Cover to Cover

NEW ZEALAND'S INSURANCE MARKET MAGAZINE

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Welcome to the first issue of Cover to Cover for 2019

Welcome to our first edition of Cover to Cover for 2019.

In this edition, we focus on the two most important reviews of the insurance industry in Australasia in recent times.

First, the Financial Markets Authority and the Reserve Bank of New Zealand released their Life Insurer Conduct and Culture Report. The report sets out findings from the regulators' review of the conduct and culture of 16 New Zealand life insurers and represents the second phase in their review of the financial services industry. We examine the key findings and share our views on the report recommendations.

The final report of the Australian Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry has also been released. It is the culmination of more than 12 months of intensive scrutiny and analysis of the conduct and culture of Australia's financial services sector. We discuss implications for the New Zealand insurance industry.

We also provide a brief update on the latest New Zealand regulatory developments affecting the insurance sector, following our regulatory update in Issue 15 of Cover to Cover.

This edition also includes case law updates, with reports on a recent earthquake case and a class-action decision where the High Court made orders permitting two policyholders to bring a class action against government-owned, Southern Response. We also discuss developments to the duty of disclosure.

We also introduce our new co-editor, Olivia de Pont. Olivia joined us in June 2018 and is a Senior Associate in our Dispute Resolution team. She has previously worked for another national New Zealand law firm and a boutique litigation firm, and specialises in insurance law.

We hope you enjoy this issue of Cover to Cover. If you have any suggestions on how we can improve the publication or topics you would like us to cover, please email us at covertocover@minterellison.co.nz

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FMA/RBNZ Life Insurer Conduct and Culture Report

Following our regulatory update in our October 2018 edition of Cover to Cover, we provide a brief update on the latest regulatory developments affecting the insurance sector.

Life Insurers given 30 June deadline to address regulator feedback

The Financial Markets Authority and the Reserve Bank of New Zealand released their Life Insurer Conduct and Culture Report on 29 January 2019 (**Life Insurer Report**)[1]. The Life Insurer Report sets out findings from the regulators' review of the conduct and culture of sixteen New Zealand life insurers and represents the second phase in their review of the financial services industry.

As widely predicted, the Life Insurer Report is much more critical of the life insurance sector than the regulators' November 2018 Report on the Banking Sector (**Banking Report**). The Life Insurer Report found *"extensive weaknesses in life insurers' systems and controls"* [2], including weak governance and management of conduct risks and a lack of focus on good customer outcomes. The regulators also make it clear that, while life insurers were prioritised for the review, *"all insurance sectors should be actively considering conduct risk within their business"*.

Although the regulators conclude that they would not currently categorise instances of poor conduct and potential misconduct as widespread (and issues similar to those highlighted in the Australian Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (**ARC**) are considered to be on a *"much smaller scale"*), in line with the extent of the issues identified, the regulators have set out explicit guidance on the matters they expect life insurers to address. There is a clear expectation that life insurers will consider and act on all relevant recommendations made in the Life Insurer Report.

Key findings in the Life Insurance Report

The Life Insurer Report makes the following key findings:

Insufficient systems, controls and policies

- There are "extensive" weaknesses in life insurers' systems and controls.
- There was a lack of analysis of the systems, processes and controls in place against the matters highlighted by the ARC and related investigations. Insurers' confidence that the issues identified by the ARC would not occur here is "misplaced".
- While most insurers had a whistleblower policy, these did not always provide an anonymous, confidential and independent channel for raising concerns. The policies were not always well-known and were infrequently used (although the regulators noted that staff across most insurers indicated that they would be comfortable raising an issue).

Conduct risk

- Life insurers have been complacent in addressing conduct risk, too slow to implement changes following FMA reviews and insufficiently focussed on developing a culture to balance shareholders' and customers' interests.
- There were instances of poor conduct and potential misconduct (albeit these were relatively few). However, there is a serious risk of further conduct issues arising in the future. The regulators saw evidence of insurers' sales incentives structures creating risks that sales would be prioritised over customer outcomes.
- Reporting on conduct risk was limited and often focussed on 'lag' indicators such as complaints. Conduct risk management was insufficiently integrated and risk management functions were frequently resourced too thinly. The processes and systems for customer complaints and incident management were generally under-resourced and inconsistently used. The regulators observed that they cannot be confident that life insurers are aware of all current issues.
- Remediation of conduct issues has been poor with insurers' responses being slow or insufficient (with insufficient systems to monitor and manage remediation). In some extreme cases there was a complete lack of interest in remediation at all.
- Until the review, few life insurers had seriously considered conduct and culture issues. Boards and senior management were not setting the tone to manage these issues and prioritise good customer outcomes. The Report expressed some concern that the boards of insurers which were part of a bank or a foreign-owned insurer were not sufficiently independent.

Product design and training

- The Regulators saw limited evidence of products being designed (and sold) with good customer outcomes in mind, as well as a varied approach to ongoing contact to monitor the continued suitability of products. There were limited policies to deal with potentially vulnerable customers.
- Training on products, sales, and advice was generally under-resourced and under-prioritised. In particular, training for intermediaries was inadequate and there was little evidence of training on conduct expectations.

Intermediaries

- In situations where sales and advice were provided through an intermediary, the regulators found a lack of oversight and responsibility for the sales, advice, and customer outcomes.
- As provided above, training for intermediaries was considered inadequate and there was little evidence of training on conduct expectations.

The regulators observed that *"consumer trust is paramount to the effective functioning of the life insurance industry in New Zealand. We are concerned that this trust could be eroded unless life insurers – led by boards and senior management – transform the way they approach conduct risks and issues, and achieve a customer-focused culture."* [3]

Recommendations for Insurers

In line with the extent of the issues identified by the Report (for which an overview is provided above), the regulators have been more prescriptive in their requirements of the sector, providing clear direction on the matters that need to be addressed and by when (30 June 2019). The Life Insurer Report identifies a number of areas for life insurers to make substantial improvement in order to identify, manage, remediate and report on conduct and risk issues and to deliver consistently good customer outcomes, including:

The role of Boards

- Boards need to take responsibility for setting the tone from the top, with a focus on good customer outcomes, by having a clear plan for change that sets targets, assigns responsibility, includes milestones and ensures information flows to all parts of the organisations.

Oversight of intermediaries

- Insurers need greater oversight of how intermediaries are selling and managing their products. Both insurers and intermediaries need to be responsible for ensuring good customer outcomes, but the insurer remains ultimately responsible for this.

Product design, training and support

- New products should be designed to provide good customer outcomes. Target markets and intended outcomes for products need to be clearly identified.
- Staff need to receive ongoing comprehensive training on the products they sell and support.
- Insurers need to proactively and regularly communicate with their customers and encourage customers to consider whether their needs have changed and whether the product remains suitable for them.

Policies and processes

- Risk management processes need to be appropriate and incorporate all material risks, including the monitoring and management of conduct risk, and the review of advice provided at point of sale and over time.
- Insurers must have a relevant code of conduct, educate staff on good conduct, and have clear policies, processes and training for identifying and dealing with vulnerable customers.
- Insurers need to have an accessible, confidential and independent whistleblower process.

Identification and remediation of issues

- Insurers need appropriate and sufficiently resourced systems and processes to record and resolve customer complaints and incidents and to proactively identify and resolve issues.

Incentives

- Insurers are expected to remove or substantially revise incentives linked to sales for sales staff and all layers

of management no later than the first performance year after 31 December 2019, and, if not removed, to be able to explain to the regulators by 30 June 2019 how control systems will be strengthened to mitigate conflicts of interest and risk to customers.

