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Cover to Cover
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In this edition, we examine the most important development in insurance law in a century.

The exposure draft of the Insurance Contracts Bill proposes fundamental and long overdue changes to New Zealand's insurance law, including significant changes to policyholders' duty of disclosure. Its scope is ambitious and it is intended to roll up our disparate insurance legislative regime into a coherent whole.

Perhaps of equal importance to life and health insurers, we look at the Government's proposed social unemployment scheme and its likely effect upon the income protection insurance market. Change is afoot for general insurers as well, as we report upon the Government's recent about-turn in signalling the cancellation of significant changes to the Fire and Emergency Services levy that were to have taken effect.

We provide an update on the COVID-19 Business Interruption class actions, with the much-awaited Full Federal Court of Australia decision in the "second test case", *LCA Marrickville Pty Ltd v Swiss Re International,* as well as recent New Zealand High Court decisions regarding the settlement and management of insurance class actions.

In addition to commenting on other regulatory issues, we take a look at the risks presented by mandatory climate-related disclosures, which are a burning issue for equity and debt issuers as they prepare to respond to the Government's XRB (Te Kāwai Ārahi Pūrongo Mōwaho / External Reporting Board) consultation request.

We also report on recent court decisions of interest to the insurance industry, including an English decision regarding an insurer's waiver of the right to disclosure of material information.

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

An introduction to the Insurance Contracts Bill

Co-authored by Lloyd Kavanagh, Maria Collett-Bevan and Sarah Jones

The release of the Insurance Contracts Bill for public feedback on 24 February 2022 foreshadows the most fundamental revisions to insurance law in New Zealand since the reforms of the late 1970s which limited insurers' rights to decline claims for misstatements and rely upon certain exclusions. The Bill proposes to:

- Make fundamental changes to the duty of disclosure.
- Open up insurance contracts to the unfair contract terms (UCT) regime in the Fair Trading Act 1986 (FTA).
- Introduce new obligations upon insurers in relation to the presentation of consumer insurance contracts.
- Modernise the ability of third parties to make claims upon the liability insurance of persons they are sueing, including providing broad powers to request information.
- Consolidate New Zealand's disparate insurance legislative regime into (nearly) a single statute.

The Bill follows a public consultation on proposed reforms to insurance contract law in late 2019. It aims to address shortcomings in insurance contract regulation identified in the Ministry of Business, Innovation and Employment's 2019 consultation. Interested parties have until 4 May 2022 to make submissions upon the proposed changes.

In this article, we outline the main features of the new Bill and the potential impacts for insurers. The changes are significant and their impact upon the insurance industry is likely to be profound. They will fundamentally change insureds' duties of disclosure, introduce new unfair contract terms rules and consolidate other laws.

Who will the Bill apply to?

The Bill will apply to a "contract of insurance" as defined in the Insurance (Prudential Supervision) Act 2010 so it will have broad reach over the insurance industry, affecting both general and life insurance providers as well as reinsurers, and providing greater protections for policyholders. In addition, insurers who enter into consumer insurance contracts will have additional disclosure obligations.

What are the key changes?

Changes to the duty of disclosure

Part 2 of the Bill reforms the current duty of disclosure placed on policyholders. Currently, before a contract of insurance is entered into or renewed, a policyholder must disclose to the insurer all information that could influence the judgement of a reasonable insurer in assessing the risk they are assuming by providing the insurance, regardless of whether the insurer explicitly asked for the information or not. This must be done in accordance with the common law duty of "utmost good faith" which is a very high standard.

The Bill replaces the current duty with separate levels of disclosure duty for consumers and non-consumers.

These are fundamental changes. While much of the detail around disclosure obligations is still unclear, as it will be detailed in regulations that have not yet been shared in draft, the Bill makes an important move away from the present requirement for policyholders to put themselves in the shoes of an insurer and disclose what a reasonable insurer would consider relevant, to a requirement upon insurers to ask necessary questions of consumer policyholders and a duty of fair presentation upon non-consumer policyholders.

Consumer policyholder

A policyholder under a "consumer insurance contract" – a contract of insurance entered into by a policyholder wholly or predominantly for personal, domestic, or household purposes.

Duty

Policyholders must "take reasonable care not to make a misrepresentation to the insurer" taking into account all relevant circumstances.

Relevant circumstances include: type of insurance product, how clear and specific the questions asked by the insurer were, how clearly the insurer communicated the importance of disclosure and whether the consumer received financial advice.

Consequence of breach

An insurer will no longer have the absolute right to avoid an insurance contract where there is material non-disclosure by the policyholder. The new Bill provides that where the policyholder has breached the duty to take reasonable care, the insurer will have proportional remedies available based on how the insurer would have responded to the information and whether the policyholder's nondisclosure was intentional or reckless. Remedies range from reducing the amount paid on a claim (where the insurer would have entered the contract on different terms) to avoidance of the contract (where the nondisclosure is deliberate or reckless, or where the insurer would not have entered into the contract on any terms).

Note that the Bill carries on the prohibition on life insurers in the Insurance Law Reform Act 1977 from avoiding a contract of insurance for misrepresentation unless it was made in certain circumstances.

Non-consumer policyholder

A policyholder to a contract that is not a "consumer insurance contract" (i.e. a contract taken out for business purposes).

Duty

Policyholders must make a "fair representation of the risk" of the contract.

The Bill details what a "fair representation" of risk means. Briefly, the non-consumer policyholder must make a disclosure of material circumstances that they know or ought to have known, in which every representation made is substantially correct.

Consequence of breach

Where there is a breach of this duty, the Bill provides (similarly to that for consumer policyholders) that an insurer has a proportionate remedy available.

A related change that is also very important is that insurers will no longer be entitled to avoid policies and decline to pay claims where there has been a material non-disclosure or misrepresentation in every case, as these remedies have been replaced with 'proportionate' remedies that may in some cases result in partial payments to policyholders who would otherwise have had no entitlement at all. This will create challenges for insurers' actuaries who will have to calculate premiums on an assumption that policyholders who misdescribe their risks may nevertheless be entitled to a partial indemnity. This is likely to result in an increase in premiums for careful and honest policyholders who present their risks accurately as well as those who do not.

The Bill also introduces new duties on insurers to:

- inform all policyholders of their disclosure duty and its consequences before they enter into a contract; and
- where an insurer seeks permission to access medical or other third-party records, the insurer must inform consumer policyholders of the information the insurer will likely access.

Insurance contracts to be subject to UCT regime

The Bill proposes to make insurance contracts subject to the UCT regime by removing the insurance specific exemptions in the FTA and clarifying how the generic exemptions apply to insurance contracts.

Currently, the UCT regime only applies in respect of consumer contracts. However, from 16 August 2022, it will benefit small businesses who have contracts that meet the definition of a small trade contract as defined in the Fair Trading Amendment Act 2021, being a contract with an annual consideration of NZD250,000 or less. If the Bill comes into force in its current form, insurance contracts that are consumer contracts or small trade contracts will need to comply with the UCT regime. We consider a small trade contract in relation to insurance contracts that will be caught by the UCT regime to be those with an annual premium, including any fees payable, of below NZD250,000 annually.

The present UCT regime applies to most standard form consumer contracts but it includes exceptions for insurance contract terms, including the subject or risk insured against, the sum insured, exclusions to liability, the basis on when claims may be settled, payment of premiums, the duty of utmost good faith, and disclosure requirements.

The original rationale for these insurance-specific exceptions was to apply the generic "main subject matter" and "upfront price" exceptions, meaning that the terms which relate to these aspects of a contract are not subject to the unfair contract terms regime, to insurance contracts. However, the insurance-specific exceptions effectively remove insurance contracts from the UCT regime in the FTA altogether.

