COVER TO COVER

MAGAZINE FOR THE NEW ZEALAND INSURANCE MARKET

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MinterEllisonRuddWatts

Welcome to the final edition of Cover to Cover for 2017

We are investing in an artificial intelligence legal start-up focusing on the automated legal review of documents to assist our work.

We lead with coverage of how Insurtech is changing the face of the insurance market. There has been increasing media coverage of smart technology in the financial services sector and it is permeating all areas of the insurance value chain.

Smart technology will no doubt become an integral part of the insurance lifecycle – from policy review and comparison to claims management. We see significant opportunities for insurers and brokers to utilise smarter and more efficient technologies in all areas of their businesses. As with all new developments, industry players will need to keep an eye on their legal obligations and we discuss the key issues in this edition.

Indeed, we are investing in an artificial intelligence legal start-up focusing upon the automated legal review of documents to assist our work. There is no reason in principle why this could not occur in the insurance industry and we see this happening in the future.

We also discuss how insurers deal with Privacy Act information requests. We provide guidance on the key questions that insurers face, including the kind of information that must be provided, information that can be withheld and how insurers should prepare to enable them to meet their obligations.

In the Canterbury earthquake context, we analyse the recent High Court decision in *Xu v IAG*, which deals with assignments of the proceeds of insurance claims and applies the 1990 Court of Appeal decision in *Bryant* (which we discussed in this year's first issue of Cover to Cover). We also cover an interesting case involving the need to prove the cause of damage, which is reassuring for insurers in claims where there is unsatisfactory evidence of the cause of damage.

Finally, we discuss an Australian non-disclosure case relevant to the New Zealand market and contrast this case with an earlier New Zealand Court of Appeal decision on the same topic.

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

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Insurtech | Disruption is inevitable - are you ready?

While FinTech innovation has been the flashy attention grabber over the last few years, Insurtech has had a somewhat lower profile and slower rate of growth. This is set to change as the traditional business models of insurers are increasingly challenged by digital disrupters, and digital transformation in the insurance sector becomes an imperative.

Insurtech is the fusion of technology and business models to enable, enhance and disrupt the provision of insurance services, and it is becoming a key growth driver for early adopters worldwide. At its heart is the ability to enhance the customer experience, making buying insurance, paying premiums and making claims, easier than under traditional business models.

Innovative Insurtech solutions provide an ability to enhance business operations and scale rapidly, presenting a risk (including possible market share erosion) to insurers that are slow to adapt to digital business solutions.

However there are inherent risks in technology driven solutions, especially if a business' underlying infrastructure cannot cope with rapid growth, or change management strategies are limited or non-existent. Understanding and managing the relevant business and regulatory risks to your insurance business when developing Insurtech solutions, will therefore be an essential component of your digital transformation journey.

In this article we look at some of the innovations that are being adopted overseas and in New Zealand's insurance sector, as well as how New Zealand's regulatory regime responds to those innovations.

Market disruption

Disruption in the insurance market is inevitable. New Zealand has already seen the rapid impact of FinTech in the financial services sector, and insurers can certainly take cues from the banking industry, which has encountered similar disruption.

New entrants providing technology driven insurance solutions are putting impetus on insurers to adapt to these technological advancements. The ability for technologically savvy start-ups to develop innovative business solutions and customise those solutions for the regulatory environment in different jurisdictions, is intensifying competition between traditional insurance companies, established technology companies and start-ups.

In New Zealand, Cyber Indemnity Solutions (CIS) is one such new entrant. CIS recently announced a new cyber insurance product, has now launched in Australia, and expects to expand further internationally. CIS used New Zealand's scale and expertise in programming to test their product (which provides digital asset protection insurance) in a micro space. CIS is not a licensed New Zealand insurer. Instead, it licenses insurers to use its policies (which includes a cyber insurance product), systems and software. Insurer partners can embed the insurance policy content into their own cyber policies and/or provide it concurrently with their policy offerings.

Established insurance companies are also investing in Insurtech solutions. Sovereign has recently announced that it has created a cloud data centre through Amazon, capable of powering "innovations, integrations and automations" for Sovereign and its customers. In practice, a cloud data centre can be scalable to a business' needs, and when coupled with an integration suite, can produce customer centric, data-led experiences in various forms (including through applications and platforms).

Globally, Insurtech is appearing in various guises with start-ups targeting all areas of the insurance value chain. These include, for example:

Planning and preparation are essential to performing strongly in an Insurtech market.

- data analytics and developing risk analysis programs (e.g., using algorithms to more accurately assess a customer's risk profile, policyholder behaviour or for more precise insurance pricing);
- industry-specific technology (e.g., technology that helps farmers to farm better, reducing their overall risk);
- bespoke policies (including on demand, event-specific insurance policies or insurance for digital businesses);
- smart contracts (i.e. programs using distributed ledger technology to facilitate the automated performance of contractual obligations (e.g. for assessment and payment of claims) without the need for human intervention);
- establishing centralised claims platforms (that can be accessed by companies, insurers and insurance brokers to manage claims more efficiently); and
- aggregator services using algorithms that assess an applicant's insurance need, and match an insurer's product to that need.

In addition to the above Insurtech uses, there are examples of start-ups looking to remove the need for a traditional insurer altogether by using peer-to-peer business models. A peer-to-peer business model allows insureds to pool their capital, self-organise and self-administer their own insurance.

Be prepared

Planning and preparation are essential to performing strongly in an Insurtech market. Identifying and managing the risks presented by Insurtech will be a key aspect of any digital transformation project. Insurers that develop clear growth strategies that incorporate technology driven, customer-centric solutions, that use technology to strengthen their identity (ensuring cultural identity and brand are not compromised), and that have a keen understanding of the regulatory framework and risks, will be better positioned to provide sustainable business models.

