PROTECT

Cover to Cover Issue 25

Our publication for New Zealand insurance professionals

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MinterEllisonRuddWatts.

Contents

Editorial

With this, our 25th edition of Cover to Cover, we start by looking back on the nearly eight years since we published our first edition. In our first edition, we covered topics including:

- licencing of financial advisers (now into its second iteration with the FMCA);
- combatting "e-risk" and new-to-NZ 'cyber risk policies' (still a hot topic today); and
- case notes on Canterbury earthquake insurance decisions.

We examine a number of developments in insurance law, including significant changes to brokers' duties and calls for further reforms and an update on the Insurance Contracts Bill, which was released for consultation earlier this year, signalling the Government's intention to make fundamental revisions to insurance law in New Zealand.

All of these issues are still relevant today. In this issue, we examine calls from patient advocates to ban insurers from accessing predictive genetic test results when underwriting health or life insurance cover. Surprisingly, this issue does not appear to have received significant attention as part of the Insurance Contracts Review.

It remains to be seen whether MBIE will pick up on this issue and amend the draft Insurance Contracts Bill before it is debated in Parliament.

We also discuss whether insurers discriminate unfairly against customers with mental health issues, and how the reforms proposed in the draft Insurance Contracts Bill relating to an insured's disclosure obligations may impact on insurers' approach to underwriting and handling mental health claims.

COVID-19 continues to present challenges for the insurance industry. As the world opens up, many Kiwis are now planning long-overdue getaways. The decreased risks of severe COVID-19 infection, thanks in large part to vaccine efficacy and evolving variants, have emboldened many to travel once again. But overseas hospitalisation and associated expenses are not the only way COVID-19 can derail travel plans. Testing positive or becoming a household contact of a positive case prior to departure may also create a big dent in travellers' wallets if their flights and accommodation are non-refundable. We analyse how travel insurers are responding to these risks.

Andrew Horne
Partner

Nick Frith
Partner

Olivia de Pont
Senior Associate

We provide an update on the increasing challenges presented by cyber insurance and some of the ways in which insurers and brokers are meeting those challenges.

Finally, we are delighted to introduce Zoë Bowden, the newest Senior Associate in our team. Zoë specialises in litigation and dispute resolution with a particular focus on complex commercial disputes and contentious insurance matters. Before joining MinterEllisonRuddWatts, she worked in the financial services and insurance practice at a national United Kingdom law firm, prior to which she was with another national New Zealand law firm specialising in insurance law.

We hope you find our silver anniversary issue of Cover to Cover useful and interesting.

New duties, higher penalties and fewer revenue streams:

Brokers and the ICB

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

The Insurance Contracts Bill was released for consultation on 24 February 2022, signalling the Government's intention to make fundamental revisions to insurance law in New Zealand, including significant changes to the duties of brokers and their ability to use premiums.

The key changes for brokers are:

- changes to the existing duties in the Insurance Law Reform Act 1977 to introduce a new duty on intermediaries to pass on information to the insurer;
- changes to the ability to use premiums, currently permitted under the Insurance Intermediaries Act 1994; and
- fundamental changes to the policyholders' duty of disclosure, introducing new duties for policyholders to disclose information to an insurer.

Brokers should also note the changes to require insurers to present consumer insurance contracts in a clear, concise and effective manner, which may result in a number of insurance policies being substantially re-drafted.

Am I a broker, specified intermediary or insurance intermediary?

The Bill aims to consolidate the many pieces of insurance legislation, but has had little success in consolidating the various terminology used to describe brokers and intermediaries. Brokers, specified intermediaries and insurance intermediaries are all defined in the Bill, and each carry separate obligations. The terminology is further complicated by the use of "intermediary" in the Financial Markets (Conduct of Institutions) Amendment Bill.

MBIE has acknowledged that the Bill contains these three separate concepts, however, considers that this is "unavoidable as all these concepts capture different groups of people". We encourage MBIE to analyse and consolidate these piecemeal definitions, rather than grandfather them into the Bill from the current piecemeal legislation. We consider that including all three separate concepts within the Bill is confusing and counterintuitive to the aim of the Bill to consolidate and simplify insurance law.

BROKER

means a person:

(a) who carries on the business of arranging contracts of insurance (whether or not the business is the person's principal business or is carried on in connection with any other business); and

(b) who is not the employee of the insurer; and

(c) who is not appointed under a signed agreement as the agent for the insurer for the purposes of receiving:

(i) money due to the insurer from the policyholder; and

(ii) money due to the policyholder from the insurer.

SPECIFIED INTERMEDIARY

in relation to a contract of insurance:

(a) means a person entitled to receive from the insurer commission or other valuable consideration in consideration for the person's arranging, negotiating, soliciting, or procuring the contract of insurance between a person other than that person and the insurer; but

(b) does not include an employee of the insurer.

INSURANCE INTERMEDIARY

means a person:

(a) who for reward, arranges contracts of insurance in New Zealand or elsewhere; and

(b) who does so as the employee of or agent for one or more insurers or as the agent for the policyholder,

and includes a broker.

New duties when passing on information

The Bill places additional obligations on "specified intermediaries" in relation to passing on information to the insurer. Currently, under s 10(2) and (3) of the ILRA 1977, insurers are deemed to know information known to "representatives of insurers" (which generally includes brokers). Where a representative fails to pass on information from the policyholder, the insurer is still deemed to know that information.

***Consumer insurance contract**

A contract entered into by a policyholder wholly or predominantly for personal, domestic, or household purposes.

These sections of the ILRA 1977 have been carried over to Part 2 of the Bill, which also includes a new obligation on "specified intermediaries" (a term which replaces "representative" in the ILRA 1977) to:

- *in relation to consumer insurance contracts*:* take all reasonable steps to pass onto the insurer all material representations a policyholder made to the intermediary in relation to a consumer insurance contract unless the intermediary believes on reasonable grounds that a representation was a misrepresentation (clause 63); and
- *in relation to non-consumer insurance contracts:* take all reasonable steps to disclose to the insurer every material circumstance known to the intermediary (clause 64),

in each case before the insurer enters into the contract or agrees to a variation.

The effect of the proposed change is to provide an insurer with an avenue of redress against the specified intermediary in the event a specified intermediary fails to pass on the relevant information. Where information is not passed on to the insurer, the loss may be borne by the specified intermediary. The intention of this change is to protect policyholders from loss.

MBIE considers that the obligations placed on specified intermediaries are "not unreasonable". However, the term "specified intermediary" (as defined above) includes persons who are not agents of the insurer. Imposing such a duty on intermediaries effectively requires the intermediary to act as if it were an agent of the insurer, passing on information it has received. However, unlike an agent, where the insurer fails to acquire the relevant information from the policyholder, unlike an agency relationship, liability will sit with the intermediary.

This new duty represents a departure from the requirements in the Australian and UK jurisdictions, which only deem insurers to know information disclosed to an intermediary if that intermediary is an agent of the insurer.

We expect that brokers may require insurers to increase their commission to reflect this new requirement.

Passing on premiums

The IIA provides protections for clients of "insurance intermediaries" (which includes brokers). The IIA is mainly concerned with premium payments made by a policyholder through an intermediary. The IIA provides protection for policyholders where a premium is paid by the policyholder, but is never passed on to the insurer by the intermediary. The Bill carries over the provisions of the IIA into the proposed Act (see Part 4 of the Bill) and updates the provisions (e.g., to remove references to cheques). A number of further changes are also proposed, as discussed below.

