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Chairman's Corner

by Richard C. Lambert, CPCU, ARM, AIM, ARP

Richard C. Lambert, CPCU, ARM, AIM, ARP, has been chairman of the Agent & Broker Section Committee since 2001. Lambert began his national CPCU Society involvement in 1985. Previously, he has been a regional vice president, director, chairman of the Chapter Affairs Committee, chairman of the Leadership Development Committee, chairman of the Annual Meetings and Seminars Task Force, and has served on several other committees or task forces. In addition to his CPCU, Lambert also holds the ARM, AIM, and ARP designations.

Welcome to our second Agent & Broker Section newsletter of 2004!

Our committee continues to try to bring you quality newsletters, filled with information that you can use in your everyday activities. Some of the articles in this issue are reprints from the Big I and the *Insurance Mergers and Acquisitions* newsletter. When we see appropriate articles in other publications, we gain their permission to use them in our newsletter. This allows us to bring more diversity to you. As I have brought up in the past, we are always looking for good articles. If any of you has access to authors, would like to author an article yourself, or has ideas we can pursue, please let any committee member know and we will be sure to follow up.

We encourage you to attend the Annual Meeting and Seminars held in Los Angeles, CA, October 23-26, 2004. You can register online and get more information at www.cpcusociety.org. The Agent & Broker Section is working with the Information Technology Section on a seminar entitled Agency-Company Automation and Technology Compatibility. In addition to this seminar, 24 additional property and casualty insurance track seminars and 25 leadership and career development track seminars are planned for attendees. Eighteen hours of continuing education credits will be available from the property and casualty insurance track seminars. This is a tremendous opportunity to fulfill all of your continuing education requirements, while networking with many CPCUs from around the country.

The Agent & Broker Section met on April 24, 2004, in Tampa, Florida during the Leadership Summit to plan our activities through the Annual Meeting and Seminars in 2005. We discussed seminar topics that should be timely for that meeting. Our hope is to contribute to two seminars for that meeting. We also reviewed our New Designee contact program and the needs of our web pages in the CPCU Society web site. If you have any thoughts on what our section could do to improve its communications to you, please contact us through the CPCU Society. It is our intent to continue to bring you the best product we can.

Thank you for your support. I hope each of you has a great summer. ■

What's in this Issue?

Lost Policies . . . No Coverage?

Editor's note: This article originally appeared on the Independent Insurance Agents & Brokers of America (IIABA) web site and is reprinted here with permission.

Important: The views expressed in articles written by the IIABA faculty members and others do not necessarily reflect the views of IIABA.

Abstract

The insured is sued for damages arising out of an occurrence that took place many years ago. The insured is unable to find the policy in force at that time, so the insurer says they won't respond. What do you do when a policy is lost?

Question: "We have an insured with a claim arising out of occurrences that took place in the late '60s and early '70s. We have received a copy of a letter that the carrier sent to the insured that reads in part:

> If you have copies of the alleged policies, please forward them to us immediately. While we will continue to cooperate with you in an effort to locate documentation of the alleged policies, please be advised that it is the burden of the party seeking benefit of an insurance policy to prove both its existence and provisions. Until the existence and provisions of the alleged policies are proven through satisfactory written evidence, we cannot undertake any action whatsoever on behalf of (insured named) in regard to this matter under the alleged policies.

"Isn't this why insurance companies micro-fiche their files? Is the insured ultimately responsible for providing these copies? Your prompt attention would be appreciated as we have to reply now to the insurance company."

Answer: As a general rule, yes, it is the responsibility of the insured to demonstrate that a policy or policies existed. If it's reasonably certain, even from circumstantial evidence, that the insurer was the insurer at that time, we'd like to think that the insurer has some obligations to assist in the search . . . if not legally, at least ethically.

Also, the agency, from both E&O and customer service perspectives, should keep an archived copy of policies indefinitely. It is probably not necessary to keep a copy of every policy of every insured, as long as you keep a sample copy of each form edition. For example, if you have dozens of insureds covered under a company's proprietary policy, you could retain one copy of that policy as long as the Dec. page or customer file accurately identifies that policy edition.

Here are some quick responses from our faculty, then we'll explore this situation in more detail.

Faculty Response

I recall several years ago that an agency insured a pharmacy which was sued, based on an occurrence 15 years earlier. The current agency was not the agency at the time of the occurrence . . . that agency had been purchased by the current agency.

In the agency's current customer file, they did have a document that mentioned who the carrier was at that time, but no daily report or any other information. When the insurer was contacted, they said, "We don't keep records that far back." (Yeah, sure.) Basically, the company was unresponsive and took the position, "Prove it."

Luckily for the insured, the agency finally found evidence of the policy (but not, of course, the policy itself) in some dead files that were in storage. It was a huge and timely undertaking, but they came through for the client and the company (grudgingly, I presume) tendered a defense and settled the claim within limits.

