Burand's Insurance Agency Adviser

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It was recently suggested that I begin writing stories of my colorful consulting adventures. That would be self-indulgent, though possibly entertaining to readers. But I like to make my articles beneficial to

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My research suggests insurance companies are in far more trouble than is being made public. Just think about these

readers so they may be better positioned to build their businesses stronger.
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recent actions taken by insurance companies:
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Wait! There's more...

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Wondering where to go for great, in-depth discussions on a wide variety of insurance topics?

We have you covered with the Insurance Banter podcast! Recent podcast topics include:

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Listen to these topics and many, many more at: burand-associates.com/insurance-banter or wherever you listen to podcasts.

Don't Forget!

Beneficial Owner Information (BOI) Reporting
A reminder for you and your clients: Beginning this year, the U.S. Department of Treasury began imposing a new requirement upon certain companies to report information about their beneficial owners. "Non-exempt" companies in existence as of January 1, 2024 must file their BOI Reports with FinCEN **by January 1, 2025**. Those formed after January 1, 2024 need to file BOI Reports within 30 days of formation.

Learn more at https://www.fincen.gov/boi. Companies that may be subject to the reporting obligations should contact legal counsel for assistance in complying with the rule.

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An Introduction to BRIC, by Chris Boggs

Writing an article about yourself "ain't" easy -- unless you are a total narcissist. I have a hard time even penning my bio for publication and introduction when I speak at conventions and other education events. And worse than writing the bio is hearing it read to the group.

I wasn't reared that way. I was always taught it was rude for you to highlight - you.

To be fair, Burand did not ask me to write about me -- not directly. Chris asked that I write about Boggs Risk & Insurance Consulting (BRIC). So, I guess I can separate myself from this request and write about the services offered by BRIC.

BRIC, founded by Chris Boggs (that's me), is best described as an insurance and risk consulting service built on an education and training model. I work with agents on a myriad of coverage and errors and omissions (E&O) related issues. BRIC services offered to agents include:

- Technical P&C insurance advisory services
- Technical P&C claims services
- Coverage comparisons
- In-house education services
- Errors and omissions (E&O) consulting services
- New business and niche consulting services

BRIC's goal is to be your agency's resource for all technical property and casualty coverage issues. My weird thrill is to work with agents to help expand coverage knowledge, fight against improper claim denials, avoid bad decisions that can lead to an E&O claim (or mitigating the claim after the actions has already occurred), and work with agents to expand their markets.

I can’t make this article all about me or BRIC; before I go I feel I have to provide some level of technical information else I wouldn’t feel right. However, I have a limited amount of space so this will be a quick hit. Remember, this is a high-level article that does not dig into all the details – but you may find it useful.

Polling Letters – Indispensable E&O Tools

“Polling Letters” are indispensable errors and omissions (E&O) tools of utmost importance. As the name suggests, these letters “poll” the insured’s key employees to inquire whether or not those polled are aware of any incidences that qualify as or may lead to a “claim” when coverage is written on a “claims made” basis.

Coverage written on a “claims made” basis responds to defend and/or pay/indemnify only those “claims” made or filed during the policy period or any applicable extended reporting period (ERP). Any “claim” or “potential claim” suspected or known to have been made or received during the policy period but **not** reported to the carrier during the policy period or applicable ERP may be subject to severe coverage or limits restrictions up to and including the total denial of coverage.

When liability coverage is provided by a “claims made” form, polling letters are necessary (not just recommended) when any one of four events occur:

1. When the “basic” or “automatic” extended reporting period is triggered;
2. When there is a reduction in coverage (limits or terms);
3. When the retroactive date is advanced; or
4. When coverage is transitioned to an Occurrence form.

Triggering the Polling Letter

Regardless which event triggers the need for a polling letter, the insured and key employees must be polled to inquire whether there are “claims” or “potential claims” that require reporting to the insurance carrier. If a “claim” or “potential claim” that should be filed is **not** filed during the policy period or ERP, the insured will face severe penalties introduced previously -- which will likely lead to an E&O suit against the agent.

