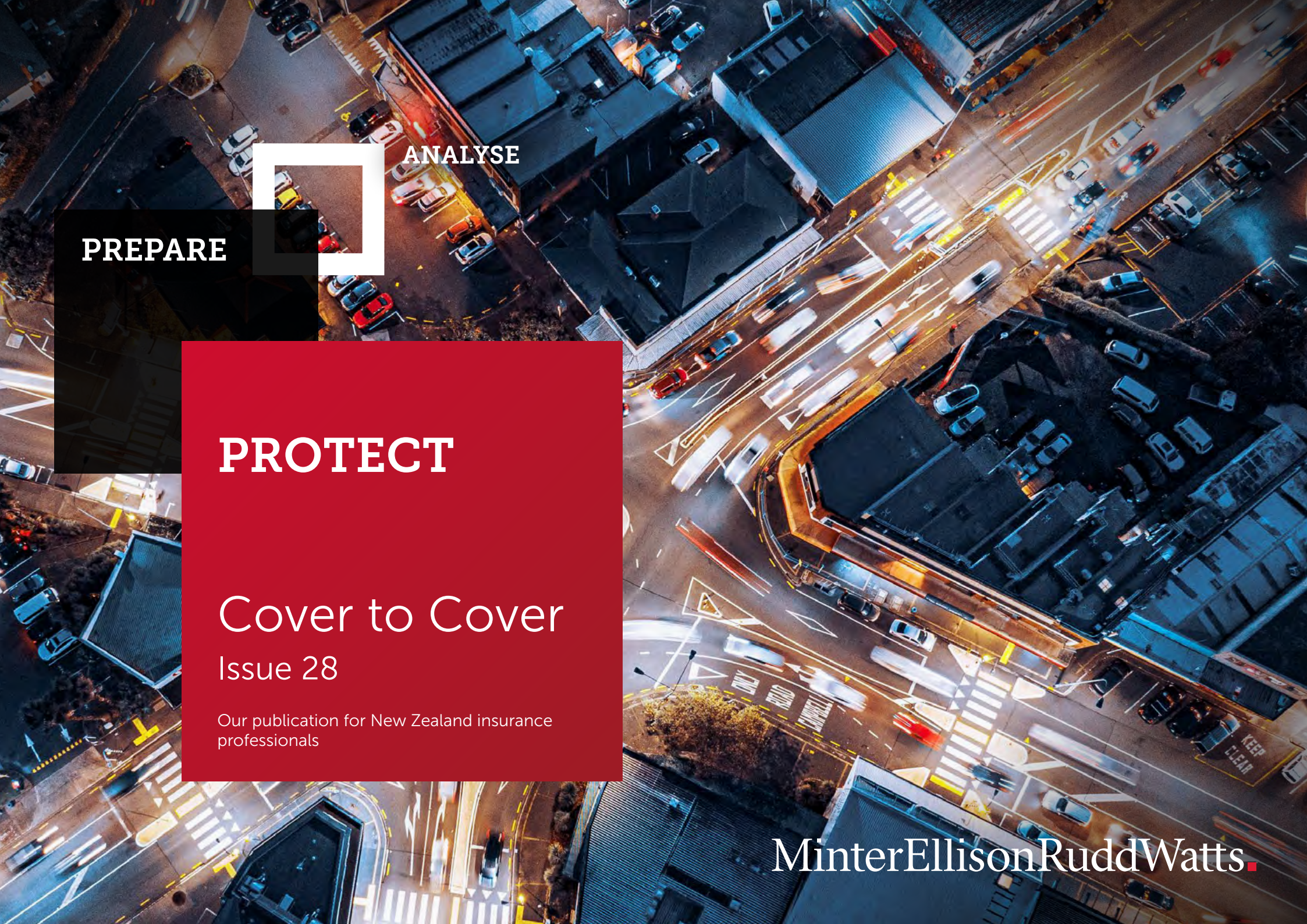

Cover to Cover

Issue 28

Our publication for New Zealand insurance professionals

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Contents

Foreword

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Welcome to our mid-year edition of Cover to Cover for 2023.

In this edition, we cover topical issues that flow through the insurance policy life cycle.

We discuss the transformative power that generative AI is likely to have in the insurance industry and the role it could play. We've seen AI burst onto the scene in other areas, and insurance is the perfect candidate for AI given the benefits associated with getting wordings right and ensuring that claims are dealt with fairly and consistently. Generative AI is not, however, without risk.

We cover the implications of CoFI for intermediated distribution – undoubtedly, an important topic for licenced insurers who are covered by CoFI and distribute their products via intermediaries. However, it is also highly relevant to intermediaries, which will face more oversight from insurers given the need to ensure delivery on their fair conduct programmes. We provide insights on who qualifies as an intermediary and, if so, how you and your organisation can prepare.

Intermediaries are not the FMA's only focus, with banks and insurers' systems also being top of mind. Since June 2020, the FMA has launched seven proceedings in relation to alleged breaches of the fair dealing provisions of the Financial Markets Conduct Act. Of those, five related to insurance products. We discuss the issues and three key learnings distilled from these cases.

We also look at three fascinating claims cases, all involving the court's interpretation of different kinds of policies, from MDBI to the RiskPool mutual scheme.

We hope you find this edition interesting and informative.

The transformative power of generative AI in the insurance industry:

Opportunities and risks

Authored by Andrew Horne

In the rapidly evolving landscape of the insurance industry, technological advancements have played a pivotal role in reshaping its operations and customer interactions. One of the most promising developments in recent years is the emergence of generative artificial intelligence (**AI**). Generative AI, driven by sophisticated algorithms and deep learning techniques, has the ability to create new content, insights, and solutions that were previously thought to be exclusively within the realm of human creativity. As the insurance sector continues to explore and implement generative AI, several opportunities and risks come to the forefront.

The title of this article and the opening paragraph you have just read were not drafted by a human being. They are – word for word – what the generative AI tool, ChatGPT, produced when we asked it to write an introduction for an article for the insurance industry on the opportunities and risks arising from the use of generative AI. It isn't quite how we would have put it, but it's not a bad effort – it is on point, it makes sense, the grammar is correct, the sentences flow well and even the tone is appropriate.

Generative AI is an artificial intelligence technology that can produce text, images, artworks, audio, computer code and other content in response to instructions given in everyday English. It works by using complex algorithms to run 'foundation models' that learn from data patterns in the enormous volume of data that is available online and produces new content based on what it has seen in that data. This goes a step beyond the AI tools that have commonly been available until now. Those tools will typically analyse examples of a subject, such as pictures of plants, and learn from them to identify plants of a particular species or those that are diseased. They can also understand and respond to simple queries and commands within a limited range of parameters, as most people have become accustomed to, through interacting with AI-powered tools such as Apple's Siri and website 'chatbots'. Generative AI takes a step forward from this, as it can not only interpret pictures or other content or answer simple queries, but it can also create wholly new content. The latest generation of generative AI has taken a further leap forward in capability by utilising self-supervised learning based on the data that is available online, rather than being guided by humans.

