

# Hans Dieter Meyer

Contact <mailto:hansdmeyer@versanet.de>

## RATING and CLASSIFICATION in AUTOMOBILE LIABILITY INSURANCE

December 1980

-

### FOREWORD BY RALPH NADER

-

FOREWORD BY THE AUTHOR

SOURCE of MATERIAL

INTRODUCTION

FINDINGS

COMMENTARY

WHAT IS INSURANCE ?

The Imperfect Regulation of the Insurance Contract

Defects of the "Risk Bearing Theory"

The Risk is Eliminated

No Mutuality of the Insurance Contract

The Computation of the Gross National Product Proves: Insurance is a Performance  
of the Insureds - the Companies only Perform a Service

Loss Payments are no Costs / Premiums are no Prices

Lacking Premium Breakdown – Reason for a Wrong Structure and Abuses

Insurance Science – a Lobby of the "Industry"

To Whom Does the Insurance Money Belong ?

Contradictions to the Question: To whom does the Insurance Money Belong?

Lack of Investigations and Generally Accepted Definitions

Creation of an Understanding Prejudicial to the Insureds

Loss Payments Remain the Same under any System

A "Risky Insurance" by Speculation or Gambling ?

The German Dispute on the Basis of Insurance

### HISTORICAL DEVELOPMENT OF INSURANCE

The Traditional Insurance Institutions

Unbreakdown Contributions

The Change in the Field of Insurance Caused by the "Insurance by Stock Companies"

No Structure for Performing Services

The Origins of the Existence of "Fixed Premium Insurance"

The Mixing of Insurance and Service

### SELECTION – A "NON PERFORMANCE COMPETITION"

#### WHAT IS COMPETITION ?

No Competition Prerequisites in the Insurance Field

Rivalry over the Surpluses of the Insurance

The Informed Consumer – the Most Important "Competitive Force"

No Competition without Premium Breakdown and Service Price Quotation

Long Term Contracts Hinder Competition

### RATING AND CLASSIFICATION IN AUTOMOBILE LIABILITY INSURANCE

Background (Development in Germany and USA)

Arguments – for and against the Present System

State and Automobile Liability Insurance

The Insurance Technique for Rating and Classification

Classification and Risk Assessment by "Risk Interponents' Criteria"

Difficulties in Classification of Automobile Insureds

Selection Led to Classification of Fictitious Groups

Automobile Insureds are not Classified as Individual

Classification Alternatives

### DEFECTS OF THE PRESENT CLASSIFICATION SYSTEM

Statistics with a Wrong Underlying Question

Former Loss Records are no Means to Measure Exposure to Risk

The Group – a Result, but not the Starting Point

Grouping by Agreement or Experimentation

Violation of Statistical Principles

Impermissible Generalization

Statistical Results are no Causation Criteria

A group Criterion of Heterogeneous Groups has Predictive Value  
only for the Group, not for Heterogeneous Units

The Present Classification-Groups are Fictitious and Overlapping

Surrogate Criteria lead to Discrimination of the Individual Insurance

The Real Criteria Combination "Driving Behavior – Driving Area  
Mileage" cannot be Ascertained

The Vicious Argumentation Circle of the Actuaries

Contradictions of the Actuaries

A Wrong Premium-Subsidy between Equal Insureds from Differently Rated Groups

Loss Pooling Subsidy

"Premium Subsidy"

The Highest Premium Subsidy from the Loss-Free Young Drivers

No Premium Fairness for the Individual Insured

Removal of the Present System without Further Measures Leads  
to Availability Problems

Basic Conflict "Insurance and Profit Striving"

### SOLUTION OF THE PRESENT CONFLICT

Compulsory Insurance and its Regulation is "State Action"

Provision of Equal Treatment by a New "Insurance-/Service-Theory"

Equal Protection System in other Countries

Rating and Classification by State Rating Bureaus and Insureds' Representatives

A Uniform System and Equal Protection only by "State Action"

### OTHER RELATED ABUSES

The Commission System and Expenses Allocation

and a State Guarantee for 20 Percent "Profit"

### FINAL REMARKS

### OUTLOOK

### EXECUTIVE SUMMARY OF FINDINGS AND CONCLUSIONS



## FOREWORD BY RALPH NADER

For years I have been concerned about the lack of adequate insurance expertise within the consumer movement. I am pleased that the National Insurance Consumer Organization (NICO) of the United States is now operating to help fill this gap through international cooperation among insurance consumerists. Reform of insurance has begun.

In the United States insurance is a big business, with two and one half times the assets of the oil industry, nine times the assets of the auto industry and two-thirds of the assets of the combined Fortune 500. According to the Federal Trade Commission, insurance premiums absorb 11.6% of the average consumer's disposable personal income in America.,

In the United States insurance is not required by the federal Government; it does not come under the federal anti-trust laws. Although the Supreme Court held that insurance is an inter-state business, engaged in inter-state commerce, Congress has delegated the regulation of this industry to the states without establishing any standards of performance. Thus, for instance, cartelized ratemaking still flourishes in this highly protected and favored industry.

Insurance has long been viewed as an area of unique public interest since, should a company go bankrupt, the claimant is left with little or no recourse. Thus, even the staunchest free marketeer accepts the financial regulation of insurance. The service is unique, since it is people funded and supplied. The "product" of insurance is the performance and record of the people. The premiums paid in by the people are sufficient to cover the losses and expenses of operation. Therefore, the real insurance company is the people. We are the insurance company, with that what now are called the insurance companies serving the function of glorified bookkeepers.

Insurance is just that -- people getting together to help each other in times of need and assuring that no one will suffer a particular unexpected financial set back alone. Although this definition of insurance goes back to the very roots of the institution and is known as "spread of risks", there has been in recent decades the displacement of this concept by the insurance companies' propaganda that would have us believe that they are the sole risk bearer rather than the people. Statistics show that the property/casualty insurance industry has never had a negative cash flow year in at least the last 20 years. Thus it is clear that the people are the insurer in fact as well as in theory.

Why would insurers advance the notion that they are at risk" rather than the people? The plain and simple truth is that this enables the industry to ask for higher-profits than would be considered at all reasonable for their true role of accounting and claims disbursement. It fosters such practices as up rating the young, cancelling the old, not renewing the female divorcee, and redlining areas in our nation's cities.

If you went to a dry cleaner and were told that you would have to clean your own suit or dress and that the charge would be for the service plus a percentage of the value-of the garment, would you accept the offer? This is essentially the way insurance companies operate in the nation today. The economic result or "product" of insurance is the record of safety or accident of you, the consumers. The funds are supplied by you,

the consumers. The insurance company does do an important accounting and claims settlement service, and is dues some profit for that; but current ratemaking practice allows the insurer to keep a percentage of the overall premium, including a percentage on that major part of the premium for which the product and the money are wholly consumer supplied.

Moreover, the insurance companies collect these premiums in advance of any service performed and invest these policyholder advanced monies in securities yielding investment return. This investment of consumer's money (or "float") has been long recognized as an issue of importance to consumers by regulators, as described in the first study of NICO (by Robert Hunter) "Investment Income In Ratemaking". Yet, in the United Sates, most states continue to ignore this important and obvious element in setting rates, much less explore the more subtle, yet substantive issues mentioned above.

This important study reviews classification of automobile insurance -- an area much abused in the United States. The author, Hans Dieter Meyer, makes it clear that competition through classification discrimination is not appropriate. Mr. Howard Clark, former South Carolina Insurance Commissioner and now director of NICO, will represent the National Insurance Consumer Organization of the United States in German hearings to warn Germany about the abuses in America, and to request that the German Government be aware of that.

The consumer movement is devoting more attention to insurance. This paper signals a beginning of important international consumer cooperation in studying and reforming this industry.

-- Ralph Nader

Washington, December 1980

## Time To Set The Record Straight

Insurance Commissioners from several states and the Acting Federal Insurance Administrator, met today in Worcester, Massachusetts, at the invitation of an organization Of small business people. The Commissioners from New Jersey, North Carolina, Massachusetts, and a representative of the Pennsylvania Insurance Commissioner, were joined by the Acting Federal Insurance Administrator to discuss insurance problems. They issued a joint statement as follows:

"We find that millions of Americans are suffering from an insurance system characterized by excessive premiums, arbitrary cancellations and refusals to insure, and unfairly discriminatory rating practices. Insurance companies have long tried to convince the people of each state that the problems exist in their state alone. We think it is time to set the record straight. These are not problems unique to one or two states. -They are countrywide problems and they exist in virtually every state. Each of our states has been threatened with mass withdrawal by the insurance industry when unjustified rate increases have been denied.- We are tired of seeing cur citizens forced to live under these threats.

Automobile insurance is where all of these problems are most visible. We are convinced that, if positive changes are made in the insurance system, everyone can obtain adequate insurance at affordable rates. We pledge to work together to bring about changes in such areas as:

... Excessive Rates. Insurance companies have been keeping two sets of books. The books for the shareholders show ever-increasing profits. Yet, the books shown to the regulators to support rate increases often show losses. This practice must stop.

... Arbitrary Cancellations and Refusals to Insure. Auto Insurance is a necessity. Companies can not be permitted to deny coverage to any licensed driver. High rate assigned risk pools for good drivers must be ended.

... Unfairly Discriminatory Rating Practices. Insurance companies use rating based on age, sex, marital status, race, where you live and other such groupings to price many good drivers out of the market. Rates should instead be based primarily an individual driving record.

For too long insurance companies have played one state against another. This tactic has been designed to weaken state regulation. Only our cooperative efforts can overcome this divide-and-conquer strategy. The changes we seek are absolutely necessary."

James M. Stone  
Massachusetts Insurance  
Commissioner

James J. Sheeran  
New Jersey Insurance  
Commissioner

J. Robert Hunter  
Acting Federal Insurance  
Administrator

John Ingram  
North Carolina Insurance  
Commissioner

For William J. Sheppard  
Pennsylvania Insurance  
Commissioner

May 22, 1977

## FOREWORD BY THE AUTHOR

This study was supported by J. Robert Hunter (actuary, former Federal Insurance Administrator of the USA, former President of the National Insurance Consumer Organization, NICO, former Insurance Commissioner of Texas, Director for Insurance with the Consumer Federation of America) and Howard B. Clark (lawyer, former Insurance Commissioner of South Carolina, former Special Assistant to the Federal Insurance Administrator, former Director of NICO).

In the process of completing the work on a joint study encompassing the entire insurance field, the participants decided, in November, 1980, not to publish the unfounded study but, rather, to release it simply as an orderly study which could, among other things, be used incident to suits based upon constitutional and/or civil rights issues or suits seeking damages from public officials for derelictions of their official duties.

I was compelled to write and release this study within but a few in 1980, because it had to be presented December 16, 1980, incident to a hearing held at the Department of Economics at Bonn on a state-ordered Study on the Regional Structure in Automobile Liability Insurance" conducted by the Institute of Traffic Science, Cologne, West Germany, October, 1980. In 1981, the study was completed with some postscripts. Here is one: The greatest German and European news magazine DER SPIEGEL wrote in December 1980 that this study would make "maculature" (waste paper) from the state-ordered study, which proposed more refinements of classification. The magazine "Wirtschaftswoche" stated in March 1981 that the state-ordered study was in the "waste paper box".

Fundamentally, this study is intended to contribute a collection of materials to the end that the public may be informed in a well balanced way. It must be pointed out how essential is a disinterested study on the procedures currently employed in the insurance field, no such study having been undertaken or funded by those bearing responsibility. It is simply intolerable that the gigantic "insurance industry", along with its funded associates, year after year employ millions of dollars, contributed by policyholders out of their premiums, contrary to the interests of those policyholders, while the latter are left entirely without means or financial assistance in the designing of "their" insurance or in the controlling of their money supplied by them through their premium contributions for loss pooling.

It should be understood that the views expressed herein are mine alone, and while I appreciate the assistance and collaboration of those who have worked with me, mine alone is the responsibility for this study.

I want to thank in advance all journalists and other members of the media who will deal seriously and in depth with this study in the interests of the millions of insured citizens and the hundreds of billions of dollars of the insureds redistributed and invested by the insurance companies.

I thank my many German and American friends for their assistance, and, above all, I thank my wife, Dalia, without whose tireless support the study would not have been possible.