Restriction on use of premiums

The consultation paper released by MBIE asked for submissions on whether changes should be made to the current s 8 of the IIA (allowing intermediaries to hold onto premiums for up to 50 days) and s 15 of the IIA (allowing intermediaries to invest premiums and keep profits on such investments). At present, those sections are carried over in the Bill in respect of brokers, however MBIE could add in certain restrictions (for example, limiting the ability for brokers to invest premiums and keep returns on investment) before the Bill is presented to Parliament.

In the consultation paper, MBIE stated that it had received submissions from insurers suggesting that the current sections create an incentive for brokers to hold onto premiums for as long as possible. MBIE also stated its concern that this could increase the risk associated with brokers defaulting on payment obligations, and that such an ability is unusual given the restrictions on

using such monies for intermediaries of financial products under the client money or property rules in the Financial Markets Conduct Act 2013.

MBIE is currently considering whether such restrictions will be introduced. We have concerns about whether such restrictions would benefit policyholders. If MBIE decided to impose restrictions on the use of insurance monies, this would remove a source of income for brokers. This would be an unsatisfactory outcome, as brokers may seek higher commissions as a result, raising the cost of insurance for policyholders. Further, there is no risk to policyholders if the premium is not paid on to the insurer because the broker is liable to the insurer for the money once the policyholder has paid the money to the broker. Therefore, a restriction on the use of premiums, as there is for client money and property services under the FMCA, is not warranted.

Increased penalties for failure to pass on premiums

The Bill also proposes to substantially increase the penalties for failures by brokers to pass on premiums, to bring the penalties in line with similar provisions in the FMCA (in particular, the penalties match those for client money and property service providers). A contravention in this respect will give rise to civil liability under s 449(4) of the FMCA, including a penalty not exceeding NZD200,000 in the case of an individual or NZD600,000 in any other case (compared to, respectively, NZD5,000 and NZD10,000 under the IIA).

Additionally, a new section has been included to provide that where a broker fails to notify the insurer that a premium has not been received within the relevant period, the broker must pay interest to the insurer on the amount of the premium that has not been received. This has been added as MBIE considers it is best practice to have a consequence for non-compliance of a duty (noting that the equivalent s 10 of the IIA did not appear to have a consequence).

Supporting clients to meet their new 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.

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

Brokers should note the changes to the duty of disclosure and consider how they can best support their clients to meet their obligations under the proposed Act. There is a duty on insurers to notify the policyholder of their duty of disclosure. In practice, however, it will fall to brokers to explain the duty, the consequences of a breach of duty, and provide assistance to the policyholder to disclose information to the insurer in accordance with their respective duties.

Brokers will need to be familiar with the applicable disclosure duties for their clients when passing on information from the policyholder. In particular, specified intermediaries dealing with consumer policyholders will need to assess whether the policyholder is taking reasonable care not to make a misrepresentation or if there are otherwise reasonable grounds to believe that that policyholder is making a misrepresentation (in which case, the specified intermediary is not required by the Bill to pass on that information to the insurer).

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" (determined by taking into account all the relevant circumstances).

Relevant circumstances include (among other things): type of consumer 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. Any particular characteristics or circumstances of the policyholder of which the insurer is aware, or ought reasonably to have been aware, must also be had regard to.

Consequence of breach

Where the policyholder has breached the duty to take reasonable care, the insurer will have proportionate remedies available if:

- they can prove that, without the misrepresentation, they would not have entered into the contract (or agreed to the variation), or would have done so on different terms; and
- whether the policyholder's nondisclosure was deliberate and/or reckless.

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 presentation of the risk" of the contract.

A "fair presentation" of the risk is, in brief, one that makes a disclosure of every material circumstance that the policyholder knows or ought to know, 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.

When will these changes happen?

Consultation on the draft Bill closed on 4 May 2022. MBIE is in the process of analysing the feedback and considering 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 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.

Are insurers discriminating unfairly against customers with mental health issues?

Authored by Zoë Bowden

Insurance cover for mental health has been placed in the spotlight following the recent publication of a *Consumer NZ* article which examined the fairness of mental health exclusions (*Consumer NZ*, 14 April 2022). The article cited the results of a 'mystery shopping' exercise undertaken with 14 health insurance providers to identify whether cover for health, life and income insurance would be available to consumers with a history of mental health issues or conditions.

The scenarios that *Consumer NZ* canvassed range applicants from the very mild, such as a person with no formal mental health diagnosis who was included only because she had attended counselling sessions as a result of her marriage ending, to the more serious, such as a person who was formally diagnosed with depression as a teenager and continues to take medication as a working adult.

Consumer NZ expressed the view that, while there was limited cover available to policyholders with a known history of mental health concerns, the prevalence of coverage exclusions "point to systemic failure in the insurance market, which can amount to discrimination".

The limited availability of life and health insurance cover both specifically for mental health conditions and cover more generally for persons with pre-existing mental health conditions is not a new issue, and it affects many people. A New Zealand Medical Journal article published in July 2017 reported that New Zealanders face a 40% lifetime prevalence of a mental illness diagnosis. The article considered the mental health cover provided by 36 health insurance policies offered by five insurers. While noting its limitations, it concluded that there was negligible cover available in respect of mental health conditions when compared to other common health issues.

Similar research has been reported elsewhere. In the United Kingdom, MPs and mental health campaigners lobbied the Government in 2018 to investigate what they viewed as insurer discrimination against people with mental health issues which prevented them from obtaining insurance cover. There, it was reported that individuals who suffered mild depression or anxiety, or one-off mental health episodes, were declined life insurance and other forms of cover.

The Royal Australian and New Zealand College of Psychiatrists' September 2021 submission to the Financial Services Council in respect of the development of a revised Life Insurance Code of Practice recorded their concern that what they saw as inconsistent treatment between mental health and physical health conditions could be considered discriminatory and unfair.[3] While they recognised the challenges associated with underwriting mental health cover, including measuring and proving symptoms, they recommended that underwriters be required to have the same skill set for assessing mental health as they do for physical health.

Customers report similar concerns. In a 2020 report on mental distress and discrimination in New Zealand, the Health Promotion Agency reported that 16% of respondents to a 2018 health and lifestyle survey who had mental health conditions reported being discriminated against in an insurance setting. A 2011 survey undertaken of Australians living with a mental illness undertaken by the Mental Health Council of Australia in partnership with the mental health charity, BeyondBlue, revealed that respondents felt they suffered significant difficulty and discrimination when applying for insurance products. 35% of the survey's respondents reported that they strongly agreed that it was difficult to obtain insurance due to mental illness.

Why insurers' conduct may be viewed as discriminatory

The issue, in summary, is that insurers are seen to take a harder line with prospective policyholders with a history of mental health concerns than they do for people who have had other health conditions. A policyholder with a history of, say, cancer may be offered insurance after they have been in remission for a given number of years, based upon their prognosis and an actuarial assessment of the risk. The concern is that with mental health issues, insurers do not rely upon an evidence-based assessment of the risk but instead impose permanent, blanket bars on cover. This is thought to result in cover being denied to people whose risk of making a claim is not objectively uninsurable, because insurers are not willing to underwrite risk based upon the evidence and an actuarial assessment as they are prepared to do with other health conditions.

Consumer NZ recommends that insurers' use of blanket mental health exclusions is banned. It proposes that broad, assumption-based underwriting is replaced with a tailored approach that takes into account individuals' circumstances and utilises current research and data to assess the risks that policyholders with mental health issues present objectively.