Anytime the need for a polling letter is triggered, the letters should be completed as quickly as possible **before or following** the end of the relevant policy period (preferably in less than 20 days following the end of the policy period).

Key Definition -- “Claim”

“Claim” is a key term in “claims made policies.” When constructing a polling letter, the definition of a “claim” as provided in the policy must be included within the polling letter. Why? Because there is no singular definition of a “claim.” Those completing the polling letter must understand the actions or events about which they are being polled.

Who Must Complete the Polling Letter?

The larger the company, the more personnel required. Neither the CEO, CFO nor COO know every possible situation that may give rise to a claim. Each person has a different

area of responsibility, expertise and knowledge of events. Every person in a leadership that may or should have knowledge of a “claim” or “potential claim” must be polled.

When the Organization is a…	The polling letter should be completed by…
Corporation	All officers and directors at minimum
LLC	All members and managers at minimum
Partnership (LLP, GP or Other)	All partners at minimum
Sole Proprietorship	The sole proprietor and any key managers at minimum

Go over all responses with the insured and keep copies in your files (scan into system). If a “claim” or “potential claim” that was not reported in the polling letters appears later, this documentation is of utmost importance.

Sample Language

Named Insured(s): XYZ, Inc
Address: 987 Main St.
Any Town, USA
Insurance Carrier: Name of the insurance carrier
Coverage Provided: [D&O, EPLI, E&O, Etc.]
Policy Number: ABC-EASY-AS-123
Effective Dates: January 1, 20XX to January 1, 20XX

[Named Insured’s] [Type of Policy] is written on a “claims made” basis. A “claims made” policy responds to defend and/or pay or indemnify only those claims made or filed against the company and other insureds during the policy period. Any “claim” or “potential claim” known to have been made or received during the policy period but not reported during the policy period or applicable extended reporting may result in severe coverage restrictions or the denial of coverage.

[Named Insured’s] [Type of Policy] defines a “claim” as, [Insert the definition of a “claim” from the coverage form].

A “potential claim” is defined as [Insert the definition from the form].

Are you aware of or have you received notification of any “claim” or “potential claim” as defined in [Named Insured’s] [Type of Policy] for a “wrongful act” defined in the policy as: [Insert definition of “wrongful act” from the policy]

Yes ___ No ___

If “Yes,” the carrier must be notified. Please describe:

____

____

____

The undersigned attests that the above information is true to the best of their knowledge. The undersigned also attests that completion of this document does not replace nor negate the insured's requirements to comply with all responsibilities and duties contained within the insurance policy referenced in this document.

Signed: ____

Print Name: ____

Position: ____

Date: ____

Conclusion

BRIC looks forward to working with you and your agency as we work together to take care of your clients. Remember, the above article is only a surface description of polling letters; this and other E&O preventative measures are not complicated but can be very detailed.

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Carrier Terminology

I received a request to write an article relative to critical insurance carrier financial ratios. The suggestion was to give explanations and definitions of various terms. My first reaction to this request was, I should have done that long ago!

My second reaction was the impossibility of fulfilling the request. I have spent probably a solid 1,000 hours studying insurance company financial definitions. It really should have taken less than 40 hours. Maybe I'm slow but this industry's measures are so screwed up that it's literally impossible to list the definitions because the definitions change with almost every report. There is so little consistency from one report to another that definitions are a joke.

We need a National Standards Board for this industry. For example, the U.S. National Standards Board defines various units such as a mile, a kilogram, and so forth with extreme precision. This is in comparison to the reality that, and I'm slightly paraphrasing,

“In this report, claims mean this, but in that report, claims means something else and also, carriers are allowed to count claims as they choose.”

