New Zealand Insurance Update

December 2021

kpmg.com/nz/insurance

Contents

Foreword

Nick Moss Partner, Head of insurance

Our **New Zealand Insurance Update 2021** provides you with access to our KPMG Insurance Insights Dashboards which, for the first time, include the financial information of health insurers.

KPMG General and Health Insurance Insights Dashboard

KPMG Life Insurance Insights Dashboard

As well as our Insights Dashboards, the Update also provides insights into three important topics:

- ESG (Environmental, Social and Governance), with a particular focus on claims
- the power of claims-related data and how this can be harnessed through proper management and analytics
- an overview of the Conduct of Financial Institutions (CoFI) regime and how this should be approached holistically across an insurance organisation and not just seen as more regulatory change.

Our Insights Dashboards bring to life key financial information from insurers' filed financial statements through a range of interactive charts and graphs presenting key industry metrics, financial position and results up to 30 June 2021. We have published two Insights Dashboards – the KPMG General and Health Insurance Insights Dashboard includes financial information on all general and health insurers and the KPMG Life Insurance Insights Dashboard includes financial information on all life insurers.

On page 6, we summarise the information from the KPMG General and Health Insurance Insights Dashboard to provide an overview of these markets to 30 June 2021 and on page 10, we provide an overview from the KPMG Life Insurance Insights Dashboard.

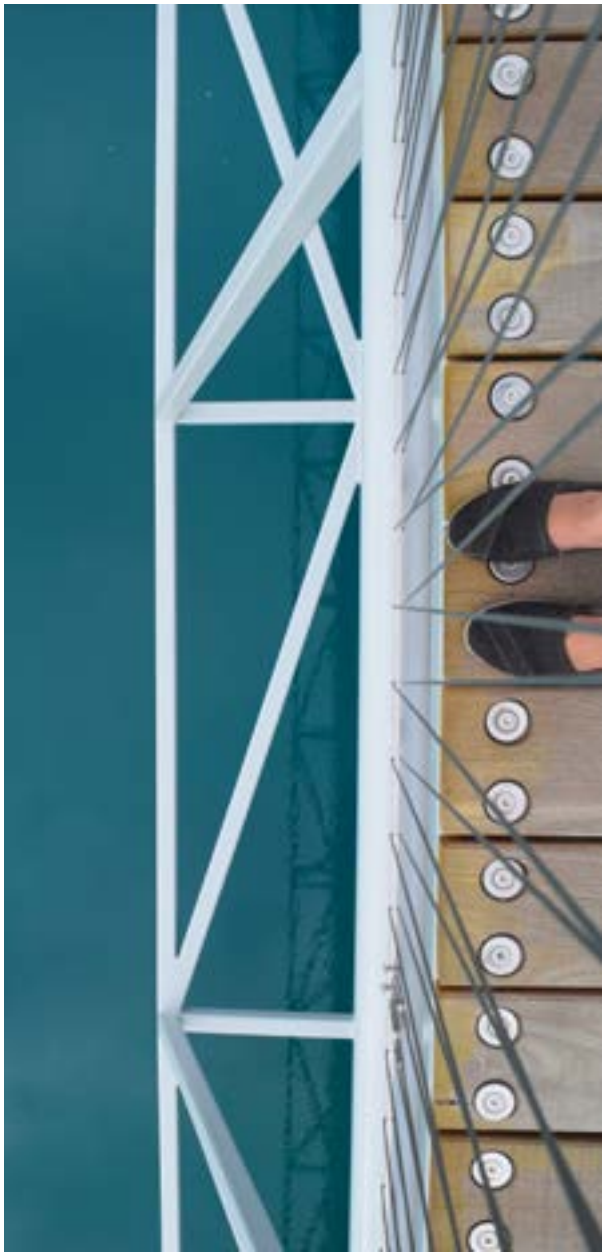
> We have never been more aware of the impact of business practices on our society and environment. Insurers are in a unique position to connect with a wide range of individuals and businesses to positively influence public behaviour concerning today's important social and environmental issues.

On page 13, Dr Charles Ehrhart and James Young-Drew outline a vision with strategies and decision-making to support a better ESG outcome for claims. Insurers hold huge amounts of data that can be amalgamated and leveraged to inform public policy and enhance loss prevention. In this way, insurers can be a real force for good in the fundamental shift required for the world to be truly ESG focused.

On page 18, Stephen Hastings and Alistair Evans focus on claims but with a view to unlocking the potential of claims-related data using analytics techniques. Businesses in every sector are pursuing game-changing digital capabilities to drive growth and success in a new era of customer-centric service and today's forward-looking insurers are no exception. They are exploring ways to maximise meaningful use of claims-related data, using analytics techniques and technologies that promise to optimise the client claims journey, and open new opportunities for efficiency and competitiveness. Data and analytics is just one of the forces that is transforming the claims function.

Financial service regulatory bodies and the general public are demonstrating less tolerance for financial institutions making mistakes or not taking a customer-centric approach. CoFI is being introduced to ensure good conduct is adhered to, not only in all customer interactions including those conducted through an intermediary, but also to govern how employees should act and behave in all business functions. On page 24, Hester Cutts and Adele Wallace set out how the work required for CoFI is best approached holistically across an insurance organisation to implement real, meaningful and sustainable organisational change.

On behalf of KPMG, we hope you enjoy the read. Please do not hesitate to contact the team at KPMG to assist your organisation in addressing any of the matters raised in this publication.



01

New Zealand General and Health Insurance Market: Results and analysis

New Zealand General and Health Insurance Market: Results and analysis

KPMG's 2021 New Zealand General and Health Insurance Insights Dashboard contains a range of interactive charts and graphs, presenting key industry metrics for the last five years and enabling the comparison of metrics for an individual insurer to others in the market.

KPMG General and Health Insurance Insights Dashboard

This year, for the first time, we have expanded our dashboard to include analysis on the health insurance industry.

General Insurance

The highlights

Overall, insurance profit decreased 4% from $2,147 million in 2019/20 to $2,061 million in 2020/21, compared to 3% growth between 2018/19 and 2019/20.

Results and analysis

The key contributors to the decrease in industry profit include:

- a net claims expense increase of 6% from $2,607 million in 2019/20 to $2,772 million in 2020/21.
- a gross written premium increase of 3% from $7,343 million in 2019/20 to $7,558 million in 2020/21. Overall net earned premiums increased 2%, largely consistent with gross written premium, from $4,755 million in 2019/29 to $4,833 million in 2020/21.

