SENATE
COMMERCE & LABOR
COMMITTEE

Minutes of Meeting
Monday, March 28, 1977

The meeting of the Commerce and Labor Committee was held on March 28, 1977, in Room 213, at 1:30 P.M.

Senator Thomas Wilson was in the chair.

PRESENT: Senator Wilson
Senator Blakemore
Senator Ashworth
Senator Bryan
Senator Close
Senator Hernstadt
Senator Young

OTHERS
PRESENT: See attached list.

The Committee considered the following:

S.B. 357 CREATES SOUTHERN NEVADA POWER DISTRICT. (BDR S-779)

SENATOR JOE NEAL stated the purpose of S.B. 357 is to permit the people to vote in the district that is now represented by Nevada Power as to whether or not they would like to own and operate the public utility system. He stated that is all the bill is intended to do at the present. The other act would follow if the people decided they would like to take such action. He stated the bill would provide for acquisition under the Act of Eminent Domain, as found in Section 6.

He said it involves most of Clark County and a portion of Nye County. He stated the franchise for Nevada Power is coming up and it will be re-negotiated and covers approximately 50 years. He said he cannot see where rates are going to stabilize or decrease and feels that something is going to have to be done. May have to let the people run this themselves as a non-profit enterprise.

SENATOR ASHWORTH asked if Senator Neal felt that a power district owned by the people could deliver power cheaper than free enterprise.

SENATOR NEAL indicated he did believe this and this was the thrust. Refer to Tape 1 for full testimony.

A.B. 290 PROVIDES FOR REFUNDS OF UNEARNED MORTGAGE LOAN FEES. (BDR 54-744)

Mr. Les Goddard, Commissioner of Savings Assn., indicated support of A.B. 290 and submitted Exhibit A for the Committee's consideration. He discussed advance fees in relation to this bill. Refer to Tape 1 for testimony. Also discussed relationship of A.B. 290 to S.B. 313.

A.B. 269 PROVIDES FOR OPTION TO ESSENTIAL INSURANCE POLICYHOLDERS TO PAY ANNUAL CHARGE IN LIEU OF ASSESSMENTS. (BDR 57-15)

Mr. Robert Byrd, President, Nevada Medical Liability Insurance Assn., stated he had reviewed the bill and feels that it is a natural step in our essential insurance plan. He has no basic arguments with it and thinks they can live with it.

He stated in response to questions by SENATORS YOUNG and WILSON that the purpose of the bill is to provide a stabilization fund in lieu of the assessment provision of the existing bill. If the liabilities ever exceed the assets, the Board of Directors shall assess each physician insured during the period of time that caused it to become bankrupt up to an additional annual premium. If that does not satisfy the deficit, then they assess the admitted insurance industry.

For the record it was indicated that the Nevada Medical Liability Insurance Association is a quasi-public organization that is insuring doctors.

Mr. Dick Rottman, Insurance Commissioner, stated he favored this bill. He believes it would be a positive addition and is an outgrowth of the Interim Committee.

Senate

A.B. 343 PROVIDES PENALTY FOR MISAPPROPRIATING INSURANCE PREMIUMS. (BDR 57-1012)

Mr. Dick Rottman, Insurance Commissioner, told the Committee this bill is a brief and simple one that rises out of the problem they have experienced in the last few years where a small employer (usually prior to closing his business) has collected monies to pay for group health insurance for his employees, but has not transmitted it to the company. The employees don't know that they don't have coverage.

He said the D.A.'s office has indicated that it is hard to do much with just an embezzlement thing, which is hard to prove in this type of case, and they would attempt to prosecute these people so that the employees would not suffer a total loss.

SENATOR CLOSE discussed the wording of the bill and the severe penalty that would be incurred for being late in making a payment or being short as little as one dollar.

Mr. Rottman discussed penalities for felonies with the Committee. He indicated they drafted the bill at the request of several people - most recently from the D.A. in Winnemucca.

SENATOR WILSON discussed with Mr. Rottman the constitutionality of this bill as worded.

SENATOR BLAKEMORE suggested a remedy would be to notify the employees that their premiums had not been paid.

A.B. 345 PROVIDES FOR YEARLY PAYMENTS OF UNCLAIMED INSURANCE FUNDS INTO GENERAL FUND. (BDR 57-1011)

Mr. Rottman advised that the purpose of A.B. 345 is merely to simplify what is now for the most part a clerical procedure. It was recommended by the Legislative Auditing Section. Should have been included in another package. Asked favorable consideration. In response to a question by SENATOR BLAKEMORE, Mr. Rottman indicated they were talking about $12,000-$15,000 per year.

Senate

S.B. 350 REPEALS BASIC REPARATIONS PROVISIONS OF AUTOMOBILE INSURANCE. (BDR 57-1216)

Mr. Jack Lehman, Las Vegas, testified in favor of S.B. 350. He stated it seeks to repeal the no-fault insurance. He discussed the no fault policy and his personal experience over the past 2 years with it. He discussed slow payment of claims and submittal of doctor's reports. Refer to Tape 2 for testimony.

SENATOR TY HILBRECHT told the Committee Senator Gibson has a good file on the commitments made by the insurance industry in aid of the no-fault. One item promised was lower premium costs. He felt, along with Senator Gibson, that the Committee should have the opportunity to be provided some vehicle to re-examine the concept based upon the promises the insurance industry made. Both were quite optimistic that either you might implement this bill or some modification of it, they simply ask that the state of law be generally put back with respect to motor vehicle liability insurance to the position it was before no-fault was enacted. However, that we preserve the limitations on registration requirements to try to insure compliance with the safety responsibility act. They want the mandatory insurance certicate prior to registration concept, but delete the first party provisions in no-fault. Or, if you are going to maintain no-fault perhaps extract some more promises from the insurance industry if they are interested in pursuing this concept.

He continued saying the intent was simply to repeal the mandatory first party coverage, the socalled no-fault coverage, but to retain the provisions of mandatory liability insurance.

Jim Crockett, Lawyer, Las Vegas, spoke on behalf of this bill. Mr. Crockett told the Committee that in any insurance system the people who are rated are people who are of driving age. The people the insurance company are concerned about are the people who it is insuring or will actually be operating the car. The problem with no-fault is that they are insuring everyone in the world.

Refer to Tape 3 for full testimony.

Senate

Mr. Crockett discussed the $5,000 survivor benefit and policy limits and no-fault coverage. Cited examples of coverage on a childless couple vs. that of a family. He urged the Committee to give S.B. 350 earnest consideration.

Mr. Tom Bendorf, member of the Bar of South Carolina, represents the Assn. of Trial Lawyers of America in Washington, and appearing at the request of the Nevada Trial Lawyers Assn., talked about rates. See Exhibit on Insurance Facts, 1976 Edition, Property Liability Marine Surety. Refer to page 64.

Frequency x severity = raw costs.
No. of accidents x costs of accidents and severity = how much costs insurance company to pay a claim.

He said Oregon has $5,000 first party package for medical expenses. Has a maximum of $9,000 for wage loss, $1,000 for funeral expenses. First party basis-no-fault with no torque liability restriction. He said their records prior to the no-fault bill compared with their records subsequent to no-fault bill showed a decrease of 25% in the frequency. They now have 75% of the torque claims that they had prior to the adoption of their bill.

Mr. Bendorf stated the elimination of claims will automatically raise the severity as a matter of average and that equals approximately 90% of the costs they had prior to the adoption of their bill. So, a first party package which covers net economic loss of about 76% of all injuries, without any restriction on torque and decrease of frequency by 25%, has increased the severity 20% and reduced the raw costs of insurance 10%. Florida has a $1,000 threshold. Bill went into effect 1/72. Shows a 65% reduction in the frequency of torque claims, and a 330% increase in the severity rate and that produces a cost increase of 25%. Refer to Tape 3 for testimony.

He stated that the threshold from 500 - 1000 will eliminate complete compensation at 92.4% and from 2500 - 5000 at 98.1%.

Frequency x Severity = Raw Cost.

OREGON
.75 x 1.20 = .9
FLORIDA
.35 x 3.30 = 1.25

If the goal of the threshold is to abolish rights the higher threshold, the more severe the verbal threshold, the more effective it becomes. You have to abolish rights to make no-fault an effective system. Oregon doesn't think so. Oregon has a zero threshold. Refer to Tape 3 for extensive testimony.

Mr. Bendorf further advised that an insurance company had compiled the following statistics:

At the end of 1975, 178 million Americans (more than 8 out of 10) were protected by one or more forms of private health insurance. Of the remaining Americans (military personnel and families, retired military personnel and families, public health service, institutional inhabitants, Medicare recipients) all have first party health insurance. So, a no-fault insurance that mandates health insurance is simply the mandating of a duplication of benefits which will cover the net economic loss of automobile accidents. 62 million Americans out of 83 million have wage continuation plans. Have to add military, etc.

He discussed no-fault in many of the United States. Refer to Tape 4 for testimony. He said Massachusetts is the highest rate state and Texas is the lowest. He discussed portfolio losses and actual increases in insurance companies net worths. He went into detail on various states on risk and rates.

Mr. Bendorf further stated they believe that people's rights are important and thresholds, the deductions of statutes and limitation, the elimination of general damages, the elimination of punitive damages and the limitations on contingent fees, are designed to shrink individual's rights in society to be secure in their person against the wrong doing of another. He told the Committee the principle factor that goes into Nevada's insurance that makes it different from other states is that we are a very high single car accident

Senate

state. He stated that if you go to a no-fault system and are a high single car accident and a high speed state, you have to go up in price.

Mr. George L. Ciapusci, State Farm Automobile Insurance Company, stated that he is a claims superintendent. He opposes this bill. Talked about Nevada experience, as well as State Farm experience. Told Committee that State Farm insures approximately 20% of the registered vehicles in the State and that in total policy count is 92,763 policies. He said it costs State Farm $18.75 to issue a policy. $175,000 dollars in paper. $150,000 dollars spent on the same item in 1974 when they went on no-fault. From a clerical standpoint they are talking about $350,000 dollars on the change over. If the act is changed, the current pending claims on the books at the date of turnover would continue to pend through inception so there would be no cut off.

Mr. Ciapusci said he feels strongly that if the no-fault is repealed that the bodily injury claim costs would continue to rise in cost. There has been a substantial rise in bodily injury costs in the state since the inception of the no-fault plan. Inflationary trends in medical, the abuses on the current no-fault act, the trends today in settlements made on bodily injury coverages have all contributed to this rise. He said they have no quarrel with the no-fault concept but believe that the Nevada Act as is currently written is ineffective. He believes it could be strengthened.

SENATOR WILSON expressed concern as to how much of the rate increases are attributable to specific problems or to inflation.

Mr. Ciapusci stated that he had figures beginning April 1, 1968 through December 31, 1976:

		Actual Increase
Crash parts index increase	172.4%	72.4%
Semi Private Rooms increase	173.8%	73.8%
Consumer price index overall		73.3%
Insurance Rates		54.2%

He feels that the amended act is going to give the companies the controls and is not going to take a deserving nickel away from the desiring claimant.

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SENATOR WILSON asked Mr. Rottman, Insurance Commissioner, what kind of data he had that develops information that leads him to conclusions of fact as to the approximate cause of insurance premium levels. Mr. Rottman responded that the bulk of it is the result of inflation.

In response to a question by SENATOR ASHWORTH, Mr. Rottman indicated that pre-1974 would be less costly. That torque system would possibly be less costly than the no-fault is now.

SENATOR ASHWORTH asked what needed to be done in order to make the no-fault less costly and Mr. Rottman stated that he thought that a reduction in benefits might help.

George Ciapusci stated the average paid liability claim is $5,140.00. Earned premium in 1976 is $13,650,813.00 on his mutual company.

SENATOR BRYAN stated that the bottom line, according to Mr. Rottman, seems to be that if S.B. 306 passed it would not have a substantial impact on the premium dollar that the public is paying and if we repeal the no-fault system, his projections are that it may cost a lot less in terms of premium dollars to the motoring public in Nevada.

Mr. ~~Dave~~ Neil Galatz submitted Exhibit D.

ADMINISTRATIVE MEETING:

A.B. 345 PROVIDES FOR YEARLY PAYMENTS OF UNCLAIMED INSURANCE FUNDS INTO GENERAL FUND. (BDR 57-1011)

SENATOR HERNSTADT moved DO PASS.
Seconded by SENATOR BLAKEMORE.
Vote: Unanimous (Senators Ashworth and Bryan absent.)

S.B. 357 CREATES SOUTHERN NEVADA POWER DISTRICT. (BDR S-779)

SENATOR HERNSTADT moved for indefinite postponement.
Seconded by SENATOR YOUNG.
Vote: All in favor except SENATOR BLAKEMORE who voted NO. (Senators Ashworth and Bryan absent.

Senate

SENATOR YOUNG moved for approval of minutes for March 2, March 9 and March 18, 1977.
Seconded by SENATOR BLAKEMORE.
Vote: Unanimous except for Senators Ashworth and Bryan who were absent.

A.B. 343 PROVIDES PENALTY FOR MISAPPROPRIATING INSURANCE PREMIUMS. (BDR 57-1012)

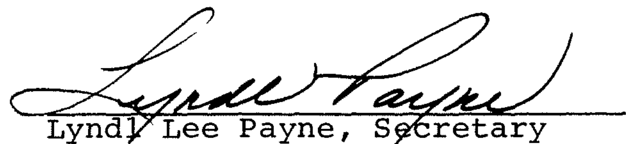
SENATOR BLAKEMORE moved to KILL.
Seconded by SENATOR YOUNG.
Vote: Unanimous except for Senators Ashworth and Bryan who were absent.

A.B. 269 PROVIDES FOR OPTION TO ESSENTIAL INSURANCE POLICYHOLDERS TO PAY ANNUAL CHARGE IN LIEU OF ASSESSMENTS. (BDR 57-15)

SENATOR CLOSE moved to DO PASS.
Seconded by SENATOR YOUNG.
Vote: Unanimous except for Senators Ashworth and Bryan who were absent.

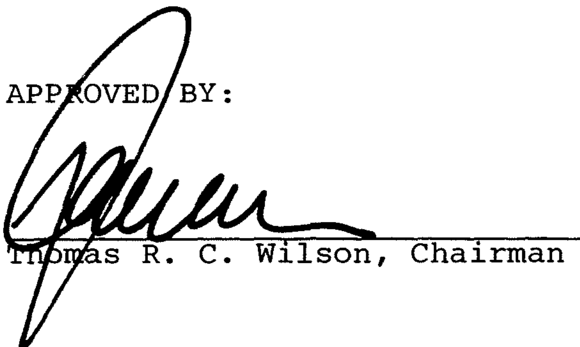
There being no further business the meeting was adjourned.

Respectfully submitted,



Lyndl Lee Payne, Secretary

APPROVED BY:



Thomas R. C. Wilson, Chairman

SENATE

AGENDA FOR COMMITTEE ON COMMERCE AND LABOR

Date Monday March 28, 1977 Time 1:30 p.m. Room 213

Bills or Resolutions to be considered	Subject	Counsel requested*
S. B. 357	Creates Southern Nevada Power District (BDR S-779)	
A. B. 290	Provides for refunds of unearned mortgage loan fees (BDR 54-744)	
A. B. 269	Provides for option to essential insurance policyholders to pay annual charge in lieu of assessments (BDR 57-15)	
A. B. 343	Provides penalty for misappropriating insurance premiums (BDR 57-1012)	
A. B. 345	Provides for yearly payments of unclaimed insurance funds into the general fund (BDR 57-1011)	
S. B. 350	Repeals basic reparations provisions of automobile insurance (BDR 57-1216)	

*Please do not ask for counsel unless necessary.

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SENATE

3/28/7

DATE ____________

PLEASE PRINT PLEASE PRINT PLEASE PRINT PLEASE PRINT PLEASE PRINT PLEASE

TESTIFYING?	NAME	ORGANIZATION	ADDRESS	PHONE
NO	STEVEN Stucker	NORTH LAS VEGAS	1816 HOWARD - L.V.	783-862
YES ✓	GEORGE CIAPUSCI	STATE FARM INS	1735 VASSAR ST RENO	329-1011
	KENT ROBISON	NTLA	10 STATE ST #216	323-861
Yes ✓	C T Bondorf	ATLA	3615 Overcreek Rd Columbia SC	803 782-695
YES ✓	JIM CROCKETT	ATLA/NTLA	401 S. THIRD #201 LAS VEGAS, NEV	385-2533
YES	Les Goddard	Commerce Dept	201 S Fall St, CC	885-4259
no	Pete GAMAGE	LAS VEGAS	1992 CITROEN ST	452-0835
Yes	JAMES WADHAMS	INS DIV	NYE BLDG	885-4270
"	Gene Leverty	INS DIV	NYE BLDG	" "
	STANLEY SAMUEL	UNLV	764 E. TWAIN LV	737-205
	DARYL E. CAPURRO	NMTA/NFADA	P.O. Box 7320 Reno, Nev 89510	323-5153
✓	Robert BIRD	NMLIA	P.O. Box 7456 Reno 89509	329-2246
✓	Dick Rottman			
✓	Jack Lehman			
✓	Roy Hilbrecht			
	Dave Galatz			

Exhibit A

State of Nevada

Commissioner of Savings Associations

Capitol Complex
Nye Building
Carson City, Nevada 89710
(702) 885-4259

Mike O'Callaghan
Governor

Lester O. Goddard
Commissioner

March 28, 1977

TO: Members, Senate Commerce and Labor Committee

FROM: Lester O. Goddard, Commissioner of Savings Associations LOG

SUBJ: Suggested change to Subsection 1 of AB 290 (NRS 645B)

I am in favor of AB 290, as an aid in controlling "advance fee" artists.

However, if SB 313 becomes law, subsection 1 of AB 290 would be virtually meaningless, as the vast majority of "advance fees" are taken by people who do not advertise in the media. Also, I believe subsection 1 should specifically exempt those institutions and persons exempted from licensing by NRS 645B.090.

Therefore, I suggest that subsection 1 of AB 290 be changed to read:

1. A person who acts in any capacity defined in subsection 2 of NRS 645B.010, whether or not advertising in the media and who is not exempted under NRS 645B.190, shall:

a division of the Department of Commerce
Michael L. Melner, Director

4. The mortgage company shall, upon reasonable notice, account to the commissioner for all funds in the company's impound trust account.
(Added to NRS by 1973, 1543)

645B.180 Exemption from execution or attachment; commingling prohibited.
1. Impound trust account funds are not subject to execution or attachment on any claim against the mortgage company.
2. It is unlawful for any mortgage company knowingly to keep or cause to be kept any funds or money in any bank under the heading of "impound trust account" or any other name designating such funds or money belonging to the debtors of the mortgage company, except actual funds paid to the mortgage company for the payment of taxes and insurance premiums on property securing loans made by the company.
(Added to NRS by 1973, 1543)

MISCELLANEOUS PROVISIONS

645B.190 Applicability of chapter. The provisions of NRS 645B.010 to 645B.230, inclusive, do not apply to:
1. Any person doing business under the laws of this state or the United States relating to banks, mutual savings banks, trust companies, savings and loan associations, common and consumer finance companies, industrial loan companies, insurance companies or real estate investment trusts as defined in 26 U.S.C. § 856.
2. An attorney at law rendering services in the performance of his duties as attorney at law.
3. A real estate broker rendering services in the performance of his duties as a real estate broker.
4. Any firm or corporation which lends money on real property and is subject to licensing, supervision or auditing by the Federal National Mortgage Association as an approved seller or servicer.
5. Any person doing any act under order of any court.
6. Any one natural person, or husband and wife, who provides funds for investment in loans secured by a lien on real property, on his own account, who does not charge a fee or cause a fee to be paid for any service other than the normal and scheduled rates for escrow, title insurance and recording services, and who does not collect funds to be used for the payment of any taxes or insurance premiums on the property securing any such loans.
(Added to NRS by 1973, 1542; A 1975, 962)

645B.200 Statutory and common law rights unaffected. NRS 645B.010 to 645B.230, inclusive, do not limit any statutory or common law right of any person to bring an action in any court for any act

Allstate

Dave Galatz Exhibit D

J L R

WASHINGTON OFFICE

Allstate Plaza
Northbrook, Illinois 60062
312 291-5000

Donald L. Schaffer
Vice President
Secretary and General Counsel

July 3, 1975

S. Lynn Sutcliffe, Esq.
General Counsel
Senate Commerce Committee
128 Russell Senate Office Building
Washington, D. C. 20510

Dear Mr. Sutcliffe:

As I indicated to you in my letter of June 16th we had heard considerable talk that State Farm's costing of Senate 354 was quite different and substantially lower than the costing to which Allstate testified in your Subcommittee hearings on April 30, 1975. Perhaps as a result of that letter the Committee mark-up sessions of Thursday, June 26th, became open sessions and State Farm was invited to present their costing of Senate 354. From the transcript of that mark-up session and the letters from State Farm to the Committee it becomes much more understandable why Allstate and State Farm actuaries did arrive at substantially different costing conclusions. While the session did not produce a detailed explanation of all of the State Farm assumptions, calculations and projections, it did become apparent that certain major assumptions caused the costing spread rather than any difference in calculations or actuarial computations.

The first substantial difference is that when Allstate appeared on April 30th we costed Senate 354 in its form as of that date. Apparently State Farm later was furnished with an advance copy of the Staff working draft which had been amended in ways which made a major difference in the cost implications. At the time of our costing, Section 111 precluded Loss Cost Transfer activity among insurers in commercial vehicle private passenger accidents unless the economic loss exceeded $5,000. That provision saved money for commercial vehicles to the detriment of private passenger vehicles. The Staff draft which State Farm costed reduced the $5,000 figure to $100 and this provision was

subsequently adopted by the Committee as an amendment to the bill. This amendment, if interpreted as we assume it was intended, substantially changes the cost impact of Senate 354 on private passenger automobiles and requires an updating of our costing projections. We are attaching this update as Exhibit A.

The other differences in State Farm and Allstate costing reflect a differing assumption on the probable amount of survivor's benefits and some differences in the assumption made as to whether or not increased utilization of medical services will result from requiring each state to provide unlimited medical and rehabilitation coverage for victims of automobile accidents.

On the first point relating to survivor's benefits, State Farm assumed that the states would select a $5,000 survivor's benefit and we assumed, and still assume, that the states would select a $15,000 survivor's benefit. This difference is of major significance in costing because the survivor's benefit is a major cost component.

Why did we settle on $15,000 as a probable figure? We reviewed existing state no-fault laws and found that the present pattern was for states to establish survivor's benefits at the same level as loss of income benefits (the minimum income loss benefit under Senate 354 is $15,000). It seems obvious to us that a national no-fault bill which is alleged to take care of all major economic loss, provides unlimited medical expenses and a minimum of $15,000 income loss, would be expected by the public to provide more than $5,000 survivor's benefit in the compensation scheme which has been established. As to dependent survivors, if they need $15,000 income compensation during pendency of the injury they are at least in equal need if the victim dies of the injury. Perhaps survivor's benefits should be excluded because they are an experience component, but if included they must be reasonably adequate.

Certainly this was the approach used by the National Conference of Commissioners on Uniform State Laws in drafting UMVARA, the model bill on which Senate 354 was technically based, and which recommended that states establish survivor's benefits at the same level as wage loss benefits.

The general approach of equating survivor's benefits with income loss benefits has been followed in Connecticut, Kansas, Kentucky, Michigan, Minnesota, Nevada and New Jersey. In an instance or two this provides survivor's benefits substantially over $15,000 because the income benefit levels are substantially higher and in a number of instances this provides survivor's benefits substantially under $15,000 because the income loss benefits are at a substantially lower figure. However, if the Federal bill would require the states with lower levels to increase the income loss to a minimum of $15,000 we believe they would be almost required to establish survivor's benefits at the same level.

Certainly Senate 354 is intended to require adequate benefits for survivors and in the general scheme of the bill $5,000 would certainly not be an adequate benefit. Accordingly, we believe fairness demands, and the public interest requires, that the cost projections circulated by the Committee and other proponents of Senate 354 be premised on what is likely to happen in the real world. Thus Senate 354 should be costed on the basis of $15,000 survivor's benefits. To require the states to provide unlimited medical expenses and a minimum of $15,000 income loss and to then assume for costing purposes $5,000 survivor's benefits flies in the face of common sense and actual need.

This difference in assumption of survivor's benefits accounts for most of the apparent difference in the costing provided by State Farm and the up-dated costing provided by Allstate. Our Exhibit A with our new costing based on the present provisions of Senate 354 results in doubling the number of states which on a state-wide basis would experience price reductions under Senate 354. However, 38 states would still experience increases ranging up to 56% in Georgia and 76% in Kansas. On an average countrywide basis our projections indicate complying with Senate 354 would increase Allstate's automobile premiums by 4.4%. Of course, there is a great variance among states as I have indicated.

On the subject of whether or not complying with the standards set forth in Senate 354 would produce increased utilization of medical benefits, we believe there could be no doubt based on present experience that this would result. In Florida even with a limited medical benefit, we find a major escalation of utilization. In New Jersey with the

unlimited medical benefits in effect which would be required elsewhere under Senate 354, we find a fantastic escalation in utilization producing major cost increases in first-party benefits. We find it difficult to believe any company writing a substantial amount of no-fault automobile insurance in Florida and New Jersey would not agree with this assumption. Certainly with regards to New Jersey the comments of the Reinsurance Association indicate the belief that unlimited medical coverage will cause a major increase in utilization and a substantial increase in reinsurance costs for smaller companies required to reinsure this coverage.

We believe our assumptions relate to actual experience and common sense. While differing distributions of business will produce some variance between State Farm and Allstate costing from state-to-state, even using the same actuarial techniques, it appears to us that the overall computations are substantially identical with the exception of these two differing assumptions. It is these two differing assumptions which produce the overall differences in costing produced by the actuaries of the two companies.

Accordingly, we are submitting Exhibit A as our costing which would apply to about 85% of our policyholders who presently carry broader form coverages. The other 15% of our policyholders who presently carry minimum coverages would be required to pay somewhat higher rates, but Exhibit A relates to the great body of policyholders who presently carry broader coverages.

We still believe that a good deal more experience is needed in the various states and that the enactment and modernization of state automobile compensation laws should be left to the states and not at this time mandated by the Congress. We still do not believe enough knowledge has accumulated to see a clear national pattern which would work effectively and equitably in every state.

Accordingly, we are submitting this letter to update the costing data available to your Committee.

Sincerely,

Donald L. Schaffer

DLS:jz
Enclosure

State	Cost of S. 354 As Favorably Reported By Commerce Committee (1)
Alabama	+ 18.1
Alaska	+ 17.1
Arizona	+ 17.5
Arkansas	+ 9.5
California	+ 2.9
Colorado	+ 37.5
Connecticut	+ 2.0
Delaware	+ 2.1
District of Columbia	- 10.4
Florida	+ 9.3
Georgia	+ 52.0
Hawaii	+ 3.2
Idaho	+ 34.3
Illinois	- 7.3
Indiana	+ 25.0
Iowa	+ 24.1
Kansas	+ 76.1
Kentucky (2)	- 7.9
Louisiana	- 1.0
Maine	+ 2.7
Maryland	- 11.3
Massachusetts	- 11.6
Michigan	- 14.6
Minnesota	+ 45.5
Mississippi	- 2.1
Missouri	- 1.1
Montana	+ 32.5
Nebraska	+ 36.8
Nevada	+ 14.1
New Hampshire	- 9.0
New Jersey	+ 4.9
New Mexico	+ 20.8
New York	- 10.3
North Carolina	+ 7.9
North Dakota	+ 39.8
Ohio	+ 7.4
Oklahoma	+ 0.0
Oregon	+ 22.0
Pennsylvania (3)	+ 24.8
Rhode Island	- 11.4
South Carolina	+ 17.8
South Dakota	+ 36.3
Tennessee	- 6.1
Texas	+ 10.5
Utah	+ 39.2

State	Cost of S. 354 As Favorably Reported By Commerce Committee (1)
Vermont	+ 28.7
Virginia	+ 30.8
Washington	+ 18.2
West Virginia	+ 1.2
Wisconsin	+ 4.4
Wyoming	+ 31.0
Countrywide	+ 4.4

FOOTNOTES

(1) This pricing is based on those insureds who carry bodily injury liability, uninsured motorist coverage, medical payments, or personal injury protection coverage (PIP) in no-fault states, and any excess medical payments or excess PIP coverages. While these coverages are representative of approximately 85% of Allstate insureds, they substantially exceed those coverages required by law in most states. Thus, that group of insureds which carry only the minimum required by law, which presumably would include most low-income persons, will experience even greater price increases or lesser price decreases, depending on the state in question.

(2) Kentucky cost projections are based on Kentucky premium levels under that state's tort system. Optional no-fault program becomes effective in Kentucky July 1, 1975.

(3) Pennsylvania present premiums are based on projected no-fault costs as of July 19, 1974.

Attached is a copy of the latest No-Fault communication between the Allstate Insurance Company and the Senate Commerce Committee, dated July 3, 1975.

The figures reflect the changes in the bill which required adjustments in Allstate's original cost projections delivered to the Committee on April 30, 1975.

Two things should be noted. First, the Allstate figures are conservative in that they are based on the driver who carries "med-pay" and "uninsured motorist" coverage. Motorists without this coverage would receive even greater price increases. Second, where Allstate reflects a 4.4% increase "countrywide" they have weighted the state figures by the number of Allstate policies sold in each state. An averaging of the state average increases shows a nationwide average increase of about 14% while an extrapolation weighted to the number of passenger vehicles registered in each state shows a nationwide increase of about 18%.

All of these figures clearly indicate a need for further experimentation by the states. The results in the states do not make a case for Federal No-Fault.

AUG 18 1975

NO-FAULT: FAILURE

by Craig Spangenburg

The pending federal no-fault auto insurance bill, S. 354, demands that every state enact a no-fault system which will provide as a minimum: medical and rehabilitation expense payments unlimited in time and amount; wage-loss payments up to $1,000 per month for 15 months (average amount per state variable by formula); "reasonable" replacement-of-services benefits (dollar amount undefined); and, "reasonable" survivors' benefits in death cases (dollar amount undefined, but assumed in the major costing formula to be *only* $5,000). These benefits are coupled with a tort exemption which will abolish all general damages unless the victim suffers death, permanent or serious injury, or total continuous disability for 90 consecutive days.

Twenty-four states have now enacted no-fault plans. Twenty-two have benefit amounts less than the federal minimums. The other two have lower thresholds. Thus, every existing state plan will be obliterated by the federal "minimum" standards. ATLA has long urged Congress to wait until actual performance figures are in from the state experiments rather than to enact national standards based on hypothesis. It takes about two years after a state plan becomes effective to generate fairly reliable "real-world" statistics. A few states have now run diverse no-fault plans long enough to provide hard data on the comparative performance of high-threshold and no-threshold (or "add-on") systems. Experience has proved that the threshold plans are rank failures.

The failures were predictable to any thoughtful analyst. First, there are only 100 cents to a premium dollar. A system which pays out more dollars in benefits has to take in more dollars in premiums if the expense percentage remains constant. No-fault proponents have long promised that a threshold system would pay more victims, would pay twice as many benefit dollars, and would reduce premiums 15% to 25%. The promise was too good to be true, but it did generate hope for the miracle. The miracle has not happened. It cannot. No-fault has paid 40% *fewer victims* in Massachusetts. It has paid about 35% more victims in other states than tort alone (not counting medical-pay benefits). It has paid more dollars in most states, but it has not reduced system expense. Premiums have risen sharply compared to traditional tort states, where the bodily injury liability premium has been stable for the past five years. Large thresholds have not reduced residual tort costs nearly as much as predicted. Residual tort claims alone may cost *more* than the total tort system formerly cost. The "add-on, take-off" system which does not impair the tort remedy at all, but reduces tort recovery by the amount of first-party benefits, has reduced tort costs just as much as the threshold plans.

The cost of losses paid by an insurance system is calculated by a simple actuarial formula: frequency times severity. "Frequency" means the number of claims received from every unit number of policies sold. A frequency index of 5% would mean that every 100 policies sold would produce five separate claims. "Severity" means average claim cost.

If four of the five claims per 100 policies were settled for $250, and the fifth cost $4,000, the average claim cost would be $1,000. When smaller claims are knocked out of a system, frequency decreases but severity increases. In the example, if the four small claims were knocked out by a threshold but the large fifth claim remained, frequency would drop from 5% to 1% but severity would increase from $1,000 to $4,000.

Allstate recently released its figures on residual tort claims from several

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states. All of the states have verbal thresholds defining the type of serious injury or disfigurement which passes the threshold, and a general minimum medical-expense threshold of a specified dollar amount. New York has a $500 medical-expense threshold. Frequency has decreased by 40%. That is, only 60% as many victims now make a residual tort claim, after passing the threshold, as formerly made tort claims under the unrestricted liability system. Severity has increased by 50%. That is, the average residual claim costs 150% as much to close as the average tort claim cost before no-fault. The resulting cost index, frequency times severity, shows a change measured by 60% times 150%, or 90%. That is, residual tort claims now cost .9 times as much as the total tort system used to cost. Savings are far less than the predicted amount and will not fund the high level of New York first-party benefits. Premiums must rise, and the insurers are now demanding substantial rate increases.

New Jersey has a medical-expense threshold of only $200. It was predicted in New Jersey that this modest threshold could not reduce residual tort costs as much as the New York $500 threshold could. In fact, the New Jersey performance is identical. Frequency of above-threshold claims is 60% of former tort claims, and the severity of residual claims is 150% of former tort claims. Residual tort costs 90% as much as the whole tort system used to cost, and that saving will not pay for the additional first-party benefits. New Jersey has experienced heavy rate increases.

Connecticut has fared worse, with an intermediate threshold of $400 in medical expense. Frequency is down by a surprising 70%. Only 30% as many victims make claims after passing the threshold, but the increase in severity more than matches it. Average claim cost is 350% of the former tort average. The resulting index, .3 times 3.5, gives a combined index of 1.05. That is, residual tort in Connecticut now costs 5% more that the total tort system cost in benefits paid before no-fault. Premiums must increase as costs rise.

In Florida it was predicted that a moderate benefit package of $5,000 for combined medical expense and wage loss, coupled with a $1,000 medical-expense threshold, would produce premium savings of at least 15%. At the time Florida enacted no-fault, State Farm's average premium cost in the Miami territory for $15,000/$30,000 bodily injury, $10,000 property damage, medical pay, and uninsured motorist coverage was $72.20. After no-fault, the same coverage for the same average motorist in the same territory, plus $5,000 in first-party personal injury protection benefits, has required a series of premium increases culminating in a rate filing of $120.94 in October 1975. That is a 68% *increase* instead of the predicted 15% decrease!

Part of the reason for the Florida failure is the heavy utilization of first-party benefits. A major additional reason is the failure of high-threshold no-fault to reduce the cost of residual tort claims. Returning to Allstate's actual cost figures, frequency in Florida is down to 35%, but severity is up to 330%. Only 35% as many claimants now exceed the threshold and make claims, but the severity factor of 330% shows that the average claim cost for the residual claim is 3.3 times the average claim cost under tort. The combined index, .35 times 3.3, is 1.15. In short, residual tort claims in Florida cost 15% more than the total tort system formerly cost.

Compare Oregon, which elected to try a mandatory add-on, take-off plan. Every liability policy sold must carry a first-party rider providing more benefits for medical pay and wage loss that the Florida plan does. There is no

(continued on page 44)

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70 LEGAL PROBLEMS IN BROADCASTING

Hypothetical 5–1

Upon his return from covering a spectacular nighttime fire, the ambitious young news reporter learned to his dismay that the cameraman had gotten no usable footage.

Believing that the impact of the story depended upon an "on-the-scene" look, the reporter donned a sou'wester and had himself filmed in front of a rear screen, projecting some stock film footage of an apartment fire, while a sound effects record blared sirens and "fire sounds" under his voice. The result was an amazingly realistic news story, unless the viewer spotted the 1938 fire engines. The facts of the real fire were told, and thanks to the film, they were told in an exciting way.

Since that time, the station's news department has employed this technique whenever technical difficulties, staff shortages or cost factors make it impossible or inconvenient to provide on-the-spot coverage.

The question finally was asked: Is this news staging?

Comment:

So long as the facts of the story are truthfully told and the audience does not receive a deliberately distorted version, this practice would not fall within the broad category of news staging.

However, the practice must be judged by the standards of journalistic integrity as well, and on that score it may represent a serious breach of faith between the media journalist and his audience. The technology of the media is capable of indetectable conjury. While these techniques are useful in the illusions of stagecraft and have considerable entertainment value, they have no place in news programming, unless the media journalist has a low regard for factual reporting.

The "Extrinsic Evidence" Test

The FCC has developed vague criteria for judging whether a charge of news rigging or slanting warrants investigation and, if the charge is found true, justifies revocation or denial of renewal of a station's license. A Commission inquiry or investigation is deemed appropriate where extrinsic evidence materially indicates that a licensee has staged news events.

Extrinsic evidence does not include the typical situation where someone who is quoted on a news program claims that he said something other than what was reported. Allegations that a newsman had been offered a bribe to slant the report of a certain event would be sufficient, however.

The Commission has emphasized that the extrinsic evidence must indicate that a licensee, as differentiated from an employee such as a newsman, is responsible for the staging or distortion. Concomitantly,

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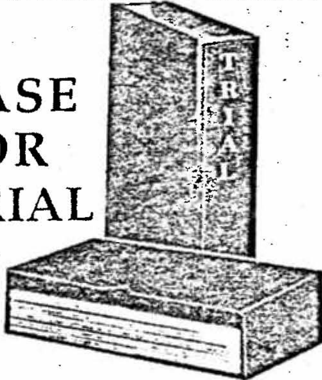

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restriction on tort claims, except that the victim who chooses to pursue a tort remedy must pay back the first-party benefits out of his recovery if he makes one. This reduces the total cost of first-party benefits in the system and effectively discourages the making of uneconomical small claims. As a result, the frequency of tort claims has been reduced by 25%. At the same time, the severity index has increased only 20%. That is, 75% as many tort-eligible claimants now pursue the tort remedy, and the average claim now produces a 20% higher settlement. The resulting cost index is 90% (.75 × 1.2) which means that the unrestricted tort system now costs 10% less than the old tort system. The cost saving is the same as that produced by the New York and New Jersey thresholds, and greater than the saving under the Connecticut and Florida thresholds. There is no pressure on a claimant in Oregon to over-utilize his medical benefits in order to build a claim above a threshold, and, as a result, Oregon has maintained low premium rates without increases for the past three years.

Congress has, in the past, relied heavily on the Milliman and Robertson costing formula to predict no-fault savings. The Milliman and Robertson study (hereafter called M & R for short) contains in Appendix II a state-by-state prediction comparing the cost of the state's pure tort system with a "Low Benefit-Loose Threshold System." "Low Benefit" means: unlimited medical; $15,000 wage loss; and $5,000 in death benefits. The "loose threshold" is death; serious and permanent injury; or 60 days of continuous total disability, which M & R says is equivalent in effect to a $600 medical-expense threshold.

M & R estimates that with a $600 threshold, general damages will be reduced to 58% (on a 50-state average) of the general damages paid by the tort system. In reality, no state has come close to that saving, even with higher thresholds. M & R also estimates that the benefit schedule will pay out 198% as much in economic-loss payments per "radix," or base, of 100,000 injured victims as the tort system pays. These estimates, if valid, will compel higher premiums. The tort-liability system for the past decade has paid out over 60 cents of the premium dollar in losses to claimants. Insurance company expense for sales, acquisition, general and administrative expense, taxes, and all loss-adjustment and claims-

fault systems have produced no savings in the total expense ratio, and no actuarial formula predicts any substantial change in the expense ratio.

Under pure tort, according to M & R, 50% of the claim payment goes for economic loss and 50% goes for general damages. This produces a simple table:

Premium Dollar

All expense and profit by the insurer	40%
All payment for economic loss	30%
All payment for general damages	30%

If the prophecy for no-fault is correct, the 30 cents for economic loss would increase by 98% to 59.4 cents. The 30 cents for general damages would decrease by 42% to 17.4 cents. Combined payout would increase from 60 cents to 76.8 cents. This would require a premium of $1.28 in place of each present $1.00 in order to maintain the 40% expense ratio. Total expense would increase to 51.2 cents.

M & R has two mathematical devices to reverse the apparent cost increase. First, M & R assumes that all medical payments under voluntary options are part of the tort liability system. Clearly they are not tort payments at all, but a voluntary no-fault add-on. Curiously, M & R counts medical pay as part of tort cost, but does not count the number of claimants receiving medical payment as victims paid by tort. Using medical payment as an increase in tort cost, M & R predicts that total no-fault payments will be only 12% greater, on a 50-state average, than tort-system payments. This should still require a premium increase of 12%, except for the second mathematical device, the "per-insured" cost.

M & R assumes that all of the tort cost is borne by 80% of the drivers who are estimated to be insured under the present non-compulsory system. It is further assumed that half of the presently uninsured drivers would buy the compulsory no-fault coverage, so that all no-fault cost would be borne by 90% of the motorists. The cost per driver would be represented by the fraction 100/80 for pure tort, 113/80 for tort plus medical pay, and 128/90 for compulsory no-fault. The fraction 113/80 is essentially equal to 128/90 and therefore no-fault should cost each driver the same amount on average as tort does, while paying 12% more in

Spangenburg *from p. 44*

Obviously this is a paper argument in favor of compulsory insurance. If tort were compulsory and produced a 90% insured ratio, then tort would either pay 12% more in benefits or be 12% cheaper. Indeed, the M & R formula predicted that when Kentucky adopted its unique optional system, in which a driver must elect whether to take a no-fault system and accept a threshold on his tort rights or take a straight tort system with no loss of rights, the no-fault system would cost 12% more than the tort system.

The essential fallacy of the whole compulsory argument is that it assumes, first, that half the uninsured drivers will in fact buy the insurance with no added enforcement cost; and second, that the newly insured drivers will have the same claim frequency and claim severity as the group of formerly insured drivers. On this point the state of New Jersey can furnish some threatening statistics. When no-fault became compulsory, it did happen that about half of the uninsured motorists in the state bought the new coverage and were added to the pool of insured drivers. The first year's results have demonstrated that this class of insured drivers had an accident and claim frequency *2.19 times as great* as the formerly insured group. Furthermore, the severity, or average claim cost, was *1.38 times* the average of the older insureds. The cost index, frequency times severity, was 3.02.

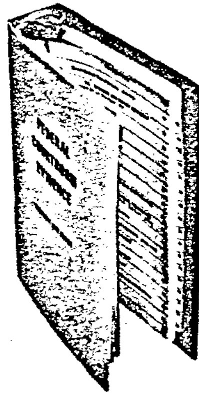
In short, the cost to the insurer in loss payments when he took on the newly insured driver under compulsory no-fault was three times as great as the average cost in claim payments for the class of formerly insured drivers. It did not reduce cost per driver, as M & R had predicted, but substantially increased it.

Florida had a similar experience. A relatively small percentage of new insureds were added to the system, but the new insureds had a cost 76% greater than the former insureds. A net loss to the system resulted.

In the legislative debates over no-fault, the American Insurance Association, the American Mutual Insurance Alliance, State Farm Mutual Insurance Co., and Milliman and Robertson have all produced costing formulas which predicted varying percentages of increased benefits and decreased premiums. Every one of the formulas has been shown to be false by current experience. Allstate's formula predicted premium increases. It too was in error, but not greatly so. The dicted by the Allstate formula, but it has been far closer to the mark than the rosy optimism of the other costing predictions.

In summary, no-fault has not kept its promises. There are no miracles. It is not more efficient. It does not deliver substantially greater total benefits. It does not reduce system expense ratios. It increases rather than decreases premiums. It does restrict the rights of many innocent victims, but does not produce the great savings guaranteed by its proponents. It does force the private passenger car driver to subsidize the commercial driver, the good driver to subsidize the bad driver who hits him, the prudent driver to subsidize the reckless driver who wraps his car around a tree, the adult driver to subsidize the juvenile driver, and the rural driver to subsidize the urban driver — these are not necessarily good and just results. Threshold no-fault has failed. Modest-benefit, add-on, take-off plans still offer some promise.

Further experience is necessary before any ultimate standard can rationally be formulated. Federal standards based on conjecture would be a disaster.



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TRANSCRIPT OF REMARKS BY CRAIG SPANGENBERG ON NATIONAL NO-FAULT*

MR. SPANGENBERG. The bill, S-354, which is before you, in general calls for unlimited medical payment and rehabilitation expense payment, a rather complex formula for calculating wage loss, but with the states now permitted to limit total wage loss payments to an average of $15,000. A very loose provision on death benefits which says simply that the states may provide for a reasonable amount of death benefits, and the states may also provide for a reasonable amount of survivors' loss, with no definition whatever of what that "reasonable limit" might be.

On that level of benefits, coupled with the present tort exemptions, there have been three major cost studies. One is by Milliman and Robertson, one is by State Farm, one is by Allstate, and one is by the committee staff itself.

I don't intend to take much time going through them, but you should know the basic differences between them. Milliman and Robertson is the original cost prediction for the bill. In addition to predicting costs for old S-354, they did an analysis of variants of three different possible forms of S-354, and compared it to the tort system.

The analysis is basically fraudulent. The tort system as defined by M&R is not the tort system; it is the tort system plus all medical payments on the assumption that every driver in the state carries medical pay in the state average amount. This increases the relative cost of tort.

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*Mr. Spangenberg is Co-Chairman of the ATLA Automobile Accident Reparation Committee. The transcribed remarks were delivered as part of the report of that Committee to the ATLA Board of Governors on November 8, 1975 at The Breakers, Palm Beach, Florida.

