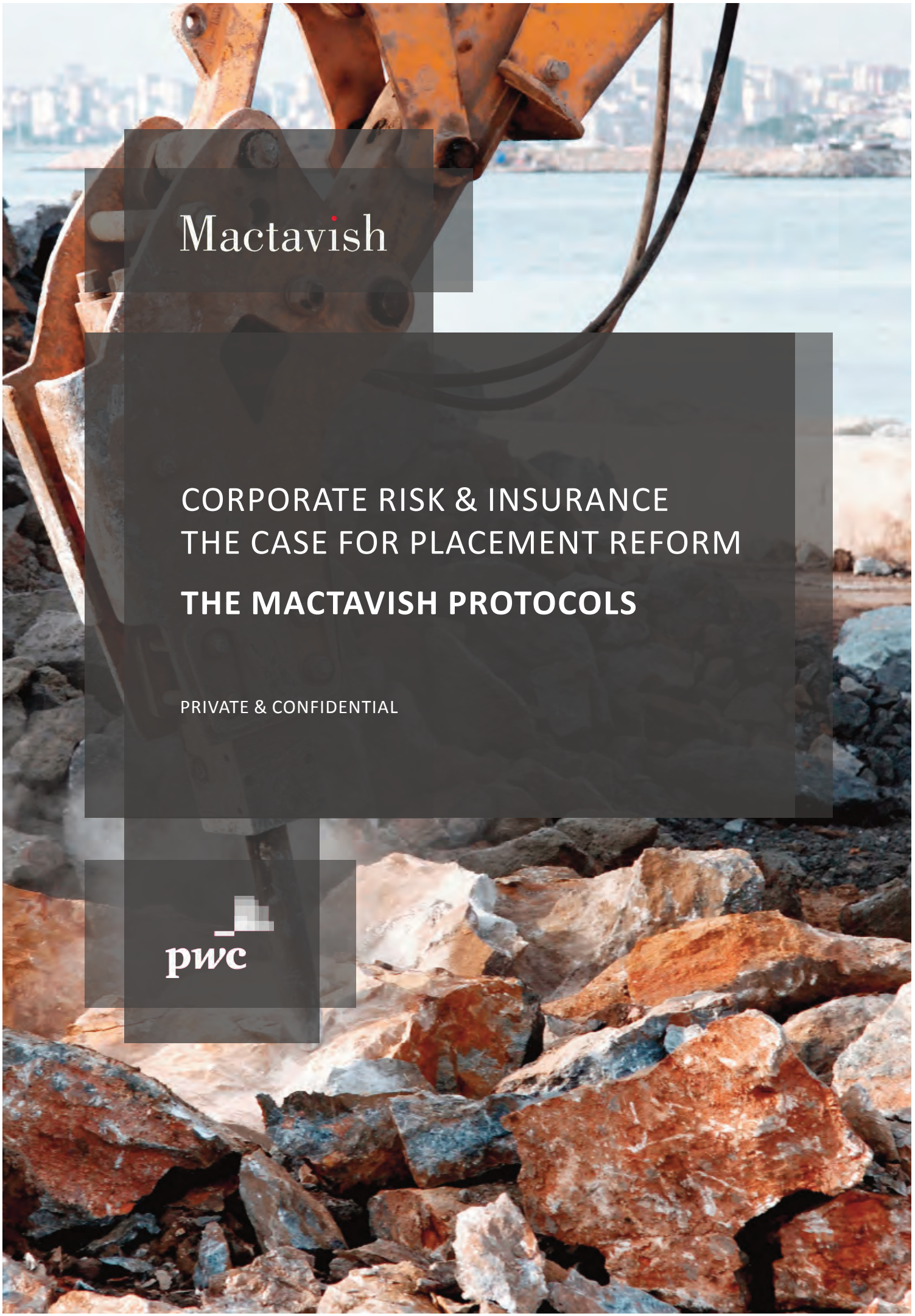

Mactavish

CORPORATE RISK & INSURANCE
THE CASE FOR PLACEMENT REFORM

THE MACTAVISH PROTOCOLS

PRIVATE & CONFIDENTIAL

pwc

“It is amazing that the market has resisted this way of working for so long; customers are yearning for change”

DIRECTOR, MANUFACTURING, £5BN+

Dear Reader,

Welcome to the second instalment of the Mactavish Risk Research programme, by far the most in-depth study yet of the corporate risk environment and of the procedures used to arrange corporate insurance in the UK marketplace.

The 2010 report concluded that neither companies nor insurers were sufficiently on top of the significant changes to corporate risk caused by the recent economic upheaval. This 2011 study digs much deeper into how risk is transferred from businesses to insurers and uncovers major flaws in how insurance is arranged. These flaws pose a real threat to UK firms, far greater than almost any business we talked to currently recognises. The threat is particularly acute for mid-sized firms, those businesses with turnovers of between £50 million and £5 billion, which represent the engine room of the British economy and the key to growth and recovery. This report also exposes serious failings on the part of Boards of British businesses to properly govern their insurance arrangements.

The system through which corporate insurance is arranged in the UK prioritises, above all else, low (and declining) transaction costs, i.e. broker fees. This means relatively little time is devoted to getting the customer a reliable contract. This is understandable given the need for all businesses to keep costs in check. However, it ultimately leads to a low level of contract certainty. Given that the insurance industry, in its own words, "sells promises", this is highly damaging for the customer. Not only does it undermine the perceived value of insurance, it also guarantees a position low down on the customers' corporate agenda.

We analyse how this situation hurts everyone from insurers to brokers and, in particular, well run businesses seeking security through insurance. It is also clear from this research that the UK legal system and current levels of regulatory oversight exacerbate rather than alleviate the problem.

The Mactavish Protocols put forward in this report set out a blueprint for practical reform of the processes governing the way in which corporate insurance is arranged. These reforms are already gathering real support from customers and key leaders across the insurance industry. What we propose will modestly increase the cost of arranging insurance through slightly higher broker fees. However, we believe this increase will be far outweighed by vastly more reliable insurance policies and lower premiums for well run businesses relative to the market. The reforms will also enable brokers and insurers to properly understand where companies really need insurance protection and the value it ultimately provides to them.

This report and the protocols contained herein are the culmination of a rigorous and detailed research programme. We have conducted over 600 detailed consultations with customers over the past two years, analysed hundreds of submission documents and company balance sheets and carried out over 100 consultations with senior insurance industry executives. It has been a huge undertaking, but we believe a vital one.

I would also like to take this opportunity to sincerely thank everyone who has contributed to the research and development of this report.

We hope this report helps to usher in a new era where corporate insurance is recognised by customers for the critical value it provides to their businesses up and down Britain. And that customers, brokers and insurers start to invest adequate time upfront to ensure that the basis of the arrangement provides the security that the customers' balance sheets require. A better insurance placement process is imperative: the industry must unite to achieve it.

Bruce Hepburn

Chief Executive Officer
brucehepburn@mactavishgroup.com

“In the recent past claims were paid because brokers called in a favour from the insurer; that bank of goodwill is going, and rapidly”

MANAGING DIRECTOR, LOSS ADJUSTER

Welcome to 'Corporate risk and insurance: The case for placement reform'. PwC is pleased to support this timely, insightful and powerful study. I would like to thank all the policyholders, insurers, brokers and other participants who gave their valuable time and insight to this research. I would also like to commend the research team at Mactavish for the depth and rigour with which they have highlighted the serious flaws in the risk placement and risk protection process.

A major part of our work is advising corporations about the nature and implications of their risks and how to manage them more effectively. We also advise insurers on how to capitalise on market opportunities and sharpen competitive differentiation, along with how to develop the risk analytics, customer insights and operational processes to support this. The findings of this study reflect our concerns about the approach to buying insurance within many UK companies and the lack of value they attach to insurance cover. The findings also highlight what we believe is many insurers' failure to engage closely enough with their clients and understand their changing risk management needs. This lack of engagement and understanding is compounding the deficiencies in the placement process. It is also a missed commercial opportunity for corporate insurers at a time when many are struggling to sustain growth and differentiate themselves in the eyes of both customers and investors.

The starting point for addressing these flaws is a more active partnership between brokers, insurers and corporations and that is exactly what the Mactavish Protocols recommended in this report seek to achieve. By harnessing the latest advances in risk analytics and taking more time to get to know about how their client's risk profile is evolving, insurers can help corporations to anticipate emerging threats and mitigate and control their exposures more effectively. This more valued and valuable service would help to attract and retain customers and enable insurers to convey a clear and differentiated growth story to their investors. More effective service and support from insurers would in turn help corporations to bring insurance placement closer into line with their overall strategy and risk appetite and make more informed decisions about how much risk to transfer and how to balance that with the costs.

I hope that you will find this report insightful and thought-provoking. Please do not hesitate to contact us if you have any feedback or would like to discuss any of the issues raised in more detail.

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“I’d say it’s verging on dishonest; companies are induced to taking policies out in the belief that they’re covered, but with insufficient advice from insurers over what should be disclosed. The duty for brokers to provide this advice is often inadequately fulfilled”

DIRECTOR, UK INSURANCE CLAIMS CONSULTANT

CONTENTS

ONE | EXECUTIVE SUMMARY

This report is the second part of a major programme of research by Mactavish into corporate risks in the UK. The first instalment, published in January 2010, analysed how the forces of globalisation and recession had caused UK firms to make unprecedented strategic and operational changes to protect themselves against economic downwinds. The speed, scale and concurrence of these changes have had a material impact on the risk exposures of British businesses, an impact that was neither adequately recognised by corporate Britain nor properly explained to insurers.

This follow-up report looks in detail at the insurance protection companies have in place against these risks and the consequences of the widespread lack of understanding of how risks are changing. It sets out a very strong case that most companies in the UK today, particularly the mid-size firms that compose around half of private sector GDP[1], are left desperately exposed when it comes to their insurance arrangements. In addition, it puts forward key recommendations about how to reform the insurance placement system.

The report paints an alarming picture of Boards of British companies failing to properly govern their insurance arrangements.

Corporate insurance has never been more important to the health of British businesses than it is today. Balance sheets are still vulnerable as businesses continue to deleverage after the global recession. And insurance – which can be drawn upon in the event of a major loss – is a particularly vital financial backstop given the prevailing constraints on credit.

If, for whatever reason, a major insurance policy fails to pay out, most firms would either struggle to raise debt to pay for the loss, or would be charged prohibitively expensive amounts to do so.

On the supply side, **the financial health of Property & Casualty (P&C) Insurers is coming under increasing pressure.** The unexpectedly long period of soft market conditions has created cut-throat competition for premiums, prompted widespread coverage increases and eroded margins. To compound matters, insurers are also earning relatively poor investment returns and prior-year reserve releases propping up combined ratios are thought by many commentators to be running out. Despite the delay (and few signs entering 2011 of immediate rate hardening), a major correction remains inevitable at some point: rates will have to rise and coverage will become much more difficult to secure.

This may well be further exacerbated by the new regulatory framework for insurers in the EU – Solvency II. Although its impact on the capital bases of P&C carriers remains unclear, the likely effect, for many insurers, will be to further tighten the screws on balance sheets already under considerable pressure.

Meanwhile, this research finds unequivocally that **the financial backstop insurance provides for business is unreliable and becoming more so.** Furthermore, the disclosure process, and subsequent placement, of major risks in the corporate insurance market are **deeply inadequate.** If these deficiencies are not addressed the impact of the eventual market correction will be much worse.

The problem starts with insurance law. Risk transfers are underpinned by an outdated, unfair legal framework that is largely unknown to most customers, unless they have suffered a disputed major loss. Although it is long overdue for reform, the fundamental legal framework for insurance will probably not be changed by the Law Commission in its upcoming review, except for consumers and small businesses.

Eighty-seven per cent of customers consulted by Mactavish for this study were unaware of how onerous the duty of disclosure really is for them, or what this means when things go wrong. Most UK businesses simply assume that secure insurance coverage is in place despite mounting evidence to the contrary.

We would argue that this is a major regulatory failing. Corporate insurance appears to fall into something of a regulatory vacuum; it is not high on the FSA's agenda today, nor is it likely to become so in the current economic climate.

Standards of risk disclosure are generally poor and inadequate, a point supported by a wealth of evidence we have gathered from across the insurance market by analysing submission documents, detailed later in the report. Systemic weaknesses, in almost every case studied, include major flaws in the information set used to explain risk to insurers and consistent, highly material omissions from disclosures.

Perhaps the most significant omission we commonly see is any reference to business changes and the accompanying effect these have on operational risks. This is crucial in today's paradigm-shifting, post-recession world.

In light of these limitations, it remains extremely concerning that **65%**[2] **of insurance buyers do not review the materials used to place their risks** in the market, with many unaware of such documents' existence or purpose. The submission, policy wording and underwriter slip form a de facto contract. Effectively one third of this contract is neglected, a worry not only for the customers who ultimately rely on this insurance but also for the insurers and reinsurers whose business models rely on the same information set.

This study shows that it is not just disclosure of risk that is fundamentally deficient; **the process of placing corporate risks in the market is also flawed.** Feedback on this was gathered from those closely involved in all parts of placement activity. Key weaknesses include:

- Routine lack of engagement by operational management in gathering information for insurance placement.
- Excessive reliance throughout the process on undocumented risk information.
- Failure to review relevant loss scenarios or policy wordings.
- Over-reliance on follow insurers, reinsurers and external third parties for claims payments: all without any advance requirement to engage with the customer.

