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28 June 2019

Financial Markets Policy
Building, Resources and Markets
The Ministry of Business, Innovation and Employment
PO Box 1473
Wellington 6140

By email to: Insurancereview@mbie.govt.nz

Dear Sir/Madam,

Re: Submission on the Options Paper Insurance Contract Law Review, April 2019.

Thank you for providing an opportunity to submit on the options paper.

Southern Cross Medical Care Society (**Southern Cross**) is New Zealand's leading health insurance business, with more than 870,000 insured members and 62% of the health insurance market. In the financial year ended 30 June 2018, Southern Cross paid $906 million of private healthcare claims, representing 74 per cent of all health insurance claims. As a not for profit friendly society that exists for its members, for every dollar collected in premiums, Southern Cross paid 92 cents in claims back to members.

Southern Cross welcomes the review of New Zealand's insurance contract law and agrees that there is a need to update and consolidate existing insurance contract legislation. We also agree that a well-functioning insurance system is integral to ensure that insurance continues to serve all New Zealanders and that consumer's interests should be recognised and protected when participating in the insurance market.

However, we are not convinced that there are "significant problems in New Zealand's insurance industry" requiring wide-ranging reform and believe that care should be taken to not react to what may simply be the poor practices of a minority of insurers.

Specifically, the duty of disclosure is a critical part of insurance contract law and is essential to insurers to enable them to correctly price risk. Having said that we recognise the need to ensure reasonableness is applied in the duty to disclose and that proportionate remedies would even the balance and ensure that consumers are not overly disadvantaged, while ensuring that insurers can properly assess and price risk. We are confident that there are practical ways these outcomes can be achieved, having successfully adopted a different approach to our health insurance business.

Throughout this review we believe it's important that the interests of the insured and insurer are balanced to ensure good outcomes for both parties.

We have provided feedback on the specific questions raised in the Options Paper below. Please note these submissions do include some confidential information and we'd appreciate being consulted before any information is disclosed to a third party.

Yours faithfully,

Megan Mackintosh
Special Counsel

Objectives of the review

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

Overall we support the revised objectives of the review.

In respect to Objective 2 while we have no problem ensuring that our interactions (presumably meaning communications) with our members are fair, efficient and transparent at all points in the lifecycle of an insurance policy, given health insurance policies are long-term contracts we'd like to understand what specific obligations the requirement for transparency imposes. We take care to ensure our communications are as clear as possible but note that the use of the word "transparent" is inherently vague and uncertain at law.

We are pleased to see the addition of objective 3, which means thought is being given to the changing environment insurers are facing. We are conscious of the increasing compliance costs insurers are facing and concerned this will result in barriers to entry/ reduced participation in the market. Care needs to be taken with the numerous proposals for reform and review to ensure it doesn't result in a confused, cumbersome mix which does little to improve outcomes or choice for consumers.

Duties to disclose information

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?

Feedback on options for disclosure by consumers

We agree that the status quo (being the current duty to disclose and consequences for non-disclosure) is an issue to the extent that it's not well understood by consumers. However, it's our view that the main problem is more the consequences for non-disclosure (i.e. that it currently allows an insurer to void a policy for non-disclosure of a matter that may not even be directly related to claim subsequently made) rather than the duty itself.

Further, we don't believe that, just because consumers don't clearly understand the duty of disclosure and the implications if they don't disclose, that the duty should be removed altogether. Rather, if consumers do not understand the duty of disclosure then more care needs to be taken by insurers to explain it to them and thought needs to be given to ensuring proportionate consequences

Disclosure is an important part of insurance contract law and is essential for insurers to enable them to understand, assess and correctly price risk. The fact remains that insurers do not know the previous history of the applicant at the time they apply for cover. This knowledge (to the extent that its relevant and material) needs to be passed on to the insurer for the risk to assessed and priced.

