Cover to Cover

Issue 26

Our publication for New Zealand's insurance professionals

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Contents

Foreword

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We invite you to look back on the year that was and consider trends affecting the insurance sector that we may experience in 2023.

To cap off a welcome return to normality post-Covid, two of our editors, Andrew Horne and Nick Frith, recently enjoyed the NZILA conference in Queenstown. The topics included a fascinating keynote address by the Hon Rhys Harrison KC, a panel update on directors' and officers' liability insurance, and a spirited debate on developments in litigation funding and class actions. It was fantastic to reconnect with friends and colleagues from across the industry. We are looking forward to more in-person functions, which are the lifeblood of social networks in the insurance industry.

In our final issue of *Cover to Cover* for 2022, we discuss the future of insuring polluters in an age of increasing social regulation and environmental advocacy. Climate change activists, frustrated at a lack of progress from targeting large emitters directly, are targeting insurers and other financial services firms that provide services to emitters. Large financial services firms are generally more susceptible to threats to their brand and other societal pressures than large emitters and they are not wholly reliant upon carbon-intensive industries for their profits.

We see three key areas where the insurance industry may play a role in reducing climate change, all of which are critically analysed in this issue of *Cover to Cover*.

A new trend is emerging that sees international brokers setting up offices in New Zealand, blurring the line between insurers and brokers. We discuss the global players entering the New Zealand market and the implications for local firms.

We look at changes to the businesses that provide insurance products in an age of increasing regulatory scrutiny. Our trading banks, for instance, have been selling off their life insurance and related businesses.

This change follows increased scrutiny of life insurance and related products and the way in which they are marketed and sold.

On the regulatory front, we also examine how insurers are exposed to risks where they have not indexed or otherwise adjusted premiums and sums insured strictly in accordance with representations made to their customers.

This issue also provides updates on the unfair contract terms regime and class actions.

We hope you find this issue thought-provoking.

The future of insuring greenhouse gas emitters

Co-authored by Andrew Horne and Jade Yu

In a 2021 speech to Lloyd's of London, King Charles III, then the Prince of Wales, told the insurance market "*We have never needed you more than we need you today*", urging insurers to do their part to help with the transition to a low carbon world.

King Charles III said that there would need to be a seismic shift in investment to new technologies, and that "*if there is one insurance policy we need, it's the one that guarantees the survival of the natural systems that sustain all life on earth.*"

The King stopped short of mentioning any specific ways in which the insurance industry might help guarantee the survival of the natural world. The focus of his brief speech was upon assisting with new technologies rather than working against those that contribute to climate change.

Increasingly, others are less circumspect. Climate change activists, frustrated at a lack of progress from targeting large emitters directly, are targeting insurers and other financial services firms that provide services to emitters. Large financial services firms are generally more susceptible to threats to their brand and other societal pressures than large emitters and they are not wholly reliant upon carbon-intensive industries for their profits.

We see three key areas where the insurance industry may play a role in reducing climate change:

- Reducing or withdrawing insurance cover for greenhouse gas emitting industries, forcing them to pay higher premiums as competition decreases, or forcing them to self-insure, increasing their risk and thereby reducing their ability to raise equity and debt funding.
- Increasing reluctance to invest their reserves in those industries, further denying them essential equity and debt funding.
- Policy clauses targeting greenhouse gas emissions reductions.

Reduced or withdrawn cover for large emitters

Large greenhouse gas-emitting industries are increasingly reporting difficulty in persuading insurers to cover their risks. This is not because of a concern that those industries will suffer insured losses as a result of the effects of climate change, such as storms and flooding, but because insurers are beginning to respond to activists' demands that they recognise a wider responsibility not to support businesses that contribute to climate change.

In 2021, the UN convened a Net-Zero Insurance Alliance of insurers and reinsurers representing more than 11% of premium values globally. Its members are a 'who's who' of global names such as AXA, Allianz, Aviva, Zurich, IAG, Munich Re and Swiss Re. They have committed to transition their insurance and reinsurance underwriting portfolios to net-zero greenhouse gas emissions by 2050. While this remains only a small proportion of the global industry and the target date is decades in the future, it is an indication that the insurance industry is committing to move away from insuring carbon intensive businesses.

The language used is strident. The Chief Executive of AXA, Thomas Buberl, is reported to have said that the goal is to have "*all the insurers applying a methodology to only underwrite companies directed toward climate transition and not to the dark ages of burning coal.*"

Some climate change activists have criticised the Net-Zero Insurance Alliance for a lack of ambition. The Association of British Insurers, in contrast, has issued a climate change 'road map' with an earlier target of 2030 to halve emissions linked to its members' operations, supply chain, investment and underwriting portfolios. That is only eight years from now.

European insurance companies appear to be leading the way, with a number having announced restrictions on their willingness to cover the coal and mining industries. AXA was an early adopter, announcing in 2015 that it would not make new investments in the coal industry, initially excluding companies that earned 60% and then 50% of their revenue from carbon-emitting operations. Other insurers followed. Chubb, for instance, avoids making new debt or equity investments in companies that generate more than 30% of their revenue from thermal coal mining or energy production from coal, and it no longer offers underwriting for the construction and operation of new coal-fired plants for companies that generate more than 30% of their revenue from coal production. It has said that it will phase out its insurance cover for existing coal plants that exceed this threshold this year. Large US insurers appear at present to be moving more slowly in this direction, although that could change quickly.

The effect of this is likely to result in large emitters increasingly becoming uninsurable at commercial rates, which will force some to self-insure. Therefore, those industries will become operationally riskier, making them less attractive to lenders and investors. This will drive down their market values, resulting in investor losses (or lower profits) and reduce their ability to grow and maintain their businesses.

Not only coal miners and coal consumers will feel the pinch. Other large emitting industries such as aviation, shipping, cement, steel, oil and gas are likely to experience rejection from insurers in time. Methane-intensive agriculture such as dairy farming may also experience the same problems, a significant issue for New Zealand.

Increasing premiums are also likely to drive business behaviour. As the liability risk associated with emitters increases, so too will premiums, which could in turn lead insured businesses to move away from operations which put them at risk of claims. As financial markets and regulators react to the threat of climate change by requiring disclosure of insured businesses' climate information (see our article on climate-related disclosure), the risk of liability for disclosure breaches and other liabilities such as regulatory action for "greenwashing" is also on the increase. Underwriting focus, particularly in D&O, statutory liability, and environmental liability lines, will likely sharpen given the increased risk of climate change-related regulatory actions.

These changes could have a very significant effect upon the global economy as insurers' actions starve essential industries of critical investment. While this may assist in the move to a net-zero economy, it risks doing so in an ad-hoc manner that may not produce the best outcomes for the least economic pain.

