Towards profitability
European general insurance

February 2015
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>The digital challenge</td>
<td>3</td>
</tr>
<tr>
<td>New tricks or old dog – a fresh look at claims service centers</td>
<td>7</td>
</tr>
<tr>
<td>Meeting emerging customer trends in a digital world</td>
<td>13</td>
</tr>
<tr>
<td>Let’s communicate</td>
<td>17</td>
</tr>
<tr>
<td>A fine balancing act for finance</td>
<td>21</td>
</tr>
<tr>
<td>European regulatory outlook</td>
<td>25</td>
</tr>
<tr>
<td>Solvency II Pillar 3 – the focus of finance for 2015</td>
<td>29</td>
</tr>
<tr>
<td>European Court tax changes affect intercompany services</td>
<td>31</td>
</tr>
<tr>
<td>FATCA and data protection issues</td>
<td>35</td>
</tr>
<tr>
<td>EY authors</td>
<td>38</td>
</tr>
</tbody>
</table>
2015 is set to be a challenging year for the European insurance industry with slow growth and low interest rates. However, I am optimistic that the year ahead will also present many opportunities for those insurers searching for profitability.

The search needn’t be elusive for all. Regulatory changes around Solvency II and international financial reporting standards are already leading many insurers to the natural conclusion of bringing together finance and actuarial functions. In other parts of the industry, we are looking at the opportunities to streamline claims and reviewing the way to onshore and offshore services. For those who haven’t already, then I am sure that the digital “nettle” will be grasped, if not indeed “grabbed.” And, for an industry rich in customer data, some will better utilize data to make sure that products and services are better aligned to customers’ expectations.

All of these themes and more are explored in this, our first publication for the European general insurance industry. Our intention is that it becomes the first of an interesting series.

I look forward to hearing your thoughts and comments on the features we’ve included, and hope that it prompts discussion and action within your organization.

Towards profitability.

Andreas Freiling
EMEIA Insurance Leader
So digital communication will be a key channel for customers but, with a huge issue of inflexible legacy systems and manual processes, making a business case for digital can be tricky.
The digital challenge

By Chris Lamberton

General insurance across Europe faces a continually increasing customer expectation, combined with significant cost and margin issues, including:

- Price transparency, especially in markets where aggregators dominate (e.g., UK), with consequent low customer retention rates and margin pressure
- Service transparency, where poor service is instantly known across social networks – with social networks or friends being a key channel for product recommendation
- Increasing fraud caused by the continuing financial pressure in Europe
- Low levels of trust – our Global Consumer Insurance Survey 2014 highlights that trust in insurers is lower than in banks (see more on page 17)
- A complex and costly distribution model that is different across Europe, and often not set up to allow direct communication between policy provider and customer, to the detriment of both
- New competitors with simpler distribution models and established or deeper relationships with customers – e.g., retailers, banks and utilities providers
- Low levels of innovation in products and services to customers, driven by high costs and complexity of existing systems and operations
- Poor product penetration, with typical holdings per customer not exceeding 1.2 products
- A lack of interaction, with providers often not interacting with customers other than at yearly renewal and hence not building relationships or loyalty with customers

These issues mean that there is continual pressure on margins. As a result, general insurers need to service customers more efficiently, look for new means of encouraging loyalty and brand “stickiness,” and provide new services for evolving customer needs.

If these challenges aren’t enough, there are two other significant issues facing insurers. Firstly, a huge legacy systems problem with associated significant cost overheads, causing expensive manual processes and preventing simple introduction of the new services needed to attract customers. Secondly, an ongoing move to digital channels by customers – with predictions that digital interactions with financial services organizations will outnumber face-to-face in some markets by 250:1 by 2016, and mobile interactions outnumbering calls by 30:1.

So digital communication will be a key channel for customers but, with a huge issue of inflexible legacy systems and manual processes, making a business case for digital can be tricky. If poorly implemented, it could end up as window dressing i.e., a nice front end but poor fulfilment of the digital promise.
Faced with all these issues, what are general insurers to do?

EY’s belief is that the significant combination of issues means that traditional approaches may not deliver the transformation that general insurers need to go through.

Traditional approaches may include introducing a large program to create digital channels, integration and master data management to make links between systems and a single customer view, and package replacement of legacy systems. However, doing all these things together is very expensive, massively impactful on the organization and leads to inevitable compromises between affordability and breadth of transformation — i.e., it will probably not deliver true transformation and is, at most, a large “sticking plaster” across some of the problems before the money runs out.

But there may be another way, and we are working with a number of leading general insurers to deliver a far more cost-effective and benefits-led approach.

Key to our approach is recognizing emerging themes coming from outside of the industry, including:

- **Digital passports**, and the ability to positively identify customers (including Know Your Customer), creating a simple way of truly linking product holdings to customers, and a simple way for customers to share key information digitally with insurers and intermediaries. In a digital passport world, the customer does most of the work of maintaining these product links and keeping personal details up to date, and provides far more customer insight than insurers are typically capable of gathering.

- **Digital channel software as a service (SaaS)** whereby insurance-specific, highly capable digital services across web and mobile are delivered as a service, require simple setup and don’t involve significant development projects or costs. Typically, these SaaS services include a digital vault for all policy documents and communications, self-service of policy changes, easy quote and buy, personalized offers with one click purchase, video support or web chat to provider or intermediary, loyalty services, digital engagement — including personalized social networks and communities of interest, as well as educational videos and lots more. In fact, these SaaS services are far more capable than those used by the current general insurance digital leaders, operating at a fraction of the cost, delivering under a pay per use model and working across all the products an insurer provides.