Regulatory considerations

Regulatory ambiguity is perhaps one of the biggest challenges facing regulators in this area. Insurance legislation written as recently as 7 years ago did not anticipate the way technology would be developed and applied in today's market. Ultimately, regulation will need to evolve to ensure the right balance between policyholder protection and encouraging innovation.

Below is a brief summary and some observations of the key legislation affecting the provision of insurance in New Zealand:

Insurance (Prudential Supervision) Act 2010 (IPSA)

- The IPSA is the primary Act regulating insurance business in New Zealand. Its primary purpose is to promote the maintenance of a sound and efficient insurance sector and promote confidence in the insurance sector. The Reserve Bank's current review of IPSA presents a timely opportunity to future proof the Act to accommodate technological innovation, and the Reserve Bank has indicated a willingness to do so, consistent with its aim of promoting cost efficiency in the insurance sector.

  IPSA focuses on legal entities carrying on the business of insurance in New Zealand and places minimum governance, capital adequacy and solvency obligations on the licensed insurer as a legal entity. IPSA will therefore capture all significant insurance activity carried on by such licensed insurer entities, including services provided through technology-based innovations. In addition, the broad definition of "contract of insurance" under IPSA could arguably include innovative new contracts including smart contracts using artificial intelligence and distributed ledger technology, as long as the contract involves, among other things, the transference of risk in accordance with the definition.

  However, areas where IPSA could benefit from 'future-proofing' amendments include:

  - the *"carrying on insurance business in New Zealand"* test: This test is linked to companies that are required to be registered (including as overseas companies) under the Companies Act 1993. The issue of territorial reach is relevant here, when overseas-based entities may offer digital insurance services from an offshore jurisdiction, without triggering the requirement to register as an overseas company under the Companies Act;
  - *licence conditions and risk management provisions:* The scope of these should reflect specific risks associated with providing Insurtech innovations. Sensible amendments would include incorporating new licence conditions that relate to insurance services through an automated platform, or a requirement to include, for example, procedures for managing risks associated with Insurtech in a licensed insurer's risk management programme (e.g. cyber risk and change management risks); and
  - *adopting a broad exemption regime:* Allowing the Reserve Bank to issue class or individual exemptions from aspects of the regime or from the requirement to be licensed, making it easier for new entrants and traditional insurers to bring innovative insurance solutions to the market as they emerge.

> The draft Code is still being written, so it is not yet clear how robo-advisory services will be monitored and assessed under the new Code.

New financial advisers' regime

- The Financial Services Legislation Amendment Bill (currently before Parliament), repeals the Financial Advisers Act 2008 (FAA) and will move the relevant financial adviser provisions into the Financial Markets Conduct Act

2013. The new regime will enable the provision of "robo-advice" or digital advice services (including advice on insurance products), establishing new standards of conduct and governance that will take into account the provision of advice through both traditional and digital channels. Specifically, the new regime:

- will require insurers providing a financial advice service to retail clients to be licensed as a "Financial Advice Provider";
- will enable Financial Advice Providers to be licensed to provide digital financial (as the requirement for a human to provide personalised advice will be removed); and
- will introduce a new Code of Conduct (Code) which will set standards of professional conduct for those providing regulated financial advice (including for "robo-advisers").

The draft Code is still being written, so it is not yet clear how robo-advisory services will be monitored and assessed under the new Code. However maintaining the standards of consumer protection provided by the legislation while encouraging providers to harness emerging technologies, will likely be a key objective of the Code Working Group (the group tasked to establish the Code).

In addition to the Code, the conditions that the Financial Markets Authority (FMA) will likely impose on a robo-advice licence may include strict governance and disclosure obligations on Financial Advice Providers offering advice via a robo-advice platform. The Australian Securities & Investments Commission's (ASIC) guidance for digital-advice licensees provides some indication as to what licensees might expect under the new regime. ASIC's expectations in respect of digital advice licensees include (among other things):

- a requirement for the financial advice provider to have at least one responsible manager who meets the minimum training and competence standards;
- to ensure there is at least one person that has an understanding of the technology and algorithms used to provide digital advice;
- to conduct regular reviews of the digital advice generated by algorithms to ensure it is legally compliant;
- to ensure the business has sufficient technological resources to maintain client records and data integrity, and to protect confidential information;
- to establish and maintain adequate risk management systems; and
- to assess cyber security using recognised frameworks.

Principle 5 (storage and security of personal information) is especially critical as insurers now have access to ever-increasing quantities of policyholder data.

Class exemption for robo-advice

- A class exemption to enable digital-advice under the existing FAA regime, prior to enforcement of the new financial adviser regime, is currently under consultation by the Financial Markets Authority (FMA). The exemption will enable the provision of robo-advice by removing the requirement for personalised advice to be provided by a natural person. To address the risks posed by the scalability of digital advice (i.e. poor outcomes could affect a larger number of consumers), the FMA has proposed various limits and conditions. These include:

Importantly, based on the FMA's indicative timing, the exemption anticipates the ability to provide digital-advice in New Zealand by late 2017, supporting the growing demand for digital-advisory services.

- limiting the exemption to products which are easy to exit (including, for example, general insurance products such as home, contents and vehicle insurance). The FMA has omitted personal insurance products – such as life, health and income protection – from the types of products that would be covered by the exemption, on the grounds that such products cannot always be easily exited, and the consequences of failing to disclose material information are high. FMA has sought submissions on this approach, suggesting that personal insurance products could be included in the exemption, provided they are subject to a value cap or duration limit; and
- providing disclosure tailored to robo-advice and maintaining appropriate expertise to provide the personalised robo-advice service.

