PROTECT

Cover to Cover
Issue 23

Our publication for New Zealand insurance professionals

MinterEllisonRuddWatts.

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Introduction

Welcome to Issue 23 of Cover to Cover – our publication for New Zealand insurance professionals.

In this edition, we look at important developments in the way that New Zealand's financial markets regulator, the Financial Markets Authority, is looking at insurers and intermediaries. We report upon developments in the FMA's views and expectations in relation to conduct and culture for fire and general insurers, following its earlier investigations into the life and health insurance industry, and concerns expressed in its initial findings that most fire and general insurers are not presently meeting its expectations. We also look at the effect of the new regime that will be implemented when the Financial Markets (Conduct of Institutions) Amendment Bill is passed into law. In addition, we report upon recent civil proceedings that the FMA has issued against insurers and what they may signify for its approach to dealing with those who voluntarily self-report and remedy issues.

We also provide an update on COVID-19 claims under business interruption insurance policies around the world, some recent successes by regulators and insureds and upcoming cases that are due to be heard.

Cyber risk continues to be a priority for all organisations and their insurers, with recent 'lockdowns' once again presenting additional risks arising from remote working and the associated need for remote verification and increased loading upon resources. We summarise perspectives gained from a Cyber Risk breakfast we hosted in June this year, at which industry speakers provided different perspectives on cyber risk and the place of cyber insurance.

We report on recent court decisions of interest to the insurance industry, including a New Zealand decision relating to the position of overseas liability insurers faced with claims under a statutory charge and a helpful English decision upon the meaning of "deliberate act" in a liability policy.

Our experts discuss these issues and more in this edition of Cover to Cover. We hope you find it useful and interesting.

Key conduct issues for insurers

What should insurers consider

The Financial Markets Authority (FMA) expects the insurance industry to prioritise and improve its conduct and culture ahead of the new regime to be brought in by the Financial Markets (Conduct of Institutions) Amendment Bill (CoFI Bill).

The Insurance conduct and culture: Fire and general insurers update (Review), released in July 2021, makes clear that many fire and general insurers are not meeting the FMA's conduct expectations. This review echoes the findings in the FMA and RBNZ's joint review of Life Insurer Conduct and Culture in 2019 (Life Insurer Review).

The Review found that, overall, insurer responses showed poor understanding of and commitment to good conduct and culture practice across the sector. Just two (MAS and IAG) of the 42 insurers met the FMA's expectations. Around 95% of insurers' responses were unsatisfactory.

While current laws do not provide specific conduct requirements for insurers, the FMA is clear that now is the time for the industry to take meaningful steps to improve its conduct or risk facing regulatory action to prepare for the new conduct regime. In this article, we explore the key findings and recommendations from the Review and what will be required of insurers under the new conduct regime.

Governance

The Life Insurer Review included a directive for all insurers to actively consider conduct risk within their businesses. Ahead of the Review, fire and general insurers were asked to complete specific tasks, including a requirement to develop an action plan to address any issues in their business arising from the recommendations in the Life Insurer Review (which included weaknesses in governance and accountability for conduct and culture). The Review found that responses were well below their expectations.

The FMA found that Board engagement was mixed across the industry. Only one board amended its charter to reflect their governance of conduct and culture, while others used audit and risk committees to discuss conduct and culture issues. However, others were not sufficiently engaged: eight insurers' audit and risk committees overlooked and excluded conduct and culture risks in their risk management frameworks, and in several cases, it was unclear how conduct and culture risk identification and management was integrated and embedded across the business.

The CoFI Bill includes a requirement for a fair conduct programme to clearly

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Insurer responses showed poor understanding of, and commitment to, good conduct and culture practice across the sector.

define the roles, responsibilities and accountabilities for managing risks associated with conduct that fails to comply with the fair conduct principle (new section 446M FMCA). Therefore, insurers should further develop their conduct plan with the future CoFI requirements in mind. Each plan should clearly outline governance arrangements, including the roles of the Board and senior management in managing conduct and culture.

The FMA expects Boards to prioritise conduct risk. Boards should ensure they have a clear mandate over conduct. In particular, foreign-owned insurers should ensure they have the independence and control to identify and manage conduct and culture risks in relation to their New Zealand practice. While there is no one-size-fits-all approach, conduct governance should occur at both a Board and sub-committee level, with effective two-way communication channels within the business.

Boards and senior management need to set the tone for managing conduct risk and prioritising good customer outcomes. The Review encouraged each Board to further articulate their expectations for managing conduct risk in the business. Boards then need to ensure that they have sufficient information from the business to satisfy themselves and to hold management accountable for meeting their expectations.

Controls and processes

The FMA found that the majority of insurers are not yet prepared for the new conduct regime. The Review shows that insurers need to prioritise investment in improving internal systems, processes and controls in order to effectively manage conduct risk.

Insurers now have a directive to consider conduct risk within their businesses. Each insurer should ensure that it has set an appropriate risk appetite, which acknowledges conduct risk as a material risk. Insurers should also ensure that conduct risk is embedded in its risk management policies. Policies should set out roles and responsibilities, outline systems and processes to monitor and control material risks and be subject to regular review.

The CoFI Bill will require insurers to apply a principles-based approach to ensure good customer outcomes. This represents a shift from compliance-led regulation to conduct-led regulation, which requires insurers to consider the fair conduct principle throughout their businesses and act beyond minimum requirements. The new regime will require insurers to conduct a deeper examination of their existing culture, governance, policies, processes and procedures.

Insurers should review their existing policies and frameworks by applying a conduct risk lens. In particular, insurers should ensure that they have sufficient controls in place to manage conduct risk (focusing on key policies such as vulnerable customer and whistle blowing policies) and that each control effectively manages conduct risk. In particular, insurers should review their code of conduct to ensure a focus on good customer outcomes. New or amended policies should be communicated to, and implemented by, staff ahead of the new regime.

Product review

Only 22 out of 42 insurers conducted the systematic review of products and policy-holder portfolios requested by the FMA. Of those, all but four identified "major issues". Most issues related to weaknesses in systems and processes, poor value, legacy products, and insufficient ongoing monitoring of product suitability. Positively, six insurers withdrew poor value or legacy products from sale as a result of the Review.