- **Software robotics**, which is virtual workforce technology allowing fully automated processes across any type of legacy system. This technology is becoming widespread in banking, but is still new to insurance, and fundamentally allows software robots to perform all the operations that typical back-office agents would perform. Fundamentally, if the process does not require expert judgment and is rule based (i.e., processes that are often outsourced), software robotics can do the same as an agent, but more quickly, more accurately and for a fraction of the cost. Software robotics can also interact with digital channel SaaS very simply — i.e., if a customer does a quote and buys on a mobile,
the software robotics is told to perform end-to-end fulfilment (e.g., set up a policy in an administration system, set up a bill in a finance system, and then send out policy documents through the digital channel).

EY believes that the adoption of this combination of newer technologies avoids the common roadblocks of traditional transformation programs.

- The combination of digital passport and digital SaaS and robotics can be deployed for a fraction of the cost of traditional technology, and hence can be delivered quickly for one product or country, then rapidly rolled out across all other products, irrespective of the use of legacy platforms.

- The pay per use nature of this combination means that insurers don’t have to spend millions on a system and hope for its adoption. They only pay when customers use digital services. And every time a customer uses the digital platform (e.g., for self-service), this saves significantly more cost than the service and hence pays for itself very quickly.

- The use of software robotics allows existing legacy platforms to be wrapped, so they still provide good fulfilment through digital channels, without the need for expensive integration of package replacement. This allows any package replacement program to be better targeted (e.g., to allow new products and services), and at a pace the company can far better accommodate. In fact, some companies are using software robotics as part of the migration from legacy to new systems – e.g., moving customer policies at the point of renewal.

- Creating a reusable platform for new customer-focused services, with little further investment. Hence, once deployed, these technologies can be rolled out across existing products, yet also form the basis for simple and cost-effective delivery of new products or customer services.

- Fundamentally, these technologies allow general insurers to create a true trusted relationship with customers, either directly or via intermediaries, with this relationship allowing a win-win for customers and companies. Customers want better service and simpler ways of interacting, being better understood, being rewarded for loyalty and with better control of their relationship. And the companies have lower costs, more engagement and efficient channels to customers – and happier customers, which impacts retention rates.

Currently, general insurers are in significant customer-relationship deficit and digital deficit, but by putting customers at the heart of their operations, and through new innovation, insurers can truly become customer-focused and, ultimately, more profitable organizations.
Despite the very public headlines, there is a renewed wave of focus on optimizing the claims operating model across front and back office, through a combination of local hubs, nearshore centers and more “traditional” offshore centers, to achieve similar objectives to the first wave of change.
New tricks or old dog – a fresh look at claims service centers

By Imran Ahmed and Stefano Bellandi

Driven by the desire to reduce costs, and in line with other industries, many insurers in Europe created large-scale technology and operational service centers offshore in the 1980s and 1990s.

More recently, roles and activities are being brought back onshore, with insurers commonly citing the reluctance of customers to accept overseas service. Despite the very public headlines, there is a renewed wave of focus on optimizing the claims operating model across front and back office, through a combination of local hubs, nearshore centers and more “traditional” offshore centers, to achieve similar objectives to the first wave of change. The difference now is that the maturity of technology and offshore capability management is far more advanced than was previously the case.
There are two broad trends driving this renewed interest:

**Global economics and talent development** – the insurance industry has a history of creating both UK-based service centers and offshoring activity in India and the Philippines but, in recent years, the list of possible destination countries has grown far longer. It now includes China, Poland and Mexico, as the pools of talent grow and the search for cost efficiency takes companies to new geographical locations. However, the recent political upheaval in Eastern Europe should serve as a reminder that it is not all about unit labor cost and that political and economic risk should feature highly in any management decision-making process.

Technology – advances have shifted some previously perceived obstacles: for example, latest generation workflow has removed many of the issues with case or file sharing. The quality of data available from many of the newer claims applications is far better, and the channel shift in consumers has meant that offshore web chat has had far greater acceptance than phone calls ever had.

In principle, well-implemented, shared service centers, whether onshore or offshore, can lead to increased productivity and improved claims outcomes, and create a scalable organization for future growth. There are, however, a number of issues in the implementation and ongoing running of a model that can erode benefit and therefore need to be managed effectively.

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**Searching for better claims outcomes at a lower cost**

With fast-changing expectations from both personal and commercial customers regarding the way they want to have their claims handled, on top of increasing cost pressure, there are four areas that claims directors are wrestling with:

1. **Inefficient organization structure**

Often, a legacy of acquisitions or historical change has left some claims operations below critical mass, as they are spread over too many locations, with separate processes and separate management.

Bringing fragmented teams together can create economies of scale, improve spans of control and reduce cost. A critical mass of skills can also bring greater efficiency and effectiveness, and provide claims staff with a clearer and more structured path for career progression.

2. **Inconsistent practice**

With separate teams under different management, customers can get a different experience or even different outcomes, depending on their type of claim – this is a particular problem for intermediated business, where brokers often cite consistency as being key to good service.

Identifying and applying the same high standard of handling practice across all adjusters not only improves customer experience, it will shorten claims life cycles, reduce leakage and improve claims costs.
With a number of insurers having significant presence in, or close to, major cities, this is an area that often comes under the microscope. At a minimum, organizations should be considering opportunities to create shared operations in lower-cost locations.

While there may, at first glance, be big savings to be gained from offshore locations, the salary inflation can be far higher (wage inflation in India is still in double digits, despite the recent downturn) and, in some cases, turnover can be significantly higher too. Managing operations effectively does require local expertise and experience and, as a result, over time, offshore clusters of expertise have emerged. This has led to a pool of management talent and experience to work with.

Central and Eastern Europe region salary range, includes: Hungary, Slovakia, Poland, Romania, Bulgaria, Lithuania, Latvia and Estonia

With different practices and philosophies, and disparate staff, ensuring that claims are being dealt with by the right handler with the right skills can be difficult. Regardless of whether claims should be segmented by complexity, line of business, broker or location, any ineffective segmentation will lead to increased cost and poorer claims outcomes.

