MINISTRY OF BUSINESS, INNOVATION & EMPLOYMENT
HĪKINA WHAKATUTUKI

COVERSHEET

Minister	Hon Kris Faafoi	**Portfolio**	Commerce and Consumer Affairs
Title of Cabinet paper	**Insurance Contract Law Reforms**	**Date to be published**	4 December 2019

List of documents that have been proactively released		
Date	**Title**	**Author**
20 November 2019	*Insurance Contract Law Reforms*	*Office of the Minister of Commerce and Consumer Affairs*
20 November 2019	*DEV-19-MIN-0311*	*Cabinet Office*
November 2019	*Impact Statement: Insurance contract law reforms*	*MBIE*

Information redacted **YES**

Any information redacted in this document is redacted in accordance with MBIE's policy on Proactive Release and is labelled with the reason for redaction. This may include information that would be redacted if this information was requested under Official Information Act 1982. Where this is the case, the reasons for withholding information are listed below. Where information has been withheld, no public interest has been identified that would outweigh the reasons for withholding it.

Coversheet: Insurance contract law reforms

Advising agencies	Ministry of Business, Innovation and Employment (MBIE)
Decision sought	Amend insurance contract law
Proposing Ministers	Minister of Commerce and Consumer Affairs

Summary: Problem and Proposed Approach

Problem Definition

What problem or opportunity does this proposal seek to address? Why is Government intervention required?

There are significant problems with aspects of New Zealand's insurance contract law. These problems undermine the effectiveness of our insurance markets and impact those who do not receive the support they anticipated from their insurance policies. In particular:

- The duty of disclosure on policyholders is onerous and the consequences for not complying with the duty can be disproportionate (see from page 11)
- Some terms in insurance contracts which might be genuinely unfair could be immune from challenge under the Fair Trading Act 1986 (see from page 29)
- Consumers often have difficulty understanding and comparing insurance policies (see from page 39)
- A 'duty of utmost good faith' has been established in the common law but policyholders may be unaware of it, and it may be difficult for them to bring a case against an insurer for a breach (see from page 48)
- There are various technical legal provisions that affect insurers' ability to measure the risk they are insuring (see from page 51)

Proposed Approach

How will Government intervention work to bring about the desired change? How is this the best option?

To address the problems summarised above, the key proposals are that:

- Consumer policyholders be required to "take reasonable care not to make a misrepresentation" (effectively to answer any questions asked by the insurer truthfully and accurately).
- Requiring insurers to respond proportionately to any non-disclosure by policyholders.
- Removing the current insurance exceptions to the unfair contract terms provisions, and instead, tailoring to insurance the exceptions which apply to all consumer contracts.
- Requiring consumer insurance policies to be in clear and plain language, and to comply with regulations in relation to presentation requirements and information to be made publicly available.
- Codify the duty of utmost good faith in legislation.

Government intervention will reduce the risk of disproportionately negative consequences

for consumers. Intervention will also balance the need to protect insurers' ability to measure and price risk. Intervention will also increase efficiency in the insurance market.

The proposals also aim to change the rules about disclosure to better reflect the information known by consumers and businesses, and better protect customers from genuinely unfair terms, as well as make insurance contracts clearer.

Section B: Summary Impacts: Benefits and costs

Who are the main expected beneficiaries and what is the nature of the expected benefit?

New Zealand consumers of insurance products are expected to be the main beneficiaries of these proposals. Policyholders will better understand their obligations and be able to comply with them. They will also be better protected against genuinely unfair contract terms. This will increase efficiency in the insurance market and reduce the risk of disproportionately negative consequences for policyholders.

Where do the costs fall?

Insurers will face moderate-to-high initial costs to implement the proposals, for example, making changes to their contracts and systems. The proposals are not expected to significantly increase costs for insurers on an ongoing basis.

The government and the Financial Markets Authority (FMA) will face increases in administration, monitoring and enforcement costs in relation to the proposals, including those for comparing and understanding insurance policies and unfair contract terms provisions in relation to financial services contracts. It is currently unclear what these costs will be, they are not expected to be significant but a further assessment of costs may be necessary at a later date. The Commerce Commission may have a small increase in costs in relation to enforcing unfair contract terms.

What are the likely risks and unintended impacts, how significant are they and how will they be minimised or mitigated?

One risk is reduced access to, or more expensive, insurance products and services, for instance if costs are passed through to customers. This is expected to be low impact because ongoing compliance costs are not likely to be high, and will be spread across a large number of customers.

Identify any significant incompatibility with the Government's 'Expectations for the design of regulatory systems'.

None.

Section C: Evidence certainty and quality assurance

Agency rating of evidence certainty?

Overall we have a moderate level of confidence in the evidence base for the problem

definition.

We have evidence of common problems faced by consumers from the large number of submissions received and a 2018 MBIE/Colmar Brunton survey of insurance consumers. Industry stakeholders have given us evidence of many of the technical issues with insurance contract law. We also have data on complaints numbers to financial dispute resolution schemes, as well as claims numbers held by insurers (for example, number of claims declined due to non-disclosure of material facts by policyholders).

We are satisfied that evidence of the problems with the duty of disclosure, at least insofar as it relates to consumers, is moderate to strong.

The evidence base for the problem of unfair contract terms in insurance is weakest, because it is largely based on anecdotal evidence of contract terms which may or may not be unfair in the circumstances in question. As the regulator has not yet taken any enforcement action on unfair contract terms in insurance contracts, it is difficult to know the extent of the problem and the harm. We have not sought legal advice to go through insurance contracts to identify potentially unfair contract terms.

To inform our analysis of the options, we have drawn on advice from Professor Rob Merkin QC, an expert on insurance law in the UK, New Zealand and Australia.

To be completed by quality assurers:

Quality Assurance Reviewing Agency:
MBIE
Quality Assurance Assessment:
Meets the criteria necessary for Ministers to make informed decisions on the proposals in the Cabinet paper.
Reviewer Comments and Recommendations:

Impact Statement: Insurance contract law reforms

Section 1: General information

Purpose
The Ministry of Business, Innovation and Employment is solely responsible for the analysis and advice set out in this Regulatory Impact Statement (RIS), except as otherwise explicitly indicated. This analysis and advice has been produced for the purpose of informing key policy decisions to be taken by Cabinet.
Key Limitations or Constraints on Analysis
This RIS relies on a range of qualitative data to assess the impacts of the proposed options, including anecdotal evidence from public submissions. For example, the views of individual submitters have helped to inform whether a particular option would be reasonable for a consumer to understand and implement. The sources used did not include much quantitative evidence of the problems identified or quantitative assessments of the costs and benefits of the options. We have made use of multiple evidence sources where possible to increase the confidence we can place in the conclusions reached.
Responsible Manager
Authorised by: Sharon Corbett Manager, Financial Markets Policy Building, Resources and Markets Ministry of Business, Innovation and Employment November 2019

Section 2: Problem definition and objectives

2.1 What is the context within which action is proposed?

Social and economic context

Insurance plays an important social and economic role. Insurance provides cover for the losses that consumers and businesses can face when an unexpected, harmful event occurs. It helps individuals to cope with unforeseen life events and provides businesses with greater certainty. Having insurance also means that consumers and businesses have less need to hold reserve funds for dealing with emergencies, thereby freeing up money for more productive uses. It can better enable businesses to take on risks, and therefore grow and innovate, and protects individual consumers from significant financial loss in the event of disruptive events.

Given the importance of insurance, it is in the public interest to ensure that insurance provides the cover that it is intended, and expected, to provide. A well-functioning insurance system is integral to ensuring insurance continues to serve all New Zealanders. We need all parties (insurers and consumers) to be able to transact with confidence and we need these interactions to be fair, efficient and transparent.

The unique importance and risks of insurance products and services

There are a number of factors that distinguish insurance products from other types of products and services that consumers purchase on a regular basis. These factors create a unique set of risks for consumers and insurers, which are detailed in the problem section below.

The importance of insurance products and services for wellbeing, coupled with the risk of harm and the consequences of that harm mean that insurance products and services can have a bigger positive or negative impact on individuals and society than most other products and services.

Individual consumers typically have an asymmetrical relationship with insurers – they generally have less information about insurance products and less power (although consumers will have more information about their own circumstances). Relationships between insurers and business customers may still be asymmetrical, but businesses tend to have more power and information than individuals.

Insurance contract law has some differences to general contract law, because insurance contracts are about transferring risk and require both parties to act with utmost good faith.

Industry structure

Most New Zealanders have some kind of insurance. There are 88 licensed insurers in New Zealand.

In the general insurance market, two insurers (IAG and Suncorp) make up around 70% of the market. Both insurers provide insurance direct to consumers (IAG through State and AMI, Suncorp through Vero and AA insurance (a joint venture with the New Zealand Automobile Association)). IAG also underwrites white label insurance for a number of banks (including

BNZ, Westpac and ASB) and sells insurance via brokers under the NZI and Lumley brands.

There are also other, smaller insurers in the market. The largest of these is Tower Insurance, which provides insurance direct to consumers under the Tower brand and provides personal insurance for Kiwibank, TSB and TradeMe. Tower supplies a limited amount of commercial insurance.

Life and health insurers vary in terms of their size – from less than $15 million to $700 million annual income from premiums. Some prominent life insurers include AIA, Partners Life and Asteron Life. Some health insurers include Southern Cross, nib and Accuro. Some insurers are large and have considerable market power. However, intermediaries (particularly in the general insurance market) can also be large and exercise market power over insurers.

A number of banks and other parties (for example, Warehouse Money and TradeMe) are active in insurance markets as an adjunct to other products or services they offer.

The counterfactual

This RIS addresses separate problems relating to insurance contract law in turn. The counterfactual for each policy proposal is set out under each problem.

2.2 What regulatory system, or systems, are already in place?

Insurance falls within the financial markets regulatory system. The system's purpose is to have well-functioning, fair, efficient and transparent financial markets which support informed participation by businesses and consumers.

Key features of the regulation of insurance

New Zealand's law relating to insurance contracts is currently spread across a mix of case law and various pieces of legislation. This reflects the incremental development of insurance contract law in New Zealand.

Insurance contract law in New Zealand has developed from the principles and practices established in the eighteenth and nineteenth centuries. Back then, insurance contracts were primarily for marine insurance and existed between insurers, shipowners and cargo owners. The contracts were commercial rather than consumer and insurance contract law reflected this.

The foundation piece of insurance contract law in New Zealand is the Marine Insurance Act 1908 which was itself based on the Marine Insurance Act 1906 (UK). Although the Marine Insurance Act 1908 appears to apply only to marine insurance, many of its principles have been applied to non-marine insurance on the basis that it accurately states the common law.

New Zealand's existing insurance contract-related statutes are:

- the Marine Insurance Act 1908
- the Life Insurance Act 1908
- the Law Reform Act 1936

- the Insurance Law Reform Act 1977
- the Insurance Law reform Act 1985
- the Insurance Intermediaries Act 1994.

A number of these Acts have targeted specific issues. In some places this has resulted in inconsistent outcomes in similar scenarios.

A number of jurisdictions with similar laws have reformed them to reflect the changing nature of insurance and to provide more protection to consumers. This leaves the New Zealand regime out of step with what is occurring elsewhere.

Government regulation is preferable to self-regulation

Given the multitude of players in the industry, it is not reasonable to expect all players to comply with certain voluntary standards without government intervention. The characteristics of insurance products and services mean that some underlying issues such as information asymmetry, conflicts of interest and an imbalance of power exist. While voluntary initiatives are welcome, we do not think that they are an adequate substitute for clear laws on the contract between the insurer and policyholder.

The industry body for general insurance (home and contents, car, travel, credit card, commercial), the Insurance Council of New Zealand (ICNZ) has a Fair Insurance Code which sets out reasonable standards of commercial practice for insurers when dealing with individual consumers. This is largely focused on conduct, but also includes matters such as how insurers should treat non-disclosure "reasonably." However, this only applies to general insurers and not to life and health insurers, where, we are told, problems with non-disclosure are most prevalent. Breaches can be assessed by one of the relevant financial dispute resolution schemes. Material breaches can be assessed by an independent disciplinary committee with fines of up to $100k and expulsion.

The Financial Services Council (FSC) Code of Conduct came into effect in January 2019. FSC members comprise 95% of the life insurance market in New Zealand. Given its recent introduction, we do not yet know how effective this has been. The Code is largely focused on conduct in the form of high-level commitments to delivering good outcomes for customers. Similar to the Fair Insurance Code, material breaches can be assessed by an independent disciplinary committee with fines of up to $100k and expulsion.

The Health Funds Association of New Zealand (HFANZ) also has a Health Insurance Industry Code which sets out commitments to act in good faith and a responsible manner when dealing with customers. This includes matters such as not acting in a misleading manner, having a fair complaints procedure, and respecting customers' personal information. However, it is not largely concerned with aspects of contract law.

Agencies with a role in the system

There is no single regulator responsible for enforcing insurance contract law. There are several regulators responsible for enforcing regulation that applies to insurers:

- The FMA has some powers in relation to insurers' and insurance intermediaries' conduct through the regulation of financial advice and through powers relating to

'misleading and deceptive' conduct under Part 2 of the Financial Markets Conduct Act 2013 (FMC Act). The FMA will also take on a new role of regulating the conduct of financial institutions such as banks and insurers under separate work in relation to the conduct of financial institutions.

- The Commerce Commission is responsible for enforcing unfair contract terms in standard form consumer contracts, including consumer contracts for insurance.

- The four financial dispute resolution schemes (the Insurance and Financial Services Ombudsman, Banking Ombudsman, Financial Services Complaints Ltd, and Financial Dispute Resolution) can and do consider consumer complaints on matters relating to insurance contract law, including claims being declined for non-disclosures. It is largely the role of individual consumers to take action and achieve redress through either settling their complaint directly with insurers, through dispute resolution schemes, or via court action.

- The Reserve Bank (RBNZ) is responsible for the prudential regulation of insurers (for example, minimum capital requirements).

- MBIE has policy responsibility in relation to insurance contract law.

Assessment of overall fitness-for-purpose of the system

MBIE has primary responsibility for maintaining, monitoring, evaluating, and improving the financial markets regulatory system. In doing so, MBIE is directly accountable to the Minister of Commerce and Consumer Affairs. A regulatory charter for the wider financial sector has been put in place under the auspices of the Council of Financial Regulators involving MBIE, FMA, RBNZ, and the Treasury. A regulatory system assessment is expected to take place every five years.

Problems with some aspects of New Zealand's insurance law were identified many years ago, including in the Law Commission's 1998 report, *Some Insurance Law Problems.* Previous efforts to reform insurance law have stalled due to other priorities.

The conduct of insurers is also currently being reviewed as part of a parallel piece of work on the conduct of financial institutions. Any gaps with regard to the conduct of insurers are being identified and addressed there. These two reviews are not, however, an assessment of the overall fitness-for-purpose of the regulatory system, or a broader review of insurance markets in New Zealand.