Product review will become an essential part of an insurer's fair conduct programme when the new conduct regime comes into force. In order to treat consumers

We suggest that insurers:

- Clearly articulate intended outcomes for products (including new products) to consumers.
- Review products regularly to ensure they remain fit for purpose and relevant to those intended outcomes.
- Review existing products to assess whether they remain relevant, suitable and fit for purpose. Insurers should also review the product review process to ensure that design and suitability is appropriately assessed. Where issues are identified, root cause analysis should be conducted.

"Under the new regime, insurers must treat consumers fairly when providing a relevant service"

fairly, insurers will be required (among other things) to ensure that their services and associated products are likely to meet the requirements and objectives of likely customers (new section 446B(2)(d) of the Financial Markets Conduct Act 2013 (FMCA)). This obligation applies when the product is designed, offered to consumers and provided to consumers.

Remediation of issues

Remediation activity to address issues identified in the Review is already underway by several insurers, with thousands of customers set to receive refunds as a result. The FMA considered that many insurers did not meet the "basic requirement that premiums are accurate, transparent, administered correctly and with value communicated to the customer". The FMA expects compensation to be paid in a timely manner, and for the root cause of issues to be adequately addressed.

Under the new regime, insurers must treat consumers fairly when providing a relevant service (for example, when acting as an insurer, providing a financial advice service or acting as an intermediary for those services), which includes any dealings or interactions with a consumer in relation to their insurance policy (section 446C(c) and (d) FMCA). Among other things, we expect regulators to have heightened attention on insurers' conduct during claims and complaints handling.

Insurers need to review their remediation practices to ensure that they have formal remediation frameworks, policies and processes which centre around treating customers fairly. In particular, insurers should consider how their remediation processes ensure that they:

- pay due regard to consumers' interests;
- act ethically, transparently and in good faith;
- assist consumers to make informed decisions; and
- not subject consumers to unfair pressure or undue influence.

Incentives

While many insurers were addressing staff incentives (including removing volume-based sales incentives), there was less proactivity in relation to commissions paid to intermediaries. The FMA expects insurers to have better oversight on commissions and incentives, including to intermediaries, which should be "fair and reasonable to customers, and understood by customers".

The Government has signalled its intention to take action in relation to sales incentives with the introduction of the new conduct regime. The CoFI Bill contains a regulation-making power which allows for the prohibition or regulation of any practice or conduct related to offering or giving incentives. The Bill also includes an obligation on insurers (and other financial institutions) to put in place policies, processes, systems, and controls for designing and managing incentives to mitigate or avoid the actual or potential adverse effects of incentives on the interests of customers (new section 446M(1)(b) FMCA).

In the consultation paper (issued 24 May 2021) on regulations to support the new regime, the Ministry of Business, Innovation and Employment (MBIE) indicated its preferred option was to prohibit sales incentives based on volume or value targets. MBIE considers that such a prohibition would prevent the inherent conflict of interest with consumer interests that is created by such incentives.

Insurers should consider how their existing remuneration structures would comply with the incoming conduct regime. In particular, insurers should consider the inherent conduct risk attributed to sales incentives,

and whether they should be removed from remuneration structures ahead of the new regime. Insurers should also consider how to incentivise good conduct, such as through remuneration based on customer satisfaction, compliance with policies or through demonstrating good conduct culture.

Oversight of intermediaries

Intermediary oversight by insurers was identified as a key issue in the Review. The FMA considers that fire and general insurers, like life insurers (per the joint review of Life Insurer Conduct and Culture 2019), should take ultimate responsibility for customer outcomes regardless of how products are sold. However, in its consultation paper (issued 24 May 2021) on the treatment of intermediaries under the new conduct regime, MBIE indicated that it would pare back the obligation to have oversight of intermediaries.

The Finance and Expenditure Committee amended the CoFI Bill at Select Committee stage to remove the requirement for intermediaries to have a fair conduct programme, and for financial institutions to ensure the intermediaries' compliance with its fair conduct programme. It is likely, following MBIE's consultation, that the application of the CoFI Bill to intermediaries will be further limited. In its consultation, MBIE proposed to limit the CoFI Bill's application to intermediaries involved in the sale and distribution of the financial institution's products or services and narrow the financial institution's oversight obligations.

While intermediaries are no longer directly subject to the obligations in the CoFI Bill, financial institutions are required to have oversight of intermediaries to ensure they are supporting a financial institution's compliance with the fair conduct principle including by (new section 446M FMCA):

- conducting competence and fit and proper checks;
- setting clear conduct expectations;
- establishing procedures to address an intermediary's misconduct; and
- monitoring whether intermediaries are treating consumers consistently with the fair conduct principle.

It is unclear how extensive the requirements for oversight of intermediaries in the CoFI Bill will ultimately be. However, insurers should note the obligations under the new financial advice regime and the need to ensure that they and their intermediaries comply with the duties under the regime and the Code of Professional Conduct for Financial Advice Services (which includes, for example, the duty to always treat clients fairly when giving financial advice).

Insurers should therefore be proactive in managing the relationship with the intermediaries it engages, particularly with those involved in sales and distribution. Insurers should ensure that their contractual arrangements with an intermediary set clear conduct expectations and include robust procedures for monitoring and enforcing those expectations.

Next steps

The Review provides a useful guide as to those matters the FMA expects fire and general insurers to consider as they prepare for the introduction of the new conduct licensing regime set out in the CoFI Bill (which is expected to be in force in early 2023). Re-assessing their conduct and culture governance frameworks, and considering and acting on the relevant recommendations in the Review, will be essential to insurers demonstrating readiness for the new regime.

Co-authored by Sarah Jones and Maria Collett-Bevan.

When will the FMA go to court against insurers?

FMA guidance

The FMA's website features six separate guidance notes in which it discusses how it decides when and how to use the regulatory weapons in its armoury. They are as follows.

1

Regulatory Response
2016

These guidelines are intended to describe how the FMA brings enforcement action in response to contravention of the financial markets legislation, outlines its response options, and discusses how it decides upon a regulatory response.

