FinancialServicesCouncil.
growing and protecting the wealth of New Zealanders

Financial Services Council
of New Zealand
Level 33, ANZ Centre,
23-29 Albert St, Auckland 1010
P: +64 9 985 5762
E: fsc@fsc.org.nz
www.fsc.org.nz

13 July 2018

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

By email: insurancereview@mbie.govt.nz

Submission: Review of Insurance Contract Law

This submission is from the Financial Services Council of New Zealand Incorporated (**FSC**).

The FSC represents New Zealand's financial services industry having 35 members at 30 June 2018. Companies represented in the FSC include the major insurers in life, disability, income, and trauma insurance, and some fund managers and KiwiSaver providers plus law firms, audit firms, and other providers to the financial services sector.

FSC members represent more than 95% of all New Zealand life insurers[1]. In the 12 months to 31 December 2017, FSC members helped New Zealanders by paying $1.22 billion in claims, providing peace of mind through more than four million insurance policies.

The FSC's guiding vision is to be the voice of New Zealand's financial services industry and we strongly support initiatives that are designed to deliver:

1. Strong and sustainable consumer outcomes;
2. Sustainability of the financial services sector; and
3. Increasing professionalism and trust of the industry.

We therefore support the review of Insurance Contract Law because the review is intended to promote a well-functioning insurance system that delivers fair, efficient and transparent consumer outcomes.

We recognise that that this review is complex due to the fragmentation and age of the different Acts. Given the Government's intention to introduce a Bill before the next election, there is a lot of work needing to be undertaken in a relatively short time period. We submit that the more consultation we can have as we work through the review, the better the outcomes will be for consumers and the industry.

We look forward to working with the Ministry through the coming rounds of consultation and welcome a conversation at any time.

I can be contacted on s 9(2)(a) or s 9(2)(a) to discuss any element of our submission.

Yours sincerely
Richard Klipin
Chief Executive Officer, Financial Services Council

[1] Based on premium income, FSC Statistics 31 December 2017

Table of Contents

Responding to the Issues Paper – our approach

This submission is the result of an extensive consultation process across our member-base and represents the views of our members on behalf of the life and health insurance industry. Where we refer to insurance and insurers throughout our response, we are generally referring to life and health insurers only.

The FSC's guiding vision is to be the voice of New Zealand's financial services industry. Given the different business models, diversity and expertise of our members, there are times when there are a range of insights and views. Where this has been the case in relation to this submission, we have adopted the FSC's standard approach to managing significant issues:

- **Principles-based**: keeping the conversation focussed on the big issues while acknowledging the detail
- **Best practice**: ensuring the recommendations and solutions are aspiring to high standards of service for clients and driving consistency within the industry
- **Market competition**: believing a free market will find the balance that works best for the consumer and the industry

We acknowledge the time and input of all our members in contributing to this submission.

For alignment with the Issues Paper, we use the terms 'consumer' and 'customer' interchangeably throughout our response. This replaces the more technical terms used by the insurance industry such as policy-holder, life insured, prospective insured and other.

Strategic Intent – our view

The intent of the proposed changes is clear – ensuring a well-functioning insurance system and simplifying current legislation for both consumers and the industry. We fully support this intent and believe it is in the best interests of the financial services industry, our members and all consumers.

Our view is the questions raised in the Issues Paper have been a good start in the conversation, and our members are seeking further engagement as consultation progresses. We acknowledge that FSC members are striving for the same outcomes as the Government and that FSC members are taking responsibility for driving industry-change.

Change is unlikely to be easy, and given the current full regulatory change environment (for example, the overhaul of the financial advice regime), there is a risk of many major changes happening at the same time. We acknowledge that change is needed because it is the only way in which we can deliver the twin outcomes of improving the professionalism of the market and lifting consumer trust. We support steps which deliver on these outcomes. We highlight that there will likely be a need for a transitional period to the new legislation.

This review is a good opportunity to discuss how insurance works and help more consumers understand that insurers are in business to pay valid claims. Insurance is a promise to pay when things go wrong, and therefore life and health insurers want to pay valid claims so they can honour that promise. Our response provides further information on the nature of insurance.

The following section provides an overview of what we see as the four main themes and areas of opportunity from our response.

Themes

Theme One – Conduct and Self-Regulation

Good conduct is important. We support initiatives designed to:

- Deliver strong and sustainable consumer outcomes; and
- Ensure a strong industry that continues to deliver on the promises made to consumers.

We acknowledge the proposed legislative changes are one part of the overall solution around the larger questions of 'what is good conduct?' and 'how do you ensure good conduct?'. The legislation is an important part because it sets the overall framework for how market participants should behave. The behaviour of all market participants is key to building confidence and trust.

Acknowledging that good conduct comes from the behaviour of people within the industry, we believe that self-regulation is key to promoting change. Our members have taken responsibility for this change by working together to develop the FSC Code of Conduct (**Code**).

Reflecting the importance of self-regulation, the development of the Code has taken material time and effort and involved people from across the FSC membership on a journey of more than 18 months. This industry Code is designed to help FSC members deliver good customer outcomes, and increase trust and confidence in the financial services industry.

The FSC Code of Conduct consists of nine Code Standards with an over-riding ethical principle that 'Members must carry out business professionally, with due care, competence and skill, and act with integrity. They must behave in a way that promotes public confidence in the financial services industry.'

All FSC members will be bound by the Code from 1 January 2019, and are subject to industry sanctions (including termination of membership, reprimands, fines, reparation orders and public notification) for material non-compliance. The Code will be launched in late 2018. FSC members will continue to work together to develop best practice guidelines that will set clear expectations and aspirations for the industry.

Theme Two - Disclosure

In insurance, the duty of utmost good faith underpins the duty to disclose. Better disclosure means:

- A better underwriting and risk process upfront – which produces more accurately priced premiums – benefiting all consumers, not just the insured.
- For the insured, more certainty that a claim will be paid.
- For the insured and insurer – a quicker claims process, particularly important for the insured given claims payments are usually required in a time of need.

In order to protect all consumers and promote a sound insurance industry, we therefore recommend that the review focus on ways to ensure a good flow of information between the consumer and the insurer, with insurers having a range of appropriate remedies in cases where a consumer has failed to provide good information. Insurers should have the obligation to treat customers fairly when applying any such remedies.

Theme Three – Reinsurance

Insurers often seek insurance for particular or aggregated risks through reinsurance.[2] The New Zealand insurance market therefore relies on reinsurers for a functioning market. Overseas reinsurers increase choice and competition and provide specialist services not otherwise available in the New Zealand market.