MBIE has not yet decided how the UCT regime will apply to insurers. The Bill sets out two options for consultation, which we have set out in the table below. Either way, the Bill proposes that the UCT regime will apply to insurers. In deciding how to tailor the regime to insurance contracts, it will be critical that any amendment can provide protection to policyholders while allowing insurers to adequately calculate the risk of a policy. This is also in the interests of policyholders as it will ensure that their policies are accurately priced, and that availability is not unduly affected.

Option A

Define the main subject matter of insurance contracts in narrow terms (clause 171 of the Bill). This means that the main subject matter exception would apply only to the thing insured, the terms that set out the sum insured, and terms that set the quantum of the excess.

Pros/Cons: Option A provides a high level of protection for policyholders, but it opens insurance contracts (and the risk they cover) to review by the Courts, which results in significant uncertainty for insurance underwriters.

Option B

Define the main subject matter of the insurance contracts (clause 172 of the Bill). This would mean that the policy limitations and exclusions that affect the scope of cover would be considered part of the main subject matter and therefore excluded from being declared unfair.

Pros/Cons: Option B would not be of any great benefit to consumers given that it would exclude clauses that set out the scope of cover (exclusion clauses) from being subject to the unfair contract term regime. In its initial consultation, MBIE highlighted a number of terms in insurance contracts related to exclusions from the scope of cover – Option B would do little to remedy such terms.

We think that the approach of setting out two options for consideration is sensible. Both should be considered carefully as they each have differing merits. Most other consumer facing industries have moved to a point at which the need to comply with unfair terms legislation is an accepted part of doing business and we expect that the insurance industry will do likewise.

Presentation of consumer insurance policies

The Bill introduces a requirement for consumer insurance contracts to be written and presented clearly, at subpart 7B of Part 7. This involves complying with specific presentation requirements and publishing certain information in a prescribed format to assist consumers in choosing and comparing insurers.

These obligations will apply to contracts entered into by licensed insurers that are consumer insurance contracts, or contracts of insurance that provide for life and/or health insurance.

The Bill proposes to amend the Financial Markets Conduct Act 2013 to introduce a duty for licensed insurers to ensure that consumer insurance contracts are worded and presented in a clear, concise and effective manner. It is expected that further regulations will be issued providing more detail on the form and presentation of consumer insurance contracts as well as what information must be presented to policyholders. Many insurers already attempt to issue policies in 'plain English', with varying degrees of success, but the statutory requirements will likely result in a wholesale reconsideration of those terms. Some types of policy are difficult to set out in plain terms, including because there are necessarily a range of exceptions and exclusions of cover, and the industry is likely to face challenges in this respect.

Changes to third party claims upon liability insurers

The Bill proposes to replace the present entitlement of third party claimants to rely upon a statutory charge on the proceeds of a defendant's liability insurance policy (section 9 of the Law Reform Act 1936). Instead, the Bill will allow third parties to claim directly against an insurer. The Bill aims to resolve issues experienced with the previous statutory charge, namely whether costs that were subject to the statutory charge could be paid out to policyholders to defend a claim and priority issues where there are multiple statutory charges.

The key features of the new subpart 4 of Part 3 are:

Leave of the Court
A person must have leave of the Court to make a third-party claim.

Limited to insolvency/death
A person can only claim where the policyholder is insolvent or dead.

Exclusion for reinsurance
A person cannot make a third-party claim in the case of reinsurance.

Limitation period linked
The claim against the insurer is treated as a claim against the policyholder for limitation purposes, removing the need for the third parties to make a claim against the policyholder.

Insurer cannot rely on defences after event giving rise to liability
Insurers cannot rely on defences arising from their acts or after the event that gives rise to liability.

Multiple Claimants
The first claimant to obtain a judgment or settlement has priority, putting third parties in the same position as if they were claiming against a policyholder.

In addition, the Bill provides new rights for a third-party claimant to access information about a defendant's insurance. Clause 93 of the Bill provides that if a person making a third party claim reasonably thinks that another person has information that would assist with their claim, they can request this information from them. Schedule 3 of the Bill sets out the information that can be requested, how that information may be requested, and who that information may be requested from.

The Bill introduces a broad right to information, allowing a third-party claimant to require information from any person who is able to provide it, including the policyholder, insurer, or broker. The information that may be sought includes who the insurer is, what the terms of the contract are, whether the policyholder has been informed that the insurer has claimed not to be liable in respect of the supposed liability, details of any proceeding between the insurer and policyholder, limits on funds available to meet claims, and whether there are security interests on any sums paid out under a contract.

Codification of common law duty

The Bill replaces the common law duty of good faith with a statutory duty of good faith, but without any guidance or explanation as to its intended scope. It is not clear, therefore, whether it is intended to differ from the common law duty in any way. It is difficult to see how this assists insurers or policyholders.

Consolidation of other insurance legislation

Parts 3, 4 and 5 of the Bill will consolidate and replace a number of pieces of existing insurance legislation:

Marine Insurance Act 1908
To be kept separate

Redundant provisions of the Act have been repealed in relation to the duty of disclosure. The Bill proposes to repeal certain provisions relating to warranties.

Life Insurance Act 1908
Part 5

The Act has been carried over and updated.

Insurance Law Reform Act 1977
Part 3

The Bill largely carries over the provisions of the Act, although it makes changes to:

- The time limits for making claims under claims-made liability policies (section 9 of the Act). The Bill provides that an insurer can decline a claim under a claims-made policy if the policyholder notifies the insurer of a third-party claim or potential third-party claim after a defined period after the end of a policy term.
- The insurer's ability to rely on increased risk exclusions (section 11 of the Act). The Bill provides that in some instances of an increased risk exclusion, and insurer may be able to rely on the exclusion even where the exclusion did not cause or contribute to the loss subject to a claim (such as where a policyholder on a personal policy uses the car for a commercial purpose).

Insurance Law Reform Act 1985
Part 3

The Act has been carried over and updated.

Insurance Intermediaries Act 1994
Part 4

The Act has been carried over and updated, with small changes to provide clarity, remove references to cheques and include references to security interests in light of the Personal Property and Securities Act 1999.

The Bill proposes to increase penalties for non-compliance significantly, bringing penalties in line with civil pecuniary penalties under the FMCA.

What next?

Consultation on the draft Bill closes on 4 May 2022. Once consultation closes, MBIE will analyse the feedback and consider any changes that may be required to the Bill. Once finalised, the Bill will be introduced to Parliament. MBIE have not indicated when they expect the Government will introduce the Bill, let alone when the Bill will be enacted and receive the Royal assent. However, our expectation is that the Government would like that to occur before the next election, which must take place before the end of 2023.

Generally, the provisions in the Bill are proposed to come into force by Order in Council, with all provisions coming into force by the third anniversary of the Bill receiving Royal assent. The commencement date for the Bill will likely be scheduled after the Bill is in its final legislative stages. It follows that the core reforms in the Bill are likely to be in force some time in 2025 or 2026, although the Government could move more quickly if it regards the regime as a priority.

" Once consultation closes, MBIE will analyse the feedback and consider any changes that may be required to the Bill. "

It will be important that MBIE listens carefully to feedback from the insurance industry. The industry is complex and the availability and pricing of its products are sensitive to changes that may have unintended effects. It would be unfortunate if the end result of the reforms included premium increases and a reduction in the availability of cover, as the resulting disadvantage to policyholders could outweigh the intended benefits.

A new social unemployment insurance scheme for New Zealand?

Co-authored by Nick Frith and Olivia de Pont

The Government is currently consulting on a new social unemployment insurance scheme. The proposed scheme would be managed by ACC and would provide New Zealand residents and citizens with 80 percent of their usual income (up to a maximum cap) for up to six months if they lose their job through redundancy or need to stop working due to a health condition or disability.