The FMA has indicated that the requirements under the exemption may be different from those that will finally apply once the law reform takes place. Importantly, based on the FMA's indicative timing, the exemption anticipates the ability to provide digital-advice in New Zealand by late 2017, supporting the growing demand for digital-advisory services.

Financial Markets Conduct Act 2013 (FMCA)

- The FMCA, which regulates the

offering of financial products in New Zealand, is a modern Act designed to be flexible and to encourage innovation in the market. The fair dealing provisions under part 2 of the FMCA apply to persons providing a financial service (which includes "acting as an insurer"). The provisions (which include the obligations not to engage in conduct that is misleading or deceptive, or make a false or misleading representation, in respect of a financial service) are broad and will apply to insurance services provided through both traditional channels and via online platforms or mobile applications.

- These fair dealing provisions, together with the financial adviser regime discussed above, provide the FMA with oversight over the way in which insurance products are marketed and sold. The FMA has already signalled that it will be looking closely at life insurance sales and advice. With the added complexity, and potential risk around digital sales channels, we see it as a real possibility that the FMA will focus on Insurtech innovation and compliance with the fair dealing provisions of the FMCA.

Privacy Act 1993

- While the twelve privacy principles in the Privacy Act apply broadly to any personal information collected by an insurer (including any third party platform provider), advances in technology have dramatically changed how information is collected, stored and shared. Principle 5 (storage and security of personal information) is especially critical as insurers now have access to ever-increasing quantities of policyholder data.

The Privacy Commissioner has recently recommended changes to the Privacy Act and a new Privacy Bill is expected to be introduced this year (although timing is currently unclear). The recommendations are based on rapid changes in data science and information technology in the five years since the last review and, if adopted, could mean, among other things, an increase in the penalty for a serious or repeated breach of the Privacy Act to a fine of up to NZ$1 million for body corporates. Additional guidelines for data use are being developed by the New Zealand Data Futures Partnership, which is currently consulting the New Zealand public in relation to how information about them is used and shared.

Enforcing stricter penalties and narrowing defences under the new Privacy Bill will go some way to ensuring companies invest heavily in security and data management. However consideration should also be given as to whether more prescriptive regulation is needed in respect of technical / organisational measures – including, for example, in relation to data transferability between providers, IT management, cyber security and internal controls for outsourcing services.

Conclusion

Increasingly, there is an impetus on insurers to compete against, and/or work with, new entrants and established technology companies to improve customer engagement through technology, and to digitise certain back-office functions to create more efficient and nimble business models.

While existing laws and regulation have tended to lag behind technological developments, there is an increasing awareness and acceptance by regulators of the need to accommodate technological innovation in the delivery of business products and services. Awareness of changes in the way in which regulation applies in this new environment must be maintained as a key developer and user requirement at all stages of the digital transformation journey.

If you would like further information regarding Insurtech, or would like advice on the application of relevant legislation to your business, please contact one of our insurance experts.

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Insurers and Privacy Act requests

Insurers have experienced a recent surge in Privacy Act requests from homeowners with unresolved claims arising from the Canterbury earthquakes. Some requests coincided with the impending expiry of the time limitation extension to 4 September 2017 agreed by the insurers who are members of ICNZ. Others appear to be an inexpensive means to gather evidence for proceedings or complaints.

In this article, we consider some issues that commonly arise in Privacy Act complaints against insurers.

What may insureds ask for?

Insureds who are natural persons (companies have no such rights) are entitled to access their "personal information" held by insurers on request, without giving a reason. There is no particular form for a request and it does not have to be in writing or mention the Privacy Act to be effective.

Insurers must provide a decision on whether to grant the request within 20 working days and must then process the request without undue delay.

What information must be provided?

Personal information is information "about an identifiable individual". This is interpreted broadly.

In Case Note 228045 [2012] NZ PrivCmr 8 the Privacy Commissioner ordered an insurer to disclose an engineering report about an insured person's house. The report did not name the insured, but that person could be identified because the report referred to the "property owner", contained the property address and described the damage it had sustained. The report was "about" the insured because it related to the insured's house.

When considering what documents to provide in response to a request, insurers should consider whether they contain information that could identify the insured and whether they relate to the insured person or his or her property.

Insurers should also check their privacy policies to ensure they are not acting inconsistently with them.