In our view removing the duty of disclosure altogether and replacing it with a duty on the applicant to take reasonable care not to make a misrepresentation (Option 1) is unlikely to result in a better process or outcome for consumers. Effectively this puts the onus on the insurer to ask all pertinent questions to cover each possible scenario by an

applicant, leaving the insurer to take the risk if it fails to do so, rather than requiring the applicant to proactively disclose a material health event using a set of questions as prompts. This will effectively result in a much more complex, detailed questionnaire and the unintended consequence of making the completion of an application for insurance too onerous for both the applicant and the insurer. This is more likely to have the perverse outcome of increasing the effort while reducing the ability of vulnerable consumers or those with low medical or insurance literacy to complete an application without assistance.

We believe that Option 2 is the preferred option. This approach results in the applicant still being required to disclose relevant information but only to the extent that a reasonable person would know to be relevant. However, importantly the applicant remains responsible to disclose anything they are aware of that they may not have been specifically asked.

We don't agree that this is less favourable to consumers or that it leaves uncertainty, particularly when a carefully drafted set of specific questions is provided to prompt the applicant as to what they must complete and provide (which is our current practice).

Further we already take care to explain the process and what happens with respect to conditions disclosed. This leads to a better outcome for the consumer as they have certainty as to what cover they have at the time they take it out (rather than paying for a policy for years only to find they are not covered for what they thought they were) and they can cancel early on if they are not happy with the cover offered.

We don't believe that Option 3 would lead to a better outcome for consumers or that it could work in practice, certainly without adding significant costs. There is a risk that a large amount of personal (and health) information is unnecessarily disclosed to the insurer, which is obviously not in the consumer's best interests and doesn't actually help the insurer either.

We strongly believe that consumers need to understand that their heath records are theirs and <u>they</u> need to control their collection and disclosure. The Privacy Commissioner has previously warned life insurers against "trawling" (meaning requesting "full medical notes") as under the Privacy Act insurers are only legitimately able to collect the personal and health information that they actually need for a lawful purpose. We have care to ensure that we ask applicants and policyholders to disclose and then obtain any relevant medical information – so they are always aware of what information about them is being disclosed by their medical providers and collected by us.

This option also places all the onus on the insurer to ask the correct questions/ approach all relevant health professionals (there are likely more than just GP notes required to ensure proper underwriting).

It is also likely to add significant delays in the underwriting process and the issuing of a policy, in some cases quite substantially while a health records are sought and assessed and further information requested.

Do you agree with the costs and benefits of the options?

Option 1 – We agree that requiring consumers to answer a specific set of questions truthfully and accurately provides more certainty of their obligations, but do not agree to the removal of the underlying duty of disclosure in principal. Otherwise, if a specific question doesn't cover the matter to be disclosed an applicant has no obligation to disclose it, which disadvantages the insurer and creates unfairness for those who do

fully disclose. As noted above its likely that this option will increase costs for insurers, and therefore premiums will necessarily rise.

Option 2 – we agree with the benefits noted but refer to our additional points above. We don't agree that this option is less favourable to consumers, particularly if a specific questionnaire is provided to assist them in disclosure (counters both bullet points under "costs" for this option). In our view this balances the interests of the insurer and insured the most effectively and is likely to result in the best outcomes for both. As it is very similar to what we do today it's unlikely to result in any increase in costs.

Option 3 – we agree that this option would likely add significant compliance costs to insurers and don't believe this option necessarily results in a better outcome for consumers or that the benefits noted would be realised.

We also question the legality and practicality of requiring a health insurer to collect all relevant medical information of an applicant in order to underwrite properly. In our experience the requirement to collect and review an applicant's previous health records (sometimes amounting to hundreds of pages) and the consequent underwriting process can increase the processing time of an application by up to 400%. If this requirement was extended to every person on every application (including those with no prior medical conditions) we would need to increase the size of our underwriting team by a significant number, which would result in a large increased cost, which is ultimately met by consumers through premium increases.

Do you have any estimates of the size of those costs and benefits?