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from Peter A. Neumann

In addition, the M&R formula has a very ingenious mathematical device for proving that what costs more costs less. When you go through the whole analysis in just about every state they predict a cost increase. In order to show a cost decrease, however, they then do a kind of mathematical trick. I will deal just with national average rather than state by state figures.

They say that on average, nationally, about 80 percent of drivers buy tort liability insurance; therefore the cost of paying for the tort system falls on 80 out of a hundred drivers.

They further assume that under no-fault, because of the compulsory features, 90 percent of the drivers will be insured. Therefore they say no-fault costs will be borne by 90 out of a hundred; therefore you divide tort costs by 80, you divide no-fault costs by 90. The difference is twelve and a half percent.

So in effect they say if no-fault costs twelve and a half percent more, it costs the same, by going through the cost per insured. The answer to that is now coming out of state statistics and I think it's a very important answer.

I have done some writing on it. First of all, Professor Brainard pointed out last year in his testimony that this is not an argument for no-fault. It is simply an argument on paper for compulsory insurance. If you made tort compulsory, you would have to divide both numbers by 90. Then if no-fault did cost more, it would still cost more.

The best example of that is Kentucky, which did pass a bill making it compulsory to buy either no-fault or tort. You had to buy one or the other. If you elected to remain in tort, you gave up any no-fault benefits, but you kept your right to recover in tort.

The Milliman & Robertson comparison in Kentucky is beautiful. They predicted that in Kentucky no-fault would cost 14 percent more than tort, when both systems operated in the same state with the same people, same highway, but both compulsory. That's just one part of it.

The second major assumption in that mathematical device you should understand is that if you predict that you can save costs per insured by compelling more people to buy insurance, you are necessarily implying that when you bring in the twelve and a half percent additional insureds they will have the same accident ratio and the same loss ratio as the whole group of old insureds.

Now, Milliman & Robertson concededly makes that assumption. The new insured will have the same cost impact as the old insured. Therefore you can divide it by 90 instead of by 80 and get an accurate result.

Actual figures have shown that assumption is invalid. In New Jersey where we now have some very good figures, it was true that compulsory no-fault in the state did compel about half of the uninsured drivers in the state to become insured. The uninsured drivers had an accident ratio so much higher than the old group of insureds, and with severity so much greater than the old group of insureds, that it actually cost more to bring into the system the worst drivers in the state, instead of costing less.

The same has not quite been true in Florida because not half of the uninsureds did buy insurance. Some did. Those that did had a cost to the system of about 75 percent more on average than the old insureds, which is part of the reason for the cost increase in Florida.

If you have followed that, you will understand that the fact that state plans have now been in operation long enough to develop some actual statistics for no-fault has enabled us to make comparisons of how valid the Milliman and Robertson formula was. Its accuracy index is about minus 35 percent.

That is, in states that have adopted no-fault, if you apply the M&R formula, the actual cost to the state is in fact about 35 percent greater than the formula predicted.

Florida, for example: M&R formula says 15 percent decrease for the Florida plan. Florida fact: 20 percent increase rather than fifteen percent decrease.

The M&R formula has not proved out in New Jersey, New York, in Michigan, and that allows me for the first time since 1968 when you gave me the job of being a no-fault researcher -- has given me some optimism that the tide is running our way and that no-fault may achieve the failure it deserves.

The great benefit we have had this fall has been the Allstate cost predictions. Their formula originally did predict cost increases. The A.I.A.'s formula predicted great cost savings; Milliman & Robertson moderate cost savings; State Farm, moderate cost savings; A.M.I.A., about even on cost; and Allstate's formula predicted some increase in cost. Those are all theoretical.

Allstate's actual figures now have shown that their formula was the most accurate of all the formulas, but their formula in itself underpredicted the actual cost. That is, the formula that predicted the highest cost increase did not predict them as high as they have been in fact.

The Price of No-Fault

By Craig Spangenberg

One of the most infuriating forms of disillusionment is finding out that all the old clichés are true; it's hearing I told you so once too often. In this sense, evaluating the economic value of no-fault insurance to the average consumer is particularly frustrating. Despite all the attention and acclaim the no-fault rules have received, a look at some basic facts and figures of insurance mathematics reminds us that the old maxim still applies: You get what you pay for. If no-fault insurance delivers a substantial increase in consumer benefits, it will only be at the cost of proportionally higher premiums. The simple rule of insurance cost is that for every 15 cents in additional benefits the consumers obtain, they must first pay 25 cents in insurance premiums.

The automobile industry delivers back to the consumer, in benefits, 60% of the premiums paid in to the system. Benefits equal .6 times cost. The reverse is necessarily true: Cost equals 1.67 times benefits. B=.6C. C=1.67B.

To better understand this principle, examine the facts. The premium dollar contains only 100 nonstretchable cents. No theory and no rhetoric can increase its content or its value. The one premium dollar must be divided up to pay the benefits to claimants and the insurance company expenses, with enough left over for a profit. (In the vocabulary of insurance, benefits gained by the claimant are called "losses incurred." The expenses of the insurer are classified as: "commissions and brokerage;" "other acquisition," which includes advertising and promotion; "general," or "general and administrative;" "taxes;" and "loss adjustment." All of these expenses come under the umbrella term, "underwriting expense." The detail for each expense item of every property and casualty insurer in the United States is published once a year in the authoritative compilation of A. M. Best & Co., called "Best's Aggregates and Averages.") Simply stated, total premiums minus total underwriting expense equals underwriting profit or loss. Calculations can be made in either dollars or percentage.

Profit and loss figures vary from year to year, but in general, the expenses as a percentage of premium remain the same for all the common lines of insurance. The constant ratio, for all lines of automobile insurance for many years, has been about 38% of premium to cover expense in all the automobile liability lines; and 35% to 36% for the auto physical damage lines, such as collision, comprehensive fire and theft. The ratio will remain the same under no-fault. It does so in theory, and it has proven so in fact in the laboratories of existing state no-fault systems.

Suprisingly, automobile insurance has the lowest expense ratio of all the common lines of individual coverage the consuming public buys. It is not the "least efficient," as no-fault propagandists shout, but the most efficient. Best's "Aggregates and Averages" prove this every year.

To find the expense ratio: Take the annual totals for every different line of insurance for every stock insurance company and every mutual insurance company; add the annual totals for every different line of insurance for every stock insurance company and every mutual insurance company; add the loss incurred percentage to the underwriting profit or loss percentage, plus or minus, and deduct this total from the premium total. The result will be the total of all expenses, including loss adjustment expense.

Example: In Best's 1974 edition, the grand total of premiums for all the fire insurance writers in the United States, both stock and mutuals, was $2.448 billion. The stock companies had a loss incurred ratio of 50.6%, with an underwriting profit of 10.3%. Combined loss incurred and underwriting profit was 60.9% Deducting this from 100% of premium yields 39.1% of the premium as the total of all the expenses. The mutual fire insurance writers paid out 46.0% of premiums in losses incurred, with an underwriting profit of 17.2%, which leaves 36.8% of the premium as the amount paid for total expenses.

The weighted average for combined stocks and mutuals was 38.7%. In general, the mutual companies have a lower expense ratio than the stocks, and a higher underwriting profit by a few percentage points, but the stock

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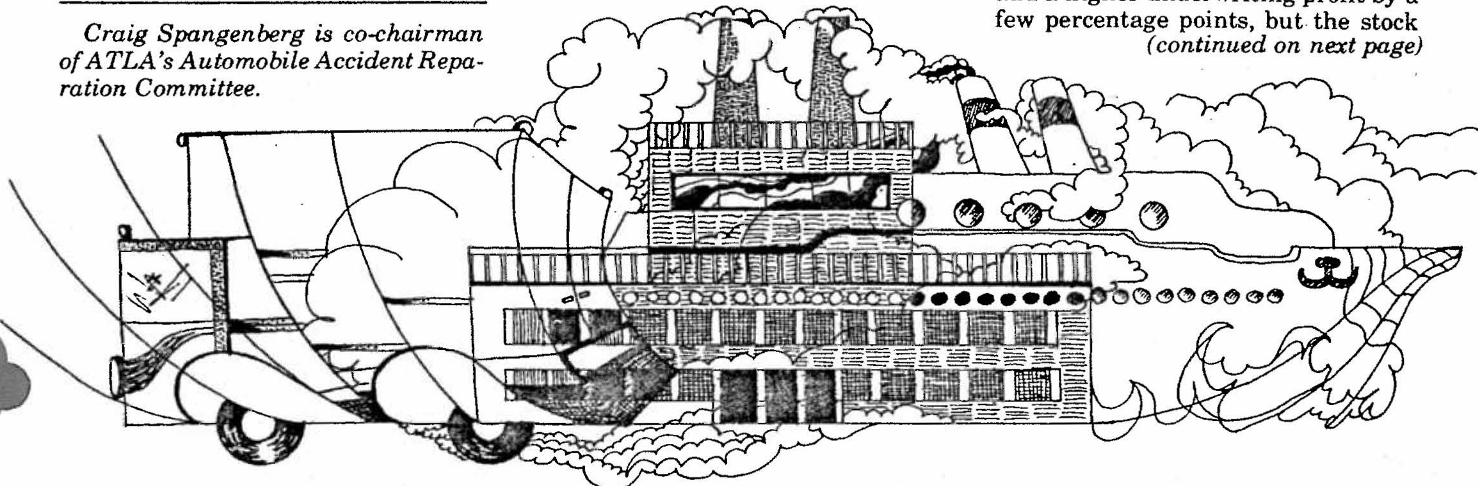
Craig Spangenberg is co-chairman of ATLA's Automobile Accident Reparation Committee.



companies command a much larger share of the market and write about five times as much business as the mutuals.

Dealing with expense ratios only, the same method of computation yields the following retained expense ratios for all the common lines of property or casualty insurance the individual consumer might buy:

Best's 1974 ratios

Total expense retention of combined stock and mutual companies

Fire insurance	38.7%
Allied lines	39.8
Homeowner's	42.2
Inland marine	40.1
Miscellaneous liability	51.7
Non-group accident and health	43.6
Private passenger auto liability	37.4
Private passenger auto physical damage	35
Commercial auto physical damage	37.2
Combined auto, private and commercial, liability and physical damage	37

Note that the total private passenger auto liability premiums in 1974 were $8.45 billion. At least 35% of this premium was for property damage liability, which is not affected by no-fault. The premium in which the consuming public has a stake under S.354, private passenger bodily injury liability, was about $5.5 billion in the 1974 report of Best's. This is substantial, but nowhere near the newspaper columnists' figures of a "Twenty Billion Dollar industry" which will be changed by no-fault.

The 1974 compilation shows that the stock companies paid out 64% of their premiums in their private passenger auto liability line in losses incurred, with an underwriting loss of 2.3%. The mutuals paid out 60.8% in the same line with an underwriting profit of 3.5%. The industry underwriting loss, weighted average, was 0.2%, or very nearly break even at a weighted average payout of 62.4%.

It is a financial rule of insurance that in the auto liability lines $1.00 of premium will generate $1.00 of reserves. The investment profit on reserves makes the insurance business profitable at a break-even, or zero, underwriting profit. Nevertheless, an underwriting profit of 2% is not unreasonable, and consumers should be satisfied with an expense ratio of about 38% in the liability lines, with a payout of 60%, and insurer's underwriting profit of about 2%.

No-fault systems can do no better. Many factors tend to drive expenses up and to shrink reserves. Since investment income on the reserve accounts must diminish under no-fault, the insurance companies need a higher margin of underwriting profit in order to retain their capacity to satisfy the market demand for new and renewal policies. Confirmation of these ratios may be found in the Report of Hearings before the House Subcommittee on Consumer Protection and Finance on the House versions of federal no-fault bills. On page 595 of the Report (Serial No. 94-42, late 1975), the following table is included in the testimony of T. Lawrence Jones, president of the American Insurance Association:

Distribution of premium dollar stocks, mutuals, reciprocals

Private passenger and commercial auto liability (percent)

	Tort system	No-fault
Operating expense (commissions, other acquisition general administrative, taxes)	26	26
Loss adjustment	12+	9.5*
Losses incurred	60	60
Underwriting profit	2	4.5
	100	100

+Actual *Estimated

A caveat should be entered that the prophecy of a reduction in loss adjustment expense by 2.5% of the premium, (based on the Milliman and Robertson formula) has not been realized in actual experience in the no-fault states. There is little hope for a reduction in adjustment expense percentage, which means that the theoretical underwriting profit of 4.5% will be reduced to 2% if payout remains at 60%. This may be an inadequate profit margin for industry health if investment income continues to fall as reserves are reduced.

In summary, auto liability insurance expense and profit take 40% of the premium. Benefits to claimants can properly take 60% of the premium. Higher benefit levels lead to underwriting loss. These ratios have held true for more than a decade, and remain true under no-fault systems as they did under tort. Tort benefits cost the consumer $1.00 in premium for every 60 cents in benefits. If no-fault delivers additional benefits, the added benefits will cost 50 cents in added premium for every additional 30 cents received by the public. The benefit is .6 times premium. The cost in premium is 1.666 times the benefit.

The "bargain" for the consumer is an illusion. The staff of the Senate Commerce Committee has invented a table of benefits, published at page 595 of the Commerce Committee Report on 2.354, which states that on a national average 37% more victims will receive compensation under S.354, and total benefit dollars paid out will be 43% greater than tort system benefit dollars. If these figures were true, it would mean that the consumers face a 43% premium increase. Benefits, at 60 cents of the premium dollar, would rise to 86 cents (tort plus 43%). Expenses, at 40 cents of the premium dollar, would rise to 57 cents (tort plus 43%). The premium, compared to each $1.00 for tort liability, would rise to $1.43. The consuming public would receive 26 cents more in benefits than the tort system provides per dollar of premium, but would have to pay 43 cents more per dollar of tort premium to get that 26 cents. The rule would hold: Cost=1.67 Benefits.

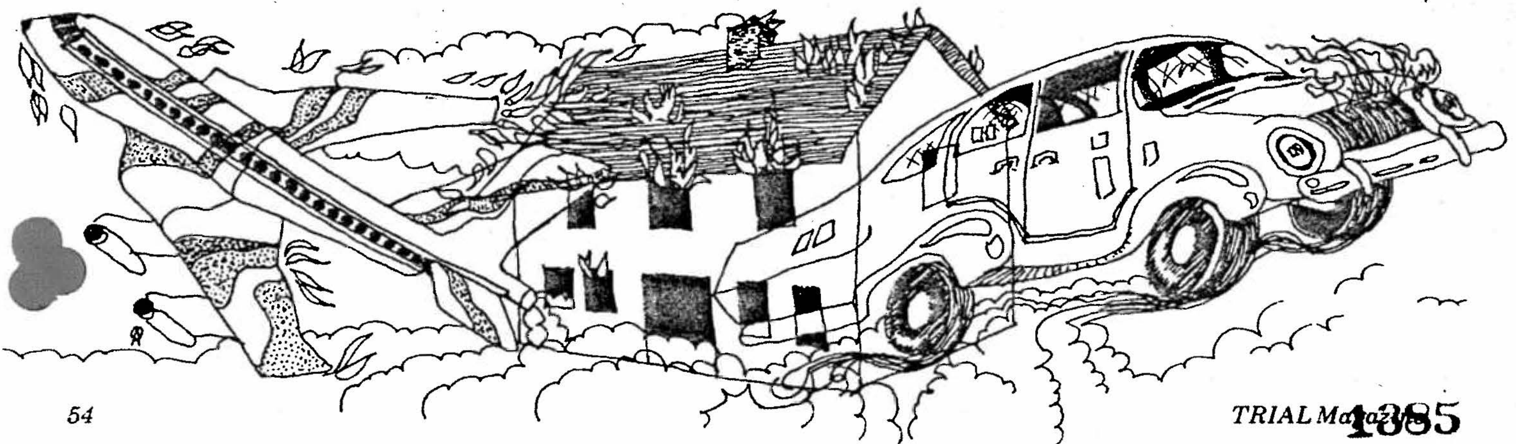


Exhibit C

MEMORANDUM

TO:	Senator Thomas R.C. Wilson, Chairman Senate Commerce and Labor Committee	DATE:	March 29, 1977
FROM:	George L. Ciapusci, Property Claim Superintendent, State of Nevada State Farm Insurance Companies	RE:	S.B. 350 - Repeals basic reparations provisions of automobile insurance

As requested of me during the March 28, 1977 Committee Hearing on the captioned, I provide you and your Committee with data relative to State Farm Insurance Company's history in the State of Nevada since the inception of the No Fault Act. For comparison purposes, I provide data from 1973, the year before No Fault was the law, through 1976.

During the Committee Hearing I testified State Farm Insurance Company's policy count in the State of Nevada totaled 92,591 as of December 31, 1976. This policy count is the combined total of two State Farm Companies which write automobile insurance in the state. These are State Farm Mutual Automobile Insurance Company with a policy count of 85,525 and State Farm Fire and Casualty Company with a policy count of 7,066. The Mutual Company insures our preferred book of business while the Fire and Casualty Company insures those individuals who do not meet our preferred risk standards. For the purpose of this report, I will include only the statistics of the Mutual Company as they are representative of the larger number of our policyholders and are a true reflection of our statewide operations.

State Farm Mutual Automobile Insurance Company
Nevada

	Automobile Policy Count	Automobile Premium-All Coverages
1973	65,583	$ 9,870,016
1974	72,848	$10,724,842
1975	78,585	$11,517,241
1976	85,525	$13,648,664

Automobile Premium - Bodily Injury Liability

1973	$2,715,000
1974	$2,062,164
1975	$1,759,229
1976	$2,245,428

Automobile Premium - Basic Reparation Benefits

1973	None
1974	$2,323,498
1975	$2,451,338
1976	$2,638,459

Bodily Injury Liability

Number Reported		Number Paid	Total Dollars Paid	Average Paid Cost
1973	948	553	$1,682,424	$3042
1974	686	343	$1,438,370	$4194
1975	606	351	$1,756,578	$5005
1976	673	437	$2,246,220	$5140

Basic Reparation Benefits

Number Reported		Number Paid	Total Dollars Paid	Average Paid Cost
1973	None	None	None	None
1974	1134	504	$ 698,827	$1,387
1975	1484	1011	$1,296,444	$1,282
1976	1416	1282	$1,587,635	$1,238

With these figures in mind, I ask you take into consideration the fact that during the period of 1972 through 1976, the Consumer Price Index rose 32%. Our rate history for the time frame of 1968 through 1976 reflects an overall percentage increase of 29.1. At year end 1976, State Farm Mutual reported a $4,883,729.00 Underwriting loss in the State of Nevada. This represents an operating loss ratio of 135.8%. As reflected in the figures above, the most significant item we can point to as a major contributor to this loss is the 170% difference between the $3042.00 we paid per bodily injury claim in 1973 (before enactment of No Fault) and the $5140.00 we were paying per bodily injury claim in December 1976. True, the number of reported bodily injury claims dropped significantly with the enactment of the No Fault law but, as you will note, the frequency is on the up-swing and history in other states tells us it is not impossible to meet and exceed the reported figures which preceded No Fault. In addition, there has been a substantial increase in benefits and payments therefore under the No Fault coverages.

These, because of the nature of the protection afforded, far exceed the limited benefits formerly available under the old Medical Payment coverages.

Another area which must be taken into consideration by you and your committee relates to the generally accepted goals of no fault reform. These are:

1. To promptly compensate accident victims for such out of pocket expenses as medical bills and lost wages, without fault.

2. To finance the broader distribution of benefit payments by limiting the accident victim's rights under tort law to those who have suffered certain types of serious injury.

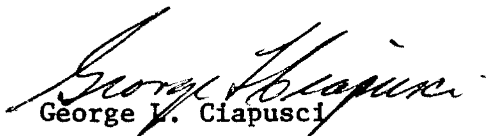
In our judgment, those goals can only be met by passage of S.B. 305, as relates to the independent medical examination requirement, and S.B. 306, as relates to a "verbal" threshold. It is State Farm's position that no fault laws can reduce bodily injury insurance costs if they are designed for that purpose. They can also increase costs if benefits are added without cost-saving offsets. The main advantage of the no fault system is not cost reduction, however, but a more equitable distribution of the auto insurance dollar. The figures we furnish with this report clearly reflect that under the current act the greater portion of our premium dollar continues to be paid to the third party bodily injury liability claimant.

Attached to this memorandum please find a copy of the Insurance Backgrounder, published by State Farm, which states our position on No Fault as of December 1975. Although the article addresses itself to the Federal No Fault standards which were being discussed at that time, it contains statements of policy with regard to the various state acts which accurately reflect State Farm's current position on the issue at hand. You may copy and distribute this issue of the Insurance Backgrounder to your Committee members if you so desire.

Yesterday, you heard testimony from a witness who implied among other things that an underwriting profit was not necessary for an insurance company to survive in today's market. I am attaching a reprint of the Best Insurance News Digest, October 4, 1976

Senator Thomas R.C. Wilson
March 29, 1977
Page Four

issue which addresses this very issue and refutes the implications contained in the witness' testimony. I cannot suggest it be copied but you may wish to route it to your Committee members for their review.


George L. Ciapusci

Insurance BACKGROUNDER

Background information on insurance topics for the news media
Published by the Public Relations Department of the State Farm Insurance Companies
One State Farm Plaza, Bloomington, Illinois 61701 . . . Phone (309) 662-2625

No-Fault: Putting it in Perspective

Recent critics of the cost performance of existing state no-fault laws are unwittingly providing the most powerful arguments yet for the passage of the federal no-fault standards bills in Congress.

Much of the criticism is unfounded, for the no-fault laws now in operation in 16 states are a solid success in accomplishing the basic purpose of no-fault: to pay more of the insurance premium dollar to accident victims and to do it more fairly and promptly.

Some of the criticism is justified, however. This criticism reflects failures caused by certain defects in most state no-fault laws. These defects can be remedied by the passage of federal no-fault standards. No-fault advocates have been aware of the defects since the laws were enacted.

The most serious of these defects is the weak restriction on lawsuits found in most existing no-fault laws. Of the 16 laws now on the books, 14 have lawsuit restrictions that are grossly inadequate.

Another serious defect in most no-fault laws was a mandatory cut in insurance rates not justified by the weak restriction on lawsuits. 15%-BI in Nov.

These defects are directly responsible for the problem areas in current no-fault laws that are causing criticism.

The general theme of this criticism, reported by the *Wall Street Journal*, the New York *Times*, and other publications, is that (1) no-fault has driven up the cost of auto insurance, when it was supposed to reduce it, and (2) high claim payments in no-fault states are causing insurance companies to suffer heavy financial losses.

When these so-called "failures" of no-fault are placed in perspective and viewed in the light of all the facts, conclusions emerge that are quite different from those reached by no-fault critics:

—The purpose of no-fault is to distribute more of the insurance dollar to victims and to do it more equitably. No-fault laws are doing a good job of that.

Published January 29, 1976. If you use this Backgrounder several weeks after this date, please call above number and ask whether a later edition is available.

ao 12-75

—Sound no-fault laws don't push up insurance costs and may even reduce them slightly, although the weak laws passed by most states may force costs up.

—No-fault isn't the cause of heavy financial losses by insurers. These losses are caused by severe inflation and inadequate rates imposed by some legislatures and state insurance departments. Losses are equally severe in coverages not affected by no-fault.

—The criticism of the weak no-fault laws enacted at the state level demonstrates the need for federal standards requiring states to adopt strong laws with effective restrictions on lawsuits and abuse of benefits.

State Farm, the largest auto insurer in 32 states and the second largest in eight others, provides insurance for 15½ million vehicles. Consequently, it's in a unique position to evaluate the effects of no-fault laws on the auto insurance marketplace.

The Purpose of No-Fault

From the time it first reached the public consciousness, no-fault has had the misfortune of being misunderstood. A possible side-effect of certain types of no-fault laws—a slight reduction in insurance costs—was seized upon by over-zealous supporters, political leaders, and misinformed segments of the news media and portrayed as the basic reason for switching to no-fault. But the real advantage lay in another direction altogether.

No-fault was designed to remedy certain deficiencies in the traditional tort liability (or fault) system of automobile accident reparations.

Under the liability system, an accident victim receives no benefits unless he can prove the negligence of another driver caused his injuries. This automatically excludes all victims of one-car accidents, which account for more than one-third of all fatal crashes. It excludes all accident victims who were themselves solely at fault in causing the crash. And it usually excludes those hurt in accidents where the fault can't be determined or is shared about equally by both drivers. As a result, nearly half of all accident victims can't receive benefits from the liability system. The economic loss suffered by them often becomes a burden on society.

Even for the victims who can get benefits, the system doesn't work too well. Those with serious injuries are compensated for only 30 per cent of their economic loss by the fault system, while victims with minor injuries receive far more than their economic loss, according to a 1970 study by the Department of Transportation.

This situation develops because the tort liability system allows an injured person to recover more than his actual economic losses from the negligent driver at fault in the accident. The victim can also recover general damages, usually known as damages for pain and suffering. Courts often allow general damages equal to three or four times the amount of the victim's economic loss in suits for small amounts.

As an example, the lawyer representing a victim who spent $200 on medical treatment may ask for $600 in general damages, even though his client's pain was minor and his suffering minimal. For the insurer, settlement of these small claims is less costly than going to court.

Seriously injured persons, who have many thousands of dollars of medical bills and lost wages, receive quite a different response from the liability system. Since a large amount of money is at stake, a hard-fought legal battle frequently takes place. The negligent driver rarely carries enough liability insurance to cover a large award. Finally, a big slice (a third to one-half) of the money awarded to a seriously injured victim goes to his attorney for fees and legal expenses. The net result is that most seriously injured victims—the ones who need help the most—don't receive enough from the fault system to cover their actual losses. And the help they do get frequently comes too late.

Because of the requirement that fault be legally proved, much of the insurance premium dollar goes for legal fees, claims adjustment costs, and other expenses inherent in the liability system. Only 25 cents of it finally reaches the accident victim as compensation for actual expenses.

No-fault was designed to remedy these deficiencies by removing automobile accident reparations from the legal fault system and placing them under a first-party insurance system similar to health insurance or fire insurance.

By guaranteeing benefits to virtually all accident victims, no-fault insurance would be paying money to a vastly greater number of injured persons than the liability system does. Normally, insurance rates would have to rise. No-fault tries to avoid this by taking much of the money formerly paid out in general damages and legal fees and using it to compensate the additional victims for their actual economic loss.

To do this, no-fault eliminates the right to sue for general damages when injuries are minor. Where the lawmakers draw the dividing line between minor and severe injuries is critically important to the success of a no-fault law. The number of cases removed from the liability system must be large enough to generate savings equal to the additional dollars paid to victims through the no-fault system.

If the savings don't equal the extra dollars paid out, rates must go up. Of course, when the savings are larger than the extra dollars, rates will go down. *This is the only way no-fault can actually cut insurance costs.*

According to actuarial estimates, the kind of no-fault system required by the federal no-fault standards bills in Congress would double the number of premium dollars available to compensate victims for economic loss without forcing up insurance costs in terms of fixed dollars. In fact, a slight cost reduction might occur, compared to the costs of the present system.

This, then, was and is the purpose of no-fault: to pay more of the insurance premium dollar to accident victims, and to pay benefits to all victims regardless of fault. It was never intended as a way to keep insurance rates from rising. No-fault can't repeal inflation.

No-Fault Laws Are Accomplishing Their Purpose

Are the no-fault laws now in operation in 16 states actually paying more dollars of benefits to more accident victims? In other words, are they accomplishing the purpose for which they were designed? There are no figures available that can precisely measure the effectiveness of no-fault laws, because the results of no-fault are intertwined with the results of other factors. But the available figures do provide a fairly reliable indication of how well no-fault is working. They indicate it is definitely returning more of the premium dollar to accident victims than the liability system did.

After no-fault took effect in Florida, the portion of the premium dollar received by victims for economic losses increased by 44 per cent, while in Michigan it jumped 68 per cent.

These figures are not precise measurements of no-fault effectiveness because they are unavoidably distorted by other factors. But they demonstrate that the percentage of the premium dollar actually being received by accident victims for real out-of-pocket expenses has increased sharply under the no-fault systems now in existence.

Experience in no-fault states proves that these laws are accomplishing their purpose. They are paying more benefits to more accident victims. They are doing it promptly. They are returning more of the premium dollar to victims for economic losses, while reducing the amount spent for general damages and attorney fees.

Sound No-Fault Doesn't Increase Rates

One of the two major charges being leveled by no-fault critics is that the existing no-fault laws are causing sharper rate increases than those being experienced in states with the fault system.

A brief look at the recent history of auto insurance rates will show this is untrue. From mid-1971 until the beginning of 1975, State Farm's rates were reduced in most states and remained stable in others. In addition, the company was able to refund more than $300 million in dividends to its policyholders. These rate cuts and dividend payments were possible, during a period of inflation, because the frequency of accidents was declining.

Accidents generally stopped declining in 1974, however. In the meantime, the most severe inflation in recent history sent insurance claim payments skyrocketing. For example, hospital room rates went up more than 60 per cent between 1970 and 1975.

Because of this unchecked inflation, auto insurance rates began going up across the country in 1975, both in states with no-fault and without it.

Critics forget that no-fault affects only the personal injury coverages, which account for about 40 cents of the insurance premium dollar. The other 60 cents buys coverage for loss or damage to vehicles. But even when total insurance rates are considered, they haven't gone up faster in no-fault states than in others.

Although one no-fault state–Florida–had extremely sharp rate increases, the 16 no-fault states as a whole received an average increase of 9.8 per cent during 1975, compared with 10.9 per cent for all states combined and 12.2 per cent for the states without any type of no-fault law. In other words, there was no significant difference between State Farm rate increases in no-fault states and tort liability states.

Even if it were true that rates in no-fault states went up more than average, that fact would not indicate that a sound no-fault system increases insurance costs. No-fault critics forget that only two or three of the no-fault laws now in existence can be termed "sound." Most of them have weak restrictions on lawsuits for general damages.

A no-fault law should have a lawsuit restriction that will save enough on payments for general damages, legal fees, and claim adjustment costs to provide the extra dollars paid out in benefits under no-fault. Very few of the existing no-fault laws have a lawsuit restriction strong enough to do this.

All no-fault laws except Michigan's allow accident victims to sue for general damages if their medical costs go above a certain level, known as a threshold. In 13 of the 16 no-fault states, this threshold is set at $1,000 or less–usually less. At today's inflated medical costs, an attorney finds it easy to develop $200, $500, or $1,000 in medical bills for his injured client. This has been particularly true in Miami, Fla., where abuse of that state's $1,000 threshold helped to produce the sharpest rate increases in the nation in 1975.

No-fault systems with adequate lawsuit restrictions won't drive up insurance costs. The national no-fault standards bills now in Congress would not permit suits for pain and suffering unless the victim was disabled for more than 90 days or suffered serious and permanent injury or disfigurement.

The experience of Michigan, which prohibits recovery for pain and suffering unless the victim has serious impairment of body function or permanent serious disfigurement, demonstrates that no-fault laws with strong restrictions on lawsuits can provide benefits for all injured persons without pushing up insurance costs.

State Farm rates in Michigan were increased 10.7 per cent on Jan. 15, 1976–slightly less than the 10.9 per cent average increase for all states combined in 1975. Rates in Michigan are now only 11 per cent higher than they were in 1970, although the Consumer Price Index has gone up

more than 40 per cent during that time. This rate level appears to be adequate at present to finance the unlimited medical and rehabilitation benefits and the high benefits for income loss provided by the Michigan no-fault law. However, moderate future increases may be necessary because of continuing inflation.

No-Fault Isn't Causing Financial Losses of Insurers

No-fault critics are charging that many existing no-fault laws are causing heavy financial losses for insurance companies. So many more dollars are being paid out in claims under no-fault, the critics contend, that insurers are losing money at an alarming rate and their financial stability is threatened.

Ironically, this accusation merely demonstrates that these no-fault laws are doing what they are supposed to do: pay out more money to more accident victims. If insurance companies are losing money in no-fault states, their losses are caused by inflation combined with rates that were set too low by legislators and state insurance departments, not by no-fault.

When most no-fault laws were enacted, the legislatures put provisions in them requiring insurance companies to reduce their rates for personal injury coverages by a certain per cent—most commonly, 15 per cent. In some cases, state insurance departments later pressured insurers to cut their rates still more.

The fact that most existing no-fault laws have weak restrictions on lawsuits has already been discussed. In view of that fact, there was no basis for reducing rates. These mandatory rate cuts were political acts made for political, rather than actuarial, reasons. Inflation has made the effects still worse.

Knowledgeable observers knew the reduced insurance rates would be inadequate when these laws were passed. State Farm noted when the New Jersey law was enacted, for example, that "the generous no-fault benefits of the New Jersey law cannot be financed out of the modest restrictions the law places on tort recoveries. . ."

In its *No-Fault Press Reference Manual*, State Farm voiced similar warnings when the no-fault laws were enacted in New York, Connecticut, Georgia, and Pennsylvania. It should come as no surprise to no-fault critics that insurance companies are now losing money in many no-fault states.

The severe effect these mandatory rate cuts have had on insurance company finances is demonstrated by looking at State Farm rates from 1971 through 1975. At the end of 1975, rates in the 16 no-fault states were only 3.2 per cent higher than they were at the beginning of 1971, while in all states combined they were an average of 10.2 per cent higher.

These figures show all too clearly why some insurers are suffering heavy financial losses in many no-fault states. These losses are not caused by no-fault. The culprit is the mandated rate cuts that were not justified by the weak restrictions on lawsuits in the no-fault laws.

Federal Standards Only Hope For Strong No-Fault Laws

The experience of the 16 no-fault states indicates that the no-fault concept is working well. The problems encountered by insurance companies and the public have been caused by the weaknesses of the restrictions on lawsuits found in most existing laws and by unjustified rate cuts forced on insurers by legislators, compounded by uncontrolled inflation.

State Farm has worked for well-designed no-fault laws at the state level since the early years of this decade. The results have not been rewarding. Time after time legislators have weakened good no-fault bills by watering down thresholds until they were too low to generate the savings needed to pay for the no-fault benefits. Then the legislators have often compounded their mistake by requiring mandatory rate cuts when no-fault laws took effect.

State Farm has reluctantly decided that a federal no-fault standards law is the only way to achieve well-designed no-fault systems throughout the country. Only in this way can the political stumbling blocks in state legislatures be circumvented, and confusion and costly errors avoided.

State Farm supports federal no-fault standards of the type found in Senate Bill 354 and House Bill 9650. These bills would require states to provide no-fault coverage with high benefit levels. To pay for this extensive coverage without raising insurance rates, lawsuits for general damages would be prohibited unless the victim was disabled for more than 90 consecutive days or suffered serious and permanent injury.

State Farm's actuaries estimate that the extensive no-fault coverage required in these bills could be provided without any increase in insurance costs, in terms of fixed dollars. (Insurance rates would, of course, continue to rise along with inflation.) In fact, on a nationwide basis, calculations indicate that costs might be reduced slightly.

Despite the charges of no-fault critics, the experience of 1975 has not proven that no-fault doesn't work. It's merely demonstrated that most existing no-fault laws need considerable improvement. That isn't news to State Farm. It's the reason State Farm has worked for a federal no-fault standards law since 1973.

LV Sun P.8 4/26/76

New York Okays Big Insurance Hike

NEW YORK (UPI) — The State Insurance Department, to keep Government Employees Insurance Co. from going out of business, granted the firm an average 47 per cent automobile insurance rate increase, a spokesman said Saturday.

The new rates are scheduled to take effect May 3, and follow a pattern in several other states of granting permitting GEICO which reported 1975 losses of $124 million, to charge higher rates for auto insurance.

GEICO had reported profits of $26 million in 1974. An insurance department spokesman said the financial tailspin was traceable to suddenly rising costs of medical services and auto repairs, the two major auto insurance company expenses.

"In the New York City area, medical service costs went up 30 per cent last year. The cost of replacing crash parts — particularly bumpers and grillwork — in the last two years went up 65 per cent. That means that if you wanted to buy the parts of a car unassembled it would cost $23,000," he said.

"GEICO's one big edge had been its lower rates, because it didn't have agents," the spokesman said.

Editorial

'No-Fault's' Misleading Record

Well, how is no-fault auto insurance doing?

That was the legislative rage two and three years ago. The dream of automatic payoffs (without lawyers, delays entailed by litigation, and bickering) was supposed to save casualty insurance companies and motorists a bundle.

Beautiful name, too — "no fault." Interesting how it worked out, though. The June edition of Fortune magazine offers an accounting.

Twenty-four state legislatures adopted the misnamed "no fault" principle in various forms. Several insurance companies pressed for enactment in the belief the new legal environment would eliminate the horrendous jury awards of the type that makes inch-high headlines.

Catastrophic

According to the Fortune piece, one company in New Jersey (Geico) is facing ten catastrophic injury cases, most of them involving young people. The anticipated loss is expected to average $500,000 per case.

That is a total of $5 million outgo on just 10 cases. It seems the New Jersey Legislature, in its wisdom, provided for unlimited medical benefits.

And no-fault didn't end lawsuits. Under most no-fault laws, Fortune reported, it has remained easy to sue. Typically the laws set up dollar minimums the injured party had to cross before being able to sue.

Minimums

The New York Legislature put the minimum at $500. An injured party can almost run up that bill by merely driving past a hospital, Fortune said.

Moreover, experience demonstrated what foresight accurately guessed at. The mere existence of the minimums encouraged claimants to jockey to reach them.

Also, the quick and easy payoffs under certain types of coverage had the effect of "financing" claimants while they negotiated for additional damage payments under other types of coverage.

Expectations

And, since no-fault was supposed to eliminate the insurance company costs, the several legislatures tended to expect that the savings ought to be passed along to the policyholders. So a number of legislatures mandated a reduction in premium rates.

Some forbade rate increases during the period that no-fault was being tested. The grand result was that important companies went through a peroid of higher outgo without a proportionate rise of income.

At the height of the fanfare for the "no fault" movement, the Santa Ana, Calif., Register pointed out that the very term "no fault" was misleading.

Suspicions

Specifically, the label tends to eliminate the element of accountability, an element usually present in the case of auto mishaps. Our reasoning was that when you have a suspect label, you can reasonably suspect the contents.

That's a pretty good rule of thumb by which to size up legislative innovations.

Inside Labor

New No Fault

Editorial

Casualty Insurance Problems

The mysterious sinking of the supertanker Berge Istra on Dec. 29 symbolized the kind of year 1975 was for casualty insurers — companies that insure automobiles, homes, and businesses against accidental loss. Total insurance losses for the Norwegian vessel and its 188,000-ton cargo of Brazilion iron ore are expected to exceed $27 million, of which Lloyds of Lmndon is liable for $13 million.

If Lloyds has reason to feel glum, consider the plight of the American casualty insurance industry. According to A. M. Best Co., which charts the industry's performance, casualty insurers suffered an aggregate underwriting loss of about $4.2 billion in 1975. Stated another way, Best said the industry paid out nearly $108 in claims and expenses for every $100 it earned in premiums.

"There are a lot of reasons for the losses, Alexander Auerbach wrote in the Los Angeles Times. "Inflation has raised the cost of auto repairs, medical care and a host of other items that liability insurance pays for, so claims have risen sharply. Juries have been increasingly generous in their awards. The number of product liability lawsuits being filed — and won — against manufacturers has also shot up."

Some Blame

Such factors are beyond the insurance companies control, but the industry itself is not without blame. In the early 1970s, hundreds of companies abandoned the traditional goal of 5 per cent profit from underwriting operations. Rates were cut by 15 per cent or so to attract more premium income for investment purposes. The new goal was a loss of up to 5 per cent on underwriting, with increased investment profits more than making up the difference.

Then along came a bear market, and the companies' hoped-for capital gains from their stock holdings turned into precipitous declines that compounded the underwriting losses. In the past 18 months 30 companies have gone under, the largest number since the Great Depression.

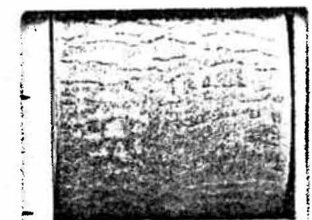
In Nevada, State Farm Mutual Insurance Co. took an underwriting loss of $750,000 in the first nine months last year. The company wants to raise its rates 23 per cent on auto insurance. That will hit policies on 77,000 cars and trucks in the state.

Loss Payment

The average loss payment per collision claim for subcompact cars last year was $690.

The casualty insurance industry "now faces a long period of consolidation and reconstruction," Business Week observed in an editorial. "Rates will have to be identified and forced to pay full fare. The state regulatory agencies ... will have to ... help the industry bring underwriting income into line with losses."

In the process, more companies probably will fold and consumers may find it more difficult to obtain insurance. The strongest companies will survive, but the shakeout will be painful for all concerned.



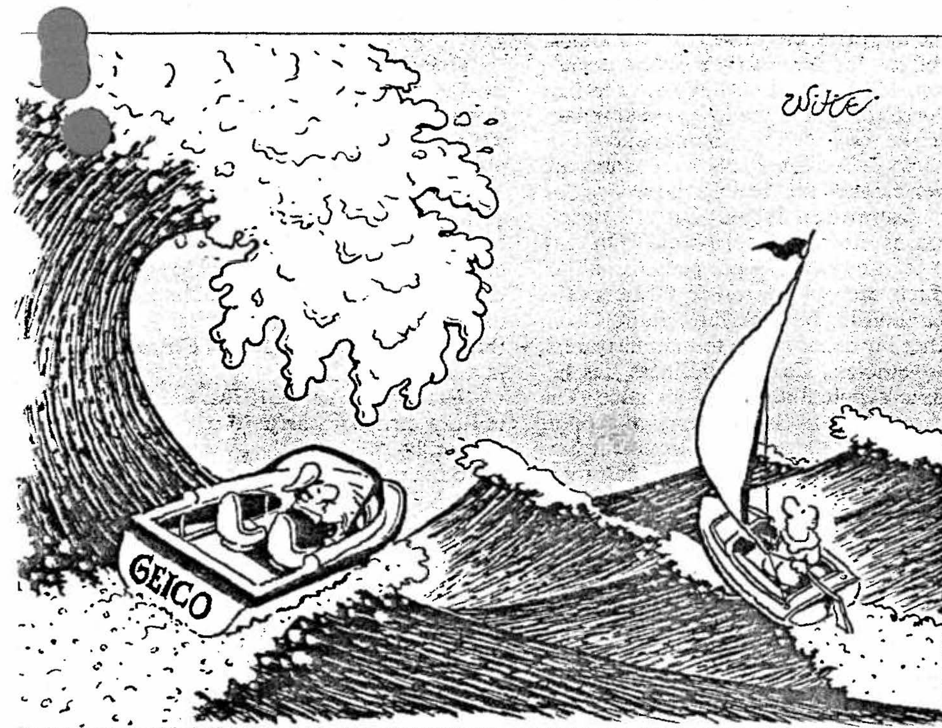


ILLUSTRATION FOR TIME BY MIKE WITTE

"My insurance company? I am an insurance company. Why?"

INSURANCE

GEICO at the Brink

Once upon a quite recent time, the staid insurance industry had a Cinderella firm called Government Employees Insurance Co. (GEICO). By charging low premium rates, GEICO skipped past older firms to become the fifth largest auto insurer in the land. Investors from far and wide flocked to buy a piece of GEICO, bidding its stock up to more than $60 a share. Then Cinderella turned into a pumpkin.

Today GEICO stock is selling at about $2.50 and the company is on the brink of bankruptcy. A GEICO crash would be costly to the company's 2.8 million policyholders in 25 states, who would lose some of the $660 million a year they have been paying GEICO in premiums, and to other insurers, who would have to take over payment of claims against GEICO. The company has lost $150 million since the start of 1975. Worse, Maximilian Wallach, Superintendent of Insurance in Washington, D.C., where GEICO is headquartered, seems to be failing in a rescue attempt.

Costly Pullout. For weeks Wallach has been phoning executives of other insurance companies to persuade them to reinsure 40% of GEICO's policies and give GEICO $26 million in cash commissions in return for a share of future premium income. He also sought their agreement to buy whatever part of a planned $75 million offering of GEICO convertible preferred stock the company's present shareholders do not purchase (shareholders must approve the offering at a meeting next week). By late June, Wallach had rounded up enough pledges to put off a deadline he had once set for moving to have GEICO declared bankrupt.

But last week State Farm Mutual Automobile Insurance Co., the nation's largest auto insurer, withdrew its offer to reinsure 6% of GEICO's policies. State Farm had warned Wallach that it would carry out the agreement only if other insurers agreed to reinsure 34% of GEICO's policies by June 30. With State Farm out, it is now doubtful that other insurers can be persuaded to pump enough cash into GEICO to keep the company alive. GEICO directors are planning to offer 300,000 shares of senior preferred stock (which would have first priority on any future dividends) in case the $75 million convertible preferred issue does not sell, but who might want to buy the senior preferred—and why—is open to question.

How did GEICO get into such a mess? Founded in Texas in 1936, GEICO from the start sold policies directly to customers. By doing without agents it was able to set premiums as much as 25% below what competitors charged. Initially, too, it insured only federal, state and municipal government employees—a responsible, low-risk group. So it was one of the very few insurers that actually made a profit on underwriting (premium income matched against claims payments) as well as on investments.

Later, GEICO sold insurance to just about anybody, and for a while underwriting profits continued. During the rapid inflation of the early '70s, however, the costs of automobile parts and medical care—two chief items in claims against GEICO—rose even faster than prices generally. GEICO lagged in raising premium rates and failed to set up adequate reserves to pay claims. In 1974 GEICO squeezed out a $26 million overall profit, but in 1975 it plunged $125 million into the red.

