
Commercial Insurance Claims by SMEs: Report of Findings from File Reviews

Prepared by Camford Sutton Associates for the Financial Conduct Authority (FCA)

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The views expressed in this report are those of the authors and not necessarily those of the FCA (nor do they reflect FCA policy or constitute guidance to firms).

Introduction

As part of the FCA's thematic review to look at the handling and management of first party Property and related Business Interruption claims submitted by small and medium-sized enterprises (SMEs)¹, Camford Sutton Associates (CSA) were engaged by the FCA to review in detail 20 cases selected largely from the Policyholder interviews undertaken by market research agency, Quadrangle.

The aim was to gain a better understanding of the insurance coverage, insurance technical, claims management and other issues behind the Policyholder's experience, as described to Quadrangle, and to more fully understand the roles of the different parties involved.

As described in their own report, Quadrangle conducted 100 interviews with SME Policyholders who had first party claims over £5,000 in the previous two years. Based on the feedback from Policyholders and the wider work of the thematic review, the FCA selected the 20 cases for more detailed review. All were cases where issues had arisen: not only expressions of dissatisfaction, but also where comments had been made by the Policyholder – perhaps about the people or parties involved, the cover, claims management or procedure – and these comments needed to be better understood.

Note: Camford Sutton Associates are specialist claims consultants who provide practical solutions and advice on claims related challenges and issues. The author is a Chartered Loss Adjuster and Chartered Director with over 35 years loss adjusting, claims management and insurance industry experience.

¹ The Department for Business Innovation and Skills describes businesses with 0-49 employees as small businesses and businesses with 50-249 employees as medium businesses. The Federation of Small Businesses further segregates the small category into micro (0-9 employees) and small (10-49 employees) categories. We have used these definitions in this work.

Review Methodology

The UK commercial insurance sector is complex. There is a huge variety of underwriters, insurers and brokers and many different distribution and operating models; hence the potential for a number of different parties to be involved in a claim and influence the Policyholder's claim experience. These would typically include:

- Insurer
- Managing General Agent (MGA)
- Third Party Administrator (TPA)

The cases selected for review were generally higher value and/or more complex claims, where typically the handling and management of the claim had been outsourced to a loss adjuster.

The priority, therefore, was to review the files of those parties directly involved in managing the claim and hence with the closest relationship with the Policyholder, typically:

- Insurance Broker – who arranges the cover
- Loss Adjuster – who manages the claim for the insurer/MGA/TPA
- Loss Assessor – retained by the Policyholder to act on their behalf

We will comment in more detail about the roles of these parties – from our findings – later in the report.

All 20 cases selected and reviewed originated from and involved at least one of the businesses supporting the Project, i.e. "in scope". Where it proved necessary to obtain files or information from other parties to support the review, introductions were provided via the FCA and/or a participating insurer.

Most of the 20 cases were high value and/or technically complex claims. Whilst the overwhelming majority of commercial property claims – something over 90%, are less than £10,000 in value, 75% of the cases selected for this review were over £10,000. Hence:

- **15** were > £10,000, of which
- **7** were > £100,000 (usually managed by "Major /Complex Loss" specialists where available)
- **19** were managed by a field based loss adjuster; plus one desktop
- **10** involved also a loss assessor (or Policyholder representative); 3 of these referred late for advice

It is also worth noting that the UK commercial insurance sector encompasses a huge range of risks from global conglomerates to small independent traders. This review focussed on first party Property and related Business Interruption claims by SME businesses, Policyholders with varying degrees of sophistication and often limited insurance knowledge.

Policy Cover Issues

A claims handler, loss adjuster and/or loss assessor can only deal with a claim within the parameters of the policy cover that applies.

In terms of the buying process, in 17 of 20 cases, the policy had been bought/arranged via an insurance broker; in 3 of 20 cases, directly from the insurer (via the internet, telephone or both).

In 13 cases our research found that the policy coverage purchased by the SME did not fully cover what they were claiming for. We found:

- 3 cases where the scope of cover was inappropriate for the business needs. For example:

In one case, a SME was sold directly by the insurer a “Property Owners” type policy. Two years later, this cover was found to be inappropriate when there was a theft and claim for heavy tools, but it was found that the relevant cover was not in place.

