partners life

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Financial Markets Policy
Ministry of Business, Innovation and Employment
PO Box 1473
Wellington 6145

By email: insurancereview@mbie.govt.nz

Exposure draft Insurance Contracts Bill – Submissions of Partners Life Limited

1. Thank you for the opportunity to provide submissions in respect of the draft Insurance Contracts Bill (**Draft Bill**). The below is submitted on behalf of Partners Life Limited (**Partners Life**).

2. Partners Life is a life and health insurer, offering a range of products including life insurance, income protection, medical insurance, disability insurance, trauma cover and business risk protection.

3. We understand that the Ministry of Business, Innovation & Employment (**MBIE**) is seeking submissions on whether the Draft Bill, "*…achieves the policy intent or could have unintended consequences*."

4. It is important to understand that there are two different types of insurance and there are crucial differences between how those insurance sectors operate. These are:

   a. fire and general (**F&G**) insurance (including liability insurance); and

   b. life insurance.

5. It appears to us that the Draft Bill has been drafted with more focus on F&G and liability insurance (ie annually renewing policies) and as a result, may have unintended consequences that are detrimental to life insurers. These include (but are not limited to):

   a. Life insurers moving to the use of generalised underwriting rather than individualised underwriting, which has the potential to result in unnecessary blanket exclusions and limit the offer of customised cover to many customers.

   b. Life insurance potentially becoming unaffordable due to the inability to underwrite effectively and therefore adjusting pricing, which could discourage customers from purchasing the product.

6. Considering the above, the Draft Bill also fails to achieve the policy intent (in respect of life insurance) as it may not allow individuals to adequately protect themselves with appropriate life insurance.

7. We discuss in detail below the key differences between F&G insurance and life insurance.

F&G vs life insurance

8. The fundamental differences between F&G insurance and life and health insurance include:

   a. the item that is being insured (an object vs a human life);

   b. the duration of the contract (a contract of one-year duration vs a long-term contract); and

   c. the ability to underwrite (at each renewal vs once at the date of application) and the nature of the underwriting.

9. The Reserve Bank of New Zealand recognises that there is a distinction between the nature of F&G insurance and life insurance. For example, in accordance with the Insurance (Prudential Supervision) Act 2010 (**IPSA**) life insurers are required to hold a statutory fund (reflecting the guaranteed long-term nature of those contracts), whereas this is not required of F&G insurers.

Item being insured

10. F&G insurers provide cover against damage to a customer's belongings or business, which has been caused by an external event such as an accident. The event triggering the claim is separate from the customer's personal circumstances (i.e. natural disaster that is outside of their control).

11. Life insurers provide cover for human lives against the financial burden that arises following an injury, illness and/or death. The event triggering the claim is intrinsically linked to the life insured's personal circumstances (i.e. high blood pressure that has resulted in a heart attack).

12. Often, the financial impacts on F&G insurers are one-off in nature (the need to repair or replace the insured asset).

13. In contrast, the financial impacts on life insurers can occur over a long duration (a total disability claim may continue indefinitely if the life assured is not able to return to work).

Duration of the contract

14. F&G insurance contracts are commonly of one-year duration. At the end of the term, both the insurer and the customer have the option (but not an obligation) to renew the contract. F&G insurers place an onus on the customer to advise of any change in circumstance (i.e. a change in risk) at each renewal date. At the end of each policy, an F&G insurer can minimise its risk by not renewing contracts and/or altering the benefits provided.

15. Life insurance contracts are often long-term (and in most cases, last for the entire lifetime of the life assured). Policyholders effectively have the sole ability to cancel or alter the policy (absent any material misrepresentation in the application, the insurer is only able to cancel if the premiums are unpaid).

16. Life insurers have one opportunity to assess the customer's risk (which is at the date of the application). The decision it makes regarding cover to be offered, and the benefit terms to be offered are then guaranteed to remain in place for the duration of the contract (which is as long as the customer continues to pay its premiums). Premiums can only be increased in accordance with the 'claims experience' of the relevant pool of customers, not adjusted as a result of an individual's claim behaviour.

Underwriting

17. Underwriting is a process that allows an insurer to determine how likely a certain claim is to occur (and when) for the purpose of assessing whether the presented risk is insurable (and if so, on what terms). It can either be individualised (determining each client's individual risk of a certain claim), or it can be generalised (excluding all potential for certain claims from customers, regardless of their risk profile).

18. F&G insurers often rely on generalised underwriting. The risk of claiming is predominately based on rating factors (i.e. the value of the item being insured, the location in which it is stored, the risk of natural disasters in that area etc). As well as this, underwriting occurs at each renewal date (usually annually).

