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Financial Markets Policy
Building Resources and Markets
Ministry of Business, Innovation and Employment
Wellington

Attention: Rose Wang, Principal Policy Advisor
By email: rose.wang@mbie.govt.nz

Dear Rose,

RE: ICNZ Submission on MBIE's further consultation on the Insurance Contracts Bill

Introduction

Thank you for the opportunity to submit on the MBIE's further consultation on the Insurance Contract Bill (**ICB**).

ICNZ represents general insurers that insure about 95 percent of the Aotearoa New Zealand general insurance market, including about a trillion dollars' worth of Aotearoa New Zealand property and liabilities. ICNZ members provide insurance products ranging from those usually purchased by individuals (such as home and contents insurance, travel insurance, motor vehicle insurance) to those purchased by small businesses and larger organisations (such as product and public liability insurance, professional indemnity insurance, cyber insurance, commercial property, and directors and officers insurance).

This submission is in two parts:

- Overarching comments
- Responses to the questions in the consultation paper.

Overarching comments

- ICNZ welcomes MBIE's ongoing engagement with the sector on the ICB and on these specific but important aspects of the legislation and note there were other key changes in the Bill that were also raised in earlier consultations. We trust there will be further engagement on revised drafting before it is introduced to Parliament.
- We believe that the classification of contracts as "consumer" or "non-consumer" requires an objective approach. It is best for insurers to be able to classify products as consumer or non-consumer ahead of the marketing, sale, and distribution of the product. We note that even the consultation paper presupposes that this is how insurance companies approach the development and distribution of their products.
- The proposed regulation making power to enable clarification of the status of policies as a 'future proofing' mechanism does not alleviate concerns with the proposed subjective approach. We see a regulatory 'deeming power' to be an additional measure rather than an alternative to refining the underlying definition.

- ICNZ continues to recommend that Parliament not codify the duty of utmost good faith in legislation at all (oppose Proposal 3). If the duty was to be codified (which we oppose), then the Bill should make it clear that the common law duty is simply being confirmed and that it continues to apply unaffected by the Bill.
- We do not consider the introduction of a late payment duty is required. However, if it is progressed, we consider the provision should only apply to consumer contracts and not to non-consumer contracts (there should be no need to contract out for non-consumer contracts).
- The Bill should include an exception for when an insurer has 'reasonable grounds for disputing a claim'. This is practical and necessary to mitigate the risk of baseless proceedings in circumstances where an insurer has valid grounds not to accept or pay a claim promptly.
- Whether an insurer has paid part of the claim should be taken into account, even if other parts of the claim are still being assessed or are in dispute.
- Proposal 6 is supported, but Proposal 6A appears unnecessary. For Proposal 6, we suggest that "circumstances" should be defined based on the policy wording rather than attempting the difficult task of defining this in legislation. Proposal 6A would create awkward situations as it is too narrow and would not address the reasons for why the current law needs to be changed.

Answers to the specific questions

Policyholders' duty of disclosure - definition of 'consumer insurance contract'
Summary view on the proposal: • ICNZ does not support Proposal 1. While we can support most of the drafting of the definition, ICNZ maintains that an objective test is more appropriate than a subjective test. It is not practical for the assessment of whether a contract is consumer or non-consumer, and therefore which disclosure duty applies, to be undertaken from the perspective of each individual policyholder. • An objective assessment enables insurers to be certain in the design, distribution, and management of their policies. This would also be more consistent with the situation under the Consumer Guarantees Act (CGA) or the Fair Trading Act (FTA) in which the test of the product is one that is "ordinarily acquired" for a domestic purpose. Thus, the assessment could be of an "insurance product ordinarily acquired for" as opposed to an individual assessment of each customer). • We recommend adopting a CGA/FTA-style objective test for this Bill and the CoFI regime for the reasons above and to maintain legislative consistency. Section 446P of the FMCA (CoFI regime) could simply refer to the ICB definition to achieve complete alignment and to recognise that the Bill is the key statute for insurance contracts. • Regarding Proposal 2, we see a regulatory deeming power to be an additional measure rather than an alternative to refining the underlying definition. • It is unnecessary for clause 11 of the exposure draft Bill to provide a presumption in favour of a contract being treated as a consumer insurance contract. In comparison, there is no presumption in the CGA that a person is a consumer and there is no apparent justification to apply such a presumption to an insurance contract in this context.