Centralizing claim notification and assignment has proved to be one of the effective tools in addressing this issue and, in turn, can reduce leakage and improve customer service. This can often be delivered effectively across both onshore and offshore locations.
Can it really work for me?

Even when claims leaders have identified that a centralized service center, onshore or offshore, may bring some benefits, there are a wide range of questions that will need to be answered to convince their boards that the investment and upheaval is going to be worth it.

**Common design questions**

- **Where do I put it?** Low-cost locations may help with lowering staff cost but will we be able to source the skills to improve claims outcomes and maintain service quality?
- **How long will low-cost locations remain so and, if this is the only benefit driver, will we have to relocate again in three years’ time?**
- **What activity do I put where?** For example, do I keep my high-complexity handlers in the same center as low-complexity adjusters? Where I have class-specific expertise in multiple locations that can be hard to source in a single site, or a customer demand for local presence, can a virtual service center provide a workable solution?
- **How do I build a model that supports the customer proposition across all product and claim segments — particularly in the higher-value or specialist market?**

**Key migration questions**

- **Do I move all the work at once or in phases?**
- **How do we ensure service levels are maintained, as staff morale may be affected during the transition?**
- **Realizing the full benefit doesn’t start until the center is running, how do I maintain a disciplined approach to performance management throughout the program and after migration?**

**Maintenance questions**

- **How do we maintain the development and sharing of good practice and ensure it continues to be applied?**
- **Can practice and processes be shared across different classes of claim or line of business?**
Be clear about what you are trying to achieve

The number of questions and the apparent contradictory nature of some of the issues and solutions mean that having a structured process to work through is critical. Typically, time spent reaching consensus among stakeholders on key questions will be well spent and will help define what success looks like, particularly if some have had painful experiences from previous initiatives.

A good place to start is to be clear what business strategy and benefit levers are guiding your design. For example:

1. Agree with the board the long-term priorities for claims and claims service to support the customer proposition
2. Identify not only the key metrics that will drive your future success, but also where today’s performance stands against them
3. Be clear on what the root causes and drivers are to any performance issues or benefits you are trying to deliver
4. Agree with all stakeholders on a set of principles that will govern your decisions or design for future claims operation
5. Consider, in a structured way, a range of options for claims service centers, taking into account what you are looking to achieve in the long term
6. Prepare a detailed implementation and change management plan

If you don’t know what the problem is, you can’t know that claims shared services is the answer

For some claims functions, there are undoubtedly benefits from building a service center that has consistent processes, best practice, efficient spans of control and is, if possible, located where salary costs are relatively low. This is not, however, a panacea for all problems.

The creation of a claims service center should be considered where it is seen as a long-term, strategic approach to serving customers efficiently and effectively, consistent with the broader business strategy. It is less likely to succeed if it is viewed as an idea in isolation from the rest of the business: for example, a way to reduce the cost of claims. This could mean that customer service and claims outcomes will become expensive victims of any solution.

It is a vision that’s easy to fall for – assuming that having all claims staff in a single claims environment will drive consistent processes, enable common technology use and bring a single management structure – with the belief that doing all this will inevitably solve all your performance issues or drive future performance ambitions. But beware, claims managers must be sure that these changes will address the underlying causes of performance problems or support future strategy.

The worst position is reserved for those who find the only thing they have to show for their multimillion pound investment is all the same problems as before, but many miles away under the same roof.
The real digital opportunity for insurance providers over the next five years, however, is to transform themselves into trusted institutions with innovative products and personal customer relationships.
Customer adoption of digital technology is accelerating rapidly. As customers become used to around the clock access and self-service in the banking, retail, entertainment and news sectors, they expect such levels of service from all service providers. While insurers ponder the benefits of a single view of their customers, customers themselves want a single view of their products and are becoming increasingly sophisticated in knowing how they want to share data and have that data used.

In order to become customer centric and provide customers with user-friendly interfaces that meet their expectations and engender trust, insurers need to make a range of internally and externally focused changes. These include enabling the customer to service all their policies in an efficient manner and ensuring that the total value of the customer is reflected in product and pricing decisions.

The real digital opportunity for insurance providers over the next five years, however, is to transform themselves into trusted institutions with innovative products and personal customer relationships. If they can achieve this, they will reduce commoditization and ensure that purchase decisions are based on factors beyond price alone, improving or maintaining margins as a result.

### What customers want technology to deliver

<table>
<thead>
<tr>
<th>Identity and verification</th>
<th>Portfolio of products</th>
<th>Customer self-service</th>
<th>Sharing of digital data</th>
<th>Simple support</th>
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<td>I’d like to see all my products and reuse the same information to prove who I am to any provider.</td>
<td>I’d like to see all my products in one place – both in summary and with all supporting documents and correspondence.</td>
<td>I’d like to change my details or products by mobile or web and have all providers and products automatically updated.</td>
<td>I’d like to share my portfolio of products with service providers that can help me.</td>
<td>I’d like to get direct support for any product and not keep having to re-identify myself.</td>
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We are currently working with a number of insurers on Trust Portal—a digital customer channel built on top of a digital passport that provides a single customer view. This solution can be delivered using a SaaS model and integrated using traditional approaches or in an accelerated manner, the use of software robotics (see below) to connect to legacy systems. While this solution enables a consistent single customer view from both customer and provider perspectives, and provides the digital channel, providers still need to do more to build the levels of customer engagement.

**Increasing customer engagement**

Genuine customer engagement comes as a result of insurers gaining a clear understanding of each customer’s touch points and tailoring their response to meet that customer’s expectations. If insurers can find ways to increase the frequency and quality of contact, benefits from increased scope of sales to individual customers, better targeting, better product alignment and simpler, higher-quality interactions should follow. Apple iPhone and iPad customers rarely shop around to find the cheapest place to download a particular song or album—they just use iTunes.