As a result of the increased claims experience, there has been a slight deterioration in loss ratios, with a market average of 57% in 2020/21 compared to 55% in 2019/20.

Overall, insurance profit decreased 4% from $2,147 million in 2019/20 to $2,061 million in 2020/21, compared to 3% growth between 2018/19 and 2019/20.

2021 Results snapshot

Gross written premiums

$7,558m	2021/21
$7,343m	2019/20
$7,045m	2018/19
$6,745m	2017/18

Net earned premium

$4,833m	2021/21
$4,755m	2019/20
$4,503m	2018/19
$4,199m	2017/18

Loss ratio

57%	2021/21
55%	2019/20
54%	2018/19
61%	2017/18

Insurance profit

$2,061m	2021/21
$2,147m	2019/20
$2,091m	2018/19
$1,651m	2017/18

Net incurred claims

$2,779m	2021/21
$2,607m	2019/20
$2,412m	2018/19
$2,548m	2017/18

The market increase in gross written premium can be attributed to the performance of some of the largest general insurers including:

- AA Insurance Limited, which had an increase of $97 million from $453 million in 2019/20 to $551 million in 2020/21;
- IAG New Zealand Limited, which had an increase of $77 million from $2,904 million in 2019/20 to $2,981 million in 2020/21; and
- Vero Insurance New Zealand Limited, which had an increase of $46 million from $1,140 million to $1,186 million.

Insurance Council of New Zealand (ICNZ) data shows a continued trend of higher natural disaster events, demonstrating how the impacts of climate change are becoming more visible. There were nine natural disaster events in the June 2021 year at a total cost of $309.5 million, the largest of these being the Napier flood in November 2020 with a cost of $88 million. This compares to six events at a cost of $245.3 million in June 2020 year and four events at a total cost of $14.7 million in the June 2019 year.[1]

Finally, the results announcements from some of the large insurers highlight key themes of 2020/21 as increased claim costs, higher weather event related claims, ongoing customer support offerings and continued uncertainty as a result of Covid-19.

1 Cost of natural disasters - ICNZ

Health Insurance

The highlights

Overall, insurance profit decreased 6% from $294 million in 2019/20 to $276 million in 2020/21, compared to 34% growth between 2018/19 and 2019/20.

Results and analysis

The key contributors to the decrease in industry profit include:

- a net claims expense increase of 15% from $1,215 million in 2019/20 to $1,403 million in 2020/21.
- a gross written premium increase of 11% from $1,516 million in 2019/20 to $1,690 million in 2020/21. Overall, net earned premiums increased 11%, consistent with gross written premiums, from $1,142 million in 2019/20 to $1,203 million in 2020/21.

As a result of the increased claims experience, the loss ratio has deteriorated, with a market average of 84% in 2020/21 compared to 81% in 2019/20.

Southern Cross Medical Care Society was the key contributor to the industry with a 76% share of gross written premiums. The Society experienced an increase in gross written premium of $139 million from $1,152 million in 2019/20 to $1,290 million in 2020/21. This increase in gross written premiums was offset by a greater increase in net claims incurred of $159 million, a shift from $956 million in 2019/2020 to $1,125 million in 2020/21.

2021 Results snapshot

Gross written premiums

$1,690m	2021/21
$1,516m	2019/20
$1,421m	2018/19
$1,303m	2017/18

Insurance profit

$276m	2021/21
$294m	2019/20
$220m	2018/19
$187m	2017/18

Net earned premium

$1,679m	2021/21
$1,510m	2019/20
$1,414m	2018/19
$1,296m	2017/18

Net incurred claims

$1,403m	2021/21
$1,216m	2019/20
$1,194m	2018/19
$1,109m	2017/18

Loss ratio

84%	2021/21
81%	2019/20
84%	2018/19
86%	2017/18

Across the market, all insurers experienced growth in gross written premium as the Covid-19 pandemic encourages New Zealanders to prioritise their health and insurers look to factor the increasing cost of health care into their premiums.

02

New Zealand Life Insurance Market: Results and analysis

New Zealand Life Insurance Market: Results and analysis

KPMG's 2021 New Zealand Life Insurance Insights Dashboard contains a range of interactive charts and graphs presenting key industry metrics for the past five years. It also enables the comparison of metrics for an individual insurer to others in the market.

KPMG Life Insurance Insights Dashboard

The highlights

Overall, the financial results of the life insurance market haven't been impacted significantly by Covid-19. Despite the challenges faced by life insurers with the current operating environment, the size of the market as measured by gross premium revenue has remained relatively stable. In 2020/2021, gross premium revenue increased by 1% to $3,765 million while gross claims expense decreased by 1% to $1,985 million. The gross claims ratio of 53% is in line with the average throughout the five-year period.

In 2020/2021, the life insurance market has generated $389 million in insurance profits, translating to an overall growth of 4% as compared to last year.

Results and analysis

The market increase in gross premium revenue can be attributed to the performance of some of the largest life insurers and reinsurers in 2020/2021:

- Partners Life Limited, which had an increase of $39 million from $287 million in 2019/20 to $326 million in 2020/21;
- AIA New Zealand Limited/Sovereign Assurance Company Limited, which had an increase of $35 million from $913 million in 2019/20 to $948 million in 2020/21; and
- Swiss Re Life and Health Australia Limited, which had an increase of $14 million from $569 million in 2019/20 to $582 million in 2020/21.

This was offset by the decline in gross premium revenue noted for Cigna Life Insurance New Zealand Limited/OnePath Life (NZ) Limited ($62 million decrease from $351 million in 2019/20 to $289 million in 2020/21); and AMP Life Limited – NZ Branch ($14 million decrease from $430 million in 2019/20 to $416 million in 2020/21).

The gross claims ratio remained consistent over the five-year period, averaging at 53%. 2020/2021 saw a slight decrease of $19 million in claims expense versus 2019/2020.

In 2020/2021, we've seen reinsurance expense increase by $279 million to $1,850 million, yet the $788 million recovered from reinsurers only reflects a $29 million increase on 2019/2020. This suggests the cost of reinsurance has increased.

In 2020/2021, all life insurers included in our dashboard met the Reserve Bank of New Zealand's minimum solvency requirements.

