Mactavish
Expert insurance buyers

Mactavish Insurance Claim Litigation Index

Our analysis of commercial insurance claim litigation and insurance trends and practices

Building corporate resilience.

Foreword

"The Mactavish Insurance Claim Litigation Index provides statistical proof of what many people have been experiencing for some time, that in a hard market some insurers have "sellers regret" over the risks they have written and the terms or price they wrote them on. Policyholders get caught between soft market underwriting and hard market claims handling, meaning that cheap policy no longer looks quite so attractive. The change in attitude by insurers leads to more claims being declined which in turn leads to more legal challenges at court. However, as at least some policyholders will already be aware, the usual outcome of a disputed claim is not a judgement at court, but more often a delay in the payment of the claim and a discount on the total amount claimed. Litigation as a form of negotiation, if you will.

Generally, disputes arise in the context of a single policy and loss. However, circumstances can occur which give rise to many similar or linked claims. Whilst insurers are commercial entities, sometimes such losses need to be considered in a wider social and economic context. The social utility of insurance is after all its "raison d'être". In our view, the market missed its "San Francisco moment" with business interruption claims and Covid. Rather than copying what happened after the 1906 earthquake and paying reasonable losses without major investigation or argument, many insurers looked to challenge all Covid claims arguing that in effect, they never intended to insure such a loss. The decision generated terrible publicity and near-unanimous unfavourable decisions in the High Court and the Supreme Court, yet even then, despite some large total payout sums, a relatively small proportion of all affected policyholders got paid given the scope of the FCA action, and well over a year after the Supreme Court decision there remain thousands of unsettled claims. This was not a good outcome for anyone.

A tool for tracking insurance litigation and claim performance has been long overdue in the UK market. For too long, the market in its widest sense - and observer commentary on market conditions – has focused on what insurers are charging by way of premiums instead of what the policies provide and what insurers are paying out by way of claims. A classic case of price over quality. The Mactavish Claims Litigation Index is an excellent first step towards redressing this balance and getting the market to focus on what really matters, the product you buy with your premiums, not just the premium itself."

David Hertzell
Chairman – Dispute Resolution

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Introduction

London is not just a leader in the global insurance market, it is also the world's most important destination for the resolution of legal disputes. Every year, hundreds of insurance related disputes are lodged with the courts of England and Wales, representing billions of pounds worth of disputed insurance claims.

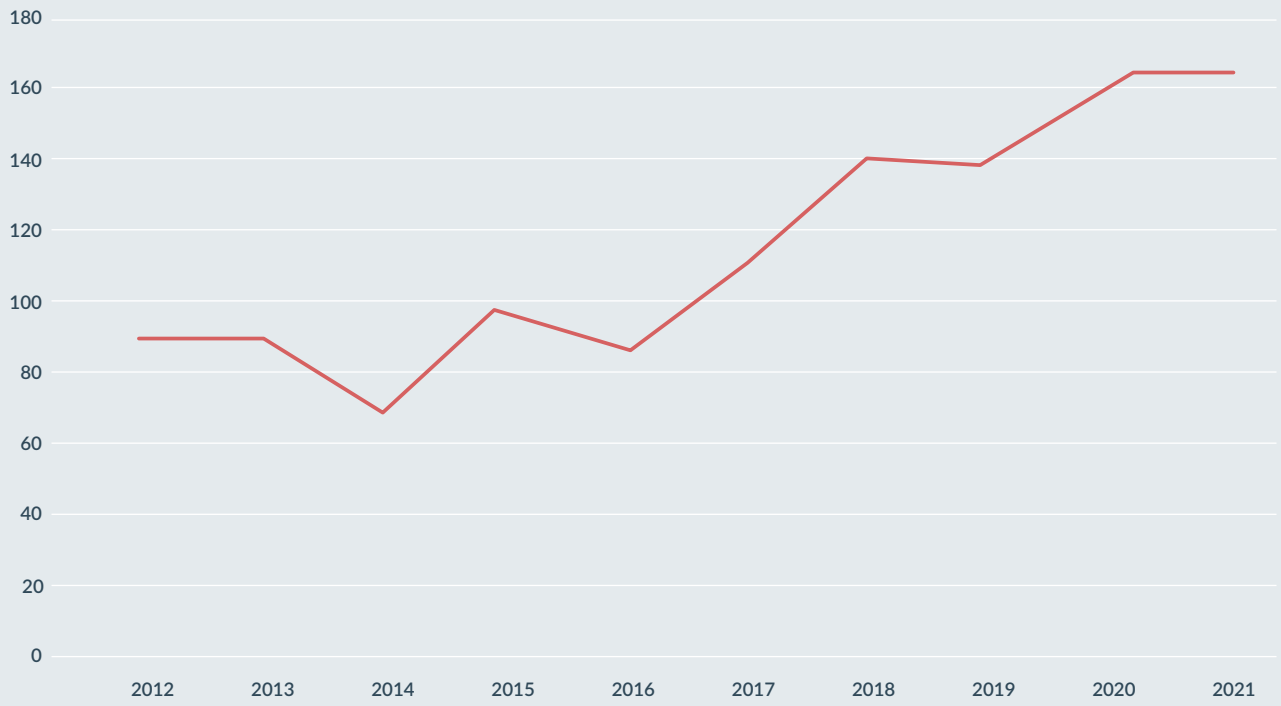
These legal battles stem from all parts of the market: marine, technology, property, finance, manufacturing, as well as areas that are non-core for this report, such as claims stemming from road traffic accidents and asbestos. This is the sharp end of the industry, where insurers and their clients lock horns, unpicking insurance contracts, scrapping over exclusions, cover definitions and disclosures whilst battling it out to determine who owes what to whom.