2.3 What is the policy problem or opportunity?

The separate policy problems and opportunities addressed in this RIS are set out in turn below.

2.4 Are there any constraints on the scope for decision making?

Ministers have committed to making legislative changes on insurance contract law.

The terms of reference for the review, agreed to by Cabinet, ruled the following areas out of scope:

- concerns about "underinsurance" – including whether consumers are underestimating the level of cover needed under "sum-insured" home insurance policies
- any competition issues related to the structure of insurance markets, such as the number and market share of insurance companies (these issues are the responsibility of the Commerce Commission)
- the prudential regulation of insurers (separately being considered by the Reserve Bank in its review of the Insurance (Prudential Supervision) Act 2010)
- earthquake insurance as governed by the Earthquake Commission Act 1993 and accident compensation insurance as governed by the Accident Compensation Act 2001, and
- regulation of financial advisers and the dispute resolution regime in relation to insurance (considered in the 2017 review of the Financial Advisers Act 2008 and Financial Service Providers (Registration and Dispute Resolution) Act 2008).

MBIE is undertaking a parallel review of the conduct of financial institutions, including insurers. The outcomes of this review will have implications for how insurers conduct themselves towards policyholders, such as how they handle claims. Any changes proposed to insurance contract law will need to work alongside any new conduct obligations.

There is also a connection to MBIE's work on unfair commercial practices. In July 2019 Cabinet agreed to extend the prohibition on unfair contract terms (UCTs) in the Fair Trading Act to standard form business contracts (below a certain monetary threshold). Any existing exceptions for insurance will be carried over. The starting point would be that any changes made to the way UCTs apply to consumer insurance contracts will also apply to standard form business contracts. Some insurers have expressed concerns about extending unfair contract term protections to businesses.

2.5 What do stakeholders think?

Stakeholders include general insurers, life and health insurers and their representative groups, law firms, dispute resolution schemes, consumer advocacy groups, financial advisers and other intermediaries, individual businesses and individual consumers.

Stakeholders, including insurers, generally recognised the need for reform in some key areas. They have been supportive of reviewing the law around the duty of disclosure for consumers in particular, and a number of other technical changes to the law. The issue with the greatest divergence in views is whether the existing exceptions for certain insurance terms from the unfair contract term provisions are appropriate. Consumers and consumer advocates believe that the exceptions are not appropriate, while insurers think otherwise.

MBIE has not identified any issues with insurance contract law that affect Māori in particular. However, Māori have particularly low rates of insurance uptake.[1] The proposed changes will make insurance contracts fairer, more accessible and easier to understand, which could increase uptake among Māori.

MBIE released an issues paper (May – July 2018) consulting on the issues addressed in this impact statement. We received 120 submissions, from a mix of insurers, consumers, businesses, law firms and dispute resolution schemes.

MBIE released an options paper in April 2019. Consultation closed in June 2019. We received around 400 submissions (292 of which were template submissions).

2.6 Objectives

Our policy objectives for the review are as follows:

Participants in the insurance market are well informed and able to transact with confidence at all points in the lifecycle of an insurance policy: This objective reflects that both parties to an insurance contract have information needs and will be able to make better decisions if they have better information.

Interactions in the insurance market are fair, efficient and transparent at all points in the lifecycle of an insurance policy: This objective recognises that there are better outcomes for insurers and policyholders in a fair, efficient and transparent market.

Barriers to insurers participating in the insurance market are minimised: This objective recognises that it is important to ensure that New Zealand remains an attractive place in which to provide insurance. New Zealand has high natural hazard risks, and therefore carries a high level of risk for insurers. We are mindful of the need to maintain a deep market for the provision of insurance in New Zealand.

Consumers' interests are recognised and protected when participating in the insurance market: This objective recognises the need to protect consumer interests, especially in light of the power and information asymmetry between insurers and consumers.

[1] Commission for Financial Capability (1 May 2019). *Low insurance among Māori*. Retrieved from https://www.cffc.org.nz/news-and-media/news/low-insurance-among-maori/

Section A: Duty of disclosure and remedies for non-disclosure

Section A1: Problem definition and objectives: Duty of disclosure and remedies for non-disclosure

A3.3 What is the policy problem or opportunity?

Status quo

Before entering into a contract of insurance, prospective policyholders must disclose to the insurer information that would influence the judgment of a prudent insurer in setting the premium or deciding whether to take on the risk of providing insurance ("material facts"). Answering an insurer's questions does not relieve a policyholder of the duty to disclose other material facts. This duty is intended to help the insurer measure the level of risk.

If a policyholder does not disclose all material facts ("non-disclosure"), the insurer is entitled to "avoid" the contract (refuse all claims under it, return all premiums in the absence of fraud and the insurance contract is treated as if it never existed). The insurer can do so even if:

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

Problem: consumers don't understand what needs to be disclosed

An ordinary consumer cannot reasonably be expected to know what an insurer might consider material and therefore what to disclose. For example, consumers usually know that they must disclose official medical diagnoses, but not necessarily signs or symptoms which have not been diagnosed.

Problem: consumers may not be aware of the duty of disclosure

Insurers are not required to bring the duty of disclosure to the attention of consumers. If consumers are not aware of the duty and fail to disclose fully, they may end up not being covered for a loss which they expected to be covered for. Lack of warning is not an excuse for breaching the duty.

Insurers said that consumers are aware of the duty and its consequences and said they made efforts to make their customers aware. Meanwhile financial advisers, dispute resolution schemes and law firms noted that despite disclosure being signposted in policy documents, consumers do not necessarily understand the duty and its implications.

Consumers commonly misunderstand their disclosure obligations. In a 2018 Colmar Brunton survey commissioned by MBIE, 51% of respondents thought they need to tell the insurer everything that might affect their insurer's decision, even if the insurer doesn't specifically ask for it. Another 24% thought that they need to tell the insurer everything relevant that they can remember, while 18% thought that they only need to answer the insurer's questions.

A common assumption is that if the insurer needs information (for example, medical records or claims history), the insurer will ask about it or get it from a third party (with permission). Of

respondents to the Colmar Brunton survey who had life, health or income protection insurance, 45% said they thought their insurer checked their medical records before agreeing to give them insurance. However, while a consumer may have given permission for their insurer to access their records, the insurer usually only does so after the consumer has made a claim.

Problem: disproportionate consequences of non-disclosure

If policyholders do not disclose material facts (i.e. non-disclosure), the law currently permits the insurer to avoid the contract and refuse all claims under it, even if there is no connection between what was not disclosed and the claim. Insurers can avoid a policy even if disclosure of the information would not have made them decline cover.

This can be a disproportionate response which has serious consequences for policyholders. It can affect their ability to be protected against economic loss in the short and long term. Apart from the immediate loss, it can impact their ability to obtain cover in the future if they have a history of having a previous contract avoided.

Insurers told us that they do not always exercise their right to avoid the contract in response to non-disclosures. They said they responded reasonably to non-disclosures on a case-by-case basis, and that it would be counterproductive for them to develop a reputation for claims avoidance. One general insurer said that in 32% of its responses to non-disclosure, it does nothing; 59% of the time it adjusts the customer's policy; and only 9% of the time cancels or avoids the policy.[2] COMMERCIAL INFORMATION [3] [4]

(Note that these examples are not directly comparable as some insurers are referring to policies voided while others refer to claims declined.)

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

However, other submitters suggested that non-disclosures are not always dealt with reasonably, as evidenced by the number of disputes about non-disclosure. The Banking Ombudsman Scheme said that it frequently sees disputes about banks declining claims due to non-disclosure, mostly to do with pre-existing health conditions.[5] Insurance and Financial Services Ombudsman (IFSO) commented that in its experience, insurers tend to avoid policies and decline claims based on non-disclosure. About 10% of the claims received by IFSO relate to non-disclosure,[6] with the issue being the third most common topic of complaint to the scheme.[7] MBIE's Colmar Brunton survey found that of respondents who had

[2] Issues paper submission – IAG

[3] Options paper submission – AIA/Sovereign

[4] Options paper submission – Partners Life

[5] Issues paper submission – Banking Ombudsman Scheme

[6] Issues paper submission – Insurance and Financial Services Ombudsman

[7] Insurance and Financial Services Ombudsman (2019). *Annual Report 2019.* Retrieved from https://www.ifso.nz/assets/Uploads/IFSO-Scheme-Annual-Report-2019.pdf

a claim denied or reduced, 15% said the reason was that they had not told the insurer information that the insurer thought they should have. Of those, 25% of respondents said that this was information specifically related to the claim, 38% said this was information the insurer wanted to know but did not specifically relate to the claim, and 31% said it was some information that related to the claim and some other information that was not.

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

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

Problem: disclosure for businesses

We have little evidence to suggest that the same problems identified with non-disclosure also exist for businesses (of any size). An insurer that primarily provides commercial insurance estimated that it has avoided fewer than 10 policies in the last decade, across 30,000 policies.[8] The insurer submitted that most of its business customers are advised by brokers and are well-informed. Another submitter with experience handling commercial insurance claims said that it was not aware of large or mid-sized businesses having policies avoided based on non-disclosure.[9]

However, many submitters noted that small businesses are similar to consumers in their knowledge and resources and should be treated similarly. Submitters argued that large businesses should be treated differently because they have greater resources and bargaining power, for example, sophisticated record-keeping systems, in-house legal teams and brokers.

Despite the lack of evidence that the current laws are resulting in negative outcomes for businesses, the expectation that any policyholder should know what a prudent underwriter would consider to be material may be unreasonable. Notably, Australia and the UK have both reformed the law of disclosure as it relates to businesses. In the UK, it was suggested that the law no longer reflected commercial practices in relation to business insurance, and that the duty was poorly understood by business policyholders and allowed insurers to play a passive role when obtaining information to underwrite risk.[10]

Section A4: Options identification: Duty of disclosure and remedies for non-disclosure

[8] Issues Paper submission – Vero Liability Insurance

[9] Issues Paper submission – Assure Legal

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

A4.1 What options are available to address the problem?

The options in relation to the duty of disclosure are set out below. These options are not mutually exclusive.

Option 1: Duty for consumers to take reasonable care not to make a misrepresentation (consumer option)

This option, based on the law in the UK for consumers, would abolish the duty of disclosure for consumers and replace it with a duty to take reasonable care not to make a misrepresentation. Insurers would have to identify the information they need to underwrite the risk through questions. Consumers must answer truthfully and as accurately as is reasonable. Whether or not a consumer has taken reasonable care would take into account factors such as how clear and specific the insurer's questions were and whether the consumer had a broker.

The majority of submitters supported Option 1 for consumers. Many acknowledged that it could result in longer questionnaires; however we do not expect the impact consumers to be significant. The United Kingdom moved to this approach to disclosure over seven years ago and application forms have not increased in length in a significant way during this time. We have also sought feedback from an insurer that is changing its approach to disclosure in advance of a law change, and they confirmed that the impact on the length of questionnaires should be fairly limited. Furthermore, insurers already require a lot of specific information from consumers in order to accurately price the risk of offering insurance.

The benefits should outweigh any costs for both parties as the change is likely to reduce the number of disputed claims due to non-disclosure better than the status quo or alternative options.

Dispute resolution schemes and financial advisers preferred Option 1.

Option 2: Duty to disclose what a reasonable person would know to be relevant (consumer or business option)

This duty is based on the duty in Australia for consumers and businesses.[11] The duty is to disclose information that the policyholder knows, and that a reasonable person in the circumstances could be expected to know, to be relevant to the insurer in accepting the risk. Whether a reasonable person would know the information was relevant would take into account the type of insurance product and the target market for the insurance. In practice, a higher standard would apply for businesses because they can be expected to have a higher level of knowledge and resources, and because they are more likely to use brokers.

Generally submitters saw this Option as unclear and uncertain for consumers. On balance, the majority of insurers supported Option 2, but many supported Option 1 as well. ICNZ noted the majority of its members supported Option 1, but it recognised that both Options 1

[11] However, the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry recommended that the current duty in Australia "be amended for consumer insurance contracts, to replace the duty of disclosure with a duty to take reasonable care not to make a misrepresentation to an insurer" (p. 32) i.e. the UK duty for consumers. Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (February 2019). *Final Report – Volume 1* –accessed at: https://www.royalcommission.gov.au/sites/default/files/2019-02/fsrc-volume-1-final-report.pdf

and 2 could be workable.[12]

Option 3: Require life and health insurers to use medical records to underwrite (consumer option)

This option could work with the status quo or any of the other options. It would require life and health insurers to seek permission to access the policyholder's medical records and use these records to assess the risk. This would only address non-disclosure in relation to personal insurance products, for example, health, life and trauma insurance.

Some consumers thought Option 3 would be a good idea, often in combination with another option, but on the whole most insurers, law firms and dispute resolution schemes thought that Option 3 would largely be unworkable. It would increase costs and significantly delay application times, which impacts policyholders if their cover is delayed. Many insurers noted that medical records can be incomplete or fragmented and still not tell insurers all they need to know. Partners Life also pointed out that it would increase the rate of cancelled applications, which would have cost implications.

COMMERCIAL INFORMATION

13

Option 4: Duty for businesses to make fair presentation of risk (business option)

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

Under this option, a business policyholder would be presumed to know:

- if the policyholder is an individual in business, the information known to the individuals responsible for the insurance
- if the policyholder is a corporate, the information known to the senior management of the policyholder or the individuals responsible for the insurance
- if an individual or a corporate, the information that should have been revealed by a reasonable search of information available to the policyholder.

Option 5: Requirement to inform policyholders of the duty (consumer or business option)

This would impose a statutory requirement that insurers must warn policyholders of the duty and possible consequences in writing before a contract is entered into.

All submitters who commented thought insurers should warn consumers of the duty. Many insurers said they already do so.

[12] Options paper submission – ICNZ

[13] Options Paper submission – Partners Life

Option 6: Disclosure of the use of third party information (consumer option)

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

This would require insurers to inform the consumer about whether, and when, they will access third party records (if the consumer has consented to the access), and state whether this relieves the consumer of the duty to disclose particular matters. If the insurer intends to rely on such information as part of pre-contractual disclosure, this should be declared and the consumer's duty to disclose in relation to those matters waived. This would be a general requirement intended to inform the consumer of whether the insurer will access their records to underwrite the policy, or will only access their records at claims time, rather than a specific requirement to inform the consumer every time they access the information.

Consumers, dispute resolution schemes and consumer advocates thought insurers should tell consumers what third party information they will access, and when. Dispute resolution schemes thought this would address the issue of consumers assuming that insurers obtain their medical records before underwriting. Insurers did not like the idea of informing consumers every time they accessed third party information, as this would be onerous. Insurers generally thought that the requirements of the Privacy Act were enough to oblige insurers to tell consumers about the information that may be accessed.