1. Can you provide any examples of operational or implementation challenges you consider the current (subjective) definition would cause?
At present insurance contracts are explicitly designed to meet the needs of customers in relation to certain types of risks and these usually have a consumer (often referred to as personal lines) or commercial/corporate customers (referred to as commercial lines). Under the proposed ICB regime, clarity of this segmentation (consumer/non-consumer) will be very important because the way disclosure is managed for each segment can be fundamentally different. Under the CoFI regime, insurers also need to be clear about which products are consumer insurance contracts and which are not (especially as it relates to the product design obligations, product training, and potentially for reporting on CoFI to the FMA, and so on). As part of a target market determination, the insurer would outline what class of customers the products have been designed for. This explicit design of insurance contracts (consumer vs commercial) arises because it is central to the risk being insured and the needs of the customer. The consumer/commercial character of a contract manifests in its nature (covers provided, exclusions), drafting, distribution, related collateral, pricing, and administration. Disclosure and/or representations made are potentially integral to the way the product is designed and so the nature of disclosure required and the consequences for poor disclosure cannot be seen in isolation. For commercial type policies, for example a liability policy, for an insurer to understand the risks sufficiently to understand whether it is within the insurer's risk appetite and if so to then underwrite and price it – the variety of possible situations makes a proactive disclosure by the insured critical to offering this kind of product. Should the ICB be passed into law in its current form, insurers will need to review and update their policy wordings and collateral and how the products are distributed (e.g., application forms, question sets) for a variety of reasons. As part of this, insurers will need to be very clear on which policies are consumer policies and which are non-consumer policies. Insurers will then in turn need to design the distribution and administration of these contracts accordingly and communicate to each customer their obligations with regard to the relevant disclosure duty and beyond. The potential for an insurance contract to be considered a "consumer" or "non-consumer" contract based on the subjective intent of the individual customer would create operational or implementation uncertainty and challenges because it does not fit with the reality of how insurance products are developed, distributed, and managed. Given the number of policies written each year, it may well be the case that confusion about the nature of a contract will only arise if a claim is made against the particular policy. Nonetheless, the potential for such confusion and complication would create uncertainty for insurers, who would need to put in place measures to mitigate the risk. This in turn could make the distribution of insurance products more complex than would otherwise be necessary. Note: the confusion arising from a subjective approach means that a tribunal or court could consider a consumer contract to be a non-consumer under the Bill (and vice versa). In neither case would it be workable to apply the mismatched duties to a specific policyholder whose nature would be reflected in the design and distribution, etc, of their policy.

2. Can any of these challenges be addressed or mitigated through measures such as:
- Questions in application forms (e.g. to confirm intended usage)
- Steps in the distribution process
- Policy terms or exclusions
- Declarations or certificates (refer cl 11 of draft Bill)?
Why or why not?

In the consultation document it states that "We anticipate that insurers would in practice classify products as "consumer" or "non consumer" prior to distribution and put in place processes to assess the position; but we seek further feedback on this." This is a sensible assumption as outlined above; however, it does not address the issue of the subjective test which is that the test allows for this classification to be subverted after the fact.

Products are currently clearly designed (as noted above) and marketed with a focus on consumers or businesses/organisations (Home Insurance vs Commercial Property Insurance, Car Insurance vs Commercial Motor Cover). This is explicitly reflected in the names of the products, their content, and how they are marketed and distributed to potential customers. It is already important for insurers to identity what sorts of customers are the target market and the split disclosure duty under the ICB, and product design and other requirements under CoFI, will further reinforce this need to classify and segment products (consumer/non-consumer) ahead of time.

- **Questions in application forms (e.g., to confirm intended usage)**

Questions in application forms are revised periodically and will need to be revised in implementing the ICB (once passed) to reflect the new duties of disclosure. This is to confirm that insurers are collecting the necessary information and that the product is appropriate for a customer as this is critical independent of what disclosure duty might apply.

Even if application forms include questions seeking to clarify intended usage, there is a risk, especially for customers of direct rather than intermediated products, that customers will not provide the information necessary for insurers to ascertain that the policy is intended to be consumer rather than non-consumer as they will not grasp the significance.

Note: for intermediated products, insurers may work from application forms provided by insurance brokers using the broker's own template.

- **Steps in the distribution process**

These channels are generally set up to engage consumers or businesses and, in the case of distribution through brokers, the broker should advise the customer on relevant aspects of the product and what the customers responsibilities are.

For direct distribution, the marketing of products is usually clear on personal and commercial uses and the question set and distribution process is designed to determine whether the policy is right

for the customer, as well as gathering sufficient information on the customer(s) and the risk/s being insured (to meet underwriting and pricing needs).

- Policy terms or exclusions

Policy terms and exclusions will, as noted above, directly relate to the nature of the product and may reinforce the need to classify products as consumer/non-consumer and ensure customers are segmented appropriately.