Reinsurers require that an insurer only pay valid claims that are within the terms and conditions of the insurance cover. This means that the role of reinsurers needs to be considered in the review to ensure that:

- We avoid the potential unintended consequence of restricting capacity and access to the global reinsurance market; and
- The law acknowledges that life and health insurers are sometimes bound by their arrangements with consumers and reinsurers.

Theme Four – Consumer Interests

Providing life cover, trauma cover, total and permanent disability insurance, mortgage protection and income protection insurance, and health insurance, is different to providing insurance for property. Our contracts are renewable at the sole discretion of the consumer until the termination date.

Consumers and insurers have a shared interest in an efficient and effective insurance market. Insurance companies have strong commercial drivers to pay valid claims. An insurer that does not pay valid claims develops a poor reputation, and customers may move to other insurers.

Conversely, if an insurer were to pay invalid claims, all customers would pay higher premiums to cover these additional claims costs. Hence, insurers take care to pay valid claims, and reinsurers regularly audit insurers' claims.

It is important to understand these forces when considering issues such as the perceived power imbalance between insurers and consumers.

So, while insurers may have access to greater resources, and may in some cases have more information, in dealing with a policyholder at the point of claim (when more information may be provided), the situation was the reverse when the contract was established: the applicant knows a lot more about their health than the insurer does. On the basis of the disclosure the insurer makes an open-ended commitment to insure them for decades to come – with limited rights of termination.

[2] Reinsurance is insurance of insurance risks or of a particular book of insurance business. Reinsurers have no relationships with consumers, policyholders or intermediaries.

Responses to discussion document questions

Regarding the objectives of the review

1	Are these the right objectives to have in mind?
	We broadly endorse the objectives as they seem fair, appropriate and balanced between the consumer and the industry. However, the explanatory paragraphs 15-18 do not adequately acknowledge the unique nature of insurance contracts and insurance business. We suggest that the main purposes of the Financial Markets Conduct Act 2013 (FMC Act) referred to in paragraph 18, cannot simply be applied to insurance contracts. The FMC Act seeks to address the information asymmetry between market participants and consumers. A consumer will know less about an FMC Act financial product, particularly the risks of that product, than the product provider. To rebalance the information asymmetry between provider and consumer, the FMC Act requires (among other things) disclosure of information and can impose other protections, such as licensing. Information asymmetry that disadvantages the consumer provides the justification for regulation of securities and is inherent in the purposes of the FMC Act. When the product being provided is insurance, there is two-way information asymmetry. The customer has significantly more information about the facts relating to the customer that determine the price of the risk and influence other key terms (such as exclusions) that form the basis of the insurance than the insurer. This is particularly the case for life and health insurance. This two-way information asymmetry is part of the unique nature of insurance contracts and must be reflected in the objectives of the review. This is particularly important as a central part of the review is to consider the flow of information between the customer and the insurer.
2	Do you have alternative or additional suggestions?
	The review must also take into consideration factors inherent in the nature of insurance business which include: **Pure risk insurance is not a savings product** Consumers purchase peace of mind when they buy insurance. Insurance is unique, in that the best outcome for a consumer may be that he or she never claims, and the only benefit is peace of mind. For example, a young parent buys term life insurance so that her family will be cared for if she dies before she reaches the age of 65. The best outcome for her is that she lives beyond the age of 65 and never claims on the insurance. **Policyholders share risks and share costs** Insurers create "pools" of policyholders. Life insurance contracts are generally long-term contracts and dealings with one policyholder can affect other policyholders. For example, if an insurer pays a claim that is not covered by the terms of the insurance contract, the cost of that claim will be reflected in the future premiums paid by the other policyholders in the pool. **Information is costly to acquire and review** Costs at the underwriting stage increase the premium for all policyholders, so insurers actively seek to make the underwriting process efficient and minimise costs. Each consumer has the best available information about their own health and life-style. If a consumer provides insurers with the best information he or she has, underwriting will be efficient, and costs kept to a

minimum. Specifically, the cost of acquiring all medical information would increase the cost of underwriting, and flow on to the cost of insurance for a consumer. It is unfair to impose that cost on everybody.

People don't like to think about negative situations

Generally, no-one likes to think about negative situations, or the need to put plans in place in case things go wrong. This means that insurance has traditionally needed to be actively sold i.e. distribution of insurance is supply driven.

Insurers want to pay valid claims

Insurers provide peace of mind to consumers through providing insurance policies. Insurance is a promise to pay when things go wrong, and therefore insurers want to pay valid claims so they can honour that promise. Not paying a valid claim can damage an insurer's brand in the eyes of both consumers and intermediaries (who may be engaged to distribute an insurer's product). Having a strong claims-paying reputation is important to insurers because it promotes confidence in the product and in the promise of claim payment. A lack of consumer or intermediary confidence is likely to lead to less insurance policies being sold/bought and therefore a negative commercial outcome for insurers.

However, insurers cannot pay claims that are not covered by the terms of the insurance contract. Firstly, the pooled nature of insurance business means that paying invalid claims would increase future costs for other policyholders. Secondly, insurers often seek insurance for particular or aggregated risks through reinsurance. Reinsurers require that an insurer only pays claims that are within the terms and conditions of the insurance cover.