Table 1: costs and benefits of options for duty of disclosure

Where the costs and benefits differ between consumers and businesses, these have been identified below.

Proposal	Benefits	Costs
Option 1 duty: duty for consumers to take reasonable care not to make a misrepresentation	• **Consumers** do not have to guess what an insurer would consider to be relevant to underwriting risk. Consumers clearly understand what they need to disclose, as they only have to answer questions truthfully. • Reduces the number of disputed claims which cause delays and expense to both parties. • Consumers have more certainty that a claim will not be declined due to non-disclosure, which will also improve trust in the insurance industry. • It is only in unusual circumstances that a consumer risk would exhibit	• For **consumers**, if insurers have to draft and ask questions to obtain all the information they need, this may take more time and resources. However, drafting questions would likely only incur one-off costs, at least for consumer insurance where potential risks are more standard and predictable. • Compliance costs for insurers could raise premiums.[14] • Insurers may not be able to identify all the information they need. This may impact insurers' certainty of the risk they are insuring.

[14] In the UK the change was expected to translate to a 0.08% increase in premiums for consumers. However, consumers bear both these costs and the benefits of the change. Law Commission and Scottish Law Commission (1 December 2009). *Impact Assessment of Reforming Consumer Insurance Law: Pre-contract Disclosure and Misrepresentation.* Retrieved from https://s3-eu-west-2.amazonaws.com/lawcom-prod-storage-11jsxou24uy7q/uploads/2015/03/lc319_Consumer_Insurance_Law_Pre-contract_Disclosure_impact_assessment.pdf

	non-standard features that could not be picked up by express questions.	• Consumers may have to spend more time to respond to slightly longer questionnaires. However, insurers likely already ask about specific matters relevant to their assessment of risk under the status quo. • Would need to distinguish between business and consumer policyholders, which adds complexity.
Option 2 duty: duty to disclose what a reasonable person would know to be relevant	• **Consumers** have an active duty to identify the information that insurers will need, which means insurers have more confidence that they can measure and price risk, if it is more likely that full disclosure happens (without insurers needing to ask specific questions about everything). • Slightly reduces the number of disputed claims which cause delays and expense to both parties. • **Consumers' and businesses'** understanding of what to disclose is improved compared to the status quo. Would not require businesses to know what a prudent insurer would consider to be material to assessing the risk. Large businesses with legal teams and brokers could be expected to have the knowledge of a prudent insurer, but this may not be reasonable for all businesses. • Provides flexibility to take into account the circumstances of the **business**, its size, nature and resources in any assessment of whether the duty of disclosure has been fulfilled. • Retains an active duty on businesses to disclose material facts accurately and therefore supports the ability of insurers to measure and price risk. • This option could be applied to both consumers and businesses and would not require insurers to distinguish between types of policyholders.	• **Consumers** still need to identify information that a reasonable person would expect an insurer to consider relevant. There may be some uncertainty as to what must be disclosed. Specifically, what a reasonable person in the circumstances could be expected to know to be relevant may be debatable and the extent to which the consumer's own personal understanding is to be taken into account would have to be determined. • **Businesses** will still need to identify what information is likely to be relevant. However businesses, particularly those using brokers, are likely to have greater knowledge of this and it may be appropriate to apply a higher standard. • Creates some uncertainty if there are differing standards of reasonableness.
Option 3 duty: require life and health insurers to use medical records to underwrite	• **Consumers** are relieved of the duty to disclose in relation to matters which the insurer obtained elsewhere. Insurers could not use a consumer's non-disclosure of information in their medical records as a reason for declining a claim.	• Adds significant compliance costs for insurers. Many insurers do not access medical records at the time of entering the insurance contract because of the costs of doing so for every application. • If a non-disclosed issue was not in a consumer's medical records, the same issues with non-disclosure under the status quo would persist. • Would not address non-disclosure problems in relation to general insurance. While problems with non-disclosure are higher in life and health than for general insurance, there are cases of disproportionate consequences of non-disclosure in

		general insurance. • This option could be extended to a general requirement to access relevant third party records, but this could create confusion about what matters the consumer must disclose and what the insurer will access elsewhere.
Option 4 duty: duty for businesses to make fair presentation of risk	• Encourages active participation on the part of **business** policyholders and insurers to volunteer and seek information respectively. It therefore supports insurers to measure and price risk. • Makes the duty slightly clearer, by clarifying what a policyholder is presumed to know and allowing policyholders to provide enough information to put an insurer on notice to ask questions. • Creates a positive duty to undertake a reasonable search, rather than relying on the policyholder's knowledge only, which has the potential to benefit insurers by providing more information. • Minimises compliance costs for insurers if it means policyholders are more likely to provide relevant information. • Slightly reduces uncertainty of Option 2, as it does not rely on interpretations of reasonableness or what a hypothetical reasonable person in the circumstances ought to have known.	• The test depends on what the particular policyholder knew or ought to have known. This requires businesses to know what a material circumstance is (and therefore what would influence the judgment of a prudent insurer in determining whether to take on the risk and on what terms). This is fairly similar to the current test under the status quo. • Would need to distinguish between business and consumer policyholders, which adds complexity.
Option 5: Requirement to inform policyholders of the duty	• Policyholders are more likely to know the existence of the duty and its importance, which is likely to incentivise accurate disclosure. • While some insurers do this already, a requirement would make it consistent across the industry.	• Will not on its own solve the issue of consumers not knowing exactly what to disclose, or of disproportionate consequences being applied.
Option 6: Inform consumers when accessing records	• Will inform consumers of what records will be used to underwrite policies, meaning they have a better idea of what to disclose versus what is obtained via third party records.	• Will not on its own solve the issue of consumers not knowing exactly what to disclose, or of disproportionate consequences being applied.

Responding to non-disclosure or misrepresentation

Option 1: Remedies based on intention and materiality

This option (based on the remedies for consumer insurance in the United Kingdom) would allow insurers to avoid contracts for deliberate or reckless non-disclosure or misrepresentations that are material. A non-disclosure or misrepresentation would allow avoidance if it was objectively material and if it induced the insurer to enter into the contract on those terms. The insurer:

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

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

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

Option 2: Remedies based on intention and materiality (as for option 1); but no avoidance unless fraud

This option (based on the remedies in Australian law) would allow insurers to avoid contracts where the non-disclosure or misrepresentation was fraudulent and induced the insurer to accept the contract on those terms.

This option is similar to Option 1, but the key differences are:

- A court (or dispute resolution scheme) could disallow avoidance (or order the insurer to pay an amount towards the claim), where the insurer has not suffered any significant loss; or where it would be harsh and unfair.
- An insurer would not be allowed to avoid a contract unless there was fraud, even where the insurer would not have entered the contract initially.

Option 3: remedies based on materiality only

This option would create proportionate remedies based on what the insurer would have done had it known of the correct information at the time of application. These would be similar to the proportionate remedies described in Option 1 above.

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

Table 2: costs and benefits of options for remedies for non-disclosure or misrepresentation

Option	Benefits	Costs
Option 1 disclosure remedies: remedies based on intention and materiality	• Policyholders have greater certainty about being covered because they are not unduly penalised due to innocent or non-material non-disclosures or misrepresentations. • Applying more serious consequences to deliberate or reckless non-disclosure compared to other non-disclosures would discourage fraud and carelessness, and incentivise care and accuracy when filling out applications. • Proportionate remedies that take into account whether the insurer was induced to enter the contract ensure that both parties are no better or worse off than if they had all the facts at the time of application. This helps to support an effective insurance market by ensuring predictable outcomes for both parties. For example, allowing an insurer to reduce claim amounts by the higher premiums it would have charged means that a policyholder who has deliberately not disclosed something, and then does not have to pay for past actions, is not in a better position than a policyholder who disclosed a matter for which they were then not covered or had to pay higher premiums to obtain cover.	• May add costs for insurers if they have to prove that a non-disclosure or misrepresentation was deliberate or reckless. • May add costs if insurers must retrospectively assess what they would have done if the policyholder had disclosed accurately. However, according to many insurers, they already use a range of proportionate remedies based on what they would have done had they known of the information at contract formation. This should not be onerous for insurers to comply with or involve significant costs. • Where a dispute resolution scheme or the Courts need to consider non-disclosure, additional time will be needed to consider both intention and materiality.
Option 2 disclosure remedies: remedies based on intention and materiality; no avoidance for non-fraudulent material non-disclosure	• The benefits of this option are similar to Option 1.	• The costs of this option are similar to Option 1. • The proportionate remedies for non-fraudulent disclosure do not always leave both parties in the same position as if the information had been disclosed at contract formation time. Under this option, if the insurer would have refused to enter the contract had it known the information, it cannot avoid the contract unless the non-disclosure is fraudulent. This is different to Option 1, in which insurers can avoid the contract if they would have refused to enter the contract at formation time, even if the misrepresentation or non-disclosure was not deliberate or reckless.
Option 3: disclosure remedies based on materiality only	• Would not require insurers to consider intention. This would potentially have fewer costs for insurers if they don't have to investigate misrepresentations and/or go to court to prove intention. It would provide more certainty to insurers.	• Would not provide a strong incentive against intentional (fraudulent or deliberate) non-disclosure or misrepresentation. For example, it would put a consumer who had deliberately concealed a medical condition they had in the past five years, knowing that (or not caring if) it

	was relevant to the insurer, in the same position as a consumer who had not known to disclose a medical symptom that occurred twenty years ago, if both non-disclosures would have made the insurer exclude certain matters from cover. While the effect on the insurer may be the same, and the loss incurred is equal, this does not necessarily incentivise consumers to disclose material facts accurately.

A4.2 What criteria, in addition to monetary costs and benefits, have been used to assess the likely impacts of the options under consideration?

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

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

b) Policyholders understand clearly what information they need to disclose

c) Remedies are proportionate to materiality

d) Costs are minimised.

A4.3 What other options have been ruled out of scope, or not considered, and why?

We have not considered abolishing the duty to disclose or otherwise provide material facts altogether, as this would not allow insurance to function effectively if insurers were unable to assess and manage risk. It would likely mean that insurers would cease offering many insurance products.

We have also not considered a duty to take care not to make a misrepresentation for businesses, as it can be difficult to require insurers to ask specific questions about the complex and unique risks of some business.

Section A5: Impact Analysis: Duty of disclosure and remedies for non-disclosure

Marginal impact: How does each of the options identified at section A4.1 compare with the counterfactual, under each of the criteria set out in section A4.2?

Duties – consumers

	No action	Option 1 (care not to misrepresent)	Option 2 (reasonable person test)	Option 3 (medical records to underwrite)	Option 5 (warn policyholders of duty)	Option 6 (inform when accessing records)
Insurers can effectively measure and price risk	**0**	**+** Policyholders are more likely to know what information to disclose, resulting in useful disclosure, but insurers may not be able to identify all material information	**+** Policyholders are more likely to know what information to disclose and have an active duty to identify material information, resulting in useful disclosure	**+** Could result in insurers obtaining more material information than status quo, but only for life and health insurance (although they can choose to do so currently)	**+** Policyholders are more likely to know what information to disclose, resulting in useful disclosure	**0** Unlikely to result in insurers obtaining more material information
Policyholders understand what they need to disclose	**0**	**++** Policyholders clearly understand what to disclose as they only have to answer questions truthfully	**+** Improves understanding compared to status quo, but the test of a reasonable person is uncertain	**-** Could be confusing to policyholders, who won't always know what is in their records and what does not need to be disclosed	**+** Would help policyholders understand nature of duty and importance of correct disclosure	**+** Would help policyholders to understand whether records will be accessed to aid disclosure
Costs are minimised	**0**	**-** Insurers will incur upfront costs of drafting questionnaires, which may increase premiums	**0** We expect insurers' processes to remain largely unchanged	**- -** Significant compliance costs for insurers, which may increase premiums	**-** Minimal costs of informing policyholders at contract formation	**-** Minimal costs of informing policyholders at contract formation

Overall assessment	**0**	**++**	**++**	**- -**	**+**	**0**

Duties – businesses

	No action	Option 2 (reasonable person test)	Option 4 (fair presentation of risk)	Option 5 (warn policyholders of duty)
Insurers can effectively measure and price risk	**0**	**+** Businesses are more likely to know what information to disclose and have an active duty to identify material information, resulting in useful disclosure	**+** The test is very similar to the status quo, but does clarify that businesses must undertake a reasonable search to provide material information	**+** Policyholders are more likely to know what information to disclose, resulting in useful disclosure
Policyholders understand what they need to disclose	**0**	**+** Improves understanding compared to status quo, but the test of a reasonable person is uncertain	**+** Similar to the status quo, but clarifies that limited disclosure is sufficient if it puts the insurer on notice to probe further	**+** Would help policyholders understand nature of duty and importance of correct disclosure
Costs are minimised	**0**	**0** We expect insurers' processes to remain largely unchanged (except to the extent they must distinguish between consumer and business duties)	**0** We expect insurers' processes to remain largely unchanged (except to the extent they must distinguish between consumer and business duties)	**-** Minimal costs of informing policyholders at contract formation
Overall assessment	**0**	**++**	**++**	**+**

Remedies

	No action	Option 1 (materiality and intention)	Option 2 (materiality and intention; no avoidance unless fraudulent)	Option 3 (materiality only)
Insurers can effectively measure and price risk	**0**	**++** Incentivises truthful disclosure to help assess risk; insurers do not have to pay	**-** Insurers may have to pay claims they never would have covered	**-** Does not help to incentivise truthful disclosure

		claims they never would have covered		
Remedies are proportionate to materiality	**0**	++ Consequences are based on how insurer would have responded at contract formation	++ Consequences are based on how insurer would have responded at contract formation	++ Consequences are based on how insurer would have responded at contract formation
Costs are minimised	**0**	- Some costs of re-underwriting and investigating whether non-disclosure was deliberate or reckless	- Some costs of re-underwriting and investigating whether non-disclosure was deliberate/ reckless	- Some costs of re-underwriting
Overall assessment	**0**	**+++**	**0**	**0**

Key:

++	much better than doing nothing/the status quo
+	better than doing nothing/the status quo
0	about the same as doing nothing/the status quo
-	worse than doing nothing/the status quo
- -	much worse than doing nothing/the status quo

Section A6: Conclusions: Duty of disclosure and remedies for non-disclosure

A6.1 What option, or combination of options, is likely best to address the problem, meet the policy objectives and deliver the highest net benefits?

Preferred approach – duty of disclosure

Our preferred approach is to implement Option 1 (duty to take reasonable care not to make a misrepresentation) for consumers and Option 4 (duty to make a fair presentation of risk) for businesses. In addition, we think that Option 5 (requirement to warn policyholders of the duty and its consequences) should apply to both consumers and businesses, and that Option 6 (requirement to inform policyholders of what, and when, third party information will be accessed) should apply to consumers, but that this should be a general requirement rather than a requirement to inform every time insurers access this information. Options 5 and 6 would not by themselves solve the problems identified, but would aid understanding of the duty and its consequences.