Insurers' responses

In response to *Consumer NZ's* critique, the FSC said that "insurers have adapted their underwriting approaches to reflect changes [to societal and medical attitudes to mental health] and to discern between mental ill health or distress at varying degrees of severity, management and recurrence". In an interview with the financial product website Good Returns, the FSC's CEO, Richard Kilpin, said that the *Consumer NZ* article did not represent fairly the industry's approach to insurance cover for mental health. He said that underwriting had become more "granular" and noted the importance of ensuring that risks are understood and fairly managed (*Good Returns*, 21 April 2022).

Should insurers expect regulatory intervention?

Conduct that may be discriminatory ordinarily falls within the scope of the Human Rights Act 1993. However, the Act's prohibition on refusing to provide goods or services, or treating any person less favourably in connection with the same, by reason of discrimination does not apply to the provision of insurance policies in certain circumstances.

Insurers benefit from an exemption if conduct that might ordinarily amount to discrimination is reasonable, having regard to the particular circumstances, and is based on:

- actuarial or statistical data which is reasonably reliable; or
- where no such data is available, reasonably reliable reputable actuarial or medical advice or opinion.

Insurers should be mindful of the limitations of this exemption as it applies to mental health cover. They should ensure that their underwriting processes are robust, up to date, and evidence-based.

While it is not clear whether New Zealand regulators may intervene in or provide any guidance in this area, the issue appears to be receiving increasing attention in Australia and regulatory review and reform there may be imminent. Australia's Productivity Commission released a report into mental health in November 2020 which recommended that:

- the insurance sector improves the way in which it collects information about, and relating to, persons with mental illness; and
- the Australian Securities and Investment Commission (ASIC) reviews, in 2022, the operation and effectiveness of the insurance industry codes and standards relevant to the provision of services to persons with mental illness.

The Productivity Commission recommended that ASIC assess whether insurers have removed blanket exclusions relating to mental illness and that it should also consider the extent to which insurers

distinguish between the types, severity and duration of mental health illness suffered by applicants and use up to date information to assess risk and make decisions about claims. The Commission recommended that, in the event that ASIC's review finds that satisfactory changes have not been made, regulation should be used to require change.

Australian insurers appear to have taken these concerns on board. Australia's Financial Services Council recently released its updated life insurance Code of Practice which will come into effect in July 2023. The Code incorporates new protections for consumers with mental health conditions, including by:

- providing that new standard form life insurance products designed by its members will not incorporate blanket exclusions for mental health in their general terms and conditions;
- ensuring that underwriters have the appropriate skills and training to assess mental health risks; and
- committing to take into account a customer's circumstances as part of the underwriting process, such as the history, severity or type of mental health condition.

Any findings or actions taken by Australian regulators may impact New Zealand insurers. In their joint thematic review of Life Insurer Conduct and Culture issued in January 2019, the Financial Markets Authority and the Reserve Bank of New Zealand recorded their expectation that, in relation to issues identified by the Australian Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry, New Zealand insurers should proactively review the work of regulators and related international examples to identify potential conduct and culture issues. We anticipate that the FMA would expect insurers to act proactively to identify regulatory concerns relevant to the provision of mental health cover.

Additionally, insurers who are members of the FSC are bound to comply with its Code of Conduct which is intended to increase trust and confidence in the financial services industry by promoting good conduct and a strong customer focussed culture. The Code of Conduct's core objectives include delivering good customer outcomes, ensuring effective products and distribution, training, risk management, management of conflict, and fair treatment of customers. Arguably, refusing cover to prospective customers with mental health issues where the evidence does not justify that treatment may breach the Code.

Insurance contracts law reform

Proposed reforms to the disclosure duties set out in the draft Insurance Contracts Bill may have an impact on insurers' approach to underwriting and handling mental health claims.

As set out on page five of this edition, the draft Bill provides that a policyholder's existing pre-contractual duty to disclose all information that could influence the judgement of a reasonable insurer will be replaced by a duty on consumer policyholders to take reasonable care not to make a misrepresentation to the insurer, in the relevant circumstances. This will increase the focus upon the questions that insurers ask prospective customers about mental health issues and how they use the answers given.

The Bill also proposes to modify the remedies available to insurers if a policyholder breaches his or her duty of disclosure. The proportional remedies provided for in the Bill vary in accordance with materiality of the non-disclosure and the policyholder's intent. Where the misrepresentation or breach is neither deliberate nor reckless, the insurer may modify the amount payable on a claim with reference to the difference in premium it would have charged, or where it would not have entered into the contract on any terms, it may avoid the contract and return the premiums paid. However, to avoid a policy and retain the premiums paid, an insurer must show that the policyholder's misrepresentation or breach was deliberate or reckless. It is important to note that the existing prohibition on life insurers avoiding an insurance contract for misrepresentation (unless made fraudulently, or in the relevant three year period) survives and will be incorporated into the legislation.

We expect that increasing attention will be given to this issue. We recommend that New Zealand insurers monitor national and international regulatory and legislative developments relevant to mental health cover. Insurers should also ensure that they implement and maintain reasonable, evidence-based underwriting and claims handling processes for policyholders with mental health issues.

Should insurers have access to customers' predictive genetic test results?

Co-authored by Andrew Horne and Olivia de Pont

Patient advocates in New Zealand are calling for a ban on insurers accessing predictive genetic test results. Those advocates say that allowing insurers to access such genetic information would disincentivise people from having the tests, which may mean that they lose the opportunity of taking additional screening tests that would identify issues or preventative treatment that would help them.

Those in favour of a ban also point out that a number of countries have introduced partial or total bans on insurers accessing predictive genetic test results and say that the law in New Zealand is out of step with the rest of the world.

Is this a good idea? One problem with a ban is the risk of anti-selection. In other words, high-risk consumers who know that they are genetically predisposed to certain illnesses will be more likely to purchase life and/or health cover. There will then be an information disparity and insurers, without access to the same information available to the consumer, may not be able to price the risk accurately. Assessing risk is critical for an insurer to set the right premium at policy commencement for life and health cover, and if risks cannot be fully assessed, policy exclusions or an overall increase in premiums may be required. An argument could also be made that disclosure of predictive genetic test results could provide an opportunity for health insurers to help their customers reduce their health risks by funding preventative treatment.

Insurers' access to predictive genetic test results is therefore a complex issue, and one which, surprisingly, does not appear to have received significant attention as part of the current Insurance Contracts Review. As discussed in 'New duties, higher penalties and fewer revenue streams: Brokers and the ICB', a draft Insurance Contracts Bill was offered for consultation earlier this year. The submissions MBIE received as part of this consultation included one advocating for a ban on insurers using predictive genetic test results in making underwriting decisions. It remains to be seen whether MBIE will pick this up and make any changes to the draft Bill. If MBIE does consider it appropriate to introduce a ban in some form, it will likely have regard to the regimes currently in place in the United Kingdom or Australia, and perhaps those in Canada and the United States.

Even if MBIE does not pick up on this issue as part of the Insurance Contracts Bill, calls for a ban are likely to increase as the use of predictive genetic tests becomes more widespread. Insurers should keep a close eye on overseas developments in this area, and on the status of calls for change in New Zealand.

Overseas approaches

A number of countries have imposed limits upon insurers' ability to access predictive genetic test results. If reform is considered in New Zealand, regard will likely be had to these.

