Liberty Global Transaction Solutions™

Claims briefing

Exclusive insights guiding global decision making



Claims briefing 2026

The current state of the R&W insurance market[1]

The R&W insurance market is at a critical inflection point, driven by a combination of pressures that have been building over time:

1. Coverage has expanded significantly over the last few years and is now as wide as it has ever been.
2. Despite this, rates and retentions have fallen across the board over the same period — all at a time when insurers' cost bases have been going up due to high inflation.
3. The market is experiencing a notable uptick in claims frequency and severity, which is leading to an increase in actual and projected loss ratios.

Our MGA-dominated industry will naturally look to solve for this through rate increases. That will help, of course, and is definitely needed. However, on its own, this is unlikely to be a silver bullet, and the R&W insurance industry as a whole must do more to address these challenges, not only to restore the confidence of capacity providers and/or reinsurers, whose views on the class have turned notably bearish in the last few years resulting in several high profile exits in the last couple of months.

The original idea of a R&W policy was to replicate the buyer's ordinary recourse against the seller on an uninsured deal (disregarding the standard limitation clauses). The product we now have looks very different, with any number of enhancements that policyholders can get for free as standard or can buy for an additional premium. Retentions have been slashed (and in some cases reduced to nil); once standard exclusions have been removed or pared back; policy periods have been pushed out; coverage for new heads of loss has been bolted on; and the warranties that are being insured now are much broader than they used to be. None of these enhancements are typically available from a seller on an uninsured deal. For the most part, this is, of course, just part and parcel of the natural evolution of the product and healthy competition. That said, the loss emergence that the market is now seeing suggests that pricing and underwriting discipline may not have kept pace with how far coverage has evolved.

This is prompting a wider debate about the future of the product and where it goes from here. This is all part of making sure that the R&W product remains on a sustainable footing, which is ultimately to the benefit of the M&A community given the intrinsic role that it now plays in dealmaking. We know that buyers and sellers like using the product; we know that the fundamental value proposition of the product remains as strong as ever; and we know that the product now has an established track record of paying claims. However, the product needs to work for everyone — insurers included. The reality is that there are certain aspects of it that currently do not, especially in the Americas. R&W insurers, Liberty GTS included, need to lead this change.

We expect that as more insurers look to shift their appetite towards mainly excess business, where the loss experience is better, there will be less competition for primary business. This will mean that primary insurers will be able to dictate terms in a way that has not been possible in recent years due to oversupply of capacity and the drop-off in deal activity. There are signs of green shoots: Rates are now moving in the right direction, and retentions have stabilized. However, more is needed. A return to more normal dealmaking conditions will help accelerate change, but the first steps need to be taken now.

In this claims briefing, we will look at some of the R&W claims trends that we are seeing, speculate as to what might be driving these, and examine how they are impacting insurers' bottom line. We also explore what change might look like beyond simple rate increases, which are unlikely, on their own, to address some of the underlying issues discussed above.

1 R&W (Representations and Warranties insurance) is known as W&I (Warranty and Indemnities insurance) outside of the Americas.

Focus on notification activity



We received a record number of R&W notifications in 2025 [see Figure 1].

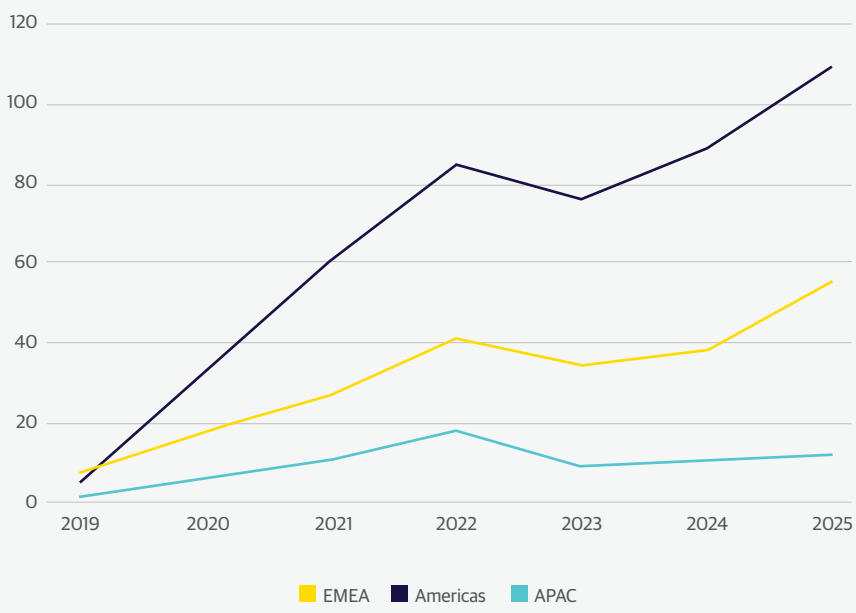
Overall, we received 176 R&W notifications across all of our regions in 2025: the most we have ever received in any given year and an increase of approximately 26% vs. 2024. The signs are that this trend is set to continue as our notification data for H1 is projecting a further (albeit more modest) increase this year.

There are two main reasons for this:

- First, it simply reflects the fact that our policy count has increased year on year over the same period, driven by an uptick in deal activity, particularly at the lower to mid-end of the market in terms of deal size.
- Second, we are starting to see signs of an uptick in notification frequency on some of the more recent YOAs, indicating that policyholders are notifying more claims than in the past. We look at this point in more detail below.

What this means in practice is that R&W claims teams have never been busier. While some R&W insurers have struggled to keep up with the demands of servicing and resolving these claims, others — like Liberty GTS — that have invested in their claims function by building out a specialist in-house team dedicated entirely to handling transactional liability claims, have been able to continue to deliver the high standards of service and care that our clients and brokers expect.

Figure 1 **Number of R&W notifications received by calendar year in each of our regions**



Notification frequency is on the rise [see Figure 2].