Reduced investment

Importantly, large insurers, because of their need for substantial financial reserves to enable them to pay claims, are significant investors in the bond and equity markets. This means that greenhouse gas emitting businesses face a double-whammy. At the same time insurers are increasingly reluctant to insure them, their sources of finance, which provide a buffer against losses and permit them to self-insure to some extent, are also becoming constrained.

As major participants in the equity markets, the spotlight will be on insurers to ensure that they are investing appropriately and consistently with their advertised environmental, social and governance targets.

New policy obligations

The insurance industry is also beginning to experience a push for mandatory disclosure of climate-related information. Insurers are beginning to request disclosure of climate-related risk information from insureds.

New policy clauses may play a role in this. Some insurers, particularly those based in the US, recognise that many large greenhouse gas emitters are essential industries that will require a transition period if economic collapse is to be avoided. They may seek out a pragmatic middle ground where they continue to support essential large emitters provided they demonstrate an intention to reduce their impact.

The recently established Chancery Lane Project provides "climate clauses" for use in many kinds of contracts, with insurance policies being no exception. Model clauses specifically for insurance purposes include:

- a general condition requiring companies to carry out a climate change risk assessment (*Kitty's clause*);
- a coverage extension to cover any pending climate change litigation on the condition that the insured discloses its net-zero targets and climate risk exposure *(Cassie's clause*);
- explicitly excluding cover for climate liability, costs, and losses where the insured fails to meet its greenhouse gas emissions reduction targets (*Conor's clause*); or
- incentivising insureds to mitigate their climate risk and for insured's directors and officers to comply with their duties by reducing insurance premiums for insureds that meet agreed disclosure standards regarding climate-related financial risks (*Archie's Clause*).

Whether these market changes will ultimately drive better business behaviour remains to be seen. One possible development could be a growth in captive insurance for large-scale emitters, although the reinsurance market may in time come to respond to the same pressures as the primary market.

Insurers bear a heavy responsibility. While they have an opportunity to lead meaningful change, they will need to tread carefully and consider the risks that their actions will have unintended consequences.

The present and future of class actions in New Zealand

Co-authored by Nick Frith and Thomas Leggat

The possible advent of a class actions regime has been perhaps the hottest topic in the New Zealand civil litigation landscape in recent years. Group litigation has been increasingly utilised to enable plaintiffs with common interests to prosecute claims they otherwise would not be able to. As a corollary, large companies, together with their directors and insurers, are increasingly exposed to litigation risk that is different in kind and potential magnitude.

Responding in part to the growth in representative actions, and recognising the imperfections in the current procedural regime, the Law Commission undertook an extensive review with its final report released in June 2022.

In this article, we summarise the report's findings and, drawing on local and overseas trends, forecast what that might portend for the future of group litigation and its impact on the New Zealand insurance market.

Law Commission report

The Law Commission's headline recommendation is the creation of a class actions regime principally governed by a new "Class Actions Act".

The key features of that regime are proposed to be:

- The conduct of a claim would be led by a representative plaintiff, acting in the best interests of the class.
- Class actions could be commenced in relation to all types of claim in the High Court, with the potential for an equivalent regime in the employment jurisdiction.
- Class actions would need to be certified. This would require the Court to be satisfied that the proceeding discloses a reasonable cause of action and the manner in which it is being brought is appropriate (e.g. the class' interests are sufficiently aligned and the representative plaintiff is suitable).
- Class actions could be certified on an "opt-in" or "opt-out" basis. Certain persons could only join on an opt-in basis (e.g. those based overseas, government departments etc).
- Proceedings carried on as class actions would need to be case managed actively to ensure they are conducted efficiently. This includes allowing for the creation of sub-issues and staged hearings to deal with discrete matters.
- Any agreement to settle a proceeding brought by class action would require Court approval. Individual members of the class would have some (but curtailed) right to opt out of settlement.
- Litigation funding would be expressly permitted, including by abolishing the torts of maintenance and champerty, but regulated by the Act and overseen by the Court in individual cases. Key points include: disclosure of funding agreements (broader than as already required), a rebuttable presumption that funded representative plaintiffs provide security for costs, and jurisdiction to make costs awards directly against funders.

The Law Commission report provides nothing more than recommendations. The report could well gather dust for some time given the government's current priorities. However, given the keen interest in the area and the comprehensiveness of the report, we expect at least some of its recommendations to be adopted in statute.

The future of class actions

We expect the creation of a class actions regime to lead to a rise in such claims. Litigants, lawyers and funders will all be more comfortable bringing claims without the uncertainty imposed by the existing, more limited, representative action framework. Evidence for this prediction is available in jurisdictions with established class action regimes, that, unsurprisingly, also see greater volumes of class actions and more mature litigation funding industries. For example, the number of class actions in Australia has increased significantly over the last decade.

As for the nature of those claims, we can seek guidance from the types of representative actions we have observed in New Zealand, most if not all, of which (one assumes) would be brought as class actions if the regime existed. Notable examples arise in banking (claim against ANZ by former investors in Ross Asset Management), insolvency (proceedings arising from the collapse of CBL) and construction (product defect claims brought against James Hardie). In Australia, four categories dominate the list of class actions currently before the Federal Court (in roughly equal number): insolvency, consumer (including product liability), banking/financial services (including insurance), and employment. We would expect to see a similar split in New Zealand, with the caveat that employment class actions would depend on the creation of a separate employment jurisdiction (the Law Commission having limited its recommendations to the High Court).

Impact on insurers

The growth in representative actions and the looming prospect of a class actions regime is significant for insurers in two respects. First, insurers are a potential target. As deep-pocketed companies with large numbers of customers possessing identical claims, they are vulnerable to the exact kind of claim that the proposed class action regime is intended to facilitate. Indeed, we have already seen in the claim against Southern Response relating to settlement agreements entered into to repair Canterbury Earthquakes damage an instructive example of the risk faced by insurers. That emerging risk – potentially enhanced by a class actions regime and an increase in natural disasters – accentuates the need for insurers to be careful in making decisions that affect all, or a significant portion of, their customers.

Second, many insurers underwrite the exact kind of risks that are likely to be the subject of class actions (e.g. D&O, product liability). A class actions regime will likely increase the quantum associated with that risk and the chances of it coming to pass (through a proceeding being brought). Insurers already appear to be responding – at least to the some of the significant representative actions we have seen in recent years. In previous editions of Cover to Cover, we have noted, for example, recent premium increases in the D&O market. We would expect this trend to continue, if not spread, as the insurance market continues to grapple with what appears to be an ever-increasing aspect of civil litigation in New Zealand.

"The emerging risk – potentially enhanced by a class actions regime and an increase in natural disasters – accentuates the need for insurers to be careful in making decisions that affect all, or a significant portion of, their customers."

Unfair contract terms regime:

What this could mean for insurers

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

The Insurance Contracts Bill (Bill) released for consultation on 24 February 2022, proposes to make insurance contracts subject to the unfair contract terms regime under the Fair Trading Act 1986 (FTA) (UCT regime). If introduced, this will have a profound impact on the insurance industry.