Australia

Our closest neighbour, Australia, does not have a legislative ban on insurers using predictive genetic test results, but there has been a moratorium in place since 2019. This moratorium applies to life insurance policies with a sum insured of up to AUD500,000, and means that consumers do not have to disclose an adverse genetic test result or take a test when applying for life insurance. Life insurers can still request information about genetic test results where life insurance is sought with sums insured greater than:

a. AUD500,000 of lump sum death cover;
b. AUD500,000 of total permanent disability cover;
c. AUD200,000 of trauma/critical illness cover; and
d. AUD4,000 a month in total of any combination of income protection, salary continuance or business expense cover.

This moratorium is due to expire in 2024 and it is currently unclear whether or not it will renewed or replaced with a legislative regime.

Australian health insurers do not risk rate individuals; premiums are instead charged on the basis of community ratings. Accordingly, the results of predictive genetic tests are not relevant for their underwriting decisions and on the status of calls for change in New Zealand.

Canada and the USA

The regimes in place in Canada and the United States are less likely to inform any reforms that may be considered in New Zealand, due to the different environment in which insurers, particularly health insurers, operate. However, some consideration may be given to:

- The Canadian legislation, which is the Genetic Non-Discrimination Act 2017, which prohibits insurers from using genetic test results without an individual's written consent; and
- The Genetic Information Nondiscrimination Act (2008) which prohibits US health insurers from using genetic information to make coverage or rating decisions. It does not apply to life insurance, disability insurance or long-term care insurance, although some individual states have legislated to limit genetic discrimination in life insurance. For example, Florida has enacted a genetic privacy law that prohibits life insurance companies from cancelling, limiting or denying coverage and from setting different premium rates based on genetic information.

United Kingdom

The approach taken in the United Kingdom is similar to that in Australia, but applies beyond life insurance, presumably because health insurers do not apply community ratings. The approach taken in the United Kingdom may therefore be more relevant for New Zealand if reform is considered.

A moratorium was first put in place in 2001, which was replaced with the Code of Genetic Testing and Insurance in 2018. The Code is a voluntary agreement between the UK government and the Association of British Insurers which prohibits insurers from requiring or pressuring an insurance applicant to undertake predictive or diagnostic genetic testing to obtain insurance. Insurers may only rely on the results of a predictive genetic test in specific circumstances as follows:

Type of insurance	Financial limits above which predictive genetic tests may be relied on	Medical conditions for which insurers may ask for and take into account predictive test results, for policies above the financial limits
Life insurance	GBP500,000 per person	Huntington's disease
Critical illness insurance	GBP300,000 per person	None
Income protection insurance	GBP30,000 (per annum per person)	None
All other types of insurance	Predictive genetic test results will not be asked for or taken into account whatever the level of cover	

Case study

Late notification under claims-made policies

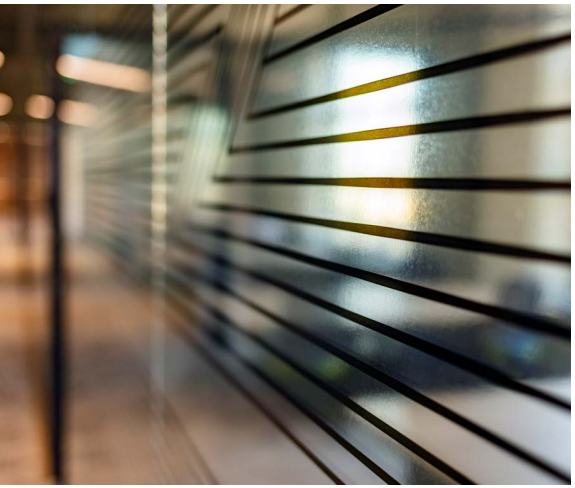
Avant Insurance Limited v Darshn [2022] FCAFC 48

Co-authored by Nick Frith and Zoë Bowden

A recent Australian appellate decision is a reminder of the prospect of New Zealand insurers being on risk for late-notified claims under claims-made policies. The proposed limitation period for late notification in the Insurance Contracts Bill provides some comfort. But, as drafted, there are prescriptive requirements which must be met before it will assist. We discuss these below.

The case

Dr Darshn, a cosmetic surgeon, held continuous professional indemnity cover with Avant Insurance between September 2011 and June 2019.



Dr Darshn's unfortunate claims experience

a. In March 2018, Dr Darshn notified proceedings brought against him and his former workplace by a former patient. Avant accepted the notification and appointed panel lawyers to represent him. The Policy relevantly provided that the lawyers were engaged directly by the insurer and not as the insured's agent, were to supply services to the insurer not the insured, and contained the usual waiver of privilege.

b. In January 2019, Dr Darshn was issued with a subpoena requiring him to produce documents in relation to a separate class action commenced in 2017 against his former workplace.

c. In February 2019, panel lawyers sent several emails to Avant which recorded the similarity of issues between the above cases and referred to the possibility of Dr Darshn being joined to the class action as a defendant.

d. In the months that followed, Dr Darshn called Avant's medico-legal advice service twice, notified yet another claim and discussed the subpoena he had received. Avant suggested that Dr Darshn provide a copy of the subpoena in case he required advice. He did not do so, but it transpired that Avant had already received a materially similar copy of the subpoena from another insured.

e. On 22 May 2019, panel lawyers sent an email to Avant which again referenced the overlap between the three sets of proceedings above.

f. On 30 June 2019, Dr Darshn's insurance with Avant lapsed.

g. In June 2020, Dr Darshn and 10 other surgeons were joined to the above class action. Dr Darshn sought to notify Avant but it refused to accept his notification on the basis that no claim against him had arisen while he held insurance and he had failed to notify in writing as required.

In Australia, s 40(3) of the Insurance Contracts Act 1984 provides that where an insurer is notified of circumstances that may give rise to a claim during the policy period, it is not relieved of liability in respect of a claim arising from those circumstances only because the claim was made after the policy has expired.

The Federal Court of Australia held that the panel lawyer's correspondence with Avant, when viewed in the round, amounted to notice in writing of circumstances that may give rise to a claim against Dr Darshn, within the meaning of s 40(3). The Court found that the nature and the scope of the class action proceedings featured prominently in the correspondence, and the facts conveyed within it conveyed the possibility, if not the likelihood, of Dr Darshn being joined as a defendant. It did not matter that the correspondence was made by panel lawyers, and not Dr Darshn personally, because they were acting on his behalf, pursuant to the lawyer-client relationship that existed between them.

The decision was appealed. The Full Court of the Federal Court rejected Avant's arguments that: (a) the panel lawyers did not have authority to give notice under s 40(3) as agent for Dr Darshn because their retainer was limited to representing him in respect only of proceedings issued against him while the Policy was current; and (b) the panel lawyers were engaged expressly on Avant's behalf, and not as Dr Darshn's agent.

While the Court found that the Policy was silent in relation to the nature of the legal relationship between the panel lawyers and Dr Darshn (expect that it provided that Avant would appoint a lawyer to provide it with services), it was "*untenable*" to find that the panel lawyers were not acting as Dr Darshn's legal representative in the relevant proceedings – notwithstanding the separate legal relationship that existed as between the panel lawyers and Avant. The Court found that it would be an "*expected incident*" of the legal relationships between the parties that the panel lawyers would do so if they came into possession of facts that might give rise to a claim against Dr Darshn under the Policy.

The Court found that intention was irrelevant in determining whether notification had been made – meeting Avant's argument that the panel lawyers' communications were not for the purpose of notifying claims. It "*could hardly be doubted*" that Avant had been notified that Dr Darsh was a potential, or even likely, defendant in the class action.