19. In contrast, life insurers commonly rely on individualised underwriting. Our view is that this is the best tool to reflect the customer's actual risk of claiming and therefore maximises the benefit to the customer as:

    a. higher risk customers are not subsidised by lower risk customers; and

b. lower risk customers do not have their coverage restricted through blanket exclusions that apply to all, when they pose no particular risk of that occurrence on the date that they purchase the insurance.

20. For example, if a customer had been diagnosed with depression 15 years prior to the policy commencement, and since that episode had not experienced any other symptoms, individualised underwriting may allow an insurer to provide cover for depression (as the risk of claiming is likely to be low). Whereas, if the underwriting is generalised, that customer may never be able to receive cover for depression if there were to be a blanket exclusion on the basis that they had experienced depression prior.

21. The more detailed and individualised underwriting can be, the more specific the terms offered can be (and therefore the better outcome to the consumer). Low risk customers are treated completely differently from high-risk customers. In other words, those customers who buy life insurances before their health deteriorates to the extent of increasing their risk of certain claims will pay less or be offered more comprehensive coverage, than those who seek to buy insurances after their health has deteriorated.

22. Blanket exclusions in respect of pre-existing conditions, which may be a consequence of complying with the draft Bill, effectively mean that all customers are being assessed as if they equally share the worst risk of certain claims.

23. In the case of life insurance, the process of underwriting only occurs once and that is at the date of application (irrespective of the duration of the policy) and so insurers only have once chance to get it right.

24. Suggestions to make underwriting easier, faster (or due to the draft Bill's requirements) more standardised in the life insurance space might achieve the opposite of what is intended, given that the more detailed and individualised underwriting can be, the more specific the terms offered can be to the individual's health profile and the more aware of those terms the customer can be before purchasing the insurance.

The Draft Bill

25. The key areas of the Draft Bill that require amendment in respect of life insurance are:

    a. section 14, which fails to recognise that the policyholder and the life assured are not always the same person and potentially fails to create a sufficient obligation on customers; and

    b. schedule 2, requiring insurers to prove that the customer failed to take reasonable care before any remedy is available to it.

We welcome the opportunity to discuss this with you further.

Yours sincerely

Privacy of natural persons

Naomi Ballantyne
Managing Director
Partners Life Limited

partners life

Submission on *Exposure draft Insurance Contracts Bill*

Your name and organisation

Name	Naomi Ballantyne
Organisation (if applicable)	Partners Life Limited
Contact details	Privacy of natural persons

[Double click on check boxes, then select 'checked' if you wish to select any of the following.]

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Responses to consultation paper questions

Part 1: preliminary provisions	
1	*Do you have any feedback on Part 1 of the Bill?*
	As discussed in detail above, there are significant differences between life insurance and F&G insurance, and in our view, Part 1 of the Draft Bill needs to recognise this. In particular, it would be helpful for Part 1 to define the different types of insurance contracts including F&G contracts, liability contracts, life insurance contracts, disability insurance contracts (including trauma), income protection contracts, and health insurance contracts (i.e. private medical cover).
Part 2: disclosure duties and duty of utmost good faith	
2	*Do you have any feedback on the Bill's provisions in relation to the duty for consumers to take reasonable care not to make a misrepresentation, including the matters that may be taken into account to determine whether a consumer policyholder has taken reasonable care not to make a misrepresentation?*
	We do not consider it appropriate in life insurance for there to be different classes of insureds and different duties of disclosures. In our experience, most consumers and non-consumers have the same level of knowledge about insurance. All customers (whether commercial or not) should have a duty to answer questions accurately and honestly. Further, in the context of life insurance policies, the object being insured is always a human life. This is the same for both consumers and non-consumers. In our view, at least in the life and health insurance sector, there should be an equal duty of disclosure for both consumers and non-consumers. Life insurers only have one opportunity to underwrite the risk that a customer presents, which is at the time of the application. As such, we need to be able to trust that customers are encouraged to tell the truth, and in situations where customers do not provide all material information (whether intentional or not), we need to be comfortable that adequate remedies are available (considering the long-term nature of the contracts). We support that an insurer can only rely on questions asked, and those questions need to be specific. A life assured should not be required to guess what information the insurer wants to know. We also support that an insurer is under an obligation advise the policyholder of their disclosure duties and the consequences of failing to do so. However, we are concerned that s 14 does not impose a sufficient duty on customers to be completely open and honest about their health. If insurers are not able to trust the disclosures made by customers, it may result in generalised underwriting and blanket exclusions, which may detrimentally impact those who would not have had those exclusions imposed had individualised underwriting been undertaken (see our example at paragraph 20 above). Alternatively, it may result in life insurers obtaining all medical records for applications, which could have detrimental consequences for consumers, including: • Insurers will have access to all personal details of applicants, which can often include sensitive matters. This would be the case even if the applicant chooses not to take the policy out. • It could increase the cost of insurance as additional cost would be incurred by the insurer in reviewing the medical records (which can be several pages in length), and there is a cost involved in obtaining the customer's medical records from a third party.