As the reforms we propose demonstrate, improving this process is eminently achievable and the will to do so is growing. In today's era of increasing scrutiny of corporate governance and economic turbulence, not to do so puts **large numbers of UK companies at grave risk of being caught up in a major insurance dispute.**

There is real and growing evidence over the last year to suggest both that more major corporate claims are being reported and that there is an increased likelihood of them being questioned. Far too many large insurance losses already end in dispute and our research suggests that **insurers are already taking, and will continue to take, a much tougher stance on claims.** Participants in our study overwhelmingly expect this trend to continue. It's worth pointing out that disputes do not necessarily mean outright refusal of claims; rather, they more often mean delays in settlement or protracted negotiations about the size of claims payments.

The companies that will be hardest hit by this increase in claims disputes won't be large multinationals; at the upper end of the turnover spectrum, customers have enough buying power and leverage to partly insulate themselves from such complications. Nor will it be small businesses: they may be partially covered by consumer-focused legal reforms, can generally expect more sympathetic court treatment and may have recourse to the Financial Ombudsman if claims are unfairly disputed. No, it will be the mid-tier engine room of corporate Britain that suffers most from the deficiencies of a system that is clearly not meeting its needs.

So what are the implications here? There are three related impacts, all of which have severe ramifications for customers in light of the disclosure and placement weaknesses outlined.

| Tougher claims environment & potential hard market coinciding with restricted access to credit

When the insurance market eventually hardens, access to contingent insurance capital will become much more constrained. Given the current economic outlook, this is likely to coincide with a time when alternative forms of credit to mid-size businesses – in the form of debt or equity – remain at best expensive or, at worst, severely restricted or even closed. **Companies will therefore face much higher direct insurance costs and will have increasing difficulty getting major claims settled, deepening their reliance on debt and equity capital just when their supply also remains uncertain.**

The last time a recession coincided with a hard insurance market in Britain was in the mid-1970s, following the Oil Crisis. The current generation of insurance and financial managers in British businesses has not had any experience of dealing with this combination.

| Claims disputes are on the increase

It makes intuitive sense to conclude that an increasing number of claims will be questioned in such a challenging environment. The likelihood of this happening is also supported by a wealth of anecdotal evidence gathered from across the market.

Statistics emanating from the Royal Courts of Justice (RCJ) already confirm that corporate disputes affecting insurance are on the increase. Given the lag from incident to final dispute resolution, conclusions made using these statistics must be treated with caution. However, they do suggest a structural increase in major UK corporate disputes, where insurance is a major driver (consistent with our research findings from 2009)[3] :

- Between 2008 and 2009 there was a 45% increase in the total volume of corporate RCJ disputes (excluding bankruptcy).
- Corporate professional negligence cases increased by 131% in that 12 month period.
- Shipping cases have doubled year-on-year.
- There has been a 44% increase in technology, engineering and construction disputes.

| Potential loss of confidence in insurance, but few alternatives

Although claims disputes are on the increase (in itself evidence of the deterioration in the UK business climate) there is also the danger that an increase in the fear of claims being questioned could lead to a wider loss of confidence in the corporate insurance market.

In hard markets insurance buyers are fond of talking up alternatives to costly insurance cover, although captives and more esoteric Alternative Risk Transfer instruments largely remain the preserve of the bigger companies. For most they do not represent a viable response.

In the current climate, however, when alternative capital is scarce other options are much reduced. So where does this leave companies?

They could do nothing, take on the risk and accept the consequences when things go wrong. This pumps more risk into the business system and will result in major losers. A further consequence would be that firms have to **pay more to secure expensive debt or equity as and when losses occur**. This is a costly alternative to securing contingent capital and could actually inhibit the growth of individual firms, as productive expenditure is diverted to the capital markets rather than being ploughed into the businesses.

Alternatively, they could take the strategically difficult choice markedly to **increase spending on risk management as a means of securing limited expensive coverage** in a hard market. To some extent this happened in 2002-2004 when businesses in the hard-hit food manufacturing sector were forced by insurers to increase capital expenditure on factories to remove composite panels. Again, this could divert spending away from more productive areas and constrain growth (although it could indeed reduce the likelihood of losses).

The last option is to **invest time and effort to ensure better access to insurance capital.**

Although these options are not mutually exclusive the last one would be the most positive response to the quandary facing corporate Britain today. The widespread shortcomings in disclosure and placement which are at the heart of these problems are definitely addressable. And, furthermore, **the trough of the soft market, when competition between insurers is fierce, is the ideal time to demand change and for providers to listen.** But this can only happen if the combined will of buyers, brokers and insurers forces the issue.

This report sets out the **Mactavish Protocols.** These seven specific reforms are a set of practical recommendations that, during the consultations for this paper, have been endorsed by a number of major players in the UK corporate insurance market. The seven reforms deal with seven very real and pertinent problems with disclosure & placement reliability, summarised below.

The most surprising element of this report is that none of the pragmatic suggestions we make are followed by participants in most corporate risk placements today. This is both startling and damaging to all companies that purchase insurance, often at a high financial cost. It hugely undermines the value insurance provides.

ONE | BUYERS DO NOT ADEQUATELY UNDERSTAND INSURANCE LAW AND THE DUTIES IT IMPOSES ON THEM

The burden of disclosure imposed on customers by UK insurance law is absolute. The insured has to disclose all facts that may be material to an insurer's appraisal of the risk. No less than **87%** of buyers consulted in this study lack an understanding of how onerous this duty of disclosure really is. Few understand that merely answering the questions posed by brokers and insurers in a full and frank way is not sufficient in law.

The terms and conditions of customer contracts with brokers do not assign responsibility for defining the scope of disclosure to the broker. This duty absolutely sits with the insured who, in essence, is forced to second guess what a "prudent underwriter" finds material to the risk it takes on.

And it is not just the burdensome duty of disclosure that causes problems for customers. Almost all buyers consulted do not spend sufficient time getting to grips with legal terms in insurance contracts such as warranties and conditions. The small minority who read policy wordings do so with a broad brush understanding of general contractual law. But this differs fundamentally to insurance contract law, so much so that terms like warranties have opposite meanings in an insurance context, and can fatally undermine coverage.

This widespread underestimation of the burden of insurance law regarding disclosure and risk placement cannot continue and must be addressed by customers and brokers. To this end, Mactavish recommends that at each renewal there is:

- Reiteration of the insured's disclosure responsibilities and a specific update on relevant case law developments from the preceding policy year to help illustrate the duty of disclosure in practice. There are important lessons for buyers to heed in sector case updates.
- An explicit discussion of:
  - Warranties and who in the insured's business has to be made aware of these warranties to ensure operational compliance.
  - Conditions precedent to the validity of the policy (e.g. payment of premium) or to the insurer's liability (e.g. notification of a claim within a specified time).

Customers must be brought face to face with the reality of their contractual obligations and the risks of non-compliance: something which this study clearly shows not to be the case at the moment. Treating Customers Fairly regulations enshrine principles of which insurers should be fully cognisant. It is not fair for insurers to trade with customers knowing full well that they are generally ignorant regarding insurance law.

TWO | CURRENT RISK DISCLOSURE IS FUNDAMENTALLY INADEQUATE

As noted, customers face a demanding obligation to share all information that might be deemed material if it would have influenced the judgement of a prudent insurer in determining whether to take on the risk. This is a tall hurdle for customers to clear and requires brokers and insurers to step up their efforts to conduct forensic assessment of operational risks and better develop the submission materials used to contractually place risk in the market. Only through much more in-depth engagement can buyers expect to understand what a prudent underwriter thinks is material. Without this guidance, customers today are really shooting in the dark with most unaware of how exposed this may leave them.

We remain in the trough of a soft market at present. Risk disclosure is poor and actually worsening as this soft market deepens, impeding policy reliability and contract certainty. Companies may be paying less in premiums at the moment, but they can be less confident of what they get for their money.

THREE | THE PREVAILING MODEL OF INSURANCE BUYING IS DEEPLY FLAWED

The process by which insurers tender for business should be made less rushed and allow a much more detailed assessment of risk and coverage. At present, underwriter workload is heavy at the end of each quarter and tight deadlines hugely limit the time and information available to appraise risk and coverage.

To address this, Mactavish proposes a two-stage tender process to maintain transaction efficiency, while allowing for proper evaluation prior to final placement. A plausible exercise would be for brokers to use last year's submission with potentially interested insurers six months prior to renewal. This consultation phase, requiring insurers to put forward indicative pricing and terms, would help customers to understand what drives underwriter pricing and where to focus effort. For instance, customers can ask 'which assumptions bound up in the indicative offer could be replaced by fact?'

In the second tender phase there would be a much greater meeting of minds around risks and coverage with credible competitors before policies were placed in the market.

FOUR | BUYERS CURRENTLY HAVE NO WAY OF VETTING INSURER UNDERSTANDING OF RISK

Every professional services firm, whether in management consulting, advertising, or corporate banking, has to present to customers how they are going to meet their needs. Yet it remains very rare in the corporate insurance industry for carriers to present to customers their understanding of key risks and how their offer affords protection. The absence of this type of presentation, where customers can vet the insurer's understanding of key operational risks, means there is a real (and often realised) possibility of the wrong cover being secured, pricing being inappropriate and coverage remaining unclear.

A genuine beauty parade, with a small number of pre-qualified markets, should become a standard feature of the second part of the tender phase. It would deal with a range of issues but must include a presentation by the insurer to demonstrate its understanding of the customer's business and critical risk exposures. This will allow carriers to raise any specific risk concerns they may have, clarify coverage and wording and provide the necessary details about their financial health that go beyond credit ratings (e.g. reserving changes or exposure to sovereign debt). Ultimately, this process will seek to eradicate any misinterpretations of risk and enable the customer to reach a much more informed decision.

FIVE | INSURERS & BROKERS ROUTINELY FAIL TO DEMONSTRATE THE VALUE INSURANCE OFFERS TO CORPORATE CUSTOMERS

The analysis presented here suggests that insurance has never been more important to firms in the UK than it is today and that access to alternative forms of capital remains challenging. Insurance is vital contingent capital that helps businesses survive in the event of a large loss, yet many buyers do not recognise or analyse its importance to them. This collective underestimation of the value of corporate insurance further undermines the incentive to improve disclosure and demand more secure placement.

This report argues that it is critical to carry out relatively simple analysis of an insurance programme and the potential impact of a disputed insurance claim on a company's capital structure. Imagine a typical manufacturing business with lean margins, significant existing debt and available cash of just £5m. Analysis of the insurance programme and the effect of a protracted claim dispute shows that raising further debt or equity capital post-loss would be difficult or costly. All major loss scenarios far outweigh cash reserves and sensitivity to large cost fluctuations in expenditure is high. A disputed or delayed claim settlement, at even a fairly small proportion of the £100 million plus insurance limit on key lines, could place the business in severe danger and any sudden change in insurance cost could wipe out profitability.

Working out the pain point at which a business would be placed under strain if a policy fails is an extremely worthwhile exercise. It would highlight the value that brokers and insurers add and also provide a clear incentive for buyers and their management teams to pay further attention to the ways in which policies are placed.

SIX | WORDINGS & LOSS SCENARIOS ARE RARELY DISCUSSED PRIOR TO CLAIMS OCCURRING

Once businesses have worked out this "pain point", they should look at each key class of business and ask: 'What are the loss events that could conceivably deliver a large claim of this magnitude and how clearly am I covered?' There will always be "black swan" events that cannot be foreseen by buyers or insurers; however, large claims are often events other than conventional fires or product failures. Buyers can narrow the scope for subsequent uncertainty if they sit down with underwriters, clarify the intention of coverage offered and voice any possible areas of concern up front.

The key benefit of this proposal is that customers will understand how policies respond in the event of losses and avoid misunderstandings or wording ambiguities prior to inception. Policy wordings seem arcane to even the most sophisticated insurance buyers. Yet in this study as few as two per cent of customers had reviewed wordings and held discussions with insurers about potential loss scenarios. Such a process can reduce the risk of claims disputes, especially in times of high financial vulnerability.

SEVEN | UPFRONT POST-LOSS PLANNING IS NOT THE NORM IN THE CORPORATE INSURANCE MARKET

Most management teams have never suffered a major loss and, as this research confirms, they are therefore ignorant of the processes to follow, and the parties involved, when things go wrong. Precious time and money are lost when information and requirements following a loss are not made clear. Such uncertainty can exacerbate any claim dispute. Indeed, by taking the wrong steps a customer can actually prejudice the eventual outcome of a claim.

This recommendation is therefore that the explicit clarification of post-loss procedures for large losses should become a standard component of placement. This is partly to do with providing practical information like notification requirements and the protection of subrogation rights. But there is also value in explaining the involvement and roles of various internal and external parties (e.g. lawyers, loss adjustors and forensic accountants) in resolving large claims. For the sake of customers, there should be clarity on what reserving rights and other steps mean in practice. This includes making clear who appoints each third party, what their reporting lines are and which pieces of information need to be shared with them throughout the process. Without talking through these critical issues in advance customers ultimately do not know what they are buying.

Although the Mactavish Protocols may seem somewhat simplistic and obvious, the reality is that these practices are not generally carried out when corporate risks are placed in the insurance market.

In light of over one hundred consultations with senior insurance executives to test these reforms, we believe there is an urgent need to re-engineer the way corporate risks are currently placed. Implementation of these pragmatic recommendations will allow everyone to win; they should result in greater policy certainty and fewer surprises when it comes to claims; well-run companies with good risk management programmes should be rewarded; and insurers should have less variability in their underwriting results.

More robust and transparent risk placement will also create a fairer UK business environment. The only possible losers from the Mactavish Protocols will be those poorly managed companies currently free-riding on the back of an inadequate placement system that is long overdue an upgrade.