Faculty Response

We have actually done some historic reconstruction of insurance programs. We have dug and dug through dusty basements to pull insurers who shall remain unnamed into old Superfund claims. This is not fun work but can be done. You can bet the old policies will not turn up unless someone besides the insurer produces some evidence of coverage.

Faculty Response

And what are the procedures for an agent to maintain liability files? I once traced billing records for some liability policies back to 1939. As soon as the insurance company received copies of the payments, the policies magically appeared in their files. My, my, my.

Faculty Response

I have traced several policies back for years, and one almost 50 years. Invariably, the insurance company "finds" their files when you submit evidence.

Faculty Response

Insurance Archeology Group and R.M. Fields, International provide these kinds of services. They are consultants who rebuild historic insurance coverage. I can tell you that APH claims are still coming in from the '50s and '60s. The burden does lie with the insured.

As indicated above, the insured usually has the burden of proof in establishing that a policy existed and the basic terms, while the carrier has the burden of demonstrating exclusionary provisions. The insured does not necessarily have to produce the actual policy. In general, if a diligent search does not produce the policy, but does produce secondary evidence, a majority of courts appear to take the position that coverage may be established by a preponderance of evidence.

For example, the insured can use testimony of employees, correspondence and notes, accounting records, daily reports, certificates of insurance, internal carrier documents, etc. More information on this approach can be found in the article, "The Paper Chase: Locating and Leveraging Value of Past Corporate Insurance Policies."

Dart Industries, Inc. v Commercial Union Insurance Company *has nothing to do with asbestos, but will likely end up making the most noise in that arena.*

From the standpoint of litigation on this issue, this article discusses several cases. More recently, attorney Randy Maniloff, who is a frequent contributor to the VU, published his *Top 10 Insurance Court Cases of 2002*. Included was the following case of *Dart Industries, Inc. v Commercial Union Ins. Co.*

Dart Industries, Inc. v Commercial Union Insurance Company, 28 Cal. 4th 1059, 52 P. 3d 79 (2002)

Dart Industries, Inc. v Commercial Union Insurance Company has nothing to do with asbestos, but will likely end up making the most noise in that arena. In *Dart*, the Supreme Court of California examined what an insured must prove in order to establish its rights under a lost or destroyed insurance policy. The dispute involved CGL policies that were allegedly issued to Rexall Drug Company, a predecessor to Dart Industries. Dart was one of several pharmaceutical companies that manufactured and marketed DES, a synthetic estrogen used to prevent miscarriages.

Dart was named as a defendant in actions brought by adult women whose mothers had ingested DES while the claimants were in utero, and who, when they reached child bearing age themselves, developed precancerous and cancerous lesions as well as deformities of their reproductive organs, resulting in infertility or miscarriages.

Following settlements with certain of its insurers and a lengthy procedural history, the issue that made its way to the Supreme Court of California was whether Dart was entitled to defense and indemnity under a lost policy issued by Commercial Union from September 1, 1946 to September 1, 1951.

The *Dart* court held that a claimant seeking coverage under an insurance policy that has been lost or destroyed without fraudulent intent on the insured's part has the burden of proving: (1) the fact that it was insured under the lost policy during the period in issue, and (2) the substance of each policy provision essential to the claim for relief. The insurer has the burden of proving the substance of any policy provision essential to the defense.

The *Dart* court held that there was sufficient evidence to support the trial court's finding that the policy in question covered injuries arising from DES ingestion during the policy period, and that, therefore, Commercial Union had a duty to defend and indemnify Dart. In reaching this decision, the Supreme Court of California reversed the decision of the California Court of Appeal, which had held that Dart must prove the material provisions of the policy by introducing evidence of the specific language used in those provisions. Instead, the Supreme Court adopted the following requirement for insureds that are seeking coverage under a lost insurance policy:

> When, as here, it is undisputed that there was an insurance policy covering the relevant time period and that the policy was lost in good faith and not recovered after diligent search, there is no reason either in the law of contract or of evidence why secondary evidence that attests to the substance but not the precise language of an

Continued on page 4

Lost Policies . . . No Coverage?

Continued from page 3

> insurance policy should be insufficient as a matter of law to establish the insurer's contractual obligations.

While an important issue in many lost policy cases is the court's determination of the proper burden of proof—"preponderance of the evidence" or "clear and convincing evidence"—such issue was not before the Supreme Court in *Dart*. The Supreme Court was constrained to apply a preponderance of the evidence standard, on the basis that it was the law of the case.

There is no question that when it comes to securing coverage under a lost insurance policy, the Supreme Court of California adopted a less stringent standard than did the Court of Appeal. While *Dart* has been hailed as a significant victory for policyholders (the case was the subject of a front-page story in *Business Insurance)*, the court noted that it was precluded from examining the appropriate burden of proof and substituting its own determination of the credibility of *Dart*'s key witness for that of the trial court.

