Submission on discussion document: Insurance contract law review

Your name and organisation

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Responses to discussion document questions

Regarding the objectives of the review

1	Are these the right objectives to have in mind?

Yes largely these are correct, however, the review should also consider and bear in mind the way in which the modern insurance sector operates. The industry has been through massive changes since the late 1990's. These changes are

1) Structural
   In the 1990s the industry in Australasia went through unprecedented change; consolidation strategies, sharemarket listings, regulation changes and technology change saw insurers become large, sector spanning multinationals. The number of insurers in the market has lowered and the size of insurers has increased. In most sectors the market is now dominated by a few large insurers; Vero and IAG in the domestic market are representative of these changes. The focus of these companies is on a national market rather than local markets. The same forces have occurred in insurance broking and loss adjusting companies. Many insurers are in effect multinational corporations. While there are positive aspects to these changes, there are also scale issues consumers and s.m.e. are contracting with organisations whose operating budgets run to hundreds of millions of dollars, and as seen in the Christchurch earthquake context, internal decisions by insurers have immense impact on customers. An example would be the change in mid 2014 which led to insurers hardening their position with regard to what EQ claims met rebuild criteria. Under the current framework insurers are allowed and incentivised to treat all disputed claims in the same way, because of the fact that most Christchurch Earthquake cases exceeded the District Courts jurisdiction (until the recent uplift) insureds must litigate in the High Court where the rules and process are designed around large commercial disputes, and are un-necessarily expensive and complex for consumer litigants. The process with its reliance on disputed expert evidence means that the process is expensive and given the insurers commercial clout with the engineering and construction firms the process is stacked against the insured. The use of loss adjusters has also been problematic, a good loss adjuster is somewhat independent of the insurer, and when involved in claims they do assist the process. However, there is no requirement of independence and as insurers have consolidated the commercial power of larger insurers has diminished the independence of loss adjusters and other purportedly "independent" experts.

2) Increasingly complex products
Before the 1990s the majority of products on offer were relatively basic single risk policies; for instance fire, theft and storm house policies which only covered losses for these 3 basic contingencies. The policy wordings were short, running to a few pages, and while heavy with technical language were relatively simple in effect and, for interpretive purposes, were straightforward. Modern policies are considerably longer and more complex. It is telling that many referrals I receive are from general practice solicitors and insurance brokers, and the complexities of modern policies mean that they feel the need to seek specialised assistance for policy interpretation.

3) The modern industry is now composed of a smaller number of large often multi-national carriers. Industry changes mean that almost no insurers have local branches, rather sales and claims are services provided remotely on a nationwide basis. This means that for many consumer and s.m.e. insureds are dealing with staff in a different city who may not fully appreciate local issues. It also leads to uninformed individuals dealing with highly organised, well financed, specialised entities, where the subject matter is often highly complex.

4) Modern consumer products offered are relatively generic as, unlike the UK market, there are few bespoke policy options. This means that if a single insurer changes rates or imposes an exclusion it is likely that the rest of the market (which is only partly subject to market forces, given the duopolistic nature of, for instance, the domestic market) the rest of the industry will soon follow suit.

5) Technology changes allow an increasingly granular approach to underwriting. This is seen in Tower's increase in premiums for perceived "earthquake prone" residential properties. There is a risk that this approach will undermine the risk spreading nature of the industry and make sectors of the market uninsurable.

All in all I believe that these changes mean that insurers have considerable advantages in terms of resourcing, and changes in technology on top of the advantages already conferred by the existing legal situation. There is a lack of market forces to off-set these advantages. I believe that this justifies a re-balance including simplified insurance law rules which are sympathetic to consumers and SME.