Consumer duty

Our preferred option is Option 1 (duty to take reasonable care not to make a misrepresentation). It reduces uncertainty compared to Option 2 and the status quo, which will not only help consumers, but also helps insurers identify material facts. While this may impose some costs, such as longer time to draft and complete questionnaires, the benefits outweigh the costs. It is likely to reduce the number of disputed claims due to non-disclosure more than the status quo or Option 2. Option 2 still requires consumers to exercise judgement in deciding what information is relevant to disclose, which could be problematic as it leaves it up to interpretations of what is reasonable. While Option 3 would have some benefits for life and health policyholders in relieving them of the need to assess what information they must disclose, ultimately the costs of this option are significant and it would only address part of the problem.

One insurer thought that Option 1 might be no better than the status quo, because it puts onus on consumers to answer more questions.[15] Another insurer opposed Option 1 on the basis that consumers are better placed to know their own situation, and Option 1 would condone the current "low effort approach" of consumers.[16] We do not think this would be the case, because if consumers have to fill in questionnaires, they may in fact be likely to identify more relevant information than under the status quo, because they know what they are being asked to disclose and do not have to guess what might be relevant to the insurer.

Many submitters agreed that while it may take longer to answer questionnaires, the costs of not doing so when it comes to claims time are greater. Further, the inconvenience for consumers is minimal compared to what is required by the status quo.[17] Some disagreed

[15] Options paper submission – Southern Cross

[16] Options paper submission – IAG

[17] Options paper submission – Banking Ombudsman Scheme

that Option 1 imposes unreasonable risks that insurers would not find out the relevant information, because detailed questionnaires can mitigate this.[18] Meanwhile some insurers said that Option 1 aligns with their current practice[19], in which case this should not impose additional compliance costs.

We intend to incorporate provisions in Option 1 to prevent insurers from relying on general catch-all questions. The UK law, for example, provides that whether or not the policyholder is taken to have complied with their reasonable care duty may depend on how specific the insurer's questions were.[20] The Australian law provides that the insurer waives compliance with the duty if they ask the policyholder to disclose any other matter that is relevant.[21] Without such safeguards, this option would not work much better than the status quo because it would allow insurers to ask questions such as "Is there anything else we should know?" which would leave it up to the consumer to determine what the insurer should know.

Duty for businesses

While there is little evidence of a problem for businesses stemming from either the duty or the remedy, we think there is a case for reforming the remedies for businesses. The current 'all or nothing' remedy provided by the law (i.e. the remedy of avoidance) can be disproportionate, harsh and unfair. We are therefore recommending that the remedies for non-disclosure for business insurance be reformed in line with the same option for consumers (more detail on preferred option below).

As there is little evidence of a problem for businesses, our preference is Option 4 because it is similar to the status quo and therefore would not require a significant change in existing processes, but it does clarify some matters which the status quo does not. These clarifications benefit both the policyholder (for example, since it means that direct disclosure of every material circumstance is not necessary as long as enough information is provided to allow the insurer to investigate further) and the insurer (for example, the policyholder must disclose what is revealed by a reasonable search).

The distinction between businesses and consumers would be based on either the primary purpose of the policy (i.e. whether it is for private or commercial use) or the type of policy (i.e. commercial, life, health) etc. We also think consumer insurance should include group insurance policies (e.g. policies purchased by an employer for a group of employees) where cover is provided to a third party (e.g. employee), where the third party is responsible for providing disclosure either directly or indirectly and which would otherwise be a consumer insurance contract.

Treatment of small businesses

Some submitters thought that consumers and small businesses should have the same duty, and large businesses should have a separate duty as they have much more knowledge and resources. Generally life and health insurers favoured the same duty

[18] Options paper submission – Financial Services Complaints Limited

[19] Options paper submission – Health Funds Association NZ; Options paper submission – Partners Life

[20] Section 3(2)(c) of the *Consumer Insurance (Disclosure and Representations) Act 2012*.

[21] Section 21A(4)(b) of the *Insurance Contracts Act 1984*.

applying to both small businesses and consumers for life and health products, but general insurers did not agree for general insurance. This is possibly because the nature of the risks for life and health insurance are similar regardless of who is taking out the policy. Further, the distinction is less likely to affect life and health insurance.

There was no preference for any particular way of distinguishing small businesses. Some thought that a 19 FTE threshold could be a poor indicator of size and knowledge. Others submitted that a distinction could be made based on the purpose of the policy (i.e. for business or personal use), rather than who was taking it out. ICNZ noted that sometimes the same policy is offered to small, medium and large businesses and that having different standards for disclosure would require two different sets of policy wordings.[22]

We agree that any line drawn around a proxy for a small business will be arbitrary. It may further complicate processes for insurers, who would have to apply a test to distinguish between small and other businesses and provide two sets of different disclosure obligations accordingly. This would increase costs for insurers.

The complex nature of business risks may be such that a very small business (with few FTEs and low turnover) could have unusual risks that make it inappropriate for standardised questionnaires to apply. While we acknowledge that 97% of New Zealand businesses have fewer than 20 employees,[23] because of the different nature of business risks compared to consumers, we consider the size of the business is not necessarily a good indicator of whether that business has standard or complex risks.

We note that there is no distinction drawn between the treatment of small businesses in other common law jurisdictions. While policymakers in the UK considered this, they ultimately concluded that it was difficult to define a small business, that there was not enough evidence of a problem for small businesses to justify such a radical change in the disclosure duty and that financial dispute resolution services were already available for small businesses, to provide greater protection than for other businesses.[24] We suggest that the same applies in New Zealand. It could also have adverse effects if it means that insurers are reluctant to cover small businesses because they have less certainty about the risks they pose, and therefore raise premiums for small businesses.

Furthermore, Option 4 provides flexibility in its application to both large and small businesses. Small businesses may benefit from the provision saying that they can provide enough information to put the insurer on notice, if they are not certain what information is likely to be material to the insurer.

Preferred approach: Remedies for non-disclosure or misrepresentation

Our preferred approach is Option 1 (remedies based on materiality and intention). This is because it puts both parties back in the position they would have been in had they had the facts at contract formation, creates the right incentives to carefully and accurately disclose, and provides the most proportionate remedies i.e. where something is material enough that the insurer would not have covered the policyholder, the insurer can choose to avoid

[22] Options paper submission – Insurance Council of New Zealand

[23] https://www.mbie.govt.nz/assets/30e852cf56/small-business-factsheet-2017.pdf

[24] The Law Commission and Scottish Law Commission (June 2012). *Insurance Contract Law: The Business Insured's Duty of Disclosure and the Law of Warranties: Joint Consultation: Summary*

the contract. While some insurers were concerned that this option would require insurers to prove intentional conduct in order to access the avoidance remedy, on balance we think the benefits outweigh the costs of this option. Further, a higher evidence threshold may be appropriate where insurers resort to the most extreme remedy of avoidance without returning premiums. As insurers themselves pointed out, they rarely use the remedy of avoidance even though they have no evidentiary burden currently, therefore this should not impose significant costs.

Option 1 was the most popular option, especially among insurers. Most insurers said they already applied these remedies in practice, so Option 1 would codify good practice. These submitters agreed that intentional non-disclosure should be treated differently from unintentional non-disclosure and that it is important to retain the ability to avoid a contract, where it is justified to do so. Otherwise, Option 2 could require insurers to provide cover to a consumer who is uninsurable, which would in turn create uncertainty for insurers and make it difficult to price premiums to reflect the risk. Option 2 is therefore potentially less fair to other policyholders.

We do not support having remedies based on materiality only (Option 3). While this option would pose no costs on insurers to prove that a non-disclosure/misrepresentation was intentional, it also risks creating the wrong incentives, as it does not discourage intentional non-disclosure. It would be the least effective at preventing fraud.

Section B: unfair contract terms

Section B3: Problem definition and objectives: Unfair contract terms

B3.3 What is the policy problem or opportunity?

Counterfactual

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

Terms that cannot be declared to be unfair ('generic exceptions') are terms that:

a) define the main subject matter of the contract
b) set the upfront price payable under the contract
c) are required or expressly permitted by any enactment.

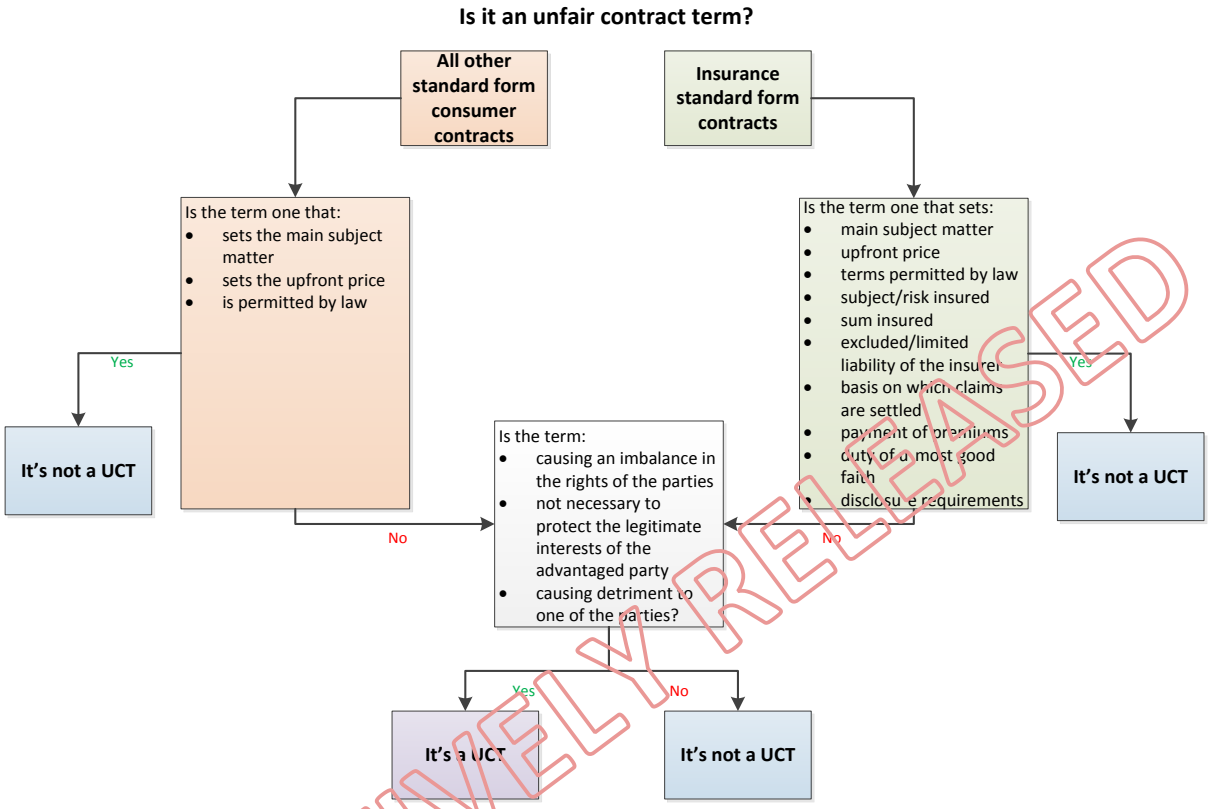
There are also some exceptions for insurance contract terms ('insurance-specific exceptions'). The following terms in insurance contracts cannot be declared to be unfair:

a) the subject or risk insured against
b) the sum insured
c) excluded/limited liability on the happening of certain events
d) the basis on which claims may be settled
e) payment of premiums
f) the duty of utmost good faith
g) requirements for disclosure.

The prohibition on UCTs was introduced to protect consumers from terms that are detrimental to the consumer and are not necessary to protect the interests of the other party. Most consumer contracts are standard form, meaning they are not subject to effective negotiation, but are offered on a 'take it or leave it' basis. Consumers therefore do not have the opportunity to challenge unfair terms. Contracts are also lengthy and complex, meaning that unfair terms can be difficult to identify.

The generic exceptions were introduced because the main subject matter and upfront price are generally terms that consumers have a choice about and can negotiate over, and therefore these terms should not be able to be considered unfair. The insurance-specific exceptions meanwhile, were introduced to clarify what cannot be declared to be unfair in an insurance contract on the basis that these types of terms are needed to protect the legitimate interests of the insurer.

Diagram: Is it an unfair contract term?



Problem definition

Consumer stakeholders were concerned that the insurance-specific exceptions mean that consumers are not protected from genuinely unfair terms. Submitters have given the following examples of terms which they thought might be unfair and which might meet the test of creating an imbalance in rights and obligations, not being necessary to protect the insurer's legitimate interests, and would cause detriment to the consumer, but which might also be excluded from being assessed as unfair on the basis of the insurance-specific exceptions:

- travel insurance: requiring preapproval before incurring healthcare costs
- insurer may make unilateral changes to the contract
- income protection policies: insurer has the discretion to decide whether the policyholder is unable to work
- third party claims: policyholder must follow the defence recommendations of the insurer's lawyer
- car insurance: insurer may decline a claim for an accident if they cannot contact the person at fault
- travel insurance: broad exclusions for any claim related to mental health
- life insurance: exclusions for any unlawful act
- broad exclusions for pre-existing conditions (insurers can decline claims for any

symptom, regardless of whether the policyholder knew it was a symptom).

Some of the examples could be exempt from being declared unfair by virtue of the insurance-specific exceptions, but could otherwise meet the tests of creating imbalanced rights and obligations, being to the detriment of one party, and not being necessary to protect the legitimate interests of the party advantaged by the term (although they might also be excluded under the generic exceptions). This suggests that there is a problem with the status quo, which results in consumers being disadvantaged by genuinely unfair terms. The insurance-specific exceptions can potentially capture much of the content of an insurance contract, and thus may limit what actions can be taken against UCTs in insurance contracts. This can affect how insurance markets fulfil their objectives of protecting consumers in the event of loss. However, our evidence is limited as there has been no formal enforcement action on UCTs in insurance contracts which would give guidance about whether particular insurance terms would be UCTs.

Without intervention, we do not expect insurers themselves to ensure all terms are fair to the same standard as other contracts, because the statutory exceptions allow this. This means that consumers of insurance do not have the same level of protection as for other contracts.

Insurers say the status quo is not a problem: the exceptions clarify what cannot be declared to be unfair in an insurance contract on the basis that they are needed to protect the legitimate interests of the insurer. Without the exceptions, insurers say they would face uncertainty regarding the extent of risk they take on. For example, an insurer may include terms which exclude it from liability on the happening of certain events, and prices its premiums based on those exclusions. If a court can strike down those terms as unfair, the insurer has not factored this additional liability into its premiums. If insurers can't accurately price risk, they may cease offering cover or increase premiums.