Dart's real significance will likely come into play in the asbestos context. As has been widely reported, the bankruptcy of large asbestos defendants has caused the need for plaintiffs to cast a wider net in their search for new asbestos defendants. Thus, many companies, usually smaller ones, are for the first time seeing their names on an asbestos complaint. First order of business for these new defendants will be to attempt to compile their complete coverage history. Given that this could mean finding policies dating back to the 1940s and 1950s, it is virtually inevitable that many of these new defendants will be confronted with lost policy issues (and their insurer likely telling them that the burden is on the insured to prove the policy).

While there are lots of ancient cases that address lost deeds, wills, and notes, lost insurance policy case law from the modern era, and especially from state supreme courts, is not overly abundant. Thus, *Dart*, coming from the Supreme Court of California, is likely to be cited in many future lost policy disputes. And, while the *Dart* court was forced by the law of the case to apply a "preponderance of the evidence" standard, it is possible that, over time, that procedural nuance may get lost, leaving policyholders to erroneously contend that, in a lost insurance policy case, the Supreme Court of California held that a preponderance of the evidence standard applies.

> ***. . . the court required the insured to stand for several triggered years in which it had allegedly purchased insurance, but had lost or destroyed the policies.***

Incidentally, another important lost policy-related decision in 2002, but with much less fanfare than *Dart*, was *Security Insurance Company v Lumbermens Mutual Casualty Company*. In *Security Insurance*, a Connecticut trial court held that pro-rata time on the risk was the appropriate method for allocating both defense and indemnity in the context of numerous asbestos bodily injury claims that triggered several successive years of policies as a result of a continuous trigger. Most significantly, for allocation purposes, the court required the insured to stand for several triggered years in which it had allegedly purchased insurance, but had lost or destroyed the policies.

In 2002, the Connecticut Supreme Court agreed to hear *Security Insurance v Lumbermens Mutual Casualty Company*, making it perhaps the first Supreme Court to address the specific question whether an insured's obligation to stand for uninsured periods applies to long-expired policies that the insured can no longer locate. In other words, is the allocation outcome different when the insured can not locate a long-expired policy, as opposed to an insured that made a conscious decision not to purchase insurance? ■

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An Interview with Andrew J. Barile, CPCU

Editor's note: This article originally appeared in the July 29, 2003, issue of *Insurance Mergers & Acquisitions*, a biweekly newsletter published by SNL Financial, and is reprinted here with permission.

Harbor Capital Advisors Inc. is a financial consultant to the insurance industry. The Rancho Santa Fe, CA-based firm has represented both buyers and sellers, with a particular focus on managing general agencies.

Associate director Andrew J. Barile joined the firm 18 months ago. Barile was among the first insurance executives to establish reinsurance in Bermuda—he was co-founder of Aneco Reinsurance Co.—and has also worked in insurance brokerage and agencies.

After four decades in the insurance business, he said that working in M&A was a different perspective.

"I'm coming not from the M&A business that is the traditional route that people have—they refer to me as a practitioner," Barile said. "I go back to 1979, we did the first public offering of a Bermuda insurance company. We did $10 million and today they do $1 billion. I equate it to the baseball player contracts: Mickey Mantle would have never dreamed that he could make as much money as Bernie Williams makes."

Barile discussed his experience in the insurance industry as well as the current state of the market for acquisition in an interview with Insurance Mergers & Acquisitions *editor Dail Willis recently. What follows is an edited transcript of that conversation.*

Does your firm represent the seller or the buyer?

We generally represent the seller. But we can represent the buyer if we are retained, say, supposing a bank has a particular agenda that they're looking for. . . . They say "we're looking to buy a managing general agency, but it has to be in the state of Tennessee." Therefore, we would be retained by the bank to go search the state of Tennessee to find a managing general agency that would fit what they're looking for. So it's more what I consider focused acquisitions, where people have a definite agenda that they've thought out. . . . [Or] somebody comes to us and says "would you be willing to sell our managing general agency?" and it's in California and we get retained by them to find a potential buyer. It's focused advisory services. Then we're also doing agencies' strategic planning, where we would get called in by an agency saying "What should we do? We have four owners and we've decided now that maybe we should sell the whole place." Sometimes there are differences of opinions among the owners, so you get called in to sort of referee and say, "Well, this is the best course of action that you should do as owners of an agency." There's a lot of that going on now, because the values of agencies are all increasing so dramatically.

Are a lot of agencies looking to sell? In a hardening market, aren't they too busy?