- **Declarations or certificates (refer cl 11 of draft Bill)?**

Declarations or certificates would be very clunky and would just add another piece of paperwork and step to the distribution process.

Overall, it is hard to see where a certificate approach would be useful or workable (a written document that is separate from the insurance contract or the contract for the relevant service) for most distribution processes (e.g., over the phone, online).

We are also concerned that in some instances the use of the proposed certificates may be of limited effect. For example, a customer may later say that they did not appreciate the significance of the certificate when taking out insurance and simply signed to expedite the purchase of cover. A regulatory decision-maker, when considering the subjective test (with a presumption that a contract is a consumer contract) may not consider that a certificate in those circumstances is a true reflection of the insured's subjective intent.

The use of the certificate may be viewed as an unfavourable customer experience (placing administrative barriers to access) or might even be viewed as some form of unfair pressure, contrary to the intent of CoFI.

Insurers need a definition that provides certainty in the categorisation and application of insurance policies, rather than certificates being used as a workaround for a more uncertain definition.

However, if MBIE is determined to retain a subjective test for 'consumer insurance contract' then we prefer to have the option of a certificate if it will assist to overcome implementation difficulties that will occur in some cases.

We think MBIE should explain:

- what do you think is the specific intent as to certification?
- is it for use only in special circumstances, where it is possible it could have a role, or would its use become the standard operating procedure?

3. Do you have any other feedback on Proposal 1?

As discussed, it is important to be clear about the difference between issues with segmentation of consumer/commercial policies (clear for the vast majority of policies, possibly arguable for some), which is required regardless of what the definition is, and crafting the clearest possible definition that can be applied with certainty.

4. Do you support the proposal to add a regulation-making power (Proposal 2)? Why or why not?

The proposed regulation making power to enable clarification of the status of policies as a 'future proofing' mechanism does not alleviate concerns with the proposed subjective approach.

Should disputes arise as to whether a contract is a consumer or non-consumer contract, such a regulation-making power could be a useful tool in cases where the application of the definition is potentially unclear and the sector and regulators can reach a consensus on how a certain type of

insurance contract should be treated and how it could be suitably defined (i.e. does the uncertainty relate to all policies of a certain type, or only to some policies of a type that have particular features that create uncertainty).

We believe that this regulation making power would be more consistent with an objective test as it makes it necessary to identify the relevant customers/potential customers as a class, which we support, rather than considering the customers' specific intent.

We see a regulation making deeming power to be an additional measure rather than an alternative to refining the underlying definition (Proposal 1).

5. Can you provide any examples of policies where you consider the classification as a 'consumer' or 'non-consumer' insurance contract is unclear?

We recognise that the application of the planned definition to some types of policies could be uncertain because of the nature of the customer(insured) and/or to what the cover relates.

Examples include:

- Landlord polices are commonly based on "Home" policies as they relate to residences and are often managed within that portfolio, although the customer landlord's interests are generally commercial in nature (i.e., it is not for their personal, domestic, or household purposes).
- For multi-unit residential building policies the insured is generally a Body Corporate and as they relate to large often multi-story buildings that could have many units (i.e. tens or hundreds), large sums insured (i.e. can be tens or even hundreds of millions of dollars), they tend to be managed within portfolios for commercial property, however, the members of the body corporate might generally have the policy for their personal, domestic, or household purposes. There are also different kinds of policies that reflect different buildings and nature of occupancy (scale and could be purely residential or mixed use).

Another example of where the classification of 'consumer' or 'non-consumer' is not clear would be where a policy is treated as commercial, but it covers risks related to a mixed-use building; that is, commercial operations and residential accommodation.

When treated as a commercial-type cover, insurers may ask a set of questions in the application form that rely on the fact there is an onus is on the insured (e.g., the body corporate) to disclose anything relevant to the cover being sought.

If under the ICB these were to be considered a consumer policy (due to the fact it covers some or all residential units), then the entity seeking cover (usually a business landlord or body corporate) would probably have to request more detailed information from its unit owners at policy application/inception and at renewal time.

This could create problems since Body Corporates administering these policies[1] may not be able to otherwise answer the detailed questions that would be required, and the time and cost insurers

[1] Particularly for large buildings with numerous residents and/or buildings where residents may change over time.

would need to spend administering the policy[2] would also be increased with such costs ultimately being passed on to customers.

Another example is home (and potentially contents as well) insurance for a holiday home that is used for short-term paying guests and not used by the owner[3]. The policy is for domestic purposes given it covers a residence, but it protects the insured's commercial rather than personal assets.

The nature of any uncertainty will in some cases depend on whether the test is subjective or modified to objective as we recommend. Nonetheless in either case some uncertainty could remain and ICNZ would like to engage with MBIE and the FMA on how this is best resolved.