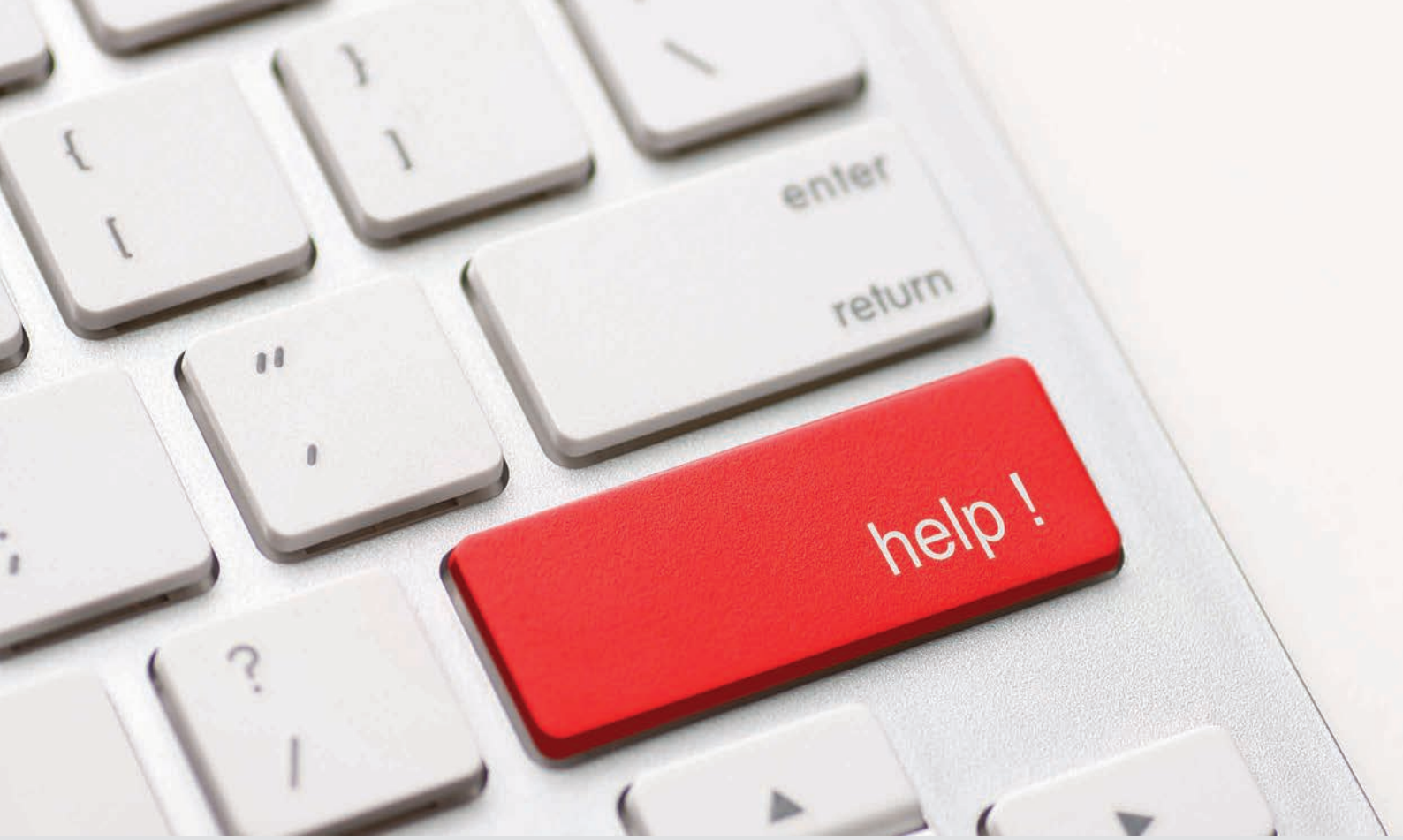
Do insurers have to provide all the documents in their file?

Insureds will often request a copy of the insurer's "file". This can exceed the insured's entitlement under the Act, as most insurers hold personal information and non-personal information in a range of formats and locations associated with an insured or a claim.

If an insured requests the "file", insurers are entitled to review the file and provide only those documents that contain personal information about the insured.

What about emails, phone call logs and recordings and other records not in a "file"?

This depends upon the request. If an insured requests a "file" for a



particular claim and the insurer has a system that manages and stores its records for that claim, such as a hard copy file or a computer based file, the insurer may take the view that the request relates only to that "file".

However, if the request appears to encompass all documents relating to a claim, the insurer is obliged to provide access to all documents that it holds that contain personal information about that insured, whichever form they are in.

An insurer's documents may not extend to documents held by its employees in their personal capacity, such as text messages on personal telephones and diaries that are their personal property.

What information can be refused?

Insurers may refuse to disclose, or may redact, information that is protected by legal professional privilege. This generally falls into two main categories:

- Solicitor-client privilege, which in summary protects documents sent or received by lawyers for the purposes of obtaining legal services or advice;
- Litigation privilege, which in summary protects documents prepared for the purposes of a proceeding (not just documents sent or received by lawyers) that is reasonably apprehended. Normally this requires the claim having been declined - claims which involve a difficult relationship between the insured and the insurer do not necessarily meet the "reasonably appended" test. In February 2015, the Privacy Commissioner decided that an insurance company could not rely on litigation privilege to withhold an investigation report, as the dominant purpose of the report was to set out the details of the incident that gave rise to the claim and advise the insurance company whether to accept it (Case Note 248835 [2015] NZ PrivCmr 5). A proceeding was not reasonably apprehended until the insurer had made its decision based on the report.

Another ground to withhold a document is that it contains information that would disclose a trade secret or be likely unreasonably to prejudice the commercial position of an insurer. In the insurance context, this may include information about claim reserves, the method by which an insurer calculates the level of reserves to pay out on a claim, and estimates of costs. EQC will generally release cost estimates, although there are circumstances in which it will not, primarily where commercial negotiations for repairs are occurring.

Insurers can refuse to provide evaluative material if that would breach an express or implied promise to keep the material confidential. The Privacy Act recognises that evaluative or opinion material used for the purpose of deciding whether to insure or renew insurance for an individual or property qualifies as "evaluative material".

What about draft documents?

Draft documents may expose information that an insurer decided not to pass to an insured or may otherwise reveal a weakness in its position. There is no special protection for draft documents and they must be reviewed on their own merits and disclosed if they contain personal information that cannot be withheld for a recognised reason, such as solicitor-client privilege.

What about consultants' documents held on their files?

Insurers may instruct loss adjustors and other consultants who will have additional documents on their files that contain personal information.

The Privacy Act applies only to documents that an insurer "holds", but this is interpreted widely. The Human Rights Review Tribunal has decided that an agency holds information that it controls, whether or not that information is in its physical possession.

Insurers are therefore obliged to provide personal information held by a consultant where the insurer is entitled to that information. In most instances, however, the consultant will have provided the insurer with all the information to which it is entitled, such as a final report. A consultant is not normally obliged to provide an insurer with other information. In the context of professionals such as accountants and lawyers, the usual test is whether the document was intended to become the property of the client and does not extend to internal records, notes and draft documents.