New Zealand position

In *Nicholson & Ors v Icepak Coolstores Ltd*, the High Court confirmed that a lawyer appointed by an insurer to defend an insured against a third party claim assumes a lawyer-client relationship with the insured – albeit this relationship does not exist to the exclusion of a similar relationship with the insurer. As is the case in Australia, notice may be given by an insured's agent or any person acting on its behalf, provided that there is no policy provision requiring otherwise.

While there is no equivalent to s 40(3) of the ICA in New Zealand, many policies provide that circumstances notified during the policy period are covered even where a formal claim is not notified until after the policy expires. So there is nothing to prevent insurers from being at risk for circumstances notified by panel lawyers, as the insured's agent, during the currency of the policy.

The position in respect of claims first raised after the policy period is arguably worse for insurers in New Zealand. Express policy provisions that prescribe the manner or time in which notice of a claim must be given may be subject to s 9 of the Insurance Law Reform Act 1977, which has the practical effect of overriding time limits applied to claims-made policies in the complete absence of notification during the policy period where the policy trigger for notification (knowledge of circumstances that may give rise to a claim) had been met (*Minister of Education v McKee Fehl Constructors Ltd*). The insurers in this case failed to show prejudice, leading to the Court applying s 9 to allow a claim to be brought against them.

The case for reform

The Government has recognised the need for insurers to have certainty when closing years of account on liability policies. The Insurance Contracts Bill will, if enacted, operate to restrict the application of what is now s 9 of the ILRA to claims-made policies, by permitting an insurer to decline a claim where:

a. the policy's notice clause defines the period within which claims made (or those arising out of circumstances notified) are within the risk period accepted by insurers in the policy;

b. the policyholder failed to notify the insurer of the relevant claim or circumstances before 60 days after the end of the policy term; and

c. the insurer clearly informed the policyholder in writing of the effect of failing to notify before the expiry of that period within 14 days of the end of the policy period.

The requirement in (c) above is prescriptive and insurers will be vulnerable to late-notified claims, in the absence of prejudice, if they fail to give the required notice.

COVID-19 and travel insurance:

Insurers take tentative steps back into the market

Co-authored by Andrew Horne and Siobhan Pike

As the world opens up, many Kiwis are planning long-overdue overseas getaways. The decreased risks of severe COVID-19 infection, thanks in large part to vaccine efficacy and evolving variants, have emboldened many to travel once again. But overseas hospitalisation and associated expenses are not the only way COVID-19 can derail travel plans. Testing positive or becoming a household contact of a positive case prior to departure may also create a big dent in travellers' wallets if their flights and accommodation are non-refundable.

How are travel insurers responding to these risks?

Insurers' initial responses to COVID-19

When travel insurers first became aware of the COVID-19 pandemic, they reacted cautiously by setting dates after which they were not prepared to cover COVID-19 related losses, on the basis that travellers who booked holidays after those dates did so knowing of the pandemic. Insurers were understandably nervous of a risk that was difficult to value at first and affected large numbers of travellers, so they imposed broad exclusions for COVID-19 losses.

As mass vaccination and the prevalence of less harmful variants of COVID-19 turn what was once a threat to life and health to a minor inconvenience for most people, insurers have become less concerned about their exposure to substantial medical costs for hospitalisation. Insurers remain concerned, however, about losses that occur when people cannot travel because of government-imposed lockdowns or because they or a travelling companion test positive for COVID-19.

What COVID-19 costs are travel insurers now covering?

Medical costs

Most insurers now provide cover for medical costs incurred as a result of COVID-19. Insurers appear to be comfortable that the risk of serious illness resulting in substantial medical bills is now both sufficiently low and predictable to be insurable.

Most policies, however, continue to exclude cover for travel to countries that are on the New Zealand Government's 'do not travel' list reflecting a high risk of COVID-19, where travel is banned, and for multi-night cruises (some offer cruise extensions). Most policies do not offer cover where the policy

was purchased within a specified period of travel, such as 21 days, to ensure that the traveller does not already have COVID-19 when they take out the policy and will still be testing positive when they are due to travel.

Coverage for medical expenses resulting from COVID-19 is normally offered to the usual limits, where limits of NZD1 million or unlimited cover are not uncommon. Some, however, may still be restrictive.

Limited cover for travel disruption costs

While insurers have been more cautious about insuring costs and losses resulting from travel disruption caused by a COVID-19 illness or positive test, travel insurance policies are increasingly offering cover for events relating to COVID-19 that impact travel plans as well as medical costs. These additional costs include:

- costs to change travel arrangements if a traveller or another relevant person such as a family member or travelling companion are diagnosed with COVID-19 before they leave, and travel plans must be cancelled as a result; and
- costs to change travel arrangements if a traveller or a relevant person is diagnosed with COVID-19 while away so that the trip is cut short.

However, travel insurance typically provides much more limited cover for costs caused by delays and disruptions associated with COVID-19 than from other causes. Most travel insurance policies provide coverage of only NZD5,000 for these costs. For an international holiday requiring cancellation and rescheduling of flights, accommodation, and activities, these modest cover limits can easily be exceeded.

For some people

Some travel insurance policies only provide coverage if the policyholder or a travelling companion is diagnosed with COVID-19 and must alter their travel plans to self-isolate and recover. Under other policies, but not all, being obliged to self-isolate as a household contact will also trigger cover.

Importantly, some travel insurance policies only cover COVID-19 expenses for fully vaccinated travellers. This requires the policyholder to have received an approved COVID-19 vaccine at the specified dosage and consistently with New Zealand government recommendations, including boosters.

To some places

Even for the fully vaccinated traveller, cover for COVID-19 expenses is not necessarily a given. Most travel insurance policies only provide COVID-19 benefits if the policyholder is travelling to a destination with a SafeTravel travel advisory level of 1 or 2 (low to moderate risk). COVID-19 cover will be denied to destinations with a higher travel advisory level under most policies. This appears to be the case even if the policyholder tests positive before their journey and is unable to travel, so that the high-risk nature of the destination would have made no difference.

Tips for travellers before they book

Is travel insurance still worth it?

With travel insurance being limited for COVID-19 expenses, some travellers may question its necessity. We strongly recommend that all travellers obtain the most comprehensive travel insurance policy they can afford. With the constantly evolving COVID-19 landscape, travellers should be prepared, and the right travel insurance policy can eliminate or significantly reduce major expenses.

Shop around

All travel insurance policies are different. It is important for travellers to shop around to find the deal that provides maximum coverage. For those planning a family holiday, finding a policy with highest possible cover limit will be essential to cover multiple flights and higher accommodation fees.

When considering different travel insurance policies, travellers should carefully check available policies to determine exactly what they cover. They should make sure they understand who will be covered in the event of delayed or cancelled travel and read the exclusions carefully.

Plan carefully

COVID-19 and its effects can be unpredictable, and it pays to be prepared. Planning holidays in advance increases the time travellers have to research and purchase appropriate travel insurance and ensure that they are complying with the requirements for cover. This includes making sure all policyholders meet vaccination requirements. It is also essential to purchase travel insurance well in advance – often at least 21 days before travelling - to ensure that COVID-19 cover requirements are met.

Where possible, paying a bit extra for flexible or refundable flights, accommodation or activities can ensure that, where plans are delayed or cancelled due to COVID-19, any financial loss is kept to a minimum. Preparation is more important than ever to prevent a financial headache and the stress of being uninsured for a loss and allow travellers to enjoy their travel without worrying about COVID-19.

Further consultation on IPSA:

Enforcement and distress management for insurers

Co-authored by Andrew Horne, Lloyd Kavanagh and Sarah Jones

The Reserve Bank of New Zealand has released a consultation paper on whether the penalties and enforcement tools available to it when supervising insurers and its powers to manage distressed insurers should be expanded. The consultation is the third (of the proposed five) in relation to the review of the Insurance (Prudential Supervision) Act 2010. Submissions have now closed.