If the scheme is implemented, the Government would take over a segment of risk presently covered by the private insurance industry in the same way that it did in 1974, when ACC essentially replaced private liability insurance for personal injury. High income earners may still wish to purchase additional private income protection cover, where they want to have cover for more than six months or above the proposed cap. However, the private insurance sector would no doubt need to demonstrate that any "top-up" insurance it offers is good value in order to attract custom, remain marketable and ensure that any products provide meaningful cover, consistent with insurers' regulatory obligations.

Key features of the scheme

The Future of Work Tripartite Forum (a partnership between the Government, Business New Zealand and the New Zealand Council of Trade Unions) has released a discussion document setting out its case for a new social unemployment insurance scheme. The key features of the scheme include:

- workers who lose their jobs through no fault of their own (e.g., through redundancy, or as a result of health conditions or disabilities) could receive up to 80 percent of their usual income (up to a cap of NZD130,911) for up to six months while they look for new work or retrain – plus an initial four-week bridging period paid for by their former employer;
- claimants may only claim up to six months of entitlement every 18 months;
- to qualify for cover, workers would need to have contributed to the scheme for at least six of the 18 months preceding their claim (with statutory parental leave included in the calculation);
- insurance payments would be calculated individually, without reference to an individual's assets or partner's income, and would reduce dollar for dollar once their income and insurance payments total 100 percent of their pre-loss income;
- claimants would be expected to show "effort" to search for suitable employment or to prepare for employment by, for example, undertaking training, but would not be required to accept offers of employment that did not offer pre-displacement wages and conditions;
- the scheme would be funded by way of an initial levy of 2.77 percent of wages and salary, split equally between employers and employees.

Arguments for and against the scheme

The Forum argues that the scheme would be beneficial for New Zealand on the basis that research suggests that, compared with workers in other countries, displaced New Zealand workers experience greater wage losses when they return to work. This suggests, the Forum says, that displacement results in poor use of workers' skills, lower income and poorer conditions. The scheme is then promoted as offering displaced workers the time and security to find jobs which better match their skills, to upskill or retrain, or address any underlying health issues. It would also give workers confidence to accept jobs in emerging and more risky areas, such as in start-ups, and help communities and industries weather economic shocks and transitions.

The Forum also argues that the scheme would address some of what it views as inequity caused by ACC. Currently, a person who is involved in an accident and is unable to work as a result can receive up to 80 percent of their pre-accident wages under ACC (also up to a cap of NZD130,911), while a person with a health condition or disability which was not caused by an accident receives far more limited support, even though their ability to work may be similarly affected. The scheme would partly address this gap, albeit only for those who were originally working and for a limited time. The scheme's detractors, however, would point to the potential moral hazard built into the scheme. People may game the system in order to make income protection claims or enjoy a holiday instead of searching for a new job in the knowledge that they have a secure income stream for up to seven months, including the four weeks paid for by their former employer. The increased costs of employing people under the scheme are not insignificant, and some may take issue with the fact that the scheme forces people to purchase insurance cover when they might prefer to carry the risk of redundancy and keep their money, or purchase other cover, such as cover for sickness.

A related issue is how the existence of the scheme may affect employment claims and their resolution. There is likely to be a strong motivation for both employers and employees to resolve issues that would otherwise have led to a dismissal on the basis that allows the affected employees to claim cover. It may result in employees feeling pressured to accept redundancy rather than bring a personal grievance claim that will be uncertain and may result in less compensation in any event.

It is also unclear whether the Forum considered how the scheme may operate if the private market offers "top-up" cover. Some of the difficulties that can arise when the government offers a layer of primary insurance and the private market offers secondary cover were seen following the Canterbury earthquakes, where the involvement of both the Earthquake Commission and private insurers on material damage claims lead to difficulties in duplication of claims management processes, apportionment issues and significant delays in resolving claims. It is not clear how insurance claims involving the scheme and private insurers would be handled.

The future for insurance

The Forum has suggested that the Government is better placed to provide income protection insurance than the private market, arguing that adverse selection means that those who are unlikely to claim under income protection insurance choose not to purchase it, leaving only high-risk individuals in the market. This raises premiums which further discourages people from purchasing cover. The insurance industry will no doubt dispute the suggestion that it is not able to offer efficient and effective income protection cover, however with the Government looking to intrude further into the private market, insurers will need to continue to demonstrate that they can offer better value or more comprehensive cover than government schemes. The scheme, if implemented, may enable private insurers to offer more cost-effective and comprehensive cover as an add-on to the public scheme, so there may be opportunities for innovative insurers that help make up for the loss of their existing private redundancy insurance business.

Climate-related disclosures

Co-authored by Lloyd Kavanagh, Maria Collett-Bevan and Sarah Jones

Climate change is now widely recognised as an economic risk that is likely to impact business' performance and prospects materially. Climate change risk encompasses physical risks such as volatile weather and events, changes in land uses, and bio-incursions and transition risks such as governmental and market responses to the threat of climate change. Liability risk is a further topic to consider.

In its 2017 recommendations, the international Task Force on Climate-related Financial Disclosures (TCFD) recognised a need for better information to support informed investment, lending and insurance underwriting decisions, and improve analysis of climate-related risks and opportunities. They reflect the original objective of the Financial Stability Board in forming the TCFD: to assist financial institutions to understand and plan for the potential impacts of climate change on them, and for disclosure under headings of Governance, Strategy, Risk Management, and Metrics and Targets of how the institutions are preparing.

In October 2021, New Zealand enacted legislation requiring large listed companies and financial institutions to disclose climate-related risks and opportunities affecting their businesses. Although New Zealand claims to be the first to pass such legislation, many other countries have taken or are taking similar steps e.g. France, Switzerland and the United Kingdom.

In this article, we outline the new climate-related disclosure framework and what will be expected of insurers and other climate reporting entities, potentially from as early as financial years ending in 2024.

Climate statements

The Financial Sector (Climate-related Disclosures and Other Matters) Amendment Act 2021 amended the Financial Reporting Act 2013 and the Financial Markets Conduct Act 2013, introducing a mandatory requirement under new Part 7A of the latter Act for certain reporting entities to prepare climate statements in accordance with the climate-related disclosure framework to be issued by the External Reporting Board (XRB) (the CRD regime).

Who will this apply to?

The new requirements will apply to FMC reporting entities that are considered to have a higher level of public accountability than other FMC reporting entities, which are referred to as "climate reporting entities" (CREs). It is estimated that around 200 large financial institutions will be required to make climate-related disclosures, including:

- listed issuers of quoted equity securities or quoted debt securities (i.e. entities with a market capitalisation exceeding NZD60 million);
- large registered banks, licensed insurers, credit unions and building societies (with total assets exceeding NZD1 billion, or, in the case of licensed insurers, where premium income exceeds NZD250 million); and
- large managers of registered managed investment schemes (with total assets exceeding NZD1 billion).

Insurers (and other financial institutions) who are not caught under the new CRD regime should nevertheless consider the benefit of providing climate-related disclosures to stakeholders and the extent to which they would benefit from voluntary disclosures. All insurers and other financial institutions should be familiar with the requirements of the CRD regime as they may be required to provide such information to entities they deal with as a condition of business. We also think it likely that the CRD regime may expand over time to include other financial institutions, such as all insurers.

What will be required?

CREs will be required to:

- prepare climate statements that comply with the climate-related disclosure framework;
- keep proper records that will enable them to ensure that their climate statements comply with the climate-related disclosure framework. These records must be retained by the entity for a period of at least seven years after the records are made;
- obtain an assurance engagement in relation to statements, to the extent those statements are required to disclose greenhouse gas emissions; and
- lodge copies of climate statements prepared with the Registrar of Financial Service Providers within four months after the CRE's balance date.

