be deemed representatives of the insurer. In those situations, an insurer would not be deemed to have notice of matters which those intermediaries fail to pass on.

111. In defining which intermediaries are agents of the insured, one option is set out factors for determining whether an intermediary is acting as an agent of the consumer or of the insurer (the UK approach). Under this approach, the law would:

- set out certain scenarios where an intermediary is taken to be the insurer's agent e.g. when the intermediary collects information under express authority from the insurer
- in other cases, provide that an intermediary is an agent of the consumer unless the relevant circumstances indicate otherwise. Examples of factors indicating an intermediary to be acting for the consumer include that the intermediary undertakes to give impartial advice to the consumer or a fair analysis of the market.

112. Another option is to follow the Australian approach where responsibility for the intermediary's actions is determined under common law agency principles.

Option 3: Impose a statutory obligation on intermediaries to pass on information to insurers

113. Under this option, a statutory obligation would be introduced requiring representatives of insurers to pass on all relevant material matters known to the intermediary to the insurer.

114. While insurers could contractually require this of intermediaries now, in some cases larger brokers have sufficient bargaining power that insurers cannot simply impose such a requirement.

Table 7: Costs and benefits of options in relation to intermediaries

Option	Benefits	Costs
Option 1 status quo	• Insured does not bear risk of intermediary's failure to pass on information.	• Costs as described in the problem definition section above, some of which may be able to be managed by insurers by deciding who they deal with and on what terms.
Option 2 provide for some intermediaries to be agents of the insured	• From insurers' perspectives, they do not bear responsibility for failures to pass on information by intermediaries not controlled by the insurer.	• May sometimes be unclear whether an intermediary acts for the insurer or the insured. Would be left up to the courts to decide on a case-by-case basis. • Some insureds may be worse off compared to the status quo if intermediaries who are determined to be the insured's agent fail to pass on relevant information to the insurer. Insureds may be able to obtain redress against intermediary e.g. for failure to act with due care, skill and diligence.
Option 3 obligation on intermediaries to pass on information to insurers	If an intermediary fails to pass on relevant material information to the insurer, an insurer would be able to seek redress against the intermediary for failure to meet a statutory obligation (though some insurers may be reluctant to do so if a broker has large market power).	Would impose compliance costs on intermediaries. However, the statutory obligation should not require much more than responsible intermediaries' existing practices.

Other options

115. Other options that could be considered include:

- Treating consumer and non-consumer insureds differently. Commercial insureds generally engage brokers to negotiate insurance contracts and are in a better position than consumer insureds to bear the risk of intermediary failures. We welcome feedback on whether consumer and non-consumer insureds should be treated differently.
- In 2008, it was proposed that responsibility for an intermediary's actions should be determined based on who the intermediary has a written authorisation from. Where there is no authorisation, the intermediary would be the agent of the insurer.[17] However, it may be difficult for insurers to determine or control whether written authorisation had been obtained from insureds by independent brokers.

[17] Insurance: Contracts, Agency and Assignment, January 2008. http://www.med.govt.nz/upload/55058/insurance-contracts.pdf.

116. Aside from responsibility for an intermediary's failure to pass on relevant information, some submitters have also suggested clarifying the extent to which an insurer is otherwise responsible for the actions of intermediaries. We welcome more detailed feedback on how any uncertainty has given rise to problems in the status quo, and suggestions for options to address such problems.

17	*What is your feedback on the options in relation to intermediaries? In particular: Do you agree with the costs and benefits of the options? Do you have any estimates of the size of those costs and benefits? Are there other impacts that are not identified? Are there other options that should be considered? Which option do you prefer and why?*
18	*Can the issues with the status quo be overcome with insurers contractually requiring representatives to pass on all material relevant information? What are the benefits of a statutory obligation requiring representatives to pass on information?*
19	*Should consumer insureds be treated differently from commercial insureds in relation to these issues?*

Exclusions with no causal link to loss

Status quo

117. Section 11 of the Insurance Law Reform Act 1977 provides that insurers cannot decline a claim based on a policy exclusion if:

- the policy contains the exclusion because the insurer considers that the risk of loss is likely increased in the specified scenario; but
- in the circumstances of the particular claim, there is no causal link between the exclusion and the loss.