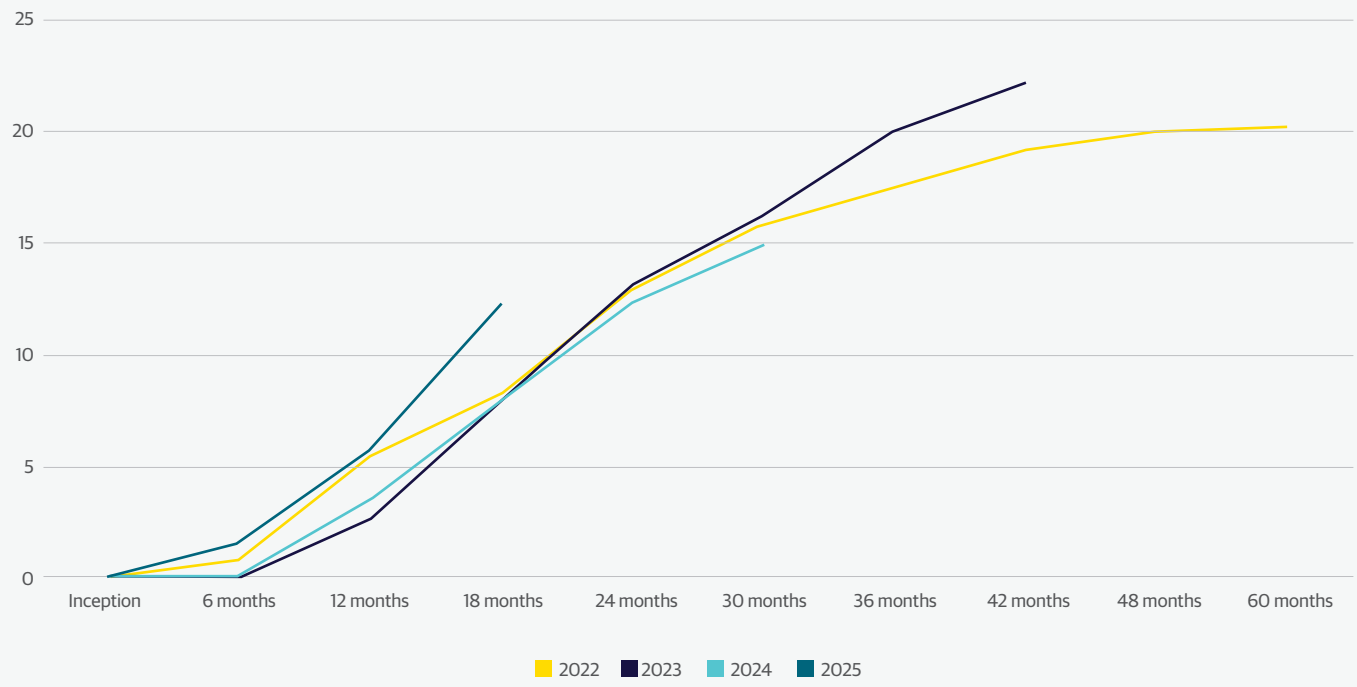
Our historical data, corroborated by other claims studies in the market, indicates that we can expect that about 1 in 5 (i.e. 20%) R&W policies will be the subject of a notification at some point in their lifecycle.[2]

However, there are signs that this number is increasing, and we are now projecting that it could end up being more like 1 in 4 (i.e. 25%) on some of the more recent YOAs.

The increase is most pronounced in EMEA, where notification frequency is currently sitting significantly above historic levels from the 2023 YOA onwards. There is undoubtedly an element here of policyholders being more cautious in terms of deciding whether to notify, with many notifications being precautionary in nature. However, it is also notable that coverage has expanded significantly in EMEA over the same period, with broader terms and lower retentions (often tipping to nil) being offered. An element of the increase is, therefore, probably down to policyholders notifying issues that either may not have been covered previously or that they may not have been inclined to notify previously because of their size.

A further notable feature of our data is the fast start to the 2025 YOA across all of our regions, with notification frequency currently sitting at 12% globally, which is about 4% higher than prior YOAs when compared to the equivalent point in their lifecycle. This supports a widely held theory that, increasingly, there are some policyholders that are looking to find a way of extracting value from the product by actively searching for issues that could constitute a breach of warranty by way of a post-closing review. This is very different to how the product has been used historically and is significant from insurers' perspective because it is leading to an increase in severe claims — a point that we discuss in more detail later in the briefing.

Figure 2 **Global R&W notification frequency by YoA**



2 See Aon 2026 Claims Study and Marsh 2026 Claims Study

About 1 in 5 notifications on primary policies will result in a payment or reserve, but this is likely to increase due to falling retentions [see Figure 3].

Our historical data indicates that we can expect about 1 in 5 (i.e. 20%) of our primary layer notifications to result in a paid or reserved claim (referred to here as the "conversion rate").

However, it is possible that we may see the conversion rate start to increase on more recent YOAs due in large part to the impact of lower retentions. The trend towards lower retentions started in earnest in 2023 when deal activity collapsed. Prior to this, it was common to see retentions of 1.5% of EV. These have now all but disappeared. Now most retentions are <0.5% of EV. Tipping to nil retentions have also become more common in some regions.

The impact of smaller retentions is several-fold.