2021 Results snapshot

Gross premium revenue

$3,765m	2020/21
$3,725m	2019/20
$3,178m	2018/19
$2,951m	2017/18
$2,615m	2016/17

Reinsurance expense

$1,850m	2020/21
$1,571m	2019/20
$928m	2018/19
$636m	2017/18
$469m	2016/17

Claims expense

$1,985m	2020/21
$2,004m	2019/20
$1,680m	2018/19
$1,636m	2017/18
$1,362m	2016/17

Reinsurance recoveries

$788m	2020/21
$759m	2019/20
$529m	2018/19
$349m	2017/18
$308m	2016/17

Claims ratio

53%	2020/21
54%	2019/20
53%	2018/19
55%	2017/18
52%	2016/17

Insurance profit (NPAT)

$389m	2020/21
$373m	2019/20
$424m	2018/19
$536m	2017/18
$492m	2016/17

03

ESG in claims

ESG in claims: Vision, strategies and decision-making for better outcomes

Dr Charles Ehrhart, Director and **James Young-Drew**, Assistant Manager, KPMG New Zealand

Given the nature of their business, insurers are in a unique position to connect with a wide range of individuals and businesses and positively influence public behaviour concerning today's important social and environmental issues.

Insurers, like all businesses, have a responsibility to implement sustainable practices and respond strategically to ongoing social changes and evolving public expectations. Claims teams in particular are well positioned to engage with customers and take on a leading role in the commitment of their businesses to environmental, social and governance (ESG) issues. Responding to systemic issues such as climate change is critical for futureproofing business in light of today's increased risk and the destructive impacts of climate change.

The ESG agenda takes on greater prominence

We have never been more aware of the impact of business practices on our society and environment. Public expectations of businesses are growing in line with this awareness; ethical, inclusive and sustainable practices are in the spotlight and facing unparalleled public scrutiny. Insurers are wisely acknowledging and responding to the importance of embedding ethics and sustainability into their strategies.

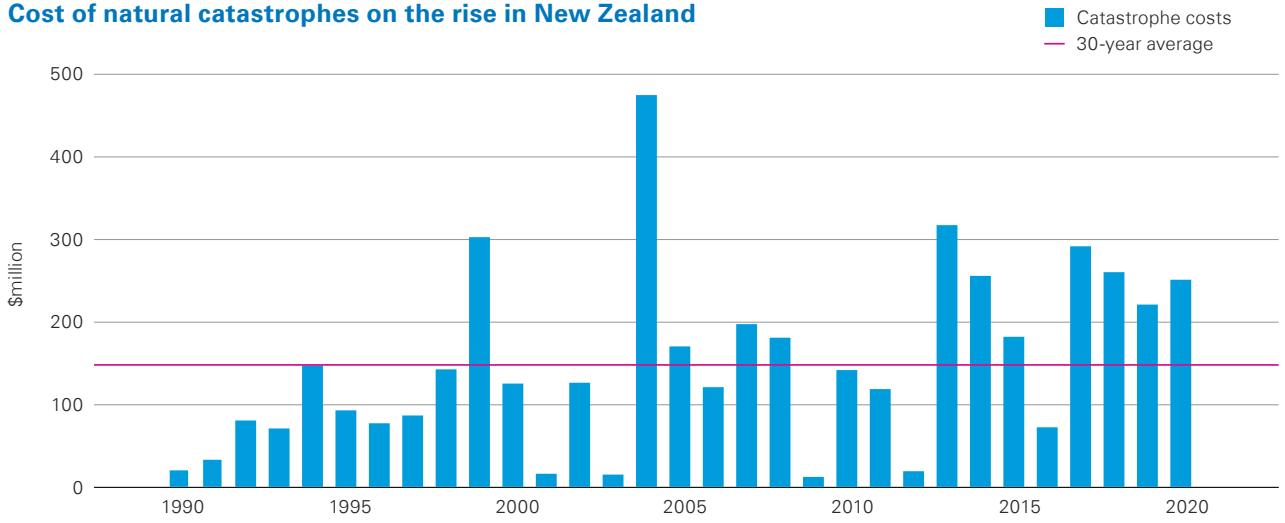
Companies can no longer get away with 'greenwashing' – conveying a false impression of ESG progress – and instead need to clearly demonstrate their ESG focus to all stakeholders. The claims function is the 'moment of truth' for customers, and ensuring a positive journey and outcome is crucial to reputations and success.

ESG issues are not tomorrow's problems; they demand a response here and now. To quote the Reserve Bank of New Zealand's recent report Climate Changed: 2021 and Beyond: "the climate has already changed and with it we face a new financial, legal, economic and policy climate. Business as usual no longer exists."[1]

> Ethical, inclusive and sustainable practices are in the spotlight and facing unparalleled public scrutiny.

1 Climate Changed 2021 & Beyond – The Reserve Bank Climate Change Report - Reserve Bank of New Zealand (rbnz.govt.nz)

Cost of natural catastrophes on the rise in New Zealand



Source: Insurance Council of New Zealand, CoreLogic, Reserve Bank estimates

Note: The cost of catastrophes is adjusted by the CoreLogic total value of housing stock, which is used as a proxy to represent growth in built-up areas and the total value of property protected by insurance.

Storms, floods and fire - the cost of events resulting from natural disasters has been increasing for some years now, and climate change is predicted to make severe weather events worse and more frequent across New Zealand. The recent 16-19 July 2021 storm, which saw a rare red weather warning issued by Metservice, caused at least $122m in insured losses (preliminary information). As of September 2021, the cost of natural disaster-related claims for 2021 already totals more than $250m.[2]

ESG issues demand stronger governance, strategy and disclosure

Building a robust governance structure that aligns decision making with ESG strategies has become crucial. Global market leaders in every sector, including today's insurers, are recognising the value of this approach as they begin to adopt it.

Market leaders are also pivoting their strategies to include ESG at their core and to shape their values. This includes greater emphasis on contributing to wider societal outcomes, such as the United Nation's Sustainable Development Goals (SDGs). As a result, businesses are reporting on an increasingly wide range of content and activity, with the volume of shared information growing accordingly for investors, stakeholders and other parties.

Mandatory reporting on climate-related risk has been driven by public entities, including the New Zealand Government and the Reserve Bank of New Zealand, recognising the threat that climate change poses to financial stability. New Zealand's Financial Sector (Climate-related Disclosures and Other Matters) Amendment Act 2021 now requires insurers, banks and most NZX-listed companies to report in accordance with the External Reporting Board's (XRB) (in-development) climate reporting standards, that build upon the recommendations of the Task Force on Climate-related Financial Disclosures (TCFD). The Act also empowers the XRB to develop non-binding guidance for other areas of non-financial reporting, such as gender pay gaps and inclusion practices. This reflects the normalisation of wider ESG reporting in recent years.