- Insurers are also expected to review commission structures for intermediaries and change their qualifying criteria for soft commissions to ensure they are incentivising the delivery of good customer outcomes.

Recommendations to Government

The Life Insurer Report also makes a number of recommendations to Government for strengthening the regulatory framework governing conduct in the life insurance sector (and by implication, the general insurance sector as well).

The Life Insurer Report notes (among other things) that:

- While the review has not identified any notable regulatory gaps from a prudential perspective, there would be benefit in progressing some of the enhancements being considered under the Insurance (Prudential Supervision) Act 2010 (IPSA) review.
- The RBNZ, the FMA and the Commerce Commission each regulate parts of the wider insurance industry, but no regulator has oversight of insurers' and intermediaries' conduct over the entire insurance policy lifecycle.
- Given the similarities in the nature of the regulatory gaps identified as part of the Banking Report, the drivers of risk and the benefits of having consistent frameworks across regulated industries, these areas may be equally relevant to life insurance. The regulators suggest that the Government consider:
    - establishing basic duties on life insurers to protect and enhance customer interests and outcomes (regardless of the distribution channel)
    - requiring life insurers to have adequate systems and controls to govern, manage conduct risk, and remediate issues, in all distribution channels, and through the life insurance product lifecycle
    - reviewing whether the regulators have sufficient supervision and enforcement powers and resources to ensure life insurers meet these obligations, including requiring better information on conduct issues or risks, and the option of penalties to incentivise appropriate behaviour
    - clarifying accountability and individual responsibility for management of misconduct, including the potential for direct liability for senior managers

Government Response

Immediately after the Life Insurer Report was released, the Ministers of Finance, Commerce and Consumer Affairs advised that the Government will fast-track legislation to address the consumer protection issues highlighted in the Life Insurer Report.[4]

The proposed changes will promote:

- clearer duties on banks and insurers to consider a customer's interests and outcomes, and to treat customers fairly
- an appropriately resourced regulator to monitor the conduct of banks and insurance companies, with strong penalties for breaching duties
- changes to both banking and insurance regulation, as the issues identified in both are similar. There are also overlaps between the sectors, with banks also selling insurance products
- a strong response to internal sales incentives and soft commissions

While the scope of the legislative changes has not been explained in detail, Cabinet has specifically agreed "to get rid of sales incentives in the insurance industry that are driving behaviour that is not in the best interest of consumers". A consultation paper will be released in May and legislation will be introduced later this year. This will run parallel to the review of insurance contract law, with the intention that both bills will be in Parliament by mid-2020.

Our view

The regulation of the insurance sector (both life and health, and general) has been under intense scrutiny over the past two years. This follows the IMF/World Bank releasing the 2017 regulatory assessment of New Zealand's financial system, which identified a number of gaps in our regulatory framework, including a lack of conduct regulation of the insurance industry.

In addition, through several thematic reviews and discussion documents, the FMA has been critical of the heavy reliance by some life and health insurers on commission-based sales structures and the potential harm that these can cause to customers. The FMA has signalled the need for the sector to make significant changes to the way in which insurance products are marketed and sold, through to the way in which claims are managed, requiring a more customer-centric approach than exists currently.

What is already being done?

Many insurers are already moving to address some of these concerns. A number of life insurers last year voluntarily abolished the use of soft commissions following the findings of the FMA in its May 2018 report on conflicted remuneration in the life insurance industry. In addition, the Financial Services Council (whose members include 95% of the life insurance market in New Zealand) introduced a new code of conduct (Code) for its members on 1 January this year. The Code covers ethical, communication and consumer outcomes which are designed to complement existing regulation and laws. A breach of the Code can result in fines of up to $100,000 or termination of membership.

However, despite these initiatives, the regulators have continued to be vocal in their concern about their findings of conflicted conduct in the life insurance sector and inadequate attention paid to customer needs identified in the various thematic reviews. It therefore must come as no surprise that the Life Insurer Report is critical that more and faster change in the sector has not yet occurred, and that the requirements for change in the sector are more prescriptive than those in the Banking Report.

Regulatory gaps

The themes emerging from the Life Insurer Report will likely be reflected in important policy decisions in connection with the review of insurance contract law and conduct currently being undertaken by MBIE, and the review of IPSA being undertaken by RBNZ.

This has already been confirmed by the announcement that the Government will fast-track legislation to address the issues identified in the Life Insurer Report (and the Banking Report that preceded it), including a ban on conflicted sales incentives.

This demonstrates the importance placed by Government on ensuring that consumer interests are adequately protected by regulation both in the wider insurance and banking sectors.

The RBNZ has also indicated that it will be discussing its newly established Relationship Charter for working effectively with banks with insurers in the first quarter of 2019. The Relationship Charter *"commits the Bank and the financial sector to a mutual understanding of appropriate conduct and culture".*[5] Along with the underlying principle of the Charter (expressed by RBNZ Governor Adrian Orr as the principle "'te hunga tiaki', the combined stewardship of an efficient system for the benefit of all"), this may suggest that the RBNZ is keen to work with the insurance sector to ensure a mutual understanding of appropriate conduct and culture across the financial services industry.

In the meantime, the imminent changes to financial advice regulation (to be introduced by the Financial Services Legislation Amendment Bill) will go some way to address the Regulators' concerns around the mis-selling of insurance products and insurance churn, but will not be sufficient to address the deeper concerns expressed around insurer responsibility for good customer outcomes.

The regulators' deadline of 30 June for life insurers to report on the measures taken and plans in place to remediate the poor conduct they have observed during their review, and the promise of Government-led regulation to enforce changes to the incentives-based sales structure of the insurance industry, will serve as an immediate incentive to insurers to make those changes ahead of the regulatory imperative to do so.

What next?

The regulators will be providing specific findings to all 16 life insurers by the end of February 2019 and will require them to report back and provide an action plan to address the feedback by 30 June 2019 (including how they will address incentives based on sales volumes for internal staff and commissions for intermediaries).

The insurers will also be required (among other things) to undertake a gap analysis against the ARC Report findings (released on 4 February 2019) against their own business structures and processes. The ARC Report is discussed in a separate article in this issue of Cover to Cover, and sets out a summary of the findings of the ARC in relation to insurance misconduct in Australia (an aspect not covered in the previous ARC Interim Report).

Conclusion

Although the Life Insurer Report focuses on life insurers, all participants in the insurance industry need to read the Life Insurer Report. The Regulators note that non-life insurers are also expected to assess their conduct and culture frameworks against the findings in the Life Insurer Report and consider and act on all relevant recommendations made by the Regulators.

The Boards and senior management of life insurers will also need to digest the Life Insurer Report's contents quickly, so that its key messages can be disseminated appropriately and any operational and cultural changes required to address the regulators' concerns are able to be put in place and reported on by the deadline of 30 June 2019.

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[1] https://fma.govt.nz/assets/Reports/_versions/12147/Life-Insurer-Conduct-and-Culture-019.1.pdf; [2] Refer page 5 of the Life Insurer Report; [3] Refer page 5 of the Life Insurer Report;
[4] See https://www.beehive.govt.nz/release/govt-act-protect-bank-insurance-consumers; [5] See https://www.rbnz.govt.nz/news/2018/12/reserve-bank-aims-for-best-regulatory-relationships

Report into Misconduct in the Banking, superannuation and Financial Services Industry

The Final Report of the Australian Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry (Hayne Commission) was released on 4 February 2019[1]. It is the culmination of more than 12 months of intensive scrutiny and analysis of the conduct and culture of Australia's financial services sector.