118. Section 11 means an insurer cannot decline a claim just because an unrelated circumstance subject to a policy exclusion happened to exist when loss was suffered.

119. For example, the policy may exclude cover where a vehicle does not have a current Warrant of Fitness. However, a third party may cause an accident while the vehicle is without a warrant but parked unused. The lack of a current warrant would not have contributed to the loss. In that scenario, section 11 of the Insurance Law Reform Act 1977 may prevent the insurer from declining the claim based on the warrant exclusion.

120. However, some circumstances may give rise to a greater statistical likelihood of loss even if they do not cause the loss. For example, a policy may exclude cover for a vehicle used for commercial purposes because it is more likely to be involved in an accident as it tends to

be driven more. Section 11 may also prevent insurers from declining claims in those scenarios.[18]

Problem definition

121. Per the commercial use example above, insurers will often seek to exclude cover in certain circumstances because of a greater statistical likelihood of loss. However, section 11 means that insurers may end up covering risks that they had sought to exclude and may interfere with insurers' ability to charge different prices to reflect higher levels of risk.

122. As Crossley Gates and Frank Rose of Keegan Alexander Lawyers submitted, section 11 interferes unintentionally with the way some insurance products are intended to work. If a cheaper vehicle insurance policy is available on the basis it will be driven only by those over 25 years old, but the vehicle is driven by an under-25 year old who did not cause or contribute towards an accident, section 11 allows a claim contrary to the common intention of the parties.

123. The Insurance Council submitted that section 11 is also open to potential abuse. For example, an insured could choose to insure their car for private use at lower cost and then use it for commercial purposes. Section 11 means that an insured would still have the benefit of cover if the commercial use did not cause or contribute to the damage.

124. Section 11 may also be viewed as giving rise to fairness issues as between different insureds. As insurers cannot effectively exclude certain risks even if there are policy exclusions, the overall risks being insured are higher, likely resulting in higher premiums. Insureds that "comply" with policy exclusions could be seen as cross-subsidising part of the costs of losses suffered by other insureds in excluded circumstances.

125. The extent of the problem is unclear. The Law Commission identified cases where section 11 prevented insurers from declining claims based on policy terms where vehicle cover was confined only to a named driver; equipment was insured for private use; or drivers were required to be licensed, not be in breach of the terms of a licence, or be over a certain age.

Criteria

126. The criteria that MBIE has identified to decide between the status quo and other options presented are:

    a. insurers have confidence that they can effectively measure and price risk

    b. insurers cannot use policy exclusions to decline a claim where it would be unreasonable to do so.

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[18] A policy term whereby a vehicle is only covered for private use could arguably be a term that defines the risk rather than a policy exclusion, meaning the insurer may still be entitled to rely on the term following the judgment in *Barnaby v South British Insurance Co Ltd* (1980) 1 ANZ Ins Cases 60-401.

Options in relation to exclusions with no causal link to loss

Option 1: Remove certain types of exclusions from the operation of section 11

127. The Law Commission proposed reform by removing certain types of exclusions from the operation of section 11, being exclusions relating to the characteristics of the operator of a vehicle, aircraft or chattel; the geographic area in which the loss must occur; and whether a vehicle, aircraft or chattel was used for a commercial purpose. If a policy contained one of those exclusions, an insurer would be entitled to deny a claim where the excluded circumstance existed regardless of whether it caused or contributed to the loss.

128. This option could include an ability to add other types of exclusions via regulations where it was considered they should be able to apply given greater statistical likelihood of loss.