Insurers argue insurance contracts contain a number of terms which do not meet the generic exceptions (the main subject matter or the up-front price payable) but which are necessary for the insurer to assess and price risk. The counter-argument is that as the courts can already weigh the legitimate interests of the insurer in determining an unfair term (i.e. if it is reasonably necessary it is not unfair), the exceptions are not necessary.

We don't support a continuation of the status quo. It creates a disjuncture between the protections available for consumers of insurance and consumers of other products and services where standard form contracts are used. We don't think the current exceptions are necessary or appropriate because:

- the subject or risk insured against – is the main subject matter of the contract, so would be exempt anyway.
- the sum insured – is not the upfront price, but we think a court would easily consider that the sum insured for, if agreed in the contract, is fair. It is arguably part of the main subject matter of the contract.
- excluded/limited liability on the happening of certain events – an exception is not appropriate because many policy exclusions will be necessary to protect the insurer's legitimate interests, and if they are not necessary, then they should be assessed for unfairness.

- the basis on which claims may be settled – an exception is not appropriate because there are terms that might describe the basis on which claims are settled that might be unfair

- payment of premiums – we think a court would easily consider terms that require the payment of premiums or the quantum of premiums to be in the legitimate interests of the insurer

- the duty of utmost good faith – terms are already exempt if required or expressly permitted by an enactment (if the duty of utmost good faith is codified)

- requirements for disclosure – are already exempt as they are required or expressly permitted by an enactment.

Section B4: Options identification: Unfair contract terms

B4.1 What options are available to address the problem?

Option 1a: Tailor generic unfair contract terms provisions to insurance; narrow definition of main subject matter

This option would remove the insurance-specific exceptions, and instead tailor the generic UCT exceptions to accommodate specific features of insurance contracts. Australia is currently considering a similar proposal.[25] Under this option, the law would:

- define the 'main subject matter' of an insurance contract narrowly to mean a term that describes the thing that is insured (house, car etc)
- define the 'upfront price' to include the premium payable[26]
- consider a contract to be standard form even if the policyholder can choose from various options of policy coverage.

Option 1b: Tailor generic unfair contract terms provisions to insurance; broad definition of main subject matter

This would be similar to Option 1a above, but it would define the 'main subject matter' of an insurance contract broadly as terms that clearly define the insured risk accepted by the insurer and the insurer's liability. A broad definition would mean that policy limitations and exclusions that affect the scope of cover would be considered part of the 'main subject matter' and would not be open to review.

[25] *Exposure draft: Treasury Laws Amendment (Unfair Terms in Insurance Contracts) Bill 2019.* Retrieved from https://www.treasury.gov.au/consultation/c2019-t372650?utm_source=TSY+website&utm_campaign=2e944b785d-EMAIL_CAMPAIGN_2019_07_16_10_15_COPY_04&utm_medium=email&utm_term=0_a593710049-2e944b785d-225170325

[26] The Australian proposals suggest excluding terms that set the quantum or existence of the excess from being considered unfair. The rationale is that the quantum of the excess can increase or lower premiums, so is a feature that the consumer chooses. We don't think this is necessary to provide an exclusion for in New Zealand because it will already be excluded through the definition of upfront price – the Fair Trading Act, in contrast to Australia's existing UCT provisions, provides that the definition of upfront price includes anything that is contingent on the occurrence of an event, as long as it is transparent.

This option would also clarify that a term is reasonably necessary to protect the legitimate interests of an insurer if it reasonably reflects the risk accepted by the insurer and it does not disproportionately or unreasonably disadvantage the policyholder. This would provide additional guidance on the general provisions for when a term in a standard form contract is deemed to be reasonably necessary.

Option 2: Rely on generic unfair contract terms provisions

This option would remove all insurance-specific exceptions from the Fair Trading Act. The generic UCT provisions would apply to insurance contracts unconditionally. Insurers would have to rely on their terms being reasonably necessary to protect their legitimate interests as a protection from the terms being considered for unfairness.

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

Under this option, insurance contracts would be largely or completely exempted from the UCT provisions in the Fair Trading Act. The costs and benefits of this option would rely on the outcome of a separate review being carried out by MBIE into the way that conduct is regulated in the insurance industry.

Table 3: costs and benefits of options for unfair contract terms

Option	Benefits	Costs
Option 1a unfair contract terms: narrow definition of main subject matter	• Benefits policyholders by bringing insurance contracts under the general UCT provisions for all standard form consumer contracts. This would better protect policyholders from unfair insurance terms compared to the status quo. • Provides some certainty and clarity to insurers about how the generic exceptions apply to insurance contracts. • Improves quality of insurance products (with fair terms), and helps policyholders to get what they think they paid for, which would in turn increase trust in the insurer-policyholder relationship and support the effective functioning of insurance markets. • Could reduce costs for insurers (compared to some other options) since this would support trans-Tasman alignment, for insurers that operate in both markets.	• Insurers would bear initial costs of reviewing contracts for unfair terms and potentially legal and administrative costs if terms are challenged.[27] • Increases uncertainty for insurers because terms may be challenged, which may lead to increased premiums or reduced coverage, to the detriment of policyholders. • Increases enforcement costs for the regulator, as they can challenge a wider range of terms. • Insurance premiums may increase to take into account the insurer's expectation of increased risk. Policyholders would face increased costs.
Option 1b unfair contract terms:	• Would provide certainty to insurers about how the generic exceptions apply, compared to Option 2.	• The cost to insurers of reviewing contracts would be slightly less compared to 1a.

[27] The Australian Treasury estimated that the cost of this option for the Australian insurance industry would be AU$3.5 million, based on costs of anywhere between AU$8,000 to AU$184,000 for a single insurer to review all its contracts. Australian Treasury (2019). *Draft Regulation Impact Statement – Extending the protection from unfair contract terms to insurance contracts*. Retrieved from https://www.treasury.gov.au/sites/default/files/2019-07/c2019-t372650-ris.pdf

We have not attempted to quantify the costs for the New Zealand insurance industry, as we did not receive data from insurers about the costs of reviewing contracts or how many policies each insurer has. Costs for each insurer will vary significantly depending on the size of the insurer, the number of policies they have and the number of their policies that are standard form consumer contracts or business contracts under $250,000.

broad definition of main subject matter	• Provides slightly more protections for consumers than status quo, and therefore slightly improves quality of insurance products.	• Legal and administrative costs of defending terms would be lower than 1a. • This would only minimally increase enforcement costs for the regulator, as a broad definition limits the scope of terms they can investigate.
Option 2 unfair contract terms: rely on generic unfair contract terms provisions	• Provides certainty and clarity to the regulator and policyholders that insurance contracts are covered by standard protections. • Ensures that policyholders have the same level of protections as non-insurance contracts. • Would prompt insurers to improve contract terms, thereby improving quality of insurance products (with fair terms). While policyholders may not automatically be aware that their contract is fairer, they are more likely to receive cover that matches their expectations.	• Would leave it up to the courts to determine whether the 'main subject matter' includes terms that limit the insurer's liability. This may increase uncertainty for insurers that terms they think are necessary could be challenged in a court (although if the courts establish precedent to eliminate uncertainty for insurers, this cost will be short-lived). However, arguably many insurance-specific exceptions could be considered necessary to protect the legitimate interests of the insurer, and therefore these terms may be exempt from being declared unfair even without the insurance-specific exceptions under the status quo. • Insurance premiums may increase to take into account the insurer's expectation of increased risk. Policyholders would face increased costs.
Option 3 unfair contract terms: completely exempt insurance contracts from UCT provisions and rely on conduct regulation	• Insurance contracts would be treated in a unique context and therefore take into account the insurer's need to measure and price risk.	• May not provide sufficient consumer protection, even if a conduct regime is implemented. UCT provisions protect against unfair contract terms, while conduct regulation aims to protect against unfair conduct. • If policyholders are not protected from insurance UCTs, insurers have little incentive to avoid using UCTs. This could reduce choice in quality insurance products, which may in turn impede the effective functioning of insurance markets. • Unless the UCT provisions were replicated in conduct regulation, the industry and regulator would have less certainty over what constitutes a "fair contract".

Submissions

In MBIE's Options Paper, we consulted on Options 1b, 2 and 3. We did not consult on Option 1a, which is being considered in this analysis because Australia is considering a similar approach. All consumer submitters thought insurance should be subject to the UCT provisions in some form, but there was a mix of views between Options 1b and 2. Insurers generally objected to Option 2 and thought that Option 3 wasn't appropriate because contract terms should be treated separately from conduct. Insurers mainly supported the status quo, but acknowledged that if there had to be change, Option 1b (with a broad definition of main subject matter) would be preferable. Dispute resolution schemes were mixed.

The Commerce Commission (the agency responsible for enforcing the unfair contract terms prohibition) supported Option 2, and considered that the generic exceptions can accommodate the business needs of insurers. They were concerned with a broad definition of main subject matter in Option 1b because the risk is that the main subject matter would be

so broad so as to circumvent the intent of the UCT provisions and operate similarly to the current exceptions. (The Australian regulators also held similar views when submitting on the Australian proposals, as well as the Financial Services Royal Commission.) The Commerce Commission also thought the test for what is unfair should be the same across all standard form contracts, not based on specific things for insurance (such as whether it reasonably reflects the underwriting risk accepted by the insurer).

B4.2 What criteria, in addition to monetary costs and benefits, have been used to assess the likely impacts of the options under consideration?

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

a) Consumers are protected from unfair contract terms

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

B4.3 What other options have been ruled out of scope, or not considered, and why?

We have not considered a complete exemption for insurance contracts from the UCT prohibition without any other additional protections. Such an exemption would place insurance consumers in New Zealand out of step with consumers of other standard form contracts and in other jurisdictions in terms of the protections they are provided.

Section B5: Impact Analysis: Unfair contract terms

Marginal impact: How does each of the options identified at section B4.1 compare with the counterfactual, under each of the criteria set out in section B4.2?

	No action	Option 1a: narrow definition of main subject	Option 1b: broad definition of main subject	Option 2: rely on generic provisions	Option 3: exempt insurance from UCTs
Consumers protected from unfair contract terms	**0**	++ Brings insurance contracts under general protections to better protect consumers	+ Better protections than under status quo, but still a limited scope of protections	++ Brings insurance contracts under general UCT protections to better protect consumers	- - Unlikely to provide the same protections against unfair contracts as are available for other products and services
Insurers can effectively measure and price risk	**0**	- - Increases uncertainty that terms defining risk may be challenged, upfront costs to review contracts, legal costs if challenged	- Slightly increases uncertainty that terms may be challenged, upfront costs to review contracts but fewer legal costs as the scope of terms up for challenge is limited	- - Increases uncertainty that terms defining risk may be challenged, upfront costs to review contracts, legal costs if higher risk of being challenged	- Treats insurance contracts in a unique context, but without prescription related to contracts may create uncertainty
Overall assessment	**0**	**0**	**0**	**0**	- - -

Key:

++ much better than doing nothing/the status quo

+ better than doing nothing/the status quo

0 about the same as doing nothing/the status quo

- worse than doing nothing/the status quo

- - much worse than doing nothing/the status quo

Section B6: Conclusions: Unfair contract terms

B6.1 What option, or combination of options, is likely best to address the problem, meet the policy objectives and deliver the highest net benefits?

Preferred option

Our preferred approach is Option 1a – remove the insurance-specific exceptions and tailor the generic provisions to insurance. While we think the benefits and costs are similar to completely removing the insurance-specific exceptions altogether (Option 2), 1a would bring us into alignment with Australia, which would allow New Zealand to draw on Australian case law (and vice versa) and would minimise costs for insurers who operate similar policies on both sides of the Tasman. This would mean that any insurers who provide products on both sides of the Tasman would only have to review their policies once in light of the law changes for both jurisdictions, for example, IAG and Suncorp, who make up about 70% of the general insurance market in New Zealand are Australian-owned and may have similar products in both markets.

There is probably little difference between Options 1a and 2 in practice, as both will mean that insurers have to rely on the test that the term is not reasonably necessary to protect their legitimate interests, in the absence of insurance-specific exceptions. While Option 1a will define the main subject matter narrowly, Option 2 would have no insurance-specific definition of main subject matter. Without any relevant case law in New Zealand, it is difficult to say what the courts would consider the main subject matter to cover.[28]

The costs and benefits of Option 1a and Option 1b are more different. We agree with the Commerce Commission that the risk with Option 1b is that the main subject matter would be so broad so as to circumvent the intent of the UCT provisions and operate similarly to the current exceptions. A broad definition would exclude from the protections terms setting out the conditions and exclusions to obtaining cover, where the UCT protections are likely to be very relevant.

Option 1b would mean that there are a greater number of terms that cannot be assessed for unfairness. While under Option 1a and 2, the same terms might not be considered unfair anyway (because terms that define the risk, even if they weren't considered to be part of the main subject matter, are often necessary to protect legitimate business interests), at least they can be assessed to determine whether they meet the test, whereas Option 1b precludes them from being assessed in the first place.

Risks

There may be concerns about the ability to obtain reinsurance with Option 1a. If reinsurance is about insuring retail insurers against the event of claims being made against them, and if insurers have uncertainty about the scope of the risk they are insuring, then this could impact reinsurance. We note that in markets like the UK, which applies UCT provisions to insurance, insurers are able to obtain reinsurance. While New Zealand's

[28] Commerce Commission guidance suggests that terms that set the main subject matter are those that are central to the transaction and that the customer has a clear choice about accepting, are typically transparent and the customer is unlikely to misunderstand what they are purchasing. Commerce Commission (February 2018). *Unfair Contract Terms Guidelines*. Retrieved from https://comcom.govt.nz/__data/assets/pdf_file/0025/90925/Unfair-contract-terms-Guidelines-February-2018.pdf

insurance environment is different (e.g. high seismic risks and a single event may have a material impact on insurers' overall liability), it is likely that there would need to be a very large increase in the overall liability of insurers before reinsurance arrangements are impacted. We therefore consider the proposal is unlikely to impact reinsurance.

The argument that opening up insurance contract terms to be challenged as unfair would create significant uncertainty may be overstated. Prior to the introduction of the general UCT prohibition, many businesses (not just insurers) argued that it would create business uncertainty.[29] However, the reforms do not appear to have directly increased the costs of goods and services. The main cost borne by businesses has been reviewing their contracts for potentially unfair terms and amending where necessary. As part of reviewing contracts, we would expect insurers to be identifying terms that might be considered unfair but also to be able to justify terms that are in their legitimate business interests. The courts would be very unlikely to decide that terms that define the risk are not necessary to protect the insurer. If an insurer thinks a term is reasonably necessary, it should be able to justify it; if not, then it is reasonable that it can be assessed for unfairness. The test for a term not being in a business' legitimate interests is a high bar, and this test is broad enough to allow insurers to assess and price the specific risks insured against.