May an insurer charge a fee for providing a file?

Insurers may impose a reasonable charge for responding to a Privacy Act request, which may reflect the urgency requested by the insured.

An insurer may charge for the costs of material and labour for time spent locating the relevant material, collating, transcribing and copying it. However, an insurer may not charge for the time spent deciding whether to disclose particular information, such as a legal review.

The Privacy Commissioner[1] and Human Rights Review Tribunal[2] have endorsed the Ministry of Justice's Charging Guidelines for Official Information Act 1982 Requests dated 18 March 2002 as a useful starting point. The guidelines provide that the first hour of staff time and 20 pages of photocopying should normally be free and then charges of $38 per half hour and 20 cents per page (GST inclusive) apply.

What about EQC?

Insureds may make Privacy Act requests to EQC. They may also make requests for information from EQC under the Official Information Act 1982, which does not apply to private insurers.

Who enforces the Privacy Act?

Persons who wish to complain that an insurer has failed to provide information that it is obliged to provide under the Privacy Act may complain to the Privacy Commissioner. The Privacy Commissioner has limited powers and normally seeks to resolve complaints by agreement.

In serious cases, the Privacy Commissioner or the insured person may refer a complaint to the Human Rights Review Tribunal, which may make orders and award damages for breaches of the Privacy Act. Such cases normally involve circumstances in which sensitive personal information such as medical information has been disclosed in a way that has harmed an individual.

How should insurers prepare for Privacy Act claims?

Insurers may prepare to respond to Privacy Act claims by:

- ensuring that their staff do not record statements or information that would be harmful or embarrassing if provided to an insured
- keeping commercially confidential information in a separate location or file
- having an efficient system for managing client files which includes relevant emails, contact notes and records of telephone calls
- deleting any unnecessary files and records

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1 *Case Note 204595* [2009] NZPrivCmr 14 (October 2009).
2 *Director of Human Rights Proceedings v Schubach* [2015] NZHRRT 4 (19 February 2015).

Buyer beware:

Xu v IAG and the assignment of insurance claims

The recent High Court decision in *Xu & Diamantina Trust Limited v IAG New Zealand* [2017] NZHC 1964 confirms a longstanding rule that when a damaged building is sold and the insurance claim is assigned to the purchaser, the purchaser is entitled only to indemnity value, not replacement value. The decision follows the leading Court of Appeal decision recording this principle, *Bryant v Primary Industries Insurance Co Limited* [1990] 2 NZLR 142 (CA).

The decision is reassuring for insurers that are facing an increasing number of claims by purchasers under former owners' policies. However, the decision has attracted criticism from those who consider that the rule is unfair to insureds and purchasers as it allows insurers to avoid paying for repairs for which they would have been liable had the property not sold.

The decision

The Court's decision confirms that where the owner of a damaged building insured on a "replacement value" basis assigns its insurance claim to the purchaser, the purchaser will not normally enjoy the seller's entitlement to replacement value. Instead, the purchaser's claim is likely to be limited to indemnity value, which will often be significantly less. The difference may be particularly significant where the building is old or in poor repair and its value or the cost of repair to its pre-damage standard is considerably less than the cost of replacement or repair to an "as new" standard.

In this case, IAG insured a residential property which was damaged in the Canterbury earthquakes. The policy required the insured to restore the home in order to receive the actual costs of restoration. The insured took no steps to restore it but instead sold it and assigned its rights to pursue the insurance claim to the purchaser.

The High Court confirmed that an insured may assign an insurance claim if it constitutes an entitlement to be paid a debt due from the insurer under the policy. However, on the terms of that policy, which required the insured to restore the home in order to be entitled to the actual costs of restoration, the insured was not entitled to assign the right to actual restoration costs. As the insured had sold the home, the insured would never restore it. It did not matter that the purchaser intended to restore it because the right to restore and receive the actual restoration costs was personal to the insured and could not be assigned.

This decision will be welcomed by insurers who have sought reassurance that the courts will follow the rule in Bryant and will not oblige them to pay replacement value to an assignee who is not their insured.

Appeal or law change?

The Court of Appeal has registered that an appeal has been filed so the previous decision of the Court of Appeal in *Bryant* will be reconsidered and it is possible that a different approach may be taken.

The policy reasons behind restricting the assignability of "replacement" policies begin with the issue that replacement policies are not wholly consistent with the fundamental insurance principle of indemnity, which says that an insured should not be put in a better position as a result of the event that caused the loss. A replacement policy will often put the insured into a better position than they were in before the loss because they receive a new house that is worth more than the old one, or repairs that improve the damaged parts of the house to an "as new" standard.

When an insured elects not to rebuild and instead assigns the insurance claim to a purchaser, the insured does not wish to have their house back or a new or repaired house in its place. The insured has sold the house, presumably for its unrepaired market value plus the value of the insurance claim. If the insurance claim is valued on an indemnity basis, whether assessed as the market value of the house or the cost of repairing it to its pre-damage condition, the insured should receive a total amount that is equivalent to the market value of the house before the damage occurred. As the insured receives the market value of the house, which is the amount that a seller would expect to receive in the usual course, it is compensated fully. Similarly, the purchaser has paid actual market value so it is not prejudiced.

If the insurer was to pay the purchaser an amount representing replacement value, the purchaser would arguably receive a windfall, because it will have paid market value for a damaged house which it has then been able to improve at the insurer's expense. The market value of the house once repaired may exceed the amount that the purchaser paid.

