Cover to Cover

NEW ZEALAND'S INSURANCE MARKET MAGAZINE

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MinterEllisonRuddWatts

Welcome to the final issue of Cover to Cover for 2018

Group insurance policies arranged by a firm on behalf of a number of individuals are commonplace, particularly in life and disability insurance. They are most prevalent in an employment context where offered as part of an employment benefits package. We discuss the basic structure of group life policies, issues that can arise and lessons for all parties.

The Court of Appeal recently heard a case where three drivers fell victim to accidents caused by negligent at-fault drivers. They each hired replacement vehicles from Right 2 Drive while their vehicles were being repaired. We discuss their claims against the at-fault drivers for the cost of their replacement vehicles on credit hire and the recent Court of Appeal decision.

We report on the various legislative reviews currently under way that affect the insurance sector, as well as noting some new regulatory consultations under way by the Reserve Bank in relation to its prudential supervision of licensed insurers.

We also provide an update on the FMA's response to the Australian Royal Commission into insurers' conduct.

Finally, Parliament has introduced the Canterbury Earthquakes Insurance Tribunal Bill under urgency, aiming to establish a quick and efficient alternative dispute resolution forum to determine unresolved earthquake insurance claims. We discuss a number of the Bill's key features which are likely to create debate.

We hope you enjoy this issue of Cover to Cover. If you have any suggestions on how we can improve the publication or topics you would like us to cover, please email us at **covertocover@minterellison.co.nz**

Andrew Horne
Editor

Nick Frith
Editor

Reflections on group life policies

Group insurance policies arranged by a firm on behalf of a number of individuals are commonplace, particularly in life and disability insurance. They are most prevalent in the employment context where offered as part of an employment benefits package. However, their structure, where the policyholder is not the ultimate beneficiary and there is no direct relationship between insurer and beneficiary, can give rise to issues when a coverage dispute arises.

Structure of group life policies

Although details can differ, the basic structure of group policies is that the insurer and employer enter into a life or life and disability insurance policy covering employees. An important characteristic of this arrangement is that the employer is the policyholder with the rights and obligations under the policy, including the sole right to receive payment of any benefits due in respect of any employee. The policy typically provides that the employees do not have any rights against the insurer.

An employer may (but does not have to) enter into a separate agreement with the employees as to how they will deal with any claims under the policy. This may form part of the employment contract and it may be on different terms to the group policy. The following chart describes this arrangement:

In some circumstances, however, employers do not assume any obligations to their employees with respect to the policy. They may not even inform the employees of its existence, using it instead to provide assistance payments to employees and their families in the event of death or disablement. It is also commonplace for employers to arrange for a trustee to manage the policy and receive claim benefits for distribution to employees, instead of the employer doing it themselves.

Benefits of this structure

The group policy structure has a number of benefits:

- lower premium rates due to:
  - a large number of lives insured under one policy
  - reduced administration costs through dealing with a single employer or trustee rather than individual employees
- limited underwriting, if any, due to the pooled nature of the cover. This reduces administration costs for the insurer and enables employers to procure cover for higher-risk individuals at lower rates. This is facilitated by automatic acceptance limits
- no need for a review before annual renewals
- the employer has control of the policy, enabling it to ensure that obviously unmeritorious claims are not made, so as to avoid rate increases.

Issues that can arise when cover is disputed

The group structure raises issues where an employee's claim is declined in contentious circumstances. What claims – if any - may an employee bring against the insurer, the employer or a trustee?

May an employee bring a claim in contract against the insurer?

Normally, an employee has no direct right against the insurer, as there is no direct contractual relationship between them. The structure has been described by the courts as imposing:

"a curtain between the plaintiff and the second defendants [employees]. The first defendants [employers] were that curtain."

While s12 of the Contract and Commercial Law Act 2017 (previously s4 of the Contracts (Privity) Act 1982) allows a party upon whom a benefit is conferred by a contract to enforce it, this does not apply where the contract was not intended to create an obligation enforceable by the non-party. Most group life policies expressly provide that the policy is not intended to confer benefits enforceable by an employee.