The key risk of this option is that it may increase premiums for consumers, if insurers believe that there is uncertainty created by the possibility that their contract terms could be challenged, whether or not this is justifiable. Option 1b would lessen this uncertainty for insurers somewhat. However, the consumer protections it would offer in practice would probably be similar to the status quo, as least regarding those terms that exclude or limit the insurer's liability. Option 1a may therefore provide the most balanced approach between Options 1b and 2, providing greater consumer protections than the status quo or Option 1, but greater certainty for insurers than Option 2.

An interdependency relating to the options being considered is that Cabinet recently agreed to extend the unfair contract terms protections to standard form business contracts valued at $250,000 or less in a given year. This extension will automatically include business-to-business insurance contracts. We do not have a good idea of how many business insurance contracts would be considered 'standard form' (i.e. not subject to effective negotiation) and less than $250,000 a year (although we would expect that most standard form commercial insurance contracts are taken up by small and medium enterprises). It is therefore difficult to say the effect that our preferred option for insurance UCTs would have on business insurance.

[29] Ministry of Consumer Affairs (December 2010). *Regulatory Impact Statement Consumer Law Reform*. Retrieved from https://www.mbie.govt.nz/assets/47a289c4a6/clr-egi-ris-december-2010.pdf

Section C: Improving consumer understanding of insurance policies

Section C3: Problem definition and objectives: Understanding and comparing insurance policies

C3.3 What is the policy problem or opportunity?

Status quo

Currently insurers are able to write and present insurance policies as they see fit. There are no legal requirements in regards to language, presentation or length. Other jurisdictions such as the UK, Australia and United States all have more prescriptive legal requirements to help aid consumer understanding.

Some insurers have started to move to plain language policies, while others provide summary information sheets on insurance policies. However many insurance policies are complex and technical. There is, on the whole, inconsistency across the industry in relation to how policies are presented.

Problem: consumers don't understand their insurance policies

As insurance policies are legal contracts that set out the rights and obligations of the parties, they can be complex and use legal terms that many consumers are not familiar with. In many instances, consumers don't have time or expertise to peruse long technical documents. They will often only read a small part of the documentation. However, the detailed terms could have a significant impact on whether a particular loss is covered and the size of the payout the consumer may be entitled to for that loss.

Submissions indicated a general lack of understanding amongst consumers about their insurance. In the Colmar Brunton survey commissioned by MBIE, 35% of respondents said that it was quite, or very difficult, to understand insurance information they find. This can lead to problems at claims time when consumers may discover limits or exclusions which affect their ability to claim. Submitters gave examples such as:

- Discovering at claims time that excess deductions applied to every item in a claim, rather than the whole claim itself.
- Discovering that all subsequent losses in a chain of events are not covered if the initial cause of the loss is excluded in the policy.
- Under a travel policy, discovering that their losses were not covered because the incident occurred above a certain height.

This means that an insurance policy may not provide the protection the consumer expected.

Furthermore, trust in insurers may also be eroded and may lead to perceptions that insurers deliberately have complex insurance policies in order to discourage consumer understanding

and increase their ability to decline claims.

Problem: consumers can't compare different insurance policies

Difficulties understanding insurance policies means it is also difficult for consumers to "shop around" for the policy that best suits them. If consumers are unable to understand and compare the policy features offered by different insurers, they are unable to make an informed choice. For example, it may be a lot of work for a consumer to establish that one policy excludes coverage in a wider scope of circumstances than an alternative policy.

Submitters have also noted the lack of resources facilitating comparisons such as comparison websites. The problem is more pronounced in general insurance than in life insurance because there are existing life insurance comparison platforms.

Limited ability to compare means that consumers may end up with insurance policies which are ill-suited to them, or less-suited than other comparable policies.

Section C4: Options identification: Understanding and comparing policies

C4.1 What options are available to address the problem?

The regulatory options we have considered are outlined below. All options relate to consumer insurance policies only, and the options are not mutually exclusive. In all cases, there will also be a role for financial education to educate consumers about the factors they should bear in mind when purchasing insurance.

Option 1: Require policies to be written and presented clearly

This option would see a general obligation requiring insurers to ensure that consumer insurance policies are written and presented clearly (exact wording of obligation to be refined) to aid consumer understanding. This would be accompanied by some specific requirements as to how policies are presented and worded. This option would not involve prescribing full details of how insurance policies must be laid out, but might include requirements along the lines of "exclusions must be highlighted prominently".

Option 2: Require a summary information sheet to be provided

This option would require insurers to provide a summary sheet of key features of an insurance policy to aid consumer understanding. The sheet would highlight core policy features such as cover, exclusions and cost.

Option 3: Require a sheet outlining core policy wording and definitions

This option would require insurance policies to contain clear definitions of core policy terms. This may help clarify exact meaning of otherwise subjective terms, and clarify the meaning of legal terminology or jargon.

Option 4: Facilitate comparisons through comparison websites

This may be achieved in the following ways:

Option 4a: Require insurers to work with comparison websites

This option would require insurers to provide information to third-party websites for the purpose of providing comparison services.

Option 4b: Establish a government-run or endorsed website and require insurers to work with it.

This option would see the establishment of a government-run comparison website to provide consumers information on insurance policies for comparison purposes, and to more generally increase financial capability in relation to insurance.

Following consultation further consideration was given to the costs and benefits of establishing or enabling comparison websites per option 4a or 4b. There would likely need to be a high level of regulation applied to facilitate a comparison website (both in the information required of insurers and the operation of the website itself). The evidence is not clear at this stage that the benefit such a website would provide to consumers would outweigh the costs involved. We consider that further analysis would need to be undertaken before we can recommend an option relating to comparison websites.

Following consultation, an alternative option to assist consumers to compare insurance policies was developed (Option 5 below).

Option 5: Require insurers to publish or provide information in a prescribed format

This option would allow for regulations to require insurers to publish or provide certain information in a prescribed format. The information may be about insurers' policies and the operation of their business (for example claims approval rates or numbers of complaints upheld). The availability of this information could be used to help consumers choose an insurance provider and to promote transparency by providing standardised information through which consumers could compare policies or insurers.

This option was not explicitly consulted on as part of the options paper consultation. However, it is being considered as having certain information publicly available would likely assist consumers with accessing and comparing information before choosing an insurer. Consultation would be carried out before making any regulations setting out the details of information insurers are required to publish.

Table 4: costs and benefits of options for understanding and comparing insurance policies

Option	Benefits	Costs
Option 1: requiring policies to be written and presented clearly	• Consumers may understand insurance policies better since they will be required to be written and presented clearly. This includes policy features which may otherwise require legal expertise to understand. • Likely to reduce the number of problems at claims time with declined claims due to lack of understanding.	• Consumers would still be required to read through their policies, so apathetic consumers may not be more informed. • Insurers will bear compliance costs, especially those who have not begun a transition to plain-language policies. • Small risk that more prescription may

	• Would enable easier comparison between policies. • May incorporate features and benefits of options 2 and 3.	stymie innovative methods of communicating with customers.
Option 2: require a summary information sheet to be provided	• Consumers will have easy access to key features and exclusions of a policy document. This will lead to better understanding of these key features. • May help reduce some problems at claims time. • Some features of insurance policies would be more accessible. • Would enable easier comparison between policies.	• There is a risk that consumers would rely solely on the summary information sheet without reading the entire policy. Consumers might not access the finer details of a policy, which may remain hidden. This might not help problems at claims time resulting from policy features not on a summary sheet. • This option could result in long summary documents which duplicate policy documents, encouraging consumer apathy. This has been the experience with summary sheets in Australia. • There would be compliance costs for insurers for minimal benefits to consumers.
Option 3: require a sheet outlining core policy wording and definitions	• Consumers would be given a glossary which would aid their ability to understand complex policy documents. • This may help reduce some problems at claims time.	• Policy documents would remain complex, thus hindering many consumers not inclined or not able to fully follow the thread. • This option puts the onus on consumers to figure out policies rather than on insurers to provide more readable policies. • This may make policies even longer, encouraging consumer apathy.
Option 4: Facilitate comparisons through comparison websites	• Consumers would more easily make comparisons between different insurance policies. The size of the benefit would depend on the design of the comparison website. • Competition in the insurance industry could be improved.	• Costs to insurers to provide the information required to facilitate such website. • There is a risk that consumers would end up comparing on price alone but this can be ameliorated by careful design, and should not be overstated.
Option 4a: Require insurers to work with third party comparison websites	• This would allow for the private provision of comparison websites. Depending on the form this option takes, compliance costs to the Crown are less, compared to option 4b.	• There is a higher risk that consumers would end up comparing on price alone, if comparison websites are not in turn regulated to ensure appropriate design. • There may be inconsistency in different private comparison websites, which could lead to consumer confusion. • Any regulation of comparison websites would impose further costs.
Option 4b: Establish a government run or endorsed comparison website and require insurers to work with it	• This would increase consumer financial capability in relation to insurance, with information being able to be targeted well. • The risk that consumers end up comparing on price alone may be reduced since the government can control website design features.	• There would be a high cost to the Crown of establishing the website.

Option 5: Require insurers to publish or provide information in a prescribed format	• Standardised presentation of insurers' information would facilitate consumers choosing an insurance provider and insurance policy. • There would be an increased ability to compare insurers on certain metrics. • Having particular information in the public domain would increase transparency and accountability. • Having the information published in a prescribed format may enable comparison websites in the future.	• There would be compliance costs for insurers which would depend on the nature of the information prescribed.

C4.2 What criteria, in addition to monetary costs and benefits, have been used to assess the likely impacts of the options under consideration?

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

a. Consumers better understand their insurance policies

b. Does not unduly limit innovation

c. Compliance costs to insurers are minimised

d. It is easier for consumers to compare insurance policies

C4.3 What other options have been ruled out of scope, or not considered, and why?

The options relate to consumer insurance policies. We have ruled out plain-language requirements pertaining to business insurance policies. This is largely because it is unclear if there is a problem for businesses, and we would expect that businesses would have the resources to undertake analysis of complex policies.

Section C5: Impact Analysis: Understanding and comparing insurance policies

Marginal impact: How does each of the options identified at section C4.1 compare with the counterfactual, under each of the criteria set out in section C4.2?

	No action	Option 1 (policies to be written and presented clearly)	Option 2 (Require a summary sheet)	Option 3 (require a sheet outlining core policy wording and definitions)	Option 4 (enable comparisons through comparison websites)	Option 5 (Require insurers to publish or provide information in a prescribed format)
Consumers better understand insurance policies *[weighed higher than other criteria]*	**0**	**+++** Will allow consumers to read and understand the scope of their cover and exclusions	**+** Will allow consumers to understand the main features of their insurance policies	**0** Will to some extent enable consumers to better understand their policies, however this would be minimal	**+** If designed correctly it could allow consumers access to central features of their insurance policies **+** may be more effective if Government designed or regulated website	**+** Will allow consumers access to information relating to policies and insurers' business, which may increase overall understanding
Does not unduly limit innovation	**0**	**-** Some limits on insurer design of policies due to some prescription	**0** Will have minimal to no effect on insurers' ability to innovate	**0** Will have minimal to no effect on insurers' ability to innovate	**0** Will have minimal to no effect on insurers' ability to innovate	**0** Will have minimal to no effect on insurers' ability to innovate
Compliance costs to insurers are minimised	**0**	**-** Insurers will be required to re-write their insurance policies	**-** Insurers will have to prepare and provide additional documents	**-** Insurers will have to prepare and provide additional documents	**- -** Insurers will have to provide additional information.	**--** Insurers will have to gather and publish information
It is easier for consumers to compare insurance policies	**0**	**+** Consumers will have access to easy to read insurance policies, facilitating easier comparison between policies	**+** Consumers will have access to summary documents of insurance policies, facilitating easier comparison	**0** Unlikely to improve policy comparisons	**+** If designed correctly it could provide an effective resource for comparing different insurance policies **+** may be more effective if Government designed or regulated	**++** Consumers will have access to information about insurers' policies and business which may aid comparison. The information may also be used in the future to facilitate

						comparison websites.
Overall assessment	**0**	**++++**	**++**	**-**	**++**	**+++**

Key:

++ much better than doing nothing/the status quo

+ better than doing nothing/the status quo

0 about the same as doing nothing/the status quo

- worse than doing nothing/the status quo

- - much worse than doing nothing/the status quo

Section C6: Conclusions: Understanding and comparing insurance policies

C6.1 What option, or combination of options, is likely best to address the problem, meet the policy objectives and deliver the highest net benefits?

The preferred option is to combine **Option 1** and **Option 5.**

Option 1 will require consumer insurance policies to be subject to a general obligation in relation to presentation and language. There would also be an associated regulation making power so that regulations can set more prescriptive requirements as to how policies are presented and worded, for example, exclusions must be listed prominently on the front page. Where needed, these requirements may be clarified or supplemented by FMA guidance.

Option 1 is preferable over Options 2 and 3. This is because clear and plain language policies can encompass features of Option 2 (a summary sheet) and Option 3 (definition of core terms). Option 1 may also make the whole policy more accessible to a consumer, whereas some important matters may still remain relatively hidden and complex in Options 2 and 3. This is because they may not be features which are central enough to merit inclusion in a summary sheet or list of core definitions under Options 2 or 3.

As such, we think more problems at claims time may be reduced under Option 1 (where all terms are clear and in plain language) than under Options 2 and 3. Consumer submissions and ministerial correspondence suggest that the problems often result from features which are arguably not 'central'.

Option 1 also goes some way towards increasing consumers' ability to compare different policies, since if policies are easier to read, they will in turn be easier to compare. However, the ability to compare policies would be significantly strengthened in combination with Option 5. Option 5 allows for regulations to require insurers to provide or publish specified information in a prescribed format. This information would relate to insurers' policies and business. Consumers could use this information to compare between different insurance providers. This could help consumers to narrow down or choose an insurer and insurance policy, which in turn would be easier to understand.

Option 5 has wider benefits beyond increasing consumer ability to compare policies. Having policy and business information in the public domain will lead to greater transparency and accountability of insurers. This information could be used by consumers, regulators and media outlets. Having the information in a prescribed format would also allow for the provision or establishment of comparison websites in the future if needed.

During consultation, consumers and consumer advocates were strongly in favour of Option 1. Insurers largely agreed in principle that they should take steps to aid consumer understanding of insurance policies – but by and large, they opposed the government mandating how this is done. They submitted this on the grounds that insurance policies are unique and have technical features, and that it can be difficult to summarise them or express them in standardised plain language. However, there are some examples of plain language insurance policies.

A prescriptive approach may have a negative effect on the ability of insurers to employ

innovative solutions to improve consumer understanding. This can be managed through avoiding a heavily prescriptive approach, and further consulting on regulations which will prescribe the requirements.