Once the appropriate governance structure is in place, each process within the claims function should be reviewed through a sustainability lens. Market leading insurers will look at the environmental, social and governance impact of each process and identify how they can be improved. A clear set of guidelines will need to be set from the top of the organisation and implemented across various functions.

Leading the way on today's ESG agenda

Where relevant to the business, publicly demonstrating alignment with best practice and going beyond what is required by mandatory reporting will increase trust and confidence among stakeholders and differentiate insurers as being informed, proactive and forward-looking. The infrastructure required to compile this data takes time to embed, making it vital that insurers focus on the data they need now while preparing to meet future requirements.

There is a risk that some insurers may simply remain focused on minimum targets rather than putting ESG at the heart of their business, culture

2 www.icnz.org.nz/natural-disasters/cost-of-natural-disasters

and strategy. Insurers have an opportunity to make real progress, embedding innovative sustainable approaches within the business, empowering staff to embody positive values and communicating their efforts in compelling ways through reporting.

Some leading firms are already demonstrating what can be done. We are seeing more companies aligning their best practices and reporting frameworks with the SDGs and highlighting their ongoing efforts to meet them. Insurers leading in this category are likely to be paying closer attention to their suppliers; for example, ensuring that they are following best practices on fair treatment and equitable pay for their employees and contract workers. They may also be focusing on responsible consumption and production — ensuring that the outcome of every claim is responsible and minimises waste as defined by the SDGs.

A closely aligned supplier network is now crucial

Large organisations are increasingly being held accountable by their customers, stakeholders and the public for the behaviour of their suppliers, and insurers are no exception. Reputations can be tarnished in an instant by questionable practices that can come under global scrutiny and severe criticism in today's connected world. Suppliers should possess values which ensure ESG best practice and protect reputations as well as the bottom line.

Claims functions are also aware of the need to limit the carbon footprint of their activities, and this includes giving customers the option of locally sourced services and labour. Signatories to New Zealand's Climate Leaders Coalition, for example, have committed to proactively supporting suppliers, as well as their own people, to reduce their emissions.

Having a strong network of local suppliers is becoming increasingly important for insurers hoping to uphold ESG values and meet targets. A future-proofed supply chain will also complement wider strategic efforts, including the management of ESG-related risks. Suppliers should be encouraged to integrate ESG targets into their own businesses, creating continuity and visibility throughout the value chain.

There are examples across the world. A British grocery retailer pledged to remove one billion pieces of plastic from its UK operations. They made it clear to suppliers that packaging will influence which products are sold in its stores.

A global healthcare company has announced an ambitious target to ensure all direct suppliers are targeting 100 percent renewable power by 2030. To reach the target, they will work alongside suppliers, sharing key learnings on embedding renewable power throughout its operations.

Understanding the spirit in addition to the letter of coverage

Given the nature of their services, insurers are often the first 'port of call' during times of hardship for customers who are dealing with a loss and need support. Insurers could consider the spirit of a policy and ensure that their customers are fully aware of any caveats and clauses within the policy wording which may impact them in the future during completely unforeseen circumstances like natural disasters. This would support the wider community and positively impact the insurer's reputation. There is also the opportunity to feed into loss prevention services, to limit the potential claim event from occurring in the first place.

For instance, many policyholders were affected by the Covid-19 pandemic and suffered significant losses, filing corresponding claims under their business interruption (BI) policies. In the UK, some insurers accepted liability under 'disease clauses' while others disputed liability, requiring additional clarity from the UK's Financial Conduct Authority. The court ruled in favour of policyholders regarding coverage for BI losses in the wake of the pandemic, impacting 370,000 policies.[3]

We are on the cusp of change. Regulators are expecting businesses to do more to support customers experiencing hardship, while the global pandemic and ESG agenda have both increased the focus on sustainable values, ethics and trust. An insurer who focuses on doing the right thing for their customers will likely drive significant benefits and progress for both society and their business.

> Being a purpose-led organisation that strives to have a positive impact on the planet and its people matters today as never before.

3 www.fca.org.uk/news/press-releases/supreme-court-judgment-business-interruption-insurance-test-case

Embedding sustainability into your culture

Being a purpose-led organisation that strives to have a positive impact on the planet and its people matters today as never before. An effective way to embed sustainability is to encourage and listen to the views and insights of employees, who today see employment as a partnership and want a voice in how the business is run. By giving all staff a voice in shaping strategy and policies, insurers can drive progress while limiting attrition and boosting engagement and productivity.

Employees also have a role to play in the 'S' of ESG. Promoting diversity among the workforce should be high on every business agenda. Claims functions should focus on training or retraining people to provide the skills needed for future employment and advancement, as well as developing employees to contribute increasing value to the business.

Social licence to operate

Incorporating ESG and sustainability principles into every aspect of operations is increasingly becoming a necessity for businesses, particularly in the financial services sector. Customers, employees, suppliers, shareholders, and other stakeholders require insurers to earn their social licence to operate, ensuring that society can have confidence that they are endeavouring to act responsibly in all dealings. Businesses that make ambitious commitments and are transparently accountable to stakeholders are likely to be more resilient in the long term.

Collaboration has become critical to progress

Insurers can also drive progress by working together and sharing best practices. Historically, insurers have pursued a more short-term competitive advantage, but sustainability is an area in which collaboration can make a powerful difference. Market leading companies across different sectors are already sharing experiences, expertise and working together in new ways to implement smart changes for a better future.

Insurers hold huge amounts of data that can be amalgamated and leveraged to inform public policy and enhance loss prevention. They can continue to work more closely with governments and policymakers to provide new perspectives and insights on risk and modelling, for example, looking at data related to health claims, traffic accidents, weather impacts, travel issues and shipping claims. In this way, insurers can be a real force for good in the fundamental shift required for the world to be truly ESG focused.

Making a difference — four steps for progress

ESG is complex and informs many different aspects of business. Think about what it means in the claims area by considering these four points that can make a difference:

1. Define how the claims function feeds into the overarching ESG strategy for the organisation. Understand how claims can promote ESG practices and the ESG ambition of the insurer and start to take a leading role.

