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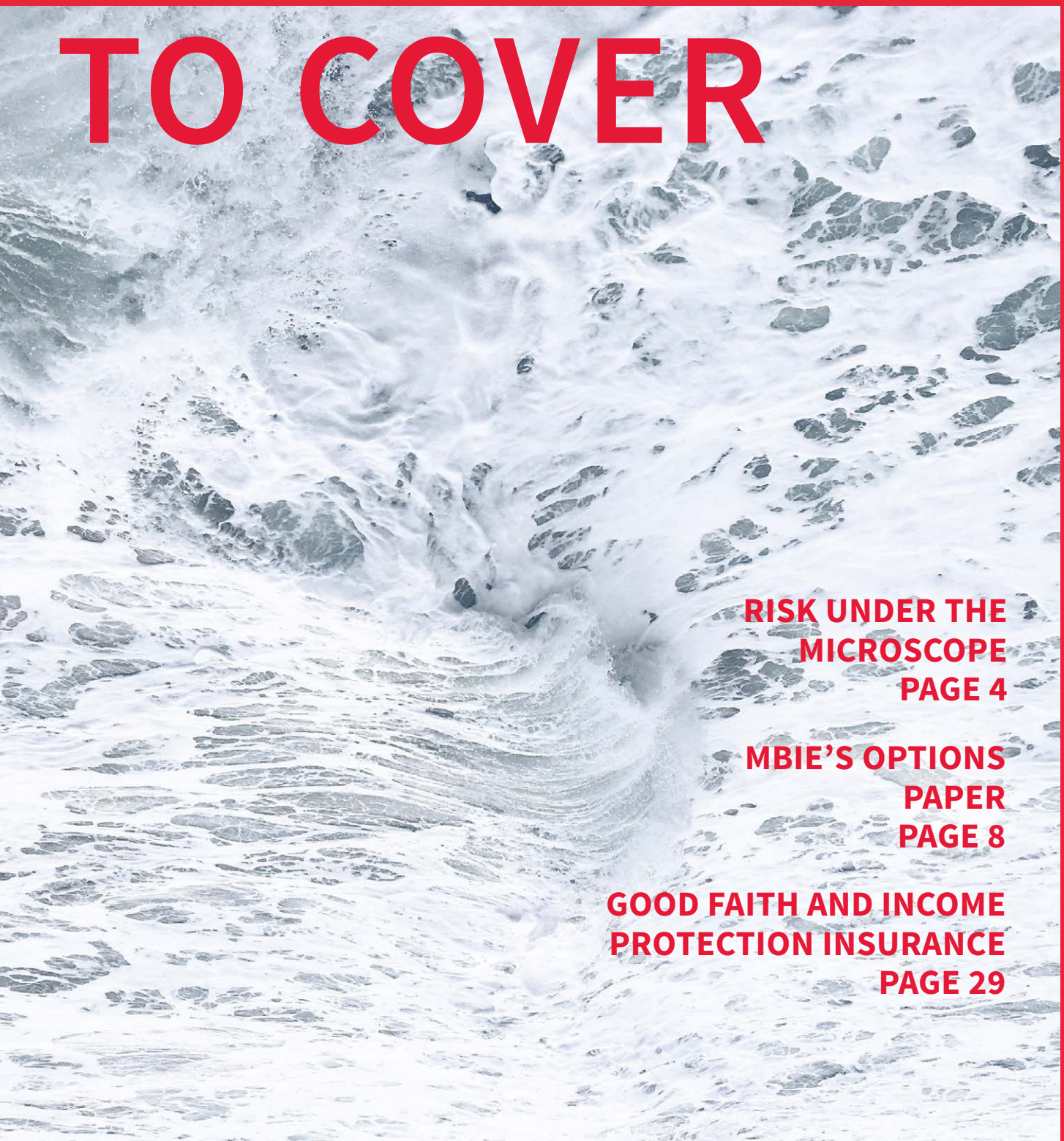
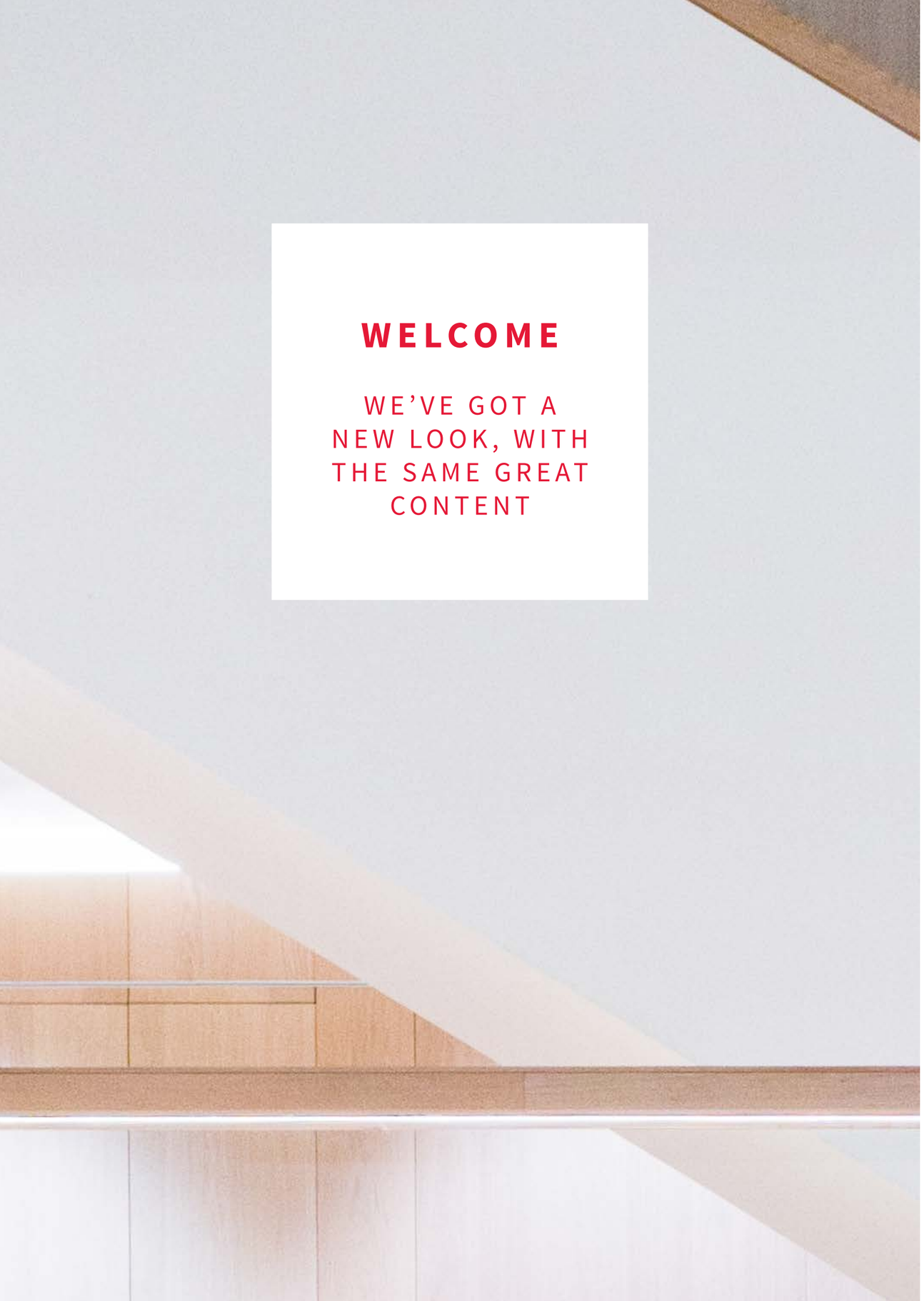
NEW ZEALAND'S INSURANCE MARKET MAGAZINE

JUNE 2019 / ISSUE 17

COVER TO COVER





WELCOME

WE'VE GOT A NEW LOOK, WITH THE SAME GREAT CONTENT

Welcome to the 17th issue of Cover to Cover, our magazine for New Zealand insurance professionals

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While the word "change" is often overused, there seems to be no better way to describe the near-daily news of mergers, exits, premium increases, industry reports and regulatory upheaval across all sectors of the New Zealand insurance market.

This issue's key focus is the recent shift towards risk-based pricing for property insurance in New Zealand. We look at the recent drivers for change across the country, the commercial decision making, underwriting criteria and property owners' perspectives.

We cover the continued developments in insurance law and regulation, including MBIE's recent Options Paper for its review of Insurance Contract Law, which covers the duty of disclosure, unfair contract terms in insurance policies and clarity in policy drafting. We also take a brief look at the recently enacted Financial Services Legislation Amendment Act 2019 and the RBNZ's thematic review of the appointed actuary regime.

We also look at six points which New Zealand insurers should focus on in the Australian Law Reform Commission's recent Final Report on Class Actions and Litigation Funding.

Finally, we provide the usual update on case law developments, including:

- A UK case with guidance on which policy applies where related or similar claims are made in different policy years under claims made and notified liability policies.
- The Court of Appeal's rejection in *Doig v Tower Insurance* of an attempt to circumvent the rule against assigning reinstatement benefits.
- Asteron's success in obtaining full restitution of benefits paid under an income protection policy where the insured's claims were not honest.
- A warning to brokers and insurers on potential continuing duties of care when circumstances which may impact on the adequacy of cover arise after placement.

Risk under the microscope - a sea change in pricing property insurance

New Zealand's largest property insurer group recently announced a move towards more risk-based underwriting for property and contents insurance in areas considered prone to natural disasters. These changes will result in premium increases – some of which will be very substantial - for customers in affected areas.