2

Enforcement policy
*2011**

This sets out, among other things, the FMA's enforcement priorities and the factors it weighs in deciding whether to pursue a breach that comes to its attention.

**No longer featured on the FMA's website, but apparently not subsumed into the Regulatory Response Guidelines as they refer to this policy.*

3

Co-operation policy
2016

This outlines the circumstances in which the FMA might exercise its discretion to take a lower level regulatory response or no action at all in exchange for information and full, continuing and complete co-operation.

4

Prosecution policy
Undated

This sets out the FMA's decision-making criteria to be applied when considering a criminal prosecution.

5

Model litigant policy
2013

This policy outlines the FMA's intended approach to litigation and conducting investigations.

6

Strategic Risk Outlook
Annual

This identifies, among other things, the FMA's view of the main risks to, and the opportunities it has for promoting fair, efficient and transparent financial markets, which include enforcement options.

The table on the previous page provides a lot of guidence. Key points that may be distilled from it include the following:

- Whether the FMA takes action in a particular case will depend, among other things, upon:
  - Its assessment of whether the matter fits within its regulatory and enforcement strategic priorities (including whether the conduct is likely to harm fair, transparent, and efficient financial markets).
  - Whether it is of general relevance, rather than a one-off issue or one that is confined to the individual parties.
  - Whether the person involved cooperates with the FMA.
  - Prospects of success.
  - Seriousness of the conduct.
  - Whether the conduct can be remedied or undone.
  - Other mitigating or aggravating circumstances.
  - Whether serious loss has been suffered.
  - The wider public interest.
  - Whether another agency of the State is better placed to pursue it.
  - Whether the FMA has the resources to pursue it in light of its other priorities.
- Where the FMA does pursue a breach, its approach will depend on a number of additional considerations, including the following:
  - Demonstrating real and credible consequences of misconduct or non-compliance.
  - Being consistent in its responses and in how it uses its regulatory tools.
  - Encouraging reporting misconduct, appreciating that a lack of willingness to do so may prevent it from hearing about potential misconduct and harm in the market.
  - How best to achieve specific regulatory objectives and whether they can be met by an alternative resolution.
  - Whether there is a need to clarify the law.
  - Whether there is a need to educate the market and change behaviours.
  - The need for deterrence, balanced against whether the defendant may be seen as a 'martyr'.
  - Whether there is an appropriate alternative to litigation available.
  - Whether litigation would result in compensation or reparation to affected persons.

Perhaps surprisingly, the FMA indicates in its Regulatory Response Guidelines that if harm has been identified, it "may also take regulatory action of some sort even though no 'rules' appear to have been broken". This seems contrary to fundamental legal principles relating to the rule of law.

A change in approach?

Most insurers are large, professional organisations with sophisticated processes to ensure compliance with their regulatory obligations. Historically, they have had constructive relationships with the FMA, as one of their primary regulators. They are also regulated by the Reserve Bank, as their prudential regulator with responsibility for licensing, solvency and adequacy of reserves.

On the whole, when issues with compliance arise, as they inevitably will when providers serve a large number and variety of customers with a range of complex financial products in a developing regulatory and commercial environment, they have been dealt with in a constructive and professional manner. The financial markets providers and the FMA have generally been focussed upon resolving issues, compensating any customers who have been affected and ensuring that systems and processes are improved to avoid a recurrence.

"Most insurers are large, professional organisations with sophisticated processes to ensure compliance with their regulatory obligations."

This was the approach taken when the FMA (and the Commerce Commission, which previously had regulatory responsibility for insurers' market conduct) entered into a 2016 settlement with Westpac to resolve an issue involving some NZD4 million in fees which had inadvertently been overcharged to New Zealand customers who used ATM machines in Australia. Westpac proactively brought the issue to the regulators when it became aware of it and agreed an appropriate remedy. The matter was resolved without court proceedings and without any penalty on the basis that the bank agreed to pay appropriate

compensation to affected customers.

The Commerce Commission, with the FMA's involvement, entered into a similar settlement agreement with Tower Insurance in 2017 to resolve an issue in which Tower had inadvertently overcharged customers who were entitled to multi-policy discounts by calculating their discounts incorrectly. Tower proactively informed the regulators of the issue when it came to light. The resolution was that Tower would calculate and pay compensation to the affected customers and would make a charitable donation to reflect its inability to reimburse some customers. Again, no proceedings were issued and no penalty was paid.

In both instances, the FMA resolved the issues in a constructive and practical manner, recognising that the bank and the insurer had identified the errors themselves, self-reported them to the regulator and made sensible proposals to compensate affected customers. This responsible behaviour was rewarded with a light regulatory response that did not involve court proceedings or a penalty.

The FMA had previously entered into similar settlement agreements with three banks to resolve claims of misleading conduct with respect to interest rate swaps. In each case the issues were resolved out of court, with the banks making compensation payments to affected customers and without penalties being paid.

Has there been a change?

A different approach appears to have been evident in the FMA's dealings with insurers more recently. Two cases illustrate this.

In 2019, ANZ Bank proactively informed the FMA that in 2018 it had identified issues with credit card repayment insurance policies that it had provided to some of its credit card customers. The issues related to the inadvertent issuing of multiple policies to a small number of customers and the issuing of policies to an even smaller number of customers who were ineligible because of their age. The errors were inadvertent, and their monetary value was relatively low compared with earlier cases. The bank reimbursed the affected customers in full, with interest. Unlike the previous cases, however, the FMA issued court proceedings against the bank under the misleading conduct provisions of the Financial Markets Conduct Act 2013 (FMCA). The bank admitted the claim in full and agreed to pay an agreed penalty of NZD280,000. While the proposed penalty was agreed in a settlement agreement, as proceedings had been issued, it was imposed in the form of a fine imposed by the court.