Hans Dieter Meyer, December, 1980 / July 1981

## SOURCE OF MATERIAL

Intentionally, out of deference to the convenience of the lay reader, I have avoided exact citation of source of material. In general, I have relied upon and extensively quoted the following:

"German Study" "Study on the Regional Structure in Automobile Liability Insurance",  
Institute of Traffic Science, University of Cologne, October, 1980.

"U.S. Report" "Private Passenger Automobile Risk Classification",  
A Report of the Advisory (NAIC D-3) Committee, May, 1979.

"Senate Hearing" "Hearings before the Subcommittee on Citizens and Shareholders Rights  
and Remedies of the Committee on the Judiciary, United States Senate,  
Part I – Discrimination by Property and Casualty Insurance Companies:  
The Fairness in the Coverage and Cost of Insurance", January, 1978.

"FIA Report" "Full Insurance Availability, Report of the Federal Insurance Administration,  
September 1974.

-

## INTRODUCTION

The main question of the dispute on the insurance classification problem is: Where is the classification problem placed ? - What are the surroundings ? -

The so-called "insurance industry" calls rate making by classification "cost-based pricing". According to this classification has something to do with the calculation of a price. The general opinion is that the insurance premium is this price, and that insurance is a product of the insurance companies, which is offered and sold to the consumers in a competitive market.

Up to now, there has been no doubt on this general opinion – even not among the opponents of the present classification system.. Without asking or investigating, if these fundamental suppositions of the classification discussion are right, all participants in this dispute start from them – although they find and state that insurance is "a unique product" and that selection competition is "unique" in the whole economy and marketplace. There are hundreds of studies, there were thousands of discussions, hearings and meetings which found and stated this "uniquism". So the never ending dispute, talking and writing on insurance and regulation, on classification and competition arrived in a dead end street with all participants running around in the turning circle. The branch is against State intervention. But without State intervention a lot of the insureds, compelled by law or economical necessity to ensure themselves, would not be able to get this protection. Without State regulation the rates would be excessively high in the intransparent insurance field and the companies would not pay back even a part of the surpluses from the permanently and necessarily overcalculated premiums. Everybody knows this. Yet, the branch spokesmen maintain that State intervention and regulation was against cost-based pricing, competition and the free enterprise system in the insurance field.

The most astonishing thing is that, despite the mass of discussions, there was no generally accepted solution for the problem. Up to now, nobody was suspicious about that. To stop this never ending quarrel, to take it out of the dead end street and to lead it in a new direction, it needs a "unique" study – a study like this, which investigates for the first time the suppositions of the present classification dispute and which does not only maintain, but proves that they are wrong ! -

In this study it is investigated if classification is a cost-based pricing- and competition-process, or if classification in a compulsory insurance has something to do with the equal protection clause. Competition and the equal protection clause are something totally contrary. If classification is a part of the pricing process and a competitive measure, the equal protection clause is not affected. Equal insurance contributions for equal drivers can only be required and legally or judicially carried through after it is proved that classification has nothing to do with calculation, pricing and competition. To prove the latter is the target of this study.

A fact is that the companies can influence the surpluses in the loss pooling area by selection of the insureds. A fact is that a grouping or classing of insurance contracts according to specific group criteria leads to different loss data and – with selection – to different surpluses among the companies. This study will demonstrate, how a wrong understanding of insurance as a "product of the insurance companies" led to a wrong employment of these surpluses from the loss pooling area "as profits", that this led to the so-called "selection competition" and how this selection-competition caused the present false rating and classification system.

## **FINDINGS**

- 1.) There was a great – historically conditioned – false change in the insurance field, when after the traditional mutuals profit-striving stock insurance companies entered the insurance field. In this moment, insurance and the companies' services had to be separated, because they are two very different things. But this did not happen. The "fixed premium insurance" arose.
- 2.) Insurance can impossibly be a product of the insurance companies. Insurance – establishing a common fund to eliminate the computable financial risk of a large number of insureds – is the performance of the insureds. The companies can only offer and perform a service as to the organization and administration of this common fund provided by the insureds.
- 3.) The premium is no price but consists of two parts: a contribution for loss pooling into the common fund and a remuneration for the companies' services (a price, which is not quoted up to now – against the German price quotation law and the requirements of competition).
- 4.) The insurance contract consists of two parts: a contract with the group of insureds (the real insurance contract) and a service contract with the company.
- 5.) Classification is only related to the pure insurance contribution. Ratemaking and classification as to the insurance contribution has nothing to do with pricing. Calculation and cost-based pricing can only, take place in the area and for the price of the companies' services.

6.) Loss payments can never lead to costs for the insurance companies, because they are performed by cost-free provided money of the insureds. Costs are only the companies' expenses in the service area.

7.) Ratemaking and classification as to the insurance contribution has nothing to do with competition. Selection by insurance companies is a "competition in a wrong area", which leads to "profits from an extraneous performance". The companies' competition and profit area are only the service area and the service price.

8.) State intervention in insurance and regulation of the insurance contributions and of the employment of their surpluses is legal. But State intervention in the companies' services and regulation of their prices and profit's is wrong and illegal. State intervention and regulation of the companies' services is against the principles of the free enterprise system and competition.

9.) The compulsory automobile liability insurance and its regulation is "State action" and requires provision of constitutionality in the treatment of the compulsory insureds in the insurance area by State regulation of the contributions for loss pooling and the classification of the compulsory insureds.

10.) The State must provide for equal driver to pay statewide equal contributions their compulsory insurance and get equal repayments, and for them to be accepted by every insurance company. This can only be achieved by a premium breakdown into a regulated contribution for loss pooling and a competitively established service price, and by a statewide arithmetical compensation of the different surpluses from the loss pooling area among the companies for an equal reserving or repayment of these surpluses for the individual insureds.

### **COMMENTARY**

I hear already the branch-spokesmen cry that, this was "nationalization of the insurance industry". Let me state in the beginning that there is no "insurance industry", because insurance can never be produced by insurance companies, which are no "insurers", but should be better called "insurance service companies". Let me state in the beginning that regulation of the insurance area and especially of the insurance contributions and the employment of their surpluses (not of the service area!) has nothing to do with nationalization. Up to now, nobody has ever complained about nationalization of the bank industry, because the banks are not allowed to take in the customers accounts "as profits".

What NICO and I fighting for is to bring constitutionality and legality into the insurance area and competition and free enterprise system into the insurance services' area. This can only be achieved by separating these two fields by a breakdown of the premium.

Recently, some good studies and activities came out in this area – for example US-Senator Metzenbaum's "Competition Improvement Act, Bill S. 2474" or the New Jersey "Classification Prohibition" of April 9th, 1981. But these activities are unfortunately condemned to failure, because they don't recognize the two different areas in the insurance field and, thus, start from the wrong idea that insurance is a competition area and ratemaking and classification is a competitive pricing process.

Because this is very important, let me give some examples: In Senator Metzenbaum's "Competition Improvement Act" is written of "minimum standards governing competition in the business of insurance" and "the price of insurance coverage". "Conclusions" of the study of the Department of Insurance of New Jersey quotes: "Automobile insurance classification is a competitive tool" and "classification generally affects the distribution of costs among insureds" and "competition among insurers" and "competitive forces in the automobile insurance market" and price comparisons".

My Goodness ! – Who made these seriously concerned people, concerned for the interest of the consumers, believe all that ?! – Who ever substantiated that insurance was a business and that there could be competition as to insurance ? – Who ever gave reasons that the premium or the contribution for loss pooling were a price ? – Who proved up to now that loss payments were costs ? Who made these people believe that there was an insurance market ?

When not leaving the wrong suppositions and the vicious circle of the present argumentation, even seriously concerned people cannot solve the tension of regulation and competition. Unfortunately, these people also don't see the consequences of removing the current classification system without enforcing compulsory acceptance, separation of the premium and compensation (equalization) of the different surpluses from the loss pooling area. Activities like these of Senator Metzenbaum and the New Jersey Insurance Commissioner are so important, but, unfortunately, not well devised consequently.

In this classification dispute the starting question of the consumers and experts was up to now: Is it right that a young male loss-free driver from a black neighborhood of a city has to pay more than 2,500 \$ for his automobile liability insurance, while an old female driver in a rural area pays less than 200 \$ for the same car after 2 recent losses ? -

For Germany the question must be put this way: Is it correct that a young loss-free worker from a city pays more than 2,000 DM, while a loss-free state employee in a rural area pays only 200 DM for the same car ? -

Questions like this concern only the obvious results or symptoms of the present classification system. By starting studies, discussions and hearings with these questions, up to now, no answer and solution was found.

In this study I don't want to treat the symptoms without investigating the origins of the system. Therefore I start my study with a quite different question. (You will see, how easily the right answer to this question solves all problems in the insurance field – not only the classification, regulation and competition problem). The question is:

### **WHAT IS INSURANCE ?**

It is useless and would fill up volumes to demonstrate the total confusion ,in the theories about the fundamental procedures and the definitions of the basic terms of insurance. There is such a mass of different theories, definitions and statements that everybody can nearly prove everything in the insurance field. But this means on the other hand that actually nothing can be proved.

Prof. Dieter Farny starts his book "Production- and Costs-Theory of Insurance" with the statement that there is no lack of the most different definitions of "insurance", and that there are enough definitions suitable for any respective investigation.

In the autumn of 1980, the "Scientific Services of the German Parliament" performed a study for members of the Parliament in which it is said: "Up to now, there are no uniformed generally accepted definitions" for questions regarding insurance and the insurance contract.

Descriptive of the state of the insurance science is the statement of Prof. Dr. Dr. Schmidt-Rimpler who said in his book "The Mutuality in the Insurance Contract": "When a quarrel in a scientific field does not find an end, not even the end of a clearly dominating thesis, but only, ultimately, a cemetery end, namely the resigned dying off of interest in the quarrel, then this is very often caused by a wrong problem-setting."

#### *Actual remarks in German at the end*

The present prevailing, but controversial opinion is that "insurance" is a product of the companies, produced by a service, by taking over the risks of the insureds and compensating or bearing them. According to this the insurance companies sell promises of payments for the case of loss to the insureds, who pay the premium as a price. The companies take measures for risk compensation by covering a corresponding money-need, providing reinsurance and building up reserves.

This theory is a fairy-tale, introduced by the stock insurance companies to make the consumers believe that they buy insurance like bread or butter, that the premium was a price, and that – last, but not least – the surpluses from the premiums were the companies' profits. And by employing the money of the insureds, the "stock insurers" found and still find enough academics who confirm this nonsense.

### **The Imperfect Regulation of the Insurance Contract**

This whole complex of related insurance problems would not exist, and the question of classification, regulation and competition would not arise if there were a clear, legal regulation of the insurance contract. He who believes that such clarity is created by a 200-sections German Insurance Contract Law is, unfortunately, wrong. Indeed, a more precise consideration of section # 1 of this more than 70 years old law shows that this law is no "masterpiece of legislation", as the "insurance industry" and their academics (who, together, drafted it) seek to portray it. Nor does such consideration confirm the correctness of the view of the former Minister of Justice, Vogel, that the "permanence of this legal sector indicates the quality of this codification", However wrong, a thing can be permanent and enduring as long as there exists a self-admitted "peaceful coexistence" between the legislator and the persons concerned as "co-legislators".

According to section # 1 of the Insurance Contract Law (ICL) "the insurer is bound to the payment of an insurance performance", and "the insured is bound to the payment of the premium". Out of this arises a whole catalogue of questions which are as much of an economic nature as they are of a legal nature.

What is "insurance" and what is an "insurer"? - Who is the "insurer", the company or the group of insureds who pool their contributions to cover their losses ? - How, and by whom, is rendered the payment of the "in-

insurance performance" in fulfilling the economic and contractual obligation ? – What does that insured, who paid his premium but had no loss, get by the way of counter performance from the insurance company or from the group of insureds ? – If the majority of the insureds do not receive "insurance performances", can the premium be a price for the "insurance performance" as an equivalent counter performance by the insurance company ? – Is section # 1 of the German ICL binding, in the same fashion, upon stock insurance companies, mutuals, upon all insurance branches, including life insurance with its combined saving process ? – Is the paying out of the sum, saved by the insured through a part of the life insurance premium, an "insurance performance" by the company and the premium, in that context, a price ? -

This catalogue of questions could easily be extended. In the study conducted by the Scientific Services of the German Parliament it is said: "In this long existing controversy over the nature of the insurance contract, an investigation is lacking as to whether there is any way that one of the theories can cover the insurance contracts of all insurance branches. This is highly doubtful. Moreover, no one has tried to substantiate in the literature, that the insurance contract could be a "service contract" which consists of the organization of a redistribution of entrusted money of the insureds".