The smarter ones are recognizing that the busyness is not going to last as long as it sounds. And also you're at the top of your game, so to speak, when your clients are complaining the most you know your prices are way up. We don't see that changing for the next year, year and a half at least. Some of them are saying, "Right now is a great time because I've never had so much revenue in my life because the price of the insurance products has gone so high."

Which will help with the sale multiples.

Exactly. That's what everybody looks at the end, in trying to figure out what's the best situation for the particular sale.

What did you do before you joined Harbor Capital?

I started a reinsurance brokerage firm, then sold that to my partners. Coming from the distribution system of the industry, I'm having a lot of fun because I understand the concepts of how a policy gets written in an insurance agency and it gets put in an insurance company and it gets reinsured out of the insurance company to a reinsurance broker and into a reinsurance company. My strength is, I've been in each of those types of companies.

When we did the Bermuda thing, people really considered it controversial. They said, are you really going to do business there, isn't that an offshore tax haven, are you doing something that's illegal—the whole stigma of operating in a tax haven. . . . [Our company] was called Aneco Reinsurance Co. Ltd.

After it went public, I exited on the basis that we were not protected from the standpoint of people trying to take us over. The next people that did it, they did it privately so they could control the ownership of the company. In our offering, we did not do it privately so somebody like an investment banker who feels that you're not party to what they're trying to do, they're intelligent enough to say "well, maybe we should put the stock with somebody else who's a lot more friendly." So some of the issues that are happening today with the investment banking business we encountered in 1979.

For instance, technically in a public offering, who controls the stock of the publicly held company at that time? In our case, the investment banker did. It was their clients that bought our stock, and they listened to their clients. So their relationship was stronger than our relationship. That's the thing I learned in 1979 . . . to say to people, make sure when you're going public you cover a lot of these points.

In our day, . . . we were doing a startup IPO, which was even more challenging. We didn't even have a book of business, an earnings record. It was almost like a dot-com concept. It was just the idea that in the future, Bermuda should be a great place to formulate capital because of the ease of entry, but more importantly, there were significant advantages to starting a reinsurance company in Bermuda. It was an interesting time . . . they were changing the tax laws, captives had to write outside third-party business. . . . It's amazing today what's been done with the Bermuda billion-dollar companies and how it's been improved upon.

Continued on page 6

An Interview with Andrew J. Barile, CPCU

Continued from page 5

With the property insurance market loosening some, and maybe at or past the peak of the pricing cycle, what's the outlook for some of the Bermuda startups?

I think the Bermuda startups are going to have a strategy of coming onshore in the sense that they will move closer to the distribution systems of the insurance industry. They built their track record off the opportunities that existed at the time of the public offerings and then their management skills will permit them to come onshore. If you look at some of the historical things, you look at what these originally started as. We were another pioneer in that field because the ACE [Ltd.] concept of setting up a non-controlled foreign corporation offshore reinsurance company was depicted in our prospectus in 1979. That was something to formulate an ACE. So you look at ACE today and look at where it started, you can see that the progression was logical and that they built it into a worldwide insurance empire.

You do have an advantage if you start a company in Bermuda particularly in the insurance industry at the right time of the cycle. The biggest advantage is that the executive team and the board of directors is working on only the new opportunities and you don't have the historical problems that a lot of the other companies have had. You go down the list . . . look at what we've been through so far in the last couple of years. The Kemper Corp. problems, the St. Paul Cos., exiting the malpractice business, Chubb Corp. having tremendous losses in the surety business—all those historical underwriting mistakes are not in the league of the people that are on the board or the CEOs running the Bermuda companies. So you start with a fresh plate and make your own mistakes. But what you don't do is come into a situation where you say, "My God, we have a 1954 liability policy that was written in one of the major companies that happened to insure Halliburton." I underwrote Johns-Manville [Corp.] when I was at the Home Insurance Co. [of New York] and I'll tell you right to this day that my boss who signed the agreements to write that particular risk never would have dreamed that we would have that kind of exposure on that kind of Home Insurance Co. policy.

Some of the Bermuda companies you've mentioned started at the top of a hard market also, 10 or 15 years ago. How do they compare to conditions today?

Right. Most of those companies were formulated on the basis that the clients had an outcry for a professional liability policy on directors and officers liability insurance. And the people that were handling those clients recognized that they could not buy enough limit, and so consequently the people that were pioneers in that business . . . they were clever enough to understand that perhaps we should go back to the clients and ask them to capitalize the company and say that we would manage the company for them. Therefore, they converted the concept of risk-taking back on the clients who were buying it!

Obviously, if you have very astute people at the board level, which they certainly did, who understood the risk of the particular company . . . they started with a nucleus of tremendous intelligence as well as capital. And then that became the formulation for the particular company to start out writing its own risk.