2. Review current processes through a sustainability lens. Use ESG criteria to understand what the current ESG impacts are of the claims function and the wider supply chain, to identify areas of concern and opportunities to work more in line with the ESG ambition.

3. Encourage suppliers to work within the same ESG values. Promote sustainable practices with suppliers and other relevant parties.

4. Identify the ESG data which will be required in the future. Review current data collection and system inputs which will be required in the future for reporting, and can provide insight and value to customers.

04

Unlocking the power of claims

Data and Analytics: Unlocking the power of claims

Stephen Hastings, Partner and **Alistair Evans**, Director, KPMG Lighthouse New Zealand

Businesses in every sector are pursuing game-changing digital capabilities to drive growth and success in a new era of client centric service, and today's forward-looking insurers are no exception. They are exploring ways to unlock the potential of claims-related data using analytics techniques and technologies that promise to optimise the client claims journey, and open new opportunities for efficiency and competitiveness. Data and analytics is one of the forces transforming the claims function.

New Zealand's insurance sector is a field ripe for growth and innovation through the utilisation of data and analytics. The regulatory changes facing insurance companies in New Zealand today provide challenges – but also open the door of opportunity. As many insurers upgrade their financial IT systems to prepare for IFRS 17 adoption, the need for increased transparency of reporting should be fulfilled in tandem with an increased ability to garner insight from the data internally.

New Zealand's unique insurance innovation opportunity

Several features make New Zealand's insurance sector unique from a data and analytics perspective. These include New Zealand having the second-highest expected losses from natural disasters, whilst also having the fourth-highest rate of insurance penetration, among 43 studied countries[1]. The high levels of both insurance and risk speak to the need for personalised, flexible insurance plans. Utilising data and analytics can help ensure that premiums are accurately and effectively priced from policy to policy. Machine learning (ML) and Artificial Intelligence (AI) can be employed to analyse the swathes of historical data present in insurance company systems to predict risk and accurately underwrite policies for new customers. Insurers could also use streaming data sources to provide variable cost policies based on customer location. The future of insurance is open-ended and exciting.

Tapping into the power of data and analytics can dramatically transform the claims experience for customers who could potentially see claims assessed and settled within a matter of minutes. Some insurers are already enhancing loss prevention among customers, using data-based insights to better understand the outcomes of claims, as well as improve reserving accuracy and product pricing.

New digital entrants may present a threat, offering modern client experiences and operational efficiencies however, established market players have large pools of client information that can be used to facilitate informed, evidence-based decision making. The key to unlocking these insights is increased use of data and analytics.

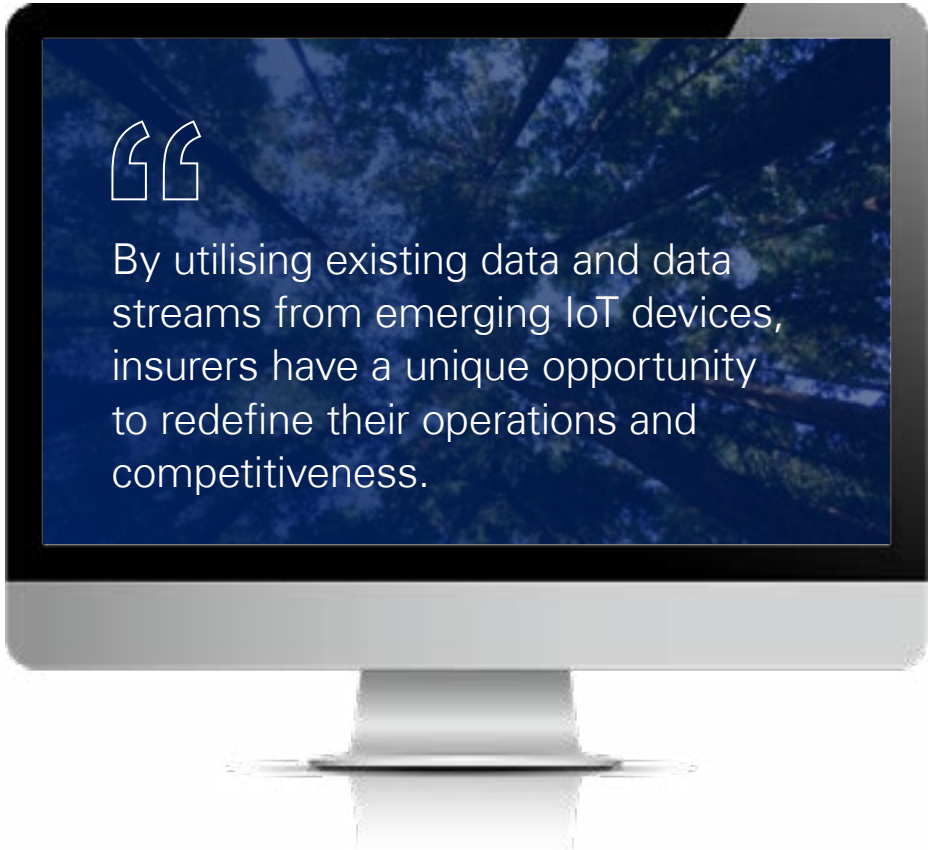
Insurers have traditionally maintained passive relationships with customers – the typical

1 www.lloyds.com/~/media/files/news-and-insight/risk-insight/2018/underinsurance/lloyds_underinsurance-report_final.pdf

engagement being through renewals and claims. By utilising existing data and data streams from emerging IoT devices, insurers have a unique opportunity to redefine their operations and competitiveness as client expectations and connectivity continue to evolve in the digital era.

Using data to meet today's cost challenges

Data use can help insurers reduce indemnity spend by improving loss prevention and claims processing. By proactively using data and engaging with customers to identify risks related to vehicle safety or home security, for example, insurers can provide customers with personalised service that enhances their experience. This can, over time, also provide wider societal benefits related to personal injury or environmental damage, which can help insurers demonstrate their ESG credentials alongside advancing their commercial position. We explore the ESG force in more detail in our article ESG in Claims: Visions, strategies and decision making for better outcomes.



Leading insurers are also beginning to use claims data to automate the processing of routine claims. This allows claims teams to focus on complex claims in which expertise and judgement are crucial.

