Burand's Insurance Agency Adviser

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interest in mind. Multiple government entities have new, and some old, options for piercing the corporate veil and your clients’ corporate veils. As their broker, you can help protect them, but protect yourself too. Read more...

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An Important Supreme Court Decision re: Life Insurance

If you happen to sell life insurance to fund buy/sell agreements and such, or if you have life insurance for your own buy/sell agreement, YOU MUST pay attention to the June 2024 Supreme Court decision, Connelly v. United States https://www.supremecourt.gov/opinions/23pdf/23-146_i42j.pdf.

The importance of this case is how life insurance, if not written correctly, may now inflate the value of your business by the amount of life insurance proceeds paid upon death. Many buy/sell life policies' sole purpose is for the proceeds to purchase the deceased partner's equity. For example, the partner's equity share is $1 million so each partner buys a $1 million life policy. One partner dies and the surviving partner uses the $1 million life insurance proceeds to pay the deceased's estate $1 million for the equity value the estate holds.

Now, written incorrectly, the value of the business increased by $1 million. Therefore, the potential taxes increase and the survivor will not have enough money to buy the deceased's shares.

If you have life insurance funding your buy/sell, YOU NEED to review your life policies and buy/sell agreement immediately. If you are selling life policies to fund buy/sell agreements, you had better become familiar with this case so you can design the policies to avoid setting up your clients for failure.

Chris Burand
Certified Business Appraiser (CBA)
Certified E&O Auditor and Instructor
Burand & Associates, LLC
215 S. Victoria Ave., Suite E
Pueblo, CO 81003
719/485-3868
chris@burand-associates.com
Visit us at: burand-associates.com

Critical Benchmarks

If you are interested in running or building a high-quality agency/brokerage that is focused on commercial (though not exclusive to commercial), below are nine critical metrics.

The following metrics are a subset of the detailed metrics I provide exclusively for my clients. My firm has developed the most important metrics for agents and brokers at a depth previously unseen in our industry. Our predictive metrics eschew averages and quartiles, which are absolutely horrible metrics in a performance environment and should likely be avoided at all costs. If you are interested in obtaining a comprehensive set of additional predictive metrics for your organization, contact me to learn more.

1) The most obvious metric is always maintaining a trust ratio of 1.1 or better. As the growth of surplus lines has exploded, agency bill business has increased significantly increasing the importance of this insurance specific financial metric.

Any ratio less than 1.0 (although I suggest using 1.1 so you have a little cushion) indicates that if management is relying on professionals and those professionals are

not advising this is an issue, those professionals are inadequately knowledgeable about the industry. If management is running a sub-1.0 trust ratio on its own, management is incompetent, ignorant, or cheating. A ratio of less than 1.0, in every single state, indicates the agency is likely violating multiple laws and potentially committing fraud.

2) Maintain working capital of at least 30 days. This metric used to be commonly accepted but then the money supply grew infinitely, and debt was so easy that many people, including some serial buyers, stopped paying attention.

As noted, my data and analytics are the best I've seen, and I have completed deep comparisons to more well-known benchmarks. To that point, contrary to what some "experts" are advising, Wall Street definitely recognizes high debt loads by valuing the debt-ridden firm far less, with all else being considered. A firm that lacks adequate working capital is valued even lower.

3) Be sure your account manager/CSR/account executive tenure runs at least four years overall for a firm within the normal growth range. When agencies have high staff turnover, retention is impaired which reduces the ability to grow, even if the agency is otherwise capable of growing quickly. Additionally, high turnover leads to more E&O issues, worse morale, and lower customer satisfaction. In other words, absolutely nothing good comes from high staff turnover.

If you have high staff turnover, management is the problem. Identify what management is doing wrong.

4) Much focus has been placed, particularly by buyout firms, on producer compensation. On an apples-to-apples basis, producer compensation usually decreases to less than 20% once their books are adjusted for all the accounts excluded from their compensation calculations.

The "best" producer compensation ratio varies by agency depending on the line of business, job description (does the producer just produce or do they also service and if they service, how much do they service, etc.), and the resources provided to the producer. In some shops 25% is too high while in others, 35% might be too low.

Most agency owners and executives do not think through what producers should be paid other than to identify what other local shops are paying. A huge opportunity exists with better analysis to hire good producers from other shops without overpaying.