And once it's expanded out of doing the directors and officers liability on its own risk, on the group of investors, what do they do next? Well, they wrote the D&O policy on other risks, and then they expand from that into "we're really an insurance company." So what do they do? ACE bought the CIGNA property and casualty group. So that put them in the U.S. business, because that strategy was opportune. In other words, what usually happens is, there's a crisis where there's the need for capital and the capital that rushes in to get the crisis is going to get a phenomenal return for the first few years.

But then your management ability and your success rate have to say how you manage that continuously. Because anybody can write property-catastrophe covers after a catastrophe has occurred. So all the rates are going to be way high. What's going to happen three years from now when the rates are starting to go the other way? What do you do with your company then? That's where the time is out on the new companies.

Certainly, what they've been doing—if you look at the people like Arch Capital Group Ltd., the first thing they do is they bring in some superior management. I've known Paul Ingrey for almost 35 years, he's always been successful at the reinsurance business. So he's on the board of Arch Capital. They bring in Dinos (CEO for insurance Constantine Iordanou) from the Zurich, who knows how to run the property and casualty insurance business and now they've built that structure, they buy some companies for him and he's at a tremendous advantage. He can sit there all day and say "I want to look at the new risks, at the new pricing" and he doesn't have to worry about the contract, the book that's back here in California that's going to have humongous losses on it that was written eight years ago.

What kinds of niche specialties are in demand among buyers?

That particular area is booming now, as you can imagine. As the standard companies retreat back into their core competencies, it usually blows up the surplus-lines people. . . . I would pick lines like nursing home professional-liability insurance where it was not done properly in the past and now people are coming into that particular area of the business with more risk-management techniques and concepts as far as running a nursing home. You'll get spotty situations there. You're seeing it in the insurance homeowners policy; it becomes a niche when there's a mold explosion. All of a sudden everybody wants to exit the homeowners business. . . . I always defined a niche as when the underwriting philosophy of the insurance industry changes to a point where all of a sudden nobody wants to do it. My idea was, I'll come in and design something where we'll do it and we'll make an underwriting profit at doing it. But how long will we be able to make the underwriting profit is the issue the industry always faces. ■

Agent & Broker Section Members Looking for Valuable Information and CE Credits

Don't Miss these Seminars at the 2004 CPCU Society Annual Meeting!

The 2004 Annual Meeting and Seminars will offer 25 property and casualty insurance track seminars and 25 leadership and career development track seminars. Attendees can earn up to 18 continuing education credits from the property and casualty insurance track seminars, some of which are highlighted below. Please visit the CPCU Society web site at www.cpcusociety.org to register today and for information on all technical seminars being produced.

Commercial Property Coverage

As insurance industry professionals, it's important to stay on top of the latest developments—and this seminar does just that for the Commercial Property Policy. Come and learn from R. Bryan Tilden, CPCU, CLU, ChFC, CIC, about the new mold and terrorism exclusions and new Flood Coverage endorsements. You'll also hear about changes in the Causes of Loss forms and Time Element coverages; new coverages and changes to the Additional Coverages and Coverage Extensions; and how changes in Replacement Cost will affect the insured.

Malecki and Tilden on the 2004 CGL

Learn from "the masters" (Donald S. Malecki, CPCU, and Tilden) everything you wanted to know about the latest Commercial General Liability program. Learn about its impact on the industry, particularly, changes that reflect the global nature of business, personal injury, and property damage changes relating to Internet-related businesses, and ISO coverage vehicles such as product-withdrawal endorsement and employee-benefits liability insurance. Malecki and Tilden, recognized country-wide as leading experts in P/C insurance education and training, team up again to present this lively and informative program.

Donald S. Malecki, CPCU, and R. Bryan Tilden, CPCU, discussed how the CGL program impacts the insurance industry at the CPCU Society's 2003 Annual Meeting and Seminars. The two will team up at the Society's 2004 Annual Meeting and Seminars in Los Angeles this October.

CPCU Society Master Series Seminar: Contractual Transfer, Additional Insured, and Certificate of Insurance Issues

Join Tilden, Malecki, and Richard G. Rudolph, Ph.D., CPCU, for a stimulating presentation on today's most important insurance issues. Having presented hundreds of CPCU Society workshops over the past 20 years, these three speakers are considered to be "masters" in their fields. Attendees will understand underlying reasons for risk transfers through indemnification agreements, contractual liability, and insurance policies; identify potential defenses to indemnity; understand the concept of additional insured status under various insurance policies; identify the appropriate and inappropriate use of insurance certificates; recognize potential legal problems associated with the issuance of insurance binders and certificates; identify what constitutes "proof of insurance;" and understand appropriate and inappropriate use of insurance certificates.

Insuring Defective Construction

Do you know the latest information on construction defects and how the 2001 CGL handles this exposure? Attend this seminar and learn from Tilden about new additional insured endorsements that exclude damage arising from the work of a subcontractor, the various coverages and exclusions applicable to construction claims, and coverage applicable to contractors. You'll learn to identify the problem of defective construction; scrutinize defective work as property damage; understand the various trigger theories available, including allocation among policies; and analyze the defective work exclusion. ■

Register today for the 2004 Annual Meeting and Seminars at www.cpcusociety.org!