Consumers and consumer advocates were also strongly in favour of comparison websites; with insurers expressing some reservation because they considered that there is a risk that consumers could end up comparing on price alone. We expect that this can be controlled for through careful design of a website. Furthermore, this risk already exists (with consumers having to go to multiple websites to get insurance quotes). Nonetheless, in order to mitigate the risk and because the benefits of comparison website are unclear, we consider there is some merit to waiting and determining the need for a platform in the future, once these reforms have embedded. Having insurance information in a prescribed format would help enable the comparison platform, if it is determined in the future that the problem still requires intervention.

Research[30] indicates that reducing the volume, and simplifying the quality of documents consumers have to consider has a positive impact on consumer engagement. Overall, we expect increased consumer understanding and engagement as a result of Options 1 and 5.

[30] Senate Economic Reference Committee, August 2017, *Australia's general insurance industry: sapping consumers of the will to compare*, page 28, available: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Economics/Generalinsurance/~/media/Committees/economics_ctte/Generalinsurance/report.pdf; Kirsch, L. 2002, *Do product disclosures inform and safeguard insurance policyholders?*, Journal of Insurance Regulation, vol. 20, no. 3, page 271-295, available: https://search.proquest.com/docview/204947414/fulltextPDF/A715294F1CFB4661PQ/1?accountid=46495

Section D: Duty of utmost good faith

Section D3: Problem definition and objectives: duty of utmost good faith

D3.3 What is the policy problem or opportunity?

Status quo

There is a common law duty of utmost good faith which applies in relation to insurance contracts. Both the insurer and the policyholder have a duty to act in good faith. This is an implied term of the contract, which means that parties can seek damages for breaches of the duty.

Problem: policy holders may not be aware of the duty, and it may be difficult for them to take action against insurers for a breach

Because the duty is an implied term of the contract between the policyholder and the insurer, many policyholders would not know about the duty of good faith. As there is little precedent on what the content of the duty is for the insurer, it may be difficult for policyholders to pursue claims against insurers for beach of the duty of good faith. This means that policyholders may bear the cost of the insurer's actions, even in cases where the duty has been breached.

Section D4: Options identification: Understanding and comparing policies

D4.1 What options are available to address the problem?

We have considered one regulatory option to address the problem.

Option 1: Codify the duty of utmost good faith

The option would involve stating in legislation that it is an implied term of every contract for insurance that both parties act in the utmost good faith. The FMA would be able to take court action in relation to breaches of the duty by insurers (and individual policyholders could continue to seek redress through dispute resolution schemes or the courts). Any such actions would also give more certainty as to what types of conduct is considered a breach.

The details of this duty would be refined during the drafting process, including consideration of any overlap with work on regulation of the conduct of financial institutions.

We would also consider whether the option should include providing that unfair reliance on a policy term in light of the pre-contractual disclosures that were made would be a breach of the duty of utmost good faith, and that the insurer cannot rely on it. This could be modelled on section 13(2) and 14 of the Insurance Contract Act 1984 (Australia).

Table 4: costs and benefits of option to codify the duty of utmost good faith

Option	Benefits	Costs
Option 1: codify the duty	• The option would have signalling benefits to insurers and policyholders, possibly acting as a deterrent to poor conduct. • It would bring New Zealand law into line with other jurisdictions.	• Some submitters were concerned that codifying the duty would limit the ability and flexibility of the Courts to develop the duty further. However, codifying the duty in a basic way (ie stating that it exists and that it applies to insurers and policyholders) should not impede the ability of the Courts to continue to develop the duty in the common law

D4.2 What criteria, in addition to monetary costs and benefits, have been used to assess the likely impacts of the option under consideration?

MBIE has identified the following criteria for determining options to address the problem described above:

a. Clarity on what the duty of utmost good faith means for insurers and policyholders

b. Appropriate action can be taken in regards to a breach of the duty of utmost good faith

c. Costs and other negative impacts are minimised.

D4.3 What other options have been ruled out of scope, or not considered, and why?

n/a

Criteria	No action	Option 1: Codify duty of utmost good faith
Clarity on what the duty of utmost good faith means for insurers and policyholders	**0**	+ Codifying the duty in legislation makes it clear to policyholders that the duty of utmost good faith applies to insurance contracts. Court action could result in the Courts clarifying the duty, which would reduce uncertainty for insurers and policyholders as to what the duty is.
Appropriate action can be taken in regards to a breach of the duty of utmost good faith	**0**	+ Giving the FMA the ability to take action in relation to breaches of the duty by insurers means policyholders are more likely to get action taken in relation to breaches of the duty. We consider the insurer already has the means to enforce a breach of the duty of utmost good faith by a policyholder and so the situation would remain the

		same as the status quo for policyholder breaches.
Costs and other negative impacts are minimised	**0**	+ More risk that insurers would be faced with an action under the duty (either from a policyholder or from the FMA). However, we think this would be outweighed by the corresponding reduction in costs to policyholders as a result of insurers complying with the duty.
Overall assessment		+

Section E: other issues

Insurers have raised issues with some of the more technical provisions in insurance legislation. We have heard that these provisions can variously:

- interfere with insurers' ability to exclude cover in some circumstances where there is a greater statistical likelihood of loss;
- affect insurers' ability to measure risks they are exposed to for past liability insurance policies;
- give rise to uncertainty about how liability insurance policies operate; or
- otherwise require insurers to cover losses in some circumstances where it may be unreasonable to do so.

These matters affect insurers' ability to effectively measure and price the risks that they are insuring. This could in turn lead to higher premiums for policyholders. The specific problems identified are outlined below.

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

a) Insurers have confidence that they can effectively measure and price risk (including that the problems identified with the various provisions are addressed, and insurers are not required to pay claims in circumstances where it would be unreasonable to expect them to do so)
b) Insurers cannot decline claims where unreasonable to do so
c) Costs and other negative impacts are minimised

Given the technical nature of these issues, this document analyses only the preferred option for addressing each issue. Each problem, preferred option and conclusion is discussed below. A summary impact analysis table is set out at the end of this section E.

Problem 1: Insurers responsible for intermediaries' failure to pass on information

Problem definition

Section 10 of the Insurance Law Reform Act 1977 provides that the insurer is deemed to know matters known to a "representative of the insurer" before the contract of insurance was entered into. A representative of the insurer is defined to include any person entitled to receive commission or other consideration from the insurer (such as an insurance broker).

For example, a consumer when applying for insurance may disclose information to an insurance broker who receives commission from an insurer. If the broker fails to pass the relevant information onto the insurer, section 10 means that the insurer cannot treat it as a case of non-disclosure because the insurer is deemed to know what the broker knew. Insurers may therefore end up being required to pay claims that they would not have covered (or would not have covered on the same terms) had the intermediary passed on all relevant information. For example, if an intermediary fails to pass on that the policyholder had a pre-

existing condition, an insurer may have to pay out a claim even though it would not have provided cover had it known about the pre-existing condition.

We have heard anecdotes of brokers suggesting policyholders sign insurance proposal forms that state they have no relevant information to declare, despite the policyholder having told the broker relevant information.

Section 10 was enacted on the basis that insurers are better placed than policyholders to bear the risk of failure by a broker or other intermediary to pass on information, and insurers should only pay commission to those who the insurer is prepared to trust.

However, industry practice is that intermediaries are paid commission by the insurer, even if the intermediary is selected by the policyholder to arrange insurance on behalf of the policyholder and is not closely controlled by the insurer. Some insurers suggest it is not appropriate for insurers to always bear responsibility for failures by intermediaries just because commission is payable.

Insurers may sometimes be able to contractually require the intermediary to pass on all client information to the insurer, so that the insurer can recover losses from the intermediary if they fail to pass on information. However, some larger brokers have sufficient bargaining power and insurers may not be able to simply impose such a requirement.

Option: Require intermediaries to pass on information to insurers

To address the above problem above, this option would involve adding a legislative requirement for intermediaries to pass onto the insurer all relevant material information known to the intermediary prior to the contract of insurance being entered into.

If an intermediary fails to pass on relevant material information to the insurer, an insurer could seek redress against the intermediary for failure to meet the legislative obligation.

Conclusion

Stakeholders were generally supportive of this option. Some submitters suggested that some intermediaries should be treated as agents of the policyholder such that the insurer is not deemed to know what those intermediaries know. However, it can be difficult to determine whether a person should be treated as the agent of the insurer or the policyholder.

As with the status quo, consumers and other policyholders would not be made worse off under this option if an intermediary fails to pass on information. This is because the insurer would still be deemed to know the information held by the intermediary and would not be entitled to decline claims (or exercise other remedies if the options in section A of this document are adopted) due to non-disclosure. Under this option the insurer would be able to seek redress from the intermediary if the intermediary does not pass on relevant information. This option should be consistent with best practice for intermediaries so should not impose excess cost, but should better ensure that insurers have all relevant information.

Problem 2: Insurers cannot rely on policy exclusions in some situations

Problem definition

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

- the policy contains the exclusion because the insurer considers that the risk of loss is likely increased in the specific scenario; but
- in the circumstances of the particular claim, the excluded matter did not cause or contribute to the loss.

Section 11 means an insurer cannot decline a claim just because an unrelated circumstance subject to a policy exclusion happened to exist when the loss was suffered. For example, a policy may exclude cover where a vehicle does not have a current Warrant of Fitness. However, a third party may cause damage to the vehicle while the vehicle is without a warrant but parked unused. Section 11 may prevent the insurer from declining such a claim based on the warrant exclusion as the lack of a current warrant would not have caused or contributed to the loss.

However, some circumstances may involve a statistical likelihood of loss even if they do not cause the loss. Insurers will often seek to exclude cover in those situations. For example, a policy may exclude cover for a vehicle used for commercial purposes because it is more likely to be involved in an accident as it tends to be driven more. However, section 11 may prevent insurers from declining a claim where a private vehicle was used for commercial purposes.

Section 11 means that insurers may end up covering risks that they had sought to exclude and may interfere with insurers' ability to charge different prices to reflect different risk.

Option: Insurers can rely on some exclusions even if the excluded circumstance did not cause or contribute to loss

To address problem 2 above (insurers limited in ability to exclude cover in some situations), this option would remove certain types of exclusions from the operation of section 11 of the Insurance Law Reform Act 1977, because those exclusions relate to circumstances that raise a greater statistical likelihood of loss. For example, it may be specified that whether a vehicle is used for a commercial purpose, or whether the operator of a vehicle is licensed or not are not subject to section 11. Therefore, if a policy contained one of those exclusions, an insurer would be entitled to deny a claim where the excluded circumstance existed regardless of whether it caused or contributed to the loss. The exact details of matters that are not subject to section 11 would be refined through the drafting process but would have regard to the previous recommendations of the Law Commission on this matter. A regulation-making power would also be included if further relevant exclusions are identified.

Conclusion

Roughly half of the submitters supported the above option. Some submitters suggested retaining the status quo as it ensures that insurers cannot unreasonably rely upon an exclusion to decline a claim. [31] Others supported the approach recently adopted in the UK,

[31] The Insurance and Financial Services Ombudsman also noted that the Courts have already ruled that terms which define what losses are covered by the policy are not subject to section 11 of the Insurance Law

which asks whether a term could possibly have increased the risk of the loss which actually occurred (for example, cannot decline flood claim for failure to have smoke alarm because the lack of a smoke alarm could not possibly have increased the risk of flood damage). We do not recommend the status quo given the problems that have been identified, nor the UK approach, which is untested and may be difficult to apply in more marginal scenarios.

We recommend defining certain exclusions that insurers can rely on to decline claims, even if they did not cause or contribute to the loss, for example, whether a vehicle is used for a commercial purpose. This is consistent with the approach previously recommended by the Law Commission. This option allows insurers to more effectively price insurance, knowing that certain pre-defined circumstances are not covered, even if those circumstances did not cause or contribute to the loss. It may be difficult to identify a complete list of exclusions which should be able to be relied on. However, having a regulation-making power provides some flexibility to adjust this over time.

Problem 3: uncertainty about how third party claims for liability insurance money are dealt with

Problem definition

Section 9 of the Law Reform Act 1936 allows a plaintiff to access insurance proceeds when proceedings against the policyholder are not possible or are pointless (for example, if the policyholder is missing or insolvent). To do this, section 9 provides for a property right called a "statutory charge" to be attached to the insurance proceeds.

There are a number of issues with the current operation of section 9 which affect insurers' ability to measure and price risk:

- Under current case law, the statutory charge attaches to the full sum insured under the policy, regardless of whether some of that money has been paid to the policyholder to defend the claim. This could leave policyholders without funds to defend the claim and/or the insurer being liable for more than the sum insured. Insurance companies have developed workarounds for the problem but say that there is some remaining ambiguity. This affects insurers' ability to measure and price risk.

- Uncertainty about which claims to prioritise when multiple claims are received on the same day

- The courts allow section 9 claims against reinsurers, but this presents practical problems especially if an insurer reinsures its whole book on an "aggregate liability" basis (reinsurer incurs liability only when aggregate claims against the insurer exceed a threshold). That is because, without knowing the totality of claims against the insurer it may not be possible to determine the reinsurer's liability.

- The charge attaches on the happening of an event giving rise to the insurance claim. As a result:

Reform Act 1977 (*Barnaby v South British Insurance Limited* (1980) 1 ANZ Insurance cases 60-401). For example, if a policy covered a unmodified car, under the status quo and following *Barnaby,* an insurer may be entitled to decline a claim for losses to a modified car, even if the modifications did not cause or contribute to the loss. However, there may be a fine line between a loss not covered by the policy as against an excluded circumstance where the risk of loss is increased. We therefore consider it beneficial to clarify that certain specified exclusions are not subject to section 11.

- If a policyholder switches from insurer A to insurer B, the charge could attach to the sum insured with insurer A even though the claim is made to insurer B.
- There is uncertainty about when the claim arises (for example, whether it is the date of the policyholder's negligent action, or the date that loss occurs).

Option: Replace section 9 of the Law Reform Act 1936

This option would involve replacing section 9 of the Law Reform Act with a provision that allows the third party to claim directly against the insurer. The insurer would stand in the shoes of the insured person. This is the approach that has been taken in New South Wales.

There would be no property right/statutory charge created, which would resolve many of the problems with section 9.

As is currently the case, leave of the Court would still be required in order to make a claim. It is expected that the Court would continue to apply the same test for granting leave. In practical terms, this would limit claims to situations where there is an arguable case of liability, where the insurer's policy covers the liability, and there is a real possibility that the defendant would be unavailable to meet the liability (for example, they are insolvent or missing).

The provision would specifically exclude contracts for reinsurance, and would contain a provision that prevents insurers from using the policyholder's action or inaction as an excuse to get out of the contract.

The provision would also state that the issue of a claim form against the insurer would be treated as a claim against the policyholder for limitation purposes, which removes the need for the third party to claim against the policyholder.

Conclusion

We favour the above option as this is consistent with other jurisdictions and addresses the current issues with section 9. Stakeholders were generally in agreement that section 9 needed to be replaced.