The Hayne Commission focussed on the life insurance and general insurance industries (not marine or health), alongside banking, financial advice and superannuation sectors. This focus was consistent with complaints made to the Hayne Commission and material provided by the Australian Securities and Investments Commission (**ASIC**) and the Financial Services Ombudsman, as well as with the misconduct and conduct falling below community expectation disclosed by insurer responses to the Hayne Commission's inquiries.

The Hayne Commission has already had an impact in New Zealand, being the trigger for the FMA and RBNZ report on life insurer conduct and culture released on 29 January 2019 (the **Life Insurer Report**). That is discussed in a separate article in this issue of Cover to Cover.

In this article, we look specifically at the findings of the Hayne Commission in the Final Report with regard to life and general insurance and consider how those findings may be relevant to the New Zealand insurance industry.

We conclude with a brief round-up of other over-arching themes in the Final Report that will have broad application across all financial services in Australia and, given the attention that is being paid to the Hayne Commission by the New Zealand regulators and government, in New Zealand as well.

Immediate Government Response

The Australian Government has already indicated that it will take action on all 76 recommendations in the Final Report.

The NZ Government has indicated that it will look closely at the Hayne Commission's recommendations to consider whether they should be implemented here in New Zealand.[2] The Ministers of Finance, Commerce and Consumer Affairs had already announced, following the release of the Life Insurance Report, that a consultation paper on proposed legislative changes to address regulatory gaps identified by the regulators would be released by May with legislation to be introduced later in 2019.[3]

The Ministers advised that they want to see:

- Clearer duties on insurers and banks to consider a customer's interests and outcomes, and to treat customers fairly.
- An appropriately resourced regulator to monitor the conduct of insurance companies and banks, with strong penalties for breaching duties.

- Changes applied to both insurance and banking, since the issues identified in both are similar, and there are industry overlaps.

In relation to financial advice in relation to life insurance, the Financial Services Legislation Bill (**FSLAB**) which is still before Parliament and the regulations yet to be made under it present other avenues for change. However, only minor changes are likely at this late stage, as the Government does not want to delay FSLAB coming into force before the next election due in late 2020.

Hayne Commission Insurance specific recommendations:

"Hawking" of insurance products:
The Hayne Commission recommends that "hawking" (unsolicited selling) of insurance products be banned.

It remains to be seen whether a similar ban will be imposed in New Zealand, but our view is that is unlikely – the use of uninvited selling techniques was not identified by the FMA and RBNZ as a significant issue in the New Zealand life insurance market and there are already a range of protections under the Fair Trading Act 1986 for consumers in relation to uninvited direct sales. These require insurers or brokers engaging in uninvited direct sales to give the customer a copy of the sales agreement (policy) with a clear description of what is being purchased and a summary of the customer's right to cancel within 5 working days and receive a full refund.

Looking to the future, however, if insurance conduct is brought within the remit of the FMA and insurance products are included in the definition of financial products under the Financial Markets Conduct Act 2013 (**FMCA**), the additional protections set out in the FMCA in relation to unsolicited offers of financial products would then apply.

Funeral expense insurance policies:
The Hayne Commission recommends that funeral expense insurance policies should be included in the definition of a financial product, bringing it under the oversight of the Australian Securities and Investments Commission (ASIC) and removing any doubt that the consumer protection provisions of the ASIC Act apply to such policies.

This recommendation has no direct equivalent in New Zealand because funeral expense insurance policies are treated for regulatory purposes in the same manner as other life insurance policies. The sale of insurance policies to retail consumers is subject to compliance with the Financial Advisers Act 2008, the Fair Trading Act 1986 and the Consumer Guarantees Act 1993, as well as the fair dealing provisions in Part 2 of the FMCA.

However, as indicated by the Government following the release of the Life Insurer Report, the regulatory gaps identified by the FMA and RBNZ with regard to the conduct of life and general insurance business more generally will be addressed as a matter of priority, potentially by the end of 2019.

A deferred sales model for add-on insurance and a cap on commissions: ***The Hayne Commission recommends that there should be an industry-wide deferred sales model for the sale of add-on insurance products and a cap on commissions that motor vehicle dealers can be paid for the sale of such insurance.***

In New Zealand, extended warranties are excluded from the definition of "insurance contract" in the Insurance (Prudential Supervision) Act 2010 (**IPSA**)). The definition of insurance contract is one of the matters to be considered as part of RBNZ's review of IPSA, which is currently on hold. Whether or not the sale of add-on insurance or extended warranties by motor vehicle dealers is regarded as problematic in New Zealand remains to be seen. However, the question of commission payments is likely to be addressed in New Zealand as part of a broader regulatory response to concerns around conflicted remuneration.

Pre-contractual disclosure and representations:
The Hayne Commission recommends that the Australian Insurance Contracts Act be amended in relation to consumer insurance contracts by replacing the duty of disclosure with a duty to take reasonable care not to make a misrepresentation to an insurer, and such that an insurer may only avoid a contract of life insurance on the basis of non-disclosure or misrepresentation if it can show it would not have entered into that contract on any terms.

The New Zealand Government has long signalled that the duty of disclosure, is not well understood by consumers and places consumers at unfair risk should they innocently fail to disclose relevant information to the insurer at policy inception or renewal. The duty of disclosure is one of a number of insurance contract law issues being considered by the Ministry of Business, Innovation and Employment (**MBIE**) in its review of insurance contract law. The recommendations of the Hayne Commission on this issue are therefore likely to be considered by MBIE when developing government policy to address this issue.

Unfair contract terms: ***The Hayne Commission recommends that the unfair contract terms set out in the ASIC Act should apply to insurance contracts and that the duty of utmost good faith set out in the Insurance Contracts Act should operate independently of the unfair contract terms provisions.***

MBIE is also considering, as part of the review of insurance contract law, whether insurance contracts should be made fully subject to the unfair contract terms provisions of the Fair Trading Act. It seems likely that the views of the Hayne Commission will also be taken into account in any final recommendations made by MBIE on this issue.

Claims handling: ***The Hayne Commission recommends that the handling and settlement of insurance claims should not be excluded from the definition of "financial service".***

This recommendation should not have any repercussions for New Zealand insurance business, because claims handling would be viewed as part of the financial service of "acting as an insurer" for the purposes of section 5(1)(m) of the Financial Service Providers (Registration and Dispute Resolution) Act 2008 (**FSP Act**). There is no equivalent exclusion of claims handling from the definition of 'financial service' in that Act.

Status of industry codes: ***The Hayne Commission recommends that the law be amended to provide for mandatory and enforceable industry codes. The Australian Life Insurance Code of Practice and the Australian General Insurance Code of Practice should be amended to empower the Life Code Compliance Committee or the Code Governance Committee to impose sanctions for breach of the applicable code.***

This recommendation could be one that the Government will look at either as part of the insurance contract law review or the fast-tracked legislation proposed to close the regulatory gaps identified in the Life Insurer Report. The Insurance Council of New Zealand's Fair Insurance Code (applying to member organisations' general insurance business) and the recently adopted Code of Conduct for members of the Financial Services Council (which includes 95% of New Zealand life insurers) both include sanctions for serious breach of the relevant Code by a member, including fines of up to $100,000. It remains to be seen, however, whether the Government would seek to make compliance with these codes (or variants of them) mandatory for all industry participants.

External dispute resolution: ***The Hayne Commission recommends that the law be amended to require Australian Financial Services licence holders to take reasonable steps to co-operate with the Australian Financial Complaints Authority in its resolution of disputes, including making available all relevant document and records.***

This recommendation is unlikely to have any impact in New Zealand because the FSP Act already requires registered financial service providers to be members of approved external dispute resolution schemes. The rules of those schemes would require that all relevant documents and records relating to disputes be provided.