Regarding disclosure obligations and remedies for non-disclosure

3	Are consumers aware of their duty of disclosure?
	FSC insurance members work hard to ensure that consumers understand their duty of disclosure. However, a fundamental difference between the formation of an insurance contract and other types of contracts is the two-way information asymmetry of the contracting parties. In the life and health insurance context, the potential customer possesses information about his/her health or other facts (including information about pastimes, occupation, financial position) that may be material to the assessment of the risk for the specific insurance benefits the prospective insured is applying for. The insurer only has access to information disclosed, or shared with the insurer, by the consumer. Given the legal requirements regarding the protection of personal information, it would be very difficult (if not impossible) for an insurer to find out these facts without the insured disclosing or agreeing to share that information with the insurer. The insurer will need to consider these facts when determining the terms of the insurance to offer and/or the premiums to be charged. The duty of utmost good faith, particularly the duty of disclosure, seek to address this imbalance of information and to enable the insurer to assess the risk presented by the potential customer. The insurer needs to assess the risk presented by the potential customer so that appropriate terms (typically exclusions, extended wait periods or limited benefit periods) can be applied to the insurance cover or premiums (which may have extra premiums charged based on the assessment of risk) can be set. Insurers and insurance intermediaries (where involved in the sales process) draw consumers' attention to the duty of disclosure which is set out in application forms (whether in hard copy application forms, online application forms or telephone sales processes). As the duty of disclosure is fundamental to insurance it is typically outlined in plain English in the application form/personal statement and set out in the declaration that the potential customer and policy owners sign or in verbal/online confirmation provided by the potential customer and policy owners. Typically there will also be a reference to the potential consequences of material non-disclosure and/or mis-representation in the application form. Where intermediaries are involved in the process, our expectation is that the importance of the duty to disclose will be explained. In addition, the policy terms and conditions will contain provisions dealing with the rights of a insurer where non-disclosure or mis-representation is identified. Life and health insurers want to pay valid claims that meet the terms of the policy. It is not in the interests of the insurance industry or for consumers to have non-disclosure issues arise or be identified once the policy is in force or at claim time. Certainty of cover for consumers and the assessment of the appropriate terms to be applied and the correct premiums to be charged are fundamental to the life and health insurance industry.
4	Do consumers understand that their duty of disclosure goes beyond the questions that an insurer may ask?
	FSC insurance members work hard to ensure that consumers understand their duty of disclosure. Please see our response to Q3 for more information.

	Typically life and health insurers outline the extent of the duty of disclosure in the application forms and declarations signed or confirmed by the person applying for insurance and policy owners. In addition insurers explain that the duty of disclosure extends until the risk is accepted by the insurer and the first premium is paid.
5	Can consumers accurately assess what a prudent underwriter considers to be a material risk?
	Insurers use plain language and specific questions to help consumers understand what will be a material fact as opposed to a material risk. Life and health insurers set out questions in an application form (online, hard copy or over the telephone) for a potential customer to answer. The information provided by the potential customer is then considered by the insurer when assessing the risk and determining the terms of the insurance to offer and/or the premiums to be charged.
6	Do consumers understand the potential consequences of breaching their duty of disclosure?
	Please see our response to Q3. Life and health insurers highlight the potential consequences of breaching the duty of disclosure in the application form and the policy terms and conditions. From time to time, consumers contact insurers or insurance intermediaries to find out what they have disclosed in the past and to check whether information they may have failed to disclose would have been material to a prudent insurer. This may result in the insurer asking the customer for more information or re-underwriting the existing insurance cover with consideration of the recently disclosed facts.
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?
	A consumer will always have better knowledge of the facts (as opposed to the risks) relating to him or her. The life and health insurer, by comparison, will have a better understanding of the relevance of those facts to the risks insured. We expect this is an inherent imbalance that will continue. New technologies will provide consumers with better access to their personal information. New technologies seem also likely to enable consumers to share more personal information with their insurers. However, the sharing of personal information is likely to require well defined consumer owner consents. These consents will put the task of determining which data might be relevant back in the hands of consumer to some degree. In any case, the new trend in data rights assumes that a consumer owns his or her data and has rights (which would include access and sharing with third parties) and, in turn, assumes that the consumer as 'data controller' is best placed to know which facts are relevant to the risk insured. Consumers' health information is siloed between various types of health providers (DHBs, private, NGOs) and between regions. A variety of shared information technology solutions have been used but with limited success. A near term solution that links all providers and regions appears unlikely at this stage. For life and health insurance, it is also important to note that the ability of consumers to share their health information is currently constrained by privacy law and practice. Current privacy

	practices also constrain insurers from seeking broad medical information, instead having to ask specific questions.
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.
	No, wherever possible our members seek to respond to consumers fairly and proportionally. Insurance companies have strong commercial drivers to pay valid claims. An insurer that does not pay valid claims develops a poor reputation, and customers move to other insurers. Conversely, if an insurer were to pay invalid claims, all customers would pay higher premiums to cover these additional claims costs. Hence, insurers take care to pay valid claims and deny invalid claims, and reinsurers regularly audit insurers' claims. We include a generic claims process in Appendix One. In our experience, insurers treat customers fairly if they have not disclosed, balancing the needs of the person who has non-disclosed against the rights of other policyholders. We do not believe that there are disproportionate consequences for consumers. All FSC life and health insurance members have their own complaint resolution processes and belong to independent dispute resolution schemes. Depending upon the circumstances, customers may be able to escalate their complaints to those independent Dispute Resolution Schemes. These schemes are free for the customer.
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?
	Comparing the facts on the application form to real-life events is the best practical way to determine whether non-disclosure is unintentional or intentional. This usually means that insurers are the best placed to make such an assessment. However, it is hard to determine whether the facts show that there is unintentional non-disclosure or intentional non-disclosure because: 1. It is not easy to define intention and consumers and insurers might have a different view 2. It is not easy to prove intention - If intention were easy to prove, we would submit that unintentional non-disclosure should be treated differently from intentional non-disclosure. Unfortunately, in practice it is very difficult to prove. Instead, we recommend that the focus should be ensuring the outcome the customer receives is a fair representation of the risk accepted by the insurer. **Unintentional non-disclosure** All policyholders receive the fairest outcome when the insurer re-underwrites the customer as if they had known the non-disclosed information at the time of application. The amount of cover would only be reduced, or exclusions given, if the non-disclosure is material. If the policyholder receives cover that doesn't properly reflect the medical or financial history of that policyholder, it is not fair to other policyholders. It also creates a moral hazard, that customers who unintentionally non-disclose are better off than those who disclose correctly. In some cases, if the insurer had known the non-disclosed information, they would not have offered cover. In these cases, the insurer should be permitted to decline a claim and cancel and/or avoid the policy.

Intentional non-disclosure

People should not be able to benefit from their misconduct. This is not fair to other policyholders. All premiums would have to increase to cover intentional non-disclosure claims, and it would undermine the insurance industry.

This also creates a moral hazard. If policyholders could ignore disclosure on their applications and be treated as if they non-disclosed unintentionally then customers would be better off if they non-disclosed. Anti-selection would become a significant problem, because consumers could wait until they suffer symptoms indicating an imminent claim, and then apply for insurance.

Recommendation

Insurers should have alternative remedies available in the event material non-disclosure is notified or identified. These remedies should include avoidance, declining the claim and cancelling the policy or re-underwriting the consumer and applying the appropriate terms with retrospective effect. Insurers should have the obligation to treat customers fairly when applying these remedies.

