Financial Services Council.
Growing and protecting the wealth of New Zealanders

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

By email: insurancereview@mbie.govt.nz

Submission: Insurance Contracts Law Review options paper

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

The FSC is a non-profit member organisation and the voice of the Financial Services sector in New Zealand. Our 35 members comprise 95% of the life insurance market in New Zealand, and manage funds of more than $47.5bn. Members include the major insurers in life, disability and income insurance, fund managers, KiwiSaver, professional services and technology providers to the Financial Services sector

Our submission has been developed through consultation with FSC members, and represents the views of our members and our industry. We acknowledge the time and input of our members in contributing to this submission.

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

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

We support the review of Insurance Contract Law, in particular promoting a well-functioning insurance system that delivers fair, efficient and transparent consumer outcomes. However, because the proposed changes represent a significant, generational modernisation of insurance law, we strongly recommend that the detail of the chosen options be carefully considered through a robust exposure draft process.

We look forward to engaging with you to ensure the creation of fit-for-purpose outcomes for customers, industry and the economy.

I can be contacted on 021 0233 5414 or richard.klipin@fsc.org.nz to discuss any element of our submission.

Yours sincerely

Richard Klipin
Chief Executive Officer

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Executive summary

The scale and pace of change in the financial services industry is intense.

The past three years have seen an increasing volume of legislative, regulatory and industry activity both at home and abroad. The activity runs the gamut from the Financial Services Legislation Amendment Act (**FSLAA**) and its enactment through a raft of regulatory thematic reviews, the Australian Royal Commission enquiry and reports, the recent Conduct of Financial Institutions options paper and the development and implementation of the FSC Code of Conduct.

Reforming insurance law
The proposed reforms should take account of the unique nature of insurance products. In particular, these products have two-way information asymmetries between insurer and consumer; are intended to protect customers' financial stability rather than generate new wealth; and are designed so that risks are effectively shared across policyholders.

It is important that the proposed reforms do not produce detrimental results for consumers by increasing uncertainty in assessing risk thereby raising costs of providing insurance and creating unintended barriers for New Zealand consumers to obtaining insurance. The proposed reforms may impede the provision of products designed to provide affordable and accessible insurance cover (which is what many consumers now expect). It is difficult to get consumers to read the policy documentation they currently receive. There is a very real concern that adding further documentation – however worded – would reduce consumer engagement and understanding.

There are several areas where there are important differences between a life insurance contract (where there is generally no insurer right to cancel and it is not an annual contract) and a general insurance contract (where usually insurers can cancel on notice and it is an annual contract which expires). These differences may be relevant, for example, in respect of the application of the new regime, transitional arrangements, and remedies for non-disclosure.

Financial Services in New Zealand
The contribution of the broader financial services industry to the New Zealand economy is significant and is evolving through innovation and technology. We see our contribution in the industry as sustainably growing and protecting the wealth of New Zealanders, and promoting the wealth management sector on the global stage.

Financial services are valuable to New Zealand in many different ways. The financial services sector has been the second fastest growing and third largest contributor to economic growth in New Zealand over the past 40 years.[1] The sector is highly skilled, diverse and is future focussed. The sector helps New Zealanders get on with their everyday lives, covering risk and helping them save for their futures.

Good policy and regulations are the responsibility of all market participants, and active engagement between the Government, the regulators and industry bodies will drive good outcomes for all. Regulators' reports (both in New Zealand and Australia) have clearly indicated there is room for improvement.

[1] For details, see "Towards Prosperity: An insight into New Zealand's Financial Services Industry | December 2018" available at www.fsc.org.nz

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FSC members have listened and understood the regulators' messages and have been actively working together to create a blueprint for the future that should build a sustainable financial services industry delivering good outcomes for customers. We also recognise that good things take time, and there needs to be a careful balance between responding quickly to issues and taking time to properly consider the implications and consequences of the proposed changes, particularly in light of other regulatory reforms.

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Key themes we support

In particular, we support the following major themes in the options paper, because they are likely to help ensure that insurance remains accessible and affordable for customers, and sustainable for insurers:

Theme one: consolidation and modernisation of Life Insurance legislation

We support the consolidation and modernisation of Life Insurance legislation to improve clarity and succinctness.