For an insurer to increase digital engagement, they need to create compelling reasons for customers to interact more than once a year for their renewal.

There are three main categories of approach:

1. **Non-product inducements** (loyalty schemes, games, publicity and competitions)

2. **Partnerships with third-party high-frequency products**—e.g., relationships or white-labeling with retailers to bring their relationships to the insurer’s customers

3. **Redefinition and expansion of the insurer’s products to change the frequency of interaction**

While the first two options are not new, we are starting to see more examples of the third option, particularly around the telematics concept of variable pricing based on distance traveled, location, driver and driving style. Such products create a reason to interact to “check the balance”: for example, to see if discounts for good driving style have been awarded. This approach can be extended to allow the equivalent of “in-app purchases” against a reduced-cost base product, converting a single expensive decision, worthy of the effort of price comparison, into a series of small decisions that are made on convenience.
Changing business models to become genuinely customer focused

To place customers truly at the heart of their organizations, and to remodel their products to increase engagement, insurance companies need to move from a product-led to a customer-led profit and loss view. Only then will the total lifetime value of a customer be recognizable, and a holistic approach to products and services for a given customer will be aligned with business performance indicators. Underpinning this move is the need to know customers better than ever before and hold a single view of them that is shared across the organization in its different functions, business units and systems.

A single view of customer should be seen as the foundation of customer service excellence, because it is what customers want and increasingly expect. It is based on complete and accurate data, including different components relating to who customers are (personal details, segment and value); what policies they hold; claims expenditure; historical multichannel touch points; and commercial opportunities targeted to customers’ needs and potential requirements. From a customer perspective, it features one login; linking of relevant products; one place to change details across all products; and recognition in the form of discounts where they buy a range of services. It also gives a seamless multichannel customer experience at every touch point across the customer life cycle.

Once delivered, insurers will be able to build one-to-one relationships across their customer base, providing customers with targeted and relevant offers by channel in an automated, rules-driven manner. Analytics solutions can be deployed that enable rapid interpretation of internal and external data holistically and across departments. Assessing all customer touch points, solutions and outcomes, and continually redefining the products and services offered based on these insights, will be key. The use of big data solutions will increase through assessing behavioral characteristics in customer servicing, interpreting data from new technologies such as telematics or assessing customer sentiment analysis using social media data.

This is an exciting and dynamic time to be selling insurance, with the amount of customer- and data-driven change significantly challenging current operating models, which will not be fit for purpose in the medium term. Insurers who start fostering a culture that places the customer at the heart of the decision-making process, and reshape their product offerings to increase engagement, will have deeper relationships with customers at a lower cost and will develop a competitive advantage and deeper customer relationships that increase customer longevity. Key to this will be exploiting the opportunities associated with the drive toward greater customer engagement and addressing these challenges via market-leading, agile and low-cost analytics and technology solutions, including single customer view and software robotics.
Insurance is a win-win industry: customers gain protection from bad events, and neither they nor the insurer want those events to happen. Why then do customers have such little trust in insurance companies?
Let’s communicate

By Graham Handy and Belen Alzugaray

The fact that insurers are trusted even less than banks was one of the shock findings from our Global Consumer Insurance Survey 2014. We asked around 24,000 people (including almost 11,000 in EMEIA) about how they perceive insurers. Globally, 30% of respondents claimed to have minimal or no trust in insurance companies, with a similar proportion (32%) expressing the same view in the Europe, Middle East, India and Africa (EMEIA) region.

When it comes to the propensity to switch insurer, our global and EMEIA findings were again almost identical. For non-life products, 26% of global participants and 25% in EMEIA said they were likely to switch insurance providers in the next 12 months. For life products, 18% of global participants said they were likely to switch, compared with slightly more (20%) EMEIA respondents.

When asked their reasons for switching, policy costs and terms are most often cited by EMEIA customers (both life and non-life). However, they also consider policy benefits and coverage as relatively influential. Other factors play a part too, such as the level of service received, recommendations by brokers or friends, the frequency and relevance of insurer communications, customer loyalty benefits and brand reputation.

The value that customers place on factors other than price is encouraging, but the low levels of trust and high degrees of switching intent among customers do provide a wake-up call for insurers. There is work to do to build and strengthen customer relationships. However, we also discovered that many customers are willing to recommend their insurer: 66% of customers globally are likely or very likely to recommend their insurance provider to friends or relatives. In addition, when customers change insurance company, they don’t necessarily dislike their former provider’s company or service: 38% of customers willing to recommend their insurer have closed policies in the last 18 months. These findings are replicated in EMEIA: there is no correlation between the attrition rate and those likely to recommend or who are neutral on the matter.

This suggests that insurance companies have scope to improve their customer relationships and potentially their retention rates. Globally, 71% of customers took some action concerning their policy during the last 18 months (perhaps updating an address, asking for information or closing the policy), and a similar proportion (68%) of EMEIA customers did so. Many of these interactions concerned ongoing policies.
Such interactions are important because they enable insurance companies to create “moments of truth” — experiences that change their customers’ opinions. Among our survey participants, the majority of those who took action concerning their policy experienced such a moment of truth. In EMEIA, the minority (11%) of these moments of truth were related to claims. Far more (30%), concerned potential new policies, and 50% were related to existing policies. Particularly encouraging for insurers is the fact that, for 78% of EMEIA customers who experienced a moment of truth, the outcome was a positive one: they had questions answered, problems resolved, they renewed their policy, increased their coverage or purchased another product. This suggests that if insurers create more opportunities to interact with their customers, they may well change perceptions in positive ways that encourage additional policy sales or at least more policy renewals.