2 Do you have alternative or additional suggestions?

I believe that simplified rules for policy interpretation for consumers and s.m.e. favouring the insured party would be useful. The legal fiction is that the rules of interpretation are there to allow the intentions of the parties to be objectively construed (*Vector Gas v Bay of Plenty Energy* [2010] SCNZ 5 at [19]). This is problematic for consumers as often products are purchased online without advice or guidance, and the complexity of modern products means that the intention (or the reasonable expectations) of the insured may not be likely to be reflected at all in the scope of cover. The common law remedies (the interpretive rule *contra proferentum* and authority that a standard form contract must not have onerous or unusual terms) are limited in scope. Interpretive material (pamphlets and policy summaries) may be of use, however in my experience such material can at times complicate consumers understanding of wordings as it generally does not capture the nuances of cover which is where the majority of disputes occur. I believe that the use of standard clauses (as is common in Lloyd's bespoke policies) which have agreed interpretations would be of use. Another remedy could be for a standardised and simplified glossary of terms to be used where, whereby a standardised legislative dictionary is applied across all consumer policies,

	standardising interpretation and assisting understanding amongst consumer insureds. I also believe that an insurance list process (like the Australian Federal Court's Insurance list) and an insurance tribunal (similar to the tenancy tribunal) should be established. These would allow for better and fairer resolution than is currently provided by the commercial dispute resolution providers like the IFSO, FSCL or FairWay. I develop on this in my comments regarding regulation.

Regarding disclosure obligations and remedies for non-disclosure

3	Are consumers aware of their duty of disclosure?
	No. My own experiences handling, reviewing and advising on claims since 2000 are that the belief is that what is material is limited to those questions asked or subjects referred to on the proposal and renewal forms. At renewal, most consumers let their policies roll-over without advising if there have been events which are material to the underwriter. Most people do not appreciate that the contract is re-formed at renewal and that the original pre-contract disclosures must be updated. Insurers do not routinely require that new questionnaires are answered and this feeds into the insured's lack of understanding.
4	Do consumers understand that their duty of disclosure goes beyond the questions that an insurer may ask?
	No. The attitude of clients I've advised on non-disclosure issues tends to be confusion about how the undisclosed information is relevant, and that if the insurer wanted to know, why didn't they ask? This is particularly apparent when the issues are technical and relate to say, the moral hazard of bankruptcy, or complicated medical conditions (especially when authority to collect medical records has been given) issues which are not well understood.
5	Can consumers accurately assess what a prudent underwriter considers to be a material risk?
	Yes but only to a degree. For some areas; such as having had a car stolen when applying for motor vehicle insurance there is a sufficient logical connection that a factual instance is seen as reasonably material. In other instances such as dishonest criminal offending, there is a general awareness that this would be material. However, beyond the obvious, it is not apparent what will be material. For instance if there are technical issues such as medical conditions, which may have occurred when the insured was a child or a teen, or bankruptcy and the event was historical. Certain insurers have very particular guidelines related to their particular appetite for risk and even for specialist brokers this can be difficult to predict. Even within insurance companies the separation between claims and sales/underwriting functions (which used to be within the same branch with cross-over of personnel, but are now often not even in the same city) means that often relatively experienced claim staff do not fully appreciate what their own underwriters would consider material.
6	Do consumers understand the potential consequences of breaching their duty of disclosure?
	Generally no. Some proposal forms state the consequences of non-disclosure (Vero personal insurance proposal for instance) but others do not, often stating that the effect of not providing information will mean cover is not provided (rather than avoidance of the policy and refusal to pay claims). The uberimmes fidae basis of the duty is unique to insurance. Compare this to the duty in, for instance, credit contracts where the scope of materiality is