An employer or trustee who wishes to allow an employee to pursue a disputed claim under a group policy may elect to assign the claim to the employee, subject to any prohibitions in the policy. Unlike the assignment of policies, which must comply with Part 2 of the Life Insurance Act 1908, there is no particular requirement as to the form of the assignment of a claim.

May an employee bring a claim in negligence against the insurer?

Employees have sought to circumvent the difficulty of having no direct contractual right against an insurer by alleging that the insurer owes them a duty in tort to pay a valid claim. Whether a claim in tort could succeed

Briscoe v Lubrizol Ltd – Quick facts

- Briscoe claimed to suffer severe back pains as a result of his employment and said that he was unable to work
- Lubrizol made a claim under the policy in respect of Briscoe
- Lubrizol made payments to Briscoe pending the outcome of the claim
- The insurer declined cover on the basis that Briscoe did not meet the requirements of the policy
- Lubrizol ceased making payments to Briscoe
- Briscoe brought claims against Lubrizol (in contract) and the insurer (in negligence)

"… it was reasonable for the insurers to protect themselves against claims by employees of Lubrizol who might turn out to be impecunious and unable to pay costs."

will likely depend upon the nuances of the particular group structure and the duty alleged to be owed by the insurer.

The issue has been considered in England, in the context of an allegation that an insurer owed a duty to an employee (Briscoe) to take proper steps to ascertain whether or not the claim came within the terms of a group policy between the insurer and Briscoe's employer (Lubrizol).

Like most group policies, Lubrizol was the policyholder. Briscoe had no direct contractual rights against the insurer. However, Briscoe had an employment contract with Lubrizol, under which Briscoe was entitled to the benefits of Lubrizol's policy with the insurer.

Whether the insurer owed a duty directly to Briscoe was heard as a preliminary issue. The court at first instance answered in the negative. Briscoe appealed unsuccessfully to the Court of Appeal. The Court held that the insurer did not owe a duty of care to Briscoe, in large part because of the specific contractual matrix that the parties had intentionally employed.

The well-accepted formulae for deciding the question of imposition of a duty of care has three elements:

- sufficient proximity between the parties
- reasonable foreseeability
- a duty is just and reasonable in the circumstances

The Court considered that, although there was sufficient proximity between Briscoe and the insurer, it was not foreseeable that Briscoe would suffer financial harm if the insurer failed to take proper steps to ascertain whether or not the claim came within the terms of the policy. Nor did the insurer assume responsibility for an employee. In fact, the contractual regime was clearly directed at ensuring that was not the case. The court found among other things that *"… it was reasonable for the insurers to protect themselves against claims by employees of Lubrizol who might turn out to be impecunious and unable to pay costs."*

The contractual structure was also considered a powerful indication that the proposed duty was not just and reasonable. Specifically, the Court considered that Briscoe was not left without a remedy, because Briscoe had a claim in contract against Lubrizol. This, however, would depend upon the employment contract, and rights against an employer will not exist in all claims.

Lessons

For insurers –

A group policy should state explicitly that employees have no direct rights or benefits under the policy, that the only relevant contractual relationship is between the insurer and policy holder (employer) and exclude the operation of section 12 of the Contract and Commercial Law Act.

For employers –

Consider the implications of employees having direct recourse against you, including your obligations under your employment contracts. It may be appropriate to consider expressly disclaiming any obligations to pursue claims under group policies.

For employees –

Consider whether you have standing to bring a claim against an insurer or an employer.

Andrew Horne
Partner

Hannah Jacques
Senior Solicitor

A new entitlement to replacement vehicle hire costs

A recent New Zealand court decision confirms that drivers who are not at fault in accidents may recover the cost of a replacement hire vehicle from the at-fault parties' insurers. The decision will have substantial cost implications for motor vehicle insurers.

The case was brought by a specialist hire company that provides replacement vehicles at no cost to not-at-fault drivers. The claims were brought in the names of drivers who fell victim to accidents caused by other drivers. They each hired replacement vehicles from Right 2 Drive (R2D), a credit hire company, while their own vehicles were being repaired. R2D assured them that it would not pursue them for hire costs, provided they co-operated in recovering the hire fees from the at-fault drivers' insurers.