A similar approach was taken in a court proceeding commenced in 2021 by the FMA against AIA Insurance. AIA identified and self-reported three issues in 2018 as part of the FMA's review of life insurers at that time: a purported enhancement of policy benefits, charging premiums after the termination of a policy and treating policies as terminated when they should have remained in force, and incorrect inflation adjustments. AIA admitted the claims in the proceedings and agreed with the FMA a joint penalty recommendation of NZD700,000, which remains subject to a penalty hearing in court.

> "Insurers may wish to reflect upon whether their regulatory environment has changed and what this may mean for their engagements with the FMA."

These examples appear to illustrate a change in the FMA's approach to cases in which insurers identify an inadvertent error that has disadvantaged customers, act prudently and openly to remedy it and self-report the issue to their regulator. Prior to 2019, the FMA's approach was to resolve these matters with an agreed compensation process and undertakings to ensure that the problems did not recur. Now, it appears more likely that the response will be to rely upon the insurer's self-reported admissions to issue proceedings, in the knowledge that the insurer will not defend them and a judgment will be issued.

Such a change would be consistent with the FMA's statements in its 2019-20 annual report, which included a statement that financial services firms should expect a more robust enforcement response, as the new financial services regulatory regime matured and firms had had an opportunity to become aware of their new regulatory obligations. This would also be consistent with one of the FMA's strategic priorities being to maintain a credible deterrence effect through enforcement action.

This apparent change in approach also came at a time in which the FMA's funding for litigation was tripled. The FMA exceeded its litigation budget in the 2019 financial year, spending almost NZD3 million against a budget of NZD2 million. For the 2020 financial year, the Government tripled the FMA's litigation funding budget to NZD6 million. A report by PwC observed that they expected to see relatively more of the budget directed to investigation and enforcement over coming years.

More generally, the Government's 2020 budget nearly doubled the FMA's overall funding, increasing it in increments over three years by an additional NZD24.8 million per annum to a total of NZD60.8 million, with the majority of the increase coming from increased levies upon insurers and others in the financial sector. An MBIE discussion paper released in January 2020 identified a number of reasons for the budget increase. One reason identified was an increase in the number of potential breaches identified, requiring additional resource for enforcement activity, and that financial services providers' systems, controls and governance around conduct risks was lower than expected, so there was an increased need for investigation and enforcement activity by the FMA.

A change in the FMA's enforcement approach from a constructive and cooperative approach to resolving unintended process or systems issues to one in which court proceedings will be issued as a matter of course against insurers who have acted prudently to remedy issues, compensate customers fairly and proactively report the issues to the FMA, may have unlooked-for consequences. The FMA identify one such consequence in their own guidance note, which is that it may discourage insurers and other market participants from reporting misconduct, so that the FMA may learn less about potential misconduct and harm in the market. Another may be that insurers become less willing to proactively compensate affected customers except as part of a settlement with the FMA because they see that as a potential bargaining chip to use with the FMA to avoid court proceedings and a financial penalty.

Insurers may wish to reflect upon whether their regulatory environment has changed and what this may mean for their engagements with the FMA. While we do not expect that insurers will withhold information that they are obliged to provide, some may wonder whether more cautious and less open engagements in some respects may be appropriate. It will be interesting to see whether any changes and developments that occur will assist the FMA in achieving its regulatory objectives.

Authored by Andrew Horne.

Cyber threats, insurance and the legal response

Cyber-attacks on businesses and other organisations are both increasingly common and increasingly damaging. It is no longer a surprise to read a news or business website and learn of a cyber-attack that has caused significant disruption and loss.

In May of this year, the public health system in Waikato was thrown into disarray by a large-scale cyber-attack upon the Waikato District Health Board which left it unable to manage and carry out routine medical procedures. The DHB was compelled to cancel many patient procedures and had to resort to manual record-keeping and workarounds. A number of patients were transferred to Tauranga or Wellington along with their Waikato clinicians. By mid-June, while some services and systems had been restored, many had not and the DHB reported that there was still a long way to go.

This incident illustrates the risks that New Zealand organisations face from cyber criminals and the disruption and damage their actions may cause. The very nature of cyber-attacks mean that national borders are meaningless; New Zealand organisations are as likely to be targeted as those in larger countries.

In June this year, we hosted a Cyber Risk breakfast jointly with global brokerage firm Aon, with the title: "The changing risk landscape: corporate resilience for the rise of technology". Four organisations provided different perspectives on cyber risk and the place of cyber insurance:

- Datacom provided a perspective from an IT security provider.
- AIG provided a perspective from a cyber insurer.
- Aon provided a customer's risk perspective.
- MinterEllisonRuddWatts discussed the legal risks raised by cyber events and how to respond.

In this article we summarise these perspectives.

Cyber-attacks – a technical perspective

Cyber crime is low-risk profiteering because of offenders' ability to maintain anonymity. It is thought to have surpassed all other types of crime combined. Cyber criminals usually take or lock up commercial or customer information and issue ransoms with the threat of deleting the information or releasing it to media and other global platforms if not paid.

Some key points:

New Zealand is exposed

New Zealand is a soft target for cyber criminals because we think too locally. Although we tend to view ourselves as tucked away at the bottom of the world with clear borders, which has benefited us in our response to a real-world virus in COVID-19, cyber criminals exist in a borderless universe and New Zealand is as exposed as anywhere. Our naivety makes us an easy target.

Keep up with hygiene

Good hygiene is important. Up to date software patches, identity verification and device security are all key. CERT NZ's top 11 suggestions for cyber security are a good place to start.

Cyber crime is profitable

Most cyber crime is committed for profit – and it is very profitable and relatively low risk.

Do the basics well

Do the basics well first. Email security and multi-factor authentication are critical. Train and test your staff often. Deploy a managed EDR (endpoint detection and response) solution to protect your devices, as this is the most likely way into your network.

Quick response is critical

When an attack happens, timeliness of response is critical. If you do not have sufficient visibility of your environment, that will hamper your response, as will not having tools like EDR already deployed. In any event, get professional help as early as possible. You can make things worse.