What does this mean for the insurance industry? The answer lies in the areas of insurance practice that require evaluative assessments or the generation of a written work product. A number of potential uses spring to mind. These could produce substantial efficiencies, as well as more reliable and accurate assessments and responses, resulting in better customer outcomes. However, there are some potential pitfalls.

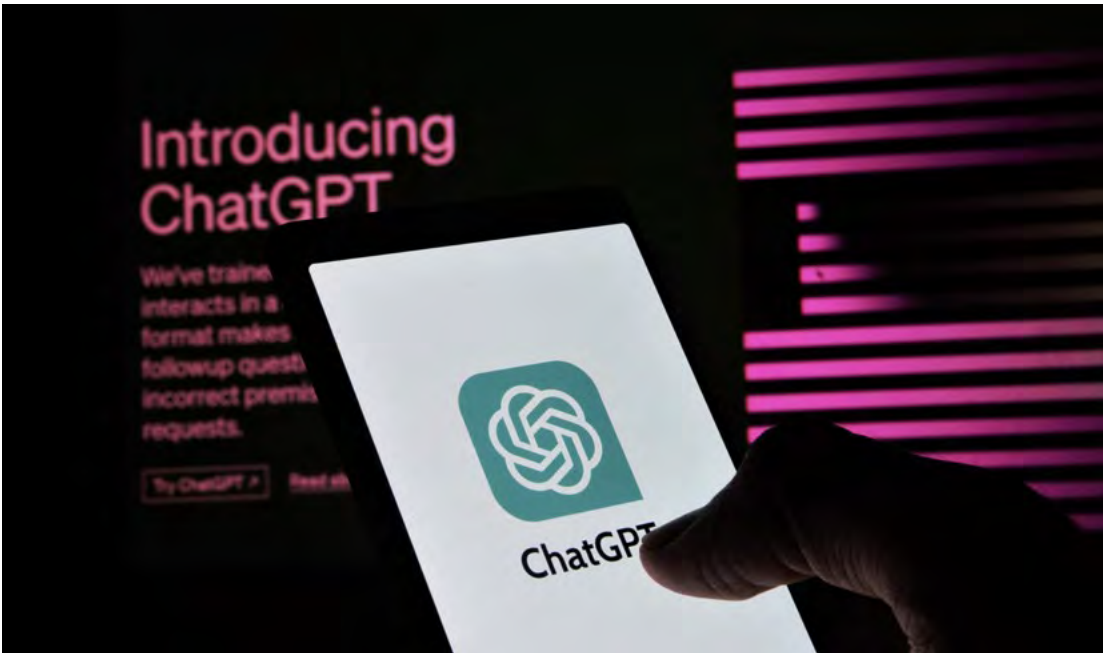
This is not merely a future possibility – some insurers are using this technology already. Lemonade, a peer to peer insurer in New York that provides cover to homeowners and renters, advertises that it uses AI for underwriting and claims

processing and is investing in generative AI to automate other business processes. Global insurer Chubb is also considering the use of generative AI, although its recent public statements have expressed caution about the time it is likely to take before the technology is sufficiently mature.

The opportunities

Customer service

Generative AI has the potential to revolutionise customer service in the insurance industry. AI-driven chatbots are already engaging in natural language conversations with customers, providing real-time assistance and answers to queries. Tower Insurance, for instance, boasts a chatbot named Charlie, 'born and bred in Auckland'. At present, these chatbots tend to be limited to answering simple queries or directing customers to the right page of a website. We asked Charlie whether it could tell us if our claim would be accepted, to which the answer was a polite suggestion that to get an update or discuss our claim, we should contact our claims manager directly (with a thumbs up emoji), along with some links to the claims pages on the website. A question about whether there was a maximum sum insured for a house was answered with a suggestion that we refer to the policy wording, along with some information relating to cover for lawns, flowers and shrubs. While using a chatbot may be quicker and easier than searching a website, the outcome is often largely the same.



Mojahid Mottakin / Unsplash

Generative AI-driven chatbots, in contrast, have the potential to offer personalised advice and recommendations based on the customer's risk profile, history and needs, thus enhancing customer satisfaction and loyalty as well as reducing personnel costs as AI tools replace human employees. Generative AI chatbots will have the advantage of access to an enormous database of information from which they will be able to derive principles to answer new questions and deal with new challenges. A generative AI chatbot might, for instance, have access to a database of hundreds or thousands of questions and answers between customers and customer service agents, from which they will be able to derive and process answers in new cases. A chatbot that has learned that customers within certain age ranges who have certain health profiles are offered life and disability insurance, or are offered it on certain terms, will be able to draw conclusions in new cases and provide preliminary responses to inquiries.

Claim assessment

The claims process is a critical aspect of the insurance industry. Generative AI can be employed to analyse and process claims efficiently. By examining claim data and policy details, AI algorithms can determine the appropriate response to a claim, such as whether it should be approved, denied, or subjected to further investigation.

A generative AI tool could learn the details of thousands of claims made under a particular insurance policy, which of them were accepted or declined and the reasons why, from which it will be able to deduce the outcomes of future claims following the same principles. Such a tool could review and assess claims submitted online and write a response either accepting or declining the claim, with reasons, or asking for more information. This could be done almost instantly, so that customers would not have to wait for a decision and could ask for decisions to be reconsidered in real time if more information was provided.

AI may also assist in detecting fraudulent claims, based upon an assessment of a claim against features that arise from a large database of fraudulent claims. A claim that presents no obvious red flags to a human observer may trigger an alert when assessed by a sophisticated algorithm.

This is a markedly different approach from the traditional expectation of the way in which technology might replace human claims assessors, only a few years ago. There was once an expectation that computer-assisted claims assessments would involve a program being designed to reflect the requirements of an insurance policy by asking a series of predetermined questions that stepped through a flowchart to identify whether a claim met the relevant criteria. That approach is necessarily limited to the specific words used in the policy and binary questions; it does not allow for decisions to be made at the margins or judgement calls, and it may not be able to deal with complex claims that raise a number of issues. The difference with generative AI is that it is capable of analysing thousands of evaluative decisions made by claim managers against policy requirements and reflecting their usual approach, potentially resulting in a more consistent and reliable outcome than a human operator. This has the potential to enable quicker, more accurate and more consistent claims processing, reducing operational costs and enhancing customer trust.

Risk assessment

Assessing risks accurately is fundamental to insurance operations. Generative AI can analyse vast amounts of data from various sources to provide insurers with insights into potential risks. By identifying patterns and trends, AI algorithms can aid underwriters in making informed decisions about policy issuance and premium rates, ultimately leading to more tailored and competitive insurance products.