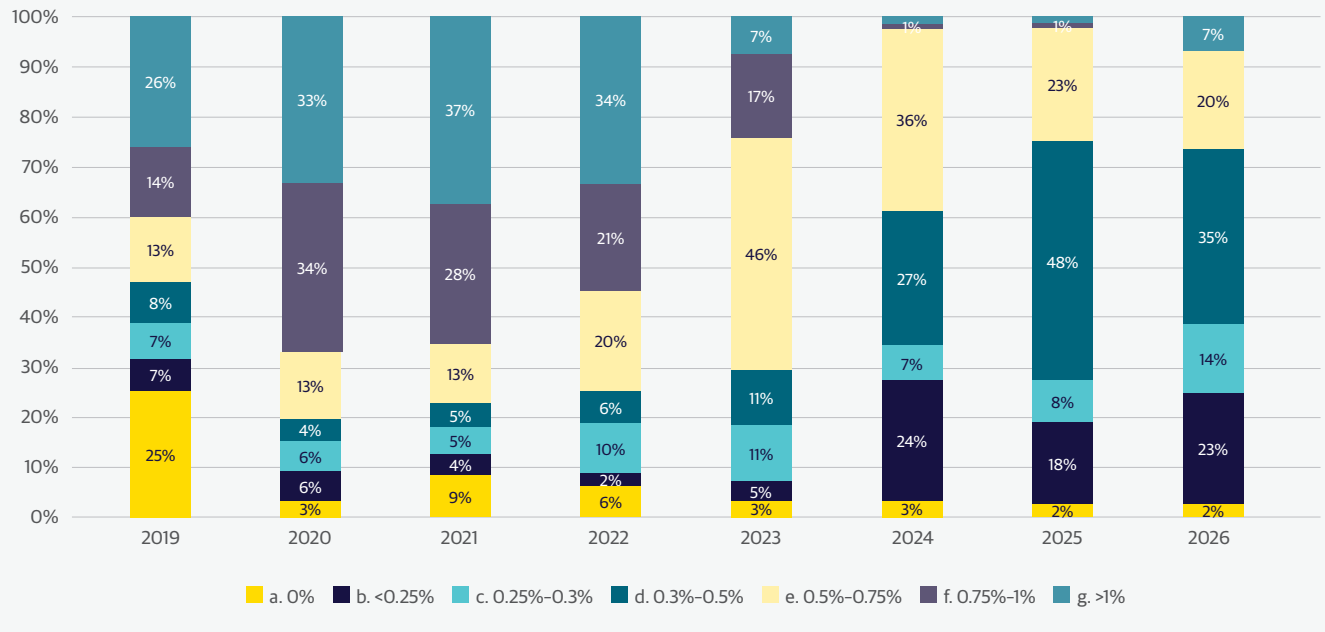
- First, and most obviously, they will result in more dollars being paid by simple function of the lower attachment point.
- Second, they increase the risk that some buyers may rely on the R&W policy as a backstop in place of proper due diligence — especially on smaller deals.
- Third, they help to make nil seller recourse deals more palatable from a buyer's perspective since the financial exposure that they are left to carry is smaller — and potentially nil in some cases. If retentions were higher, it is likely that more buyers would insist that the seller retain some liability, which ought, in turn, to provide the seller with a greater incentive to carry out a thoughtful disclosure exercise and to more rigorously negotiate the warranties.

As we discuss later, given that this erosion in buyer-seller incentives is thought to be one of the contributing factors behind the uptick in claims frequency and severity that is being seen in the market, R&W insurers need to look at whether a meaningful increase in retentions is needed in order to rebalance incentives.

Excess policies see far fewer payments or reserves vs. primary policies, but are by no means risk free

For notifications involving deals where we were an excess insurer, the conversion rate is much lower: currently less than 5% on all YOAs (aside from the 2019 YOA). This illustrates that excess business performs significantly better than primary business and explains why more insurers are looking to shift their appetite towards mainly excess business. However, as we discuss later, when a payment is made on an excess policy they tend to be large and not all excess business is the same — indeed, in many cases, because of the drop-off in retentions, the first excess layer is now attaching at the same level that the primary layer would have attached prior to 2023. Therefore, excess business is far from risk free.

Figure 3 **Global R&W retention levels as % of EV by calendar year**



Focus on timing of notifications

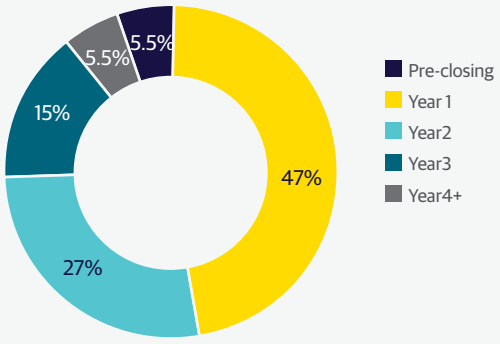
Notifications still tend to be front-loaded towards the start of the policy period [see Figure 4].

The general warranty period has now expired on (almost) all of the R&W policies that we issued between 2019 and 2022. We can, therefore, use the notification data we have for these YOAs to provide insights into the timing of notifications involving an alleged breach of a general warranty.

The data shows that a high proportion of our notifications — 47% — were received in the policyholder's first year of owning the target business (Year 1). There is then a steady decline in notification activity from this point onwards, with 27% of notifications coming in the second year of ownership (Year 2) and 15% coming in the third year of ownership (Year 3). There are, however, some notable regional differences in our data: one being that, in the Americas, we see a greater proportion of our notifications being made in Year 3 (17%) and in Year 4+ (7%) (during the extended reporting period[3]) compared to other regions.

Figure 4

Gap (in years) between closing and receipt of non-tax R&W notifications [2019 to 2022 YOA only]



3 We highlighted the increased number of claims that we are receiving during the extended reporting period ("ERP") in our last claims briefing and observed that R&W insurers may respond to this development by tightening up their wordings in order to preclude a policyholder from relying on the ERP provision if it learned about the issue in question more than a few weeks before expiry of the policy period or, perhaps, by reducing the length of the ERP period.

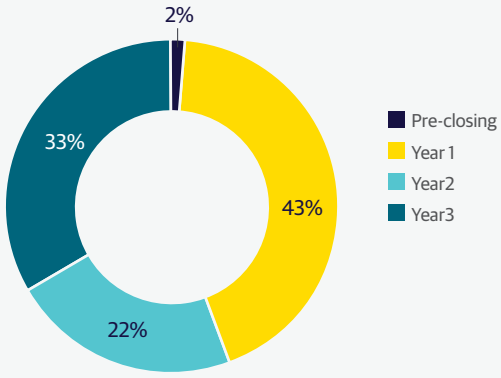
Extending coverage to Year 3 is proving to be a significant enhancement [see Figure 5].