BEAR (Banking Executive Accountability Regime): ***The Hayne Commission recommends that over time, provisions modelled on the BEAR be extended to all APRA-regulated insurers. (The BEAR, which came into force in 2018, is set out in Part IIAA of the Australian Banking Act and establishes accountability obligations for authorised deposit-taking institutions (ADIs) and their senior executives and directors. It also establishes deferred remuneration, key personnel and notification obligations for ADIs).***

In the banking sector, an existing concern of the CEOs of New Zealand subsidiaries of Australian banks is that they may be an "accountable person" under BEAR and have responsibilities under the Australian law for the CEO's actions running the subsidiary. A key question, in times of stress, will be the compatibility of the CEO's BEAR responsibilities with their NZ law responsibilities to act in the best interests of the subsidiary. When the BEAR is extended to cover Australian insurers, the CEOs of their NZ subsidiaries will have similar concerns.

We expect that the New Zealand Government will look closely at the principles underpinning the BEAR as a potential means to focus financial service firms' boards and senior management on their responsibility for modelling good conduct and culture, and ultimately as a measure of performance against their performance indicators (which may require revising in the light of the FMA/RBNZ conduct and culture reviews). It also remains to be considered whether a New Zealand equivalent to the BEAR legislation is appropriate.

Group life policies: ***The Hayne Commission recommends legislating universal key definitions and exclusions for default MySuper group life policies. It also recommends that the Australian Prudential Regulation Authority (APRA) should amend prudential standards to require RSE licensees (regulated superannuation funds and an approved deposit funds) that engage related parties to provide group life insurance or who enter into arrangements with a life insurer giving the life insurer a priority or privilege in connection with the provision of life insurance, to provide APRA with independent certification that the arrangements and policies entered into are in the best interests of members of the superannuation scheme. A recommendation is also made that APRA amend prudential standards to require RSE licensees to be satisfied that the status attributed to a member in connection with insurance is fair and reasonable.***

These recommendations may be viewed as particular to the Australian market because it is common for Australian superannuation schemes to include a group life insurance benefit. Such arrangements exist in New Zealand superannuation schemes but they are not common. The more likely take-out for New Zealand insurers is the importance placed on certification that group insurance provided to customers of one entity by a related entity are in the best interests of those members. Such a certification would go beyond the concepts embedded in the FMCA in relation to related party dealings between managers of superannuation schemes and other managed funds and their related entities requiring certification that such dealings are on arms-length commercial terms.

Other key themes of the Final Report

Twin Peaks Regulation: The Final Report reviews and recommends strengthening the existing "twin peaks" model of regulation, with APRA responsible for prudential supervision and ASIC for conduct supervision. One change recommended is a stronger focus by ASIC on using litigation as an enforcement tool over "soft enforcement" and use of enforceable undertakings.

The Hayne Commission findings highlight the lack of clarity in the New Zealand environment for supervision of conduct in insurance sector, with both the Commerce Commission and (to a lesser degree) the FMA having some responsibilities. New Zealand insurers (and banks) are not subject to conduct licencing. In our view it is likely that the NZ government will look at whether conduct licensing is appropriate for both life and general insurance and who should be the supervisor. The gaps in the regulation of insurers' and intermediaries' conduct was one of several issues highlighted in the IMF's FSAP Report in 2017.

Changing culture and governance:
A consistent theme through the Final Report is the need for boards and senior management to set the necessary tone from the top. The Hayne Commission recommends that all financial services firms should, as often as reasonably possible, take proper steps to assess their culture and its governance; identify any problems with that culture and governance; deal with those problems; and determine whether the changes it has made have been effective. In addition, the Hayne Commission notes that boards cannot operate properly without having the right information. And boards do not operate effectively if they do not challenge management.

These themes are similar to the themes arising from the FMA/RBNZ reports into conduct and culture in the banking and life insurance industries, and must be a key focus for boards and senior management to address in the immediate term, and continue to monitor.

Financial Advice and conflicted remuneration: The Hayne Commission makes a number of recommendations in relation to commission payments for financial advice, many of which are not directly relevant to New Zealand given that our financial advice regime differs from Australia's, which has had capped commissions and grandfathering of conflicted remuneration provisions in place for some years.

However, a key take-out from the financial advice recommendations is the view that conflicts of interest and duty cannot be "managed". Rather, they should not be permitted. This is most relevant with regard to commission based payments for insurance sales, with the Hayne Commission recommending that caps on commissions for life risk-insurance products should be reduced and ultimately set at zero, and all remaining conflicted remuneration exemptions should be reviewed with a view to banning them outright.

The fast-tracked legislation announced by the government following the release of the Life Insurer Report will likely seek to place some restrictions on commission payments, potentially following the Hayne Commission's lead.

VIOS: Despite criticism of the conflicts inherent in vertically integrated sales models, no recommendation has been made for such structures to change due to the cost and disruption that would follow. The Hayne Commission does however agree with the recommendation of the Australian Government Productivity Commission that the Australian Competition and Consumer Commission (the **ACCC**) 'should undertake 5 yearly market studies on the effect of vertical and horizontal integration in the financial system'. The FMA and RBNZ have been critical of vertically integrated organisations in both their banking report and insurance report. We expect that both regulators will keep a watching brief of the ACCC's market studies in this area.

Conclusion

The Final Report of the Hayne Commission, despite its stinging criticisms, is best embraced as a 'once in a lifetime' opportunity for Australian financial service providers to reset their moral compass and seek to regain customers' trust. The same is true for the financial services industry in New Zealand, where customers' trust is in a stronger position. By responding positively and proactively, the industry can avoid the worst of the difficult environment in which their Australian colleagues find themselves.

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Kara Daly
Special Counsel

[1] Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, https://financialservices.royalcommission.gov.au/Pages/reports.aspx [2] Press Release, "Australian Royal Commission findings concerning, but NZ moves to protect consumers already in train", 4 February 2019, https://www.beehive.govt.nz/release/australian-royal-commission-findings-concerning-nz-moves-protect-consumers-already-train [3] Press Release, "Govt to act to protect bank, insurance consumers " 29 January 2019, https://www.beehive.govt.nz/release/govt-act-protect-bank-insurance-consumers

Regulatory developments affecting the insurance sector

Following our regulatory update in our October 2018 edition of Cover to Cover, we provide a brief update on the latest regulatory developments affecting the insurance sector.

Financial Services Legislation Amendment Bill (FSLAB)

The FSLAB remains before the Committee of the Whole House for consideration and is expected to be progressed during the first quarter of 2019. However, it is possible that the passing of the legislation may be delayed if the Government wishes to use the FSLAB as one of the vehicles to address any of the regulatory gaps identified by the FMA and RBNZ in their reviews of bank and life insurance conduct and culture, or any of the recommendations of the Australian Royal Commission that the Government considers merit adoption in New Zealand.

On 13 December 2018, a discussion paper was released on the proposed financial advice provider transitional and full licensing fees and changes to the FMA levy that will apply in the new financial advice regime. To the extent an insurer provides regulated financial advice to retail clients, it will be required to be licensed as a financial advice provider.

The discussion paper proposes a flat transitional licence application fee, with additional fees charged for each authorised body included in a licence application and any later applications to vary licence conditions or add (or remove) an authorised body. The application fee for a full licence will depend on the size of the adviser business, the amount of authorised bodies named in the application and whether the business engages nominated representatives and/or financial advisers to provide financial advice services. A full licence applicant may also incur an additional hourly fee where the licence application is complex.