The insurers refused to pay so the drivers commenced proceedings against the at-fault drivers for the cost of hire, together with other, associated costs incurred by R2D. The proceedings were consolidated into a "test" or "lead" case that was in reality driven by R2D and defended by the at-fault drivers' insurers.

The Court treated it as a claim for mitigation costs. The drivers initially sought to claim special damages, arguing that the at-fault drivers caused their loss, being their expenditure on replacement vehicle hire. However, their loss was fully mitigated by the replacement vehicle. The Court

The insurers refused to pay so the drivers commenced proceedings against the at-fault drivers for the cost of hire

therefore posed the key question as whether ***"the plaintiffs are entitled to recover their mitigation expenses – that is, whether those expenses have been reasonably incurred."***

In defence of the claims, the insurers argued that the drivers had completely mitigated their loss by obtaining replacement vehicles from R2D. They had not suffered any loss as they had no obligation to pay R2D for the vehicle hire. Not only had R2D promised them that they would not have to pay, but the contract was arguably defective, as it did not specify rates or charges.

The Court rejected the insurers' arguments. Although the drivers had arguments to resist a claim by R2D if they were pursued for hire charges, there was still a risk of liability. The Court relied upon the drivers' agreement with R2D that it obtained their authority to recover the costs of a replacement vehicle on their behalf and recorded their obligation to pay. The replacement car had a cost, which is the mitigation expense claimed. R2D was entitled to waive its rights against the drivers. The Court held that any 'sloppiness' in the operation of R2D's business did not entitle the at-fault drivers' insurers to avoid liability.

The Court relied upon the general principle that, once an at-fault driver is found liable for the normal measure of damage (the cost of repairs and other losses flowing directly from an accident), they are generally also liable for the cost of the reasonable steps taken by the not-at-fault driver to reduce their loss, whether or not those steps are effective.

The issue was therefore whether the drivers' hiring of the R2D cars was reasonable.

The insurers argued that the drivers' choice to take the R2D cars was unreasonable, as they would have explored other vehicle hire options if faced with the prospect of having to pay R2D's charges, which were higher than other hire companies. Alternatives included other hire companies, a courtesy vehicle provided by a repairer or taxis/public transport. In assessing reasonableness, the Court held that the most helpful test is whether a prudent driver would take up R2D's replacement car offer while they waited for damage they caused to their own car to be repaired.

The Court heard evidence from other car hire companies, demonstrating that R2D's fees were in the vicinity of their fees. While other companies offered lower prices for longer term hire rates, this was a counsel of hindsight, as the drivers did not know how long it would take to repair their vehicles, so it was not clear from the outset that longer term hire rates would be available. The Court also considered the additional cost of R2D's pick-up and drop-off service and considered that to be reasonable. Not only was it comparable to one hire company's similar service, but it provided continuity of availability of a vehicle, thereby mitigating further potential loss.

The key question for insurers when faced with a claim for mitigation costs such as this is whether the costs are reasonable in the circumstances. It is not for the not-at-fault driver to prove that they are reasonable, but for the at-fault driver (really, its insurer) to prove the contrary. As the English Court of Appeal has said in a similar case, it is for an at-fault driver to demonstrate, by evidence, that there is a difference between the credit hire charge agreed between the not-at-fault driver and the credit hire company and the [basic hire rate]."

Reasonableness is not to be determined with too critical an eye in hindsight, but what would have appeared reasonable to the driver at the time. Factors include:

(a) whether the not-at-fault driver can afford to take other mitigation steps or whether they have to resort to "credit hire";

(b) the not-at-fault driver's insurance position is not to be considered; i.e. whether they could have claimed on their own insurance for a hire car, for that insurer would likely pursue the at-fault driver's insurer;