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While all insurance pricing is risk-based to some extent, insurers have traditionally spread the cost of natural disaster risks evenly across the country. With an increasing focus by reinsurers on the extent to which New Zealand insurers are exposed to risks in specific areas, this is changing. Insurers are now under pressure to ensure they are not disproportionately exposed in high risk areas. Risk-based pricing helps ensure that their insurance books are appropriately weighted to areas and types of risk.

Currently this shift will affect customers of Tower Insurance and the IAG group of companies, which include the State, NZI, AMI and Lumley brands and provide insurance through ASB, BNZ, The Co-Operative Bank and Westpac. Together, these brands provide around half of all property insurance in New Zealand. Vero Insurance has indicated an intention to move to partially risk-based pricing. Other insurers are likely to follow.

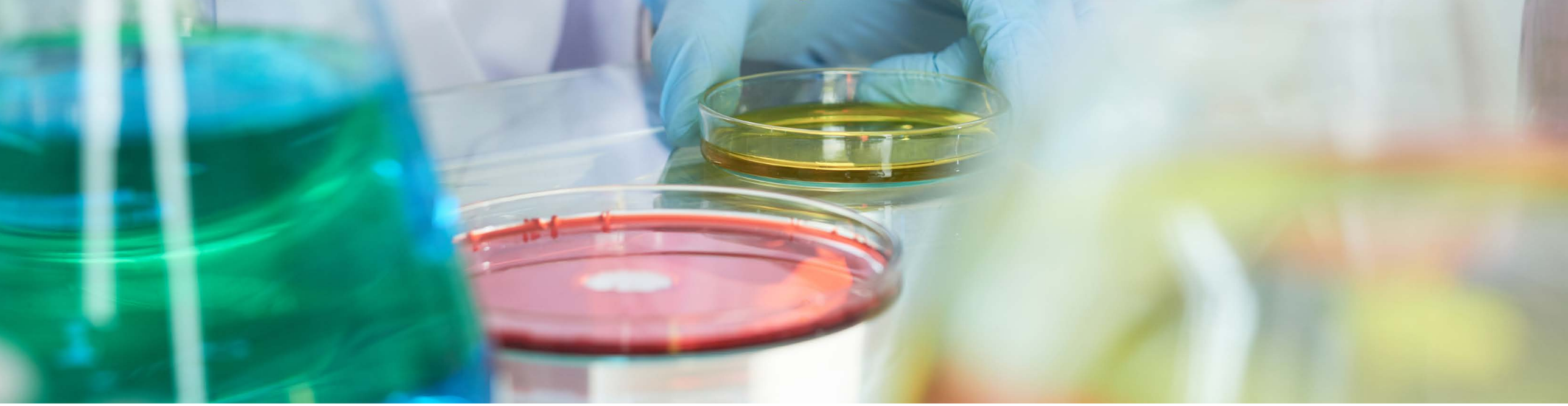
Premium increases

There have been media reports of very substantial premium increases for customers who are viewed as at an increased risk of natural disaster loss due to the location or type of their property. In 2018, one Tower Insurance customer reported that the annual premium on a Karori home had increased from $2,200 to nearly $7,200. More recent reports include a premium increase of $15,000 for a house in Fendalton, Christchurch and increases of $12,000 and $5,000 for houses in other areas.

Tower informed its customers that property insurance in earthquake-risk areas like Wellington, Napier and Gisborne would be likely to pay the most, but increases have not been confined to those areas or older properties. For instance, an Auckland homeowner reported a premium increase from $2,089 to $3,012 for a Green Bay house built in 2014 and an Auckland investor reported an increase of 40% on another property.

Tower initially said that very substantial increases will be confined to a small number of customers. Tower's Chief Executive, Richard Harding, told media that the majority of customers would not see a significant change, with fewer than 2.5% receiving an increase of more than $250 and only 1% increasing by more than $2,000. While this may reflect only an initial round of increases, it suggests that, in the first instance, substantial increases will be confined to specific properties or areas that are regarded as particularly high risk. Insurers are also withrawing from regional markets, which may have the effect of removing some of the highest premiums from their books.

The premium increases will not only be linked to the risk of earthquake. Tower has indicated that pricing of flood insurance will also change according to risk.



Insurers tighten criteria

In addition to premium increases, IAG has indicated that it will be taking a "conservative approach" to underwriting new business in Wellington due to higher earthquake risk. There have been reports that IAG has tightened its criteria for accepting new risks from the Wellington, Porirua, Wairarapa and Hutt Valley areas. IAG reportedly insures around half of all homeowners in the wider Wellington area so its cautious approach to this exposure may have the effect of constraining supply in this region.

What does this mean for property owners?

For some owners, insurance may become unaffordable. Owners of apartments may be hit particularly hard. The premiums at one small apartment complex in Wellington were reported to have trebled since 2016. The owners voted by a slim majority to continue buying insurance. This resulted in an increase in the annual body corporate levy to more than $12,000 per apartment.

Going without natural disaster insurance is not a realistic option for apartment owners. This would breach the Unit Titles Act, which requires that body corporates organise full cover, and also the terms of owners' mortgages. It would also make apartments unsaleable to buyers who require mortgage finance, which is likely to reduce their value significantly.

The move to risk-based pricing is also likely to affect values of properties that become more expensive to insure, depending upon the extent of the increase. As significant as the increasing cost of insurance may be, buyers' apprehensions that an increase in premiums now may foreshadow a reluctance by insurers to provide cover at all in future may have an even greater impact upon property values.

Buyers of property will also need a more sophisticated understanding of the specific risks attaching to a property than is presently the norm. Buyers may obtain a copy of the Land Information Memorandum report for a property and look for any risk modelling obtained by the local council for such events as landslips and flooding. They may also wish to take advice from brokers or insurers as to whether the property is likely to be insurable in future. Brokers and insurers will need to be careful to explain all of the risks to their customers, including the risk that insurance may become increasingly difficult to obtain.

If insurers move entirely to risk-based underwriting, this could result in whole areas that are earthquake or flood prone or otherwise at risk becoming uninsurable. Some properties are likely to become unsaleable as they become too expensive or impossible to insure. People may become 'trapped' in houses or apartments where their insurers are willing to renew their existing cover, but buyers find themselves unable to insure the property as a new risk on reasonable terms.

What regulatory considerations are relevant?

While insurers' conduct towards their customers is under increasing scrutiny by regulators in New Zealand and Australia, this is largely focussed upon life insurance and areas in which large commissions are payable or products are mis-sold. Property insurance has not been a particular area of focus as it is not generally susceptible to these issues.

Insurers do not generally owe their customers any duties with respect to pricing or their decisions as to whether they will insure risks at all, provided their conduct does not amount to unlawful discrimination under human rights legislation. Insurers will, however, be conscious of the need to explain these changes to their customers carefully and accurately.

What has happened in other earthquake-prone countries?

According to the California Earthquake Authority website, only around 1 million of California's more than 7 million homeowners have earthquake insurance. California is a known earthquake risk and is believed to be due for a major earthquake within decades. The low up-take of insurance presents a substantial risk for California's economy.

The state legislature first stepped in to address this in 1985 when insurers became obliged to offer earthquake insurance to homeowner customers. Over time, however, premiums increased and eventually almost all insurers ceased offering homeowner earthquake insurance altogether.

Accordingly, in 1996, the California legislature set up the California Earthquake Authority (**CEA**), a non-profit, publically managed, privately funded statutory body which provides the majority of earthquake insurance in California. It offers earthquake cover through insurance companies that are CEA members. Policies have relatively high deductibles, ranging from 5% to 25%.

The CEA assesses premiums based upon a range of factors, including the following:

- The age of the building
- Whether it is constructed from brick or masonry
- Whether it has more than one story
- Ground conditions
- Whether it is up to current code

The CEA appears to have enabled those who wish to have earthquake insurance to obtain it, although uptake remains low by New Zealand standards.

Will the New Zealand Government intervene?

There has been no immediate indication that the New Zealand Government intends to look into a statutory scheme like that in California or otherwise take action to prevent insurance becoming unaffordable.

The Minister of Commerce and Consumer Affairs, Kris Faafoi, said in early 2019 that he would continue to monitor the situation, but that he understood insurance companies other than IAG were still offering policies and did not intend to withdraw from the market. The Minister said that the Government was "a long way from intervention" but invited insurers to share more information with consumers so they can be better informed about availability of policies and risk-based decisions.

Final thoughts

In time, it seems likely that premiums will continue to rise for areas that are regarded as high risk. Ultimately, some areas may become insurance 'black spots' where property values plummet and calls for Government intervention become increasingly loud. In the meantime, careful consideration will be required by those who choose to invest in potentially affected areas.

MBIE's Options Paper considers proposed insurance law changes

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MBIE has now released an Options Paper for its review of insurance contract law. The review is intended to:

- ensure that insurers and insureds are well-informed and able to transact with confidence;
- increase fairness, efficiency and transparency within the market;
- minimise barriers to insurance being provided; and
- protect consumers' interests.

The Options Paper identifies three primary problem areas in insurance contract law:

(i) Insureds' duty of disclosure;

(ii) Exceptions to the unfair contract terms regime; and

(iii) Insureds' difficulties in understanding and comparing policies.

Duty of Disclosure

Insureds are under a duty to disclose material information to their insurer, based on what a prudent insurer would consider material. Failure to disclose may result in the insurer rejecting claims under the policy and avoiding the policy altogether. However, insureds often do not understand what a prudent insurer may consider to be material or may be unaware of the duty to disclose. This lack of understanding around disclosure obligations creates risks for insureds and reduces the quality of information available to insurers, making it more difficult to operate effectively.