How the Bill will do this, however, is not yet finalised. The Ministry of Business, Innovation and Employment (MBIE), having consulted on how best to apply the regime to insurance contracts, is yet to confirm how insurance contracts will be subject to the regime.

In this article, we outline the Bill's proposal for making insurance contracts subject to the UCT regime, and what this means for insurers.

UCT regime basics

The Commerce Commission may apply to the Court for a declaration that a term in a contract is unfair.

If a Court makes such a declaration, from that time the business must not include the term (unless done in a way that complies with the Court's decision) or attempt to apply, enforce or rely on it.

Which contracts are affected?

The UCT regime applies to **standard form, consumer contracts** and **small trade contracts.**

Standard form

Standard form contracts are typically contracts with standard terms and conditions that are presented to customers with little real opportunity for negotiation or consideration. We expect that many insurance contracts are standard form.

Consumer contract

In the context of insurance, consumer contract means a policy with a person who enters into the policy for personal, domestic or household use.

Small trade contract

A contract will be a small trade contract if:

- each party is engaged in trade;
- it is not a consumer contract; and
- it does not comprise part of a 'trading relationship' that exceeds the 'annual value threshold' of NZD250,000 (including GST, if applicable) per annum for goods, services or an interest in land when the relationship first arises. In the context of an insurance policy, that's potentially the case if the annual premium is NZD250,000 or less.

We also note that small trade contracts will not be subject to the regime if entered into before 16 August 2022 (unless renewed or varied on or after that date).

When is a term unfair?

A term can be declared to be unfair where:

- reliance on the term would cause a significant imbalance in rights between each of the parties;
- the term is not necessary to protect the legitimate interests of the party who is relying on it; and
- one party would suffer detriment if the term was to be relied upon.

The extent to which the term is transparent and the context of the contract as a whole must also be taken into account.

Certain terms are exempt from the UCT regime. These are terms that:

- define the main subject matter of the contract;
- set the upfront price payable under the contract, to the extent that the price term is transparent; or
- are required or expressly permitted by any enactment.

The carve out for insurers

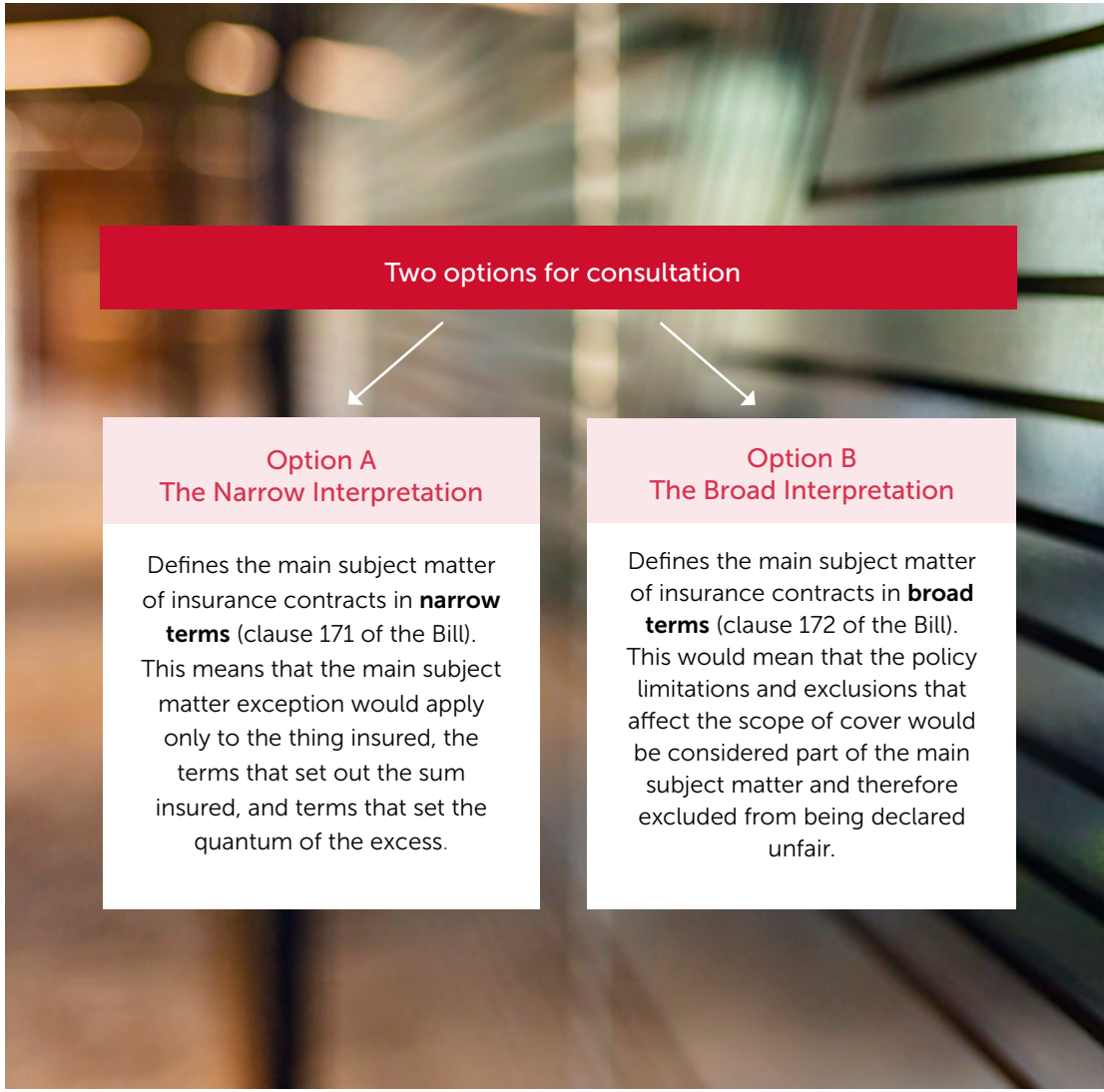
The UCT regime currently includes exceptions for insurance contract terms, including the subject or risk insured against, the sum insured, exclusions to liability, the basis on which claims may be settled, payment of premiums, the duty of utmost good faith, and disclosure requirements.

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 an insurance contract are not subject to the UCT regime. However, the insurance-specific exceptions effectively carve out insurance contracts from the UCT regime.

What does the Bill propose?

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.

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 to the right.



How the Narrow Interpretation and the Broad Interpretation apply in practice

To examine the impact of each option on the insurance industry, we have considered how each interpretation would impact some example provisions.