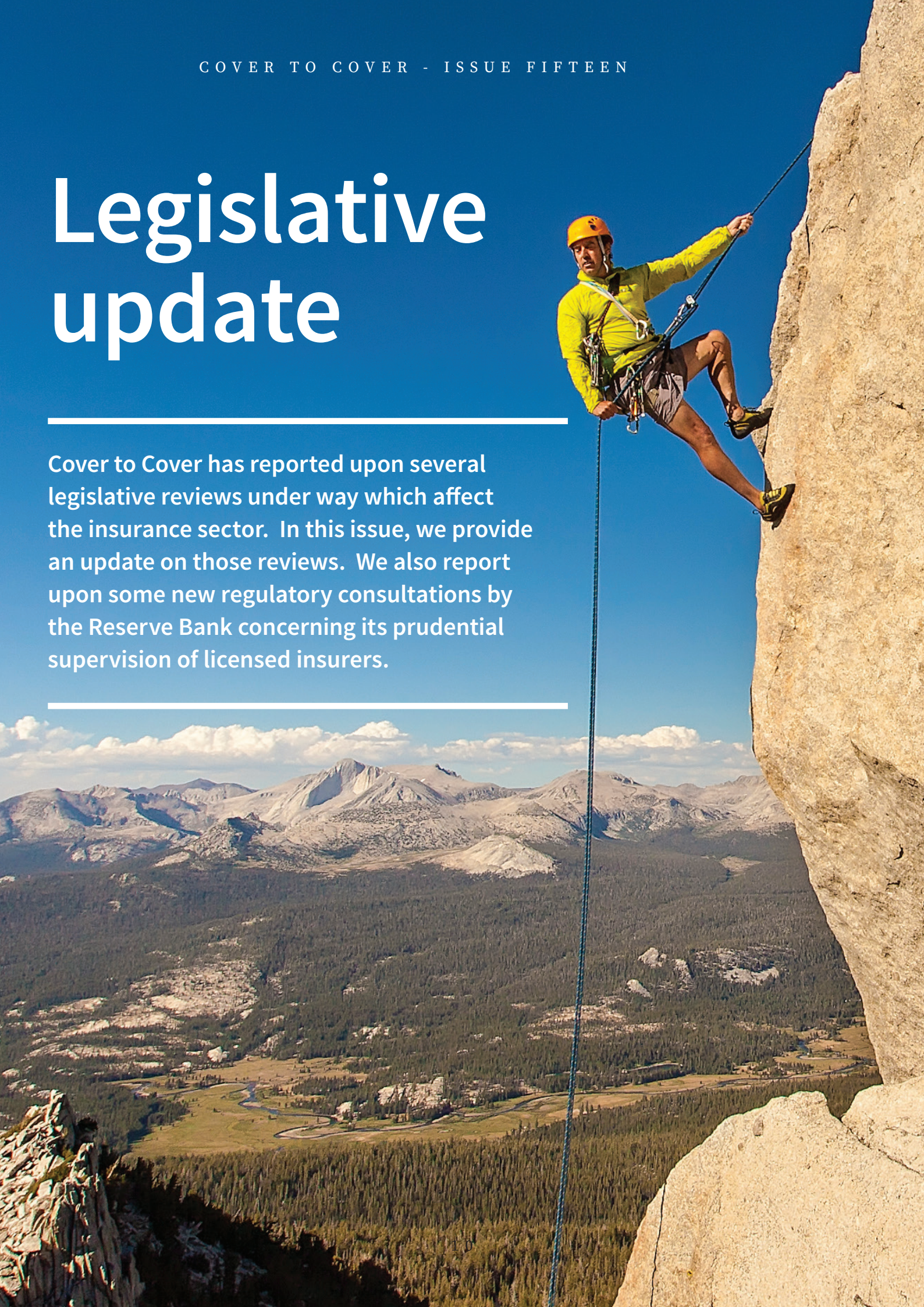
(c) where a not-at-fault driver has options, their reasonable adoption of one option is not to be held against it simply because another may be more effective or economic.

In the end, the question is whether a prudent driver would take up R2D's replacement car while they await the repair of damage they caused to their own car. At-fault drivers' insurers will need to prove to the contrary if they wish to avoid paying these costs.