Our research also shows that customers are open to more communication from their insurers. We asked survey participants how often they were contacted by their insurers and how often they would like to be contacted. Among global and EMEIA customers generally, we found a communication gap of around 10 percentage points in favor of more frequent contact than just one communication a year. Customers are generally receptive to receiving more frequent information on their policies and on special deals or promotions.
It is now up to insurers to establish the best way of contacting customers, tailored to their personal preferences. Based on our findings, customers in EMEIA usually contact their insurers in person, unlike in the UK, where phone and web communication is the norm. However, EMEIA customers are open to contact by email, and even by apps.

Insurers in EMEIA could perhaps learn from the UK market, where the move to digital – particularly the spread of online price comparison sites and limited personal interaction between insurer and individual – has made insurance a price-driven commodity and encouraged particularly high switching levels. Embracing digital technology doesn’t automatically lead to benefits though; it needs to be controlled and used to enhance the customer’s experience as much as possible.

At its best, digital technology can help in the redesign of communication materials, documentation and processes – reducing communication costs at the same time as providing better, more targeted information to customers. Regulators are also looking at the way that insurers communicate with their customers, and new, disruptive market entrants could increase competitive pressure to act. So, whether driven by customer demand, cost opportunities, a regulatory imperative or competitive pressure, insurers need to take the opportunity to make their customer contact as powerful as possible.

To explore our Global Consumer Insurance Survey 2014 in more detail, please visit: ey.com/insurance/GCIS2014.
With the onset of increasing regulation, there will be far less tolerance of errors or surprises in reported results.
A fine balancing act for finance

By David Foster and Ian Robinson

According to our Global Insurance CFO Survey 2014, and after some tough years in the insurance sector, global insurance finance leaders are looking both to support business growth and reduce costs. With the onset of Solvency II, finance leaders also have a clear eye on the pace of regulatory change, and this is influencing CFOs’ visions for finance through to 2020.

CFOs ranked their top key business drivers as:

- Relieving pressure on costs and margin (64%)
- Achieving growth, expanding into markets or expanding through M&A activity (59%)
- Improving capital and liquidity position (41%)
- Addressing competition from globalization and new market entrants (41%)
- Responding to regulatory change (35%)

In response to these main business drivers, CFOs are focusing on prioritizing actions to meet the increasing demands on finance and actuarial teams through to 2020. Our survey demonstrates that the top priorities for CFOs reflect the need to add value to the business through performance management and improved decision support.

The top priority of “being a better business partner” (81% ranked in top three) reflects the need for finance to have a closer relationship with the insurance business. Through this, finance will be able to develop a deeper understanding of the management information that the business requires to make key operational decisions.

Finance leaders’ second priority of improving the quality of internal and external reporting (62%) demonstrates the desire to produce consistent data on multiple reporting bases in ever more granular detail. With the onset of increasing regulation, there will be far less tolerance of errors or surprises in reported results. The challenge here for non-life insurers is the legacy multiple-source systems resulting from a history of growth through acquisitions and a lack of investment in finance systems over the last 10 years or more.

The third priority for CFOs is implementing new regulatory and reporting requirements (43%), particularly for EMEIA general insurers with Solvency II approaching, where the need to strike a balance between delivering value to the business and meeting daily operational demands will continue to be challenging.

As a result of these priorities, non-life insurance CFOs have been increasing their efforts to improve the capabilities of their finance and actuarial teams. In the survey, 71% of global non-life CFOs stated that they had started a change program, while a further 24% said that planning for a change program was under way.
Please rank in order the following finance and actuarial priorities facing your organization through to 2020 (results are for the 16 global non-life insurance CFOs surveyed).

**Key levers for finance change**

The role of finance and actuarial functions has become ever more critical as insurance companies around the globe continue to invest in data management and analytics capabilities. As a prime source of management information, the processes and systems supporting these functions are key to developing deep insights into business performance and customer behaviors. The main challenges to developing such insight can be seen in the chart below.
Weakness in the quality and granularity of data (83% ranked in top three) is a frequent theme when talking to finance and actuarial executives in the non-life insurance sector, with technology issues (57%) close behind. Considerable movement has already occurred in this area toward greater centralization of systems and processing through shared service centers and outsourcing. While there is potential for further centralization, interestingly, there is an increasing preference for onshore, as opposed to offshore, shared services. This may be the result of decreasing wage differentials between the highly developed Western economies and other rapidly developing economies. It also reflects other organizational and cultural factors.

Finance leaders also identify a significant people challenge (51%) in relation to accessing the resources and skills they need. In addition to strong analytical skills, effective business partners must understand the business and the relative return on capital across different business lines. This may reflect their growing interest in working in the wider organization and it highlights the heightened war for talent across all business functions.

**Finance vision 2020**

Looking forward to 2020, finance will require cultural change and numerous specific people and organization initiatives, mainly linked to the development of the business partner role. Global non-life CFOs can lead their finance function by focusing on three key activities.

1. Fix the current reporting process through the development of an efficient reporting solution architecture

2. Enhance the added value to the business by driving real commercial awareness through timely and relevant management information and by linking strategic objectives to performance indicators

3. Improve finance and actuarial operational performance by working “smarter not harder” with processes “right skilled” to strike the optimal balance between effectiveness and efficiency

Through these activities, finance will leverage its enhanced reporting capabilities to drive real commercial benefit, all at a lower cost than today. Non-life finance teams will thus be able to address the cost management, regulatory and reporting challenges that the industry faces through to 2020.
As negotiations come to a close on Solvency II, the regulatory focus is shifting toward increased consumer protection. There are three key regulatory developments at a European level that will have a significant impact on the strategic and operational decisions of European insurance businesses over the next few years.
European regulatory outlook

By Anthony Clapton and Steve Southall

In recent years, the continually changing regulatory landscape at both a national and European level has significantly influenced the activities of European insurers. The successful conclusion of the Omnibus II Directive negotiations has finally provided clarity over the long-awaited implementation of Solvency II, which is now set for January 2016. However, as negotiations come to a close on Solvency II, the regulatory focus is shifting towards increased consumer protection. There are three key regulatory developments at a European level that will have a significant impact on the strategic and operational decisions of European insurance businesses over the next few years. In this article, we discuss these proposals and how the increased focus of European regulators on consumer protection is likely to impact the regulatory landscape in which insurance businesses operate in the future.