This latter statement is not quite accurate. The author himself, some years ago, endeavored to substantiate such a theory but the "literature" refused to print it for reasons such as "economic regard for the established insurance industry, which is our exclusive and most important target group" or that such theory "does not correspond to our opinion". Yet it is only this, up to now, suppressed conception and framework which can reanimate the moribund theories controversy and provide the solution framework for all the problems in the present insurance system, solutions in theory as well as in practice.

### **Defects of the "Risk-Bearing-Theory"**

Insurance science could not forever Overlook or ignore the manifest contradiction that, according to the text of section # 1 of the ICL, the "not befallen" (those who have, no loss), do not receive any counter performance for their premium. Thus, the only generally accepted opinion among insurance scientists appears to be that section # 1 ICL is an imperfect regulation, something which, for a period of 70 years up to date, has not concerned anyone, even the Legislature, despite the fact that this regulation governs matters running into billions of DM.

To make the "insurance performance" a performance by the insurance companies a "risk bearing theory" was postulated. Under this, the performance is alleged to consist of the take-over of the risks, taking measures for risk compensation by covering a corresponding money-need, providing reinsurance, building up reserves, and generally bearing risks for the insureds. The concept of counter-performance is clearly not described in this way in the ICL.

### **The Risk is Eliminated by the Common Fund**

The "risk-bearing-theory" is revealed as the nonsense which it is when one considers what insurance really is. Insurance is a means of making something certain, of converting uncertainty into certainty. Here, it is to make certain that there is no longer a financial risk for the insureds in respect to the subjects of insurance.

Alfred Manes, in his dissertation "Insurance, Principles and History" (Encyclopedia of the Social Sciences, Vol. 8, 1935, page 95), puts it this way:

"The essence of insurance lies in the elimination of the uncertain risk of loss for the individual through the combination of a large number similarity exposed individuals who each contribute to a common fund of premium payments sufficient to make good the loss caused any one individual.

This means: We can ascertain that next year there will be automobile liability losses in an amount of about 22.5 (?) billion \$ (considering more or less driving and trends of inflation in repair costs). But, we cannot ascertain, which drivers will be befallen by these losses. And nobody can prevent the accidents and their consequences (damage, bodily injuries etc.). But, by establishing a common fund of 25 billion \$, the group of all drivers can prevent that the – maybe – 10 percent of them, who will be responsible for compensation, will not suffer a financial loss. This is the essence of insurance: elimination of the uncertain financial risk of loss for the individual by combining a large number of individuals and establishing a common fund ! – Now, what risk shall the insurance companies bear or compensate, after the insureds have eliminated all risks by the common fund, to which they have contributed money sufficient to make good all financial losses ? -

This is only an insurance technical argument that proves the fault of the risk bearing theory. But there are also legal and economical arguments for this.

### **No Mutuality of the Insurance Contract**

The risk bearing theory also ignores that the insurance contract has to be a mutual contract to be an object of the market. A market consists of products and services that are offered and prices that are paid. Nobody pays for nothing. There must be a performance exchange. The market is only open for mutual contracts. You will not find anybody standing in the marketplace and shouting: "I sell donations" – And nobody can stand in that marketplace offering to sell "conditional promises for payments" (what the insurance companies pretend to do). Only lottery tickets or a participation in gambling can be offered – contracts without mutuality. But did you ever hear about a "lottery or gambling market" ? –

Just to make the insurance contract one of mutuality of performance, suitable to the market as a "market object", the "risk bearing theory" was postulated. But the risk bearing theory ignores the fact that risk bearing can never constitute a contractual performance but that the measures taken during the intervening time can only, at best, constitute preparatory action for the owed performance (i.e. the money distribution for loss compensation) which, alone, even according to this theory can constitute the particular contract performance and fulfillment action. Thus, the question of mutuality and performance exchange in respect of the insurance contracts of those not sustaining loss remains unanswered by this theory.

After rejecting the risk-bearing theory, the commentary of Professor Proells and Dr. Martin says without examination of exposition: "This controversy has no great importance because the insurance contract is also a mutual contract according to the opinion represented here". In so stating, the commentators refer to the "solution attempt" of Professor Dr. Schmidt-Rimpler who says that an "unconditional premium payment and a conditional insurance performance can very well stand in a 'synallagmatic' (reciprocal) relationship depend-

ing solely on the agreement of the Parties as to the evaluation basis". Such an opinion completely ignores the fact that to define a mutual contract is not the question whether the parties to the contract agree upon an evaluation basis or not, but whether there is a generally accepted basis for such evaluation. Otherwise, for example, the regulation provided by section # 306 of the German Civil Law Code, which invalidates a contract which has as its object something impossible of performance, might not be applicable for the purchase of a ticket to the moon if the buyer considers a flight to the moon next Sunday as being possible. Such a transportation contract would not only be effective according to the "Party evaluation theory", but the ticket buyer would be without compensation or any action for unjust enrichment against the seller, notwithstanding the entire absence of counter-performance\* One might argue, paraphrasing the words of Professor Schmidt-Rimpler: "For it goes without saying that it can be seen as just for one party to bind himself unconditionally and simply to perform his obligation the other party being only conditionally bound (or bound to an impossible performance)". Such "evaluation" could, perhaps" be interpreted as a renunciation of the repayment for advance performance or as the renunciation of a counter-performance (hence, as a donation), but the fact remains that such contracts can never constitute mutual contracts under which there must be an exchange of actual and unconditional performance and counter-performance.

It can thus be stated that according to the manner in which the insurance contract is now regulated and performed in practice, the insurance contract is not one of mutuality of performance. The contract between the insurance company and the insured can only be a mutual contract when it is certain as to which performance can be performed for all insureds and that such performance is, in fact, rendered.

### **The Computation of the Gross National Product (GNP) Proves:**

#### **Insurance is a Performance of the Insureds – The Insurance Companies only Perform a Service**

Totally incorrect opinions suggest that the insurance premium represents the price paid for the intangible product insurance. According to this reasoning, insurance would have to be classified as the production of goods and the insurance contract would have to be constituted a purchase contract. Such a view of the matter is as nonsensical as would be the contention that the performance by the physician consisted of the selling of the intangible product health rather than a service, i.e. the treatment of the patient.

The prevailing view can be stated to be that insurance shall be a service which is produced by the insurance companies and "sold" to the insureds in return for the payment of the premium. According to this view, the loss payments constitute "costs", the premiums constitute "prices" and the premium surpluses constitute "profits". Such a theory is obliged to concede the existence of many "peculiarities" which are outlined in the following in the form of questions.

How can the loss payments constitute costs when the money with which they are paid is provided free of costs by the insureds ? – Clearly, the companies do not provide this money, how, therefore, can it be considered a production factor when it is only redistributed by the companies as the so-called "object factor" of their service ? – What is to be said of a "service insurance" wherein the external object of the service has to remain the property of those for whom the service is performed (as for example, the suit left at the cleaners, or the money deposited in the bank), but where, in the insurance environment, it is contended that the

money provided for redistribution as loss payments passes over to become the property of the insurance companies through payment of the premiums ? – How can premiums be said constitute prices when representatives of Government, of the Supervisory Authority, and some academics say that the "risk surpluses are not operational profits, but must be repaid to the insureds" (which, in fact, is actually done or prescribed in certain branches of insurance such as life and automobile insurance) ? – Above all, why is the total premium income of the insurance companies not taken into account in the computation of the GNP as the reflection of the value of their services rather than only including the administration expenses portion as the actual price, that price being, oddly enough, ascertainable only through estimation. -

The author and Howard B. Clark, a director of NICO, had a conversation in November, 1980, with officials of the U. S. Department of Commerce, National Wealth Division, Bureau of Economic Affairs. During this conversation those officials Stated that "as regards non-life insurance, only the remainder, after losses are subtracted from premiums, is included in the GNP." In short, this confirms the finding in Germany that the loss component of the premium is never included in the GNP.

Professor Werner Mahr has written on this same subject in the "Insurance Economics Studies". In that part of this work dealing with "The Gross National Product and its Partition," Professor Mahr examines "The Contribution of Individual Insurance to the Domestic Gross National Product." There, he says:

"The services performed by the insurance companies are valued through the administrative costs portion separated from the premium income."

"The risk and saving portion, also contained in the gross premiums are not taken into consideration when measuring the value of the service of an insurance company because these are performances which other economic units, namely, the insureds, have provided. The risk portion included in the premiums stem from the income yielded by the insureds and are transmitted through the so-called 'insurance performance' to the economic units upon which the insurance loss has befallen. The organizational service, which the insurance companies contribute to this process, is expressed in the remuneration paid for it; this is the administrative costs portion of the premium income. Thus, it is not the total premium income which characterizes the contribution of the insurance companies to the domestic Gross National Product but only the administrative costs portion of the total premium income assessed according to the balance sheets presented."

"As the gross product value of the private insurance companies, the remuneration for the services, as contained in the gross premiums, is valued but not the risk portion or saving portion of the premium income . . ."

"In its characteristic features, the accounting for the procedures connected with private insurance occurs as follows:

1. The administrative costs portion of the gross premium is accounted for in the 'Accounts 1 – Production and its Employment' as the expression of the services of the insurance companies. The insurance companies sell these services to the economic units.
2. The risk portions in the premiums for all insurance is regarded as current transfer. The risk premium is accounted on the 'Accounts 4 – Income Redistribution'.

3. The saving portion (including interest) of life insurance premiums are accounted as savings of the private households on the accounts 'Fortune and Credit Changes' of the private households.

"The integration of the so-manifold insurance in the general scheme of the National Accounts requires complicated bookings if the National Accounts is to provide information on the origin and employment of performances, who ultimately performs them, and to whom they must be assigned.

"Insurance science has not given the necessary attention to these problems"

In April 1981, the German Federal Economic Department wrote to the author: "The price for insurance companies' services is only administration costs portion of the premium."

[From this is drawn the illustration on the following page which, for better understanding, is completed by examples from other economic areas.]

No other accounting of the financial transaction of the insurance field is possible. The money for loss payments is produced by the insureds; it is "cost-free" money provided for a redistribution which is performed by the insurance companies as their service.

According to the "Business Report" of the German Insurance Industry Association:

"Professor Braess proves convincingly that the insurance industry has only a distribution function as to the risk premium without price-influencing actions. This was shown by the fact that the insurance industry enters into national accounts for determination of the Gross National Product not with its total premium turnover but only with its costs and profits."

### **Loss Payments are no Costs – Premiums are no Prices**

In all the other economical fields and industrial areas cost come into being for and when procuring the production factors for their combination to a product (input). In this mysterious – not existing – "insurance industry" this all shall function another and – once again – "unique" way. Costs for the procuring of the money for loss payments don't arise. The payment of the premium, which contain this money for loss payments, are accounted as price income – not as provision of a production factor or product costs. But then the paying out of this money, the provision of which never caused costs for the companies, are accounted as costs, although they can impossibly be costs. This curious procedure – the arising of product-costs by the output of the product – is just as little the employment of costs as the "input" or "output" of parcels in the mail (or money in the banks). But the "insurance industry" found professors, who confirmed this nonsense, that loss payments are costs and "produced" the funny argumentation, that loss payments are costs because they are regarded and accounted as such for hundred years and nobody doubted this.

The money of the insureds, provided by them cost-free for distribution, can never become a production factor of the insurance companies in the production of insurance by companies. In no sense do the insurance companies provide this money by "buying" it from the insureds and using it as production materials. This

cost-free money provided by the insureds for loss payments never leads to costs for the insurance companies.

Hence, it is simply nonsense to talk of costs in connection with loss payments or to speak of "cost-based pricing" in connection with ratemaking. Such considerations as these invite an entirely new perspective, and there is some evidence that this may be forthcoming.

Thus, in the U. S. Report, it is stated:

"The National Association of Insurance Commissioners (NAIC) is moving forward from the philosophical perspective that the insurance industry needs to be changed, that economic pricing is not functioning properly, and that regulatory action is needed to change the industry."

The insurance premium does not represent the price for the particular services rendered by the insurance companies: the price for these services is represented only by the administrative cost portion of the premium. It is only this latter which can be the subject of an individual enterprise calculation, as Professor Mahr demonstrates above. This is also indirectly confirmed by Heinz Sievers, President of the German Automobile Insurers Association, who says:

"The individual enterprise portions, that is, the charges for costs and profit, which determines competition in the area of premiums, occurs in the remaining relatively low margin of about 15 percent of the gross premium."