Nick Frith
Senior Associate

Legislative update

Cover to Cover has reported upon several legislative reviews under way which affect the insurance sector. In this issue, we provide an update on those reviews. We also report upon some new regulatory consultations by the Reserve Bank concerning its prudential supervision of licensed insurers.



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Second reading of Financial Services Legislation Amendment Bill (FSLAB)

FSLAB passed its second reading in Parliament on 12 September with unanimous support. It is now with the Committee of the Whole House for consideration.

Broadly, the Bill will expand the minimum professional standards on giving financial advice to retail clients, requiring those who are permitted to give regulated financial advice to comply with standards of ethical behaviour, conduct and client care and to give priority to a client's interests. The Bill is also intended to simplify the regime and its terminology.

Members of Parliament commented that it is vital that consumers have confidence in the financial advice they receive and that it is given in a principled way. These comments echo the messages of the Financial Markets Authority and Reserve Bank concerning conduct, culture and the importance of non-conflicted advice and good consumer outcomes.

The Ministry of Business, Innovation and Employment has recently updated the indicative timeframes for the new financial advice regime to be introduced by FSLAB. Once the Bill has its third reading and receives Royal assent, some provisions will come into force immediately, with the Code of Conduct and Regulations currently expected to be finalised by early to mid - 2019 and the six-month period for transitional licensing applications opening three months later. The new regime is therefore expected to start upon the completion of transitional licensing around the second quarter of 2020, with a transition period for some aspects of the regime extending into the second quarter of 2022.

Review of insurance contract law

The Ministry of Business, Innovation and Employment is considering public submissions on its Insurance Contract Law and Conduct Issues Paper. Submissions closed on 13 July 2018, but we expect development of policy themes arising out of the Issues Paper and that consultation will be delayed as MBIE takes into account the themes underpinning the changes to the financial advisers regime in FSLAB, as well as the focus of regulators on the conduct and culture of New Zealand's financial services firms. This follows the fallout from the Australian Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry.

Insurance (Prudential Supervision) Act 2010 review

In 2016, the Reserve Bank began a comprehensive review of the Insurance (Prudential Supervision) Act 2010. The review aims to assess the performance of the Act against its purposes and to evaluate the consistency of the regime with international guidance and other New Zealand legislation.

Phase 1 of the review is complete. The Reserve Bank considers that the responses to its consultation document support a comprehensive review of the Act in Phase 2, with the following issues to be given initial priority:

- the scope of the Act (including ensuring that it caters for existing and new insurance models);
- the treatment of overseas insurers;
- disclosure and financial strength rating requirements; and
- regulatory mechanisms, balancing the enforcement tools available to the Reserve Bank with its enforcement and supervisory approach.

Although Phase 2 was intended to start in November 2017 and be completed by mid-2019, the Reserve Bank's issues paper feedback statement indicated that the timeframe may change depending on resource availability and competing priorities. Indeed, this resulted in the review being suspended in April this year, with no indication as to when it will recommence. When it does, the Reserve Bank has made it clear that issues will be appropriately explored and options developed with consultation.

Amendments to the Fire and Emergency New Zealand Act 2017 (FENZ Act)

In August this year, Cabinet provided policy approval for a number of amendments to the FENZ Act, including changes to key definitions and a delay to commencing the new fire services levy regime.

The FENZ Amendment Bill would delay commencement of the new fire services levy regime by a minimum of 12 months to 1 July 2020. This will be achieved by moving the backstop

commencement date for the new levy regime to 1 July 2021, with an ability for this date to be brought forward to 1 July 2020 by Order in Council.

This delay is due to industry feedback that, once the regime is finalised, insurers will need around 15 months to make necessary changes to contract wordings, introduce new business processes and systems and notify policyholders three months before the new levy regime comes into force.

A number of drafting defects have also been identified in the FENZ Act, particularly with reference to definitions (for example, motor vehicle, residential property and personal property definitions). The proposed amendment bill will update the definitions to bring them in line with past and current levy collection practice.

Of particular importance is the proposed change to the definition of "amount insured" which is the new term introduced by the FENZ Act on which the fire service levy will be charged.