	much more limited, and the effect less severe. The cancellation or avoidance of an insurance contract occurs when a loss has occurred already, if the subject of that loss is significant, such as a house fire, or the economic total loss of a vehicle, the avoidance occurs in addition to an already significant loss.
7	Does the consumer always know more about their own risks than the insurer? In what circumstances might they not? How might advances in technology affect this?
	No. This was true when Lord Mansfield laid down the rule which underlies our current law of non-disclosure in *Carter v Boehm* (1766) 3 Burr 1905. It remains true for some classes of business such as health insurance, income protection insurance, and business interruption. In these classes there are material circumstances which are unique to the risk being insured. However, for many classes of business, such as motor vehicle, home insurance, professional indemnity, etc there are generic aspects to the risk. Often through data aggregation, publically available databases and industry reporting, the underwriter has better or equal access to industry information than the insured, and has much better tools for processing and analysing the data. Often the information available (for instance in LIM reports, or medical files) is highly technical and the average person lacks the skills to analyse it or the resources to obtain advice, whereas the insurer will usually have the skills in-house to interpret such information. Examples of this would be access to flood modelling, information about liquefaction prone soils, data about professional complaints or those types of building prone to earthquake damage, or the cost to rebuild a building on poor soils or steep sites.
8	Are there examples where breach of the duty of disclosure has led to disproportionate consequences for the consumer? Please give specific examples if you are aware of them.
	In my personal experience I have seen many instances of disproportionate consequences, these include: 1) a substantial house fire claim was not paid and the policy avoided due to non-disclosure of a criminal conviction. The policy holder had an assault conviction for which he was imprisoned when he was 18 but had no subsequent convictions or arrests. He insured the house when he was in his mid-thirties, and mistakenly thought the Criminal Records (clean slate) Act 2004, applied to his conviction. In 2012 his house was badly damaged in a fire due to an electrical fault. The insurer's investigations discovered the conviction and the policy avoided. 2) A standalone income protection claim declined because the insured had not disclosed psychological problems she had as a teenager, following abuse. She insured in her early 30's and claimed in her early 40's when cancer treatment left her unable to work for approximately 18 months. There was considerable sensitivity around the issues experienced in her teens which led to her non-disclosing. Ironically if the policy had been bundled with a life cover (as is frequently the case) section 5 of the ILRA 1977 would have applied and the claim is likely to have been paid. 3) A truck trailer unit under commercial motor vehicle was an economic total loss in an accident. The driver had criminal convictions including numerous motor vehicle offences which had not been disclosed to the employer. In my experience this would have been overturned by the IFSO or in litigation (as for commercial policies convictions of employees are a lower order of materiality, objectively) but the quantum of the loss was above the IFSO's jurisdiction, and the client unable to afford litigation and soon went into liquidation due to the loss of the truck trailer unit. 4) A woman in her late 50's whose husband was killed when their car was hit by a drunk

	driver. The policy was a continuation of one taken out when the couple had first married nearly 30 years previously and the underwriter had relied upon the original proposal form answers. The husband had been made bankrupt in his early twenties, and the bankruptcy was cleared before the couple met. The policy was avoided for the moral risk of the bankruptcy which the wife had never previously been aware of, the vehicle was under finance and the wife was left with a considerable debt which she was unable to recover from the drunk driver.
9	Should unintentional non-disclosure (i.e. a mistake or ignorance) be treated differently from intentional non-disclosure (i.e. fraud)? If so, how could this practically be done?
	Yes it should be. Fraud is intentional and insidious, and undermines the system in that if self report cannot be trusted then claims costs will increase and the affordability of insurance will be undermined. There is also a large amount of case law around fraud which gives guidance on how either direct evidence of fraud or circumstantial inference may be used to prove fraud. (see for instance *Angus and Ors v ACE Insurance Ltd and Anor* [2014] NZHC 258). If it can be shown that the insured knew or should have known that by withholding the non-disclosed information they were obtaining an advantage then there is no real difficulty in applying the fraud standard. This is already done by insurers when declining for mis-statement at claims time, and removing unintentional non-disclosure will present no additional difficulties.
10	Should the remedy available to the insurer be more proportionate to the harm suffered by the insurer?
	Yes. Avoidance of policies only ever occurs when claims are made and investigated. In 18 years dealing with insurance claims I have never heard of avoidance occurring in any other circumstances. This means that the insured has already suffered a loss for which they are otherwise insured, but for the non-disclosure. They have paid premiums, often for a number of years, and the insurer has often suffered no economic loss. In the absence of fraud if the risk which has eventuated, and is claimed for, is a risk which would have been priced differently had the material information been disclosed, then it is fair that the insurer can look to retrospectively apply terms which are relevant to that claim. If the risk which has eventuated, and is claimed for, is not connected to the non-disclosure then that claim should be paid. If the insured then wishes to cancel the policy or impose additional or different terms, they already have the right to do so. For instance, if the non-disclosed information was the insured's bankruptcy, but the loss is a motor vehicle accident, the insurer has suffered no loss, it priced that particular risk (MV accident), collected premiums accordingly, and should pay the claim accordingly, however if the non-disclosed information was material a history of driving convictions it is fair to allow the retrospective imposition of terms, including those which could allow the claim to be declined. There was a rationale historically around moral risk; if the person was a bankrupt they may be committing fraud to improve their financial position. However, times have moved on, bankruptcy is more prevalent and there is no moral stigma attached these days. If there is a suspicion of fraud, in the modern environment insurers are very well placed to investigate and take steps to protect their positions.
11	Should non-disclosure be treated differently from misrepresentation?
	No there is no principled reason why non-disclosure and mis-representation (which is effectively just incomplete disclosure) should be treated differently. The law as it currently stands is confusing with the differentiation between life and non-life policies and the difference between mis-representation and non-disclosure conceptually. This leads to issues