Data analysis can also identify unusual patterns of activity related to fraud. Historically, claims handlers have used their experience and intuition to spot fraud (or simple algorithms). Our data and analytics team, KPMG Lighthouse, analysed the historical claims data of an insurance client to find instances of fraud. The analysis was able to be turned into a real-time streaming solution that detected fraud and alerted the business as soon as it occurred – a past, present and future solution. Enhanced fraud identification and response also helps insurers reduce costs and improve the client experience.

Data and analytics can transform claims products and settlements

Insurers can use claims data to help support the development of new product solutions that are designed to complement a change in focus from traditional claims management to consistent and reliable claims prevention. 'Parametric' products can be created for a variety of insurance lines, with prior claims data used to determine a set of conditions whereby a settlement is instantly confirmed for the client. A parametric product would also support the insurer by providing increased certainty to their exposure, providing additional clarity to the pricing process for the business.

Enhancing the current use of data and analytics can help insurers to engage in claims prevention for customers. This could be done by taking in external data streams, such as car dashboard camera footage to support motor insurance claims, or by supporting customers by offering analytics-backed risk management as a service, and assisting them in reducing their exposure to a claims event.

Unlocking the various benefits of a digital, data-based claims environment begins by ensuring that the data being entered is clean, accurate, and able to be 'read' by other systems. In many cases, insurers can improve both their data quality and the time that is spent on value adding data-based activities by improving their current state processes.

Insurtech companies often find it easier to effectively use data as they do not have the legacy systems or corporate structures of larger, more established insurance companies. That freedom allows them to focus their resources on innovating specific offerings in the insurance market. Partnerships between established insurance companies and insurtech companies allow new technologies to be integrated into an existing customer database – a promising mutually-beneficial relationship.

Some insurers may require upgrades to their digital architecture to unlock the efficiencies and analytic capabilities from their data. With an efficient digital architecture in place, advanced analytics can be overlaid with client behaviours and expectations as well as important marketplace trends to reliably identify patterns in claims and reduce their

indemnity spend and supplier costs. Their analytics capability can identify, for example, which types of vehicles are most likely to be written off as a total loss, regardless of what initial damage reports state.

Breaking through the roadblocks to progress

While some leading insurers are looking to embrace the power of data and analytics, many others are facing obstacles in leveraging claims data to improve efficiency and transform the client claims journey and experience. Legacy issues with systems and data architecture limit their ability to extract and manipulate information or integrate new digital technologies.

Legacy systems will need to be reviewed to determine whether the right information is being adequately captured to optimise analytics results – and whether the procedures around processing the data are ensuring the information captured is of sufficient quality. Many insurers face the difficult decision of whether legacy systems can and should be patched, or whether a new platform should be added to their architecture or replace an existing system.

> As underwriting, pricing and claims become increasingly data-centric, insurers should ensure they can use their data to provide value-adding insights to their customers.

The answer of how to unlock this value will vary for different insurers. KPMG can help insurers leverage their data by transforming the processes governing how they capture data into core systems. We can also guide them on identifying new systems that ingest data cleanly and provided them with advanced analytics.

> The average person will likely leave a trail of more than one million gigabytes of health-related data in their lifetime (based on current technologies). There is huge potential to be unlocked from claims data.

Insurers are recognising that continuing to use legacy systems and processes can be as costly as pursuing a transformation project due to inefficiencies, and the unrealised benefits of harnessing the data held within the claims department. Integrating transformation requirements and capabilities into the end-to-end client journey is crucial and requires executive-level input and strategic support to ensure new processes or system changes encompass all organisational needs beyond claims.

The use of data and analytics can also make it easier to identify and remediate past issues. Leveraging our regulatory expertise, we were able to use natural language processing (NLP) to produce analyse combination of customer complaints and CRM data to identify and categorise themes within specific products and across the company as a whole. This enable us to help create an action plan for the company to more easily remediate any identified issues and build on any identified strengths.

Another significant obstacle we have seen in the journey to leveraging data is an inability to extract and manipulate valuable claims data, which limits key capabilities, from managing operations effectively to being able to reserve or price products accurately. By utilising the data held within the department, and overlaying analytics, leaders can receive enhanced management information reports, which will support their decision making – such as providing better quality resource management information, helping the business fix capacity to meet demand.

We are seeing some insurers successfully identify trends in claims and enhance their claims operations – identifying spikes in demand or providing real-time data to suppliers to resolve claims more efficiently. The challenge for many organisations is a desire for a completely accurate view of past performance, restricting focus to lagging indicators instead of building leading indicators for the business.

There also remains a perception that using data and analytics is a 'magic bullet' that will either solve all problems or replace all people in the claims team, neither of which is the case. Insurers ultimately need to strategically identify both what data and analytics can do for their business, and how it will be deployed to achieve their goals.

Map out your journey to a data-based claims function

Transitioning to a data-based claims department will not just require insurers to review whether they need to update or upgrade their systems architecture. Insurers will also need to review the adequacy of the processes that underpin data processing and analytics, alongside ensuring claims colleagues are receiving sufficient training to leverage the data available.

Once an insurer has the right quality of data being entered into their systems, and the right processes and people capabilities to maintain the information, it is important that they develop the system intelligence needed to effectively utilise their data. This will require analytics functionality that combines policy-administration data with data from various key internal and external sources. To maximise the opportunity, insurers will need to enhance their data science capabilities to interpret the data for analysis as models become more complex and increasing amounts of data are used to derive outcomes.