This has the potential to streamline applications for cover, particularly in areas where customers' individual risk profiles are highly relevant to whether cover will be offered and at what premium. Cyber policies, for instance, are notorious for requiring extensive information about a prospective customer's systems and processes. A generative AI tool could assist in putting those in context against a database of other responses and loss data, rather than merely assessing them against a list of criteria that has been prepared by a human and is essentially subjective in terms of its assessment of risk. A generative AI tool could also, for instance, identify new risks and trends in underwriting more quickly and accurately than humans who rely upon imperfect market information.

Policy drafting

Generative AI can already be used to draft simple contracts. ChatGPT will draft an insurance policy if asked to do so. Generative AI could potentially assist in converting traditional policies into "plain English" policies or make substantive changes as the market moves. The technology also offers the opportunity to spot market trends and move quickly to update policies when circumstances change, or other insurers begin to make changes. For instance, a generative AI tool could identify a need for a new clause to exclude, for instance, claims arising from a pandemic or epidemic, and then draft it.

Developing clear and comprehensive policy documents is, however, a complex task, ideally undertaken by lawyers. Small differences in policy wording may have a very substantial effect, particularly if they appear in long term policies such as life and health policies that are not amended or policies that are widely used and are relevant to a large-scale loss event such as the Canterbury earthquakes. Generative AI can, however, assist in drafting policy wording by preparing first drafts, suggesting issues that need to be covered, and by analysing legal and technical terminology, ensuring that policies are accurately written and easy to understand. This can help prevent misunderstandings between insurers and policyholders, reducing disputes and enhancing transparency.

"The difference with generative AI is that it is capable of analysing thousands of evaluative decisions made by claim managers against policy requirements and reflecting their usual approach, potentially resulting in a more consistent and reliable outcome than a human operator."

Insurance broking

Insurance brokers play a crucial role in connecting customers with suitable insurance providers. Generative AI can assist brokers by analysing customer profiles against insurers' offerings to match customers with the most appropriate insurers and policies. There is an obvious potential not only to save time for brokers but also to ensure that customers receive policies that align with their needs and preferences. There is a risk, however, that over-reliance on AI tools may lead brokers into error, particularly if the tool does not have all the relevant and up to date information.

The risks

The use of generative AI, a technology still very much in its infancy, is not without risk. We discuss some important considerations below.

Data privacy and security

The insurance industry deals with sensitive personal and financial information. The adoption of generative AI introduces potential vulnerabilities to data breaches and unauthorised access. Implementing robust cybersecurity measures and data protection measures is essential to mitigate these risks generally, but generative AI introduces new vulnerabilities.

One important challenge is that the use of generally available generative AI tools such as ChatGPT requires the input of information from the user which is then available to the tool, which the user does not control. This means that the insurance industry cannot use tools such as ChatGPT unless they are careful to anonymise the data submitted in their requests. Many firms that wish to benefit from generative AI, such as law firms, are working to develop their own, in-house generative AI tools that draw from publicly available data but do not share the firm's own information outside their own IT systems. Insurers will need to consider doing the same.

Initially, generative AI should be applied to closed data sets. The generative AI model may itself be a pre-trained large language model, but it should be used with the insurer's own data initially. There are risks in combining internal data with external data, and certainly insurers' own data should not be disclosed to external databases.

Bias and fairness

Generative AI systems can inadvertently perpetuate biases present in the data on which they are trained. Biased data could lead to unfair policy pricing or discrimination against some demographics, or even biased claims decisions. Insurers must be cautious in the selection and pre-processing of training data to ensure equitable outcomes.

Accuracy

While generative AI can produce impressive results, the lack of transparency in how it arrives at conclusions can pose challenges. Insurers will need to ensure that AI-driven decisions are accurate and understandable, as complex models may produce outputs that are difficult to interpret or validate. ChatGPT famously produces wildly inaccurate statements and conclusions at times, which is a reflection of the unreliability of parts of the data pool from which it draws. Lawyers using it to draft legal opinions or submissions have been surprised to find cases referred to that do not support the principles or conclusions for which they are cited, and in some instances are even wholly imaginary.

Regulatory compliance

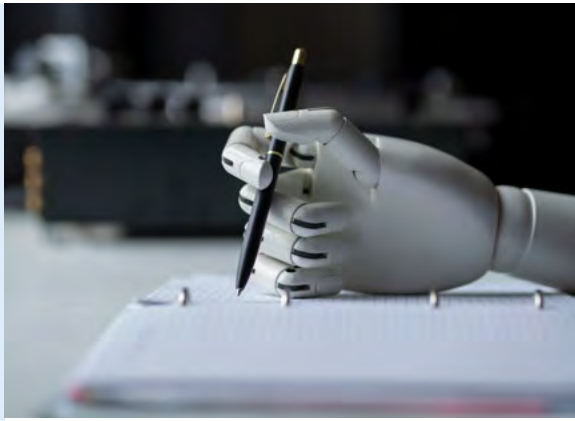
The insurance industry is subject to strict regulations that govern its conduct and practices, particularly with respect to customer outcomes. The introduction of generative AI will need to produce outcomes that align with these obligations to avoid legal and compliance issues. The Financial Markets Authority is highly critical of financial services firms that do not do enough in its view to invest in systems and processes to ensure that errors do not affect customers negatively. Generative AI is an immature technology which is more likely than mature technologies to give rise to errors.

Human-AI balance

Humans will need to remain in the loop, at least until the technology fully matures. Striking the right balance between automation and human expertise is crucial to ensure that the integration of generative AI enhances efficiency without compromising the value of human judgement and interaction. Decision making cannot be delegated to an AI model, however impressive, as human checking or input is essential as a sense-check.

Process-appropriate

Insurers may manage the risks of beginning to utilise generative AI by starting with the safest parts of the operations first. The first uses may be with employee-facing tasks, as if they go wrong, the employees are likely to be able to identify and resolve the issue without customers knowing or being affected. A higher level of risk arises when generative AI is used to deal directly with customers, as errors or inappropriate responses may result in embarrassment, complaints and even regulatory action.



Conclusion

The integration of generative AI into the insurance industry offers considerable potential for transforming various aspects of its operations. From optimising customer interactions to revolutionising risk assessment, claims assessment and policy drafting, generative AI could revolutionise the way insurers operate. However, careful consideration of the associated risks and ethical implications will be important to ensure that these opportunities are harnessed responsibly and safely.

Finally, this article contains another paragraph that was also generated entirely by ChatGPT – the first paragraph under the Risk Assessment heading. Did you spot it?