	with covers which are sometimes bundled with life policies (casualty, income protection etc) and sometimes not, leading to a different regime applying, again for no principled reason. In terms of materiality a partial disclosure can be as significant as non-disclosure. The important issue is whether the non-disclosure (partial or otherwise) is innocent or intentional.
12	Should different classes of insureds (e.g. businesses, consumers, local government etc.) be treated differently? Why or why not?
	Yes, in my experience they currently are, in that different standards are applied because larger insureds have more clout commercially. For instance when I handled commercial claims I dealt with some client companies who were large multinationals. Their annual premiums ran into the $millions, they had relationship managers internally and senior brokers to lobby on their behalf. This meant that if I wished to decline a claim I was required to involve the underwriter, the relationship manager and the broker, for obvious commercial reasons. This can be compared with individual consumers who have no such support or economic clout. Because of this I struggle to recall an instance when a large or mid-sized corporate had a policy avoided for non-disclosure. Larger organisations have professional advisers and often have in house legal counsel. They have good record keeping systems, compared with consumers who often rely on memory. Corporate and local government insureds are far better placed to deal with more complex obligations than consumers. If a claim is declined larger entities are far better equipped to challenge the decision as they often have in house legal teams, and have access to external expert legal counsel (it is telling that the majority of large corporate law firms in New Zealand have insurance legal tems which are dedicated to serving this profitable sector of the market).
13	In your experience, do insurers typically choose to avoid claims when they discover that an insured has not disclosed something? Or do they treat non-disclosure on a case-by-case basis?
	This varies from insurer to insurer. When I worked for IAG and Vero, there was a case by case approach. At State, discretion was applied at branch level. Other insurers who I have dealt with as a lawyer for the insured appear to have a blanket approach, if there is non-disclosure they will avoid and decline to pay claims as a matter of principle. When I handled claims for insurers, as a rule if we had suspicions about a claimant, whether objectively justified or not, we would look for a non-disclosure because it allowed for the claim to not be paid and a "troublesome" insured could not make further claims as the policy was avoided. This is problematic, as it means that often subjective (one could say capricious) criteria are applied. This leads to uncertainty and is undesirable.
14	What factors does an insurer take into account when responding to instances of non-disclosure? Does this process vary to that taken in response to instances where the insurer discovers the insured has misrepresented information?
	This varies between insurers. At State we would consider the claims history and the circumstances of the particular loss. However, this meant that if the loss was large, there were often financial expectation that the non-disclosure would be used to avoid the policy so the claim (and the corresponding claims loss) would not be paid. It also led to instances where claims such as for thefts from cars, which are perceived to be more likely to be fraudulent, were treated differently from say theft from a house. Working for AMP General, the commercial relationship was given considerable weight, however this meant that if an insured was a small business or had a less well connected agent or broker, they were less

likely to have a claim paid in case of non-disclosure.