Theme two: disclosure of information to insurers

We support the modernisation of the duties regarding the disclosure of information to insurers. Current practice in the life and health insurance sector already reflects several of the key policy elements set out in the options paper, including for example:

- clearly informing customers of their duty to disclose
- designing forms and processes to elicit more accurate information from consumers during the application and policy issuance process
- the widespread use of proportionate remedies, with limited recourse to avoidance.

Theme three: making it easier to read and compare policies

We strongly support initiatives, including for example through FSC Code Standards 2[2] and 4[3], to encourage communication with customers that is clear, effective and timely. However, we recommend that this be done on a principles basis in conduct legislation, and not as a set of prescriptive, insurance-specific rules.

Theme four: unfair contract terms (UCT)

Our members support the continuation of an unfair contract terms regime, and note that it would now operate in conjunction with the principles-based conduct duties proposed in the Conduct of Financial Institutions options paper. We consider that the current insurance-specific exemptions to the UCT regime remain appropriate, and – to the extent that there is any reform of the detail of the UCT regime – regard should be had to the complementary effect of those new conduct duties.

[2] Members must communicate with customers clearly and effectively
[3] Members must seek and consider customer feedback

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Adequate transitional arrangements

We recommend that in changing the legislative framework, detailed consideration be given – preferably through a robust exposure draft process – to the adequacy of transitional periods, including to allow for systems changes and renewed documentation.

We would not support retrospective changes to existing contracts as that would undermine agreements already reached by the parties, such as how those products are priced and structured (for example based on existing consumer disclosure duties).

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Detailed responses to consultation questions

Question 1: review objectives

Our members support the objectives of the review, and make two comments on them:

- We recommend that submissions be assessed against an additional objective, aligned with paragraph 33 of the options paper, to ensure that "insurance is accessible and affordable for customers, and sustainable for insurers".

- It is unclear how the options paper has addressed objective 3: barriers to insurers participating in the insurance market are minimised, including to ensure that the reforms do not create barriers to participation by reinsurers in the New Zealand market.

Question 2: consumer disclosure

Our members support the approach taken in the options paper to consider consumer disclosure duties in comparable jurisdictions. To the extent that overseas regimes are relevant to and appropriate for New Zealand conditions, we encourage the broad alignment of duties and remedies.

Duties and remedies also have consequences for reinsurance – the reforms should be carefully structured to neither unnecessarily complicate nor disincentivise the provision of cost effective reinsurance in New Zealand.

Our members are in favour of change to the disclosure duty, and would like to work with MBIE to ensure that the best option is developed. The potential unfair outcomes for consumers caused by the current duty and remedies has been recognised for a long time. That was highlighted by the Law Commission's reports in 1988 and 2004, and has been regularly noted by dispute resolution schemes and consumer advocates.

Whatever duty is chosen, ideally it should be set out in a form that provides as much certainty as possible for customers and insurers. Our members support further consideration of options 1 and 2 and make these comments in respect of them:

- We support a duty that is consumer-centric. We note that the final form of the duty must work both for consumers and insurers, and would be happy to assist to workshop this further.

- It would be preferable if option 1 could be worded in the positive: negative obligations are more complicated to explain to consumers. For example, we would prefer language that requires "fair presentation" or to be "fairly representative". In addition, reference could be made to "having regard to the information / questions given by the insurer".

- Option 1's limitation to only having to "take reasonable care" not to misrepresent would not only abolish a duty of disclosure that has existed in insurance contract law, but also replace the law relating to contractual misrepresentation which looks whether a misrepresentation occurred and what the justification for this is, noting that consumers are not able to misrepresent in any other contracts.

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- More generally, the use of "reasonable" in each duty creates a hypothetical standard that can be difficult for customers to understand.

- We recommend that guidance be provided for key terms, for example: ensuring "misrepresentation" includes omissions, and (similar to the UK approach) setting out what needs to be considered by the courts when establishing whether a customer has taken "reasonable care".