The number of disputes which come to court is a small but visible proportion of overall claims – a classic tip of the iceberg. Analysis of trends in these claims provides important insights into wider trends, including the extent to which disputes are being prolonged to the brink of litigation. This report summarises our conclusions from a review of well over 2,000 court claims issued over the last decade. Viewed together, the variety and volume of disputes lodged at the High Court provides an extraordinary vista on the culture and practice of the UK insurance market, particularly when it comes to understanding the pivot upon which the entire industry swings: how and when claims are paid. For all the glossy marketing brochures, policy add-ons and new product launches, it is the payment of claims that provides an insurer's social and economic worth. General statistics for claims handling published by insurers often include large volumes of uncontentious or low value claims (such as retail, motor and low value SME claims), which mask the reality of pursuing a large commercial claim. The reality of how difficult it can be to pursue a commercial claim was examined in detail in 2015 when the FCA carried out a Thematic Review of SME claims handling. The report noted that the claims experience of SMEs was significantly worse than in the retail sector, with delay identified as a key factor. There has been no equivalent study of larger claims.

To better gauge how insurers are dealing with claims and detect trends across the industry, Mactavish harvested all possible data from the courts over the last decade. As we explain more fully in the section on methodology, we looked into all disputes involving the top 20 insurers in the UK across all the High Courts, Appeal Courts and the Supreme Court.

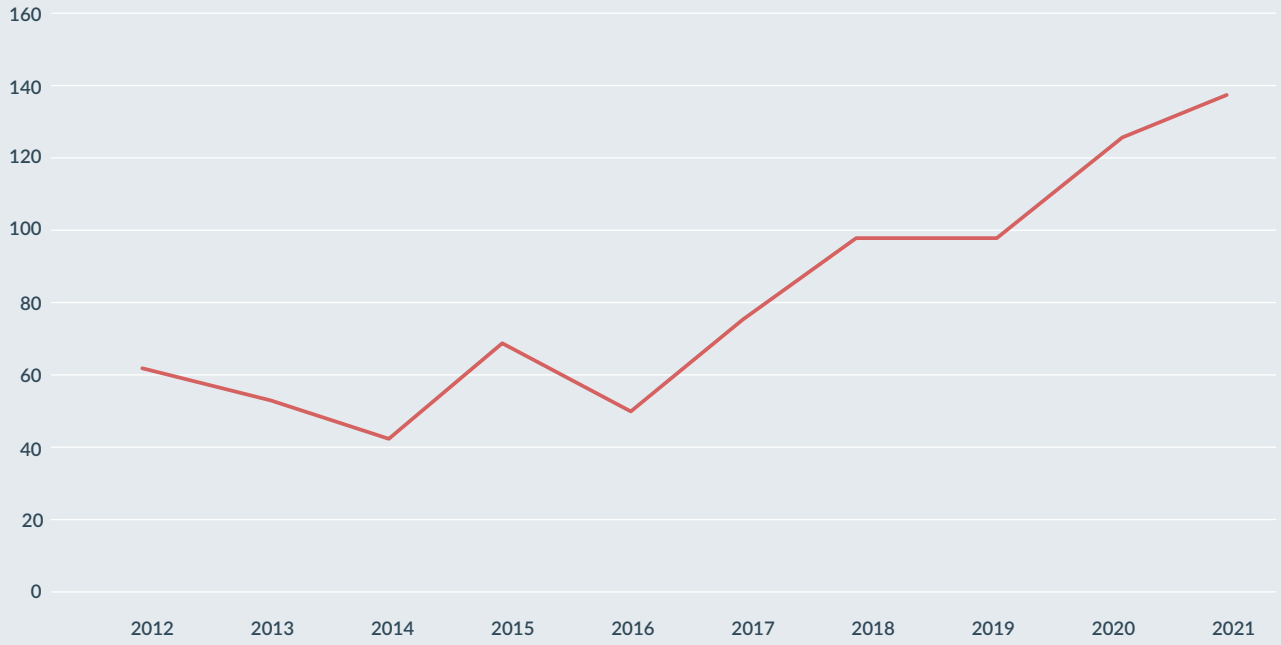
What we discovered was alarming. As our graph on the following page (Figure 1) demonstrates, High Court claims are spiking. At the most fundamental level, the number of cases filed each year involving insurers has doubled over the last 10 years. This data echoes observations Mactavish shared in the report *"Hard Market, navigating the current Insurance Market dynamics is vital to getting the right cover in place"*[3], issued in April 2019: the insurance market is getting more litigious. More disputes, whether about unpaid claims or otherwise, are ending up in court. In broad terms, it would appear from Figure 1 that insurance companies are now more than twice as likely to end up in court than they were a decade ago. It is reasonable to suppose that this trend will also be seen in the much higher number of claims arbitrated, brought to the brink of litigation before settlement or being litigated in the lower courts.