Backstop Scheme. Some insurance officials feel that D.C. Superintendent Wallach let the situation drift too long before taking action. Says one executive: "It's inconceivable that a company of GEICO's size could run up such a loss in one year without Wallach saying 'Hey, fellas, what's going on here?' " In May GEICO directors ousted Chairman Norman L. Gidden, 59. New Chairman John J. Byrne, 44, has pulled GEICO out of New Jersey—a dismally unprofitable state—and pledged to trim by 20% the 2.4 million auto policies in force (there are 400,000 homeowner policies too). Byrne is also eager to get rate increases wherever possible; even before his arrival, GEICO had won a 40% increase in New York.

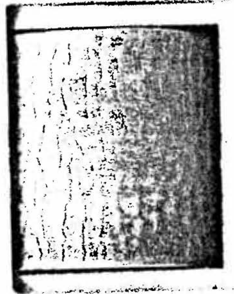
If GEICO should nonetheless go under, policyholders would have from 30 to 60 days, depending on their state, to find another insurer. Most would lose some part of the premiums they have already paid to GEICO. Claims against GEICO would be paid out of state-run insurance guaranty funds, which are empowered to assess other insurance companies up to 2% of their premium income. Those companies would then divide GEICO's assets—if any were left.

Since insurers are far from eager to be assessed to pay GEICO's claims, they may yet band together to save the company. Wallach and GEICO officials could conceivably soon decide to consider the reinsurance scheme a success if only 30% of the premiums are taken over. There is also a slim chance that the D.C. Department of Insurance may exercise its legal right to take over management of GEICO, though Wallach has not yet suggested it. Whatever happens, the fiasco could well rekindle congressional interest in setting up a federal body to insure insurers the way the Federal Deposit Insurance Corp. guarantees the safety of bank deposits. Efforts to set up such a backstopping scheme have never made much headway, but the largest failure in insurance history—or even a cliff-hanging escape—would dramatize the need as nothing else has done.

1397

R-J viewpoint

Let's drive the habitual offender off the road



More than half of those killed and maimed on America's highways each year — and there were 46,200 in the first category in 1974 — are victims of the HOD, the Habitual Offender Driver, says the National Association of Insurance Agents (NAIA).

Statistically, the number of HODs is few, only about 5 per cent of the driving population, but the wake of destruction they leave is enormous.

The Habitual Offender Driver drives too fast, and the number one cause of all fatal accidents on rural roads in 1974 was speeding.

The HOD drives left of center, and that was the number two cause of 1974 fatal accidents.

Then comes failure to yield right of way, improper overtaking, making improper turns and following too closely — and the arrogant and irresponsible HOD is guilty of all these.

Police files in one state show a HOD who in 11 years was arrested 25 times for traffic violations — 10 arrests for drunk driving. 10 for driving under suspension, and five for speeding, reckless driving and running a red light. He has been arrested an average of 2.3 times a year, has held his license legally for only three months during the 11 years, yet he continues to drive, says the NAIA.

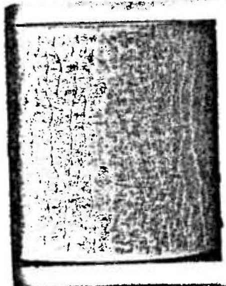
Records from another state show 1,365 convictions for 100 habitual offenders. Still another state shows one man with 32 convictions that have cost him over $5,000. Despite his revoked driver's license, he is still driving.

The NAIA, which represents independent insurance agents in each state, has long campaigned for laws to get the HODs off the road and keep them off, which means putting them in jail if necessary.

In 1968, Virginia became the first state to pass habitual offender legislation. Its law stated that any driver with three major or 12 minor traffic convictions within a 10-year period was to be certified as a Habitual Offender Driver, lose his driver's license for 10 years and go to prison for one to five years if caught driving after losing his license.

When the law went into effect in Virginia, 36 HODs didn't believe it. They did after they started serving time in the state penitentiary.

The law was credited with a drop in Virginia's highway death rate of some 20 per cent within two years. By contrast, states which lacked anti-HOD laws continued to record increases in traffic fatalities.



Other legislatures began looking at the NAIA's model law, which requires no outlay of state funds, requires no additional manpower, keeps licensing at the state level and makes for uniform definitions, enforcement and penalties.

Since Virginia in 1968, 20 other states have passed habitual offender legislation: North Carolina, New Hampshire, Rhode Island, Vermont, Maine, Massachusetts, Washington, Indiana, Georgia, Florida, Kansas, Ohio, Delaware, Louisiana, South Carolina, Oregon, Colorado, Tennessee, Iowa and Montana.

But in 29 states the HOD is still allowed at large.

Until all the states join the fight to get the Habitual Offender Driver off the road, says M. Jay Wanamaker, president of the NAIA, the nation's auto fatality and injury toll will continue to be tragically and needlessly high. high.

SUN Local News

/ednesday, November 12, 1975 LAS VEGAS SUN 13

NEVADA INSURANCE:

No Fault Plan Working

By PENNY LEVIN
SUN Staff Writer

'No fault insurance is going ısonably well in Nevada," Dick Rott- ın, commissioner of insurance for the vada Insurance Department said in s Vegas Tuesday.

Rottman said there are a few areas ere no fault could be improved in- ding "putting more teeth into the tion which makes insurance man- ory."

n an interview with the SUN, Rott- n said there are still a significant m f persons in the state who are in d but there are no real ıal in the law which would make se people see the necessity of getting urance.

'The uninsured motorist problem in state is not as severe as it once was, wever," said Rottman.

he commissioner was in Las Vegas deliver the welcoming address to the ıual meeting of the National Associa- ı of Independent Insurers meeting ough Thursday at the Las Vegas ton Hotel.

No fault is a good program, but it is a panacea," said Rottman.

It does not reduce crashes nor does it viate pain and suffering," said Rott- n.

le added, "Basically, no fault has ıe what it was supposed to do. It has uced litigation and allowed for more mpt payments to the insuree."

lottman said there is still more work ɔe done on no fault to clear up some he problems which remain.

le declined to elaborate on the blems.

ı prior years, insurance companies e criticized for cancelling out on cies when someone had an accident n de a claim against their com- y.

T olicies aren't being cancell- li ey were in the 1960s and early)s," according to Rottman.

e attributed part of this in Nevada non-cancellation and non-renewal s which were passed by the state slature in 1971.

ottman said he also believes that surance field realize they can't treat people in a shoddy manner.

He suggested that anyone who is unhappy with his insurance agent change agents.

"Agents are supposed to give continuing service. If they don't, a person should find an agent who will," said Rottman.

He said anyone who has a complaint about an insurance agency or agent should file a complaint with his office.

In another area, Rottman discussed malpractice insurance and some of its problems.

DICK ROTTMAN
... Insurance Commissioner

He said that many insurance companies in the past had not done characteristic evaluations of doctors to see how good a risk they might be.

For example, he said, there are some physicians who are "practicing outside their field of expertise."

Additionally, he said, there are doctors whose patients loads are so great that they are not good risks.

Rottman said it is a complex problem and blame cannot be placed singularly on physicians, patients or attorneys.

He said much work is being done on

study is being conducted in relation to the situation.

Asked if many doctors in the state are forming their own underwriting company, Rottman said he knew there was some talk of such a move but did not have any knowledge of definite plans for that type company.

Almost 1,000 persons are attending the NAII convention.

No-Fault Insurance May Go To Feds

NEW YORK (UPI) — The insurance industry still is divided over whether Congress should set minimum standards for compulsory state no-fault automobile insurance but the balance may be swinging in favor of federal standards.

The companies belonging to the American Insurance Association, including many very big ones, are for federal standards. T. Russell Jones, head of this group, was a pioneer in advocating the basic no-fault principle.

Now State Farm Mutual, one of the largest companies outside the AIA, and originally a strong advocate of state control of automobile insurance, has come out strongly in favor of federal no-fault standards.

On the other hand, Sears Roebuck's huge Allstate Insurance group is against the bills in Congress and the Insurance Information Institute says much of the rest of the industry is divided on the question. Some companies still oppose no-fault altogether.

A few months ago, the division appeared to be based as much on cost predictions as on principle. Allstate, for example, predicted that setting up federal standards would be likely to increase bodily injury insurance rates by 17 per cent but State Farm said it probably would slash such rates about 10 per cent. In recent weeks, however, the two sides have narrowed the gap between their cost predictions by adopting more uniform or similar bases for cost predictions.

The opponents still are against Congressional standards because, they say, this would infringe on the states' sovereignty and might lead ultimately to complete federal regulation or even a federally financed no-fault system.

The companies that advocate the federal standards say they have decided, in some cases reluctantly, that federal standards are the only path to sensible improvement of nofault insurance because the state legislatures have shown they can't or won't do an adequate job. These supporters feel minimum federal standards for state laws may be the only alternative to imposition of a tough national no-fault system.

Donald P. McHugh, vice president and general counsel of State Farm, said cost projections are not the real issue. What is at stake, he said, is the quality of insurance protection motorists are going to get and his company is convinced federal standards for state no-fault laws are the only answer to improve the quality. "Not only will there be more benefit payments to more claimants but payments will be received more rapidly and with considerably less friction," he added.

McHugh said it would be false and misleading to promise insurance rates definitely will go down if federal no-fault standards are adopted. He said inflation and other rising cost factors could prevent that.

New no fault

Vegas Bill

Flaws In No-Fault

You know, come Feb. 1, the no-fault auto insurance law goes into effect. With it, there is provision for compulsory liability insurance. It will be against the law for a driver to venture forth upon the highways without at least $15,000 per person liability insurance, $30,000 per accident, $5,000 property damage insurance.

This means a motorist is legally obligated to have that much protection for claims arising out of injury, death to other persons, or damage to other property, when the motorist is at fault.

Our city editor asked me to write a news piece about no-fault, which I shall do at a later date; but having attended one seminar, and about to attend another, I thought it would be interesting to get into some of the off-beat ramifications of the law and its eventual application.

Motorcycles Exempt

First of all, the law has nothing to do with motorcyclists. They cannot buy the protection which will be afforded, nor can they be exempted from suit up to $750 as set out by the new law. They should continue present insurance coverage as if nothing else happened.

The same is true of people who are old enough to be on Medicare. It is not necessary for them to buy the no-fault portion of insurance coverage; but again, they would not be exempt from suit—same as the motorcyclist. They do have the option to buy, and in my opinion, they should. There are many benefits, which I shall detail in the future news article.

The senior type citizen has the option to buy — the motorcyclist does not.

Many Exceptions

There are some other exceptions, which I shall get into later.

One of the provisions of no-fault is to provide a fund whereby an injured person in an auto accident can hire a substitute to perform non-work duties. The classic example cited is a housewife who is laid up, and cannot perform normal home duties. A person can be hired to do the housekeeping, up to $18 per day.

I shall leave to you the obvious question which is always raised by husbands in these seminars. And it was the opinion of those in charge, that there may be no legal objection to a paid love substitute.

Unique Category

One other peculiar spin-off: there is provision for a fund to pay medical expenses for those who do not come under any insurance for auto injuries. The classic example here is a drunk wandering into the side of a car.

If this individual does not own a car, has no insurance, and if the auto driver has no insurance, this fund takes care of the drunk.

There are many ambiguities in the law, and it will take time, practice, and legal decisions to clarify.

New Benefits

I've left the answer to the most often asked question: no, there will be no savings in auto insurance premiums. While there has been a reduction in the rate for the bodily injury portion of the insurance premium, there will be an additional charge for the new benefits which are part and parcel of no-fault. Actually, premiums will be slightly higher.

And there is no provision for enforcement of the compulsory section of the law. The only penalty which will be imposed upon non-complying motorists will be the same as those presently invoked by the Financial Responsibility Law: in case of involvement in an accident, suspension or revocation of driving license, limitation of driving upon renewal, filing with the Motor Vehicle Department for three years, with a policy of insurance. Buying a policy under this circumstance gets pretty expensive, too.

The meat and potatoes of no-fault in a future news piece.

LV Sun 1/20/74

New no fault   LV Sun 8/27/75

Insurance Too High For Cyclist

FRANKFORT, Ky. (UPI) — Jack Miller says he's "not an iron horseman or a hell's angel" but just a fellow who likes to ride his motorcycle.

However, he can't. It costs too much for insurance.

No-fault insurance took effect in Kentucky last July and Miller's rate for his BMW 900 jumped from $119 to $835 a year.

Miller of Edgewood in Northern Kentucky, works part-time for a motorcycle escort service in Dayton, Ohio. He said he is thinking of selling his motorcycle to the company.

That way, he would retain control of the motorcycle for his own use, but the premium would be paid for by the company.

The Air Bag:

Why we're for it.

It's not that we're against the seatbelt/ignition interlock system. We're all for any system that will help reduce injuries and death on America's highways. Unfortunately, studies show a large majority of people resist using belts.

But we believe the air bag/lap belt, or air cushion restraint system, is an alternative safety system with a definite advantage. It eliminates the need for the ignition interlock apparatus. And the need for shoulder belts. The bags are tucked away, out of sight until you need them—in a frontal-type crash at a speed high enough to cause serious injury. Then, they automatically inflate. In a split second. Protecting the driver and front seat passenger.

As for reliability—air bags are a passive restraint system proven reliable in over 50 million miles of on-road testing.

This year, General Motors is making the air cushion restraint system available to the public. On a limited number of Oldsmobiles, Buicks, and Cadillacs. It's being offered as optional equipment in lieu of the interlock system.

Allstate commends GM on its progressive stand.

And now that air bags have become a reality on certain production line cars, Allstate introduces a new auto insurance discount:

The Allstate Air Bag Discount. For owners of any factory-equipped air bag cars, Allstate will provide a 30% reduction on the medical coverage portion of their auto insurance. We hope all new cars will qualify for this discount soon.

In the meantime, be sure to buckle your seatbelts every time you drive.

Allstate®

Working to hold your insurance costs down.

And the Allstate Air Bag Discount. Oldsmobiles, Buicks, and Cadillacs.

Air Bag Discount not available in Miss., N.J., N.C., Oklahoma or Texas.

10 — Las Vegas Review-Journal — Friday, March 14, 1975

New no Fault

No-fault law hard to enforce

CARSON CITY (UPI) — State Insurance Commissioner Dick Rottman testified Thursday that 30-35 per cent of Nevada drivers don't carry the mandatory no-fault insurance coverage.

Rottman told the Senate Finance Committee that since the 1973 no-fault insurance law, those without the required coverage dropped only about five per cent.

"Making insurance mandatory is fraught with problems and not easy to solve," said Rottman. He said he has been told by the State Motor Vehicle Department it does not have the staff to check if drivers do have coverage.

Rottman said it would take "substantial funding" to police such a program.

The 1973 Legislature enacted a no-fault insurance law which requires all drivers to have insurance.

Rottman asked the Finance Committee for a $5,000 appropriation to hire an outside attorney to defend an expected constitutional challenge to the no-fault insurance law.

"Sometime within the next year I feel a constitutional suit will be brought," Rottman said. "I feel I should have outside legal counsel."

Sen. William Raggio, R-Reno questioned whether drivers got a decrease in rates as promised when the no fault law was enacted. Raggio said one of the main selling points was lower premiums and a survey of his constitutents showed most felt they had to pay higher rates.

Rottman said 75-80 per cent of the drivers got a small decrease which was about 2-3 per cent of the total insurance policy premiums. But many chose to increase their medical coverage which, in effect, pushed the rates higher.

Rottman reviewed his budget which does not propose any new programs for the coming two years. And he received a pat on the back from Wendell Cutler, a Las Vegas insurance man.

He said the actuary was needed as an "protective device" by the agency to review applications by companies for permission to raise insurance premium rates.

The committee did not take any action on the budget.

8-19-75

Car Insurance Freeze Predicted in House

By DICK LAMERE

The Legislature will vote overwhelmingly to freeze the 1976 auto insurance rates in Massachusetts at the 1975 level in the face of an industry request for a record $244 million rate increase, the House chairman of the Committee on Insurance predicted yesterday.

Rep. Raymond LaFontaine (D-Gardner) said he has encountered "general opposition" to the industry proposal to hike rates by 46 percent overall for drivers throughout the state.

"The $244 million rate hike request is a fraud," charged LaFontaine. "I've even been approached by insurance agents who said they didn't think it was justified.

"I have no idea what Gov. Dukakis will do. But it seems if there is overwhelming support for the freeze in the Legislature, he will find it fruitless to veto it."

LaFONTAINE COMMENTED after he and Sen. Daniel J. Foley (D-Worcester) filed an order calling for auto insurance rates to be frozen. Foley is the Senate chairman of the Committee on Insurance.

LaFontaine said he expected the late-filed order to be admitted by the Committee on Rules, headed by House Speaker Thomas McGee (D-Lynn) for legislative consideration. McGee is already on record as being "appalled" at the huge increase sought by casualty companies.

If approved, the rate increase would jump premiums paid by some drivers in the under-25 age category by as much as $500 and substantially hike those of other motorists.

The order would require state Insurance Comr. James M. Stone to carry over the 1975 rates into 1976. When the possibility of a freeze was raised by Sen. Joseph Timilty of Boston last week, Stone said he would not want to take such action because it would likely be overturned by the courts.

STONE HAS SCHEDULED public hearings on the rate hike request beginning Sept. 2, but those hearings may be postponed two weeks at the request of Atty. Gen. Francis X. Bellotti.

"Personally, I don't think a freeze will mean a hardship for the industry—but it will give us time to decide in what other directions we can go so that we can be sure the rates are equitable," declared LaFontaine in advance of a meeting to be held today with Comr. Stone.

Even though the insurance industry contends it is losing money on property damage coverage, LaFontaine said he was not impressed. He said it was important that the total financial picture of the firms be brought to light "and not just what's transpiring in property damage."

LaFontaine said the insurance companies "refused to cooperate and give us any statistical data" when requested on two occasions when malpractice legislation was being discussed on Beacon Hill.

"We asked them twice for statistical data and they provided only skeletal information," the Gardner lawmaker asserted.

"EVEN THOUGH THE insurnce companies contend they are losing money on property damage, I don't see any casualty compaines leaving the state," he added.

Meanwhile, Comr. Stone has tacked on some amendments in a Senate bill that would include setting up a state rating bureau so that regulatory agencies would not have to rely on statistical data provided by the Massachusetts Auto Rating Bureau, the industry's statistics-gathering arm.

He complained that the industry has unlimited resources and experts to prepare and present evidence and testimony at rate setting hearings while "we have only two actuaries, both of them well past their 60th birthdays."

One of Stone's amendments would allow for the hiring of two certified public accountants at salaries of $25,000 and $30,000 a year, two attorneys in the same pay bracket and six actuary statisticians at salaries of $30,000 and $40,000.

Stone said these additions would enhance regulatory scrutiny, not only insurance cases but in others where rate hikes are being sought affecting Massachusetts residents.

Las Vegas Review-Journal — Wednesday, March 10, 1976

NO-FAULT

Auto replacement part costs hiking insurance

WASHINGTON (AP) — The White House consumer affairs office says costs of auto repairs and insurance for an average family is rising quickly — mostly because of increases in the prices of auto replacement parts.

Edward J. Heiden, director of economic policy and planning for the Office of Consumer Affairs, told a Senate commerce panel Monday that the average family of four probably spends $300 a year now for repairs and insurance, $50 more than in 1974.

"Much of this increase is due to one cause — the escalating price of automotive replacement parts, particularly crash parts," he said.

Heiden said one way to curb the rapid rise in costs would be to require that auto makers stop selling auto body repair parts exclusively through franchised new car dealers.

Heiden said a government survey shows that prices of crash parts, such as fenders, bumpers and grills, increased 32 per cent in 1974, 25 per cent in 1975 and are still rising.

He said the increase raises the question whether auto manufacturers and dealers have increased parts prices to compensate for declining new car sales.

The present system of distributing parts needed to repair collision-damaged cars has "tended to raise consumer prices substantially with little or no offsetting benefits," he told the hearing on escalating prices of auto "crash parts" and related insurance rate increases.

Spokesmen for franchised dealers of domestic and foreign cars opposed opening of manufacturers' parts warehouses to independent auto body repair shops, claiming it would not result in lower costs to consumers and would decrease the availability of repair parts.

Heiden, speaking for Virginia H. Knauer, President Ford's special assistant for consumer affairs, said complaints about auto prices and repair delays outnumber any other category by two and a half times.

Heiden said his office will cooperate in an investigation on the matter just begun by the Council on Wage and Price Stability.

John J. Pohanka of McLean, Va., president of the National Automobile Dealers Association, said new-car dealers have an incentive to stock little-used body parts to keep their customers, while independent wholesalers have no such incentive and deal mainly in fast-moving parts.

Responding to the suggestion that dealers are raising parts prices to offset loss of new car profits, Pohanka said "the prices haven't changed that much, and competition wouldn't allow it."

Robert M. McElwaine, executive vice president of the American Imported Automobile Dealers Association, said franchised dealers in foreign cars sell parts to independent shops at discounts of 15 to 20 per cent and many dealers are losing money after absorbing the expense of stocking and delivering the parts.

The system, he said, "does not discriminate against the independent garage owner, nor cause hardship to the consumer."

New No Fault — LV Sun 1/30/76

State Farm Insurance Asks 25% Rate Hike

CARSON CITY (UPI) — A rate specialist for the State Insurance Division testified Thursday that State Farm Mutual Insurance Co., had an underwriting loss of $750,000 during the first nine months of 1975 but wants to raise its auto insurance premiums to bring in an additional $2.6 million a year.

Charles Knaus, an insurance rate analyst, told a public hearing conducted by State Insurance Commissioner Dick Rottman that State Farm's loss in 1974 was $500,000.

Rottman said the company must prove the rates requested aren't excessive. State Fram has asked for permission to raise auto rates by 23 per cent effective March 1.

Knaus testified there were deficiencies in the company's application and insufficient documentation in some areas.

State Farm writes more than 77,000 auto policies in Nevada, covering about 25 per cent of the private autos, according to company figures.

George Burt, an assistant vice president in the actuarial department of State Farm, said despite covering 25 per cent of the vehicles, it receives only 18 per cent of the total insurance premiums paid. He said this was due to lower rates charged by the firm.

Burt said the company has not had a long term profit from auto policy holders in Nevada. Since State Farm began writing insurance in 1928, it has sustained an operating loss of $129,000 until September, 1975, he said.

State Farm is proposing the property damage-bodily injury section of an auto insurance policy be increased by 59.8 per cent; that collision rise by 13.3 per cent; uninsured motorist coverage go up 90 per cent and there be no change in no-fault or comprehensive coverage.

State Farm given okay on rate boost

3/2/76 File New No Fault LVRJ 3590

CARSON CITY (UPI) — Rates for motorists who insure their vehicles through State Farm Mutual Insurance Company, will be going up an average 15-16 per cent, State Insurance Commission Dick Rottman said Monday.

The company asked for an overall 23.8 per cent increase in auto rates but Rottman said it did not summit the necessary data to support the amount.

Rate hikes will be a little higher in Las Vegas than in the Reno-Carson City area because of the rating schedule, Rottman said. State Farm Mutual is the largest private auto insurer in Nevada with more than 77,000 policies in effect. That covers about 25 per cent of the cars.

The rate hike broken down into categories will mean a 35 per cent boost in bodily injury-public damage coverage; 13 per cent higher on premiums for collision and 90 per cent more for uninsured motorists protection, which is only a minor part of the premium of any policy.

Reno rejects book store bid

RENO (AP) — The Reno City Council has refused to issue a business license to an adult book store.

The council drew cheers from a crowd of 75 Monday when it turned down a license application

nsurance board: Regula

By Phillip M. Stern
pecial to The Washington Post-Outlook

ASHINGTON — The place is Olympic Hotel in downtown ttle.

ne time is June 8, 1975, and the asion is the semi-annual meet- of the National Association of irance Commissioners — the state officials charged with ecting the public by regulat- the $91 billion-a-year insur- e industry.

hat, at any rate, is what the ers in the hotel lobby pro- m. Among the color-coded ges in the lobby and around meeting rooms, however, re are few white badges be- ging to the commissioners and a smattering of blue ones n by the commissioners' staff nbers. Everywhere, the pre- ni color is green — worn re ntatives of the insur- e stry: salesmen, com- y executives, trade associa- officials. Indeed, the official stration desk in the Spanish nge has only one position for ing in the commissoners and r staffs, but three, alphabeti- y divided, for accommodat- the industry participants. e wonder: The official regist- on roster shows attendance 4 commissioners (not count- three from Canadian pro- ces), 265 members of their s, and 718 industry repre- atives.

his is supposed to be a meet- of the state commissioners, yet, in the meeting rooms, as week progresses, green-bad- industry participants uently fill all the seats while commissioners stand against valls.

this, then, a convention of the lators — or of the regulated?

r many reasons, that ques- great importance to the ions of Americans who rance, health insur- auto and homeowners in- nce and other kinds of pro- on.

rst, the stakes are huge: erican families and busi- es spend $91 billion a year ng insurance — twice what spend on automobiles, and rmous numbers of people are cted; two out of three Ameri- s are covered by life insur- e and eight out of ten cars are red.

problems..." But do they Most of the commissioners are here in Seattle; the industry is surely here, in force; but where are those "interested members of the public"? The NAIC color-coding system has a special badge color (gold) set aside for those representing "academic and consumer organizations"; but the official registration roster lists only three academicians and not a single consumer spokesman. (One reason: consumer representatives have to pay their own way.) Then, clearly the commissioners and their staffs will hear but a single point of view: the industry's.

In at least one respect the NAIC gatherings truly do belong to the industry: they are paid for by industry money. Each of the 718 company and trade association representatives in Seattle has paid a $100 registration fee and another $50 if he has brought his wife.

Industry support is sometimes even more extensive. The magazine "Busines Insurance" reported that before the December 1970 NAIC meeting in Chicago, insurance company funds provided "a 'press and public information committee ... headed by a paid lobbyist for the Illinois auto insurance industry ... assisted by two publicists for major insurance companies domiciled in Illinois." In addition the magazine said the Illinois insurance commissioner had "appointed two leading Chicago insurance company executives as 'general chairmen' of the meeting.'' All of this prompted "Business Insurance"' to conclude that "the insurance industry is clearly running the NAIC, even down to its registration and press relations."

the positions of the NAIC and those of the insurance industry.

"If you compare the NAIC stand on national health insurance with that of the Health Insurance Association of America," White says, "you'll find they are almost identical.

It can be said that the NAIC is the industry's most effective trade association."

The most important question on which the NAIC and the industry positions agree is that of state versus federal regulation. In fact preservations of state control — the stand the industry embraces — is, in fact, one of the NAIC's officially stated "objectives."

The industry has not always favored state control. In the early part of this century, concerned about the disparity in state policies, the industry tried unsuccessfully to get the Supreme Court to rule that insurance was subject to federal regulation.

Later its enthusiasm for federal control waned, and when the Supreme Court finally did rule in favor of federal control, in 1944, industry lobbyists persuaded Congress, in just two months time, to enact the McCarran-Ferguson Act prohibiting federal control as long as there is effective state regulation.

Today the industry continues its strong support of state control, and well it might, for the balkanization of insurance regulation offers built-in barriers to reform. With the regulatory task fragmented among 50 widely dispersed state officials, the only vehicle for change is the cumbersome NAIC.

But the NAIC has almost no personnel to support its work and commissioners are invariably short-staffed.

"The insurance industry is clearly running the NAIC, even down to its registration and press relations."

Industry largesse goes beyond the business aspects of NAIC meetings. At the end of each working day, the commissioners and their staffs are welcome in various "hospitality suites." In the Olympic Hotel's $200-a-day presidential Suite, for example, there is open house for all-comers, courtesy of the Insur-

The industry agreeably offers its services and the hard-pressed regulators accept. Thus, study after study is either conducted or paid for by insurance companies or trade associations. The results are evident in Seattle, at a meeting of the NAIC's Committee on Rates and Ratings, in this sequence of events.

(ISO) which represents 1,100 companies in state rate hearings.

—Report of the Task Force on Policy Readability, given by Carl Black, executive vice president of ISO.

The committee's consideration of the important question of whether there is justification for auto-insurance surcharge rates for special groups such as young people and commuter's illuminates another problem faced by the regulators: They have none of the statistical data needed to arrive at a judgement.

Circumstances conspire against prompt NAIC action. For one thing, the commissioners as a rule are political appointees, subject to instant removal from office when a governorship changes hands. One subcommittee reported in Seattle that its work had been substantially delayed by the departure of four of its members.

William White, of the New Jersey insurance department, complains that the NAIC rarely deals with problems that are of day-to-day concern to regulators, such as the matter of scrutinizing new kinds of life insurance policies that companies are continually introducing, often on a multi-state basis.

"It's absurd and inefficient for 50 separate insurance departments to be looking at the same policy and duplicating each other's work," White says. "But that's not the sort of practical problem the NAIC deals with."

But the geographic dispersion of the commissioners and their staffs is probably the greatest enemy of bigorous action. To illustrate: In 1973, the NAIC decided to take up the question of requiring life insurance companies to pay minimum cash surrender refunds to persons who cancel life policies early. In true NAIC style, the matter was relegated to a subcommittee with a chairman from California and a vice chairman from New Jersey, 3,000 miles away.

White, the vice chairman, tells what this meant: "The way to get action on a problem like this is to sit the experts down for a week of intense work — the way any insurance company would tackle an urgent problem. But instead, I find myself having to deal by mail with my colleagues in California and Tennessee. We meet

Stop. Play that back. really be that the state Jersey, which collects mo $50 million a year in tax fees from the 700 insuranc panies doing business ther afford to send its top life ance actuary to Milwaukee

It's true, and it points u may be the single most imp obstacle to effective insu regulation by the states. New Jersey legislature e its insurance department, professional staff of about perform these tasks:

—Rule on more tha requests each month from erty-casualty and health ance companies for action increases and related matt

—License more than 40, surance agents and brok year.

—Approve each month provisions in life insuran licies that companies want in New Jersey.

—Handle nearly 10,00 sumer complaints a year.

—Scrutinize the finance operating methods of insu companies that seek licen do business in New Jersey.

—Assure the financial st

en, and preventing companies rom wriggling out of paying laims.

Third, the regulatory task is mmense: More than 4,600 companies sell insurance, most of hem on a multi-state basis.

Fourth, almost no expert consumer organizations are doing attle with the insurance companies. (Insurance is, for example, one of the few areas in which Ralph Nader has no full-ime expert staff.)

Finally, and most important, he insurance industry is the only ne of its size and national character that is wholly free of federal control, Congress having decreed that it be subject to regulation nly by the states. Insurance companies are even exempt from ederal antitrust laws.

Hence, almost the only voices capable of speaking for the hapless insurance buyer are the 50 state insurance commissioners who make up the NAIC. They face impossible odds. While the insurance industry is well-financed and highly organized on a national basis, (it has more than 60 trade and professional associations whose budgets total more than $30 million a year, the regulators are dispersed in the 50 state capitals with meager and underpaid staff, and a single "trade association," the NAIC, operating on a central-office budget of just $583,400 a year.

And here they are in Seattle, standing around the edges of the meeting rooms of "their" convention, while industry representatives occupy the seats, ask almost all the questions, do all the buttonholing in the lobby and the corridors, and, after hours, do all the entertaining in the various "hospitality suites."

According to the NAIC's official description of its functions, these semi-annual gatherings are supposed to "provide a forum for the commissioners, the industry, and interested members of the public to discuss regulatory

regulatory staff members to breakfast as guests of the National Liberty group of insurance companies.

Faithful industry participants in these semi-annual, four-day get-togethers achieve a first-name familiarity with the regulators.

While the NAIC, as an organization, is largely dormant between meetings, its president occasionally testifies before Congress on insurance-related matters, and William White, chief life insurance actuary of the New Jersey insurance department, is troubled by the remarkable similarity between

...r or regulated?

80 insurance companies domi-led in New Jersey and about 100 others doing business in the state.

—Protect the interests of po-licyholders of insurance com-panies that go bankrupt.

Gayle Smookler, Executive Director
100 North Arlington, Reno, Nevada 89501, Phone (702) 786-1858

March 10, 1977

Sen Cliff Young
Nevada State Senate
Nevada Legislature Building
Carson City, Nevada 89710

Re: S.B. 304, 305 and 306 (Modifications to Nevada No-Fault Scheme)

Dear Cliff:

Senator Dodge has recently referred to the committee on Commerce and Labor Senate Bills 304, 305 and 306 which seek to modify Nevada's No-Fault Scheme. These bills should be viewed with much suspicion and skepticism because they do absolutely nothing except take away more legal rights of injured Nevadans, to the benefit of the casualty insurance companies whose coffers will be further enriched and fattened should any of these bills pass.

S.B. 304 increases the (unconstitutional) monetary "threshold" from $750.00 to $2,500.00 and removes the exception to the threshold of "chronic" injury, so that a person with a chronic injury would not be entitled to seek reparation from the tort feasor and would have an additional $1,750.00 requirement of medical bills imposed upon him, before he was deemed injured severely enough to seek reparation for general damages for pain, suffering, anguish and disability.

Suggestion: An amendment to S.B. 304 at page 2, line 5 and line 13 so that it would read $250.00 rather than $2,500.00. A further amendment at line 6 should be made to allow the word "chronic" and also to add the words "or serious."

S.B. 305 seeks to give no-fault insurance carriers the absolute, unbridled and unmitigated right to send their insured claimant of no-fault benefits to an independent medical examination "at any time." The present statutory provision allows the insurance company to seek a court order to do this. If we change the law and allow the insurance company to command its insured claimant to go to a doctor of the insurance company's choice, any time it wants to do so, without a court order, you are obviously going to see a tremendous increase in cases in which insurance companies

seek to escape their responsibility to provide no-fault coverage, or at least to delay that responsibility, by exercising the unbridled power that S.B. 305 gives to them. Present law at least has some check and balance to it in that the insurance company must get a court order if the parties cannot agree. There is no evidence that this has been a problem and I can tell you from personal experience that in cases where my client's insurance companies (no-fault) have requested the medical exam, it has always been granted. Nevertheless, a time will probably come when an insurance company will want to send one of my clients to an "insurance" doctor whom I believe will be unfair and in that event, I would like the right to have a court determine this.

No other kind of no-fault insurance, such as Blue Cross, Blue Shield, other hospital insurance, disability insurance, etc., gives this broad of a power to the insurance carrier to command its insured to go to a physician of the insurance company's choice, on penalty of witholding of insurance benefits automatically. That is what S.B. 305 does and I would hope that this measure would be defeated in the interests of injured Nevadans.

S.B. 306 completely changes the "threshold" requirements, and takes out monetary threshold (which is commendable) and substitutes a "philosophical" threshold in its place instead. The philosophical threshold includes death, dismemberment, permanent loss of bodily function, permanent injury, significant permanent scarring or a temporary disability of ninety (90) days or more.

S.B. 306 is not acceptable as drafted but it might improve the state of the law somewhat if an amendment were made which added the following:

"(7) Any injury which is traumatic in nature and which causes serious pain, suffering, anguish or disability."

S.B. 306 is also not acceptable with respect to the language in lines 24 through 33 of Page 2. What this language attempts to do is take away the right to jury trial and substitute in the trial judge as the jury. Under this language the judge has an absolute right to dismiss the case if he is not satisfied "that plaintiff's injury comes within one of the threshold exceptions." Obviously, under the present state of the law, under Rule 56 of Nevada Rules of Civil Procedure, providing for motions for summary judgment, judges do have certain powers to dismiss if the facts are absolutely clear.

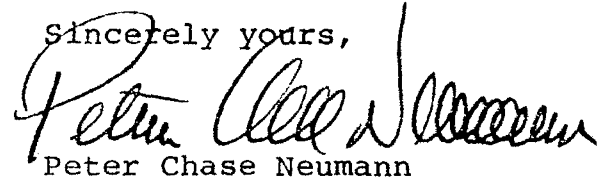
But S.B. 306 gives judges extraordinary powers and would appear to subvert the substantive and procedural due process

Sen. Cliff Young
March 10, 1977
Page Two

requirements of the Nevada Rules of Civil Procedure in cases wherein a party asks for summary judgment. Therefore, the amendment contained in lines 24-33 should not be adopted.

With kindest regards, I remain

Sincerely yours,



Peter Chase Neumann

PCN:lj
cc: Senator Richard Brian
Senator Spike Wilson
Senator Richard Blakemore
Senator Mel Close

bcc: Pat Cashill, Esq.
Neil Galatz, Esq.
Kent Robison, Esq.
Allan Earl, Esq.
Jack Lehman, Esq.

Editor's Note: The following is a reprint of the *Best's Insurance News Digest,* property and casualty edition, of October 4, 1976. It provides an insightful overview of the property and casualty industry today, and reinforces several points State Farm senior management people have made in speeches before many industry groups.

We feel you as first line field management will be interested in the opinions of the respected industry observers at A.M. Best, and we thank them for their kind permission to reprint.

The Outlook for the Property and Casualty Insurance Industry

By the Editors of the Property/Casualty and Magazine Divisions of the A. M. Best Company

Industrywide figures for the first two quarters of 1976 appear to offer some grounds for hope that rate increases, tighter underwriting and better expense control are bringing an end to the worst period of underwriting losses the property/casualty insurance business has ever experienced. But the very fact that any utterance of subdued optimism is possible in the wake of a quarter in which the underwriting loss was more than $600 million tells better than a page of statistics how deeply the industry has been in trouble – and still is. The momentum finally has turned in the direction of improvement, but for many good reasons the last thought appropriate to the occasion is jubilation. This is a time for analysis and reflection – have the causes of the industry's worst two years in history been eliminated, or is there the chance that some or all of this could happen again?

There are many exceptions to every statement when a business as large as insurance is treated as a single entity. It is a fact, however, that over the last 20 years the insurance industry overall did perform in a certain manner, and that company managements tended to act and react more or less similarly to the temptations, conditions and problems with which they had to deal. This is particularly true of the large agency stock companies.

Our observations at the A. M. Best Company of the trends of the business since World War II, and especially since enactment of the multiple-line underwriting laws in the mid-1950s, cause us to conclude that insurance company managements followed a course of action which inevitably produced the underwriting fiascos of 1974 and 1975.

We are mindful of the remarkable diversity of pressures and problems with which the insurance business had to deal. There are no simple answers when management must cope with stockholders, policyholders, politicians, new technology, a changing legal scene, a shift in social values, economic fluctuations involving inflation and high interest rates, scientific discoveries that create undreamed of new risks and consequent demands for coverage – perhaps of a nature beyond the industry's ability to fulfill – and other influences of lesser importance but numerous enough to help divert attention from primary areas. We also recognize that the insurance business has varying degrees of control, ranging from near zero to about 90%, over all of these influences and pressures. And, last but not least, we are aware that it is far easier to criticize, especially after the fact, than it is to participate in decision making at a time when there is no apparent satisfactory solution.

With all of these qualifications, it is still safe to say that the insurance business switched off the main track about 20 years ago. Had it been operating under a different basic philosophy, the disaster of the last two years probably would not have occurred.

In the 1950s and 1960s, the assets of insurance companies began to become interesting to the larger financial world. Part of the education insurance company managements received in their dealings with this differently-oriented melange was the belief in and emphasis attached to the importance of "the bottom line." The theory of the bottom line is quite lenient to managements, in that it forgives the failures in one area if successes in another are sufficient for the operation overall to reflect those two vital catchwords: growth and earnings.

Insurance managements for many years have maintained that their industry is "different," and in the case of the bottom line we wholeheartedly agree that it is. Nevertheless, for 20 years many insurance carriers managed to operate with a certain amount of success on the bottom line theory, even though more than half the time the combined loss and expense ratio exceeded 100%. The theory came apart

(continued)

when the market went down in 1974 and the perennially unreliable underwriting operation also happened to be in decline, a combination which nearly wrecked the industry.

The key to this situation was the known uncertainty of underwriting experience. It had become conventional wisdom that a combined ratio of 102 or 103 was acceptable because investment income would more than offset the underwriting loss, and, together with capital appreciation, would insure an operating profit and provide funds for growth. In a relatively stable economy with only modest inflation, this proposition more or less works out; but too many things have to be right to make it successful in the long run. One of those things that has to be right is the ability to meet the objective of a 102 combined ratio. We haven't seen the company yet that can call the shots on its underwriting within a point or two.

The element that is essential to the success of an insurance operation is the achievement of an underwriting profit. Underwriting is the foundation of the source of money for investments. If profits cannot consistently be produced from underwriting, then ultimately the company will be leveraged into an impossible position. A management that accepts as satisfactory a combined ratio of 102 invites disaster. Planning that concedes an underwriting loss runs contrary to the very purpose of engaging in the insurance business and contributes to the erosion of the basic undertaking.

Economists presently seem agreed that the long-term outlook is for inflation at a rate two to three times that which prevailed up to the early 1970s, and the insurance industry is now faced with the need to support two types of growth: a growth that keeps pace with inflation, and real growth in new business that keeps pace with an expanding economy.

One lesson the insurance business has learned is that its growth must be funded internally. Debt capital expansion calls for interest rates that are virtually prohibitive. The only way money can be created to sustain both inflationary and new business growth is that there be an underwriting profit. Investment income alone cannot pay dividends to stockholders, support an underwriting loss and provide growth of the enterprise. Historically, stockholder dividends have run 40% or more of investment income – and this is a necessity if there is to be investment capital. Investment income overall runs about 7.5% of direct premiums written; if 40% of this goes to the stockholders, then investment income – free of paying for underwriting losses – can contribute enough for a growth in business – new policyholders, new risks – to the tune of about 10% annually. The growth that comes from inflation – the need for higher premiums to support increased underwriting exposure, or, in other words, an enlarged potential loss liability – must be met by underwriting profits. Failure to realize an underwriting profit results in a drain on investment income and limits or eliminates development of new business; it may even reduce surplus. If this goes on too long the companies cannot respond to needs or opportunities in the marketplace.

We think the case for underwriting profit is irrefutable both in terms of the financial well-being of an insurer and its psychology of operation.

* * *

The remarkable underwriting profits recorded in 1971 and 1972 were destroyed by the failure of company managements to recognize the accelerating change in social and judicial attitudes with which were combined the onset of substantially higher rates of inflation than had existed for nearly two decades. Not only were these two danger signals overlooked, the industry simultaneously indulged itself in competition for premium dollars to such a degree that rates were pushed to ruinously low levels. The outcome of this bad timing in the race for discounted premiums when more, not less, money was needed to cover an expanding risk potential, should have created in the minds of carrier managements a permanent impression of the folly of ignoring the necessity for an underwriting profit. Many people had lifelong attitudes imbued in them as a consequence of the Great Depression. It is to be hoped that the memory of 1974 and 1975 will infuse into carrier managements a lasting acknowledgement of the essential goal of an underwriting profit.

It is not likely that the excesses of the past few years will be quickly forgotten, but competition in the insurance business is a strange thing. What constitutes sharpening up a quotation to one company might look like irrational rate cutting to another. The operation of the insurance marketplace is such that there is a tendency to follow the loser – which is to say that many companies are willing to write business at known inadequate rates rather than pass and pick it up at the right price on the rebound. No company that is cutting rates can take all of the market, or even enough of it to set waves in motion if companies which know the difference between a realistic rate and a hopeful one decide – in their own interest and that of their policyholders – to stay with rate adequacy. If enough

companies get caught up in the hunger for premium dollars and will sacrifice sound underwriting to get them, everyone pays eventually through a constricted market and ultimately even through guaranty fund assessments.

* * *

There is, moreover, a newly emerging reason for maintaining rate adequacy and underwriting profits that becomes more compelling each year, and that is that the structure of the insurance business has been weakened to the point where it simply cannot stand another shock like 1974-75. The business today is not what it was 20 years ago, and to think of it and operate it in terms of the mid-1950s could well mean that a gross misjudgment is being made of the composition of the underwriting exposure and the industry's capabilities.

What has happened to the insurance industry in the last 20 years that has caused us to question its ability to weather further serious adversity?

Before trying to answer that, a word about loss reserves. The establishment of loss reserves is subject to the limitations of information available to those who must attempt to determine a realistic figure; and once set, reserves are subject to the influences of economic change, social and judicial change, and liberalizing legislation – to say nothing of the second thoughts of those who put them up in the first place. We believe that loss reserves are today, more than at any other time in the history of the insurance business, the most volatile item on the balance sheet; they are of prime importance to future solvency. To relate loss reserves to policyholders' surplus provides a fairly simple test of the leveraged position of insurers which we think tells a good deal more significantly the extent of their exposure than does the premium-to-surplus ratio.

Loss reserves, as a measure of a company's known loss liability, used to be a place for hiding profits, and the IRS had to tighten up this haven by limiting tax-free redundancy to 15%. Managements are no longer concerned with this ruling – there is very little, if any, redundancy in current loss reserves. In fact, research we have seen indicates loss reserves are inadequate by as much as 10% for those companies heavily involved with third party lines. The leverage of reserves to surplus, therefore, becomes a critical matter. A company with $100 million in reserves and $100 million in surplus pays dollar for dollar from surplus for a deficiency in loss reserves; a company that has $200 million in reserves and $100 million in surplus and is 10% under-reserved will lose 20% of its surplus making up the $20 million deficiency. When the leverage exceeds two-and-a half times reserves to surplus, deficiencies in the loss reserves become very serious indeed.

The amount of money that has gone into loss reserves in the last five years indicates that there has been an understatement and that there is quite likely a continuing overall deficiency. The surpluses of many companies are imperiled (a) to the extent that loss reserves are understated and, (b) more significantly, as the ratio of loss reserves to surplus moves upward. We have seen the operation of the reserves to surplus formula in two spectacular cases in the last two years, and the effect of making up a reserve deficiency from an already leveraged position is devastating.