10	Should the remedy available to the insurer be more proportionate to the harm suffered by the insurer?

It is difficult to quantify the harm to the insurer, as the extent of the non-disclosure might not be fully known at the time the remedy is determined (only the extent of non-disclosure relevant to the claim).

It is important to note that the harm may be suffered by other members of the risk pool – other policyholders. Insurers may increase premiums to cover their costs. Sometimes insurers may be unable to increase premiums because the premiums are fixed, and unanticipated costs may eventually limit the ability of the insurer to offer new cover.

It is also important to note that life and health insurers have only one opportunity to assess the risk of a new customer. Once a policy is issued, the policyholder has the right but not the obligation to renew the policy on its anniversary. The insurer is obliged to renew the policy if the policyholder exercises their right.

In cases of moral hazard (see our response to Q9), the remedy should address the moral hazard, rather than seek proportionality for the insurer and other existing policyholders.

We also note that insurers often seek insurance for particular or aggregated risks through reinsurance. Reinsurers require that an insurer only pay valid claims that are within the terms and conditions of the insurance cover.

11	Should non-disclosure be treated differently from misrepresentation?

At the moment the classification is critical because there are different rules for remedies depending on the classification. Also, there is a current distinction between written and verbal misrepresentation. However, the focus should instead be on consumers providing good information and insurers having a range of appropriate remedies in cases where a consumer has failed to provide good information.

12	Should different classes of insureds (e.g. businesses, consumers, local government etc.) be treated differently? Why or why not?
	There are grounds for treating both individual consumers and small-medium businesses the same, in the interests of regulatory simplicity, and because they will share the same general values and objectives in obtaining life and health insurance. Individual consumers and small-medium businesses make up the majority of insureds in New Zealand. We will consider this point in more detail as the review progresses. However, there is merit in treating large businesses and enterprises (including government agencies) differently, given the nature of their interactions with the insurance market. Large business/enterprise typically require bespoke policies covering risks that are sometimes unique and often high value. These insureds will have the resources that enable them to navigate the complexities of insurance law, and the bargaining power to achieve the outcomes they seek in taking out the policies. Large business/enterprise insureds value certainty – that they can rely on the express terms of the policy agreements they enter, and that long-standing principles of insurance law will be applied. They also value contractual flexibility that allows them to obtain the terms that reflect the best deal they can make with the insurer. Where they have insurance programmes comprising of both New Zealand and overseas insurers, large business/enterprise insureds will prefer rules that are consistent with international norms.
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?
	Our members each have their own processes for dealing with non-disclosure. When non-disclosure is identified at the time of claim, members follow their defined processes. It is common for insurers to seek remedies for customers other than avoiding policies. There are strong commercial reasons for doing so – an insurer who develops a reputation for not paying claims will struggle to write new business and, in some cases, retain existing business. Insurers will often review the materiality of non-disclosure, and ask what cover they would have offered the policyholder if they had known the non-disclosed information.
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?
	Our members generally take account of the following factors when responding to instances of non-disclosure: • Whether the non-disclosure or misrepresentation is material – would it have affected the underwriter's decision at the time of application; • Whether there is anything to indicate the information was disclosed but not captured by the intermediary during the application process; • Has the policyholder's health improved since the application was made; • The length of time between commencement of the policy and the time of claim; • Are there any factors suggesting that the customer did not act honestly? For example, claims denied by other insurers, suspicious circumstances, material issues that the

policyholder is unlikely to forget that are identified in medical notes obtained at the time of claim;

- The circumstances, event or condition that gave rise to the claim; and/or
- Conditions imposed by the reinsurer.

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?
	Good conduct is important. We support initiatives designed to: • Deliver strong and sustainable consumer outcomes • Ensure a strong industry that continues to deliver on the promises made to consumers. We acknowledge the proposed legislative changes are one part of the overall solution around the larger questions of 'what is good conduct?' and 'how do you ensure good conduct?'. The legislation is an important part because it sets the overall framework for how market participants should behave. The behaviour of all market participants is key to building confidence and trust. Acknowledging that good conduct comes from the behaviour of people within the industry, we believe that self-regulation is key to promoting change. Our members have taken responsibility for this change by working together to develop the FSC Code of Conduct (**Code**). Reflecting the importance of self-regulation, the development of the Code has taken material time and effort and involved people from across the FSC membership on a journey of more than 18 months. This industry Code is designed to help FSC members deliver good customer outcomes, and increase trust and confidence in the financial services industry. The FSC Code of Conduct consists of nine Code Standards with an over-riding ethical principle that 'Members must carry out business professionally, with due care, competence and skill, and act with integrity. They must behave in a way that promotes public confidence in the financial services industry.' All FSC members will be bound by the Code from 1 January 2019, and are subject to industry sanctions (including termination of membership, reprimands, fines, reparation orders and public notification) for material non-compliance. The Code will be launched in late 2018. **The following information contains confidential information about the forthcoming FSC Code of Conduct. We ask that the following information is not released until 1 January 2019.** Code Standard 9 states "Members must treat customers fairly." Guidance with the standard includes: "Members should deal with claims and product withdrawals promptly and efficiently. Customers should be kept informed of progress. "When a Member does not pay a claim or allow a withdrawal, the reasons should be clearly communicated to the customer. Any written notice to the customer should include details of what the customer should do if the customer disagrees with the Member's decision."
16	To what extent is the gap between ICP 19 and the status quo in New Zealand (as identified by the IMF) a concern?
	We agree with the IMF's findings that sales, claims and complaints are currently regulated primarily through self-regulation and dispute resolution processes. Recognising this, we believe that improving self-regulation is key to promoting good consumer outcomes. Our members have taken responsibility for this change by working together to develop the FSC Code of Conduct (**Code**).