Option 2: Exclusion does not apply if insured can show non-compliance with the exclusion could not possibly have increased the risk

129. Under this option, the UK position under section 11 of the Insurance Act 2015 would be adopted. An exclusion cannot be used to decline a claim if the insured can show that "the non-compliance with the term could not have increased the risk of the loss which actually occurred in the circumstances in which it occurred".

130. For example, a home and contents insurance policy may exclude cover where the house does not have functioning smoke alarms. An insured who does not have smoke alarms suffers flood damage. It is expected that the insurer would not be entitled to decline a claim as the insured could show that the lack of smoke alarms could not possibly have increased the risk of the flood damage.[19]

Table 8: Costs and benefits of options in relation to s 11 of the Insurance Law Reform Act 1977

Option	Benefits	Costs
Option 1 remove certain types of exclusions from the operation of section 11	• Allows insurers to more effectively price different risks in the knowledge that losses which arise in certain pre-defined circumstances will not be covered, even if the exclusion did not cause or contribute to the loss. • As insurers are able to more effectively exclude certain risks, this may result in lower premiums for some insureds.	• It may be difficult to identify a complete list of exclusions which should not be subject to section 11. However, this issue may be partly mitigated if there is a regulation-making power to add further exclusions. • Some losses that are covered under the status quo would not be covered under this option. However, this may not be unfair if the relevant exclusions are carefully selected.
Option 2 exclusion does not apply if insured can show non-compliance with the exclusion	• Allows insurers to more effectively price different risks in the knowledge that losses which have a greater statistical likelihood of occurring in excluded circumstances will not be covered.	• As for option 1, some losses that are covered under the status quo would not be covered under this option. However, this may not be unfair given the policy wording excludes cover in the relevant scenarios and

[19] Terms that "define the risk as a whole" are explicitly not subject to section 11 of the Insurance Act 2015. In the example of a vehicle insured for private use, but driven for a commercial purpose, and damaged through the fault of a third party, the term that the insured fails to comply with is one which "defines the risk as a whole". The insurer would be entitled to decline the claim and the insured would not be able to rely on section 11.

Option	Benefits	Costs
	• Compared to option 1, this option likely better enables insurers to exclude those losses which truly have a greater statistical likelihood of occurring (while preventing insurers from declining claims based on unrelated excluded circumstances). • As for option 1, as insurers are able to more effectively exclude risks which have a greater likelihood of occurring, this may result in lower premiums for some insureds.	given the greater statistical likelihood of loss. • The UK provisions are untested and there may be uncertainty for insurers as to what types of non-compliance with policy terms would be deemed to have potentially increased the risk of loss, or what policy terms may be ones that "define the risk as a whole". The benefit of the large body of developed case law under section 11 of the ILRA 1977 would be lost.

20	*What is your feedback on the options in relation to section 11 of the Insurance Law Reform Act 1977? In particular: Do you agree with the costs and benefits of the options? Do you have any estimates of the size of those costs and benefits? Are there other impacts that are not identified? Are there other options that should be considered? Which option do you prefer and why? Are the options preferable to the status quo?*