Figure 1 - Legal claims filed at court involving insurers as either claimant or defendant



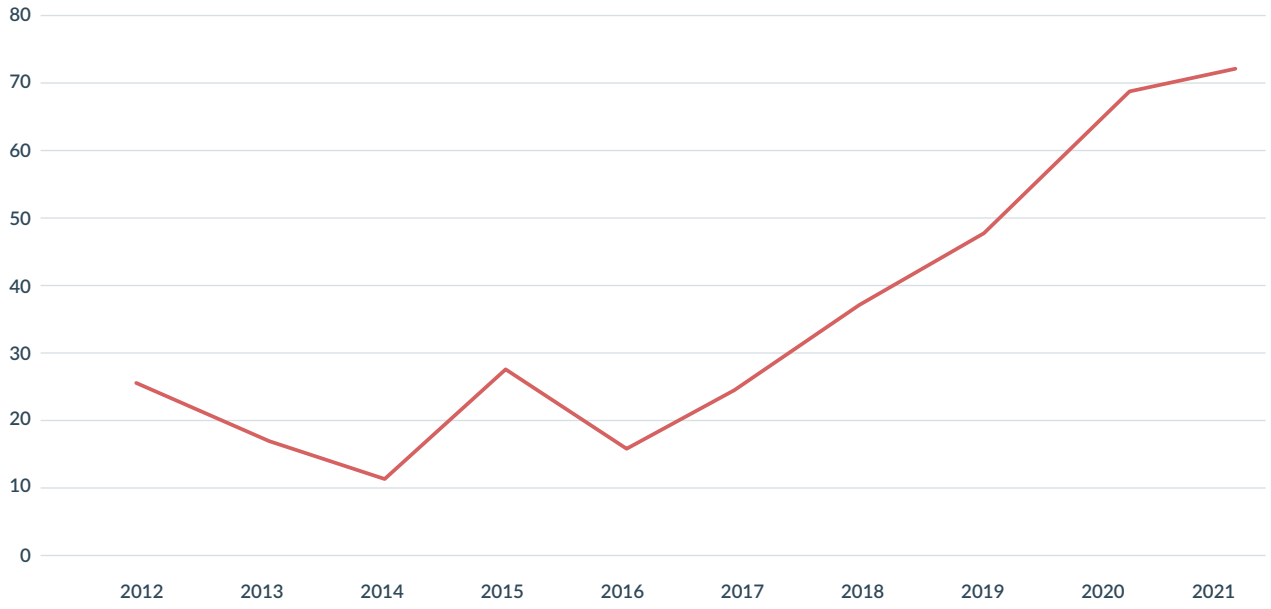
However, this data analysis, which examines cases where an insurer can be either claimant or defendant, is something of a blunt instrument. To better understand how commercial claims are being handled, it is instructive to strip out those cases filed by insurers as the claimant[1], and focus only on cases where insurers are defendants (Figure 2). These cases are almost exclusively about the pursuit of unpaid insurance claims. Here, we see an even more marked increase, with around 50 cases filed against insurers per year in the first half of the decade, ballooning out to well over 130 last year. This trend commenced well before the pandemic.

Figure 2 - Legal claims filed with insurer as a defendant



To focus more narrowly on commercial insurance claims, we stripped out claims relating to road traffic accidents, (Figure 3) getting to what we believe is the best measure of what activity at court can tell us about how the commercial insurance market is handling claims.

Figure 3 – Commercial insurance legal claims filed with insurer as a defendant



As the graph shows, between 2012 and 2016 there was an average of just under 20 cases filed each year against our top 20 insurers. Last year, that figure was 72, the year before that it was 69. Compare the two levels and you see that the rate at which these legal disputes are ending up in court - almost all of which relate to unpaid claims - has more than tripled. This is only the tip of the iceberg in that the majority of disputes will be resolved in mediation or commercial settlement with the looming threat of litigation being used as a heavy instrument to drive down the settlement. The policyholder may already be in crisis due to the loss event that has led to the insurance claim in the first place, with no spare money to sue an insurer.

It is worth stepping back for a moment and considering what is going on here. There is no evidence that the number of commercial insurance claims has more than tripled, nor is it likely that the Insurance Act 2015 is a root cause - after all, the Act was introduced to try and avoid the necessity for litigating disputes. The rise in Covid Business Interruption (Covid BI) claims will have had some impact on the volume of legal disputes, but not as much as some may think given the consolidation around the FCA test case. These cases are closely monitored by the Courts which provide regular updates[2]. In its latest update, published earlier this year, the Court said it had identified just 10 BI claims live cases currently making their way through the courts, (of over 2500 unsettled claims reported to the FCA as of March 2022) clearly nowhere near enough to materially alter the trend exposed by our data.

In the absence of any other drivers, the overwhelming conclusion is that this jump in litigation in pursuit of insurance claims is due to a corresponding jump in such claims being contested or delayed by insurers. This, in turn, backs up the anecdotal evidence reported to Mactavish by brokers and clients that claims departments are increasingly disputing, declining or otherwise challenging insurance claims on an increasing variety of grounds. Has the frequency by which insurance claims are being declined or delayed increased exactly in line with the rise in High Court litigation? As we explore below, the situation is likely to be more nuanced than this. There may be various drivers for the increase in legal disputes, such as an increase in fraud, corporates becoming more litigious or a deterioration in the quality of insurance contracts. However, we don't believe any of these reasons can account for the sharp rise our data has identified. Given the data, and the reasonable assumption made above, our conclusion is that commercial policyholders are now more than three times as likely to have to sue their insurers to get their claims paid, than they were just five years ago.

Corporations are now more than three times as likely to have to sue their insurers.

In bald number terms, the number of high court cases as against the total number of claims is a drop in the ocean and was used by those opposed to legal reform to argue that all was rosy. However the vast majority of disputed claims are resolved without litigation either by negotiation or by more informal dispute resolution mechanisms such as mediation, with others being resolved in confidential arbitrations. That is the Mactavish experience too. That does not mean these disputes are resolved satisfactorily and previous Mactavish research pointed out that when a claim was disputed, the policyholder had to wait on average three years for payment and only received on average 60% of the claim.