Duty of utmost good faith

6. Do you have any feedback on Proposals 3 or 4? Do you have any comments on specific matters that we should bear in mind when drafting these provisions?

Summary view on the proposal

- ICNZ continues to recommend that the duty is not codified in legislation at all (oppose Proposal 3).
- Since the 2019 Cabinet decision to codify, the duty has evolved in the New Zealand common law and, along with the creation of the wide ranging "fair conduct principle" under CoFI, we believe this makes a general fair treatment conduct duty unnecessary.
- MBIE's intent is to "confirm the common law position and help draw attention to the existence of the duty". The proposed draft bill would represent a fundamental shift from the state of common law in New Zealand and therefore would not align with MBIE's intent.
- If duty was to be codified (which we oppose), then the Bill should make it clear that the common law duty is simply being confirmed and that it continues to apply unaffected by the Bill.
- ICNZ administers the Fair Insurance Code under which ICNZ members commit to "act transparently and with integrity and utmost good faith towards you."[4]

The duty of utmost good faith under the Common Law

We note the draft Bill (clauses 59-60) provides that "A contract of insurance is a contract based on the utmost good faith" and that the consultation paper states that:

> *"Under the common law, both parties to an insurance contract must act with the utmost good faith. The requirement is a fundamental principle of insurance contract law. However, many policyholders are unaware of its existence."*

In insurance, the duty of good faith bookends the insurance contract at two stages. First, its formation where full disclosure is required to identify the nature and extent of the risks to be covered, and the costs in doing so. Second, where any claim is made or notified to the insurer, for much the same reasons, to identify any issues regarding indemnity and then to know the nature and extent of any potential liabilities.

[2] Across the life of a policy – from initial information collection, through renewals, and in cases of claims being made. Difficulties in information collection could also lead to situations where a "valid dispute" arises in a claims assessment.

[3] Holiday rentals or AirBnB type residences.

[4] See page 3 of the Fair Insurance Code 2020, https://www.icnz.org.nz/individuals/about-the-code/ .

The duty also does not apply across the board to every aspect of the parties' dealings in connection with the contract, but rather the obligations owed are context specific: *Southern Response v Dodds* [2020] NZCA 395. There is also authority suggesting that the post-contract duty is one of "good faith" rather than "utmost good faith".

Proposal 3
Given the main purpose of the duty of utmost good faith has been related to the duty of disclosure, which the Bill will explicitly reform regarding consumers, then the purpose of codifying the duty is unclear. In substantially reforming the duty of disclosure, the ICB provides consumers with the necessary knowledge of their disclosure duties.

The duty of good faith is unsettled at common law. It is therefore questionable whether codifying the duty enhances knowledge of the duty or how it applies.

The common law in this area is evolving. Historically, the duty of utmost good faith applied to the formation of an insurance contract and the claims process. It recognised the imbalance of information in favour of the customer about the subject matter of the insurance (the risks being insured) and the details of claims, where the insurer relies on the customer's honesty. The 'rights' of customers are created in the contract of insurance itself and are protected and enforced under the normal law of contract.

At present, the only case in NZ which purported to extend expand duty was *Young v Tower Insurance Ltd [2016] NZHC 2956* by Justice Gendall, along with subsequent decisions (mainly from the same justice) and the Canterbury Earthquakes Insurance Disputes Tribunal.

The only case at appellate level (post *Young v Tower*) to consider whether a broader duty of good faith existed was *Southern Response v Dodd*, where the court per Justice Goddard rejected the notion of a broader duty of good faith and opined that 'good faith' only applied at specific touch points in the relationship and establishing an amorphous concept of Good Faith across all dealings between the parties was not appropriate.

In the *Dodd* decision, which was released on 7 September 2020, the Court noted at [194]:

> *"We would however observe that it does not follow from the fact that a contract of insurance can be described as a contract of good faith that there is an implied term of good faith in every insurance contract, that applies across the board to all aspects of the parties' dealings in connection with the contract. To the contrary, the authorities suggest that the obligations that one party owes the other are context-specific. For example, an insured must not act dishonestly in connection with the making of a claim. We consider that it is likely to be more productive to consider what obligations are implied by law, or can be implied as a matter of fact, in relation to particular aspects of the dealings between the parties. That was the approach recently adopted by this Court in Taylor v Asteron Life Ltd."*

It would be unhelpful for the Court to have Parliament interfere with the evolution of the law by attempting to codify a first instance decision, when doing so would contradict the appellate court's view. Adding that "*applies in respect of any matter in relation to the insurance contract*' doesn't codify the law, it changes it as this is contrary to the express views of the Court of Appeal in *Southern Response v Dodd* and *Taylor v Asteron Life*. Therefore, if the intention of codifying the duty is intended to provide greater visibility for how it applies to the insurer after contract formation, that is a problematic objective because the scope of the duty is unresolved.