The fact is, however, that this price for the particular services actually rendered by the insurance companies, that is... the price for their actual performance, is never quoted "in the market", from which it necessarily follows that the most important prerequisite to marketplace competition does not exist. Currently, the insurance companies intermix the internally calculated service price (the administrative cost plus profit factor), with the "service object .. factor", the money provided to them by the insureds without cost to be used for loss-pooling. Like every object factor of a service (for example, the suit at the cleaners, the money in the bank), the money so provided must remain the property of those who ordered the service on the object.

### **Lacking Price Quotation and Premium Breakdown – Reasons for a Wrong Structure and Abuses**

The author, in his booklet "Insurance and Regulation Services and Competition", wrote:

"All problems in the field of insurance have arisen for the following reasons: That insurance as the performance of the insureds and the service of the companies were so intermixed that the erroneous idea arose that insurance could be the "product" of a stock insurance company. That the contributions for loss pooling and the price for the service were mixed into an individual premium so that the mistaken idea arose that these mixed processes and premiums could be the object of competition. That the surplus arising from the contributions for loss pooling and the surplus arising from the price for service were mixed so that the mistaken idea arose that all surpluses arising from these mixed processes, including the surplus arising from the insureds' contributions for loss pooling, constituted profits of the stock insurance companies. Finally, that the stock insurance companies, through this mixing, obtained a grip upon the surplus arising out of the perform-

ance of the insureds and thereby all problems of insurance, which are connected with uncertainty as to the future, because the profit problems of the stock insurance companies.

From this mixing of the insureds' money with the service price, the following "advantages" accrue to the insurance companies:

1. They need not quote a price for their particular services; so they need not calculate exactly and competitively.
  
1. They need not perform competitively as to these services, so they need not strive for increased productivity and decreased costs.
2. For the covering of their costs - especially with miscalculations - they can take liberally from the money entrusted to them for loss-pooling.
3. The insurance companies can also allocate to themselves and absorb as "profits" the surplus from the monies entrusted to them for loss payments because the property of the insureds in this money is no longer recognizable. Yet, these surpluses belong to the insureds.

A quote from the German magazine "Capital", 1979, to underline point 3.):

"The insurers make it simple. When the costs exceed the limit, calculated in advance, they simply take the additionally necessary money from the surpluses, they are bestowed with automatically by the investments and the cautiously calculated loss course. But this is money, to which the insureds are normally entitled."

A quote from the "Insurance Economic Studies" to underline point 4.):

"The premium must be sufficient not only for a normal course of losses but also for an extremely high course of losses. Therefore, in the single years, premium surpluses arise which cannot be called operational profits (performance success). They are, rather, excess contributions which must be repaid to the insureds."

Director Claus, chief supervisor for life insurance of the German Insurance Supervisory Authority in the "Official Publications" of this board, 1980:

"Since the supervisory authority has the legal task, to watch over the fulfillment of the contracts, it will be exposed to more strict challenges than the insurers. Thus the insurance contributions must include quite considerable safety margins, which generally lead to very high surpluses. They consist mainly of risk surpluses and surpluses from the investments.

"What happens to these surpluses ? – They are not operational profits in the usual sense, which the companies can decide freely, but they are over-raised, that is not needed contribution portions, which must be repaid to the insureds. The insureds as a whole / in their totality have a right / claim on these surpluses."

"The supervisory authority unfortunately found out, that. the repayment quotas / shares of many insurance companies are dissatisfying, partly even totally insufficient, so that the repayment to the insureds is insufficient, too."

"In the general economy, when poor management adversely affects the enterprise, the enterprise alone bears the loss. In insurance, however, the consequences of bad decisions, or even mismanagement, fall first and foremost upon the insureds because losses simply lead to a reduction of the cost-free funds supplied by those insureds. Surely, it is no longer necessary to suggest that this is incompatible with the principle of protecting the interests of the insureds."

"My thesis that, under the current system, competition is insufficient and ineffective is clearly demonstrated by the fact that there are many companies swimming comfortably in the stream which would long ago have disappeared if competition were really functioning."

In response to a question raised by Mrs. Martiny, a member of the German Parliament, Dr. Boehme, Parliamentary State Secretary of the Ministry of Finance said, in May, 1980:

"It is correct, that risk surpluses and interest yields are not operational profits in the usual sense insofar as they are based upon the conservative rating bases prescribed by the supervisory authorities; but, insofar as they result from other reasons, they are normal operational profits like those in other commercial fields."

The last quoted remark has no practical value by reason of the fact that no one can possibly determine which surpluses constitute "risk surpluses and interest yields" or which constitute "surpluses based on other reasons". The reason, is, of course, that the undivided premium renders that determination impossible.

It is just these conditions and this structure in the insurance field, with all of the attendant potentials for profit-making from the entrusted money of the insureds, which has led to selection and the present classification system. It is this structure, which can never be reconciled with the computation of the Gross National Product, which defies all legal and economic principles, and which violates the principles of the free enterprise system and competition. This faulty structure cannot exist, once it is clearly understood that insurance can never constitute a product resulting from the performance of the insurance company.

It is just this faulty structure in the insurance field which enables the so-called "insurance industry" to make, through its own performance but through the performances of the insureds, profits twice those of the oil industry [Forbes, January 8, 1980] while complaining at the same time of high losses. The "high losses" complained of result from determining permissible loss ratios (expected losses) solely on the basis of premium income while totally ignoring the investment income and value increases flowing from the billions of dollars supplied by the policyholders to the insurance companies without cost and their XX.

It is easily understandable why the "insurance industry" wants to maintain this competition-free, profit paradise and does not want to be dependent only on profits arising solely from the area of service and which can only be gained through competition.

### **Insurance Science – a Lobby of the Companies**

In order to secure and buttress its position, the insurance industry has created its own "insurance science" through which it has gained control over legislators and insurance regulatory authorities. The satisfactory

nature of this arrangement, so far as the insurance industry is concerned, is indicated in the "Business Report of the German Insurance Industry Association" where it was stated:

"Nothing has changed in the harmonious cooperation of insurance industry and insurance science. In insurance science we have had and have the best helper in recognizing our peculiarities."

In the United States Senator Metzenbaum recalled:

"I am not new to state regulation of insurance. As a young man in the Ohio Legislature, I attempted to put teeth in the Ohio insurance law, but that was 'love's labor lost'. The insurance lobby was in control. The fact is that neither the Insurance Commissioner nor the Legislature ever really made the regulations. They do what the industry tells them to do."

The German laws, such as the Insurance Supervision Law, Insurance Contract Law, Compulsory Automobile Insurance Law, Automobile Insurance Tariff Order, Accounting Regulations, etc., are, in effect, made by the insurance scientists and the "insurance industry", and right now "their" European Insurance Laws are being made in exactly the same way. That part of the Contractual Conditions Law which creates an exemption for the insurance industry from its prohibition against long-term contracts was won by the "insurance scientists." (It should be noted that, in Germany, 10-year insurance policies without a general right of cancellation are normal – often with premium adjustment clauses.) All of the accountable institutions – the "insurance industry", insurance supervisors, government – rely upon these laws to explain and justify their actions.

Thus, the contention that the premium constitutes a price is attributed to Section 1 of the German Insurance Contract Law which binds the insured to the premium payment and the "insurer" to the loss payment. Georg Buechner, President of the German Insurance Industry Association said in 1980:

"According to the Insurance Contract Law, the premium is owed as a remuneration completely forfeited with its payment. Therefore, the premiums are the money of the insurers and the investments their investments."

But even "insurance science" cannot, and does not, dispute that Section 1 of the Insurance Contract, an incomplete regulation because according to its text mutuality of performance is not effected, because he who has no loss consequently, will receive no counter performance under Section 1. It is quite astonishing that, until now, this incompleteness has troubled no one, even though it affects financial transactions amounting to hundreds of billions of dollars annually. The real reason for the lack of concern regarding the incompleteness of this law lies along lines stated by the German Minister of Justice when he said:

"For a long time, the insurance industry and my house have lived in peaceful co-existence."

It is high time that governments and supervisory authorities finally deal with these antiquated, false, and never examined legal premises before the courts do it.

### **To Whom Does the Insurance Money Belong ?**

A further argument of those who are profiting handsomely from the present system rests upon the implications of the accounting rules and regulations under the Stock Corporation Regulations. According to these regulations allocations of the surpluses arising from the loss pooling to profits is permissible. However, in the first place, this could only be valid if the property in the money which the insureds have turned over to the insurance companies has passed over to the latter. Certainly, these regulations cannot nullify the property guarantee of the constitution and the corresponding legal rules governing property rights. If the premium is not a "price", as has been shown, then there could be no transmission of the property from the insured other than the "purchase" of his money or a donation, neither of which has occurred.

Equally untenable is any claim that there has occurred a transmission of property from the insured to the insurance company through a "mixing, combining, or manufacturing" because, in the case of money, a fungible commodity, the real value in the paper plays a subordinate role and because, in any event, even after relinquishing the specific paper, there arises the right of an identical reclaim in money (i.e., a legal claim for the value of the money after the mixing, combination, etc.)

### **Contradictions to the Question: To Whom Do the Insurance Assets Belong?**

Maybe, someone will say: "What has this question to do with the classification problem?" He will see, that this question very well concerns the classification discussion, too. If the contributions for loss pooling are no price and don't become the property of the insurance companies, so that these cannot take in the surpluses "as profits", then classification is not the task of the companies, but the task of the insureds or regulators, representing the insureds and their interests. If title passes to the insurance companies only as to the administration costs portion of the premium (the service price), then State intervention in the insurance area and the regulation of the contributions to the common fund was no nationalization ! -

The invested capital of all German insurance companies reaches an admitted value of DM 280 billion. To this must be added the hidden reserves such as the difference between book values and actual values (e.g. written off real estate or securities valued at less than their current value). Giving consideration to these hidden reserves, the German companies administer assets approximating DM 400 billion. To whom do these huge assets belong? – Here terms such as "ownership", "property", "belong" and the like, are used, for purposes of simplicity, in the legal and constitutional sense of property and include issues of legal constitutionally protected title.

Professor Alex Moeller, general manager of a stock life insurance company, and formerly Minister of Finance (in Germany, the over-all head of the Insurance Supervision Authority) has said:

"The collected capital belongs to the insureds."

Dr. Georg Buechner general manager of a stock insurance company and current president of the Association of the German Insurance Industry says, however that:

"The assets belong to the insurance companies."

Between these two totally Incompatible positions, the president of the German Federal Supervisory Authority, Dr., Walter Rieger treads cautiously and uneasily. With the waffling statement that:

"Although nothing is written in the laws, the insurance companies administer the money quasi-fiducially for their customers."

The exact meaning of the term "quasi-fiduciary" is quite difficult to comprehend, but it would seem to be somewhat like "quasi-pregnancy". One would think that either someone is a fiduciary, or he is not.

These obvious inconsistencies noted above, can be found even in the statements of the same company, institution, or person. Thus, the marketing and legal departments, as well as the board and the general manager of the Allianz Life Insurance Company regularly refer, in their correspondence and marketing materials to their enterprise as a "trustee of entrusted savings money of the customers". However, after a consumer group filed an information, accusing the company of embezzlement for its consistent drawing down of profits from this purportedly fiduciary money, the board proclaimed itself, to the public prosecutor and the Supervisory Authority, the proprietor of all the money and other assets it administers. On the basis of this latter claim, the information for embezzlement has now been expanded to include a count for misleading and deceptive advertising.

Although the president of the Supervisory Authority speaks of a "quasi-fiduciary relationship", he knowingly allows the surplus yields and value increments from this money and assets to be taken in by the companies as profits, even though the director of his institution, Gottfried Claus, as well as the Parliamentary State Secretary of the Minister of Finance, Dr. Boehme, have both stated that risk surpluses and interest yields are not operating profits and must be repaid in full to the insureds.

While the president of the Association of the German Insurance Industry maintains, on the one hand, that the assets and investments belong to the insurance companies, another member of the board of the association, Dr. Bach, general manager of the Continentale Insurance Group, has stated, on the other hand, that "the insurance industry is fiduciary investor of extraneous financial means". Similarly, the editor of the same association's periodical, Dr. Fritz Feigler, has written that "the money was left fiducially with the insurers".