TWO | RESEARCH OVERVIEW

2·1 | Background

Mactavish is a specialist research business focused on the risk and commercial insurance segment. We have been conducting cutting-edge industrial research programmes across the UK, US and mainland Europe since the early 1990s, both independently and in partnership with leading insurers, reinsurers, brokers and investment banks.

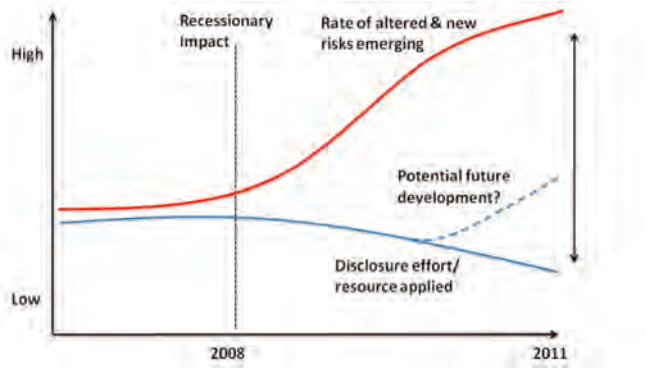
This report calling for reform of the corporate insurance placement process is the second part of a major cross-sector study undertaken throughout 2009, 2010 and 2011. The first part, published in January 2010, focused on how the recession and continued forces of globalisation have markedly changed operational risk profiles in a range of industries: from manufacturing to retail, construction and financial services.

In addition to changes outlined in our previous study, there have been many high profile operational disruptions to businesses over the past 18 months. Although not necessarily linked to recession and forces of globalisation, they amply highlight the problems operational risk issues of the types analysed can cause:

- The Deepwater Horizon incident.
- Widespread disruption from the Icelandic volcanic ash cloud.[4]
- Boeing's sixth postponement of its 787 Dreamliner.[5]
- Toyota's woes in having to recall eight models to fix a problem with a sticking pedal.[6]

Given this backdrop, the key question for businesses, and any firms involved in the insurance placement process, is whether material changes to operations and strategies have been adequately disclosed to insurers. Based on Mactavish consultations over 2009, 2010 and 2011 it is clear that in a lot of cases the simple answer is no. This is perhaps the single most fundamental deficiency in the insurance placement process today, and it is getting worse (see fig.1 opposite).

FIG. 1 | NEED TO ADDRESS GROWING RISK UNDERSTANDING GAP



SOURCE | MACTAVISH

In this second report, Mactavish has investigated this inadequacy much more deeply, and seeks to analyse:

- What exactly is deficient about the corporate risk placement process.
- What can be done, relatively easily, to address these deficiencies: namely, clear and practical steps customers and their suppliers can take to dramatically improve risk transfer.
- Why addressing these deficiencies is a win for everybody: businesses will have more reliable insurance policies and insurers should have less variability in their underwriting results.
- How brokers and insurers can start to compete on value rather than price, something many admit to being poor at right now.

2·2 | Study Methodology

Mactavish set out in this study to undertake a highly detailed, working level analysis into how corporate risk is placed and the limitations to this system. As part of the study it was necessary to draw on an extensive programme of primary qualitative research and our practical experience formed over a decade of involvement in corporate insurance transactions.

Our aim here was to combine the perspectives of dispassionate external researchers with sufficient insider knowledge of how things work today, in order to move beyond the ivory tower of pure research to a set of evolutionary recommendations for change.

As such, the investigation comprised three core workstreams:

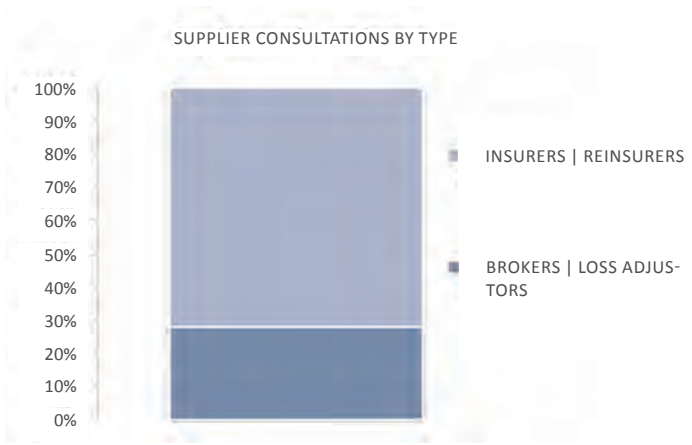
- Corporate consultations with risk and insurance decision makers and operational managers responsible for key areas of risk.
- Supply side consultations with insurers, brokers and additional service providers involved in analysing risks and resolving claims.
- Direct analysis of current risk disclosure and additional materials used to place corporate insurance policies.

The breakdown of the first two sets of consultations is shown in fig.2 opposite: analysing the range of supply and demand side consultations held by type and size. In total, this is a very significant sample of in-depth discussions: approximately 15% of the UK market. In total over the two year programme, 624 detailed customer consultations have been undertaken, including some follow-up discussions from the first part of the study in 2009 to probe more deeply into interesting responses and to gather examples of difficult claims.

Correspondingly, over 100 consultations have been held with senior personnel in insurers, brokers and relevant service providers on the need for risk placement reform representing a very wide sample of opinion across the UK corporate insurance market. The case for reform has also been debated following our cross-sector report with a range of insurance and industry sector trade bodies, key insurance policy makers (critically the FSA insurance supervisory team and the Law Commission) and AIRMIC (the main UK insurance customer lobby). Overall, these reforms were not arrived at lightly and have been thoroughly tested for relevance and viability prior to the publication of this paper.

The third workstream, on direct analysis of placement information, has also been a material undertaking. Of the companies consulted on this topic, nearly 100 sets of submission materials used to explain and place risk have been given to Mactavish to analyse. The aim here was to build a detailed view of what is covered and any major areas of recurring deficiencies. Further, 50 deep-dive follow-up investigations have been undertaken to interview key operational personnel across the businesses concerned to gather additional risk insights and prove the availability and relevance of deeper risk knowledge to insurance placement.

FIGS. 2A | 2B | CUSTOMER RESEARCH PROGRAMME BREAKDOWN



SOURCE | MACTAVISH

THREE | CLAIMS DISPUTES IN CONTEXT

3·1 | Backdrop to the increase in claims disputes

The P&C industry is facing a challenging time at present. Competition for premium income in the prevailing soft market remains cut-throat. Insurers are making lower returns from their investment holdings and profitable underwriting is increasingly difficult given a surfeit of underwriting capital. Furthermore, equity analysts monitoring the industry believe that insurers are exhausting prior year reserve releases to prop up combined ratios.

Against this backdrop, Britain has suffered from the deepest recession for over seventy years. This, along with the ever-present forces of global economic competition, has forced businesses to make unprecedented strategic and operational changes to cut costs and find new revenue streams. Risks have undoubtedly altered in light of these changes. When this is married with the generally inadequate disclosure standards seen in the insurance market (highlighted elsewhere in this report) it is clear why insurers are now feeling the pinch.

One major implication of this confluence of factors is that insurers are taking, and will increasingly continue to take, a much, much tougher stance on claims. This is already leading to a noticeable increase in claims disputes. This does not necessarily mean outright claims avoidance by insurers; rather, it more likely means delays in settlement or protracted and lengthy negotiations about the size of claims payments.

Firm statistical evidence of an increase in claims disputes will undoubtedly take several years to filter through. However, beyond the anecdotal evidence, there are now suggestions that there has been a structural increase in UK corporate disputes where insurance has played a role. Take these below statistics from activity within the Royal Courts of Justice: [7]

There has been a 45% increase between 2008 and 2009 in the total volume of major company RCJ disputes (excluding bankruptcy proceedings less likely to relate to insurance)

Corporate professional negligence cases have increased by 131%

Shipping claims have doubled year-on-year

There has been a 44% increase in technology, engineering and construction disputes

"We do see a stricter interpretation of wordings... the likelihood of insurers being generous on claims is behind us"

Client Relationship Manager, P&C Insurer

"In difficult times, insurers are driven to act quickly to protect their results"

Head of Claims, P&C Insurer

"Claims departments are under pressure to save money, particularly for high level claims"

Claims Director, P&C Insurer

"It has become standard procedure recently to issue a reservation of rights against claims in order to leave the door open to decline policy liability at a later date"

Commercial Director, Loss Adjuster

"Claims are always a struggle: you get reservation of rights slapped on as a matter of course, despite all the AIRMIC agreements"

Insurance Manager, Construction, £300m-£1bn

The British Insurance Brokers' Association (BIBA) has also sought to quantify the extent of the increase in claims disputes.[8] A survey of 132 BIBA members in the summer of 2010 showed that 70% of respondents have had to fight harder with insurers, on behalf of their clients, to get claims paid during the recession. Chief Executive of BIBA, Eric Galbraith, said in the resulting paper: "I recognise that with fraud being a major issue, there is a need for insurers to validate claims. However these statistics seem to suggest a too frequent reduction in the amount offered in claims settlements."

3.2 | Drivers of the increase in disputes

One of the predominant drivers of the increase in claims disputes is the soft insurance market and the consequent financial pressures faced by insurers. The current levels of claims acrimony are to a large extent cyclical; many of the most intractable insurance litigation cases in the period 2002–2010 arose from disputes about policies written at the bottom of the last soft market between 1998 and 2001. In a market awash with underwriting capital, as carriers jostle to secure premiums, insurers tend to offer broad cover terms, the inclusion of extensions and very low rates. Today we are almost certainly at a similar point in the insurance cycle again.

In the event of a big claim, many insurers in these conditions might reasonably assume that the account will be lost and so will not cave in quickly when it comes to claims that they think they can defend. Given lower industry profitability, it makes financial sense to staunchly defend claims of reduced value. Customers who believe that goodwill and reasonableness are cornerstones of their relationship with insurers should remember that this goodwill is very unreliable; above a certain claims amount brokers have little leverage and insurers tend to resist cutting a deal without investigating all other avenues.

Although there is a definite cyclical element to the increase in claims disputes, there are wider structural forces at play. This suggests that insurers are now taking a more defensive stance on claims as a matter of course and that this will be a permanent, rather than fleeting, fixture in the P&C industry.

The massive increase in general fraud over the last two decades, reaching an all-time high in 2009, has been an important factor in this shift.[9] Serious fraud cases totalling £1.3 billion reached the courts that year, the highest recorded since the KPMG Fraud Barometer started 22 years ago. More specifically for the P&C industry, according to the Insurance Fraud Bureau, undetected general insurance fraud claims amount to some £1.9 billion a year.[10] Anti-fraud initiatives involve insurers taking a tougher overall stance on claims, whether these are personal lines or relate to corporate insurance.

"Many of our largest and most intractable complex claims for many years arose from risks written at the end of the soft market. These stem from the combination of very low rates, broad cover terms and significant changes in insurer personnel and/or attitudes in the following hard market"

Partner, Insurance Practice, City Law Firm

"Commercial favours and compromises secured from insurers by brokers are now few and far between on big claims"

Claims Director, Insurance Broker

"Insurers are very, very reluctant to make deals now. In the US, companies are prepared to make a commercial deal. British insurers have lost the will – and are fast losing the skill – to do that"

Director, Loss Adjuster

"In the recent past claims were paid because brokers called in a favour from the insurer: that bank of goodwill is going, and rapidly"

Managing Director, Loss Adjuster

Another explanation of increased claims disputes is the generally poor but currently declining standard of risk disclosure in the insurance market. The soft market puts underwriters under intense pressure to secure new business. They must operate with the knowledge that there are other penholders ready to write business on the back of the most meagre information in submission documents.

Weak submission standards along with changing risk profiles for businesses are probably responsible for a large share of this claims increase, but this has only just started. The transition from soft to hard market will see an acceleration of the trend, something which buyers should be preparing for now.

Finally, the shadow of Solvency II is looming on the horizon. Although the financial impact of the new regulatory framework for insurers in the EU is unknown, the solvency ratio of carriers may be cut to around 135% from about 200%, reducing surplus capital and tightening the screws on balance sheets already under pressure.[11] This adds to the widespread pressures on insurers to get tougher on claims management.

3.3 | Features of the new heightened claims environment

One development of interest to buyers is the way insurers increasingly use outside experts to handle claims. Insurers are moving towards a model of bespoke teams (e.g. forensic accountants, lawyers & loss adjusters) to defend claims. Financial pressures require more sophisticated methods but these external parties were not party to the original risk placement and underwriting intention. That in itself may be problematic for buyers in the event of a dispute.

Commentators also point out that in the current environment insurers are also appointing legal counsel on both third and first party claims more quickly and in a greater proportion of cases, reflecting a stronger stance on claims overall. While external expert involvement should not favour one party over another, these outside experts are paid by the insurers who appoint them:

- Theoretically, everyone should win as engineers and accountants can, for example, help businesses get up and running again after a Property Damage & Business Interruption (PDBI) disruption.
- Where the insurer is in charge of these appointments rather than the insured, however, it is reasonable to assume that the result will not always be favourable for buyers. Customers have very little control over the use of outside parties in disputes and their appointment can often cause goodwill between parties to be eroded quickly, undermining established relationships with, say, an underwriter who has written the business for several years.

"Insurers are definitely looking at claims much harder and the main reason for this is the anti-fraud initiatives prevalent in the industry"

Commercial Director, Loss Adjuster

"Programmes to clamp down on fraud have bred a defensive culture in insurers that seeps way beyond attritional or third-party claims"

Director, Loss Adjuster

"It is a sad testimony to the fact there is so much underwriting capital out there that people are prepared to drop their standards, which affects submissions and underwriting"

Head of Broking, Insurance Broker

"Underwriters should do more due diligence on the risks they want to take on rather than relying on submissions"

Audit Manager, Financial Institution, £300m-£1bn

"The quality of submissions varies massively, but in a soft market underwriters just don't pay much attention to them"

Claims Director, Insurance Broker

"In a soft market, when it is awash with capital, certain sections of underwriters extend their remit"

Head of Claims, Property & Casualty Insurer

While the appointment of lawyers by insurers to investigate bigger claims might not necessarily be thought of as combative, this is often how it feels to customers. This same attitude of insurers has also affected relationships with loss adjusters; several prominent loss adjusting firms we talked to suggested that the profession's impartiality might be under threat.