This term is defined by reference to the express maximum limit on the amount for which a property is insured over the term of the contract, and where there is no maximum limit, the "declared value" of the property (calculated in accordance with the FENZ Act). The definition was intended to be principled and simple, distinct from the term "sum insured" as commonly used in the insurance industry, and designed to prevent avoidance by capturing the actual maximum that can be paid out under an insurance contract.

Policy makers have accepted insurers' concerns that the calculation of the express maximum limit on many insurance contracts will be complex and costly, including on policies where there is little risk of avoidance. The proposed solution is calculating the levy on the "sum insured" (as that term is commonly used and understood in the insurance industry) only where it represents a fair and reasonable value of both the greatest value of insurance over the term of the contract and the value of the insured property.

Draft levy regulations have been released and are expected to be finalised in 2019 when the new levy rate is set. The infringement offences and fire plans regulations are expected to be approved later this year.

Audit requirements for insurer data returns

The Reserve Bank released a consultation paper in October 2017 on audit requirements for insurer data returns to consider introducing an audit requirement for the year-end insurer return and strengthening the existing requirement for year-end insurer solvency return. Consultation closed in December last year and the Reserve Bank is still considering submissions.

Solvency Standards and NZ IFRS 16 Leases consultation paper

As a result of the introduction of the new lease accounting standard NZ IFRS 16 applying for financial reporting periods beginning on or after 1 January 2019, the Reserve Bank proposes to amend the solvency standards for licensed insurers to allow for new right-of-use assets and lease liabilities, to be factored into minimum capital requirements.

Consultations on the paper closed on 24 August 2018 and the Reserve Bank aims to finalise the proposed changes and amend the current solvency standards to take effect from 1 January 2019.

Kara Daly
Special Counsel

Jemimah Giblett
Solicitor

Canterbury Earthquakes Insurance Tribunal Bill

Parliament has introduced the Canterbury Earthquakes Insurance Tribunal Bill under urgency, with a view to establishing a quick and efficient alternative dispute resolution forum to determine unresolved earthquake insurance claims.

The progress and development of this Bill will be of interest to both insurers and Cantabrians – who, as a result of the urgency of the Bill's introduction, were not consulted on its drafting. A number of the Bill's key features, including the Tribunal's jurisdiction, powers and procedures, have already been the subject of debate.

Jurisdiction

A number of limits will be placed on the Tribunal's jurisdiction. The Tribunal may hear disputes in relation to residential – but not commercial – insurance claims, and only claims brought by the original policyholder.

The Tribunal will not have jurisdiction over claims brought by purchasers of earthquake-damaged homes who have taken an assignment of an insurance claim. This is because of the complexities inherent in many such cases - the drafters of the Bill wished to ensure that the Tribunal does not become clogged with complex cases which the courts are better placed to determine. Those who have purchased earthquake-damaged properties will, however, query whether such a bright-line test is appropriate.

Also, the Tribunal will not have jurisdiction over claims relating to earthquakes other than the 4 September 2010, 22 February and 13 June 2011 Canterbury earthquakes. This limit on the Tribunal's jurisdiction may be viewed as surprising given the resources invested in its establishment and the country's ongoing earthquake risks. It is not obvious,

The basis on which the Tribunal will make decisions is also of interest. The Bill provides that claims will be decided "based on existing law and (if relevant) the terms of the insurance contract between the parties."

for instance, why those affected by the Kaikoura earthquake should not be entitled to use the Tribunal.

Other aspects of the Tribunal's jurisdiction remain unclear. For example, the Bill does not address whether the Tribunal will consider claims that were settled on a "full and final" basis which a policyholder wishes to re-open. It is possible that the Tribunal will need to refer questions of law to the High Court for determination and await its decision before proceeding. However, the delays involved in doing so may undermine the Tribunal's goal of resolving claims in a "speedy" and "cost-effective" fashion.

Powers

The basis on which the Tribunal will make decisions is also of interest. The Bill provides that claims will be decided "based on existing law and (if relevant) the terms of the insurance contract between the parties." As the insurance contract governs the policyholders' entitlements, it is unclear when the terms of the insurance contract would not be relevant to the resolution of a claim.