The FMA levy proposed is a base levy for each financial advice provider with additional amounts applicable where the financial advice provider gives advice on its own account or where it has nominated representatives. Financial advisers will also be required to pay the FMA levy separate from the financial advice provider.

Submissions on the discussion paper closed on 22 February 2019.

Amendments to the Fire and Emergency New Zealand Act 2017

On 7 November 2018, the Fire and Emergency New Zealand (Levy) Amendment Bill passed its first reading. The commencement date of the proposed changes to the levy system is likely to be brought back by one year, to 1 July 2020, with a backstop date of 1 July 2021. The bill is now before the Governance and Administration Committee with the report due back on 1 April 2019.

Audit requirements for insurer data returns

On 24 October 2018, RBNZ released their decisions after considering submissions on the consultation paper (October 2017) on audit requirements for insurer data returns. RBNZ has decided to defer the introduction of the audit requirement for the insurer return.

Updated Solvency Standards for Life and Non-life Insurance Business

The Solvency Standards for Life and Non-life Insurance Business were amended in 23 November 2018 to:

(a) include changes as a result of the new lease accounting standard NZ IFRS 16, including an additional change to the treatment of leases of intangible assets, with effect to reporting periods that begin on or after 1 January 2019;

(b) consolidate the non-life catastrophe risk charge loss return period within the Solvency Standard for Non-life Business 2014; and

(c) include the requirement that a licensed insurer engage an auditor to undertake a "reasonable assurance level audit" of the annual solvency return.

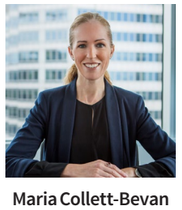
Review of insurance contract law and the Insurance (Prudential Supervision) Act 2010

At the date of this article, there are no new developments that we can report on with regard to the RBNZ's review of the Insurance (Prudential Supervision) Act 2010 (IPSA), or the review of insurance contract law being undertaken by the Ministry of Business Innovation and Employment. As noted in Issue 15, the RBNZ suspended active work on the IPSA review following a review of resourcing and priorities (although the deferment is to be regularly reviewed by the RBNZ).

Further, the progress of the insurance contract law review could now slow down, in order to take into account the findings of the FMA and RBNZ as part of their recent reviews of bank and life insurance conduct and culture.

The Government announced that it would fast track legislation to address the regulatory gaps identified by the regulators during these reviews. It also announced that it would look closely at the recommendations of the Hayne Commission in its final report, and whether any of those recommendations should also be adopted in New Zealand.

Jeremy Muir
Partner



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The duty of disclosure - will it be modernised at last?

A little over twenty years ago, the Law Commission published a paper with a title that hinted only vaguely at its contents: "Some Insurance Law Problems".[1] It examined five unrelated aspects of insurance law that were generally accepted as problematic, with the potential to produce unfair outcomes.[2]

The first issue discussed was the most problematic and contentious: an insured's duty to disclose material circumstances to an insurer. Then, as now, under New Zealand law an insured owed an insurer a duty to disclose circumstances that a reasonable insurer would regard as material to its decision to accept the risk insured.[3]

The Law Commission identified four problems with this approach:

- what the insured is obliged to disclose is uncertain
- an insured's honest ignorance of what it must disclose will not assist if it fails to make the necessary disclosure
- where an insurer asks specific questions of an insured, the insured still has a general duty of disclosure in addition to answering the insurer's questions
- a breach of the duty may have disproportionately harsh consequences for an insured, as the insurer is entitled to treat the policy as void from the outset even if it would have accepted the policy had it known the relevant facts (albeit on different terms, such as a higher premium).[4]

The Law Commission observed that non-disclosure issues

were one of the main reasons for complaints to the Insurance Ombudsman (now the Insurance and Financial Services Ombudsman). Reference was made to judgments in which the Courts had remarked upon the unfairness that resulted where insureds innocently failed to appreciate that circumstances outside the questions asked by the insurer, such as prior criminal convictions, were considered material by insurers.

The Law Commission discussed a number of possible reforms, including the following:

- limiting the duty of disclosure or changing what was considered material
- warning insureds of their duty more clearly
- requiring insurers to set out expressly what they required to know in questions (in effect, abolishing the duty and replacing it with an obligation to answer specific questions truthfully)
- limiting the consequences for insureds of getting it wrong

The proposals made were, in short, the following:

- insurers would have 10 working days in which to pose specific questions to the insured and have them answered - within this time period the insurer could cancel the policy from the outset if it did not find the answers acceptable
- only an inaccurate answer or "blameworthy" conduct would entitle an insurer to cancel a policy from the outset. "Blameworthy" was intended to mean circumstances where the insured knew, or a reasonable person in their position would have known, that the undisclosed circumstances would be material to an insurer

How the issue has been dealt with in the UK and Australia

In the intervening years, both the UK and Australia have passed legislation to amend the duty of disclosure.

In Australia, the insured's duty is limited to disclosing circumstances that the insured knew or a reasonable person in their position would have known were relevant to the insurer's assessment of the risk.
The insurer must inform the insured of this obligation.

Furthermore, the insurer may cancel the policy for innocent non-disclosure only if it can prove (for instance by using examples of its refusals in other cases) that it would have refused cover had the circumstances been disclosed. In other cases, it may reduce the payment instead, for instance, by deducting the amount of a higher premium that it would have charged if disclosure had been made. Where a claim is fraudulent, a court may order that the insurer pay what is "just and reasonable", which may be ordered where, for instance, the fraud related to an insignificant part of the claim.

In the UK, the duty of disclosure has been abolished for consumers, who instead owe a duty to take reasonable care not to make a misrepresentation when answering an insurer's questions. Insurers are obliged to ask questions upon all circumstances that they wish to consider when deciding whether to offer cover.[5]

Insurers may cancel consumer policies only for a deliberate or reckless misrepresentation by an insured (in which case they may keep the premiums unless it would be unfair to the consumer to retain them) or a careless misrepresentation where the insurer would not have accepted the policy if it had known the relevant circumstances. Where, however, the insured made a careless misrepresentation but the insurer would have offered cover on different terms (such as limited cover or a higher premium) then the policy will be treated as if it was entered into on those terms.

With business policies, the duty of disclosure is amended to a duty of "fair presentation", in which the insured must provide enough information to enable the insurer to make a fair assessment of the risk or identify a need to investigate further.

MBIE issues paper

In May 2018, exactly 20 years after the Law Commission's paper was published, the Ministry of Business, Innovation and Employment issued a paper inviting comment on (among other insurance issues) essentially the same issues with respect to insureds' non-disclosure that the Law Commission had discussed. While observing that reform of insurance law generally was well overdue, no explanation for the lengthy delay was given.

The MBIE's paper indicated that policy options to address the issues raised were expected to be circulated towards the end of 2018 in a second consultation document. While this has yet to appear, it seems very likely that it will propose changes to the duty of disclosure along the lines of those that have been enacted in the UK and Australia.

The options

It is likely that the insured's duty of disclosure in New Zealand will either be reduced so that it applies only to circumstances that a reasonable person in the insured's position would have regarded as relevant to an insurer (the Australian approach), or removed altogether and replaced with a duty to answer an insurer's questions accurately (the UK approach).

We view the Australian approach as problematic, as it only partially answers the main problem with the present duty, which is that many insureds do not know that they must disclose circumstances that an insurer would consider material and they do not know what those circumstances are. There is also considerable uncertainty as to what a reasonable person should know about insurers' views. If the obligation is amended to a "reasonable person" test, this will leave insureds at risk.