	Unfair?	Insurance carve out apply?	Application of Narrow Interpretation	Application of Broad Interpretation
Life Insurance Exclusions for any "unlawful act"	**Likely** There may be an imbalance of rights/obligations if the contract has unreasonable expectations of the insured to ensure that third parties refrain from unlawful acts. This could be necessary to protect the interests of the insurer – it deters illegal activity. There is detriment to the beneficiaries of the insurance where there are actions outside of their control.	**May be excluded under s 46L(4)(c) –** it limits liability of the insurer on happening of certain events.	**Included** This provision does not relate to the thing insured, the terms that set out the sum insured, and terms that set the quantum of the excess. Therefore, it will be subject to the UCT regime.	**Excluded** This would likely be excluded from being declared unfair as this term is a policy limitation/exclusion which affects the scope of cover. This would be considered part of the main subject matter and therefore excluded from being declared unfair.
Income Protection Insurer has discretion to decide whether the insured is unable to work	**Likely** The insurer has the ability to unilaterally make decisions which affect the insured. Having total power to make the decision is unlikely to be necessary for legitimate interests where an insurer could use an independent party to make this decision. It has the ability to cause detriment to the insured where they are unable to work but their claim is not paid.	**May be excluded under s 46L(4)(d) –** basis on which claims may be settled.	**Included** This provision does not relate to the thing insured, the terms that set out the sum insured, and terms that set the quantum of the excess. Therefore, it will be subject to the UCT regime.	**Excluded** This provision does not relate to a policy limitation, but rather the basis on which the insurer may pay a claim. Therefore, it will be subject to the UCT regime.
Car Insurance Insurer may decline a claim for an accident if they cannot contact the person at fault	**Likely** There is an imbalance of rights/obligations – the consequences are borne by the insured, even though the insurer has responsibility to pay the claim. There is a possible legitimate interest in including this clause to ensure the insurer does not suffer loss as it cannot claim from a third party. However, there is detriment to the insured if they do not get their claim paid through no fault of their own.	**May be excluded under s 46L(4)(c) –** it limits liability of the insurer on happening of certain events; or under s 46L(4)(d) (the basis on which claims may be settled).	**Included** This provision does not relate to the thing insured, the terms that set out the sum insured, and terms that set the quantum of the excess. Therefore, it will be subject to the UCT regime.	**Excluded** This would likely be excluded from being declared unfair as this term is a policy limitation/exclusion which affects the scope of cover. This would be considered part of the main subject matter and therefore excluded from being declared unfair.
Unilateral changes Insurer may make unilateral changes to a contract	**Possibly** There is an imbalance in obligations – the insured does not have the same ability. There is a possibility that this could be necessary for the legitimate interests depending on the nature of the change made. It could cause detriment to the insured if they lose cover they previously had.	**May be excluded under s 46L(4)(a) –** (the subject or risk insured).	**Likely included** This provision is unlikely to relate to changing the thing insured, sum insured or quantum of the excess. However, this provision could be excluded to the extent that it allows the insurer to add or remove cover – which would fall within the narrow interpretation of main subject matter.	**Limited exclusion, possibly included** Where the ability to make a unilateral change allows for the addition/removal of exclusions from cover, this may be excluded from the regime on the basis that it is a term which impacts the scope of cover. However, to the extent that the provision allows changes beyond this (such as to the basis on which claims are paid), then it will be subject to the regime.

Our view

We understand that the inclusion of insurance contracts within the UCT regime has been the subject of great opposition in the industry. However, MBIE, in the consultation for the Bill, presented two options which both make insurance contracts subject to the UCT regime. Further, in its submission in the consultation process, the Commerce Commission (the regulator for the UCT regime) advocated for insurance contracts to be subject to the regime.

In addition, it should not be ignored that other jurisdictions (including Australia and the United Kingdom) have introduced amendments to make insurance contracts subject to their unfair contract regimes.

Insurers should, therefore, prepare themselves for a Bill to be introduced which contains either the Narrow Interpretation or the Broad Interpretation. It is difficult to predict which option MBIE will opt for, at this stage. It is clear that the Narrow Interpretation provides greater protection for consumers. However, the Broad Interpretation provides greater certainty for insurers. If we look to overseas jurisdictions, however, the legislation favours consumer protection. For example, the Australian UCT regime uses the Narrow Interpretation; the United Kingdom UCT regime does not provide for any special treatment of insurance contracts at all – they are simply subject to the UCT regime.

MBIE is currently considering submissions on the draft Bill. Ideally, we would like to see a Bill that accommodates the insurance industry's need for certainty – in particular the need for certainty of any exclusions from the scope of cover. There will be significant costs and disadvantages for insurers arising from inclusion within the regime, in particular if exclusion clauses are brought within the regime. Further, the Bill needs to take into account the raft of incoming legislation affecting insurers (such as the Financial Markets (Conduct of Institutions) Amendment Act 2022). Therefore, a large lead-in period should be built into the commencement of the proposed Bill so that insurers have adequate time to prepare for these substantial changes.

Case study

Pushing the boundaries of exclusions

Napier City Council v Local Government Mutual Funds Trustee [2022] NZCA 422

Co-authored by Nick Frith, Zoë Bowden and Rosa Laugesen

The Court of Appeal's recent decision in *Napier City Council v Local Government Mutual Funds Trustee* provides helpful clarification on the interpretation of exclusion clauses when assessing liability for 'mixed cause' claims. The Court also affirmed its previous approach in respect of an insured's right to recover the amount of its reasonable settlement under an insurance policy in circumstances where the insurer has wrongfully repudiated cover.[1]

Background

Local Government Mutual Funds Trustee (RiskPool) insured Napier City Council under a professional indemnity policy covering its potential civil liability arising from its public functions, including in relation to building defect claims. The Council sought indemnity under the policy in respect of negligence claims made against it by the owners of an apartment building on the Napier waterfront (Claims). The Claims were 'mixed' in that they arose from weathertightness and non-weathertightness defects.

RiskPool declined the Council's claim on the basis that an exclusion for weathertightness defects applied to the Claims in their entirety.

The exclusion relevantly provided that the policy did not cover (our emphasis):

*"...**liability for** Claims alleging or arising directly or indirectly out of, or in respect of:*

a. *the failure of any building or structure to meet or conform to the requirements of the New Zealand Building Code contained in the First Schedule to the Building Regulations 1992... in relation to leaks, water penetration, weatherproofing, moisture, or any water exit or control system; or*

b. *mould, fungi, mildew, rot, decay, gradual deterioration, micro-organisms, bacteria, protozoa or any similar life forms, in building or structure."*

Claim was defined as... *"the demand for compensation made by a third party against the Member..."*

1. *Napier City Council v Local Government Mutual Funds Trustee Limited* [2022] NZCA 422.

Case study:

Pushing the boundaries of exclusions
Napier City Council v Local Government Mutual Funds Trustee [2022] NZCA 422

Following RiskPool's declinature, the Council settled the owners' Claims for a global sum. It then issued proceedings against RiskPool in which it sought to recover the amounts paid by it in settling non-weathertightness Claims.