Failure to notify claims within time limits

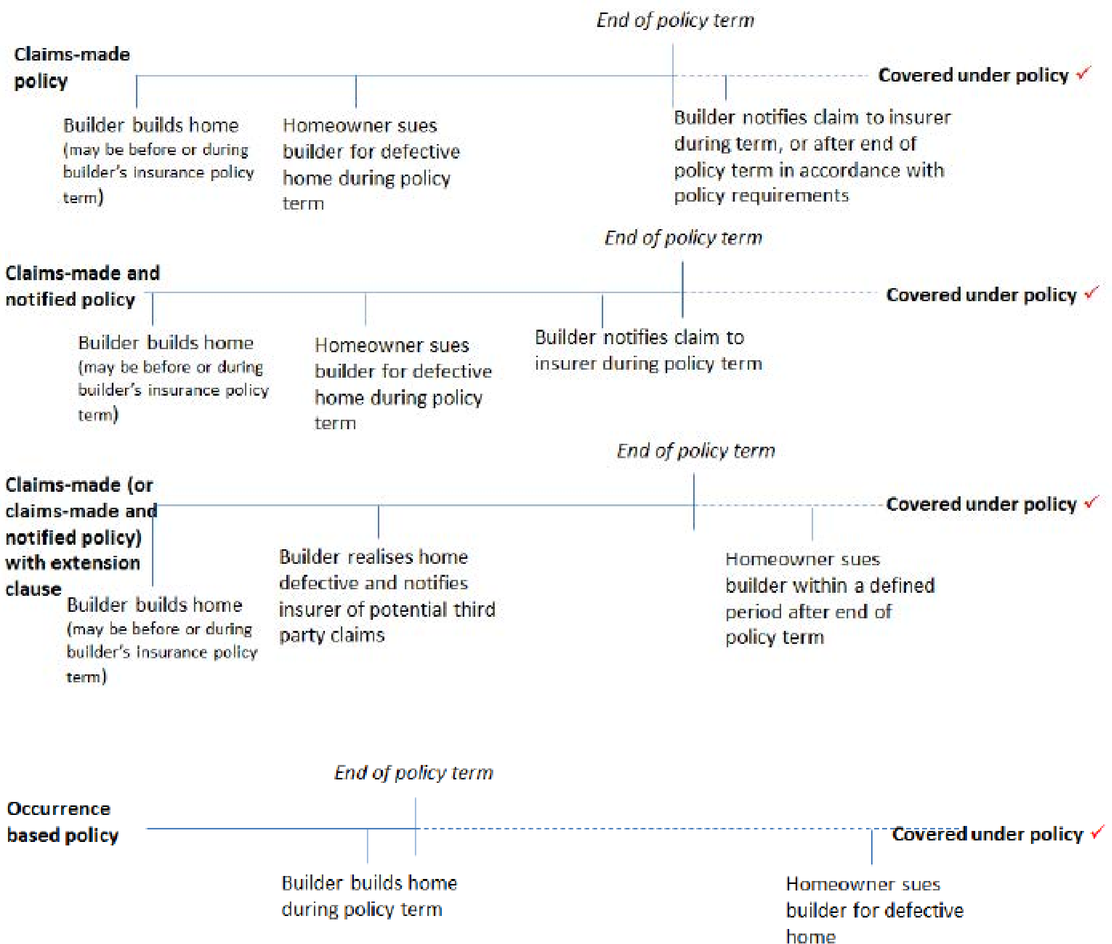
Status quo

131. Section 9 of the Insurance Law Reform Act 1977 provides that a claim cannot be declined on the basis of an insured's failure to comply with time limits for making claims unless failure to meet the time limit prejudiced the insurer such that it would be inequitable that the time limit did not apply.

132. The purpose of section 9 is to prevent insurers from declining a claim where the insured has merely failed to comply strictly with the policy's terms and where that failure caused no real prejudice to the insurer.

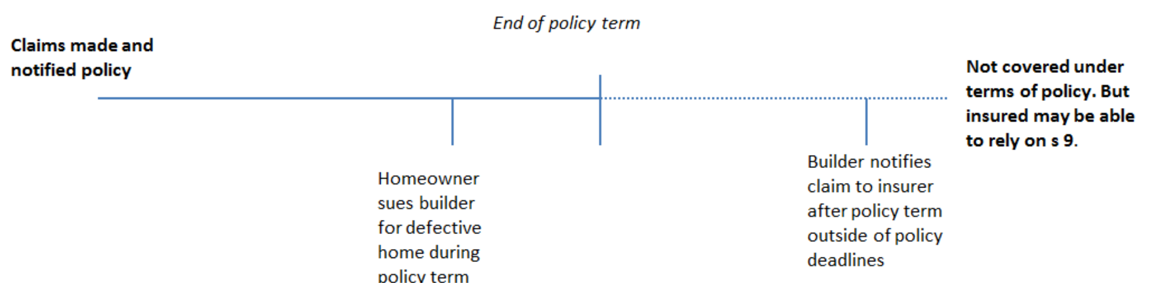
Problem definition

133. Section 9 is seen as problematic for "claims made" and "claims made and notified" professional indemnity insurance policies. The following diagrams from the issues paper illustrate different types of claims-made policies compared to an occurrence based policy.