Professor Dr. Dieter Farny, an insurance and economics academic, has developed a "production theory of insurance" which postulates that the premium is the price paid for the product "insurance". According to this reasoning, logically, there would have to be a complete transfer of title in the property of the money to the insurance company. Yet, in the very same book in which Professor Farny presents his production theory, he writes the astonishing statement that: "The biggest part of the considerable assets are only administered fiducially". Every clue is lacking as to how fiduciary money could conceivably arise from the payment of a price for a product.

### **U.S. TREASURY DECISION NUMBER 1743**

This question (Dividends) was argued at great length and in full detail before the Internal Revenue Department and before Congress during the early months of 1911. The income tax clause of the Tariff Bill of 1911 proposed an income tax on Life insurance dividends. Representatives of companies featuring participating

insurance vigorously protested against this tax. The arguments and contentions of these companies are clearly set forth in the following quotations from UNITED STATES TREASURY DECISION NO.1743:

"Reduced to final analysis the contentions of the various companies are...

"That dividends declared by participating companies are not dividends in a commercial sense of the word, but are simply refunds to the policyholder of a portion of the overcharge collected, which overcharge is merely held in trust by the company issuing the policy. Annually, or at stated periods, all, or a portion thereof, is returned to the person holding the policy...

It was vigorously contended by counsel, representing certain of these companies that it was necessary at the outset to disregard entirely the policy contracts, the published literature, the representatives of officers and agents, the sworn returns of state authorities, and to consider the proposition only after items had been eliminated; that owing to the urgent need of business and the competition of insurance companies, it was necessary, in order to secure new business, to convince the prospective policyholder of the desirability of the same, and that this commercial necessity had resulted in the companies making misrepresentations of facts as to DIVIDENDS to prospective purchasers of insurance, and that names and designations, having a single specific meaning in the commercial world and which were therefore attractive to prospective policyholders, had been adopted to represent transactions which they now hold are entirely different from what their name implies and represents, and from which the policyholder himself believed he was receiving, and that business necessities had caused a continuance of these misnomers. It was represented that, in fact, there were no dividends, but merely a refund of overcharges, which, for reasons above stated, were usually referred to as dividends."

In this connection, it is interesting to note how life insurance dividends are referred to in the present Federal Income Tax Regulation 94. In article 22, on Gross Income, Regulation 94, this statement appears: "Amounts received as a return of premiums paid under life insurance, endowment, or annuity contracts, and so-called DIVIDENDS of a mutual insurance company which may be credited against the current premium, are not subject to tax."

### **Lack of Investigations and Generally Accepted Definitions**

This basic question, "property or fiduciary money" and the inconsistencies in the myriad statements dealing with the subject have never been seriously investigated, Seemingly, the manifest contradictions have never struck the people charged with responsibility or else they have simply overlooked these contradictions intentionally. Understandably, the insurance companies have no interest in clearing up this question since they handle the money left with them by the insureds as if it were their own and take from it as much as they want in the way of expenses and profits, By acknowledging the relationship as only a fiduciary status, their current practice of taking profits from the insureds' money would contain all of the elements of the offense of embezzlement. The explosive effect of the situation is best demonstrated by the fact that the board of the Association of the German Insurance Industry has forbidden all of its members to enter into any public discussion of the question»

The Government and Supervisory Authority, charged by the Insurance Supervision Law with responsibility for preventing abuses in the insurance field, have also displayed very little interest in confirming the fact that they have overlooked or ignored the expropriation from millions of insureds of billions of DM over the years,

The insureds themselves, what with the mystique surrounding insurance and the total in transparency of the premiums, simply do not know and lack the means of knowing what has occurred and is occurring. Moreover, because of the host of special legal regulations on insurance and the 4 existence of State supervision, the insureds would rather believe that the question of ownership has been asked and answered. The fact is that the insureds have the wrong impression, produced and conserved by the "insurance industry", that they have paid their money as a price for the purchase of security and that, having so paid, they have no later claims to the surpluses, arising from the loss pooling. It is in this fashion that the insurance companies have, in the course of the years, built up "their" assets of DM 400 billion. The Supervision Board itself consistently asks for "considerable safety margins in ratemaking" (Gottfried Claus, director of this board) which, generally, lead to large surpluses in the loss pooling funds. The German insurance companies have an annual income of DM 80 billion in premiums and DM 20 billion in investment income (excluding any consideration of asset appreciation)<sup>9</sup> or a total annual income of DM 100 billion from which they pay out only DM 40 billion. Although some academics and officials of the Supervision Board and Government admit that risk surpluses and interest yields do not constitute operating profits, such statements are addressed only to the companies and are not made for general public consumption. How, then, is the single insurance consumer to understand these technical niceties involving billions of DM and recognize his possible legal ownership of fractions of this money? –

In the study of the "Scientific Services of the German Parliament" the one-sentence statement was made, without analysis or investigation: "The premiums pass over, in any event, into the property of the insurers. They are not entrusted funds." In saying this, they rely upon Professor Rudolf Gaertner who also says, without analysis or reasoning:

"There is no question that the assets of the insurers are their property and are not administered fiduciarily. It would be a curious concept that someone could be considered trustee of others' fortune while at the same time he has in his hand and can appropriate to himself parts of this fortune."

To this, one can only reply that it is a curious situation when an academic attempts to substantiate his belief by the incredibility of the opposite; the money cannot possibly belong to the insureds because, then, the current practice of drawing down profits from this money would constitute embezzlement. This is incredible for the academics – but, in fact, this embezzlement is committed daily to the tune of billions of DM.

The courts have never had to deal with this 400 billion question because this problem has never, thus far, become a legal issue.

As to insurance science – it is a pity that only special insurance academics have dealt with these questions of the insurance field. In all too many instances, there insurance academics have personal or financial ties with the insurance companies or their associations. Indeed, the Association of the German Insurance Indus-

try is not afraid to point to their harmonious cooperation and to proclaim the insurance scientists to be their best helpers.

### **Creation of an Understanding Prejudicial to the Insureds"**

Although government, ministries, supervisory authorities, and the cartel board have., for years., been informed of this complex of problems" its consequences, and the present system's contradictions to the legal and economic system, they have done nothing, not even to the point of investigating, If any studies were ordered, it was only for the purpose of proving that the present system is right, never for the purpose of ascertaining if it is just possible that the present system might be All those bearing legal responsibility, as well as the insurance scientists and the so-called "insurance industry" have thrown up a stone wall of silence to all questions. It almost seems as though a decision of the Association of the German Insurance Industry in late 1980, not to discuss this question, is binding upon a whole nation – even including its media. It surpasses understanding why not even a public discussion has come to pass on these questions which involve DM 404 billion, 350 million insurance contracts, and every citizen.

The suspicion of a collaboration arises from a reading of the following statements:

Hans Joachim Vogel, former German Minister of Justice, has said:

"For a long time, the insurance companies and their associations have lived in peaceful coexistence with my house".

Hans Apel, former Minister of Finance (overall head of the Supervisory Authority has, said:

"State and insurance industry got along quite well during the years behind us. But, along the way, the suspicion could arise with third persons that here an understanding prejudicial to the insureds was created."

One is reminded of the statement of U.S. Senator Howard M. Metzenbaum who said:

"The fact is that neither the insurance commissioner nor the Legislature ever really make the regulations. They do what the industry tells them to do.

In this connection, in view of the vaunted "harmonious cooperation of insurance industry and insurance science" and taking into consideration the recent statement of the president of the Supervisory Authority In which he said that he had only the "function of a night watchman", it can be seen that this apparently simple, but consequentially weighty, legal question involving ownership of DM 400 billions becomes a juridical issue of tremendous importance. Not less important becomes the issue regarding adequate representation of the insureds' interests and their participation in the control. over their money supplied for pooling of losses.

Just as the insurance scientists cannot succeed in their endeavor to make the insurance, premium into a price, neither can they succeed in their endeavor to substantiate a transmission of property from insured to the insurance company. Such a transmission is essential to justification for the allocation of the insureds' money to insurance company profit. If this transmission does not occur, there is no law or regulation which

can allow the insurance company to apply the money of others as "profit". To put it even more clearly: No one can legitimize the embezzlement of entrusted money. This is not different after an "orderly accounting or balancing" of the extraneous money as "property of the company".

### **Loss Payments Remain the same – under any System**

Whenever anyone wishes to abolish or reform the present system, the specter is immediately raised: "Who is to pay the losses if the premiums are not sufficient?" This ghost of additional payments by the insureds quickly reveals itself to be false. If the money provided by the insureds for loss pooling never did and never could really pass into the money of the insurance companies,' then it necessarily follows that all of the assets and investments which arose out of it belong to the insureds. Therefore, if the premiums should not be sufficient, occasionally, the same safety means are at hand to cover the deficiency as now with the all important proviso that the safety valve would be represented by the property recognized as belonging to the insureds rather than the insurance companies.

No one is against insurance. Insurance is a noble and essential social performance; but it is the performance of the insureds, not of an "insurance industry". No one wants to abolish the system of insurance on the basis of a fixed contribution by the insured; but the surpluses arising out of the regularly excessive contributions must be accumulated and invested as safety reserves of the insureds whose property those surpluses remain.

Under the present or any other system, no one can expect that less money will be needed to compensate for losses that are not subject to influence; but after a clear delineation of the property rights of the insureds in the loss compensation funds and the securing of real competition in the service area by the premium breakdown, the services costs of insurance will surely go down. Investigations in the USA and Germany demonstrate that, currently, the property and casualty insurance companies do not even pay out half of the money, they take in, for the payment of losses – an incredible fact.

### **A "Risky Insurance" by Speculation or Gambling?**

If the "insurance industry" wishes to substantiate any profit justification, it can only do so by making of insurance a speculative endeavor. In that event, however, the government must ask itself if the state wants to, or can, license such a gamble and how it will reconcile this speculative risk with promotion of the safety efforts of the insureds; how the state will reconcile its supervisory efforts for solvency in order to avoid risk for the loss funds with the necessity of an existing risk as profit justification for a speculative endeavor. If the state were called upon to license a "risky insurance" business, it might no longer care to supervise the solvency of the insurance companies.

### **The German Dispute on the Basis of Insurance**

In Germany, this underlying dispute has smoldered for many years but only recently (November, 1980) surfaced in the remarks of Georg Buechner, president of the German Insurance Industry Association, who said:

"Now, what do our opponents say? They tell the insurer: You are nothing, the group of the insureds is everything. Insurance is mutual help, the common providing of money by the insureds for the purpose of a common loss pooling. Thus, insurance is the performance of the insureds themselves, not the performance of the insurer, just as saving is the performance of the saver and not that of the bank. The insurer was nothing more than the organizer of all that, the service performer and cashier. For this he is entitled to compensation for his costs and a reasonable profit, but he has nothing to do with the insurance risk; this is exclusively the business of the insureds. Therefore the risk portion of the premiums belongs to the insureds and only to them as do the assets and premiums created out of the risk portion. This separation of the insurance business into service and risk would correspond to a separation of the premium into a service remuneration, the price for the insurer, and an insurance contribution. Only such a recognizable separation of the premium in the tariff and the invoice would create the price transparency which, until now, has not been provided in the insurance field. And, last: By drawing profits from the risk business and its investments, the stock insurer has invaded the money of others and made itself liable to prosecution. So, for our opponents, what shall one say to answer them? One must say that this is a legally and economically untenable, quite naive, and not attainable conception."

Nevertheless, in the same speech of Mr. Buechner, he indicates that the insurance industry itself, its scientists, and its lobbyists have often contradicted the present practice. In this connection, Mr. Buechner cautioned:

"Some of you will have thought, incident to the presentation of this new model, that we ourselves say a lot which is quite similar to this in our Sunday speeches. We often talk in a romantic figure of speech of a risk community and the group of insureds; and we like to call ourselves trustees of this group. If we do not energetically stop these thoughtless utterances, we must not be surprised if the bill for it is presented to us with a loud bang."

The following represents some of these "Sunday speeches" which must be "stopped energetically" because they disclose and confirm the present practice of "profit-making from fiduciary money". Thus, in a letter written by the legal department of the Allianz Life Insurance Company, it was said:

"As you know, we exercise a trustee function for our insureds as to the money we are entrusted with." –

Or: As a trustee of the insureds' community Mr. Baeumer, principal manager of the Allianz Life Insurance Company, and former president of the German Insurance Industry Association, has said:

"The German life insurers invest the savings money of their clients."