Consumer Disclosure

The Options Paper considers the following possible options in relation to disclosure:

- replacing the duty of disclosure with a duty to take reasonable care to not make any misrepresentations in answering insurers' questions. The insurer would then be required to identify (through questions) the information they require to underwrite the risk;
- amending the duty to cover only what a reasonable person would know, or would in the circumstances be expected to know, to be relevant to the insurer in making a decision to accept risk;
- retaining the duty of disclosure, but requiring life and health insurance providers to seek permission to access and use consumer medical records to underwrite their risk;
- requiring insurers to inform insureds in writing of the duty to disclose before any contract is entered into; and
- requiring insurers to inform insureds about their access to third-party records.

Business Disclosure

In relation to customers who are businesses, the Options Paper makes a number of specific suggestions:

- replacing the duty of disclosure with a duty to take reasonable care to not make any misrepresentations in answering insurer questions;
- amending the duty to cover only what a reasonable person would know to be a material fact; and

- changing the duty to require businesses to disclose enough information for a prudent insurer to be put on notice that it should make inquiries (perhaps with the ability to contract out of this duty).

The Options Paper also asks for comment on whether such modified duties should apply to small businesses, which lack the resources and sophisticated processes of larger businesses.

Disclosure Remedies

In relation to disclosure remedies (for both insureds and businesses), the Options Paper suggests that remedies may be based on:

- intention and materiality, allowing avoidance where the non-disclosure or misrepresentation is deliberate, reckless or objectively material, as well as permitting proportionate responses to careless non-disclosure or misrepresentation that induced the insurer to enter into the contract;
- the same as the previous option, but without allowing avoidance for material disclosure that is non-fraudulent; or
- materiality alone without regard to intention, allowing proportionate remedies based on how the insurer would have acted if it had known the correct information when the insured applied to them.

The consequences of avoiding a contract on past claims that have been paid out would also need to be decided upon, as would the interaction between this new law and general contract law.

Unfair Contract Terms

Under the existing regime (which only applies to policies entered into after 17 March 2015), unfair terms in standard form consumer contracts are prohibited, with a list of specific exceptions which apply to insurance contracts. The Options Paper also considers:

- removing these specific exceptions but amending the other generic exceptions so that they can more easily accommodate the specific features of insurance contracts (either in statute or through guidance from the regulator);
- removing the specific exceptions and leaving the other generic exceptions as they are to apply to insurance contracts unconditionally; or
- exempting insurance contracts completely from the unfair contractual terms regime and relying only on conduct regulation, the costs and benefits of which would depend on the outcome of a separate review being carried out by MBIE into the way that conduct is regulated in the insurance industry.

Understanding and Comparing Policies

Insureds face a number of difficulties in trying to understand and compare policies. Different insurers also often present their policies in different ways, which can make it more difficult to compare.

The Options Paper considers requiring:

- insurers to have their policies written in plain language;
- insurance contracts and policies to include clear definitions for core policy wording;
- policies to highlight core policy terms or include a summary statement to draw insureds' attention to its key aspects;
- insurers to work with third-party comparison platforms; or
- insurers to disclose key information, clearly, concisely, effectively and using plain language, to insureds.

Miscellaneous Issues

The Options Paper also raises a number of issues outside those primary areas, for example that:

- insurers are deemed to know everything known to their representatives;
- insurers may be able to rely on exclusions where the conditions are satisfied even though there is no causal link to the loss in question; and
- insurers cannot decline claims on the basis that the insured failed to comply with time limits for making claims unless that prejudiced the insurer such that it would be inequitableto require the insurer to accept the claim.

Our view

Any reforms that come out of this review may have a considerable impact on the insurance sector. We expect the end result to include some change (likely a reduction) in the duty of disclosure.

MBIE has asked for submissions on the Options Paper by Friday 28 June 2019. It will be important for insurance industry participants to engage in the law reform process to ensure any law changes are fit for purpose.

Regulatory Update

Financial Services Legislation Amendment Act 2019

The Financial Services Legislation Amendment Act 2019 was passed into law in April 2019. This new regime will be supplemented by regulations and a new Code of Professional Conduct for Financial Advice Services. The Act has remained substantially in the same form as considered in the second reading late 2018.

The Code is intended to provide for minimum standards of professional conduct when regulated financial advice is given to retail investors. The Code was submitted to the Minister of Commerce and Consumer Affairs by the Financial Advice Code Working Group on 6 March 2019, and was approved on 7 May 2019. The Code will come into force late 2019, and existing advisers will have a further two years after that to move into compliance with the new standards.

The nine standards of the Code are divided between two parts, with Part 1 covering ethical behaviour, conduct and client care, and Part 2 covering competence, knowledge and skill. Each of the standards is accompanied by a description of the ways that it can be demonstrated, as well as commentary to explain it. These standards are designed to be high-level principles rather than prescriptive rules, and are framed around promoting positive, rather than forbidding negative, conduct.

Regulations supplementing the new regime are also to be released. These will provide specific requirements around disclosure, registration, and levies and licensing fees. Of particular importance are the disclosure requirements, which have been decided on by Cabinet but are yet to be set in regulations. Currently, the intention is for disclosure of specified matters to be provided to consumers at particular points in the advice process rather than all at once, allowing it to be more comprehensible to consumers as well as simpler for advisers to tailor to their processes.

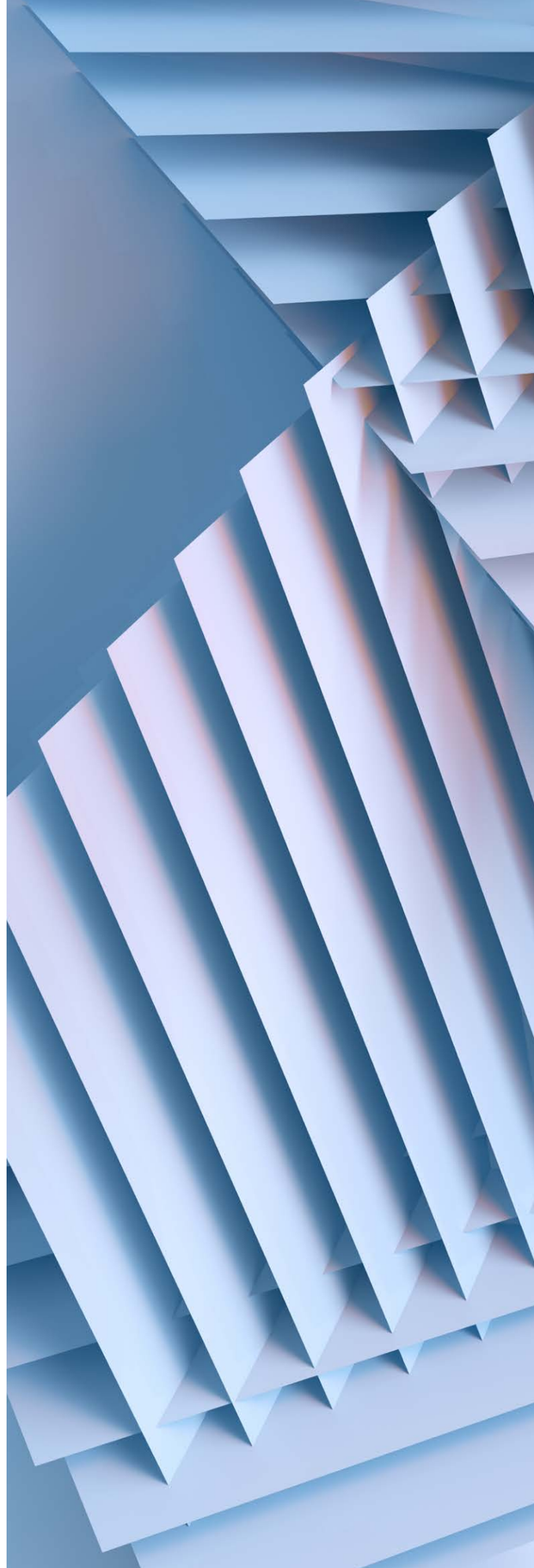
While some of the provisions of the Act came into effect following the Royal Assent, most are still to follow by Order in Council. Any remaining provisions will come into force on 1 May 2021. The regime is intended to commence once the Code and Regulations come into force, which is likely to be the second quarter of 2020. This will be followed by a 2-year transitional period, with a competency safe harbour and transitional licensing in effect. Applications for transitional licensing will open six months before the transitional period begins.

Appointed actuary review

The Reserve Bank of New Zealand is conducting a thematic review of the appointed actuary regime with the objectives to:

- better understand how the appointed actuary role works in practice for insurers, actuaries and supervisors; and
- identify potential areas for improvement to make the role and regime more effective for insurers, actuaries and the Bank.

In March/April 2019 the Bank conducted meetings with industry and stakeholder groups to discuss the draft plans for the review and seek feedback. The Bank incorporated some aspects of that feedback into its finalised plans for the appointed actuary review, whilst it intends to use other feedback in the general Insurance (Prudential Supervision) Act 2010 review. In May 2019 the Bank issued letters and fact-based survey requests to selected insurers and appointed actuaries to participate in the review, with a view to conduct on-site visits with those selected insurers and appointed actuaries later in 2019. Other stakeholders can provide input on a voluntary basis. The Bank intends to publish a report in early 2020 with generalised findings, good practices, and suggestions for possible changes to the regime. We understand that the selected insurers will receive individual feedback. Any consultation on intended policy changes is intended to occur early 2020.