To return to the question of the changed capabilities of the industry. Twenty years ago loss reserves of the property/casualty insurance business totaled almost $4.7 billion and aggregate policyholders' surplus totaled $9.1 billion. By the end of 1975, loss reserves had grown to $37.9 billion and aggregate policyholders' surplus to $24.2 billion. That is a 708% gain in loss reserves against a 164% gain in the aggregate net resources available to meet contingencies. The relationship turned completely around. Meantime, premium writings increased 368% and the ratio of premiums to surplus doubled.

Those are discouraging statistics, but there is more in them than the simple numbers, because it should be emphasized that when we speak of "aggregate surplus" it is not to be confused with "consolidated surplus." The point here is that holdings in affiliates rose from 15% of surplus in 1955 to 37% in 1975. Of the $9 billion of holdings in affiliated operations at the end of 1975, over $4 billion was invested in property/casualty subsidiaries. If only the latter holdings were consolidated, the $24 billion of aggregate surplus drops to $20 billion and the ratio of reserves to consolidated surplus is at the maximum danger point of two times while premiums to surplus are at a ratio of 2.5 to one.

This being the present position of the industry, its ability to withstand further severe underwriting losses, substantial drops in the stock market or even modest reserve deficiencies is highly questionable. Put any two of these factors together, and a number of companies would require extreme emergency treatment.

Twenty years ago insurance company managements were working with operations of unchallenged solidity. Every year since the business has become weaker. For example, if in 1955 loss reserves had been *100%* deficient, that deficiency could have been

covered by consolidated policyholders' surplus and there would have been sufficient money left over to maintain a 3.2 to one premium-to-surplus ratio. But the industry which could cover a 100% reserve deficiency 20 years ago and stay on its feet would be in shock over a 10% inadequacy today – that shortage would wipe out 20% of the surplus and raise the reserves to surplus ratio to 2.8 and the premium-to-surplus ratio to 3.2. Note that the premium-to-surplus ratio after a 10% deficiency in 1975 is the same as that resulting from a 100% deficiency in 1955. Then the question is, could the industry stand the added burden of even a relatively minor disturbance in either underwriting loss or stock market decline?

The situation for the stock companies is, as might be guessed, noticeably tighter than for the mutuals. The stock companies, with the benefit of the stock market recovery in 1975, at last year end had a reserve to consolidated surplus ratio of 2.2 times against 1.7 times for the mutuals; the stock companies were writing business at 2.6 times consolidated surplus against 2.3 times for the mutuals. If loss reserves of the stock companies are understated by 10%, the reserve-to-surplus ratio becomes 3.1 to one and the premium-to-surplus ratio 3.4. If the reserves are understated by 10% and the stock market were to go 10% lower than its December 31, 1975 position, the reserve-to-consolidated-surplus ratio of the stock companies rises to 3.3 and the premiums-to-consolidated-surplus ratio to 3.9.

* * *

From this perspective – a vastly different one from that of 20 years ago, and, in respect of the enormous increases in loss reserves and investments in affiliates, substantially changed from only five years ago – some things seem evident:

(1) The use of policyholders' money for investment in 100% ownership of an affiliated operation, which is in effect the use of the same dollar twice, has reached the stage at which this practice must be considered dangerous. Forty-two percent of the stock companies' surplus is involved in this type of investment. Until recent years, most of the investments in affiliates were in subsidiary property/casualty carriers; now they have expanded to life companies and a wide range of ventures outside the expertise of insurer managements.

(2) Competition of the sort that characterized the insurance business in the years 1973 through 1975 – and we are speaking about competition in which insurance principles were disregarded in favor of cash flow – will, if resumed, very likely ruin a large number of companies.

(3) The change in the mix of business over the last 20 years has resulted in a leverage in the loss reserves which makes any deficiency a threat to surplus. The importance of maintaining adequate reserves cannot be overstated. For one thing, deficient reserves lead to the conclusion that rate levels are adequate or perhaps even redundant. If rates are moved downward on the assumption that loss reserves fairly reflect underwriting results, the hole the company is already in suddenly becomes much deeper.

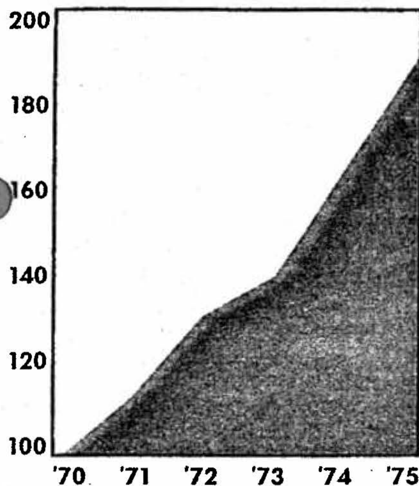
(4) The necessity for an underwriting profit as a fundamental in the philosophy of conducting an insurance business becomes inescapable. The industry's aggregate underwriting achievement, after dividends to policyholders, over the last 20 years is a loss of nearly $9.5 billion. This averages out to nearly $500 million annually. Think what a drain that has been, what an obstacle to growth! Admittedly it is tough to make an underwriting profit, but the lack of it year after year is the biggest single reason why the industry is so much weaker today than it was 20 years ago.

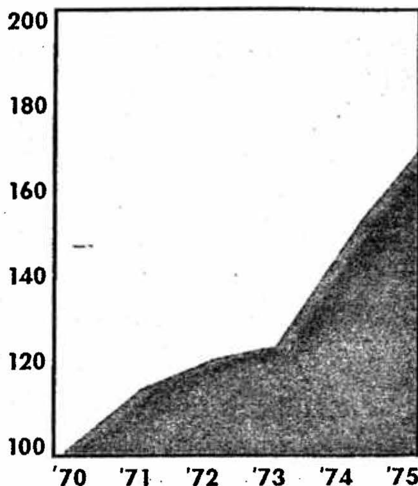
* * *

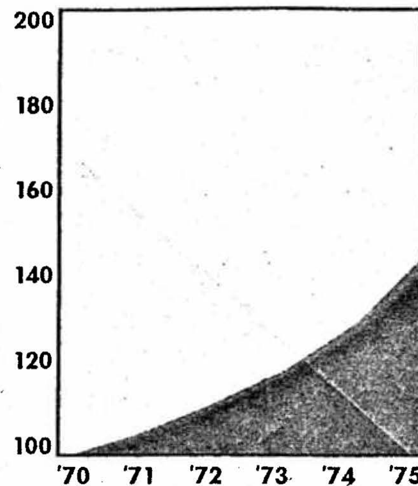
The enduring value of insurance arises from the fact that it is essential to a free enterprise economy. Even though today the industry is weakened by 20 years of change in its financial structure and mix of business, it has shown the ability to withstand the acute crisis of 1974-75; all the plus factors remain. But if the industry is to have a future as a dynamic element in the private sector, we think two things should be kept in mind:

(1) Adherence to sound accounting principles which recognize the insurance company's responsibility to the policyholder as the primary function of its operation must be maintained. The fact that insurance is essentially fiduciary in nature cannot be forgotten.

(2) The state of the business today and its opportunities for tomorrow make it a requirement that whatever available funds exist be put back into the business to provide capacity for growth in step with our expanding economy and that of the world. Financing insurance company growth is almost entirely internally generated, and additional funding to overcome the present capacity shortage and allow the industry to move into a position of leadership in the economy is vital to the future of the business.







And you thought it was all up to us how high your auto insurance rates go.

Insurance companies don't raise rates. Not alone.

We get a lot of help.

In the area of automobile insurance, we get so much help that we'd like you to know about it.

For instance, the cost of fenders, bumpers, doors, and other automobile replacement parts went up 70.6% from 1970 to 1975.* The overall cost of all types of automobile repair is up almost 40% for the same period.** And hospital costs per patient, per day have risen 93%.†

Given these increases in cost, insurance companies have had to increase premiums. But, believe it or not, our increases nationwide have risen more slowly since 1970 than hospital room rates, auto repairs, and even the cost of living.

Still, auto insurance today is high.

And at The Travelers, we don't think that the costs that make car insurance high are likely to level off over the next few years, much less go down.

We do think you should know what to blame after you're through blaming your insurance company or your agent for the rising cost of insurance.

Which, of course, is exactly why we're running this ad.

THE TRAVELERS

Source: *State Farm Insurance Company **Bureau of Labor Statistics †American Hospital Association and Health Insurance Institute ‡The Travelers experience

The Travelers Insurance Company, The Travelers Indemnity Company, and Affiliated Companies, Hartford, Conn., 06115.

CONSUMER EXPECTATIONS AND CONSUMER VALUES IN THE NO-FAULT CONTROVERSY

The original argument for No-Fault was that it would give more benefits to the consumer at a lower cost. The accumulated evidence from the many state No-Fault experiments is that the ratio between benefits and cost remains constant. A plan which produces more benefits produces more cost and higher premiums, and the total premiums paid by the consumers will be 67% greater than the total benefits received.

The failure of No-Fault to deliver the promised premium reduction has caused the proponents to claim that the value of No-Fault protection to the consumer is so great that the consumer should be forced to buy it despite the higher price. This argument has little appeal for the average policy purchaser. Although the general public may not know the specific odds on the risk of automobile accident injury, the average motorist certainly feels that the risk of suffering an injury-producing accident is slight and remote. No one really expects to be injured when he rides in an automobile. The need for protection against loss from automobile accidents ranks very low in the priorities of the American consumer, and he is properly and prudently unwilling to assign many dollars from a limited budget for insurance protection which he regards as unnecessary and unrewarding.

The actual statistics of automobile accident injuries prove that the consumer is right in believing that his individual risk of injury and loss is too small to justify a high annual premium payment.

The final report of the Department of Transportation's study of auto accidents, titled "Motor Vehicle Crash Losses",says that in 1967 about 4,200,000 persons suffered some type of automobile-related injury, and about 50,000 suffered death. In that year, the total population was about 199 million, and the motor vehicle mileage driven on all roadways was about 1 trillion. The numbers mean that the risk of any one individual sustaining any type of injury that year, if he rode in an automobile the average number of miles (about 9,500), was 2.14%. In other words, the consumer could expect that he would sustain some degree of automobile-related injury once in 47 years of average automobile use.

These odds might seem too high if all the injuries were serious, but they are not. Most injuries are minor. According to the Department of Transportation's final summary report, 88% of all the injuries included in the estimated total were classified as "less than serious". The average loss in this large number of persons sustaining nonserious injury, comprising 3,750,000 individuals, was $131 in medical expense, and $81 in wage loss, and $12 in other expense. By definition of "less than serious" no individual in the class sustained a total economic loss exceeding $1,500, and of course, most losses were far less. The number of consumers who could not stand this level of loss is miniscule. For the overwhelming majority of consumers there would be no net actual loss at all. Blue Cross or other hospital insurance, medical insurance, medical pay auto insurance, sick leave and wage continuation benefits, and other first-party benefit coverages,in addition to tort liability claims,would pay these small losses in full in almost every instance.

This leaves a small class of "serious" or fatal injuries which might produce heavier economic loss. In the base year 50,000 deaths were attributed to the use or misuse of motor vehicles. The odds on any one consumer suffering death in that year were .00025 to 1, which means that the average consumer could expect to travel the average automobile mileage for 4,000 years before the fatal accident struck. Although the loss in the rare death case might be great, in most cases life insurance, Social Security and other coverages in addition to tort liability help defray the loss. It is significant that the proponents of S.354 suggest only $5,000 as a "reasonable" level for survivor's benefits.

The remaining class of victims, about 450,000 in total, sustained injury of a degree classified as "serious" by the Department of Transportation in its separate study called "Economic Consequences of Automobile Accident Injuries". The definition of "serious" in this study must not be confused with the definition of "serious" used in the minimum threshold provision of S.354, where a disability is serious only if it produces a continuous and total disability for at least 90 days. In the D.O.T. study the definition was far less stringent, classifying an injury as "serious" if it produced three weeks loss of time from work; or 6 weeks of partial disability for unemployed persons; or a total of two weeks hospitalization for treatment or therapy; or $500 in total medical costs exclusive of hospitalization. Under these alternative criteria, it was estimated that about 10.6% of all auto-related injury victims would have a "serious" injury. The mathematical probability

of being "seriously" injured in any one year is .00226, which means that the average consumer traveling the average annual mileage in a motor vehicle could expect to sustain one such injury in 442 years.

Even the defined "serious" injury will not necessarily produce long term disability or extensive economic loss. The "Economic Consequences" study does a detailed breakdown of all estimated past and future loss for the entire class of both "serious" and fatal injury victims. Those with total losses between $5,000 and $10,000 numbered 59,723; or about 12% of the "serious/fatal" class, or 1.4% of all auto injury victims, or 0.03% of the population. The total number of "serious/fatal" victims sustaining economic loss between $10,000 and $25,000 was estimated at 45,153. The losses in this class were extraordinary, averaging over $76,000 per victim with a heavy weighting from survivor's loss of the wage-earner's support in death cases and permanent total disability cases. No-Fault plans such as S.354 with a proposed $15,000 wage loss benefit and a $5,000 death benefit do not pretend to cover this very limited class of catastrophic loss cases. The cases are, fortunately, rare. Only 9% of the "serious/fatal" class sustain such heavy loss-producing injury; or 1% of all auto-accident injury victims; or 0.02% of the population.

Combining the figures for the entire class of victims sustaining a "serious" or fatal injury with a total economic loss exceeding $5,000 produces the combined average of 27% of the "serious/fatal" class; or 3.2% of all auto-related injuries whether major or minor; or 0.07% of the population.

The analysis in "Economic Consequences" may overstate the case. The insurance industry has criticized the study on the ground that the extent of economic loss was based solely on the victim's unchecked and unverified estimate of what his future losses might total. A leading proponent of S.354 is State Farm Mutual Insurance Company. In the hearings before the Senate Commerce Committee in 1973, State Farm's Vice-President, Thomas Morrill, submitted a chart based upon the insurance industry's "Personal Injury Claims" study (1969) which showed that only 2% of all automobile accident victims sustained economic losses exceeding $5,000, instead of the 3.2% figure derived from the other studies. This would reduce the total number to 85,000. It follows that if State Farm's estimate is correct, then the average consumer traveling the average annual mileage in a motor vehicle could expect that he would suffer injury and a loss exceeding $5,000 just once in 2,380 years. If the other Department of Transportation estimates are correct, the odds are that the average consumer traveling the average annual mileage in a motor vehicle would sustain an injury producing $5,000 or more in economic loss just once in every 1,428 years.

On either figure the risk facing the individual policyholder at the time he writes his annual premium payment check is a very slight risk indeed. He will understandably resent a government-compelled payment for a commodity of such slight utility. The resentment will be even greater among that great majority of consumers who already have broad range hospital and medical expense coverage and wage continuation coverage. The compulsory duplication of protection against slight risk is an economic waste.

No-Fault proponents might argue that the 1967 figures are no longer valid statements of the present risk of injury and loss. In fact, the proportions and percentages show almost no change. During the period from 1967 to 1975, according to the "Statistical Abstract" of the United States, the population increased from 199 million to 212 million. Annual automobile registrations and motor vehicle travel increased in a higher proportion, with annual total motor vehicle mileage on the nation's roadways increasing from 1 trillion to 1.3 trillion miles. Although the average injury rate per mile declined, the total number of injuries and deaths increased until 1972. Since then, the continuing decline in the rate of accidents per mile has reduced faster than total mileage has increased. The latest figures show an annual death rate of only 46,000 which is less in total than the 1967 figure and much less in ratio. The latest estimate of total injuries in the 1975 Statistical Abstract is 4,600,000 which is about the same percentage of the population as the 1967 figure; and a lesser injury rate per mile. The combination of improved safety devices in automobiles and a lowered national speed limit should continue to reduce the per-mile ratios of serious injury or death. At the same time, increasing voluntary participation in hospital, medical, and wage continuation insurance reduces the economic impact of automobile-related injury and loss.

There is no doubt that No-Fault could generate considerable consumer appeal if it could really produce substantial premium savings. If it continues to produce premium increases in real world experience,

one can expect to see growing public pressure for the repeal of the costly state experiments. The cost-benefit ratio is too low to make No-Fault a good consumer value.

THE SIMPLE RULE OF NO-FAULT COST: C=1.67B

There is one simple, fundamental, inexorable rule of insurance mathematics which should eliminate all further argument as to the consumer value of No-Fault. If the consuming public wants more benefit dollars for automobile accident injuries, the No-Fault system can deliver them. It can deliver 25% more dollars, or 50% more,or twice or three times as many total payment dollars. The rule of cost is that for every 15 cents in additional benefits the consumers obtain, they must first pay 25 cents in insurance premiums. If the consumers want lower premiums, they must accept lesser benefits. If they want more benefits, they must pay even more in increased premiums.

The automobile insurance industry will deliver back to the consumer in benefits 60% of the premiums paid in to the system. Benefits will equal .6 times cost. The reverse is necessarily true: Cost will equal 1.67 times benefits. B=.6C. C=1.67B.

The premium dollar contains only 100 nonstretchable cents. No theory and no rhetoric can increase its content or its value. The premium dollar must be divided up to pay insurance company expenses and profit as well as paying benefits to claimants. In the vocabulary of insurance, benefits gained by the claimant consumers are called "Losses Incurred", which can be stated either in absolute dollar amounts or as a percentage of the premiums written or earned. The

expenses of the insurer are classified as "Commissions and Brokerage", "Other Acquisition" (including advertising and promotion), "General" or "General and Administrative", "Taxes", and "Loss Adjustment" expenses. The detail for each expense item of every property and casualty insurer in the United States is published once a year in the authoritative compilation of A.M. Best & Co., called "Best's Aggregates and Averages". When all Losses Incurred, Loss Adjustment Expense, and all the other expense (called "Underwriting Expense") has been calculated and deducted from the premiums for the same year, the result in dollars or percentage is called Underwriting Profit or Loss.

Profit and Loss figures vary from year to year, but in general, the expenses as a percentage of premium remain the same for all the common lines of insurance. The constant ratio, for all lines of automobile insurance for many years, has been about 38% of premium to cover expense in all the automobile Liability lines; and 35% to 36% for the Auto Physical Damage lines, such as Collision, Comprehensive Fire and Theft. The ratio will remain the same under No-Fault. It does in theory, and it has proven so in fact in the laboratories of existing state No-Fault systems.

Surprisingly enough, Automobile Insurance has the lowest expense ratio of all the common lines of individual coverage the consuming public buys. It is not the "least efficient", as No-Fault propagandists shout, but the most efficient. Best's "Aggregates and Averages" prove this every year. To find the expense ratio, take the

annual totals for every different line of insurance for every Stock insurance company and every Mutual insurance company, add the Loss Incurred percentage to the Underwriting Profit or Loss percentage (plus or minus) and deduct this total from the Premium total. The result will be the total of all expenses, including Loss Adjustment expense.

Example: In Best's 1974 edition, the grand total of premiums for all the Fire insurance writers in the United States, both Stocks and Mutuals, was $2.448 billion. The Stock companies had a Loss Incurred ratio of 50.6% with an underwriting profit of 10.3%. Combined Loss Incurred (benefits paid to public) and Underwriting Profit was 60.9%. Deducting this from 100% of premium yields 39.1% of the premium as the total of all the expenses. The Mutual Fire insurance writers paid out 46.0% of premiums in Losses Incurred, with an Underwriting Profit of 17.2%, which leaves 36.8% of the premium as the amount paid for total expenses.

The weighted average for combined Stocks and Mutuals was 38.7%. In general, the Mutual companies have a lower expense ratio than the Stocks, and a higher underwriting profit by a few percentage points, but the Stock companies command a much larger share of the market and write about 5 times as much business as the Mutuals.

Dealing with Expense ratios only, the same method of computation yields the following retained expense ratios for all the common lines of property or casualty insurance the individual consumer might buy:

BEST'S 1974 RATIOS

TOTAL EXPENSE RETENTION OF COMBINED STOCK AND MUTUAL COMPANIES

Fire Insurance	38.7%
Allied Lines	39.8%
Homeowner's	42.2%
Inland Marine	40.1%
Miscellaneous Liability	51.7%
Non-Group Accident and Health	43.6%
Private Passenger Auto Liability	37.4%
Commercial Auto Liability	39.9%
Private Passenger Auto Physical Damage	35%
Commercial Auto Physical Damage	37.2%
Combined Auto, Private and Commercial, Liability and Physical Damage	37%

It may be of interest to note that the total Private Passenger Auto Liability premiums in 1974 were $8.45 billion. At least 35% of this premium was for Property Damage Liability, which is not affected by No-Fault. The premium in which the consuming public has a stake under S.354, Private Passenger Bodily Injury Liability, was about $5.5 billion in the 1974 report of Best's. This is

substantial, but nowhere near the newspaper columnists' figures of "Twenty Billion Dollar industry" which will be changed by No-Fault.

The 1974 compilation shows that the Stock companies paid out 64% of their premiums in their Private Passenger Auto Liability line in losses incurred, with an Underwriting Loss of 2.3%. The Mutuals paid out 60.8% in the same line with an underwriting profit of 3.5%. The industry underwriting loss, weighted average, was 0.2%, or very nearly break even at a weighted average payout of 62.4%.

It is a financial rule of insurance that in the Auto Liability lines $1.00 of premium will generate $1.00 of reserves. The investment profit on reserves makes the insurance business profitable even at a break-even, or zero, underwriting profit. Nevertheless, an underwriting profit of 2% is not unreasonable, and consumers should be satisfied with an expense ratio of about 38% in the liability lines, with a payout of 60% and insurer's underwriting profit of about 2%.

No-Fault systems can do no better. Many factors tend to drive expenses up, and to shrink reserves. Since investment income on the Reserve accounts must diminish under No-Fault, the insurance companies need a higher margin of underwriting profit in order to retain their capacity to satisfy the market demand for new and renewal policies. Confirmation of these ratios may be found in the Report of Hearings before the House Subcommittee on Consumer Protection and Finance on the House versions of federal No-Fault bills. On page 595 of the Report (Serial No. 94-42, late 1975), the following table is included in the testimony of T. Lawrence Jones, President of the American Insurance Association:

DISTRIBUTION OF THE PREMIUM DOLLAR
STOCKS, MUTUALS, AND RECIPROCALS;
PRIVATE PASSENGER AND COMMERCIAL
AUTO LIABILITY - IN PERCENT

	Tort System	No-Fault
Operating expense (Commissions, other acquisition, general administrative, and taxes)	26	26
Loss Adjustment	12 (actual)	9.5 (estimated)
Losses Incurred	60	60
Underwriting Profit	2	4.5
	100	100

A caveat should be entered that the prophecy of a reduction in loss adjustment expense by 2.5% of the premium, (based on the Milliman and Robertson formula) has not been realized in actual experience in the No-Fault states. There is little hope for a reduction in adjustment expense percentage, which means that the theoretical underwriting profit of 4.5% will be reduced to 2% if payout remains at 60%. This may be an inadequate profit margin for industry health if investment income continues to fall as Reserves are reduced.

In summary, auto liability insurance expense and profit takes 40% of the premium. Benefits to claimants can properly take 60% of the premium. Higher benefit levels lead to underwriting loss. These ratios have held true for more than a decade, and remain true under No-Fault systems as they did under tort. Tort benefits cost the consumer $1.00 in premium for every 60 cents in benefits. If No-Fault delivers additional benefits, the added benefits will cost 50 cents in added premium for every additional 30 cents received by the public. The Benefit is .6 times Premium. The Cost in premium is 1.666 times the Benefit.

The "bargain" for the consumer is an illusion. The staff of the Senate Commerce Committee has invented a table of benefits, published at page 595 of the Commerce Committee Report on S.354, which states that on national average 37% more victims will receive compensation under S.354, and total benefit dollars paid out will be 43% greater than tort system benefit dollars. If these figures were true, it would mean that the consumers face a 43% premium increase. Benefits, at 60 cents of the premium dollar, would rise to 86 cents (tort plus 43%). Expenses, at 40 cents of the premium dollar, would rise to 57 cents (tort plus 43%). The premium, compared to each $1.00 for tort liability, would rise to $1.43. The consuming public would receive 26 cents more in benefits than the tort system provides per dollar of premium, but would have to pay 43 cents more per dollar of tort premium to get that 26 cents. The rule would hold: Cost=1.67 Benefits.

CRAIG SPANGENBERG

OREGON NO-FAULT EXPERIENCE

Oregon's experience with its own style of no-fault has been so outstanding that it should serve as a model for other states which might need some form of first-party auto accident compensation system. The Oregon success should also chill the enthusiasm for a Federal plan which would destroy the Oregon experiement and mandate a different and untested approach. The expenses of running any insurance system (except group plans) are remarkably constant. The insurance company retention of part of the premium for selling, general and administrative expense, for loss adjustment expense and taxes have long been the same for most lines of casualty and property insurance, including automobile insurance, whether benefits are paid on a fault or no-fault basis. If the expense is the same percentage of premium, and benefits are increased, premiums must rise. An increase in payments to at-fault victims means that premiums must increase, unless there is an offsetting decrease in benefits to innocent victims.

The Oregon plan creates an offset, but relies on voluntary factors to achieve the result. It is an Add-on, Take-off plan which requires each car owner to buy a first-party protection package which will pay to the accident victim, regardless of fault, benefits up to $5,000 for medical expense, up to $9,000 for wage continuation, and replacement of service benefits up to $18 a day. There is no restriction on tort claims, no threshold to bar lawsuits, and no limitation on general damages. If the innocent victim does elect to proceed with a tort claim, and recovers, then he must pay back the no-fault benefits he has received.

This "Take-off" feature eliminates the cost of duplicate benefits, reduces the total cost of the first-party benefit payments, and makes it economically impractical to pursue the smaller tort claims. Oregon's Insurance Commissioner has reported declines in tort claims filed against representative insurance carriers, both agency and direct-writing companies, ranging up to a 52 percent decline after no-fault. There was not only a decline in the first year of no-fault, but the decline has continued thereafter despite an increase in population and an increase in automobile registrations. Allstate has reported to the Senate Commerce Committee that its own decline in tort claims, as a percentage of policies sold, has been 25 percent. It must be expected that when the smaller claims drop out of a systme, the average claim cost for the remaining larger claims will rise. Allstate has reported an increase in average claim cost of 20 percent. When 75 percent as many claims are filed after no-fault, compared to claims per policy before no-fault, and the average claim cost increases by a factor of only 20 percent, then the total cost of all claims is reduced by 10 percent. (.75 X 1.2 = .9). The net effect is that bodily injury liability premiums are <u>lower</u>, on average, in Oregon in 1975 than they were in 1971 despite inflation. Overall premium rates for automobile insurance in Oregon have stabilized, while other states which have adopted higher benefit packages and thresholds have incurred the higher premiums which should have been expected.

The threshold plan to reduce costs has been counter-productive in Florida. The mandatory first-party benefit package in Florida is subject to an overall maximum of $5,000 for medical expense, wage loss, and replacement of services. This is only moderately expensive, and

it was assumed that a high threshold would produce such great savings in residual tort claims that a net premium reduction of 15 percent could be compelled. In real world experience, the plan has failed. Tort costs have actually increased, and premiums for the no-fault and tort benefits have risen sharply.

The Florida threshold bars all tort claims unless the victim has at least $1,000 in medical expense. This is comparable to the threshold effect expected to be produced by S.354. (Milliman and Robertson's cost model assumes that a $600 medical expense threshold is equivalent to a 60-day total disability threshold; and a $2,000 medical expense threshold is equivalent to a six month total disability threshold. It would follow, if the assumptions of the cost model are valid, that a $1,000 Florida threshold would be equivalent to the proposed 90-day total disability threshold of S.354.)

Allstate has reported its real world experience in Florida. Residual tort claims have been reduced by 65 percent. Only 35 percent as many tort claims, per policy, are made under high-threshold no-fault as compared to claim frequency under the former tort system. The increase in average claims cost has been startling. It costs 333 percent as much, on average, to pay the residual tort claim under no-fault as it formerly cost to pay the traditional tort claim. With average Frequency down to 35 percent, and average claim Severity up to 330 percent, the resulting total cost is <u>increased</u> by 15 percent (.35 X 3.3 = 1.15). In short, it costs more to pay the present residual tort claims with the Florida $1,000 threshold than it used to cost to pay for all of the tort claims, large and small, under the unrestricted system. There is, of course, additional cost for the first-party

protection package. Florida law has the Take-off feature, or total costs would be even higher.

New York has adopted a $500 threshold. Its early experience has shown a drop in claim Frequency to 60 percent. Severity, or average claim cost, has risen to 150 percent for the residual tort claims as compared to the former unrestricted tort system. The resulting total cost is 90 percent of former tort cost. (.6 X 1.5 = .9).

New Jersey has found an identical experience with a $200 medical expense threshold for soft-tissue injuries. The residual liability claims have a Frequency factor of 60 percent and a Severity factor of 150 percent, with a total cost of 90 percent for residual tort compared to all liability claims under unlimited tort. Again, these are Allstate's real experience figures as distinguished from earlier predictions. New York and New Jersey both have high benefit and high cost first-party packages. The cost of the benefits will be so high that the small savings in residual tort liability cannot possibly offset the increase.

It should be interesting, if not frightening, to a Senator to compare the predictions of no-fault costing models with the true life experience. Milliman and Robertson and State Farm use similar formulas which predict cost decreases on a theoretical basis, based on assumptions instead of the hard data of real experience. Allstate also has a costing model, based on different assumptions, which predicts cost increases. The Milliman and Robertson and State Farm models predicted a net 15 percent decrease in Florida. The Allstate model predicted a moderate 7 percent increase for its average policyholder. The Milliman and Robertson and State Farm models were flagrantly wrong.

Allstate's model was less in error, but still predicted a cost lower than the cost shown by true experience. The Florida cost increase exceeds 15 percent. Costs have increased, rather than decreased as predicted by Milliman and Robertson and State Farm in both New Jersey and in the developing figures in New York. State Farm has applied for an increase in New Jersey, and in Florida, similar in percentage to the Allstate application.

It is strange that the Senate Commerce Committee still relies on Milliman and Robertson, and on State Farm cost predictions, when the actual data in experimental states has conclusively established that those models predict substantial cost decreases instead of the true life substantial increases. At the same time, the models predicted cost increases, based on erroneous assumptions, for the Oregon plan, instead of cost reductions which have in fact occurred. The Senate should not abolish the good and time-proven Oregon plan, relying on the wistful prophecies of actuarial models which have tested to failure.

background reference 4

HOW RATES ARE MADE

The basic principle of insurance is the *sharing of risks.* In other words, many persons make small contributions—or premiums—as a safeguard against severe loss or financial hardship in the event of a traffic accident, a fire or other misfortune.

Since the birth of the insurance concept hundreds of years ago, its sole objective has been to provide security—security of purse to victims of storm, fire or other peril, and security (or peace) of mind to those fortunate enough not to sustain a loss. But where early-day insurers were forced to rely largely on judgment in the assessing of fees for their services, today's highly advanced professionals have the benefit of years of experience upon which to draw in the development of rate structures which reflect varying degrees of risks—or the loss potential—of the many persons or interests they are called upon to insure.

In fire insurance, for example, it is recognized that the chances of a "fire-resistive" factory being destroyed by fire are far smaller than the chances of a wooden factory burning down, other conditions being similar. In automobile insurance, it is recognized that persons who regularly drive their cars to work through rush-hour traffic are exposed to greater hazard than persons who drive only for pleasure in the same city or community. The rates vary accordingly.

For the major lines of property and liability insurance, the rates vary from state to state and even from community to community, depending on the accident record of local motorists, the extent of fire protection available for property owners, etc. But while many such factors are considered in ratemaking, rates basically are dependent on two primary factors:

1. The frequency of claims (which generally parallels the frequency of such occurrences as auto accidents, fires and thefts).
2. The cost of each claim (which in turn is affected by inflationary and other considerations).

In their periodic reviews of rates, the companies use this "loss experience" of the immediate past, supplemented by factors reflecting economic trends, as a guide to the amount they will need to pay claims in the immediate future and to defray the usual costs of doing business.

Exhibit B

AUTOMOBILE FINANCIAL RESPONSIBILITY LAWS

Every state has a law on its books, commonly known as a financial responsibility law, under which a person involved in an automobile accident may be required to furnish proof of financial responsibility (usually done in the form of automobile liability insurance) up to certain minimum dollar limits. The provinces of Canada have similar laws. Mexico has no financial responsibility law as such, but requires an auto liability insurance policy written with a Mexican company.

Laws requiring registered car owners to have liability insurance or, in some cases, some other approved form of security are in effect in California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, South Carolina, Utah, Puerto Rico and the Virgin Islands.

Even where ownership of automobile liability insurance is not compulsory, the existence of the financial responsibility laws, along with the ever-present threat of a financially-crippling judgment in the event of an accident, has come to make the possession of automobile liability insurance a virtual necessity for most motorists.

Nevertheless, there are many motorists who are considered doubtful risks or whose poor driving records label them as obviously bad insurance risks. In all states, there are procedures through which such persons are able to obtain coverage. For additional information about these procedures, see "Automobile Insurance Plans," page 28.

STATEMENT OF THE ASSOCIATION OF TRIAL LAWYERS OF AMERICA
IN OPPOSITION TO S.354
THE NATIONAL STANDARDS NO-FAULT MOTOR VEHICLE INSURANCE ACT

BEFORE THE COMMITTEE ON COMMERCE
UNITED STATES SENATE, 94TH CONGRESS

MAY 5, 1975

1426

STATEMENT OF
THE ASSOCIATION OF TRIAL
LAWYERS OF AMERICA
TO THE
UNITED STATES SENATE COMMITTEE ON COMMERCE
APRIL 30, 1975

It is a privilege to be able to present to the Senate Committee on Commerce the statement of the Association of Trial Lawyers of America on the subject of No-Fault Automobile Insurance in general and upon S.354 specifically. The Association of Trial Lawyers of America is an organization of 27,000 lawyers who represent, for the most part, individuals and consumers rather than major corporate and insurance interests.

A.T.L.A. does not now and has never opposed no-fault insurance or insurance reform. We have, since 1967, consistently supported a plan which would pay levels sufficient to pay in full the entire economic loss of at least 95% of all accident victims. This plan would alleviate a social need without increasing cost and without shearing away fundamental private rights.

We have consistently opposed the destruction of the legal system as it applies to automobile accidents. The benefits of no-fault, deriving from prompt payment of losses from first-party source, can all be realized without abolishing the rights of innocent victims.

Injured drivers can be treated, healed, and restored in substantial measure by any type of health and accident insurance; but the laudable purpose of binding up the wounds of the guilty does not justify enlarging the loss of the innocent.

In brief preview, we support state action and prefer diverse state solutions. We oppose a national, uniform, federally controlled plan. We support the concept of no-fault, first-party automobile insurance. We oppose thresholds and other arbitrary limitations on long-established and long-cherished individual rights.

If Congress deems that it must act, then we urge that Congress enact a true minimum-standards act, compatible with the laws of the 24 states which have already responded to the urging of the Department of Transportation to begin experimentation with diverse plans.

S.354 in particular involves serious constitutional questions of federalism which will require some consideration of the Policy and the Findings contained in the bill on final passage by the Senate, which are said to justify Congressional intervention in a problem traditionally reserved for state solution.

I. DUE PROCESS AND EQUAL PROTECTION

The United States Constitution, Amendment V, adopted in 1791, provides in part:

> No person shall . . . be deprived of life, liberty, or property without due process of law.

The United States Constitution, Amendment XIV, adopted in 1868, provides in part:

> Nor shall any State deprive any person of life, liberty, or property, without due process of law . . . .

The concept of due process of law limits the powers of both state and federal governments. The Fifth Amendment limits the legislative power of the national government, and the Fourteenth Amendment limits both the legislative and the constitutional powers of the states. The origin of "due process" can be traced to Chapter 39 of Magna Charta in 1215, which provided that certain rights of a free man could not be impaired "except by the lawful judgment of his peers and _by the law of the land_." The Latin phrase "_per Legem Terrae_," as used in Magna Charta, was translated into "Due Process of Law," in 1355, in Chapter 13 of 28 Edward III.

"Due Process of Law" does not mean simply that a legislature must pass a law destroying rights before those rights can be constitutionally destroyed. Sir Edward Coke is credited with first announcing that the proper interpretation of "_per Legem Terrae_" is "by due process of _the common law_". See Bonham's Case, 8 Co. 107a, 118a, 2 Brownl. 255, 265 (C.P. 1610), in which Coke stated that common law would invalidate an act of Parliment if the act were contrary to common right and reason. It was the belief of Coke that "due process of the common law" was intended to protect "the fundamental rights of Englishmen"

from any governmental attempt to inflict arbitrary injustice. Coke, 2 The Institutes, 50 (1817 Edition).

In Jones v. Robins, 8 Gray 329 at 342 (Mass. S. Ct. 1857) Chief Justice Shaw said:

> We are to look at it (due process of law) as the adoption of one of the great securities of private rights handed down to us as among the liberties and privileges which our ancestors enjoyed.

Due process, then, is a primary guaranty derived from the Constitution itself that the fundamental rights of free men as defined by the English common law will be protected against governmental abolition. An expanded interpretation of due process, asserted by some scholars and judges, is that the "natural law," in John Locke's theory of the "natural" rights of man, is the source of the rights protected by the Constitution, and the source of "the fundamental rights of Englishmen" as well. See Corwin, "The 'Higher Law' Background of American Constitutional Law," 42 Harv. L. Rev. 149, 365 (1928).

A parallel concept of the Fourteenth Amendment is that the rights of a citizen must be accorded the "equal protection of the laws." Where due process has a negative thrust, forbidding government to destroy fundamental rights, "equal protection" states a duty on the part of the government of give equal non-discriminatory protection to the natural rights of free men. See J. Ten Broek, "Equal Under Law," 51 (1965).

> . . . it is the duty of government to protect men in their natural rights by laws.

A critical issue is the determination of just what the "natural rights of men" are, or what "the fundamental rights of English free men" were, with

respect to reparations from a stranger who wrongfully inflicted injury. There can be no doubt that the common law of England recognized the right of the injured victim to obtain full compensation for both special and general damages. Blackstone, the pre-eminent authority on the laws of England, had no doubt about the fundamental nature of that right. The following quotations give ample proof of the proposition. (Page references are to Chase's Edition of Blackstone's Commentaries).

> For the principle aim of society is to protect individuals in the enjoyment of those absolute rights, which were vested in them by the immutable laws of nature; but which could not be preserved in place without that mutual assistance and intercourse, which is gained by the institution of friendly and social communities. Hence, it follows, that the first and primary end of human laws is to maintain and regulate these absolute rights of individuals. (p. 63)
>
> * * *
>
> And these (rights) may be reduced to three principal or primary articles; the right of personal security, the right of personal liberty, and the right of private property.
>
> * * *
>
> I. The right of personal security consists in a person's legal and uninterrupted enjoyment of his life, his limbs, his body, his health and his reputation. (p. 68)
>
> * * *
>
> Besides those limbs and members that may be necessary to a man, in order to defend himself or annoy his enemy, the rest of his person or body is also entitled, by the same natural right, to security from the corporal insults of menaces, assaults, beating and wounding; though such insults amount not to destruction of life and member.

The same principle is stated to be derived from "natural" law by Rutherforth in his Institutes of Natural Law, wherein he states:

> As the law of nature forbids us to hurt any man, it cannot allow any act of ours, whereby another is hurt, to stand good, or to obtain any effect. But the law, if it does not allow such act to stand good, or to obtain any

> effect, must, after we have done it, require us to undo it again. The only way of undoing it again, or of preventing the effect of it, that is, the only way of satisfying the law, is to make amends for what any person has suffered, who was hurt by it, or to make reparation for the damages which such person has sustained. The same law, therefore, which guards a man from being hurt, by requiring others not to hurt him, gives him a demand upon them, when they have done him any hurt, to undo it again, or gives him a right to demand reparation of damages. If such reparation be refused, the law gives him a right to it, and allows him to support this right by all such means as are necessary for that purpose, because a right which he is not at liberty to enforce or bring into execution, is, in effect no right at all.

To like effect is the expressive language of Puffendorf, in his Laws of Nature Book 3, Chapter 1:

> In the series of absolute duties, or such as oblige all men antecedently to any human institution, this seems with justice to challenge the first and noblest place, that no man hurt another; and in case of any hurt or damage done by him, he fail not to make reparation. For this duty is not only the widest of all in its extent, comprehending all men on the bare account of their being men; but it is at the same time, the most easy of all to be performed . . . .

Early cases in the state court reports follow the principle that the right to reparations from a wrongdoer is a natural and fundamental right of every man living in our society. See the language in Kerwhacker v. Railroad, Co., 3 Ohio St. 172 at 176 (1854):

> A maxim of the law, tested by the wisdom of centuries, exacts of every person, in the enjoyment of his property, the duty of so using his own as not to injure the property of his neighbor. It is in accordance with this principle, that it has been held, that though a person do a lawful thing, yet, if any damage thereby befalls another, which he could have avoided by reasonable and proper care, he shall make reparation. [Emphasis added]

It was said in Park v. Free Press Company, 72 Mich. 560 (1888):

> It is not competent for the legislature to give one class of citizens legal exemption for wrongs not granted to others; and it is not competent to authorize any

> person, natural or artificial, to do wrong to others without answering fully for the wrong.

The key word in the quotation is "to do wrong." If the "wrong" consists of the violation of a rule of conduct defined by the legislature, then the legislature may (in a rational way) redefine the rule of conduct. That is, conduct which was "wrong" may become permissible conduct under new rules adopted to meet the needs of a changing society. The principle is analyzed well in New York Central R. Co. v. White, 243 U.S. 188 (1917). The issue in that case was whether a workmen's compensation law which met the requirements of an amended state constitution was permissible under the Fourteenth Amendment of the U.S. Constitution. The Supreme Court said, at 243 U.S. 188, p. 198:

> The common law bases the employer's liability for injuries to the employee upon the ground of negligence; but negligence is merely the disregard of some duty imposed by law; and the nature and extent of the duty may be modified by legislation, with corresponding change in the test of negligence.

The White case restates a proposition found in one of the leading earlier cases, Munn v. Illinois, 94 U.S. 113, 134, (1876), where Chief Justice Waite said:

> A person has no property, no vested interest, in any rule of the common law. That is only one of the forms of municipal law, and is no more sacred than any other. Rights of property which have been created cannot be taken away without due process; but the law itself, as a rule of conduct, may be changed at the will, or even at the whim, of the legislature, unless prevented by constitutional limitations.

The Munn case and the White case are often cited for the proposition that the legislature may abolish the right to recover for any type of wrongful conduct. The proposition is unsound. Munn and White stand for the proposition that rules of conduct may be modified, and when they are so modified, then compliance with the modified rules can no longer be considered a "wrong" requiring reparation. As applied to the no-fault controversy, it is obvious that the basic "fault" in most automobile accident cases could be eliminated by legislative abolition

of all the motor vehicle codes. It could, theoretically, become the law of a state that any driver could drive on any portion of the road he chose, without regard to the center line. The driver on the "wrong" side of the road in a head-on collision would not be liable if the concept of "right side" and "wrong side" of the center line was itself obliterated. If it were legal to drive through either a red light or a green light, then the "rule of conduct" would be changed, and the liability of all drivers for light-crashing would be abolished.

It must be apparent, however, that nothing in the no-fault laws makes the slightest change in the traffic laws or the generally-accepted rules of the road. The rules of conduct remain the same. Speeding, light-crashing, and wrong-side driving, remain wrongful conduct. The sole change proposed is that in most cases the driver who is both legally and morally wrong shall not be liable to make reparation for his wrong. Neither White nor Munn justify this proposition.

The Origin of the Negligence Action

It is said, in the Report of the Senate Commerce Committee of the last Congress on S.354, that "the concept of negligence as an independent ground of liability is of recent origin." (S. Report No. 93-382, 93rd Cong., 1st Sess. at 7). If it is a recent invention of the law, then recovery for wrongful injury is not a constitutionally protected right, and liability can be summarily abolished, the argument continues. This argument mistakes what no-fault does. It does not return to an older doctrine of no-fault and non-liability. No-fault asserts a radically new idea -- that individuals are not responsible for their conduct.

The time-tested, universal rule in human history has been that the individual is liable for the results of his conduct. The ancient English rule was that any man who injured another was liable to make restitution. He was liable simply because he acted and the action produced an injury, regardless of fault. This concept is diametrically opposite to the no-fault idea that the man who causes injury is not liable for the consequences, regardless of fault. The principle of strict liability cannot be converted by semantic legerdemain into strict non-liability.

The history of the negligence action is reported in the Department of Transportation's Auto Insurance Study entitled "The Origin and Development of the Negligence Action" (1970). It can be simply summarized. The original rule was absolute liability for the results of the actor's conduct. The "fault" was that his action caused injury to another, which violated the fundamental right of the injured man to enjoy his life and body free of harm.

It was suggested in case law in the early 1600's that if the actor was wholly without fault or blame, and the injury was unavoidable, this should be a defense to liability. This idea gradually became incorporated into the law, and if the defendent could plead and prove total absence of fault on his part, he was excused. The present negligence action evolved as a change in the burden of pleading and proof. The obligation was transferred to the claimant to show that the defendent was not free of fault in causing the injury. The doctrine of contributory fault evolved from the idea that liability should not depend solely on injury-producing action, but rather on faulty or careless action. If both parties were at fault, recovery was denied. The concept of contributory fault is still evolving, and there is a strong trend to make liability depend on fault, with damages measured by comparative fault. Where

the negligent conduct of both parties produces the injury, then damages are apportioned on the basis of relative fault. Congress wisely adopted this view in both the Federal Employers Liability Act for railroad workers and the Jones Act for seamen. England has abandoned contributory negligence in favor of comparative negligence, and so have several of the states.