In another, following a fire a SME found that they did not have cover for their computers (Electronic Business Equipment), which had been overlooked at last renewal when the cover was placed with a different insurer.

- 3 where the scope of cover was misunderstood. For example:

Construction Plant was stolen which the Policyholder had bought almost new, but second hand, some years previously. After negotiation, the value of the machine at the time of the loss was agreed to be just over half that originally paid, but the Policyholder could not find a similar machine and felt considerably “out of pocket” against the cost of a new one. It appears it was not understood that the cover was provided on a “market value” (i.e. indemnity) basis.

There were issues around the application of cover for Customer’s Goods in two claims. In both, the Policyholders were being pressed by customers for the replacement of damaged goods and/or compensation. On both occasions, the loss adjuster failed to respond to repeated requests for advice and appeared to be uncertain about application of the cover and whether it was written on a reinstatement or indemnity basis.

- 8 cases where one (or more) Material Damage Sum(s) Insured was inadequate. For example:

In one case, the Buildings Sum Insured was around £200k less than (and about two thirds of) the rebuilding cost. There were several cases of circa 50% underinsurance on Trade Contents and Stock.

- 4 cases where the Business Interruption loss exceeded a 12 month Maximum Indemnity Period (MIP)

In one case, the building was not fully repaired and hence the tenant SME was unable to reopen and resume trading within the 12 month MIP. In the other cases, although the businesses were able to continue some trading, profits were not restored and did not reach anticipated levels within the 12 month MIP applicable.

Note: Business Interruption insurance typically covers loss of Gross Profit or Revenue, but only for a defined period, the Maximum Indemnity Period, often 12 months from the date of the damage. A longer period can often be selected, but a higher premium results. Some insurers provide cover for longer – 24 months – under “package” policies as standard.

- 1 case where no Business Interruption cover at all.

In this case a fire broke out which resulted in a constructive total loss of Machinery, Trade Contents and Stock. This had a significant impact on the business and the BI loss would have been substantial had cover been taken out. According to the broker, this was the Policyholder's choice and instruction, and contrary to his advice.

- 1 case where the Sum Insured on Gross Profit was inadequate:

Following a fire, it was quickly recognised that the Sum Insured on Gross Profit was technically inadequate. It emerged that the Policyholder had computed and declared a Net Profit figure, rather than Gross Profit as defined within and insured by the policy and which accordingly did not allow for the running expenses of the business. Fortunately, however, because the cover had been written on a declaration basis and the BI loss was eventually agreed at less than the effective limit, proportionate reduction did not apply.

We conducted more detailed enquiries into the arrangement/placing of cover on eight cases, and from these and the review files generally:

- It was often not clear from the papers we were provided by the brokers what level of guidance and advice the broker had provided regarding the scope and levels of cover appropriate to a risk. The broking or placing files we were sent (or extracts therefrom) generally comprised things like renewal quotations, invitations and confirmations. There were only occasional "demands and needs statements" (or similar) and likewise notes of meetings, the latter not detailed.
- Those policies purchased directly from insurers were arranged on a "non-advised" basis.
- In the few cases we reviewed in detail, brokers generally did not keep records of initial or pre-renewal review meetings or conversations with their Policyholder clients, outlining the guidance and advice given and any discussions relating to policy coverage issues. Where direct, however, some insurers record such conversations.
- The general approach seemed to be that: based upon any such guidance and advice, it was for the Policyholder to choose the scope and levels of cover (Sums Insured) required. However, we saw no obvious guidance or advice, whether bespoke or general, regarding computation of Sums Insured.
- A large amount of paperwork was sent to the Policyholder at initial quotation, renewal invitation and renewal confirmation; often the same paperwork (such as Policy Schedule, Summary of Cover, Key Facts, Proposal or Statement of Facts etc.) each time with a slightly different covering letter, but which invariably included somewhere a "warning" to the Policyholder to check that the cover provided met with their requirements (or similar); some "warnings" more prominent than others. However the volume and repetition of paperwork did not ultimately prevent cover issues from arising.

In a case involving a theft of tools (see Case Studies – Inappropriate Cover - 2 below), the Policyholder appears not to have been aware of a relevant exclusion. The summary of cover sent with both renewal invitation and renewal confirmation made the exclusion reasonably clear, but was either overlooked, not read or understood.