When will this apply?

CREs may be required to prepare climate statements as early as 2023, as described below. Once the XRB issues the relevant climate standards, CREs are then required to prepare and lodge their first climate statements within four months after the end of the accounting period of the CRE and/or scheme. The requirement to obtain an assurance engagement in relation to statements which are required to disclose greenhouse gas emissions is expected to first apply three years later.

Climate-related disclosure framework

The XRB is in the process of drafting the climate-related disclosure framework, expected to consist of:

- *Aotearoa New Zealand Climate Standard 1: Climate-related Disclosures (NZ CS 1).* The XRB is currently revising the first climate standard, NZ CS 1, following consultations on Governance and Risk Management last year, with the remaining standards, notice and accompanying guidance to follow. The remaining sections, Strategy and Metrics and Targets, are scheduled to be released for consultation in March 2022. NZ CS 1 is expected to be issued in December 2022, meaning that CREs will need to report against these standards for accounting periods starting on or after 1 January 2023.
- *Aotearoa New Zealand Climate Standard 2: Adoption of Climate-related Disclosures (NZ CS 2)*. The XRB has indicated that NZ CS 2 will offer various provisions for CREs when the new standards are required to be applied for the first time, including phased adoption, relief from providing comparative information, and practical expedients.
- *Aotearoa New Zealand Climate-related Disclosures Concepts (NZ CRDC): this is an authoritative notice containing climate-related disclosure concepts.* The NZ CRDC will contain climate-related disclosure concepts to which CREs must have regard when preparing climate statements. This notice is expected to outline the objective of disclosures, the broader context of sustainability reporting, qualitative characteristics of useful information and the interconnection between financial statements and climate statements.

The XRB has indicated that the climate standards are supposed to be forward-looking and succinct, focusing on high-level areas for disclosure rather than being overly prescriptive. The climate statements will, in line with the TCFD recommendations, relate primarily to the potential impact of the physical risks and the transition risks of climate change on the CRE, but they may also require disclosure in relation to the greenhouse gas emissions of the CRE.

In addition to the above standards, the XRB will release guidance on an ongoing basis to assist CREs with preparing climate statements. As the standards are currently sector-neutral, we expect that the XRB will use guidance in order to provide further detail on sector-specific requirements.

> "We expect that the XRB will use guidance in order to provide further detail on sector-specific requirements."

Insurers should also take note of the TCFD guidance and resources in relation to insurance companies in relation to underwriting and asset owners in relation to investment activities.

NZ CS 1

Following the TCFD recommendations, the climate standards will be divided into four sections: Governance, Risk Management, Strategy, and Metrics and Targets.

The XRB has released draft sections of NZ CS 1 in relation to Governance and Risk Management as follows:

Governance

The draft section on Governance focuses on the level of oversight and monitoring by boards and senior management on climate-related risks and opportunities. CREs must disclose how the board accesses expertise, performance metrics for climate-related policies, holds the business accountable on climate-related targets, and processes for making decisions on climate-related issues.

Risk Management

The draft section on Risk Management focuses on how climate-related risks are identified, assessed and managed, and how those processes are integrated into existing risk management processes. CREs must disclose the tools and methods used, time horizons considered, and value chain stages covered when describing its processes for identifying and assessing climate risk. The section also requires disclosure of how the CRE determines the significance of climate-related risks compared to other risks and how decisions are made to address this.

This section will combine with the Strategy section to provide a picture of the CRE's overall risk profile and the robustness of the CRE's risk management processes.

Enforcement

While the FMA has indicated that it will focus on supporting CREs as they prepare for the new CRD regime, CREs should note the significant range of enforcement actions introduced by the CRD regime:

Infringement offence

A failure to keep records or make records available in the prescribed manner, lodge climate statements, or include the prescribed information about climate statements in the annual report is an infringement offence. A CRE that commits an infringement offence is liable to a fine not exceeding NZD50,000.

Penalty

A failure to keep proper records, prepare, or lodge climate disclosure statements may give rise to a civil penalty not exceeding NZD1 million (individual) or NZD5 million (in any other case). A failure to keep records may give rise to a civil penalty not exceeding NZD200,000 (individual) or NZD600,000 (in any other case).

Criminal liability

The CRD regime introduces an offence for a CRE and its directors that knowingly fail to comply with the climate standards. A director may be liable for a fine not exceeding NZD500,000 or a term of imprisonment of up to five years, or both. A CRE may be liable for a fine not exceeding NZD2.5 million.

CREs should also note that their climate statements, including statements made in the annual report, will be subject to the fair dealing rules in Part 2 of the FMCA. The FMA has indicated that it will focus on ensuring that climate statements comply with the prohibition on false, misleading and unsubstantiated statements.

Preparation

CREs will be required to make disclosures from the accounting period beginning on or after 1 January 2023 if the XRB's expected timeline stands. However, they are expected to be preparing now. The FMA has indicated that, from January 2023, it will not hesitate to take enforcement action against CREs that fail to prepare and lodge financial statements.

The XRB has released the draft sections of NZ CS 1 so that CREs have an opportunity to begin preparation ahead of the final standards being published. CREs should ensure that they have the systems in place to prepare climate statements in accordance with the expected standards.

In the longer term, CREs should consider how they uplift their governance and risk management processes, adapt their strategy and align their metrics and targets to meet the ever-increasing exposure to climate change risk. We recommend that CREs start with the proposed governance standards, considering how their governance structures need to adapt before the new CRD regime begins. CREs should then consider their risk management processes and whether they are sufficiently robust to determine risk exposure to climate change and any mitigation strategies employed.

Underwriting the unvaccinated

Rating risk in a pandemic

Co-authored by Andrew Horne and Olivia de Pont

A person's COVID-19 vaccination status and how they may be treated as a result has become an increasingly controversial topic. Among other issues, it raises the question of how insurers may take vaccination status into account when underwriting life and health insurance cover.

Some American employers, such as Delta Airlines, have increased the health insurance premiums payable by unvaccinated employees. Legal and General, a UK insurer and financial services provider, has said that high risk applicants are having their applications for new life insurance postponed for 12 months unless they provide proof of vaccination. A New Zealand insurer, Partners Life, has also commented that it may take into account insureds' vaccination status when underwriting health and life insurance. However, rating applicants' and insureds' risk based on vaccination status is not a straightforward exercise.

Challenges for rating risk based on vaccination status

There are a number of obvious reasons why an insurer might take into account vaccination status when underwriting life and health cover. Insurers routinely take into account other behaviours and status when underwriting these types of risk, such as whether an applicant smokes and how much an applicant drinks. Vaccination status may be taken into account as another indicator of risk. Being vaccinated against COVID-19 may also correlate with an increased willingness to take other vaccines, or take medical advice and assistance more generally, thereby reducing an individual's exposure to other diseases and health risks. An increase in premiums for the unvaccinated may also encourage applicants to get vaccinated, which may reduce the overall risk to the population and an insurer's client base.

However, this also raises the question as to whether insurers should be taking into account other vaccinations an applicant has. It also raises questions about whether it is worth modifying underwriting practices at all in circumstances where the variant of COVID-19 that is currently dominant is both less responsive to the vaccines currently available and may be less likely to result in serious illness or death than earlier variants.

Other challenges for underwriters to consider include:

- Unlike chronic health conditions, the risk presented by COVID-19 may initially be high and decline over time as less virulent strains of the virus take over and vaccination rates increase. It may not be worth making long-term changes to how risk is underwritten in circumstances where the risk posed by COVID-19 may be relatively short-term compared to permanently dangerous diseases such as polio and measles.
- If vaccination status is relevant to underwriting decisions, should immunity gained through a prior infection also be relevant?
- Vaccination status does not, on its own, define an individual's risk of becoming seriously ill or dying of COVID-19, which is influenced by other comorbidities and the likelihood of being exposed to the virus – which may be influenced by overall vaccination rates in a particular area. If vaccination levels in a particular area are high, then there may be little to be gained by adding vaccination status as a rating factor.
- If regular booster vaccines are required to maintain immunity, then vaccination status would need to be reviewed regularly, increasing an insurer's administration costs.