An excellent example I’ve often used is the definition of loss ratio. Because of poor internal controls, most carriers’ reporting systems have different definitions of loss ratios based on what some programmer modeled 20 years ago. Few companies ever go back to create a consistent definition of loss ratio.

The NAIC has a common definition of loss ratio, the only one I know. It is the “Pure” loss ratio. Every carrier must submit its pure loss ratio to the NAIC quarterly and annually. As an interesting side story, I was advising a client that a specific carrier’s pure loss ratio was X%. I was literally reading the number from the NAIC report. I was not making any of my own calculations. The top brass of the carrier became rather upset and absolutely, categorically denied that was their loss ratio and furthermore, they never measured their “pure” loss ratio and did not know what it was! This was a publicly traded national carrier. So I gave them their NAIC report.

What follows then should be read and considered with the understanding these are generic definitions and explanations. The details matter a lot and no one should ever read a financial report or a carrier’s production report or even a contingency statement, without knowing the exact definition of each term as that term is used in that document. Premium, for example, is not premium from one report to another.

Direct Written Premium is the premium charged to the consumer. This is the premium upon which agents’ commissions are generally based (with some major exceptions). While not exactly correct, written premium is like cash accounting. It’s recorded as received.

Net Written Premium is the direct written premium plus or minus reinsurance. For example, if the direct written premium is $100 but the carrier buys $1 of reinsurance, net written premium is $99.

Earned Premium is after reinsurance and is accrual in nature. For example, if the annual premium is $1,200, then the earned premium per month is $100 (obviously major exceptions exist such as those policies where the premium is fully earned, i.e., not refundable after 60 days).

A major national carrier got caught by the SEC several years ago for treating all their premiums for a certain product as earned immediately. In other words, their written premium matched their earned premium. They paid some fines and got off with a slap on the wrist.

Loss Ratios are a function of losses divided by earned premiums, but the definition of losses is complex. What constitutes a loss and when should the loss be recorded? Those are tricky questions because losses often take years to fully develop. When someone steals a ring, the loss is simple to calculate. Let’s say it’s $1,000, paid tomorrow, and there

is almost no uncertainty left. But let's say someone is horribly injured. No one knows how much it will cost to settle that claim at the moment the claim is delivered.

This is why we have calendar year and accident year loss ratios. It is also why carriers set reserves. Does the loss ratio include reserves? A good question to ask. Then one gets into the various types of reserves. That discussion requires more pages than I have room.

Combined Ratios are supposedly the key profit ratio for insurance companies. Executives frequently talk about how bad their combined ratios are and how they can never make money because their combined ratio is above 100%. Combined ratios are the losses plus expenses (including commissions and reinsurance) divided by earned premiums. If this industry had to have combined ratios below 100%, the industry would have gone broke sometime around 1940 because the industry average combined ratio is about 100% over the last twenty years (it was worse prior to that).

The combined ratio is a red herring in many ways. The most important profitability measure is the Operating Ratio. The key difference between the Combined Ratio and the Operating Ratio is that the Operating Ratio includes investment income. As Warren Buffett said years ago, insurance companies are nothing more than glorified mutual funds. He said this because insurance companies rarely make an underwriting profit and this is by design or incompetence (take your pick).

Every investor makes investment money the same way with the same two variables. The first variable is yield. When I ask carrier CFOs what two variables determine how much money they make, they typically correctly identify "yield". But they almost never get the second part correct. The second part is the amount of money invested. This is the first hour of Finance 201 in college so all CFOs should know the answer. For insurance companies, what matters most is how much money they've invested relative to their net written premiums because that is how the operating ratio is calculated. The more investment income relative to premiums, the more profitable and also, the more flexibility carriers have in setting prices.

Surplus is defined as assets less liabilities. Surplus is highly correlated to the amount of money invested relative to premiums. But surplus can include or exclude certain investments from a regulatory perspective, so the numbers are not the same. The more surplus a company has, all else being equal, the more stable the carrier will be in the event of large losses such as catastrophes. Therefore, if you live along the coast and the carrier has $3 million in surplus, I would not count on having my claim paid if a hurricane or even a tornado hits. You're probably just throwing premiums down the tubes other than satisfying your mortgage company.