There are also technical and/or consequential issues that should be addressed. We would be happy to provide assistance to identify and address these. Some examples are:

- the effect of change on composite insurance policies and on policies where there are co-insureds

- the effect of the change where the insured is a different person from the life assured (noting that UK law deems information provided by the life assured to have been provided by the policy owner, and the insurer also retains rights against the life assured in the event of any misrepresentation by that person)

- the effect of the change on the doctrine of waiver and how does that operate in the context of (a) specific and (b) general questions asked by the insurer in the proposal form

- the outcome where a non-disclosure or misrepresentation is material for one benefit under a policy but not another (e.g. material for a disability benefit but not for a death benefit)

- the effect on other legislative regimes should be considered.

Our members do not support option 3. Requiring life and health insurers to obtain and review medical records for every application would be administratively burdensome, would significantly increase the cost of insurance and potentially impede accessibility for customers, and at a practical level is likely to be unviable due to medical records often not being complete, if available at all. That would risk increased reliance being placed on records which may not be complete, and delaying cover for customers. Other potential problems include:

- unintentionally and unfairly prejudicing customers whose medical records are difficult to obtain, such as those who have moved from overseas

- how to address situations where doctors do not provide full information

- how this option might create a burden on medical providers.

We note that the operation of the insurer remedies (see response to question 8) are as important as the drafting of the duty itself.

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Question 3: inform consumers of duty to disclose

Current industry practice is to clearly inform customers of their duty to disclose. That practice is further strengthened by FSC Code Standard 2[4].

Our members support this option. We note that there are situations where it is not appropriate for the duty to disclose to be communicated in writing prior to the commencement of the policy, so the requirement should be sufficiently flexible to allow for other approaches, such as initial advice verbally followed up by a written explanation of the duty.

Question 4: disclose use of third party information

Policy considerations may differ depending on whether the third party information is specific (for example: the insured's own medical records or financial information) or generic (for example: internally developed actuarial material relied upon to create underwriting guidelines).

We note that some information that is relied upon by the industry is confidential to particular insurers or is proprietary to other parties. For example, industry participants rely upon materials provided by their reinsurers when underwriting risks. Reinsurer materials cannot be shared outside the individual insurer. If this option is pursued there would need to be recognition that insurers are not legally in a position to provide copies of all information that is relied upon. That would suggest that the policy response should be flexible, rather than a fixed legislative requirement. For example, this could be addressed in industry best practice recommendations.

In general, our members consider this option to be less workable as an absolute legislative requirement and would prefer a more principles-based approach in relation to making customers aware of any reliance on third-party information. Requiring insurers to advise customers of the time when information will be accessed and if it will be used to underwrite creates additional steps in the underwriting process which will increase the cost to consumers, without any identifiable benefit to customers.

In whatever form this option takes, it is important that it does not inadvertently create a waiver in respect of the customer's general obligation to disclose or not make a misrepresentation. It should also be structured to be compatible with privacy law.

Question 5: business disclosure

Some of our members are not convinced that there should be a difference in the disclosure duties for consumer and business insureds. This is particularly the case in respect of life and health insurance where a difference in the duty would create complexities.

An example of a complexity arising from dual duties is: What is a policy on the life of a farmer – why should an arbitrary turnover rule apply when the underlying purpose in two cases could be identical? What if the policy is owned by a trust that operates the farm business – does that change the categorisation? What about a group insurance policy owned by an employer or the trustees of a superannuation fund? Does it

[4] Members must communicate with customers clearly and effectively

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make a difference if the employee has (or does not have) a separate contractual right to enforce the insurance obligations against the insurer?

Question 6: small business

As noted in the response to question 5 above, we are not necessarily convinced that there should be a difference in the disclosure duties for consumer and business insureds, therefore avoiding the need for a small business definition. To the extent that there is any difference in the disclosure duty for businesses, some of our members recommend that the distinction between "consumer" and "business" should be based on who has the information advantage, although in some situations that approach may be difficult to apply in practice, and/or there may be scope for confusion. In short, where the insured is likely to have specialised knowledge about complex or uncommon risks, they should be treated as businesses. Genuinely small businesses with typical, standardised needs should be treated as "consumers".

Some members support the UK approach, which does not define small businesses, on the basis that it would be easier to apply in practice – that is the test is clearer. If the insured is acting as a private person then the Consumer Insurance (Disclosure and Representations) Act 2012 applies. If the insured acts in the course of a business, then the Insurance Act 2015 applies. Small businesses, including one-person operations, are not treated as consumers. The test is the purpose of the policy, not the identity of the policyholder.