Mis-representation was treated differently simply because the legal remedy was different.

Regarding conduct and supervision

15	What do you think fair treatment looks like from both an insurer's and consumer's perspective? What behaviours and obligations should each party have during the lifecycle of an insurance contract that would constitute fair treatment?

Fair treatment from an insurers point of view is honesty in disclosing information before inception, and payment of the premiums. Fair treatment from an insureds point of view is about having claims paid promptly and generously. When an insured is claiming they have had a loss, this may well be a significant loss and for a number of consumers, they only claim if the loss is large. For instance when damage to the home is involved, a person is reminded of the damage every day they are in the home and any dispute about the loss has particular personal effect. If the loss is to a car and the person relies on the vehicle to get to work, or collect children from school, there is obvious personal inconvenience. This means that there is a heightened sense of unfairness when a claim is declined or part paid. I have had clients who have suffered burglaries, but end up more aggrieved at their insurer than the burglars because their trust in the insurer was "betrayed" by the treatment of what is seen as a legitimate claim.

I believe that the insureds' obligations to their insurer (uberimmes fidae) are well established and if anything, are overly onerous in comparison to comparable relationships (banking, or telecoms etc). However, the insurers' obligations require development. There is no requirement to pay claims in a timely fashion beyond the payment of interest in a court judgment which is limited to simple interest at a non-commercial rate set out in the Judicature Act. The approach taken is often about costs management rather than considering the particular needs of the insured. While usually the insurer will act fairly and promptly for moral or sympathetic reasons, in some situations such as the aftermath of the CES, or when there is suspicion cast on the insured (whether this is reasonable or not) there is no legal compulsion to act fairly. Given that in these situations the insured is at their most vulnerable and given the gross disparity of resources (both financial and in terms of access to professional advice) in my view there must be legal force given to require prompt payment and equitable treatment of insureds. This should include;

1) a more streamlined complaints procedure, with in cases of poor behaviour by the insurer the handling and settling of the claim delegated to an independent third party (at cost to the insurer)
2) In cases of confirmed poor or unfair practice by the insured there should be a simplified damages procedure. Currently rules of general damages (for unquantifiable losses such as suffering and distress) or special damages (for quantifiable loss) are applied by the Courts[1] and there is a considerable amount of uncertainty about which should be applied and how. This uncertainty and the New Zealand Courts traditional hesitancy against high general damages awards means that Insurers face kittle or no real consequences for poor claims handling practices.
3) Requirements for timely handling of claims, with financial penalties (whether fixed

[1] See *Stuart v Guardian Royal Exchange … No2* (1988) 5 ANZ Insurance Cases 60-844, *Kerr& Kerr v The State Insurance Manager* (1987) 4 ANZ Insurance Caess 60-781, and *Cedenco Foods v State Insurance* (1997)

	fines or a more generous damages regime) for delay. 2 possible remedies are set out in part 4A of The Insurance Act 2015 (UK) which implies a term of reasonably timely claims settlement with damages as a remedy, or the Texas chapter 542 subchapter b which in the case of an insurer using "unfair claims practices" makes them subject to a punitive interest rate (18% pa) and full payment of legal fees required to remedy the situation. 4) A simplified jurisdiction (similar to Australia's Federal Insurance list) which allows for simplified, cheaper access to the Courts for legal interpretive issues,
16	To what extent is the gap between ICP 19 and the status quo in New Zealand (as identified by the IMF) a concern?
	It is a concern because there is no real dis-incentive for poor claims handling practices. There is no requirement for dispute resolution providers ("DRP") to report to the Reserve Bank on complaints. In fact DRP will not provide such figures. When I worked for the Insurance and Savings Ombudsman, there were insurers whose complaints numbers far exceeded their market share. When reviewing the files it was obvious these insurers complaints procedures did not follow best practice. These same insurers are over-represented in Earthquake List cases, and in terms of the number of inquiries I have in private practise. There is also a problem with DRP since 2010 as since the Financial Service Providers (Registration and Dispute Resolution) Act 2008 dispute resolution provisions came into effect, DRP are now operating in a competitive environment, and are subject to commercial pressures. In my anecdotal experience DRP in the current environment are less willing to push back against insurers on more finely balanced decisions, which is detrimental to the interests of consumers and ultimately bad for the standing of the insurance industry..
17	Does the lack of oversight over the full insurance policy 'lifecycle' pose a significant risk to purchasers of insurance?
	Yes as beyond individual claims decisions, insurers can pursue poor claims practices with no consequences.