However you look at it, the increase in the number of insurance claims ending up in court is deeply worrying. It is worrying for corporations who face more cost and delay when looking to claim on their policies; it is worrying for the insurance industry which is in the process of damaging its relationship with its customer base and eroding the value of its product as an ever greater share of premiums is lost via legal and adjusting costs. This is also worrying for the wider economy; if businesses do not have confidence in the insurance market, they are less likely to take the kind of business risks that are required to maintain economic growth. They will be less likely to expand into new markets, geographies, products or services. The insurance market has a considerable responsibility for supporting the wider economy, something for which it is well remunerated. It needs to face up to that wider responsibility by meeting the needs of its customer base - ultimately by selling clear policies, adjusting them fairly and avoiding springing unnecessary surprises on policyholders.

Stuck between a rock and a hard market

As our data makes clear, the rate at which commercial policyholders sue their insurers in pursuit of claims is on the up, more than tripling in the last five years. But as well as showing us what is happening, the data can also help explain why it is happening.

In each of the graphs we have presented above, the trend is the same. The number of lawsuits bounces around at a similar level between roughly 2012 and 2017. Then from 2018, the graphs take off, the number of claims rising 36%, 38% and 21% over the next three years.

As any student of the insurance market will spot, the increase in the frequency of legal disputes closely correlates with the onset of the hard market. At Mactavish, we warned of this risk in our report Hard Market back in April 2019. In the report, we identified seven signs of hardening conditions, including increased premiums, withdrawal of capacity, reduced coverage and claims being rejected. Tracking these changes, at least with respect to increased premiums, withdrawal of capacity and reduced coverage is relatively easy, and is something that has clearly come to pass. Quantifying the rate at which insurers are challenging insurance claims has always been much harder. Back in 2019 we wrote:

> *A Mactavish study conducted during the soft market found that **45%** of large or significant claims were disputed. This is likely to be tougher in a hard market. Businesses should be prepared for a challenging environment for claims, especially in the most sensitive sectors.*

Based on the data available to us in the Mactavish Claim Litigation Index, we can now confirm this situation has come to pass. The data strongly suggests not only that a significant proportion of large insurance claims are being disputed, but also that the nature of those challenges is becoming more severe based on the escalations of cases commenced in court. In the soft market, many challenges to insurance claims, while problematic, were likely to be marginal and could be resolved through negotiation and compromise. Now, the challenges are more frequent and more likely to be so material that the insured party has no choice but to litigate.

This is a grim outlook for corporates. Battling against the headwinds of rising inflation, a tight employment market and an increasingly difficult international trading outlook, the last thing they need is to feel they are losing the support of their insurers. However, our data suggests that more legal claims are flowing. At least in part, this is due to a more confrontational approach to the payment of claims. Insurers are getting tough.

By denying claims, insurers are effectively protecting their balance sheets at the expense of their customers. To a limited extent, this might not be unreasonable. Some insurance claims do sit in the grey area where liability or quantum are not immediately clear. In the soft market, those claims may have been paid without question as insurers looked to promote their business off the back of a good claims record. However, in a hard market, insurers can get seller's remorse, with the risk suddenly not looking as attractive. This grey area is not inevitable – well written insurance policies should leave little room for uncertainty. What is more, as we have seen with the Covid Business Interruption controversy details below, it is the higher value claims that are more likely to be challenged by insurers. When the sum at stake is large, the parties to the dispute are as likely to be arguing about quantum as they are about liability. It can, of course, be in an insurer's interest to push matters to court to see if they can use the legal process to reduce the value of the claim either through settlement or judgment.

Unfortunately, this situation is only likely to get worse. There is little evidence that the market is going to turn any time soon – in fact, quite the opposite – rates are still climbing. A combination of the war in Ukraine, global inflation, the impact of sanctions and new classes of risks emerging will all drive premium rates up, and claims pay-outs down. Already in the first quarter of this year, premium rates for commercial insurance have risen 11pc, the 18th consecutive quarterly rise, according to data from the world's largest broker, Marsh.

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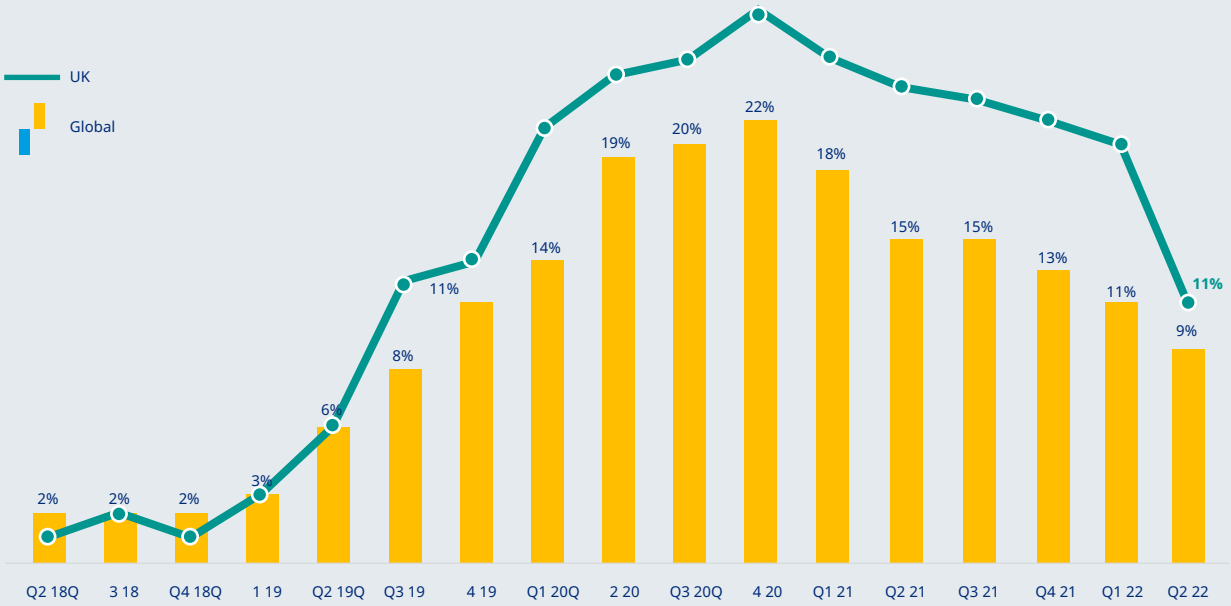
While not an exact science, overlaying the data on premium rises as produced by Marsh, against the Mactavish legal claims data produces an uncanny match. When premiums go up, so do disputed insurance claims. As the rate of premium cost increases starts to level off, so does the incidence of legal claims being filed at court. Of course, there are anomalies, and it is unlikely the two data sets will always move in lockstep, however the general trend is clear. When insurers start to increase their prices, they also cut back on paying out claims.