If the duty is articulated in legislation, the drafting must make it clear that the legislation is just restating and not adding to the common law duty. If the ICB simply clarifies that it is a mutual duty owed by insurers and policy holders, then it is simply restating the position at common law.

The duty as expressed in the bill would also lead to uncertainty as to how far the duty extends. Insurers will face difficulty in defining and pricing risk. For example, could the duty result in an insurer unable to rely on policy exclusions, even despite the existence of section 11 of the Insurance Law Reform Act 1985 (see cl 71 of the draft bill)? Express contract terms requiring parties to act in good faith have been held unenforceable for uncertainty.

We note that CoFI (section 446C(2)(b)) has a requirement to act in good faith, so there is potential for uncertainty and confusion if there is also a good faith provision in the ICB.

Proposal 4:
We disagree with Proposal 4 and do not consider the legislation should say the duty applies in respect of any matter in relation to the insurance contract. This is vague and broad and creates uncertainty including as to whether the scope of the duty in the Act is intended to extend the common law position.

For example, would this extend to pricing or decisions around terms that are imposed? What if it conflicts with existing legislation or established law? An example of this latter point is that this could be taken to modify the current rule that the duty of utmost good faith applies until proceedings are issued, at which point this is overtaken by the rules of the Court.

The uncertainty also means there is potential for insurers, customers, financial dispute resolution service providers such as the IFSO and the FMA (as regulator of insurance contract law) to interpret this differently.

If such a provision were to be included in legislation, it would need to be drafted in a way that reflects the current duty rather than expands it.

The Australian position
The equivalent provision in the Australian Insurance Contracts Act 1984 has led to uncertainty as to how far the duty extends (for example, does it extend to promotional material before the contract is entered into?).

It is undesirable to create such uncertainty here – for example, as we ask above, could the duty be applied to pricing decisions, or the imposition of exclusions or conditions for specific risks. The Australian Act contains provisions in relation to the duty of utmost good faith that in some cases may be taken to go further than the NZ Bill. Therefore, although the proposed provision may be appropriate in the context of the Australian Act it is not appropriate and will only create uncertainty if included in the NZ Bill.

Again, if the duty is to remain in the Bill (which is opposed), the Bill should make it clear that the common law duty is being confirmed and that it continues to apply unaffected by the Bill. This would be consistent with the purpose of codifying the duty as expressed in the Regulatory Impact Statement.

Late payment duty
7. As in the UK, we propose that parties can contract out of the provision for non-consumer insurance contracts, but not for consumer insurance contracts. Do you agree with this proposal?
As outlined below in response to Question 10 – we do not consider the introduction of a late payment duty is required. If it is progressed, we consider the provision should only apply to consumer contracts and not to non-consumer contracts (there should be no need to contract out for non-consumer contracts).
8. We are considering whether the UK exception that applies when an insurer has 'reasonable grounds for disputing a claim' should be included and note that this may reduce the effectiveness of the duty. Do you have any views on this?
The exception for when an insurer has 'reasonable grounds for disputing a claim' should be included. In *Young v Tower*[5], the Court expressly stated that an insurer will not breach this implied term by failing to pay a claim during a dispute (provided there are reasonable grounds for that dispute). We do not think this reduces the effectiveness of the duty but rather is practical and necessary to mitigate the risk of baseless proceedings for breach of this provision in circumstances where an insurer has valid grounds not to accept or pay a claim promptly, and of incentivising disputes to be drawn out so that insureds may then seek damages for breach of this provision. Without this exception, the duty would not otherwise be suited to the situation where a claim is accepted, but there is a dispute over the extent of the policyholder's entitlements. Often there is a genuine dispute about the policyholder's entitlements, both factually (for example, a dispute over the extent of the policyholder's loss) or legally (such as an interpretation of policy entitlements). The insurer should not be penalised for pursuing genuine disputes.
9. We are considering providing that whether the insurer has paid the claim in a reasonable time may take into account whether it has paid part of the claim even if other parts of the claim are still being assessed or are in dispute. Do you have any feedback on this?
Yes, whether an insurer has paid part of the claim should be taken into account, even if other parts of the claim are still being assessed or are in dispute. As noted below, we consider a number of other factors should also be taken into account when considering whether the insurer has paid the claim in a reasonable time. This would be logical should the duty be progressed.
10. Do you have any other feedback on Proposal 5?
The UK legal situation is different. One of the legal fictions of insurance law (at least in England & Wales) is that an insurer has an obligation to prevent the peril insured against from occurring (known as the "hold harmless" principle). The insurer is deemed to be in breach of the insurance contract upon the occurrence of the insured peril and the insured has an immediate right to receive the indemnity. As a result, claims payments themselves are considered to be damages for breach of contract by an insurer and English law does not allow damages for late payment of damages (*The President of India v Lips Maritime Corporation (The Lips)* [1988] AC 395). The only claim that an insured has is for interest on the late payment.