An insurer's observations of trends

AIG, which has offered cyber solutions for two decades, observed the following key trends in cyber-attacks and their effects:

- A significant increase in insurance claims due to the increasing prevalence of ransomware – a form of software that infects a cyber system and encrypts files, which cannot be accessed until a ransom is paid in exchange for a decryption key. Ransomware typically infiltrates systems through phishing emails with attachments containing the ransomware. A study by AIG found that ransomware and extortion claims under cyber insurance policies increased by 150% between 2018 and 2020, by which time they accounted for one in every five claims.
- Cyber criminals often now take their time and conduct data reviews prior to encryption to make their attacks more effective. They work through networks and identify the best, most valuable data and critical systems, right to the top of the IT architecture. Attacks that are more targeted are more harmful. When this approach is taken, ransom and extortion claims are typically for amounts twice as high as less-targeted attacks: hackers demand a higher price for the most valuable data.
- Typically, businesses are unable to operate properly for between seven and 10 days following a cyber breach.

Losses caused by cyber-attacks usually impact multiple aspects of insurance cover:

- Extortion and the cost of ransoms.
- Event management costs – IT forensics and legal counsel are required to respond to technical and legal issues.
- Network interruption losses – traditional business interruption losses of profit.
- Security and privacy – regulatory actions, defence costs and fines, potential customer claims.

Cyber-attacks are increasingly expensive for the insurance industry. To ensure that the risk profile does not continue to rise, insurers are now looking carefully at the following factors:

- Understanding the similarities in deficiencies and controls of victims' businesses to gauge when other insureds may be vulnerable.
- Tailoring cyber insurance cover to how well or poorly cyber risk is managed by an organisation.

Addressing cyber risk requires a two-pronged approach

Aon report that from an insured's perspective, there are two key ways to address cyber risk: increased cyber security and risk transfer through cyber insurance. Both are necessary for risk mitigation.

All organisations are now more exposed than ever because of the changing ways in which we work. Remote working is widely accepted and commonly employed, which results in the 'perimeter' of organisations disappearing or changing. Often, organisations include customers in their business processes through shared portals, online logins and other means which create further points of entry to data.

Many organisations, particularly SMEs, did not 'bake' security into their systems early on in the process and now have minimally protected legacy systems running core processes with multiple updates and services added in ways that create gaps in existing security.

The key 'at-risk' organisations are those who hold customer data, have access to other parties' systems or data as part of the service they provide or are information conduits for service providers.

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There are two key ways to address cyber risk: increased cyber security and risk transfer through cyber insurance.

Insurers are asking increasingly detailed questions of insureds and they will not generally offer cyber risk insurance to organisations that do not have adequate cyber security systems. Even if insurers are prepared to offer cover, the price will depend on the security environment. One advantage of cyber insurance is that it helps organisations to identify weaknesses in their systems and it encourages them to increase investment in security to reduce premiums. From a business perspective, the fact that an organisation has obtained cyber insurance may become a mark of quality of its existing security measures which may be a selling point for customers.

Cyber insurance is therefore an overall value proposition – it minimises the risk and allows organisations to operate and interact more effectively.

The legal impact of cyber-attacks

MinterEllisonRuddWatts commented that a cyber-attack or security breach will inevitably require a legal response as well as an IT response.

The following legal claims and issues often arise:

- The target organisation suffers its own losses – money is stolen through payment diversion schemes or data is stolen or locked up so that it cannot be accessed and normal operations are affected. This causes financial loss to the organisation. These losses can potentially lead to actions by shareholders against directors if they have not put effective cyber security in place.

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A cyber-attack or security breach will inevitably require a legal response as well as an IT response.

- The target organisation incurs liability to customers or other third parties such as those whose personal information is released. Customers' money may be lost or their data locked up or released to the public.
- Regulatory action, such as by the Privacy Commissioner or the Financial Markets Authority, can result in defence costs, fines and penalties.

Organisations can take steps to protect themselves from legal risks during and immediately following a cyber-attack. These include:

- Make no admissions about the adequacy or otherwise of cyber security arrangements or any other matter. Expressions of regret that an incident has occurred may be appropriate but take professional advice first.
- Take prompt steps to respond with appropriate IT assistance to mitigate any loss.
- Involve insurers at the outset.
- Take advice. Many cyber insurance policies will identify IT experts and a panel of specialist lawyers who will assist.

Co-authored by Andrew Horne Hannah Jaques.

Burnett v International Insurance Co of Hanover Ltd [2021] UKSC 12

Meaning of "deliberate act" in a liability policy

Unsurprisingly, most liability insurance policies exclude cover for deliberate acts. The reason is obvious – insurance is there to protect against fortuities – not the insured's own deliberate conduct.

Issues can arise in determining precisely what constitutes a "deliberate act", especially where the exclusion is drafted in a generic boilerplate fashion. In *Burnett v International Insurance Company of Hanover Ltd*, the Supreme Court of England and Wales was recently seized with the issue of whether a "deliberate act" exclusion applied where an employee of an insured had inflicted a fatal injury on a third-party.

Background

The insured was a private security contractor which provided door stewards to bars in Aberdeen, Scotland. One of its employees, while attempting to restrain a patron, used excessive force that resulted in the patron's death. With the insured in liquidation, the patron's widow sought to recover damages for her husband's wrongful death directly from the insurer. The insurer refused cover on the basis that any vicarious liability on the part of the insured was excluded as it arose as a result of "deliberate acts, wilful default or neglect".

The relevant clause contained no detail as to what would constitute a deliberate act. Its application was therefore unclear. Did it require the employee to intend to kill the patron? If so, it was common ground that he did not and so the exclusion would not apply. If, however, the employee merely needed to intend to apply the restraint to the patron, it was inarguable that he did and so the exclusion would take effect to deny cover.

At first instance, the court found that the exclusion would apply only where the employee intended to kill, since that was the outcome that gave rise to the insured's

potential liability. This conclusion was upheld on appeal, albeit in softer terms. The requisite intention was to create liabilities for losses that would be covered by the policy. This would capture an intent to kill but also an intent to create serious injury. A deliberate act accidently causing injury would not qualify.