Case Studies – Inappropriate Cover

Case Study 1

A SME was mistakenly provided with a Property Owners Policy covering Buildings and “Contents of Common Parts”. The “error” was only discovered when, in the third policy year, a claim was submitted for the theft of heavy tools. The policy had been sold directly by insurers by telephone on a “non-advised” basis, but somehow, the questions asked and/or responses provided by the Policyholder, and/or the scripts, directed insurers to allocate the wrong type of cover. Despite the various subsequent Renewal documents and clear warnings to check the cover, the error was not realised.

The claim was declined as there was no cover for the tools and the Policyholder immediately complained. Following a detailed investigation, a decision was taken by the insurers to retrospectively provide the relevant cover and pay the claim.

Case Study 2

A SME was arranged a policy by brokers that did not cover theft of vehicles and contents unless parked overnight in a locked building or guarded compound. When one was stolen from outside a residential property and tools were stolen, the claim was declined.

The producing brokers’ file as provided did not record any discussions, to establish the Policyholders’ insurance requirements or, indeed, to explain the standard cover and extensions available. The impression we gained was that the necessary conversation did not take place. However, the Renewal Invitation and Confirmation documentation was quite clear about the restriction in cover.

Case Management

Our findings can be summarised under headings largely reflecting key stages in the claims process.

1. First Notification of Loss & Triage

In the files we reviewed, performance was variable. In some cases we found a pre-visit process in place aimed at establishing the Policyholder's predicament, meaningful advice was given, damage management or other contractors were appointed to provide immediate assistance and/or a timely Initial Visit was arranged appropriate to the circumstances.

However, in other cases we found that the predicament and/or needs of the Policyholder were not quickly established or understood and/or initial help/advice was not given. We also saw many cases where pre-visit checks were not carried out, despite the existence of these processes in many loss adjusting firms.

Failure to adopt these processes or otherwise establish and understand the urgency of a situation led to occasional delays in the initial visit by the loss adjuster, as did sometimes the long and/or complex chain of notification.

Case Studies – FNOL & Triage

Case Study 1

A serious fire in a "Buy to Let" property occurred early one Sunday morning. The Policyholder contacted insurer's Out of Hours "Helpline", actually manned by their TPA claims handler, who established the Policyholder's needs and arranged specialist contractors to attend and help make the property safe/secure and then for a prompt visit by a loss adjuster.

Case Study 2

A shop fire Saturday morning, which could not be reported by the Policyholder to the local broker until Monday, which was then passed in turn to the broker's London office, the MGA (insurer), their TPA claims handler and finally the loss adjuster, who then contacted the Policyholder. This all led to an Initial Visit on a relatively "urgent" and certainly traumatic claim 10 days post fire.

Also, there were a few cases where the lack of or a poor triage process led to inappropriate (individual) case allocation within the loss adjuster. This can and did lead to serious handling issues when not recognised and rectified. For example: the General Case Study – Case Management on page 13.

As above, there were cases where Policyholders were unable to report urgent claims at weekends and generally, the (few) cases passed to a loss adjuster on a Friday were not visited until the following week. On these, it was not clear whether a weekend visit was asked for or offered, but generally, appropriate advice and assistance with mitigation appears to have been provided.

In one case, a fire occurred just before the weekend but the claim was not notified until the Insurers opened for business on the Monday morning. It is not clear why this was the case but this was a significant fire and action could and should have been taken over the weekend. The Policyholder's recollection of the initial handling was that Insurers were slow to react. This could have been avoided by use of an effective Out of Hours service.

Like Pre-Visit triage processes, we know that "Helplines" exist and/or "Out of Hours" Visits can be arranged.

There were some good examples of FNOL and triage processes working well, but the overall picture was inconsistent.

2. Action Plans/Customer Guidance & Advice

A structured approach to action planning and next steps was absent from most files. Even where a more methodical approach had seemingly been taken, it was rarely documented on file. Despite the fact that structured “Claim Plans” or “Next Steps” type documents are available within most loss adjusting businesses, we found no evidence of their use on the files we reviewed. Nor did we see sufficient use of written confirmation of actions agreed and anticipated timescales.