	Reflecting the importance of self-regulation, the development of the Code has taken material time and effort and involved people from across the FSC membership on a journey of more than 18 months. This industry Code is designed to help FSC members deliver good customer outcomes, and increase trust and confidence in the financial services industry. The FSC Code of Conduct consists of nine Code Standards with an over-riding ethical principle that 'Members must carry out business professionally, with due care, competence and skill, and act with integrity. They must behave in a way that promotes public confidence in the financial services industry.' All FSC members will be bound by the Code from 1 January 2019, and are subject to industry sanctions (including termination of membership, reprimands, fines, reparation orders and public notification) for material non-compliance. The Code will be launched in late 2018. As noted in other responses, the Financial Services Legislation Amendment Bill also addresses the identified gap by requiring anyone offering financial advice to comply with duties under that legislation, including prioritising the customer's interests and complying with a Code of Conduct for financial advice. It will also raise minimum education standards for financial advisers. The Bill will therefore address some of the current identified gap with ICP 19.
17	Does the lack of oversight over the full insurance policy 'lifecycle' pose a significant risk to purchasers of insurance?
	We refer to our answer on Q15 and Q16, noting that the implementation of the FSC Code of Conduct will strengthen industry self-regulation and, for FSC members, mitigate any potential significant risks to purchasers of insurance. We highlight that the insurance industry has strong commercial drivers to pay all legitimate claims (see our response to Q2). In 2017, FSC members paid $1.2 billion in claims, and provided peace of mind through more than four million insurance policies. This shows that the industry adds real value to New Zealanders in their times of need, and demonstrates a lack of any significant risk from the identified lack of regulatory oversight. We note there are also various dispute resolution schemes and processes in place for consumer to use – these schemes and processes act as a safeguard for the consumer, with the aim of providing oversight and reducing the risk of important concerns being overlooked or disregarded. We also note that customers have a cooling period available when they purchase insurance. This provides customers with, at least, 15 days to consider the insurance they have purchased and cancel the insurance (for free) if they decide the product does not meet their needs.

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)

	We include a generic claims process in Appendix One.

	The process flow, shows that decisions to accept or decline a claim are preceded by a structured process. Escalation points within the process ensure that a customer's claim is given fair consideration. These escalation points may include: • Escalation to team leader or manager for proposed declined claims • Claims review committees – senior stakeholders within the insurer's business review decisions to avoid a policy or benefit • Complaints review committees – senior stakeholders within the insurer's business review escalated complaints • External, independent, dispute resolution schemes – for a, free-to-customer, review of the insurer's decision. All insurers are required to be a member of a dispute resolution scheme Monitoring complaints and ensuring good conduct is a key focus for FSC life and health insurance members, as evidenced by the introduction of the FSC Code of Conduct. Individual FSC members have processes and governance in place to ensure good consumer outcomes.
19	Have you ever felt pressured to accept an offer of settlement from an insurance company? If so, please provide specific examples.
	As stated in Q2, it is in the best interests of insurers to pay valid claims. FSC members have worked to create an industry Code of Conduct designed to help members deliver good customer outcomes, and increase trust and confidence in the financial services industry. From 1 January 2019, all members of the Financial Services Council will be bound by this Code of Conduct (please see our response to Q16). **The following information contains confidential information about the forthcoming FSC Code of Conduct. We ask that the following information is not released until 1 January 2019.** Code Standard 9 states, "Members must treat customers fairly." Guidance with the standard includes: "Members should deal with claims and product withdrawals promptly and efficiently. Customers should be kept informed of progress. "When a Member does not pay a claim or allow a withdrawal, the reasons should be clearly communicated to the customer. Any written notice to the customer should include details of what the customer should do if the customer disagrees with the Member's decision."
20	When purchasing (or considering the purchase of) insurance, have you been subject to 'pressure sales' tactics?
	We have a shared concern over pressure sales tactics, and insurers have strong commercial drivers to identify and eliminate such tactics. Sales made under pressure, to people that would prefer not to buy, or have stretched their budgets, tend to terminate within the first year. Because of the high costs associated with new business (underwriting and commission) Insurers typically need the contract to stay in-force for several years before they make a profit. Therefore, our members have systems in place to identify and stop poor quality sales methods. FSC members have worked to create an industry Code of Conduct designed to help members deliver good customer outcomes, and increase trust and confidence in the financial services industry. From 1 January 2019, all members of the Financial Services Council will be bound by this Code of Conduct (please see our response to Q16).

	The Financial Services Legislation Amendment Bill will require anyone offering financial advice to comply with duties under that legislation, including prioritising the customer's interests and complying with a Code of Conduct for financial advice. It will also raise minimum education standards for financial advisers. These requirements should significantly reduce the risk of pressure sales tactics by those offering financial advice. We continue to work with the Financial Markets Authority to understand the balance between consumer outcomes and incentives. **The following information contains confidential information about the forthcoming FSC Code of Conduct. We ask that the following information is not released until 1 January 2019.** Our members take responsibility for ensuring good consumer outcomes from the products they design and distribute. This is why Code Standard Five of the new FSC Code of Conduct states "Members must design and distribute products responsibly." Code guidance includes: "Members should mitigate the risk of inappropriate selling of products and services, including working with their intermediaries to do so. Members and their intermediaries should have frameworks in place to promote and monitor appropriate sales behaviour. "Members should design, manage and monitor their cross-selling sales processes to promote good customer outcomes."
21	What evidence is there of insurers or insurance intermediaries mis-selling unsuitable insurance products in New Zealand?
	Please see our response to Q20. We note that, if there is mis-selling by insurers or intermediaries who offer financial advice, this behaviour will also be addressed by the Financial Services Legislation Amendment Bill.
22	Are sales incentives causing poor outcomes for purchasers of insurance? Please provide examples if possible.
	FSC insurance members work hard to prevent poor consumer outcomes from sales incentives. Please see our response to Q20. Insurance is distributed through various channels, including face-to-face, by telephone, and over the internet. In each case, insurance may be sold with or without financial advice. It may also be provided directly by the insurer, or by intermediaries. Financial advisers, intermediaries and employees can be paid salaries, commissions, bonuses and other incentives. In all cases, customer outcomes must be carefully managed. Insurance – particularly life and health insurance – is supply driven. For many reasons, customers rarely seek to buy insurance. Mostly customers are approached by an insurer or intermediary. Moreover, because the best insurance experience is when the customer never suffers a claim event, and people value their present-selves over their future-selves, consumers are reluctant to pay for advice about insurance policies. We acknowledge that sales incentives potentially create conflicts of interest. We also acknowledge some concerns about poor consumer outcomes arising from these conflicts, e.g. from FMA reviews and the work already underway by both the FMA and MBIE to address these issues. We continue to work with the FMA and MBIE to understand the balance between consumer outcomes and incentives.