Euro Pools Plc v Royal & Sun Alliance Insurance Plc

[2019] EWCA Civ 808

This recent English Court of Appeal decision provides useful guidance to insurers in relation to notifications of circumstances under liability policies where related claims arise in different policy years and there is an issue about which policy responds

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The facts

The insured, Euro Pools, specialised in the installation and fit out of advanced swimming pools with two key features – raising and lowering floors and movable vertical walls, called "booms", which were used to divide pools into different swimming zones.

Euro Pools had professional indemnity insurance with Royal & Sun Alliance Insurance for the 2006/2007 (First Policy) and 2007/2008 (Second Policy) policy years. Both policies provided primary liability and mitigation costs cover up to an aggregate limit of £5 million for each year. They contained the usual notification obligations (emphasis added):

> *"[Euro Pools] shall as a condition precedent to their right to be indemnified under the insurance give written notice to [the insurer]… **as soon as possible after becoming aware of circumstances… which might reasonably be expected to produce a Claim…** for which there may be liability under this Insurance. Any Claim arising from such circumstances shall be deemed to have been made in the Period of Insurance in which such notice has been given"*

In February 2007, Euro Pools became aware that its air-driven boom system was failing and causing booms not to rise properly. It identified the problem as a failure of the bracing of the steel air tanks in the system and suggested that the installation of inflatable bags could be a solution. Euro Pools notified its insurer of the issue and the proposed solution.

On 9 June 2007, Euro Pools completed a renewal form ahead of purchasing the Second Policy. Euro Pools was asked if it was *"aware of any circumstance which may give rise to a claim"* and responded by stating, *"tanks on booms but we are fixing these with inflatable bags".* Euro Pools was hopeful that its proposals would succeed, but made a precautionary notification under the expiring policy in case they did not. As it transpired, the inflatable bags failed to fix the issue.

On 2 May 2008, Euro Pools notified its insurer that its inflatable bag solution had begun to fail and that it intended to change from an air-driven boom system to a hydraulic system. The following month, Euro Pools informed the insurer that installing a hydraulic system was the only realistic solution to the problem of failing booms.

The insurer confirmed that it would cover the costs of installing such systems as mitigation costs but insisted that the claim had been notified under the First Policy. The costs of installing the replacement systems exceeded the First Policy's limit.

Euro Pools contended that its further notification in May 2008 brought the claims for hydraulic installations under the Second Policy. This was because there was no causal connection between the initial notification regarding failing bracing and the later failure of the inflatable bags intended to remedy that problem. Euro Pools sued the insurer for the booms claim.

High Court

In the first instance, the High Court ruled in favour of Euro Pools on three grounds.

1. The email sent on 2 May 2008 was treated by the insurer as a valid notification of circumstances under the Second Policy.

2. The scope of the notification in February 2007 was limited to problems with some of the steel tanks. There was no causal link between these issues with the tanks and the decision to switch to a hydraulic system.

3. Even if there had been a link, an insured can only give notification of a flaw that they are aware of at the time. Euro Pools was not aware of the flaw in the air drive system that led to the adoption of the hydraulic system in February 2007, so they could not give notification of it.

The Judge held that there was no notification of the circumstances giving rise to the installation of the hydraulic system under the First Policy. The relevant notification was made in May 2008 and thus the mitigation costs fell under the Second Policy.

Court of Appeal

The Court of Appeal overturned the High Court decision. Its key finding was that there was a sufficient causal connection between the 2007 notification of circumstances and the installation of hydraulic systems as a potential solution to avoid claims being made:

> *"… the remedial works were carried out in order to mitigate a loss or potential loss that might have been the subject of a potential Claim from a third party on the grounds that the booms, powered by an air drive system, were not rising and falling properly."*

The following key principles come through in the short judgment:

1. In order to give a valid notice to the insurer, the insured must be aware of the circumstances in question – it is that awareness which triggers the duty and the right to notify. Knowledge of the problem is all that is required, the insured need not be aware of the solution;

2. The insured must only have a reasonable expectation that the circumstances in question may produce a claim falling within the policy. Whether the policy responds is determined with when a claim is eventually made against the insured by a third party;

3. If a claim is subsequently made against the insured, *"the question will be whether [it] is one 'arising from such circumstances'. This requires 'some causal link', but this is not a particularly demanding test of causation."* The following three questions will generally need to be answered where circumstances are notified in one year and a claim made against the insured in the next:

   (i) What was the scope of the circumstances which were notified? The notification is to be considered according to ordinary principles of interpretation. The High Court in this case was found to have erred in applying a narrow interpretation to the 2007 notification.

   (ii) Does the necessary causal link exist? Keeping in mind the reasonably low bar for causation as discussed above.

   (iii) Is there liability under the policy for the defect in question?

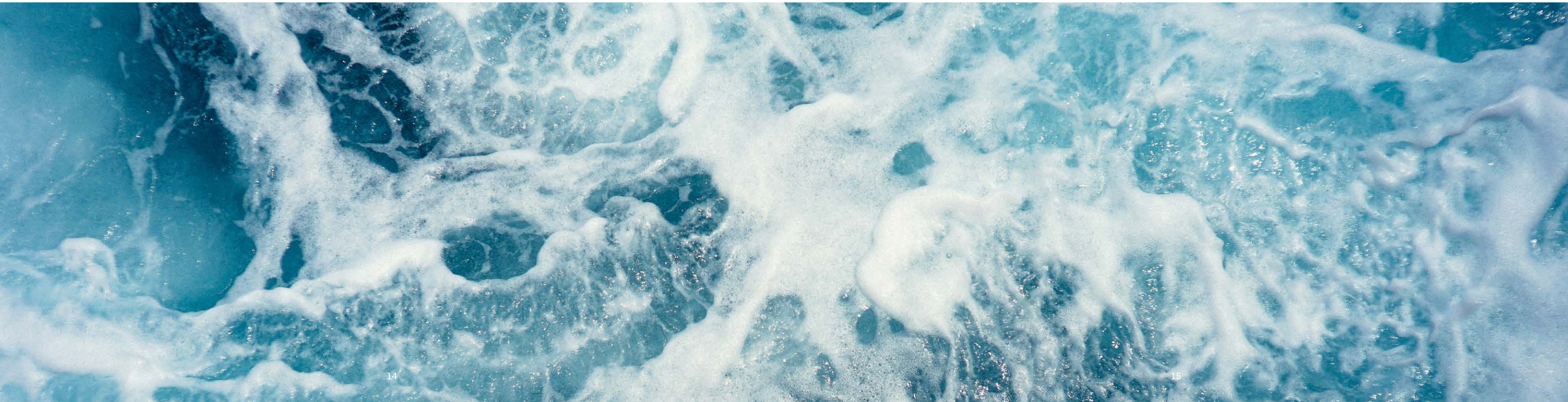
4. The causation question is slightly different where the insured expends mitigation costs. The issue remains whether there is a causal link, but the question is whether the costs were incurred to mitigate or avoid a claim *"which might reasonably be expected to arise from the notified circumstances".*

Case lessons

We see two key lessons coming out of this case:

- When reviewing claims notifications, care should be taken to identify the practical problem that is notified, in the context of the facts known to the insured. A practical, rather than narrow, approach should be taken; and

- The question is then whether there is a causal link between the original claim and the later notification. The bar is low. A useful frame of reference when considering whether a claim arises from what appears to be a connected notification is whether there is only a "purely coincidental" connection between the original notified circumstances and the later claim.



The ALRC Final Report on Class Actions and Litigation Funding: Six things NZ insurers should know

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In January 2019, the Australian Law Reform Commission released its Final Report on Integrity, Fairness and Efficiency: An Inquiry into Class Action Proceedings and Third-Party Litigation Funders.

New Zealand lags behind Australia and other influential common law jurisdictions in having no established legal framework to govern procedure in true "class actions". The "representative action" procedure permitted by High Court Rule 4.24 (a 19th century rule), as it has been developed by the courts, is creaking at the seams and lacks the mechanics to grapple adequately with the minefield of issues that frequently arise in complex group litigation.

Change is coming. A New Zealand Law Commission review, currently on hold due to resourcing and other projects taking priority, will look into the current state of NZ law on class actions and litigation funding. When it does, it will draw upon the work of the ALRC.

Australia has more than 25 years' experience with a developed class action regime. From a law reform and policy design perspective, there is much to be learned from the Australian experience. Not everything that the Australian regime has fostered is to be encouraged here. A number of the issues identified by the ALRC in its second-generation review and the measures it has proposed seek to ameliorate the undesirable design features of the Australian class actions regime. These will offer food for thought for the NZ Law Commission looking at class actions and litigation funding.

Why should NZ insurers pay attention?

1. Australia has experienced significant growth in class actions and litigation funding. Shareholder (known as "stock-drop") claims against company directors have been the dominant type of class claim, often engaging D&O insurance policies. This has impacted on premiums and the availability of cover. Claims of other types have been brought as class actions as well and the nature of those claims will have engaged other insurance products. NZ insurers could find themselves on risk for claims of a similar nature. The scale of potential liability is large.

2. Particular features of the Australian regime have encouraged an active third-party litigation funding market. Litigation funders are currently largely unregulated in both New Zealand and Australia, although Australia has more controls than New Zealand through its procedural rules and judicial supervision over class action settlements. The ALRC's consideration of regulation for litigation funders takes Australia several steps beyond where NZ is currently, and whilst the ALRC has not gravitated towards a litigation funders licensing regime, the ALRC recommended a number of measures in lieu of it.

3. Many insureds operate trans-Tasman businesses. Conduct in some cases (e.g. consumer protection claims, cartel damages claims, or product liability claims) could extend across both jurisdictions.

4. Group litigation in New Zealand is growing gradually, even in the absence of a supportive legal framework. Group cases are here to stay and are among the most complex and challenging litigation for the parties and the courts to manage.