134. Claims made policies reflect that in the case of professional liability insurance, third party claims may be brought many years after the event giving rise to a claim. This could mean insurers setting aside large reserves for potential claims under policies that have long-expired. Claims made policies allow insurers to estimate risks with greater accuracy and allow insurers to know the risks that they are exposed to at the end of the policy term.

135. However, section 9 of the Insurance Law Reform Act 1977 means that an insured that fails to notify the insurer of a third party claim within time limits is excused from that failure unless the insurer suffers prejudice as in the diagram below.



136. This is seen as partly undermining the purpose behind claims made policies as the insurer is not able to identify its risks with certainty at the end of the policy term.

Criteria

137. The criteria that MBIE has identified for determining options are as follows:

    a. insurers have confidence that they can effectively measure and price risk under professional indemnity policies

    b. insureds under professional indemnity policies do not lose cover merely due to failure to comply strictly with policy terms.

Option in relation to failure to notify claims within time limits

Option 1: Provide that section 9 does not apply to time limits under claims made policies

138. The Law Commission proposed amending section 9 essentially so that it does not apply to late notifications under a claims made policy where the notification took place after the end of a policy term. An insured would no longer be able to rely on section 9 in the example under paragraph 135 above. An insured would still be able to rely on section 9 for delays notifying claims during the policy term.

139. If this option is adopted, it may be necessary to provide for a longer notification timeframe (e.g. 28 days) at the end of a policy, so that insureds who become aware of a claim or potential claim close to the end of their policy term do not lose cover simply because they failed to comply strictly with the standard notification timeframes under the policy.

Table 9: Costs and benefits of option - failure to notify claims within time limits

Option	Benefits	Costs
Option 1 section 9 does not apply to time limits under claims made policies	• Claims made policies would operate as intended, allowing insurers to know their risks at (or soon after) the end of a policy term, potentially allowing them to carry lower reserves.	• Risk that some insureds will miss out on cover because of mere late notification of a claim or potential claim at the end of a policy period (even with an extended notification period). • Risk that insureds will favour continuing their policy with the same insurer to mitigate the above risk, as many insurers will provide continuing cover despite late notification at the end of one policy term. This may adversely impact competition in the market.

21	*What is your feedback on the option to provide that Section 9 of the Insurance Law Reform Act 1977 does not apply to time limits under claims made policies? In particular: Do you agree with the costs and benefits of the option? Do you have any estimates of the size of those costs and benefits? Are there other impacts that are not identified? Are there other options that should be considered? Is the option preferable as compared with the status quo?*
22	*If the option is adopted, should there be an extended period (e.g. 28 days) for notifying claims or potential claims after the end of a policy term?*

Third party claims for liability insurance money

Status quo

140. Under a liability insurance policy, an insured is protected against the risk of liability to third parties caused by the insured's wrongdoing.

141. Section 9 of the Law Reform Act 1936 allows a third party who has been wronged by a person with insurance to claim directly against the person's insurer, by creating a statutory "charge" that attaches to the insurance money from the date of the event giving rise to the third party's claim. The charge attaches even if the insured is insolvent or bankrupt, which means that the third party's claim is prioritised over claims from the insured's other creditors.

142. Without section 9, the priority between the third party and other creditors would be governed by common law. Specifically, the insurance payment would be deemed to form part of the insured's general assets for distribution to creditors, and the third party would be an unsecured creditor with equal priority to the insured's other creditors.