Income, Wealth, and Perpetuation: Leading by Example and Managing by the Numbers

by Wayne A. Walkotten, CPA

■ **Wayne A. Walkotten, CPA,** is senior vice president, Marsh, Berry & Company, Inc.

Insurance agency owners fall into several categories, including owners that began as a producer. Through excellent production results, they helped build the value of the agency and in the process, earned a strong income. Through perseverance, they received the opportunity to buy into the agency. Others, after joining their father's agency, became owners through inheritance or a bargain purchase. The last group slugged it out, and even though those owners did not generate extraordinary volume and production, they became owners of the agency by putting up hard currency and taking risk. The leadership skills of today's insurance agents will determine the sellers and the survivors of the future. As the industry continues to consolidate, owners will build an agency that has the choice of perpetuating, and will be forced to sell.

While it doesn't take an Ivy League business degree to perpetuate an agency, it does take an individual with a drive to make the tough decisions and to set an example for the agency. There is no substitute for strong leadership and the informed decisions of management to leverage the agency to new heights.

Agency leadership must set goals and direction of the firm. While such basic goals of growth and profitability are common, the leadership of the agency must establish the ultimate target, to sell or perpetuate. As agencies and their shareholders mature, they are faced with a basic decision. Will they bring youth into production and ownership who are willing to accept the risk of taking on the debt of departing owners, or will they sell the agency as they have not been willing to invest in the right group of younger producers and risk takers?

Second, agency leadership must be willing to invest in the balance sheet, technology, and retain earnings. By building the cash and liquidity of the agency, the balance sheet strength will build an offensive and defensive war chest. Furthermore, investments in new producers should include emphasis on sales targets, training, and management. Finally, by setting profitability goals, the agency will develop the cash flow to continue reinvestment in the above.

Unlike a public company that has a management team hired by the shareholders and board of directors, an insurance agency is often managed by its owners. Do the owners have the discipline to expect the same results from themselves as their employees? We often find agency owners make rules for everything from production to accounts receivable credit and collection; however, they don't follow the rules themselves.

We believe the following management guidelines will help the leadership of the agency achieve its long-term plans.

Strengthen the Balance Sheet and Liquidity of the Agency

- Establish an accounts receivable policy that results in an average collection period of less than 20 days.
- Set retained earnings goals that build toward a tangible net worth equal to 20 percent of revenue.

Develop a Total Agency Sales Culture

- Improve the sales skills of producers, leading to more qualified leads, reducing the sales timeline, and differentiating the agency from the competition.
- Working with producers on high payoff activities and including the entire agency in the sales and retention process, will improve the agency's growth.
- Set growth targets encouraging the high payoff activities and reward the attainment of goals.

Service Standards and Consistency

- Develop workflows that promote efficiency, consistency, and protect the agency from errors and omissions.
- Retention will improve, as the customer service staff, using these procedures, will have more time available to get closer to the clients of the agency.
- Audit the procedures as a means to encourage conformity and protect against E&Os.

The final step in building an agency that will have a choice in the future is to reward producers and managers with an ownership opportunity, while testing their ability to accept risk. Agency leadership can test producers by establishing a Producer Stock Incentive Plan (PSIP). By rewarding producers that achieve goals with the opportunity to buy stock equal to an amount rewarded for achieving goals, the owners both provide incentive and develop prospective owners willing to make a financial commitment.

In summary, agency owners that lead by example, with an articulated goal, will provide the guidelines necessary for managing the agency's day-to-day progress. By improving the agency's growth and profitability, the increase in cash flow will enable the owners to make a choice of perpetuating in the future, rather than being forced to sell. ■

The Real-Time Revolution: Redefining How We Work

The Agents Council for Technology (ACT) has published "The Real-Time Revolution: Redefining How We Work," a report to help independent agents and brokers and carriers better use real-time technology to improve workflows, customer service and sales, and understand the broad reach technology is likely to have in the industry.

ACT, affiliated with the Independent Insurance Agents & Brokers of America (IIABA), Alexandria, Virginia, formed a work group to study the potential of real-time transactions and to help agents and brokers and their carriers keep pace with the efficiencies provided by technology that allows the agency system to effectively compete long-term with other distribution systems.

The report notes that real-time interface, in its simplest terms, means that a user can make a request electronically and promptly receive a response. The transactional request typically is a policy quote, service inquiry, policy view, request for information, or billing query. The user's electronic response can be in the form of a message, direct access to the requested information, or the initiation of an online process.