There was little evidence of ongoing guidance and advice. There were several instances of repeated requests from the Policyholder for guidance and/or advice re: policy cover, mitigation measures (MD & BI), next steps etc. Please see the General Case Studies – Case Management at the end of this section on pages 12 & 13.

In one of these cases, we counted eight explicit requests over a four month period for (variously): advice, guidance, assistance, procedure, and timelines, which were largely ignored.

These comments apply equally to the loss assessors and loss adjusters. Also, in a small number of cases, the Policyholder seemed unable to “take on board” all said and/or agreed at the Initial meeting, an issue reminiscent of the “grief cycle” and perhaps more common with traumatic household claims, but the point reflects that many SMEs are owner managed and generally unsophisticated businesses.

Case Studies – Action Plans/Guidance/Advice/Proactivity

Case Study 1

An escape of water damaged a (commercially owned) residence. The loss adjuster failed to understand at the outset the quality of some of the damaged finishes and establish the family’s circumstances and use of the residence. This resulted in an unclear and inappropriate action plan and over simplistic approach to the claim.

Possibly due to a lack of meeting notes and telephone call records, the overriding impression is that for this Policyholder and in their circumstances, insufficient direction and advice was provided, and that case management should have been more proactive.

The claim was progressed appropriately only after the Policyholder appointed loss assessors. Ultimately, the claim took longer to resolve than could or should have been the case; and because of the related additional alternative accommodation expenditure, also proved more costly.

The claim was initially (incorrectly) estimated at just over 10% of the final settlement amount.

Case Study 2

A fire in a small business dealing with consumer goods resulted in the appointment of both a loss adjuster and loss assessor. The claim was not significant but took nearly two years to settle. The Policyholder made it clear that they did not understand how the Policy responded to cover Customers Goods and Business Interruption. However neither the loss adjuster nor loss assessor took the time to explain the cover. The loss adjuster visited once at the very start of the claim and thereafter appeared to take the view that it was the loss assessor’s role to explain policy cover.

The loss assessor made two visits, both at the start of the claim and thereafter “managed” the loss from behind his desk. Requests for help from the Policyholder were ignored. As a consequence, even after the claim had settled, the Policyholder did not really understand how the settlement had been calculated.

Case Studies – Action Plans/Guidance/Advice/Proactivity

Case study 3

A storm claim led to a sizeable loss that was ultimately settled within £5k of the initial reserve.

The claim was handled by a Major and Complex Loss team and at an early stage the loss adjuster explained how the cover operated and what supporting documents would be required. Once those documents were received, to help manage the ongoing Business Interruption claim, the loss adjuster mapped out the anticipated Turnover had the damage not occurred and agreed this with the Policyholder. Thereafter, the Policyholder provided monthly records demonstrating actual Turnover achieved which enabled the loss adjuster to compute the ongoing shortfall in Turnover and Gross Profit, and recommend regular interim payments to fund that shortfall.

The Policyholder knew exactly what was required and how his loss would be calculated. At the conclusion of the claim, the Policyholder wrote to the loss adjuster thanking them for their time and assistance.

3. Proactivity

The lack of “proactivity” was a common issue on the files we reviewed. We found little or no proactivity to resolve issues and drive a claim to conclusion. Both loss assessors and loss adjusters tended to wait for things to happen and were reactive far too often. In most cases at most times we saw there was no obvious diary system in use and there were too many instances where Policyholders had to chase for information or updates.

In the cases we looked at, brokers tended only to become involved when they were asked or complained to by Policyholders.

We also considered that in some cases there was a reluctance to re-visit the Policyholder when such a meeting could have been beneficial. There were several cases where a meeting would have more effectively dealt with or resolved one or more complex issues.

Email communication was also often used when telephone or face to face discussions might have been more appropriate to cover complex and technical issues (and then later confirmed in writing).

Case Study – Proactivity

This claim showed a clear lack of proactivity and what appeared to be reluctance on the loss adjuster’s part to revisit and deal with issues that were arising.

The loss adjuster first attended in the immediate aftermath of the incident but did not revisit. The Policyholder struggled to understand what he needed to do in order to evidence the loss and how to deal with Customers whose property was damaged in the incident. The SME also experienced cash flow problems which led to significant pressure from their bank.