In particular, some cited the issue of claims leakage assessment, whereby insurers' contracts with loss adjusters are specifically renegotiated each year on the basis of a small sample of historic claims files. The objective of this is to ascertain the difference between actual settlement values versus estimated correct values. If discrepancies show the insurer has "over-paid" the overall impact on the insurer is estimated by scaling up this sample. In some instances, the financial compensation sought as a result of this sampling method can be highly significant. Over time, this inevitably puts pressure on loss adjusters to minimise insurer payouts.

3·4 | What this increase means for customers

Outright refusal to pay, the most draconian response, is not the outcome of the majority of claims disputes. After all, pursuing claims in court costs insurers and corporate clients a significant amount of time and money. While refusal is a weapon in their armoury, disputes more usually end up with delays, uncertainty and a potential reduction in the value of the claim paid out. This is stressful for buyers and, at a time when balance sheets are stretched and insurance capital has never been more important, represents a risk that companies should confront head on. More and more are in the position where a long delay on a major claim settlement could prove financially damaging or even fatal.

Acrimony over claims might not even stem from clear-cut disputes. For example, respondents in this study frequently expressed dismay at the way Business Interruption claims play out. The issue may be as simple as a failure to explain how initial values behind estimated interruption loss potential are calculated. In such a situation the lack of a common understanding leaves the buyer feeling that the insurer has unfairly renegotiated the expected payout post hoc.

As you will read in section 4.2.4 claims disputes can adversely impact corporate balance sheets at a time when finances are stretched and alternative forms of credit finance (e.g. pre-settlement financing) are still largely restricted. This is a crucial point; almost none of the companies consulted include the risk of insurance policy failure in their risk registers. In light of the issues raised throughout this report, this represents a serious failure on the part of Boards to properly govern their insurance arrangements.

"I was immediately told by my insurer that they had appointed outside counsel, even before we had started to talk about the reasonableness of the claim. I thought to myself 'so this is how it's going to be is it?'"

Internal Audit Manager, Financial Institution, £300m-£1bn

"Lawyers are becoming extensions of claims departments"

Managing Director, Loss Adjuster

"Insurers are unwilling to listen to expertise and adjusters therefore think they are being manipulated"

Commercial Director, Loss Adjuster

"There is nothing better than a claim to take you through your policy and to show you how much value it adds to the business"

Insurance Manager, Manufacturing, £300m-£1bn

"You only have to get involved in one sizeable claim and you're on a pretty substantial learning curve regarding insurance law. The whole thing becomes a real nightmare of interpretation"

Risk Manager, Manufacturing, £300m-£1bn

FOUR | DEFICIENCIES IN THE RISK PLACEMENT PROCESS

4·1 | Insurance law & the duty of disclosure

In the UK the duty of disclosure (i.e. the requirement to inform insurers of all facts material to assessing risk) sits firmly with the insured. This is established by over two centuries of common law and enshrined in the Marine Insurance Act 1906. However, very few buyers recognise the extent to which the burden sits with them or the sharp contrast between insurance law and general contract law.

In short, insurance law requires buyers alone to identify and disclose everything that might be relevant to a prudent insurer when considering the risk, regardless of whether or not it is asked for by the insurer. If any part whatsoever of this obligation is not met, an insurer may (under the law) avoid the policy entirely, even if the omission is both accidental and irrelevant to the claim. Although a more reasonable commercial outcome is often negotiated in practice, that will depend on the amount of goodwill in the market at the time (a commodity which ebbs and flows through the cycle). As we will examine in section 5 below, this will leave less powerful buyers exposed.

The case which sets out the legal test for judging non-disclosure is Pan Atlantic Insurance Company Limited & Others v. Pine Top Insurance Company Limited, July 1994.[12] The judgment sets out the conditions that have to be met for an insurer to avoid an insurance policy (in other words, reject the claim, dissolve the contract, return the premium, seek repayment of any prior paid claims under that policy and treat it as having never existed):

- **Material facts**: It is the duty of the insured to disclose all facts material to an insurer's appraisal of the risk which are known or deemed to be known by the insured but are neither known nor deemed to be known by the insurer.
- **Influencing the underwriter**: A fact is deemed to be material if objectively it would have influenced the judgement of a "prudent underwriter" in determining the premium or deciding whether to accept the transfer of the risk.

The case of Assicurazioni Generali SpA v. Arab Insurance Group, July 2002, sets an additional requirement that the underwriter proves non-disclosure of the material fact actually induced the particular underwriter to write the risk on the terms that he did.

These conditions place a heavy burden of disclosure on the insured and raise several questions that must be considered:

- What exactly is a material fact?
- What facts would influence the mind of a prudent underwriter?
- What level of detail does an insured need to provide to lessen the probability of non-disclosure problems?

The duty of disclosure is not the only thing that sets insurance law apart from general contract law. Contract terms that are thought to be familiar have fundamentally different meanings in an insurance context. Several of these, set out below, if they are misunderstood, can also result in claims being disputed.

Under ordinary contract law there are conditions (these are fundamental terms, breach of which entitles a party to repudiate) and warranties (these are ordinary terms, breach of which gives rise to a right of damages). Insurance law turns this on its head; warranties are fundamental terms, breach of which entitles insurers to treat themselves as off risk from the date of breach, whereas conditions are the ordinary terms of the policy,

Warranty | This is a pre-contractual promise by the insured that a fact provided is true, will remain true, or that an insured will not behave in a particular way. A breach of warranty has serious consequences; the insurer will be off risk from the date of the breach.

Notification provisions | These require the insured to give notice to the insurer of a claim or loss within a specified period. If these are not adhered to then the insurer may be able to decline the claim (where the notice provision is a condition precedent to liability).

Basis Clauses | The provisions in the proposal form (incorporated into the policy) by which the insured warrants the truth of answers to questions in the proposal form. If any of the answers are untrue, then the insurer can repudiate the policy.

breach of which usually only gives rise to a right to damages (which is often of little consequence because the insurer suffers no real prejudice capable of being quantified in money terms).

The recent judgement handed down in the case Sugar Hut Group Ltd & Ors v Great Lakes Reinsurance (UK) Plc & Ors [2010] EWHC 2636 (Comm) re-affirmed the courts' strict reading of warranties (see section 4.4.) It highlighted that there does not necessarily need to be a link between the breach of a warranty and the cause of a loss for an insurer to avoid a particular policy.

Mactavish is not a law firm and only aims to warn insurance buyers that risk disclosure and other tenets of insurance law are important and require their attention. However, there are clear grounds for concern. The vast majority of buyers (87%) are unaware of how onerous the duty of disclosure really is. Key legal terms such as warranties and their implications when it comes to policy coverage are not understood. Much remains to be done to rectify this, work that is obviously far better tackled in advance of a major loss than in response to one.

4·2 | Poor current standards of disclosure

4·2·1 | The status quo

Customers and underwriters have openly reported to Mactavish their general dissatisfaction with the lack of information in disclosure documents and the risk this poses. Furthermore, information standards in 2011 at the end of a long soft market cycle (affecting both placement fees and premiums) are thought by many to be lower than ever.

It has to be worrying for brokers and insurers that 65% of insurance buyers at large companies do not review the materials used to place their risks in the market, with many unaware of such documents' existence or purpose. In light of this revelation it seems extraordinary that the insured takes on legal responsibility for judging what facts might be material to an insurer. Without detailed knowledge of what exactly is disclosed buyers are taking a blind leap of faith by assuming that important, low-frequency high-severity risks are adequately covered.

Even buyers who carefully scrutinise submission materials must ask themselves an additional question when gathering the data and information to be disclosed to the insurer: who exactly at the insured should be involved in this process? Many risk managers and buyers sit in central business functions, quite distinct and separate from the activities of diverse operating units in complex and increasingly global organisations. It is plainly asking a lot of insurance buyers to have sufficient knowledge of all operational details that may be germane to a particular risk.

"You take the duty of disclosure as read: it's quite vague to be honest. I've never looked at anything like warranties or basis clauses"
Audit Manager, Manufacturing, £100m-£300m

"I'm probably expressing my naivety here, but my understanding is that if something is not material to the claim then it has no bearing"
Insurance Manager, Retail, £5bn+

"I've never looked at insurance law myself. I firmly put myself in the category of not having a clue"
Company Secretary, Manufacturing, £300m-£1bn

Nevertheless, the law is very demanding in this respect. Insurance buyers are effectively responsible for gathering together all relevant material facts that may have an impact on corporate risks, no matter how large, complex or decentralised their businesses might be; clearly this is an extremely demanding task. (It is open to buyers as a matter of insurance/ contract law to agree with insurers how this process is carried out or to limit formally what needs to be disclosed, but few buyers do so). **It is a key conclusion of Mactavish that the typical practices of businesses in gathering together data and information for renewals are inadequate to meet their legal responsibility of disclosure.**

It is not just insurance buyers who fall foul of poor disclosure. In the cross-sector research paper Mactavish published earlier in 2010, a wealth of evidence from leading corporate risk underwriters demonstrated that the information provided to help them understand risk exposures was fundamentally inadequate. Many have more recently commented that standards continue to decline.

If standards of disclosure to underwriters are generally considered inadequate – and Mactavish has amassed enough evidence over the past two years to show that this is the case – companies should further understand that insurers hold the whip hand, from a legal perspective, when it comes to large claims. In these instances insurers have, with the benefit of hindsight, the ability to determine what material facts should have been disclosed. This has two key implications:

- There is clearly an opportunity to reduce claims volatility were disclosure standards to be higher.
- Customers may be unduly and unhealthily reliant on the goodwill of insurers (which varies with the cycle and according to insurer fortunes) to ensure that their claims are resolved to their commercial satisfaction.

Insurance buyers should be deeply concerned to read underwriter criticisms of risk-relevant information standards, particularly as the legal responsibility for such inadequacy lies squarely at their feet.

4·2·2 | Are the brokers to blame?

At this juncture it would be relatively easy to turn to brokers and criticise them for failing in their duties to:

- Advise clients as to what is the appropriate level of disclosure.
- Provide the necessary documents to support this process.

But such an analysis would be overly simplistic. Brokers, given the range of requirements placed on them and the limited resources at their disposal to forensically analyse risk across the client's organisation, cannot be expected to play this role in full. What's more, the current environment

"If we open our insurer's eyes as to our risks I think they'll be horrified by what they think they've been insuring"

Risk Manager, Healthcare Sector

"We've changed so much and so fast that I'm not sure insurers have kept pace with us"

Company Secretary, Retail, £300m-£1bn

"We don't hide anything from our insurers but it's up to them to understand the risk: if they don't ask, they don't know"

Finance Director, Manufacturing, £300m-£1bn

for broker remuneration is undoubtedly tough; based on this study, typical fee levels in 2010 in the mid and large corporate segment have fallen (following a broker tender) by at least 25-30% on 2007 levels, with this trend further accelerating over the past year.

Anecdotal examples of much greater broker fee cuts - of 50% or more - were far from rare in our study. The pressures are further exacerbated by the long-term trend towards reduced contingent commissions (payments to brokers from insurers in relation to aggregated placement of risks), itself due to increased regulatory scrutiny of potential conflicts of interest. That said, there are signs over the last twelve months that these commissions have crept upwards in part to compensate for the downward fee pressure.

Brokers have made serious efforts to reduce costs over the past few years in response to fee cuts. And although not necessarily consciously, buyers have acquiesced in a trade-off between lower fees and less intensive servicing and placement. Brokers, after all, are service providers and cannot be expected to do more for significantly less.

Besides, insurance arrangement fees are really quite low by comparison with the fees charged by other intermediaries responsible for capital arrangement. Insurance brokers arrange contingent capital whereas investment banks arrange non-contingent debt and equity capital, so any structural comparison is far from simple. Nevertheless, it is valid to compare broking fees as a proportion of insurance limits purchased with the fees earned by investment banks. Typically, brokers earn placement fees which equate to somewhere in the region of **0.1 to 0.2 per cent** of contingent capital arranged (though variations are significant within this range due to differences in programme structures, risk type and industry sectors), whereas banks earn between **two** and **ten per cent** (debt arrangement being at the lower end of this spectrum, and Initial Public Offerings at the higher end).

The measure of broker fees as a proportion of limits remains methodologically crude, so it would be wrong to place too much emphasis on this analysis alone.[13] The broad comparison, however, is a valid one and poses a challenge for brokers at a time when fees seem to be falling further. With company operations becoming increasingly complex it is surely the case that more and not less time should be devoted by brokers to studying the operations and risk profiles of their business clients.

Many brokers, of course, are faced with buyers who are somewhat disengaged from the disclosure process; as we have shown many do not even review disclosures let alone seek actively to improve the presentation of corporate risks, or engage colleagues to assist. Is it not unrealistic to expect brokers to be more than pragmatic? Broking houses

"We have to sense check everything in submissions, particularly wage and turnover figures. These fluctuate wildly and I suspect they are often wrong in presentations"

Construction Underwriter

"My team routinely experiences brokers saying 'that information isn't available, just quote!' Presentations are definitely thinner nowadays, probably as a result of just pointing underwriters to company websites and other sources of public information"

Senior Casualty Underwriter

"Brokers often give us next to nothing. We get a short company description, turnover and if we are lucky the claims experience"

Senior Property Underwriter

need tightly managed cost bases; they typically do include small-print reference to legal responsibilities in customer terms and conditions, even though very few customers read them and little effort is made to improve the standard of disclosure.