Furthermore, the Bill empowers the Tribunal to award general damages for mental distress. However, distress damages are not generally payable for breaches of contract. Only one case on the Earthquake List has resulted in an award of general damages, and in that case a nominal award was made on the basis of a breach of a duty of good faith as an implied term of the contract. However, the principles relating to the nature and scope of any duty of good faith are unsettled and, by allowing for such damages awards to be made, the Bill skims over a complex legal issue that may be better resolved by the courts.

The Tribunal may set an amount of money payable by a party if they fail or refuse to do a particular thing by a stipulated date. In circumstances where parties are often reliant on a third party to carry out work to meet a deadline (such as an expert), such orders may prove inappropriate.

Process

Notable aspects of the Tribunal's process include:

- **Mediation:** at the first case management conference, the Tribunal may direct the parties to mediation and set time frames for that process. Given the large number of earthquake insurance claims which settle shortly before trial, building in an early referral to mediation is likely to be welcomed by both policyholders and insurers.
- **Cross-examination:** the Bill provides that the Tribunal may "permit" cross-examination, but this is at the discretion of the Tribunal. Given that most cases will involve disputed expert or claims handling evidence, it is unclear when it would be appropriate not to permit cross-examination.
- **Experts:** the Tribunal may appoint its own expert. This may help resolve disputes between existing experts appointed by the parties, and enable the Tribunal to better understand technical issues relevant to any given case.
- **Case management conferences:** the Bill states that the Tribunal must "take a proactive approach to case management, for example by setting time frames for providing information or convening conferences of experts". However, many of the delays experienced on the Earthquake List are not the result of poor case management but a shortage of experts who are available to assist and delays in preparing expert reports and arranging joint expert site visits. As the same pool of experts will be drawn upon for both Court and Tribunal proceedings, the Tribunal will likely encounter the same delays with expert conferral processes as the courts.

Next steps

The Bill has been referred to a Select Committee. Public submissions on the Bill are due by 18 October 2018.

Olivia de Pont
Senior Solicitor

Insurance conduct and culture – a new regulatory focus

Australian Royal Commission and New Zealand review

Insurers and insurance intermediaries in New Zealand are under intense scrutiny by regulators, the media and customers as the Australian Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry unfolds.

The Financial Markets Authority and the Reserve Bank of New Zealand are undertaking their own review of the banking, insurance, superannuation and financial adviser sectors to determine whether the systemic failures that have been identified in Australia exist in New Zealand. The focus is upon business processes, conduct and culture.

The insurance sector review is on-going, with a report expected later this year. This will follow the FMA's report on its review of the banking and superannuation sectors, which is due in October.

Context – the FMA's earlier QFE investigation

The FMA was already focussing upon conduct and culture in the insurance sector before the present review, primarily in the sale of life insurance - particularly replacement life insurance. In its July 2018 report on QFE insurance providers' business practices in relation to replacement insurance, the FMA reported that it had reviewed the processes of eleven QFE life insurers and explored whether their processes were designed with good customer outcomes in mind. The FMA found that fewer than half advised customers of the risks of replacing existing life policies with new policies, and three of them may have breached their legal obligations.

The FMA focussed upon replacement insurance policies as a particularly high-risk transaction for customers, because of the risk of claims being declined in the future and original policy benefits being lost. Even where the impacts on policyholders are neutral, the FMA was concerned that replacement of policies benefits the QFE rather than the customer.

The FMA was particularly concerned that the vertically integrated product sales model that many QFE insurance providers employ creates an inherent conflict of interest. The FMA considered that this sets QFE advisers up to fail in complying with their obligations, even if they do not receive commission based remuneration. The FMA said that it will continue to use its regulatory tools to monitor conduct, sales and advice practices and commissions structures in QFE insurance providers.

The key findings in the report were the following:

- Most firms had processes to identify when a customer was being advised to replace life insurance. However, these seemed oriented towards reducing the provider's legal risk, rather than risks for customers.
- Fewer than half of the firms reviewed advised customers that replacing their life insurance could lead to worse cover or the potential loss of benefits.
- Although firms use specific "replacement business forms", these were used mainly as a risk management tool for insurers at the

end of the advice process, not to help customers' decision-making.