[5] **Young v Tower Insurance** Ltd [2016] NZHC 2956.

The "hold harmless" principle was out of step with English contractual law generally: under ordinary contractual principles, where one party suffers loss because the other party has failed to meet its contractual obligations, the innocent party may claim damages for foreseeable losses suffered (*Hadley v Baxendale*). It was therefore necessary to remove this defect in the English common law through legislation.

To the extent that the "hold harmless" principle applies in New Zealand (and there are indications that it might not), New Zealand courts have the power under section 2 of the Money claims Act 2016 to award a "compensatory lump sum" if a customer can demonstrate that their loss of use of the claim payment exceeds a creditor interest rate. Further statutory intervention is, therefore, unnecessary in New Zealand.

No need for the proposed duty

The proposal seems to suggest that a breach of the late payment duty would be argued in some form of proceedings, which no doubt would seek to litigate the merits of the claim. However, customers who commence civil proceedings against an insurer for non-payment, or wrongful delay of payment, of a claim *already have* statutory rights that recognise their 'loss of use' of the money. This is in the form of interest under the Interest on Money Claims Act 2016.

The purpose of the IMC Act in section 2 is instructive:

> "***Primary purpose***
>
> (1) The primary purpose of this Act is to provide for the award of interest **as compensation for a delay in the payment of debts, damages, and other money claims** in respect of which civil proceedings are commenced.
>
> (2) **That purpose is to be achieved by the award of interest** in accordance with the following principles:
>
> (a)interest is to be awarded on all money claims except those expressly excluded by this Act:
>
> (b) interest is to be paid from the day on which the money claim is quantified until the day of payment:
>
> (c) the interest rate to be used for the purposes of this Act is to reflect fairly and realistically the cost to a creditor of the delay in payment of a money claim by a debtor and, in particular, —
>
> (i) the rate is to be capable of fluctuating in accordance with changes in the retail 6-month term deposit rate published by the Reserve Bank of New Zealand; and
>
> (ii) interest is to be compounded so that it yields the per annum simple interest rate over the period of a year; and
>
> (iii) interest is to be calculated using a calculator that is publicly available on an Internet site maintained by or on behalf of the Ministry:
>
> (d) in special circumstances, a court is to have power to award any interest or compensatory lump sum it may direct, or make no award." [*emphasis added*]

Customers already have the ability "in special circumstances" to receive a "compensatory lump sum". This would apply if a customer could demonstrate that their loss of use of the claim payment exceeded a creditor interest rate. For example, if a homeowner was forced to sell an income earning asset to meet repair costs and lost earnings which exceed the 'creditor interest formula' they have recourse in this Act already.

There is no reason to single out and penalise Insurers as defendants in damages claims in this way. Why not apply this to all financial services and professional service providers that attract money claims, including for instance banks, escrow agents, estate trustees who caused the same type of loss resulting from wrongful delays in payment? In which case, any "reform" by statute should be made within the Interest on Money Claims Act.

If the proposal is adopted

We have concerns with this proposal due to the uncertainty around what 'reasonable time' means. We note that MBIE has not proposed specific wording at this stage. If MBIE were determined to include this provision, then it should include the qualifications on this duty set out in *Young v Tower*. We suggest that the provision be expressed along the following lines:

> Insurers must accept (or reject), assess and pay claims within a reasonable time. When determining whether an insurer has met this obligation regard must be had to all the circumstances including but not limited to the following factors:
> a) The time required to properly investigate and assess all aspects of the claim.
> b) The type of insurance policy.
> c) The size and complexity of the claim.
> d) If the claim arises from a large-scale event.
> e) If the claim arises from one event where there are a number of events within a short timeframe.
> f) If the insurer is acting as agent for Toka Tū Ake EQC in respect of a natural disaster.
> g) Factors outside of the insurer's control.

Insurers wish to note that acceptance of claims may take some time and may occur almost simultaneously with payment where claims are complex and require detailed investigation and assessment of the facts and their impact on the policy response. So, the provision should not assume that acceptance will occur significantly in advance of payment.