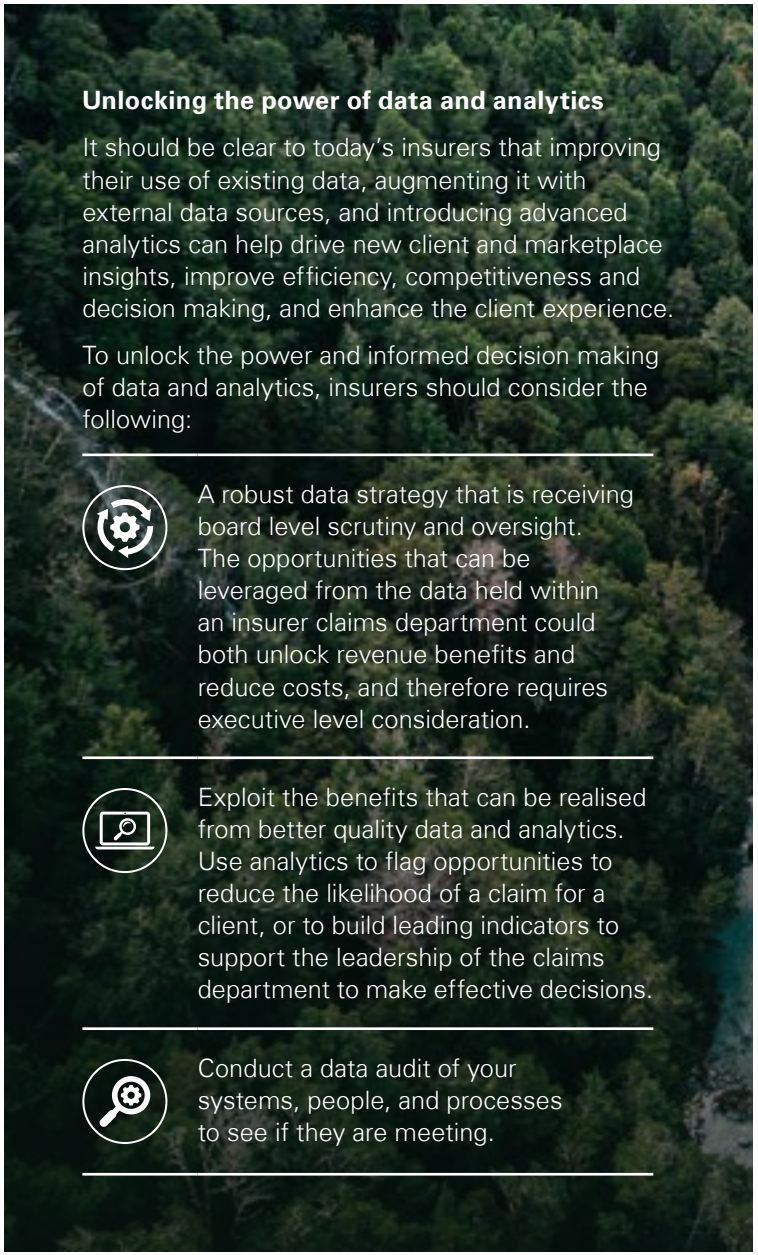
For instance, as electronic medical records, digitised diagnostics, and wearable medical devices proliferate, the average person will likely leave a trail of more than one million gigabytes of health-related data in their lifetime (based on current technologies) – which is the equivalent of about 300 million books, and is also being updated on an ongoing basis.[2]

The sheer amount of information that will need to be processed with analytics in order to realise the benefits that this data will bring is astronomical. Millions more data points are being collected within car telematics. Car telemetry data paints a picture of driver performance that can be used to analyse the driver's behaviour to more accurately price vehicle insurance premiums. There is huge potential to be unlocked from claims data and insurers that do so can gain a significant competitive advantage. Those that delay will likely be left behind.

Using expertise to kickstart your data transformation

KPMG Lighthouse can help facilitate the data transformation for New Zealand's insurance sector.

Lighthouse is the KPMG centre of excellence for data and analytics, AI and automation. Our utilisation of industry knowledge combined with our proficiency in delivering technical solutions gives our insurance customers the confidence to tackle challenges from all angles. If you'd like to discuss how we can help your organisation with its claims transformation journey, please contact us.



Unlocking the power of data and analytics

It should be clear to today's insurers that improving their use of existing data, augmenting it with external data sources, and introducing advanced analytics can help drive new client and marketplace insights, improve efficiency, competitiveness and decision making, and enhance the client experience.

To unlock the power and informed decision making of data and analytics, insurers should consider the following:

- A robust data strategy that is receiving board level scrutiny and oversight. The opportunities that can be leveraged from the data held within an insurer claims department could both unlock revenue benefits and reduce costs, and therefore requires executive level consideration.
- Exploit the benefits that can be realised from better quality data and analytics. Use analytics to flag opportunities to reduce the likelihood of a claim for a client, or to build leading indicators to support the leadership of the claims department to make effective decisions.
- Conduct a data audit of your systems, people, and processes to see if they are meeting.

2 www.ibm.com/downloads/cas/LQZ0O1WM#:~:text=With%20ever%2Dincreasing%20health%20data,equivalent%20to%20300%20million%20books

05

Embracing conduct and culture in insurance

Embracing conduct and culture in insurance

Hester Cutts, Associate Director, and **Adele Wallace**, Director, Consulting

The Financial Markets Authority (FMA) recently published its Insurance conduct and culture: Fire and general insurers update which summarised findings from its evaluation of responses to the Life Insurer Conduct and Culture review by the FMA and Reserve Bank of New Zealand (RBNZ) in 2019.

The review found many insurers:

- had a low level of maturity
- failed to actively monitor product suitability
- failed to effectively withdraw poor value or legacy products
- may have over-charged some customers
- needed to have a clearer view of commissions paid to and an overall stronger oversight of intermediaries.

It also stated that few general insurers would not be ready for the scheduled implementation of the Conduct of Financial Institutions (CoFI) regime; "Overall, the responses showed there is a poor understanding of and commitment to good conduct and culture practice across the sector, and that the majority of these insurers are not yet prepared for the new CoFI regime."

In the report, the FMA also stated that "with the introduction of a new conduct licensing regime, insurers need to give more attention to how they are identifying, managing and mitigating conduct risks within their business. The vast majority of these insurers need to do much more work to meet our expectations and prepare for the new regime."

So how do insurers prepare for this new regime?

What is CoFI and why is it important?

The aim of CoFI is to close any conduct gaps, building on previous findings including the Conduct and Culture Review of 2018 and legislation like the Financial Services Legislation Amendment Act (FSLAA) and Credit Contracts and Consumer Finance Act (CCCFA). Previous legislation dealt with either specific products (consumer lending: CCCFA) or a point in time on the customer journey (financial advice at the point of acquiring, maintaining or disposing of a financial advice product: FSLAA) but what about other customer interactions? What about the complete customer journey? And what about all employees? FSLAA dictated that those providing advice, Nominated Representatives and Financial Advisers, sign up to the Code of Professional Conduct, but there is no common code of conduct for all employees nor, surprisingly, for all customer facing staff. CoFI is being introduced to ensure

good conduct is adhered to, not only in all customer interactions including those conducted through an intermediary, but also to govern how all employees should act and behave in all business functions.

Isn't it just another compliance programme?