Insurers are reluctant to accept assignments of replacement value claims because they enter into contracts of insurance cautiously and reject prospective insureds who they consider untrustworthy, such as those who have had insurance claims declined or who have convictions for insurance fraud. Insurers are resistant to being compelled into an ongoing relationship with an assignee who wishes to step into an insured's shoes and manage a building project in which the project and its costs need to be managed honestly and fairly.

There are, however, criticisms of the approach in Bryant and Xu. If an insured elects to rebuild a house that was insured on a full replacement basis, they may receive a windfall if they subsequently sell it. The windfall may be substantial where the original house was old or in poor condition and is replaced with a new, modern house that is worth substantially more. Arguably, the insured should be entitled to the same or an equivalent outcome notwithstanding that they do not wish to rebuild the house themselves but wish to purchase another house instead. This is particularly the case where the policy, as some do, entitles the insured to rebuild at another location. Some insureds, such as elderly people or families with young children, are not well placed to manage a building project.

Insurers are reluctant to accept assignments of replacement value claims because they enter into contracts of insurance cautiously and reject prospective insureds who they consider untrustworthy.

From an insurer's perspective, however, an insured that wishes to sell is compensated fully by a payment of indemnity value because they should receive the full market value of their house. Insurers view replacement value policies as existing only to address the problem that arises when insureds are unable to repair or rebuild their houses for indemnity value, leaving them out of pocket or without an ability to restore what they had before in terms of a functional house. The purpose of a replacement value policy is to enable the insured to receive back the functional equivalent of their former house, which inevitably involves the insurer paying for improvements. Insurers may view this as unnecessary where the insured sells the house because they have elected not to restore it.

One option for insureds or purchasers is to request confirmation from their insurers prior to a sale that they will afford a purchaser the same rights under a replacement policy as the insured. Insurers may be willing to agree to this if they are satisfied that a purchaser is an appropriate customer.

While changes are possible, for the meantime, the High Court's decision in Xu provides a level of certainty that replacement value claims cannot be assigned other than for indemnity value. Those affected by this rule would be well advised to either restore the affected property themselves or request an assurance from the insurer that a purchaser will be afforded that right.

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Pre-existing damage defeats earthquake claim

Sadat v Tower Insurance Limited [2017] NZHC 1550

The High Court has rejected a claim by homeowners against their insurer and EQC for earthquake damage arising out of the 4 September 2010 Canterbury earthquake on the basis that the home had extensive pre-existing damage.

The case demonstrates that, where there is pre-existing damage, an insured must prove that an insured event caused damage that materially added to any pre-existing damage.

Background

In 2006 the Sadats purchased their home in the Hoon Hay suburb of Christchurch. They insured their home with Tower.

In 2008, the Sadats attempted to sell the property. A prospective purchaser arranged for a building inspection of the home that revealed there had been significant subsidence to the foundations, sloping floors and significant cracks in the exterior. As a result, the sale did not proceed and the Sadats retained the house.

In August 2010, the Sadats made an insurance claim for damage caused by water leaking from the kitchen waste under the house. The assessor noted and reported extensive cracking to the foundation and cladding and significant cracking on interior walls. Tower declined the claim on the basis the policy excluded the damage because it was gradual damage and damage from subsidence.

The first Christchurch earthquake struck on 4 September 2010. The Sadats lodged claims with Tower and EQC for earthquake damage. EQC was not made aware of the reports from 2008 or August 2010 that identified significant existing damage and defects. EQC paid a total of $43,621.41 in settlement of the Sadats' claim.

Based on the August 2010 report, having determined that the property was a poor risk, Tower cancelled the policy with effect from 26 January 2011. As a result, the Sadats did not have any cover for the damage caused to the house by the subsequent Canterbury earthquakes.

The Sadats' claim

The Sadats filed proceedings against Tower in the High Court for the full replacement value of the property, estimated at $864,214.15. They also claimed general damages of $50,000 for anxiety and emotional distress. As against EQC, the Sadats claimed $70,263 and general damages of $50,000.

Tower and EQC both denied liability on the basis that the Sadats could not establish there was earthquake damage to their home that was materially different from the damage it had already sustained before the September 2010 earthquake.

The Court heard evidence from the parties' geotechnical and engineering witnesses. Based upon the geotechnical evidence, Justice Nation was satisfied that the Sadats' home was built on land that was not strong enough to bear the load of the house and it was likely that there had been significant subsidence of the foundations at various times before the September 2010 earthquake. This was likely to have caused significant structural damage to the foundations before that earthquake.

Based upon the structural engineering evidence, the Judge was satisfied that it was likely that some damage had been done to internal wall linings and there may have been some slight increase in the extent to which the floors were out of level as a result of the September 2010 earthquake. However, the Judge found that the Sadats had failed to prove that the September 2010 earthquake had caused damage that was materially different to the damage that existed prior to the earthquake.

The decision

The defence for both Tower and EQC was that the earthquake damage was not material because it did not materially add to the pre-existing damage. The Sadats argued that the damage to their property caused by the earthquake was material because it affected the value of their home and it rendered it uninhabitable.

The defence for both Tower and EQC was that the earthquake damage was not material because it did not materially add to the pre-existing damage.

The Judge rejected both of these arguments, finding that any impact on the value of a property will not be relevant in determining whether there has been material damage, because a home insurance policy does not cover pure economic loss. Similarly, whether a home is habitable is not the test as to whether there has been damage that is covered by the policy. In any event, the measures required to deal with the underlying problem were the same after the earthquake as they were before and the evidence established that the Sadats' home remained habitable.

The Judge found that it would be inconsistent with the intended purpose of the policy to find that damage suffered in the September 2010 earthquake was material where such damage required no more work to be done than would have been necessary to repair the pre-existing damage before the earthquake.

Accordingly, neither Tower nor EQC were liable to the Sadats. EQC did not seek recovery of the payment they had already made to the Sadats.