Our data shows that 43% of the dollars that we have paid out and reserved in respect of these notifications involve claims that were notified in Year 1, and 22% involve claims that were notified in Year 2. What is more interesting is that, for claims that were notified in Year 3, the figure is 33%, which is an outsized amount bearing in mind that Year 3 notifications only accounted for 15% of our total notifications across these YOAs (see above).

The fact we are seeing some significant claims being paid that were notified in Year 3 illustrates one of the key advantages of a R&W policy, which is that it provides cover for warranty breaches for a longer period of time compared to an uninsured deal where the seller would usually only be prepared to stand behind the warranties for a maximum of 24 months (sometimes less). We can point to multiple examples of claims where our policyholder has made a multimillion-dollar recovery in circumstances where it simply would not have been able to do so but for its decision to buy a R&W policy because of the timing of when the issue giving rise to the claim came to light.

Figure 5

Dollars paid and reserved according to gap (in years) between closing and receipt of non-tax R&W notifications [2019 to 2022 YOA only]



Adjustments must be made to pricing to reflect this increased exposure

However, this raises an obvious question about whether R&W insurers are properly pricing in the risk of extending coverage for a breach of the general warranties beyond 24 months. The data is clear: This is a significant coverage enhancement. Indeed, our two largest paid claims in the Americas last year were both notified in Year 3. We do not expect 36-month policy periods to be suddenly taken off the table given that they are such an important differentiator for the product. However, we do foresee a debate around whether coverage should be stripped back to a default 24-month policy period with the option of an extra 12 months for those that want it in return for an additional premium that fairly represents the additional risk that insurers are taking on. This is all part of a wider conversation that is needed around coverage and how the product may need to evolve in response to some of the claims trends that we are seeing. We will return to this point in the next section.

Drop-down retentions are also coming under increased scrutiny

This data may also prompt calls for changes to the way drop-down retentions operate, which are a common feature of the Americas market. These see the original retention "drop" for any claims that are discovered more than 12 months after closing — sometimes by as much as 50%. The rationale for drop-down retentions has always been that the facts giving rise to the largest claims ought to come to light during the policyholder's first year of owning the target business. However, our data shows that this is not true. Of our largest 20 paid claims to date, only nine were notified in Year 1 and, as noted above, our two largest paid claims in the Americas last year were both notified in Year 3. There are various ways change could be achieved short of dispensing with drop-down retentions entirely: from pushing out the drop-down date, to reducing the size of the drop-down — especially on large deals, or even carving out third-party claims and tax-related issues from the concept (on the basis that a policyholder generally has less control over when the matters giving rise to these types of issues are discovered and typically only does so when a claim is actually made, which can be several years after closing).



Focus on claims severity



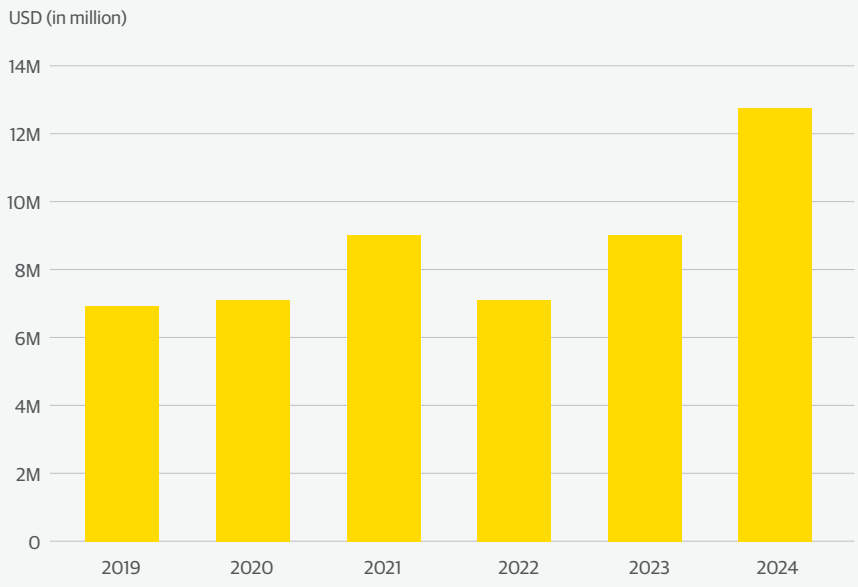
Claims severity is on the rise [see Figure 6].

As noted earlier, the R&W insurance market is experiencing a notable uptick in claims severity, which is leading to an increase in actual and projected loss ratios. We are seeing this both in the claims that we are paying and in the new claims that we are receiving. By way of illustration:

- The average size of our payments for claims notified to the 2019–2022 YOAs is around $7M (except for the 2021 YOA where it is around $9M[4]). However, in the last few years, rates have fallen sharply, but the average size of our payments has increased materially and currently sits at $9M for claims notified to the 2023 YOA and $13M for claims notified to the 2024 YOA.[5]
- Payments of $10M or more now constitute about 75% of the dollars that we have paid out in total (up from about 68% at the end of 2024).
- In the last 12 months, we have received more notifications involving an alleged loss of $10m+ than at any other point in time.

The key question is: What is driving this increase in claims severity? The logical place to start is with coverage. Undoubtedly, this has got a lot broader over the last few years. However, while it probably does have a role to play, we do not think it is the only driver making it necessary to look elsewhere for explanations.

Figure 6 **Average R&W payment size by YoA**



4 Our best explanation for the jump on the 2021 YOA is that, because of the frenzied state of the M&A market at that time, due diligence might have been compromised in some instances in the rush to get deals done under compressed timeframes resulting in some big issues being missed. Of course, back then, rates were high and so insurers had more margin to absorb these bigger losses.

5 This figure is somewhat skewed by one very large payment and we do expect it to come down as we pay & reserve more claims on this YOA.

A change in deal dynamics caused by nil seller recourse deals?