Intermediated distribution:

How intermediaries can prepare for CoFI

Co-authored by Lloyd Kavanagh and Sarah Jones

The incoming Conduct of Financial Institutions (**CoFI**) regime, introduced by the Financial Markets (Conduct of Institutions) Amendment Act 2022 (**CoFI Act**), is primarily concerned with licencing and regulating the conduct of financial institutions (i.e. licensed insurers, banks, and non-bank deposit takers) in relation to their consumer business.

However, it will also change how intermediaries distribute products for those financial institutions. For the insurance industry, brokers and other intermediaries can expect greater oversight and expectations from insurers in relation to conduct.

The CoFI regime does not directly apply to brokers and intermediaries (except in the case of incentives). However, insurers, as financial institutions, are required to:

- set and maintain a fair conduct programme which provides for the distribution methods they use (including distribution methods that involve intermediaries) to operate in a manner that is consistent with the fair conduct principle; and
- regularly review whether the distribution methods are operating in a manner that is consistent with the fair conduct principle, and ensuring deficiencies are remedied within a reasonable time.

This will have flow through effects for insurance intermediaries, and their relationships with insurers.

In addition, the CoFI regime prohibits intermediaries from receiving certain sales incentives.

This article sets out some of the matters which intermediaries should be thinking about in advance of the regime coming into force. In particular, this article examines the key points for intermediaries in the Financial Markets Authority (FMA)'s recent guidance on intermediated distribution (Guidance).

Am I an intermediary?

Under the CoFI Act, a person will be an intermediary if:

a. the person is involved in the provision of a relevant service or an associated product to a consumer, meaning either:

   ii. arranging for the service or for the acquisition of the product; or

   iii. giving regulated financial advice in relation to the product.

b. the person is paid or provided with a commission or other consideration in connection with that involvement; and

b. the commission or consideration paid or provided (directly or indirectly), by or on behalf of the financial institution providing the service or the product the intermediary is involved with.

Relevant service, in relation to insurance, means "acting as an insurer", and associated product means the associated contract of insurance.

For the purposes of the CoFI Act, a consumer is:

a. a policyholder who enters into the contract of insurance wholly or predominantly for personal, domestic, or household purposes (including any beneficiary or person who is offered such insurance);

b. a policyholder under a contract of insurance that provides for life insurance or health insurance (or both); or

c. a person who benefits from a contract entered into by a policyholder in order to provide insurance cover for one or more persons, provided the person has the benefit of the cover wholly or predominantly for personal, domestic, or household purposes.

An ancillary point to note in relation to paragraph (b) is the absence of a reference in relation to life insurance or health insurance to "personal, domestic, or household purposes", meaning that for those types of insurance when a policy holder is considered a "consumer" can be wider than is the case in ordinary parlance.

What can I do to prepare?

Understand the insurer's obligations in preparing a fair conduct programme

Review contractual agreements

Review internal policies

What can I do to prepare?

Ahead of the CoFI regime, insurers and intermediaries will need to consider carefully their relationship, bearing in mind that a distribution system needs to work for both parties. Intermediaries should:

Understand the insurer's obligations in making the fair conduct programme

The CoFI regime requires financial institutions to set and maintain a fair conduct programme which provides for the distribution methods they use (including distribution methods that involve intermediaries) to operate in a manner that is consistent with the fair conduct principle.

The FMA states that treating customers fairly is a shared responsibility of financial institutions and their intermediaries. Ahead of the regime, the FMA expects financial institutions and intermediaries to collaborate on constructing the distribution section of the fair conduct programme. In our view, both will need to consider carefully how their relationship may need to be re-calibrated to operate effectively and compliantly for both parties once the CoFI regime comes in to force.

Intermediaries will want to understand the financial institutions' obligations because, of course, the insurers must operate in compliance with the CoFI regime, and can be subject to substantial penalties for failing to do so. So the financial institutions will be changing the way they are willing to work with intermediaries. At the same time, intermediaries will need to ensure that their roles and responsibilities under the resulting fair conduct programme are practical and achievable.

Intermediaries should consider what roles and obligations it is willing to have responsibility for, the level of compliance burden it feels is warranted, including in relation to oversight, reporting and ongoing training. Where the balance between the interests of the two finally lands will be at least in part a matter of commercial negotiation.

In constructing a fair conduct programme, financial institutions and intermediaries should consider the following:

- the likely consumers of the products;
- what distribution methods are appropriate and why;
- the roles and responsibilities of the financial institution, and the intermediary;
- how distribution arrangements will be managed or recorded;
- what processes, controls and data are needed; and
- what product information, training or accreditation will be provided.

Intermediaries and financial institutions are also expected by the FMA to collaborate (to varying degrees) on establishing a framework by which to review the fair conduct programme, and remedy any deficiency.

In undertaking this exercise, intermediaries should consider the following:

Risk-based approach

The FMA has stated in its Guidance that financial institutions should take a risk-based approach to setting controls around distribution arrangements. The Guidance also sets out that a high compliance burden on intermediaries should be avoided. For example, the FMA does not expect constant surveillance of intermediaries or supervision of the intermediaries' compliance with the financial advice provider (**FPA**) regime. And if financial institutions do have such contractual powers, that may in future be argued to imply a duty of care in favour of the underlying customers, in the event of failures by the intermediaries. So the balance needs to be carefully considered.

Intermediaries holding a FAP licence will already be subject to complementary conduct obligations under Part 6 of the Financial Markets Conduct Act 2013 (**FMCA**) and the Code of Professional Conduct, and of course direct supervision by the FMA. The Guidance acknowledges that these intermediaries pose a reduced level of risk to consumers because they are already demonstrating a prescribed level of compliance when distributing products and services.

We consider that intermediaries which are FAPs, and the financial institutions using them, can therefore legitimately take the view that a lower level of controls is warranted in relation to their distribution arrangements, than in relation to those intermediaries that are not themselves regulated.

Roles and responsibilities

A financial institution is required to have clearly defined roles, responsibilities and accountability arrangements in relation to identifying, monitoring and managing risks associated with conduct that fails to comply with the fair conduct principle.

In practice, what roles and responsibilities are taken on by an intermediary will vary. For example, if an intermediary is a licensed FAP, it may be responsible for assessing the suitability of the product for the consumer. In some cases, responsibility may be shared.

In relation to product information, the FMA expects that financial institutions will be responsible for providing product information and training. For intermediaries who are FAPs, this can take into account the standards of competence, knowledge and skill that they must meet under the financial advice regime.

Review framework

Financial institutions are required to include in their fair conduct programmes effective policies, processes, systems and controls for regularly reviewing whether distribution methods are operating in a manner consistent with the fair conduct principle.

Financial institutions are encouraged in the Guidance to take a risk-based approach to the frequency and the intensity of the review. The FMA has made clear that it does not expect constant surveillance of intermediaries, or monitoring of individual actions. Intermediaries can therefore expect, depending on the perceived risk of the distribution arrangement, a degree of sample-based monitoring.