- The timeframe to issue policies may be lengthened as it would be dependent on the ability of medical providers (eg GP practices) to provide the records (which can cause significant delays in the claim and application process), and the insurer would be required to review the medical notes in detail before the policy could be issued.
- Insurers may still not be able to accurately assess the risk if they were not made aware of all medical practitioners who held the customer's records.

Considering the above, in our view there needs to be a stronger duty on the customer to tell the insurer their full medical history.

Further, s 14 fails to acknowledge that in the context of life insurance policies, the policyholder, and the life assured are not always the same person. There is often the situation where Partner 1 (P1) will take out a life policy on the life of Partner 2 (P2). In this scenario, P1 is the policyholder and P2 is the life assured. Section 14 only requires P1 to take reasonable care not to make a misrepresentation, but it is the health information of P2 that we (insurers) are concerned about.

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

As the law stands currently, regardless of whether the customer has taken all reasonable care, the remedies available to the insurer are the same. The focus is on whether there has been a failure to provide all information and whether that information is material.

At present claim declinature rates for life insurance products arising from customer non-disclosure or misstatement are in the very low single percentages demonstrating that very few customers experience poor claims outcomes because of their current obligations to disclose fully.

If an insurer is required to establish that a policyholder has failed to take reasonable care, before any remedies are available to it, it may encourage policyholders to withhold information so that their premiums are less, but accepting that if they need to claim, they can pay the increased premium at claim time. Another potential scenario is that policyholders withhold information to receive more favourable terms and/or wait to buy insurance until their health deteriorates without any consequences for doing do.

These scenarios assume that insurers will be unlikely to establish that policyholders have failed to take reasonable care and/or that they withheld information deliberately. This may result in increased premiums, making the product more expensive for consumers. As well as this, those customers who do choose to tell the truth (which is the majority), are likely to be worse off than those who don't, as unhealthy applicants will effectively be subsidised by healthy applicants.

In our view, rather than requiring an insurer to establish that the policyholder has failed to take reasonable care, the wording in the remedy section should be focused on the conduct of the insurer. For example, an exclusion could be included whereby no remedies are available to the insurer if they have failed to ask specific questions, remind the insured of their duty of disclosure etc. This creates certainty for insurers and would allow them to maintain individualised underwriting (as they could be confident that provided they met their obligations, they would have the ability to amend or cancel the contract if there was material non-disclosure), which will ultimately have a favourable outcome for consumers.

We also have concerns in respect of the remedies available under scenario 2 (where the misrepresentation was neither deliberate nor reckless and the insurer would not have entered into the contract).

Under scenario 2, all premiums must be returned the customer. While we agree in this scenario (where the misrepresentation was not deliberate) that some costs should be returned to the customer, there are costs associated with issuing a policy and/or reviewing a claim. In the context of life insurance, these costs include (but are not limited to), the cost of obtaining a customer's medical records from a third party, the cost of the underwriter to review the medical information (which may span over at least a five-year period and can be