Question 7: contracting out (only if fair presentation of risk duty adopted)

This question is less likely to be relevant for life and health insurance. Nevertheless, in that context our members would not support the ability to contract out of a duty to make fair presentation of risk. There is a power imbalance between insurers and intermediaries, and the concern with having the ability to contract out of the duty is that some intermediaries may take advantage of their relatively powerful position to dispense with the duty in relation to all risks placed.

Question 8: insurer remedies

The overarching principles for insurer remedies should be both to:

- put the parties in the position they would have been in had the customer complied with their duty of disclosure
- incentivise customers to be careful and accurate, and discourage deliberate deception.

Our members prefer option 1, subject to the comments below, because it provides a proportionate remedy, which puts the parties in the position that they would have been in had the information been given as required, provided that the customer has not deliberately or recklessly misrepresented the position. This option provides an incentive for customers to be careful when providing information to insurers.

It is important that the remedies provide for both resolving any claim and also the treatment of the contract going forward, which require two separate considerations. To accomplish this we suggest that the

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reference in the second and third bullet points of paragraph 53 should be "and/or the insurer can cancel the contract …" rather than only "or" as the first limb may be appropriate for resolving the claim while the second limb would deal separately with the policy's ongoing existence. This is particularly important for contracts of life insurance which provide the insurer no opportunity to refuse or offer different terms at renewal or elect cancellation. It is important to be able to avoid where the insurer would not have entered the contract on any terms: this needs to be part of whichever remedy is adopted.

We do not support option 2 because it forces the insurer (and other customers) to bear the costs of one customer's carelessness. To allow a customer who has provided inaccurate information to be put in a position that they could never have been in if they had been careful and accurate, is unfair and contrary to objective 2.

Option 3, similarly, does not incentive customers to be careful and accurate.

We note that, in practice, avoidance is a rarely used remedy, with proportionate remedies usually adopted. However, the availability of avoidance is important, particularly for cases where customers deliberately provide incorrect information.

In relation to option 1, we note that the phrase "deliberate or reckless" is taken from the UK law. Under that law it is further defined by reference to the customer's knowledge (or constructive knowledge) or indifference of the truth of the matter and its relevance to the insurer. Further, in the UK there is a presumption that the insured had the knowledge of a reasonable consumer and knew that a matter about which a clear and specific question was asked by the insurer is relevant to the insurer. Those aspects of the remedy are vital to ensure a fair and balanced outcome. For example, even an innocent misrepresentation could be "deliberate" in one sense of that word.

We recommend there should be a rebuttable presumption that an insurer in fact was induced to enter into a contract by an objectively material representation. It could be burdensome for an insurer to have to provide evidence, potentially many years later, that demonstrates to the civil standard of proof that the insurer was induced to enter into the particular contract.

Question 9: unrelated misrepresentation

Our members do not support such a requirement because it is not proportionate and it does not incentivise customers to be careful and accurate. If insurer remedies option 1 (intention and materiality) is adopted – see question 8 above – a proportionate response would still allow the insurer to be put in the position they would have been in had there not been a non-disclosure. So, if an insurer would never have entered the contract had they known all the facts, they are permitted to treat the policy as if it had never existed.

A misrepresentation that does not relate directly to a claim can be material to the underwriting decision. For example, insurers may have an underwriting rule that they will not insure a person who has been convicted of a dishonesty offence because they pose an unacceptable moral hazard. While an insurer may not be able to prove that there is a link between the misrepresentation and the claim, in the underwriters' view, the fact that a person has been found guilty of a dishonesty offence makes it more likely that they will be the subject of a claim.

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Question 10: non-claim misrepresentation

Our members support this option because it is a proportionate remedy that incentivises appropriate customer behaviour. It also puts the customer in the position that they would have been in if they had disclosed as required. To allow otherwise, would reward customers for not taking reasonable care when answering questions (assuming insurer remedies option 1 is adopted).