A second visit to explain the policy cover and to address the quantum issues would, in our view, have led to better support, the possibility of more proactive interim payments and a quicker settlement.

4. Communication & Updates (to Policyholder)

We found infrequent and/or irregular communication by both loss assessors and loss adjusters and the use of insurance jargon which was often not explained.

The roles of interested parties (e.g. loss adjuster, loss assessor, contractors or suppliers introduced) were also not always explained. This was unexpected, given that most loss adjusting and assessing type businesses have standard Policyholder/Customer Information literature available. Nor was there obvious reference to information held on relevant websites. The need for such information and transparency becomes even more acute when such as Surveying and/or Contractor services are provided “in house”.

For example, in cases:

- a. *where the loss adjuster introduced in house surveying and contractor services to locate and repair leaking drainage, and*
- b. *where the loss assessor introduced in house damage management contractors to dry a building post flood and an in house contractor to quote for repairs,*

We found no evidence that the business relationships were fully explained.

5. Payment Issues

Interim payments or “payments on account” are the critical means, so far as policy cover will allow, of funding a business through the repair and reinstatement process, and from a business interruption perspective, of funding the shortfall in anticipated Gross Profit until trading is back to normal.

Whilst we saw some good use of interim funding on some cases, perhaps related to proactivity, payments on account could have been more frequent and more timely. These often had to be requested rather than offered.

We saw examples of prompt funding of replacement equipment or stock, and of regular, monthly consideration of the trading results and a Gross Profit payment, as business was being restored.

However in other cases, we came across businesses pleading for cash and/or looking to their bank (not always evident in the files, but from feedback to Quadrangle), to support the business through the process.

Once a payment had been agreed (Interim or Final), there were occasional delays by loss adjusters in issuing reports and separately, upon receipt, occasional delays on the part of insurers or TPAs in issuing cheques. There was at least one delay in payment in 6 cases. Altogether, across all of the cases that we reviewed, we found that delays occurred in about 15% of the payments that were made.

We saw two instances where the delay in payment was due to “insufficient funds” held in the TPA’s client account.

We also saw cases where payments had been Mandated and/or paid to the loss assessor including one where the funds were not promptly passed on.

Case Studies – Payment Issues

Case Study 1

A good understanding of the Policyholder's business, proactive management and clear communication resulted in a framework for regular payments to be requested and made promptly to help support the business through difficult times, rebuilding after an insured event.

Case Study 2

Payments on account were not proactively offered but were agreed only when requested after the broker intervened.

Case Study 3

It took at least five weeks from date of agreement to make the final payment due to: one week to issue report, which was not actioned for two weeks upon receipt by TPA; then possibly a mix-up over preferred method of payment and finally, the need to "...top up the client trust fund."

6. Complaints

Nine of the cases reviewed contained at least one complaint by/on behalf of the Policyholder and generally, these were logged and actioned accordingly.

However, whilst the immediate cause for complaint was resolved, in some cases, underlying issues were not addressed and the complaint was a "missed opportunity" to recognise those and put the case back "on track".

For example, in one case there were multiple ignored requests for guidance and advice. After several (but not all) such requests, about 6 weeks after the date of loss a complaint was raised via the broker, yet the complaint was deemed unjustified. The shortcomings in handling and management may have been recognised and more appropriate action been taken had the "Customer Services Team" undertaken or commissioned a deeper review.

We consider that in some instances, the complaint was being managed to a process, rather than the opportunity being taken for a deeper look at conduct of the case.

Below (pages 12 & 13) are two more detailed General Case Studies each covering multiple issues from Case Management.

General Case Study – Case Management (1)

Following a fire - building repairs were not completed to enable the tenant Policyholder to resume trading from the premises within the applicable 12 month Maximum Indemnity Period.

Although the fire was reported to Insurers and a loss adjuster was appointed same day, the initial visit took place a week later. That may have been due to lack of safe access but the reason was not obviously recorded. It was not entirely clear what was discussed and agreed at the initial visit, but the following day, specialist damage management contractors were appointed to remove and restore Contents as deemed possible and prepare a list of those deemed beyond economic repair (BER). This was confirmed to the Policyholder in a brief follow up letter.