We note that MBIE expects the provision would be flexible enough to take into account that insurers may be dealing with a large number of claims after large-scale events. It is important to recognise that:

- dealing with claims for large-scale events can take a prolonged period, particularly when there is more than one event within a short time frame, such as the Auckland floods and Cyclone Gabrielle.
- a large-scale event causes processing backlogs on all claims, even those outside of the affected region. This is because it takes time to scale resources and so the same people dealing with large-scale event are also dealing with claims in other parts of NZ.
- suppliers across NZ may divert resources (e.g., builders) to the affected region meaning there are less resources in other parts of NZ to carry out reinstatement.
- after large-scale events there are issues with the land underlying the properties that can mean that properties can't be accessed (e.g. landslip safety issues), are impacted by land damage to other properties that slow settlement (e.g., landslips above or below), or are subject to some sort of area wide land reclassification or retreat (E.g. Christchurch red zone or Category in Hawke's Bay following Cyclone Gabrielle) that takes time to resolve. All these can significantly delay access to the property and/or create uncertainty around whether a damaged property can or should be repaired.
- the nature of the EQC scheme means that if a claim could be addressed under the EQC scheme for a prolonged period before going over-cap and then becoming a claim under the private insurance policy directly. This was a major issue following the Canterbury earthquakes and while this has been reduced by insurer's now managing EQC claims as its agent which

gives them better visibility of potential future claims, this is nonetheless a New Zealand specific dynamic that needs to be considered.

Protracted settlement is generally the result of several different factors, and the 'reasonable grounds for dispute' exception might not arise until well into the life of the claim (e.g., difficulty contacting the insured/unavailability of specialist assessment resources/assessment of complex repairs could mean that the claim is not fully assessed for some months). How might those earlier delays be considered if the 'reasonable grounds for dispute' exception did not apply during that time?

We note the ICNZ's *Fair Insurance Code*[6] already sets out timeframes for claims handling and CoFI also places new obligations on insurers including to act ethically and in good faith when handling a claim. CoFI specifically allows for prescribing additional requirements for dealing with insurance claims (s546(1)(0a)(v)). This mechanism would be more appropriate for implementing provisions relating to late payment of a claim if it is considered necessary after the regime has had time to embed.

Where insurers are acting as EQC's agent pursuant to the Natural Disaster Response Agreement they are required to follow EQC's process and requirements, which may cause delay. Insurers should not be exposed to the risk of claims for such delays that are outside of their control.

It is important to note that insurers already have a financial incentive to pay claims as quickly as possible including because unpaid claims liabilities must be expressly provided for in an insurer's finances and for solvency purposes as a contingency, and because delays may create an exposure to inflation in repair or remediation costs.

There is a risk that a situation may be created whereby insurers essentially are expected to manage matters beyond the scope of insurance (indemnifying customers for loss) and related in the supply chain. This would likely cause higher costs that need to be passed on to the customer or may lead to policy changes that have different outcomes where, for example, cash settlement is the only outcome. Or the market might be disrupted by insurers moving to resolve supply chain disruptions and ending up so that only insurance work (rather than private work) is prioritised by certain industries.

Time limits under claims-made liability policies

Summary view on the proposal:

- Proposal 6 is supported but Proposal 6A appears unnecessary.
- We do not support Proposal 7. A grace period of 30 days is considered normal, while 60 days is long, and 90 days is unusually long.
- On numerous occasions, insurers have had to accept "late reported" claims. This is something the market has simply had to accept for many years, as identified by the Law Commission back in 1998. While there is no register of these sorts of claims, some insurers have indicated they could provide MBIE with data on this. It was not possible to provide with this submission given the short timeframe for response.