Links to the consultation and the general IPSA review webpage are available on RBNZ website.

Who needs to read it? Why?

All insurers and actuaries should read the consultation document and consider the proposed changes. The consultation broadly proposes an expansion to the RBNZ's enforcement powers and increased powers when an insurer is in distress.

What does it cover?

The consultation focuses on the following areas:

Penalties and enforcement

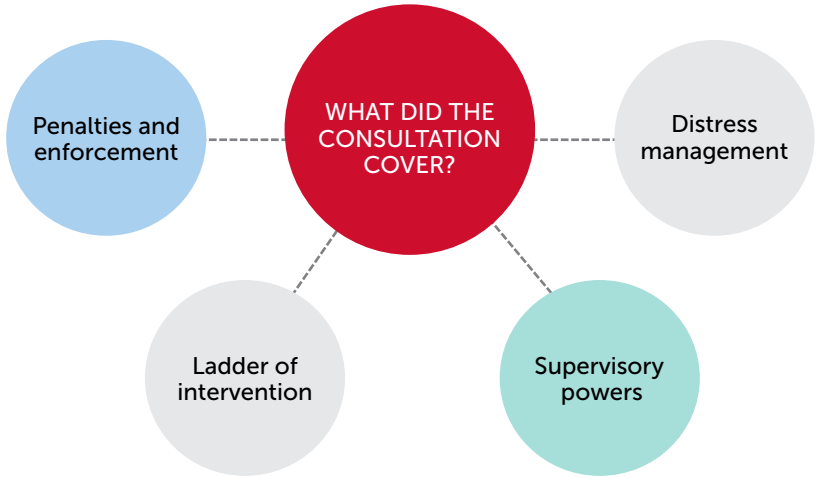
The RBNZ stated in the consultation that it aims to design an effective enforcement and penalties regime under IPSA. Currently, IPSA has a wide range of offences and penalties for breaches of obligations under the Act. However, enforcement action is confined to written warnings or criminal sanctions.

The consultation proposes a wider range of penalties and enforcement tools with the aim of allowing the RBNZ to take a proportionate and escalating response to breaches of IPSA. The RBNZ is considering the following enforcement actions:

- public or private warnings;
- remediation plans of insurers in breach of IPSA;
- enforceable undertakings;
- infringement notices; and
- civil pecuniary penalties.

The consultation refers to the proposed enforcement tools available to the RBNZ in the recent Financial Markets Infrastructure Act 2021 and proposed Deposit Takers Bill. The clear intention of the proposals in the consultation is to introduce similar enforcement action for insurers under IPSA as there are for other entities regulated by the RBNZ (primarily deposit takers such as banks).

The consultation paper also proposes raising the maximum penalties in IPSA to account for inflation and for consistency with the proposed Deposit Takers Bill.



Supervisory powers

The consultation paper discusses broadening the RBNZ's information gathering and investigation powers. The consultation points out that these powers apply in respect of licensed insurers only, and do not extend to instances where an entity is carrying on business as an insurer but is not licensed. In addition, the consultation notes that, unlike the Financial Markets Authority, the RBNZ is not authorised to request information from *any* person in pursuit of its statutory functions (the power currently relates to the licensed insurer only, but does not extend to brokers, outsource providers or entities that may be carrying out insurance business but are not licensed).

The RBNZ proposes an extension of its direction powers. Currently, the RBNZ can impose an enforceable requirement on an entity to perform or not perform particular actions. The RBNZ has a wide-ranging power to direct an insurer to take a number of actions (such as to carry on business in a certain way, or cease to issue new policies). However, IPSA does not currently allow the RBNZ to direct an insurer not to renew existing policies – the RBNZ proposes to introduce this power.

The consultation paper also seeks submissions on whether breach reporting should be required of insurers and whether, as proposed in the Deposit Takers Bill, the RBNZ should have the power to conduct on-site inspections.

Distress management

The consultation considers, in relation to distress management, whether:

- there should be a purpose statement included in IPSA to govern the RBNZ's involvement in distress management of insurers;
- insurers should be required to undertake some form of resolution planning;
- IPSA provisions should include details of the RBNZ's role in administration and liquidation;
- the current triggers for statutory management are too demanding and whether the RBNZ should be given powers of the statutory manager; and
- the provisions in IPSA addressing stays on certain contractual rights under statutory management are sufficient.

The RBNZ raises whether, given its considerable input into the statutory management process, it should have the power to exercise resolution powers itself. The consultation discusses whether, as with the proposed Deposit Takers Bill, resolution powers should vest with the RBNZ.

Ladder of intervention

The consultation also discusses what enforcement and distress management powers the RBNZ should be equipped with in the new "ladder of intervention" introduced by the new solvency standards.

Briefly, the solvency standards currently applicable operate on the basis of a single solvency standard (the Minimum Solvency Capital). The interim solvency standard proposed by the RBNZ includes two control levels: a higher "Solvency Capital Requirement" and a lower "Minimum Capital Requirement". This allows the RBNZ to have an escalating response as capital levels decline i.e., a "ladder of intervention".

The RBNZ has indicated that it will issue a policy as to what enforcement action it will take at each rung of the ladder. However, the RBNZ is taking submissions on the statutory triggers i.e., when an enforcement action can be taken by the RBNZ under IPSA.

The RBNZ considers that all powers should be available once the Solvency Capital Requirement is breached or is likely to be breached. How the RBNZ will use these powers would then be published in guidelines.

> "Following the omnibus consultation, the RBNZ will aim to introduce a draft amendment bill to Parliament before the end of 2024."

What is next for the review?

The RBNZ has indicated in the latest consultation paper how the review will proceed. The RBNZ proposes to consult on "key officers and control functions, supervisory approvals in Q3 2022 and regulatory mechanisms, disclosure requirements and other issues" in Q4 2022. Once the targeted consultations are completed, the RBNZ will release an omnibus consultation setting out its recommended reforms for IPSA (expected to be in the first half of 2023).

Following the omnibus consultation, the RBNZ will aim to introduce a draft amendment bill to Parliament before the end of 2024. The timing for the implementation of the Bill has not been released.

Our view

We welcome the RBNZ's intention to create an effective and proportional penalties and enforcement regime. In particular, we welcome the broadening of the RBNZ's enforcement toolkit so that criminal sanctions are reserved for the most serious offending. We encourage the RBNZ to consider the purpose and proportionality of these penalties and enforcement actions as it develops the new provisions.

The omission of a power to direct insurers not to renew existing policies in IPSA was highlighted in the Trowbridge report into the failure of CBL Insurance and the International Money Fund's review of the financial sector. However, if the RBNZ has the power to direct an insurer not to renew policies, this could create significant problems for some types of policyholders, particularly in relation to life or health insurance. As the RBNZ suggests, restrictions could be placed on this power requiring that the RBNZ have regard to policyholder interests. It will be critical that this new duty balances the need to reduce the exposure of an insurer and the interests of the policyholder in maintaining their cover and current cost of insurance.

> "We welcome the RBNZ's intention to create an effective and proportional penalties and enforcement regime."