Laying the blame solely at the feet of brokers would be unfair. If market standards are as inadequate as Mactavish believes them to be, all actors in the risk placement process (buyers, brokers and insurers) must share the blame and accept the responsibility for trying to remedy the situation. Buyers bear the ultimate risks of inadequate disclosure and the danger that they are not covered for major loss events. As such, it is buyers who should take the lead in reform and demand that changes are made.

4·2·3 | Where exactly is disclosure inadequate?

A team of Mactavish risk analysts has talked to around 100 senior insurance executives and reviewed over 100 market submissions over recent years, in the build up to this report. The firm has also conducted around 50 in-depth studies of specific company risks, investigating the availability and accessibility of information beyond what exists in submissions. This sample is sufficient to establish detailed insight about a wide variety of sectors, companies and risk types. It enables us to comment authoritatively on:

- Existing disclosure standards and the major systemic weaknesses.
- The extent to which these problems can be addressed by gathering (and adequately structuring) more complete information about risks.

The first conclusion to be drawn from Mactavish's research is the remarkable consistency of information provided by businesses to insurers: the same weaknesses and limitations seem to crop up in almost all cases. The senior insurance personnel consulted as part of this work concurred that the weaknesses are endemic and market-wide. Of course, there is some variation in the standards of disclosure – and specific areas of error and omission – but the overall picture is consistent enough to confirm that current market standards are inadequate.

The three main structural Mactavish criticisms of insurance submission documents are:

1. An excessive focus on presenting bare facts, rather than crucial information about the context.
2. A common lack of structuring, indexing and signposting. Underwriters complain that they increasingly get given a "data dump" of information, some of it relevant to risks but a great deal of it not.

"The broker role seems to be increasingly looked at with the paperclips and toilet rolls: a commodity with no science to it at all"

Account director, major UK Broker

"Brokers in general are terrible at justifying the value of what we do – this makes it impossible to control fees in this environment"

Division head, major UK broker

"I honestly think we undersell our value and are our own worst enemies. You see it time and time again where someone undercuts the fee by 30% without having any understanding at all. It's inevitable that the client base always think there's fat in the process, regardless of whether that's reality"

Global client manager, major UK broker

3 A reliance on verbal briefings from either in-house staff at the insured or the broker, aimed at supplementing information provided in the briefing documents but which is seldom documented or recorded on file.

Shortcuts, like relying on public information sources or simply re-directing underwriters to company websites without flagging specific information, obviously save time. But they are myopic to the extent that they do little to protect buyers from their exposed legal position. For example, excerpts from annual company reports on business developments almost always stop short of explaining operational factors such as supply chain re-engineering that might materially change risks. Annual reports also routinely ignore details about non-core parts of the business that are not strategically or financially significant but which nonetheless carry significant risks.

| Errors in submissions

Similarly, there are often errors in disclosure documents. Although many examples are relatively minor and can be resolved through normal placement questioning, the errors were notable enough in a significant number of cases reviewed by Mactavish to suggest that they materially affected pricing and coverage:

- The pricing of risk was adversely affected through incorrect exposure information and/ or values, either directly driving the assessed price up or indirectly through generating insufficient insurer competition.
- Reported claims costs were unduly high by several orders of magnitude, materially influencing pricing (for example, several claims were presented as high value and outstanding even though the underlying incidents had long since been resolved at minimum cost).
- Confusion over coverage requests (e.g. extensions or conditions requested that were inconsistent or not required), again with a marked premium impact.

All these errors potentially created scope for claims disputes. They also affect specific pricing judgements.
But it is not just what can be found in disclosure documents that is at stake. A more significant criticism of the traditional data set given to insurers is that it excludes a much larger body of material information. Some underwriters might classify this information as ‘nice to have’ and, in many cases it becomes material with the benefit of hindsight (i.e. after a claim). However, the willingness of the market to function without such information should be of no comfort to buyers given the laws governing disclosure.

| Significant omissions

There are many powerful examples of material and potentially damaging information gaps in submissions, grouped around the following recurrent themes:

- Very limited focus on business changes and the risk impact of these changes. This often leads the underwriter to make outdated or erroneous judgements about a company’s operations.
- Cursory and often inaccurate discussion of product or service details, particularly the end-use to which customers put them which nearly always has a bearing on risk. For instance, using marketing materials to explain product risks without providing additional commentary can prove highly misleading:
  - It can falsely suggest large exposures when the underlying reality is often more prosaic.
  - Or, conversely, it can omit possible risky applications of the product that are not necessarily relevant to the marketing message, leaving underwriters unaware of the possible exposures.
- Insufficient engagement with operational complexities, in particular, the underlying drivers of business interruption risk, e.g.:
  - Areas of single source dependency.
  - Bottlenecks in the process which could impede business recovery after a loss.
  - Specific details about Business Continuity arrangements.
- Lack of discussion of non-core activities. Large, complex companies often undertake a variety of activities and their products or services are used for a range of different – and not immediately obvious – applications. Each of these applications has its own risk profile, for example apparently innocuous components being used for riskier medical, space or nuclear applications. Mactavish has reviewed several cases where extremely high risk activities or product uses were not included in the submission, usually because they did not represent a material proportion of a firm’s revenues or margins.

- Little or no discussion of critical risk management activities. These activities should provide vital context to the interpretation of values and claims data in the submission. To the extent that any commentary on risk management is included it usually has a marketing edge rather than being rooted in fact. It may also be rather vague and thereby fail to provide details that would allow an underwriter to assess quality, or consider whether improvements in claims trends might be expected.
- A common lack of detailed analysis of large, one-off or anomalous claims. In particular, there is often no consideration of the risk management responses and subsequent potential for recurrence of such claims.

These examples are necessarily generic and far from exhaustive but they do give a flavour of why insurance buyers must scrutinise submission materials more diligently than they currently do. This is imperative if they are to manage the risk of material non-disclosure that lies squarely on their shoulders.

4·2·4 | What does this mean for customers?

Inadequate disclosure carries a huge risk and cost for customers in terms of:

- The price paid for cover and the level of competition and risk appetite from insurers.
- The scope for unnecessary coverage, or an inappropriate programme structure.
- The potential for delay in the payment of a claim or, even, avoidance of the insurance contract.

The alternative to providing underwriters with the necessary information for them to make more informed judgements is to accept a portfolio pricing approach, where a particular rate is unthinkingly applied to all companies in an industry sector. At the level of large, complex corporate risks however, no two companies are the same and very few could readily fit into neat industry classifications. Looked at in this way, reform of the placement process is crucial.

Research by others, meanwhile, confirms that customers are indeed concerned with the disclosure of risks. AIRMIC published a survey in March 2010[14] showing that a third of buyers reported non-disclosure issues in relation to claims in the last five years. This number is remarkably high given the relative paucity of complex event claims where disclosure standards are most questionable. The same survey also reported that only half of those non-disclosure cases were resolved to the customer's broad satisfaction. This suggests that reliance on insurer goodwill in the absence of legal protection is an unwise strategy, and likely in current market conditions to become more dangerous before it gets better.

The most extreme outcome of non-disclosure - and by far the least common one - is when an insurer avoids an insurance contract entirely. The lower level costs of poor disclosure, however, (e.g. delays, reduction in the value of claims paid, higher premium cost through reduced insurer competition or inappropriate programme structure) remain highly significant.

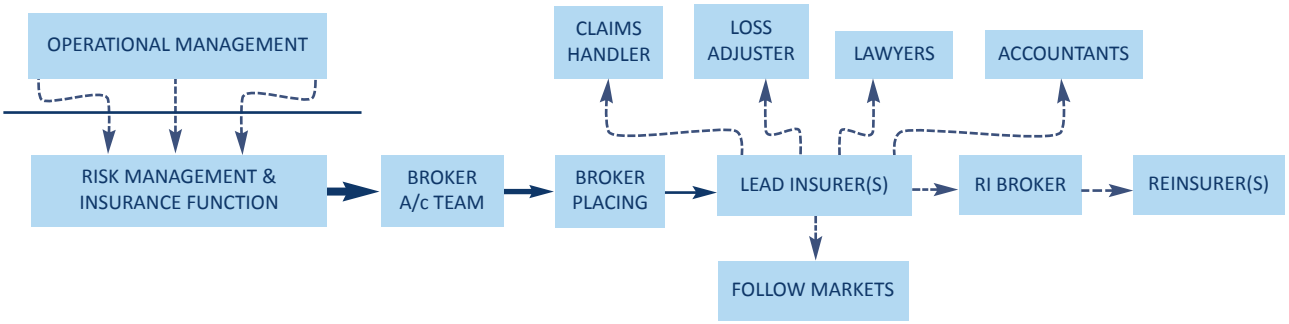
Mactavish's core conclusions about inadequate disclosure of risks are simple and underpin the case for change:

- Current scrutiny of submission documents by customers is strikingly inadequate given the risks they assume under insurance law.
- Complex and difficult though it may be to provide insurers with more qualitative information about risk management practices, such information is no less necessary or material.
- Avoiding complexity through limiting disclosure efforts (whether consciously or by default) without the prior agreement of insurers – as is the norm currently – is a high risk strategy in light of insurance law.

It will be challenging for brokers and insurers to widen the traditional disclosure data set to include more complex contextual information. Greater underwriting judgement to supplement the number crunching required for underwriting models will be needed to sift through what will be rich and sometimes conflicting information about risks. This is, however, by no means beyond the wit of insurers. In recent years, the insurance industry has grasped emerging areas of risk and vastly refined underwriting models in areas like business interruption.

The alternative to reform is helplessly waiting for unexpected claims to show up in loss patterns and retrospective actuarial data. Even a partially structured appraisal of richer information about corporate risks would represent a big leap forward for the industry.

FIG. 3 | DIAGRAM OF RISK KNOWLEDGE FLOWS - COMPLEXITY OF PLACEMENT AND CLAIMS RESOLUTION



SOURCE | MACTAVISH

4·3 | Concerns with placement processes

The evidence is clear that, thanks in large part to inadequate and worsening disclosure levels, the insurance policies upon which major companies depend are not as reliable as they should be.

The problem, however, doesn't end there. While the information used to explain and place risk is not fit for purpose, the same can be said for some key aspects of how risks are placed. These two areas are, of course, inextricably linked; it is impossible to improve the placement system without better information, but on the other side of the ledger risk insights can be put to better use. This section outlines some of the problems voiced by the customers, brokers, insurers and claims professionals we spoke to. They further strengthen the case for placement reform.

A useful aid to this analysis is to consider the flow of risk knowledge along the chain shown in fig. 3 above: from operational staff to risk management function; to broker; to lead insurer; to follow insurers and/ or reinsurers; and potentially also to the external parties (loss adjusters, forensic accountants, lawyers etc.) increasingly involved in complex claim resolution. Inadequate understanding by the last party in this chain of information, transmitted all the way from the first, may well have a material impact on a claim's outcome.

This is a complex two-way picture. An underwriter wants to know about the risk before offering coverage (and even more so before paying a claim), but equally a buyer must communicate to colleagues what is relevant to underwriters. This knowledge is ultimately derived from the other end of this chain.

Various hurdles currently inhibit policy reliability, though it is clear that major improvements should, and can readily, be made.

4·3·1 | Disconnect between insurance function & operational management team

First, at the very start of the chain, insurance functions often lack sufficient access to, and engagement with, the senior colleagues and operational managers who have the most granular knowledge about operational risks. In the current climate the risk management resources to build such links and gather information are shrinking in more and more companies. All the while the complexity of the task continues to increase with wider, more global operations and increasingly inter-connected supply chains.

4·3·2 | Reliance on undocumented risk information

Second, the proportion of critical information supporting the understanding of corporate risk that remains undocumented is too great. This impedes the flow of knowledge along the chain, in particular the wider contextual elements (detailed elsewhere in this report) often lacking in submissions. Information that might fall between the gaps if undocumented includes discussions between buyer and broker over the many years of service, questions raised by staff during underwriter open days or supporting explanations given by the placing broker to the underwriter when

questioning terms. Such undocumented knowledge is clearly hard to rely upon in the event of a disputed claim.

This concern is accentuated by the relatively high staff turnover among insurers, brokers and insurance buyers, which reduces understanding on the supply side. While brokers and insurers point to better systems and easier electronic data transfer of core submission material than was the case even ten years ago, this does not extend to wider contextual risk knowledge of the sort previously described.

4·3·3 | Placement is a 'black box' for buyers

Third, insufficient buyer contact with underwriters undermines efforts to meet disclosure requirements or understand wider coverage intention. This point is critical for policy certainty. Very few buyers profess to have enough contact with underwriters to second guess what the "prudent underwriter", whose needs they must meet by law, actually cares about.

Instead, most buyers report little understanding of how risk is actually placed; the process remains a 'black box' conducted by a broker that spits out pricing details and a recommendation of which carrier to choose. Questions about risks may or may not be passed on, all the more unlikely in a soft market with plentiful capacity. But even where they are, the rationale behind these questions, or the relevance of the answers to specific loss scenarios, is seldom discussed.