Surplus is affected by many factors including the amount of reinsurance purchased and also the quality of surplus, including the liquidity of such surplus. These calculations get rather complex and to say subjectivity of the analyst is not a factor is to fool oneself. For simplicity purposes, I highly recommend reviewing A.M. Best's BCAR (Best Capital Adequacy Ratio) score. Other capital adequacy ratios exist but Best's is likely the most

accessible for most readers. The scores themselves are plotted on a statistical confidence model which unfortunately is similar to reading Chinese for most people but I don't have an alternative solution. For my clients, I've created additional context that helps them understand these scores in English, but I don't know of any other options besides getting a statistical degree.

I appreciate the request for more information on the terminology, and I sincerely hope that it helps readers better understand insurance company financial metrics. Always though keep in mind how the actual measure of these numbers varies materially from one report to another and from one carrier to another. And last, always check the carriers' numbers they present to you against their actual results. Sometimes the variances are significant.

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Getting Legal Advice

It was recently suggested that I begin writing stories of my colorful consulting adventures. That would be self-indulgent, though possibly entertaining to readers. I like to make my articles beneficial to readers so they may be better positioned to build their businesses stronger. With this in mind, I'll share a few stories about largely incompetent attorneys with the hope that readers will see the need to hire the highest quality legal advisors they can find.

The first time I experienced a serious level of legal incompetency (or maybe it was an innocent mistake, I'm trying to give the attorney the benefit of the doubt), it involved a buy/sell agreement where the purchase price was set at two times premiums. This is not a typo on my part and it was not a typo on the part of the attorney. The attorney did not know or take the time to learn the difference between premiums and commissions. That point became an expensive endeavor to correct. I've since seen several attorneys make the same error.

It has also become apparent to me that many attorneys cannot do math. This may be why they are attorneys. They put mathematical formulas into contracts that make no sense. Furthermore, attorneys have a penchant for prepositions, often extremely useless prepositions that only muddy the contract. What they don't seem to understand when writing formulas is that the word “of” is not a preposition in a mathematical formula. Instead, it is an “order" meaning to multiply. This makes a difference!

For example, in one buy-sell agreement, the attorney did not seem to understand math resulting in the shares totaling around 140% of the actual existing shares. In other words, the shareholders all thought they had way more value than they actually did.

Similarly, many attorneys know next to nothing about finance or valuations. As a result, they write entirely wrong formulas. For insurance agencies, they often omit the need to consider the balance sheet in the value of the agency. This is a serious sin. Not considering the balance sheet is prohibited by the IRS and in every valuation case I've

ever read along with every finance and valuation class I've ever taken. For example, in one contract, the buy/sell formula was 1.5 times commissions. But the agency was out of trust by $1 million. The buyer was forced to pay 1.5 times commission and then find another $1 million to fix the trust money deficit. At the very least the buy/sell formula should have read, "1.5x commissions plus or minus the balance sheet value."

If your generic attorney thinks they know how to write a buy/sell agreement for you without learning or understanding the insurance industry, you should find a better attorney. At the least, get them to agree to work with an industry expert. For example, I had an attorney argue with me that contingencies and commissions were the same thing. The agent probably should have fired that attorney.

Another important point is contracts are supposed to have definitions. Why an attorney would write a contract that does not define the key terms is beyond me. Key terms in a buy/sell agreement that should likely be defined include words like revenues, commissions, assets, liabilities, default, and failure to perform. Contingencies should also likely be considered in the formula and defined. Timelines should be defined, such as "100 monthly payments are due beginning August 1" rather than "You have 100 payments to make" (that is a quote from a buy/sell contract!).