However, following the initial visit, the file showed that the claim was actioned in a meaningful way only when progress was chased by the Policyholder. The first such occasion was two weeks after the visit, but there were others later.

Money concerns were also expressed within weeks and although a payment on account was computed and confirmed to the Policyholder, the report to insurers recommending the payment was not issued until a month later. Before the payment could be issued, the Policyholder raised a formal complaint directly to insurers, including negative comments regarding the loss adjusters, that they did not return telephone calls, that next steps had not been clearly stated and there was confusion over estimates.

Thereafter, there were more regular payments on account against the BI claim, but the final payment was made following expiry of the 12 month Maximum Indemnity Period with the business still unable to reopen.

We saw no evidence of direct enquiry or intervention by the loss adjuster with those acting for the building insurers (whose identity was quickly established) to understand the reasons for the delays with the (landlords') building repairs. Whilst the reality is: it is hard for a tenant's insurer to bring pressure to bear, no attempt appears to have been made and the loss adjuster relied throughout on the intermittent (and vaguely recorded)

General Case Study – Case Management (2)

The SME business premises suffered damage by water ingress, penetrating the office ceilings, damaging office computers, contents and stock, but perhaps of most significance, a demonstration room. The cause of the damage was eventually established to be a roof defect. The physical damage appears to have been relatively modest, and to continue trading, the Policyholder moved partly to an adjacent unit owned by the landlord, but crucially, they were ultimately without the use of the demonstration room for about 5 months.

It was not clear from the files what initial actions were discussed by the loss adjuster at the first visit and agreed with the Policyholder. A standard form “Action Plan” was left outlining basic next steps. A Material Damage (only) Reserve was allocated.

We saw no evidence that the initial loss adjuster considered the cause of the damage in relation to policy coverage, nor established or understood the potential implications of the incident for the business. There was no obvious attempt to intervene and bring urgency to the landlord’s investigations into and attempts to cure the roof problem.

There were regular progress updates from the Policyholder and at least eight of these included explicit requests for (variously): advice, guidance, assistance, procedure, and timelines – with little or no response from the loss adjuster.

Part way through this period, the brokers picked up on this and raised a complaint, but the Customer Services Team recorded it as “Not justified”. By this time, a sizeable provisional claim had been submitted, just over half of which was for estimated Loss of Profit. In our opinion, a proper review of the file at this stage would have revealed the poor case management.

It appears that the case was also raised at an account management meeting between the brokers and loss adjusters, but again the opportunity was missed.

Ultimately, the Policyholder approached loss assessors. An executive there realised that the claim should probably have been with the “Major and Complex Loss” Team at the loss adjusting business and who should have been dealing with it. The issue was flagged by the assessors with appropriate individuals and eventually the case was reallocated.

From this point on, the case was appropriately and reasonably well managed by the MCL team. In the context of the damage and its claimed financial impact on the business, we consider it appropriate that the budgets and forecasts behind the BI claim were understood and debated before final settlement was agreed.

Application of Policy Cover

We summarise our findings under the main issues a claims professional is typically required to consider.

1. Policy Liability

Generally, in the cases that we reviewed, policy coverage was interpreted and applied correctly, but we found two cases where coverage issues may not have been fully considered.

For example, the General Case Study – Case Management (2) on Page 13 above - a claim for water ingress through a defective roof which was dealt with throughout and paid as “Escape of Water”.

In another case, the Policyholder provided serviced offices for a range of tenants. The building was broken into and Contents stolen. When the claim was presented, it included office equipment belonging to tenants. This should have led to a discussion about insurable interest or consideration of any grounds upon which the Policyholder landlord might be considered responsible for his tenants’ possessions. These points appear to have been overlooked entirely as the loss adjuster proceeded to settle the claim including significant equipment that did not belong to the Policyholder.

We also found decisions to admit liability being taken quickly and appropriately and that any delays were justifiable.

For example, there was a case where the Police considered it appropriate to investigate.

In another, there was a potentially material misrepresentation at presentation of the risk by the brokers. After clarification and explanations had been sought and obtained, 6 weeks from the date of loss, policy liability was admitted.

2. Quantum

Quantum was generally well managed and the settlements agreed appeared appropriate. However, we found on a small number of cases that the rationale for the settlement figure had not been fully explained to the Policyholder or was not understood, this mainly on cases where a loss assessor was involved and the effective point of contact for the Policyholder.