Mr. Bach, General Manager of an insurance group and a member of the board of the Insurance Industry Association stated:

"The insurance industry is, fiduciarily, the investor of the capital administered for the insureds, that means that it is the fiduciary investor of extraneous money."

The editor of the Insurance Industry Associations' magazine, "Insurance Industry" wrote:

"The insurers bring on the capital market the money that their clients leave with them in trust."

Mr. Rieger, president of the German Insurance Supervisory Authority' has said:

"Though there is nothing written in the laws, the insurance companies administer the assets as a quasi-fiduciary for their clients."

Mr. Claus, of the German Insurance Supervisory Authority, has said:

"Risk surpluses and their interest yields are not operation profits."

Many of the "insurance academics" also confirm that "the means for the insurance performance are provided by the insureds or the group of insureds". Thus, Professor Farny has said:

"The insured provides the money for loss payments. In the insurance company, there are always considerable assets. The greatest part of these are only administered fiduciarily."

Professor Roehrer has said:

"The financing problem consists of storing the inflowing extraneous capital."

Professor Schanz has stated:

"In a group of insureds, the insurer organizes the financial compensation between loss-free and loss-burdened risks."

Professor R. Schmidt has concluded:

"The grouping together of endangered people, which is meant here, is primarily a technical organization principle."

Professor Loeffler has written:

"The task of the insurer is to organize a collective of insureds."

A five-volume work, "German Insurance Industry", published in 1936, states:

"Therefore, insurance companies, no matter in what form they are operated, are trustees of the group of insureds in the best sense of the word. The insurer is only the organizer of the protection community, but the insureds are the financial risk bearer. Insofar as the reserves of the insurance company do not consist of yields from the stock or guaranty capital, they are broken down portions or surpluses from the contributions of the insureds. They belong, according to their determined purpose, to the totality of the insureds.

From the foregoing, it is evident that the most important risk bearer in the insurance industry is the insured through his performance in the form of contributions. Compared to his economic participation, the participa-

tion of the other financial backers is paltry. Considering the reserves currently existing the capital of other financiers represents only a fraction of p the guarantee function. It is the insureds who, collectively, through their contributions, provide the means through which the insurance company is enabled to perform the insurance function. Seen in this light, the insurance management is nothing more than the administrator and trustee of the means provided by the insureds. The management, in effect, acts only according to the mandate of the insureds."

As started by Professor Alex Moeller, former German Minister of Finance, and General Manager of a stock insurance company:

"The state must take care that no abuse is done with respect to the collected capital. The collected capital is – regarded economically – not the property of the companies, but belongs to the insureds."

Similar views are held in the United States. Former Federal Insurance Administrator, J. Robert Hunter, has said:

"We need to explore the ways to make it clear to the people that they are the insurers and the insurance companies are the accountants. We need to make it clear that profits of stock insurers on the loss portion of the rate are improper."

Similarly, Ralph Nader has concluded:

"The real insurance company is the people. We are the insurance company, with what are now called the insurance company serving the function of glorified bookkeepers."

The many quotations and explanations above amply demonstrate that insurance can never constitute the "product" of the insurance companies and that the premium can never constitute a price. Thus, the surpluses can never be "profit". It has also been clearly demonstrated that, because of the incorrect structuring of the insurance field, stock insurance companies wrongfully appropriate as "profits" surpluses resulting from the loss pooling, that is, surpluses arising from an extraneous performance.

The reason for all this is, as has been pointed out, the fact that the insurance premium is not separated into its component parts of (1) the contribution for loss pooling and (2) the service price for the performance of the insurance company. It is only when such a breakdown of the premium has been achieved that there will be a clear perception of property rights in the common fund for loss compensation, and only then will there be effective competition for the consumer.

The defenders of the present system finally advance a last gasp argument. The president of the German Insurance Industry Association asks:

"Where else is it given that prices are broken down that way?"

Here, once more, the fact that premium is not a price is ignored. No one is asking the insurance companies for separation of their service prices; all that is asked is for a breakdown of the premium into the loss-pooling contribution and the service price, just as the banks separate the clients' money and the banks' fees.

It is amazing how the "insurance industry" its academics, and its lobby has succeeded in seeing to it that these obvious contradictions are never publicly discussed nor investigated by official bodies:

Insurance: Is it the "product" of the companies, or the performance of the insureds?

Insurance contract: Is it a contract of mutual performance or a contract without mutuality?

Insurance premium: Is it a price, or is it composed of the service object factor (money for loss-pooling) plus a price for the services of the companies?

Loss Payments: How can they be costs since they represent the distribution of entrusted money?

Money for loss payments: A production factor or an object factor?

Contributions for loss pooling: Are they property of the insurance company or the property of the insureds?

Surpluses from the loss funds: Are they the property of the companies or of the insureds?

Assets: Are they property of the companies or of the insureds?

These obvious contradictions involve not just millions of dollars but billions; assets of \$650 billion in the USA, \$150 billion in Germany excluding hidden reserves which probably would increase the total by, perhaps, 50 percent. This conflict comes into the light through the questions surrounding the automobile insurance rating structure.

## **HISTORICAL DEVELOPMENT OF INSURANCE**

Before demonstrating these connections, the historical development of insurance shall be described to underline these connections and to firmly establish the doubts of all those who say now: "Unbelievable ! How could all this happen and come into being ?"

About this the author wrote in his booklet "Insurance and Regulation – Services and Competition":

### **The traditional Insurance Institutions**

Professional corporations and house owners in the Middle Ages were united in "mutual insurance associations" and "public insurance institutions", since more than any other association the groups of insureds required an administration office which undertook the collection and distribution of the funds provided.

These administration offices of the insurance institutions of the Middle Ages assessed reference to statistics and the law of averages the amount of money required to cover the losses and the expenses for a particular

period of insurance. This money requirement was apportioned to the members and insureds and paid by them in advance in the form of contributions. Naturally this money requirement could only be assessed. Fortuitous and unforeseen variations in losses created both plus and minus irregularities. If, after the application of money for costs and damage compensation something was left over this was either repaid to the insureds or set off against future contributions. If the contributions paid in advance were insufficient, then the insureds had to make corresponding additional payments. The insurance institutions and the administration offices claimed no profit, not even for the efficiency of their services which they gave to the insureds. Above all costs were for the personnel and, only to a small extent, for technical equipment. All the costs were paid in advance by the members. There was no risk for the enterprise. The mutuals and their property belonged to the members, who at meetings of the annunciation and through representatives dictated the business policy.

The mutuals and the administration offices provided work for the group of insureds, a service for the economic solution of the problem of "insurance", in the same way that banks provide a service for the economic solution of the problem of saving or transfer of money.

But just as the banks do not save but the savers themselves and just as the banks do not pay the bills of their clients but the clients themselves, so the insurance institutions do not insure the members but the insureds insure, themselves through the mutual financial help and the provision of their money.

### **Unbrokendown Contributions**

It is important to realize that the insurance contribution was made up of two parts which were entrusted to the administration offices and until used remained the property of the insureds:

1. one share for the costs of administration (contribution for expenses)
2. the actual "insurance contribution" for loss pooling within the group (contribution for loss pooling)

The insurance contributions were, for a variety of reasons, not divided and the two very different parts were specified either before nor after the insurance period. The insurance institutions were run by public institutions or with the cooperation or control of the members and operated as cooperatives with no view to profit. Great trust was placed in them in that they handled the money entrusted to them in a responsible manner. On account of the uncertainty of the future that could never be avoided the payment for damages could not be specified exactly in advance. The resultant subsequent settlement of the contributions was controlled by the public institutions or by members and all the surpluses of contributions were correctly repaid, set off against future payments of contributions or passed into security reserves.

### **The Change in the Field of Insurance Caused by the "Insurance by Stock Companies"**

The insurance world was, until the 19<sup>th</sup> century, in order and insurance had until that time developed peacefully. Nobody can maintain after the representations so far shown, that insurance an mutual help of insured or the performances of the insurance administration offices are complicated or could cause reproach.

Then, however, there was a complete revolution which led insurance towards complication and mistrust and to the necessity for State control. In the 19<sup>th</sup> century the stock companies encroached into the insurance field. The so-called "profit making insurance" came into being.

For the consumer it appeared that there was no great difference between the method of operation of the stock companies and their predecessors and "competitors".

The stock companies applied the same terms and conditions of insurance as their predecessors and "competitors". They collected an undivided contribution and did not quote in advance the costs of operation and the actual insurance contribution just like the predecessors and "competitors". As their predecessors and "competitors" the stock companies gave no subsequent account explaining the expenditure of the money paid to them, which they no longer called a contribution but a "premium".

But the stock companies did not have the intention to return premium surpluses to the insured, but, instead, retained them as profits, Therefore they relinquished the right to require additional payment from the insured in the event that the premiums collected were insufficient to cover the loss. When such a case happened then the stock companies had to cover the loss by making payment from its own capital. The stock company offered a "fixed premium insurance" which could not be altered either by refund or additional payment.

The novelty in this method of operation of the stock companies was that all surpluses were claimed and applied as profits. From the surpluses that resulted at the end of the company's financial year the stock companies paid dividends to the shareholders and besides accumulated money in the form of reserve funds, and thereby the quoted value of the shares increased. In order that the quoted value of the shares did not increase too much, the reserve funds were, from time to time, applied to increase the original stock – a transaction, that the stock companies referred to as "self financing of privately owned capital from one's own assets and which resulted in regular free issues of shares to the shareholders (in addition to payment of high dividends).

For a layman it is practically impossible to say what the difference between a traditional insurance institution and a stock company is. Both perform the same tasks such as advising in the conclusion of the contract, collection of premiums, management of the contracts and the money, claim settlement etc. All these tasks are paid for from the cost portion contained in the premium paid in advance by the insured. Since the stock companies in the insurance field do not have to invest in "production plant" the operating risk of their functions is extremely small, These particular circumstances in the management of insurance portfolios is the reason why the traditional insurance institutions have operated in a non profit making way up to now.

### **No Structure for Performing Services**

The fact that the traditional insurance institutions operated without profits is no reason why the stock companies should not perform the same tasks profitably and make their profits through the efficiency of their method of performance and management of capital. However it would have required very

important alterations in order to change the performance of the traditional insurance institutions into a profit making service.

For this service the stock companion should have demanded a price and could have retained the price surpluses over their costs as profit. They should then, however, in contrast, to the non profit making insurance institutions, divide the premium into a price for their services and the contributions for loss pooling of the insureds. The prices for services would have become the property of the companies and the contributions for loss pooling would have remained the property of the insureds. The contributions for loss pooling would – as in the case of the traditional insurance institutions – have been assessed in advance and could have been regulated according to the outcome of losses by refunds or additional payments. It could however have been fixed in advance after the setting up of corresponding safety reserves which would have remained the property of the insureds.

The stock companies could, for example, have made the following offer: "For the pooling of losses within the group of insureds you have to pay a sum of 100 dollars as a contribution for loss pooling. A surplus will be refunded and a deficit will be required from you in the form of an additional payment. The price for our services is 50 dollars. We shall pay a certain interest from reserves, which we shall invest from the surpluses of the insureds' contributions for loss pooling. For any particular services particular fees will be accounted."

This offer and method of operating would have corresponded to the procedures in the field of banking. The division of the premium and the quotation of a price for the services would also be compatible with the method in which the insurance institutions are dealt with in the National Accounts and determination of the Gross National Product – namely as service firms. As a result the stock companies had to quote a price for their services, since the regulations concerning the quotations of prices, which is a condition for any competitive trade, also apply to them. However, they do not specify prices for their services! –

It goes without saying that companies that wish to perform a profit making service in the field of insurance, must designate the insureds' money and deal with it separately in the statements of accounts and should not take any profit from it.

If the stock companies had, 100 years ago, undertaken their functions in accordance with all these legal and economic fundamental rules and if they did not today, then "insurance" would not have become complicated and the questions concerning the performance of stock companies, the price and the property in the premium would never have arisen:

- the stock companies could find their profit justification on a service,
- the prices for this service would be specified definitely,
- an undivided premium would not have existed. This would be broken down into a price for the service and the contribution for loss pooling. Only the service price would pass over into the property of the stock companies. The contributions for loss pooling would remain, until payment to the persons suffering a loss, the property of the insureds.