	We submit that requirements in the Financial Services Legislation Amendment Bill and associated regulations will adequately address conflicts of interest arising when financial advice is provided.
23	Does the insurance industry appropriately manage the conflicts of interest and possible flow on consequences that can be associated with sales incentives?
	As stated in our response to Q22, insurance (particularly life and health insurance) often needs to be actively sold to consumers, because it is not generally something consumers actively buy. Reasons for this include: the best experience is to pay a regular premium and never make a claim; generally speaking, no-one enjoys contemplating adverse situations; behavioural bias leads consumers to prioritise their present-selves over their future-selves; and view contingency planning as a last resort, rather than a real possibility The need to sell insurance led to various models to incentivise sales. All of these models have inherent conflicts of interest. The International Association of Insurance Supervisors state that conflicts of interest are inherent in insurance distribution. Because of the Commerce Act, insurers cannot collaborate to redesign incentives. Moreover, any insurer who reduces incentives will reduce their competitiveness in the market – Financial Markets Authority research shows that intermediaries may be influenced by these incentives. Therefore, there is a last mover advantage for insurers. Access to high quality advice is a key objective of the financial advice regime, and international experience shows that banning commission reduces access to high quality advice. In the UK, commissions were banned in the Retail Distribution Review, and insurance commissions were subsequently reintroduced after adviser numbers fell, the cost of advice increased, and advice became more limited. Insurers acknowledge that conflicts of interest exist in all distribution channels. FSC members have worked to create an industry Code of Conduct designed to help members deliver good customer outcomes, and increase trust and confidence in the financial services industry. From 1 January 2019, all members of the Financial Services Council will be bound by this Code of Conduct (please see our response to Q16). In addition, the Financial Services Legislation Amendment Bill introduces s431J into the Financial Markets Conduct Act, which requires anyone giving financial advice to give priority to the customer's interests if there is a conflict of interest. Hence, while insurers currently have mechanisms to manage conflicts of interest, these are likely to be strengthened after the FSC Code of Conduct and Financial Services Legislation Amendment Bill come into effect. We continue to work with the Financial Markets Authority and the Government to ensure that conflicts of interest are managed in the best way to drive good consumer outcomes. **The following information contains confidential information about the forthcoming FSC Code of Conduct. We ask that the following information is not released until 1 January 2019.** Code Standard Eight states: "Members must manage conflicts of interest fairly and in a way that promotes good customer outcomes."

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.
	We think the current exemptions are fair for life and health insurance. Life and health Insurance companies have strong commercial drivers to pay valid claims. An insurer that does not pay valid claims develops a poor reputation, and customers move to other insurers.
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?
	We think the current exemptions are fair for life and health insurance.
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"?
	Maintaining the exclusions under the FTA is key to meeting Objective One, which requires that insured and insurers are able to transact with confidence at all points in the lifecycle of an insurance policy. It is particularly relevant to objective 1(a) (certainty around claims) and 1 (b) (effectively measuring and pricing risk). We consider each exclusion here: **Identifying the subject matter or risk of insured against, including terms identifying an uncertain event** The subject matter and risk insured against (including identifying uncertain events) are main terms of the contract. As main terms, these should already be excluded as unfair contact terms under section 46K(1)(a) of the FTA. That said, they should continue to be expressly excluded as unfair contract terms to ensure certainty. Intrinsic to the special nature of insurance is that the amount payable (benefit to the consumer) relies on the occurrence of uncertain events. The fact that a consumer might pay premiums for the life of a contract but never be entitled to make a claim could be argued as being unfair in the absence of this exclusion. The nature and degree of event uncertainty varies across insurance products, and identifying their nature and scope is therefore a critical feature of the insurance contract and central to pricing risk (e.g. for Life Insurance, there are both certainties (death) and uncertainties (form of death). **Specifying the sum(s) insured** Specifying the sum insured is also key to pricing risk. Insurance cover cannot be priced for an undefined amount. **Excludes or limits the liability of the insurer to indemnify the insured** There needs to be certainty over the cover that is being provided, based on the risk presented. Insurers use exclusions to define the scope of coverage. This can provide limits on the types of costs that a product will respond to and can be a useful control for ensuring that overall premiums for a product are reasonable, while providing meaningful cover to customers. For example, a health insurer may cover corrective lenses under an optical benefit but exclude more expensive treatments like laser eye surgery. The result is that the premiums can remain lower for the whole customer base.

Additionally, insurance cover is limited in many cases for public policy reasons. For example, limits on life insurance cover are designed to reduce the possibility that people take out life insurance policies for a high value, then injure others or themselves (as insureds).

The exclusions under a policy are an essential factor in pricing risk. Consumers demand a range of pricing for policies, which would not be possible if the effect of exclusions for the policies was uncertain.

Describe the basis on which claims may be settled or that specifies any sums to be contributed by the insured, such as an excess

The basis on which claims may be paid or sums to be contributed has a material impact on pricing risk. For example, for income protection, 75% of income payable is the norm. Increasing the amount payable to a higher amount would increase the premium payable.

Provide for the payment of the premium

This is the upfront price payable under the contract, and should already be excluded as an unfair contact term under section 46K(1)(b) of the FTA.

Relate to the duty of utmost good faith owed by all parties

In insurance, the duty of utmost good faith underpins the duty to disclose. Better disclosure means:

- A better underwriting and risk process upfront – which produces more accurately priced premiums – benefiting all consumers, not just the insured.
- For the insured, more certainty that a claim will be paid.
- For the insured and insurer – a quicker claims process, particularly important for the insured given claims payments are usually required in a time of need.

Specify the requirements for disclosure or relate to the effect of any non-disclosure or misrepresentation by the insured

A similar point can be made (as above) – better disclosure means more accurate pricing of risk, better certainty for both the insured and insurer, as well as a quicker claims process. Terms setting out the impact of non-disclosure or misrepresentation by the insured are main terms of the insurance contract, and are required to be certain in order to meet Objective 1.

27	What would the effect be if there were no exceptions? Please support your answer with evidence.

Please see our responses to Q24-26. There is a risk that if there were no exceptions there would be a lack of certainty for the industry and consumers. This would likely lead to extra costs for the industry which would result in a higher cost of insurance for consumers and a reduction in availability of cover.