There is a long-recognised principle arising in relation to indemnity policies that insurers are not required to cover insureds for damage where the damage was caused predominantly by excluded causes and less so by insured causes. The Sadat judgment lends support to this line of authority in the context of "as new" replacement value policies.

Underinsurance

If the Sadats had succeeded, there would have been an issue of under-insurance. The house was insured for an area of up to 120m2 whereas its actual area was 141m2. Tower argued that a pro-rata reduction of the rebuild costs when a house is under-insured was appropriate. While Justice Dunningham recently approved this approach in *Myall v Tower Insurance Limited* [2017] NZHC 251, Her Honour made it clear that this would not necessarily be appropriate for smaller houses where proportion-ately more of the cost would be required to provide items that are not affected by floor area, such as kitchen appliances. (Every house needs an oven and its size does not diminish by reference to total floor area.) In Sadat, the Judge did not reduce the claim for the cost of items which would be unaffected by floor area and applied a pro-rata reduction only to items that would be affected. This is likely to be instructive as to how the Courts will assess rebuild costs for under-insured homes.

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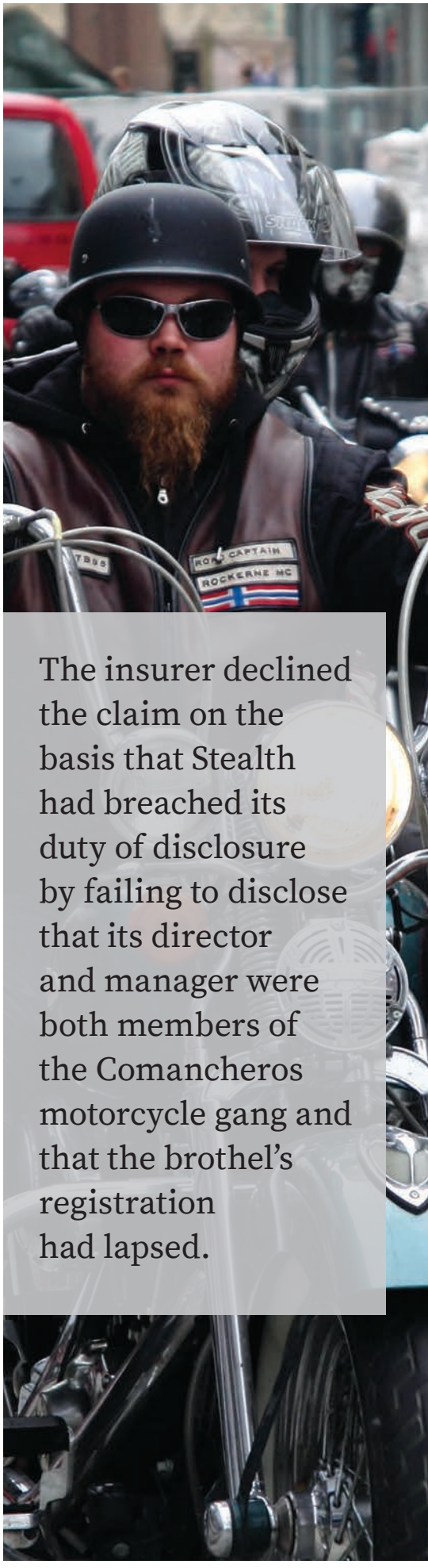
Motorcycle gangs and non-disclosure

A recent case in Australia and an older case in New Zealand address issues of non-disclosure where insureds fail to disclose their motorcycle gang connections.



Stealth Enterprises

In *Stealth Enterprises Pty Ltd t/as Gentleman's Club v Calliden Insurance Ltd* (2017) 19 ANZ Insurance Cases 62-131, the New South Wales Court of Appeal held that a failure by the insured "gentlemen's club", Stealth, to disclose its managers' gang affiliations was not a breach of its duty of disclosure to its insurer.

Stealth operated a brothel that it insured under what was described in the judgment as an Adult Industry Insurance policy. The brothel was damaged by fire on New Year's Day 2012. The insurer declined the claim on the basis that Stealth had breached its duty of disclosure by failing to disclose that its director and manager were both members of the Comancheros motorcycle gang and that the brothel's registration had lapsed.

The Court considered the insureds obligations under section 21 of the Insurance Contracts Act 1984 (Aus) which provides that before entering into a contract of insurance an insured must disclose facts that it knows or that a reasonable person ought to know would be relevant to an insurer's decision to accept the risk. The Court held that Stealth had not breached this duty, as the insurer had not specifically requested information regarding memberships or associations in the insurance proposal. The Court held that a reasonable person would not have been expected to know that gang membership was relevant to the insurer's decision to insure a brothel because, although they may have associated gangs with violence and conflict, they would have also associated brothels with conduct of that nature. The Court held that violence and conflict was part of the risk of insuring a brothel.

It was also relevant that the insurer had issued a specialist adult industry policy. The Court viewed this as meaning that the insurer was prepared to take on the risk of insuring a brothel, which was a business of a character that attracted the risks of "arson, standover tactics, fights and dissatisfied customers" and a particular character of persons.

The Court accepted that Stealth's failure to disclose that its registration had not been renewed was a breach of its duty of disclosure. However, this omission was not intentional and the insurer had not established that if the lapse had been disclosed, it would not have issued the policy. The Court held that had Stealth made this disclosure, the insurer would have advised Stealth of the need to register and Stealth would have done so. The claim therefore succeeded.