Supreme Court

The insurer's argument in the Supreme Court was that "deliberate acts", for the purposes of the policy, meant acts which are intended to cause injury (of any kind) or acts which are carried out recklessly as to whether they cause injury. The Court accepted only the first part: "deliberate acts" included acts intended to cause injury. It noted the potential for absurdity on this point – that the perpetrator must have intended the specific injury that occurred – arising from the fact that chance will often determine whether the specific consequence matched the perpetrator's intent and that a perpetrator's intent will often not be fixed to a particular injury.

The problem for the insurer was that there was no evidence to suggest that the insured's employee had intended to inflict injury. In fact, there was evidence to the contrary. The insurer therefore needed the Court to accept the second strand of its proposed interpretation of the exclusion clause: that it extended to acts carried out recklessly as to whether they cause injury. The Court found against the insurer on this point. The natural meaning of "deliberate" did not include reckless acts. The insurer could point to no authority in which "deliberate" had been interpreted in this manner and there was nothing in this policy or its surrounding context suggesting such an intent.

Comment

The criminal courts are well-versed in determining questions of intent in uncertain circumstances. However, this case demonstrates that the same issue can arise in insurance law. And it causes similar uncertainty. Its key finding reduces this uncertainty somewhat – all other things being equal (and always subject to particular policy terms) exclusions for deliberate acts in public liability policies covering injury will be engaged only where the act giving rise to liability was intended to cause injury.

This case is likely to have wider ramifications. Many liability policies contain "deliberate acts" exclusions. In our view, this case will be persuasive authority for the proposition that "deliberate" does not include "reckless" conduct and that "deliberate acts" exclusions are likely to be interpreted as requiring a clear connection between the act in question and the consequence.

More generally, this case is a reminder of the importance of carefully drafting exclusion clauses. It is important to focus upon exclusion clauses to mitigate uncertainty and address the particular circumstances intended to be captured by the clause. Otherwise, excessively generic language is likely to deprive insurers of the benefit of an exclusion clause on which they intended to rely to limit the scope of liability.

Co-authored by Nick Frith Thomas Leggat.

> "This case is a reminder of the importance of carefully drafting exclusion clauses."

Livingstone v CBL Corporation Limited (in liq) & Ors [2021] NZHC 755

Overseas liability insurers defend statutory charge claims by plaintiffs

The High Court has recently reconfirmed that overseas insurers are immune from statutory charges under the Law Reform Act 1936 (LRA). However, overseas insurers looking to strike out claims by New Zealand claimants will need to be careful to be armed with clear evidence showing that they do not operate a business in New Zealand.

Background

The plaintiff made various claims against failed insurer CBL. One of those claims was that CBL held insurance policies (a Public Offering of Securities Insurance policy (POSI Policy) and a Directors and Officers Liability Policy (D&O Policy)) indemnifying CBL and its directors against the plaintiff's other claims. The plaintiff sought a declaration under section 9 of the LRA that any money payable to CBL under those policies was subject to a statutory charge in the plaintiff's favour.

As the Court said, section 9 of the LRA was enacted to overcome the unfairness of insurance proceeds being paid to the pool of creditors of an insolvent insured rather than to the party who suffers the loss insured by the policy. The LRA avoids this by creating a charge over the money payable by the insurer in favour of third-party claimants, such as Mr Livingstone, on the happening of the insured event.

A bar on claims against overseas insurers

CBL relied on the Supreme Court's decision in *Ludgater Holdings Ltd v Gerling Australia Insurance Co Pty Ltd* as authority for the proposition that section 9 of the LRA does not have extraterritorial application.

Because the facts pleaded in strike out applications are presumed to be true, only indisputable evidence is admissible to prove the incorrectness of the pleadings. Affidavit evidence by Mr Dennett, a partner of the law firm that acts for the underwriters of the POSI and D&O Policies, being Dual Corporate Risks Limited (DCRL) and Liberty Specialty Markets (Liberty), showed that DCRL is registered in England and Wales and that both DCRL and Liberty's head offices were based in London.

However, the plaintiff filed evidence in response that DCRL is the principal legal entity for the DUAL Group which has an office in New Zealand as well as a New Zealand website. In addition, the plaintiff's contained evidence showed that Liberty's contained claims that it has teams across multiple countries including New Zealand.

Outcome

The Court indicated that it had no reason to doubt Mr Dennett's evidence and that CBL's argument appeared to be unassailable as both policies were underwritten and administered by entities having their place of business outside of New Zealand. However, the plaintiff's claim included allegations that both DCRL and Liberty were resident in multiple places including New Zealand, when they underwrote the policies for the relevant periods. As is fundamental in strike out applications, the Court proceeded on the basis that allegations made in the statement of claim were correct. The Court did not consider Mr Dennett's evidence to be sufficiently indisputable to overcome the allegations.

> "Overseas insurers looking to strike out claims by New Zealand claimants will need to be careful to be armed with clear evidence showing that they do not operate a business in New Zealand."

While the Court refused to strike out the plaintiff's claim, it found that the plaintiff should not be permitted to proceed unless CBL's underwriters were afforded the opportunity to be heard. The Court directed that the plaintiff either apply to join the underwriters as parties to the proceeding or apply for leave to commence an action against them under the LRA which by 11 June 2021, or the claim would be struck out.

Authored by Nick Frith.

When flooding is a natural disaster – and when it isn't

A newspaper recently reported an insurer's decision to decline a claim for flood damage under a motor vehicle policy on the basis that flooding was not a "natural disaster" for the purposes of the policy.

The policyholder suffered flood damage to her vehicle as a result of the widespread flooding that occurred in the Auckland region in late August 2021. She made a claim under her motor vehicle insurance policy with her insurer, State Insurance. The policy included cover for natural disaster, so she expected to be covered.

The policy was a "third party, fire and theft" policy of the sort commonly taken out by younger drivers with low value vehicles, to keep premiums low. These policies cover liabilities to third parties (usually other drivers whose vehicles are damaged) and losses that result from causes other than the policyholder's driving errors, but damage to the insured vehicle itself caused by the policyholders' own driving is not covered. As young drivers are statistically more likely to be involved in motor vehicle accidents, this reduces the risk for the insurer, while incentivising policyholders to drive safely.