Product Liability

The common law has long recognized absolute liability for injury-producing conduct. Despite the introduction of the negligence principle, absolute liability was retained for many kinds of conduct. There is a trend to broaden the areas of absolute liability. For example, most states now hold a manufacturer strictly liable for injury caused by a defective product marketed by the manufacturer. It should be noted that a considerable element of "fault" remains. The manufacturer is not liable simply because his product caused injury. Liability depends on proof that, as manufactured, the product was *defective*, and not reasonably safe for use. The defect is deemed to be within the manufacturer's ability to control.

In the same way, automobile liability does not depend on the simple fact that the victim was injured by an automobile. The injured claimant must show that *defective* driving conduct caused the injury.

Workmen's Compensation

Proponents of No-Fault argue that workmen's compensation laws furnish a proper analogy to prove the constitutionality of no-fault automobile insurance laws. The analogy fails. Workmen's compensation laws deal with the specialized rights of employer and employee within the confines of their industrial-family relationship. The common law recognized that employer-employee rights are wholly different from the rights between strangers and independent actors. It was a judicial concept that the probability of a fellow workman's negligence

was one of the natural and ordinary risks of industrial work, assumed by the employee and compensated for in the wage scale. Defects in the ordinary tools furnished by the employer were also one of the standard risks to be assumed. The special immunities of the employer were comparable to other well-known immunities of the common law: family-relation immunity, governmental immunity, charitable immunity, and host-guest immunity. There is no comparable immunity known to the common law applicable to all travelers on the public highways. The early constitutional test of workmen's compensation laws reached the high courts because employees were resisting the imposition of liability for compensating their employees where no liability existed under common-law doctrines.

The early compulsory workmen's compensation laws were uniformly struck down as unconstitutional. In New York, the state's high court said:

> Every man's right to life, liberty and property is to be disposed of in accordance with those ancient and fundamental principles which were in existence when our constitutions were adopted, and when our constitutions were adopted, it was the law of the land that no man who was without fault or negligence could be held liable in damages for injuries sustained by another. . . . (Ives v. South Buffalo Ry, Co. 201 N.Y. at 293, 294 N.E. 431, 439 (1911).

Ohio held its first workmen's compensation law constitutional only because it was structured in voluntary terms, with the option preserved either to comply with the act's requirement or to retain common-law rights and remedies. The statute was held not coercive and therefore permissible in State, ex rel v. Creamer, 85 Ohio St. 349 (1912). In order to make its statute mandatory, Ohio later amended its constitution. New York also amended its constitution to permit a compulsory workmen's compensation law. The new statute,

free of state constitutional defects, was tested against the Fourteenth Amendment in New York Central R.R. Co. v. White, 243 U.S. 188. The Supreme Court upheld the state as not denying "due process" to employer or employee. Its reasoning must be studied to determine whether no-fault laws would receive comparable approval.

The Court said (at 197, 198):

> The close relation of the rules governing responsibility as between employer and employee to the fundamental rights of liberty and property is, of course, recognized. But those rules, as guides of conduct, are not beyond alteration by legislation in the public interest. * * * The Common law bases the employer's liability for injuries to the employee upon the ground of negligence, but negligence is merely the disregard of some duty imposed by law, and the nature and extent of the duty may be modified by legislation, with corresponding change in the test of negligence. Aside from injuries intentionally self-inflicted . . . it is plain that the rules of law upon the subject in their bearing upon the employer's responsibility are subject to legislative change; for contributory negligence, again, involves a default in some duty resting upon the employee, and his duties are subject to modification.

White held that the duties of both the employer and the employee could be modified. The new duties were to be enforced by new remedies. The remedies could be modified when the duties were modified, provided the new remedies were a fair and reasonable exchange for the old remedy for breach of the old duty.

The opinion in White requires a "reasonably just substitute." The court said (243 U.S. at 201):

> It is true that in the case of the statutes thus sustained, there were reasons rendering the particular departures appropriate. Nor is it necessary, for the purposes of the present case, to say that a state might, without violence to

> the constitutional guaranty of 'due process of law' suddenly set aside all common law rules respecting liability as between employer and employee without providing a reasonably just substitute. * * * It perhaps may be doubted whether the state could abolish all rights of action, on the one hand, or all defenses on the other, without setting up something adequate in their stead. No such question is here presented. * * * The statute under consideration sets another system in its place.

The White case stands for the proposition that the special relationship between employer and employee may be regulated with a fair substitution of remedies. It does not mean that the rights of individuals against total strangers may be summarily abolished. The discussion of the meaning of White in the later case of Truax v. Corrigan controls the effect to be given to White.

Truax v. Corrigan, 257 U.S. 312 (1912) concerned the constitutionality of an Arizona Statute which attempted to make abusive, libelous picketing and boycott permissible conduct, immune from injunctive restraint. The court said (at 328):

> A law which operates to make lawful such a wrong as is described in plaintiff's complaint deprives the owner of the business and the premises of his property without due process and cannot be held valid under the Fourteenth Amendment.

The court noted the argument that there was supposedly no vested right in regulations of the state for maintaining peace and order, and that the state has the inherent power to withdraw all protection from property rights. The court then said, (at 329):

> This doctrine is supposed to find support in the case of New York C.R. Co. v. White, 243, U.S. 188, and cases there cited. These cases, all of them, relate to the liabilities of employers to employees growing out of the relation of employment for injuries received in the course of employment. They concern legislation as to the incidents of that relation. They affirm the power of the state to vary the rules of the common law as to the fellow-servant doctrine, assumption of risk and negligence in that relation. They hold that employers have no vested right in those rules of the common law. The broad distinction between one's right to protection against a direct injury to one's fundamental property right by another who has no special relation to him, and one's liability to another with whom he establishes a voluntary relation under a statute, is manifest upon its statement.

In short, the Supreme Court has warned that the rules announced in White for employer-employee relationships cannot be extended to the non-voluntary relationships among strangers that exist in most tort cases. Indeed, as to tort cases, the Court indicated that equal-protection doctrines would prohibit depriving selected members of the class of tort victims of their remedies. The court said (at 337):

> In adjusting legislation to the needs of the people of a state, the legislature has a wide discretion, and it may be fully conceded that perfect uniformity of treatment of all persons is neither practical nor desirable, that classification of persons is constantly necessary, and that questions of proper classification are not free from difficulty. But, we venture to think that not in any of the cases in this court has classification of persons of sound mind and full responsibility, having no special relation to each other, in respect of remedial procedure for an admitted tort, been sustained. Classification must be reasonable.

The distinction between voluntary and involuntary relationships is a valid one. Some states limit the right of the guest passenger to recover from his host driver. The common law did the same, classifying the duty to a social

guest as much less exacting than the duty to a stranger. The guest loses no rights against outsiders and third persons who invade his rights. For example, in a guest-act State, if the guest passenger is injured because of the joint negligence of his host driver and the negligence of the driver of the other car in a two-car collision, his rights against the other driver are unlimited. The same principle applies under all of the workmen's compensation statutes. If an employee is injured during the course of his employment by reason of the negligent conduct of a third party unconnected with his employer, his right to full recovery against the third party is preserved intact. The hired taxi driver hit and hurt by a light-crasher will recover scheduled workmen's compensation benefits from his own employer, but at the same time may proceed to recover full damages from the other driver.

There is another feature of workmen's compensation which distinquished it from the proposed no-fault legislation. Under common-law master-servant doctrines, the rights of the employee to recover from his employer were limited, circumscribed by multiple exemptions and defenses, difficult to enforce, and relatively valueless. The effect of the workmen's compensation statute was to expand greatly the employee's right to recover. The employer was made liable for injuries where no liability existed before. That was precisely the ground of the employer's legal attacks of the statutes. A form of absolute liability was imposed on the employer, who had to meet his new legal burden by purchasing insurance, becoming a self-insurer, or contributing to a state fund. No cost burden was imposed on the employee.

It is doubtful that any workmen's compensation law would have passed the legislature, or would have been upheld in the courts, if it had provided that (a) the employer had no liability at all to the employee, regardless of employer fault; and (b) that the employee for his own protection would be required to purchase a health and accident insurance policy from a private agency and show it at the plant gate before being permitted to work.

No-fault insurance is substantially the reverse of workmen's compensation. The rights of the innocent driver are valuable and enforceable with relative ease. Indeed, in the opinion of some parts of the insurance industry, they are too valuable. It is said that tort victims are being "overcompensated" merely because they can threaten suit. These valuable rights are obliterated. The driver who caused the injury is not subjected to a new and broader-based liability. He is given immunity, or "tort exemption," so that he is not liable at all, regardless of actual fault. He gains no substitute rights for those he loses. On the contrary, he is ordered to go out and purchase private health and accident insurance in the private market as a condition of his right to own a motor vehicle. There is no fair exchange or "just and reasonable substitution" of rights. He completely loses his fundamental rights, and, in addition, must assume the burden of purchasing a specialized health and accident policy which will duplicate the benefits many drivers already carry.

The "Findings" in S.354

In determining whether there is compelling necessity for a legislative body to modify common-law remedies, the courts will look to see whether there is reason to believe a social evil exists, and whether the remedies and classifications established are non-discriminatory and have a reasonable basis as a solution to the problem. It is a rule of decision that the courts will not ordinarily look beyond the legislative findings and the legislative statement of policy.

It would seem that a legislator who has taken an oath to uphold the Constitution would be bound, in all conscience, to make honorable "findings." It is unthinkable that he would merely invent fictitious ones as a slick means of avoiding constitutional problems. A brief review of the findings in the present draft of S.354 is thus within the scope of this Committee.

The present draft "finds" that it is necessary to have a "low-cost, comprehensive and fair system of compensating" accident victims to "avoid any undue burden on commerce during the interstate or intrastate transportation of individuals," and that the "maximum feasible restoration" of all individuals injured in automobile accidents "is essential to the humane and purposeful functioning of commerce."

It will be admitted by the proponents of S.354 that there is no Department of Transportation study and no testimony which indicate that any driver ever took, or refused to take, any ride in, into, or across any state because of the existence or lack of a state liability or compensation law.

There has been no showing that it is not "humane" to pay innocent victims full damages. The corollary principle that the driver in the right should not be compelled to compensate the victim who is wrong has been considered a "humane" rule for centuries.

This does not mean that it would be inhumane to ask the guilty victims to purchase first-party benefit insurance. A self-insurance program may well be needed and desirable. The issue is whether valuable rights should be transferred from the innocent to the guilty by means of threshold tort exemptions to fund the benefits.

The findings further pronounce that "careful studies, intensive hearings, and some State experiments have demonstrated" that no-fault insurance of the

S.354 type is a "low-cost, comprehensive, and fair system." The fact is that no studies and no state experimental data have demonstrated that a threshold plan of the S.354 type will be low-cost or fair. (It will be comprehensive.) The data presently available indicate that "genuine no-fault" costs more to administer than tort liability, has a higher expense ratio, pays less of the premium dollar back to the public, and compensates few additional victims. (It may even, as in Massachusetts, compensate fewer victims.)

The report in favor of the bill suggests that automobile liability cases are costly, time-consuming, and expensive, and thus are incompatible with a low-cost system. The fact is that the D.O.T. study specifically concerned with automobile accident litigation proves that it is a very efficient system, because litigated cases constitute a miniscule proportion of the total claims. It sets the standard by which many cases are disposed of, by settlement or dismissal. The statistics are surprising. It was shown, in "Automobile Accident Litigation," that only 220,000 cases are filed in the United States annually which are concerned with automobile accident injuries. This is to be compared with the estimate that over 4,200,000 persons are injured annually. In short, only 5% of all accident victims ever file a lawsuit.

Most lawsuits are settled. Only 7% of all suits filed are ever carried to verdict. With 5% of injury victims filing suits, and 7% of suits tried, it follows that only .0035% of all potential claims result in trials. Stated another way, only one injured person out of three hundred ever needs to use the full court system for a jury verdict.

Although that one-in-three-hundred trial may be expensive, it sets the standard by which all of the two hundred ninety-nine other potential injury claims are handled.

The cost per claim of the rare standard-setting trial is small.

The no-fault system, even if the threshold is high, will retain the same system cost. The "serious" case will still be settled, depending upon values established by the trial system. It is not realistic to assume that residual tort claims will produce a lower incidence of trials than the present system requires.

II. THE EXCHANGE OF RIGHTS FOR EXEMPTIONS

The constitutional cases and authorities agree that, within limits, legislatures can exchange one system of rights, duties, and remedies for another, provided that the new system is a reasonable substitute. A fair exchange is required.

There is little doubt that Congress can mandate a system of compulsory first-party private insurance to assure that all victims of automobile accidents will receive medical treatment and some level of wage continuation.

The dubious issue is whether high threshold plans, like Title II of S.354, or complete abolition of all tort remedies, like Title III of S.354, do meet the test of a fair trade.

A superficial approach to the problem is to rationalize that the victim of injury gives up his right to seek whole compensation under tort remedies and accepts a duty to buy his own health and accident rights, but at the same time gets the benefit of personal exemptions from liability for his own misconduct. As one witness on constitutional issues has said:

> Thus the requirement that the first party insure himself is . . . a fair recompense for the freedom from liability to others which is given him by the plan.

The concept of a fair trade can be satisfied by bartering rights for freedom from liability only if the group which loses its rights is the same group exempted from liability. It is not fair if one substantial group of citizens do not have any liability, and are unlikely ever to have any, but are stripped of all rights for the benefit of another substantial group who owe the liability. Rights are individually owned, liabilities are individually owed. A fair exchange cannot be forced unless the individual who loses rights is the same

individual who owes, or potentially may owe, the liability.

Automobile tort liability is imposed, almost without exception, only upon the driver of a motor vehicle, or upon the owner-employer whose employee drives the motor vehicle. The class of victims includes all persons who come within striking distance of a moving motor vehicle, which is just about the whole population of the United States not institutionalized or incarcerated.

In broad terms, there are over 200 million persons who may be injured, and just over 100 million active drivers. The non-driving, non-employing, non-owning class of potential victims, comprising half the population, has no liability to exempt. Many of them, the innocent victim class, will have very valuable rights taken away.

Consider the senior class of citizens over 65, numbering somewhere between 20 and 25 million in total. About 20 million are drawing Social Security benefits and eligible for Medicare. They will receive little, if anything, from the S.354 benefit package. They will not have any wage loss for the most part, and will receive medical treatment from deductible Medicare. A substantial proportion of these senior citizens do not drive at all. In some families, only the husban or only the wife does the driving. The non-drivers are non-liable.

The young population is larger than the aged. The "Statistical Abstract of the United States," 1974, estimates a total of 68 million persons under 17. A small number may drive, but it would be a fair estimate that over 60 million children and young teenagers do not own a car, drive a car, control a car, or otherwise expose themselves to liability for causing automobile accidents. They ride as passengers, and use the streets and

sidewalks as pedestrians. Many of them are painfully injured each year. The benefits they receive will be limited. Wage loss is unlikely. Medical-expense benefits will be paid, but 90 percent on average are already covered for medical expense. The pretended "fair exchange" of freedom from liability in return for loss of tort rights is a mockery when applied to these millions of children.

In the middle age group over 17 and under 65 are many citizens who do not drive. Most of them do, but many never have and never will. What is the "fair trade" between rights and exemptions for this group? The non-driving housewife who, critically injured, suffers months of painful disability will give up her potential right to full recovery for her loss, if she is the innocent victim, with no compensating exchange.

A less obvious point, statistically less provable, is that many good drivers will never have an accident. Insurers try to rate the probable risk that a particular driver will be in an accident <u>and</u> will be at fault. The good drivers, with predicted lower risk, pay a preferred rate. High-risk drivers are required to pay a higher rate.

The good driver is penalized under no-fault for the benefit of the chronically bad driver. About two-thirds of all drivers can expect their rates to go up, while one-third of all drivers will pay lower rates, if the <u>average</u> rate under no-fault remains the same. The good driver pays more for the potential benefit and gives up rights which are more valuable because he is likely to be innocent. He is freed of potential liability, but is less likely to be liable than the bad driver. The exchange between the customarily good driver and the chronically reckless and aggressive one is highly unfair.

III. S.354 AND FEDERALISM

Over the last several years, constitutional scholars have filed written statements with, and have addressed, the Senate Commerce Committee on whether there is Constitutional power in Congress to compel state officials to perform specific state functions. This chapter will not debate the case law, but will zero in on the provisions of S. 354 which create a serious problem in state-federal relations. Certain general propositions, long accepted in principle, can be stated.

The powers granted by the people to the state and to the federal government are separate. No state government can enact a federal law. The state cannot give authority to a federal official, nor compel him to act in a state-designated way in carrying out his official federal duties. The reverse of this proposition is also true. The federal government cannot confer authority upon a state official to act in a way not authorized by state law unless the state official acquiesces. The federal government cannot compel a state official to perform his duties in a particular, federally specified way. The federal government must establish the required performance of federal officials, while the state government controls the performance of its own officials.

Senate Bill 354 is structured in violation of the doctrine of division of powers. It attempts to enact a <u>state</u> law in certain states, rather than a federal law applicable to those states. It attempts to command specific categories of performance by state officials. It attempts to authorize state officials to conduct their offices and perform their duties under a federal mandate even if the state has chosen not to grant such authority. A congressman, mindful of his oath to support the Constitution of the United States, must search his conscience before voting for a bill so destructive of the traditional principles of

federalism.

Specific Provisions of S.354

The plan of S.354 is to create three separate titles. Title I contains definitions, findings, and general provisions intended to apply to either state-imposed or federally-imposed no-fault laws. Title II contains specific minimum provisions which a state law must meet or exceed if it is to comply with federal standards. Title III imposes an "alternative state no-fault plan" in any state which does not enact its own plan in a manner satisfactory to the Secreatary of Transportation.

Title II gives the state an apparent choice. Its language is optional in form. Section 201(b) provides, "a State MAY establish a no-fault plan for motor vehicle insurance in accordance with this title." If the state will not, or if the state under its constitution cannot, establish a "minimum state plan," then, under Section 201(e), "the alternative state no-fault plan" under Title III "SHALL become applicable" on a date designated by the Secretary of Transportation.

Title III, Section 301, provides that the "alternative state no-fault plan" which "goes into effect" is composed of sections 103 - 111 and section 114 of Title I, and sections 201(d), 203, 204(e), 204(f), 205, 207, 208, 210, and 211 of Title II, plus the additional sections of Title III (Sections 302, 303 and 304). The "alternative state plan" is misnamed. It is in fact an alternative federal plan which is imposed by federal statute upon any state which cannot or will not pass its own law, or will not amend its own satisfactory no-fault law to make it meet the federal standards. The federal no-fault law is constructed from selected sections of the bill. The sections are drafted in language which is suitable for a state to enact, but the language is inappropriate for a federal act. The terms command state officials to act in multiple respects,

and unlawfully grant authority to state departments and officers.

Section 105 deals with the availability of insurance, and requires the state to form and administer an assigned-risk plan. Section 105(a)(1) provides: "the commissioner SHALL establish and implement or approve and supervise a plan" -- a plan making insurance available to assigned risks.

Section 105(a)(2) requires that the plan to be established "SHALL make available" coverages "which the commissioner determines are reasonably needed."

Section 105(a)(4) provides that insurers may consult and agree as to operation and rates under the plan, "subject to the supervision and approval of the commissioner," and rates shall be "first adopted or approved by the commissioner," and rates shall be reasonable and non-discriminatory "pursuant to regulations established by the commissioner."

Section 105(a)(5) requires the plan to give favorable rates to "any economically disadvantaged individual," which rates shall be "determined by the State" and "subject to the supervision and approval of the commissioner."

Section 105(a)(6) purports to make an extraordinary grant of power to the state insurance commissioner. It is here quoted in full:

> to carry out the objectives of this subsection, the commissioner may adopt rules, make orders, enter into agreements with other governmental and private entities and individuals, and form and operate or authorize the formation and operation of bureaus and other legal intities.

It is clearly beyond the constitutional power of the Federal Government to "make applicable" within a state a federal law which empowers the state insurance commissioner to exercise such broad authority. State law alone can define the powers of the state's insurance commissioner.

Section 108 provides for the establishment of an "assigned claims plan," requiring the creation of a fund in each state which has a no-fault plan under Title II (State Law) or Title III (Federal Law).

Section 108(b)(1) authorizes insurers to organize an assigned claims bureau plan and rules "subject to approval and regulation by the commissioner." If the plan is not organized in a manner "considered by the commissioner" to be in accordance with the federal act and with state law, then the state insurance commissioner is empowered and directed to "organize and maintain an assigned claims bureau and an assigned claims plan." The act states that "he SHALL' do so. The assigned claims bureau in the state, so organized, must operate and must follow certain specific requirements of the federal act, even though the state might wish to solve the problem by other means.

Section 109, captioned "State Regulation," is one of the sections adopted by reference in the federal act applicable to non-complying states. Section 109(a) provides that "the commissioner...shall regulate" restoration obligors, but this section has the saving grace that he shall do so only "in accordance with the provisions of the applicable rating law of such state." Other subsections are not so limited. Section 109(b) requires that "the commissioner SHALL provide the means to inform purchasers of insurance" about the rates charged by insurers for no-fault benefits and tort-liability insurance. The commissioner's information must be given to purchasers "in a manner adequate to permit them to compare prices." Presumably the Secretary of Transportation will determine whether the manner is "adequate."

Section 109(c)(1) compels the commissioner to "establish and maintain a program for the regular and periodic evaluation of medical and vacational rehabilitation services." The commissioner "SHALL establish and maintain" the program "to assure that" the services are necessary and the recipient is making

progress, and "to assure that" the charges are reasonable. Under Section 109 (c)(1), progress reports on rehabilitation must be submitted by the supervising physician to the state vocational rehabilitation agency, and "the state vocational rehabilitation agency SHALL file reports with the applicable restoration obligor." Further, "there shall be provision for determininations" to be made of rehabilitation goals and needs and for periodic assessment of progress.

Section 109(c)(2) states that "the commissioner is authorized to establish and maintain a program for the regular and periodic evaluation of his State's no-fault plan." It follows that if the state legislature does not authorize him to do so, the state is a non-complying state, and the federal act then gives the state insurance commissioner the authority withheld from him by his state.

Section 109(d) makes a similar broad grant of authority to the state insurance commissioner to create emergency health-service systems. "The commissioner is authorized. . . to take all steps necessary to assure that emergency medical services are available for each victim suffering injury in the State." "The commissioner is authorized to take all steps necessary to assure that medical and vocational rehabilitation services are available for each victim resident in the State." It might well be that a particular state would believe that its department of health was the logical agency to provide for medical and rehabilitation services, or might believe that its highway department should administer emergency ambulance service. This determination, however, is not left to the states. The state insurance commissioner is empowered, by grant of federal authority, to "take all steps necessary to assure" both emergency health service for all accident victims, and medical and vocational rehabilitation services. No state insurance department presently regulates

such services, and the federal government has no power to direct the state to give regulatory power to one state agency in preference to another.

Section 111(d) provides that a restoration obligor shall promptly refer each victim to whom basic restoration benefits are expected to be payable for more than two months "to the State vocational rehabilitation agency." If the state does not have one, the state is under federal compulsion to create one. As shown above, the state insurance commissioner is directed and empowered to assure the creation. The federal act will require the state to process absurd referrals. A simple fracture of the shinbone will require a long leg cast and produce substantial disability for more than two months, entitling the victim to benefits. Most such midshaft fractures of the bones of the extremities, however, heal without the slightest need for any vocational rehabilitation. It is medically ridiculous to refer all properly set and casted long-bone fractures to a vocational-rehabilitation center. This imposes a useless work load on state agencies.

Section 201(d) provides that "the commissioner in each state shall submit to the Secretary (of Transportation) periodically all relevant information which is requested by the Secretary" so that the Secretary may "evaluate the success of such [no-fault] plan in terms of the policy" of the act.

Section 211(a)(2) provides that any automobile liability policy will automatically be deemed to include no-fault benefits in the state of issue unless the "commissioner determines by regulation" that the liability coverage is only incidental in that policy."

Section 211(b) provides that all the terms and conditions of any policy issued pursuant to either a state enactment or the Title III federal enactment "are subject to approval and regulation by the commissioner in such State."

"The commissioner shall approve only terms and conditions" consistent with the purposes of the act and equitable. The commissioner is empowered to limit the variety of coverages available.

It is submitted that if state law does not affirmatively give the state insurance commissioner the power to limit the choice to coverages, federal law cannot extend or enlarge his official authority. A federal commissioner could, of course, exercise such power.

Permissible Alternatives

This discussion will assume that Congress does have power, under one of its grants in the Constitution, to enact a federal no-fault law. How can Congress administer it? The supremacy clause has never been used to compel state officials to administer a state law which is invalid under the state constitution; nor to compel state officials to administer a state law which does not exist as a state enactment; nor to compel state officials to administer what is in fact an exclusively federal law.

Federal authority can be used, however, to supply federal administration to the federal law. The structure of S.354 provides that if a fully-complying state no-fault law is not enacted within a given time, then Title III will supply a federal law erroneously entitled "The Alternative State No-Fault Plan." When this occurs, the federal government must carry the burden of administering and regulating the federally-imposed "alternative state plan." A federal insurance commissioner administering a federal insurance department can be created to perform all those duties and exercise the discretionary authority described in Sections 105(a)(1), 105(a)(2), 105(a)(4), 105(1)(5), 105(a)(6), 108(b)(1), 109(a), 109(b), 109(c)(1), 109(c)(2), 109(d), 111(d), 201(d), 211(a)(2), and 211(b).

This would produce an anomalous situation is which the Federal Insurance Commissioner would regulate and administer the "alternative state plan" and the individual state commissioners would administer all insurance in the states having true state plans under Title II. In a Title III state, the state insurance commissioner would still regulate all insurance except automobile no-fault insurance, and would necessarily be required to co-ordinate his regulatory authority with that of the Federal Commissioner. This solution is probably unacceptable politically. It is obviously contrary to the Congressional policy announced in the McCarran-Ferguson Act.

An alternative approach would be to use the fiscal power of Congress to persuade or bludgeon the states into following the federal guidelines. There are several precedents for this kind of action, notably the Highway Safety Act of 1966, which provides that "Federal aid highway funds apportioned. . .to any state which is not implementing a highway safety program approved by the Secretary of Transportation shall be reduced by. . .ten per centum of the amount which would otherwise be apportioned to such state. . .until such time as such state is implementing an approved highway safety program" (23 U.S.C. §402(c)).

The Supreme Court has approved this method of obtaining state consent to federal standards, saying, "The offer of benefits to a state by the United States dependent upon co-operation by the state with Federal plans, assumedly for the general welfare, is not unusual." (Oklahoma v. United States Civil Service Commission, 330 U.S. 127, at 144).

There is a practical consideration which mitigates against the grant-in-aid or consent approach. It is the announced purpose of S.354 to compel a

national no-fault program in which every state must have an operative no-fault law including both minimum benefits and a specified abolition of traditional legal remedies. The weakness of a consent plan is that it does depend upon state consent. The state which fails to consent will lose the proferred federal benefits, but will avoid federal standards and control. A grant-in-aid or consent statute cannot guarantee a uniform national plan.

In the context of an automobile accident reparations system, the withholding of highway funds would be illogical and counterproductive. The grant of highway funds is intended to produce a safer highway system, reduce accidents, the number of victims, and the severity of their injuries. The act of withholding highway funds would increase the hazards on highways and promote more accidents and more serious injuries. It does not seem sensible to threaten a state that if it does not change its sytem for compensating accident victims, Congress will take action designed to produce more victims and require more compensation.

It is possible, of course, for Congress to tie the automobile accident reparations program to other federal funds besides highway safety funds. It is questionable, however, whether Congress would find it politically desirable to limit revenue-sharing funds, or school lunch funds, on the condition that the states consent to federal minimum standards for automobile insurance.

It might be argued that no state would refuse to cooperate if threatened by the loss of federal grants. The problem is not so easily dismissed. It must be conceded that, in several states, the prohibitions in state constitutions would prevent the state from enacting a no-fault plan complying with S.354. This fact is not a bar to a grant-in-aid approach, but it does mean that the state would be forced to amend its own constitution in order to permit

legislative enactment of the required statute. There are strong psychological barriers to the amendment of a constitution and it cannot be predicted that the people of every state would willingly yield constitutional guarantees. It cannot be predicted, either, that people want the kind of extreme no-fault stated as "minimum" in the proposed federal bill. When a substantially similar plan was laid before the votors of Colorado by referendum in 1972, it was rejected by a powerful three-to-one majority. A federal plan which would mandate constitutional amendment as a condition for receiving allocated federal funds would remove the velvet glove, and the threatening federal fist might well produce more popular resentment over the disdain of states' rights than Congress would wish to face.

The problem of states' rights is as much a practical one as a constitutional one. Even if Congress could authorize a mandamus action to compel a state legislature to pass the congressional brand of no-fault, or could mandamus the citizenry to amend a restrictive state constitution, the moral question would remain. Should Congress so stretch its potential powers? The states are not asking for national intervention. For the most part, the states are insisting on the right to solve their own problems, and the parallel right to attempt different types of solution. If the constitutional debate concludes with a congressional finding that Congress does have the ultimate power to enact S.354, Congress should still debate whether it has sufficient wisdom to override the considered determinations of the legislatures, governors, and courts of Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New York, North Dakota, Oregon, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Virginia, and Washington, where a state no-fault law is in effect and being experimented with this very day.

IV. THE RELATIVE EFFICIENCY OF AUTOMOBILE LIABILITY INSURANCE

In the course of past consideration of National No-Fault proposals, testimony has been given by the American Insurance Association to the Senate Judiciary Committee that automobile liability insurers pay only 44 cents of the premium dollar to the claimants. The testimony was given to support the proposition that automobile liability insurance is inefficient and wasteful. The quoted figure is grossly inaccurate. The hard data proves that liability insurance is one of the most efficient types of insurance offered to the public. The actual amount paid out by all liability insurers doing business in the United States exceeds 60 percent of the premium dollar.

The following figures come from the insurance companies themselves, in their own official reports. Every year, every insurance company doing business in this country compiles an annual report detailing its actual experience in the preceding calendar year. These reports are published not only to stockholders, but also to various state regulatory agencies, and to the rating bureaus. They are all gathered and analyzed by the A.M. Best Company, which publishes an annual reference work summarizing all the reports. The title of the report for the property-liability insurance field, is "Bests's Aggregates and Averages, Property-Liability." The most recent edition, dated 1974, compiles the 1973 results.

Auto Liability Insurance

An example of the type of data available in "Aggregates and Averages" can be shown by listing the income, losses, and expenses of the Aetna Casualty Group, a major stock underwriter, and of State Farm Mutual Insurance Company, the largest mutual underwriter. Only one line, private passenger automobile liability, is presented here.

	Aetna Casualty Group	State Farm Mutual
Net Premiums Written	$329,215,000	$1,291,203,000
Unearned Premiums	$ 99,601,000	$ 346,245,000
Net Premiums Earned	$327,613,000	$1,280,455,000
Losses Incurred	65.8%	61.5%
Adjustment Expense Incurred	10.5%	15.3%
(Loss and Adjustment Expense Incurred, Combined)	(76.3%)	(76.8%)
Commissions and Brokerage Incurred	16.6%	1.4%
Other Acquisition Expense Incurred	3.2%	9.8%
General Expense Incurred	8.0%	3.4%
Taxes Incurred	3.4%	2.5%
Total Underwriting Expenses Incurred	31.2%	17.1%
Combined Loss and Expense Ratio	107.4%	93.9%
Underwriting Profit or Loss (Statutory)	-$ 24,876,000	+$ 75,925,000
Ratio to Premiums Earned	-7.6%	+5.9%

Special interest will center in "losses incurred," exclusive of "adjustment expense." This figure represents losses actually paid to claimants, plus or minus the

net change during the year in the loss reserves which represent the insurer's best estimate of the amount due and payable to claimants. Losses are stated as a proportion of earned premiums. The following table shows the 1973 results for all the stock companies, all the mutual companies, and all the reciprocal companies writing private passenger auto liability and commercial auto liability in the United States in 1973.

	Net Premiums	Losses Incurred	Underwriting P/L
Stock, Private Passenger	$ 5,448,332,000	64.0%	-2.8%
Stock, Commercial	$ 1,802,203,000	67.8%	-7.5%
Mutual, Private Passenger	$ 3,065,665,000	60.8%	+3.5%
Mutual, Commercial	$ 440,571,000	64.4%	-2.3%
Reciprocal, Private Passenger	$ 1,010,638,000	61.7%	+7.0%
Reciprocal, Commercial	$ 53,209,000	57.6%	+4.4%
Total	$11,820,618,000	63.5%	-0.1%

It should be noted that in the above table the coverage for automobile liability includes both bodily-injury liability and property-damage liability, inclusive of both statutory minimum coverage and excess-coverage underwriting. Best's has not separated the bodily-injury and property-damage liability covered since 1970. A fairly accurate breakdown between the two can be obtained by turning to the Annual Reports of the New York State Department of Insurance, which separate the two coverages, though they do not subdivide between private-passenger and commercial. The New York reports tabulate results both for New York and the national experience of all companies writing in New York, which includes all the major underwriters in the United States. The New York

figures for nationwide, earned premiums for stocks and mutuals show bodily-injury coverage at $5,578,900,000 and property-damage coverage at $2,673,627,000. This is good evidence that the national average for all underwriters would divide the total liability premium into 67% for bodily injury and 33% for property damage, and the current percentages can be expected to hover around these figures. Applying these percentages to the table derived from Best's Aggregates and Averages gives the following breakdown:

	1973 AUTO LIABILITY NET PREMIUMS
All Company, Private Passenger Bodily-Injury Coverage	$ 7,919,814,000
All Company, Private Passenger Property-Damage Liability Coverage	$ 3,900,803,000
Total	$11,820,618,000

Commercial-vehicle liability insurance, with its total net earned premiums of $2,295,983,000, would presumably show a similar breakdown, with $1,538,308,000 attributable to property-damage liability.

Automobile Physical-Damage Insurance

A classic form of no-fault insurance is automobile physical-damage (collision-loss) insurance, in which the policyholder pays the premium to insure against the risk of damage, regardless of fault, and recovers his losses (less agreed-upon deductibles) regardless of fault. The grand total for all insurers writing automobile physical-damage insurance in the United States in 1973 was a payout of 60.3% in losses incurred. Note that the "inefficient" liability insurance paid back to the public 3.2% more of the premium dollar than was paid by the "efficient" no-fault collision insurance. The following table shows the results, as reported by the companies themselves, for 1973.

AUTO PHYSICAL DAMAGE INSURANCE, 1973

	Net Premiums	Losses Incurred	Underwriting P/L
Stock, Private Passenger	$3,500,539,000	61.2%	+1.7%
Stock, Commercial	$ 883,032,000	57.2%	+4.8%
Mutual, Private Passenger	$1,841,103,000	59.8%	+9.0%
Mutual, Commercial	$ 194,325,000	57.2%	+9.1%
Reciprocal, Private Passenger	$ 547,527,000	64.0%	+7.6%
Reciprocal, Commercial	$ 24,039,000	58.5%	+11.3%
Grant Total	$6,993,556,000	60.3%	+4.7%

The division of premium damage to people and damage to the automobile can be obtained by adding the property-damage liability premium to the physical-damage premium, and comparing that combined figure with the total premium attributable to bodily-injury coverage.

	DIVISION OF 1973 PREMIUM DOLLARS
All Physical Damage	$ 6,993,556,000
All Property Damage	$ 3,900,803,000
Total, Physical and Property	$10,894,359,000
Total Bodily Injury	$ 7,919,814,000
Total for Physical, Property Damage and Bodily Injury	$18,814,163,000
Percentage of Premium for Injury to Person	42.1%

It is less expensive to evaluate the physical damage from one collision to one car, and pay a single bill, than it is to evaluate continuing injury, medical expense, wage loss, and intangible loss in a bodily-injury claim. The cost differential is surprisingly small. The break-even point for liability insurance is quite close to the break-even point for physical damage insurance. The combined figure for losses paid plus underwriting profit for liability insurance was 63.4% of the net earned premium in 1973. This means the total expense ratio was the balance, or 37.6%. The expense ratio for physical damage was 35.0%.

Compared to Fire and Group Health Insurance

Many proponents of no-fault auto insurance argue that it could be as simple, uncomplicated, and efficient as fire insurance. The operating results prove that fire insurance is "efficient" in making extravagant profits for the insurance industry, but very inefficient in paying benefits to the consumer. The following figures are taken from the companies' own reports, as compiled in Best's Aggregates and Averages.

FIRE INSURANCE
1973

	Net Premiums	Losses Incurred	Underwriting P/L
All Stock Companies	$1,993,156,000	50.6%	+10.3%
All Mutual Companies	$ 398,922,000	46.0%	+17.2%
All Reciprocal Companies	$ 59,513,000	51.8%	+ 5.8%
	$2,451,591,000	49.9%	+11.6%

The combined percentage of loss and profit in fire insurance was 61.5%, which necessarily means that the total expense ratio to net earned premiums was 38.5%. The expense ratio for no-fault fire insurance is greater than the expense ratio for automobile liability insurance.

Another argument of the automobile no-fault proponents is that health and accident

insurance is an example of no-fault insurance that is "efficient" and distributes benefits at low cost. The fact is that group health insurance is very efficient, because of small sales commissions and because the group employer does most of the claim-filing paperwork without cost to the insurer. Most automobile insurance is non-group, sold as individual policies covering a single car. Auto insurance should be compared to non-group accident and health insurance. The results are published in Best's for all insurers' 1973 operations.

OTHER THAN GROUP ACCIDENT AND HEALTH INSURANCE - 1973

	Net Premiums	Losses Incurred	Underwriting P/L
All Stock Companies	$340,091,000	55.0%	+0.8%
All Mutual Companies	$ 80,615,000	55.3%	+3.9%
Grand Total	$420,706,000	55.0%	+1.3%

The Report of the Senate Committee on Commerce on S.354 of the 93rd Congress, (S.Rep. No. 93-382, 93rd Cong., 1st. Sess., August 15, 1973) makes statements, at 21, unfortunately at considerable variance with the truth. The statement of the report is quoted here not to endorse it, but as an introduction to the demonstration of its error:

> According to the D.O.T. study, the present insurance system 'would appear to possess the highly dubious distinction of having probably the highest cost-benefit ratio of any major compensation system currently in operation in this country' (Footnote, Final Report at 95). The present system returns only about 44 cents in benefits to auto accident victims for each dollar paid in premiums to insurance companies. For the most part, this inefficiency is not the fault of either trial lawyers or insurance companies; . . . a fault insurance system that pays benefits on the basis of loss after a showing of fault is more expensive than that one which pays on the basis of loss only.

The error is repeated at page 27 of the same report:

> A nationwide system of state no-fault plans . . . would return to consumers . . . a far greater percentage of the premium dollar than the 44 cents out of the dollar paid to victims under the negligence liability insurance system.

What are the facts? Is it true that automobile liability has the highest cost-benefit ratio? Is it true that a system which pays "on the basis of loss only" is more efficient than a system which pays on the basis of fault? The D.O.T. studies will not give the answer. Not a single one of the twenty-four volumes of the D.O.T. study reports attempts a comparative analysis of the cost-benefit ratios of the multiple lines of insurance sold in the United States. The epithets in the Final Report of the D.O.T. Study are unsupported and unsupportable. The hard-fact answer can be supplied by Best's Aggregates and Averages, which tabulates the results for all lines of insurance sold by all the stock insurance companies writing in the United States in 1973. "Losses incurred" are stated as a percentage of "premiums earned." For convenience in analysis, the table from Best's is here rearranged in descending order from the highest percentage of benefits paid to consumers, or victims, to the lowest percentage of pay-out.

STOCK INSURANCE COMPANY PERFORMANCE
IN 1973 BY LINES

TYPE OF INSURANCE	LOSS-INCURRED RATIO TO PREMIUM
Group Accident and Health	84.4%
Workmen's Compensation	69.3%
Commercial Auto Liability	67.8%
Private Passenger Auto Liability	64.1%
Miscellaneous Liability	62.0%
Private Passenger Auto Physical Damage	61.2%
Farm Owner's Multiple Peril	59.9%
Commercial Auto Physical Damage	57.2%
Other than Group Accident and Health	55.0%

(cont'd)

TYPE OF INSURANCE	LOSS-INCURRED RATIO TO PREMIUM
Homeowner's Multiple Peril	53.5%
Fire	50.6%
Inland Marine	49.9%
Commercial Multiple Peril	49.7%
Fidelity	46.8%
Glass	43.4%
Allied Lines	40.7%
Boiler & Machinery	32.4%
Burglary and Theft	32.0%
Surety	29.2%

It might be suggested that 1973 was an unusual year, and perhaps the Reports of D.O.T. and the Senate Committee on Commerce were accurate for 1967 or some other recent year. That explanation is not available. Without repeating the whole compilation of lines, the following sample of stock-company underwriting results in 1967 shows that the performance then was much the same.

STOCK COMPANY LOSS RATIOS - 1967

TYPE OF INSURANCE	LOSS INCURRED RATIO TO PREMIUM
Automobile Bodily Injury	62.2%
Workmen's Compensation	63.9%
Auto Collision (No-Fault)	56.8%
Fire Insurance	56.2%
Health and Accident (Non-Group)	50.2%

Loss ratios for the decade, 1963 through 1972, are reported in Best's 1973 Edition at pp. 134-136. A combined figure for loss incurred plus adjustment expense is given for each year, and for decade average. The single "loss-incurred ratio" can be obtained by deducting the allocated adjustment expense (based on the 1972 tables) in order to find the amount of benefits paid to the public. The following table gives the results. The loss incurred is the loss payable to claimants, exclusive of allocated adjustment expense:

DECADE 1963 - 1972
STOCK INSURANCE COMPANY LOSS RATIOS

TYPE OF INSURANCE	LOSS-INCURRED RATIO TO PREMIUM
Automobile Liability	64.1%
Workmen's Compensation	64.8%
Fire	55.3%
Allied Lines	55.1%
Homeowner's	60.2%
Commercial Multiple Peril	50.4%
Inland Marine	56%
Accident and Health, (Non-Group)	49%
Miscellaneous Liability	49.8%
Automobile Physical Damage	59%
Fidelity	48.9%
Glass	51.1%
Burglary and Theft	49.1%
Credit	39.3%
Boiler and Machinery	36.6%
Surety	29.2%

The Myth of Inefficiency

The only lines of insurance paying out a higher percentage of premium in the form of dollar benefits to the consumer in the whole decade 1963 -1972 were group accident and health (at 79.7%); ocean-marine (at 67.8%); and workmen's compensation, which (at 64.8%) paid just 0.7% more than auto liability.

In view of the actual verified annual reports of the insurance companies themselves, what is the justification for the repeated statement that automobile liability insurance pays only 44 cents of the premium dollar in benefits to victims? In all of the many volumes of D.O.T. studies, the sole reference to "44 cents" is found in the final summary report titled "Motor Vehicle Crash Losses and Their Compensation in the United States." It is said at p.51:

> One analysis addressing the cost efficiency of the automobile accident liability insurance system from the consumer's perspective has indicated that forty-four cents out of every premium[14] dollar is used to compensate accident victims for their losses...

Footnote 14 reads:

> Robert E. Keeton, Automobile Insurance Reform Tailored to the Need, Statement Prepared for the Joint Committee on Insurance, Massachusetts, March 11, 1969, pp. 1-8.

The statement made to the Joint Committee in Massachusetts is not an official D.O.T. study, and is nowhere referenced except by its adoption in the summary report. In all fairness to Professor Keeton, his Massachusetts figures have been misquoted to begin with, and are inapplicable to states which have only one-third the average claim experience and one-third the ratio of lawyer representation which obtained in Massachusetts.

The final report of the D.O.T. study makes an analysis of "system" expenses for automobile liability insurance (p. 47-51 of M.V.C.L.) which is supposed to demonstrate a high cost-benefit ratio. It is said that it costs $1.07 in "system" expenses to deliver $1.00 in benefits. It is highly misleading in that most of the "system" expenses

calculated are present in all other insurance systems, and will remain as long as the private insurance industry participates in the system, whether fault-based or no-fault. For example, the cost to the states of administering a compulsory insurance law is included as "system" cost, as well as the cost to the state of regulating the industry. The cost of the court system is included, but the courts will remain, with or without no-fault. Another listed "system" cost is the expense of the insurance company in investing its unearned premium and loss reserves, though no accounting credit is given for the profits from the investment. Insurers sales expenses, in the form of commissions, brokerage, and other acquisition expense, are said to total 36% of the "system" expense.

No-fault proponents over-argue their case with the artificial "costs of the system" expense. All of the Milliman and Robertson reports on cost guesses for S.354 contain the caveat that they expect the sales and administrative (and investment) costs of the insurance industry to remain the same, and they calculate adjustment costs for the combined no-fault benefits and residual tort claims of S.354 at nearly the same total cost as is reported by the insurers under the existing system.

A Simple Solution

If cost of the system is the criterion, then the inescapable conclusion from the D.O.T. analysis is that individual private insurance for automobiles must be abolished. The cost ratio of Social Security is said to be only 10% of the premium dollar. The cost ratio of non-profit group health plans, such as Blue Cross, is said to be only 7% of the premium dollar. Puerto Rico's government-funded no-fault plan is said to to cost only 10% of the premium dollar. If it is the sense of Congress that automobile insurance should continue to be serviced by the private sector, then the whole elaborate cost argument of the no-fault proponents must fail. Automobile liability insurance, or individual health and accident insurance, or almost any other insurance the individual

automobile owner buys for himself. Measured by the simple test of the percentage of premium dollar paid back to the public, automobile liability insurance is the best buy the average individual can make in the whole private marketplace!