5) House business. One of the only reasons serial buyers are able to survive is because they move so much business to the house. House business has the highest profit margins. A house book constituting at least 20% of all commissions provides a tremendous subsidy with which new talent can be developed.

6) Commercial producers should generate a dead minimum of $300,000 in commissions after five years. Anything less than this is an indication the producer is not a fit for the agency, the producer is not cut out to be a producer, or the agency failed to develop the producer to their full potential. Figure out what went wrong and avoid that mistake going forward.

Adding on to this, all experienced producers should be at $500,000.

7) Carrier books need to be at least $500,000 with even the smaller regional carriers. The agency's main carrier books should exceed $1,000,000. These are the bare minimums. Anything less than this makes the agency unimportant to the carrier, and this increases the agency's vulnerability.

Also, don't place more than 40%, at the very most, of your premiums with any one carrier. Even the best carriers are run by humans who make bad, even ridiculously illogical decisions, and having more than 40% of your book with any one carrier creates material vulnerabilities.

8) Procedures: an anathema to all producers and owners. To paraphrase a famous movie line from the *Treasure of the Sierra Madre*, "We don't need no stinking procedures!" Well-run agencies not only have excellent procedures, but the producers follow those procedures! The end result is a lower cost organization, with lower E&O exposures, and believe it or not, the producers sell more!

Measure compliance. The compliance score should be at least 90% by desk and employee, including producers. WE have a proprietary low-cost test.

9) Growth. In a soft market, growth should be at least 5%. In a hard market, growth should be at least 10%. Anything less indicates the agency is falling behind. Analyze why it is falling behind and lead the changes required to overcome the hurdles you've identified.

If you adhere to these nine metrics, your agency/brokerage will likely prosper beyond your expectations. If you want to excel with more exclusive, predictive, in-depth insights, or if you need assistance working through these nine points, contact me.

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Sanpo Yoshi

Sanpo Yoshi is a 17th century Japanese philosophy which means "three-way satisfaction". The principle is that a business transaction should be good for all three parties: the buyer, the seller, and society.

What if Sanpo Yoshi were the guiding principle for the insurance company, the agent/broker, and the consumer relationship? I'm confident some readers are thinking, "Insurance is already good for all three parties!"

I know insurance is supposed to be a three-way benefit, but the practice of insurance is quite often anything but. Sometimes one party benefits far more than the other two and sometimes two parties benefit far more than the third. How would the balance of "good" in insurance even be measured?

For the carrier, the measure is easiest. A carrier should be able to achieve a 100% combined ratio over the life of the policy, as if that policy created an adequate premium pool. Why a 100% combined ratio? Because that is the industry average combined ratio over the last 30 years. Carriers make plenty of profit (the average is over $50 billion annually) at a 100% combined ratio.

For the agent, the measure is slightly more complicated because they have the actual direct contact with the insured. The most basic measure is the sale needs to be profitable.

Agency management has much to do with whether a sale is profitable but for the moment, let's assume the quality of agency management is a neutral factor. Generally, a 13% commission rate with neutral management is sufficient to be profitable on medium-size and larger accounts. On small commercial and personal lines, 13% is not enough if the agency is doing much more than placing or if a producer is involved. The dollars generated at 13% are just too limited.

Next, consider reputation. The agent must build and maintain a reputation. If the agent is a peddler, they are hoping for nothing to go wrong, rather than focusing on anything but making the sale. And this is an issue because if the goal is to simply make a sale, the consumer is being left from the triad. The E&O legal world absolutely supports this view because the foundational premise preached is the agent should be nothing more than a placer of the insured's orders. The agent is an order taker, not an advisor.

Excluding the large commercial accounts with professional loss control and consultants who evaluate policies on behalf of their clients, somewhere between 95% and 98% of all clients do not know what coverages or amounts to request. But the E&O burden is on the insured to request the coverages they need. It's like going to the doctor and telling them with extreme precision what surgery you need or telling an attorney every single thing they need to include in your contract. It's an unrealistic burden, but courts have placed that burden on the backs of consumers. This enables order taking agents to sell clients policies that benefit the carrier and benefit the agency, but the insured is not getting the coverages they need.

Measuring the benefits to the insured is most difficult if, for no other reason, most insureds do not have a claim very often. If they have inadequate coverage without a claim, is anyone injured? Generally, no. (A significant exception to whether the insured is injured is most applicable to medium to large commercial and high value net worth personal lines

where the total cost of risk is measured and the wrong coverage is shown to have collateral effects on the insured's balance sheet.)