Current developments

Insurance Mediation Directive 2 (IMD2)

The most influential regulatory development for general insurance businesses is likely to be the IMD2. Its goal is to strengthen the degree of consumer protection by significantly extending the scope of the original Insurance Mediation Directive (IMD1) and introducing a harmonized range of information requirements and conduct of business rules for insurers across Europe. The directive seeks to improve product oversight, increase the level of information provided to the customer and ensure insurance businesses act with the best interests of their customers in mind.

Key features of the directive

- An expansion of the scope set out in IMD1 to cover:
  - Direct sales of insurance contracts by insurance and reinsurance undertakings without the intervention of an intermediary.
- Products sold via aggregator websites or as ancillary services, such as travel agents or car rental firms, and sold by firms carrying out secondary intermediary activities such as claims management, loss adjustment and expert appraisal of claims.
Introduction of a number of rules specific to the sale of insurance-based investment products adapted from the recent Markets in Financial Instruments Directive (MiFID II).

Setting a minimum level of information that must be provided to customers prior to the conclusion of an insurance contract; this includes information on issues such as remuneration of intermediaries and employees, direct or indirect holdings in a given insurance undertaking or parent of a given insurance undertaking, the separation of “bundled” products, and the nature of any advice provided to the customer.

Packaged retail and insurance-based investment products

Another important development is the Packaged Retail Investment Products (PRIPs) regulation, approved by the European Parliament in May 2014. Its aim is to address, at the precontractual stage, the risks and inconsistencies of investment and insurance-based investment products and make them more transparent for retail investors. Under this regulation, customers will need to be provided with a Key Investor Information Document (KIID) that states the nature, main objectives and features of the product. It should include details of any insurance benefits, the term of the product, its risk and reward profile, costs (both direct and indirect), past-performance details and, for pension products, projections of potential future returns.

Guidelines on product governance and oversight arrangements

On 27 October 2014, European Insurance and Occupational Pensions Authority (EIOPA) published a consultation paper on proposed guidelines to protect consumers better during the early stages of product development to prevent misselling of insurance products due to poor product design.

The guidelines seek to ensure that:

- Insurance products are always designed with specific consumer needs in mind
- Insurance products are always tested before being brought to the market
- Insurers only use distribution channels for products with the knowledge and expertise needed to inform and advise the consumer about the products
- Insurers consider how too many product variants can be bad for the consumer
What this means for European insurers

These regulatory developments are likely to have varying impacts upon insurers, depending on their location and the territories in which they operate, and the current level of conduct regulation and regulatory scrutiny. However, it is clear that European and local regulators will increasingly focus on consumer protection issues in 2015 and beyond. Insurance businesses should therefore start considering how these new regulations are likely to impact them at both a strategic and operational level. In particular, insurance firms should be asking themselves the following questions:

**People**

- What training will be required, and how will this be designed and delivered before the expected implementation dates?
- What additional skills or resources will be needed?

**IT and data**

- How should we collect, store and maintain accurate data to fulfil the information disclosure requirements?
- What changes to our IT infrastructure will be required?

**Market and competition**

- How will our business model be impacted by the likely increase in competition arising out of increased transparency?
- How will the changes impact our firm’s strategy on pricing and remuneration?

**Product governance and oversight**

- Does our product design process meet the requirements of the proposed guidelines?
- Do we have adequate and effective oversight of the distribution of our products?

**Governance and control framework**

- Does our existing governance and control framework reflect consumer protection as a key risk?
- Do we have appropriate management information to enable us to judge whether we are meeting our consumer protection objectives?

**Customer operations**

- What changes will we need to make to our processes and procedures?
- What changes will we need to make to our documentation?

**Internal control**

- Is our current internal control model appropriate and effective?
- Are our internal control functions capable of monitoring and providing assurance on these new obligations?
By taxing a new set of services, European insurers’ VAT cost base will increase significantly. This is because insurers, as providers of VAT-exempt services, are not entitled to recover their VAT costs.
European Court tax changes affect intercompany services

By David Bearman and Simon Harris

The Court of Justice of the European Union’s (CJEU’s) recent judgment in the Skandia America Corporation USA case (Skandia) could force a fundamental change to the value-added tax (VAT) treatment of intercompany services. By taxing a new set of services, European insurers’ VAT cost base will increase significantly. This is because insurers, as providers of VAT-exempt services, are not entitled to recover their VAT costs.

The Skandia decision

The Skandia case focused on the interaction of VAT grouping provisions and the VAT treatment of branch-to-branch services, which are typically disregarded for VAT purposes. Skandia, a US parent company, purchased services that it supplied free of VAT to its Swedish branch, which was a member of a local VAT group. The Swedish branch used these services to make onward supplies to entities both inside and outside of the VAT group. The Swedish tax authorities challenged this approach and the matter was referred to the CJEU for clarification.

The CJEU held that a VAT group is a taxpayer in its own right, distinct and separate from its members. Following this logic, supplies from a head office to its VAT-grouped branch are to be treated like those made to the independent VAT group, and not the branch. Because of this, the supplies may be subject to VAT.