- Only one of the insurance providers reviewed had an independent process to distinguish between new and replacement business.

Australian Royal Commission's Interim Report

At the time of writing, the Australian Royal Commission has just released an Interim Report following the first four rounds of public hearings held between March and July this year, focussing on misconduct in the banking and financial adviser sectors.

The FMA and RBNZ have been awaiting the Interim Report before they report on their review on New Zealand Banking Conduct and Culture, which is expected towards the end of October.

Although the Australian Royal Commission's Interim Report does not cover the insurance round of hearings that have been held more recently, it will nonetheless be used by all financial institutions, including insurers, to continue to further guide the improvements in their own practices and procedures that have already begun.

The Interim Report is lengthy, comprising three volumes. Its findings make sobering reading. In answer to the question – "Why did this misconduct happen?" the Commission suggests that the answer is: *"Too often, the answer seems to be greed – the pursuit of short term profit at the expense of basic standards of honesty."* In answer to the question "How did it happen?" the report says that:

"Banks and all financial services entities recognised that they sold services and products. Selling became their focus of attention. Too often it became the sole focus of attention. ..From the executive suite to the front line, staff were measured and rewarded by reference to profit and sales.

Where misconduct was revealed, it either went unpunished or the consequences did not meet the seriousness of what had been done. The conduct regulator, ASIC, rarely went to court to seek public denunciation of and punishment for misconduct. The prudential regulator, APRA, never went to court…"

We anticipate that the Australian regulators will become much more proactive in taking enforcement action for misconduct in future.

FMA review

In New Zealand, Rob Everett, the CEO of the FMA, recently stated (in his speech to the September 2018 Conference of the Financial Services Council and Workplace Savings NZ) that:

"We are still learning on the job and we appreciate that the industry is too. We have however signalled that while we are proud of the efforts we have made to engage with and set out our expectations for the industry, we are also frustrated in places with the slow pace of change. That frustration will manifest itself over time as we become less understanding and less tolerant of firms that talk a good game but don't put the hard yards in to make sure it happens."

It can be safely assumed that financial services providers that do not take heed of the regulators' warnings and make changes to meet expected standards of conduct will run the risk of attracting the FMA's critical scrutiny and potentially regulatory action.

What insurers should be doing

Insurers are taking heed of these warnings. They are using the FMA's findings, as well as the misconduct identified during the Australian Royal Commission hearings, to guide improvements in their own practices and procedures. The need to change historical sales driven business models to more customer-centric models is becoming widely accepted. The financial adviser regime reforms soon to be introduced with the passing of the Financial Services Legislation Amendment Bill will also assist to drive cultural changes within the financial services industry, including in the insurance sector.

It is imperative that insurers and intermediaries ensure that their business processes and culture are fully aligned to the FMA's view of good conduct, as set out in its updated Guide to the FMA's View of Conduct in February 2017. The five "building blocks" of these good conduct principles are:

- **Communication:** Listen to customers and help them understand your products and services.
- **Capability:** Have the skills and experiences to provide the right products and services. Meet professional standards of care. Seek continuous improvement through training.
- **Conflict:** Serve business and customer interests. Disclose and discuss conflicts. Explain related party arrangements.
- **Control:** Maintain systems to support good conduct. Seek out continuous improvement. Effectively manage complaints.
- **Culture:** Act in the interests of customers. Treat customers honestly and fairly. Conduct expectations communicated clearly by leaders and understood by staff. Address poor conduct and recognise and reward good conduct.

Jeremy Muir
Partner

Kara Daly
Special Counsel

Andrew Horne
Partner

Zane Kennedy
Partner

Stacey Shortall
Partner

Neil Millar
Partner

Lloyd Kavanagh
Partner

Jeremy Muir
Partner

Oliver Meech
Partner

Kara Daly
Special Counsel

Nick Frith
Senior Associate

For more information, please contact us:
covertocover@minterellison.co.nz
minterellison.co.nz

MinterEllisonRuddWatts

MINTERELLISON.CO.NZ