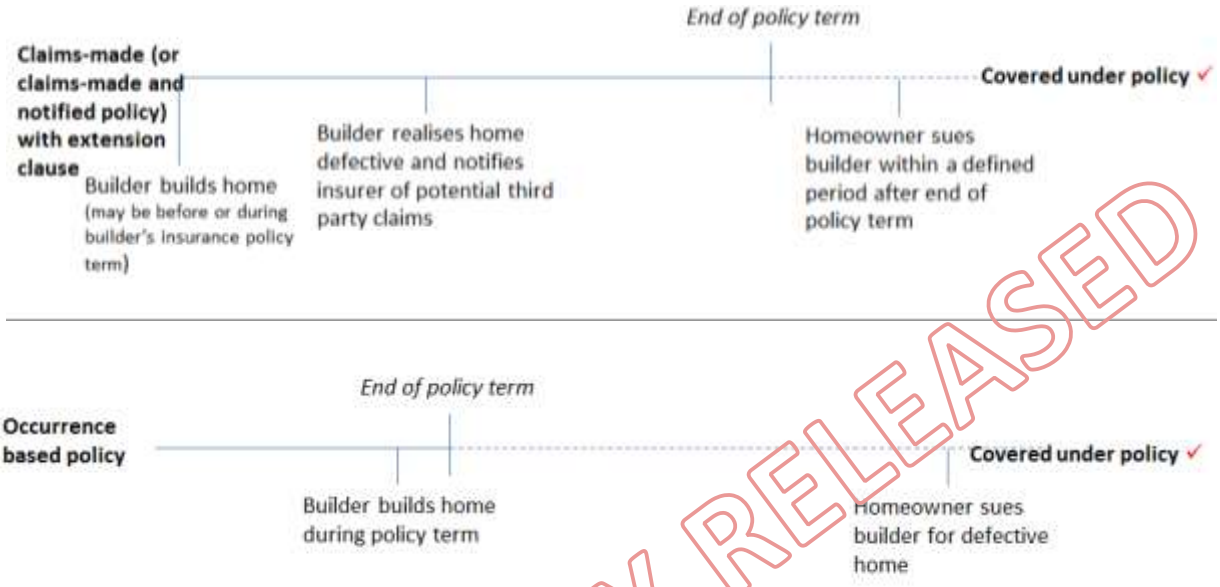
Problem 4: Insurers required to cover some claims under long-expired liability policies

Problem definition

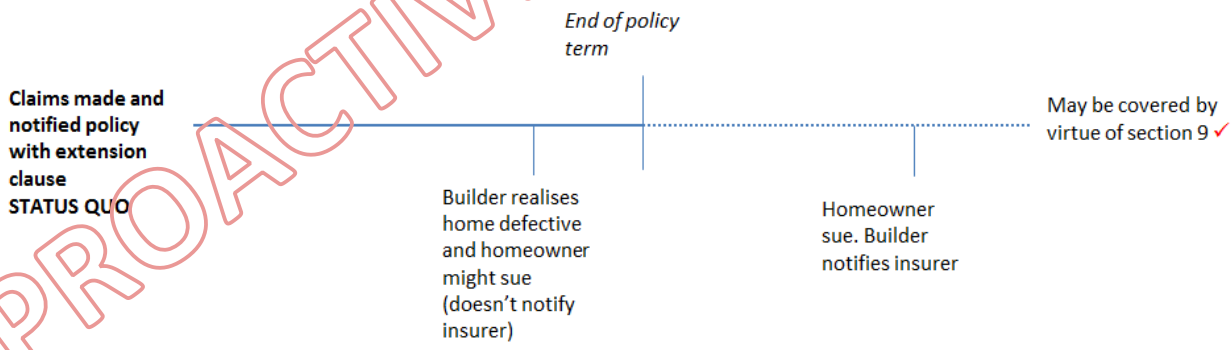
Section 9 of the Insurance Law Reform Act 1977 provides that an insurer cannot decline a claim due to the policyholder not notifying the claim to the insurer within time limits specified under the contract, unless the insurer has suffered prejudice. This was intended to prevent insurers from declining a claim where the policyholder has failed to comply with a technical process requirement in the policy where that failure caused no real prejudice to the insurer.

However, section 9 is seen as problematic for "claims made" and "claims made and notified" professional indemnity insurance policies. The following diagram illustrates the different types of claims-made policies compared to an occurrence policy.

Claims made policies reflect that in the case of professional liability insurance, third party claims against the policyholder may be brought many years after the event giving rise to a claim. Claims made policies are intended to allow insurers to estimate risks with greater accuracy so that they know at the end of the policy terms what risks they are exposed to.



However, section 9 of the Insurance Law Reform Act 1977 means that a policyholder may still be able to make a successful claim despite not notifying it within policy time limits.



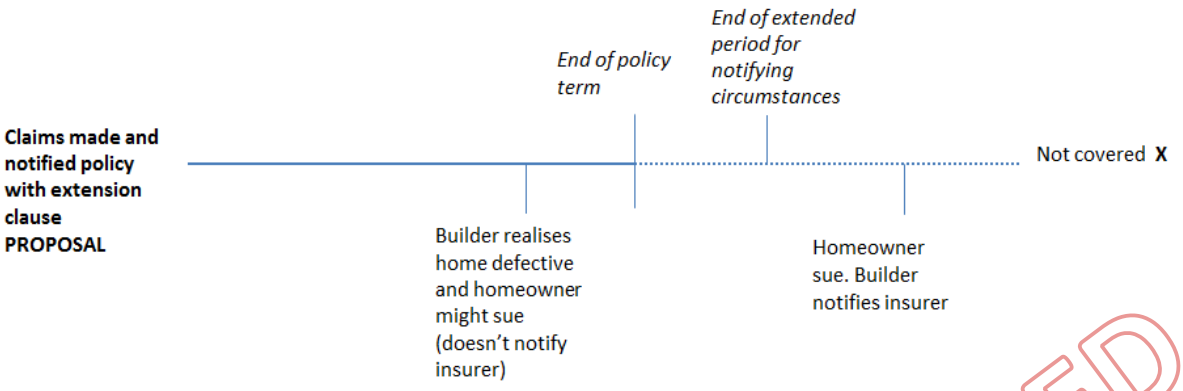
This is seen as partly undermining the purpose behind claims made policies as the insurer is not able to identify its risks with certainty at the end of the policy term.

Option: late notifications not excused under "claims made" policies

This option would involve amending section 9 of the Insurance Law Reform Act 1977 so that insurers under claims made or claims made and notified policies can decline claims where the policyholder notified the claim or circumstances giving rise to a claim more than a defined period after the end of a policy term.

The extended period for notification after the end of policy term means that policyholders who become aware of a claim (or circumstances that might lead to a claim) close to the end of their policy term have an extended (but not indefinite) period to establish the relevant facts and make a notification. The length of the extended period would be subject to further consultation.

Under this option, insurers would, after the extended notification period following the end of the policy term, better know the risks it was exposed to under that policy.



Conclusion

We recommend the above option so that the insurer will better know after the end of a policy term (after the end of a recommend extended notification period) the risks it is exposed to.

Some brokers opposed this option as it could mean some policyholders losing out on cover. It was also suggested that policyholders would favour continuing a policy with the same insurer, so that they can get the benefit of a "continuity of cover" clause, whereby insurers may allow late notification under an expired term. This may adversely impact competition in the market.

However, this may be mitigated by more careful notifications and the extended period for making notifications. This option would bring New Zealand more into line with the position in the UK and Australia.

Impact Analysis: Technical issues

Marginal impact: How does each of the options identified compare with the counterfactual, under each of the criteria?

	No action	Option 1: require intermediaries to pass on relevant information to insurers	Option 2: insurers can rely on some exclusions even if did not cause or contribute to loss	Option 3: Replace section 9 of the Law Reform Act 1936	Option 4: late notification not excused under "claims made" policies
Insurers can effectively measure and price risk	**0**	++ Better ensures that insurers have all relevant information. If intermediary does not pass on relevant information, insurer can seek redress against intermediary.	++ Insurers better able to exclude coverage in some circumstances that have a greater likelihood of loss. Could result in some lower premiums for some policyholders.	+ Insurers better placed to know the risks they are exposed to.	++ Insurers better placed to know the risks they are exposed to soon after the end of a claims made liability insurance policy.
Insurers cannot decline claims where unreasonable to do so	**0**	**0** Consumers and other policyholders still covered by insurance even if intermediary does not pass on relevant information.	- Some losses covered under status quo would not be covered. May not be unfair if carefully define which exclusions can apply even if did not cause or contribute to loss.	**0** Third parties would still be able to claim against insurers.	- Some policyholders will miss out on insurance cover due to late notification of claim. More careful processes for notification may mitigate this.
Costs and other negative impacts are minimised	**0**	- Some compliance costs on intermediaries. But should be consistent with responsible intermediaries' practice.	**0** Unlikely to be additional compliance costs for insurers	+ Compliance costs associated with resolving priority issues with the statutory charge under section 9 would be reduced. Scope of the right of action would be clearer for policyholders and insurers.	- Risk of adverse impact on competition, as policyholders will favour staying with same insurer as many insurers will allow contractually allow late notification if continuing cover.
Overall assessment		++	+	+	+

Key:

++	much better than doing nothing/the status quo
+	better than doing nothing/the status quo
0	about the same as doing nothing/the status quo
-	worse than doing nothing/the status quo
- -	much worse than doing nothing/the status quo

Section 7: Conclusions

7.1 Summary table of costs and benefits of the preferred approach

Affected parties *(identify)*	**Comment**: *nature of cost or benefit (eg ongoing, one-off), evidence and assumption (eg compliance rates), risks*	**Impact** *$m present value, for monetised impacts; high, medium or low for non-monetised impacts*	**Evidence certainty** *(High, medium or low)*
Additional costs of proposed approach (all proposals covered in this impact statement as a whole), compared to taking no action			
Regulated parties	We expect a low-medium increase in the costs to regulated parties (including financial advisers and other intermediaries). These will come in the form of up-front costs of revising contracts as well as revising systems and processes. It is not expected that there would be a significant increase in costs to regulated parties on an ongoing basis.	Low-medium	Medium
Regulators	The Financial Markets Authority will have an increase in costs. These will include the costs of monitoring and enforcement as well as developing guidance. We estimate these costs to be of low impact, but further assessment may be required at a later date.	Low	Medium
Wider government	We do not foresee increased costs to wider government.	Low	High
Consumers	Some increased costs to regulated parties may be passed on to consumers in the form of higher premiums. However, we expect this to be of low impact.	Low	Medium
Other parties	We do not foresee increased costs to other parties.	Low	Medium
Total Monetised Cost	Without accurate quantifiable evidence, it is difficult to provide an estimate.	Not known	Not known

Non-monetised costs	We anticipate a low increase in overall costs.	Low	Medium

Expected benefits of proposed approach, compared to taking no action			
Regulated parties	The proposed approach will assist regulated parties to measure and price risk.	Low	Medium
Regulators	The regulator will have new tools to intervene when there are problems related to insurance contract law.	Low	Medium
Wider government	May contribute to confidence in financial markets.	Low	High
Consumers	We expect better outcomes for consumers through more reasonable disclosure rules and provisions that protect consumers from genuinely unfair contracts	Medium -High	Medium
Other parties	We do not foresee increased benefits to other parties.	Low	Low
Total Monetised Benefit	Without accurate quantifiable evidence, it is difficult to provide an estimate.	Not known	Not known
Non-monetised benefits	We anticipate a medium increase in benefits from reduced consumer harm and increased ability for insurers to measure and price risk.	Medium	Medium

7.3 What other impacts is this approach likely to have?

We do not foresee other impacts not included in the table above.

7.4 Is the preferred option compatible with the Government's 'Expectations for the design of regulatory systems'?

The preferred package of options is compatible with the Government's 'Expectations for the design of regulatory systems'.

Section 8: Implementation and operation

8.1 How will the new arrangements work in practice?

The preferred approach for most of the proposals will be implemented through the creation of a new piece of insurance contracts legislation and legislative amendments to the Marine Insurance Act 1908 and the Fair Trading Act 1986. The preferred approach for comparing and understanding policies would likely be implemented through changes to the Financial Markets Conduct Act 2013 (FMC Act). We also propose that the FMC Act be updated to include UCT provisions for financial services contracts that are equivalent to the UCT provisions in the Fair Trading Act 1986. This will facilitate shared responsibility for enforcement of the UCT provisions in relation to financial services (including insurance) by the Commerce Commission and the FMA.

There will be consultation on exposure draft legislation to check that the proposed drafting achieves the policy intent and is workable in practice.

Once legislation is passed, we expect there will be a sufficient period of time (for example, 12 months) before any changes come into force, to allow time for insurers to adjust policies and processes. This transition period will enable regulated parties to manage any implementation risks proactively.

The proposals in relation to comparing and understanding policies will be enforced by the FMA as the regulator for financial markets conduct. The FMA will also take on shared responsibility for enforcement of UCT in relation to financial services. It will be important to ensure the FMA is adequately resourced to carry out these new functions. If not, the FMA may not be able to act as an effective regulator of these requirements.

Financial dispute resolution schemes will also play a part in enforcing the changes in individual cases.

Appropriate penalties and remedies in line with other financial services legislation will be designed to accompany a breach of the new obligations in relation to comparing and understanding policies. The proposals in relation to the duty of disclosure and various other proposals will largely be enforced through contractual mechanisms rather than public enforcement.

8.2 What are the implementation risks?

A potential implementation risk is overlap or conflict with new changes coming out of MBIE's review of the conduct of financial institutions, which will impose new conduct and licensing obligations on insurers. The timeframe for those changes and the ones proposed in this RIS may mean that insurers have to make significant changes to their systems and processes in response to both reviews in a short timeframe. Insurers have previously raised this as a concern and consider it important that both reviews work together to produce consistent outcomes.

This risk will be mitigated by keeping in close contact with persons at MBIE working on conduct, proactively identifying and discussing any areas of potential conflict, and adjusting commencement dates if necessary.

Section 9: Monitoring, evaluation and review

9.1 How will the impact of the new arrangements be monitored?

MBIE and the FMA would monitor the regulatory settings as part of their wider regulatory stewardship obligations. We will use existing channels such as the Council of Financial Regulators, which both MBIE and the FMA sit on, to monitor and discuss any issues as they arise.

We intend to monitor data from the financial dispute resolution schemes to see whether the number of disputes related to non-disclosure are declining. This data can currently be obtained through annual reports.

9.2 When and how will the new arrangements be reviewed?

There is no plan to conduct a formal review of the amendments within a particular timeframe. However, the interaction with stakeholders following implementation of the amendments, as well as the FMA's (and Commerce Commission's) ongoing monitoring and enforcement of relevant obligations, should assist to uncover whether there are any issues.