The High Court found that RiskPool was not liable to indemnify the Council because the Claims were excluded in their entirety, finding that the definition of "Claim" was sufficiently broad as to encompass both weathertightness and non-weathertightness claims.[2] The Council appealed.

RiskPool cross-appealed on the extent to which the settlement reached between the Council and the owners in respect of their claims fixed the amount that RiskPool must pay to the Council under the policy, specifically whether RiskPool was entitled to challenge the same.

Appeal allowed

The Council's liability for non-weathertightness defects is covered by the policy

The Court of Appeal overturned the High Court's decision and found that the Claims were only excluded to the extent that the Council's liability arose out of weathertightness defects. It rejected RiskPool's contention that if part of a Claim (as defined by the policy) was causally attributable to weathertightness issues, cover was excluded for the whole Claim.

The Court focused on the following issues in determining that certain parts of the Claims that were not causally attributed to weathertightness defects fell within the scope of cover:

(a) **The structure of the parties' bargain:** The Court acknowledged that RiskPool clearly intended to exclude all cover for weathertightness defects. However, the structure of the parties' bargain, as evidenced by the terms of the policy, was not to exclude cover for non-weathertightness defects when made together with separate Claims for weathertightness defects.

(b) **The real nature of the Council's liability for a 'Claim':** While the Court accepted that a Claim for policy purposes is a demand for compensation, and not a cause of action, it held that an inquiry into the real nature of the Council's liability was needed in order to determine the proper application of the exclusion to the Claims. The Court considered that this analysis could "*descend to the level of particulars*". In other words, the Court held that each Claim could be assessed and divided in accordance with the Council's liability for weathertightness defects on one hand, and its liability for other defects on the other. The Court held that the exclusion operated such that the owners' claims would be excluded only to the extent that the Council's alleged liability arose directly, or indirectly, out of weathertightness defects.

(c) **Prior negotiations between the parties:** The High Court placed emphasis on extrinsic evidence advanced by RiskPool in support of its position, including correspondence sent by RiskPool to the Council in relation to a previous unrelated claim. RiskPool had declined a similar claim in reliance on its interpretation of the exclusion, and the Council had not objected. RiskPool argued that this correspondence demonstrated a mutual understanding that the exclusion excluded cover for mixed defect claims.

Having regard to the principles established by the Supreme Court in *Bathurst*, the Court found that the Council's silence was ambiguous and did not evidence a mutual understanding. The correspondence was therefore irrelevant and inadmissible in the interpretation of the policy – the words of which retained primacy.

(d) **Interpretation of exclusion clauses:** The Court referred to the 'settled' approach to interpreting exclusion clauses in insurance law, whereby insuring clauses should be given a liberal construction, and exclusion clauses ought to be read narrowly.

(e) **The *de minimis* principle:** The Court gave short shrift to RiskPool's argument (as advanced before the High Court) that the *de minimis* principle applied in respect of non-weathertightness claims that were "*tainted*" by weathertightness, such that they would be excluded in their entirety. The Court found that the principle could not be applied neatly to the question of how to interpret the relevant policy terms on the basis that the threshold for its application could not be defined with sufficient precision, and – from a common sense perspective – it would lead to an outcome whereby the "*tail is wagging the dog*".

2. *Napier City Council v Local Government Mutual Funds Trustee Limited* [2021] NZHC 1477

Case study:

Pushing the boundaries of exclusions
Napier City Council v Local Government Mutual Funds Trustee [2022] NZCA 422

Cross-appeal dismissed

The Council did not need to prove its at-trial liability to recover under the policy

The key issue to be determined in RiskPool's cross-appeal was whether, having established that it was entitled to be indemnified, the Council had to prove what its at-trial liability to the apartment owners would have been in order to recover under the policy.

In considering the issue, the High Court relied on the Court of Appeal's decision in *Mainfreight* in support of the proposition that[3]:

- where an insurer wrongfully declines cover, leaving the insured to act as a 'prudent uninsured', then the insurer has committed a "*repudiatory*" breach, in general terms, of the essence of the contract of indemnity;
- the insured is entitled to claim damages based on that breach; and
- provided the insured has acted reasonably in settling the claim, the measure of damages is equivalent to the amount paid in settlement, together with costs.

RiskPool contended that it had not repudiated cover but it had rather mistakenly interpreted the policy. It also argued that the High Court was wrong to hold that an insurer which had repudiated liability was prevented from contending that the insured was not legally liable for the amount of the settlement reasonably paid by it. RiskPool instead argued that the insured must establish its 'at trial' or actual liability, and that the amount recovered under the policy must reflect the same.

The Court of Appeal rejected RiskPool's submissions on both fronts. The Court helpfully clarified that the relevant insurance authorities use "*repudiation*" in a narrower sense to describe the circumstances in which an insurer makes it clear that it will not indemnify the insured in respect of a claim notified under the policy. Here, while RiskPool had not repudiated the entire policy, the Court found that its conduct "*unmistakeably*" amounted to repudiation in the sense that it had forced the Council to act as an uninsured by denying it indemnity.

The Court went on to affirm that, where an insurer has wrongfully denied cover, the amount paid by the insured to a third party as a settlement sum crystallises the loss for which it is entitled to indemnity – provided that it was objectively reasonable to settle, the settlement negotiated was honest and objectively reasonable, and the express terms of the policy do not require the insured to 'prove' its at-trial liability to the third party.

In finding that the Council's settlement was reasonable, the Court noted that the reasonableness of any settlement must be assessed against the information available at the time, and will, to a certain extent, be informed by prospective 'at trial' liability. The Court helpfully opined that "*[g]enerally, a settlement is reasonable if, judged objectively, it is made to compensate the claimant for the value of the claim, by reference to its prospects of success*".

The Court held that the same approach should be taken where a Claim is 'mixed', in that the settlement must be shown to be reasonable by reference to the insured liability, having regard to the value of the total claim, what defects were included in the settlement, and the proportion of the settlement that should be attributed to insured liabilities.

3 *Royal Insurance Fire & General (New Zealand) Ltd v Mainfreight Transport Ltd* (1993) 7 ANZ Insurance Cases 61-172 (CA)

Our view

The Court's decision provides helpful clarity on the interpretation of exclusion clauses as they apply to 'mixed' claims which include both insured and uninsured liabilities. We consider the Court's approach to determining policy response to be sensible and reflective of the pragmatic approach that ought to be adopted in dealing with claims of this nature.

It is apparent that, in the absence of relevant admissible extrinsic evidence of sufficient probative value, the policy wordings will retain their primacy. Parties should pay close attention to the drafting and scope of policy terms and conditions insofar as they determine both the approach to be adopted in interpreting the scope of cover, and the structure of the parties' bargain.

Insurers should also be particularly mindful of the consequences of 'repudiating' cover in circumstances where doing so leaves insureds in the compromised position of having to settle claims as prudent uninsureds.