5. There is an interplay between private enforcement and regulatory enforcement, including regulatory and enforcement capability, will, tools, and the suite of remedies available for consumer redress. The ALRC recommends a further look at regulatory enforcement tools for consumer redress. Such measures can flow through into the scope and extent of potential liabilities in ways that could engage insurance cover.

We should care about regulatory design and settings. We do not have a true "class actions" framework. The New Zealand courts, in the absence of such a framework, interpret the existing "representative actions" rule flexibly, to facilitate group claims rather than constrain them, consistent with access to justice and efficiency rationales. However, parties and their advisers are, for the moment, left to derive the ground rules from a growing body of interlocutory judgments. This is inefficient and imposes additional costs upon litigants.

Reform is overdue - but equally it should not be rushed. Important policy considerations should be assessed properly. The NZ Law Commission is the right body to be looking such matters as it has the research capability, can consult widely, and is independent. The NZ Law Society has said publicly that it strongly supports the Law Commission project and has written to the Law Commission and Minister of Justice to express that view and a desire to see the reference reactivated as a priority project in the 2019/20 programme.

The six key points insurers should note from the ALRC review:

1. The types of claims in the Australian experience

Shareholder or "stock-drop" class action claims constitute over a third of all class action proceedings in Australia and have been the dominant type of action. That said, the types of claims mounted reflect a broad range of both commercial and non-commercial causes of action - shareholder and investor claims, cartel damages claims, mass tort claims, consumer claims for contravention of consumer protection law, environmental claims, trade union actions, claims under immigration legislation, and human rights claims.

Table 3.3: Types of class action claims filed in the Federal Court that were funded by litigation funders (March 2013-March2018)

Type of claim	No. of proceedings	No. that were funded	% that received funding	% of all funded class actions
Claims by shareholders	37	37	100%	52%
Claims by investors	26	17	65%	24%
Consumer protection claims	13	4	31%	6%
Product liability claims	8	4	50%	6%
Mass tort claims	8	3	38%	4%
Claims by emplyees/workers	5	2	40%	3%
Claims by franchisees, agents &/or distributors	3	2	67%	3%
Claims by real estate owners	5	1	20%	1%
Claims by alleged victims of racial discrimination in non-migration proceedings	3	1	33%	1%
TOTAL	**108**	**71**	**66%**	

Source: Professor Vince Morabito, Private correspondence (15 March 2018).
Table 3.3 taken from *ALRC Final Report*, page 76.

2. A key proposal is that all class actions be initiated as open class

In order to improve access to justice and to return Australia's class action regime to its original design, the ALRC recommends amending the Federal Court of Australia Act 1976 (Cth) and the Federal Court of Australia's class actions Practice Note to provide that class actions must be initiated as open class. This is said to improve access to justice by enabling all victims of a civil wrong to participate in the class action, not just those who take active steps to join in.

The amendment to the Act would be supported by amendments to the Practice Note to set out the circumstances in which it may be necessary to close the class to facilitate a settlement and the criteria for the limited circumstances in which a class action that has been closed may be reopened.

In order to support an open class regime, the ALRC recommends that the FCA Act be amended to provide an express statutory power for the Court to make common fund orders.

Both issues – "opt-in" vs "opt-out" and common fund orders – are "live" in the New Zealand context currently.

Our High Court Rules Committee prepared a draft Class Actions Bill and accompanying amendments to the High Court Rules back in 2007. The Bill was based in large part on Australian federal and Victorian legislation. The Bill was provided to the then Minister of Justice in 2009, but has not progressed since due to other government priorities. The Class Actions Bill, as drafted, preserves the possibility for both "opt-in" and "opt-out" class actions, suggesting in its introduction that the majority of class actions might opt-out.

The NZ courts' answer to date has been to permit "representative actions" to proceed on an "opt-in" basis, on the view that an "opt-out" (i.e. open class) regime requires legislation.

The policy debate remains live and the design choice will have significant implications. The High Court in a recent case referred to research showing that around 8% of class members might opt-out, whereas only around 39% might opt-in. The number of potential claimants plainly impacts on the quantum of potential exposure, which has implications for litigation funding. An "opt-out" model can offer more certainty and finality when looking to settle, than trying to resolve one "opt-in" class action if there is the looming prospect of another with a different set of plaintiffs. Design choice matters. The current draft Bill leaves both possibilities open.

The prospect of a common fund order being sought has been signalled in one recent case although the application has yet to be made and determined.

3. **Several key recommendations address the rising incidence of competing class actions**

   Multiple class actions increase uncertainty, cost and delay, making a sound public policy basis for procedural rules to permit only one class action with respect to a dispute to proceed, subject to the overriding discretion of the courts.

   The prospect of multiple "closed class" class actions seems to us to be one of the obviously undesirable features of the current Australian regime, in that it permits overlapping claims against the same defendants arising out of the same circumstances. AMP, for example, was the subject of five separate competing open class actions arising out of matters raised at the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry. There have been shades of the same issue emerging here in New Zealand, with two group claims being run against James Hardie entities over cladding, albeit focussed on different geographic areas.

   The ALRC has recommended that the Federal Court is given an express statutory power to resolve competing representative proceedings, backed by more detailed case management procedures in the Practice Note.

   Such measures require quite detailed and prescriptive rules. It seems to us that the prospect of competing or overlapping class actions is to be avoided. There are learnings to be gained from the Australian experience in designing a framework for NZ that is fit for purpose.

4. **One key recommendation would permit costs awards against insurers and funders**

   One of the key recommendations is that the FCA Act should be amended to expressly empower the Federal Court to award costs against third-party litigation funders and insurers who fail to comply with the overarching purposes of the Act.

   This recommendation is said to seek to enhance the Court's ability to supervise third-party litigation funders during proceedings, but the power would extend to insurers as well. The Court would be given an express power to impose costs on the litigation funder (and potentially insurers, if they are directing the litigation) personally if they act in a manner that frustrates the overarching purpose of the Act to facilitate the just resolution of disputed claims according to law and as quickly, inexpensively, and efficiently as possible.

5. **The ALRC proposes a suite of recommendations to improve oversight of litigation funders, in lieu of a licensing regime**

   The ALRC acknowledges that litigation funding may improve access to justice. It refers to empirical evidence that a number of successful class actions would not have run without the funding provided by litigation funders. The ALRC also notes that, notwithstanding that contribution, there are inherent risks associated with litigation funders: risk that they might fail to meet their obligations under funding agreements; or use the Courts for improper purposes; or that they may exercise influence over the conduct of proceedings to the detriment of plaintiffs.

   The ALRC proposes a suite of recommendations to improve the regulation of litigation funders. These are proposed in lieu of a licensing regime overseen by a statutory regulator.

   The Report includes some finely calibrated recommendations designed to reduce the risk to consumers of litigation funding services if a funder does not meet its obligations, and to improve the security for costs position for respondents by including a statutory presumption that funders will provided security. It also makes recommendations to ensure court approval of the litigation funding agreement, which make clear the courts' jurisdiction to review, amend, and set terms including commission rates, plus a further set of recommendations relating to the management of conflicts of interest.

"Multiple competing class actions increase uncertainty, cost and delay."

1 Common fund orders typically require all members of a class to contribute equally to the legal and litigation funding costs of the proceedings regardless of whether the class member signed a funding agreement *Money Max Int Pty Ltd (Trustee) v QBE Insurance Group Limited* (2016) 245 FCR 191, *Pearson v State of Queensland* [2017] FCA 1096 and *Caason Investments Pty Limited v Cao (No 2)* [2018] FCA 527.
2 *Ross v Southern Response Earthquake Services Limited* [2018] NZHC 3288. This appears to be the view of the Rules Committee also *Consultation on Representative Proceedings* (6 September 2018).
3 *Ross v Southern Response Earthquake Services Limited* [2018] NZHC 3288 at [22].

All of this entails much closer scrutiny and supervision of third-party litigation funding arrangements, both at the outset of proceedings and on settlement of class actions - considerably more than in New Zealand currently. In fact, the New Zealand Supreme Court has emphasised that it is not the role of the Courts to "assess the fairness of any bargain between the funder and a plaintiff" or to act as "general regulators of litigation funding arrangements", seeing these things as a matter for legislation.

6. **The ALRC identifies regulatory collective redress, and the substantive law on continuous disclosure, for further review**