Quarterly increases in premiums on financial and professional lines insurance



Graph data Source: Marsh Global Market Index Q2 0222

Covid Business Interruption claims

The global response to the Covid pandemic - national lockdowns that forced the closure of thousands of businesses - was a seminal moment for the insurance industry. As businesses closed their doors, sent staff home or restricted opening hours, losses quickly mounted. Understandably, business turned to their insurers for help.

Views differ on what the correct response from the industry should have been. For some, this was the insurance industry's San Francisco moment, the time for insurers to stand behind their clients, just at the Lloyd's market did after the 1906 San Francisco earthquake, ironically the same year the last time Parliament legislated for insurance, the Marine Insurance Act 1906. For others the pandemic and subsequent lockdowns were a blanket event that affected the whole economy so had nothing to do with the risk-sharing model under which the industry operates.

Whichever side of the debate you prefer, the reality was that with potential claims running well into the billions, the response from the industry was an almost unequivocal "no". Instead of supporting businesses, insurers looked at the fine print of their policy documents and rejected those claims. Depending on policy wording specifics, some insurers attempted to argue that the Covid19 lockdowns did not constitute an "interruption", or that the policy would only be triggered if a business had closed due to a specific event - i.e. illness - that had occurred within the premises, or even that the UK Government was not a sufficiently relevant authority. As was widely reported at the time, even those insurers, such as Hiscox, who pride themselves on a swift, no-nonsense approach to paying out claims, dug their heels in and called in the lawyers.

The response from the industry attracted some pretty unsparing criticism. Within weeks of the controversy hitting the news, the financial regulator, Parliament, business groups and the courts at all levels had been dragged into the debate, with almost no-one siding with the industry. In an attempt to resolve matters, the Financial Conduct Authority (FCA) brought a test case in which 21 sample wordings from business interruption policies issued by eight insurers were tested at the High Court. While different decisions were made in respect of each of the wordings, in the majority of cases, the insurers lost and were told to pay up. Six of the eight insurers, along with the FCA and certain interested parties, appealed aspects of the judgement. Given the urgency of the matter and the fact it was a test case, the appeal went directly to the Supreme Court. Once again, the judgement was nuanced, however, its overall direction of travel was clear – the insurers lost again.

Given the amount of coverage, legal commentary and analysis the Covid test case has already attracted, there is little value in exploring these matters further here. However, Covid disputes remain very relevant to this report as, unfortunately, the test case did not put the matter to bed. An argument often raised in conversation by insurers is that they never intended their policies to cover pandemic loss. That may be true but it is a contract and when the words suggest such cover is in fact provided, that is what the court will apply. Moreover, Lloyd's underwriters probably never intended to cover the full extent of the virtual destruction of San Francisco in an earthquake in 1906. However, the headline Lloyd's managed to generate was that its underwriters paid up without quibbling over policy terms. As a result, Lloyd's dominated the US market until WW II by doing the right thing for their customers. It gained an invaluable reputation in a crisis of no one's making.

The Covid test case set out to establish a precedent that could be followed more widely by insurers dealing with Covid BI claims. The policy wordings examined in the case were carefully chosen to be representative of selected different forms of BI policies in the market.. By examining 21 policy wordings from eight insurers, the FCA was hoping to provide clarity and guidance on some 700 types of business interruption policies across 60 different insurers and 370,000 policyholders. This was made very clear in a press release[4] issued by the FCA at the conclusion of the Supreme Court action, stating:

> *Our aim throughout this test case has been to get clarity for as wide a range of parties as possible, as quickly as possible, and today's judgment decisively removes many of the roadblocks to claims by policyholders.*

Our data suggests that the success that flowed from the test case has had its limitations. While the test case may have resolved those claims examined during the hearings, it left many others in limbo. Some of this was by design. For simplicity, only a subset of the issues governing policy coverage relating to Covid BI were included in the scope of the FCA's action, leaving other matters to policyholders and insurers to work out via separate dispute. Overall, the proof of this pudding is to be found in outcomes: while there is no great volume of claims at court, there are still notable, high-value Covid BI cases being heard. Premiership football clubs, restaurant chains, retailers and medical groups have all brought cases, many together; this means that a single claim, as counted by our data, actually represents multiple businesses, each seeking redress from their insurers. Many of the Covid BI disputes are acting as further test cases, with further Covid BI claims waiting on early judgments before deciding whether to file their own cases.

Such is the value and importance of these claims that the Courts have created a sub-list so it can manage the cases in a coordinated way. As mentioned above, in some instances, such as the Premiership Football clubs or a group of restaurant chains suing their respective insurers, the cases are being handled in groups. In others such as Greggs v Zurich, Stonegate Pub Company v Amlin and Corbin & King v AXA, the cases involved individual companies or groups under the same ownership.