Question 11: hardship

The number of cases where a policy is avoided where claims have already been paid to customers is limited. With a new disclosure duty regime the numbers will be even lower. In those cases, customers should not be able to avoid repaying benefits obtained through their own deliberate or reckless non-disclosure, even if those benefits are not easily returnable and would be difficult for the customer.

Question 12: misrepresentation damages

Our members support the clarification proposed in the options paper.

Question 13: aligning misrepresentation provisions

Our members support a single regime that aligns these provisions with the new remedies for a customer's failure to disclose.

We note it can be difficult to differentiate between a misrepresentation and an omission, and sometimes an act can amount to both.

Questions 14 and 15: unfair contract terms

The introduction of the principles-based conduct duties proposed by the Conduct of Financial Institutions options paper is relevant to the consideration of the unfair contract terms (UCT) regime. To the extent that there is any UCT reform, regard should be had to the effect of any new conduct duties that complement the objectives of those reforms.

It is important to note that the current UCT regime does apply to insurers: the insurance carve-out only applies to certain terms within the policy so as to protect the legitimate interests of the insurer and the unique nature of insurance policies as a product, rather than just an agreement to supply a product. The following are examples of clauses which currently may be unfair if included in insurance contracts:

- cancellation clauses which do not provide equal rights for the insurer and the policyholder, or which penalise one party but not the other
- terms which permit an insurer to vary the terms of a policy without consent or input from the policyholder
- policies which provide penalties for breaches of terms by a policyholder, but not by an insurer

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- terms which allow for premium to increase without giving the policyholder the right to terminate
- terms which provide the insurer, but not the policyholder with the right to interpret the policy's meaning, or to determine whether the policy has been breached
- policies which purport to limit the ability to assign rights on different terms.

Our members consider the current insurance-specific exemptions are appropriate, and support the status quo being maintained, especially in light of the likely introduction of broad conduct duties.

These exclusions were designed to reflect the unique nature of insurance contracts. We note that this is a relatively new regime, there has been limited case law/enforcement action to clarify the scope of the current regime, and members are not aware of instances where the current UCT exemptions for insurance are causing difficulties or concerns for customers.

If the unfair contracts regime is to be reformed in relation to insurance, we would then prefer option 1 (tailor generic unfair contract terms provisions to insurance) noting that it is important that any changes:

- deliver certainty that fundamental insurance terms that define risk and price are unquestionably deemed to be not unfair
- make clear that terms in existing contracts are not deemed to be unfair in the future where they comply with the law which applied at the time that the contracts were entered into – those contracts were entered into and priced on that basis.

We would be happy to provide detailed industry input to assist with further work on this topic.

Question 16: understand and compare policies

There is an overlap here with recent reforms to the law governing financial advice and advisers. The new Code of Professional Conduct for Financial Advice Services imposes standards designed to ensure that financial advice is suitable. Those reforms should help to ensure that (advised) consumers will understand their insurance.

For non-advised consumers, it seems reasonable to require that policy documents are written in clear language, however there are many potential "fish hooks" and costs with requiring a summary of key terms or that insurers are obliged to work with comparison platforms. Given in particular the lack of evidence that summary documents actually do improve understanding by consumers overall, it might be a better balance of costs and benefits to encourage consumers to seek financial advice and require warnings where a consumer is not advised.

We note also the direct relevance of the proposed new conduct laws, specifically the proposed new duty to "pay due regard to the information needs of customers and to communicate in a way which is clear and timely".

To the extent that separate requirements are developed, we suggest that they be confined to straightforward consumer policies insuring simple assets, not least because complex cover for

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sophisticated customers can be difficult to convey in standardised terms. In complex situations, standardised wording would risk confusing rather than assisting customers.

In respect of options 1 and 2, we strongly support the use of "plain English" and encouraging that at a principles level. However we are concerned that the suggested requirements would be impractical if imposed at a detailed, prescriptive level and challenging to enforce. For example, how do we define what "plain English" drafting is? With respect to option 2, the difficulty is how to define what the core policy wording is. Ultimately the core policy wording for a particular claim depends upon the subject matter of the claim. This is a key reason for recommending use of principles-based conduct laws instead.

In respect of options 3 and 5, we recommend that industry is made responsible for or heavily involved in decisions as to which policies such obligations would apply to and what the summary statements and/or key information would contain. Our members do not support, however, an approach that would lead to a regime similar to Australian-style PDS, not least because their effectiveness for consumers is questionable.