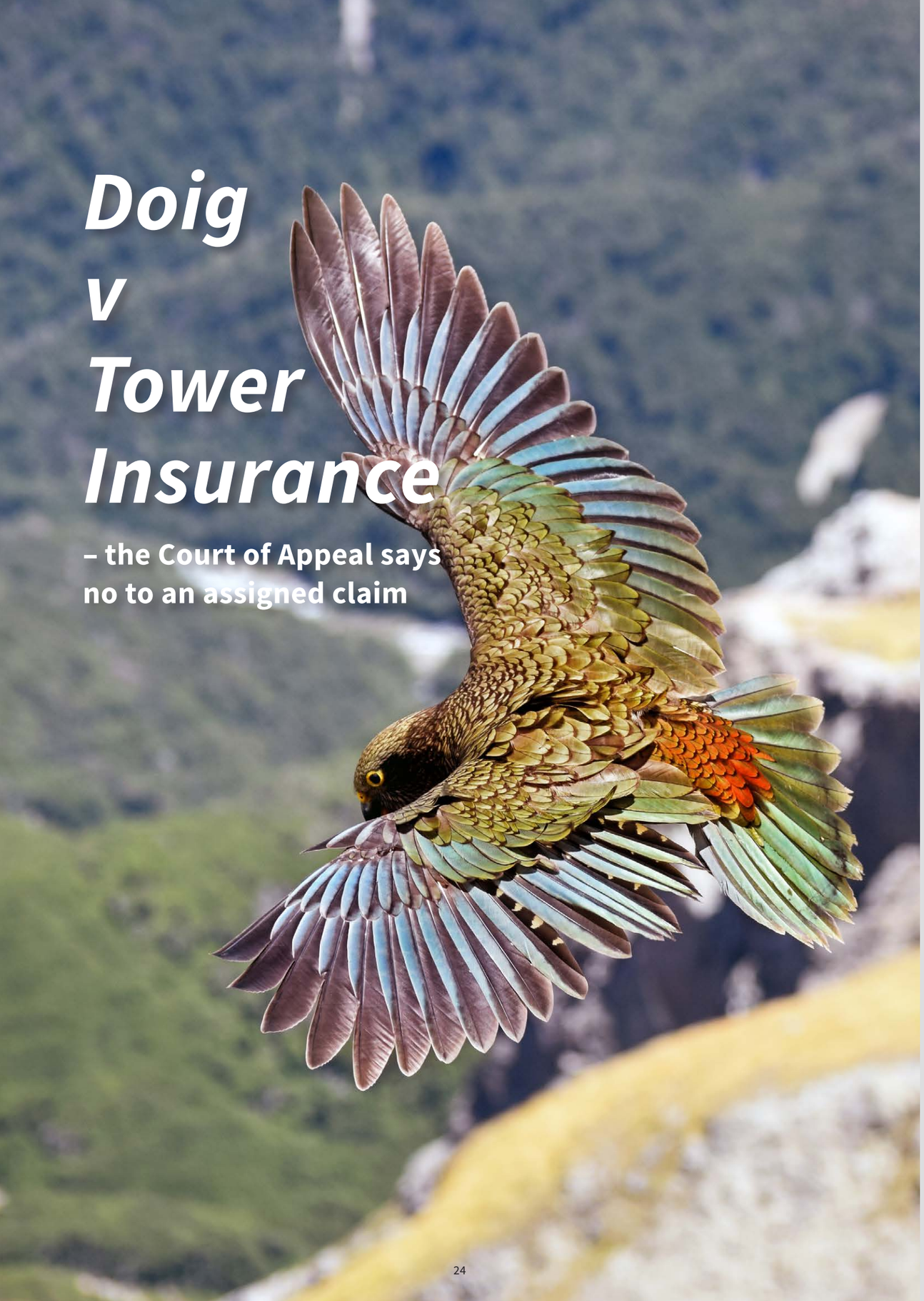
   Noting the "enhanced consumer measures" introduced in the UK in 2015, and the ability in particular of the UK's financial services and competition regulators to consider and oversee consumer redress schemes, the ALRC recommends that the Australian government review the enforcement tools available to regulators of products and services used by consumers in small businesses (including financial and credit products and services), to provide for a consistent framework of regulatory redress.

   Such redress schemes can extend beyond the obvious measure (customer refunds) to prescribe processes to be followed in more complex cases where individuals' entitlements and quantum nay need to be established and assessed and redress then made.

   The ALRC also recommends that the Australian government commissions a review of the legal and economic impact of the operation, enforcement, and effects of continuous disclosure obligations. That goes directly to the legal framework underpinning the basis for shareholder class actions. That is of interest to New Zealand, with the NZX Listing Rules having been recently amended (with effect from 1 January 2019, with a six-month transition period) for better alignment with the current Australian rules that have been slated for review.

Group litigation, while still rare in NZ, is becoming an established part of the New Zealand litigation landscape. Recognising that reality, a well-designed framework to accommodate true "class actions", with an appropriate balance between the rights of plaintiff groups and the rights of defendants, is needed.

When the NZ Law Commission does reinvigorate its project on class actions and litigation funding, it will find there is much to be gleaned from the ALRC's Final Report. When it consults, insurers will want to be heard. They will no doubt have perspectives to add from their own experiences with the class action regimes in Australian and internationally.



Doig v Tower Insurance

– the Court of Appeal says no to an assigned claim

The Court of Appeal recently delivered judgment in *Doig v Tower Insurance*, the latest in a series of assigned material damage claims. We covered the High Court decision last year

Nick Frith
Senior Associate

This decision is relevant to all material damage claims handlers. It provides reassurance, and a note of caution, when dealing with insureds and their representatives where there is a sale of damaged property.

Recap of the facts

In 2012, the Doigs entered into a conditional agreement to purchase a property which had been damaged in the Christchurch earthquakes but not yet repaired. The vendors were insured under a full replacement cover policy with Tower. It contained the usual clause that Tower was not bound to: "Pay more than the present day value if you have full replacement value until the cost of replacement or repair is actually incurred. If you choose not to rebuild or repair your house we will only pay the present day value." "You" was defined as the person named in the policy.

In anticipation of settlement, the Doigs' legal executive asked Tower how the property damage claims would be dealt with, in particular:

> *If the above scenario were to occur [i.e. if the repairs ended up over the EQC statutory cap], would Tower cover the damage under its existing full replacement cover, i.e. any repair work required over and above the EQC caps would be covered fully by Tower as per the current full replacement policy held by the vendor.*

The Court of Appeal described this question as hitting "the bull's-eye". The Doigs relied on the following particular words from Tower's response:

> *… if the EQC repairs are deemed over cap, it is TOWER's liability to repair the dwelling. The new owners would not be required to lodge an additional claim as the damages to the property were incurred under the previous owners policy and these claims will remain open until the damages in relation to those earthquake events are rectified. … All settlement will be based on the previous owners policy including their policy cover and excess.*

The vendors assigned their insurance claims to the Doigs shortly prior to settlement. In March 2014, Tower advised the Doigs that, as assignees, "its liability was limited to the pre-loss indemnity value of the house, rather than the cost to replace or rebuild." In 2016, the property damage was declared over the EQC statutory cap. Tower then determined that the property was not capable of economic repair and that it would need to be demolished and rebuilt. However, relying upon the *Bryant* principle, Tower asserted that it was only liable to pay indemnity value to the Doigs, because they were assignees – their original insureds had, in selling, chosen not to repair. Tower paid its assessment of indemnity value.

The Doigs sued Tower on the basis that they had relied on the statements Tower made prior to settlement to their detriment, by confirming the agreement for sale and purchase for the property. In the alternative, they sought compound interest on their indemnity entitlement. The High Court held that the Doigs had not established that they had acted to their detriment in reliance upon Tower's statements. It dismissed the Doigs' interest claim on the basis that Tower's liability to pay was only triggered when EQC declared the claim over cap.

> *"Tower had not made a clear and unequivocal representation that the Doigs would be able to claim the full replacement cost for repairs or replacement, post purchase."*

The appeal

The Court of Appeal dealt with three issues:

(a) Was a clear and unequivocal representation made by Tower?
(b) Had the Doigs changed their position adversely in reliance on the representation?
(c) Did the Judge err in his conclusion on interest? That is, were the Doigs entitled to compound interest on indemnity value, if that was the extent of their entitlement against Tower?

The Court proceeded on the basis that the law on the assignability of reinstatement insurance claims was as stated in by the Court of Appeal in *Xu v IAG* and previously in *Bryant*. This meant, in summary, that a person cannot assign a claim to full replacement under an insurance policy; an assignee is limited to indemnity value.

Issue 1: Did Tower make a clear and unequivocal representation?

The Court held that Tower had not made a clear and unequivocal representation that the Doigs would be able to claim the full replacement cost for repairs or replacement, post purchase. There were four reasons for this:

(a) Tower's response to the Doigs' legal executive's question above was no more than a generic and indicative discussion of the insurer's responsibility. Critically, Tower said it *"cannot agree to the claims being transferred to your client until we receive a deed of assignment"* and that a discussion as to specifics was necessary. The Court went on to say that *"Assignment was by law in the gift of the insurer, and for the time being that gift was withheld. A deed, and a discussion, were needed"*;

(b) The relevant emails were with the Doigs' legal executive, who was taken to understand the reservations in Tower's statements. She had asked a clear question, and received a "cloudy answer". This is a potentially important point for claims handlers;

(c) Tower said that its decision, including as to approving any transfer of the vendors' rights, was contingent on production of a deed of assignment. Matters were not discussed further with Tower, nor was the deed of assignment signed, until after the Doigs were irrevocably committed to the purchase; and

(d) Care was needed in commercial relations before enquiries made of third parties (e.g. insurers) should be permitted to shift risk to, in this case an insurer, from the parties to the contract.

Issue 2: Had the Doigs changed their position adversely in reliance on the representation?

This issue was moot given the answer to Issue 1 above. However, the Court expressed the view that the Doigs had not suffered qualifying detriment for the purposes of an estoppel arising, for two key reasons:

(a) The Doigs asserted that they would not have settled if Tower had not provided "confirmation" regarding the relevant claims. However, the Court said that there was no evidence, or legal support, for a right to cancel – the contract was not conditional on assignment and the vendors did not appear to have made an actionable representation as to the assignability of claims; and

(b) The Doigs had suffered no further detriment than the non-fulfilment of departure from the belief or expectation created by Tower's email. There was no relevant change of position.

Issue 3: Did the Judge err in his conclusion on interest?

The Doigs ultimately conceded that Tower could not be liable for compound interest under the Judicature Act which was in force at the time. They maintained that Tower's obligation to pay arose a short time after the event giving rise to the loss i.e. 22 February 2011.

However, the Court found that Tower's obligation to pay was only triggered by EQC "making payment", which was implicit in the policy. EQC declared the claim over cap in July 2016 and Tower made payment in November 2016, which was insufficient to constitute an unlawful delay in breach of the insurer's obligations. Consequently, even if the Doigs' claim was viewed as a claim for interest as damages, there was no breach to found such a claim. The claim for statutory interest failed for want of a money judgment.