A few years ago, I was an expert consultant in a case regarding an agency's value. It involved a purchase agreement and the contract switched back and forth between the terms "Fair Market Value" and "Fair Value". Legally and in the valuation world, these terms have two different meanings. When asked what the correct value of the agency was, I asked, "Under which definition?" All the attorneys looked at me as if I was an idiot. I had to explain, and then I had to find the legal cases and statutes explaining the difference. After the lawsuit is already filed is a bad time to learn the contract is missing basic and important definitions.

Beware of attorneys who use boilerplate contracts, especially if they charge you for the hours required as if they had written the contracts from scratch. I once reviewed a buy/sell agreement, supposedly written for an agency that was for an office building!

Quite often the tipoff that an attorney is using an inappropriate boilerplate agreement is that within the contract, different sections will contradict one another. For example, one section will refer to two shareholders and another section will be written as if only one shareholder exists. Another tipoff is the fonts will change. Or the definitions or terms will not be consistent. If you're buying a generic contract, call 1-800-generic attorney but don't get sucked into thinking that your local attorney is providing personal advice of any quality. If they were competent and providing good advice, they would write the contract so the contract is at least consistent! And then there is their common response, "Sorry about that. I'll fix it, but I don't think it's that important."

Generic boilerplate contracts cannot be used correctly for insurance agencies. At the very least, use a boilerplate contract that is written for generic insurance agencies. Then ask yourself if your agency is generic.

I also see many buy/sell agreements lacking a divorce clause. Maybe contract attorneys do not intermingle with divorce attorneys? Whatever the reason, divorce clauses are critical in buy/sell agreements.

Some attorneys' perspectives on employment contracts totally befuddles me. I cannot figure out, for the life of me, why anyone with a license to practice law would ignore the law in writing a contract. An attorney that does not understand the law or in some cases does not feel the need to write a contract that complies with the law is to be avoided. For example, one attorney advised that hourly employees could work 12 hours a day and then take Friday off without paying any overtime. This makes me wonder at what point they took the "law" out of lawyer.

Another attorney is still advising agency owners to pay themselves next to nothing to avoid paying employment taxes. I think the landmark case prohibiting this was sometime around the year 2000. Maybe because they finished law school in 1999, that ruling wasn't covered, and then maybe their CLE classes just didn't provide updates.

I recently had an attorney tell their client they should ask me to give them a contract because the attorney apparently did not write contracts, although the attorney was advertised as a business attorney. I still haven't figured that one out, but at least he or she did not write a bad contract!

I know some amazing attorneys who protect my clients with high quality knowledge and the work ethic to research each situation. They do cost more. I hate paying attorneys too, but the $150 difference between paying $250 an hour for an incompetent attorney and $400 an hour for a competent one, is most often worth it because you might as well be flushing the $250 down the drain.

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Consultants and Insurance Companies

In the fantastic book, *The Secrets of Consulting* by Gerald Weinberg, the author humorously describes common mistakes consultants make (and mistakes to which their clients should pay attention). One of his classic stories involves consultants and grocery stores. He calls it Rudy's Rutabaga Rule. Seriously, you need to read any book that has a Rutabaga Rule!

The story goes like this: A grocery chain asks a consultant to help them improve profitability. The consultant identifies sales per square foot, a common metric in grocery and retail stores. The vegetable that has the least sales per square foot is the lowly rutabaga. The consultant advises the grocery chain to eliminate rutabagas and sell oranges in that same space. Awesome! The consultant increased sales by a tiny percentage. Now what? How many vegetables does a grocery chain eliminate before making itself useless? At what point does it become the orange store?

Insurance companies must be following the guidance of the same silly consultant. The data is strong they long ago began making themselves immaterial. Using 2019 as the most recent year for fully developed claims frequency, the industry incurred 101 million claims (43 million excluding auto physical damage). In 2009, the industry incurred 90 million claims (45 million excluding auto physical damage) (per A.M. Best's *Aggregates and Averages*, 2023 edition). Auto physical damage coverages haven't changed that much, but the other coverages have many more limitations.