Problem definition

Defence costs

143. The Supreme Court decided in *Steigrad* that the statutory charge applies to the full sum insured under the relevant policy, regardless of whether some of that money has been paid (or must be paid) to the insured to defend the claim.[20]

144. As a result, if the relevant insurance policy provides that defence costs must be paid, the insurer could be liable for more than the sum insured.

145. In contrast, if the relevant insurance policy provides that the insurer has discretion to pay defence costs, there is a risk that the insured will be left without funds for its defence. Vero submitted that there have been real examples where this has occurred. In such cases, the insured would have been better off without insurance. Submitters commented that the outcome is contrary to the commercial purpose of liability insurance – to protect the insured.

146. New Zealand insurers have now changed their approach in light of the decision in *Steigrad*, and now offer separate cover for liability and defence costs. Submitters told us that the change in approach largely resolves the issues described above, but some insurers identified that uncertainty remains because the new approach has not yet been tested by the Courts.

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[20] *BFSL 2007 Limited & Ors (In Liquidation) v Steigrad* [2013] NZSC 156.

Other issues

147. Submitters also raised a range of more minor issues in relation to the operation of section 9, including the following:

    a. **Charge does not apply to sums payable overseas:** section 9 does not create a charge if the sum insured is payable overseas. As a result, third party claimants might not have priority over other creditors if the relevant insurer is not a New Zealand person, depending on where the sum insured is payable. This could create an incentive for insureds to purchase liability insurance from overseas insurers, which could give overseas insurers a competitive advantage over New Zealand insurers.

    b. **Priority of claims:** If there are competing statutory charges, section 9(3) ranks those charges based on the date of the event giving rise to liability. As a result, the third party claimant with the "earliest" charge can delay the settlement of other claims. In contrast, the common law rule that gives priority to the first claimant to obtain a judgment would incentivise claimants to advance their claims in a timely manner. Section 9(3) also provides that charges that arise on the same day rank equally. Submitters told us that there is uncertainty about how to prioritise claims received on the same day where the claims are in aggregate greater than the sum insured.

    c. **"Actual notice"**: Section 9(6) provides that an insurer may pay out sums insured for valid claims without worrying about future section 9 claims, provided that the insurer does not have actual notice of a potential claim. Submitters identified that there is uncertainty about what constitutes "actual notice".

    d. **Problems with claims-made policies:** The charge attaches "on the happening of the event giving rise to the claim for damages or compensation". If the insured has claims-made policies and switches between insurer A and insurer B, this could lead to a situation in which the charge attaches to the sum insured by insurer A but the claim is made to insurer B.

Criteria

148. Our criteria for deciding between the status quo and other options presented are:

    a. The option addresses the problems with section 9, in particular the defence costs issue

    b. Participants in the insurance market are well informed and able to transact with confidence at all points in the lifecycle of an insurance policy

Option in relation to third party claims for liability insurance money

Option 1: Allow plaintiffs to claim from insurers directly

149. Under this option, the statutory charge regime in section 9 would be replaced with provisions that would allow a wronged third party to claim directly against an insurer, as if the insurer was the insured person. This would occur without a statutory charge being created.

150. For example, similar to a suggestion made by the Law Commission, section 9 could be replaced with a new provision deeming that, in relation to section 4 the Contracts (Privity) Act 1982, a contract of liability insurance is enforceable at the suit of a third party to whom the insured is liable, as if the third party was a person designated by name in the contract in accordance with section 4 of the Act. Another method would be to have stand-alone legislation, as has been done in New South Wales and the UK.

151. The option could be designed to apply only if the insured is insolvent or be designed to apply more generally. The provision could be designed such that the wronged third party would be required to get leave of the Court to commence proceedings.

152. It would be necessary to include a provision that prevents insurers from paying the assured under the policy (at which point the benefit would be lost to the third party).