## The Origins of the Existence of "Fixed Premium Insurance"

How a whole "industry" could come into existence which pretends to "produce insurance" and be able to "sell" it for a fixed premium as a price, and in which for more than 100 years stock companies have drawn chance-related profits from – necessarily – over-calculated premiums, without equivalent performance, in only understandable when one reviews the nature and development of insurance.

Insurance can only arise from the money of the insured (contribution for loss pooling). The costs of the traditional insurance institutions were also paid with money (contributions for expenses). The particular feature in, in this case that a service is performed "on" money and paid for with money, whereby there was naturally the possibility to mix, indivisibly, the price for the service (contributions for expenses) and the "external factor" (contributions for loner pooling) – that is, money and money. For the traditional insurance institutions this meant no danger, since they did not claim for profit, all the contributions were dealt with as the property of the insured and at the end of the period of insurance any surplus was refunded. The insureds became used to this system which gave the impression of a contract of sale, although in this procedure the service of the administration office and the insurance as a performance of the insureds were bound up together.

The insureds mentally separated themselves from their money when paying their contributions because they were conscious that they had to give this money to the persons suffering a loss, if they themselves wanted to receive compensation from the other persons insured in the case of loss. The insured has quite a different idea of this corporate saving of money for compensation of loss from the person who saves for himself.

The individual saver is naturally far more interested to know what happens to his money, since he wants his money back. The idea of a person who leaves alone is that he entrusts his money to a bank to be managed and that the money remains his property and only he can dispose of it. The saver, such as the owner of a giro account would not allow the bank to take over the remnants in his accounts and profits at the end of the year.

The idea of the individual who saves in a group of insureds for a common loss pooling is, on the contrary, that he must give his money for the corporate compensation for losses and only gets something back when he suffers a loss. He gives his money away and entrusts it to an administration office. This office should manage the corporately saved money in a fiduciary way.

The founders of the stock companies, in their business with the uncertainty, took advantage of these particular circumstances:

- the fact that the "external factor" of service and the service price arise from the same material
- the traditional mixing of contributions for expenses and loss pooling
- the giddy trust of the insureds
- and their mental separation from the contribution "given away".

The stock companies could, without difficulty, introduce their novel "fixed premium insurance" which corresponded exactly with the (mistaken) idea of the insureds of the "insurance process". In this procedure, too,

the insureds give away their premiums and also receive, in the case of loss, compensation as a present. Since, however, the stock companies had done away with the "group of savers", its cooperation and control as well as every subsequent account or refund, the insureds were quite unaware, that they were making presents of certain surpluses to the stock companies; for these surpluses of money, which the insureds give away, there is absolutely no performance exchange from the stock companies.

### **The Mixing of Insurance and Service**

Nobody realized that also the stock companies like all administration offices in the field of insurance could only provide a service, because neither production nor speculation could be reconciled with insurance. On account of the particular traditional circumstances the stock companies were nevertheless successful in mixing insurance, service and speculation together and created therefore a "mass speculation without risk", which leads to unjustified enrichment.

All problems in the field of insurance have arisen for the following reasons:

- that insurance as the performance of the insureds and the service of the administration offices were mixed up so that the mistaken idea arose that insurance could be a "product" of a stock company,
- that the contributions for loss pooling and the price for the service were mixed into an undivided premium so that the mistaken idea arose that these mixed procedures and premiums could be the object of competition,
- that the surplus from the contributions for pooling and the surplus from the prices for the service were mixed and the mistaken idea arose that all surpluses from these mixed procedures - including the surplus from the insured's contributions for loss pooling – could be profits of the stock companies,
- finally that the stock companies, through this mixing obtained a grip upon the surplus from the performance of the insured's and thereby all problems of insurance, which are connected with the uncertainty of the future, became the profit problems of the stock companies."

### **SELECTION – A "NON-PERFORMANCE-COMPETITION"**

I quoted that recently an official of the German Supervisory Authority and a State Secretary stated that the surpluses from the loss pooling area are no profits of the insurance companies, but only the "surpluses, which have other reasons". These other surpluses are those from the service area. Since the premium is not broken down into the contribution for the common fund and the service price, nobody is able to ascertain which surpluses arise from which area.

The insurance stock companies and their academics believe that this breakdown was not necessary because the premium was a price and all surpluses from a price were profits. In this wrong supposition lies the origin for the present classification dilemma.

The companies can influence the surpluses from the premiums in two ways:

- by efficient service performance, distribution and money investment
- by selection

Among the many peculiarities of the business of insurance perhaps the most peculiar is that rivalry among insurance companies through the selection of risks, called "selection-competition" which is unique to the "insurance business". A former New York Superintendent of Insurance, Benjamin A. Schenck said of this phenomenon:

"In insurance, there is one form of competition that seldom exists in the case of other products or services. That is selection competition - the ability of an insurer to affect its success, not by the price or quality of its products, but by selecting its customers in a fashion that will give it an advantage over its rivals. Selection competition is a feature of the insurance economy which seems to provide a ground for distinguishing insurance from other products and services and for fashioning for insurance a series of rules unique to its problems and circumstances. Selection competition should have few admirers. It is capable of totally denying to some people the opportunity to get insurance."

Contrasting the "sale and purchase of insurance" with the sale and purchase of tangible goods, the FIA Report said:

"An insurer can enhance its profits and competitive position as much or more by not writing business as it can by writing it. In short, whereas the seller of tangible goods can, and will, sell indiscriminately to any purchaser who will pay the price and has no incentive to restrict his sales, the insurers' profits and competitive success currently are derived through its ability to select the risks."

This process, and its churning effect on the insurance mechanism was described in a report of the U. S. Department of Transportation entitled "Insurance Accessibility for the Hard-to-Place Driver" where it was stated (pp. 1 and 22):

"Insurers do not find it profitable to grant coverage to all applicants. Even within the most highly developed rating classification there are still some drivers who have distinctively higher than average loss potential. Insofar as the rating system fails to account for these differences, there is an opportunity for insurers to increase their profits through selective underwriting. The result is that some applicants are rejected. This residual group of rejected drivers is likely to become larger as competition becomes more intense. The more insurers profit margins are under pressure, whether for competitive or regulatory reasons, the greater their efforts to sort out applicants with higher than average loss potential. Cancellations and refusals to renew are manifestations of these efforts. The existence of a substandard or hard-to-place market appears to be inevitable in the context of a fully competitive insurance system. Only by placing restrictions on competition through underwriting could such a residual market be reduced in size or eliminated. Because risk variations in the driving population exceed the scope of any feasible rate classification, insurers will have a profit incentive to reject the poorer risks within each class. Thus, the substandard market is not based on unusual or temporary factors in the insurance industry; rather, it is a basic result of competition."

It should be understood that selection cannot possibly influence the total of loss payments or the macro-economic composition of losses. If one company succeeds in selecting a group of drivers with a lower loss record from this entire group of compulsory insureds and offers to them a lower premium, then, automatically, all the Other compulsory insureds have to pay correspondingly higher Premiums because the total amount needed for the compensation of automobile liability losses remains unchanged. Indeed, one of the principal criticisms of the present system is that it has no tendency to diminish the total of losses. As former Commissioner Stone observed:

"The insurance mechanism in use today observes and measures claims, but it never reduces them."

The claimed "business result" flowing from selection clearly is not brought about by any economic performance of the insurance company such as increased productivity or lowered costs, and, as observed earlier, the total need for loss compensation cannot possibly be affected through the selection activities of the insurance service companies. Rather, those activities closely resemble the action of "robbing Peter to pay Paul".

In reality, the aim of selection, so far as the companies are concerned is to maximize profits and not to "perform" payment of losses. Thus, selection is not a performance competition but, rather a "non-performance competition", which is an impossible economic process. The focus of the concern of selecting insurance companies is not the covering of needs. Selection sees to it that only the needs are covered of those who have the least need of insurance. On the other hand, in the USA, the lack of compulsory acceptance by the companies brings it about that those groups of insureds who have the greatest need for insurance are the ones not covered.

The former U. S. Federal Insurance Administrator, Gloria Jiminez, has voiced the opinion that "selection competition" is no longer tolerable. In a letter to the U. S. Department of Justice, she wrote:

" 'Companies compete by out-selecting each other', according to Grover E. Czech, Regional Vice President of the American Insurance Association. He added, 'the better the book of business they have, the lower rates they can charge.' He went on to say that the reinsurance facility would 'tell the companies: You can no longer compete on selection'."

"Although we suspect that Mr. Czech might not agree with us, the Federal Insurance Administration (FIA) would round out this statement by putting it this way:

'The reinsurance facility would tell companies: You can no longer compete on selection, you must now compete in efficiency, the lowering of your expense requirements, and superior investment performance'."

In speaking of "insurance competition" during the U.S. Senate Hearing, former Massachusetts Insurance Commissioner James Stone said:

"One of the most consistent thematic elements in their presentation in support of the current approach is the argument that any major deviation from the present relativities will be incompatible with competition. I disagree with the demands of a competitive system, and I would trace the source of the dispute to problems which surround the definition of competition.

There is no universally accepted definition for the most suitable form of insurance competition. Competition's greatest benefits have generally been presumed to be related to efficiency. Nothing in the proposals would impede overall rate level competition based on differing business efficiency. The sort of competition that risk assessment freedom provides has no incentive impact on operating costs."

### **WHAT IS COMPETITION ?**

I studied a lot of international literature (in the College of Insurance in New York, too). Except the NICO people I found only two persons doubting that there was competition in insurance and asking (but not investigating) the right questions. These are Commissioner Stone in his above printed quote:

"I disagree with the demands of a competitive system, and I would trace the source of the dispute to problems which surround the definition of competition."

The other person is Ralph Nader, who said in the Senate hearing about the Insurance Competition Improvement Act in May 1980:

"The word 'competition' in this industry is misused. It has to be given a much more profound elaboration."

### **No Competition Prerequisites in the Insurance Field**

The author, in his booklet "Insurance and Regulation – Services and Competition" wrote in a section "No Competition Pre-Requirements in the Insurance Field":

"The unfortunate result of the confusion of "social insurance performance" with the "commercial service performance" of the stock companies in that competition in thereby made impossible.

As to insurance itself, there can be no competition because the loss contributions are dependent on the chance-related development of losses and not on a performance. As long as the insurance and the service, the loss contributions and the service price as well as the insurance surplus and the price surplus are inseparably mixed with each other, there can be no competition as to service.

Competition is a regulation system of the economy through a free market. This regulation ensues on the one side through laws and officials which are concerned with the competitiveness and visibility on the offerors' side which thereby at the same time creates freedom and ability of decision-making on the consumers' side. In addition, the efficiency and innovation of the offer is regulated through the free decision of the informed consumer supplying his needs.

This second requirement, the participation of the consumer in competition as a decision-making factor, is in many fields and above all, in the insurance field, not yet realized. Rivalry of companies alone is by no means competition. This is the essential perception and basic principle of consumerism (promotion of the consumer position in the market), that in addition to several offerors, competition above all includes visibility of the market and a free consumer capable of making his own decisions.

With the decisive participation of the consumer, competition above all should prevent single firms from unilaterally taking advantage of the free market system and to achieve profits that are not performance-related. For this reason, competition in the insurance field is not realized because the stock companies demonstrably achieve profits that are largely determined by the chance-related development of losses. There is no economic performance upon which the profits are based. These profits arise above all from inevitable overcalculation of the premium, from selection and from thereby resulting surpluses and from the reduction, or refusal of loss payments – all without any economic performance ! – Only a very small part of these profits can perhaps contain a surplus from an efficient method of operation. But no one can determine whether such a surplus really exists or in what amount.

It is impossible that there can be competition as to procedures that lead to profits not based on performance, but on chance occurrences which competition is supposed to prevent. It is impossible that there can be competition as to procedures through which someone is unjustifiably enriched from the surplus that arises from someone else's performance. The surplus of the contributions for loss pooling arises from the payment by the insured and no one is permitted to appropriate these surpluses or it has to be specifically permitted in the insurance field and even left to competition which otherwise is considered embezzlement ! -

"The question is not whether there is competition in the insurance field (a question which is asked, examined, and answered incorrectly again and again); rather, the question should be which performances mixed within the fixed premium, and which parts the premium are spheres which can and should be influenced by competition?" – If the question is asked this way, the answer can only be: Competition cannot exist as to the "insurance" area, the mutual, cooperative spreading of loss, the mutual loss pooling and the classification and rates for the contributions for that loss pooling. No one could be so foolish as to believe that competition in these spheres can reduce the loss payments or have any other economic effect.