If an insured does not have a claim and will not have a claim, they don't need insurance. We really cannot easily measure whether an insured benefits until there is a claim. And because insureds do not usually have claims and most do not really understand what coverages they need or the coverages they are buying, insureds often focus on the lowest price. Price is the most tangible data point and one they may pay monthly versus having a claim every 7 to 10 years.

It is that difference between payment frequency and claim frequency that creates such a good opportunity for carriers and agents to benefit at the expense of insureds. Some of the policies I am seeing today are quite illusory. While insurance "experts" often advise that insureds win when policy language is ambiguous or misleading, insureds only win after a court determines they win. Even if a court determines coverage exists, the ruling will not be for 3 to 7 years, long after the insured needs the money. Some of the exclusions I am seeing, even in personal auto policies, are to the point of being unethical. The exclusions are so unusual that agents are not looking for them and insureds don't read their policies anyway.

I see agents selling coverages that are clearly inadequate and getting away with it because insureds do not know better. Often the agent does not know better either. And I see consultants teaching sales techniques that never emphasize the need to actually provide quality coverage. The goal is to simply make the sale, whatever "the sale" means.

While the E&O experts do not recommend it, the best three-way solution is to offer insurance consulting. The agency is the broker between the carrier and the insured. A good agent can see both sides and "broker" coverage the insured needs (this is why the term "broker" sometimes carries a higher standard of care because it implies a higher level of knowledge and duty to the insured). And then, if legal, charge a fee for being a broker rather than an order-taking, peddler of insurance policies. Consultative sales are worth far more than 13%. Carriers should pay more too because the benefit to carriers is higher when working with better agents.

My agent/broker clients who have built this model are far more successful in growth and profit margins. They also enjoy going to work more. And this holistic, three-way model is a far better environment for hiring people who want to feel like they're providing value. Everyone benefits monetarily and even emotionally (well, maybe not all the carriers).

What is your personal reason for being on earth? To make a sale and make lots of money without much concern for the other parties or is it to do good?

If your reason is to do good, let me know if you'd like to learn about consultative selling, total cost of risk, and coverages. My programs have helped bring Sanpo Yoshi to the insurance industry.

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Unintentional Consequences

It has now been 20 years since New York Attorney General Elliott Spitzer began investigating the insurance industry, and particularly one broker initially, for artificially inflating the price of insurance through “kickbacks”. He alleged the broker received these kickbacks through contingencies and also that the broker leveraged their threat to move carriers’ business if the carriers did not pay more. (Note: I am not sure these are the correct legal terms. These are my common person interpretation of what was alleged.)

I recall this caused significant turmoil, especially when so many other state attorney generals joined the band wagon smelling blood. Many agents and brokers spent tens of thousands and upwards into the millions of dollars defending themselves, providing documents that ultimately sat unreviewed in storage rooms, and all this defense was in response to rather nebulous charges. The national carriers made severe changes to their contingency contracts, that last today, to comply with their agreements to change practices. The regional carriers made virtually no changes to their contracts. The changes the national carriers made generally worked to their favor by reducing expenses and negotiating leverage under the guise of compliance.

It was a time of considerable grandstanding built on weak legal pretext as evidenced by the results: zero successful prosecutions, a negative ROI to taxpayers, and the subsequent explosion of even more leveraging.

The genesis of the original investigation has not, to the best of my knowledge, been officially revealed to this day. I would enjoy reading whatever it was, and from whom, that catalyzed Mr. Spitzer into such energetic prosecution of an empty situation. A rumor I read at the time, published out of London if I remember correctly, was that a particular carrier’s CEO reported “abuses” of that one broker to the NY AG.

That carrier has since fallen far further while the accused broker has done pretty darn well. The carrier was later investigated for some pretty serious reinsurance shenanigans costing the CEO his job. Maybe the ancient Chinese saying is true, “When you point a finger at someone, look at where the other three fingers are pointing.”

Another far more important result is that the rest of the industry awoke to how pliable insurance carriers were to negotiating extra compensation without having to give anything of real value in return. Money for nothing. These smarter, sharper aggregators and acquisition firms realized they could get carriers to pay much more in overrides, not necessarily contingencies. In other words, leveraging books has grown exponentially since Spitzer said he would shut it down.

