July **2025**

Insurer Update

In this issue

A publication for insurance carriers

Insurer **Update**
In this issue...

Welcome to our publication for **insurance carriers**

Welcome to our latest edition of Insurer Update. This publication aims to help carriers across the insurance market understand and digest some of the more pertinent financial reporting and tax developments, and highlight the implications for medium sized and smaller insurers.

The adoption of IFRS 18 is a major milestone in the evolution of financial reporting for IFRS reporters. In this edition, Financial Services Partner Satya Beekarry, and Director Michael Marslin, tell us how IFRS 18 will impact insurers and explains why they should prepare ahead of the standard coming into effect in January 2027.

For insurers and syndicates, Managing General Agents (MGAs) bring strategic benefits such as flexibility, skills, and access to underserved markets. But there are also risks to be managed. Director, Ranjeet Kumar, looks at the most common challenges faced by MGA-backed insurance syndicates and explains how these should be monitored.

Also in this edition, Technology Partner, Phil Broadbery, explains why the insurance sector is particularly vulnerable when it comes to cyber risk and provides guidance on how to protect your organisation. We also look at how artificial intelligence (AI) is transforming the insurance industry's processes. Actuarial Director, Pauline Khong, explains how AI is being applied and what you as an insurer should look out for.

From a tax perspective, Corporate Tax Partner, Mimi Chan and Senior Manager, Jannat Moyeen, discuss some of the common misconceptions of Pillar Two and explain what questions directors of UK subsidiaries should be asking.

As always, please contact any of the team to discuss how we can support your business and let us know your thoughts on future topics.

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IFRS 18 and insurers: a new era of financial reporting

Effective from January 2027, how will IFRS 18 impact insurers and how should you prepare?

The introduction of IFRS 18 Presentation and Disclosure in Financial Statements marks a significant shift in the financial reporting landscape. This new standard aims to improve transparency, comparability, and consistency in financial statements.

The key changes for insurance entities relate to:

- the structure of the profit or loss statement
- disclosures on management-defined performance measures
- aggregation and disaggregation
- presentation of foreign currency and derivatives transactions.

A newly structured income statement

One of the biggest changes under IFRS 18 is the introduction of a structured format for the statement of profit or loss. Items will be classified into one of five categories:

1. Operating
2. Investing
3. Financing
4. Income taxes
5. Discontinued operations.

Operating, investing and financing are the three most relevant categories for insurers. This structured approach aims to reduce diversity in financial reporting, making it easier for investors to understand and compare financial information from different entities.

There are specific adaptations to help insurers apply this new format, which we explain below. It's also important to note that these categories may not fully correspond to those for cash flow statements.

Operating profit subtotal

IFRS 18 requires insurers to report a newly defined 'operating profit or loss' subtotal. This should provide a clearer picture of core business activities, separating them from the investing and financing categories.

Insurers' main business activities often involve investing in assets. So this distinction as 'operating' for income and expenses associated with investing activities will present a more accurate financial performance.

Where insurers provide financing to customers, as well as the main activities of providing insurance products and investing in assets (such as bancassurers or issuing of mortgages), income and expenses that would otherwise be classified in financing are now included in the operating category.

IFRS 18 assumes that an entity issuing insurance contracts will do so as its main business activity. This means all IFRS 17 income and expense line items are classified in the operating category. The same applies to income and expenses arising from investment contracts with participating features recognised under IFRS 9.

What is a management-defined performance measures (MPM)?

Often insurers use several alternative performance measures (APMs) or non-GAAP measures to describe performance such as combined ratio, embedded value or value of new business. IFRS 18 brings in a new requirement to disclose management-defined performance measures (MPMs).

As distinct from an APM, an MPM is a subtotal of income and expenses that:

- an entity uses in public communications other than financial statements
- an entity uses to communicate (to users of financial statements) management's view of an aspect of financial performance as a whole
- does not require application of an IFRS accounting standard or is explicitly excluded from the scope of IFRS 18.

Insurers must explain how the MPMs are calculated and why they provide useful information. MPMs should be disclosed in the financial statements in a single note, including a reconciliation between the MPM and the most similar specified subtotal in IFRS accounting standards.

It may be a judgement call as to which measures meet the definition of an MPM. This in turn may lead to additional metrics and further disclosures above those provided initially. The following are not considered to be MPMs:

- regulatory ratios, such as solvency capital ratios, as these are based on regulatory measures rather than subtotals of income and expenses
- leverage or debt ratios, as these are based on balance sheet numbers rather than subtotals of income and expenses
- gross written premium or gross earned premium (for those insurers that still report these)
- new business metrics such as 'new business CSMs', as these are not subtotals of income and expenses.