The UK regime may be preferable, at least insofar as it relates to consumers, as a requirement that insurers ask questions that identify what circumstances they consider relevant should be easier for insureds to follow and should help them make full and honest disclosures. There is, however, a significant disadvantage from an insurer's perspective, which is the risk that an insured may be aware of a circumstance that is clearly relevant to the risk but is so unusual that it is not within any of the insurer's specific questions. There is also a risk that insurers may feel obliged to ask a large number of questions about matters that will be irrelevant for the great majority of insureds, which will produce inefficiencies. The Law Commission did not regard either of these factors as insurmountable, giving examples of general questions that insurers could ask such as *"Do you know of any reason particular to you why you may not attain your normal life expectancy?"*, while not going so far as becoming a general question about any risks, which would reintroduce the common law duty by the back door. However, it is too early to say how requiring insurers to ask questions about every matter about which they expect disclosure will play out.

It is less clear why there should be a different approach to consumer and business insurance, as in the UK. Many businesses are no more sophisticated than consumers when it comes to placing insurance and if a regime is considered fair and effective for consumers it is not easy to see why it should not be applied consistently to all insureds.

The UK approach to remedies in consumer insurance, where policies may be avoided only where the insured has been deliberate or reckless or where the insurer would not have accepted cover, but the policy in other cases is amended to reflect the arrangement that the insurer would have accepted, also seems fair and practical in principle. There may be difficulties, however, in drawing the line between conduct that is reckless and that which is merely careless.

What should insurers be doing?

We recommend that insurers prepare for the next round of consultation and the likely effects of changes to the law by:

- considering whether they would object to the UK or Australian models because of the issues of uncertainty and cost identified, and whether they will wish to make submissions when MBIE's next paper is issued
- considering what detailed and specific questions they might need to ask insureds if the UK model is adopted
- considering how onerous and costly the exercise of asking additional questions and reviewing the answers may be (and how additional costs may be reflected in premiums)
- considering whether a divergence between consumer and business insurance, as in the UK, is appropriate or whether it would lead to greater uncertainty and cost

Andrew Horne
Partner

Nick Frith
Senior Associate

[1] NZLC R46, May 1998; [2] One issue seems to have been of academic interest only: the continued application in New Zealand of s.83 of the Fires Prevention (Metropolis) Act 1774 (Imp.), which the Law Commission viewed as anachronistic; [3] Marine Insurance Act 1908; [4] The consequences of mis-statement (as distinct from non-disclosure) are ameliorated to some extent for contracts of life insurance by the Insurance Law Reform Act 1977. The consequences of mis-statement for marine insurance is provided for in the Marine Insurance Act 1908 and for other forms of insurance is provided for in the Contracts and Commercial Law Act 2017; [5] The Consumer Insurance (Disclosure and Representations) Act 2012 governs consumer policies and the Insurance Act 2015 provides for business insurance.

High Court prefers opt-in for class actions

In a decision released late last year, the High Court permitted two policyholders to bring a class action against Southern Response.[1] The Court did not, however, permit this action to be brought on an "opt-out" basis. Following earlier High Court authority,[2] the Court held that New Zealand's class action regime does not provide for "opt-out" class actions. Potential class members must instead "opt-in" within a prescribed period.

New Zealand is an outlier in this regard. Most common law jurisdictions permit opt-out class actions. However, most of these jurisdictions also have detailed legislative rules regulating those actions, which are missing from New Zealand's regime. Legislative reform will, it seems, be required if opt-out proceedings are to be permitted in New Zealand.

The facts

This case was brought by a couple whose home was insured by Southern Response[3] when the Canterbury earthquakes struck. The plaintiffs house was red-zoned and could not, therefore, be rebuilt on its existing site. The plaintiffs' instead elected to buy another house, which was permitted under their policy provided that the cost of doing so was not "greater than rebuilding your house on its present site".

The plaintiffs settled their insurance claim, they say, in reliance on a "Detailed Repair/Rebuild Analyses" (DRA), or cost estimate, provided to them by Southern Response. This DRA set out Southern Response's estimate of the plaintiffs' maximum policy entitlement under the 'buy another house' settlement option, and reflected Southern Response's view of the cost items payable.

However, the plaintiffs claimed that Southern Response's practice was to prepare a second version of the DRA, which included allowances for additional cost items excluded from the DRA version, disclosed to them. The plaintiffs allege that this practice was misleading, and applied for orders permitting them to bring an opt-out class action on behalf of all Southern Response policyholders who had settled their insurance claims on the basis of such a DRA.

While Southern Response consented to orders permitting the matter to proceed as a class action, it disputed the terms of the orders. In particular, Southern Response argued that membership of the relevant class should be determined on an opt-in basis.

Opt-in vs Opt-out class actions

Whether a class action can be brought on an opt-in or opt-out basis can have significant implications for the size of the plaintiff class. The Court referred to research suggesting that approximately 8 per cent of a class might opt out of proceedings, while only 39 per cent might opt in. The parties estimated the number of potential class members at approximately 3,000. Therefore, if the research statistics quoted to the Court were accurate, an opt-out order might result in a plaintiff class of more than 2,700, while only 1,200 might opt in. The difference in these numbers may reflect some apathy on the part of potential class members; if they do not fully understand the dispute or have much at stake, they may see little reason to join.

Notwithstanding this, the Court was not persuaded to make an opt-out order. All class action orders in New Zealand had been made on an opt-in basis, and the Court agreed with the decision in Houghton v Saunders (2008) 19 PRNZ 173 (HC) that the High Court Rule governing class actions, rule 4.24, does not envision opt-out class actions.

In reaching its decision, the Court rejected the plaintiffs' arguments that:

(a) There is a large potential class of claimants, each with a small claim that might be uneconomic to pursue otherwise. The Court considered that, while this may be relevant to its decision as to whether a class action should be ordered, it was not relevant to whether orders should be made on an opt-in or opt-out basis.

(b) It would be more difficult to notify potential class members of the proceedings, as the class members in this case do not have a "pre-existing community of interest". However, any potential disadvantage in this could, the Court noted, be dealt with by requiring significant steps to be taken to bring the case to the attention of potential class members.

(c) The plaintiffs did not have access to a register of potential claimants to allow them to notify them of these proceedings. This request was rejected, as Southern Response held that information and most potential class members were likely contactable.

(d) An opt-out was "fail safe". The Court acknowledged that there was some merit in this argument, but noted that potential class members in this case were unlikely to be ill-equipped to make a decision as to whether to join the proceeding. They were homeowners and likely to have some familiarity with legal and financial matters.

(e) Once a class action is brought, it is brought on behalf of all class members and time stops running for limitation purposes. There was a risk that later claims would be brought if an opt-in order were made, which would lead to inefficiencies in the courts. The Court considered that this concern was slight. Those who are aware of their rights will likely elect to be part of this proceeding, because that would be an opportunity without cost to them.

(f) Opt-out proceedings deter wrongful conduct. Again, the Court was not concerned by this. It was not relevant in this case.

The policy issues discussed by the Court in this case will likely be examined further by the Law Commission, which is currently reviewing the law on class actions and whether opt-out proceedings ought to be permitted. We will be keeping a close eye on the progress of this review, which will be of interest to insurers, banks and other large businesses which may face exposure to class actions.

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Senior Associate

[1] Ross v Southern Response Earthquake Services Ltd [2018] NZHC 3288.
[2] Houghton v Saunders (2008) 19 PRNZ 173 (HC). [3] Then named AMI Insurance Limited.

Just blame the broker?

Dalamd Ltd v ButterworthSpengler Commercial Ltd [2018] EWHC 2558 (Comm)

In this decision, the English High Court determined claims made by an insured against its insurance brokers for negligence. The decision is particularly relevant to how the courts assess an insured's loss in circumstances where it has not pursued its insurance claim against insurers but instead seeks full indemnity from its broker.