In respect of option 4, we are concerned that important policy detail may not be clearly conveyed to a customer audience and that there are complicated issues as to who is responsible for:

- the maintenance of the public data
- ensuring appropriate standards are maintained
- ensuring that data is presented in a useful and meaningful way (noting the still-present challenges with the Disclose website which works far from ideally even for a comparatively sophisticated audience).

Questions 17-19: matters known by intermediaries

We have considered these questions in light of the likely new consumer disclosure duty, the expected new overarching conduct obligations for insurers, process efficiency, and the policy benefits of encouraging customers to get advice. In particular, a customer should have confidence – assuming consumer disclosure duty option 1 – that if they have taken reasonable care not to make a misrepresentation during the advice process (for example when completing a robo-advice questionnaire) they have also satisfied their duty to the insurer (see criterion b in para 108).

Our members support option 3 – a statutory obligation on all intermediaries to pass on all relevant material matters known by them to the insurer, regardless of whether they were an agent of, or received commission from, the insurer. Ideally, the legislation should clarify the consequences of non-compliance and the available remedies. This would provide certainty – including for consumers – regarding the respective obligations of intermediaries (advice or non-advice) and insurers, in all situations regardless of business model (including whether commission was paid). It would operate in tandem with the FSLAA duties and Advice Code standards to encourage professional conduct by intermediaries. It would be consistent with the broader customer outcome objectives of the proposed new conduct laws.

We agree with the options paper that in terms of compliance costs for intermediaries this approach should not require much more than responsible intermediaries' existing practices.

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For life and health insurance, we see no reason for these requirements to distinguish between consumer and business insureds.

Question 20: no causal link exclusions

Our members support option 1. We have no detailed comments on this matter in respect of life and health insurance. However, our members recommend that need for and the operation of any such provisions be considered in light of the proposed new conduct obligations, for example an obligation to treat customers fairly.

Question 21 and 22: failure to notify in time

We have no particular comments on this matter in respect of life and health insurance.

Question 23 and 24: third party claims for liability insurance

We have no particular comments on this matter in respect of life and health insurance.

Question 25: utmost good faith

There should be alignment between any reform of the duty that applies once the contract is on foot and any relevant obligations or reforms – including in relation to claims handling – that might flow from the Conduct of Financial Institutions options paper.

Provisionally, we do not support codification of utmost good faith. However, we would appreciate the opportunity to comment further once there is greater clarity as to the likely consumer disclosure duties, and conduct and claims handling laws.

Question 26: statute consolidation generally and, specifically, section 41A of the Life Insurance Act 1908

Our members support statute consolidation and modernisation to improve clarity and succinctness.

In response to the issues paper last year, we raised one matter in connection with the consolidation of the Acts. We recommended a review of requirements in respect of interest payable on death claims (section 41A of the Life Insurance Act 1908).

Section 41A has been a longstanding problem for insurers, particularly in a low interest rate environment, where claimants and their lawyers can delay submitting proofs needed for payment of a claim while other aspects of the estate are finalised, knowing that the interest payable after 90 days is greater than might otherwise be available to the estate if the claim was processed promptly. A fairer outcome would be that interest is payable only after a reasonable period (for example, 30 days) following receipt by the insurer of all information necessary to assess the claim.

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Question 27: marine

No comment

Question 28: redundant provisions

From a life and health insurance perspective, we have no comments in respect of redundant provisions.

Question 29: registration of assignments of life policies

Any reform in this area should recognise the existence of unregistered assignments to lenders as security for loans. Lenders rarely seek to have their interests registered because they rely on section 43 of the Life Insurance Act 1908, that requires an assignment to be endorsed on the policy document. A modern, electronic transfer system is a good idea – however, if it means that an assignment can be registered without the policy document, lenders would want to ensure that their interests are not defeated. An electronic system should allow lenders to register their interests and for any subsequent assignment to be subject to a registered interest.

Questions 30: life insurance for minors

The maximum payment amounts should be increased so that the fixed portion at least covers funeral costs. We understand that $2000 is unlikely to pay for a funeral, let alone some time for the family to pause employment and grieve.