MPM or not? How to work it out

The picture is even more complex when it comes to financial ratios such as combined ratios (CORs), return on equity or alternative EPS metrics – as the ratio itself is not an MPM.

But the numerator or denominator of a ratio could meet the definition. For example, for the calculation of CORs, if the insurer adjusts the insurance service expenses or insurance revenue numbers used to calculate the ratio, the numerator or denominator could become an MPM. In other words, if the insurer adjusts the insurance service expenses to include the reinsurance result so that it becomes a subtotal of income and expenses, it may apply.

Many insurers today report a non-GAAP 'operating profit' or similar APM to provide a consistent view of earnings. The calculation of this performance measure can differ a lot between insurers, but it usually involves adjusting the IFRS operating profit after tax.

In many cases, the measure will meet the definition of an MPM. Insurers who currently refer to the APM as 'operating profit' will need to rename it unless it represents the same operating profit as determined by IFRS 18.

The disclosures introduced by IFRS 18 are expected to improve the transparency of non-GAAP measures, giving stakeholders a clearer understanding of the company's financial health and performance. This means several non-GAAP measures will be subject to audit testing as they are incorporated into the core financial statements.

Greater disaggregation of information

IFRS 18 provides clearer guidance on the principles of aggregation and disaggregation. It focuses on grouping items based on their shared characteristics. The new standard emphasises the need for greater disaggregation of information.

Where insurers include the line item 'other operating expenses', this may need to be disaggregated further. This could mean providing more detailed breakdowns of income and expenses in the notes to the financial statements, offering deeper insights for stakeholders.

Foreign exchange differences, derivatives, and designated hedging instruments

Under IFRS 18, foreign exchange differences must be classified in the same category as the income and expenses from the items that triggered these differences, unless doing so would involve undue cost or effort. So foreign exchange differences relating to insurance contract transactions are classified in the operating category.

For derivatives used to manage identified risks, including economic hedges, gains and losses are classified in the same category as the income and expenses affected by these risks. This also applies to non-derivatives designated as hedging instruments, per IFRS 9 or IAS 39.

Gains and losses on derivatives not used to manage identified risks are generally classified in the operating category. But beware: transactions related to raising finance may need some gains and losses to be classified in the financing category.

Does retrospective application apply?

IFRS 18 will be effective for annual reporting periods beginning on or after 1 January 2027, including for interim financial statements. Early application is allowed. The standard requires retrospective application, with the restatement of comparatives to ensure consistency and comparability.

What are the implementation challenges?

While IFRS 18 brings numerous benefits, it also poses significant hurdles. Insurers must adapt financial reporting systems and processes to comply. This transition will inevitably involve staff training and changes to systems and internal controls.

The adoption of IFRS 18 is a major milestone in the evolution of financial reporting for insurers. By enhancing transparency, comparability, and consistency, the new standard will provide stakeholders with a clearer and more accurate view of insurers' financial performance.

But of course the transition will need careful planning and execution to overcome the associated challenges. Even more so for insurers who are only just recovering from having implemented IFRS 17.

The same rules apply for both public and private entities, including the identification and disclosure of MPMs. Entities should begin the process of identifying their MPMs now to prepare for any process or internal control changes that might be required.

As insurers get ready for this new era of financial reporting, it's crucial to stay informed and proactive in implementing the necessary changes. Our Financial Accounting Advisory Services team is here to support you through this transition, ensuring a smooth and successful adoption of IFRS 18. For more information, please contact our experts.

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Pillar Two: common misconceptions

Pillar Two is a complex tax regime. International groups are often confused as to how it affects them. What questions should directors of their UK subsidiaries be asking?

Pillar Two has been designed to set a global minimum tax rate of 15% for large groups. In broad terms, if a group has an effective tax rate (ETR) of less than 15% in a given jurisdiction, the difference is chargeable as a top-up tax.

To date, over 140 countries have introduced Pillar Two or have committed to doing so. Many jurisdictions remain undecided. Others, such as the US where some of the largest insurers are headquartered, have voiced opposition to the rules.

What is the role of subsidiaries in Pillar Two?

Large groups headquartered in non-Pillar Two jurisdictions (like the US), or otherwise present in those countries, might believe they don't need to carry out an ETR calculation for those jurisdictions. But this is usually a wrong assumption. There are mechanisms for group members in Pillar Two jurisdictions to collect top-up taxes that are due in relation to a non-Pillar Two jurisdiction. In the UK, two such mechanisms exist:

- An income inclusion rule (IIR). This charges a top-up tax to the ultimate parent company on the low-taxed income of a constituent entity that is not collected by a domestic top-up tax. The ultimate parent is primarily liable for this tax. But if that parent's jurisdiction has not implemented Pillar Two, an intermediate parent entity is liable instead.