Intermediaries should expect financial institutions to ask them to report key metrics (such as claims, loss ratios, complaints, cancellation rates) to the financial institution in order to allow the financial institution to assess whether the distribution method is compliant with the fair conduct principle.

The review required is in relation to how the distribution method supports the fair conduct principle. However, financial institutions may wish to combine this with a review of the performance of the intermediary with other obligations under the distribution arrangement.

Remedying deficiencies

Financial institutions also required to include in their fair conduct programmes effective policies, processes, systems and controls for ensuring any deficiencies in the operation of its distribution methods are identified and remedied within a reasonable time.

The FMA has stated in the Guidance that this is not a 'one size fits all' approach. However, intermediaries can expect consequences from financial institutions in relation to non-compliance with the fair conduct programme, or the CoFI Act more generally. For example, a financial institution may wish to include non-compliance with the fair conduct programme as a material breach in relation to the distribution agreement.

"A financial institution is required to have clearly defined roles, responsibilities and accountability arrangements in relation to identifying, monitoring and managing risks associated with conduct that fails to comply with the fair conduct principle."

Review contractual agreements

The Guidance sets out that contractual arrangements between the financial institution and the intermediary is good practice. Intermediaries can therefore expect financial institutions will seek to impose a distribution agreement, or amend the current distribution agreement to include new provisions for the incoming CoFI regime.

The distribution agreement should clearly record the expectations of each party in relation to the distribution section of the fair conduct programme.

Commissions

The CoFI regime introduces a prohibition on certain sales incentives. An incentive will be prohibited if a relevant person's entitlement to the incentive, or the nature or value of the incentive, is determined or calculated in any way by direct reference to a target or other threshold that relates to the volume or value of the services or products. In relation to intermediated distribution, the relevant persons are the intermediary itself (in relation to commissions by the financial institution) or employees of the intermediary involved in the provision of the financial institution's relevant services who have direct contact or act on behalf of one or more consumers (in relation to commissions by the intermediary to employees).

Financial institutions and intermediaries will accordingly need to adapt the distribution agreement to set out a compliant commission structure.

We also consider there may well be benefit to setting out and agreeing when a commission is payable and when an intermediary is entitled to retain its commission (including, for example, in the event of a refund of premiums).

Assurance

The distribution agreement should state whether the intermediary has a contractual obligation to comply with the fair conduct principle in the CoFI Act, or the fair conduct programme of the insurer.

The distribution agreement should set out what assurances and/or indemnities are given by the intermediary in relation to compliance with the fair conduct programme.

The FMA notes in its Guidance that a formal attestation or audit from an intermediary in relation to compliance with the fair conduct programme "may" not be necessary (but is one tool by which financial institutions can ensure compliance). In our view this is a matter for the parties to decide what is appropriate in the context of their relationship.

Remedying deficiencies

Deficiencies may need to be remedied by either the intermediary or the financial institution through, for example, additional training or through changing the service or product design. Intermediaries and financial institutions therefore need to ensure that the recorded arrangement is flexible enough to allow for introducing new remedies for identified deficiencies.

Review internal policies

Intermediaries will need to consider what internal policies, systems and processes will be needed in order to meet the expectations set out in the financial institution's programme.

In particular, intermediaries will need to ensure that their policies, systems and processes are compatible against each of the fair conduct programmes for each of the financial institutions that they work with.

We accordingly recommend that intermediaries will need to carry out a gap analysis as between each of the resulting fair conduct programmes in order to ensure that its internal policies, systems and processes cover the requirements. Where possible, intermediaries may aim to align each of the fair conduct programme requirements across the financial institutions that they work with. However, they will need to consider carefully their competition law obligations before sharing these internal policies and processes with the financial institutions as part of the collaboration process.

It will be clear from the above that adapting to the new CoFI regime will require the commitment of substantial time and resources, by both financial institutions and the intermediaries they work with. It may well involve redefining what have been long-standing relationships. Both financial institutions and intermediaries may well find that they want to reduce the number of parties they deal with to keep the negotiations and ongoing relationships manageable.

As a result it will be important to start early on the process of working together to find an answer which will be acceptable for both parties to a distribution arrangement. We would recommend a well-planned and carefully thought through approach – which should involve intermediaries making sure they understand the CoFI regime obligations of the financial institutions they deal with.

Systemic systems failures:

Learnings from recent fair dealing enforcement action

Co-authored by Lloyd Kavanagh and Sarah Jones

The regulatory focus on fair dealing has never been higher. Since June 2020, the FMA has brought seven proceedings in relation to breaches of the fair dealing provisions in Part 2 of the Financial Markets Conduct Act 2013 (**FMCA**). Of those, five relate to insurance products.

The FMA and the Courts are focussed on deterrence. As Justice Muir noted in a recent case, the penalty "creates a strong incentive for financial institutions, and particularly large and well-resourced ones… to maintain adequate processes and systems".

From these proceedings, there are two key takeaway points for insurers:

- Invest sufficiently and regularly into your systems to ensure they are reliable and fit for purpose; and
- Systems need to be regularly checked for issues, and any issues need to be appropriately escalated.

We explore these points in this article.

We have also commented on the importance of self-reporting issues and remediation in a previous article.

A summary of the recent fair dealing proceedings

Each of the insurance-related fair dealing proceedings commenced to date have involved insurers making representations to customers admitted to be false or misleading (in breach of section 22 of the FMCA).

In each case, the breach related to the insurer's failure to have appropriate systems and processes in place that would ensure the representations it had made to its customers were correct rather than deliberate misrepresentation.

Examples involved systems failures in relation to:

- not applying discounts or benefits correctly – including passbacks, multi-policy discounts and no claims bonuses;
- cover cessation, duplication of cover and charging premiums after termination of policies; and
- incorrect inflation adjustments specified by the companies' policies.

Across a wide variety of types of insurance policies, the relevant representations were often made to customers through marketing material, invoices, or policy anniversary letters. In each case, as the insurer did not deliver on the statements made in these documents, or in relation to their policies, the FMA considered that the insurer made a false or misleading representation to customers.

Another feature of several of the cases is that they came to the attention of the FMA wholly or partly as a result of self-reporting, and steps were underway to remedy the systems issues. In many cases the insurers had already compensated the customers for the loss.

Out of the actions taken against insurance companies, the largest penalty imposed was $3.575 million (also the largest penalty secured by the FMA in an enforcement case to date). The three most recent alleged breaches are ongoing investigations, but the FMA is seeking declarations and pecuniary penalties for all three.

So it appears that the purpose of the FMA taking enforcement action was as indicated by Muir J's quote above – to create a strong financial incentive to avoid aspirational marketing claims unless they are rigorously underpinned by reliable systems that would always deliver on them.