Alternatives to premium increases

There are a number of alternatives to premium increases based on vaccination status that insurers may consider. Insurers could consider an overall increase in life and health insurance premiums, regardless of vaccination status. This would be less difficult to implement than differentiating between applicants and insureds based on vaccination status and may help an insurer prepare financially for the possibility of future pandemics. However, unless such an approach is adopted across the industry, an overall increase in premiums may disadvantage an individual insurer, as vaccinated applicants may be able to obtain cheaper insurance elsewhere.

Insurers may also, as suggested by Willowgrove Consulting's Jon-Paul Hale, address the COVID-19 risk by offering product discounts for the vaccinated or loadings for the unvaccinated. They may consider policy exclusions and term limitations for the unvaccinated and reducing exclusions, such as waiting periods, for the vaccinated or offering rewards points. For unvaccinated applicants with other co-morbidities, insurers may decline cover altogether.

Conclusion

The relevance of vaccination status to underwriting risk raises complex issues as to how to fairly rate risk in a pandemic, in circumstances where the nature of the risk is constantly evolving. We may be more likely to see policy exclusions for the unvaccinated and incentives for the vaccinated to address the current risk, with overall premium increases for all insureds in the long-term. The increased costs to insurers occasioned by the pandemic and the risk of new infectious diseases emerging in future may warrant a re-think of risk for health and life insurance more generally.

Government reverses course on fire levies

Authored by Andrew Horne

The Government has decided to reverse one of the most significant changes it had made to the way in which fire service levies are imposed in New Zealand. Unusually, this change of direction has occurred not in the consultation stage or before a select committee, but after the relevant legislation was passed into law and shortly before it was due to come into effect.

In our view, the Government is to be commended for acknowledging the unintended consequences of the change and abandoning it, rather than trying to salvage it with complex carve-outs and other measures, which might have been more politically expedient but would have been risky and inefficient.

The Fire and Emergency New Zealand Act 2017 made a fundamental change to the fire and emergency service levy regime which funds most of the cost of New Zealand's fire and emergency service. Previously, the levy was imposed only upon the value of the interest insured (not the premium) under contracts of fire insurance. The change transitioned it, after a transition period, to a levy on the interest insured by all contracts of insurance against physical loss or damage, whether or not fire was one of the risks insured.

The thinking behind this change was that New Zealand's fire and emergency services, whose funding is derived almost entirely from the levy, increasingly do much more than extinguish fires. They assist in responding to a range of insured perils such as accidents, floods, earthquakes and the like, although they cannot normally prevent damage from those perils in the way they might do in case of fire. There was also a desire to increase the overall levy take so that services could be improved.

The devil lay in the detail. When the new levy regime was originally proposed, a number of exemptions were made for specified classes of property and levies for some other types of property, such as residential property, were capped. The reason for this was that some types of property, such as pipelines on the sea floor, drains and tunnels, may be of high value but may not need to be insured against fire and are as unlikely to benefit from emergency services. After rounds of consultation, the list was amended several times. That did not resolve all of the issues that were identified, however. In addition, the Government struggled to confirm the magnitude of the likely change in the levy take, because private property values are confidential and there is no register that records the value of the interests insured.

As a result of increasing concern about the way in which the new regime was to work, while the Act was passed into law, the date upon which the changes were to come into effect was repeatedly delayed while efforts were made to understand the effects that it would bring about. The date on which the changes were to occur was further delayed to 1 July 2024 by the enactment of the Fire and Emergency New Zealand (Levy) Amendment Act 2019.

Finally, in late 2021, the Government acknowledged that there were insurmountable difficulties in understanding the likely impact of the changes because of the confidential nature of insurance arrangements. On 8 December 2021, it announced a proposal that, in effect, reverts to the previous regime, under which the Fire and Emergency Levy will be charged only on fire insurance instead of on all policies for property loss or damage.

An Amendment Bill to make these changes is due to be introduced this year. Following this, public consultation will be undertaken before any change to revert to the original levy regime is made. Insurers will no doubt follow the process with interest as some complexities arising from the exemption regime will remain.

Case Study

COVID-19 Business Interruption test case update

Co-authored by Nick Frith and Olivia de Pont

In the last edition of Cover to Cover, we discussed a number of test cases from around the world which have considered whether various business interruption (BI) insurance policies cover losses flowing from the government restrictions imposed in response to COVID-19.

Recently, an eagerly awaited appellate decision has been released by a Full Court of the Federal Court of Australia in *LCA Marrickville Pty Ltd v Swiss Re International SE* [2022] FCAFC 17, known in Australia as the "second test case". The second test case comprised 10 small business claims under BI policies issued by six different insurers. These claims were heard by the Federal Court in September 2021, and a decision issued in October 2021. Five of these cases were appealed (and cross-appealed) and the Full Court of the Federal Court has now issued its decision, largely upholding the first instance decision of the Federal Court.

The Court's decisions

The insurance policies at issue in the second test case differed in wording but were similar in certain key respects. The clauses relevant to the Federal Court's decisions may be summarised as follows:

Prevention of Access clauses which provide cover where the order or action of a competent authority prevented or restricted access to the insured premises because of damage or a threat of damage to property or persons.

Disease clauses which cover losses that arise from the presence or outbreak of infectious disease at the insured premises (or within a specified radius of the insured premises).

Hybrid clauses which are a hybrid of the Prevention of Access and Disease clauses, providing cover where the orders or actions of a competent authority have closed or restricted access to the insured premises, and those orders or actions are taken as a result of the presence or outbreak of infectious disease at the insured premises or within a specified radius of the insured premises.

Catastrophe clauses which provide cover for loss resulting from the action of a civil authority during a "conflagration or catastrophe".

The Court held – and the Full Court confirmed – that the Prevention of Access and Hybrid clauses could not provide cover. The Prevention of Access clauses do not apply to diseases and, in relation to the Hybrid clauses, the government orders imposing closures or restrictions on businesses operating were not made because of the presence of COVID-19 at or near the insured premises. Rather, orders had been made because of the threat posed by COVID-19 being introduced to Australia from overseas, and because of the risk of COVID-19 to people across the state as a whole.

However, in relation to one of the insureds, Meridian Travel, the Court held that the Disease Clause could potentially provide cover for losses flowing from restrictions imposed to address the COVID-19 pandemic. That clause did not require any action to have been taken by an authority to close or restrict access to the insured business. However, the Court noted, the insured would still need to show that there had been an identified case of COVID-19 at the premises (or within a specified radius of the insured premises) and that that particular case – not other cases or the risk of other cases – caused their loss. The Full Court's decision gives the parties to this case the opportunity to consider their respective positions, and the insured may pursue its claim before the trial judge.

The Court further held – and the Full Court agreed – that COVID-19 was not a "catastrophe" for the purposes of the BI policies. The meaning of the word "catastrophe" was linked to "conflagration" and, the Court said, that "conflagration" ordinarily means a physical event requiring action to slow its progression. A pandemic was not a catastrophe similar to a conflagration.

Implications for New Zealand

The Full Court's decision gives insurers increased certainty as to how BI policies are likely to be interpreted in New Zealand, as the lockdowns imposed by the New Zealand Government were, as in Australia, introduced in response to the threat posed by COVID-19 being introduced to the country from overseas and the threat of COVID-19 across regions. Insureds may have cover under Disease clauses, however causation issues may arise in individual cases.