- An undertaxed profits rule (UTPR). This requires group members to collect top-up taxes relating to a parent or sister entity that aren't already captured by a domestic top-up tax or an IIR.

Could head office get it wrong?

So what does this mean for UK subsidiaries of large insurance groups? For international, group-wide matters like Pillar Two, a top-down approach is usually taken. This means the group's head office provides instructions to its subsidiaries on what they need to do to comply with local Pillar Two rules.

But a problem arises if the head office (or its advisers) is not well-versed in the status of Pillar Two rollout across all its jurisdictions. Specifically, it may not be aware that UK subsidiaries could be liable for top-up taxes in respect of other group members. Read our previous article on how UK intermediate entities of US-parented insurance groups are affected by Pillar Two, linked below.

Directors of UK subsidiaries may instead need to adopt a bottom-up approach. They would initiate Pillar Two discussions with their head office, relay the precise UK requirements, and ask the right questions. That way the group is clear on how to help its UK subsidiaries comply with local Pillar Two requirements.

Clearing up misconceptions

Through these discussions UK company directors may discover misunderstandings from head office (or its advisers) about the application of the Pillar Two rules in the UK.

Here are some of the most common misconceptions, along with counter arguments.

Top-up tax can't be applied in respect of non-Pillar Two jurisdictions...

Although those jurisdictions haven't brought in Pillar Two rules, the UK (among other Pillar Two countries) has implemented the IIR, which can collect top-up taxes in respect of low-taxed subsidiaries of UK companies. It also has the UTPR, which can collect top-up taxes in respect of low-taxed parent and sister companies.

Our headline tax rate is at least 15% in each jurisdiction, so no top-up taxes will arise...

For Pillar Two, rather than comparing the headline tax rate to 15%, groups need to compute their ETR (based on specific rules) and compare this to the 15%.

Our ETR is at least 15% in each jurisdiction, so we don't need to prepare any calculations...

Groups will still need to file yearly Pillar Two returns. They must also prepare calculations that show the ETR is at least 15% in each jurisdiction.

Pillar Two is a temporary problem. It will be abolished sooner or later given that countries such as the US are refusing to implement it...

The OECD (which has designed the rules) says it will keep working with the US on Pillar Two. And with over 140 countries signed up so far, Pillar Two won't be going away any time soon.

As we have no top-up tax, is it possible to write to HMRC to be exempted from Pillar Two filings?...

HMRC makes no allowances for nil returns (or exempting anyone from the regime). Groups in scope will have to file returns even if they show no top-up taxes under the simplified or full ETR tests.

Groups with a UK presence that are in scope of Pillar Two are also in scope of country-by-country (CbC) reporting. Groups' filed CbC reports will contain some financial information on the group's activities in each jurisdiction (including revenues and taxes paid). HMRC will see the information in these reports, either because the group has filed them directly or because they have filed them in a jurisdiction that shares this information with HMRC. This means HMRC will use this knowledge as a database for expected Pillar Two returns.

What should UK directors do next?

UK company directors must consider whether Pillar Two applies to the group of which their UK subsidiaries form a part. After the upcoming 30 June 2025 registration deadline (where only limited information is required), directors should engage with the wider group to coordinate Pillar Two compliance that includes the UK subsidiaries.

For more information about issues raised in this article, please contact our experts.