The sums of money at stake are considerable. To date, the FCA calculates[5] that insurers have paid out just over £1bn in Covid BI claims. From our analysis of court data, the value of denied claims probably outweighs the value of those that have been paid. The Stonegate v Amlin case listed above has been valued by the claimants at £845m*; the Greggs case could be worth up to £150m. Other cases have not put a value on their losses; however, as they constitute joint claims, and essentially classes of claimants with the same policy wording, it is highly likely their losses will run to hundreds of millions of pounds. And as ever, the data we see at the High Court is just the tip of the iceberg – over 2500 Covid BI claims remained unresolved as at March 2022. For every case that ends up in court, many more will have pursued their insurance claims through mediation, arbitration or other forms of dispute resolution. For many of these companies the outlook is grim indeed. A large restaurant chain or Premiership football club will have the resources and deep pockets required to pursue their insurers through the court; what about the independent café or local sports club? It is unlikely they will have the corporate muscle to take on a large insurer in court. It may be argued that the Covid BI cases stand apart from the trends that have emerged in the hard market and the toughening up of attitudes on claim payouts.

While we will never know what would have happened had the pandemic struck in a soft market we would argue the outcome could have been very different. Insurers tend to move as a pack. It is quite possible the bulk of claims could have been paid in a soft market, thus avoiding all the unnecessary costs, delays and reputational damage that has occurred over the last 18 months.

Covid Case Study - Greggs v Zurich

As with many of the Covid BI cases, one of the key issues that insurers keep returning to is the question of aggregation. Should insurers pay out just once, at whatever capped sum had been agreed in the policy wording because of the Covid lockdowns, or should they pay out multiple times, reflecting the series of lockdowns that businesses endured? And, as in the case of Greggs, should claims be multiplied by the number of locations which were forced to close or restricted to one single claim relating to the company itself? It is these questions that are at the heart of the Greggs case. A slew of other cases could be settled on the back of the case, all of which could substantially alter payouts to insured parties. However, given the sums involved, the initial judgment (expected imminently) is likely to be subject to an appeal. In the Greggs case, in which Zurich accepts liability but contests quantum due to the question of aggregation, the range of possible payouts scales from £2.5m to £150m. That is a lot of cheese pasties.

Covid Case Study - Corbin & King v AXA

It is possible that the bulk of outstanding Covid BI claims could fail and insurers will be vindicated in challenging them through the courts. However, early signs suggest otherwise. One of the early judgments to be handed down in the Covid BI List was in Corbin & King v AXA. On 25 February 2022, the High Court ruled that AXA was liable for Covid BI claims brought by the restaurant group owning upmarket restaurants including the Delauney, the Wolseley and others. Despite acknowledging that the March 2020 lockdown, September 2020 restrictions, and the November 2020 closure were separate restrictions of access, the insurer denied that each set of restrictions gives rise to a separate limit of liability for each premise. As with the test cases discussed above the court disagreed, finding the lockdowns were separate events and should be treated as such by the insurer. No appeal was pursued by AXA.

*As this report was going to press, a preliminary judgement was handed down in the Stonegate case which had the effect of dramatically reducing the size of the claim. While it is understood Stonegate may look to appeal the judgement, if it were to stand, it would reduce the size of the claim to a fraction of the sum originally claimed.

Declaratory Actions

Faced with having to submit an insurance claim following a major incident, a fire, industrial accident or similar, the last thing a corporate will expect is to be sued by their insurer. Quite naturally, they expect their insurer to be by their side at these moments, not on the other side of a courtroom.

Unfortunately, by pursuing a declaratory action insurance companies can drag their clients into a legal battle at the very earliest opportunity. The process is simple. Rather than waiting for a claim to make its way through the usual channels, insurers go directly to the courts and apply to have their liability assessed by the court. In some circumstances, such a practice may be justifiable. Some insurance claims probably do merit an early intervention from the court. However, when they fail, the immediate impact is to pile on costs, time delays and frustration to an already painful process. There is almost no upside for an insured party to this process. They will have to expend costs responding to such an action and, even if they prevail, they may still have to sue their insurer to get paid.

Of course, one cannot assume that all declaratory actions are misplaced. It may be entirely proper to get an early decision on a point of law, to clarify a particular piece of policy wording or to resolve a fair presentation dispute. However, in general, the courts do not welcome declaratory actions if the decision does not achieve finality in the matter.

Another problem with such declaratory actions lies with the costs associated with responding to the action. What if the client brought to court is impecunious and unable to properly defend the claim? Even if successfully defended, costs recovery will typically be no more than 60-70% of the legal costs actually incurred and payment of such costs will await the final outcome of the claim. In one of the case studies we examined, the respondent, i.e. the insured party, suffered further delay in having to seek an order for its costs to be paid months after the insurer's declaratory action had failed.

We make no claim here that declaratory actions are only a phenomenon of the hard market. As we detail below, they can occur whatever the market conditions. However, given our conclusion that insurers tend to be more confrontational about claims in a hard market we would expect to see more declaratory actions over the coming months and years, something we will be monitoring carefully.

Declaratory Action Case Study - Aspen v Adana

Aspen v Adana addressed the question of whether the insurer, Aspen Insurance UK Limited was liable with respect to substantial damages that were expected to flow from the collapse of a crane in 2009. The defendant, Adana Construction Limited, had built the concrete base on which the crane was erected. The claim was initially heard at the High Court in 2013 and then at the Appeal Court in 2015. In simple terms, the argument put forward by Aspen was that the temporary concrete base was a 'product' and as such was not covered due to an exclusion in the public liability section of the policy that excluded claims for products failing to perform their intended purpose.