As noted earlier, a significant number of insured deals are now structured as nil seller recourse deals, including now in the Americas. These types of deals are extremely attractive from a seller's perspective for obvious reasons and are often imposed as a key requirement in any auction process. The problem with this is that a seller with no skin in the game (absent fraud) has much less incentive to negotiate the warranty package properly or conduct a thorough disclosure exercise. Taken at their extreme, they allow a seller to push the limit of what is acceptable in an attempt to maximize the sale price in the knowledge that it is only if they cross the line and commit fraud that they face any repercussions. While it is possible for R&W insurers to step in and solve the former to a degree (by rewriting the warranties), they are at an inherent disadvantage relative to an engaged and economically incentivized seller who understands where the material risks in the target business lie. It is, however, very difficult for R&W insurers to fix the latter.

The effects of this are difficult to quantify, but they are central to understanding the market's current loss experience. Indeed, it is noticeable just how many of our recent material claims involve an allegation that the seller has failed to disclose a significant issue, often involving a significant customer or contract. Non-disclosures like these are seldom deliberate, but they are exactly the types of issues that one would ordinarily expect to be picked up by a robust disclosure exercise. The issue is particularly noticeable on deals at the smaller end of the spectrum where incentives have always been weak anyway and the danger is that, as deal teams and their advisors get used to transacting on this basis, these types of behaviors get embedded in the deal process, and R&W insurers are left stuck in the middle without any recourse.

It would be wrong, in our view, for R&W insurers to simply accept these types of deals as "the new normal". They create a fundamentally different risk proposition — one that was not envisaged when the product started out. R&W insurers should and must be doing everything they can to ensure that the seller and its advisors are properly engaged in the deal process. The first and most obvious solution is a re-evaluation of retention levels. The main benefit of higher retentions is not that they remove attritional losses from



the system. Their greater value is behavioral. A material increase in retentions ought to improve deal due diligence at the margins because the buyer is retaining more risk before insurance responds, and — more importantly in our view — make nil seller recourse deals much less palatable from a buyer's perspective thus prompting more to insist on the seller retaining a meaningful liability. This, in turn, would help preserve incentives for thoughtful warranty negotiation and accurate disclosure. It is not only R&W insurers that would benefit from this: The buyer will too — both because it ought to lead to fewer claims, but also because we are at the point where R&W insurers will soon start looking at nil seller recourse deals through a very different risk lens, resulting in much higher rates and tighter coverage where the deal is structured in this way vs. where it is not.

The second, and perhaps more radical solution, is to look to expand the circumstances in which recourse against the seller is available. On many deals, this is now restricted to cases of fraud only. However, fraud is difficult to prove, and many disclosure failures will not meet the high threshold required even in circumstances where they have been caused by egregious action (or inaction) on the part of the seller.[6] Extending it to cover cases of willful misconduct and gross negligence as well would go some way to fixing this lacuna and provide sellers with a greater incentive to carry out a thoughtful disclosure exercise and provide proper disclosure of material issues.

6 A good example of egregious inaction would be the conscious failure by the seller to make reasonable enquiries of target management for the purposes of collating information for disclosure.

Regardless of the above, the increased fraud risk posed by nil seller recourse deals may necessitate a re-think about how the proceeds of any recovery action vs the seller should be distributed following a payout, especially where the insured loss exceeds the policy limit. The typical waterfall is that the legal and enforcement costs of obtaining the recovery are paid first, with the policyholder then being reimbursed for uninsured loss above the policy limit or any excluded loss, followed by insurers for the amount that it paid under the policy. The problem with this approach, however, is that, by preferring the interests of the policyholder, it can leave the insurer empty-handed even though both parties have suffered the consequences of the same fraud, thereby disincentivizing an insurer from commencing a subrogated claim vs the seller in the first place. A recent International Underwriting Association ("IUA") paper looked at this issue in more detail.[7] It suggested that one option would be for any net fraud recoveries to be shared pro rata according to how much of the insured loss each party actually bore. This would preserve a shared incentive for both sides to pursue recoveries vs a fraudulent seller and avoid giving either side unjust priority by giving due recognition to the economic burden borne by each.



A change in how some policyholders are using the product?

As noted earlier, it appears that more policyholders are no longer just seeing the product as a deal facilitation tool, but also an asset that they can derive real value from. This, it would seem, is leading to more instances of policyholders that are actively looking for claims, either by way of a post-closing review or an end of policy period review. Our growing sense is that the motivating factor for this type of claim is no longer limited to situations of buyer's remorse, but now includes instances where policyholders are actively looking to use the product as a way of achieving a post-closing price chip.

This change in behavior is most obvious from the growing number of large claims that: (i) are being received in the last few months of the general warranty period, especially in the Americas; or (ii) are citing multiple issues — especially vis-à-vis the financial statements, including some that are relatively minor on their own but much more significant when aggregated. These types of claims are potentially indicative of a policyholder that has carried out a detailed review exercise, presumably with help from advisors, to try and identify things that might constitute a claim. Indeed, a US law firm recently published an article which they encouraged policyholders to actively manage their R&W policies by carrying out exactly this kind of exercise. This is, of course, perfectly permissible and it does not alter how the product responds in a claim scenario, but its practical impact from insurer's perspective is significant as it is leading to an increase in severe claims, including some that are being made late on in the policy period.

R&W insurers must, of course, bear some responsibility for encouraging this type of behavior. Their decision to cover prosecution costs (typically defined to include the costs of not only investigating, but also then bringing a claim under the policy and/or against the seller) was always questionable and likely to fund affirmative claim generation. This is something, therefore, that the market might want to look at afresh and change.

Against this backdrop, another approach that is available to R&W insurers is to introduce a stricter notification requirement that involves policyholders having to notify any circumstances that are reasonably expected to give rise to covered loss above an agreed threshold within a fixed period after becoming aware of them, say within 60 or 90 days. This structure would more closely resemble the notification requirements typically found in SPA notice provisions and, therefore, an uninsured deal, while still allowing the claim notice to be supplemented as the policyholder's investigation develops.