"There's just no real way of knowing what an underwriter will think is relevant"
Finance Director, Food & Beverage, £1bn-£5bn

"It's unfair that the onus is on me; that asks me to apply knowledge I don't have"
Head of Audit, Financial Institution, £300m-£1bn

"Brokers will say they always record information received into the file notes, and it may be in the manual. However, when you get into the detail the reality is very different. It's getting worse with more and more information coming in, either verbally or data-dumps across multiple formats – there's no way it's all gone through or recorded properly"
Senior Manager, Large UK broker

"Although the availability of Management Information has improved dramatically, the standard of structuring and communicating relevant information properly is highly variable... it doesn't help that there is so much underwriting capital out there where people are readily prepared to drop their standards"
Senior placing manager, UK broker

"I think market presentations are the biggest waste of time ever. You get up in front of some slides, with some information that you'd send them anyway. They want to find out things that are material to the risk, but none of them speak up"
Company Secretary, Construction, £100m-£300m

"Policy wordings are abstruse and complicated. In the end it's not clear what's covered"
Insurance Manager, Financial Institution, £1bn-£5bn

4·3·4 | Buyers have no real basis to appraise & clarify coverage

Fourth, the wording and coverage offered by the underwriters is critical. Mactavish's prior cross-sector study found that 65% of buyers do not review the submission document used to place their risk. This obviously raises the likelihood of inaccuracy or omissions in disclosure.

However, an even larger proportion does not, or is not in a position to be able to, review the detail of insurance contract wordings or explicitly consider potential loss scenarios with underwriters – an equally concerning risk. In fact, within the sample consulted for this study only a handful did so; fewer than 2% of respondents reported that they had both a discussion with underwriters about loss scenarios and a review of policy wording within the past three years.

The customer's ability to understand potentially subtle differences in coverage, or what wordings mean given the peculiarities of insurance law and the differences with general contract law (as explained earlier), is therefore very limited. A good broker should perform this role but the unfortunate reality is that too few brokers today undertake this discussion with their clients and the expertise to do so remains thinly spread.

Like inadequate disclosure, the consequences of inappropriate wordings can include uncertainty or delay in the event of claim, fundamental coverage gaps and short-term pricing effects; this study alone has uncovered multiple examples of unnecessary and irrelevant policy extensions being requested and paid for year after year, as well as limitations to coverage fundamental to the risk. These effectively leave policyholders uninsured and paying for minimal or, worse, zero practical protection.

There is a wider overall point here. Most buyers do not feel equipped to make an informed decision between placement options when presented with basic pricing information and the credit/security ratings of each insurer.

"Attention to policy wordings, getting the right cover and explaining it to clients is, across the market, poor....It definitely increases claims uncertainty and there's massive variability in the technical competence of brokers in this regard. The transition from soft to hard market is when the problems really come"

UK corporate broker

"My broker strongly advised me not to raise any wording concerns. They thought it was better to leave the contract loose and argue about it after a claim"

Head of Treasury, Retail, £1bn-£5bn

"I don't know what we're covered for. You simply cannot tell and I've never had any clarification from the broker. As a layman, when you look at the insurance policy and ask 'are we covered?' the answer is often 'I'm buggered if I know'"

Audit Manager, Manufacturing, £300m-£1bn

"It feels pointless to take a discussion on coverage. I'm finding it difficult to envisage a question that wouldn't give rise to a bland standard answer"

Insurance Manager, Manufacturing, £1bn-£5bn

"There is a definite lack of rigour in writing and reviewing wordings... the reason for issues post-loss is almost always that people were not talking to each other enough at the beginning"

Director, UK loss adjuster

Without a richer presentation of offers many find it impossible to analyse:

- Differences in cover.
- Variations in the adequacy and clarity of risk understanding.
- Elements of the response service offered in the event of a major loss.

There is simply no mechanism in most cases for a buyer to reach an informed view on these points.

Broker innovations to broaden insurer scoring beyond credit ratings and to include qualitative views of their offerings on claims handling and policy wording, are welcome. But they are not a substitute for direct presentations on these details before choosing an insurer. In this study, only 22% of buyers consulted on the issue had been involved in focused discussions on claims service, and in every single case this only occurred reactively in response to a prior contentious loss.

4·3·5 | Potential disconnect between account & placement teams

Fifth, many buyers say the division between broker account and placing teams further inhibits the flow of risk information from customers to insurers, and of technical policy clarification in the other direction. While placement teams are more often directly involved with clients today than has traditionally been the case, there remain swathes of the market and customer segments where customer contact with placing brokers is severely limited. Extreme situations such as that suggested by the quote adjacent may not be the norm, but neither are they unheard of.

Understandably, the interface between account and placement teams remains most stretched on rushed or emergency placements. However, the majority of corporate renewals take place on the same few quarter-end dates for all customers; all risk communication and placement activity therefore competes for the same resources in the last few weeks before renewal. The worry is that this inevitably limits the amount of additional forensic questioning beyond the core submission.

4·3·6 | Ignored role of follow markets & re-insurers

The final link in the chain in fig. 3 concerns the key role of both follow and reinsurer markets, many of which will be less well known to customers but may hold decisive influence when it comes to resolving a major claim. While follow or excess layer markets usually receive the same submission information as insurers and would typically be

"The first time I spoke to a large claims department was after a difficult PDBI claim – I had to speak to people I didn't even know existed. It was an eye-opener for us."

Insurance Manager, Manufacturing, £1bn-£5bn

"Sometimes a placing broker picks up the file ten minutes before meeting an underwriter – how can they possibly know the risk in detail? Sometimes they barely know the name of the insured"

Divisional head, major UK broker

"Even where there is a good underwriter and a competent broker, there is no time; everyone is chasing their tail"

Managing Director, Large Claims Handler

"I do feel like the whole industry thinks that nothing starts until sixty days before renewal"

Risk Manager, Food & Beverage £100m-£300m

invited to group risk presentations given by companies, they are less likely to attend such events and are given a lower priority when it comes to establishing a wider contextual understanding of risks (the type that is so often undocumented).

The situation can be even more difficult for facultative reinsurers since the materials used to explain the risk often differ, typically without customer approval, from the original submission. Even in cases where the same broking firm handles the primary and facultative reinsurance placement the two teams will remain entirely separated. While this serves the primary objective of minimising conflicts of interest, it adds another link in the extended chain of the transfer of risk knowledge; facultative reinsurance underwriters routinely complain that they receive inadequate detail by this stage.

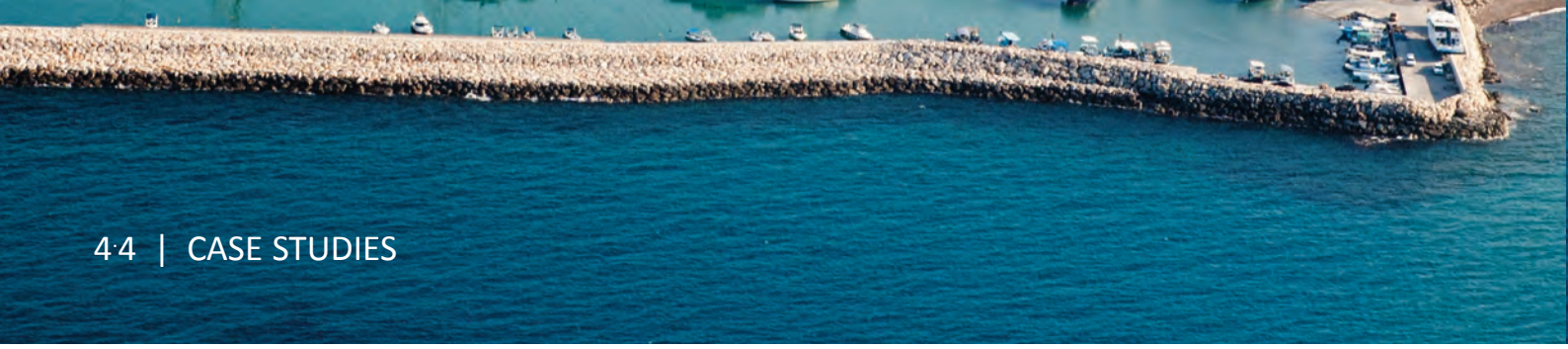
Overall, further uncertainty as to the effectiveness of risk transfer stems from a reliance on multiple additional parties for key capacity at the end of the chain, where risk knowledge is likely to be more limited. This is true both of those follow markets and reinsurers involved up front when risk is placed, but also of external parties (lawyers, loss adjusters etc.) brought in to assist with claims resolution. There are precious few grounds for buyer comfort under the current system; without a better standard of exhaustively documented risk disclosure and a more transparent risk placement process all the way through to these parties, deficiencies will remain.

"The information we get at the end of the chain is so watered down, so thin"

Head of Facultative Casualty, Major Reinsurer

"Basically all the insurers and reinsurers got in a smoke filled room, carved up the claim and decided what the outcome and division of responsibility should be. Even with our lead captive taking most of the hit, there was no consultation at all"

Head of Insurance, Manufacturing, £5bn+



WHERE MIGHT THINGS GO WRONG?

The following two case studies are derived from our analysis of around 100 sets of company submission documents. They demonstrate the type of material non-disclosure to which companies are routinely exposed, the consequent uncertainties over insurance coverage and the hidden inacurracies in risk assessment and pricing.

UK HIGH-TECH MANUFACTURER | £100-£500m

- **No information given on product end-uses, including several extremely high risk applications** | Failure to disclose these could constitute material non-disclosure and lead to policy avoidance even if the end-use was unrelated to actual loss.
- **No explanation of contractual terms of sale, warranties provided, allocation of liability across supply chain or quality control procedures in place** | This could encourage the mispricing of risk and provide grounds for a claim to be disputed where an underwriter's assumption was inaccurate.
- **No mention of sensitive contract testing work undertaken for third parties** | Potential to question a claim on grounds of material non-disclosure, exposing a gap in coverage if such activity is excluded by the wording of the contract.
- **Several key 'red flag' areas of concern to underwriters were not explained, for example, clean room manufacturing techniques** | This may cause punitive pricing based on assumed significance far exceeding reality.
- **Inaccurate description of loss recovery capability in place, for example, IT back-up facilities** | This increases the likelihood of a BI claim assessment being protracted or adversarial.

UK RETAILER | £1bn-£5bn

- **No appraisal of recent operational changes that would affect risk, for example: closure of majority of distribution sites, 25%+ reduction in suppliers while shifting sourcing to new Asian markets, major reduction in facility/risk management staff** | Material non-disclosure and the threat of policy avoidance; misalignment of existing policy structure with amended supply base creates major coverage gaps regarding interruptions arising upstream.
- **No discussion of move into product design role and associated liability risk** | Likely large-scale and unknown underinsurance.
- **Poor quality information critical to BI risk assessment, including incorrect values ascribed to major sites and conflicting data on the distribution model of the company's largest division (more than 100% overstatement of sites involved)** | Drastically increasing likelihood of protracted negotiation over any related BI loss and a lower than expected quantum of settlement.
- **High profile claim value provided without any discussion of causes, mitigations or subsequent business response** | Likely to cause overpricing as recurrence potential is overestimated.

...AND WHAT CAN HAPPEN WHEN THEY DO?

Recent case history highlights the balance of legal responsibility and the potential financial consequences for policy holders when claims are disputed.

NICHOLAS G. JONES v (1) **ENVIRONCOM** LIMITED (2) ENVIRONCOM ENGLAND LIMITED and MS Plc t/a MILES SMITH INSURANCE BROKERS [2010]

- Important 2010 UK insurance law case on the duty of disclosure once again confirmed extreme burden on corporate insurance buyers.
- Refrigerator recycling plant contained flammable material (pentane) and high temperature plasma cutters. The use of plasma cutters and their link to a number of minor fires had not been specifically disclosed to insurers.
- Major fire occurred in 2007 (fuelled by pentane and sparked by plasma cutters) causing the destruction of all plant/ equipment and closure of the site.
- Insurers successfully reduced the claim - **paying less than one sixth of the total value** - on the grounds of material non-disclosure of both the prior incidents and the use of the plasma cutters.
- Insured argued successfully that the broker had been negligent in failing to provide adequate advice on disclosure requirements (giving no indication of the meaning of a 'material fact' and relying upon standard documentation), and that the insurers had conducted surveys of the site without flagging this fire risk as a concern.
- The Court ruled that the advice on disclosure was insufficient. The broker, however, avoided any liability as it was deemed that had the full facts been made available the risk would have been uninsurable.
- Case demonstrates that the duty of disclosure lies firmly with the insured, despite notable failings on the part of both broker and insurer. Insured was effectively left paying unknowingly for worthless cover, highlighted only when the loss occurred.

SUGAR HUT GROUP Ltd & Ors v GREAT LAKES REINSURANCE (UK) Plc & Ors [2010]

- Recent 2010 insurance ruling regarding the disclosure of business changes unrelated to loss which might nonetheless be deemed material facts and undermine insurance coverage.
- Fire in 2009 at entertainment venue where PDBI insurers disputed liability due to both a) non-disclosure of a corporate restructuring arising from insolvency and b) breach of warranties in the policy relating to site maintenance and waste storage requirements.
- Either of these two factors was deemed by the Court in 2010 as sufficient grounds for the insurer to consider itself off-risk, regardless of any link to the fire loss itself. Insurer's rejection of coverage upheld.
- Case highlights the need for companies to be both extremely careful when appraising legal disclosure requirements and to pay close attention to policy warranties.

FIVE | MACTAVISH PROTOCOLS: REFINING RISK PLACEMENT

5.1 | Introduction to the Mactavish Protocols

The report so far sets out common deficiencies in the way corporate insurance is placed, particularly when it comes to the disclosure of complex risks. Mactavish believes that these inadequacies can be readily addressed; improved standards of risk disclosure and, consequently, more robust insurance coverage are highly achievable goals for buyers.