■ *Additionally, in one year, real time reached an activity level that the traditional batch model needed 17 years to achieve.*

"The long-term goal of real-time interface is that the entire business process—in response to the request—be completed immediately, and that the agency and carrier databases both reflect the changes that have been made," says Angelyn Treutel, chief financial officer of Treutel Insurance Agency in Bay Saint Louis, Missouri, who chaired the work group.

The report also shows that momentum for more real-time functionality is building. Specifically, the number of real-time inquiries and transactions is increasing by as much as 30 percent per month. Additionally, in one year, real time reached an activity level that the traditional batch model needed 17 years to achieve. Also, more carriers are in development to make real-time interface universally available to their agents.

The report cites examples of the many benefits of using real-time technology:

> Consumers would receive better customer service and get immediate answers from their carriers, agents, and brokers.
>
> Independent agents and brokers could handle inquiries and transactions in a "once-and-done" manner, eliminate multiple data entries, save time, shorten training efforts, eliminate mailing costs and file space, and dedicate more time to sales activities.
>
> Managing general agents would receive complete, legible submissions, rather than the handwritten faxes with missing information many receive today.
>
> Carriers would have billing, claims and policy inquiries automatically handled, and could transfer books of business from other carriers electronically.

The ACT report also identifies that the real-time revolution is likely to impact future insurance communications, database sharing, and processing.

For example, both agencies and carriers could alert the other party, as well as the client, to the actions they are taking in real time. Agents also could pull information from third-party computers and use it to reduce data entry and enhance agency efficiency. The report contains a comprehensive list of additional ways in which real-time technology might enhance the insurance business processes.

ACT will work with AUGIE, ACORD's organization of user group leaders, and other interested industry groups to further investigate the potential real-time applications. ■

The Danger of Not Reporting Claims

Editor's note: This article originally appeared on the Independent Insurance Agents & Brokers of America (IIABA) web site and is reprinted here with permission.

Important: The views expressed in articles written by the IIABA faculty members and others do not necessarily reflect the views of IIABA.

Abstract

When automobile claims come in we always talk to the insured about the benefits of self-insuring the loss if they can, but more and more we are seeing lawsuits being filed for claims sometime down the line. If the insured reports the claim to us (the agency) and we note their account, but they decide to self-insure (not report the claim to the insurer), are we in any way jeopardizing their coverage? Do you think this agency is jeopardizing someone's coverage?

"When automobile claims come into our agency, we always talk to the insured about the benefits of self-insuring the loss if they can, but more and more we are seeing lawsuits being filed for claims sometime down the line.

"My question is, if the insured reports the claim to us (the agency) and we note their account, but they decide to self-insure (not report the claim to the insurer), are we in any way jeopordizing their coverage down the line if, for example, they get sued for one million dollars by the party they hit two years later? Will they have coverage since it was actually not reported to the insurance company?

"Another scenario is, what if the insured calls us (the agency), they decide to self-insure, we never note their account, and two years later they are sued—will they have coverage?

"In my scenarios, I am assuming they have auto liability coverage and excess liability coverage at the time the accident occurred. I guess I am really questioning whether we are doing more harm than good by recommending self-insuring auto accidents when possible. Any feedback would be much appreciated. Thank you!"

Thanks for raising this issue. As soon as I regained consciousness, I posed your question to the VU faculty. Below are their "candid" (and edited) suggestions.

Faculty Response

This is not a good practice. Not reporting claims for any reason violates policy conditions (read that section of the policy) and could definitely create future problems. Report the claim . . . if the customer wishes not to accept money for the settlement of the claim, he or she can discuss it with the company representative handling the claim.

I understand in today's marketplace that avoiding incidents on the customer's driving record is a concern to some. Being nonrenewed or paying a higher rate due to accidents/incidents is the way of the world. Often, you have to live with it.

In any event, your E&O carrier will be much happier if customers aren't counseled in such a manner. *Report the claim*, as it's an agent's duty ethically and professionally.

Faculty Response

You are engaged in a very dangerous—to your personal finances as well as that of the insured—practice. You are advising your clients to violate a material condition of the policy. In response to your questions:

First, you are jeopardizing the insured and possibly your E&O coverage. Read the policy, it is a condition of the policy that the insured report losses. Why did they pay premium to you and the insurer if they then decide to "self-insure?" That self-insurance could go all the way to a massive judgment that is not insured and they will come looking for you for indemnity.

Second, if you record it and are an agent of the company, they had notice but will probably look to you for the damages the insurer incurs.

I suggest you contact your errors and omissions insurer for guidance.

Faculty Response

You didn't indicate whether you are telling personal or commercial customers (or both) to pay the claim themselves. I am working on the assumption that you are talking about personal lines customers. I only make this assumption because I am a parent of teenagers who drive. My son had the "misfortune" to have two accidents and one speeding ticket within 12 months of getting his license, and his premiums are now out of sight. If we had made the decision to pay the two accidents, he would still have coverage in the standard market and our out-of-pocket expenses over time would be less. The reason that we didn't pay the accidents are twofold.