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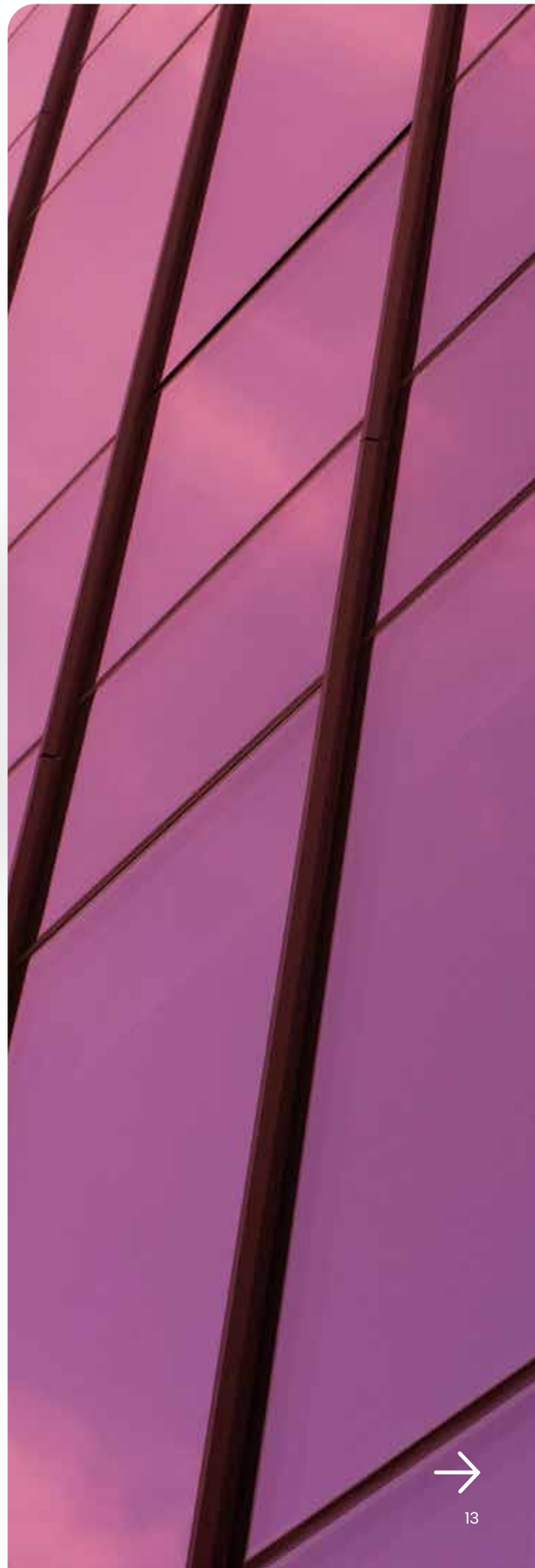
For an overview of the Pillar Two rules and which groups are in scope, read our previous article here.



Cyber risk for insurers: are you prepared?

Cyber security breaches are growing at an alarming rate. As the guardians of so much customer data, the insurance sector is particularly vulnerable. We provide guidance on how to protect your organisation.

Imagine this: it's a bright Monday morning, and you're ready to tackle the week's insurance policy changes and claims. But as you try to access the claims processing system, it doesn't respond. You check with a colleague, and they face the same issue.

Soon an announcement confirms your worst fears — your organisation has been hit by a cyber attack over the weekend. Business applications are down, customer complaints are piling up, and there's no clear resolution timeline.

The result? A significant reputational impact, lost business and financial losses.

This scenario isn't just theoretical. It's becoming a reality for many UK insurers as 2025 progresses. In April, Co-op Group, which operates insurance businesses alongside its retail operations, said hackers attempted to breach its systems. The incident forced a shut down of its back office and call centre operations. This followed a series of high-profile attacks against UK businesses, including M&S, that have demonstrated the increasing sophistication of threat actors.

How is the threat changing?

According to the Cyber Security Breaches Survey 2025 by the Department for Science, Innovation & Technology, cyber security breaches and attacks remain a major threat, with 43% of businesses reporting some form of cyber security breach in the last 12 months. This percentage jumps dramatically to 70% for medium-sized businesses and to 74% for large businesses.

Even more concerning is the rise in ransomware attacks. The survey revealed they have doubled from less than 0.5% of businesses in 2024 to 1% in 2025. This means around 19,000 affected organisations. For insurers, who hold vast amounts of sensitive customer data, the stakes are particularly high.

IT decision-makers from the insurance sector have identified ransomware as their top cyber security risk, according to research by Node4 (IT services provider). This threat is amplified by emerging technologies. According to the National Cyber Security Centre (NCSC)'s 2024 annual review, artificial intelligence enables threat actors to increase both the volume and impact of cyber attacks.

Why is cyber incident exercising so important?

Cyber incident exercising involves simulating real-world cyber breaches to test and improve an organisation's response plans. These exercises help them to detect, manage, and mitigate cyber attacks effectively. No matter how well-designed the plans might be, it's not possible to achieve the necessary operational resilience without 'organisational readiness'.

And that means testing your response capability. Have you played out the attack scenarios? Does your team know exactly what to do when (not if) an attack happens? Do you feel confident in your preparedness?

There's a growing appetite for proactive breach preparation across the industry. This ranges from technical security measures to developing breach response plans and organising tabletop exercises to rehearse breach scenarios (see below). This shift reflects a growing understanding that cyber resilience goes beyond prevention to include response capabilities.

Tabletop versus liveplay: how the exercises work

The Council of Registered Ethical Security Testers (CREST) outlines two distinct approaches for cyber incident exercising, each with its benefits and limitations:

- **Tabletop exercises:** In these discussion-based sessions, team members review their roles and responsibilities during a cyber incident. An independent assessor records responses, identifies deviations and gaps, and documents lessons learned for necessary improvements. Tabletop exercises are less resource-intensive and can be conducted many times a year.
- **Liveplay exercises:** These real-time simulations require team members to respond to controlled scenarios as they would in an actual incident. An independent assessor records the capabilities of various teams, including the security operations centre (SOC), for timely detection and response. Liveplay exercises are more detailed and time-consuming, involving extensive stakeholder engagement, but their outcomes are highly effective.