We also set out what we see as the key lessons insurance brokers can take from the decision.

Background

The Douthwaite and McQueen families owned and operated a waste recycling facility through two entities: Widnes Land Partnership LLP (**Widnes**), which was the freehold owner of the premises on which the facility operated, and Doumac Limited (**Doumac**) which leased the premises from Widnes and undertook the recycling operations.

Dissatisfied with their previous insurance brokers, Widnes and Doumac appointed the defendant, Butterworth Spengler Commercial Limited (**Butterworth**). Butterworth placed the following relevant insurances:

(a) for Doumac, material damage, Increased Cost of Working (**ICOW**), Additional ICOW and stock debris removal cover (with Novae) and contractor's all risks cover (with XL London Market Limited (**XL**)); and

(b) for Widnes, buildings and property owner's liability cover with Novae.

In January 2012, a storm caused damage to property at the recycling facility. This affected Doumac's processing ability and led to the build-up of waste at the site. Because of this, the Environment Agency inspected and reported that Doumac was in breach of its permit. Novae gave Doumac and Widnes 30 days' notice to cancel its policies as this breach of permit meant the facility was an unacceptable risk from Novae's perspective.

Butterworth approached an alternative insurer, Aviva, to underwrite the policies. Aviva's quote provided for an "External Storage Condition" which made clear that any combustible materials stored outside must be kept at least 10 metres away from any building at the facility. Doumac and Widnes instructed Butterworth to place their respective insurances with Aviva.

In around July 2012, Doumac became insolvent. A new company, JL Sorting Limited (**JLS**), was set up to take over Doumac's business. Butterworth was instructed to ensure that Doumac's insurance policies were transferred to JLS.

In October 2012, a fire destroyed the facility. Both JLS and Widnes made claims under their respective policies. Aviva raised a number of concerns:

(a) whether the insureds had discharged their duty of good faith in relation to disclosure of the past experience of fires at the site and the insolvency of Doumac; and

(b) non-compliance with the External Storage Condition.

Aviva declined the claims. Firstly this was due to the breach of the External Storage Condition. Secondly, Aviva claimed that cover was voidable as there had been no disclosure to it of Doumac's insolvency.

XL also declined cover on the basis that the insureds had failed to disclose warnings given by various authorities regarding excessive amounts of waste at the facility, previous fires that had occurred at the facility and the poor condition of the buildings.

No proceedings were commenced against either Aviva or XL. JLS and Doumac assigned its claims to the plaintiff, Dalamd Limited (**Dalamd**), who brought proceedings against Butterworth claiming that it:

(a) failed to disclose to Aviva Doumac's insolvency and/or made a misrepresentation to Aviva about it;

(b) gave inadequate advice in relation to business interruption (BI) cover;

(c) gave inadequate advice about the existence and/or effect of the External Storage Condition;

(d) failed to advise Widnes to obtain cover for loss of rent; and

(e) failed to give adequate disclosure to XL and/or gave inadequate advice to the insured in relation to the matters which should be disclosed to XL.

Alleged breaches

(a) Doumac's insolvency

The insured had informed Butterworth of Doumac's impending insolvency and asked that its existing covers be transferred to JLS. The Butterworth broker, Andrew Thomson, recorded a file note of a telephone discussion with a representative of Miles Smith London Market Broking (**Miles Smith**), the placing broker for Aviva. That note recorded that Mr Thomson had informed Miles Smith that Doumac was "going into administration" and a new company, JLS, was taking over Doumac's operations. The representative of Miles Smith asked Mr Thomson to confirm in an email to Hayley Jennings, who was the main handler of the file for Miles Smith. Mr Thomson's email to Mr Jennings did not refer to Doumac's insolvency. Instead, Mr Thomson referred to it incorrectly as merely "a change of a trading name".

Butterworth argued that it had disclosed the insolvency to Miles Smith and that Miles Smith was Aviva's agent. Butterworth acknowledged that the wording of Mr Thomson's email to Ms Jennings was unfortunate, but disclosure had already been made in the initial phone call anyway.

The Court found that Butterworth breached its duty in relation to the disclosure of Doumac's insolvency to Aviva. First, there was no cogent evidence that Miles Smith was Aviva's agent for relevant purposes – ordinarily a placing broker is an agent of the insured, not the insurer. Secondly, Butterworth could not establish that the person from Miles Smith who took the initial telephone call had authority to deal with the risk. The email to Ms Jennings, who had authority to deal with the risk, was inaccurate and did not adequately disclose Doumac's insolvency.

(b) BI insurance advice

JLS' BI insurance cover was for ICOW only, without cover for loss of gross profit. ICOW provides cover for costs incurred by the insured to mitigate a reduction in turnover as a result of property damage. Dalamd argued that standalone ICOW was not appropriate for a risk like JLS because in an event that destroyed the facility, there would be little that could be done to mitigate loss of profit until JLS' property and plant were reinstated and hence any ICOW claim would be limited. Dalamd argued that this was not explained adequately to Doumac or JLS.

The Court found that there had been lengthy discussions with Doumac in relation to BI insurance and there had been an adequate explanation given as to the differences between cover for gross profit and ICOW. Mr Thomson's advice in respect of BI insurance had not been recorded in writing. While this was unfortunate, the Court preferred his evidence to the insureds' witness. The Court also found that Doumac had not taken out cover for loss of gross profit not because of inadequate advice by Butterworth, but because it could not afford it.

(c) Existence and effect of the External Storage Condition

In a telling sign, the Court remarked that this part of the claim *"faced insuperable causation difficulties"*. Aviva's quote, which incorporated the External Storage Condition, was provided to Doumac and its terms were clear as to the effect of non-compliance.

The Court noted that it appeared Butterworth did not specifically draw the existence of the condition to Doumac's attention, at least in writing. However, the Court accepted that the condition had been brought to Doumac's attention during a survey conducted by Aviva's surveyor. This was sufficient.

(d) Loss of rents cover

As noted above, Doumac leased the relevant premises from Widnes. Consequently, loss of rent was a key risk for Widnes. Cover for this risk was not discussed by Butterworth at any stage and it appeared to have been simply overlooked. Accordingly, the Court found that Butterworth's failure to raise this with Widnes was a breach of duty.

(e) Inadequate disclosure or advice as to what should have been disclosed to XL

Dalamd firstly argued that Butterworth failed to disclose material matters about its risk of which it was aware to XL. Mr Thomson accepted that he knew there had been a build-up of waste at the facility. The Court found that this failure was in breach of Butterworth's duties.

Dalamd also argued that Butterworth gave inadequate advice as to what ought to be disclosed and failed to take proper steps to elicit such matters from Doumac. The Court considered that there were a number of failings by Butterworth in this regard. In particular, Butterworth had not advised Doumac to disclose, nor had it taken proper steps to elicit, previous fire incidents. The Court described this as "perhaps the most obvious example of the type of question that a broker ought to ask of a client in respect of a policy which covers property damage caused by fire". A reasonably competent broker ought to ask his or her client about previous fires and make it clear that that includes fires that did not result in a claim.

Causation

This case is unusual in that the insureds decided not to press claims against their insurers and instead sought indemnity solely from the broker. Most cases in this area involve either joint proceedings brought against both the insurer and broker or a proceeding brought against a broker to recover an alleged shortfall, caused by the broker's negligence, in a settlement between the insured and insurer.