Cautious reassurance

We see this case as reassuring for insurers. It demonstrates that the courts are willing to take a fairly strict approach to statements made to third parties in the claims management context. However, we view the Court's reliance on the fact that Tower's emails were exchanged with the Doigs' law firm as significant. The position, and result, may have been different if the emails were with the Doigs themselves. Insurers ought to take care to set out their position on issues such as assignment clearly.

This case is also a reminder that, at least at the time of publication of this issue, we await the Supreme Court's decision in *Xu v IAG*. That may of course change the position with respect to the assignability of reinstatement benefits under material damage policies. If so, the Doigs would not, at least in theory, have needed to rely upon Tower's emails.

Good faith and income protection insurance

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The recent case of *Taylor v Asteron Life* [2019] NZHC 978 provides guidance for insurers in two respects:

1. The High Court held that the insured's duty of utmost good faith is an implied term in an income protection insurance contract, which requires insureds to be truthful in making claims.
2. Where an insured breaches the duty of utmost good faith, the insurer may use remedies under the Contract and Commercial Law Act 2017, rather than be left with its remedies at common law. This allows insurers to reclaim settlement payments that are later found to have been improperly made, as damages for breach of contract or as repayment of amounts paid under the insurance contract.

In this case the insurer was awarded full restitution of the amounts it had paid the insured under the policy.

The Facts

Mr Taylor was a self-employed insurance broker. He became ill and was unable to work from 23 December 2009. In July 2010, Mr Taylor submitted a claim under his "Income Plan" insurance policy with Asteron Life Limited (**Asteron**), which accepted his claim and started making payments.

In May 2014, Asteron made a number of requests of Mr Taylor to supply it with financial information. Eventually he produced some financial information, including accounts for a company called Peter J Taylor and Associates Limited (the **Company**). The accounts were not for his insurance broking business, though some of the commissions earned through that business were channelled through the Company. The accounts showed that the Company had made a loss. Asteron asked about the commissions disclosed in the accounts, which totalled $551,491 and had been paid into and out of the Company. Asteron explained that Mr Taylor's insurance entitlement was subject to a deduction for prescribed income that he earned while claiming policy benefits. In September 2014, Asteron stopped making payments and advised Mr Taylor that it would not make any further payments until it could reconcile his claim.

In December 2015, Mr Taylor sued Asteron and sought:

1. a declaration that he was entitled to receive continuing benefits under his policy; and
2. an order directing Asteron to make payments of benefits under the policy together with payment arrears since September 2014.

Asteron counterclaimed and sought restitution of all amounts paid under Mr Taylor's policy.

The Policy

The Policy included two categories of cover – a "Total Disability Benefit" and a "Partial Disability Benefit". The "Total Disability Benefit" provided "Full Pay" for a period of 60 days followed by a 75% "Pay Period" until the insured turned 65, subject to the deduction of certain specified income. Mr Taylor was entitled to work up to 10 hours per week while collecting the "Total Disability Benefit". After a minimum period of 14 days on the "Total Disability Benefit", Mr Taylor could drop back to the "Partial Disability Benefit" of 75% of his insured monthly income, less specified income, if he was able to work to a limited extent so that his monthly income equated to 75% or less of his insured monthly income.

Mr Taylor's claims

Whether Mr Taylor suffered from a 'Sickness'

The first point that the Court needed to establish was whether Mr Taylor suffered from a sickness within the meaning of the policy. Mr Taylor elected not to call expert medical evidence. This would ordinarily have made the task of proving his illness very difficult. However, because Asteron did not dispute that Mr Taylor suffered from a qualifying sickness, the Court accepted that he was potentially entitled to qualify for one of the policy benefits.

Although the Court found it difficult to identify what conditions Mr Taylor suffered from, they appeared to include a long list of illnesses and complications.

Whether Mr Taylor was "Totally Disabled" or "Partially Disabled"

Mr Taylor's evidence was that he had not been able to work more than 10 hours per week since 2010. However, Asteron subpoenaed three of his former employees to give evidence which contradicted his account. It was supported by documentary records which confirmed that Mr Taylor was still actively involved in his business.

The Court concluded that Mr Taylor's evidence was generally unreliable. The Court determined that Mr Taylor was able to, and did in fact, work for more than 10 hours per week, which disqualified him from receiving the Totally Disability Benefit.

The question was then whether Mr Taylor could nonetheless have claimed the Partial Disability Benefit. The primary issue was in identifying Mr Taylor's "Monthly Earned Income" for the period during which he made claims on his policy. It was defined in the policy as "… your monthly pre-tax salary, commissions, bonuses and fringe benefits if an employee, or your monthly pre-tax earnings net of any business expenses necessarily incurred in deriving those earnings if a self-employed person." This issue was important as Mr Taylor's income was derived from a business that made money from his and others' efforts. Mr Taylor had insured all of the income he derived from his business. So the Court defined "Monthly Earned Income" in the context of this claim as:

> *… Mr Taylor's monthly pre-tax earnings from his business, net of any business expenses necessarily incurred in deriving those earnings. That is so whether or not the earnings are a consequence of his own efforts, or those of his employees, or not.*

In determining the specified income to be deducted from his claim amount for the purposes of quantifying any Partial Disability Benefit:

> *The full amount of the net profit from Mr Taylor's self-employed business gets deducted from the prescribed benefit irrespective of any arguments that it was not the product of his own endeavours, or solely his own endeavours.*

Asteron called an expert accountant to calculate whether Mr Taylor was entitled to receive the "Partial Disability Benefit" i.e. whether his Monthly Earned Income was 75 per cent or less of his Monthly Insured Income. The accountant calculated Mr Taylor's Monthly Earned Income for the 2008 – 2014 financial years, a task which was complicated by the fact that Mr Taylor had provided differing sets of the same annual accounts, one of which falsely represented that his broking business made trading losses. The evidence assumed that Mr Taylor earned his monthly income evenly across the year, and even on that assumption, the required two-thirds abatement resulted in all amounts due under the policy being fully off-set.

Consequently, the Court found that Mr Taylor's illness had not adversely affected his income in a way covered by the policy. The Court dismissed his primary claims.

Asteron's counterclaims

Asteron counterclaimed that it was entitled to:

1. cancel the contract of insurance or avoid any further liability under it; and
2. claim restitution of the amounts it had paid to Mr Taylor.

The legal framework

The Court found that the duty of good faith was an implied term of the insurance contract and its application was therefore subject to a contractual analysis. Asteron alleged that Mr Taylor "… breached his obligations of good faith under the contract by making false statements in his forms provided with his claims. It also seeks restitution of what it paid out on that basis."

The Court acknowledged uncertainty in determining the correct legal framework for an insurer's remedies following an insured's breach of the duty of utmost good faith. Asteron had relied on common law principles, whereas Mr Taylor had argued that the Contract and Commercial Law Act 2017 applied. In the end, the parties agreed that that Act could be used to address all of the issues in this case and the Court proceeded on that basis.

Sections 36 to 39 apply to cancellation where a party rescinds or treats the contract as discharged for misrepresentation, repudiation, or breach. Under section 37(1)(b) and (2), Asteron was entitled to cancel the policy if Mr Taylor breached a term of the contract that was essential to Asteron, or which substantially altered the benefits and burdens of the contract.

Decision on Mr Taylor's position

The Court found that Mr Taylor breached his obligation of good faith under the policy by making false statements about the amount of time he had spent working in the forms he provided with his claims. The Court found that Mr Taylor deliberately misrepresented to Asteron the amount of work in which he was engaged. Mr Taylor had returned to work in 2010 and worked approximately four hours a day at home or in the office and generally oversaw the overall business operation. This amounted to a breach of Mr Taylor's duties under the contract. In addition, his income remained essentially unaffected as well as being beyond that which was agreed in the policy.

Asteron had based its claim on the representations that Mr Taylor had made regarding the number of hours that he worked and not his statements about his income. However, the Court recorded that the financial statements which Mr Taylor discovered for his business for the 2010-2012 financial years presented a serious issue. They were signed by his accountants and stated that the business had made losses of $75,301 in 2010; $38,607 in 2011 and $70,881 in 2012, over the years that Mr Taylor claimed to be incapacitated by his illness. However, Mr Taylor also discovered a second set of signed accounts which reported an operating profit of $149,025 in 2010; $163,830 in 2011; and $155,407 in 2012. The Court found that the inaccurate accounts were deliberately prepared to create the false impression that Mr Taylor made operating losses when, in reality, he was making profits.

"The Court found that the inaccurate accounts were deliberately prepared to create the false impression that Mr Taylor made operating losses when, in reality, he was making profits."

Asteron's restitution claim

Asteron sought "an order requiring Mr Taylor to pay back to it all the money it has paid him under the Policy given that the payments were induced by the false claims." Notably, the restitution claims were made on the basis of Mr Taylor's statements about his hours worked, not about his income, although the Court saw the two as closely related.

The Court applied section 42 of the Act, which allows the Court to make orders with the effect of unwinding contractual obligations that have already been performed where it is just and practicable to do so. One preliminary issue was whether Asteron had given the necessary notice of cancellation, as section 43 requires the claiming party to have cancelled. Section 41(1)(a) requires cancellation to have been made known to the other party, i.e. Mr Taylor. The Court found that the necessary notice was given in one of Asteron's witnesses' briefs.

Mr Taylor attempted to advance three defences: immateriality, absence of intent and change of position. The Court found that Mr Taylor's misstatements were plainly material and deliberately false, which dealt with the first two of his defences.