	several pages in length), and the time spent by the policy team and/or the claims team in reviewing the relevant forms and corresponding with the customer. We consider that insurers should be entitled to recover these costs where there has been a misrepresentation (noting that, as currently drafted, for an insurer to have a remedy at all under the Draft Bill, the policyholder must have failed to take reasonable care). In our view, it would be fair if scenario 2 provided that all premiums are to be returned to the policyholder, subject to a retention by the insurer of costs and expenses incurred by the insurer.
4	*Do you have any feedback on the Bill's provisions on remedies for breach of the consumer duty in relation to life insurance policies where the misrepresentation was not fraudulent and more than three years ago?*
	We are comfortable for the Draft Bill to retain the special provisions in respect of life policies (as was set out in s 4 of the Insurance Law Reform Act 1977 (**ILRA**)). However, we note that the Draft Bill does not carry over the definition of 'fraudulently'. For certainty, it would be helpful if fraudulently was defined in the Draft Bill. We consider that the term was appropriately defined in s 4 of the ILRA, which defined it as: *a statement is made fraudulently if the person making it makes it—* *(a) knowing it is incorrect; or* *(b) without belief in its correctness; or* *(c) recklessly, without caring whether it is correct or not.* In addition to the above, it appears that the definition of 'life policy' in the Draft Bill also captures disability and income insurance contracts. For example, an income protection policy comes within the definition of s84(1)(d) of the IPSA. If disability and income protection policies are caught by the definition of 'life policy', this may have significant consequences for life insurers as for it to have any remedies available for misrepresentation, it has the added burden of establishing that the misrepresentation was fraudulent or within the 3-year period on which the insurer sought to avoid the contract. In turn, this may have unintended consequences for consumers as insurance will potentially become more expensive (as the risk presented to insurers is greater). As noted above, we consider that Part 1 should define the different types of insurance contracts and income and disability contracts should be separated from life policies in this regard.
5	*Do you have any feedback on the Bill's provisions in relation to the disclosure duty for non-consumers?*
	See our comments at question 2 – we do not consider that there should be separate duties of disclosure for consumers and non-consumers for life insurance.
6	*Do you have any feedback on the Bill's provisions in relation to remedies for breach of the non-consumer duty?*
	We understand that the breach of the non-consumer duties is the same as for a breach of the consumer duties. Accordingly, please refer to our comments above at paragraph 3.
7	*Do you have any feedback on the provisions in relation to the insurer's duties to inform policyholders of the disclosure duties, and insurer access to third party information, including how the duties apply for variations of insurance contracts?*

	Do you have any feedback on the consequences in the Bill if an insurer breaches duties to inform policyholders of the disclosure duties, and insurer access to third party information?
	Do you have any feedback on how the Bill codifies the duty of utmost good faith?
	The concept of utmost good faith is essential in life insurance because the customer knows about their health concerns in a way that an insurer cannot, and individualised assessment is not successful if the customer is not completely honest at the time of application. However, we do not consider that this duty needs to be codified in legislation and query what benefit would be achieved by doing so. We are concerned that by codifying this duty, it will take it beyond its development at common law, to an exercise of statutory discretion, which is less flexible. We are also concerned that the Draft Bill does not accurately reflect the common law position in respect of the duty (which we understand was the intention).
	Do you have any feedback on the Bill's provisions relating to information provided by a policyholder to a specified intermediary?
	In our view s 63(2) does not create a sufficient duty on 'A' (as that is defined in s 63) to pass on all representations to the insurer. Section 63(2) only requires 'A' to take all "*reasonable steps*" to pass on the information. Considering that the insurer is deemed to know any information known by a specified intermediary (in accordance with s 20), in our view, 'A' should be required to pass on all information to the insurer (rather than just be required to take all reasonable steps). We also query how s 63(3) will work in conjunction with s20. In accordance with s 63(3), 'A' does not need to pass on any information that they believe (on reasonable grounds) to be a misrepresentation. However, in accordance with s20, any representation made to a specified intermediary is deemed to be known by the insurer. As such, there could be situations where 'A' does not pass on information, believing inaccurately it to be a misrepresentation, but the insurer will be deemed to know that information and will therefore have no remedies available against the policyholder (and as noted above, in the context of life and health insurers, no opportunity to re-underwrite the risk that the customer presents). In our view, 'A' should be required to pass on all information to the insurer, and it should be up to the insurer to decide what is (or isn't) accurate and then be able to discuss that further with the life assured.
	Do you have any other feedback on the drafting of Part 2 of the Bill?
	In accordance with the commentary on the Bill, we understand that s 21 is intended to apply to employees of an organisation (for example). However, it could also potentially apply to the scenario described above at paragraph 2 where Partner 1 takes out cover for the benefit of Partner 2. This is a common set-up for life policies. For clarity, we suggest that the 'groups' that are intended to be captured by s 21 be specified.
Part 3: terms of insurance contracts	
12	*For claims-made policies, do you consider that 60 days after the end of the policy term is an appropriate period for allowing the policyholder to notify relevant claims or circumstances that might give rise to a claim?*