We would require more detail to give estimates of the costs of Option 1 and 3. As noted above Option 2 is substantially what we currently do so there's unlikely to be additional costs (unless more is required).

Are there other impacts that are not identified?

As noted above we have already taken steps to ensure the applicant's obligation to disclose pre-existing health conditions and signs and symptoms is as clear as possible in the application process (where it applies). We also provide a clear and specific set of medical questions for an applicant to complete, which includes a couple of more general questions along the lines of "Is there any other sign, symptom or condition not already disclosed?" to ensure that an applicant has the opportunity to offer their knowledge of these things even if a specific question was not asked about that particular thing.

Taking this approach ensures that an applicant knows what information they are required to disclose right at the start of the contract and what the consequences are if they don't provide the necessary information.

This enable us to underwrite as accurately as reasonably possible up-front, which then provides the member with certainty of cover rather than underwriting at claim time, which may be many years after the policy was taken out.

Are there other options that should be considered?

No.

Which option (including the status quo) do you prefer and why?

As noted above Option 2 is our preferred option for the reasons given.

3. ***Should insurers be required to warn customers of the duty to disclose? Why, Why not? Should insurers be required to warn all insureds of the duty to disclose, including business?***

We believe insurers should clearly advise customers of their duty to disclose and set out the consequences if they don't.

We don't offer insurance to businesses so don't have any comment.

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?***

Given it is the consumer's personal (and where applicable) health information, insurer's should obtain the consumer's authorisation to the collection and use of this information for the specified purposes (i.e. underwriting). This is our current practice and ensures that the customer is aware what information we have requested and obtained and what it's used for.

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 these 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?***

We don't offer insurance to businesses so we don't have any comment on these questions.

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?***

We don't offer insurance to businesses so don't have any comment on these questions.

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?***

We don't offer insurance to businesses so don't have any comment on these questions.

8. ***What is your feedback in relation to 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?***

Feedback on options for remedies for non-disclosure by consumers

While we believe it is the materiality of the non-disclosure that is most critical to what remedies should be available we have concerns with the current practice of avoidance by some life insurers and therefore believe that only allowing avoidance for deliberate or reckless non-disclosure or misrepresentations that are material is probably the best result to ensure balance between the insured and the consumer is achieved.

Do you agree with the costs and benefits of the options?

Option 1 – Yes, we agree with the benefits and costs of option 1. While our practice is to never void for non-disclosure (we decline the claim and vary the policy by adding the non-disclosed condition as an exclusion) as noted above it would be good for both consumers and the insurance industry to have a higher bar set on the ability to void for non-disclosure. Limiting avoidance to deliberate or reckless non-disclosure or material misrepresentation is the appropriate level in our view.

Further we agree that providing proportionate remedies for non-disclosure or misrepresentation that was not deliberate or reckless but was careless and induced the insurer to enter the contract ensures both parties are no better or worse off than if the insured had fully disclosed all the (material) facts at the time of application. This means the insured is not unduly penalised for innocent or non-material non-disclosure and the insurer has appropriate remedies when they need them. As noted above as we currently do re-underwrite when we become aware of an undisclosed condition this would not be an extra cost for us.

Option 2 – we don't believe the benefits for this option are the same as for option 1 and don't believe this is a good option.

Option 3 – We agree with the stated benefit to this option. We don't believe having more serious consequences for intentional non-disclosure or misrepresentation necessarily provides a stronger incentive to disclose material facts correctly.

Do you have any estimates of the size of those costs and benefits?

Not at this stage.

As we currently only re-underwrite in the case of material non-disclosure we don't believe there would be additional costs with either Option 1 or 3.

Are there other impacts that are not identified? Are there other options that should be considered?

No

Which option do you prefer and why?

As noted above we prefer Option 1 although would be comfortable with Option 3 as well, given our current practice. Both would result in a much more reasonable position for both parties, which we agree is the objective.