Auto Rates Anger Fla. Consumers

Journal of Commerce Special

TALLAHASSEE, Fla. — Florida Insurance Commissioner Bill Gunter said 13,065 signatures from consumers angry over high auto insurance rates will help him convince the Legislature to make major reforms.

The petition signatures presented to Mr. Gunter were collected by Gladys Wallace, a Winter Haven grandmother.

She started the drive after becoming incensed at the sharp increase in her auto insurance rates.

"I am convinced that we have a mandate not to be timid, not to simply put more bandaids and mercurochrome on a failing system, but to take a hard look and make the difficult decisions that will bring about truly meaningful rate relief," Mr. Gunter said.

However, Mr. Gunter refused to specify what major changes in auto insurance he was considering.

He said he will present his recommendations to the Legislature within four weeks.

Some leading legislative insurance experts, including Sen. Kenneth MacKay, D-Ocala, have said this is not the year to make major changes in auto insurance because a new law just went into effect last October.

However, Mr. Gunter said his office was compiling statistics on how companies are operating under the new law. He said those figures should convince lawmakers that something needs to be done this year.

Mrs. Wallace said she had help from various civic clubs in collecting the signatures which came from all over the state, although the bulk were from Central Florida.

She said she started her campaign after being notified that her insurance rate was going from $126 for nine months to $234 for six months. The petition demanded immediate action to relieve the exorbitant cost of auto insurance.

J/C

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Slowing Up

Auto Insurance Rates Should Keep Rising Next Year, but Not as Much as in 1975-76

A WALL STREET JOURNAL *News Roundup*

Some of the steam may be going out of the months-long rise in auto insurance rates.

Judging from a survey of key states by Wall Street Journal reporters, rates will continue to rise in 1977 but not as much. Conning & Co., an insurance research and management concern based in Hartford, Conn., predicts an increase of 8% to 10%, compared with an estimated increase of 20% this year and 15% in 1975.

"We believe that it may be more difficult for the industry to secure rate approvals (from state regulatory authorities) in 1977 after having raised rates by such large amounts in 1975 and 1976," Conning reports. The concern cites the prospect of milder increases in auto-repair and medical costs next year.

In addition, many smaller claims are likely to be eliminated by higher deductibles. Collision deductibles, for example, are being raised to $100 from $50 and to $200 from $100, Conning says. With motorists assuming more responsibility for losses below a specified amount, insurers can charge a lower rate.

The insurance companies' main argument for higher rates has been that inflation has accelerated faster over the past few years than anyone expected. As one insurance executive put it, "It's costing much more to fix property and to fix people - much more than any of our rates ever contemplated."

Impact of Energy Crisis

During the 1974 energy crisis, many regulators opposed higher rates on the assumption that people would drive less and thus have fewer accidents. The assumption was essentially correct, but double-digit inflation and the resulting increase in the cost of auto parts and medical payments more than compensated for the decline in auto accident claims. Then, in early 1975, Americans began swarming back onto the roads while rates remained at 1972 and 1973 levels. The result was sharp and continuing underwriting losses.

To make matters worse, many states froze auto premium rates in expectation of savings from newly introduced no-fault insurance programs. No-fault, which allows accident victims to collect directly from their insurers for medical and hospital expenses and any loss of income, regardless of who is at fault, was expected to save insurers 10% or more by eliminating long and expensive court battles.

As it turned out, inflation erased any hoped-for no-fault savings, and a few companies found themselves in financial difficulty. In addition, insurers said broader protection required by some no-fault laws added to their expenses. Where conventional insurance typically had a ceiling on an insurer's liability, some states required companies to pay all reasonable medical costs, regardless of expense, under no-fault programs.

In 1974, costs affecting insurance claims began moving up modestly, but accelerated to double-digit levels by midyear. Auto repair and maintenance costs as measured by the consumer price costs rose about 9%. Insurance regulators approved rate increases averaging about 2% in the same period.

All this paved the way for the sharp rate increases of 1975 and 1976.

Now the auto insurers are trying to cut their costs by limiting the number of drivers they cover. They say they simply aren't making any money insuring people. "If we were making money," one executive says, "we'd take all the business we could get."

Critics point out that gains from stock-market and other investments have helped insurers show an overall profit. Indeed, the Insurance Information Institute, a trade group, estimates that in the first half of 1976, auto and other property-casualty insurers earned $523.3 million despite underwriting losses of more than $1.9 billion. The insurers managed to show a profit because they earned more than $2.3 billion on their investments.

But the companies say their insurance business must stand on its own. They say dependence on stock-market gains could set them up for a big fall, perhaps triggering a rash of insolvencies, if the market ever declines drastically again as it did in 1973-74. In that bear market, some observers estimate, the value of the property-casualty industry's securities holdings declined more than $10 billion.

State Farm Mutual Automobile Insurance Co., the nation's largest auto insurer, says it plans to stop advertising its auto coverage this fall. The company has been averaging 80,000 applications a week this year despite attempts to stem the tide; and a company official says that more than 95% of the new applicants are accepted. State Farm, which insures about 14% of all U.S. drivers, has raised rates 18%, its officials say.

Assigned-Risk Category

With even giant insurers cutting back business, it's no surprise that a growing number of drivers who have had accidents or traffic violations find themselves assigned to state-supervised insurance pools. Although only 22 states require auto liability coverage, the threat of a financially crippling court judgment makes an auto policy a virtual necessity anywhere. Last year the assigned-risk category included nearly 5% of all insured motorists, and experts say that that could jump to about 7% in 1977.

Perhaps the most tragic aspect of the upward rate spiral is the plight of the average driver with a clean record and a solid insurer behind him. "What really burns people up," says James C. Schmitt, president of the Greater St. Louis Better Business Bureau and a former insurance regulator, "is when they've been with a company for 15 years, never had an accident, and all of a sudden their premiums increase 30%." Typical premiums vary widely from state to state and from city to city. In Ohio, for example, the average premium last Jan. 1 was $289 in cities, $219 in rural areas. The following is a sampling of rate trends in states across the nation:

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California: Insurance Commissioner Wesley Kinder estimates that auto insurance premiums have climbed 20% so far this year on top of a 15% to 20% increase in 1975. Mr. Kinder says he expects rates to keep climbing until insurers start making a profit insuring cars. In California, problem drivers denied insurance by major firms can apply for coverage under an assigned risk plan. Rates for those drivers increased another 13% this October.

Georgia: Auto rates have increased 17.5% this year says Steven Mason, administrative assistant to Georgia's insurance chief. The increases, he says, were sparked mostly by inflated prices for parts. "We realize you can't fix a car at 1976 prices if you're charging 1975 rates," he says. But the economy will eventually dictate what happens to rates in the future, he adds. "If inflation levels off," he says, "expect insurance rates to level off."

Illinois: Richard Rogers, deputy director of the administrative branch of Illinois' insurance department, says rates there have increased about 16% this year. He says there is no sign they will stop rising. Edward B. Rust, president of State Farm Mutual, which is based in Illinois and is its largest auto insurer, says that although further increases are likely this year and next year, they probably won't rise at "quite the recent pace."

Massachusetts: The state that pioneered no-fault auto coverage back in 1971 still has the highest insurance rates in the country. Still, the cost of insuring a Massachusetts auto climbed 20% in 1976, the largest single increase in the state's history. Officials there don't expect rates to stop rising, but there is a ray of hope for motorists in a revamped no-fault system that goes into effect next year. It could curb the pace of rate increases.

Michigan: Auto rates began rising last fall after nearly five years of stability. Harry Ruth, deputy insurance commissioner, says rates have climbed 15% to 20% for property-damage coverage, 10% to 15% for liability insurance. He says rate increases may not be so high the next time around.

Missouri: Auto insurance rates jumped between 5% and 17% last year, says H. W. Edmiston, director of insurance. "Our hope, and I think the insurance companies' hope, is that rates are probably adequate for the next 12 to 18 months, counting from last January." With companies benefiting from rate increases and with fewer losses expected to show up in first-half results, Mr. Edminston predicts a slowing down of rate-increase requests.

New Jersey: New Jersey's chief insurance actuary, Philipp Stern, says rates there have increased about 50% in the past 18 months. It has been a stormy period for the state, which has gained a reputation among insurers as unresponsive to rate requests. The state has battled with Government Employees Insurance Co. (Geico), which blamed New Jersey's rates when it decided to pull out of the state this year, and with Hartford Insurance Co. over the firm's proposed requirement that all autos it insures in metropolitan areas be garaged every night.

New York: New York State's insurance department reports that rates increased 30% so far this year, after a 60% rise in 1975. Effective May 3, financially troubled Geico, which handles about 8% of the motorists on the road in New York, received a 47% average rate increase. Still, New York, with its heavy concentration of urban drivers, has faced increasing reluctance by insurers to renew old business or take on additional risks. The state has responded by listing specific permissible grounds for nonrenewal.

Ohio: Insurance companies raised rates in eight Ohio cities between January 1974 and Janurary 1976, and the average premium increased to $289 from $232. In rural areas, average premiums increased to $219 from $167, a 31% increase. Progressive Corp. of Cleveland, a firm that insures about 29,000 high-risk motorists in Ohio, said it increased comprehensive premiums 52% since March 1975. Progressive raised the same rates 81% for unmarried male policyholders aged 25 to 29. A company spokesman said insurers are likely to seek additional increases, but the rate of increase may have topped out.

Texas: The state insurance department says auto insurance costs about 15.5% more this year than it did in 1975. Premiums are slated to rise again in October, by 7%. "Most major companies have either reduced their intake of new business considerably or are trying to reduce their business," says assistant insurance superintendent Tom Jackson. Many Texas insurers are limiting the number of new policies agents can write and are emphasizing lower-risk drivers.

West Virginia: In May, many West Virginia insurers won a 20% increase in rates for liability and collision insurance, says Steven Brown, director of the property-casualty division of the state's insurance department. State Farm Mutual, West Virginia's largest insurer, is appealing the state's decision to grant it a more modest 12% increase.

After 3 Years, Mich. No-Fault Plan Receives Mixed Reviews

After three years in operation, the Michigan no-fault auto insurance law has received mixed reviews.

Michigan Commissioner Thomas C. Jones told the Michigan house insurance committee recently that he thinks "no-fault's performance has substantially fulfilled its promises."

But Patrick J. McNally, associate counsel for National Assn. of Independent Insurers, sharply criticized the law's unlimited medical benefits provision. This provision is contributing to massive overcharges for medical services to victims of auto accidents, he told the house committee, and it is creating severe financial problems in the auto insurance industry.

Some Complaints

Commissioner Jones conceded that the Michigan insurance bureau has received complaints about the unlimited medical benefits provision and a few other features of the law. But "on the whole," he added, "I can only express satisfaction again on how well the Michigan no-fault law has done the job it was designed to do."

For example, he said the law has fulfilled its first purpose—to "fairly compensate all accident victims and their families at an adequate and realistic level."

To illustrate, he recalled statistics indicating that the former reparations system paid some victims too much and others not enough. But under no-fault, he asserted "every injured person, regardless of fault, is covered for all actual medical and rehabilitation expenses and for 85% of lost wages up to a monthly ceiling of $1,285 for up to 36 months."

In addition, he said recent data indicates that over 30% of the catastrophe claims (for over $25,000) now being paid under no-fault involved single vehicle accidents.

A high percentage of those claims involved brain damage or paralysis, he said, and the average age of the claimants was 32.

"Under no-fault," he said, "all of these catastrophic claims are being paid promptly, and to the full extent of the medical, rehabilitation, and lost wages incurred by the victim."

The commissioner also contended that the Michigan law has met two other of its stated goals: eliminating delays in claims payments, and diverting more premium dollars from legal costs into benefits.

Concerning delays, Mr. Jones said that before no-fault the average delay before settlement of claims was 16 months. Now, he said, benefits are almost always paid within 30 days.

And before no-fault, he added, 34% of families that had suffered a serious injury or fatality had to use their own assets or borrow money to pay the costs associated with the accident. "Now, that should not be necessary."

As for legal costs, Commissioner Jones observed that "at one point prior to no-fault, 40% of the litigation in Wayne county was related to motor vehicle accidents."

But he said that under no-fault, litigation has "decreased dramatically." For instance, he reported that from June, 1975 to June, 1976, auto negligence cases filed with the Michigan circuit court declined by 20%.

"These figures mean that fewer premium dollars are used to pay attorneys and court costs," he concluded, "and that more dollars are available to pay benefits to people."

A final goal of no-fault—to eliminate duplication of insurance—has met with success in one area but is still in abeyance in another, according to the commissioner.

Specifically, he said a survey performed by the United Auto Workers showed that a "substantial number" of consumers use the option in their auto policy that permits them to receive a reduced premium by coordinating their personal injury protection (no-fault) coverage with their other health and accident coverages. A 1974 amendment to the Michigan no-fault law had mandated that auto insurers offer this option in their policies.

Commissioner Jones said that the UAW survey also showed that the percentage of policyholders requesting the option on new applications and renewals is "increasing," as people become aware of its availability.

But Mr. Jones reported that another legislative effort to mandate coordination (and thus reduce aggregate premiums) is now stalled by a court case.

The legislature had mandated coordination of no-fault personal injury benefits with other governmental benefits, such as workers' compensation and Social Security, he said. But the Michigan court of appeals ruled the provision unconstitutional, and the case is now on appeal before the state supreme court.

If the appeals court decision is upheld, the commissioner contended, "the added costs to the automobile insurance system may be as high as $25 million per year."

But Mr. McNally of NAII presented a less favorable view of the law's performance in Michigan.

He told the house insurance committee that the law's unlimited medical benefits provision is helping to create a situation "that could make it difficult, if not impossible, for many people to obtain protection at any price."

To illustrate, he said that one insurance company hired a doctor and a hospital comptroller to investigate the reasonableness of medical bills in just one case. "After painstaking review of the records, as well as the charges," he said, "the company found that the medical providers had double-charged, over-charged and charged them for services never rendered.

"The unfortunate part about all this is that the company knows this is common, but it cannot afford the cost of the investigation that would be required to ferret out all these abuses.

"There is no doubt that under an unlimited medical benefit law these practices are more prevalent because by its very nature, there is little, if any, restriction on such services."

He contended that another problem

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with the unlimited medical benefits system is the burden it places on the small insurance company. He said the small insurer's "heavily concentrated exposure in a smaller area, and its difficulty in obtaining reasonably priced reinsurance because of such concentration, places it in an extremely difficult competitive position and could easily affect its financial stability."

Even larger companies have suffered partially from this phenomenon, Mr. McNally said. "The smaller ones are having even more difficult problems, particularly with reinsurance costs going up almost out of sight.

"The end result will be what is happening in New Jersey, another unlimited medical state—significant reduction in the market and all of the consequences emanating from such reduction."

NAII Study

He said a recent NAII study had shown a huge increase in case reserves in Michigan for claims reserved for $25,000 or more. The study was developed from the claim files of 40 companies that insure nearly half of the private autos in the state, he added.

"There were 443 cases reported with reserves of $25,000 and over for medical expenses. The total amount reserved was over $32 million. Twenty-one percent of the claims reserved for $25,000 and over were reserved for $100,000 or more," the NAII associate counsel said.

"These claims account for 54% of the total amount of reserves for cases $25,000 and over. It was also interesting to note that in cases originally reported for $25,000 or more, the increase in reserves in only six months was 39% in Michigan.

"These various developments, dominant in the unlimited and high limit states, boil down so far to an extremely costly system—one that may be beyond the reach of the average citizen," Mr. McNally concluded.

Commissioner Jones indicated that he is aware of the complaints about the unlimited medical benefits provision. "However," he asserted, "the industry's own preliminary data does not seem to support this concern.

"An analysis of companies representing 43% of the Michigan auto insurance market indicates that the total cost of medical claims exceeding $25,000 in Michigan is $8 per car.

"While we will have to closely monitor the cost of this no-fault benefit, the preliminary data does not justify the extent of concern being expressed by the industry."

The commissioner also said the insurance bureau has been receiving complaints about rates going up, the inability of no-fault to hold at-fault drivers responsible for collision damages in accidents, and the requirement that insureds pay a deductible for collision damages that were not their fault.

Concerning rates, the commissioner conceded that there have been increases. But he said these have been "substantially less than those experienced by other comparable states, whether they operate under a fault system or a different type of no-fault system." Despite inflation, he said, Michigan auto premiums remained "virtually level" from 1971 to 1975. And since the last half of 1975, the total average increase has been "about 20%."

Auto Insurance:

FORT LAUDERDALE NEWS, March 22, 1976

Mindboggling Investment Profits Offset Firms' Underwriting Losses

By FRED E. FOGARTY
Staff Writer

Florida's major auto insurance companies reported heavy underwriting losses last year and the brunt of blame was put on no-fault insurance, unscrupulous doctors and attorneys and suit-happy drivers.

But despite these Florida loss problems, a survey by The Fort Lauderdale News has determined most insurors produced mind-boggling investment profits in spite of inflation and recession problems suffered by most segments of American business.

While auto insurors have kept up a steady flow of information on increasing property damage and and personal injury losses, the companies haven't been quite as vocal on profit yields from huge investment portfolios.

State Farm Insurance Co., the largest insuror in Broward, Florida and the nation, reported recently it suffered a $90.2 million nationwide loss, including a $28 million deficit in Florida in 1975.

State Farm President Robert B. Rust was optimistic, however, when reporting the underwriting loss because he said an increase of about 15 per cent in premiums this year will put the company in the black in the final quarter of this year.

But the $90.2 million underwriting loss was anything but a disaster for State Farm, since it also reported investment income of $213.7 million on a $3.6 billion portfolio of stocks and bonds.

Rep. Paul Steinberg of Miami Beach, vice chairman of the state House Commerce Committee that is probing insurance rates, said it's pretty much a proven fact that insurance companies today are basically investment com-

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Florida Auto Insuror Profits Probed

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panies.

"In fact, we had an insurance executive at one of our recent hearings who admitted insurance companies are just conduits for money," he said.

And the Miami Beach Democrat is even more outspoken on continued rate increase requests that are being filed to cover underwriting losses.

"In today's business climate, many companies are cutting expenses and fighting inflation, but what amazes me is insurance people are trying to recoup their losses in a matter of a few months by simply raising their rates," he said.

Sen. Jon Thomas of Fort Lauderdale adds: "Sometimes you wonder whether the state is running the insurance show in Florida, or the companies."

While Thomas is directing his legislative efforts towards stronger controls in the title insurance business, the Fort Lauderdale Democrat said he's had to square off frequently with the state's strong insurance lobbyists on new legislative proposals.

State Farm is just one of the 250 companies writing auto insurance in Florida, but there are other major insurors who are showing high losses and handsome investment profits.

But at least one of the state's top five insurors is splitting up investment profits with policyholders even though it suffered an $8 million setback in this state last year.

United Services Auto Association of San Antonio, Texas, is the state's fifth largest insuror and its premium volume in 1975 was about $20 million. Although the company suffered an $8 million setback last year, it still paid each policy holder a 10 per cent dividend.

Col. Kenneth Charbonneau, the company's Florida manager with headquarters in Tampa, said the company is one of only a few in the nation which splits nearly all of its net profit each year with policyholders.

Charbonneau said the company was formed in 1925 by a group of

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No-Fault's Not Working; Insurance Premiums Soar

By FRED E. FOGARTY
Staff Writer

Broward motorists have fewer accidents than other Floridians, but are digging deeper to pay soaring insurance premiums.

The paradox is rooted in the provisions of Florida's no-fault insurance law, which has both motorists and insurors reeling from economic stress.

In 1975 Florida's insurance companies paid out an estimated $600 million in personal injury and property damage claims. And before 1976 expires, claims payouts and premiums may climb a few more notches.

But behind the Florida insurance fiasco are questionable claims, mysteriously high medical and hospital expenses, and soaring costs in auto replacement parts.

Caught in the middle of this vicious merry-go-round of soaring and questionable claims and unregulated premiums is the consumer. He's been promised lower rates by improving his driving habits, urged to shop for insurance bargains and other non-productive suggestions.

While Broward drivers have improved their highway safety record with a 6 per cent decline in accidents during 1975, premium rates have skyrocketed by as much as 50 per cent for some drivers.

But insurance company files reveal numerous inequities and abuses in the Florida no-fault system which has helped put the financial squeeze on Broward motorists.

According to various insurance company records, here's how some of your premium dollars were spent in Broward:

- A Fort Lauderdale claimant made 130 trips to a local chiropractor at $9 a visit to top the $1,000 minimum threshold in order to file an injury claim. His injury resulted when his 1972 Dodge rear-ended a Toyota at five miles an hour. The police report said: no injuries and $50 property damage.

- Another Fort Lauderdale claimant who asked the insuror for $3,500 for personal injuries submitted a medical bill for $2,200. Insurance files show that he was treated by five doctors for everything from a cervical sprain to post-nasal drip.

- A major insurance company ordered a claimant, who had filed a $10,000 suit, to be examined by an independent doctor. The doctor's report said: "If claimant would stop wearing all of those corrective appliances, she'd get well immediately."

While the consumer keeps riding the premium merry-go-round, neither the Florida Insurance Department nor the 365 companies writing auto insurance in the state have taken any noticeable action to correct the abuses.

Fort Lauderdale attorney Ray Ferrero, chairman of the auto insurance subcommittee of the Florida Insurance Task Force, scoffs at claims by insurance carriers of widespread fraudulent claims.

"We've asked them for documentation of fraudulent claims, but they

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Ft. Lauderdale News 3/7/76

'EXCESSIVE RATES . . . DEVASTATING'

Insurance Industry Accused of 'Overreach'

By SAM HOPKINS

The insurance industry was chastized by a federal official here Thursday about unjustified rate increases and warned that "overreaching is dangerous."

"Past economic difficulties aside, excessive rates to the consumer's detriment will be politically devastating," declared J. Robert Hunter, acting federal insurance administrator with the Department of Housing and Urban Development.

In a speech prepared for delivery to the Atlanta Association of Independent Insurance Agents, Hunter said that "last year's 25 per cent increase in private passenger auto liability insurance may have been needed, but the rate of change is beyond the inflationary rate which has been dropping in response to a variety of factors."

"No one," he added, "has a greater stake than the (insurance) industry in avoiding the stoking of the fires of inflation, but the use of exponential curves in trend projections, thus assuming that inflation will never end and indeed increase, is not only unjustified by the current facts but may amount to a self-fulfilling prophecy."

Hunter further charged that "some of the rating procedures we see today might well have been devised by a science fiction mind, rivalling some of Stanley Kubrick's greatest flights of fancy."

He said it is "becoming increasingly apparent that liability insurance—or the lack of it—is becoming a a national problem . . . While no-fault and malpractice have become common terms, gradually we are hearing more about the problem of others who have traditionally relied on liability insurance to protect themselves from financial disaster. . . .

"Thus, the rates charged those in professions other than medicine, most notably architects and engineers, are also rising rapidly. Local governments are finding that it is increasingly difficult or expensive to buy insurance covering their police departments and other municipal activities."

Hunter said that as a result of increasing lawsuits claiming injuries, insurance companies "have raised their rates to levels unheard of just five years ago or have severely restricted the kinds of coverage they will provide."

He added that it has become "crystal clear that the impact of the unavailability or the high cost of liability insurance also falls heavily upon the general consumer and that the medical malpractice and products liability insurance crises have serious implications for the economy as a whole."

Hunter said that "if any proof were needed to illustrate the retaliation of the insurance-buying public to exorbitant rate increases, one has only to look at what is happening in Michigan."

He said that last May an affiliation of doctors filed a formal petition with the Michigan insurance commissioner against the entire malpractice insurance industry, demanding stricter regulation of malpractice writers "by means of full disclosure of income, expenses and profit and loss, and an accounting of all investment income."

The petition also charged the insurance industry in Michigan "with realizing an unreasonably high rate of return from insuring physicians," Hunter said.

He added that while the charges were "vigorously denied by the industry, the petition apparently was well received by the Michigan Insurance Bureau, which has now promulgated nearly all the stricter reporting requirements" proposed by the doctors.

Hunter said that more available information about the insurance industry is needed by state agencies for better regulation.

"Meaningful insurance data," he added, "is the closest thing to a perfect vacuum that man has ever created."

Atlanta Constitution

Hunter Blasts Insurers On Ratemaking Procedures At Auto Insurance Hearing

NEW YORK — J. Robert Hunter, Acting Federal Insurance Administrator, criticized the ratemaking practices of insurers during testimony at a hearing held here by the New York senate committee on insurance. The committee is investigating charges of high rates and unavailability of auto coverage in the state.

In response to questions from the committee chairman, Sen. John Dunne, Mr. Hunter said: "Ratemaking is part fact and part fiction. Some of the ratemaking procedures we see used today could have been developed by some of the great science fiction minds—someone like Stanley Kubrick, for example."

Mr. Hunter, who is an actuary, said that some of the rate request filings he has seen recently have used trend factors that are unjustified by the data submitted to support them. He said one request he saw used an exponential curve trend line when, in his office's opinion, a straight line trend should have been used.

"Using the company's method, the data supported a 40% rate increase," Mr. Hunter said. "However, when our straight line trend factor was used, we determined that the company should decrease its rates by 3%, a significant difference."

Mr. Hunter also took issue with the economic projections being used by many insurers in their ratemaking procedures.

"Many insurers are still projecting

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future losses on the basis of increasing rates of inflation—despite the fact that inflation seems to have flattened out," he said.

Qualifying his statements somewhat, Mr. Hunter told the committee that there were several "legitimate" methods that could be used in determining rates, with room for honest differences of opinion.

Profits Predicted

Many companies are using more conservative ratemaking procedures today, he said, because of the severe losses in both underwriting and investments sustained by the property-casualty business over the last couple of years.

The more conservative ratemaking procedures and the rate increases being granted, according to Mr. Hunter, should improve the finanial position of insurers in the near future.

"I think we'll see underwriting in the black—if not this year, certainly next year—and profits will rise drastically to all-time highs." Yet, he charged, "the underwriter acts as if we were still at the bottom [of the recession]."

Another aspect of ratemaking attacked by Mr. Hunter was the use of "percentage loads" for expenses. "People pay dollars, not percentages, and that's the way [increases] should be looked at," he said.

The percentage load for expenses is unfair, according to Mr. Hunter, because the high risk policyholder is contributing more to defray overhead than the lower risk policyholder. "As far as I know," he said, "the same amount of light falls on both policies."

He also questioned using percentages of rates for determining expenses and profits from another viewpoint. "If expense and profit dollars are tied to loss dollars," he asked, "what's the incentive for loss prevention?"

When asked by the committee how the various states could oversee the vagaries of different insurers in their rate request filings, Mr. Hunter responded that the problem was immense—and practically impossible due to the number of companies licensed in each state.

However, he told the committee that the New York insurance department handled the problem very well and recommended that the committee place its trust in the department.

"You have," he told the legislators, "the finest department in the country."

Also appearing before the committee hearing was New York Superintendent Thomas A. Harnett.

Responding to a comment made by Sen. Dunne that there had been a "public outcry for adequate explanation" of the recent rate increases, Mr. Harnett said:

"At the outset, I state categorically that it would have been easier and more popular for me to have said 'no' to automobile insurance increases. However, that would have been irresponsible and would—in the long and short run—have been ruinous for the public and the insurance companies.

"Such negative action could have resulted in insolvencies of insurers and deprived the public of its full contractual rights provided by the policies."

Bolstering his argument, the superintendent reported that "from Dec. 31, 1972 through Dec. 31, 1975, the total policyholders surplus of New York licensed insurers declined from $21.1 billion to $16.9 billion, or 20%, while written premium volume was growing from $31.6 billion to $39.7 billion, or 25%." At the end of 1975, he said, "the ratio of premium writings to surplus for all New York insurers thus stood at the dangerous level of 2.35 to 1."

Mr. Harnett also disclosed his ideas on how to increase availability of auto insurance in the state.

"Adequate premium levels, coupled with a market recovery, which would increase surplus, are the responsible formula for open insurance markets," he said. "It would be an invitation to insolvency for insurers with reduced surplus to take business which would result in still higher multiple premium to surplus ratios."

Noting that finding solutions to the auto insurance market problems in New York is a difficult task requiring input from the legislature, the industry and consumers, Superintendent Harnett suggested that the senate committee work with a special task force for auto insurance established by the department in seeking to form a special statewide panel similar to the recent governor's panel on malpractice insurance.

The task force, The National Underwriter has learned, met last Friday with senior executives from the top 40 or 50 companies licensed to write auto coverage in the state.

It was one of a series of meetings the task force has held with producers and company personnel around the state to seek suggestions on how to solve the state's auto insurance problems.

Several industry representatives also testified at the hearing. Details of their testimony will appear next week.

V. THE VARIETIES OF NO-FAULT

"Pure" No-Fault

There are three general types of no-fault plans, given various catchy names by their advocates. The type called "pure" or "total" promises to pay all economic losses to all victims of all automobile-related accidents, and totally abolishes all general damages and all rights of the victim except pocketbook rights. This plan has received little public acceptance, has few active proponents, and has no chance of enactment in any legislative body. It simply costs too much. If the U. S. Department of Transportation study, "Economic Consequences," has any validity at all, the "pure" plan would have to double the premiums. Even the most extreme advocates who still champion the "pure" plan want to add impurities by limiting the wage loss to specified ceilings per month with further limitations on the totals. Survivor's losses and replacement-service losses are likewise capped. Medical costs are usually left unlimited, because, in the nature of things, medical care is self-limited. The catastrophic injury cases reach a point where no additional medical treatment will do any good, or the need for treatment is terminated by death.

"Moderate" or "Genuine" No-Fault-Thresholds

The type of no-fault plan generally called "moderate" was named "genuine" no-fault by the Senate Committee on Commerce of the 93rd Congress. In order to be "genuine," a no-fault plan has to strip away fundamental natural rights from innocent victims of the lawbreaking, reckless driver. The supposed justification is cost. Benefit levels vary among the many different subtypes, but all benefits are capped or limited. There may be separate ceilings for medical expense and for wage loss, or a combined ceiling for all losses, coupled with internal limits on wage loss, replacement-service loss, survivor's loss, and funeral costs. The benefit levels are usually high enough so that the payment of the economic loss of all victims, up to the specified

ceiling amount, would cost more than the total payments under the tort system. In order to reduce the cost to something near present premium levels, money has to be found somewhere and put into the loss pool so that the bad drivers can be paid their pocketbook losses with the money taken away from the good drivers.

Under the tort system, the good driver has a right to recover general damages for his disability, disfigurement, loss of enjoyment of life, and agony. Those rights do have value, and that value is great enough to pay the pocketbook loss of the light-crasher or wrong-side driver who causes the injuries. The phrase commonly used to justify the injustice is, "Someone has to sacrifice." Note that the only one who would sacrifice is the completely innocent injured victim. The wrongdoer has no claim of value and gives up nothing.

In these moderate or genuine plans, the abolition of rights is not total. A few victims will retain their rights, provided they can climb over a "threshold" which separates them from their rights. It is sometimes said that thresholds are intended only to get rid of "nuisance" claims or small claims. The word "small" is deceptively used. Thresholds are designed to abolish the rights of 90% to 95% or more of all victims. One would think that any permanent injury is more than a nuisance and more than "small," but, under S.354, it takes an injury both serious <u>and</u> permanent to surmount the threshold.

There is an obvious correlation between benefit packages and thresholds. A high benefit level will require a high threshold to keep costs reasonably even. Low benefit levels will not increase costs much, and the cost-reducing threshold can be correspondingly low.

<u>Add-On No-Fault</u>

The third type of no-fault plan is called "add-on." It is sometimes called "phony" no-fault by American Insurance Association spokesmen. This is the type of no-fault which has been in existence for many years in every other nation of the free world. All other countries have a multiple system in which all victims, right or

wrong, receive some level of wage-continuation and medical-care benefits. In addition, the innocent victims are entitled to full compensation under tort systems which exist all over the world. Most of these plans in other nations pay the no-fault benefits out of government funds (such as national health plans) and rely on the private market to provide the tort liability insurance. It is cheaper that way, because compulsory government funds eliminate sales and other costs, and normally pay out 90¢ or more of the premium dollar. Private insurers pay far less because their costs are much higher.

There is no reason, except the economic one, why the private insurance industry cannot operate an add-on system in which (1) the car-owner buys scheduled no-fault benefits for himself and his passengers, payable regardless of fault, and (2) the innocent victim recovers full compensation from the lawbreaker. It is sometimes asserted that add-on plans have to cost more than tort plans because more victims receive benefits. That is not true. They cost no more, and often cost less.

A more accurate name would be "add-on, take-off plans." The innocent victim receives his contract no-fault benefits up to the specified limits, but when he seeks a tort recovery, all of the first-party benefits he has received are deducted from his tort recovery. He is made whole, but double recovery is not allowed.

This means that every tort claim has a large, built-in deductible, which lowers the benefits paid, lowers average claim costs, and reduces the tort liability premium. In addition, the practical experience in states which have adopted add-on, take-off plans is that many of the smaller claims drop out of the system of their own accord. The claimant with modest injury, fully paid for all his out-of-pocket losses, finds that it is not worthwhile to pursue a tort claim against the wrongdoer for the small additional value of minor injury.

Massachusetts has reported a reduction of over 70% of tort claims with a $500.00 threshold; Florida has shown a similar reduction (71%) with a $1,000.00 threshold;

and insurers in Delaware have reported a decrease of over 70% in Delaware residents' tort claims with no threshold at all. The voluntary rate reductions which have occurred in other no-fault states which have rejected the threshold approach - such as Oregon, Washington, and Maryland - give practical proof that the mere existence of first-party benefit payments will reduce claim frequency and total claim costs.

In most of the states which have enacted no-fault plans with no tort exemption except set-off, and with no arbitrary threshold, the automobile-policy benefits are primary for the most part. Workmen's compensation benefits and Social Security benefits are commonly deducted, but payments from private insurance or from employer fringe-benefit plans are not. It would substantially reduce costs if the automobile-policy health and accident benefits were made excess over the billions of dollars annually paid out by all the other first-party systems. A proper descriptive name for the least expensive type of no-fault coverage would be "add-on, take-off, excess" insurance.

It must be readily apparent that add-on, take-off, excess no-fault would do everything to remedy the ills of unpaid victims that the more expensive primary plans would do, even though it might reduce the premium collections, cash-flow, and profits of the private insurance industry. If it is true that "someone has to sacrifice," the industry can afford it more easily than the premium-payer or the innocent victim. Such a plan would automatically be compatible with Social Security and Medicare, with Blue Cross and Blue Shield, and with the entire private health and accident insurance industry.

It would also be compatible with any National Health Insurance plan which Congress might enact, whether an Administration plan, the Ullman plan, the Kennedy-Corman plan, or any other.

VI. HEALTH INSURANCE AND AUTO HEALTH INSURANCE

An analysis of the public need for automobile no-fault health insurance requires consideration of health insurance presently carried by potential injury victims. (The following numbers are all taken from the Statistical Abstract of the United States, 1974 Edition, published by the United States Department of Commerce, or from the Source Book of Health Insurance, 1974-75, published by The Health Insurance Institute). By the end of 1972, 169.5 million Americans in the age group under 65, or 91.1% of the total class of persons under 65, were covered by hospital insurance. In addition, health insurance for the aged under Social Security furnished hospital insurance to 21.6 million by July 1, 1973.

In the age group covered by Social Security, the Medicare program covered 20.9 million persons in 1973 for medical expense other than hospitalization. For the population under age 65, 156.6 million or 84.2% of the entire class were covered by surgical benefits at the end of 1972. An additional ten million in the population group over age 65 carried private surgical-expense coverage to supplement Medicare coverage.

Regular medical-expense coverage is carried by a substantial majority of all Americans. For the population group under age 65, 72.3% were covered in 1972 for in-hospital physician's services; 76.1% were covered for out-of-hospital x-ray and laboratory exams; and 51.3% were covered for house calls and office visits. Private-duty nursing services in hospitals, where required, were insured by 56.7% of the population, and almost 60% were entitled to visiting nurse services under their policies.

Increasing Health Coverage

It should be noted that there has been a steady annual increase in the number and percentage of persons covered in every year for the past decade, both in Blue

Cross-Blue Shield and private insurance coverage. Taking only surgical-expense coverage as an example, the persons covered by private insurance, in all age groups, increased from 117.3 million in 1960 to 166.3 million in 1972 - an increase of almost 42% in that short span of years.

In addition to the above groups, millions of Americans are eligible for and receive medical care, surgical care, and hospital care through Medicaid; through various state, county, and municipal welfare programs; through privately funded charitable outpatient clinics; through veterans' and other governmental programs; and through workmen's compensation.

An increasingly popular form of automobile no-fault medical insurance is the medical-payments policy, which is carried as riders by about 80% of all insured drivers. The coverage is so widely held that Milliman and Robertson's cost estimates assume that every insured driver who carried liability insurance also carries medical-payment and uninsured motorist additions. Most of these policies provide for up to $2,000.00 of hospital, surgical, and medical coverage. That sum of $2,000.00 might seem modest, but the D.O.T. studies have shown that 98% of all injury victims have total hospital, surgical, and medical expense of less than $2,000.00

VII. LOSS-OF-INCOME PROTECTION

The number of persons protected by wage-continuation plans in case of accident or illness is also surprisingly high. These plans are designed to provide wage-earners with regular weekly or monthly payments in the event their wages are cut off because of disability due to illness or injury. This coverage takes the form of short-term or long-term protection. Short-term policies extend benefits for a maximum of two years; long-term plans cover longer periods.

At the end of 1973, according to the Statistical Abstract, 1974, the total national civilian employed work force was approximately 88 million persons. According the 1974-1975 Source Book of Health Insurance, nearly 62 million had short-term income protection, defined as income-continuation benefits up to two full years. The number of persons who also had long-term protection, for periods beyond two years, was an additional 14 million. The disability-income protection came from insurance-company disability insurance, formal paid-sick-leave plans, and coverage through union-contract fringe-benefit plans and other employee-organization group plans. This means that of the total civilian employed labor force of 88 million, there is disability-income protection now in force, exclusive of any automobile insurance, for 86%. In addition, a substantial number of automobile accident victims injured in the course of their employment will be covered by Workmen's Compensation benefits excluded in the above calculations.

A very small number of persons suffer enormous individual losses in automobile accidents each year, and their losses are not sufficiently compensated now by any of the multiple systems paying first-party or third-party benefits. The single most forceful demand made by all the advocates of extreme no-fault plans is that the system must pay all of the losses of the most catastrophically damaged victim. This argument, because of its persistence and importance, demands special analysis.

VIII. ECONOMIC LOSS NUMBERS - HOW MANY LOSE HOW MUCH

The construction of a rational plan for compensating the basic needs of automobile accident victims requires accurate data concerning the number of victims and the distribution of loss levels. In hearings before the Senate Committee on Commerce on February 6-7, 1973, dealing with Senate Bill 354 of the 93rd Congress, a Vice President of State Farm Mutual Automobile Insurance Company, Mr. Thomas Morrill, submitted a chart showing the percentage of victims sustaining specific levels of "economic" loss. The term, in that testimony, included medical expense, wage loss, replacement-of-services loss, and survivor's loss in death cases, but excluded property damage. The chart figures state that:

1. 89% of all victims lose less than $1,000.
2. 96% of all victims lose less than $2,500.
3. 98% of all victims lose less than $5,000.
4. 99.6% of all victims lose less than $10,000.
5. 99.94% of all victims lose less than $25,000.
6. 99.98% of all victims lose less than $50,000.

The charts submitted by State Farm Mutual Insurance Company also dealt with the issue of total economic loss, stating what "portion of total economic loss" would be recovered at various levels of first-party benefits paying the first dollar of loss without deductibles or waiting periods. The information is duplicated below:

First Dollar Coverage
with Per Person Limit

Limit	Portion of Cases Compensated in Full	Portion of Total Economic Loss Recovered
$1,000	89%	55%
2,500	96%	73%
5,000	98%	85%
10,000	99.6%	93%
25,000	99.94%	97%
50,000	99.98%	99.4%

How accurate are the above numbers? They are just as accurate as the D.O.T. study, "Personal Injury Claims," on which they are based. "Personal Injury Claims" was a survey of the claim files of sixteen insurance companies in nineteen states, which were closed in a ten-day period beginning October 27, 1969. The percentage of claimants sustaining loss at certain levels, as charted above, corresponds to Table V-8 at p. 50 of "Personal Injury Claims." The numbers are necessarily incomplete. They cover only the losses of paid claimants, and cover only the economic losses to date of settlement. The study itself notes that even after excluding one-car accidents, only about 65% of persons with "serious" injuries made any tort claim, and the percentage is probably lower than that in the class of "non-serious" claims. (P.I.C. p.42, citing "Economic Consequences," p.50).

In the closed-claim survey, 26,435 claims were paid (p.10) and 7,334 were closed without payment (p.9). That is, about 78% of the claimants were paid. If it be true that only 65% of injured victims make a claim--excluding single-car accident

victims--and 78% are paid, then it follows that the "Personal Injury Claims" study, surveying only paid claimants, deals with only 50% of the injured victims in multiple-car or car-pedestrian collisions.

This does not, by itself, condemn the accuracy of the figures. There is no reason to believe that the whole class of unpaid victims sustain injuries and losses which differ significantly from those of the paid claimants. The exlusion of single-car victims should make some difference in the accuracy of the tables, however. There is reason to believe that the average loss may be higher in single-car crashes than in multiple-vehicle cases, because the single-care accidents occur more often at high speed with a correspondingly higher severity of injury.

D.O.T.'s Flawed Figures

The flaw in the personal injury claims study which will necessarily produce an understatement of total loss is the fact that it tabulates only economic losses "to date of settlment." This would not significantly impair the accuracy of the loss figures in the smaller loss categories. Where injuries and losses are of limited duration, it is rare that the claim is settled and paid until the victim has terminated his treatment and has returned to work.

The statement that 96% of all vitims have total economic loss of less than $2,500 should be reasonably accurate. The corresponding statement that 99.4% of all victims have losses of less than $25,000, and that the aggregate loss of this class is 97% of total economic loss, is necessarily invalid. The statistical device of calculating loss only to date of settlement means that a large amount of future wage loss in death cases and permanent disability cases will be excluded. The Personal Injury Claims study itself warns of the discrepency, saying, at p.28: "It is clear, therefore, that 'economic loss' as defined for

this survey is not actually 'total economic loss.' It excludes a major element . . . future lost earnings. For the seriously and fatally injured, another study found future lost earnings to constitute 63% of their total economic loss exclusive of property damage."

The closed-claim survey goes on to say that some future losses could be calculated. Total economic loss, including future wage loss, excluding property damage, was $5,815,000 for fatality cases, compared to measured loss "to date of settlement" of $997,800. The total loss, as defined, for permanent disability cases was $3,198,000 compared to "loss to date of settlement" of $323,400. That is to say that in permanent disability and fatality cases, the exclusion of future lost earnings meant that only $1,321,200 of the actual economic loss occurred before the "date of settlement" and $7,691,800 after that date in the cases surveyed. In the most serious class of cases, about 15% of the actual loss is tabulated and 85% is excluded! These catastrophic cases are few in number, but large in dollar volume.

What other sources of information in the many D.O.T. studies can be used to construct a more accurate profile of loss categories? The D.O.T. final report, "Motor Vehicle Crash Losses and their Compensation in the United States," refers to "unpublished data" to support the statement that there are annually 3,750,000 persons in the cass of non-"serious" injury (using the definition of "serious" given in "Economic Consequences"). This large class has no members sustaining loss of over $1,500. The average loss for the whole class is said to be $224 each.

An additional source, of some value but of doubtful accuracy, is the Department of Transportation's data on "seriously" injured victims, as

defined, published as "Economic Consequences of Automobile Accident Injuries."

This study took a sample of 1,376 accident victims and extrapolated it to a theoretical universe of 513,000 fatality and "serious injury" cases per year. An injury was classified as serious if the victim had two weeks of hospitalization; medical costs excluding hospital costs of $500; three weeks of missed work if employed; or, if not gainfully employed, six weeks of missed normal activity. The authors stated that the criteria for serious injury were "arbitrary at best, and one can anticipate some classification error." ("Economic Consequences," p.17).

Future losses in the study were based on the respondent's answers to a questionnaire, giving an unverified estimate of future medical expense. Future wage losses were derived from the respondent's estimate of the extent and length of his disability. The authors warned against the "speculative" nature of the projections of future losses and cautioned against memory error, response error, sampling error, and classification error, all of which produced a study providing "more precise estimates of averages and ratios than of aggregates." Unreliable as the data may be, however, this is the only study of future losses available, and the Department of Transportation has widely publicized the doubtful estimates of aggregate victims and losses.

The projections of the sample conclude that 513,098 persons (out of an estimated class of 4.2 million total injured persons per year) should be classified as serious-injury or fatality cases. The serious and fatality classes are estimated to sustain an aggregate economic loss of the type called "personal and family," discounting future losses, in the annual amount of

$5,126,595,000; which means an average loss per victim of $9,991,00. (See "Ec. Con." Table 31 FS 1 at p.277).

A table can be constructed collating the data stated in the Department of Transportation's final report for"non-serious" injuries, data from "Personal Injury Claims," and data from "Economic Consequences." This table will show the speculative total number of auto accident injury victims in each category of economic loss, the average loss for each person in the category, and the total loss which each category sustains if the assumptions of the various studies are accurate.