7 IUA study

In the meantime, we expect that R&W insurers will be looking at their claims data more closely to try and identify policyholders and/or deal team advisors that they think are using the product in this way and making adjustments to their appetite accordingly on the basis that they represent a different risk profile vs. those that are not.

A change in how claims are being quantified?

An increasing number of the claims that we are receiving are taking a valuation-based approach to calculating damages instead of quantifying loss by reference to dollar-for-dollar impact of the underlying issue. This is linked to the point above but is also indicative of a wider theme we are seeing of policyholders and their advisors trying to maximize the value of their claim. This appears to mirror what other R&W insurers are experiencing, with several recent market studies suggesting that valuation-based loss calculations now account for a substantial proportion of aggregate claim payments.

This can, of course, be a valid way of assessing loss, but, for R&W insurers, valuation-based damages present several challenges. Not only do they materially increase the severity profile of a claim, but, because they often rely on competing expert evidence, counterfactual assumptions and subjective valuation methodologies, they can also make the claims adjustment process less predictable and increase the scope for a dispute.

This is increasing pressure on the R&W insurance market to think more carefully about how it can underwrite and manage this risk better. The recent IUA paper looked at this issue in more detail.[8] It suggested that one option is to treat valuation-based damages as a distinct underwriting issue, with the policy saying clearly whether valuation-based loss is covered and, if so, to what extent. This way multiplied damages would be handled as an express coverage election, with the parties choosing whether the policy responds only to dollar-for-dollar loss, to a capped multiple, or to the full deal multiple. The choice would necessarily impact not only pricing, but also the level of diligence and valuation work needed to support the transaction and any underwriting decisions.

8 IUA STUDY



Alternatively, a potential halfway house might be for R&W insurers to introduce a de minimis filter that items must exceed before any valuation impact is considered in order to prevent one or more relatively minor issues giving rise to outsized recoveries simply because they are then multiplied by a high EBITDA multiple. This would, in effect, introduce a pre-agreed materiality threshold into loss calculations. The logic here is that small items like this are often not important enough to shape diligence, disclosure, or the commercial bargain itself, so why should they then suddenly take on increased significance in a claims scenario? If this were to be implemented, the drafting would need to be very clear on things such as: whether related items can be aggregated for the purposes of determining whether the filter has been exceeded; whether the filter only applies to prevent recovery of valuation-based loss or operates to prevent any recovery full-stop; and whether all items below the filter should be ignored entirely. The last point matters a lot. For example, different options could be available and priced accordingly: a hard exclusion (where items below the filter are ignored entirely); a basket concept (where unrelated items can be aggregated and some or all of the amount counts once a predetermined tipping point is reached); or a deductible concept (where only amounts that are in excess of the filter count).

These proposals would, of course, be quite a radical change to how the product presently works and so while R&W insurers may end up moving in this direction eventually if the current situation continues, we expect that they will start off by scrutinizing how purchase prices have been calculated much more carefully and will increasingly look to cap the size of the multiple or even exclude the use of a transaction multiple altogether on a case-by-case basis.

Focus on paid claims





We recorded our highest ever payment in each of our regions last year

In total, we have now paid out or reserved around $650M in Insured Loss under R&W policies and over $100M under tax policies. A significant proportion of this has been paid or reserved in the last 12 months. Indeed, in 2025, we made our highest ever payment in each of our regions (at c.£42M in EMEA; c.$50M in APAC; and c.$44M in the Americas). This demonstrates that policyholders with good claims continue to derive significant value from their decision to purchase a R&W or tax policy.

The time to payment varies, but big claims can get paid quickly

The time it takes to resolve a claim depends on numerous factors such as the complexity of the underlying issues, the quality of the information provided to insurers, and the reasonableness of the positions taken (by both sides) — each claim is different. However, our sense, based on our own experiences and anecdotal evidence, is that the claims process is getting quicker as the product becomes more established and claims handlers (and their advisors) more experienced. Inevitably, there is some room for improvement. The general feedback that we hear from brokers and more regular users of the product is that they would like to see more focused requests for further information and documents; issues or concerns being identified and addressed as soon as possible; quicker response times; and claims handlers that make themselves available to speak and do not let their lawyers do the claims handling. These are all of the things that we measure ourselves on when handling a claim and, as a result, we have had some real success stories. For example, the EMEA claim that resulted in us paying out c.£42m last year was resolved within six months of us receiving the detailed claim notice.

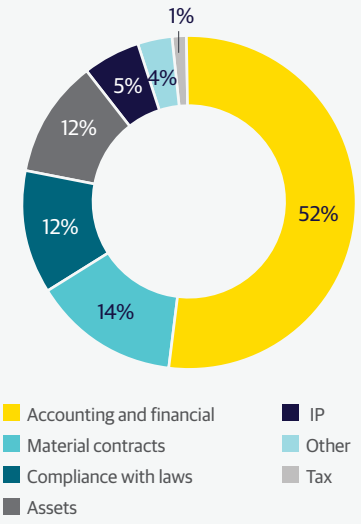
Accounting & financial issues continue to be behind the majority of losses [see Figure 7].

Our data continues to show that our payments & reserves are predominantly driven by just five breach types: accounting & financial issues (52%), material contract & customer issues (14%), compliance with laws issues (12%), condition of asset issues (12%), and IP issues (5%).

The largest claims are invariably driven by either accounting & financial issues or material contract & customer issues, with these types of issues being responsible for the majority of our full limit losses to date. Whereas claims involving material contract & customer issues still tend to cite a single issue, it is becoming much more common for claims involving accounting & financial issues to cite multiple issues. Indeed, 84% of our most recent payments & reserves involving accounting & financial issues fall into this category, and this is helping to drive a significant increase in the quantum and complexity of these types of claims. Therefore, from our perspective, analyzing, considering, and asking questions about the level and quality of financial diligence performed on deals has never been as important.