18	What has your experience been of the claims handling process? Please comment particularly on:
	• timeliness the information from the claims handler about:
	  ○ timeframes and updates on timeframes
	  ○ reasons for declining the claim (if relevant)
	  ○ how you can complain if declined
	• The handling of complaints (if relevant)

	Since the changes to the Fair Insurance code were made to include timeframes, most insurers are good about advising on timeframes in standard form letters. The reasons for declining claims can be more haphazard, particularly when the reasons for decline are technical or complex (however this is a training issue). Most insurers are good at advising of complaints procedure. The handling of complaints varies amongst insurers, some such as IAG and Vero generally have good procedure for removing complaints from the original business unit or team which made the decision to be internally reviewed by independent internal auditors. However some insurers still use claims review committees with members including claims handlers who made the decision under review. These committees are prone to issue capture

	and lead to poor decision making. Of current concern is that at least 2 insurers have isolated their Canterbury EQ claims teams from the rest of the organisation and have suspended independent internal review. I can only presume this a financially motivated move but it is poor practice and reflects poorly.
19	Have you ever felt pressured to accept an offer of settlement from an insurance company? If so, please provide specific examples.
	Not personally but I am aware of at least 3 documented cases of Christchurch EQ clients being threatened with being put on the back of the queue if an offer isn't accepted. I am aware of a client being told that they should accept an offer to settle a fire damage claim, because they couldn't afford a lawyer (they qualified for legal aid in any event).
20	When purchasing (or considering the purchase of) insurance, have you been subject to 'pressure sales' tactics?
	Not personally, I suspect I am not a suitable target for this type of sales approach. However, I know of a case where an older couple were pressured to replace a life insurance policy with a less suitable product, which subsequently ran foul of a decline for a pre-existing condition. I believe that the claim would have been upheld and paid if the matter had gone to Court (it was outside of the IFSO jurisdiction) but the widow lacked the funds to pursue the case.
21	What evidence is there of insurers or insurance intermediaries mis-selling unsuitable insurance products in New Zealand?
	Yes as above
22	Are sales incentives causing poor outcomes for purchasers of insurance? Please provide examples if possible.
	Churn in life and health insurance is an issue. Life and health policies are more effective if left unchanged, due to exclusions for pre-existing conditions and the timeframes for non-disclosure remedies in the ILRA 1977. This is not well understood by consumers and with smaller brokers being less prevalent (broking has been subject to the same consolidation as the rest of the industry) there is less quality advice than previously. As the brokerage for life and health policies in the first few years of a policy can exceed the premiums paid, there are real moral risks involved.
23	Does the insurance industry appropriately manage the conflicts of interest and possible flow on consequences that can be associated with sales incentives?
	No. There is a lack or transparency around incentives, a situation which needs addressing and which has not been resolved by the suite of Financial Providers legislation.

Regarding exceptions from the Fair Trading Act's unfair contract terms provisions

24	Are you aware of instances where the current exceptions for insurance contracts from the unfair contract terms provisions under the Fair Trading Act are causing problems for consumers? If so, please give examples.