In this case, Dalamd argued that it did not have to show that the insurance claims would have failed as a result of Butterworth's negligence. Instead, Dalamd argued that all it had to show to establish causation was that Butterworth's negligence provided the insurers with a reasonably arguable ground to defend liability. In relation to other policy issues that the insurers may have raised, Dalamd argued that it is to be assessed on a loss of a chance basis whether the insurers would have taken the point, whether the insurers would have compromised the insurance claim and what a court would decide if the point had been maintained to trial by insurers.

The Court found that Dalamd's position would "produce potentially anomalous results". Its effect would mean that if an insurer puts forward an arguable defence based on a broker's breach, then the insured could elect not to pursue the insurer and, if there were no other reason for the insurer to decline cover, recover from the broker in full.

Instead, courts have to determine whether the policy was voidable or not due to the broker's negligence either as a matter of law or, insofar as issues of fact arise, on the balance of probabilities. Whether the policy could be voided due to some other issue for which the broker was not responsible must be determined on the same basis.

The Court applied this reasoning to each of the breaches alleged by Dalamd against Butterworth. As to the breaches successfully made out against Butterworth:

(a) In relation to the non-disclosure of Doumac's insolvency to Aviva, the Court found that this provided a good defence to claims by JLS under the policy. It was more likely than not, that had disclosure been made, Aviva would at least have stipulated for some alteration of the terms on which JLS was insured. However, any argument by Aviva that Widnes' cover was voidable would have been wrong as non-disclosure by one insured under a policy will not affect the cover of the other insured.

However, the Court then turned to Aviva's reliance on the breach of the External Storage Condition, for which Butterworth was not responsible. The Court found on the balance of probabilities that Aviva could successfully argue that the policy was voidable by reason of the breach of this condition. Accordingly, Butterworth's failure to disclose Doumac's insolvency did not cause any loss to the insureds.

(b) In relation to Butterworth's failure to advise Widnes to obtain loss of rents cover, the Court found that ,even if this advice had been given, it was unlikely that Widnes would have bought the cover. Widnes' previous broker had recommended the cover but it was likely not obtained at that time due to cost considerations.

Alternatively, the Court found that it was unlikely that the insurers would have agreed to indemnify Widnes for loss of rent. By the time of the fire Doumac was insolvent and JLS had not yet entered a lease agreement with Widnes. JLS had paid no rent to Widnes.

(c) In relation to disclosures that should have been made to XL, the Court found that the non-disclosures on the balance of probabilities meant that the policy was voidable. Accordingly, Butterworth's negligence had caused loss to JLS, namely its right to indemnity under its contractor's all risks policy. The Court found that Dalamd was entitled to recover damages in the value of JLS' plant and machinery, being £1,600,000.

Key learnings for brokers

Insurance brokers can take a number of learnings from the decision:

1. Ensure that there is a written record of all advice provided to, and decisions made by, the client and that the record is provided to the client. A written record of advice and decisions provided to the client allows them the opportunity to clear up any misunderstandings or seek further clarification.

2. Ensure that you disclose material facts only to the insurer's representative who has authority to deal with the risk.

3. Where a client has decided not to buy insurance for a certain risk, it is good practice to revisit this decision with them periodically, when there are business or personnel changes or at least upon renewal.

4. Identify all risks to a client's business and discuss with the client insurances available to insure those risks.

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When “when new” is not “as new”

Fitzgerald v IAG New Zealand Ltd

The High Court has recently clarified the difference between *“when new”* and *“as new”* policies.

The case provides useful guidance regarding:

(a) Repair strategies under a “when new” standard – this case demonstrates the distinction in compliance requirements when compared to an “as new” policy; and

(b) The interplay between the Building Act, Building Code and MBIE Guidelines.

The facts

The plaintiffs’ 1920s house was built on unreinforced perimeter “rubble” foundations which largely comprised loosely cemented stones, rocks and broken bricks. Later renovations added a sun-room and garage which were founded, respectively, on reinforced and unreinforced concrete slab-on-grade.

The parties’ experts agreed that the foundations of the house and garage/sun-room had been damaged and had settled in the Canterbury earthquakes, and that that settlement (and cracking) required remediation. The question for the Court was the extent of the works IAG was required to fund – a full foundation rebuild to current Building Code requirements (the plaintiffs’ claim) or a more modest repair involving epoxy crack filling, jack and pack relevelling and re-finishing (IAG).

In determining this question, the Court considered which of the parties’ repair methodologies would meet both the policy standard and its compliance requirements.

(1) The policy standard

The policy standard provided:

> *In the event of physical damage, the Policy requires IAG to pay for the cost of repairing the house to a “condition as similar as possible to when it was new, using current materials and methods”. This is commonly known as a “when new” repair policy as opposed to an “as new” repair policy.*

Having charted the authorities on the distinction between *“as new”* and *“when new”* policies, the Court held (our emphasis):

> *… the Policy specifically requires that the plaintiffs’ house is to be restored to a condition as similar as possible to when it was new.* ***With regard to the foundations particularly, this means that those foundations must provide the same level of functional support to the building as when they were new. There is no prima facie obligation on IAG to ensure that the foundations are at the same level as modern standards****, although modern materials and methods are to be used to bring the foundations back up to their original standard. As Mander J noted in Parkin, IAG must undertake repairs sufficient to render the fact of the earthquake damage immaterial.* ***In other words, the house must, as far as possible, be put in the same position it would have been in had the earthquakes not occurred. This is the scope of IAG’s obligation under the Policy.***

This marks a clear distinction between *“when new”* and *“as new”*.

(2) Compliance

Having determined the scope of IAG’s policy obligation, the Court then addressed issues of Building Act/Building Code compliance. The Court started from the proposition that the policy required IAG to pay for the cost of ensuring that the foundations are repaired in accordance with such Government or local authority by-laws or regulations as may apply, including the Building Act and Building Code.

The Court held that IAG’s jack and pack strategy would meet the requirements of the Building Code to the extent required under the Building Act. That is, the aspects of the house that are being repaired would comply with current code requirements (where assessed by an engineer as suitable and a building consent is issued), but those aspects not repaired may be left at the same level as they were originally. This finding was made in reliance upon recent MBIE guidance on repairing rubble foundations, together with earlier case authority (see *Parkin*).

The Court was satisfied on the evidence that IAG’s proposed repairs would meet the policy standard and *“put the perimeter foundations into ‘a condition as similar as possible to when it was new’ being when it was largely built in the 1920s”.* While this would not meet current standards for a newly built home, it would comply to the extent required (see ss 17 and 112 of the Building Act). This was an effective tie-in to the policy standard addressed above. The Court also accepted that the cracks in the perimeter foundations did not cause a structural issue and, by definition, did not give rise to compliance issues as their repair was only aesthetic. Epoxy and re-finishing would be sufficient for that purpose.

The result

The Court found that:

(a) IAG’s proposed methodology would be suitable on the evidence in this particular case as the repair only needed to restore the foundations to the condition they were in when they were constructed in the 1920s i.e. *“when new”*. The Court’s conclusion was influenced by evidence that the foundations had otherwise performed adequately and had supported the house relatively well through the Canterbury earthquakes;

(b) IAG’s proposed mechanical relevel of the sunroom foundations would be sufficient to restore the room’s amenity; and

(c) the garage foundations were insufficiently out of level to require relevelling. Cracks could be fixed with epoxy and some form of finishing, such as paint if that was sufficient, to disguise the epoxied cracks.

A final caveat and lessons learned

The Court’s decision was, however, caveated. The findings in respect of IAG’s proposed repair methodology were contingent on the Council issuing consent or an exemption for the works, together with any necessary code compliance certificates. The repairs also required an engineering assessment.

Insurers will need to be mindful of precisely which compliance requirements apply to different policy wordings. This case provides further clarity around how that investigation should take place.

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