Changes in New Zealand's insurance market

Authored by Nick Frith

The last 10 years have seen significant changes in the New Zealand insurance market. These changes are largely positive, but give rise to issues that need to be carefully managed.

On the broking side, the first indication of major change came with the move towards consolidation in the industry with the 2014 purchase of Crombie Lockwood by New York Stock Exchange listed broker Arthur J. Gallagher & Co. That resulted in five brokerages with global reach: Marsh, Aon, JLT, WTW and Crombie Lockwood. Fast forward to 2019 and Marsh's 2019 merger with JLT reduced that number to four. That very nearly reduced to three with Aon's proposed takeover of WTW in 2020.

By 2021, the market had consolidated further with two large international brokerages, Marsh/JLT and Aon. WTW remained in the mix, with Crombie Lockwood staying locally focused, albeit with international connections via Gallagher. Other New Zealand brokerages, such as PIC and Rothbury, retained largely New Zealand or Australasian networks.

Two new global players then joined the New Zealand market in 2021 – Lockton in March and Howden close behind in September. Lockton's entire New Zealand team joined from WTW during 2021 and Howden's genesis was similar, with most of its New Zealand team coming across from Marsh. Both are significant international brokers, albeit start-ups in New Zealand. Lockton describes itself as the world's largest privately-owned insurance brokerage with over 100 offices worldwide. Howden also has a global footprint "*with offices in 45 countries as well as a network of partners which increases our reach to 95 territories worldwide*".

Anecdotally, both Lockton and Howden established New Zealand offices to better respond to global pitches involving international clients' New Zealand businesses. They certainly bring a more international flavour to the market, but it remains to be seen whether the nimble outpost model will thrive. Competition may benefit clients as new brokers attempt to establish themselves with a minimum viable business, although personnel movement in the market gives rise to heightened legal risk as the incumbents defend their positions. There will need to be an increased focus on restraints of trade and a need for care when safeguarding confidential information gained in former roles. These issues could come to the fore in the near future as the new entrants work to solidify their positions in the market.

On the underwriting side, despite a continuing tough global market, there is word of an increase in offshore capacity via managing agents such as Delta Underwriting. Furthering this trend, Dual, a sister company of Howden Broking, purchased International Underwriting Agencies or IUA. And Pen Underwriting, which writes business covering some insureds with New Zealand operations, is a subsidiary of Gallagher. Munich Re is also reportedly increasing its primary insurance offering, a further expansion from its traditional focus on reinsurance.

As brokers are branching out into underwriting, they are reporting more capacity in the global underwriting market. This is good news for insureds, but New Zealand-based policyholders need to be aware of the nuances of offshore cover. One potential advantage is that policy proceeds are less likely to be subject to an asserted charge in favour of claimants under the Law Reform Act 1936. Where that can be established clearly, insureds may decide to structure their insurance arrangements to omit separate defence costs cover.

Less helpfully, enforcement of a foreign policy can prove more challenging if a policy dispute arises, with truly offshore cover often subject to dispute resolution forums outside New Zealand. This may affect enforcement through the courts and also access to regulators and statutory dispute resolution forums such as the Insurance and Financial Services Ombudsman in New Zealand. Insureds and their brokers should therefore look for governing law and jurisdiction clauses that require claim disputes to be resolved in New Zealand under New Zealand law.

Another issue of which insureds should be aware is that New Zealand levies, such as Fire and Emergency NZ levies, may be payable upon policies that insure assets in New Zealand notwithstanding that they are arranged by overseas brokers with foreign insurers. Overseas brokers and insurers may not be aware of the regulatory regime in New Zealand and the penalties for non-compliance are substantial.

These developments in the broking and insurance industries will produce opportunities for clients as a result of changes and developments in the way that many policies are arranged and underwritten. However, these changes are not always without risk, and insureds and their advisers will need to be aware of the possible consequences.

Case study

The importance of clear policy drafting

Dural 24/7 Pty Ltd v Certain Underwriters at Lloyd's of London [2022] FCAFC 147

Co-authored by Nick Frith, Zoë Bowden and Siobhan Pike

The Full Federal Court of Australia recently considered the application of a conformity clause in a business interruption policy. This decision was an offshoot from the recent landmark Business Interruption (BI) test cases decided by Australian Courts in 2020 and 2021 in the midst of the COVID-19 pandemic. It reinforces the need to focus upon clear and accurate policy drafting to set the scope of cover and avoid ambiguity.

Background

The appellant, Dural, is a fitness and yoga franchising business. Lloyd's syndicates insured Dural for business interruption loss. The policy period coincided with the first year of the COVID-19 pandemic.

The policy contained a coverage extension for "Murder, Suicide, or Disease" (our emphasis):

The Occurrence of any of the circumstances set out in this extension of cover shall be deemed to be Damage to Property used by You at the Situation.

...

b. the outbreak of human infectious or contagious disease occurring within a 20 kilometre radius of Your Situation; or

c. closure or evacuation of Your Business by order of a government, public or Statutory Authority consequent upon:

...

Cover under b. and c. under this extension of cover does not apply in respect of Highly Pathogenic Avian Influenza in Humans ***or other diseases declared to be quarantinable diseases under the Australian Quarantine Act 1908.***

The Quarantine Act 1908 was repealed in 2016 meaning that COVID-19 could not possibly be a declared quarantinable disease under that legislation. It was, however, a listed disease under the Biosecurity Act 2015.

Thankfully, the policy contained a conformity clause which dealt with matters

of construction and interpretation, including the use of gendered and singular/plural words. The clause relevantly provided that "*...References to a statute law also includes all its amendments or replacements*". The insurers sought a declaration that the reference to the Quarantine Act in the above extension should be read as referring to human diseases under the Biosecurity Act, on the basis that the Quarantine Act had been replaced by the Biosecurity Act.

The Courts' decisions

In the Federal Court, Jagot J found that that the Biosecurity Act was operating in place of the Quarantine Act, and thus had replaced it. What was important was that the subject matter of the laws was the same, or sufficiently similar, such that the new law applies in place of the old – even where it "*deals with that subject-matter in a new and radically different manner from the old statute law*".

Dural appealed the Federal Court's decision.

The Full Federal Court dismissed Dural's appeal with the result that there was no cover under the disease extension for COVID-19. As a primary finding, the Court agreed with Jagot J that the conformity clause was concerned with the construction and interpretation of the policy, and the relevant part of it ("*...References to a statute law also includes all its amendments or replacements*") was directed at keeping the wording of the policy current.

The Court observed that the Biosecurity Act plainly replaced the Quarantine Act. While acknowledging that there were some "*important*" differences between the Acts, the Court agreed with the primary Judge that both Acts had the same or substantially similar fundamental aim – being the identification and declaration or listing of diseases at a national level in order to protect the Australian community. Having regard to the purpose of the conformity clause (which was to keep the policy up to date), the Court upheld the primary Judge's finding that the listing of human diseases under the Biosecurity Act replaced the declaration of quarantinable diseases under the Quarantine Act for the purposes of the operation of the policy.