State's explanatory brochure describes its policy as covering "fire, theft, attempted theft or natural disaster". Natural disaster might commonly be thought of as including a major flooding event. State's policy, however, defines it exclusively as "an earthquake, natural landslip, volcanic eruption, hydrothermal activity, tsunami or natural disaster fire, as defined in the Earthquake Commission Act 1993". Natural disaster fire is defined in that Act as a fire caused by, among other things, a storm or flood, but only in the case of residential land and in any event the insured event is a fire, not a flood.

The policyholder's loss was not, therefore, caused by a natural disaster for the purposes of the policy.

This outcome may not be consistent with the understanding many people would have of the meaning of natural disaster. Dictionary definitions generally give floods as an example of a natural disaster, as does the Insurance Council of New Zealand's website. The definition in the Act is a limited definition which may be more appropriate for insurance relating to real property than to chattels such as motor vehicles.

Policyholders who read only State's brochure, or its "Key Benefits" guide at the front of the policy, might therefore say that they assumed that it provided cover for flood damage and other natural disaster damage as it is commonly understood. Similarly, a person reading down to the basis of cover provisions in the policy would see the following wording: "You're covered for sudden and accidental loss to the car caused by: a. fire, or b. theft or attempted theft, unlawful conversion, or c. natural disaster", without any indication that "natural disaster" had a limited meaning. Only a person who read the policy wording in full would discover, near the end of the policy wording, that natural disaster did not include flooding.

Insurers have obligations under the Financial Markets Conduct Act 2013 not to engage in conduct that is misleading or deceptive or likely to mislead or deceive in relation to the supply of a financial service, which includes acting as an insurer. While insurers may say that policyholders should read the policy in its entirety, where policy wording contains definitions that may be viewed as significantly more restrictive than normal usage, policyholders may argue that they have been misled. We recommend that insurers exercise caution when issuing policies that advertise cover in terms that are defined narrowly and that may be misunderstood by a person who does not read the policy wording to the end.

Authored by Andrew Horne.

COVID-19 insurance issues from around the world

The scale of the COVID-19 crisis made it obvious that the pandemic, and the public health measures it prompted from governments, would have major implications for the insurance world. Responding to an unprecedented disruption in trading, firms naturally turned to their business interruption (BI) policies for protection. Given the number of claims and the distinctiveness of the COVID-19 circumstances, it was unsurprising that many of these claims demanded referral to the courts for resolution.

In this article, we briefly summarise the status of COVID-19 BI cases around the world.

United Kingdom

In the United Kingdom, the industry and courts moved quickly to clarify how typical BI policies would respond to COVID-19. In the last edition of Cover to Cover, we discussed *Financial Conduct Authority v Arch Insurance (UK) Ltd* in which the Supreme Court of England and Wales, hearing the case under the "leap-frog" appeal procedure straight from the High Court, made a number of significant findings in relation to key issues affecting the interpretation and application of BI policies to COVID-19, including disease and prevention of access clauses, causation, trends clauses and overruling the Orient-Express decision.

FCA v Arch, as envisaged, appears to have significantly quelled COVID-19 BI disputes in the United Kingdom. Following the Supreme Court's decision, the FCA wrote to affected insurers clarifying its effect and urging insurers to settle claims expeditiously and to resolve any legal proceedings as quickly and cost-effectively as possible. It

is also publishing a regularly updated set of COVID-19 BI claims data (obtained from insurers). The data indicates that *FCA v Arch* is having the intended effect. As at the end of June 2021, it recorded that over 40,000 claims had been accepted by insurers with over GPB500 million paid out for settled claims and a further GBP300 million in interim payments made for unsettled claims.

The FCA's letter acknowledged that *FCA v Arch* would not be a complete answer to any COVID-19 BI uncertainty. It is not unexpected, then, that other cases have subsequently reached the UK courts. In *Rockcliffe Hall Ltd v Travelers Insurance Company Ltd*, the High Court granted the insurer's application for summary judgment in an insured's BI claim where the relevant policy contained a closed list of diseases for which cover was available, which did not include COVID-19. The FCA also conceded that BI policies covering loss as a consequence of only physical damage were unlikely to respond to COVID-19 economic losses. However, given that most BI policies are structured in this way and the fact that *FCA v Arch* did not address such policies, it would not be surprising if insureds tried their luck in legal proceedings in the future.

Australia

Like the United Kingdom, the insurance industry in Australia has sensibly sought to resolve COVID-19 BI issues through test cases. In the first test case, *HDI Global Specialty SE v Wonkana No. 3 Pty Ltd*, the New South Wales Supreme Court found that references to the repealed Australian Quarantine Act 1908 (Cth) – the "quarantinable diseases" listed in which were commonly excluded in BI policies – could not be construed to include the Biosecurity Act 2015, which had replaced the Quarantine Act. The High Court of Australia recently refused the insurers' application for special leave to appeal this decision.

The second test case is more general in nature. The Insurance Council of Australia (the body representing insurers) has identified nine representative claims to be heard together, which are collectively expected to raise many of the same issues as in *FCA v Arch*. By the time this goes to print, this test case ought to have been heard by the Federal Court, and any appeal to the full Federal Court is due to be heard, expeditiously, in November 2021.