[6] https://www.icnz.org.nz/individuals/about-the-code/

11. Can you provide any examples where relevant circumstances have been notified late? We would like to better understand why it was considered those circumstances should have been notified earlier, and why they were not.
We are advised by members that many of them regularly receive late notification. There is low imperative for notification to be timely is under the current law. Again, examples can be provided with more time.
12. Do you have any feedback on Proposal 6 or 6A? Which do you prefer?
We have a strong preference for Proposal 6, and we suggest that "circumstances" should be defined based on the policy wording rather than attempting the difficult task of defining this in legislation. Proposal 6A would create awkward situations as it is too narrow and would not address the reasons for why the current law needs to be changed. That is, it would still mean that insurers cannot know their risk exposure under expired claims-made policies with certainty. Proposal 6A would not cover off the vast majority of situations in which insurers need to know about the reasonable likelihood of a demand or litigation. It also does not reflect the position under standard policy conditions that require notification if anything happens that might lead to a claim. It could be quite complex to clearly define a demand. It is rare for formal court proceedings to be first step in a claim or dispute. Allegations usually come first, possibly through communications from the aggrieved party to the policy holder. Someone being "not happy" is not a circumstance, but "I'm going to sue you" might be. As such, the practice has developed by which insurers require notification of a 'circumstance' (that might then lead to a legitimate claim or proceeding).
13. Do you have any feedback on Proposal 7?
In terms of timing, 90 days is very generous compared with the rest of the world. A grace period of 30 days is normal, with 60 days being considered long, and with 90 days being very long, unusual in fact. We would like to hear from MBIE whether it still plans to requirement notifying policyholders in writing no later than 14 days after end of the policy term? ICNZ has previously proposed drafting changes to cl 69(2) to make this more workable in practice, which should be adopted. Separate notice after renewal would be complicated as such interaction may not generally done by the insurer but rather by the broker.
Brokers holding premium money
Summary views on the proposal: In previous ICNZ submissions, we have supported the overarching proposition that money is passed on as soon as possible, as this would makes the insurance system more efficient overall by reducing the costs associated with delayed payments, including where government levy payments (FENZ and EQC) are due for insurers before the monies have been received by the insurer. We would welcome MBIE considering this matter further because current long payment terms are financially inefficient and create additional payment risks, which increases the costs of providing insurance in NZ. It also requires the transfer of (EQC/FENZ) levy payments to be lengthened consequentially to align with these.

The test of "as soon as practicable" is supported in principle, but we would note there is a need to identify a specific period for payment (otherwise, as noted by MBIE, the agreed payment terms can be too long).

In terms of specific periods, we would suggest that the optimal situation for efficiency would be as we have suggested in previous submissions: "such as within 20 days of the end of the month following receipt of the money from the policyholder". This would align with standard commercial practice in most sectors of the economy.

However, if the 20th of the following month was considered too short a period to be practicable for brokers, then an alternative could be to specify that the current period provided in the *IIA 1994* could be provided as the maximum date: "50 days after the end of the month in which the cover provided by the insurer under the contract commences to have effect"[7].

Once a specific date was determined, it would be appropriate to then align the statutory payment periods for EQC and FENZ Levies as necessary.

The ability for parties to contract has led to very long payment terms that are out of step for normal commercial practice and payment systems, which suggests a legislative requirement might be appropriate to shorten the periods while maintaining some flexibility. It is recognised that competition law would prevent this being agreed within the sector, hence, the role for regulation should government want to see more financially efficient arrangements implemented in the sector.

Separately, there is limited oversight of the use of the funds that have been paid by customers to brokers but have yet to be paid to insurers. Delayed payment also increases risks related to matters such as conduct and bankruptcy, and insurers currently must pay the FENZ and EQC levies before receiving the relevant premium from the intermediary. All this adds unnecessary cost and risk to the distribution of insurance in New Zealand and, given approximately half of premiums are paid through intermediaries, this is an important issue.

The holding of premiums should therefore also be brought into line with the regulatory oversight approaches that are taken to other situations where monies are held by intermediaries for other parties.

14. The proposed approach is that the starting position is for premium money to be passed onto insurers as soon as reasonably practicable. Do you think this is workable? Why or why not?

The intent of the framing of 'as soon as reasonably practicable' is supported but it would create too much uncertainty for both brokers and insurers. We consider a maximum time limit should be imposed on this; for example, 'as soon as reasonably practicable and no later than 20 days after the end of the month following receipt of the money from the policyholder'.

14A: Do you think the Bill should provide that interest is payable on late transfers instead of civil liability? Is this workable if a set period for transferring the funds is no longer specified?

No comment at this time.

[7] See definition of 'relevant period' in s8(2)(a) of the *Insurance Intermediaries Act 1994.*

15. Do you agree that the ability for parties to contract out and agree another timeframe should be retained? Why or why not?
Yes, the ability for parties to contract out and agree another timeframe should be retained. As noted above in the summary view of this proposal, it may be appropriate for there to be a legislative parameter to those timeframes.
16. Do you have any other feedback on Proposal 8?
None.
Interest payable from 91st day after death
17. Do you have any feedback on the proposals?
No comments, not relevant to general insurance.
18. What rates of interest are insurers able to earn while they process death claims? Does the rate of interest change once the insurer is notified of the death?
No comments, not relevant to general insurance.

Thank you for the opportunity to submit on this further consultation with respect to the Insurance Contracts Bill.

Please contact Greig Epps (greig@icnz.org.nz) if you have any questions on our submission or require further information.

Yours sincerely,

Greig Epps
Regulatory Affairs Manager