But it is not just buyers who would benefit. Mactavish has floated these ideas for reform with more than 100 senior executives from the largest UK market insurers, reinsurers and broking houses. Virtually all those consulted recognised that valuable differentiation of services could be achieved through implementing some of these reforms, showing a workable degree of consensus.

> "These reforms would avoid a lot of potential disputes as they increase the general sense of trust. Of course doing this is quite provocative, but nonetheless very positive"
>
> *Chief Underwriting Officer, P&C Insurer*

These reforms are not esoteric, fly-by-night or academic; they represent a set of practical, evolutionary steps companies can and, indeed, should take to alleviate the real problems of inadequate risk disclosure and generally poor placement processes. While corporate buyers need to take charge of driving through change, brokers and insurers will have to adapt to meet new customer demands for better service.

5.2 | **REFORM ONE** UNDERSTANDING INSURANCE LAW

Issue | *Eighty seven per cent of the insurance buyers we consulted do not understand the implications of the law regarding the duty of insurance disclosure. This must be addresed urgently given how onerous that duty is and how getting it right will help avoid claims disputes.*

Recommendation | *Buyers must be made fully aware of their obligations when it comes to insurance law. This includes explaining the burdensome nature of the duty of disclosure, other central tenets of insurance law such as the court's often strict interpretation of warranties, and relevant developments in case law.*

With the Law Commission now suggesting there is unlikely to be fundamental reform of the duty of disclosure (at least for corporate risks) in the medium term, buyers must insist that their brokers brief them on the key legal issues, notably:

1. The emphasis the law puts on the duty of disclosure (bringing this out from the shadows of the contractual small print) and the location of legal responsibility for the definition and delivery of adequate disclosure both at inception and during the policy period.
2. New case developments and precedents.
3. The dangers of failure to disclose, such as insurer avoidance of policies or, more likely, disputes about large claims.
4. Specific discussion of all terms for each major policy that might jeopardise cover, e.g. notification requirements, prohibitions to settling & warranties.
5. General differences between insurance law and ordinary contract law, in particular those around:
    - Basis clauses
    - Warranties
    - Conditions
    - Notification provisions

In May 2008 the Law Commission, which had been looking into misrepresentation, non-disclosure and breach of warranty for several years, published a summary of responses to consultation on reforming

insurance contract law.[15] Its final position has not been announced but on the basis of its more recent pronouncements we believe that the duty of disclosure will not materially change for any firms other than micro-businesses.

In the absence of legal reform, it is also to be hoped that current AIRMIC work on this issue will present a workable part solution that can be agreed and implemented contract by contract (it is looking into the possibility of inserting a special benefits clause into insurance contracts which limits the insurer's right to avoid a policy in the event of innocent non-disclosure or misrepresentation). At the very least, Mactavish hopes any proposal from AIRMIC prompts debate among insurers, brokers and customers. This debate needs oxygen and, even if a full solution is not attainable, it will help shine a spotlight on the current legal position and resulting inadequacies in placement.

This only deals, however, with material non-disclosure, by no means the be all and end all; better information about operational risks is still needed by insurers in today's increasingly complex world. Potential misunderstandings about intended coverage in policies is much more of a grey area than just the disclosure of specific 'facts' once a claims dispute does occur. More to the point, the upfront costs of this misunderstanding, in terms of competition, pricing and appropriate coverage structure, remain unaffected by the limitation of subsequent insurer rights arising from non-disclosure.

It is to the wider case for reforms that we now turn.

5·3 | **REFORM TWO** DRIVING MORE FORENSIC RISK ASSESSMENT

Issue | *The risk assessment process is fundamentally limited and there is evidence to suggest that submission standards are getting worse through the insurance cycle. This leaves customers with the risk that policies will not pay out in the event of a large loss.*

Recommendation | *Buyers, brokers and insurers should take the steps necessary to support more forensic risk assessment. This will require drastic improvements in the current information gathering and submission processes, plus explicit customer sign-off.*

The work cited in section 4 above established that current risk information is seriously inadequate, and that there are some relatively easy ways to put this right. To do so, a number of specific changes should be made to the disclosure process both by customers themselves in building better risk disclosure and by underwriters and brokers (who can help define what this better risk analysis should look like). While customers will need to provide the answers, they also need much more support in understanding the right questions.

We outline here two critical elements to support more forensic risk assessment and a greater meeting of minds around material risk exposures.

5·3·1 | Bridging the gap between insurance buying & operations

Insurance buyers can start building deeper links with their operations. The reality is that companies know their businesses, the minutiae of their operations and their risk management activities better than any broker or insurer will ever do.

This is increasingly, however, a problem in today's complex and globalised corporate world. Firms are more and more exposed to operations and upstream supply chains cutting across multiple divisions and/or geographic regions. Plus, their mix of products and services are getting more diversified and sold in a wider range of markets. Operational managers need to feed their critical 'on-the-ground' knowledge into the risk disclosure process. True, knowledge is typically diffused across a wide base of staff, is rarely documented exhaustively and is often filtered through an overly remote risk management function but these problems should not be insurmountable.

Company risk managers or insurance buyers must conduct fuller investigative activities and better explain to their operational staff why risk and insurance are important. Capturing the subsequent operational details would have two primary effects:

1. It would foster common understanding of risk management priorities across the business, rather than leaving the insurance buying function as a separate and remote silo.
2. It would bring key operational staff into the insurance disclosure tent, eliminating misunderstanding and supporting the communication of rich, risk-focused operational information of the sort outlined in section three of this document.

Building much stronger links between insurance buying, risk management and operations is a key part of the risk manager's growing remit.

5.3.2 | Customer review & approval of submissions

Section 4.2 provided an introductory analysis of some near-ubiquitous limitations of current insurance disclosures. It observed that an exclusive focus on basic underwriting data alone (e.g. coverage requirements, values and claims numbers) reflects current standardised underwriter models and keeps transaction costs low. However, it does not, by any stretch of the imagination, maximise understanding of risk. Neither does it minimise price fluctuations or the grounds for disputes in the event of a loss.

Mactavish analysis of submission documents and forensic questioning of operational staff demonstrates the clear potential for improvement in this area and how benefits would include better pricing, policy structure and greater coverage certainty.

> "The Mactavish reforms will definitely improve things. They will ensure that there is better dialogue between clients, brokers and insurers rather than just at renewal and during claims"
>
> *Risk Manager, Financial Institution, £100m-£300m*

By far the biggest and simplest failing however remains that most buyers neglect to review or approve such information, never mind refine it with all relevant operational colleagues. Calling for explicit buyer review of all submission materials must be the first step. Much more can be achieved by additional targeted interviewing of key operational staff to understand risks, mitigations and controls – but sign-off remains a fundamental minimum requirement.

5.4 | **REFORM THREE** TWO-STAGE INSURER TENDER

Issue | *Insurance procurement at the moment is typically done without a detailed assessment of risk and coverage. The process only gets under way as fixed renewal deadlines approach, while underwriting is condensed into each quarter-end period, creating bottlenecks, rather than being spread through the year.*

Recommendation | *An enhanced two-stage tender process should be introduced to maintain transaction efficiency while enabling greater dialogue. Key aspects would include using the prior year submission to come up with a shortlist of suitable insurers.*

This reform would be a pragmatic, but nevertheless significant overhaul to the current insurance procurement process. At the moment, disclosure and time limitations routinely lead to a distorted advantage for incumbent insurers and a relatively uninformed decision by buyers with respect to which of the competing coverage offers they should accept. The two stage tender process for insurance procurement would better utilise quiet periods across the underwriting year, and set up much fuller dialogue with credible and competitive insurers:

1. First, a pre-tender exercise (ideally beginning six months prior to renewal) enabling competing insurers to use the prior year's submission documents to provide indicative pricing and coverage offers. In essence, this will enable buyers to identify the insurers that are serious about competing for the business. It will also enable customers to ask for richer information from insurers to satisfy concerns about creditworthiness: this is a very real problem in light of the failures of credit rating agencies in the credit crunch.
2. Second, a much richer "beauty parade" involving presentations by shortlisted insurers and much more extensive discussion of risk and coverage.

The objective here is to recognise the central role of risk understanding to the insurance placement process, while retaining transaction efficiency. The pre-tender exercise can provide customers with useful ballpark figures for underlying technical rates and current market pricing, i.e. the difference between the cyclical and structural prices. It also limits more detailed engagement to a smaller set of insurers. So, rather than skim the surface of a large pool of potential carriers,

buyers can choose the likeliest partners and investigate them in more detail.

As well as providing an indication of competitiveness, the process has two other benefits:

1. It alleviates common timing issues with renewals. A large proportion of buyers frequently complain about a last-minute rush to get insurances placed in the market. Starting the process earlier – at a time when the markets are typically quieter – means less intensive work in the week or two prior to renewal.
2. It gives earlier and greater visibility to buyer concerns about wording or coverage. Given the earlier start date for the renewal, buyers should be able to more fully consider the importance of coverage and whether any issues can be safely accommodated.

A reformed tender process for insurance placement should, over time, bring together underwriter and client perspectives on operational risk, clarify areas of concern about mitigations and controls, better direct risk management efforts and reduce the potential for damaging disputes in the event of a claim. As part of this enhanced second stage of selection (where every part of the process is less rushed), we propose a number of explicit steps as set out in reforms four to seven below.

5.5 | **REFORM FOUR** INSURER PRESENTATION OF RISK UNDERSTANDING

Issue | *Insurance buyers have no way of knowing whether an underwriter truly understands the operational risks he has taken on. Without raising and resolving points of contention up front, buyers will be in the dark as to whether their policies are reliable.*

Recommendation | *Insurance buyers should insist that carriers competing for their business set out their understanding of the customer's risks and the detailed coverage on offer (including its value).*

As part of the second tender stage discussed earlier, we believe this should be adopted as a standard process for shortlisted insurers. There are several objectives here:

1. Clients can, for the first time, check that insurers really understand the risks they are taking on. Critically, this will prevent the sort of major misunderstandings about a company's risks that happen at the moment.
2. In entering this dialogue, underwriters will also educate buyers about the major drivers of their assessment, and any emerging areas of concern. Without this, the buyer's legal responsibility to pre-empt all possible concerns of a 'prudent underwriter' seems unfair – at least until a prudent underwriter's perspective is clearly spelt out.

Finally, having competitive insurers present their understanding and offering gives the customer, along with their broker advisors, a much more complete basis on which to assess what they are buying, and from whom. It also gives insurers an opportunity to differentiate their proposition on coverage and service grounds alongside price. The customer's decision will now rest on much more than crude credit rating agency scores and price comparison. Far from loss of intermediary 'control', a good broker gains a great opportunity to provide much more value in assisting their client's decision-making process.

5.6 | **REFORM FIVE** AWARENESS OF INSURANCE MATERIALITY

Issue | *Insurance has never been more material to most businesses. If a large claim is delayed, and access to pre-settlement financing restricted (as is still the case), many firms will be severely and adversely affected. Few, however, have analysed this vulnerability.*

Recommendation | *Buyers should explicitly quantify the financial materiality of insurance to their business. If actual materiality was recognised, many buyers would have the incentive to demand more contract certainty, disclose risks more fully and ensure suitable coverage.*

Many buyers do not fully grasp the importance of insurance as a form of contingent capital that can be called upon if a significant large loss event occurs. A good starting point, therefore, is for buyers to ask themselves: **does corporate insurance merit more attention?**

This question, rarely considered, can be answered by assessing the dependency of a business on insurance capital:

- What would happen in the event of a big claim being delayed or questioned?
- Are alternative, reasonably priced sources of credit available?

- What is the business's sensitivity to fluctuations in the cost of insurance?
- Is insurance an efficient way of financing loss events (versus other forms of money such as debt or equity)?

As such, the facts required to answer these questions are not, by-and-large, collated. None of those questions, however, are difficult to answer with a structured and pragmatic approach.

Loss limits and Estimated Maximum Loss scenarios are known or estimable in relation to most lines of insurance. Insurance costs and loss potential can be easily compared with capital either already available within or accessible to the business. The cost of debt and equity can be calculated and compared with the price of accessing contingent insurance capital.

Of course, the answers to the questions posed above will vary by industry sector and even by size and complexity of business. However, on the basis of research into this issue with around 40 companies Mactavish is convinced that businesses grossly underestimate their dependence on insurance capital, and that such dependence has significantly increased as a result of the recent economic climate.

Surely a more hands-on approach to insurance arrangement is called for in such instances, further supporting the case for placement reform. In particular, we recommend that companies identify the 'pain point' at which a business would be placed under severe financial strain in the event that a policy fails to respond or a claim settlement is delayed. This point has become more accessible for many in this climate, conceivable under a widening number of claims scenarios. Understanding their dependence on insurance adds a very clear incentive for companies to pay greater attention to how policies are placed and the underlying explanations of risk. It is thus a key component of the overall reform programme.

5.7 | **REFORM SIX** WORDING REVIEW & LOSS SCENARIO AGREEMENT (PRE-INCEPTION)

Issue | *Policy wordings are a major bugbear for customers. Even the more expert insurance buyers are often baffled as to whether loss scenarios are actually covered by policy wordings.*

Recommendation | *Insurers should be explicitly asked to discuss major loss scenarios with customers so as to establish a common understanding of coverage at the outset of the policy period.*

The reforms discussed thus far should establish a much deeper mutual understanding by insurers and customers of the nature of the risks being transferred. However, much more can be done to help buyers get their heads around which loss events will actually be covered by policy wordings.

A key plank of reform here is for insurers and customers to sit down and discuss the two or three most likely major loss scenarios for each key class of insurance that would breach the 'pain point' described above. What, in other words, could conceivably cause a material loss? The main question to be answered in such a workshop is: how will a policy and the wording contained therein respond to these loss events? If insurers agree and document this with buyers the chance of a mismatch in understanding or expectation regarding cover will be diminished. Such clarifications can be explicitly added to contract wording if deemed necessary. Of course, some degree of uncertainty remains inevitable: genuinely unexpected and unknowable events ("black swans") will continue to occur.