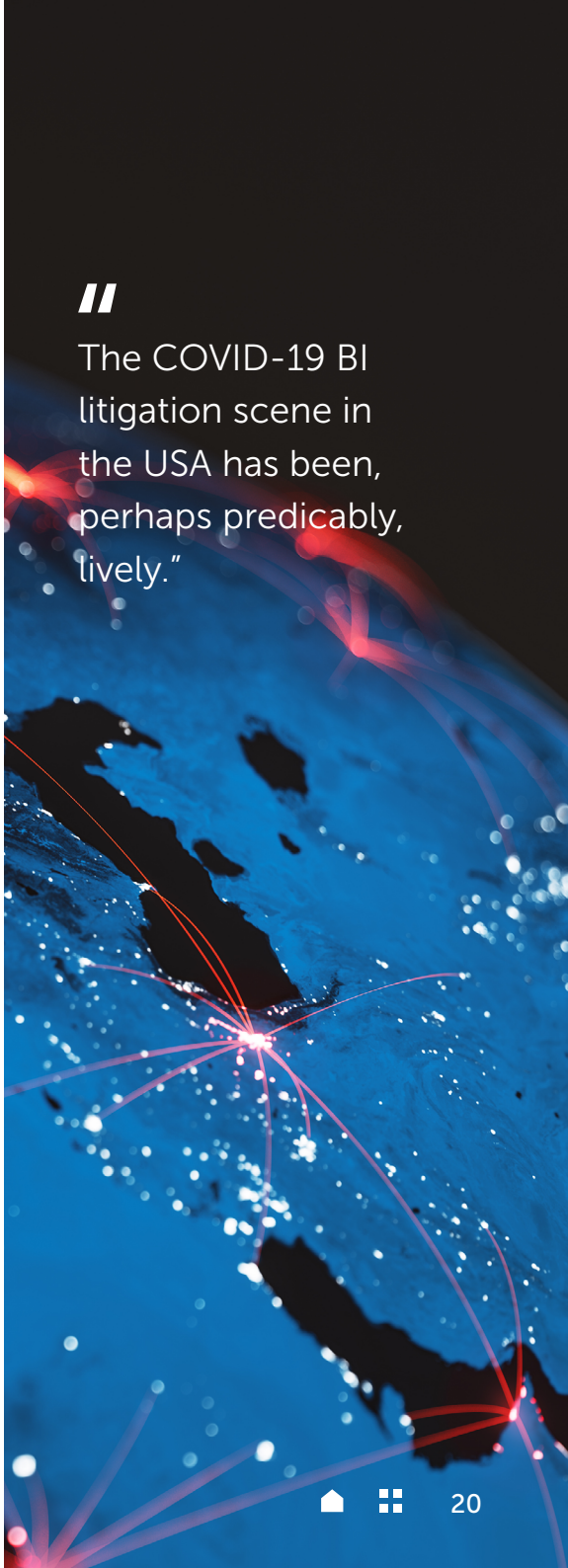
Separately, the Federal Court recently dismissed Star Entertainment Group's claim under its BI policy. Since COVID-19 does not cause physical damage, the casino operator could only claim under an extension for "loss resulting from or caused by any lawfully constituted authority in connection with or for the purpose of retarding any conflagration or other catastrophe". The Court held that the term "other catastrophe", in context, was limited to insured perils capable of causing physical damage (as covered by the policy).

USA

The COVID-19 BI litigation scene in the USA has been, perhaps predicably, lively. Cases have reached the courts involving claims by hotel chains, movie theatres, spas, restaurants and even the Philadelphia Eagles NFL team.

The most significant – the first to make it to the Court of Appeals – featured an Iowa-based dental surgeon claiming for lost income as a result of the state's suspension of non-emergency procedures between March and May 2020. In *Oral Surgeons, P.C. v The Cincinnati Insurance Company*, the

"The COVID-19 BI litigation scene in the USA has been, perhaps predicably, lively."



insurer had declined cover on the basis that the policy required the financial loss to have been caused by "direct loss to property", with "loss" defined as "accidental physical loss or accidental physical damage". The Court of Appeal for the Eighth Circuit resoundingly rejected the insured's suggestion that "physical loss" could include "lost operations or inability to use the business". It was clear that some kind of physical alteration to the property for the policy was required and, in this case, none was pleaded.

Perhaps reflecting the balkanized nature of the US judicial system, not every court has taken such a strict view of what constitutes physical loss or damage. In *Schleicher and Stebbins Hotels LLC v Starr Surplus Lines Insurance Co*, the Superior Court for the State of New Hampshire accepted the insured's argument that there had been a "distinct and demonstrable alteration" to the insured's hotels, following precedent extending the definition of physical loss beyond tangible changes to property in certain cases. Even though the COVID-19 virus could not be seen or touched, it was known to survive on certain surfaces and was widespread in the geographic locations of the hotels, thereby constituting, in the Court's view, physical damage to the insured's property.

New Zealand

The New Zealand courts have not issued any decisions regarding COVID-19 and insurance (save for issuing a restraining order protecting a broker from an insured who was dissatisfied that his income protection policy did not respond). While some claims have been paid, we suspect the lack of jurisprudence reflects the more restrictive nature of most New Zealand BI policies, together with the relatively minor impact of COVID-19 on New Zealand and the extensive support provided by the Government. If a case were to arise, the courts are likely to take guidance from the experience in other common law countries.

Looking forward – insuring the new normal

While courts around the world remain occupied, to varying degrees, with the task of determining how existing BI policies ought to respond to COVID-19, governments have shifted their attention to the task of reopening economies. While the COVID-19 risk remains, this project necessarily includes working with the industry to empower insurers to provide cover so that firms - especially those in high-risk sectors - are emboldened to resume trading activity with adequate protection against the risks of future disruption.

The UK Government recently unveiled its "Live Events Reinsurance Scheme", which will provide up to GBP750 million in reinsurance for insurers writing policies covering live event organisers against the risk of event cancellation from the possible reimposition of COVID-19 restrictions. While full details have not yet been released, the scheme broadly resembles the Pool Re public-private partnership established in 1993 to provide terrorism reinsurance in response to a series of IRA bombings and that remains in place today. One notable difference is that Pool Re protects against third party damage, whereas this scheme effectively amounts to the Government providing reinsurance for losses suffered as a result of its own action (namely, COVID-19 restrictions). It is unclear what effect, if any, will materialise from the Government having hands on both sides of the (re)insurance equation.

To date, New Zealand's successful implementation of an elimination strategy has largely enabled live events to go ahead while much of the rest of the world remained in lockdown; since March 2020, we have hosted full-capacity All Blacks games, concerts and festivals. Consequently, the need for an equivalent reinsurance scheme has not been so pronounced. However, as the Government unfurls the road to reopening and with a growing acceptance that the COVID-19 threat (especially the Delta variant) will linger, New Zealand may need to consider something along the lines of the UK model to create a suitable apparatus for sharing business risks associated with live events and other activities similarly vulnerable to COVID-19.

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