The Court also rejected Dural's argument that the conformity clause's reference to "*replacements*" was limited to the repeal of statutes in force at the date of policy inception. The Court held that the words were in aid of a general purpose, namely the maintenance of the currency of the policy wording.

Our view

These decisions underscore the importance of ensuring that references to legislation contained in policy wordings are current and up to date. Failing to do so could significantly impact the scope and availability of cover under the policy.

As evidenced by the recent findings of Australian Courts in the test cases, what may appear to be subtle differences in wordings can give rise to remarkably different results. While the cases turned on their individual facts, it is notable that the Courts had significantly different views on the meaning of each of the words that were used in an attempt to maintain the currency of the policies:

- in the first test case, the words "*subsequent amendments*" were held not to extend to the Biosecurity Act on the basis that it was a separate Act to the Quarantine Act;
- in the second test case, the Biosecurity Act was held not to be a "*re-enactment*" nor a "*re-enactment with modifications*" of the Quarantine Act on the basis that, while the Biosecurity Act had replaced the Quarantine Act, and the two Acts cover some of the same subject matter, the differences between the relevant parts of the Acts were too extensive; and
- in *Dural 24/7*, the Full Federal Court held that the declaration of diseases as quarantinable under the Quarantine Act (as "*a statute law*") had been replaced by the listing of human diseases under the Biosecurity Act on the basis that the subject matter and fundamental aim of the relevant parts of both Acts was substantively equivalent.

While the findings of the Australian Courts do not, of course, directly impact New Zealand insurers, they serve as a timely reminder to insurers to review the terms of any conformity or other clauses which concern the currency of statutes that are referenced in their polices, together with any references to legislation or regulations. In advising their clients, brokers should also be mindful of the potentially critical variances in cover and ambiguity that may arise from subtly different policy wordings.

Addendum: On 14 October 2022, the High Court of Australia refused the applications for special leave filed by two policyholders and one insurer to appeal certain parts of the Full Federal Court's judgment in the second test case.

When indexation goes wrong

Co-authored by Andrew Horne and Jamie Hofer

Indexation of coverage values and limits is a common practice in the insurance industry. It adjusts a customer's cover to a measure of inflation or value, with the intent that the policy value or limit will continue to align with the customer's asset value or its repair or replacement cost over time.

This benefits customers because it helps to ensure that they remain fully insured when values and costs increase over time for assets such as homes and other buildings, while also helping to ensure that they do not pay for cover they do not need for assets with a declining value, such as motor cars.

Insurers typically offer indexation as an option to customers who would like to ensure that their insurance cover keeps pace with inflation (i.e. to prevent customers from becoming underinsured as inflation erodes the value of their cover) and they may insist upon it where assets are expected to decline in value.

Indexation is tied to a measure of inflation or deflation which is typically specified in the insurance policy. A common measure is the consumer price index (CPI). If the insurer commits or promises to indexing its policies using the CPI, it is bound to adjust the customer's cover at the same rate as the CPI. The insurer may also adjust the customer's premiums accordingly.

Customers tend to view indexation as a purely mechanical process and trust insurers to carry out the necessary calculations correctly. Perhaps surprisingly, a number of insurers have realised recently that they have calculated their indexation in a way that does not accord with what they have told their customers.

So, what happens when insurers get indexation wrong?

We look by way of an example of issues recently uncovered by Cigna Life Insurance New Zealand Limited and the consequences of those issues. Cigna are, however, but one of several insurers to have identified issues of this nature.

When do customers suffer?

Inaccurate indexation adjustments may result in customers becoming either overinsured or underinsured, at least compared with their expectations, if not their asset values and risks. Customers become overinsured when the insurer uses an index rate that exceeds the applicable measure. Customers suffer a loss when they are overinsured because they pay higher premiums than they would otherwise have, had their cover been adjusted for inflation accurately. As the proceedings against Cigna demonstrate, the FMA takes a dim view of this and is prepared to take enforcement action to ensure that customers are not overcharged for cover.

What happened to Cigna?

The FMA issued court proceedings against Cigna for false or misleading statements about the indexation of some of its life insurance policies, in breach of section 22 of the Financial Markets Conduct Act 2013. Cigna admitted to having increased customers' premiums and cover under a series of life insurance policies, using indexation rates which exceeded the CPI. This was not consistent with the relevant policies, which required Cigna to adjust cover in accordance with the CPI. As a result, Cigna charged customers approximately NZD13.5 million in additional premiums for the extra cover that it provided over the relevant period.

The case will proceed to a penalties hearing in the Wellington High Court. However, Cigna has voluntarily commenced a remediation programme, and as at 10 August 2022 it had refunded over NZD10.7 million (including interest) to customers that it had overcharged.

The case, like all such circumstances, raises some interesting conceptual issues. On one view, customers did not suffer a loss at all, because they received the cover they paid for. It was just that they bought slightly more cover than they anticipated buying. Even then, they will have known just how much cover they were buying, because the annual renewal forms will have specified it. The indices are never more than an approximation of what is required for cover to remain broadly the same in real terms, because they do not typically reflect actual increases in values or costs for the particular risk insured. Where the insured asset is a building, for instance, a broad CPI index may not reflect a real world increase in building costs. Some customers who suffered a loss may have benefited in a very real sense because they may have been fully insured – or less underinsured – than would otherwise have been the case. The issue is therefore a subtle one – customers who believed their cover was increasing by the specified index were in fact sold slightly more (or perhaps less) than they expected.

"Remediating losses suffered by customers because of inaccurate indexing can be a complex undertaking, and therefore expensive."

Customers may become underinsured when the insurer uses an index rate that falls below the applicable measure. Contrary to the position when a customer is overinsured, underinsured customers often gain because they pay lower premiums, provided they do not suffer a loss. However, those customers suffer a theoretical loss because, had they made a claim, their cover would have fallen short of the amount they thought they had purchased. Therefore, the mere fact that customers have been underinsured for a period of time is problematic.

The FMA has made its position with respect to such inchoate losses known in a previous case. The FMA views those customers as having suffered a detriment, as in *Financial Markets Authority v ANZ Bank New Zealand Limited* [2021] NZHC 399, where the FMA took the view that customers suffered detriment when they were unintentionally uninsured (because they exceeded a maximum age), notwithstanding that in fact the insurer would not have declined their claims on the relevant basis.

What should insurers be concerned about?

Remediating losses suffered by customers because of inaccurate indexing can be a complex undertaking, and therefore expensive. Identifying which customers have suffered a loss can be difficult, particularly if different insurance policies are indexed to different measures of inflation and/or if some customers have signed-up for indexation and others have not. Calculating adjustments for thousands of individual policies is also a mathematically complex exercise and is one that many insurance firms would not be equipped to complete in-house.