A couple of better solutions existed then, and now. The situation is much larger now in scope because so much more premium is affected, premium is so much more

concentrated in 40 or so distributors, and because Spitzer pushed the extra compensation from contingencies which arguably benefit consumers to overrides which have few performance conditions that can be argued to be beneficial to consumers (especially given A.M. Best's recent report showing commission expenses have increased materially over the last ten years). As a result, carriers have more expense and more risk now in fixing their problem.

Yet an open secret is that many carriers are frustrated with the poor, even negative, ROI's they have on these books. The original complaint was meant to save carriers money and all it did was cost carriers more and put more of their premium at risk because the result increased the speed of consolidation (especially with networks/clusters/aggregators). I've studied the results of the carriers who play the game versus the ones who do not. The winners are pretty clear. Having a spine and not playing the game is good for a higher ROI.

Of course, if you are running a financially weak carrier and/or a vanilla carrier with nothing special to offer agents, maybe all you can do is pay more. Paying more is a competitive advantage, though an expensive one. And it is only defensive, a strategy to hold one's place rather than to advance one's place.

A better strategy is to mark this anniversary by redoing compensation plans. Historically regulators and insurance companies preferred a socialistic distributor compensation system whereby everyone received the same commission rate. Regulators like this model because it's easier to regulate. Carriers like this model because it's easier to operate. Also though, the reality is that given the antiquity of some of their IT systems, and thought processes, they cannot do anything more modern and performance based.

Carriers will say that distinctive quality/performance is what contingencies are for but with predictive modeling, and especially with aggregation, the large distributors' loss ratios are the carriers' loss ratios so paying based on loss ratios is a concept with little value today. Pretending otherwise is an expensive charade. It causes underwriters and marketing reps to focus on the wrong goals. More importantly, it causes significant friction with the better distributors for two reasons. First, the messaging is not aligned with reality. I've had carriers tell me they realize this is true but don't know how to change their messaging. Second, like all socialistic systems, it rewards those with size and marginal to poor performance.

Change your compensation systems to measure the return on investment rather than the power of size and the fear such concentration causes. Doing so will likely aid some dilution of that concentration, but more importantly, designed well, these compensation systems will create alignment and simultaneously decrease your expenses. The best distributors, even some of the largest distributors, would like to be paid for their performance because they realize, far better than the carriers, they are subsidizing their lazier competitors with socialist compensation systems.

Twenty years is a long time in most industries. Insurance changes at a snail's pace. But this hard market will forever change carriers' market positions and the winners will address this point constructively (the losers will simply reduce commissions across the board). I built my first merit-based carrier performance plan in 1992 which proved savings could be had simultaneously with paying the most deserving agents more. The time is now to think modern, go to the orthopedic store and buy a spine, and secure your future with merit-based compensation plans.

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Piercing the Corporate Veil

A lot of entities want to pierce the corporate veil and none of them have your best interest in mind. Multiple government entities have new, and some old, options for piercing the corporate veil and your clients' corporate veils. As their broker, you can help protect them, but protect yourself too.

A new tool is the Corporate Transparency Act (CTA). Many exemptions apply here including a "special" exemption for insurance producers!

But that only applies to your insurance business. If you have other LLCs, you may not get an automatic exemption. This might especially apply to rental properties. This law was passed specifically to pierce the corporate veil to identify people committing money laundering, tax fraud, and other illicit activities. You must register if you meet their criteria (go to the Beneficial Owner Information reporting system at www.fincen.gov/boi to learn more).

Under the Trump administration, ERISA liability was significantly increased because of the expansion of who the fiduciary is and their responsibility relative to health insurance plans. These cases are also being heard in civil court and involve whether the fees charged are reasonable. This is in addition to the regular ERISA regulations. Keep in mind, the corporate shield does not exist with ERISA – you are personally liable.

Civil litigation has found ways to pierce the corporate veil too. The following applies to you at the agency but also to your clients. Insurance agents are particularly well placed to help their clients run their businesses and engineer their insurance to offer better corporate shield protection. The over-arching key is to align and operate the business completely separately from your personal life and this includes not intermingling different companies you own.