We question the consultation's heavy reference to the Deposit Takers Bill. The RBNZ implies in its consultation that a number of enforcement tools and distress management tools should be broadly consistent with those for banks in the Deposit Takers Bill. We generally accept this premise in relation to penalties and enforcement action. However, we consider that the same level of regulation is not warranted for the insurance industry in relation to distress management. In comparison with banking, insurers do not present the same systemic risk. For example, when an insurer fails, this is not likely to result in a broader collapse across the industry. We have seen this, for instance, with the collapse of CBL, which did not result in consequential failures. The RBNZ's proposal to be responsible for resolutions in relation to statutory management may be overzealous.

We also recommend that the RBNZ exercises caution in creating its approach to intervention in the case of an insurer's insolvency. The concept of the ladder of intervention is that enforcement is proportional and progresses as solvency levels decline. Therefore, should the RBNZ wish to allow the entire range of enforcement actions to be available at the first rung of the ladder (Solvency Capital Requirement), it must ensure that it adopts an approach consistent with the ladder of intervention model in its published guidance.

What next?

If you have any questions in relation to the consultation or are considering how the proposed changes may affect your business, please contact one of our experts.

Trends in cyber insurance

Co-authored by Andrew Horne and Zoë Bowden

Cyber insurance poses increasingly complex challenges for insurers, brokers and insureds. With cyber-attacks increasing in number, sophistication and severity, insurers are aiming at a moving target as they strive to assess risks accurately and set premiums appropriately. At the same time, insurers can afford to be selective, as demand for cyber cover increases while insurer capacity and appetite for cyber risks reduces.

Perspectives from an IT expert, an insurer, a broker and a lawyer

Last year, in Issue 23 of Cover to Cover, we reported the observations from the Cyber Risk breakfast we hosted in June 2021 at which leading professionals from AIG (insurance), Aon (broking) and Datacom (IT security) offered their thoughts and shared their experiences of the developing risks and the place of cyber insurance. We added our thoughts about the legal risks presented by cyber events and the appropriate legal responses.

The key take-aways from that event include the following:

The IT expert

New Zealand is a soft target – our geographical isolation lulls us into a false sense of security. Good 'hygiene', doing the basics well and quick responses to events are critical.

The insurer

Ransomware claims increased 150% from 2018–2020 and comprise one in every five claims. They are increasingly sophisticated, with bad actors taking the time to identify the most crucial data and targeting their attacks for maximum damage and effect, and victims often unable to operate for seven to ten days. Losses include ransom costs, event management costs such as IT costs, network interruption losses, regulatory actions and customer claims.

The broker

There are two key ways to address cyber risk – mitigation and insurance. Remote working increases risk. Many organisations run legacy systems with inadequate security. Insurers are asking increasingly detailed questions of insureds and they will decline to offer cyber cover to insureds with inadequate security. Cyber cover is becoming a mark of quality for organisations.

The lawyer

Losses include the victim's own loss and damage (operations are halted, money may be stolen), liability to customers and third parties (whose data may be released or misused), and regulatory action and fines. Victims should make no admissions, take prompt steps to recover systems, involve insurers at the outset and take appropriate advice.

An update for 2022

What developments have we seen in the past year?

Threats are increasing

Unsurprisingly, there has been no let-up in the onslaught of cyber-crime. In June 2022, Forbes magazine reported that a research company had found that there had been an increase of 50% per week in attack attempts on corporate networks globally in 2021 from 2020. They observed that the FBI's Internet Crime Complaint Center had issued a public service announcement in May 2022 reporting a 65% recorded increase in identified global losses between July 2019 and December 2021.

The New Zealand Government's Budget for 2022, released in May, reflects an increasing concern about cyber-crime. It provided approximately NZD50 million in additional funding over four years for the GCSB to combat cyberattacks and engage in counter-terrorism activity, aiming to protect information services from the increasing frequency and severity of cyberattacks.

Cyber insurance is increasingly difficult to obtain

Insurers are responding to the rising risks and costs of cyber events with increasingly detailed assessments of insureds' IT systems, as well as reducing cover limits and increasing premiums. One major New Zealand insurer has dealt with the additional complexity required by the assessments by introducing a 'smart' cyber questionnaire in which an insured's answers to the initial questions trigger different or additional questions, depending upon the responses. Other New Zealand insurers have reduced limits significantly or have withdrawn cover altogether.

Cyber insurance requires increasing levels of IT resource time to respond to questions

The complexity of insurers' questionnaires, and their importance, means that IT departments need to be well prepared and properly resourced to answer them. This should be done well in advance of the renewal date, as the time commitment is significant and answers often need to be drawn from different sources. In addition, IT departments may realise as they work through the questions that the answers they would give will not satisfy insurers, so it may be necessary to take remedial steps urgently so that a better response can be given.

An additional challenge is that insurers are conducting their own security reports and scans of an insured's systems. Whereas previously, insurers might have accepted insureds' responses uncritically, many now test and challenge them. Insurers will often share reports, and sometimes insureds and their brokers will need to challenge aspects of the reports that may not tell the full story.

"It is crucial that insurers provide a full explanation of any responses that might not tell the full story."

A key lesson for brokers and insureds is that 'wrong' answers to questions asked by insurers may have significant effects upon the insurers' willingness to offer or renew cyber cover. It is crucial that insureds provide a full explanation of any responses that might not tell the full story. For instance, insurers expect to see multi-factor authentication as a core requirement for access to an insured's system, because of the impressive results it achieves in reducing ransomware demands. This means that any circumstances in which multi-factor authentication may not be used as it is not required, such as when an operator is in the building and connecting to a server with a cable, will need to be explained carefully.

Brokers and insureds need to prepare for their renewals with a full appreciation of the time and work that is likely to be required to present a compelling proposition to a cyber insurer. Insureds will also need to be prepared to consider reductions in cover or moving to different insurers as capacity and limits change.

Insurers, for their part, will need to continue monitoring claims closely and adapting quickly as bad actors change their approaches and the threat landscape develops. Cyber insurers will increasingly need to provide a proactive, advisory service to assist brokers and insureds to understand what their requirements will be and enable insureds to satisfy their expectations, rather than confining their role to a reactive response.

Insurers' reliability and consistency is increasingly valued

Another factor to bear in mind is that the market is presently volatile. Some insurers that were cyber market leaders in New Zealand in 2020 had reduced capacity in 2021, while others offered new capacity to help meet the resulting demand. Brokers report that many customers were obliged to place cover with new insurers. This further added to the burden faced by insureds' IT departments as they were asked to respond to multiple insurer questionnaires.

Because of this, insureds will increasingly value stability and consistency in their cyber insurers and may prioritise those characteristics over price and even cover limits.

Cyber insurance continues to offer real value

While cyber insurance is increasingly challenging to obtain, brokers report that it continues to benefit insureds. Perhaps because of the care taken when it is arranged, it features a relatively high acceptance rate compared with other types of insurance, so notwithstanding the cost and time investment required, it is worthwhile and provides a real benefit.

Cyber insurance also remains one of the few insurance products that assists insureds to prevent claims. Insurance assessments are often valuable tools to identify security weaknesses and remedy them, as insurers often have up to date knowledge of the latest risks. Cyber insurance discussions can therefore benefit insureds by assisting them to improve their systems and remove vulnerabilities.

There is also the additional benefit that cyber insurance provides a badge of quality, as it demonstrates that an insurer has assessed the insured as a bankable risk. For professional services firms in particular, whose own customers are increasingly demanding reassurance as to their cyber defences, this is likely to be increasingly important.

Three years of the Canterbury Earthquakes Insurance Tribunal

Co-authored by Nick Frith and Thomas Leggat

In June 2019, the Canterbury Earthquakes Insurance Tribunal was formed with the purpose of providing a fair, speedy, flexible, and cost-effective means of resolving residential insurance disputes arising from the Canterbury earthquakes.