While the second test case provides some guidance for how BI policies may be interpreted, insurers who wish to clearly exclude cover for pandemics in the future (or provide cover in particular circumstances) will need to also take into account the approach that has been taken in other countries – particularly the United Kingdom.

We discussed the approach of the English Supreme Court in *The Financial Conduct Authority v Arch Insurance (UK) Ltd and others* in issue 22 of Cover to Cover. In *Arch Insurance,* insurers had rejected BI claims on the basis that losses suffered as a result of Government-imposed closures were not proximately caused by an insured peril, such as a case of the disease within the defined radius of the insured premises. The Supreme Court held that cover could be available under Prevention of Access, Disease and Hybrid clauses where the insured could show that Government-imposed lockdowns were caused in part by an insured peril (i.e. a case of the disease within a defined radius of the insured premises) even though they were also a result of uninsured causes (i.e. cases of the disease across the country as a whole). England's Government had, the Supreme Court noted, introduced lockdowns in response to a widespread national outbreak – including cases within a defined radius of the insured premises, leading the Supreme Court to reach very different conclusions on policy interpretation than in Australia. Arch Insurance should, therefore, be considered in any review of BI policy wordings, as the guidance in that case may be more relevant depending on the circumstances of any future pandemic.

Case Study

Class actions update

Ross v Southern Response Earthquake Services Ltd and *Smith v Claims Resolution Service Limited*

Co-authored by Nick Frith and Olivia de Pont

The High Court has recently issued two important decisions on class actions, both of which have arisen out of the Canterbury earthquakes: *Ross v Southern Response Earthquake Services Ltd* [2021] NZHC 3497, the first case where a New Zealand Court has been asked to approve a settlement of a class action; and *Smith v Claims Resolution Service Limited* [2021] NZHC 3561, which illustrates the types of issues that can arise if a representative plaintiff decides to step aside.

Ross v Southern Response Earthquake Services Ltd

Insurers will have been following *Ross v Southern Response* closely since these proceedings were first commenced in May 2018. This proceeding has led to a number of firsts in the class action space – it was the first class action proceeding permitted to proceed on an opt-out basis in New Zealand, and it has now led to the first decision on how the Court will approach settlements that are submitted to it for approval.

The Ross' claim

This proceeding arose out of the settlement of the plaintiffs' insurance claim after their home was damaged by the Canterbury earthquakes. The plaintiffs alleged that Southern Response provided them with incomplete information about the cost of rebuilding their home, which caused them to settle their claims on a less favourable basis than they otherwise would have.

At around the same time, a Mr and Mrs Dodds also commenced proceedings against Southern Response, making similar allegations, and were successful in both the High Court and Court of Appeal. Following the Dodds' success, Southern Response settled the Ross's representative proceeding and submitted the parties' settlement agreement to the Court for approval.

The Courts approach to approving settlement

The Court held that whether a settlement of a class action should be approved will depend on whether it constituted a fair and reasonable resolution of the plaintiffs' claims in the interests of the class members as a whole, both as between claimants and the defendant and as between the individual claimants.

The Court considered the approach adopted in Australia and Canada where, like New Zealand, there is no statutory regime governing class actions. Following the approach taken in Canada, the Court outlined 11 factors to be considered in assessing whether or not to approve a settlement:

1. likelihood of recovery or likelihood of success if the claim was to go to trial (to ensure that the plaintiffs' interests were not being settled too cheaply);
2. amount and nature of discovery, evidence or investigation that would be required if the claim was to proceed;
3. settlement terms and conditions;
4. recommendation and experience of counsel;
5. future expense and likely duration of litigation and risk;
6. recommendation of neutral parties, if any;
7. number of objectors and nature of objections;
8. the presence of good faith, arms-length bargaining and the absence of collusion;
9. the degree and nature of communications by counsel and the representative plaintiffs with class members during the litigation;
10. information conveying to the court the dynamics of and the positions taken by the parties during the negotiation; and
11. if counsel fees were negotiated in the settlement, and if so, how big a factor they are (to ensure that the settlement is not favouring the lawyers' interests over those of the clients).

Interestingly, this approach differs from that preferred by the Law Commission in its Supplementary Issues Paper on Class Actions and Litigation Funding released in September 2021. The Law Commission specified just five factors that a court should consider when deciding whether a settlement is fair, reasonable and in the interests of the class as a whole, with an additional catch-all allowing the Court to considering anything else it considers relevant:

1. the terms and conditions of the proposed settlement;
2. any legal fees and litigation funding commission that will be deducted from relief paid to class members;
3. any information readily available to the Court regarding potential risks, costs and benefits of continuing with the proceeding;
4. views of class members;
5. process by which the settlement was reached; and
6. any other factors the Court considers relevant.

It is interesting to note that the Court in Ross took into account the recommendations and experience of counsel involved, which does not feature in the Law Commission's report. This was a weighty factor in the Court's decision, where the Court said that it had the "utmost confidence" in the exercise of judgment of counsel in that case, and that their assessment counted "significantly in the Court's assessment as to the reasonableness of the settlement": at [118]. While the parties in Ross were both represented by senior counsel with significant experience in representative proceedings and insurance, taking into account counsel's experience and judgment could be controversial in other cases if it were to involve second guessing the judgment of less experienced – or even less well regarded – counsel or where the parties are represented by lawyers with differing levels of seniority. It will be interesting to see whether and how the Law Commission comments on this when it releases its report on Class Actions.

Smith v Claims Resolution Service Limited

In *Smith v Claims Resolution Service Limited*, a class action fell apart when the representative plaintiff, Ms Smith, changed her mind about pursuing the matter. An application was made to substitute a Mr and Mrs Harris as plaintiffs, but this was declined. In reaching its decision, the Court focussed on the prejudice that the defendants would suffer if a substitution order were made.

Ms Smith's claim

Ms Smith issued the proceeding against Grant Shand and Claims Resolution Service Limited (CRS), who had previously assisted her to relation to an insurance claim for earthquake damage to her home. Ms Smith alleged that Mr Shand and CRS had breached fiduciary duties owed to her and that her contract with CRS was an unconscionable bargain. At the time, a number of other former CRS clients were defending proceedings commenced by CRS for the recovery of monies said to be owed pursuant to CRS contracts. In 2019, Ms Smith was granted leave to continue the proceeding as an opt-in representative proceeding; however complications arose when Ms Smith no longer wished to continue. Mr and Mrs Harris were willing to step in as representative plaintiffs, but as a condition of their appointment they required the Court to grant a stay pending a decision of the Court of Appeal in separate but similar proceedings, *Pfisterer v Claim Resolution Service Ltd & Grant Shand Barristers & Solicitors,* without which the substitute representative plaintiff would not be able to obtain funding for the proceeding.

The Court declines a conditional substitution

The Court declined to grant the substitution application on the basis that the conditional nature of the application rendered it illusory. Mr and Mrs Harris wanted to "accept the benefit of a substitution order while reserving to themselves the right to withdraw their consent to act in accordance with it if there is any costs risk to them". They were in effect, seeking an "option to reactivate the representative proceeding at some stage in the future".

It was also significant that members of the class had not paid money that CRS claimed was owing to them. The Court accepted that the defendants' ability to recover these amounts would diminish with further delay and as the substitution order sought by Mr and Mrs Harris would delay resolution of the proceeding for, potentially, years, this was overly prejudicial to the defendants.

Implications for class actions

This case will be of some comfort to large organisations who may face class actions; where a representative plaintiff has a change of heart and wishes to step away from the proceeding, the Court will have due regard to the prejudice that may be occasioned to the defendant if a substitution order may significantly delay resolution of the proceedings, notwithstanding that refusing a substitution order may mean that members of the represented class do not, or cannot, pursue their claims.