Learning 1

Invest sufficiently and regularly in your systems to ensure they are reliable and fit for purpose.

On 30 September 2022, Margot Gatland (FMA's Head of Enforcement) said that "financial institutions will be held to account if they fail to sufficiently invest in systems, controls and processes that ensure all customers are treated fairly… Customers should be able to rely on the robustness of their insurer's systems".

Although the proceedings issued to date all related to systems errors, the kinds of errors involved were varied. Common systems errors included:

- sales and fulfilment system errors;
- integration of policy administration systems, including internally and as between intermediaries and the insurer;
- policy administration systems not configured to deliver on a representation; and
- manual data entry errors (by employees or intermediaries), which were not picked up.

Investment in systems should be a priority for each insurer. Insurers should be evaluating their systems to ensure that they are reliable, fit for purpose and can deliver on the promises made to customers. In particular, insurers should be considering whether each of the system deficiencies noted in the recent proceedings could also apply to its systems. Insurers should also consider how their systems interact with others – such as intermediaries.

Investment in systems is particularly important given the nature of the insurance product provided. The FMA considers that compliance with the fair dealing obligations is particularly important given the nature of insurance products and the increased likelihood for harm. In one judgment, it was noted that a special relationship exists as between an insurer and a policyholder, such that the policyholder should be entitled to expect clear and transparent communication. Further, in a number of the recent proceedings, the FMA claimed that errors in relation to the payment of claims or cessation of cover caused emotional harm as well as direct financial harm. This is particularly the case where the systems errors relate to health or life insurance products.

Learning 2

Systems need to be regularly checked for issues, and any issues need to be appropriately escalated.

While the FMA acknowledges that systems errors may be unintentional, where a systems error has continued without identification or remediation, the FMA considers this to be a conduct issue.

If an insurer can demonstrate active reviews of its systems and processes, this may be considered a mitigating factor in the event of a breach. Further, while timely self-reporting may mitigate the level of penalty compared to what would be sought if the FMA detected the problem itself (e.g. as a result of customer complaints) it will not mean a significant penalty will not be considered appropriate. We discussed this further in our previous article.

In one of the proceedings, the scale of the error was not fully identified until after the FMA requested a more comprehensive investigation. In another, the FMA considered the insurer was slow to investigate the issue, despite pressure to do so from an intermediary.

Insurers need to consider whether their internal risk systems adequately allow for the identification and escalation of issues. In particular, insurer's processes should prescribe regular system reviews, with reporting of any issues escalated through governance channels. Each system review needs to ensure that the system is both operationally effective and fit for purpose.

Taking a proactive approach is crucial: the longer it takes for an insurer to identify and escalate these errors, the greater the harm to customers and therefore the potential penalty which will be sought as an incentive to that financial institution and others to avoid similar conduct in the future.

Learning 3

Before making aspirational marketing claims, substantiate them. That means making sure that the systems and processes underlying them are capable of always delivering on what has been promised.

Part 2 of the FMCA is not only concerned with intentional or negligent misrepresentation. It also prohibits making representations which are unsubstantiated, irrespective of whether the representation in fact proves to false or misleading.

What that means is that rigorous verification needs to be undertaken at the time any claims are made in relation to products or services, that the claims not only can, but will be delivered. In the context of offering a benefit such as a discount or bonus, that will mean ensuring that the relevant systems will deliver the benefit.

Implementing these learnings is crucial ahead of the incoming CoFI regime

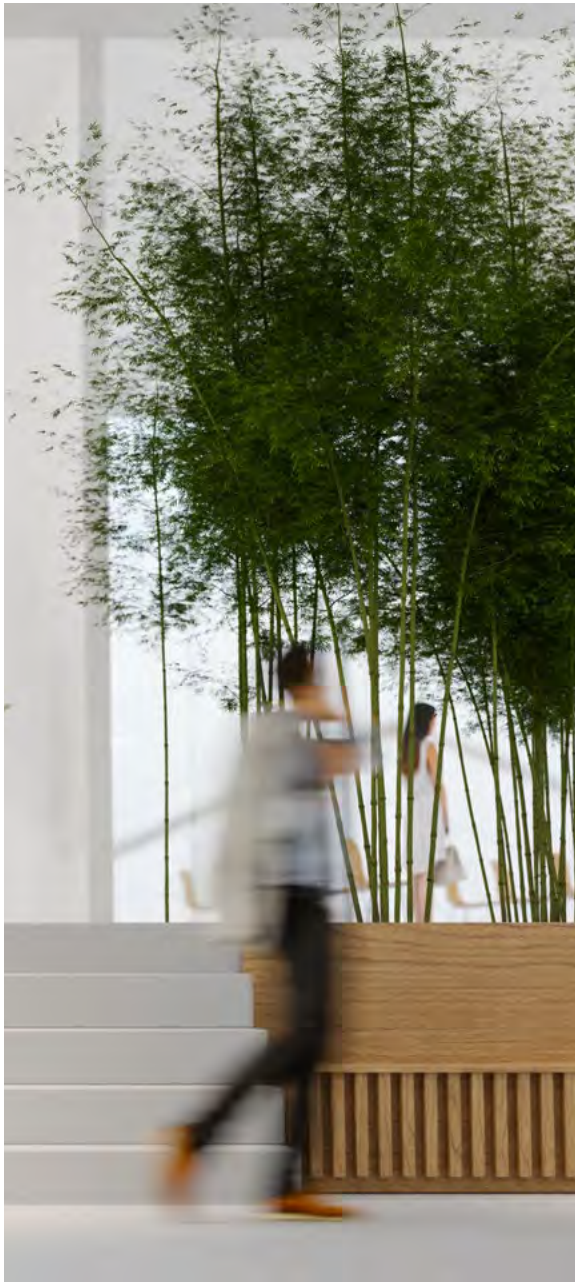
Ensuring systems are fit for purpose will become a regulatory requirement when the conduct regime comes in to forece on 31 March 2025. The FMCA (once amended by the Financial Markets (Conduct of Institutions) Amendment Act 2022) will require financial institutions to construct a fair conduct programme which sets out policies, processes, systems, and controls that are designed to ensure the financial institution's compliance with the fair conduct principle (being, essentially, the duty to treat customers fairly).

Financial institutions will need to set out how their systems support fair treatment of customers. Financial institutions will also be required to take all reasonable steps to comply with their fair conduct programme.

We consider that, if a systems error occurs once the CoFI regime comes into force, that the FMA may take the view that:

- the financial institution has not complied with the fair conduct principle; and
- the financial institution has not taken all reasonable steps (including to review its systems regularly to ensure they deliver fair outcomes) to comply with its fair conduct programme.