Table 10: Costs and benefits of option – section 9 of the Law Reform Act

Option	Benefits	Costs
Allow third party claimants to claim from insurers directly	• Would resolve the defence costs issue as well as many of the other issues with section 9. • New Zealand's approach would continue to be consistent with other common law jurisdictions. • Third parties would continue to be able to have greater access to liability insurance proceeds.	• It could be unfair to allow a third party (a contingent creditor) to have greater rights to an insolvent's funds than they have to other assets of the debtor.

23	*What is your feedback in relation to the option for section 9 of the Law Reform Act? In particular: Do you agree with the costs and benefits of the option? Do you have any estimates of the size of those costs and benefits? Are there other impacts that are not identified? Are there other options that should be considered? Which option (including the status quo) do you prefer and why?*
24	*If the option is adopted, should it apply to insolvency only? Should third parties be required to get leave of the court? Should reinsurance contracts be excluded from the application of the option?*

Duty of utmost good faith

Status quo

153. Under the common law, both parties to an insurance contract must act with the utmost good faith. The requirement is a fundamental principle of insurance contract law. It applies when a contract is formed as well as during and after a claim is lodged.

154. The main application of the duty of utmost good faith is in the context of the insured disclosing relevant information at the point of contract formation. However, the duty also applies to insurers. The recent High Court decision *Young v Tower* held that insurers must disclose material information; act reasonably, fairly and transparently; and process claims in a reasonable time.

155. *Young v Tower* also held that the duty of utmost good faith is an implied term of insurance contracts. One implication of this is that a breach of the duty can give rise to a claim for damages.

Problem definition

156. This paper is proposing changes to the duty of disclosure and the conduct options paper is proposing changes to the overarching duties on banks and insurers. If those changes are made, there could be uncertainty as to how the duty of utmost good faith applies. For example, people could be confused about whether new disclosure rules replace the duty of utmost good faith.

157. An additional problem is, because the duty of utmost good faith is an implied term of insurance contracts, it is uncertain whether the parties to the contract can agree that the duty will not apply (as would be the case for other terms of the contract).

158. Many submitters were concerned that the duty of utmost good faith is not adequately imposed on the insurer, as it focusses principally on the insured's duty to disclose. Submitters also said that some uncertainty remains about the exact scope of the duty. These concerns are to some extent addressed by *Young v Tower.*

Criteria

159. Our criteria to decide between options are:

    a. insureds and insurers have certainty that the duty of utmost good faith continues to apply

    b. the extent and content of the duty of utmost good faith are clear, while leaving the Courts flexibility to develop the law further as needed.

Option in relation to duty of utmost good faith

Option 1: Codify the duty of utmost good faith

160. Under this option the duty would be codified to reflect the current common law position in New Zealand, as articulated in *Young v Tower*. Such a codification would provide guidance on the scope and limits of the duty, but leave the courts flexibility to develop the law further. We seek feedback on the appropriate extent to which any codification should prescribe the scope and limits of the duty beyond the position in *Young v Tower*.

Table 11: Costs and benefits of options for duty of utmost good faith

Option	Benefits	Costs
Option 1: retain the status quo	• The courts might be better placed to continue to interpret the duty of utmost good faith without any statutory prescription.	• This option would not clarify the duty's current application or address the potential confusion that may be caused by upcoming disclosure and conduct reforms. • The lack of clarity could decrease confidence in the insurance system.
Option 2: codify the duty of utmost good faith	• Would ensure certainty that the duty continues to exist despite any other changes to the regime. • The option clarifies how the duty applies by codifying the current common law position, including that the duty takes effect as an implied term.	• Depending on how the duty was codified, the option could limit the flexibility of the courts to develop the duty through case law.