As a Friendly Society existing for the benefit of our members, finding practical (lower cost) remedies to non-disclosure, where we are not terminating policies and leaving members uninsured, is important to us. We are keen to see the rest of the industry look for better ways to ensure that neither party is overly disadvantaged in a case of material non- disclosure.

Further, as long as both parties are put back into the position they would have been in had proper disclosure of material facts been made, then we believe it's desirable to allow the policy to continue in place. That is how we currently deal with non-disclosure in our health insurance business, where we decline the claim directly related to the undisclosed condition and add it as an exclusion to the policy.

Having said that we acknowledge there may be cases of such material non-disclosure, where the right to void needs to be available, so we believe that option needs to remain in place.

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?***

We do not decline to enter into a health insurance policy even if full disclosure has not been made so this question isn't relevant to us but on the face of it, think that it's probably fair for an insurer to pay a claim that is not connected to a non-disclosure or misrepresentation.

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?***

Yes, as noted above if we discover, after a policy has been taken out, that there has been material non-disclosure, we decline any claim for cover that relates to that pre-existing medical condition and we add that condition as an exclusion to the policy. This means the parties are put back into the position they would have been in had proper disclosure been made.

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's not easily returnable and would be hard and unfair to the insured? Why or why not?***

While we do not avoid health insurance policies we do not believe it reasonable for an insured to retain money they have been paid out for claims that directly relate to a deliberate reckless material non-disclosure or misrepresentation, no matter how hard it may be for them to re-pay. If they have received money they are not entitled to they should be required to re-pay that money.

12. ***Do you agree that section 35 of 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?***

Yes. If the objective is to consolidate existing insurance contract law and have a separate set of rules that apply to insurance contracts then it would be helpful to have all relevant provisions in the one Insurance Contract Act. Then there is certainty for both insurers and insureds regarding their respective obligations and the remedies available for breach.

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

Yes, provided the remedies for non-disclosure are fair and reasonable to both parties (see our comments above).

Unfair contract terms

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

In our view the insurance specific exemptions to the unfair contract terms of the Fair Trading Act are important and necessary to protect the legitimate interests of insurers.

Specifically, the need to exempt terms that define the main subject matter of the contract (i.e. set out what is insured and to what extent) and terms that exclude or limit liability on the happening of certain events (i.e. clearly specify what is not covered) comprise how health insurance products are structured and how risk is assessed and how the products are priced.

We are not in a position to comment on any of the examples given other than the 2nd and 8th examples.

In respect to the 2nd example (Insurer may make unilateral changes to a contract) we do not believe that this is an unfair term if it is exercised reasonably. In long term contracts such as health insurance its necessary to ensure that policies remain up to date and relevant, both in terms of what is covered (benefits) as well as the maximums that apply. If an insurer could not vary the terms of a policy ever then consumers would be worse off quite quickly, with no ability to add cover for new tech procedures or increase maximums to reflect the rapidly increasing costs of healthcare.

In respect to the 8th example (broad exclusions for pre-existing conditions - insurers can decline claims for any symptom, regardless of whether the insured knew it was a symptom), one of the fundamental principles of health insurance is that it is only intended (and priced) to cover conditions that occur after the policy starts. This is to avoid anti-selection whereby a consumer who knows they are suffering certain symptoms or a pre-existing condition can unfairly apply for and obtain health insurance. It is possible (and in fact not uncommon) that while the condition was not diagnosed prior to the insured taking out the policy there are signs and symptoms that occurred prior to the start date that mean the applicant did know or should reasonably have known about the condition or the symptoms and should be disclosing these to the insurer so that risk can be properly assessed and underwritten and the policy priced appropriately. This is necessary for the legitimate interests of the insured and ties in with the applicant's duty of disclosure commented on above.

In practice we do not and cannot exclude cover for a symptom that the insured was unaware of prior to the start date of their insurance. All we can require is reasonable disclosure of health conditions and signs and symptoms of conditions that the applicant was aware of or should reasonably have been aware of at the date of application. Further if the symptom is unrelated to the condition subsequently arising we cannot exclude cover of that condition.