Case Study

Insurer beware – how to minimise the risk of waiving away the right to avoid *Ristorante Limited v Zurich Insurance plc*

Co-authored by Nick Frith and Thomas Leggat

A recent English High Court decision has reinforced the need for precision when asking questions in proposal forms. This decision aligns with current New Zealand law and is therefore relevant to local insurers. The principles will remain relevant even under the recently released exposure draft of the Insurance Contracts Bill.

Introduction

It is well known that insureds have a common law duty to disclose all material facts that would influence a prudent insurer in determining whether to write cover and, if so, on what terms. A common format for this disclosure is a proposal form, where the prospective insured responds to questions put by the insurer. The insured's general duty of disclosure supplements questions asked in proposal forms, so an insured must still disclose material facts that were not the subject of a question in a proposal form. However, the insurer can be deemed to have waived its right to disclosure of material facts which are outside, but proximate to, the scope of a proposal form question. One example from a leading English case is that asking a prospective insured whether they have been convicted of an offence for which they were imprisoned waives disclosure of convictions which did not result in imprisonment.

Facts

In *Ristorante Limited v Zurich Insurance plc* [2021] EWHC 2538 (Ch), the claimant, which operated a bar and restaurant, took out an insurance policy covering, among other things, business interruption caused by physical damage to its leased premises. On inception and at each renewal, the claimant was required to (and did) confirm the veracity of statements including:

> *"No owner, director, business partner or family member involved with the business:*
>
> *... has ever been the subject of a winding-up order or company/individual voluntary arrangement with creditors, or been placed into administration, administrative receivership or liquidation."*

The claimant made a claim under the policy for losses flowing from a fire at its premises. The insurer purported to avoid the policy on the basis that the claimant's directors had been directors of other companies that had been put into liquidation.

Decision

The primary issue was whether the claimant, in affirming the above statement in the proposal form, had made a misrepresentation. This largely turned on the construction of that statement accordingly to ordinary principles of contractual interpretation. The Court found that the claimant had made no misrepresentation because the statement, in context, captured only insolvency events relating to the directors/shareholders themselves and not other entities also controlled by them.

However, the claimant still owed the insurer a general duty to disclose material facts. It was common ground that the liquidations of the other companies controlled by the claimant's directors were material and their lack of disclosure induced the insurer to issue the policy. The claimant could succeed only if the insurer was found to have waived its entitlement to that information.

The Court found that the insurer had indeed waived. The test was whether a reasonable person reading the questions put to the claimant would be justified in thinking that the insurer had restricted its right to receive all material information and consented to the omission of the past insolvency of other companies controlled by the claimant's directors. The Court answered this in the affirmative because:

- the insurer had identified past insolvency events as a subject for disclosure but had limited its inquiry on that topic to certain individuals and thereby waived disclosure of other insolvency events;
- there was no special reason for a court to be slow to waive disclosure relating to insolvency; and
- there was no evidence to support the submission, made in light of the fact that a broker arranged the claimant's policy, that a reasonable broker would have identified that the other insolvency events were material and needed to be disclosed.

Our view

This case demonstrates the heavily contextual nature of the inquiry into whether an insurer has waived rights to disclosure. Poorly drafter proposal forms can unintentionally result in waiver. Insurers must therefore be careful to ensure that proposal forms are suitably and precisely worded so as to extract necessary information from prospective insureds without abridging the general duty of disclosure – the insurer's great ally – by waiver.

Waiver is one aspect of the law of disclosure in insurance contracts which has long been the subject of calls for reform on the basis that the current rules generate incoherent and unjust outcomes. In response to some of these concerns, MBIE undertook an inquiry in 2018/19. That inquiry concluded by recommending (among other things) a reform of the insurance disclosure rules to impose a requirement of reasonable care on consumers, and a duty of fair presentation on non-consumer insureds, when making disclosures to insurers (in proposal forms or otherwise) in lieu of the general duty of disclosure.

The recently released exposure draft of the Insurance Contracts Bill reinforces the risk of waiver for insurers and the need for clarity in proposal forms:

- In relation to consumer insurance contracts, clause 15 addresses matters which may be taken into account in determining whether the policyholder has taken reasonable care not to make a misrepresentation (the duty proposed to replace the general disclosure duty for consumers). Two of those matters are: (a) how clear, and how specific, any questions asked by the insurer of the policyholder were; and (b) how clearly the insurer communicated to the policyholder the importance of answering those questions and the possible consequences of failing to do so.
- In relation to non-consumer insurance contracts, clause 33(2)(e) expressly relieves policyholders, in the absence of enquiry, of the obligation to disclose a material circumstance if *"it is something as to which the insurer waives information"*.

The draft bill therefore makes it clear that insurers will need to remain ever vigilant in drafting proposal forms.

"This case demonstrates the heavily contextual nature of the inquiry into whether an insurer has waived rights to disclosure."

Case Study

Compensation for loss of control of personal data

Lloyd v Google

Authored by Olivia de Pont

Businesses and their insurers may breathe a sigh of relief following the English Supreme Court's decision in *Lloyd v Google LLC* [2021] UKSC 50, handed down in November 2021. In that case, the Court rejected a compensation claim against Google in an "opt-out" class action for loss of control of personal data. While privacy and data breaches are increasingly a source of litigation, this decision has curbed some of the momentum towards opt-out class action claims for data breaches, which could otherwise result in lengthy litigation and significant defence costs.

The claim against Google

This claim was brought by a Mr Lloyd, with the support of a litigation funder, and alleged that Google had breached its duties as a data controller under the Data Protection Act 1998 (UK) (DPA). Mr Lloyd claimed that in late 2011 and early 2012, Google "secretly tracked the internet activity of millions of Apple iPhone users" and used that data for commercial purposes. Google was able to do this using its "DoubleClick Ad cookie" which was placed on an iPhone if the user visited a website that included DoubleClick Ad content. Once placed on an iPhone, this cookie allowed Google to identify visits by that device to any website displaying an advertisement from its advertising network, and to collect information such as the date and time of any visit to a website, how long the user was on the relevant website, which pages were visited and for how long, and what advertisements were viewed and for how long. Sometimes, the user's approximate geographical location could also be identified.

Mr Lloyd's allegations were not, as the Court pointed out, new. Google has settled other, similar claims in the United States and in England and Wales. What was new was that Mr Lloyd claimed to represent everyone resident in England and Wales who owned an Apple iPhone at the relevant time and whose data were obtained by Google without their consent – a group of people estimated to number more than four million.

England, like New Zealand, does not have a legislative class action regime. Rather, it has a procedural rule allowing a representative claim to be brought on behalf of persons with "the same interest" in the claim, similar to Rule 4.24 in our High Court Rules 2016.

The central issue in this case was whether Mr Lloyd could use this rule to bring a representative claim for compensation without any individual assessment of loss. He sought GBP750 per class member on the basis that either (a) damages could and should be awarded to recognise the fact that a right has been infringed; or (b) "user damages" should be awarded, whereby damages are assessed as an estimate of what a reasonable person would have been paid for the right of the user. While GBP750 is a modest sum for each individual, if the proceeding were allowed to continue as an opt-out class action the total damages sought on behalf of the approximately four million class members would amount to GBP3 billion.

The Court's decision

The key difficulty faced by the claimant in this case was section 13 of the DPA, which requires that claimants suffer either damage or distress – a challenge to prove when most of the class were not before the court:

1. An individual who suffers damage by reason of any contravention by a data controller of any of the requirements of this Act is entitled to compensation from the data controller for that damage.
2. An individual who suffers distress by reason of any contravention by a data controller of any of the requirements of this Act is entitled to compensation from the data controller for that distress if -
    a. the individual also suffers damage by reason of the contravention, or
    b. the contravention relates to the processing of personal data for the special purposes.