D.O.T. ESTIMATES--1967
NUMBER OF PERSONS
SUSTAINING ECONOMIC LOSS

Class of Loss	Number of Persons	Percentage of Total Persons	Average Loss	Totals of Loss
Not "Serious or Fatal"	3,750,000	88.00	$ 224	$ 840,000,000
"Serious/Fatal" $1-499	28,021	0.70	332	9,302,972
$500-999	54,994	1.30	762	41,905,428
$1,000-1,499	63,843	1.50	1,251	79,867,593
$1,500-2,499	108,606	2.50	1,945	211,238,670
$2,500-4,999	121,341	2.80	3,486	422,999,766
$5,000-9,999	59,723	1.40	6,650	397,157,950
$10,000-24,999	31,417	0.74	16,459	517,092,403
Over $25,000	45,153	1.06	76,341	3,447,025,173
TOTALS	4,263,098	100.00		$5,966,589,955

The discrepancy between the "Economic Consequences" data and the "Personal Injury Claims" data is small respecting percentage of claimants, but large respecting percentage of total loss. Where "Claims" says that 99.9% of all claimants sustain no more than $25,000 in loss, comprising 97% of all loss, "Consequences" says that 99% of all claimants sustain a loss of less than $25,000, but this is only 42.5% of all loss. A complete table of loss, according to "Economic Consequences" data, can be computed as follows:

PERCENTAGES OF PERSONS
SUSTAINING PERCENTAGES OF LOSS

Class of Loss	% of Persons	Cumulative % of Persons	% of Loss	Cumulative % of Loss
Under $999	90		15	
$1,000-2,499	4	94	5	20
$2,500-9,999	4.2	98.2	14	34
$10,000-24,999	0.74	98.94	8.5	42.5
Over $25,000	1.06	100	57.5	100

Paying Losses: Tort Liability vs. No-Fault

If the data in "Economic Consequences" is reliable, then the great bulk of all economic loss lies in a very few cases where future wage loss is huge. This poses a dilemma. If the numbers are correct, "moderate" no-fault plans will not pay the enormous loss. At the same time, if the numbers are correct, the premium required to pay the losses will be so multiplied over present

rates that the American motorist will not tolerate the increases. A system will obviously not pay the catastrophic losses of a few victims--1% of all those injured--if the system pays only wages losses incurred within one, two or three years; or if the system permits or mandates arbitrary wage-loss limits as does S. 354. It is curious that the supposed justification for grandiose no-fault plans is the huge wage loss of very few victims, but no plan proposes full payment of those huge estimated future wage losses because of the prohibitive cost.

Tort Liability System Compensates Only the Innocent

A fundamental fallacy in the argument claiming a great need for no-fault is the assumption that the tort liability system is the primary system for the payment of economic loss. It is not. Tort liability does pay back to innocent victims their pocketbook losses, as well as general damages, but there are other first-party or no-fault insurance and compensation systems specifically designed to pay economic losses to accident victims, regardless of fault or kind of accident. Congress should be aware that the total payments from all the other first-party or no-fault compensation systems are substantially larger than the economic-loss repayments from the tort liability system. This result should be expected. The tort system is designed and intended to make the guilty wrongdoer bear his own loss. Blue Cross, Blue Shield, wage continuation, and health and accident insurance plans are intended to pay the guilty as well as the innocent, and they are performing creditably. The following table is constructed from data in the appendix to the D.O.T. "Economic Consequences" study, chiefly from table 31FS:

1967 PERCENTAGES, RECOVERY OF ECONOMIC LOSS FROM TORT AND OTHER SYSTEMS

Amount of Total Economic Loss	Average Loss in Class	Average Recovery	Ratio of Recovery To Loss (%)	Ratio of Recovery from Tort (%)	Ratio of Recovery from Other Systems
Under $2,499	$ 1,330	$ 1,888	142	68	74
2,500-4,999	3,486	3,520	101	40	61
5,000-9,999	6,650	5,310	80	31	49
10,000 24,999	16,459	9,364	57	24	33
Over 25,000	76,341	21,641	28 ~~5~~	5 ~~23~~	23 ~~28~~

It is apparent that in every category of loss, the average injured person sustaining loss recovers a higher percentage of his loss from other compensation systems than he does from the tort system. It is also true that the average victim sustaining a loss totalling $5,000 already recovers his average loss in full from the existing combination of tort and other systems. This group comprises about 96% of all paid claimants. This means that primary automobile no-fault benefits will impose unnecessary and wasteful premium burdens on the vast majority of injured motorists, already well protected by existing coverages.

The average victim in the class sustaining losses between $5,000 and $10,000 also recovers enough of the loss (80%) so that additional insurance to duplicate the recovery is not economically justifiable. Victims in that very small class sustaining economic loss between $10,000 and $25,000,

averaging $16,459, do not recover as great a percentage of their loss. One reason is that many states require only $10,000 as minimum bodily-injury liability coverage, and many of the first-party benefit systems have ceilings for both time and total amount. The amount of additional no-fault insurance required to take care of the average victim in this small category is modest. A combined benefit package of $5,000 would to the job adequately:

Class of Loss	Average Loss	Average Tort Recovery	Average Other Recovery	If $5,000 No-Fault Added	% of Recovery
$10,000-24,999	$16,459	$3,940	$5,454	$5,000	87.5

Compensating for Catastrophes

All compensation systems falter when the level of loss exceeds $25,000. This is the level where the class of victims is said to number just 1% of all injured victims. The bulk of the estimated loss of this class consists of future wage loss or survivor's loss of future support. Senate Bill 354 collapses its benefits when loss reaches these levels. Maximum wage-loss benefits required by state minimum statutes total only $15,000 and maximum survivor's losses can be as low as $5,000. In order to pay the losses of this 1% class, all benefits would have to be unlimited, for life. If the estimates of "Economic Consequences" are true, then 42.5% of all benefits paid under a no-fault system would be paid to this 1% of very serious injury or fatality cases. If 42.5% of the loss dollar were expended for this group, then 42.5% of the premium dollar would be attributable to their losses.

Disregarded-signal, Wrong-side and Single-car Crashes

At this point, thoughtful consideration should be given to the kind of driving that produces the catastrophic injury. The general estimate found throughout the studies on automobile compensation is that one-third of all

injuries come from single-car accidents. Data on fatalities on the Interstate Highway systems shows that more than half of all fatalities occur in single crashes with off-highway obstructions or in single-car rollovers at high speeds. Single-car accidents as a class produce a higher proportion of serious injuries than two-car collisions. A fair estimate would be that 40% of catastrophic injury and fatality arises from single-car, loss-of-control accidents. The tort system is not intended to provide compensation for the self-injuring driver.

The kind of driving which causes serious or fatal injury in multi-car collisions was investigated in one D.O.T. study called "Price Variability in the Automobile Insurance Market." The authors, Professors Brainard and Carbine, investigated the open claim files of major liability insurers to see what kind of cases had produced losses and injuries "reserved" by the insurer for more than $20,000. Analysis of the types of crashes involved in these cases shows that half of them were head-on collisions in which one driver was on the wrong side of the road. An additional one-fifth were high-speed intersection crashes where one driver disregarded a light or a stop sign. The lawbreaking driver would not recover under any tort system, even a comparative negligence system.

It can be fairly assumed that with 40% of serious or fatal catastrophic cases arising from single-car collisions, and with an additional 36% (60% of the remaining 60%), clearly excluded from recovery under the tort system, at least 76% of all serious or fatal catastrophic cases are properly excluded from the tort liability recovery pool. This accounts, of course, for the low <u>average</u> tort recovery of the whole class. The remaining one-quarter who might make full tort recovery are limited by the assets or insurance

coverage limits of the guilty drivers. Earlier versions of S. 354 would have solved this problem in large part by requiring minimum liability limits of $50,000, but this section has been deleted in the present draft.

Good Drivers to Subsidize Bad?

Fairness will be sacrificed if the majority of good drivers must pay a heavy proportion of their premium dollars to fund the no-fault recovery of the reckless, aggressive, out-of-control drivers who inflict catastrophic injury on themselves as well as their victims. The sacrifice demanded of the good driver is even more burdensome, and less justifiable, if his fundamental right to recover general damages is also extorted from him to fund the no-fault benefits of the driver who smashed into him.

IX. THRESHOLDS - SMALL, MEDIUM, AND LARGE

The stated purpose of threshold plans is to eliminate small claims. The stock phrase is: "Small claims are overcompensated."

The data supporting the "overcompensation" argument is always expressed in percentages. It is commonly asserted that claimants with small injuries receive "four times their economic loss." Perhaps it should be recalled that the scholar who first investigated this phenomenon, Professor Alfred F. Conard, (Automobile Accident Costs and Payments, Ann Arbor, MI: University of Michigan Press, 1964, p. 452), pointed out that his studies did not prove overcompensation. His findings were that a claimant with $20 in wage loss was likely to receive $100.00 in settlement, but warned that the additional $80.00 was a fair, agreed compensation for very real pain and temporary disability. His public opinion survey found further that most people believed in the principle of general damages; believed that the wrongdoer should pay for the suffering inflicted; and would resist abolition of their rights. In this view of the matter, "overcompensation" of economic loss really means fair compensation for economic loss plus fair compensation for shock, aching pain, sleeplessness, and temporary disability.

The essential weakness of the overcompensation argument is that the total dollars involved in small claims is such a small percentage of total claim dollars. The percentages are high, but the actual cost is small. The word "small" and the term "small claim" are relative. If one half of all claims are small, and the remaining one half are medium or large, then dollar values can be investigated.

The U. S. Department of Transportation study "Automobile Personal Injury Claims" found that 56% of all paid claimants received a total payment for medical loss, wage loss if any, and general damages of less than $500.00. This whole class of claims under $500.00, more than half of all claims, received in aggregate only 7.8% of all claim

dollars paid out. Elimination of the portion of that payment which goes for non-economic loss should reduce total claim payments by something between 5% and 6%. This will be only a theoretical reduction if any significant number of claimants fight back by overtreating to exceed the threshold. Claim-handling costs will not be significantly reduced.

The claim still has to be surrounded with paperwork to open, adjust, evaluate, pay, and close it.

From the consumer's standpoint, a 5% reduction in the premium for bodily injury will be only $2.00 to $3.00 a year for many drivers in many states. Their rights are worth more than 25¢ a month. The bargain is not worth the price.

In any event, the insurance industry is the last group who should complain of "overcompensation." The industry determines the compensation. These cases do not go to lawsuit or verdict. In most small claims, no lawyer is ever hired, or even consulted. It is the insurance claims adjuster who negotiates the value and makes the agreement. If claims adjusters are overpaying claims, it is up to the industry to retrain and control them.

Thresholds Eliminate Most Claims

Threshold devices are not really intended to eliminate only the "nuisance" claim or small claim. The height of the proposed thresholds proves that their true purpose is to eliminate medium and large claims as well, leaving only very large and very serious injuries in the tort system. It should be helpful to those considering no-fault plans to know just how many deserving claimants can be thrown out of the reparations system by various types of monetary and injury-defining thresholds.

The public has little knowledge how large medical expenses really are for different types of injury, and for different groups of citizens. Legislators called upon to evaluate the necessity for a particular threshold level, and the equity of a

proposed threshold, ought to know the significance of the amount selected. Unfortunately, it is seldom, if ever, that a legislator voting on a threshold bill has any conception of the number of automobile accident victims who will lose their basic rights to full compensation by reason of the dollar limit programmed in the bill.

Serious Injury

The information is available, tucked away in the appendices of the Department of Transportation's Automobile Accident Compensation Study. In its final report, entitled "Motor Vehicle Crash Losses and their Compensation in the United States," the D.O.T. (at p. 4) pronounced that "serious" injuries were defined and evaluated in its "Economic Consequences" study, and that, in addition to those injuries, there were 3,750,000 injuries neither fatal nor "serious," as that term has been defined. These 3,750,000 injured persons had average medical losses of $131.00 average wage losses of $81.00, and average additional expenses of $12.00. These numbers are said to be "based on unpublished data from the Department of Transportation's personal injury study." None of the 3,750,000 injury victims sustained medical costs in excess of $500.00. If they had, they would have been counted in the "seriously injured" class of the Economic Consequences Study.

There were four criteria postulated for the classification of an injury as "serious" in the D.O.T. study entitled "Economic Consequences of Automobile Accident Injuries." They were: (1) hospitalization for two weeks or more; or (2) $500.00 or more of medical costs excluding hospital cost; or (3) if working, three weeks or more of missed work; or (4) if not working, six weeks or more of missed normal activities. By these four criteria, a particular victim would be classified as seriously injured even if the medical costs did not reach the arbitrary $500.00 level. For example, a broken leg, such as an uncomplicated fracture of the tibia, may well be reduced or set with only a few hours' stay in the hospital clinic or doctor's office. Plaster-cast

protection for three months while the patient remains at home may complete the treatment for far less than $500.00, but the extensive disability would justify the classification of "serious."

The D.O.T. estimate from its sampling techniques, as published in "Economic Consequences," states that 452,377 persons are injured seriously each year. (This does not include the annual toll of 52,000 to 59,000 fatally injured). The total of 452,000 "serious" injuries and 3,750,000 "non-serious" injuries produces a total annual injury class of 4,200,000.

The "Economic Consequences" study, Volume I, classified the number of victims sustaining various levels of hospital and medical costs in Table 32S at page 281. The table is reproduced, in part, below:

TOTAL MEDICAL AND HOSPITAL COSTS	NUMBER INCURRING SUCH COSTS
$1 - $499	135,123
$500 - $999	116,011
$1,000 - $1,499	61,066
$1,500 - $2,499	61,321
$2,500 - $4,999	53,935
$5,000 - $9,999	18,259
$10,000 - $24,999	6,662
$25,000 - or more	none in this estimate
TOTAL	452,377

The average total medical and hospital cost per person for the whole seriously injured class of 452,377 persons is said to be $1,610, which can be compared to the

average total medical and hospital cost of $131.00 for the non-serious class of 3,750,000 persons. The percentages of accident victims sustaining a particular level of loss can be readily obtained by dividing the number of persons in the particular loss category by the total number of persons injured in automobile accidents annually.

For example, the 135,123 seriously injured (as defined) victims who sustain total medical and hospital costs between $1.00 and $499.00 constitute 3.2% of the whole number of all accident victims. The D.O.T. published estimate is that only 10.8% of the whole class of injured persons meet the D.O.T. criteria for serious injury. This means that about 7.6% of all accident victims sustain a medical-hospital loss in excess of $500.00. Stated another way, a total medical-and-hospital expense threshold of $500.00 as a condition for retaining a remedy in tort will abolish any right to general damage recovery of 92.4% of all injured persons.

The exclusionary effect of various levels of dollar threshold can be tabulated as follows:

TOTAL MEDICAL AND HOSPITAL COSTS	PERCENTAGE OF ALL VICTIMS	CUMULATIVE PERCENTAGE	EXCLUDED FROM TORT REMEDY
In excess of $5,000	0.6%	0.6%	99.4%
$2,500 - $4,999	1.3%	1.9%	98.1%
$500 - $999	4.3%	7.6%	92.4%

A state legislature which adopts for the citizens of its state a medical-hospital expense threshold of $2,500.00, is saying, in effect, that 49 out of every

50 automobile accident victims must sacrifice all of their rights to a tort recovery under the long established state law. The purpose of the governmentally imposed sacrifice is to benefit the fortunate uninjured motorists by reducing their bodily-injury premiums a few dollars a year. The essential injustice of this concept is that those of whom the sacrifice is demanded are broken, battered, lacerated, disabled, and miserably suffering through no fault of their own.

The basic fallacy of any threshold is that it is essentially, unalterably unjust. It is designed to shear away the rights of a minority - the innocent victims of the misconduct of others - for the benefit of these who violate the traffic codes and the rules of the road. It is a type of seizure of human rights by eminent domain, without compensation. The supposed benefit to the sacrificial victim is that the system will "give" him nothing. The insurance benefits he gets will be those he has bought and paid for. Indeed, under most no-fault plans, the driver must buy the benefits from private industry, at the industry's non-bargainable rates, or pay a criminal penalty.

Dollar thresholds are not the only devices invented to sacrifice the right to general damages, though the fixed dollar limit is far and away the favorite device of the insurance industry's computer programmers. It is obviously simpler to evaluate numbers than it is to evaluate human suffering.

Some no-fault plans do recognize that there is no valid correlation between the cost of the medical treatment of an injury and the misery produced by that injury. It may cost far more to save and rebuild a torn-up leg than it would cost to amputate it. It may cost far more to treat a fracture than it costs to treat torn cartilage, but the torn cartilage may well produce much greater long-term disability. Further, it is the recognized ethic of the medical profession to charge low fees to the poor and higher

fees to the weathly for the identical treatment. The inner-city clinics charge their patients at lower rates than those charged by the prestigious private clinics. It is not an American ideal that the rich man's broken arm is more worthy of compensation than the poor man's broken arm, simply because the high-priced medical service the rich man may obtain will carry him over the dollar threshold.

Verbal Thresholds

The device employed to soften the inequity of the dollar threshold is the verbal threshold. Certain types of injury are described as meritorious, with all other injuries deemed unworthy of consideration.

S.354 employs wholly verbal thresholds. The traditional right to general damages is retained if the victim suffers death. In most cases, this exception will be meaningless. The vast majority of wrongful-death statutes limit recovery to pecuniary (or economic) loss in any event. Another threshold is disfigurement, provided the disfigurement is both permanent and "serious." Token recognition is given to temporary disability. In order to pass the threshold with a temporary disability, the victim must suffer such overwhelming injury that for no part of any day for a period of three months (90 continuous days) can he perform any substantial part of the duties of his occupation. The test is based entirely on the physical capability of the injured man, without reference to the important question of whether his employer would allow him to work a minuscule schedule. If the workman is found capable of working an hour a day, three days a week in the twenty-sixth week post-injury, then he fails to meet the threshold test and joins the ranks of non-serious injuries.

The comparison between the two sets of standards is provocative. Where D.O.T. considered that three weeks of missed work would connote a serious interference with a workingman's normal life, the proponents of S.354 consider that 13 weeks of total and continuous inability to do any substantial part of normal work is the fair test of a minimum disability.

None of the D.O.T. studies give accurate information on what proportion of all victims will retain any tort remedy under S.354. It is estimated that approximately 1% of all auto accident victims suffer death. As noted above, when S.354 provides that the tort remedy for non-economic detriment in death cases is not abolished, it preserves a remedy that, for the most part, does not exist. It will have limited application for excess losses and for conscious pain and suffering preceding death, but these cases will be only a fraction of 1%.

The D.O.T. study titled "Personal Injury Claims" estimated that only 4% of all paid claimants sustained any permanent partial disability, and about 0.2% suffered permanent total disability. No subclassification exists to estimate how many of the 4% permanent partial disability class suffered "serious" disability. Indeed, only the draftsmen of the bill know what meaning they intended to give to "serious." The term is wholly undefined in the case law, the literature, and the statistical studies. It will mean, eventually, what many courts and juries finally decide it means, unaided by any recognized criterion. The same observation applies to the test of "serious" and permanent disfigurement. The D.O.T. study, "Personal Injury Claims," estimated that 2.5% of all claimants had some degree of permanent disfigurement. No subclassification or definition exists to separate serious and non-serious disfigurement. Is disfigurement "serious" if, in the usual activities of daily life, it does not show? A broken thigh, followed by open reduction, followed by osteomyelitis, can leave some hideous scars, but the scars are normally covered by clothing.

Some rough assumptions can be made. If half of the permanent disability cases are "serious," then 2% of all accident victims can pass that threshold. If half of the permanent disfigurement cases are "serious," then 1.25% of all victims can pass that restriction. It is almost inconceivable that anyone so horrendously smashed that he

could not do any work for more than 90 days a year could survive without significant permanent disability or serious disfigurement. This threshold has to overlap the others almost entirely. Perhaps an additional 0.5% of victims could pass. Probably not more than one automobile death case in five contains the element of "conscious pain and suffering," which would be compensable. The usual death case involves instantaneous death, or total unconsciousness for the variable time between impact and death. In neither situation are general damages permitted. The "death" threshold might apply to as many as 0.2% of all victims.

In total, then, S.354 preserves the tort remedy for 4.15% of the victims of wrongful misconduct. In the words of Dean Lindsey Cowen, Chairman of the Special Drafting Committee of UMVARA* on which S.354 is partly based, "Some sacrifices have to be made." The sacrificial bodies will total about 96% of all those victims who now have the right to full recovery.

One of the witnesses before the Senate Judiciary Committee testified that the thresholds of S.354 could not be more fair. Dean Griswold said:

> Death, serious and permanent disfigurement, other serious and permanent injury, more than six months continuous disability -- reflect more than minor amounts of pain and suffering. On the other hand, the absence of all these four factors indicates that the likelihood of substantial pain and suffering is small. No fairer or more practical criteria have been suggested for separating the substantial claims for pain and suffering the Congress had reason to preserve from the minor claims the public interest required it to eliminate. Consequently, the classification chosen by the Congress does not violate the equal protection concept embodied in the Fifth Amendment.

The statement that "no fairer or more practical criteria have been suggested" is a cavalier dismissal of at least eleven different state threshold no-fault plans and a denial of the "Economic Consequences" study by D.O.T. In that study, as indicated above, three weeks of disability, off the job, was considered serious instead of the 90 days of S.354.

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*Uniform Motor Vehicle Accident Reparations Act

New Jersey has determined that a $200.00 medical-expense threshold is fair. Connecticut has fixed a $400.00 economic-expense threshold. Michigan believes that any "serious impairment of any body function," even though temporary, is likely to be painful and should be compensated.

No basis exists for the assertion that, in all injuries of lesser severity than those described in S.354, "the likelihood of substantial pain and suffering is small." That is medical nonsense. Broken legs hurt. So do broken arms, broken jaws, broken backs, and fractured skulls. The majority of the painful and disabling fractures permit the victim to regain a substantial part, if not all, of his normal function or activity in less than 90 days. Most will heal without permanent disability. Indeed, brain contusions may heal sufficiently to permit the victim to return to part-time duty or other activity in less than 90 days - although residual disability may persist for several non-permanent years. A common internal-organ injury is a rupture of the spleen, which requires surgical removal. Only a witness who never underwent major abdominal surgery could pontificate that the pain is "not substantial."

The blunt fact is that the threshold of S.354 in its present form is outrageous. The only rationalization that can be mounted for it is it makes the cost of injury - and the cost of Justice - cheap.

X. THE CASE AGAINST DUPLICATE COVERAGE: THE POLICY GAME

Be that as it may, the odds are two to one against the buyers of any kind of insurance. Insurance, in its simplest terms, is simply an application of the mathematics of large numbers. If it can be predicted that in a group of one hundred people, one person will have a loss of $1,000.00, then the risk of loss for each one is $10.00. Each person who is unwilling or unable to stand the risk of being the single loser of $1,000.00 can pay his $10.00 share of the risk into a pool sufficient to pay the loss. If the amount he pays (the $10.00 in the example) exactly equals the value of the risk, then the odds are exactly even for the group and each person in it.

Assume now that the people in the group do not form their own pool, but instead hire an insurance company to collect the $10.00 payment from the 100 people and pay the $1,000.00 loss. In almost all lines of insurance, the company doing the business will collect <u>double</u> the amount of money required to pay the loss. The insurer will collect $20.00 from each person to make up a pool of $2,000.00. It will pay the loss of $1,000.00, but will also pay itself $1,000.00 for its expenses, commissions, and profits. At the same time, it will invest the money in the pool before the loss is paid, and keep the interest or profit on the investment for itself.

The odds against the premium-payer, and against the whole group of premium-payers, thus become two to one. The odds against the payer in the insurance market are the same as the odds against the player in a "policy" or "numbers" game, in which the man who picks the lucky number between one and one thousand is paid the prize of five hundred times his bet. The payoff to the winner is 500 to one, but the chances against winning are 1,000 to one, giving the house magnificent odds of two to one.

The consumer should never buy insurance to cover any risk of loss if the amount of the possible loss is small enough that he can afford to lose the gamble. It is

economically unsound to buy collision insurance for an old used car worth only a few hundred dollars. It is even more unsound to buy duplicate or triplicate coverage. Every purchase multiplies the odds. It may be prudent to pay $2.00 to buy protection against a risk of loss worth $1.00, but it is foolish to pay $6.00 for protection against a risk worth $1.00 in the hope of getting back $3.00, and making a "profit" of $2.00 if the loss occurs.

Most Economical Coverage

The consumer who cannot afford to stand a sizeable loss, and buys insurance protection, will do better to buy one policy with the broadest protection he reasonably needs. Most people will do better to buy a life insurance policy covering death from any cause rather than a series of separate policies covering death from drowning, death from avalanche, death from sky-diving, death from falling down stairs, and death from an automobile accident. Hospitalization insurance covering a hospitalization from any kind of sickness and from any kind of accident is a better buy than a policy covering only automobile accidents, or only bathtub accidents.

If a person already has hospital insurance, medical insurance, and wage-continuation insurance, it is economic nonsense to compel him to buy duplicate insurance for any specific kind of accident or illness. That kind of policy game only benefits the house.

To Reduce Costs

The simple way to make compulsory no-fault benefits cheaper is to make them excess instead of primary. If the automobile policy is written so that it pays benefits only after all other available hospital, medical, and wage-continuation benefits are exhausted, then the policy will have to be very inexpensive. Based on all the D.O.T.

studies, which show low levels of economic loss for the great majority of victims, it can be predicted with confidence that four out of five would never have to draw on their excess benefits at all. In effect, an excess-liability automobile health and accident policy would make all other health and accident benefits primary, amounting to a deductible of literally billions of dollars a year.

The cost of the excess policies, spread across the whole group of automobile owners, would have to be very low — assuming state insurance commissioners do an adequate job of supervising rates. Total payout should still be maintained at 50% to 60% of the premium; if the payout is small, the premium should be correspondingly low.

It can be foreseen that the American Insurance Association, The American Mutual Insurance Alliance, The National Association of Independent Insurers, and The National Association of Insurance Agents will all unite on this issue in violent protest. A plan which saves the consumer billions of dollars will take away from the private insurance industry billions of dollars in cash flow and reserves, and will correspondingly diminish investment income and agents' commissions. However, no-fault carries the banner of consumerism and social reform, and true consumer protection should be achieved at the lowest practicable cost to the public without undue enrichment of private interests.

XI. THE STATES AS LABORATORIES

The Final Report to the Congress and the President by the Secretary of the Department of Transportation, summarizing its extensive study of automobile accident compensation, concludes with six specific recommendations for changes in the legal system and the insurance system, and further proposes a step-by-step implementation. The section captioned "Implementation" has been overlooked by the proponents of stringent federal standards. The final report, "Motor Vehicle Crash Losses," states at page 140:

> IMPLEMENTATION. Without question, any revision of the system along the lines outlined above would entail major changes in existing institutions and practices. The orderly accomplishment of such changes would require further study, cooperation, understanding, planning and the dedicated effort of all concerned, especially of the insuring public.
>
> Mere speculation without observation of the actual operation of a new system is an inadequate basis for immediate and fundamental changes of a national scope in an important area. Experience with diverse plans in the states is essential, and one state has already, this January, taken a step down the road. The states are the best arena in which to solve the problem.

At the present time, 24 states have enacted no-fault laws, and their plans possess the essential diversity called for by former Secretary Volpe.

No prophets have yet appeared who are willing to guarantee that their visions of the no-fault paradise will, with certainty, come true. Every prediction for the future success of a particular plan is coupled with the caveat that it might very well fail if the multiple actuarial guesses turn out in actual experience to be wrong. The fact that all the plans so far enacted are diverse is not a reason to enact uniform federal standards. On the contrary, diversity is essential if enough solid actuarial and public experience are to be gained to make an intelligent choice as to what benefits are needed, what exemptions are required, and what remnants of individual responsibility should be retained.

Insufficient Experience

As the situation stands today, a substantial number of states are operating under a variety of no-fault plans, no two exactly alike. The many combinations of benefit levels, thresholds, and other clauses ought to provide some enlightening comparisons, but two problems arise. First, few of the staistics required to make reasoned judgments about the no-fault experience are currently determinable. Second, the few available are compiled in a format less useful than it might be.

During the first year of operation of any new insurance plan, the losses incurred, the reserves, and many of the expenses anticipated are merely estimates. In the second year of operation, the estimates of the first year's results can be refined, or, in actuarial terminology, "developed." By the end of the second year, fairly reliable statements about first-year peformance can be made, but the difficulty then shifts to the reporting system. Most insurers report experience on a calendar-year basis. Thus, during the first few years of a state's No-Fault plan, a company will intermingle losses and expenses for injuries occuring before the inception of the plan with those pertaining to injuries after no-fault becomes effective. Comparisons between years, then, is not instructive.

Need For Better Reporting

What is needed is reporting on an accident-year basis. Useful insights would be gained from a segregation of old-law and new-law experience. Every major insurance company with a specified level of no-fault experience should be asked to appear before the Senate Commerce Committee and to report, on an accident-year basis, exactly what has happened

to premiums, claims frequency, losses, profits, and so on under the various no-fault plans. If accident-year development is impossible, then the Committee should make some general assumptions or findings from the calendar-year figures. In the absence of statistics reported in a system which addresses itself to the problem, this analysis will continue with only those figures available.

A Threshold State (1): Massachusetts

The only states with threshold-type no-fault laws, providing for partial abolition of the tort remedy, which have been in operation long enough to develop good analytical data are Massachusetts (effective January 1, 1971) and Florida (effective January 1, 1972). Thoughtful analysis of the results of "genuine" no-fault in Massahcusetts and Florida prove that actuaries can no more predict the results of a no-fault plan in a particular state than alchemists can really transmute lead into gold.

Massahcusetts put its no-fault law into effect on January 1, 1971, with a mandated rate reduction based on cost studies by insurers' associations and by actuarial consultants, using company data and Department of Transportation studies. Two key assumptions were made by the actuaries. First, it was assumed that the total number of injury claimants eligible for payment under the new law would be 30% greater than the number of claimants recovering under the former tort system. Second, it was assumed that the average cost of each claim under no-fault (with threshold-type residual tort remedy) would be 35% less than the average claim cost under the tort system. No-fault would have a cost-increasing tendency with 30% more claimants, but this would be offset by a cost-reducing 36% cut in average claim cost. The result of the interaction of the two factors would be a reduction in pure losses of 15%.

At the same time, property damage and collision premuims were increased 38%, so that total premiums paid were increased.

None of the actuarial assumptions came within shouting distance of the actual results. It had been assumed that eligible claimants would increase from 119,353, in 1970 under tort to 155,000 in 1971 under no-fault. In fact, the number of claimants in 1971 was drastically reduced to 69,000. Instead of paying 30% more victims, the "genuine" no-fault plan paid 42% fewer victims. There is good evidence that a substantial number of no-fault claimants would have been ineligible to receive benefits under tort, so that the predicted claimants who disappeared were for the most part innocent victims of negligent drivers.

The prediction of a 35% reduction in average claim cost also turned out to be false. The average claim cost, including an arbitrary allocated-adjustment expense, was $842.00 in 1970. The average claim cost, including the similar allocated-adjustment expense, reduced to $660.00 in 1971 under no-fault. The percentage of reduction was only 20% instead of the assumed 35%. The failure of the plan to achieve the predicted reduction in average claim cost would have wiped out the assumed savings and inflicted unbearable losses on insurers if total claimants had actually increased as much as expected.

A further significant failure of prophecy in Massachusetts concerns insurance-company expense ratios. The Automobile Rating and Accident Prevention Bureau has reported that losses incurred in 1971 were $48.8 million. Insurance-company total expense, including loss-adjustment expense, was reported as $46.3 million. An underwriting profit of 1% is allowed under the state's rating laws. Converting these figures to percentages, the Massachusetts loss and expense ratios under no-fault were:

MASSACHUSETTS 1971 EXPERIENCE

Total Earned Premium	100%
Losses Incurred	51%
Insurer's Expense	48%
Underwriting Profit	1%

These results should be compared with standard loss and expense ratios for the fault system, assuming a 1% profit, as proven over the last decade's experience:

STANDARD TORT SYSTEM PERFORMANCE IN AUTO LIABILITY

Total Earned Premium	100%
Losses Incurred	61%
Insurer's Expense	38%
Underwriting Profit	1%

The expense ratio, amounting to 48% of adjusted earned premiums (after statutory rebate), proves that in the Massachusetts laboratory "genuine no-fault" is more costly than the traditional tort system. It is easy to understand why no-fault systems should be more expensive to administer if they really paid twice as many claimants, as the proponents pretend they will. The cost of handling a doubled number of claims, and reviewing medical reports and wage-loss statements and paying them monthly, is bound to be costly. There is considerable hokum about how much it costs to investigate fault, but fault investigation will still be necessary under state no-fault plans. The prudent insurer will still investigate to see who was in the accident, how bad the injuries were, and who was to blame, in order to establish proper reserves for the potential residual tort claims. In addition, almost all insured drivers carry property damage liability, and fault must be determined with respect to car damage claims. Collision payment claims are traditionally subrogated, which requires fault-determination for inter-company arbitration. "Safe Driver" rating systems also demand an investigation of fault. For all these reasons, it could be expected that system expenses would increase in Masshachusetts if more victims were paid. It is surprising that they increased so much when 42% _fewer_ victims were paid.

A Threshold State (2): Florida

The second state laboratory to be considered is Florida. The annual reporting system in Florida is on a calendar-year rather than an accident-year basis, so that old fault claims and new no-fault claims are intermingled in the official reports. However, competent actuaries have analyzed insurance company files in Florida. They have been able to separate and evaluate the claim structure and the developed losses for the first 15 months of operation of the

Florida no-fault law. It should be noted that the two states are not alike in their plans or prior claim history. Florida enacted a plan with a limit of $5,000.00 in benefits and a tort exemption based on $1,000.00 as the medical-expense threshold. Massachusetts limited its benefits to $2,000.00, and its medical-expense threshold for the abolition of tort remedies is $500.00. Florida's claims frequency amounted to six claims per year per 100 insured units. The average claim cost in Florida before no-fault, per paid tort claim, was $1,848.00, compared to $842.00 in Massachusetts. Masschusetts had a long history of compulsory insurance, and insured vehicles increased only 3% under no-fault. Florida's compulsory law, plus population growth, produced a 15% increase in the number of insured vehicles in the first no-fault year. In order to make a good comparison in Florida, it is necessary to convert some of the gross numbers into averages per insured car or per insured claim.

Florida's first-year results were quite different from Massachusetts, and also very different from actuarial predictions. Florida did produce an increase in claimants paid, and did produce a reduction in average claim cost, but the decreased cost per claim failed to offset the increase in claimants paid. Instead of the loss costs (and premiums) reducing by a prophesied 15%, the loss costs of the insurers <u>increased</u>, on average by 10%. Instead of saving premium dollars by maintaining reduced rates, Florida insurers are now demanding bodily-injury premium increases up to 20%.

Where claim frequency in 1971 (tort) had been two per 100 earned exposures, in 1972 (no-fault), Personal Injury Protection claims were 1.84 per 100 insured units, and residual bodily-injury claims were an additional 0.58 per 100 exposures. The combined B.I. and P.I.P. claims totalled 2.42 per 100 earned

exposures, an increase of 21%. The gross number of claimants increased by 37%, but since the number of insureds had increased by 15%, the increase-per-insured exposure was only 21%. This fact should be compared to the promise of Florida's insurance that no-fault would pay, and has paid, "twice as many people," and should be compared also to the prediction of Milliman and Robertson that S. 354 would pay approximately 80% more claimants than would be paid under the tort system in Florida. The facts exploded assumptions.

As noted above, the average incurred-claim cost in 1971 had been $1,848.00, which included both economic loss and general damages in tort. In 1972, the average incurred-claim cost for the first party "P.I.P." benefits was $801.00. The average claim cost for the residual bodily-injury tort claims, for those victims exceeding the threshold limitation, was $4,499.00. The number of innocent victims able to exceed the threshold and make a tort claim was reduced by 71%. That is, claim frequency per insured vehicle for general damages was only 29% of the 1971 figure. The P.I.P. claims averaging $801.00 and the residual "B.I." claims averaging $4,499.00 produced a combined, total, average claim cost of $1,680.00.

In summary, the number-of-claimants-per-insured exposure increased by 21%--substantially less than assumed. The average incurred-claim cost decreased by 9%--a decrease substantially less than assumed. The decrease in average claim cost did not offset the increase in number of claims, and "pure premium," or average loss costs per insured vehicle, increased by 10%. The increase is a fair average based on a 15-month "development" of first-year losses.

Inasmuch as the actuaries had predicted a 15% decrease in "pure-premium," the 10% increase demonstrates a total error of 25% in the actuarial predictions.

Legislators who promise rate reductions to their constituents based on untested actuarial assumptions should realize that the crystal ball of cost prediction is always cracked.

No-Fault Without Threshold: Ky., Md., Ore.

No-threshold no-fault is under daily test in state laboratories. Delaware passed a no-fault law effective January 1, 1972 which pays all losses for medical expense, wages, and loss of services up to a single combined limit. The benefits paid are not recoverable in a tort suit, but there is no threshold and no other tort exemption or impairment. It is an add-on, take-off bill. At the end of its first year of operation, the Delaware Insurance Commissioner reported that residual tort claims by Delaware residents had been reduced from former levels by 70%; that no resident had been asked to pay a higher premium for his insurance (unless he added benefits or higher limits); and that overall premiums were down by a statewide average of 8.5% for bodily-injury coverage for all carriers writing in Delaware.

Oregon passed a no-threshold, no-exemption no-fault law effective January 1, 1972. It provides separate limits for medical and wage losses, with a deductible (14 days) on wage loss. The Insurance Commissioner of Oregon has testified before the Senate Judiciary Committee that the plan works. Public reaction is good. Court cases are reduced. The "bodily injury claim count has been reduced drastically." Premiums have gone down on liability policies, on which first-party benefits are mandatory, with rate reductions ranging from 8% to 15%. Oregon's plan is add-on, take off. The tort remedy is preserved, but the successful claimant must pay back his first-party benefits.

Maryland's Reform Plan, effective January 1, 1973, has an unusual feature. The state took over the assigned-risk pool and underwrites the high-risk claims in a government-owned insurance company. Coverage is available only when the buyer

is refused standard coverage in the voluntary market. Maryland's plan mandates a single-limit first-party package for medical expense, wage loss, and loss of services, with no waiting period or artificial ceilings. The total benefit package is a mandatory $2,500, with unlimited voluntary additions available. This amount was chosen because it pays <u>in full</u> the economic loss of 24 out of 25 accident victims. There has been no increase in cost, despite actuarial warnings that it might be more expensive to add benefits. The Maryland delegate who sponsored the reform has testified that the plan works well. The Maryland Insurance Commissioner has reported that bodily-injury rates have been reduced and the downward trend is continuing.

It is not contended that the no-threshold approach, by itself, reduces rates. Rates under the tort system are bound to decrease, simply because safer automobiles and safer highways are having a substantial effect in reducing deaths and injuries, and a decided effect in reducing the severity of injuries. The experience of the no-threshold states does prove that their add-on plans do not increase rates, and do not "stabilize" rates, but on the contrary allow rates to decrease naturally at about the same rate they are decreasing in states which have retained the traditional system.

"<u>Mere speculation</u> without observation of the actual operation of a new system is an inadequate basis for immediate and fundamental changes of a national scope in an important area," says the D.O.T. final report. Experience in the testing ground of real life is proving that when actuaries predict add-on rates will go up, the rates in fact go down. When actuaries predict that a Florida threshold plan will cut costs, in real experience it increases. Massachusetts proves that no actuarial prophecy of claims frequency, average claim cost, or operating expense should be taken seriously. "The states are the best arena in which to solve the problem," says the Department of Transportation. One reason the state laboratory

is the best testing ground is that fewer people will be hurt by the errors inevitable in an untried, untested, speculative plan -- and it may be easier for a single state to undo its mistake (as in Illinois) than it would be for Congress to confess national error. Time will tell which plan is best. At the moment, Congress cannot claim superior wisdom or inspired revelation. Congress may have the power to make a blind guess, but should it leap so far with so little real knowledge?

The best state laboratory is Kentucky, where legislation was enacted in April 1974 granting the citizens of that state freedom of choice between compulsory tort liability coverage and a no-fault insurance plan containing a $1,000 medical threshold for tort action. This unique plan was devised specifically to meet the constitutional proscription of that state against abolition or infringement on an individual's right to recover for death or injury suffered in an automobile accident within the state. The law is not yet in operation, but after awhile it should provide us with very vital information, such as difference in cost between the two parallel systems, consumer demand for one or the other, difference in premium, and the like. Indeed, this rare opportunity to gather information from the two competing systems running on closely parallel tracks will provide us with the kind of information we should have before we take the drastic step required by S.354.

XII. COST ANALYSIS OF S.354 (94th CONGRESS)

A Senator who votes yea or nay on S.354, as passed by the Senate during the 93rd Congress and as re-introduced in the 94th, should know the bill's effect on premium costs in his state. The public has been told for years that no-fault will pay all losses to all accident victims at lower cost than the tort system. We have learned that the early promise was false. At best, no-fault plans propose to pay some losses, with limits and deductions, and will take away many rights in order to keep the cost down. If we take away rights, limit the benefits, compel the purchase of new insurance, and then increase the cost, the public should bitterly resent the deception.

Cost is important. A small percentage of drivers are injured. A very large percentage buy insurance. The fortunate drivers who are never injured may not be too concerned over the loss of their potential rights, but they will be deeply concerned over the premium.

Insurance Company Expenses

Every insurance system costs money to operate. The insurance company pays out expenses for sales commissions, advertising, issuance and delivery of policies, general administration, and taxes, and retains a portion of the premium for profit. It costs money to report, investigate, evaluate, and adjust losses. This is called, in insurance accounting, "loss adjustment expense," It costs money to pay claimants the agreed settlements or verdicts. While claims are pending, the money required to pay them is segregated and placed in a loss reserve.

We can find out what proportion of the premium dollar is used to pay different categories of loss and expense by reviewing the official reports of the insurance companies themselves, as gathered, collated, and published in summary form every year in Best's "Aggregates and Averages."

In the latest year reported, automobile liability insurers paid out 63.5% of the premium dollar in "losses incurred." We have seen that automobile liability insurance pays out a higher percentage of the premium dollar than any other insurance the average individual buys. (See Chapter IV.) It pays out substantially more than automobile collision insurance, fire insurance, individual health and accident insurance, or homeowner's insurance. The annual compilations in Best's and the testimony given to the Senate Commerce and Judiciary Committees on actual insurance company performance confirm this.

The traditional way for establishing a premium rate is to calculate the amount required to pay claimants or establish proper reserves. This amount is the predicted "loss incurred." Loss-adjustment expenses are calculated as a percentage of losses incurred. Next, sales and acquisition expenses are predicted as a percentage of loss incurred, and so is general administration expense. Taxes and profits are also estimated as a percentage of losses incurred.

As rates go up or down, the percentages of most expenses remain the same. If losses paid are increased by 10%, it can be expected that expense and premium will increase 10%.

No-fault May Increase Expenses

No-fault insurance may well turn out to have higher expense ratios than liability insurance. It obviously costs more money to evaluate and re-evaluate an injury claim every month, and pay a portion of it every month, than it costs to evaluate and settle it once. During the 93rd Congress, the Judiciary Committee heard testimony based on official figures of the Massachusetts Rating Bureau which showed that under no-fault in Massachusetts, losses incurred were only 52% of the premium dollar, with a profit of 1% and an expense ratio of 47%. Compare this with auto-

mobile liability insurance, where the national-average retained-expense ratio is only 37.6%, with a loss of 0.1% and a loss-incurred or payout ratio of 63.5%.

The results of a study of the Florida plan published in the Journal of Risk and Assurance show that despite predictions of 15% cost reductions, losses have in fact increased by 10% on average. The insurance industry has sustained heavy losses as a result of the failed predictions of lower costs. Allstate announced that it lost $14.6 million on auto insurance in 1973, and demanded a rate increase in 1974.

It has been reported that Massachusetts has reduced bodily-injury rates by 40% with the adoption of no-fault. What is not generally known is that the number of victims paid under Massachusetts no-fault has been reduced by over 40%, compared to the number of persons paid under tort. Instead of paying twice as many victims, Massachusetts pays three-fifths as many. Meanwhile, collision rates have been increased so greatly in Massachusetts that the total premium paid by the average motorist has increased, while rates have been decreasing in states enjoying the traditional tort system.

Effect of Losses on Premiums

With that background, we should take a hard look at the effect of the changes the amendments to S.354 on final passage have made in the cost structure. If loss costs go up, then premiums have to go up. Expense and sales ratios will remain just about the same as they have been in all lines of insurance. For example, the expense-retained ratio in fire insurance is 38.5%. The expense-retained ratio in individual health and accident insurance is 43.7%. In auto collision insurance, where no question of fault is involved and the fender damage is easily evaluated, the total expense ratio is 35%.

It is a delusion to believe that the present, efficient expense ratio of 37.6% in auto liability insurance can be significantly changed under no-fault. No state experience has given any proof that the expense ratio can be improved. Under no-fault, if we can assume that the insurers will be restricting underwriting profits to present levels, then an increase in losses paid must result in an increase in premiums charged.

The firm of Milliman & Robertson has filed with the Department of Transportation appendices for every state predicting total, pure loss costs (payments to claimants) under the existing tort system and under different thresholds or deductions. The figures show that a moderate threshold will reduce general-damage claims substantially. Severe thresholds do not produce significantly greater reductions in general damages than modest thresholds.

One state can be analyzed as a sample. All numbers used are taken directly from Appendix II-20 of the M&R report. A copy is attached. Cost figures are based on the existing "low benefit" level of S.354, requiring unlimited medical-expense payment, wage-loss limits of $15,000 maximum, and an assumed maximum of $5,000 in death benefits.