However, some explicit understanding of how policies would theoretically respond to losses is vastly preferable to postponing discussion until the unthinkable happens. This leaves much uncertainty over the necessary protocols to be followed and leads to disputes over claims, often resulting in a field day for those forensic accountants and lawyers called in to resolve competing claims. It is clearly better for a customer to establish any areas of debate with several credible competitors at the outset, rather than delaying such discussions until the point of claim when the insurer will hold most of the cards.

There are several benefits to loss scenario planning:

- Identification of the likely major loss scenarios based on both operational management knowledge and insurer/broker expertise.
- Building a common understanding of the risks and the basis of coverage, mapped against these risks.
- Correction of any material misunderstanding on either side of the insurance bargain and clarification of the coverage provided.
- Greater clarity of the intention of policy wordings.
- Better direction of internal risk management activities.

> "It is amazing that the market has resisted this way of working for so long; customers are yearning for change"
>
> *Director, Manufacturing, £5bn+*

5·8 | **REFORM SEVEN** LOSS RESPONSE SERVICE

Issue | *Insurance customers at the moment are not able to appraise the service they buy in advance (i.e. the response to a major loss). Further, precious time is often lost after a major loss because customers have no idea about information requirements and the strict guidelines that have to be followed if the subsequent claim is not to be prejudiced. This can lead to delays and additional cost.*

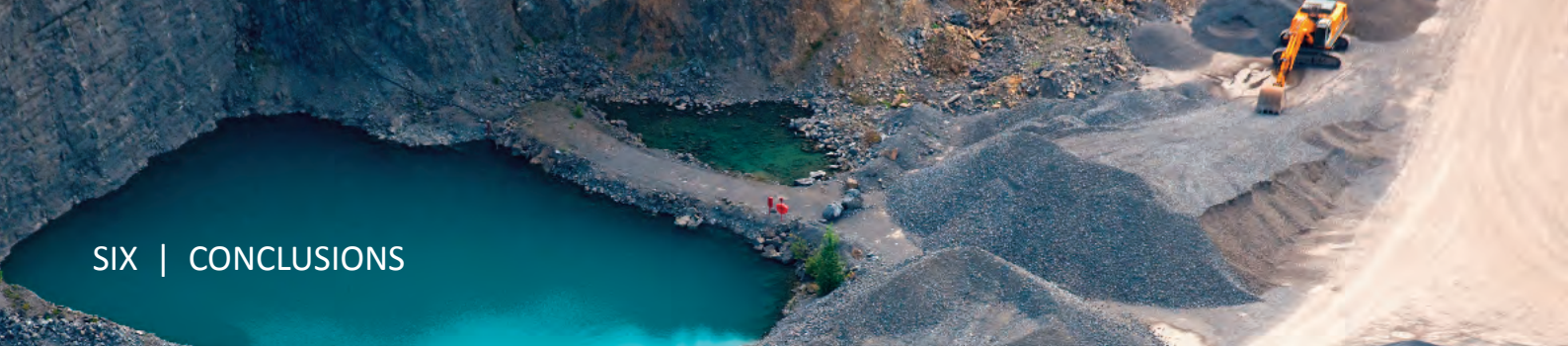
Recommendation | *Detailed loss response service elements, including the identification of information and resource requirements, should be specified upfront as part of the insurer bid process. This will allow a more informed customer appraisal and ensure readiness to deal with a severe loss event.*

Once loss scenarios have been covered, insurers and buyers should engage in a further session on **post-loss planning**. This will involve clarification of the information and resource requirements (e.g. accounting, technical and engineering) in the event of a loss to enable an optimal response. Specified deadlines and procedures to be followed immediately after a disruptive and serious incident should also be considered. Setting down and agreeing post-loss operating protocols in this manner should reduce the risk of escalating losses brought about by failure to gather the right information, and avoid any unwitting breach of policy terms.

By definition, most buyers suffer low frequency losses very rarely if at all. Insurers clearly do, but often fail to communicate clear expectations to customers in advance. The involvement of major loss teams, or at least clear insight from such teams, creates value for all parties in de-mystifying the process. This is partly about practical information requirements, but there is also value – and the potential for insurers to differentiate their offerings – in explaining the involvement and roles of internal staff and external parties (e.g. forensic accountants) in helping with claims. For the sake of customers, clarity should be provided into reporting lines, how long a resolution should take and who is appointed by each party.

Clarifying such procedures enables customers to make a more informed choice as to the major loss response service they are ultimately buying in return for years of insurance premiums. Criteria for evaluating the loss response services offered by potential insurer partners should include experience of dealing with large losses in the sector.

If post loss protocols are agreed upfront, increased claims resolution efficiency and lower uncertainty would both appear to be inevitable and mutually beneficial outcomes, along with a likely reduction in ultimate loss costs.



SIX | CONCLUSIONS

This report has set out the key deficiencies we have found in the risk disclosure and placement processes. They threaten all companies that buy insurance, but most notably mid-size firms. In response, we have crafted, tested and recommended seven reform protocols that the P&C insurance industry can use to improve the way corporate risks are transferred.

We have reached the point when corporate risk placement must be made truly fit-for-purpose. Implementation of the reforms will of course require some focused investment by buyers, brokers and insurers. However, even engagement with just a few of them should make a big difference; progress is always likely to be iterative and these measures represent evolution, not revolution.

Acting upon the reforms will allow all participants in the market to win. It will create a less risky UK business environment in which firms enjoy more reliable insurance policies, good risk management is rewarded, underwriting results are less variable and retention rates for carriers and brokers improve. **The only people who should fear the reforms are the customers who don't take risk management seriously. They alone are well served by the current system.**

The reforms will enable brokers and insurers to demonstrate where they add value to customers and help them overcome the image of insurance as a commodity offering for which price is the main differentiator. That is unsustainable: it only ensures a race to the bottom and exacerbates the cyclical nature of the market. The case for change is compelling and long overdue.

SEVEN | ONGOING RESEARCH OVERVIEW

As part two of a wider programme of work, this paper sets out critical reform recommendations arising from our current UK research into corporate risks. Consultations are ongoing as part of this work, in particular focusing through 2011 on deepening individual sector specific risk insights and revisiting the themes in our 2010 cross sector report to understand how critical risk changes continue to evolve and play out.

It is anticipated that Mactavish will publish a number of individual sector papers throughout 2011 and 2012, together with an updated aggregated cross-sector study analysing responses to date from both customers and insurance suppliers.

MACTAVISH PROTOCOLS
SUMMARY CHECKLIST

REFORM PROTOCOL	PARTICIPANTS	TIMINGS
1 **CLARIFICATION OF INSURANCE LAW**	| BUYER | BROKER	ANNUAL BEFORE START OF RENEWAL PROCESS
2 **MORE FORENSIC RISK ASSESSMENT**	| BUYER | OPERATIONS MANAGEMENT | BROKER | UNDERWRITERS - KEY LINES	1 - 6 MONTHS PRE-RENEWAL
3 **REFORMED TWO-STAGE INSURER TENDER**	| BUYER | BROKER | INSURER	PART 1: 6 MONTHS PRE-RENEWAL PART 2: 2 MONTHS PRE-RENEWAL
4 **UNDERWRITER PRESENTATION OF RISK UNDERSTANDING**	| BUYER | BROKER | UNDERWRITERS - KEY LINES	PART OF 2ND PHASE TENDER
5 **ANALYSIS OF INSURANCE MATERIALITY**	| BUYER | CUSTOMER FINANCE TEAM	ANNUAL BEFORE START OF RENEWAL PROCESS
6 **PRE-INCEPTION WORKSHOP ON LOSS SCENARIOS & POLICY WORDINGS**	| BUYER | BROKER | BROKER WORDING SPECIALISTS | UNDERWRITERS - KEY LINES	PART OF 2ND PHASE TENDER, OR PRE-POLICY INCEPTION
7 **LOSS RESPONSE SERVICE PLANNING**	| BUYER | BROKER | INSURER CLAIMS TEAM	PART OF 2ND PHASE TENDER, OR PRE-POLICY INCEPTION

KEY ELEMENTS
| BUYERS BRIEFED ON INSURANCE LAW, LEGAL CASE DEVELOPMENTS & NEW REGULATORY REQUIREMENTS | ALL KEY WARRANTIES & PRE-CONTRACTUAL CONDITIONS TO BE DOCUMENTED & ISSUED TO RELEVANT OPERATIONAL STAFF
| BUYER SIGN OFF OF ALL DISCLOSURE MATERIALS AS MINIMUM STANDARD | WIDER OPERATIONAL STAFF ENGAGEMENT IN CREATING & CHECKING RISK MATERIALS | ANALYSIS OF MOST MATERIAL CURRENT ERRORS / OMISSIONS (SEE SECTION 4.2.3 FOR MORE DETAILS)
| INSURERS ISSUE INDICATIVE BIDS USING PRIOR YEAR SUBMISSION | BUYER NEEDS CLEAR STATEMENT OF PHASE TWO INFORMATION REQUIREMENTS FROM EACH SHORTLISTED INSURER
| BUYER TO PREPARE QUESTIONS FOR INSURERS TO UNDERSTAND BASIS OF UNDERWRITING APPROACH & MOST LIKELY AREAS OF RISK MISUNDERSTANDING | COMPETING INSURERS TO SET OUT THEIR UNDERSTANDING OF THE RISK & VALUE OF PROTECTION THEY ARE OFFERING
| DEFINE FINANCIAL PAIN POINT AT WHICH IF POLICY FAILS IT WOULD MATERIALLY HURT THE BUSINESS | REQUIRES PROGRAMME STRUCTURE, HISTORIC FINANCIALS & CURRENT DEBT / EQUITY COSTS
| DEFINE 2-3 SCENARIOS FOR KEY INSURANCE CLASSES THAT COULD DELIVER LOSSES IN EXCESS OF FINANCIAL PAIN POINT | INSURER TO CLARIFY THE INTENTION OF COVERAGE & WORDING OFFERED & SPECIFY ANY ADDITIONAL INFORMATION NEEDED
| ALL PARTIES TO AGREE LOSS RESPONSE SERVICE ELEMENTS OFFERED BY INSURER | POST-LOSS PROCEDURES FOR LARGE LOSSES MUST BE DOCUMENTED & SIGNED OFF IN ADVANCE. THIS MUST OUTLINE ALL INVOLVED PARTIES, KEY STAGES OF CLAIM ASSESSMENT & STIPULATED INFORMATION REQUIREMENTS

ENDNOTES | EXTERNAL SOURCES

1 Estimate based on statistics from Business Development for Innovation & Skills, Enterprise Analytical Unit: October 2010

2 See Mactavish *Cross-Sector Risk Report* published January 6th 2010

3 Ibid.

4 'Iceland volcano: Nissan and BMW suspend more production', http://news.bbc.co.uk/1/hi/8631676.stm

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6 http://www.utexas.edu/know/2010/02/03/toyota_recall/

7 England & Wales *Judicial & Court Statistics 2009* published 23rd September 2010

8 'Insurers get tougher on claims payouts', *Financial Times*, 6th September 2010

9 KPMG Forensic Fraud Barometer, January 2010: ttp://www.yhff.co.uk/KPMG%20FB%20Jan%202010.pdf

10 http://www.insurancefraudbureau.org/

11 http://www.bloomberg.com/news/2010-09-23/solvency-ii-rules-may-cut-european-insurers-surplus-capital-study-says.html

12 http://www.mondaq.com/article.asp?articleid=138

13 Analysis was of a range of insurance programmes, across a number of sectors but covered the key commercial & corporate sectors (i.e. company turnover in excess of fifty million GDP).

14 http://www.airmic.com/en/Library/research/survey-results.cfm

15 *Reforming Insurance Contract Law; A Summary of Responses to Consultation*, http://www.lawcom.gov.uk/docs/ICL_summary_of_responses.pdf

Bruce Hepburn | CEO

Bruce graduated with a Mechanical Engineering degree from Imperial College of Science, Technology & Medicine, University of London. He worked as an industrial analyst in the manufacturing and engineering sector, later forming Mactavish to specialise in telecoms with leading clients AT&T, BT, CSC and IBM.

Between 1996 and 1998 he evolved the company to become a specialist provider of strategy consultancy and industrial analysis in the corporate insurance sector, leading to the evolution of the business as its stands today.

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Rob graduated in PPE from St Catherine's College, Oxford University and later completed his MBA study at SDA Bocconi, Milan. He spent a number of years in strategy consultancy with The Kalchas Group and Booz & Company before working with Mactavish since 2001. Rob has led the development of Mactavish risk due diligence methodology and heads the firm's overall research practice.

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Stuart spent four years in strategy consultancy, at boutique firm RSe and then in-house at Sportingbet PLC, following a degree in PPE from St Edmund Hall, Oxford University. He joined Mactavish as a senior analyst in 2009 and today leads the design and execution of the overall UK research programme.

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Antoine graduated from Reims Management School, and completed a further degree in International Business at Northeastern University, USA. After working with an international M&A advisory firm, Antoine joined Mactavish in 2005. He now leads our activity in the French market whilst maintaining involvement throughout all our research. He is a regular columnist in French risk and insurance publications.

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Ben graduated with a BA in Philosophy from Sidney Sussex College, Cambridge University. He joined Mactavish in 2009 following several years working in the executive search industry. As Head of Campaign Management, Ben maintains overall responsibility for all of Mactavish's customer research activities.

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