The claimant argued, first, that the word "damage" as it appears in section 13(1) of the DPA includes "loss of control" over personal data. He argued that, as a matter of principle, compensation awards under the DPA should be approached in the same way as for breaches of the tort for misuse of private information because the two claims have a "common source" in the form of the right to privacy guaranteed by the European Convention for the Protection of Human Rights and Fundamental Freedoms.

The Court rejected this, noting that section 13(1) provides a right to compensation for damage only if the "damage" occurs "by reason of" the contravention. This was, the Court said, inconsistent with a right to compensation based on the contravention alone. For the same reason, the Court rejected the claimant's argument that "user damages" could be awarded.

The Court noted that, even if it were not necessary to show that an individual had suffered material damage or distress as a result of a data breach, it would still be necessary to establish the extent of the unlawful processing of data in that individual's case, such as the period of time that the relevant user was tracked, the quantity of data processed, whether any of that data was of a sensitive or private nature, and what use was made of that information. The claimant accepted that the amount of compensation awarded would need to be determined by reference to such matter, but argued that it was possible to identify an "irreducible minimum harm" suffered by every class member. However, the Court noted, the facts alleged in this case were not sufficient to establish that any class member was entitled to damages.

Implications for privacy class actions

The Court left open the possibility for a case such as this to be brought by way of a two-stage process, whereby the representative action procedure could be used to determine common issues, such as whether there had been an actionable breach of the DPA. Individual issues of damage could then be dealt with subsequently, in separate proceedings.

It is difficult to see, however, how it could ever be economically viable to bring a claim in this way. As the Court noted, the claimant in this case presumably did not propose to bring proceedings in this way because "success in the first, representative stage of such a process would not itself generate any financial return for the litigation funders or the persons represented. Funding the proceedings could therefore only be economic if pursuing separate damages claims on behalf of those individuals who opted into the second stage of the process would be economic. ... it clearly would not. In practice, therefore, as both courts below accepted, a representative action for damages is the only way in which the claims can be pursued."

New Zealand's Privacy Act deals with civil claims in a different manner to the DPA, with the Privacy Commissioner being the intended litigant on behalf of affected individuals in proceedings before the Human Rights Review Tribunal. The remedies are similarly limited, though. Section 103 of the Privacy Act provides that the Tribunal may award damages to an individual only where they have suffered pecuniary loss, expenses, loss of a benefit (whether or not monetary) or humiliation, loss of dignity or injured feelings. The decision in *Lloyd v Google* therefore provides some clarity on the limitations that are likely to apply upon the Commissioner's ability to bring a claim on behalf of a large number of affected persons.

Pet insurance and the pandemic

Authored by Esmée Powell

Of the many unexpected consequences of the COVID-19 pandemic, perhaps one of the more surprising is an increase in pet insurance claims. With the pandemic resulting in extended lockdowns, it seemed initially that pets benefited, as owners were home more often and devoted more time to them. It now appears, however, that the reverse is also true – when owners return to work and school, pets may suffer. Another side effect is that owners have paid more attention to their pets' health and have noticed, and have had more time to deal with, health issues that might otherwise have been overlooked.

The COVID-19 virus does not appear to affect pets directly. New Zealand pet insurer PD Insurance reports that while animals can catch COVID-19 and international research shows that one in five pets will likely catch the virus from their owners, cats and dogs generally have mild symptoms, if any at all. PD Insurance also report that, while studies have shown that humans can pass the virus to animals, our pets do not appear to pass it to us.

Internationally, insurers have reported an increase in pet insurance claims over the past year, specifically claims for behaviour-related issues such as anxiety. In an article in the Times, specialist UK pet insurer Scratch & Patch (yes, really) reported a threefold increase in dog behaviour issues in 2021. Increases in claims for anxiety and behavioural treatment over the course of the pandemic may have a variety of causes. Separation anxiety is a known cause, which may have been exacerbated as owners begin to head back into the office, particularly for new pets that had never known anything different. PD Insurance's animal shelter partner, HUHA, reported increased instances of separation anxiety as a particular problem after New Zealand's first lockdown, as new pets became accustomed to having its owner home 24/7 and it was traumatic when they were suddenly gone all day. Symptoms of this can include soiling the house, persistent barking and howling or meowing and scratching, digging holes, general destruction and escaping.

"Pet insurance pay-outs have been reported as being at an all-time high overseas."

Interestingly, an earlier article published in the Times during the period in 2021 when most people in the UK were in lockdown reported that not all pets appreciated their owners being home all day. Cats were reportedly suffering from increased stress and anxiety because their owners were working from home and disrupting their solitary routines.

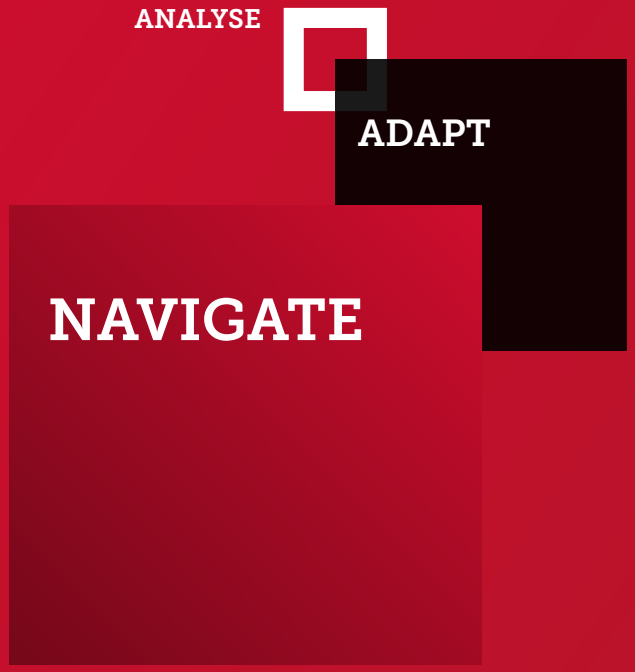
Fielding-based Totally Vets advise that pets may display signs of stress when there is an abrupt change when owners go back to work and school, leaving them home alone again, and these pets can show signs of separation anxiety and exhibit destructive behaviours which may require prescription medication – resulting in pet insurance claims. Vets have also warned about cats showing signs of stress during lockdowns, with an increase in restlessness and avoidance behaviour.

One New Zealand insurer has reported that an additional impact of the pandemic in New Zealand is that since the outbreak of COVID-19 and the resulting lockdowns, people have had more opportunity to monitor their pets' health. When pet owners are better placed to notice if something is wrong with their pets, including whether they are acting differently, avoiding food, or other relatively minor changes that might not otherwise have been picked up, they are more likely to take them to a vet.

Pet insurance pay-outs have been reported as being at an all-time high overseas. In the United Kingdom, according to the Association of British Insurers, the average claim cost insurers GBP817 in 2020, compared with GBP486 in 2010.

There are also benefits to insurers, however. In New Zealand, a pet insurer reported in 2021 that the uptake of pet insurance is likely to grow by around 25% over the next 12 months as a result of increased pet ownership during the pandemic. This jump in pet ownership is expected to be the main driver of growth in the market, alongside the increasing cost of veterinary treatment in New Zealand and improved consumer education around pet insurance.

In New Zealand, pet insurers continue to educate people on the value of pet insurance to mitigate the risk of expensive veterinary bills. Both internationally and in New Zealand, insurers have emphasised that people are often not aware of the extent of veterinary expenses for pets, especially as much of our medical health system is free or heavily subsidised so it is easy to forget that this is not also the case for pets' costs. Pet insurance has assisted owners to deal with psychological issues affecting their pets without a concern about the cost of treatment adding to the stresses they already face as a result of the extended lockdowns.



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