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?
	Considering the question of comparing insurance contracts as a whole, it is challenging for consumers to compare insurance policies. However, like the purchases of other complex goods in which consumers are non-expert a number of solutions exist which ensure a reasonably functioning market. The use of plain English policy wordings is becoming more common. Some policy documents are very clear. Professional financial advisers can help consumers to understand policies. Some consumer product ratings are available: for example, Canstar ratings, product research, and Lifedirect publishes comparison information from Quality Product Research. Some price comparison websites exist: Lifedirect.co.nz for life and health insurance. Consumer Magazine runs comparison articles on different types of insurance exploring price and product variations. Other financial adviser websites often have feature-based comparisons. Consumer finance news sites such as interest.co.nz include comparisons. Considering life, trauma, and health insurance price comparison: there are a number of websites which offer price comparison services. Lifedirect is probably the largest and best-known, although financial advisers operate several others. Many life and most health insurers provide some form of online quotation for their products. There are problems making comparisons because the products are not always directly comparable. Quotes generally assume the person will qualify for ordinary rates, while much of the market will need to pay more. That will not necessarily be known at the time of the quote. Customers using the services of a financial adviser will typically be offered a comparison.
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.
	Yes, the level of information varies. Typically, premium information for many life, trauma, and health insurance premiums can be found in a variety of places online. So, accepting that underwriting may still change the price, at least a baseline comparison can be done. Income protection is less commonly quoted online due to complexity, with comparisons coming from financial advisers for that product. Some insurance companies publish policy documents online, so that consumers can read them (if they choose) before purchasing cover.
30	What barriers exist that make it difficult for consumers to switch between providers?
	With *underwritten* life, trauma, income protection, mortgage protection, and health insurance, switching can be difficult because of the presence of health problems. If underwritten before the emergence of a health problem, a contract will typically be at standard rates. After a health problem has emerged, depending on its severity and prognosis, it can mean that new insurance will be more expensive, or issued on different terms (with exclusions). Consumers may be unaware of this issue, and terminate cover without knowing it may be hard to replace. Even where consumers are able to switch easily, care needs to be taken to ensure there is no inadvertent failure to disclose information.

31	Do these barriers to switching differ depending on the type of insurance? E.g. life, health, house and contents, car insurance etc.
	Barriers to switching do differ. With most life, trauma, income protection, mortgage protection, and health insurance, the health (and sometimes financial circumstances) of the customer is a critical factor, combined with the fact that the customer is in most cases underwritten at the time of application, and then the insurer cannot usually terminate cover. It also means that later in life a new insurer may be unable to offer terms to a customer in poor health.
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?
	One simple disclosure requirement would be to ensure that policy documents are available before purchase. Virtually all insurers make policies easily available, meeting this requirement. We note however that the policy document is only one part of the overall product and that a consumer may want to review other information such as premium pricing, product features and benefits, exclusions, waiting periods and stand down periods.

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?

The Supreme Court's decision in *BFSL 2007 Limited* v *Steigrad* [2013] NZSC 156 shows that there are several issues relating to the operation of section 9:

a. As currently drafted, section 9 is difficult to understand, even for lawyers. In particular, the words "in relation to that liability" in section 9(1) are lacking in precision; and to understand section 9(1) it is necessary to undertake a detailed analysis of the other lengthy subsections.

b. There is a lack of clarity as to the extent of the protective purpose Parliament intended section 9 to have and different judicial assessments of this affect section 9's scope.

c. Section 9 was not drafted to deal with insurance products where defence costs and third party liability are provided under a single policy with a combined policy coverage limit, where the need to balance the competing interests of the insured and third party claimants becomes acute.

d. The mechanisms provided by section 9 – i.e. the imposition of a charge and priority for the third party over all other competing claims – might not be the most suitable or sophisticated mechanisms where there are other considerations that may justify other parties sharing the same priority as the third party, at least. As the Supreme Court observed, at the time section 9 was enacted, there was no personal injury compensation scheme or comprehensive social welfare system and, accordingly, such mechanisms may have been justified in order to provide adequate protection to claimants. It is not apparent whether this justification continues to be a sound basis for giving priority to third party claimants.

The Supreme Court's decision caused commercial disruption. The decision reversed the industry norm of costs-inclusive policy limits. As a result insurance companies now offer separate policies for defence costs and third party liabilities, or separate indemnities within a single policy. New Zealand's position is inconsistent with the approach taken in Australia and other overseas jurisdictions, which has caused difficulties where there are insurance programmes comprising of New Zealand and overseas insurers. Given that the insurance market has simply changed its policies as a result of the decision, it is not apparent that third party claimants have received any enhanced protection as the majority of the Supreme Court sought.

In light of this, any reforms should consider:

a. What purpose is intended to be served by section 9 in the context of modern day New Zealand;

b. Whether that purpose justifies giving priority to third party claimants or whether they should be protected through different mechanisms;

c. What payments should be covered by any charge and those that should not be covered; and

d. Whether section 9 (or its successor) can be drafted in accordance with modern drafting style so as to be more easily understood, in particular, to more clearly delineate what payments are and are not covered (for example, by way of a specific exclusion of defence payments).

34	What are the most significant problems with the operation of section 9 of the LRA that any reform should address?
	Please see response to Q33
35	What has been the consequence of the problems with section 9 of the LRA?
	Please see response to Q33
36	If you agree that there are problems with section 9 of the LRA, what options should be considered to address them?
	Please see response to Q33

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?
	The Law Commission's concerns remain valid and we agree with its recommended reform. Section 9 has the protective purpose of ensuring that insureds do not lose the benefit of their policies due to insurers' unmeritorious technical reliance on time limits. That protective purpose might be justified with respect to, for example, insurance policies taken out by an average New Zealander. It appears less justified with respect to indemnity cover taken out by professional persons and businesses who can be expected to be aware of the time limit before entering the policy (and if it is unacceptable, negotiate an extended time limit in return for increased premiums) and would, accordingly, have processes in place to ensure that the time limit is met. This in turn raises the issue of the extent to which the policy intent behind section 9, and also section 11, continue to be valid. The Hansard comments of the Minister of Justice introducing the Insurance Law Reform show that it was motivated with a desire to ensure that all the provisions of insurance policies and their operation reflect the intention of the insured as well as the insurers. An issue needing to be considered is whether the perceived power imbalance continues currently, at least where the insureds are seeking policies to cover commercial and professional risk, and accordingly whether a more flexible legislative approach should be adopted rather than rules that apply to all forms of insurance.
38	What has been the consequence of the problems with section 9 of the ILRA?
	Please see response to Q37
39	If you agree that there are problems with section 9 of the ILRA, what options should be considered to address them?
	Please see response to Q37