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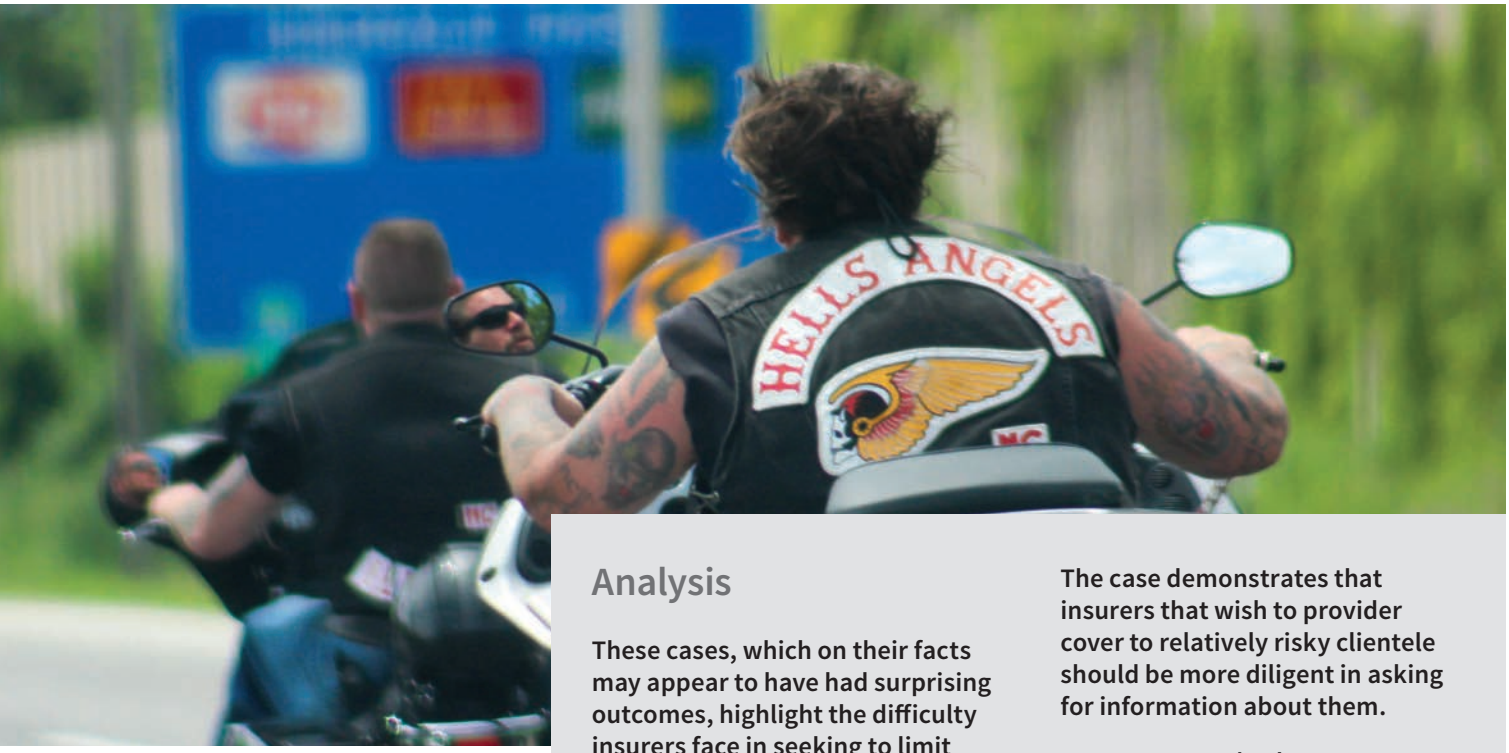

State v McHale

The New Zealand Court of Appeal has also addressed the insured's duty of disclosure in relation to gang affiliations in *State Insurance v McHale* [1992] 2 NZLR 399.

The McHales insured a residential property with NZI and did not disclose that it was let to members of the "Highway 61" motorcycle gang. The property was damaged by arson and was destroyed after the tenants moved out.

The insurer sought to avoid the policy on the basis that the McHales had breached their duty of disclosure. In New Zealand, insurers must prove that the insured failed to disclose material facts that they knew or ought to have known would have been relevant to a prudent insurer's decision to accept the risk.

The Court held that the issue of materiality was whether the tenants belonged to a group whose members were likely to behave or cause others to behave in a way that could cause damage to the property. The McHales knew the tenants were in a gang but denied any knowledge that this would increase the risk of damage to the property. The Court found that the insurer had not proved that the McHales knew or ought to have known that, as members of Highway 61, the tenants were likely to behave in such a way. The claim therefore succeeded.

Analysis

These cases, which on their facts may appear to have had surprising outcomes, highlight the difficulty insurers face in seeking to limit or avoid liability to insureds who insure property in the knowledge that they or the property are associated with persons with a disreputable reputation.

In Stealth Enterprises, the insurer faced the difficulty that it knowingly insured a business of a type that was widely known to attract disreputable persons. The insurer nevertheless called expert evidence to establish that the motorcycle gang was known to engage in activity likely to cause property damage or personal injury. Notwithstanding this, the insurer failed because it could not prove that the insured ought reasonably to have known that the involvement of the gang would have affected the insurer's decision to take on the risk, given that it was willing to insure adult entertainment businesses.

The case demonstrates that insurers that wish to provider cover to relatively risky clientele should be more diligent in asking for information about them.

In *State v McHale*, the Court accepted that there was nothing inherently material about an association with a motorcycle gang in itself and that the insurer had failed to establish that the insured knew that the tenants' gang association would increase the risk of damage to the property. With the rise of methamphetamine use and production in New Zealand residential properties which is often associated with motorcycle gangs, insurers may be increasingly cautious about the nature of tenants.

Both decisions reiterate the need for insurers to consider carefully what questions to ask insureds when assessing the risks that may arise from their associations.

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