Building resilience beyond technical controls

While technological defences are essential, true resilience comes from a comprehensive approach. The Government's Cyber Security Breaches Survey found that while 77% of businesses have updated malware protection and 73% have implemented password policies, supply chain vulnerabilities remain a worrying blind spot. Only 14% of businesses formally reviewed risks posed by their immediate suppliers, with even fewer examining the wider supply chain.

Are you truly prepared?

The question for insurance executives isn't whether you have invested in cyber security. It's whether you've tested your organisation's ability to respond. Some things to consider:

1. **Have you conducted realistic cyber attack simulations?** Not just theoretical discussions, but exercises that test your actual capabilities.
2. **Does your entire team know their roles?** From IT to customer service, claims processing to legal, everyone must understand their responsibilities during an incident.
3. **Have you tested your communication plans?** Both internal communication and external messaging to customers, regulators, and the media, are critical during a cyber crisis.
4. **Have you established response relationships?** Having pre-arranged agreements with forensic specialists, legal counsel, and PR firms can save precious time during an incident.
5. **Have you practised your recovery procedures?** Restoring systems and data should be a well-rehearsed process, not an improvised effort.
6. **Are you regularly assessing your supply chain risk?** Automated tools such as Vendifi can provide ongoing monitoring of your cyber posture to help prevent an incident and enable timely response procedures if one occurs.

What should you do next?

While tabletop exercises offer a quick health check, liveplay exercises provide a comprehensive assessment of an organisation's readiness. Regardless of the approach, adopting industry best practices and frameworks such as CREST, NCSC, MITRE or NIST, and regular testing, is crucial to stay ahead of emerging threats.

As we witness the ongoing wave of attacks hitting UK businesses, including insurers, the message is clear: technical protections alone are not enough. True resilience comes from preparation, practice, and the ability to respond effectively when an attack inevitably occurs.

CREST is collaborating with the NCSC to help customers find top-quality providers of cyber incident exercising (CIE) services. At PKF Littlejohn we are an assured CIE services provider. For more information, please contact our experts.

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AI: the opportunities and risks for the insurance market

How will artificial intelligence (AI) change the insurance market? AI and machine learning are transforming the industry's processes. How is it being applied, and what should you look out for?

Depending on the context, the definition of artificial intelligence seems to vary. But this ambiguity is dangerous, and can mask or exacerbate the risks associated with its uses. So it's crucial to understand the intended use of AI across all functions, including claims processing, reserving, pricing and underwriting.

In simple terms, an AI system is a machine-based tool that can be operated with some or no human intervention. It uses data to inform decisions and can learn and adapt based on new information or user feedback after being deployed.

AI has evolved from its beginnings as a futuristic concept to becoming an indispensable tool. Today it is widely used across the financial services industry. According to a 2024 Bank of England survey, 75% of respondent firms had already adopted AI and 10% were aiming to do so within the next 3 years. In the insurance sector, a 2024 EIOPA survey found that 50% of respondent non-life insurers and 24% of respondent life insurers had implemented AI methods.

The level of AI uptake in the sector is hardly surprising given its wide variety of practical applications. These range from claims handling and fraud detection to refining pricing models and enhancing the underwriting process.

AI versus machine learning – what is the difference?

AI is a broad field in which computer systems are designed to perform tasks that require human intelligence such as learning, problem-solving and decision-making. Machine learning (ML) is a subset of AI that uses algorithms to learn from data to make predictions. ML and generative AI are closely related and we'll explore the characteristics and uses of these tools.

Generative AI: how it works

Generative AI is a tool used to create original content. Example models include generative adversarial networks (GANs) and transformers.

GANs use two AI models working against each other. The first generates data, and the second attempts to identify whether that data is real or synthetic. The first model is refined over time to produce realistic outputs such as synthetic data.

GANs may be used to generate synthetic data to help fit models where historical data is sparse. For example, for technical pricing of new risks by the underwriting team or building models to detect fraudulent claims by the claims team. GANs can also generate synthetic data for worst-case scenarios for scenario testing, as part of actuarial reserve reviews and for ORSA.

Generative AI may require substantial training to ensure models are implemented correctly.

What is machine learning?

Unlike generative AI, ML does not generate new content. Instead it uses input data (training data) to identify patterns and make predictions. There are two main branches of ML: supervised and unsupervised learning. With supervised learning, the user provides the model with the correct output or classifications as part of the training data.

On the other hand, unsupervised learning models are based on training data with no known outputs. This means the model or algorithm must deduce patterns and classifications independently.