In previous editions of *Cover to Cover* we have discussed the Tribunal's governing legislation as it was drafted and came into force, as well as updates on significant decisions on issues including the transfer of proceedings between the Tribunal and the High Court and standards of repair.

In this article, we comment on three trends we have observed in the Tribunal's activity across its three-year history, with reference to some more recent decisions.

Tribunal takes an expansive view of its jurisdiction

The Tribunal has authority to resolve disputes between insureds and insurers and/or EQC about claims arising from the Canterbury earthquakes and relating to a residential building or land. Its decisions indicate that it will generally adopt an expansive view of its jurisdiction. This trend continued in *A Trustees v IAG New Zealand Ltd* [2022] 0078-2019, a decision issued in May 2022.

The question for determination was whether the Tribunal had the authority to decide claims made under a contractual indemnity owed to IAG New Zealand Ltd by insolvent Hawkins companies. The applicants, owners of a property insured by IAG which had suffered earthquake damage, brought a claim against IAG for allegedly defective repairs. IAG brought cross-claims against QBE, as insurer of the insolvent Hawkins companies, and various contractors involved in the repairs. The claim against QBE included reliance on an indemnity given by the Hawkins companies to IAG which covered reasonably incurred costs on a solicitor-client basis. IAG and QBE sought confirmation from the Tribunal that it had jurisdiction to determine IAG's claims under the indemnity, specifically the entitlement to solicitor-client costs (which stood outside the statutory costs regime).

The Tribunal first had to resolve whether it had the jurisdiction to determine questions of law. If a question of law arises on a

claim before the Tribunal, it may refer that question to the High Court for its opinion under s 53 of the Canterbury Earthquakes Insurance Tribunal Act. That section does not expressly authorise the Tribunal to decide questions of law. However, the Tribunal interpreted the use of "may" in s 53 to mean that the Tribunal has discretion to choose whether to refer a question of law to the High Court or to answer that question itself. The decision-maker determined that, in this case, the Tribunal would be more efficient and better-placed to evaluate the broader context since IAG and QBE were parties to a number of claims before the Tribunal.

On the specific question of whether claims under the indemnity could be determined by the Tribunal, the primary concern was whether s 47(1) of the Act, which reads that *"the tribunal may award costs against a party only in accordance with this section"*, prevented it from determining costs payable under the indemnity. The Tribunal found that it was not constrained in this way, relying on s 46 of the Act which empowers the Tribunal to *"make any order that a court of competent jurisdiction could make"*.

We regard this decision as correct. The interests of justice, and the purposes of the Act, would hardly be served if, at the conclusion of a Tribunal proceeding, the matter had to be referred to the Court to award costs on a basis for which the parties had contracted. The broader, more significant, takeaway is that the Tribunal has clearly signalled that it is comfortable answering questions of law. This had been impliedly recognised in earlier Tribunal decisions (such as *L v EQC* [2021] CEIT 2019-0036, which found that EQC had the discretion to decline fraudulent claims under s 3(f) of the Earthquake Commission Act 1993), but not squarely addressed until now.

Tribunal applies a low bar to proof

It is a basic principle of civil procedure that a party seeking relief carries the burden of proving its claim. Unsurprisingly, given the length of time since the Canterbury earthquakes and that many claims now arising relate to allegedly defective repairs, it appears homeowners are having some difficulty establishing the necessary factual foundation in claims before the Tribunal. A recent decision indicates that the Tribunal is sympathetic to homeowners in this predicament and is prepared to relax the burden of proof ordinarily imposed on them.

In *E v IAG* [2021] 2019-0013, the homeowners brought a claim against IAG (and other parties involved in repairing their house) for allegedly defective repairs. The Tribunal's decision noted the evidence available regarding the repair work undertaken was *"sparse"*. This made it difficult for the homeowners to substantiate their allegations that the repairs were inadequate or defective. The Tribunal regarded it as unjust and unreasonable for the homeowners to be disadvantaged in circumstances where IAG and the contractors it engaged were the ones responsible for failing to document repair work properly. It therefore required the homeowners to establish only a prima facie case that the damage in question was caused by defective repairs. If they could do so, the onus would then shift to IAG to establish that damage resulted from a cause other than the earthquake or defective repairs.

This decision signals that the Tribunal will hold insurers who managed repairs responsible for the evidential issues faced by homeowners as a result of inadequate documentation of those repairs. Putting to one side whether this approach is legally

"It is a basic principle of civil procedure that a party seeking relief carries the burden of proving its claim."

correct, it is significant given that a large number of claims now relate to defective repairs. Where repairs have already taken place, insurers should take care to preserve evidence of those repairs so that it can be accessed easily if a dispute later arises. Where repairs are ongoing, insurers should ensure that the contractors they engage are adequately documenting the repair process and providing this evidence to the insurer. This decision indicates that it is the insurers who are likely to bear the risk of inadequately documented repair jobs.

Flexible approach to rules of evidence

S 56 of the Act defines proceedings before the Tribunal as both *"judicial proceedings"* and *"inquisitorial in nature"*. This dual nature can cause difficulty given that judicial proceedings in New Zealand are overwhelmingly adversarial in nature. This is underscored by the fact that the Tribunal can conduct substantive hearings involving cross-examination and expert witnesses.

One issue we have observed is in relation to the rules of evidence. The Act does not specify the rules of evidence that apply in Tribunal proceedings and the Evidence Act does not apply. The Tribunal has confirmed as much, while acknowledging:

a. The need to comply with the principles of natural justice and the persuasiveness of the law of evidence. In a case involving alleged waiver of legal professional privilege, the Tribunal said that it: *"... is not bound by the Evidence Act, although it must comply with the principles of natural justice. The law in relation to matters of evidence will be persuasive."*

b. The importance of the rules of evidence: *"S 57 of the Evidence Act 2006, codifies the common law rule around settlement discussions generally, and protects against the disclosure of settlement discussions. [...] Although I am not bound by the requirements of the Evidence Act, the without prejudice rule is a very important one."*

One of the leading commentaries on evidence is consistent with this approach.

The general rule is that the Evidence Act does not extend to statutory tribunals. One of several reasons underlying the proliferation of administrative tribunals is a desire for an informal procedure. Tribunals are accordingly often given power to determine their own procedure. If the relevant statute says no more, the courts will probably infer that the ordinary rules of evidence are inapplicable to that tribunal. This does not mean that the rules of natural justice or elementary requirements of fairness may be disregarded.

Natural justice is particularly relevant when it comes to privilege. It demands adherence to the rights recognised in the Evidence Act: *"Claims to an evidentiary privilege are different: a tribunal is obliged to accede to them if they would prevail in an ordinary court."*

In our view

An admissive approach to otherwise privileged material is not open to the Tribunal. Privileged material, such as legal advice and expert reports, will often be generated before a dispute is even referred to the Tribunal. If the Tribunal does not recognise privileges (for instance, ordering a party to disclose expert reports deemed to be relevant to the Tribunal's inquisitorial function despite them being privileged if the Evidence Act applied), that could unfairly prejudice parties before the Tribunal and also unreasonably constrain the behaviour of parties in managing a dispute if they apprehend that they might become subject to the Tribunal's jurisdiction in the future. It seems artificial for a respondent, who was brought before the Tribunal by compulsion, to be denied the benefit of privilege simply because the applicant elected to go to the Tribunal in preference to court.

It would be appropriate for the Tribunal to treat proceedings before it as governed by the Evidence Act insofar as privileges apply.

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