If an insurer was prevented from having or relying on exclusions such as these arguably there would be an imbalance in the rights of the insured which would cause detriment to the insurer (resulting in an unfair contract term).

We therefore do not agree that there is a problem with the status quo which is resulting in consumers being disadvantaged by genuinely unfair terms. As acknowledged in the options paper just because a particular exclusion is a surprise to a consumer doesn't mean the term is unfair.

We maintain that the insurance-specific exemptions to the unfair contract terms are reasonably necessary to protect the legitimate interests of insurers. If insurers can't prevent anti-selection or reasonably assess and underwrite risk then they may decide it's too difficult to offer cover at all to certain people or increase premiums for everyone, neither of which are good outcomes for consumers.

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?***

Do you agree with the costs and benefits of the options? Which option do you prefer and why?

See above for general comments on UCT.

We don't believe that consumers would benefit or gain better protection from option 1 in bringing insurance contracts under the general UCT provisions for all standard form contracts or from option 2 in removing all insurance specific exceptions from the FTA. It's difficult to see how options 1 or 2 would "improve consumer choice of fair insurance products and help consumers to get what they paid for", as compared to the status quo. It's possible the opposite would be true and consumers would end up with less choice and higher premiums.

We agree with the 'costs' of option 2 and reiterate that if we could not make unilateral changes to our long-term health insurance policies over time or rely on general exclusions without risking an insured challenging us in court we would likely have to close certain books and/ or substantially change our products, neither or which are likely to result in better outcomes for consumers. Its important to understand that a health insurance policy with no exclusions is not of itself necessarily a better or fairer contract for the consumer. It may in fact lead to extremely limited policies that only cover very specified medical conditions and only in limited circumstances (for example the 'junk' health insurance policies in Australia).

The options paper refers to "broadly worded exclusions for mental health, pre-existing conditions and unlawful acts" but we would argue that these exclusions are not unfair but necessarily define the main subject matter of the contract. For example, private health insurance is intended to provide cover for specified unexpected medically necessary health treatment in private, not to replicate everything that is available in the public system or covered by ACC.

We don't believe that conduct regulation is the correct method or place to provide for exemptions to unfair contract terms or that its helpful to have UCT provisions in another separate set of regulations. If the objective is to have a consolidated insurance contract law then any specific provisions applying to insurance contracts should be set out in the insurance contract legislation they can't just be dealt with as an exception to the UCT provisions.

We believe the status quo is the preferable option (we are unaware of any actual proven problems with it) but if a change was made its most likely option 1 would be a better option than options 2, 2a and 3 in that they recognise that special nature of insurance contracts.

Understanding and comparing policies

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 option do you prefer and why?***

What is your feedback on the options to help consumers understand and compare contracts?

We would question whether there is sufficient evidence of a problem requiring a regulatory solution. We already provide a large amount of information on our policy options, benefits terms and conditions and premiums and seek to make this information available across different mediums (policy documents, benefit summaries and comparisons, a "plan finder" tool including an online product comparison, premium calculators etc).

Further we don't agree that there is no requirement for insurers to present information in certain ways. Insurers are already subject to the Fair Trading Act, which prohibits misleading or deceptive conduct, false or misleading representations, making unsubstantiated representations and as noted above unfair contract terms. Those requirements mean insurers in NZ are already required to present their policies in as clear and transparent way as possible, using plain language to the extent possible. It's also in their interests to do so.

As acknowledged in the options paper however insurance is complex and, while in theory requiring policies be presented in plain language is desirable it's not as easy as it sounds. It may also not result in being any more helpful for certain consumers (i.e. vulnerable consumers, those with English as a second language or those with low literacy of insurance or financial services, medical conditions or health procedures). Further, we are not confident its practical or feasible to legislate for this.

For example, what is "plain language"? This may differ from person to person and may not be able to cater for language and cultural differences. Most health insurers would already say that while improvements can always be made, they already make substantial efforts to try & ensure their policy wording is as clear as possible.