ML has a wide range of applications across the insurance industry. Among others, these include:

- risk segmentation in pricing
- clustering of claims into homogeneous reserving segments
- automation of some aspects of the underwriting process (eg through online forms)
- detection of fraudulent claims.

ML algorithms have also been used to replace some gradient boosting machine (GBM) pricing models and to verify rating factors in GBMs.

GBMs are tree-based models. An initial model is produced and then refined as part of an iterative process where decision trees are added, in turn, to improve the fit of the previous model. These models may be either 'deterministic' or 'stochastic', which means they follow some statistical distribution.

What are the risks?

Any models involving processes which are difficult for users to interpret may be known as 'black box' models. These are under great scrutiny from regulators due to their lack of transparency and the challenge of explaining them clearly.

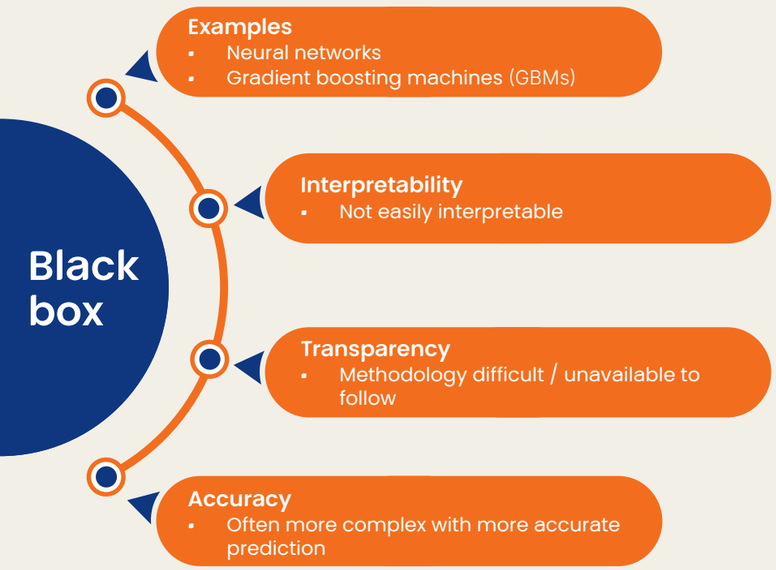
Models with little or no human oversight during the process may raise concerns with regulators, because there will be limited expert judgement before result generation. Similarly, for models with little human involvement it's difficult to know who is accountable for decisions that may be biased or discriminatory.

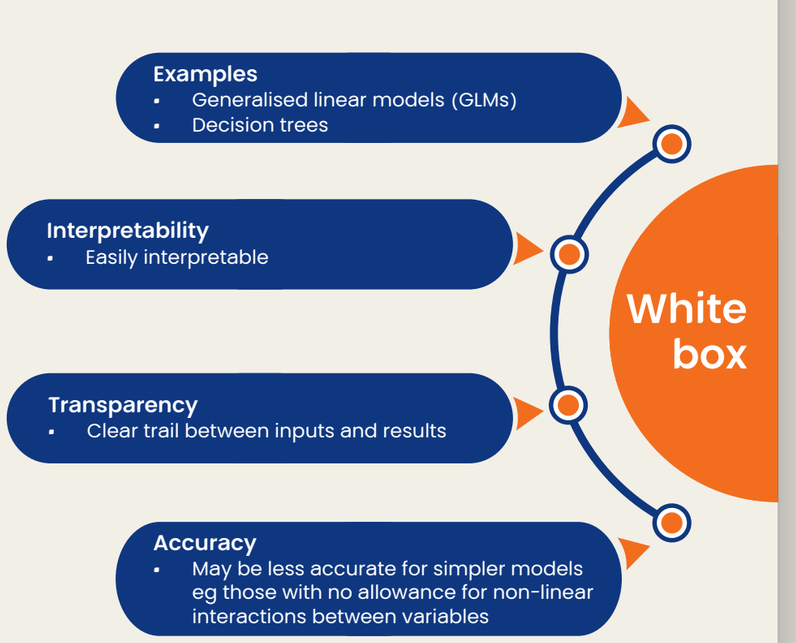
AI models usually rely on significant volumes of data. Data which is personal and sensitive must be processed in compliance with relevant data security rules (GDPR) to protect policyholders. Data security may be a particular concern for ML models. That's because they typically require large amounts of data to train a model to predict future outcomes that are based on historical experience.

There's also a risk that AI models tailored to historical data may discriminate against policyholder groups. For example, individuals may be charged a higher premium if a protected characteristic is used as a proxy outside their control. It's difficult to tell whether the predictive results have been ethically produced by such models.

Black box or white box?