We, like all consumers, purchase insurance to transfer our risk of loss to the carrier who will pay covered claims, if we have any. If you are telling your customers, after a loss, to pay the claims themselves, why are you selling insurance to them in the first place? If your agency believes that insurance should only be purchased for large catastrophic losses, why are you not discussing this with the client before the sale? Customers can then purchase a policy that includes premium saving options up front, such as high deductibles. They then have made an active decision to "self insure."

Most important, the PAP contains loss conditions (Insured's Duties after an Accident). In the PAP, the loss conditions start out with, "We have no duty to provide coverage under this policy unless there has been full compliance with the following duties . . . (1) We must be notified promptly of how, when, and where the accident or loss happened . . . " If you look at the rest of the loss conditions, you will see that the carrier is looking for cooperation in investigating the loss, protection of their legal rights, etc. All of this is intended to protect the insurer's rights, duties, and ability to investigate, verify the validity of the claim, and settle the loss. By advising your insured to pay the loss without notice, they have violated the condition to "promptly" report the claim.

You asked if the insured would have coverage two years later for suits that may

be brought for these accidents. They would have coverage, but not under their PAP . . . it can be found under your agency's E&O policy. When they report the loss to you, they are reporting it to the carrier. You have failed to transmit the information to the company, not because your insured has decided not to report it, but because you are advising them not to report the loss. Check your agency's E&O limits to see how much coverage the insured would have.

Faculty Response

Either scenario is an E&O claim waiting to happen! All I can visualize is a Reservation of Rights letter.

The first situation is clearly the fault of the agency. The wording of the policy conditions calls for prompt notification. The policy is a contract between the insured and the carrier. When the agency takes the notice and does not convey the information to the carrier, they are in violation of their contract with that carrier, which calls for notifying them of all material facts. The carrier has not had the opportunity to investigate the claim and possibly make a settlement.

The second situation is not quite as clearcut as the first, but there are many similarities. In this scenario, the client has made the decision to self-insure. Unfortunately, when the suit papers are delivered, the insured will probably say, "I told my agent about it when it happened." Even if this doesn't happen, the agent has still violated his contract by failing to notify the company of a material fact.

Always notify the carrier of any claim that the agent becomes aware of. If the insured wants to pay the initial costs out of their pocket, let that be between the Claims Department and the insured.

Faculty Response

This becomes a legal question. Two issues are implied. First, is the notice to you notice to the company? If so, they are protected, but the company may take issue with you if their position was prejudiced by the delay. The second is, if the company is successful in denying coverage (notice to you was *not* notice to them and they can show the delay was prejudicial), then the insured will have issues with you. Either way if it blows up from what is perceived as a little claim into a major claim, the agency's position is one of peril.

Faculty Response

This is probably more of a legal question than a coverage question. The problem is "prompt reporting." The policy says that the company ("we") must be notified promptly of how, when, and where the accident or loss happened. The policy is a contract between the insured and company. The agent is not a party to the contract. The agent is not "we" as defined in the policy. Is reporting a loss to the agent the same as reporting the loss to the company? If the agent gives the insured advice about not reporting a loss, the company could say that the agent was operating as an agent of the insured and not the company. If a suit is filed two years later, the company could deny coverage because they were unaware of the loss. I think your practice is very dangerous. Have you talked to your insurers about this?

Faculty Response

Here's an actual claim we had from one of our member agents. The insured left the bathtub to fill and she took a phone call. Thirty minutes later she had a lake in her bedroom. She called and reported the claim and the company paid out on it. Six months later the exact thing happened. When she called to report the claim, she asked the agent, "Will I get cancelled because of this?" The agent said, "It's hard to tell but the company will look at this and may nonrenew the policy."

The insured instructed the agent not to report the claim. A few months later, the company sent a nonrenewal due to the one claim. The insured was ticked, and called the agent to say, "If they are going to dump me, then I want to file that second claim." The agent did that and the insurer denied for lack of prompt notice. The client looked to the agent and said, "Well I reported it to you, so you pay me." We submitted an E&O claim for the agent.

Promptly report all losses to the carrier . . . as hard as that may be today.

Faculty Response

Your fear is correct. If the insured pays under liability to a third party, they can be prejudicing the insurance company's future defense of a claim. In those cases, the insurance company does not have to pay the claim. In some states, the very fact that you paid anything to a third party is an automatic denial of coverage if the loss comes back. By the way, the agency is putting itself in line for an E&O lawsuit by making those recommendations.

Do you have an opinion? Feel free to e-mail your thoughts, opinions, and suggestions to Bill.Wilson@iiaba.net. ■

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