How can it be that the economy grew by approximately 48% during this time while the number of non-auto physical damage claims decreased? I've been cautioned that the industry claim counts should not be trusted at face value (which seems to be a major issue that requires significant and immediate attention). But I'm taking this data at face value because it's all the data I have, and I get it from a trusted source.

The answer may be that when deductibles are raised sky high, people turn in fewer claims. The answer may be that carriers are simply refusing to insure a larger percentage of the economy. More exclusions have definitely been added. Without question, more people are willing to self-insure, are being forced to self-insure, or have turned to alternative risk transfer.

In fact, the last estimate I saw was that more than 50% of all commercial premiums are in the alternative market. If carriers are excluding so much and increasing premiums (premium increases have generally exceeded GDP growth over the last 15 years), this may explain why they are not more profitable than they already have been. If premiums increase as if exclusions had not been added, profitability should increase (and it has with the last ten years being some of the most profitable years for carriers in history). But if the best accounts are moving to alternative markets, then the reduced coverage may not be an adequate offset for the adverse selection and with the traditional market writing less than 50% of commercial premiums, a good case can be made the traditional market is a market of adverse selection.

Additionally, study after study shows carriers are not insuring businesses or homes to full value, another example of not being fully relevant. Multiple studies, including Hub International (October 2023), Hiscox (2023), and several others, certainly do not suggest consumers are over insured.

Moreover, the Aon studies (2022) show the majority of our economy's assets are intangible assets, and there is virtually 0% insurance coverage. When you put all this together, the industry is probably only insuring around 20% of the country's business assets. That is a poor number and indicative of nearing obsolescence.

Carriers are not insuring property on a blanket basis because of the wildfire danger or the wind danger or the roofs or you name it. No one needs insurance companies that only insure part of a property, and often exclude the most important part of the property for the

most important hazard. Insurance companies are trying to avoid all risk by only insuring the safest properties.

The problem is they all hired the same consultant so they'll compete on price to write the safest properties to the point of making that market unprofitable too. How can I predict this with so much confidence? Because this is what insurance companies always do, without any exceptions in my 35 years' experience analyzing insurance companies and the market. For some reason or possibly recency bias, their models do not adjust correctly relative to supply and demand. They project a profitability trajectory without consideration of intense competition for the "best" (as they define them) accounts.

Additionally, AI underwriting models are now determining what is not a good vegetable to be selling and those models are eliminating about everything but apples and oranges, maybe a kiwi here and there. One of the great opportunities carriers have for reducing expenses is eliminating underwriters, underwriting managers, and senior executives if a carrier is going to simply accept AI decisions. Although, I am positive that many senior executives think, and they're likely correct, that their positions are safe even if their results stink, provided they can say they depended on The Model and no one holds them accountable for conscientiously thinking through the implications, including unintentional implications, of whatever the AI model is promoting.

The executives' thought processes are identical to why people use to say, "I won't get fired buying IBM computers." They bought IBM computers even if those units were not the best for the situation and almost certainly, back in the day, not the cheapest. Many insurance companies are run by people paid to avoid mistakes even if it means failure for not identifying low risk opportunities.

No one needs an insurance company that does not provide the most important coverages. A significant consolidation of carriers is on the horizon. This could be bloody because so many carriers are useless. They don't even insure well what they're still willing to insure. And the skeletons in some carriers' closets likely can fill a mansion.

As a test, look at a carrier's results after they reduce coverages and increase rates. They should quickly become more profitable. Reduce exposures 10% and increase rates 10%, and profits should obviously follow. If profitability does not increase, fire the executives and actuaries because they're obviously incompetent. They failed to reduce the most important exposures or increase rates enough or realize the obvious. The more expensive and restrictive a carrier becomes, the more they attract adverse selection and the quicker they succumb to Rudy's Rutabaga Rule.

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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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