Refunding customers for overpaid insurance premiums is not only mathematically complex, but also complex administratively. Some customers will likely be former or historic customers, and others might be very difficult to contact. Calculating refunds for each customer, together with interest payable on those refunds, is a costly exercise that insurers would ideally avoid. Again, depending on the scale of the adjustment error, even large insurers might struggle to complete the refund exercise without external assistance.

Remediating underinsurance is normally easier, as customers have underpaid, rather than overpaid. Ordinarily, the remediation will involve identifying any customers who have suffered a loss and who have been underpaid as a result and compensating them. They will normally comprise only a small proportion of affected customers.

What should insurers do?

Firstly, insurers should take care when making representations about indexation. For example, if an insurer represents that a particular policy is indexed to the CPI, the insurer must ensure that its internal processes support that representation. Insurers should have robust processes in place to identify which of their policies are indexed and to ensure that customer's premiums and cover are recalculated at the relevant frequency, which is typically specified in the policy.

Secondly, insurers must make accurate adjustments to premiums and cover. For example, if a particular policy is indexed to the CPI, the insurer must accurately adjust cover and premiums for all policy holders in accordance with the CPI. Even minor adjustment errors can be significant if that same error is made for thousands of policyholders. The scale of any adjustment error will increase if the error is systemic and is repeated on multiple occasions. Regular audits of inflation adjustments are therefore encouraged.

One possibility that could assist in protecting against future errors may be for insurers to be less specific about how they are calculating adjustments. Insurers who adjust policies to reflect general changes in building costs do this already – they are normally careful to make clear that they do not promise that the figure they use will in fact reflect relevant real world building cost increases, which are difficult to predict. Similar language could be used in relation to other indices. For instance, instead of promising CPI increases, insurers could advise customers that they intend to offer increase at their discretion, which may reflect CPI increases but may be adjusted or otherwise differ from CPI. Such language would be less likely to be misleading in case of error.

Non-insurers retreat from the insurance market

Co-authored by Zoë Bowden, Maria Collett-Bevan and Rosa Laugesen

A few years ago, New Zealand's banks were increasingly offering their customers a range of insurance products along with their core banking products and services.

The attractions of becoming a 'one stop shop' for insurance and other financial services included opportunities to offer customers a co-ordinated range of services and streamline their customer experience as well as increasing the banks' revenues.

More recently, banks have been exiting life insurance and related businesses, such as loss of income insurance. In the past two years, three of the four major banks which previously (via group companies) underwrote life insurance in New Zealand have sold their life businesses. Two of those banks, BNZ and Kiwibank, now direct customers to their specialist life insurer partners, and do not manage the customer relationships themselves – as they do for their general insurance offerings. Westpac continues to sell life insurance products via its website, but no longer underwrites them. This brings Westpac's life insurance offering in line with its general insurance business.

This change follows a significant increase in attention by the Financial Markets Authority (FMA) upon life insurance and related insurance products and services and the way in which they are marketed and sold, including high profile civil proceedings against insurers that have resulted in large financial penalties.

We attribute this shift to a range of factors, including a push by banks to simplify their businesses. However, it also seems likely that recent regulatory change and the change in the FMA's focus will have contributed to banks' decision-making. This movement appears to be an example of regulation resulting in financial institutions becoming more focused upon their core offerings and less willing to offer associated products to customers. While this may mean that institutions remaining in the market will be focused upon (and adequately resourced to) providing good customer outcomes that regulators say they expect, it may also lead to decreased competition and consumer

choice.In particular, it seems likely to reduce opportunities for customers to enjoy the convenience of placing all their financial services with a single provider, should they wish.

Regulatory change

In 2018 and 2019, the FMA and the Reserve Bank of New Zealand (RBNZ) released the outcomes of their thematic reviews into the conduct and culture of retail banks and life insurers. While the issues identified were not as serious as those identified by comparable reviews in Australia, the reports concluded that there were extensive weaknesses in these financial institutions' systems and controls and a lack of focus on good customer outcomes.

In response to the consumer protection issues highlighted by the reports, the Government moved to establish a new regime to regulate the conduct of banks and insurers. In late June 2022, the Financial Markets (Conduct of Institutions) Amendment Act 2022 (CoFI Act) was passed into law.

The CoFI Act adds a new Subpart 6A to Part 6 of the Financial Markets Conduct Act 2013 and provides the FMA with a legislative mandate to regulate the general conduct of Financial Institutions as defined (including banks and insurers) which provide financial products and services to consumers.

Planned to come into force in early 2025, the new regime will require financial institutions to:

- Be licensed in respect of their general conduct towards customers. The licensing regime will be monitored and enforced by the FMA.
- Establish, implement and maintain, and comply with effective fair conduct programmes that ensure consumers are treated fairly.
- Comply with regulations that regulate incentives. Pursuant to the regulations certain sales incentives based on volume or value targets may be prohibited (such as overseas trips, bonuses, or leader boards).*

*This third point also applies to intermediaries.

The FMA will now begin work with Financial Institutions to ensure that they are prepared for the new regime. An exposure draft of proposed regulations prohibiting certain volume or value-based incentives, has been released for consultation, and licensing applications are anticipated to open in mid-2023.

The CoFI regime sits alongside other proposed regulatory change, notably the Insurance Contracts Bill, for which public submissions closed in May 2022, as well as the ongoing review of the Insurance (Prudential Supervision) Act 2010. We discuss the Insurance Contracts Bill in more detail here.

Exit by banks from insurance offerings

Amidst the increasing focus on the conduct of life insurers, a shake-up of the players in the life insurance sector has taken place.

In its 2019 thematic review of life insurers, the FMA and RBNZ focused on 16 New Zealand insurers that provide life insurance products, including five banks. Since the review was released, three of those five – BNZ, Kiwibank and Westpac – have sold their life insurance businesses.

Banks have assured customers that their policies will be unchanged by the sales. As noted above, Kiwibank and BNZ life insurance customers have transitioned to become customers of the acquiring insurer. Westpac has continued to sell life insurance products (via its website) as normal, but those policies will be unwritten and issued in Fidelity Life's name.

Notwithstanding the sales of their insurance offerings, registered banks will still be subject to the incoming CoFI obligations as providers of financial services, including the new licence regime. However, compliance with the CoFI regime will be simpler for banks that no longer provide insurance products. Banks acting as intermediaries for insurance services, i.e. selling insurance products but not issuing them, will also be covered by the CoFI regime in respect of these services. As we note here, the standard conditions for CoFI licences are still being developed, with industry and stakeholder consultation having recently concluded.

The introduction of the CoFI regime is an important step towards ensuring that financial institutions are adequately serving the needs and interests of consumers. While the opportunity offered by regulatory change to improve industry conduct and culture is welcomed, its full impact on competition and the structure of the insurance market remains to be seen.

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