Figure 7

Dollars paid and reserved according to breach type



Large tax claims are on the rise — especially in Mexico

Historically, notifications involving tax-related issues have only been responsible for a relatively small proportion of our paid claims. However, this may be starting to change as, over the last 24 months, we have seen a steady increase in notifications involving significant tax issues. A large number of these involve Mexican tax issues. Indeed, we have now seen five notifications involving Mexican tax issues with a quantum that exceeds the retention by more than $10M, with two of these implicating more than one layer in the tower and involving an amount in excess of $100M.
A common theme with these notifications is the combined total of interest, inflation adjustments, penalties, and fines levied significantly exceeds the underlying tax alleged to be due. The increasingly aggressive nature of the positions being taken by the Mexican Tax Administration Service, plus the fact that it is actively using AI to increase the number of assessments that it can make, when combined with recent changes to the rules around advance tax payments in Mexico, means that we now regard Mexican tax issues to be effectively uninsurable.

There are signs that the market is starting to adjust its underwriting approach to condition of asset issues, which remain a problem area

In our 2023 claims briefing,[9] we discussed how the R&W insurance market was experiencing some significant losses involving condition of asset issues, especially in the Americas. While we continue to see a steady stream of these types of claims across all of our regions, they are not as prevalent as they were in 2022 and 2023. This suggests that the market is finally beginning to learn its lesson from past claims, with many carriers now unwilling to provide cover for assets that are buried underground (such as fiber optic networks) or which are otherwise not capable of having diligence done or which have not had diligence done properly. Furthermore, we are seeing more carriers reject broadly worded condition of asset warranties and only agree to provide cover where these warranties are knowledge qualified.

9 Liberty GTS 2023 Claims Briefing

Third-party claims continue to present R&W insurers with significant exposure and this may prompt a rethink about how coverage is structured for these types of claims

In our 2024 claims briefing,[10] we wrote extensively about how third-party claims were becoming a significant driver of loss, especially in the Americas. Of our 10 largest paid claims, two involved third-party claims. The fact that retentions have got smaller and defense cost spends bigger over the last few years has only made the situation worse as it will result in more attritional losses. In total, we have now paid out around $85m in respect of third-party claims and soon expect this figure to exceed $100m. The vast majority of this figure — about 90% — involves claims with an American nexus making this very much an Americas issue.

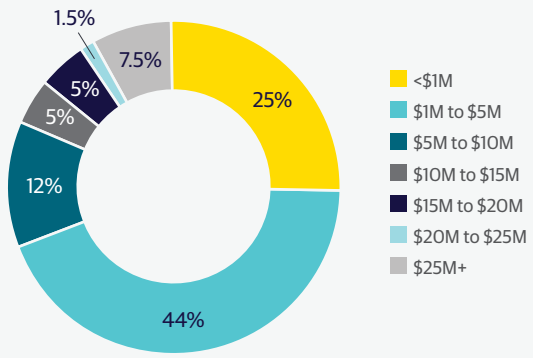
The recent IUA study suggested that the market should deal with third-party claims by modularizing or at least explicitly isolating them within a R&W policy, then underwriting and controlling them more like specialist liability risks, with appropriate sub-limits, conditions, and exclusions.[11] This suggestion has a lot of merit, especially for four types of third-party claims — IP disputes; regulatory investigations and enforcement actions; wage & hour claims; and cyber. The first two generate some of the most severe third-party claims;[12] the third generates a significant number of notifications and some large defense cost spends; and the fourth has the potential to result in sizeable losses (especially with AI threats increasing in scale and persistence). This would prevent a R&W policy from simply becoming a catch-all policy for any type of third-party claim and avoid the current scenario where the R&W market is effectively insuring specialist liability risks without the underwriting discipline normally applied to those risks.

The market also needs to think carefully about emerging areas of risk and how it deals with these. One such risk relates to the class action lawsuit threat that U.S. businesses face from consumers alleging that they should receive a share of any tariff refunds received in circumstances where the cost of those tariffs was passed on to them as the end-user by way of price increases. There are already reports of a number of lawsuits being filed along these lines, and more are expected. This is the type of claim that we think the market should be looking to exclude altogether for the more high-risk target businesses.

Finally, an additional issue for the market to revisit is the trigger for coverage in respect of defense costs. As things stand, a R&W policy will typically provide coverage for defense costs if the allegation(s) made by the third party, if true, would mean that there has been a breach of an insured warranty. The problem with this, however, is that it can lead to a situation where a R&W insurer ends up having to fund the defense of a lawsuit even where there is no truth to the allegation(s) and, by extension, no breach of warranty. Indeed, we recently paid out around $7M and $4M to cover the defense of two third-party claims that ultimately failed at trial. This is out of step with the intent of a R&W policy, which is to provide coverage for actual breaches of warranties only, and may prompt increasing discussion around whether: (i) coverage for defense costs should be restricted to situations where the policyholder can establish that the allegations made by the third party are actually true and that, as such, there has been a breach of an insured warranty; or (ii) R&W policies should include a claw-back provision that would require policyholders to reimburse defense costs in circumstances where it is shown that the allegations giving rise to the third-party claim are untrue.

Primary layer payouts vary significantly in size, but most are below $5M [see Figure 8].

Figure 8 **Size of payment or reserve (primary layer only)**



10 Liberty GTS 2024 Claims Briefing

11 IUA study

12 For example, we are aware of two notifications in the market involving IP disputes where the amount being claimed by the plaintiff is in excess of $100M.

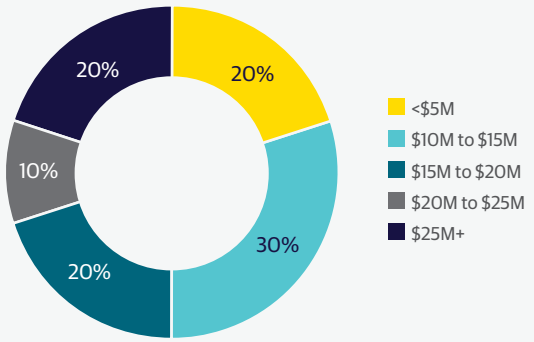
Our average primary layer payment currently sits at around $7M. This is made up of payments of varying size, with 70% being for under $5M; 12% for between $5M and $10M; and 18% for more than $10M.