It could be easy to look at CoFI as a tick box exercise, another bolt-on to underfunded, already creaking legacy systems and inefficient processes. However, thinking of CoFI as another compliance programme will prevent maximising on the opportunity to make the changes required. The work required for CoFI is best approached holistically across the insurance organisation to implement real, meaningful and sustainable organisational change. In the past, regulatory change has been approached in silos which has led to less than efficient end-to-end processes, using myriad of disparate systems creating frictional experiences for both customers and employees. New ways of thinking need to be applied to how to implement CoFI, which can transform how insurance companies operate, all the way from product design, to handling complaints, to how employees are remunerated and third-party relationships managed.

So what needs to be done?

By taking a 'compliance by design' and customer centric approach rather than treating it as a siloed regulation or individual product orientated proposition, insurance companies will see the benefits of an efficient and transparent customer experience that also satisfies the regulators.

How do insurance companies approach this?

Conduct

Insurers should create an overarching Conduct Framework that spans the whole customer lifecycle, aligns to their organisation's values and includes all the relevant regulatory obligations (e.g. FSLAA, CCCFA and CoFI). Along with the framework and values, questions should be asked around:

1 What controls can be introduced to encourage the right behaviours?

2 Can any systemised controls be introduced e.g. system access controls for different roles?

3 How can you make it easy for your employees to succeed?

4 Do you have a comprehensive Quality Assurance programme, that reviews conduct against a benchmarked standard meeting your Conduct Framework and regulatory obligations?

5 Do you have properly documented processes and systems?

6 What are the policies and processes around customers in vulnerable circumstances?

7 And finally, what is your company's Conduct Governance and how can that span multiple legislations, so that the governance is consistent across the whole organisation?

> "The work required for CoFI is best approached holistically across the insurance organisation to implement real, meaningful and sustainable organisational change.

Customers and tone

The voice of the customer is not always considered during strategy setting at executive and board level, but this is critical for organisations to meet CoFI regulations, as well as the changing expectations of customers. The customer has to be at the heart of everything, not only from a conduct perspective but also in order to succeed in the emerging digital times. Customers are demanding more from their favourite brands and all businesses need to adapt how they routinely interact with customers who are making decisions based on more than ease and cost of service. Organisations are increasingly judged on trust, ethics, social responsibility, their ESG response, conduct and how customers in vulnerable circumstances are treated. Creating a Social License to Operate (SLO) is becoming a necessity.

The key to success is to demonstrate that your purpose is to serve customers, not for customers to serve you. To achieve this, insurers need to focus on optimising processes with integrated technology, enabling employees to add real customer value, and creating a strategy to deliver customer-centric insurance products and services.

Systems

A number of factors have resulted in existing systems being disjointed, requiring manual work arounds or remediation to tackle human errors. Historical constraints around the level of investment in systems, silo resolution for legislative requirements and slow legacy replacement have all contributed to this issue, but there is scope to improve. Now is the time to act and invest in systems that are compliant by design and prioritise good customer outcomes and governance.

If processes and systems are inefficient, it takes more time and resources to get the basics right for customers. In turn, there is less capacity for personalisation, leading to poorer customer outcomes and potentially poor conduct. Creating integrated ways of working will set employees up for success and drive a better functioning, more productive business.

For example, CCCFA, AML, FSLAA and CoFI all currently or will require record keeping, and a siloed approach would see functionality added to different systems for each of these. An integrated approach would have one system that records all customer lifecycle interactions, enabling you to be compliant across the different regulations, as well as:

- know your customer needs, goals and circumstances
- evidence good conduct e.g. the advice being suitable
- provide the regulators comfort
- sustain a long customer relationship.

By considering the whole customer journey and where there is commonality or overlap of regulatory obligations and operational risk, a common control framework could be created. Automating processes and supporting employees with tools to enable systemised controls will result in a ‘one way, same way’ approach, irrespective of distribution channel.

Incentives and Intermediaries

With the introduction of CoFI, insurers will need to review their employee remuneration and intermediary interaction, as a main focus of CoFI will look to remove sales targeted incentives and commissions to employees and intermediaries.

This change in how intermediaries can be compensated is combined with a desire for insurers to have greater oversight of their intermediaries. Whilst the details are still to be determined, the FMA has recognised that existing drafting is too prescriptive on 'the how' a relationship is managed, and it has committed to changing this to describing the desired outcomes. Aligning with intermediaries who share your values around good conduct will become paramount in the future, as well as finding new ways to incentivise and reward employees.

Remediation

Financial service regulatory bodies and the general public are demonstrating less tolerance for financial institutions making mistakes or not taking a customer-centric approach. We have seen an increased regulatory focus on remediation resulting in fines, settlements and pecuniary penalties for breaches along with significant negative media attention for perceived poor customer outcomes. Even with the best controls, remediation activity will always be required and should ideally be identified internally through quality assurance (QA) processes. Having an overarching remediation framework or policy will enable remediations to be timely, transparent and robust, supported by tools to analyse data and identify trends and systematic issues. It is very important that QA is seen as a helpful tool in enabling continued improvements to conduct leading to better outcomes for customers and employees rather than something to be feared. It should only ever be viewed as an enabler to improve ways of working and customer outcomes.

And finally...

As Rob Everett, the former FMA CEO, recently stated; "A critical lesson for management and boards of regulated financial services firms is that where we see accidental harm, or even risk of harm to consumers or investors, we will take action. The fact that issues we see are not deliberate is relevant but is in no way sufficient to get you off the hook."[1]

Regulators and government understand that change is not easy or immediate. It is a journey that needs to start now, to not only show a willingness to comply but also to build consumer trust and confidence and embed a 'serve the customer' ethos.

Insurers shouldn't change simply because they are told to by the regulators. In order to achieve best practice, they should endeavour to put their customers and employees at the heart of their strategy and explore the best way to do so. Doing so will drive customer loyalty, support the social licence to operate, increase employee satisfaction and meet regulatory obligations on conduct.

1 www.fma.govt.nz/news-and-resources/speeches-and-presentations/rob-everett-speaks-at-the-fsc-conference-2021/

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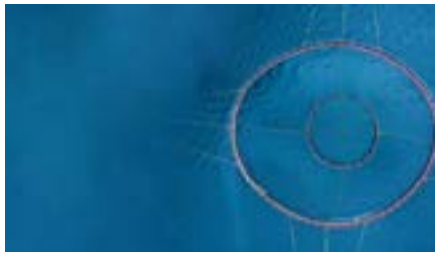

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