In advance of the change of position defence, Mr Taylor pleaded that he had received the payments in good faith and had altered his position in reliance on their validity. He relied upon his purchase of two luxury cars, expenditure on building a holiday home, and expenditure on overseas trips (including a 12 hour flight to Hawaii which the Court found difficult to reconcile with the evidence that he suffered from extreme back pain inhibiting his ability to remain seated for work activities). To be able to rely on this defence it was necessary for Mr Taylor to have acted in good faith, which he had not, given that he had induced Asteron to make payments under the policy by making false statements in relation to the extent of his ability to work.

The Court awarded Asteron full repayment of the money it had paid with interest.

Do brokers & insurers owe continuing duties of care?

A recent case indicates that insurance brokers and insurers may owe a continuing duty to inform customers if circumstances change during the policy term

This will be of interest to brokers and insurers who may have assumed that they need to consider their customers' interests only at policy inception and renewal time.

This claim involved a house that was damaged in the September 2010 and February 2011 Canterbury earthquakes. The owner, Ms Brindson, had since 2001 insured the house under a sum insured policy with Vero Insurance, arranged by her broker, Mr Beazley. Prior to that, she had full replacement cover with a different insurer. Ms Brinsdon received annual renewal notices with key policy details, including the sum insured, which was automatically increased each year. Crucially, the renewal on 12 December 2010 took place between the September 2010 and February 2011 earthquakes.

Ms Brinsdon lodged claims with EQC and Vero for both events.

EQC declared the claims over cap in August 2013. The cost of repairing the earthquake damage was found to exceed the sum insured in the policy. In March 2015, Vero offered to settle the claim for what appears to be a sum insured payment for the February 2011 event. The September 2010 event remained under the EQC statutory cap.

The claims

In September 2017, Ms Brinsdon sued Mr Beazley, claiming that her house was under-insured due to his defective advice at both inception and the renewal of her policy. She later joined Vero on the basis that it was vicariously liable for Mr Beazley's failures. Both defendants applied to strike out the proceedings on the basis that they were out of time for statutory limitations purposes.

Ms Brinsdon accepted that her claims were brought outside the primary six year limitation period. However, she contended that the limitations period should be extended because of equitable fraud or because she had late notice of the claims.

The Court recorded that the cause of action in negligence might be said to have accrued on 28 September 2014, when a building contractor provided Vero with its estimate of the cost to repair, which exceeded the sum insured. Prior to this, it could not have been said that she had suffered any loss, as it was not known whether her sum insured was inadequate.

Duties owed by brokers and insurers

Both Mr Beazley and Vero accepted that there was an arguable case that Mr Beazley (and Vero vicariously) owed Ms Brinsdon duties of care on the inception and renewal of the policy. However, they denied that those duties continued after renewal, and said that this meant that the claims were out of time:

> *…they take issue with the contention that there is an arguable case of ongoing duties of care subsequent to the last renewal of 12 December 2010. They also say that the grounds for postponement and/or late knowledge have not been made out. It is further said that the plaintiff's claim for ongoing duties of care subsequent to the last renewal, as yet not pleaded, constitutes a fresh cause of action and that this too must fail on limitation grounds.*

An expansion of duties of care?

The Court identified the following four issues in deciding not to strike out Ms Brinsdon's claims:

1. Duty of care

Is there an arguable case that the defendants owed ongoing duties of care, after the last renewal of the policy in December 2010, to keep Ms Brinsdon informed?

The Court found that Ms Brinsdon was asserting the existence of a novel duty of care, but acknowledged the rule that courts should be slow to rule on novel categories of duty of care at the strike-out stage. The Court also saw the timing of the alleged breaches of duty as relevant, as they occurred between the September 2010 and February 2011 earthquakes. The Judge said that, while there might be merit in the defendants' objections to the imposition of the alleged duties, that was a matter for trial.

The Court then held that Ms Brinsdon had (our emphasis) "*… established a tenable case that **the defendants owed ongoing duties of care to ensure and/or advise about the adequacy of insurance cover.**"*

2. Limitation extension

Had Ms Brinsdon demonstrated an arguable case for an extension or postponement of the limitation period under s 28(b) of the 1950 Limitation Act, on the grounds of equitable fraud? Was there an arguable case that the defendants had a duty of disclosure and that the failure to disclose was wilful?

The Court concluded that Ms Brinsdon had established a tenable basis for postponement of the limitations period on the grounds of equitable fraud. The Court held that it was:

> *… reasonably arguable that the defendants knew that Ms Brinsdon was under a misapprehension as to the scope of the cover. They also knew that she had not been advised as to the scope and adequacy of cover prior to or subsequent to the renewal in December 2010, and in particular during the period following the first Canterbury earthquake (September 2010).*

And that:

> *There is a tenable claim that the defendants knew Ms Brinsdon was not aware of the limitations of her policy and they delayed taking action to inform her of the correct position when they knew that the policy would not cover the full cost of repairs or that there was a real risk of that occurring.*

3. Late knowledge claim

Had Ms Brinsdon established the grounds for late knowledge under s 11(2) of the 2010 Act?

The Court found that Ms Brinsdon:

> *… did not have knowledge, and it was not reasonable for her to have knowledge, until March 2015 of:*
>
> 1. *the omissions by the defendants to advise her about the adequacy or otherwise of her insurance cover that she says have occurred (she believed that she had full replacement cover and understood the defendants had not made any omissions);*
> 2. *the fact that the omission was attributable to the defendants; and*
> 3. *the fact that she had suffered damage or loss in the sense that she would be out of pocket for any costs in excess of the total sum insured limit.*

4. Fresh cause of action issue

Was Ms Brinsdon's claim for ongoing duties of care a fresh cause of action that ought to have been brought by 26 March 2018 (three years after the late knowledge date of 26 March 2015)? The Court found that the amended pleading of an ongoing duty of care post-renewal in December 2010 would be a fresh cause of action. However:

> *The essence of the plaintiff's existing claims against the defendants in negligence is that, over a substantial time period, during which there is an alleged ongoing relationship with Mr Beazley, the defendants were under continuing obligations to act reasonably and with care in relation to advising Ms Brinsdon about insurance cover. The proposed amended claim is in substance the same kind of claim. The proposed amended claim will not be a substantial change (it is a question of degree) and in essence the legal basis for the claim remains the same.*

The Court rejected the defendants' submission that the proposed amended pleading would be out of time.

Conclusion

While the precedent value of this case is limited, as it was a preliminary strike-out application, it is an interesting indication that the Court was prepared to accept that brokers and insurers may owe novel duties of care that extend beyond policy inception or renewal.

Brokers and insurers should watch this case with interest.

Insurance lessons from the Christchurch attack

In 2015, following the tragic terrorist attack at the Lindt café in Sydney, we wrote that *"the attack at the Lindt café … serves as a chilling reminder that the unimaginable can happen anywhere"* (Cover to Cover, Issue 4).

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Olivia de Pont
Senior Associate

Four years later, the unimaginable happened here in New Zealand, with an armed gunman attacking two Christchurch mosques during Friday prayers, killing 51 people. The government, private sector and community rushed to support the families of the victims. The Prime Minister gave assurances that support from ACC would be available and banks established dedicated accounts for donations. More than $15 million has been raised to support those affected by the attacks.

Sharia-compliant life cover

The insurance sector also promptly made statements supportive of the victims and their families, with a number of insurers announcing that they would pay out claims on any life insurance policies held by the victims and would not rely on terrorism exclusions to deny cover.

It is unclear, however, whether any life insurance claims have been received. There is reason to believe that few, if any, of the victims may have held life policies with New Zealand insurers. This illustrates a gap in New Zealand's insurance market. Many Muslim scholars regard traditional insurance as being haram, or contrary to Sharia law. Muslims may enter into an alternative, co-operative arrangement known as Takaful, which is widely available in larger markets such as the UK, but we know of no domestic New Zealand providers. Some brokers may arrange foreign Takaful cover for New Zealand residents, but this does not appear to be widespread. There is an opportunity for insurers and brokers to arrange and offer appropriate products for New Zealand's Muslim community.

Terrorism insurance in New Zealand

The insurance response following the attacks also drew attention to the general unavailability of terrorism insurance in New Zealand. While insurers advised that they would not rely on terrorism exclusions in this instance, most insurance policies exclude terrorism and it is not clear that insurers would take such a permissive approach in the event of a larger loss that affected a significant number of insureds. This raises the question of whether the New Zealand government should follow the example of the United States and Australia and offer a terrorism reinsurance scheme to support the private market.

Government reinsurance schemes for terrorism developed after the September 11 attacks in New York, when private reinsurers largely withdrew from the market for terrorism cover. Primary insurers then followed suit by excluding cover for terrorism events to protect themselves from potentially significant losses in the absence of reinsurance for this risk.

With terrorism insurance unavailable post-September 11, lenders and investors held back and economic development in the US slowed. To address this, the US Congress enacted the Terrorism Risk Insurance Act, known as TRIA, to provide a form of government reinsurer.

A number of other countries followed suit. Australia, for instance, has legislation that overrides terrorism exclusion clauses when a terrorist incident is declared. Private insurers may then claim reinsurance payments from the Australian Government. Government reinsurance for terrorism is also available in France, Belgium, Germany, South Africa, Denmark, Netherlands, Russia and Spain.

Prior to the Christchurch attack, New Zealanders may have seen little need for our government to offer or support terrorism reinsurance. Perceptions of terrorism risk in New Zealand must now, regrettably, have changed and these issues should be reconsidered. We see no reason in principle for the New Zealand Government not to follow the lead of the nations referred to above and ensure that New Zealanders benefit from the same terrorism cover that is available elsewhere.

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