A base figure consists of assumed "tort system" recoveries. In 100,000 injuries, recoveries will be made as follows:

	Claimants	Average Payment	Total Payment
Death Costs	1,415	$13,606	$19,253,000
General Damages	39,832	1,162	46,274,000

Thresholds: Tight, Loose, or None

The efect of a threshold is investigated under three assumptions: no threshold, loose threshold, or tight threshold. The definition of "loose" is that claims will exceed the threshold if the injured person suffers death, serious and permanent injury, serious and permanent disfigurement, or total disability for more than two continuous months. Since no data exists to predict how many victims have two months of total temporary disability, M&R guesses that the number of injury victims with total medical expense of $600 is equivalent to the number with two months of disability.

It is estimated that this threshold will permit the same number of residual death cases as recover under the tort system, and that these claimants will recover just as much in addition to no-fault death benefits as they did under tort. These assumptions produce the following table:

LOOSE THRESHOLD

	Claimants	Average Payment	Total Payment
Residual Death Cases	1,415	$13,606	$19,253,000
Residual General-Damage Cases	10,667	2,761	29,449,000

It will be observed that a loose threshold ($600 medical expense) reduces eligible claimants from 39,832 to 10,667. This is a reduction to only 27% of the number of innocent victims who now recover general damages under tort. The amount of the average general-damage claim increases from $1,162 to $2,761, an increase of 137.6%. When a threshold knocks out small claims, it leaves the larger claims of much higher average value. When 27% as many claimants are paid

claims which average 137% more than average tort claims, the total general-damage recovery becomes $29,449,000. This is 63.6% as much as the total recovery of general damages under tort. In other words, reducing the number of claimants by 73% reduces total general-damage recovery by only 36.4%.

Would it make a significant difference in cost if the six-month disability threshold of S.354 had been retained? M&R assumes that six months of total disability is equivalent to a medical-expense threshold of $2,000. It might be supposed that increasing the threshold from $600 to $2,000 would make a big difference. Surprisingly, it does not. The following table is taken from the M&R Tight Threshold Table. It ignores the arbitary deduction of $2,500 per claim which was in the draft of S.354 used by M&R for its study. M&R assumes that the public would rebel against the artificial reduction of verdicts by $2,500 each, and would try to avoid the apparent injustice by increasing the value of each claim by $1,250. As M&R puts it, the "net effective deduction" will be 50% of the mandated reduction of $2,500. For the state of Maine, for example, the average claim cost of residual general-damage claims under a tight threshold, with the former deduction of $2,500 under S.354, is said to be $2,502. This means that actual true value should be $1,250 more, or $3,752 for each claim. The adjusted table follows:

TIGHT THRESHOLD WITHOUT DEDUCTION

	Claimants	Average Claim	Total Payment
Residual General Damages		$2,502 + 1,250 $3,752	$27,795,000

It will be observed that eligible claimants are reduced from $39,832 to $7,408, a reduction of 81%. Total recovery is reduced from $46,274,000 to $27,795,000, a reduction of 40%. In other words, 19% as many claimants recover 60% as much total money.

A comparison of the effect of the threshold is given in the following table:

EFFECT OF THRESHOLD

	Claimants	General Damage
Tort	100%	100.0%
$600 Threshold	27%	63.6%
$2,000 Threshold	19%	60.0%

Once a threshold as high as $600 in medical expense has been reached, it does not make a difference in total cost if the threshold is increased to $1,000, or $1,500, or $2,000. There will be a decided effect on the number who have their rights sheared away, but the major remaining claims will still account for nearly as much total cost.

The arbitary reduction of $2,500 per claim in the former draft of S.354 did have a significant cost impact, even if it is assumed to be only 50% effective. General-damage claims for Maine are compared in the following table under tight threshold ($2,000 medical expense), both with and without the "effective" $1,250 deduction.

TIGHT-THRESHOLD, GENERAL DAMAGES

	Claimants	Average Claim	Total Payment
With No Deduction	7,408	$3,752	$27,795,000
With $1,250 Deduction	7,408	2,502	18,535,000
Total Reduction			9,260,000
Percentage Reduction due to Deductible			33 1/3%

S.354 as amended and passed by the Senate eliminates and reduces the disability threshold to three months instead of six. It is obvious that if the M&R prediction is reliable, there will be very little cost change between a three-

month and two-month disability "loose" threshold. What effect will the change have on average premiums in the state of Maine? Total cost of the tort system payments for both economic-loss recovery and death-case recovery (per 100,000 injuries) is said to be $93,806,000.

Under S.354, economic-loss payments and death benefits plus residual death recovery will amount to $92,601,000 with "low benefit" and "loose threshold." That is, economic-loss benefits alone will cost nearly as much as total tort-system losses. In addition, $29,449,000 will be paid in residual general-damage claims under "loose threshold" with no deduction. Total payments will be $122,050,000.

In short, loss costs in Maine will increase from $93.8 million to $122 million, an increase of 30%. M&R predicts loss-adjustment expenses will be 19% of tort recovery, or $17,823,000 (excluding medical-payment loss adjustment). Loss-adjustment expense will increase under S.354 (with loose threshold) by about 3% to $18,372,000 when payout is increased.

If average costs increase 30%, then the cost to the drivers of private passenger cars with good driving records will increase much more. Passenger-car drivers are compelled to subsidize commercial operators, rental-car agencies, bad drivers, uninsured drivers, and economically disadvantaged drivers under S.354.

M&R Conceals Increases

The M&R tables conceal the true cost increase by pretending that the present cost of medical payments is a part of the cost of the "tort system." Of course, it is not tort insurance at all. It is typical first-party insurance, payable regardless of fault, purchased on a voluntary basis like Blue Cross or Blue Shield medical insurance. M&R adds $9,557,000 to tort costs, which is 10.2% of the true,

total tort-system cost, by the artificial assumption that medical-payment is a type of tort-system insurance.

The second mathematical gimmick used by M&R is to divide tort costs by an assumed percentage of insured drivers and to divide S.354 costs by an assumed, much larger percentage of assumed drivers. "Unit costs" are then compared. All this does is to assume that compulsory insurance spread over more drivers is cheaper in premium cost than voluntary insurance. New York and Massachusetts have proved that this is not necessarily so in real life. According to the M&R formula, compulsory tort insurance would still be far cheaper than compulsory no-fault insurance. Indeed, M&R came to exactly this conclusion when they did a cost study for the new Kentucky law, which makes the buyer elect whether he wants to accept the Kentucky no-fault system with a high medical-expense threshold or retain his traditional tort rights and tort remedies. Even adding medical-payment to tort costs, the Kentucky study showed that tort costs less than no-fault when a driver must buy one or the other.

The following table shows the difference in cost increase on a state-by-state basis for the states classified by M&R as "stndard," comparing the effect of a $600 threshold to the effect of a $2,000 threshold with no deduction. "Total tort cost" is the cost of economic-loss recovery, death cases, and general-damages recovery under the true tort system based on M&R data. It does not include medical-payments coverage or loss-adjustment expense. Loss-adjustment expense remains a percentage of losses paid. The ratio of no-fault general damages with $2,000 threshold is the percentage derived by dividing total tort cost by the cost of the

residual general-damage claims remaining after a $2,000 threshold is used, with no deduction. The ratio of general damages with a $600 threshold is derived in the same way. The difference between the two figures shows the cost of reducing the threshold, expressed as a percentage of total tort system costs for liability payments (again excluding medical-pay and loss-adjustment expense).

In the first state alphabetically, Alabama, total general-damage claims with a $2,000 threshold will cost 30.9% of the total cost of all tort-liability payments. This cost will rise to 33.6% of total tort-liability payments if the threshold is dropped to $600. The difference in cost is 2.5%. By reference to the Alabama appendix II-1, total liability payments (per 100,000 injuries) are said to be $69.6 million. It would, therefore, cost $1.74 million to change the threshold, per 100,000 injuries. The table follows:

	Total Tort, Economic Loss Plus General Damages	Ratio of No-Fault General Damages, $2,000 Threshold	Ratio of No-Fault General Damages, $600 Threshold	Change
Alabama	100%	30.9%	33.6%	2.5%
Alaska	"	22.2	27.2	5.0
Arizona	"	29.4	31.9	2.5
Arkansas	"	27.4	31.2	3.3
Colorado	"	28.5	30.6	2.1
Delaware	"	25.4	28.6	3.2
Florida	"	25.4	29.2	3.8
Georgia	"	30.9	32.9	2.0
Idaho	"	27.5	29.5	2.0
Indiana	"	28.7	30.7	2.0
Iowa	"	28.4	30.1	1.7
Kansas	"	29.1	31.7	2.6
Kentucky	"	28.1	30.7	2.6
Louisiana	"	22.3	25.6	3.3
Maine	"	29.6	31.4	1.8
Maryland	"	29.3	31.3	2.0
Michigan	"	27.4	30.1	2.7
Minnesota	"	26.8	29.6	1.8
Mississippi	"	30.1	32.1	2.0
Missouri	"	28.9	31.4	2.5
Montana	"	25.5	28.1	2.6
Nebraska	"	27.7	29.3	1.6

"STANDARD" STATES

State	Total Tort, Economic Loss Plus General Damages	Ratio of No-Fault General Damages, $2,000 Threshold	Ratio of No-Fault General Damages, $600 Threshold	Change
Nevada	100%	27.6%	31.3%	3.7%
New Hampshire	100	25.4	27.1	1.7
New Mexico	"	28.2	30.5	2.3
North Carolina	"	29.3	30.8	1.5
Ohio	"	27.3	29.9	2.6
Oklahoma	"	24.7	27.2	2.5
Oregon	"	27.7	29.6	1.9
Pennsylvania	"	26	29.1	3.1
South Carolina	"	27	28.9	1.9
South Dakota	"	28.2	30.1	1.9
Tennessee	"	25.6	29.3	3.7
Texas	"	29.8	32	2.2
Utah	"	30.4	32.5	2.1
Vermont	"	26.5	28.4	1.9
Virginia	"	28.7	30.6	1.9
Washington	"	27.9	30.7	2.8
West Virginia	"	27.4	30.4	3.0
Wisconsin	"	27.7	30.2	2.5
Wyoming	"	24.7	27.4	2.7

****

The preceding table dealt only with the cost of Residual Damage recoveries under amended S. 354, stated as a percentage of total tort system payment. They are costly because of the elimination of the $2,500 deduction. What will this marked increase in residual general damages, caused by amending S.354, do to overall costs and premiums?

The cost of liability coverage for bodily injury losses can be compared to the cost of no-fault coverage for both economic loss and for the residual general damage claims and the additional death case liability claims in those cases which exceed the threshold. In the following table "Tort Liability" is the total payment cost, per 100,000 injuries, to all tort claimants. "No Fault Economic Loss" is expressed as a percentage of tort liability cost. It includes medical, wage, and service benefits under no-fault at the present lower benefit level of S. 354 ($15,000 wage loss maximum). It also includes both no-fault death benefits and residual liability death case payments. M&R assumes that the same amount of death loss as is presently paid in tort will continue to be paid under no-fault, in addition to the direct no-fault benefits to all claimants regardless whether they are tort eligible or not. In general, it will cost <u>more</u> to pay economic losses as defined under no-fault than it now costs to pay all tort liability claims.

In the next column in the table is the cost of residual general damage claims which will be payable under S. 354 terms with the $2,500 deductible eliminated and the threshold reduced to $600. The cost is expressed as a percentage of tort liability cost.

The final column combines the cost of no-fault economic loss with the added cost of no-fault general damage claims after threshold to show the net cost increase of no-fault payments over tort liability payment. The table follows:

State	Tort Liability Cost	No-Fault Economic Loss and Death Cost, Percent of Tort Cost	Cost of No-Fault General Damages, $600 Threshold, Percent of Total Tort	Net Cost Increase of No-Fault Over Tort
Alabama	100%	111.6%	33.6%	+45.2%
Alaska	"	93.	27.2	20.2
Arizona	"	97.1	31.9	29.
Arkansas	"	111.4	31.2	42.6
Colorado	"	101.6	30.6	42.6
Delaware	"	102.8	28.6	31.4
Florida	"	93.3	29.2	22.5
Georgia	"	110.7	32.9	43.6
Idaho	"	111.6	29.5	41.1
Indiana	"	102.6	30.7	33.3
Iowa	"	103.7	30.1	33.8
Kansas	"	109.4	31.7	41.1
Kentucky	"	106.2	30.7	36.9
Louisiana	"	113.2	25.6	38.8
Maine	"	98.9	31.4	30.3
Maryland	"	87.6	31.3	18.9
Michigan	"	99.2	30.1	29.3
Minnesota	"	95.2	29.6	24.8
Mississippi	"	109.4	32.1	41.5
Missouri	"	93.	31.4	24.4
Montana	"	111.2	28.1	39.3
Nebraska	"	106.8	29.3	36.1
Nevada	"	103.2	31.3	34.5
New Hampshire	"	91.8	27.1	18.9

State	Tort Liability Cost	No-Fault Economic Loss and Death Cost, Percent of Tort Cost	Cost of No-Fault General Damages, $600 Threshold, Percent of Total Tort	Net Cost Increase of No-Fault Over Tort
New Mexico	"	106.7%	30.5%	+37.2%
North Carolina	"	95.	30.8	25.8
North Dakota	"	117.6	28.4	46.
Ohio	"	98.3	29.9	28.2
Oklahoma	"	107.5	27.2	34.7
Oregon	"	104.5	29.6	35.1
Pennsylvania	"	91.3	29.1	20.4
South Carolina	"	107.2	28.9	36.1
South Dakota	"	112.6	30.1	42.7
Tennessee	"	95.9	29.3	25.2
Texas	"	101.6	32.	33.6
Utah	"	95.8	32.5	28.3
Vermont	"	96.	28.4	32.4
Virginia	"	102.6	30.6	33.2
Washington	"	96.7	30.7	27.4
West Virginia	"	102.	30.4	32.4
Wisconsin	"	94.6	30.2	24.8
Wyoming	"	113.	27.4	40.4

NON-STANDARD STATES

State	Tort Liability Cost	No-Fault Economic Loss and Death Cost, Percent of Tort Cost	Cost of No-Fault General Damages, $600 Threshold, Percent of Total Tort	Net Cost Increase of No-Fault Over Tort
California	100%	78%	30.3%	8.3%
Connecticut	"	79.2	29.1	8.3
Hawaii	"	80.	27.2	7.2
Massachusetts	"	83.4	19.3	1.7
Illinois	"	94.9	28.8	23.7
New Jersey	"	71.2	29.4	0.6
New York	"	73.9	26.1	0.0
Rhode Island	"	86.8	30.5	17.3

* * * * * * * *

Great emphasis has been placed on Milliman and Robertson tables showing predicted premium reductions. None of those reductions can be guaranteed in any event, and none of them remain valid after the cost factors in the bill have been amended.

Most No-Fault Data Unavailable

The proof of no-fault will be in real-life performance. It takes a year of performance to generate cost figures and another year to collect and analyze the data. Few states have had a plan long enough to develop valid data. Certainly New Jersey and Michigan rates as published by Aetna Casualty under the new no-fault laws in those states are based entirely on estimates. Neither state has actual experience to validate the estimated cost and rates. Neither state has a plan with the same cost factors as S.354. Both plans will be struck down by S.354 if enacted after the time period allowed for change.

The cost-estimate sheets of Milliman and Robertson, relied on by the proponents, clearly predict an increase in loss costs at a national average rate of 32.7% under the present version of S.354. This must result in a corresponding premium increase. In addition, there is great danger that the actuaries have underestimated the extent of increased cost under the national bill, as they did under the Florida bill when it was proposed. The benefits of S.354 will not and cannot be delivered to the consumer as cheaply as the proponents have promised.

The man who always bought insurance will pay more. The man who used to buy minimum limits, or none at all, will pay a lot more under S.354. That will make many big insurance companies happy, but will make the paying customer miserable.

ATTACHMENT (See page 103)

APPENDIX II-20

MAINE - LOW BENEFIT LEVEL

COMPARISON OF TORT AND NO-FAULT SYSTEMS

	TORT SYSTEM			TIGHT THRESHOLD		
Benefit	Injuries	Average	Amount	Injuries	Average	Amount
Medical Expenses	41,924	380	15,914	76,401	441	33,710
Wage Loss	16,295	650	10,593	34,164	552	18,844
Services Loss	4,541	390	1,772	19,012	310	5,899
Death Costs	1,415	13,606	19,253	3,091	11,102	34,316
General Damages	39,832	1,162	46,274	7,408	2,502	18,537
Total Costs of Above			93,806			111,306
Medical Payments by Option			9,557			0
Loss Adjustment Expenses			19,639			14,496
Total System Costs			123,002			125,802

	LOOSE THRESHOLD			NO THRESHOLD		
Benefit	Injuries	Average	Amount	Injuries	Average	Amount
Medical Expenses	76,292	441	33,658	76,608	441	33,325
Wage Loss	34,118	551	18,804	33,833	550	18,617
Services Loss	18,985	308	5,846	18,814	304	5,715
Death Costs	3,086	11,112	34,293	3,055	11,180	34,154
General Damages	10,667	2,761	29,449	34,282	1,237	42,397
Total Costs of Above			122,050			134,208
Medical Payments by Option			0			0
Less Adjustment Expenses			18,372			22,663
Total System Costs			140,422			156,871

Notes: 1) Injuries shown are numbers based on a radix of 100,000 injuries.
2) Averages are in dollars per injury, amounts are in thousands of dollars.

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Insurance cancellations soar

By GLENN BUNTING

Auto insurance companies are swinging the axe more swiftly and frequently this year, resulting in an increasing number of cancellations and non-renewable policies, according to a consensus of local agents.

For a number of reasons, writing car insurance policies today is becoming a hazardous business and customers are feeling the crunch.

No-fault insurance, a three-year moratorium on rate increases and skyrocketing auto repair costs have all led to the policy non-renewable game, according to Canton agent Frank McMurray.

"Our philosophy is that we don't like to cancel policies," McMurray said. "But if the company detects a trend revealing that a client's policy is not yielding a profit, then it will be reviewed.'

"I FEEL SORRY for the customer who gets indiscriminantly canned," said one local agent who wished to remain unidentified. "I know of one case where a policy was cancelled because of one no-fault accident and a stolen CB radio.

"Now the guy can't get insurance because he's carrying the stigma of being cancelled."

All of the agents interviewed agreed that cancellations will continue as a wave of the future until the insurance companies start showing profits. The result will be more and more drivers searching for new insurance policies.

> 'Two forces (policy cancellations and entry restrictions) are pulling against one another. Sooner or later something's going to give, and either we're going to have people who can't get insurance or no insurance companies.'

"I get 5-10 calls a day from persons requesting estimates," McMurray said. "People are shopping for policies today more than I've ever seen."

New business activity has been hardest hit with restrictions being placed on the number of new policies agents can write. The reason given is money—85 per cent of new business generates financial losses in the first year, McMurray said.

"THE ELGIBILITY requirements are more stringent this year," McMurray added. "Because agents can only accept so much new business, fewer people are elgible for new policies."

The consensus of agents is for a driver seeking a new policy with one accident or ticket in the past three years to forget it. Worse yet, some companies aren't issuing policies to persons under 23 years of age unless insured with their parents.

According to Plymouth agent Matthew Fortney, insurance companies are in a strange position of having to turn down business because each new customer represents an additional measure of risk.

"A lot of companies are out of balance in their premium-to-surplus ratio," Fortney explained. The premium-to-surplus ratio is basically an indication of a company's ability to cover all its potential claims.

It is the ratio of annual business (income or premiums from policy holders) to the net worth (surplus) of the company. The lower the ratio, the stronger the position the company is in.

"The suggested ratio is 3-1, but some companies are approaching 7-1 and are consequently forced to put a lid on new business," Fortney said.

The more business a company does, the higher the ratio becomes. While more business represents more income to an insurance company, it also represents more risk and potential claims.

The classic reason cited by Fortney for a low ratio is the case of a disaster. The company with $1 behind every $3 of liability is in a better position that the company with $1 behind every $7 of potential claims. Insurance companies don't maintain a 1-1 ratio simply because the odds are strongly against every item the company insures being destroyed or damaged simultaneously.

THE CULPRIT behind the entire situation is inflation, according to Fortney. The cost of claims for almost all insurable items, such as houses, cars, and people's health continues to increase faster than premiums.

A[illegible]dditional problem faced by ma[illegible]panies began in 1973 and 197[illegible]ney said many insurance firms took a bath in the stock market

(over)

and the result was a reduced surplus (net worth) of the companies.

Traditionally, insurance companies had relied on their investments to keep them solvent, but many are still feeling the sting of 1973 and '74 when the bottom fell out of the market.

"They were losing it on both ends," Fortney said. "A lot of companies lose money on underwriting but make it up on investments. It wasn't intended to be that way, but that's how it worked. Only a few companies made money on underwriting."

A final burden shouldered by the companies that remain solvent—more than a few have gone under in the last year—is that they are required by law to help bankrupt insurance companies cover their outstanding claims.

It all adds up to insurance companies shying away from new business—especially if any extra measure of risk is involved, Fortney explained.

Some companies have ordered moratoriums on new business and others are keeping a tight lid on business increases.

"One company representative said 15 per cent will be the maximum increase allowed for new business this year, 10 per cent of which will be absorbed by current policy-holders," Fortney said. "This capacity crunch will obviously take its toll on new car drivers."

Fortney's advice is to stick with your present insurance company. The emphasis isn't so much getting good rates anymore as it is just remaining insured.

THERE ARE alternatives, however, like being placed in a company's secondary insurance group which specializes in bad-risk drivers, or assigned to a risk pool which charges a base premium and a surcharge for all previous tickets and accidents.

Drivers who feel they've been indiscriminantly cancelled may file a complaint with the Michigan Insurance Bureau on its toll-free number (1-800-292-5943). Consumers can also check a company's ratings in Best's Key Rating Guide, which can be obtained from the Dunning Hough Library, 223 S. Main, Plymouth.

The Michigan Insurance Bureau is also readying a 1977 legislative proposal to help guarantee ways for consumers to obtain insurance and keep it, according to Thomas C. Jones, Michigan Commissioner of Insurance.

"Two forces (policy cancellations and entry restrictions) are pulling against one another," one agent said. "Sooner or later, something's going to give, and either we're going to have people who can't get insurance or no insurance companies."

No. 999. Recreational Vehicles—Shipments, by Type: 1961 to 1975

[In thousands]

TYPE	1961	1965	1970	1971	1972	1973	1974	1975
Total	**62.6**	**192.8**	**472.0**	**549.4**	**747.5**	**752.5**	**529.2**	**552.0**
Pickup covers	(NA)	(NA)	91.7	98.4	164.6	223.7	233.4	212.5
Travel trailers	28.8	76.6	138.0	190.8	250.8	212.3	126.3	150.6
Motor homes	(NA)	4.7	30.3	57.2	116.8	129.0	68.9	96.6
Camping trailers	18.0	67.2	116.1	95.8	110.2	97.7	55.2	48.1
Truck campers	15.8	44.3	95.9	107.2	105.1	89.8	45.4	44.3

NA Not available.

Source: Motor Vehicle Manufacturers Association of the United States, Inc., Detroit, Mich. Data from Recreation Vehicle Industry Association.

No. 1000. Speed of Motor Vehicles: 1950 to 1974

[Excludes Alaska and Hawaii. Based on actual speed of each vehicle recorded on tangent sections of main rural highways during off-peak hours. See also *Historical Statistics, Colonial Times to 1970*, series Q 187-198]

ITEM	1950	1955	1960	1965	1969	1970	1971	1972	1973	1974
Number of vehicles recorded 1,000	280	395	459	552	388	488	430	414	632	622
Average speed, all vehicles ..... m.p.h.	47.6	50.5	52.6	56.4	60.0	59.2	60.6	60.3	60.3	55.3
Passenger cars ..... m.p.h.	48.7	52.0	53.8	57.8	61.3	60.6	62.0	61.6	61.6	55.8
Trucks ..... m.p.h.	43.0	45.6	48.2	51.8	54.9	54.7	56.1	56.2	56.6	54.0
Buses ..... m.p.h.	49.8	52.3	55.5	57.4	59.4	58.8	60.2	60.3	60.4	56.0
Vehicles exceeding—										
40 m.p.h. ..... percent	77	87	92	95	98	97	98	98	98	98
45 m.p.h. ..... percent	58	72	80	88	93	93	95	94	94	93
50 m.p.h. ..... percent	37	50	58	73	82	83	86	85	84	79
55 m.p.h. ..... percent	20	29	37	56	67	68	71	70	70	51
60 m.p.h. ..... percent	8	14	16	34	46	47	50	50	50	21
65 m.p.h. ..... percent	(NA)	(NA)	(NA)	(NA)	27	27	30	30	31	6
70 m.p.h. ..... percent	(NA)	(NA)	(NA)	(NA)	13	12	14	14	14	2

NA Not available.

Source: U.S. Federal Highway Administration, *Traffic Speed Trends*, and unpublished data.

No. 1001. Automobile Insurance: 1960 to 1975

[Money figures in millions of dollars. 1960 and 1965, direct premiums earned and direct losses incurred; 1970-1975, premiums earned basis. See also *Historical Statistics, Colonial Times to 1970*, series Q 163-174]

ITEM	1960	1965	1970	1972	1973	1974		1975	
						Private passenger	Commercial	Private passenger	Commercial
Number of companies reporting	(NA)	(NA)	925	1,035	1,048	1,094		1,275	
Total insurance:									
Premiums earned	6,448	8,358	14,612	17,739	18,570	15,630	3,306	20,267	3,593
Losses paid [1]	3,645	5,221	11,198	12,237	13,428	11,682	2,524	16,814	2,843
Percent of premiums	56.5	62.5	76.6	69.0	72.3	74.7	76.3	83.0	79.2
Bodily injury liability:									
Premiums earned	2,841	3,948	6,723	[2] 11,394	[2] 11,775	[2] 9,696	[2] 2,227	[2] 12,739	[2] 2,411
Losses paid [1]	1,697	2,459	5,256	[2] 8,255	[2] 8,814	[2] 7,312	[2] 1,777	[2] 10,348	[2] 1,929
Percent of premiums	59.7	62.3	78.2	[2] 72.5	[2] 74.9	[2] 75.4	[2] 79.8	[2] 81.2	[2] 80.0
Property damage liability:									
Premiums earned	1,219	1,567	2,836	(2)	(2)	(2)	(2)	(2)	(2)
Losses paid [1]	675	1,025	2,291	(2)	(2)	(2)	(2)	(2)	(2)
Percent of premiums	55.4	65.4	80.8	(2)	(2)	(2)	(2)	(2)	(2)
Physical damage: [3]									
Premiums earned	2,388	2,843	5,053	6,345	6,795	5,943	1,079	7,528	1,182
Losses paid [1]	1,273	1,737	3,651	3,982	4,614	4,370	747	6,466	914
Percent of premiums	53.3	61.1	72.3	62.8	67.9	73.5	69.2	85.9	77.3

NA Not available.
[1] Beginning 1970, includes adjusting expenses. [2] Property damage included with bodily injury.
[3] Covers auto fire, theft, collision, and comprehensive.

Source: 1960 and 1965, The Spectator, Philadelphia, Pa., *Insurance by States;* thereafter, The National Underwriter Co., Cincinnati, Ohio, *Argus F. C. & S. Chart*, annual (copyright).

No. 1002. Traffic Accidents, Injuries, Deaths, and Economic Loss: 1940 to 1975

[Estimates based on official reports from a representative cross-section of States. Includes all motor vehicle accidents, regardless of place of occurrence and all injuries regardless of length of disability. See *Historical Statistics, Colonial Times to 1970*, series Q 208 for total deaths]

ITEM	1940	1950	1960	1965	1970	1971	1972	1973	1974	1975
Accidents, total......1,000..	10,339	10,418	11,429	14,733	22,116	22,650	24,850	25,649	23,744	24,816
Injuries, total......1,000..	1,440	1,799	3,078	3,982	4,983	4,994	5,190	5,192	4,634	4,965
Deaths, total......1,000..	34.5	34.8	38.1	49.2	54.6	54.7	56.6	55.8	46.2	45.6
Motorcycles [1]......1,000..	(NA)	1.0	.8	1.6	2.3	2.6	2.9	3.3	3.4	3.3
Economic loss [2]......mil. dol..	1,920	3,720	10,211	14,177	23,540	25,488	28,670	30,407	30,415	35,972

NA Not available. [1] Includes motor scooters and motorized bicycles. Source: U.S. Dept. of Transportation, National Highway Traffic Safety Administration, unpublished data. [2] Wage loss; legal, medical, hospital, and funeral expenses; insurance administrative costs; and property damage.

Source: Except as noted, Insurance Information Institute, New York, N.Y., *Traffic Accident Experience in the United States*, March 1973, and subsequent issues.

No. 1003. Motor-Vehicle Accidents—Number and Deaths, by Type of Accident and Vehicle: 1950 to 1975

[See *Historical Statistics, Colonial Times to 1970*, series Q 224-232]

ITEM	1950	1955	1960	1965	1970	1972	1973	1974	1975 (prel.)
Motor-vehicle accidents......1,000..	8,300	9,900	10,400	13,200	16,000	17,000	16,600	15,600	15,800
Vehicles involved by type:									
Cars......1,000..	13,000	14,500	16,000	20,300	23,500	24,500	23,300	20,600	(NA)
Trucks......1,000..	2,300	1,950	2,000	2,550	3,200	3,500	3,700	3,400	(NA)
Motorcycles......1,000..	75	70	100	235	305	343	378	376	(NA)
Accidents per 10,000 vehicles......	1,688	1,577	1,397	1,439	1,435	1,400	1,280	1,160	1,140
Traffic deaths [1]......	**34,800**	**38,400**	**38,100**	**49,200**	**54,600**	**56,600**	**55,800**	**46,200**	**45,600**
Noncollision accidents [2]......	10,600	12,100	11,900	14,900	15,400	14,400	14,300	13,500	12,700
Collision accidents:									
With other motor vehicles......	11,700	14,500	14,800	20,800	23,200	24,200	24,200	18,100	18,500
With pedestrians......	9,000	8,200	7,900	8,900	9,900	10,700	10,500	8,700	8,600
With fixed objects [2]......	1,300	1,600	1,700	2,200	3,800	4,600	4,300	3,600	3,800
Traffic death rates:									
Per 100,000 population......	23.0	23.4	21.2	25.4	26.8	27.2	26.6	21.9	21.4
Per 10,000 motor vehicles......	7.1	6.1	5.1	5.4	4.9	4.7	4.3	3.4	3.3
Per 100 million vehicle miles......	7.6	6.3	5.3	5.5	4.9	4.5	4.3	3.6	3.5

NA Not available. [1] Includes collision categories not shown separately.
[2] Beginning 1970, not comparable with previous years due to classification change.

Source: National Safety Council, Chicago, Ill., *Accident Facts*, annual. (Copyright.)

No. 1004. Deaths From Motor-Vehicle Accidents—by States: 1965 to 1974

[By place of occurrence]

STATE	1965	1970	1972	1973	1974	STATE	1965	1970	1972	1973	1974
U.S......	**49,163**	**54,845**	**56,528**	**55,759**	**46,629**	Mo......	1,387	1,479	1,500	1,487	1,066
Ala......	1,248	1,297	1,356	1,376	1,118	Mont......	289	340	408	334	301
Alaska......	57	107	64	68	74	Nebr......	411	435	504	425	392
Ariz......	555	782	858	1,008	765	Nev......	215	278	290	292	236
Ark......	635	595	750	664	625	N.H......	148	182	172	145	170
Calif......	4,804	5,114	5,300	5,049	4,204	N.J......	1,104	1,289	1,352	1,341	1,101
Colo......	557	697	746	699	654	N. Mex......	517	568	588	645	558
Conn......	415	448	444	516	400	N.Y......	2,798	3,117	3,140	2,929	2,483
Del......	126	158	130	137	132	N.C......	1,723	1,801	2,026	1,942	1,605
D.C......	99	140	100	103	91	N. Dak......	176	194	206	230	168
Fla......	1,702	2,181	2,570	2,704	2,280	Ohio......	2,333	2,488	2,336	2,237	1,786
Ga......	1,403	1,825	1,940	1,894	1,598	Okla......	730	787	792	776	742
Hawaii......	110	163	164	146	138	Oreg......	717	739	774	658	693
Idaho......	262	320	324	342	326	Pa......	2,167	2,349	2,320	2,424	2,157
Ill......	2,197	2,267	2,216	2,293	1,700	R.I......	102	143	144	141	120
Ind......	1,550	1,587	1,578	1,629	1,253	S.C......	847	1,070	1,148	995	895
Iowa......	831	946	904	832	722	S. Dak......	252	240	312	299	249
Kansas......	684	684	678	648	530	Tenn......	1,265	1,525	1,523	1,599	1,383
Ky......	943	1,081	1,114	1,155	812	Tex......	3,067	3,570	3,714	3,609	3,127
La......	1,122	1,194	1,136	1,176	855	Utah......	314	354	354	377	263
Maine......	227	288	252	252	225	Vt......	136	116	126	137	110
Md......	710	809	852	847	756	Va......	1,072	1,251	1,256	1,264	1,095
Mass......	888	918	1,042	1,029	978	Wash......	768	902	836	826	808
Mich......	2,134	2,172	2,236	2,186	1,863	W. Va......	507	561	578	498	463
Minn......	897	1,028	1,052	1,045	858	Wis......	1,055	1,109	1,148	1,129	908
Miss......	723	947	976	932	694	Wyo......	184	210	196	200	200

Source: U.S. National Center for Health Statistics, *Vital Statistics of the United States*, annual.

No. 993. Estimated Cost of Operating an Automobile: 1960, 1970, and 1976

[1976 estimates based on a 4-door sedan, costing $4,900, with an assumed life-span of 10 years, 100,000 miles. Similar specifications used in 1960 and 1970]

ITEM	10 YEAR TOTAL COSTS			CENTS PER MILE COST, 1976 (January)					
	1960 (Oct.)	1970 (Jan.)	1976 (Jan.)	10-year average	1st year (14,500 miles)	3d year (11,500 miles)	5th year (9,900 miles)	7th year (9,500 miles)	10th year (5,700 miles)
Total	**$9,761**	**$11,890**	**$17,879**	**17.88**	**18.73**	**17.79**	**17.04**	**19.94**	**17.63**
Costs excluding taxes	8,595	10,537	16,317	16.32	16.24	16.49	15.64	18.39	16.10
Depreciation	2,542	3,185	4,864	4.86	8.38	5.54	3.43	3.08	4.86
Repairs and maintenance [1]	1,722	1,521	3,664	3.67	1.08	3.61	4.11	7.42	.87
Replacement tires and tubes [2]	181	385	448	.45	.22	.21	.59	.59	.96
Accessories [3]	140	28	91	.09	.06	.06	.07	.13	.15
Gasoline [4]	1,453	1,733	3,193	3.19	3.19	3.19	3.19	3.19	3.19
Oil [4]	187	158	170	.17	.10	.13	.19	.23	.24
Insurance [5]	1,290	1,722	1,678	1.68	1.48	1.74	1.84	1.47	2.46
Garaging, parking, tolls, etc. [6]	1,080	1,805	2,209	2.21	1.73	2.01	2.22	2.29	3.37
Taxes and fees [7]	1,166	1,353	1,562	1.56	2.49	1.30	1.40	1.55	1.53

[1] For 1976, includes lubrications, repacking wheel bearings, flushing cooling system, and aiming headlamps; replacement of minor parts such as spark plugs, fan belts, radiator hoses, distributor cap, fuel filter, and pollution control filters; minor repairs such as brake jobs, water pump, carburetor overhaul and universal joints; and major repairs such as a complete "valve job."

[2] For 1976, covers 3 new regular tires and 4 new snow tires during life of car.

[3] For 1976, includes a set of vinyl floor mats, seat covers, and a pair of extra wheels.

[4] For 1976, gasoline use set at 15.0 miles per gallon; associated oil use at 1 gallon oil to 167 gallons gas.

[5] For 1976, includes $50,000 combined public liability ($15,000/$30,000 bodily injury, and $5,000 property damage), $2,500 personal injury protection, uninsured motorist coverage, and full comprehensive coverage for the 10-year period; $100 deductible collision insurance was assumed for the first 5 years.

[6] For 1976, includes monthly charges of $12 for garage rental or cost of owner's garaging facility, parking fee average of $70 per year, and toll average of $6.88 per year. [7] For 1976, includes Federal excise taxes on tires of 10 cents per pound, lubricating oil of 6 cents per gallon, and gasoline of 4 cents per gallon; plus the Maryland tax on gasoline of 9 cents per gallon, titling tax of 4 percent of retail price, and registration fee of $20.00 for 3,700 pounds or less shipping weight, or $30.00 for vehicles over 3,700 pounds. Maryland sales tax of 4 percent included on certain items.

Source: U.S. Federal Highway Administration, *Cost of Operating an Automobile.*

No. 994. Gasoline—Retail Prices, Selected Countries: 1970 to 1975

[In U.S. cents per U.S. gallon]

ITEM	1970, mid-year	1972, mid-year	1973, Oct.	1974, May	1975, Oct.	ITEM	1970, mid-year	1972, mid-year	1973, Oct.	1974, May	1975, Oct.
United States:						Austria:					
Regular	36	38	40	55	59	Regular	50	59	85	119	121
Tax	11	11	12	12	12	Tax	32	34	43	64	64
Premium	40	43	44	59	64	Premium	57	67	98	134	135
Tax	11	11	12	12	12	Tax	32	34	43	66	67
Canada:						Netherlands:					
Regular	40	40	[1] 43	(NA)	[1] 65	Regular	61	77	114	137	141
Tax	18	19	[1] 14	(NA)	[1] 25	Tax	42	58	78	86	85
Premium	44	44	[1] 47	(NA)	[1] 69	Premium	64	81	118	141	144
Tax	18	19	[1] 14	(NA)	[1] 25	Tax	45	58	78	86	86
France:						Norway:					
Regular	74	82	110	142	149	Regular	66	84	84	147	139
Tax	55	59	81	80	84	Tax	45	60	60	93	113
Premium	80	89	119	154	161	Premium	69	88	88	150	143
Tax	58	62	85	85	90	Tax	46	60	60	93	115
Germany, F.R.:						Spain:					
Regular	58	75	106	130	131	Regular	53	60	78	116	114
Tax	43	55	77	79	79	Tax	31	33	39	38	37
Premium	65	84	119	142	143	Premium	59	71	99	139	130
Tax	43	56	78	81	81	Tax	34	36	43	41	41
Italy:						Sweden:					
Regular	58	69	101	142	165	Regular	64	81	101	118	124
Tax	46	54	76	90	113	Tax	42	53	67	63	73
Premium	63	73	107	150	173	Premium	70	84	105	123	128
Tax	47	55	78	94	117	Tax	42	53	67	63	73
United Kingdom:						Japan:					
Regular	47	48	64	96	127	Regular	52	69	83	128	138
Tax	34	33	41	50	66	Tax	30	35	37	44	44
Premium	50	49	67	100	131	Premium	60	82	96	141	151
Tax	34	33	41	50	67	Tax	30	35	37	44	44

NA Not available. [1] As of September.

Source: U.S. Central Intelligence Agency, *International Oil Developments, Statistical Survey*, Jan. 22, 1976, and unpublished data.

No. 104. National Health Expenditures: 1950 to 1975

[In millions of dollars, except percent For years ending June 30. Prior to 1960, private expenditures exclude Alaska and Hawaii. See *Historical Statistics, Colonial Times to 1970*, series B 248-261, for calendar year data]

Type of expenditure	1950	1955	1960	1965	1970	1972	1973	1974	1975 [1]
Total	12,027	17,330	25,856	38,892	69,201	86,687	95,383	104,031	118,499
Percent of GNP [2]	4.5	4.5	5.2	5.9	7.2	7.8	7.7	7.7	8.2
Private expenditures, total	8,962	12,909	19,461	29,357	43,964	53,398	58,995	63,152	68,552
Health and medical services	8,710	12,529	18,816	28,023	41,483	50,647	55,846	59,972	65,665
Direct payments	7,107	8,992	12,576	17,577	24,272	28,141	30,348	31,310	33,509
Insurance benefits	879	2,358	4,698	8,280	14,406	18,620	20,955	24,100	27,340
Other	724	1,179	1,542	2,166	2,805	3,886	4,543	4,562	4,726
Medical research	37	55	121	162	193	203	208	219	235
Medical-facilities construction	215	325	524	1,172	2,288	2,548	2,041	2,961	2,652
Public expenditures, total	3,065	4,421	6,395	9,535	25,237	33,289	36,388	40,879	49,947
Percent of total	25.5	25.5	24.7	24.5	36.5	38.4	38.1	39.3	42.1
Health and medical services	2,470	3,862	5,346	7,641	22,581	29,901	33,094	37,243	45,585
OASDHI [3] (Medicare)	(X)	(X)	(X)	(X)	7,149	8,819	9,479	11,348	14,781
Temporary disability insur. (med.) [4]	2	20	40	51	63	68	70	71	73
Workmen's compensation (med.) [4]	193	315	420	580	985	1,185	1,335	1,560	1,830
Public assistance (vendor med. pay.)	51	212	493	1,367	5,213	7,752	9,209	10,372	12,968
General hospital, medical care	886	1,298	1,973	2,516	3,417	4,293	4,712	5,061	5,492
Defense Dept. hospital, medical care	336	745	826	858	1,496	1,932	1,990	2,267	2,419
Military dependents' medical care	(X)	(X)	60	78	264	409	478	474	592
Maternal child health programs	30	93	141	223	431	495	455	493	540
School health (education agencies) [5]	31	66	101	142	247	281	300	(NA)	(NA)
Other public health activities	351	384	401	677	1,532	2,231	2,304	2,625	3,457
Veterans' hospital, medical care	583	721	879	1,115	1,651	2,256	2,587	2,787	3,242
Medical vocational rehabilitation	7	9	18	34	134	179	175	185	190
Medical research	73	139	471	1,229	1,653	1,855	2,090	2,170	2,515
Medical facilities construction	522	419	578	665	1,003	1,533	1,204	1,466	1,848
Veterans Administration	162	34	60	77	71	110	105	119	136
Other	361	385	518	588	932	1,424	1,099	1,347	1,712
Personal health care expenditures [6]	10,400	15,231	22,729	33,498	60,113	74,828	82,490	90,088	103,200
By age group:									
Under 19 years old	(NA)	(NA)	(NA)	(NA)	9,626	(NA)	13,011	13,761	15,406
19-64 years old	(NA)	(NA)	(NA)	(NA)	33,975	(NA)	46,360	50,581	57,411
65 years and over	(NA)	(NA)	(NA)	(NA)	16,514	(NA)	23,119	25,746	30,383
Private expenditures	8,298	11,762	17,799	26,540	39,568	47,796	52,428	56,630	62,276
Percent of total	79.8	77.2	78.3	79.2	65.8	63.9	63.6	62.9	60.3
Under 19 years old	(NA)	(NA)	(NA)	(NA)	7,292	(NA)	9,507	10,438	11,657
19-64 years old	(NA)	(NA)	(NA)	(NA)	25,902	(NA)	33,927	36,096	40,153
65 years and over	(NA)	(NA)	(NA)	(NA)	6,376	(NA)	8,994	10,096	10,466
Public expenditures	2,102	3,469	4,930	6,958	20,545	27,032	30,062	33,459	40,924
Under 19 years old	(NA)	(NA)	(NA)	(NA)	2,335	(NA)	3,504	3,323	3,749
19-64 years old	(NA)	(NA)	(NA)	(NA)	8,073	(NA)	12,433	14,485	17,258
65 years and over	(NA)	(NA)	(NA)	(NA)	10,138	(NA)	14,126	15,651	19,917

NA Not available. X Not applicable. [1] Preliminary. [2] Gross national product; see section 13.
[3] Old-age, survivors, disability, and health insurance. [4] Includes medical benefits paid under public law by private insurance carriers and self-insurers. [5] Beginning 1974, considered an educational expenditure. See table 460. [6] See footnote 2, table 100.

Source: U.S. Social Security Administration, *Social Security Bulletin*, January and June 1976.

No. 105. Indexes of Medical Care Prices: 1960 to 1975

[1967=100. Prior to 1965, excludes Alaska and Hawaii. These indexes are components of the consumer price index; for explanation of the index, see text, pp. 431 and 432. See also *Historical Statistics, Colonial Times to 1970*, series B 262-274]

Year	Index, total	Average annual percent change	Drugs and prescriptions	Professional services: Physicians' fees	Professional services: Obstetrical case	Professional services: Tonsillectomy, adenoidectomy	Professional services: Dentists' fees	Optometric examination, eye glasses	Semi-private room rates
1960	79.1	3.5	104.5	77.0	79.4	80.3	82.1	85.1	57.3
1965	89.5	2.5	100.2	88.3	89.0	91.0	92.2	92.8	75.9
1968	106.1	5.8	100.2	105.6	105.2	104.9	105.5	103.2	113.6
1969	113.4	6.9	101.3	112.9	113.5	110.3	112.9	107.6	128.8
1970	120.6	6.3	103.6	121.4	121.8	117.1	119.4	113.5	145.4
1971	128.4	6.5	105.4	129.8	129.0	125.2	127.0	120.3	163.1
1972	132.5	3.2	105.6	133.8	133.8	129.9	132.3	124.9	173.9
1973	137.7	3.9	105.9	138.2	138.1	132.8	136.4	129.5	182.1
1974	150.5	9.3	109.6	150.9	149.0	144.1	146.8	138.6	201.5
1975	168.6	12.0	118.8	169.4	167.2	163.3	161.9	149.6	236.1

Source: U.S. Bureau of Labor Statistics, *Consumer Price Indexes for Selected Items and Groups, Monthly and Annual Averages.*