Where models do not have the drawbacks associated with 'black box' models, they may be described as 'glass box' or 'white box' instead. The diagrams below show the differences.





Changing regulations

Firms now face greater challenges to keep up with changing regulatory requirements. Although the rules are constantly evolving, we do expect AI-specific regulations to be more strictly defined as its use continues to grow.

The European AI Act came into effect in August 2024. The framework provides regulation of AI systems used by firms operating within the EU. The Act classifies AI by risk level and prohibits the use of certain systems deemed the highest risk to the safety and rights of individuals ('unacceptable risk'). Examples include manipulative AI that aims to influence behaviour, and social scoring AI which classifies individuals based on personal traits.

There are strict fines of up to €35m or 7% of global turnover for non-compliance. Further obligations under the EU AI Act are expected to apply from August 2026.

In April 2024, the FCA provided an update on its approach to AI. This focused on ensuring fair treatment of individuals and organisations, and appropriate transparency and explainability of AI models.

In the UK, the King's Speech in July last year considered AI and plans for the Government to implement regulation to govern its use, which is good news for the public.

Make AI work for your firm

AI models provide firms with many exciting opportunities for refinement, automation and improved processes. Those already using AI must keep on top of regulation as it changes over time. But firms not yet using AI should review this area of opportunity to avoid being left behind. It's also important for insurers to update their risk registers to reflect any new risks that arise from adopting AI / ML in their business operations.

AI is reshaping the financial services industry by revolutionising processes, optimising model development and enabling sharper, data-driven decision-making. As adoption accelerates, regulations are evolving to keep pace, with initiatives like the EU AI Act introducing new complexities for businesses navigating this space.

How we can help

The challenge is clear. Firms must embrace AI's potential while staying ahead of shifting regulatory requirements.

At PKF, we can help turn challenges of AI into areas of opportunity by using our skills to establish a roadmap or governance framework to ensure ethical AI use to provide assurance to clients and regulators. For example, the development of Explainable AI (XAI) frameworks specific to actuarial pricing models.

If you would like further advice about issues raised in this article, please contact our experts.

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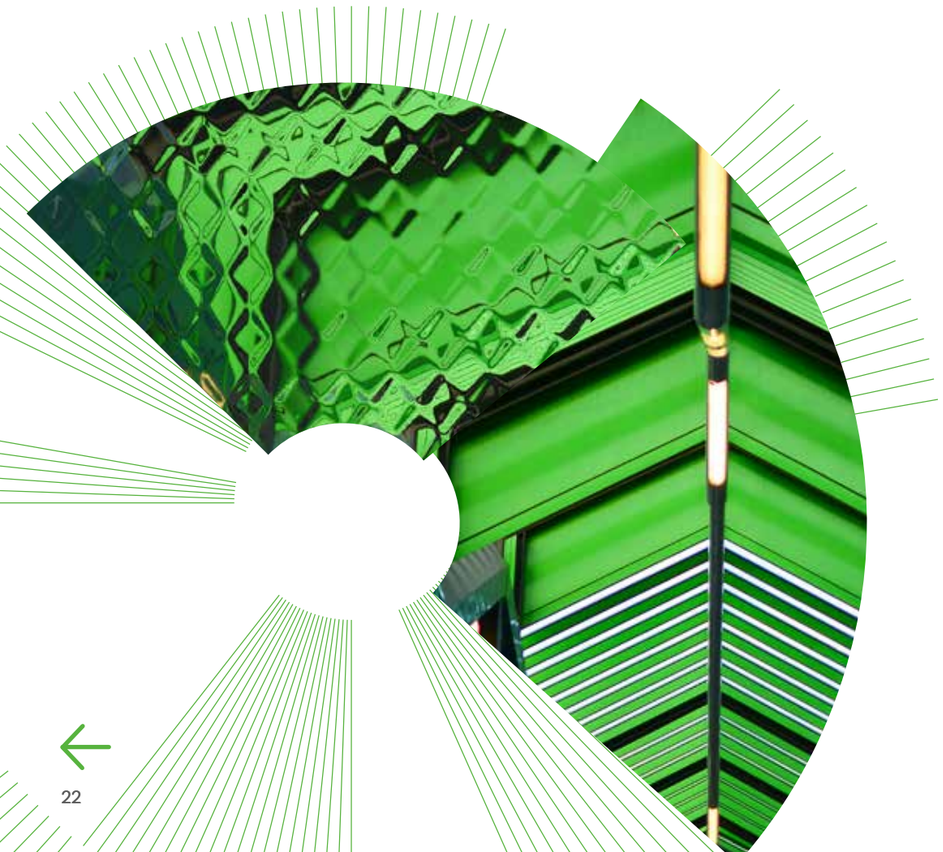
The MGA-syndicate partnership: hidden dangers

We look at the most common risks faced by MGA-backed insurance syndicates and explain how to avoid the drama.