25	*What is your feedback to the options in relation to the duty of utmost good faith? In particular: Do you agree with the costs and benefits of the options? Do you have any estimates of the size of those costs and benefits? Are there other impacts that are not identified? Are there other options that should be considered? Which option do you prefer and why?*

Legislative drafting issues

Consolidation of insurance statutes

161. To improve legislative clarity and succinctness, we intend to consolidate the Life Insurance Act 1908, the Law Reform Act 1936, the Insurance Law Reform Act 1977, the Insurance Law Reform Act 1985, and the Insurance Intermediaries Act 1994 into one statute. The consolidation will be an opportunity to modernise drafting as appropriate.

26	*What is your feedback on the proposal to consolidate non-marine insurance statutes into a single statute?*

Amendments to Marine Insurance Act 1908

162. We think that the provisions governing marine-specific insurance should remain separate from the provisions governing other insurance, and that the benefits of doing so outweigh the benefits of a single consolidated statute. Accordingly, we propose to amend the Marine Insurance Act 1908 to resolve any conflicts with other insurance statutes and any amendments made to those statutes as a result of this review. At this stage we do not consider it necessary to modernise the drafting in the Marine Insurance Act 1908.

27	*What is your feedback on our proposed approach in relation to the Marine Insurance Act 1908?*

Repeal of redundant provisions

163. We propose to repeal redundant provisions where appropriate. Submitters identified that the following provisions may be redundant:

    a. **Section 8 of the Insurance Law Reform Act 1977:** Assure Legal submitted that the same issue is dealt with by section 11 Arbitration Act 1996.

    b. **Section 12 of the Insurance Law Reform Act 1977:** Section 12 provides for insurance contract cases in the High Court to be tried before a Judge without a jury. Bevan Marten submitted that the provision is no longer necessary because civil procedure has moved away from jury trials.

    c. **Section 7(3) of the Insurance Law Reform Act 1985**: Subsection (3) may be redundant as it refers to a repealed provision, providing that when insurance is made contrary to that provision it is void.

    d. **Section 26 of the Marine Insurance Act 1908:** Bevan Marten submitted that the provision is redundant because the issue it was meant to deal with can now be dealt with through the general criminal law on fraud, or by way of a negligence action or other action.

    e. **Section 32 of the Marine Insurance Act 1908:** ICNZ submitted that this section is redundant because it relates to the interpretation of the Lloyds SG Policy, which was in use between 1779 and 1982 and is no longer in use.

    f. **Sections 34-36 of the Marine Insurance Act 1908:** These sections relate to warranties, and are covered by section 11 of the Insurance Law Reform Act.

    g. **Sections 37-42 of the Marine Insurance Act 1908:** These sections also relate to warranties.

    h. **Various other sections of the Marine Insurance Act 1908:** Submitters identified that many provisions of the Marine Insurance Act may be irrelevant in practice because they are covered by standard (usually UK-based) contract wordings.

28	*Are the above provisions redundant? Why/why not? Are there other redundant provisions in the legislation covered by this review?*

Other miscellaneous issues

Deferral of payments of premiums by intermediaries

164. The issues paper sought feedback on whether it was problematic that the law provides for intermediaries to hold onto premiums for 50 days (or longer by arrangement). While some submitters considered this to be an issue, it is unclear that statutory intervention is required given parties can contractually negotiate payment terms. At this stage, a change to the status quo is not proposed.

Registration of assignments of life insurance policies

165. The registration system for transfers and mortgages of life insurance policies under the Life Insurance Act 1908 is outdated because it is required to be paper-based. An option for reform is to prescribe that notice of assignment must be sent by writing to the insurer and registered by the insurer, without requiring any particular form.

29	*What is your feedback on the proposed option in relation to registration of assignments of life insurance policies?*

Life insurance payments for the death of minors

166. The Life Insurance Act 1908 limits the payment amount for life insurance policies for minors under 10 years old. The limit is $2000 (or more specified by Order in Council) plus the total (interest-adjusted) amount of premiums paid under the policy. Submitters commented that the limits may mean that amounts paid out under life insurance policies for minors may be insufficient to cover funeral costs.

30	*Should the maximum payment amounts for life insurance policies for minors be increased? Why or why not?*