If EU tax authorities fully implement the Skandia judgment, VAT will be due on a whole range of additional services. One need only consider the range of functions and support services an insurer’s head office may provide to, or receive from, its branch network to understand the breadth of supplies that could be brought within the scope of VAT. Skandia’s impact may not be limited to services provided within a VAT group; it could extend to a range of VAT services purchased by a stand-alone branch in one jurisdiction from a VAT-grouped branch in another.

The impact may not be limited solely to branch-to-branch supplies. In the UK, for example, VAT group membership attaches to the entity and not just its local presence. Internally generated services from a non-UK branch of a VAT group member to its VAT-grouped subsidiary are also disregarded. This treatment may similarly need to be amended following the Skandia judgment.
The future of VAT grouping

VAT grouping is a commonly used tool that allows many businesses to manage their VAT affairs. Any change to the treatment of intercompany services may lead organizations that operate via a branch network to analyse the pros and cons of grouping. While it is unlikely that businesses will move away from VAT grouping entirely, they may begin to use it in a more strategic manner.

Implementing the decision

To date, no EU tax authorities have released full guidance on the impact of Skandia. Initial comments from the Dutch tax authorities suggested that the case would be implemented in full. However, following discussions with advisors and industry groups, this policy is back under review. Both the Irish Revenue and Her Majesty’s Revenue and Customs (HMRC) in the UK have released interim guidance stating that they are analyzing the impact of the decision. Further clarification should be released in due course.

What now?

Insurance companies may be the hardest hit if the treatment of intercompany services changes. Each business should analyze their current intercompany flows to determine the level of additional cost they will incur. Developments across the EU will need to be monitored in each jurisdiction where the business operates – we are likely to see a piecemeal and imperfect implementation, which will inevitably create asymmetries and complexity.

Lastly, Skandia is more than a tax-only issue; if it is implemented in full, each insurer will need to make a critical assessment of whether their current intercompany model remains fit for purpose or whether any business restructuring is required.
Solvency II Pillar 3 – the focus of finance for 2015

By Kevin Griffith

With the commencement date of Solvency II now less than 12 months away, and the first reporting to national regulators under the preparatory measures due in the middle of 2015 for those in scope, insurance finance teams are focusing attention on future regulatory reporting. Pillar 3 of Solvency II will introduce significant new public and private disclosures – both quarterly and annually – and require these to be delivered within very short time frames. Reporting obligations will apply to all regulated insurance entities and groups in the European Union (EU), with separate reporting packages for stand-alone insurance entities and for the groups of which they are a part.

Requirements

Pillar 3 reporting requirements consist of both narrative and quantitative information – some reported publicly and some submitted privately to national regulators. Quantitative reporting will need to be submitted in a prescribed format using the XBRL reporting language. In addition to requirements set at EU level, additional national specific templates (NSTs) will be required by local regulators. In early December, EIOPA issued updated proposals on the reporting requirements that will apply to all insurers and groups in the EU. Included in this package are templates to be submitted to regulators in May 2016 containing the opening Solvency II balance sheet and capital position, and a reconciliation with the equivalent amounts under Solvency I.

Reporting under Pillar 3 will include:

- A Solvency II balance sheet alongside an accounting balance sheet
- Details of minimum and solvency capital requirement calculations
- Detailed information about all investments held
- An analysis of technical provisions and reinsurance arrangements
- Information about exposure to, and processes for managing, risk

Quarterly information is to be submitted to the regulators within 5 weeks of the quarter following approval by senior management, with annual information required within 14 weeks of the year-end. In the early years of implementation, a longer submission period will be permitted, starting at 8 weeks and 20 weeks respectively and gradually reducing thereafter. While the first official reporting will commence in 2016, national regulators require a subset of information to be submitted to them by some insurers in the period leading up to implementation, as part of the preparatory measures. These call for information on 2014 year-end data and Q3 2015 to be submitted during 2015.
Insurers are working frantically towards submitting group and individual company information to regulators just a few months after the financial reporting season. We anticipate significant activity, such as dry runs of completion of the reporting templates, finalisation of policies and methodology, and an increased focus on implementing and testing of automated reporting systems.

Major challenges in implementation

The main challenge is the need to produce, approve and sign off a significant amount of data in a very short time period. This usually requires significant acceleration of reporting processes, requiring close analysis of the levers that can be pulled to save time, the sequencing of year-end reporting tasks and coordination between different parts of the business. Getting buy-in from departments outside finance to make the necessary investment of time and resources to achieve this acceleration should not be underestimated.

In 2017, all insurers and European insurance groups will publicly disclose their 31 December 2016 Solvency II balance sheets, their capital requirements and available capital, as well as an analysis by major country and line of business of technical provisions and premiums. In addition, they will provide narrative reporting on their financial performance, capital and risk management policies and exposures, and on the valuation of assets and liabilities under Solvency II and financial reporting. For the first time, analysts and others will have information in a consistent format and on a common basis for all insurers within the EU. This will require management to be prepared for the questions that may be asked about this information, and to be sure that the disclosures provided tell a story about the organization that they understand and that is consistent with other information in the public domain.

Insurers are making decisions about reporting processes and systems to be adopted during 2015, 2016 and beyond. Often, this will require intermediate steps in moving from a very manual, tactical reporting process and solution to a strategic, automated solution to meet the accelerated reporting timelines in a controlled and efficient manner. How best to do this will be different for each insurer, as they will have to take into account existing systems, existing projects to introduce new financial reporting processes and systems, and the ability to make progress on significantly changing existing routines in finance, actuarial, investment accounting, risk and IT.
Obtaining the significant detail required on investments, their classification and detailed look through of investment funds remains a largely uncompleted task. While conversations have generally been conducted with major asset managers, there is still progress to be made on securing the functionality to store and report all required information in a timely manner. In addition, making sure that there is complete information covering the entire investment balance on the balance sheet is a task that should not be underestimated.