	I don't believe that unfair terms in an FTA sense are an issue, rather the issues are around the complexity of contract interpretation, as discussed above.
25	More generally, are there terms in insurance contracts that you consider to be unfair? If so, why do you consider them to be unfair?
	No, as above.
26	Why are each of the specific exceptions outlined in the Fair Trading Act needed in order to protect the "legitimate interests of the insurer"?
	The exception in S26A was seen as necessary because in part the ILRA (section 11 in particular) regulates insurance contracts, and because the inclusion of insurance contracts could undermine an insurers ability to underwrite and manage the scope of the risks it insures against. S46L(4) is necessary as the terms specified are required to limit the insurers liabilities, which should only extend to the actual loss being indemnified.
27	What would the effect be if there were no exceptions? Please support your answer with evidence.
	If there no exceptions: 46L(4)(a)(b) and (c) – insurance (apart from life) requires uncertainty for there to be a risk which can be priced (an event which is certain to occur cannot be insured against). If a term about the uncertainty of a future event was considered to be unfair, it would restrict the efficiency of policies which must be able to respond to events which are unforeseen. The same for exclusions or terms of limitation. If terms limiting liability for events occurring it would lead to claims being paid which were not priced, and premiums would need to be increased to pay for this. 46L(4)(d) and (e) – if unfair terms were allowed to apply there is a possibility that an insurer could not apply sanctions for non-payment of premiums, policy limits or excesses, again this would increase claims costs. 46L(4)(f) – the duty of good faith is sui generis to contracts of insurance and an unfair terms regime runs the risk of changing the basis of the relationship with unintended consequences.

Regarding difficulties comparing and changing providers and policies

28	Is it difficult for consumers to find, understand and compare information about insurance policies and premiums? If so, why?
	Yes it is difficult. There are problems comparing terms due to policy interpretation complexities, and a lack of information. Satnadrised terms as discussed above would assist this, and more open pricing information would assist consumer
29	Does the level of information about insurance policies and premiums that consumers are able to access and assess differ depending on the type of insurance? E.g. life, health, house and contents, car insurance etc.
	Not really an issue I see in my practice.

30	What barriers exist that make it difficult for consumers to switch between providers?
	In life and health issues of pre-existing conditions and exemption periods for non-disclosure. However, these favour insureds, in other cases there are no substantial barriers.
31	Do these barriers to switching differ depending on the type of insurance? E.g. life, health, house and contents, car insurance etc.
	As above.
32	What, if anything, should the government do to make it easier for consumers to access information on insurance policies, compare policies, make informed decisions and switch between providers?
	Standardised terms making it easier to understand policies and coverage.

Regarding third party access to liability insurance monies

33	Do you agree that the operation of section 9 of the Law Reform Act 1936 (LRA) has caused problems in New Zealand?
	Not really, there was an issue with differentiating between defence costs and liability for damages in Directors and Officers and PI policies after the *Steigrad* decision. However policies now "ringfence" defence costs so in effect the problem has net proved to be a problem.
34	What are the most significant problems with the operation of section 9 of the LRA that any reform should address?
	The biggest issue isn't the operation of s9, the clause is straight forward and works, the issue is that the information about the policy and the insurer is difficult to obtain and can only be obtained through discovery in litigation. A term requiring more openness about what is insured and who the insurer is would be helpful.
35	What has been the consequence of the problems with section 9 of the LRA?
	Only the defence costs issue above.
36	If you agree that there are problems with section 9 of the LRA, what options should be considered to address them?

Regarding failure to notify claims within time limits

37	Do you agree that the operation of section 9 of the Insurance Law Reform Act 1977 (ILRA) has caused problems for "claims made" policies in New Zealand?
	Yes but only insofar as the courts have distinguished between "claims made", and "claims made and notified" wordings.

38	What has been the consequence of the problems with section 9 of the ILRA?
	I don't believe that there is a significant issue to be addressed
39	If you agree that there are problems with section 9 of the ILRA, what options should be considered to address them?
	[Insert response here]

Regarding exclusions that have no causal link to loss

40	Do you consider the operation of section 11 of the Insurance Law Reform Act 1977 (ILRA) to be problematic? If so, why and what has been the consequence of this?
	The wording of the section is less than ideal, and could be simplified. However in practise the section does not appear to cause problems.
41	The Law Commission proposed reform in relation to 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. Do you agree that these are the areas where the operation of section 11 of the ILRA is problematic? Do you consider it to be problematic in any other areas?
	In theory there could be issues, however I'm not aware of the problem arising in practise or having been considered by the Courts.
42	If you agree that there are problems with section 11 of the ILRA, what options should be considered to address them?
	[Insert response here]