Other than on a few technical points, Aspen's case failed, both at the High Court and then the Appeal Court. While this failure attracted some commentary from the legal community, another aspect of the case went almost unnoticed - whether it should have been brought at all. At both the High Court and the Appeal Court, the judges made their disquiet over this aspect of the case very clear. Despite running for nearly five years, the Aspen / Adana case was seen as premature, having been brought before any finding of liability had been made against Adana, leaving many of the facts of the underlying claim uncertain. In the High Court, Judge Mackie QC, said:

> *"The insured also contends, supported by authority and good sense, that this trial is premature and that there is a risk that it will decide little."*

Lady Justice Gloster, sitting as one of the three Appeal Court Judges was even more blunt:

> *"In circumstances where, as we have been told, the claims, additional claims and defences in the liability proceedings have not yet been fully pleaded, let alone determined, I would also wish to express my grave reservations as to whether it was appropriate to determine the coverage issues on the basis that, necessarily, many of the facts were assumed or uncertain."*

Declaratory Action Case Study – Allianz v Exeter University

Our second case study is more interesting for the facts rather than law and is yet to be determined. Allianz v Exeter University was only filed in January this year. In this case, the insurer, Allianz Insurance is seeking a declaration from the court that it should not be liable for damage caused by the controlled explosion of a 2,200 lb World War Two German bomb, known as a Hermann, discovered in the grounds of one of Exeter University's halls of residence in February 2021. While the bomb was safely dealt with by way of a controlled explosion, the university suffered property damage and business interruption losses relating to the rehousing of students.

Legal documents associated with the claim make it clear the university was covered for "… loss, destruction, damage, injury of liability…" subject to the usual exclusions. Such exclusions included losses "directly or indirectly occasioned by war". It is on this basis, the war exclusion, that Allianz challenged the insurance claim and sought the declaration. Interestingly, the case is more likely to turn on the definition of "occasioned" rather than "war". Was damage caused by the explosion of the 2,220 lb Hermann indirectly occasioned by the "war" 80 years ago or was it only really "occasioned" by the bomb disposal operation in 2021?

Whichever way the claim goes, what is clear from the available legal documents is that Exeter University submitted a claim for damages, Allianz refused to pay, and now the university finds itself defending a legal action brought by its own insurer.

Declining Policy Standards

When analysing the reasons insurers give for declining claims and how insurance disputes end up in court, one has to first start with the policy wording itself. Too often, Mactavish sees policy wordings that contain errors, ambiguities and are subject to enormous differences in interpretation.

They are also written in a language that only an experienced insurance professional, or lawyer, can accurately interpret. When it comes to notifying an insurer of a potential claim, what is the difference between the words "as soon as practicable", "immediate" or "forthwith"? To the person on the street, not much. To the insurance lawyer, it could be a week, a month or more and may or may not depend on knowledge of underlying facts. But is it reasonable to expect the insured party to know how to interpret this? It is not something that is spelt out in most policies. It is only by long experience in the market that such clauses can be decoded into practical, easily understandable terms.

The two most common reasons given for rejecting claims were lack of coverage and non-compliance.

Such problems in policy wordings go beyond obtuse phraseology. Mactavish has been made aware of insurance policies produced for companies engaged in steeplejack services which have exclusions for working at heights (i.e. virtually 100% of the insured's main activities); policies produced for IT service businesses that contain exclusions for working in the premises of third-party companies, and many other obviously absurd or inappropriate restrictions. These matters usually find their way into policy documents because so many of them are produced from a template rather than being individually drafted for a particular company. The depressing truth is that given the structure of the market, this type of problem is to be expected. Documents are produced by insurers or brokers, almost never by the insured party. In some cases, they are simply topped and tailed and printed out with little detailed oversight or checking for errors.

To better understand on what basis insurers were declining claims, we did a deep dive into a sample of the 1,000-plus claims that make up the database. The analysis of legal pleadings for 50 of the most recent legal claims threw up most of the usual reasons for declining claims: non-disclosure of material facts; misrepresentation; claim alleged to be outside the scope of cover or excluded; and breach of policy conditions. We saw examples of all of these in the case studies we analysed, more often than not, multiple examples, declining them on multiple grounds. Unlike our Mactavish Claim Litigation Index, which captures nearly all claims filed at court, the deep dive into the reasons for declinature explored no more than a sample of cases and should be seen as such. Nonetheless the results were interesting. The two most common reasons given for rejecting claims were lack of coverage and non-compliance with conditions. At least some of the lack of coverage defences also stemmed from Covid cases with insurers arguing that their

clients were not covered for the BI claims flowing from the lockdowns, or that such claims should be aggregated into one loss rather than multiple losses. The non-compliance cases (in the case of first party insurance claims) generally centered on alleged negligence by the insureds being the underlying cause of the claim. In some of the cases we looked at where multiple reasons were given for declinature, at least some of the reasons faded away as the matter approached judicial scrutiny, leading to the obvious question of whether such reasons should have been put forward in the first place. This is the most striking observation from this analysis: the number and spread of alternative repudiation arguments presented confirming the difficulty facing policyholders in navigating the current claims environment.

Declinature Case Study – Niramax v Zurich

In Niramax v Zurich, the claimant was pursuing a £4.5m claim stemming from a fire at the company's recycling plant in 2015. During the protracted dispute, the claim was denied for a number of reasons, including non-disclosure and non-compliance with policy conditions. Some of the non-disclosure issues, such as allegations brought by Zurich that Nirmax was linked to an individual who had been convicted of a machete attack, were later dropped. Other non-disclosure issues relating to historical matters, such as a fine for unlawful storage of tyres or unlawful depositing of controlled waste, were "dismissed with relatively little ado" by the Judge, who added: "…it was clear in my view that none of them afforded a basis for avoidance".