- Intermingling funds. Do not do it. For agencies this means:
    - Keep a separate trust account. This is always smart for many reasons, but it also helps show that you deserve the corporate protection.
    - Do not intermingle your personal expenses. If you intermingle your personal expenses, then why should the plaintiff not be able to claim the company's

assets should not be attachable? If you claim the business is the business, then how can that be if you spend corporate money for personal uses?

- Intermingling assets.
    - Company vehicles. All kinds of games are played with autos. First, title the auto correctly and then align the insurance appropriately. If you are insuring a client and fail to do this, your client's only insurance might be your E&O policy. Simply from an E&O perspective, the title should always align with how the insurance is written. If the auto is owned by ABC, Inc., then the insurance policy should be for ABC, Inc. An insurable interest must exist for coverage to exist and if the vehicle is titled under John Doe, then ABC, Inc. does not have an insurable interest.

    - This is a key point with corporate shields. John Doe is a separate entity from ABC, Inc. even if John owns 100% of ABC, Inc. Corporate law holds that the business is a separate legal entity. Therefore, assets must be titled appropriately for insurance coverage to apply and arguably, for the corporate shield to apply.

    - Relative to buildings, protect yourself and your clients by encouraging legitimate leases are written if they own their own buildings.

    - If you own a building, or your client owns a building(s) with different LLCs, these are all different legal entities. The insurance must be written correctly respecting these are different legal entities.

      Failure to do this risks lack of coverage and also adds ammunition to a plaintiff looking to pierce the corporate veil. When the different legal entities are not respected as separate, then the logic of the corporate veil fails.

      This protection does not exist just because you have different LLCs. You must show that these entities are separately run and each is respected as a separate legal entity.

- Shareholder Loans.
    - I see many agencies with shareholder loans and those loans have no terms, no collateral, and nothing even in writing. This scenario can easily be construed as not respecting the separation of the corporate entity from the individual. Don't make these suits so easy for the plaintiff!

- Corporate Documents.
    - The IRS will look to see if you are holding regular corporate meetings and so forth. Failure to do so may be a big problem. Plaintiff attorneys will do the same. Hold your meetings, take your votes, and document your meetings!

- Affiliated Entities and Enterprise Liability.
    - When someone or multiple people own multiple entities, it makes sense to create barriers preventing plaintiffs from bringing those other entities into the

suit. This is a different version of piercing the corporate veil.

- A common weak point is where one entity does the payroll for all the entities. Or maybe one benefit package is applicable to all the entities.

One of the most common insurance clients who have this problem are contractors, especially those contractors who say, “So what? Sue me. I’ll declare bankruptcy!” You and they should review the Seven Springs Mountain Resort vs. Hess case: https://casetext.com/case/seven-springs-mountain-resort-inc-v-hess

Insurance agents are perfectly placed to review their clients’ titles and the way they run their businesses to write their insurance correctly while also helping them strengthen their corporate shield. This point requires the agent to be a true advisor instead of a peddler. One is far more important and valuable than the other. Which are you?

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Chris Burand is president and owner of Burand & Associates, LLC, a management consulting firm that has been specializing in the property/casualty insurance industry since 1992. Burand is recognized as a leading consultant for agency valuations and helping agents increase profits and reduce the cost of sales. His services include: agency valuations/due diligence, producer compensation plans, expert witness services, E&O carrier approved E&O procedure reviews, and agency operation enhancement reviews. He also provides the acclaimed Contingency Contract Analysis® Service and has the largest database and knowledge of contingency contracts in the insurance industry.

Burand has more than 35 years' experience in the insurance industry. He is a featured speaker across the continent at more than 300 conventions and educational programs. He has written for numerous industry publications including Insurance Journal, American Agent & Broker, and National Underwriter. He also publishes Burand's Insurance Agency Adviser for independent insurance agents.

Burand is a member of the Institute of Business Appraisers and NACVA, a department head for the Independent Insurance Agents and Brokers of America's Virtual University, an instructor for Insurance Journal's Academy of Insurance, and a volunteer counselor for the Small Business Administration's SCORE program. Chris Burand is also a Certified Business Appraiser and certified E&O Auditor.

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Burand & Associates, LLC is an advocate of agencies which constructively manage and improve their contingency contracts by learning how to negotiate and use their contingency contracts more effectively. We maintain that agents can achieve considerably better results without ever taking actions that are detrimental or disadvantageous to the insureds. We have never and would not ever recommend an agent or agency implement a policy or otherwise advocate increasing its contingency income ahead of the insureds' interests.

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