In respect to requiring core policy wording to be clearly defined, again while we agree in principle we would note that most health insurers already clearly set out benefit tables and include definitions in their policy documents. We already take on board feedback from policyholders and seek to make improvements where warranted in our regular policy updates if a particular provision is causing uncertainty or confusion.

Requiring a summary statement to be provided is also not as easy as it sounds as it effectively requires the insurer to paraphrase the policy terms and conditions and there are legal risks in doing so (e.g. inadvertently changing the meaning of a policy term or leaving a material term out). Also, what may be a key benefit for one customer may be inconsequential for another meaning its necessary for an insurer to set out all benefits in the summary, which defeats the purpose somewhat.

We note that Australia has a legislative requirement to provide product disclosure and in practice this results in lengthy documents that are additional to policy documents and arguably are not actually read by consumers. In our view this has not necessarily resulted in a better understanding of policy terms by consumers. Rather it has added a layer of complexity and cost to insurers with no real benefit to consumers.

While we have no issue with third party comparison platforms as a concept we don't believe that health insurers should be required by legislation to work with/ input into these. In our experience to date they usually offer overly simplistic comparisons, i.e. a pure comparison between two benefits or the maximum for a particular benefit between one insurer and another.

This may on the face of it be useful for a consumer, but in reality it's not easy to compare benefits or entitlements or recognise that different policies may structure

benefits in different ways. For example, one insurer may have a product that includes a section where all cancer cover is covered in one place. The way we cover cancer treatment however is spread across a number of benefits i.e. surgical treatment, specialist consultations, chemotherapy and radiotherapy, diagnostic imaging and recovery and support. It's not easy to compare the two in a statement or by way of a comparison table. Further, third party comparison platforms likely don't have any way of including things like claims ratios, which are an important factor in choosing an insurer (i.e. shows a consumer the claims an insurer actually pays out as a ratio of premium received).

We would therefore question the likely high costs for insurers of being required to input into these platforms in light of the actual value/ assistance they provide a consumer.

Do you agree with the costs and benefits of the options? Do you have any estimates of the size of those costs and benefits?

It's difficult to estimate the costs for the options at this stage but we'd suggest they are likely to be quite large, depending on the scale of the change.

Which option do you prefer and why?

We are not confident that any of these options will result in a better understanding of insurance policies by consumers, in that most of these are things that health insurers currently do already.

We would also question, with the other conduct related regulatory change in train, whether there is a need to legislate for these things separately and suggest that it's likely to be quite difficult to do so. If it is found that we do need more specific obligations we consider a code of conduct may be an effective way of achieving the desired outcome.

Miscellaneous issues

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?***

We don't have any comment on these options at this stage. We do question whether this is better dealt with in the FSLAA, Adviser Code and conduct regulation.

18. ***Can the issues with the status quo be overcome with insurers contractually requiring representatives to pass on all material relevant information? What benefits of a statutory obligation requiring representatives to pass on information?***

See above.

19. ***Should consumer insureds be treated differently from commercial insureds in relation to these issues?***

No comment.

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?

We currently do not decline claims relying on an exclusion that has no causal link to the loss, so we are comfortable with Section 11 of the Insurance Law Reform Act 1977 continuing to apply (i.e. the status quo).

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 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? Is the option preferable to the status quo?***

We do not apply a time limit for filing claims – our only restriction would be if a claim was filed so long after the treatment was provided that we could no longer locate the relevant information. Due to our practice of paying healthcare providers directly for a high proportion of pour health insurance claims we don't generally have a problem with this.

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.***

No comment.

23. ***What is your feedback on the option for section 9 of the Insurance Law Reform Act? 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?***

N/A so no comment.

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?***

N/A so no comment.

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 (including the status quo) do you prefer and why?***

We don't have any comment.

26 – 30

N/A so no comment.

END.

Southern Cross Medical Care Society