When the new CoFI regime comes into force, the penalty for a breach of this nature may, in addition to any action brought by the FMA in relation to Part 2 of the FMCA, include the FMA suspending or cancelling its conduct licence.



Supreme Court's decision in *Napier City Council v Local Government Mutual Funds Limited*

Authored by Nick Frith and Oscar Ji

The Supreme Court's decision in *Local Government Mutual Funds Trustee Limited v Napier City Council* has dealt a decisive blow to attempts by the Local Government Mutual Funds Trustee *(RiskPool)* to avoid liability for claims against member councils for liability arising from both weathertightness and non-weathertightness defects.

The decision is important for both insurers and other stakeholders involved in major leaky building claims. 'Mixed' defect claims are common, and consultants and territorial authorities will often be insured under a professional indemnity policy covering both insured and uninsured liabilities. The starting point will always be the terms and conditions of the policy, and this decision provides helpful clarification on the interpretation of exclusion clauses for 'mixed' cause claims. The decision also supports a careful analysis of the defects in evaluating whether non-weathertightness defects are related to uninsured liabilities.

We have previously set out a detailed background to the case in our article relating to the Court of Appeal decision.

The Supreme Court upheld the Court of Appeal's findings. In dismissing RiskPool's appeal, the Supreme Court focused on the following issues.

Exclusion clause

The Supreme Court agreed with the Court of Appeal as to the true construction of the exclusion clause. The clause is to be construed strictly and the common intention was to exclude only the risks specifically referred to, namely weathertightness. The Council faced liability for separate and divisible loss arising from breaches of the weathertightness and non-weathertightness aspects of the Building Code. Only the former was excluded from cover although the claim was presented on a mixed basis.

There was nothing in the language of the exclusion clause which suggested divisible parts of a claim that did not relate to weathertightness issues were intended to be excluded. Clear language would have been required to achieve this effect.

Application of the *Wayne Tank* principle

RiskPool argued that the Court of Appeal failed to apply the *Wayne Tank* principle, which provides that where there are two equally effective and interdependent causes of loss – one covered by the policy and one excluded by it – the exclusion applies to the entire claim. This argument was rejected by the Supreme Court.

Wayne Tank did not assist RiskPool because it was possible (in this case) to apportion loss between that caused by weathertightness issues and that not caused by weathertightness issues. The causes of loss were separate and divisible. It is important to note that the Supreme Court decision does not change the *Wayne Tank* principle. Instead, the decision clarifies that the principle is narrowly confined to situations where the causes of loss are equally effective and interdependent.

Context and commercial purpose of the policy

RiskPool contended that, if the Court of Appeal had started from the text of the policy, it would have reached the view that the commercial purpose of the policy was to exclude weathertightness claims – including mixed claims. The Supreme Court rejected this argument and found that RiskPool's position on the commercial purpose did not add anything to its case. The purpose rather supported the view that mixed claims were only to be excluded to the extent they are linked to weathertightness defects.

The Supreme Court also found that RiskPool's previous letter to the Council advising that RiskPool had resolved to cease providing weathertightness cover did not assist RiskPool. There was nothing in that letter to suggest that the cover excluded mixed claims. The contextual matters relied on by RiskPool did not have any impact on the proper interpretation of the insurance contract.

What is the significance of the judgment?

The Supreme Court's decision provides helpful clarity for the insurance industry and in particular for members of the RiskPool scheme and other schemes that have the same wording. There is now a judgment from the highest appellate court in New Zealand affirming that the relevant weathertightness exclusion only applies to those defects which have a causal connection to weathertightness defects.

Case study

High Court resolves policy interpretation dispute in insurer's favour

Co-authored by Olivia de Pont and Charlotte Wong

The High Court and Court of Appeal's recent decisions in *Catherwood v Asteron Life Limited* serve as a timely reminder to insurers to avoid ambiguous policy language. Insurers should also be mindful that, if a policy interpretation issue arises and the insurer makes "belts and braces" amendments to the policy to put its meaning beyond doubt, then an insured may attempt to use that against the insurer.

The facts

This proceeding was issued by Mr Catherwood, who held a life insurance policy with Asteron. The policy included a death benefit which would be paid if Mr Catherwood died or became "terminally ill", which was defined in the policy to mean that: "Your life expectancy is, due to sickness and regardless of any available treatment, not greater than 12 months".

In January 2019, Mr Catherwood was diagnosed with cancer and made a claim for the death benefit under his policy. This claim was, however, declined because, with treatment, Mr Catherwood's life expectancy exceeded 12 months. Accordingly, Asteron considered that he was not "terminally ill" within the policy definition. Mr Catherwood challenged this, arguing that the words "regardless of any available treatment" in the definition of "*terminally ill*" meant that his life expectancy should be assessed "without regard" to the impact of any treatment – and not "despite" any available treatment, as Asteron contended.

Approach to interpretation

The High Court approached the interpretation exercise in three stages. First, the common-sense meaning of "terminally ill" – the High Court declared that it would be contradictory to describe someone as "terminally ill" when there was an available cure. Next, the High Court looked to the policy's surrounding context. The High Court observed that Asteron offered an optional trauma recovery benefit in addition to the death benefit and expressed the view that there would be considerable and illogical overlap between those benefits if Mr Catherwood's interpretation were correct. Finally, the High Court considered Australian authorities dealing with similar subject matter, which illustrated the reasonableness of taking into account the likely outcome of available treatment when deciding whether someone was terminally ill.

The Court of Appeal upheld the High Court's decision, noting, however, the policy was not "well worded".

Changes to policy wordings

While the Courts' decisions are not surprising, this case demonstrates how ambiguity in policy wordings can lead to protracted and expensive litigation.

Further, after Mr Catherwood issued these proceedings, Asteron amended the policy definition of "terminally ill" – a fact which Mr Catherwood latched onto, arguing in the High Court that this was evidence that his interpretation of the policy was correct. While the High Court did not engage with this argument and the Court of Appeal's decision makes no reference to it, this case demonstrates that some insureds will nevertheless attempt to rely on post-dispute policy amendments as evidence to support their interpretation.

Insurers should be aware that any changes made to a policy wording after an interpretation issue has been raised could be relied on as evidence supporting the insured's interpretation.

Such arguments are unlikely to succeed and the authority to support the proposition that commercial entities may change the wording of contracts to improve the clarity of expression, and that this does not of itself mean that the earlier wording did not already express the meaning the entity intends to convey. However, debates as to the effect of a policy wording change are not uncommon and the effect of the decision in *Bathurst* will not dissuade all insureds from running the argument.

The Supreme Court's decision in *Bathurst Resources Ltd v L&M Coal Holdings Ltd* makes it clear that post-dispute conduct (as opposed to subsequent conduct more generally) will rarely be admissible.