Where Zurich's defence to the claim did succeed, in part, was in arguing Nirmax had failed to satisfy certain conditions by not installing fire suppression equipment in specific areas of its premises, as had been required by the property insurer. Aspects of the High Court judgment were unsuccessfully appealed by Zurich.

Declinature Case Study – Anderson v AIG

Anderson v AIG is a recently filed claim involving a dispute over liabilities that arose with respect to the negligence and subsequent failure of a law firm Giambrone Law LLP. The current claim, against AIG, flows from an earlier judgement against Giambrone which found it had been negligent in accepting money from investors, represented by the main claimant Anderson, in an off-plan property development known as the Jewel of the Sea in Calabria, Italy, and then paying these monies across to the developers without taking adequate security. Jewel of the Sea was never completed and the funds were lost. AIG, as Giambrone's professional negligence insurer, supported the law firm in defending the initial High Court action, but withdrew support when Giambrone unsuccessfully tried to appeal the initial judgement.

Having failed to enforce their judgment against Giambrone, the claimants are now pursuing AIG. In a key leg of its defence AIG focussed on a corporate restructuring that its client, Giambrone, undertook in 2008 when it transferred from a Partnership structure to an LLP. AIG argued in its defence that it was not liable for any liability transferred from the Partnership, such as the Jewel of the Sea matter as:

> *…it is not a liability arising from the provision by the LLP of legal services (to which the Policy responds) but, rather, is a liability arising pursuant to a transfer of business to the LLP.*

To support its position, AIG pleaded in its defence that in an earlier judgment against Giambrone, the presiding judge was "wrong as a matter of law" when he concluded that any liabilities should flow from the partnership to the LLP:

> *"…the LLP was under an obligation… which included correcting prior breaches of duty…"*

The case continues.

Declinature Case Study – Experian v Zurich

Experian v Zurich is a complex case involving not just Zurich, but nine defendants who provided cover for Experian as part of an insurance tower. In its claim, Experian alleges the insurers are liable to indemnify it for damages that flow, or may flow, from a series of regulatory and civil cases brought against the firm in relation to alleged breaches of data protection laws. While accepting liability on some aspects of the claim, the defendants are challenging other matters. These challenges to liability centre on an exclusion relating to alleged vulnerability of the software used by Experian and on the basis of "deliberate acts" in that it is alleged that senior management at Experian were aware of "wilful or reckless failures" allegedly carried out by staff that contributed to losses, or potential losses. The defence states: "The claims in [certain actions] therefore arise out in whole or in part out of wilful and/or reckless acts, errors or omissions falling within the Deliberate Acts Exclusion." The claim, which has yet to go to trial, will be an interesting one to follow as it will explore circumstances in which it may transpire that Experian got things wrong with respect to its data handling and could be found liable in separate - if connected - class action lawsuits. The extent to which the insurers should be liable for claims that flowed from these events is an interesting, and fundamental, point of insurance law.

Methodology

To offer the most comprehensive view of what is happening in the courts, and by extension the insurance market, we accessed high level data on all claims filed at the High Court involving the top 20 insurers in the UK.

This gave us well over 2,000 cases spreading back over the last decade. From here. we painstakingly filtered the data for duplicate claims, false positives and matters that were obviously irrelevant or misleading. The data was then sub-divided and categorised so it could be viewed by insurer, type of claim, which court it was going through, whether the insurer was the defendant or claimant, the date it was filed and whether one or more insurers was involved. This data set has allowed us to accurately assess the volume of cases going through the higher courts, what type of cases they are, who is involved and - most importantly - how all this has changed over time. We were conscious throughout that as our data was subdivided, so too was our sample size and therefore the reliability of the data was reduced. It is for this reason we decided not to present any comparison of how the number of claims breaks down between insurers.

While it is possible to see and analyse the legal record of each insurer and in some cases one might gain some insight from doing this, it was clear this was not the case with all insurers. Some of the smaller underwriters barely make it to court, while others are involved in such a small number of cases that the data is not meaningful and could easily be skewed by outliers. It is really only when you look at the market as a whole, i.e. all 20 insurers, that a robust and reliable picture emerges.

In addition to the pure data driven work, we also conducted a deep dive into a significant sample of key cases. Focusing in large part on cases that had been filed over the last 18 months, we accessed the claim and defence documents for each case in our sample and analysed the drivers behind each case: the reason claims were denied, challenged and then litigated. By combining the big picture data with detail on individual cases, we have been able to compile what we believe is one of the most comprehensive pictures of what is happening with respect to claims disputes in the UK insurance market, and why.

This report represents the start of an ongoing project by Mactavish to track what is happening at court and what we can learn from that, including what the insurance market is up to, particularly when it comes to paying claims.

References

1 As our section on Declaratory Actions explains, cases may be brought by insurers to establish that they are not liable to pay an insurance claim; however our central thesis is that cases involving insurers as the defendant provide the best indicator of the rate at which customers are being forced to pursue their insurance claims through the courts.

2 https://www.judiciary.uk/test-and-grouped-cases-including-covid-19-bii-cases/

3 https://www.mactavishgroup.com/reports

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

5 https://www.fca.org.uk/data/bi-insurance-test-case-insurer-claims-data

Find out more

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A member of our technical team will be delighted to talk you through any of the issues we have mentioned here or any other concerns you may have about your insurance programme.

If you'd like to find out more about our mission to create a fairer market for policyholders, visit **www.mactavishgroup.com**. In times of uncertainties and change, planning for the future and building resilient risk transfer is more important than ever.

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