Managing General Agents (MGAs) have become an ever-growing element of the insurance network. This is particularly true in the Lloyd's and specialty markets, where they often act as the distribution and underwriting arms of insurance syndicates.

For insurers and syndicates, MGAs bring strategic benefits such as flexibility, skills, and access to underserved markets. But they also present challenges.



1. Misalignment of interests

An MGA's primary source of income is commission, which is derived from the premium underwritten. The higher the premium, the higher the income (usually) for the MGA. At the same time, syndicates are focused on underwriting profitability. This mismatch in the parties' goals may result in an over-aggressive underwriting or risk selection by the MGA that doesn't match the syndicate's appetite.

On the other hand, if there is too much influence by syndicates on the underwriting ability of the MGA, the arrangement may become unsustainable by constraining their competitive advantage.

To tackle this, both parties should agree underwriting strategies and performance goals. This means aligning their risk appetites and producing incentive plans that ensure long-term profitability for both.

2. Lack of transparency and data quality issues

Syndicates often depend on MGAs to provide key data on underwriting, claims, and bordereaux reporting. So if the data is delayed or of poor quality, it can mask emerging trends, complicate actuarial analysis, and potentially lead to inaccurate reserving - too much or too little - on the syndicate's books.

Poor-quality data may also make it harder for an MGA to properly manage risk, provide a high level of service to existing customers, and attract new business.

To address this, MGAs and syndicates can establish clear data standards and commit to regular data audits. They can also jointly invest in automating systems and reporting processes to improve consistency and reporting. These moves will reduce risk for both parties.

3. Regulatory and compliance gaps

MGAs and syndicates operating in many jurisdictions face the challenge of complying with multiple local regulatory requirements. That exposes them to reputational and financial risk.

For example, MGAs based outside Europe could face scrutiny over general Data protection regulation (GDPR) compliance if they don't fully understand the local rules. The syndicates may be fined and asked to implement remedial compliance measures to satisfy regulators.

Syndicates should work closely with MGAs to understand local regulations, maintain compliance certifications, conduct compliance reviews, and agree clear contractual obligations for regulatory adherence.

4. Diversification to reduce concentration risk

Concentrating too much premium through a single MGA or distribution partner creates key person risk and portfolio concentration. It could mean losing key broker relationships and underwriting staff which, in turn, may lead to a significant decline in premium renewals for syndicates. MGAs may also be badly affected if they lose the underwriting capacity from the syndicate.

To avoid these risks of concentration, syndicates and MGAs should develop strategies to diversify their relationships and services. They might, for example, agree on non-exclusive terms, allowing both to work with other parties and collaborate across regions and product lines. This should ensure that a loss in business in one segment doesn't cause ongoing viability concerns.

5. Fourth-party risk from outsourcing

MGAs may outsource certain functions, such as claims handling, IT and data processing, sometimes offshore. This helps the MGAs (and indirectly the syndicates) to reduce costs. But it also creates 'fourth party' risk, such as operational or reputational issues when arrangements don't go to plan or they receive poor service, leading to customer complaints.

MGAs and syndicates should both be involved in vetting third-party service providers, conducting due diligence, and performing regular reviews. This collaboration should lead to transparency, quality service, and accountability, and therefore reduce operational and reputational risks.

6. Underinvestment in technology and controls

MGAs and syndicates sometimes use legacy systems or manual processes to perform their tasks. This increases the risk of errors, fraud, or cyber breaches. These, in turn, could lead to financial losses, including ransoms, disruptions to operations, and the exposure of client data. Why does this happen? It's usually because financial constraints lead to underinvestment in technology and controls.

MGAs and syndicates should work together to establish minimum IT security standards and jointly invest in the latest technology, automation, and cybersecurity solutions. This should help both parties to reduce costs, avoid errors, and mitigate risks.

7. Claims leakage and reserving inaccuracy

Ineffective claims management may lead to claims leakage or inaccurate reserving. This responsibility needs to be carefully and jointly managed.

It's best if MGAs and syndicates establish claims authority limits, maintain open communication, and conduct regular claims audits. They can have joint claims oversight and training to ensure a fair settlement, accurate reserving, and appropriate claims outcomes.

How we can help

Although MGA-backed syndicates enjoy the luxury of flexibility and access to specialist markets, the arrangement could cost both parties dearly if they don't work collaboratively.

They must treat each other as strategic allies and work together to develop effective governance mechanisms and robust data and compliance frameworks. The key to success lies in partnership and integration, not delegation.

If you have any questions on issues covered in this article, please contact our experts.

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To see how we can help...

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