Case study

WWII never ended for the insurance market

Allianz Insurance PLC v The University of Exeter [2023] EWHC 630 (TCC)

Nick Frith and Hasaan Malik

The High Court of England and Wales recently considered the doctrine of proximate cause in *Allianz Insurance PLC v The University of Exeter* [2023] EWHC 630 (TCC). This case is an interesting follow-on to the *Brian Leighton (Garages)* case that we discussed in Issue 27.

The case raises similar but different issues of damage caused by an earlier in time action. In this case, the question was whether the controlled detonation of an unexploded WWII bomb fell within the scope of a war exclusion in a MDBI policy.

Allianz successfully obtained a declaration that damage caused by the controlled detonation was not covered by the policy as it fell within the scope of the war exclusion clause.

The facts

Building works next to the University's campus unearthed an unexploded bomb. Investigations revealed that the bomb had been dropped by hostile German forces in Exeter in 1942, during WWII. The bomb was a highly explosive, 1000kg bomb nicknamed 'the Hermann'. Bomb disposal experts considered that the bomb's condition meant that it could not safely be removed from the site. The only realistic course available was to detonate the bomb on site in a controlled manner. Emergency services established a safety cordon within a 400-metre radius of the bomb, protecting residents of halls of residence owned by the University that had to be evacuated. The detonation caused damage to buildings in the immediate vicinity of the site, including those owned by the University.

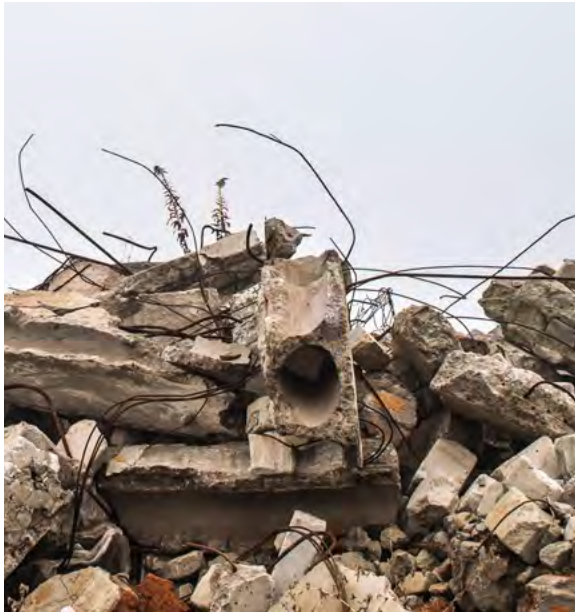
The University made a claim under its MDBI policy with Allianz for the physical damage to buildings and business interruption in connection with the temporary re-housing of students. Allianz declined the claim on the basis that the loss or damage fell within the scope of the policy's War Exclusion, being loss and damage "occasioned by war".

The main question for the Court was whether the damage was "occasioned by war". If so, the loss was excluded from cover. If not, damage fell within the terms of the insurance cover.

The policy

The policy's insuring clause clearly covered the relevant damage unless it fell within the War Exclusion. The War Exclusion stated that there was no cover for:

Loss, destruction, damage, death, injury, disablement or liability or any consequential loss occasioned by war, invasion, acts of foreign enemy, ...



Both parties agreed that the dropping of the bomb was an act of war and that the 'proximate cause test' was required to determine whether the damage was 'occasioned by war'. This required the Court to determine the 'immediate', 'real', and 'efficient' cause of the loss. See here for our note on the *Brian Leighton (Garages)* case which addressed these issues in more detail.

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Arguments

Allianz argued that:

a. the dropping of the bomb was the proximate cause of the loss; or, in the alternative

b. even if the dropping of the bomb was not the proximate cause, it was a proximate cause of the loss, requiring the judge to find for Allianz in reliance on the *Wayne Tank* rule.

The University argued that the proximate cause of the loss was the deliberate act of the bomb disposal team detonating the bomb, not the original dropping of the bomb. Damage only occurred once the bomb was discovered and detonated. The University further argued that this was not a case of concurrent cause, and even if it was, the concurrent cause rule did not apply because it was ousted by the policy's express terms.

The decision

The Court found that the dropping of the bomb was the obvious proximate (dominant or efficient) cause of the loss, noting that a determination of proximate cause is a matter of common-sense judgement rather than over-analysis.

The Judge held that, although the explosion was triggered by the decision to detonate the bomb, and that it was natural that an unguided gut feeling strongly leant towards the conclusion that the detonation was the proximate cause, the loss was necessitated by the presence of the bomb. Without the bomb there would be no need for detonation and thus there would be no explosion. The passage of almost 80 years between the bomb being dropped and the detonation did not prevent this from being the proximate cause. Further, the human intervention of detonation did not change the fact that without the bomb having been dropped, the loss (and the detonation itself) could not have occurred. Accordingly, as a matter of common-sense the Court found that the dropping of the bomb and its consequent presence at the site was the proximate cause of the damage.

The alternative

In the alternative, the Court also found that, even if the dropping of the bomb was found not to be the proximate cause, it was a proximate cause. The damage would be caused by the combined effect of the detonation and presence of the bomb, both being equal, or at least nearly equal, in their efficiency.

The Court also rejected the University's attempt to rely upon the *contra proferentum* rule, given that there was no relevant ambiguity in the policy to be resolved.

The Court therefore concluded that the dropping of the bomb was the proximate cause of the loss and that any loss suffered by the University was rightly excluded from cover.

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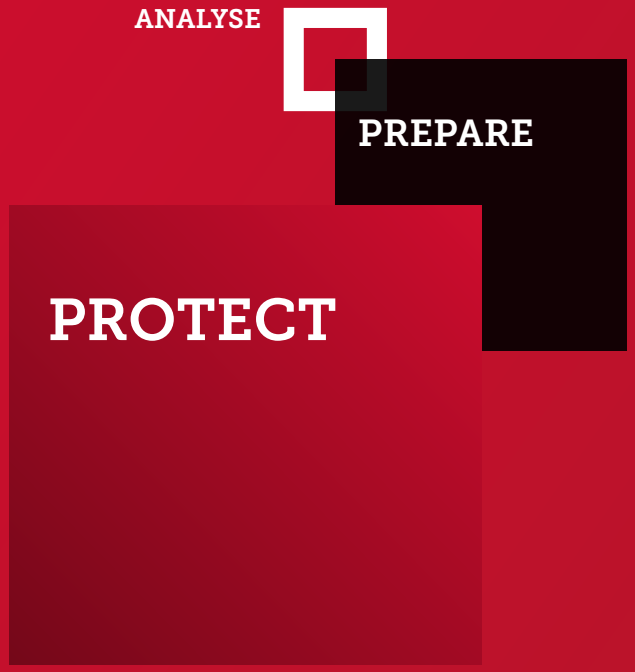

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