Resourcing challenges abound as the demand for Solvency II finance specialists, with sufficient knowledge of the organization’s systems and processes, increases dramatically. It is likely that insurers will have to think creatively about ways to manage the resourcing demand through retention, backfilling of knowledgeable individuals, and the effective use of additional external and internal resources.

What insurers should do now

If not already under way, they should undertake a dry-run exercise as soon as possible, by completing all templates and narrative disclosures that will be required – both for preparatory measures and full Solvency II reporting. This is the only way to be sure that all gaps have been identified and plans put in place to remediate.

They should ensure that there is clear and formally agreed ownership from other functions for delivery of information of the required quality and in the required timelines, as reporting will be a significant scheduling and consolidation exercise, and will fail without the cooperation of actuarial, risk and investment accounting teams.

They should finalise decisions on how reporting will be delivered. Will a software package be purchased? How integrated will the solution be with other reporting systems?

They should consider seeking help to interpret requirements, challenge plans and road maps, and review key technical and design decisions. For reporting system spend in particular, it is important to make the right decisions, as there are many software vendors, and a bewildering range of solutions. Some insurance groups made initial bad decisions and wasted significant time and money revising decisions and starting again.

They should think about the best way to involve auditors in the review process. While regulators are yet to finalise the extent of external audit requirements under full Solvency II measures, early discussions with auditors to agree timing, approaches and design of controls are likely to avoid pain later.
Insurance companies are likely to be regarded as the data controllers and therefore the data protection compliance burden will largely fall on them.
FATCA and data protection issues

By Peter Frost

Much time and effort has been devoted by governments and legislators on articulating the responsibilities for insurers that foreign financial institutions (FFIs) have under the Foreign Account Tax Compliance Act (FATCA). In particular, their data handling obligations have been considerably eased through the introduction of intergovernmental agreements (IGAs) and local regulations across many EU countries. A local legal requirement creates and facilitates the transmission of policyholders' personal data to the US authorities via local competent authorities. FFIs in the insurance sector are, however, predominantly life insurers while general insurers and insurance brokers are predominantly non-financial foreign entities (NFFEs). The IGA is of no particular assistance to NFFEs when it comes to data acquisition and handling for FATCA purposes.

The issue

Many insurers will be familiar with the requirements that FATCA places on non-US insurance brokers and insurance companies in the placement of general insurance where the payer of the premium is US and the risks covered are also US. Brokers, acting as intermediaries, are obliged under the US FATCA legislation to pass documentation to the US insurer or other US withholding agent (USWA) which is sufficient to demonstrate that they, as broker and any insurance company accepting the risks, are able to certify their FATCA status.

Certification is invariably made using a US Form W-8BEN-E. In certain circumstances, the person completing the form is required to disclose details of third-party US individuals and companies that may own more than 10% of the company. Although the completer of the form is authorizing it to be distributed to the payer of the premium, it is far from clear that there is a valid legal basis under EU data protection laws for the details of any third-party substantial individual US shareholder also to be passed to a USWA. Furthermore, there is no provision in a Model 1 IGA to facilitate the passing of this information to the US by NFFEs.

Given the recent and widely reported headlines that the Edward Snowden data leakage affair has generated, there is a heightened awareness and sensitivity surrounding data: how it is used, how it is stored and how it is transmitted, particularly to government authorities outside Europe.

It is against this background that general insurers and insurance brokers should give close consideration to their data protection roles and responsibilities.

Current data protection laws refer to data controllers (persons who determine the purposes for which, and the manner in which, data is processed) and data processors (those who process the information on behalf of a controller). It is for the data controllers to ensure that the disclosure of data is compliant with EU data protection laws, as they have primary responsibility for compliance.

Towards profitability  European general insurance  35
In the absence of a legal obligation to disclose the data (and no such legal obligation exists, as the disclosure of the shareholder information is not subject to an IGA and therefore no local disclosure obligation has been imposed by law), it will probably be necessary to get the consent of the individual shareholders to the disclosure of their information. That consent will also have to make it clear that the data is being passed to third parties and possibly authorities outside the EU (i.e., in the US).

The situation in the EU is only going to get tougher in this regard. New data protection regulations currently going through legislative approval are likely to say explicitly that a requirement to disclose data to a non-EU authority is not enforceable in the EU, and organizations will be required to have any such disclosure approved by the local data protection authority.

Action for brokers

As noted previously, data processors merely process data on behalf of data controllers and it is controllers, not processors, who have the primary duty to comply with data protection law. Accordingly, brokers may wish to set up a construct whereby they act as processors in terms of passing data for the insurance company to US third parties, thereby leaving the responsibility for getting consent from individuals with the insurance company. The broker will essentially be acting as a postbox, which, to a degree, is reflective of the current FATCA circumstances in relation to handling the documentation.

This will require appropriate contract wording with the insurance company, indicating that they require the brokers to acquire the data and transmit it to the USWA.
Action for general insurers

Insurance companies are likely to be regarded as the data controllers and therefore the data protection compliance burden will largely fall on them. It is worth noting that if the insurance company is outside an EU jurisdiction, EU data protection regulations will not apply. This will be the case for captives especially, with many established outside the EU.

Consequently, a pragmatic approach for insurance companies is to request, in each instance, the separate consent of the individuals being reported.

Should an individual make a complaint to the data commissioner, a notice reprimanding the company in question, or a fine, can be issued. The position will change with the new regulations, as there will be much higher potential sanctions and there is also likely to be a specific prohibition against complying with non-EU requests for personal data.

Conclusion

The issue of sufficient data protection safeguards is yet another concern relating to the implementation of FATCA across the general insurance sector. The industry has had to adapt on its own, without clear guidance and assistance from government or regulators.

The content of this feature was the focus of a joint seminar in London in November 2014 with Alex Brown, Partner, of law firm Simmons & Simmons LLP.
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