In a small number of cases, poor management and delays were not only detrimental to the Policyholder’s experience, but also potentially led to extend the claim lifecycle and increase total claim costs. Claims for such as Loss of Profit, Loss of Rent and Alternative Accommodation will inevitably increase with time, but poor decisions, guidance and/or proactivity around mitigation and remedy can also lead to an increase in material damage indemnity spend.

Poor case management at least contributed to the length of the Interruption Period on the cases where the 12 month Maximum Indemnity Period in the policy proved insufficient.

3. Subrogation

Similarly, subrogation issues were generally well managed – potential recovery opportunities were identified, investigated and, where appropriate, pursued in the interests of both insurers and their Policyholders.

However the potential for, or pursuit of, a recovery can influence the approach to a claim taken by an insurer or more usually their loss adjuster. This can impact the Policyholder’s experience because of the

higher standard of proof of quantum often required by a Third Party insurer. In consequence, if First Party insurers are to maximise their recovery, the scope for flexibility and pragmatism is reduced if not removed.

In one case, insurers appointed Solicitors to handle the recovery and the Solicitors' requests for additional information and documentation clearly added to the Policyholder's burden of trying to rebuild the business at the same time as manage the claim.

We also found one case where a conflict of interest was not well managed within a loss adjusting business, which knowingly found itself acting for both First and potential Third Party insurers, and although of no detriment to the Policyholder, their conduct ultimately prejudiced any potential recovery.

Conclusions

Our review involved 20 cases selected primarily from 100 Policyholder interviews undertaken by Quadrangle, where the Policyholder experience was deemed of interest and the issues underlying the comments made needed to be better understood.

Mostly, we found that the generally poor experience described by the Policyholder was understandable. However, in a few instances, from the files we reviewed, there appeared to be no obvious substance to or reason for at least some of the comments, generally dissatisfaction, made by the Policyholder.

We found:

1. Policy Cover and/or Case Management issues were at the root of virtually all poor experiences; not any failings around such as policy application. Whilst there were some (insurance) technical shortcomings, these were not as prominent nor generally detrimental to the Policyholder experience (for example, the two cases where policy cover issues may not have been fully considered, were paid).
2. Both Policy Cover and Case Management issues featured in the most “distressed” cases.
3. Policy Cover - Brokers did not (on the limited number of cases we reviewed) keep a record of the guidance and advice given and of any discussions relating to policy coverage issues at proposal or renewal. The general approach seemed to be that: based upon any such guidance and advice, it was for the Policyholder to choose the scope and levels of cover (Sums Insured) required. Whether via brokers or by insurers directly, a substantial amount of paperwork was sent to the Policyholder at initial quotation, renewal invitation and renewal confirmation. This may sometimes have resulted in, “warnings” to Policyholders to check that the cover provided met with their requirements being overlooked or ignored.
4. Policy Cover – is not always understood by Policyholders; nor were some technical nuances always understood by individual brokers, loss adjusters and loss assessors.
5. Brokers – post notification brokers, in the cases we reviewed, were generally not actively involved in the claim process unless and until required or called upon for support by their Policyholder client.
6. Loss Adjuster and Loss Assessor – where present, perform the pivotal roles that drive the Policyholder’s claim experience under any given policy.
7. Poor Case Management - by either or both the loss adjuster and loss assessor featured frequently (lack of/poor guidance and advice, action planning, communication, proactivity).
8. Application of Policy Cover – there were fewer shortcomings with less impact on the Policyholder’s experience.

9. Our research indicates that – appropriate triage and individual resource allocation from the outset is key, especially for Major/Complex Loss:
 - two of the best handled claims were allocated immediately upon notification to dedicated MCL Adjusters
 - the two most “distressed”, too late in the life of the claim.
10. Loss Adjusters - poor Case Management can only result from poor systems/processes, insufficient time on the case or a lack of motivation.
11. Loss Adjusters (and Insurers) - Complaints appear to be process driven and are a missed opportunity to identify underlying issues and put claims “back on the rails”.
12. Loss Assessors (or rather Policyholder representatives) – play a valid role in some cases, but their business structure and approach is varied and diverse.