13	*Do you consider that insurers should be required to notify policyholders in writing no later than 14 days after the end of the policy term of the effect of failing to notify a claim or circumstances that might give rise to a claim before the end of the 60 day period?*
14	*Do you have any other comments on clause 69 of the Bill (Time limits for making claims under claims-made liability policies)?*
15	*Do you have any feedback on the exclusions listed in clause 71(3), which are not subject to the rule for increased risk exclusions in clause 71(1)?*
	It does not appear that this section was intended to apply to life and/or income and disability policies (considering the examples listed in s 71(3)). For certainty, it would be helpful to clarify what policies this was intended to apply to.
16	*Do you have any other feedback on Subpart 4 of Part 3 of the Bill (Third party claims for liability insurance money)?*
17	*Do you have any feedback on Schedule 3 of the Bill (Information and disclosure for third party claimants)?*
18	*Do you have any comments on not carrying over section 10(1) of the ILRA 1977?*
19	*Do you have any other feedback on the drafting in Part 3 of the Bill?*
Part 4: payment of monies to insurance intermediaries	
20	*Do you consider that changes should be made to requirements for how insurance brokers must hold premium money such as restrictions on brokers' ability to invest or more stringent requirements in line with the client money and property rules in the FMC Act?*
21	*Do you have any feedback on the proposed penalties for non-compliance with Part 4 of the Bill?*
22	*Is it necessary to retain clause 102 (broker to notify insurer within 7 days if a premium has not been received by the broker), and if so, what should be the consequence for breach of clause 102?*

23	*Do you have any other feedback on Part 4 of the Bill?*
Part 5: contracts of life insurance	
24	*If you consider that change needs to be made regarding interest payable from 91st day after date of death, please provide any further reasons and provide feedback on whether interest should only begin accruing after 90 days if the insurer has been notified of the death claim and (where relevant) letters of administration or probate have been obtained.*
	We consider that the 91 days should begin when the insurer has been made aware of the claim (rather than following the death of the insured). Under the current law, if a claim is notified late, insurers are required to pay interest (regardless that they had no notice and were unable to pay the claim). As well as this, there are instances where the insurer is ready to pay a claim but does not have clear instructions as to where the payment is to be made (and therefore, through no fault of its own, is unable to pay the claim). This commonly arises if there is a dispute over the proceeds of the estate (and the life insurance policy makes up part of the estate). In our view, if failure to pay is through no fault of the insurer, interest should not start accruing.
25	*Do you have any feedback on the proposal that any mortgaging of life insurance policies under new policies be dealt with under the Personal Property and Securities Act 2009?*
26	*Do you have any feedback on the Bill's requirements relating to assignments and registrations generally?*
	We agree that the requirements set out in the Life Insurance Act 1908 are prescriptive and outdated. However, the Draft Bill has retained the need to maintain a register of assigned life insurance policies (s 126). In our view, this is no longer required. Technological advances mean that insurers have much better records of policy owners. When a policy owner transfers ownership to another, insurers have processes to handle these transfers (such that a separate register is not required).
27	*Are section 75A of the LIA (relating to a policy entered into by a person for the benefit of the person's spouse, partner or children) or section 2(1) of the Life Insurance Amendment Act 1920 (relating to the reversion or vesting of life policy assigned to a spouse or partner) still necessary?*
28	*Do you have any other feedback on Part 5 of the Bill?*
	Section 146 currently limits benefits to be paid on the death of a minor to be the total of the premiums paid, plus $10,000 (for historical reasons). In our experience, $10,000 is too low. We recommend that this be increased to $20,000.

Part 6: regulation-making powers and miscellaneous provisions	
29	*Do you have any feedback on Part 6 of the Bill?*
Part 7: unfair contract terms and presentation of consumer policies	
30	*Do you see any unintended consequences from removing sections 18-20, 34-39 and 42 from the MIA?*
31	*In relation to unfair contract terms: which option do you prefer and why?*
	We prefer Option B.
32	*Do you have any feedback on the drafting of either of the options?*
	With individualised underwriting, the customer is offered terms in advance of proceeding with their cover (i.e. they are made fully aware of any loadings, restrictions and/or exclusions that will apply to their cover and how much their individualised cover will cost). A customer must accept these terms before their cover is issued. This means the customer is informed of and is aware of their specific personalised acceptance terms that will apply to their cover. This can be a complex assessment by both the insurer and customer and the reason many customers seek the advice of independent financial advisers to assist them with the options in the market. This individualised assessment and personalised acceptance terms do not fit well with 'unfair contract terms' regime as customers have accepted the terms prior to the issue of the policy.
33	*Do you have any comments on the obligation that consumer insurance contracts be worded and presented in a clear, concise and effective manner?*
34	*Do you have any comments on the regulation-making powers in clause 184?*
35	*Do you think regulations specifying form and presentation requirements for consumer, life and health insurance contracts (eg a statement on the front page that refers to where policy exclusions can be found) would be helpful? If so, please explain.*
36	*Do you think regulations specifying publication requirements for insurers would help consumers to make decisions about insurance products? If so, please explain.*
Timing and transitional arrangements	

Do you have any initial feedback on when the Bill's provisions should come into effect?
Do you have any feedback on the transitional provisions in Schedules 1 or 4, or other proposed transitional arrangements?
Do you have any feedback on Schedule 5 of the Bill?

Other comments