Excess layer payouts are rarer, but tend to be much larger [see Figure 9].

Our average excess layer payment currently sits at around $19.5M, indicating that these are invariably much larger in comparison. This reflects the fact that a claim that reaches an excess layer is, by definition, going to be more severe in nature. Indeed, 80% of excess layer payments we have made have been for more than $10M, although we are obviously talking about a much smaller universe of claims here.

Figure 9

Size of payment or reserve (excess layer only)



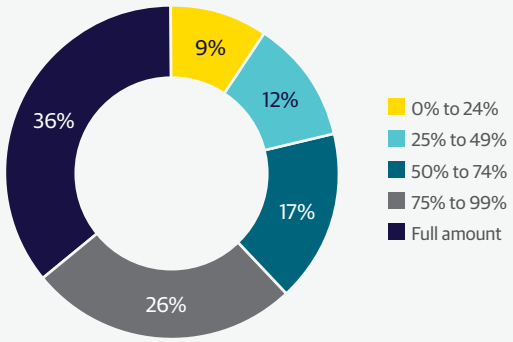
We continue to pay and reserve many claims at or close to their full value [see Figure 10].

A closer look at the claims that we have paid (or reserved) to date reveals that:

- we have paid (or reserved) 100% of the initial amount claimed in 36% of cases (down from 45% in our last claims briefing).
- we have paid (or reserved) between 50% and 99% of the initial amount claimed in 43% of cases (up from 36% in our last claims briefing).
- we have paid (or reserved) less than 50% of the initial amount claimed in 21% of cases (up from 19% in our last claims briefing).

Figure 10

Payment or reserve vs amount of Liberty limit being claimed



The slight drop-off in payments (or reserves) for the full amount claimed is probably a function of the fact that we have paid more claims over the last few years where the policyholder has adopted a valuation-based approach to calculating damages as these claims tend to have more issues from a quantum perspective vs. claims that are quantified by reference to the dollar-for-dollar impact of an issue. Importantly, from a policyholder perspective, there has not been a material change in the proportion of claims where we have ended up paying less than 50% of the amount being claimed.



It is not uncommon for claimed loss to exceed 10% of EV, especially on smaller deals [see Figure 11 and 12].

Our data shows that, for almost 50% of the claims that we have paid and reserved to date, the alleged loss was equivalent to less than 5% of deal EV. In the vast majority of cases, our policyholder had bought enough insurance limit to cover these losses. However, some policyholders opt to stop at 5% of EV, and the majority of policyholders will still stop at 10% of EV. The evidence suggests that these policyholders could end up regretting that decision because, in almost 21% of the claims that we have paid and reserved to date, the alleged loss was equivalent to between 10% and 20% of deal EV and in almost 14% of cases it was more than 20% of deal EV. In some of these cases, the policyholder was left with a significant uninsured loss (although probably still ended up in a better position because of its decision to purchase R&W cover, since the policy limit purchased will often be higher than the liability cap that the seller would have been prepared to agree if the deal was not insured).

Interestingly, our data shows that, for the claims that we have paid and reserved to date where the claimed amount exceeded 10% of EV, most of these — 57% — involved deals with an EV of under $250M. This suggests that it is especially at this end of the spectrum that policyholders are perhaps not buying enough insurance. However, this is something we see across every deal size bucket, including on deals with an EV of $1bn plus where 13% of the claims that we have paid and reserved to date involved an alleged loss of more than 10% of EV.

Figure 11

Total alleged loss for notifications that have resulted in a paid claim as a % of deal EV

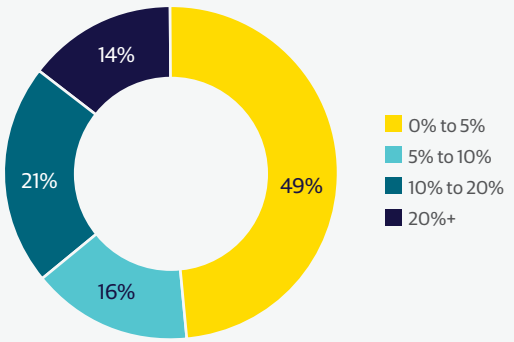
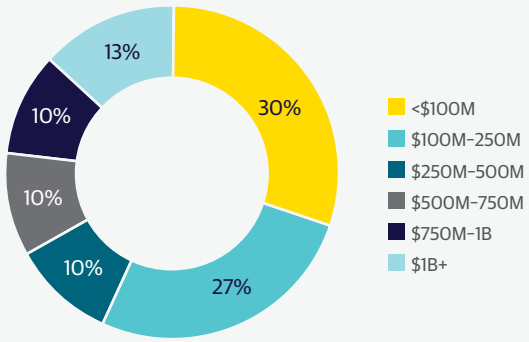


Figure 12

Deal size of our paid & reserved claims involving a total alleged loss exceeding 10% of EV



Our data shows that the smallest deals perform worse than the biggest deals [see Figure 12].

The worst performing deals in our book are deals with an EV of under $100M. By contrast, deals with an EV of $1B plus perform much better — with performance improving as the deal size increases. There are likely to be several explanations for this. First, incentives are generally weaker on smaller deals as the seller may have minimal skin in the game or may be a founder shareholder, who arguably have a greater incentive to conceal issues deliberately, especially if they are exiting the business entirely and see the sale as a gateway to an early retirement. Second, the quality of the advisors retained on the bigger deals in generally better. Third, a multimillion-dollar issue on a smaller deal is much more likely to be noticed, brought to the attention of the right people, and pursued aggressively whereas, on a very big deal, these kinds of issues are perhaps seen as less noteworthy or significant, depending on their size of course, compared to some of the bigger challenges posed by running a very large business.

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