Regarding registration of assignments of life insurance policies

43	Do you agree that the registration system for assignment of life insurance policies still requires reform?
	No
44	If you agree that there are problems with the registration system for assignment of life insurance policies, what options should be considered to address them?
	[Insert response here]

Regarding responsibility for intermediaries' actions

45	Do you consider there to be problems with the current position in relation to whether an insurer or consumer bears the responsibility for an intermediary's failures? If possible, please

	give examples of situations where this has caused problems.
	As it stands section 10(3) ILRA 1977 turns on who pays the intermediary. This can be problematic when either brokerage is deducted from premiums, or when the arrangements between an insurer and broker with regard to remuneration are opaque, for instance under some arrangements brokers are paid commission as a direct payment from the insurer, other times the brokerage is deducted from payments from the insured. The arrangements are often commercial terms negotiated between a particular broker and insurer, and it is very uncommon for the basis of the payment to be advised to the insured. For the purposes of certainty it would be preferable if there was a clause which clarifies the position.
46	If you consider there to be problems, are they related to who the intermediary is deemed to be an agent of? Or the lack of a requirement for the intermediary to disclose their agency status to the consumer? Or both?
	Both. It is unsatisfactory that deemed agency can turn on commercial arrangements between brokers/agents and insurers which are almost never disclosed. If a broker is paid brokerage, it should be deemed to be paid by the insurer, as the reality is that the brokerage is calculated and arranged with the insurer, even though it is levied from premiums paid by the insured. There should also be a requirement for intermediaries to disclose remuneration, which would help to address other issues as well.
47	If you consider there to be problems, what options should be considered to address them?
	Clarity around the payment of brokerage, as discussed above. Requirements for disclosure of remuneration.

Regarding insurance intermediaries – Deferral of payments / investment of money

48	Do you agree that the current position in relation to the deferral of payments of premiums by intermediaries has caused problems?
	No. These arrangements are long-standing industry practices which are commercial arrangements between brokers and insurers, and the only issues, when payments are made by an intermediary who then defaults, has already been addressed by the current wording of sections 4 and 5 of the Insurance Intermediaries Act 1994. (BTW this also reflects Lloyds practice and the Common law rule)
49	If you agree that there are problems, what options should be considered to address them?
	[Insert response here]

Other miscellaneous questions

50	Are there any provisions in the six Acts under consideration that are redundant and should be repealed outright? If so, please explain why.
	Section 8 ILRA 1977 is no longer necessary as the same issue is dealt with by s11 Arbitration

	Act 1996.
51	Are there elements of the common law that would be useful to codify? If so, what are these and what are the pros and cons of codifying them?
	The duty of utmost good faith should be clarified and codified. Currently it has been deemed to relate only to provision of information, however, delay is an issue which has been addressed in the Insurance Act 2015 (UK) and should be dealt with in New Zealand. I don't believe that codifying these rules would cause any issues, as currently the only thing legal experts agree on is that the insurers post-formation duties of utmost good faith are almost* non-existent. (*apart from the duty to be open with information recognised in *Young v Tower*)
52	Are there other areas of law where the interface with insurance contract law needs to be considered? If so, please outline what these are and what the issues are.
	Consumer level contracts of insurance should be recognised as being different from commercial contracts of insurance. This could be done by sui generis rules of interpretation or through simplified and defined terms.
53	Is there anything further the government should consider when seeking to consolidate the six Acts into one?
	Establishing an insurance list court to deal with interpretation issues more easily than currently needing to go through a full trial process. It would also be useful if the IFSO, DRSL and other schemes were removed and a tribunal established. This could have the power to remove the handling of claims from an insurer to an independent third party claims handler when the insurer has acted in poor faith or delay settlement unreasonably.

Other comments

	We welcome any other comments that you may have.
	Simplifying and clarifying the law will assist insurers and insured by providing more certainty.