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 Law Commission's concerns about section 11 remain valid. We agree with the Law Commission's recommended reform because it would reduce the scope of section 11 and thereby allow it to better achieve its intended purpose. As currently drafted, section 11 is too broad and does not adequately balance the competing interests. It was intended to protect insureds from having cover denied on the basis of insurers' unmeritorious reliance on exclusions where, while there was a temporal connection between the excluded circumstance and the loss, there was no causal connection. However, the courts have applied section 11 to exclusions that were formulated by reference to actuarial or statistical data establishing a generalised increased risk of loss in the circumstances covered by the exclusion, even if the exclusion has resulted in the insured paying lower premiums. The case law on section 11 is complex and difficult to understand. That complexity does not provide certainty for insurers or insureds, and encourages undue complexity in drafting the exclusions to the detriment of the insureds' understanding of those exclusions. That uncertainty and drafting complexity encourages more litigation. As a matter of general contractual principle, if actuarial or statistical data establishes a generalised increased risk of loss in the circumstances covered by the exclusion, and if the insured accepts the cover with that exclusion when the insured could have negotiated cover without the exclusion for an increased premium, then it seems inequitable for the insured to retain the benefit of the policy where the excluded circumstances apply. To the extent that section 11 operates to release the insured from the exclusion's strictures, it is effectively rewriting the bargain struck between the parties. The Minister's comments recorded in the Hansard on the introduction of Insurance Law Reform suggest that section 11 reflects an assessment of the dynamics between insurers and insureds, and lack of real consumer choice, at the time it was enacted. However, the insurance market has changed dramatically since then, with there now being more insurers and insurance products available. Accordingly, insureds arguably have more power with respect to negotiating the terms of the policies or, at least, finding an insurance product that best meets their needs. It is necessary to reappraise the appropriateness of section 11 in light of these changed circumstances.
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?
	Please see response to Q40
42	If you agree that there are problems with section 11 of the ILRA, what options should be considered to address them?
	Please see response to Q40

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?
	The registration system for transfers and mortgages of life insurance policies under Part 2 of the Life Insurance Act 1908 has previously been identified as being out-of-date. Whilst the registration system may now be out of date, the premise in the Life Insurance Act 1908 that to be effective all assignments and transfers of ownership of a life insurance policy must be registered by the life insurer is paramount and needs to be maintained. The exact way in which registration is effected in terms of the form used (paper based or electronic) and the process followed should not be mandated in the legislation. Each life insurer should be able to determine what is the most appropriate form and process to be adopted for their entity. Certainty about whose interests/ownership of a life insurance policy is being assigned or transferred (and to whom) is important. Upon registration of the assignment or transfer by the life insurer a confirmation should be provided to the interest holder or policy owner(s) confirming the effective date of the change when it was registered by the life insurer. The method or process of registration should not be prescribed in the legislation, however, the legislation should specify that the date of registration of an assignment or transfer of ownership by the life insurer is the effective date of the ownership change or assignment of interest in the policy. Prescribing a registration process or system in the legislation will not keep up with advances in technology over time and will be a cost to life insurers to implement a standard registration process or system.
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?
	Please see response to Q43

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 currently drafted, section 10 of the Insurance Law Reform Act 1977 can produce an unjust outcome for an insurer. The problem arises because of the wide drafting of section 10(3) which deems as agent of the insurer any person who receives *"from the insurer commission or other valuable consideration for such person's arranging, negotiating, soliciting, or procuring the contract of insurance"*. It is industry practice that consumers do not pay intermediaries for advice on insurance and as noted in MBIE's review of the Financial Advisers Act 2008 consumers do not want to pay for advice. Intermediaries are remunerated by payments of commission from the insurer. Accordingly, the current law does not sit well with industry practice and as a result, section 10 is ambiguous. The scope of the purpose of the deemed agency is not clear. Insurers do <u>not</u> consider that the responsibility for the intermediary's actions or omissions should rest with the insurer unless the intermediary is in fact an agent of the insurer (under the terms of the intermediary's arrangements with the insurer) and is acting within the terms of that authority. The payment of commission should not be the factor determining that the intermediary is the agent of the insurer as is the position in section 10. The intermediary's professional indemnity insurance should respond for any acts or omissions of the intermediary and the consumer should have direct recourse to the intermediary not the insurer. Generally, section 10 needs updating as it was drafted prior to the Financial Advisers Act 2008. Any provisions regarding agency should be consistent with the financial advice regulatory regime.
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?
	The problems with this provision are related to who the intermediary is deemed to be an agent of. Disclosure of the agency status to the consumer may provide a solution. Further consideration should be given as to whether this aspect of the regime should be consistent (or dealt with) in the regime for financial advice (currently the Financial Advisers Act 2008).
47	If you consider there to be problems, what options should be considered to address them?
	See response to Q46

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?
	We have no comment
49	If you agree that there are problems, what options should be considered to address them?
	We have no comment

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.
	Repealing should be done with caution, and after assessing the practical implications of the repeal on insurers and insureds, and understanding the flow on effects on other laws. Ideally, the substantive reforms should be identified first, then this question should be considered.
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?
	Whether codification is desirable in any particular instance will depend on the substantive reforms proposed, whether it would serve the policy intent of those reforms, whether it would introduce further uncertainty or clarity, and whether it is possible to capture the nuances of the common law concepts in legislative form while, at the same time, not hindering their development through case law.
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.
	It is not possible to meaningfully answer this until such time as any substantive reforms are proposed. Only then will it be possible to form a view on how these should be legislatively packaged to best give effect to the policy intent, and to assess the implications on existing legislation and law. We therefore consider that views on these matters should be sought from stakeholders after the substantive reforms have been proposed. Given the Government's intention to introduce a Bill before the next election, there is a lot of work needing to be undertaken in a relatively short time period. We submit that the more consultation we can have as we work through the review, the better the outcomes will be for consumers and the industry.
53	Is there anything further the government should consider when seeking to consolidate the six Acts into one?
	Yes. We recommend the Government consider the issue of interest payable on death claims as part of the review. Under the current law, if a death claim is not paid within 90 days after the date of death (for any reason), the insurer is liable to pay interest at a prescribed rate from the 91st day until the death claim is paid (pursuant to section 41A of the Life Insurance Act 1908).

Insurers want to pay a valid death claim promptly and in most cases death claims are settled promptly. However, there are a number of circumstances where an insurer may not be able to pay a death claim within 90 days. Some of those circumstances include:

- claims that involve the Coroner and await the Coroner's findings
- claims where there are delays in obtaining probate or letters of administration
- cases where the insurer is not notified of a death claim until after the 90 day period (may be years after death).

Having a punitive interest rate is not fair on insurers because insurers are required to act prudently in terms of their investments. So interest income received by the insurer on the claim amount is generally less than the interest payable on the claim.

Appendix One - Claim Process Flowchart – life and health insurance