This is also proven by the fact that throughout the world, associations or "rate bureaus" without competing ascertain the money requirement for losses and determine uniform "basic premiums" by working together with the same statistics. But the consumers never learn the level of these contributions for loss pooling because every company individually changes these contributions by adding costs and profits surcharges as well as by creating separate classifications and terms and conditions. What is noteworthy in this context is that the companies determine their basic premiums without competition, but that the stock companies then take in all the chance-related surpluses of these basic premiums as profit as though the calculation of the basic premium were a sphere of competition.

Since the premium is not broken down and the surpluses from the loss contributions not protected from the grasp of the stock companies, the companies' rivalry extends above all to the contributions for loss pooling. However, this rivalry by the companies cannot be considered as true competition, because events which lead to not performance-related profits, to unjustified enrichment and to unlawful appropriation cannot possibly be considered spheres of competition. There can and should be no competition as to the undivided premium because this fixed premium is based, through the inclusion of insurance and the contributions for loss pooling on chance and uncertainty, but not on a calculation of an economic performance.

There is no transparent market of services in the insurance field. The insurance customer, due to the mixture of the various services and premium components, is not in any position to understand his own contribution for loss pooling, the service of the stock company and the price for this service. He is not able to evaluate the price/performance relationship. A price/performance relationship cannot be investigated if an undivided premium is given for a package of one's own and someone else's performances with the consumer having only this premium to compare. As the expression "price/performance relationship" already says, the individual performances must be described and the prices and contributions must be quoted. Should this happen in the insurance field, then everyone could easily recognize that there cannot be any competition and negotiation as to the contribution for the pooling of chance-related losses (in personal lines) and that competition must be limited to the service of the companies and the price for this service.

"Since there is no premium breakdown nor corresponding quotation of prices, there is, in the field of insurance, no competition as to the actual service of the companies, because the insured does not know the price of the service because he does not know which services he is paying for, and since he cannot judge nor evaluate the efficiency of these services. Last, but not least, the insured cannot prove whether these services have actually been performed for him.

Thus it is impossible for the consumer to take over his "decision-making function in competition" in the field of insurance-services. The stock companies have thereby acquired a "monopoly on premium calculation and on the use of costs, profits and surpluses". The insured only knows, that with his undivided premium he pays the losses of the group of insured as well as the costs and profits of the companies.

Due to the complete invisibility of the insurance field the insured does not know,

- that the stock companies unjustifiably appropriate the chance-related and over-calculated surpluses of his contribution for loss pooling without any performance in return,
- that in many branches the expensive stock companies consume up to 50% and more of the premium for costs and
- that capital life insurance is one of the most unprofitable investments, because some stock companies consume over 20% of the paid-in premiums for business and administration costs, so that only 80% of the premium (diminished still more through the risk premium) is saved for the insured, that from the income of this saved money the stock companies appropriate part of it as additional profit and realize for themselves (and not for the insured) all increases in value from the investment of this saved insureds' money (for example, real estate).

The insured cannot see,

- that he is paying the profits and costs of reinsurance with his premium, which is absurd in some personal lines, but is undertaken by the stock companies (especially within groups of companies) to a great extent in all branches in order to defer the costs and profits,

- that his contract is burdened with costs that have not been occasioned by this contract, that the costs and profits are deferred in various ways within companies and groups of companies (also between personal and commercial lines), which do not lie in the interest of the premium-payer,
- that he is paying commissions from his premium that are not performance-related, that these commissions are used by the agents for completely different activities, (above all for acquisition of new contracts and the solicitation of customers from other portfolios), but not for performances which the premium and commission payer has paid for, so that he receives no corresponding service,
- that he finances with his money an absurd battle by the companies for their portfolios and that all these exchanges among the portfolios are burdened with costs that amount to several times the real acquired new premium,
- that with his premium he is paying the costs for an inefficient regulation of small damages that he could much more economically insure himself by fixing a deductible and saving by himself up to that amount,
- that the agents' commission is dependent on the level of the premium (not on performance), that for example the acquisition of his automobile policy costs him 100 dollars whereas for the acquisition of the same car another insured pays only 20 dollars because this insured is classified in another premium-classification. The price difference is 500%! – The acquisition procedure and expenditure of work by the agent is the same however! -

The administration offices and the agents could provide many different kinds of services to the insured (advice, conclusion of contract, management of the insurance protection, claim settlement, administration of contracts and money). These individual services could be separately calculated and priced after they have been actually performed. Or they could be paid for in advance when it is certain that the service will actually be performed. The minimum requirement must be however, that at least the total service be exactly described and a special price therefore stated. That prescribes that the premium will be broken down.

In the insurance field the erroneous theory prevails that the performance of the companies is not a service but a "production of insurance" and the unbroken-down premium is a "price" which the companies can do with what they like. Since the actual service of the companies and their price is hidden in a mixed up "product" and in a mixed up "product price", the insured doesn't know that he has given his money for services that he can neither recognize nor claim and which in part he does not receive. The companies (because they can do as they like as to the "price"), don't need to perform any services they are paid for. No insured can sue any company or agent to force him to advise him or to supervise his insurance protection. No insured is entitled to a commission or premium refund, if an agent or a company did not perform a corresponding service to him.

The performance of the companies and agents in the insurance field can only be service. And service must also be forthcoming for the calculated costs and paid prices. Costs must be put in for the calculated services just as the contributions for loss pooling of the insured must really be spent for the loss pooling and for the

damage payments. "Insurance" is not a "product" that a "manufacturer" can "sell" at an "end-price" and do with the price what he will.

Since the consumer cannot Judge the economic value of the insurance and the related services and cannot articulate his true needs, since he cannot see the misuse of his contributions for loss pooling nor the waste of the costs, no one can compel (nor can competition) the companies to use fairly and correctly the contributions and to reduce the inefficiency of acquisition, of re-insurance and of fighting for their portfolios and to reduce the inefficiency of small-claims-insurance and -settlement and of the commission system.

### **Rivalry over the Surpluses of the Insurance**

There is thus no competition in the insurance field an to the single possible economic performance – an to the services of the administration offices and agents. On the contrary, there is a rivalry of the companies with each other in which the uninformed consumer merely has the role of a victim of contracts and premium payer."

### **The Informed Consumer – the most Important "Competitive Force"**

For the economical means being employed in the most efficient and effective way, the consumer should be that part in competition who steers all production and market procedures by his purchase decisions. The offerors should compete with others by innovation, cost decrease and improvement for winning the consumer's decision. The State should provide guard rails to make the free consumer decision possible by providing free market entry for offerors, by prohibiting cartels and by requiring product information and price quotation by law.

That was competition ! – But in studies about competition in the insurance field you can only read: Competition is, when there are several offerors and changes in market shares ! – For example, Prof. Farny has written that there must be competition in the insurance field, because market shares change. A very naive belief ! – Forgotten is the real "competitive force": the consumer ! – Forgotten is his information need to make this force strong and effective, to make competition work ! -

Competition is not only a line-like relationship between two or more offerors. Competition is at least a triangle – better: a whole market area – consisting of the consumer and several offerors. This is what the term competition expresses, which is derived from the Latin word "competere" (com = jointly with others, petere = strive). At least two offerors must solicit, strive or apply for the decision of a consumer to the product of one of them. But how can the consumer decide, when he has no information about the offers ?

The most important basis for the free enterprise system and competition is freedom – freedom to produce and freedom to price the product. But there is a catch to this freedom in competition: "deceit" must be allowed. Because of the absence of direct State regulation one manufacturer can sell a product for 200 \$. Another one can sell the same product for 2,000 \$. This last deal has features of deceit. This "deceit" cannot be prohibited by State regulation of prices when competition shall function. But this deceit can be prevented. The State must provide that all consumers can be aware of this "deceit" by information. The single consumer must be capable to get all product and price information and compare these data before making his pur-

chase decision. The State must care that these data are available for everybody. If then the consumer does not use them, it is his own fault.

### **No Competition without Premium-Breakdown**

Now, some people could come and say: "Okay, the premium and the contributions for loss pooling are no price. But what does this matter ? - The consumer can compare the premiums !" -

This opinion ignores the simple fact, that under the present circumstances the worst managing company can be the cheapest "in premium" by being most successful in selecting. See the following table, which shows the premium composition of four companies, charging all \$ 800 for the same insurance coverage:

	pure premium (contribution for losses)		expense portion (service price)		Service Performance		undivided premium
1.)	\$ 460	+	\$ 240	+	Good	=	\$ 800
2.)	\$ 460	+	\$ 240	+	Bad	=	\$ 800
3.)	\$ 540	+	\$ 160	+	Best	=	\$ 800
4.)	\$ 540	+	\$ 160	+	Worst	=	\$ 800

How can the consumer find out the best and low-priced service performing company ? -

And now, it can happen that the worst service performing company, charging the highest pure premium, makes the biggest surpluses not only in the overpriced service area, but also in the "over-calculated" pure premium area, and takes the latter surpluses, too, "as profit". Can this be the outcome of any competition ? -

Beside the challenge for a premium breakdown for a service price quotation, this uneconomical result is the other – as important – reason to require the premium separation: to stop the embezzlement of the surpluses from the loss pooling area, which are no operational profits, achieved by competitive measures like efficient service improvement or costs decrease.

It is self-evident that competition in respect to the insurance companies' services cannot function in the absence of price quotation for those services, a fact confirmed by a high official of the Federal Insurance Supervisory Authority, Gottfried Claus, who speaks of the "companies, which are comfortably co-swimming in the stream, but which would long ago have disappeared if competition were really functioning".

### **Long Term Contracts Hinder Competition**

The 10 years (since 1994 5 years) - by either party - non-cancelable insurance contracts, normal in Germany and excepted from a prohibition against long-term contracts in the German Contractual Conditions Law, also hinder competition since a change to another insurance company is rendered impossible. Thus, the insur-

ance companies are not forced to compete in regard to their services through reduction in expense or improvement of services. In 1964, the "Concentration Study" of the German Government stated: "In competition in the insurance field, neither price nor performance are decisive, but, rather, the size of the middlemen organization" (is decisive). Along the same line, Professor Grossmann says: "Therefore, the insurance customer gropes totally in the dark. The market rules, relative to supply and demand are functioning imperfectly. An especially wide scope is afforded for influencing the insurance customer through the personal explanations of the agent." By reason of the latter, the insurance companies pay out billions for advertising and for their middlemen organizations – without economic efficiency. Many economists criticize this as an "economic waste".

## **RATING AND CLASSIFICATION IN AUTOMOBILE INSURANCE**

I demonstrated how the wrong understanding of "insurance" as a product of the companies led to the wrong employment of the surpluses from loss pooling "as profits", how this wrong surplus employment became the reason for the so called "selection competition". Finally, in the following is demonstrated, how this "selection" led to the present rating and classification system with all its faults and abuses:

### **Background (Development in Germany and USA)**

There is little doubt that isolated groups of drivers can be shown to have differing needs for contributions towards loss pooling in automobile liability insurance, if they are grouped together in accordance with different criteria. But the decisive question, for purposes of automobile insurance classification, is whether every group, as a group, shall provide its own money needs for loss pooling. That question is particularly crucial where the group is not insured as a group and does not pay premium as a group but, rather, is insured individually and each member of this group pays individually.

The present rate structure in Germany and the USA says "Yes" to this question. Nor will the advocates and defenders of the resulting rates even consider questions raised to their proposition that: "If it is statistically proved that a group formed by whatever criterion, had higher losses than another group under another criteria, then all members of said group shall pay higher premiums."

If groups of insureds have differing needs for contributions to the loss compensation fund and they are grouped together according to different criteria there is no doubt that companies can, and do, achieve higher surpluses by selecting their insureds through such group criteria which indicate lower expected losses (for example, the group of state employees) . Under these circumstances, the present automobile insurance rate structures were established. The development in the USA was even more dramatic than in Germany.

In the USA, as in Germany, the conclusion of automobile liability insurance is generally compulsory but, unlike in Germany, there is no general compulsion on insurance companies to accept each proffered risk. This means that, in the USA the companies need not accept every insured who is, by law, compelled to insure his car. Therefore, the possibilities of selection by the insurance companies are far greater in the USA than in Germany. In the United States, the companies are generally at liberty to select freely and freely to react to the selection procedures of other companies. Thus, if certain insurance companies discovered crite-

ria for identifying groups with lower expected losses and then selected them out from the nationwide group of compulsory insureds, then a need for higher contributions arises with respect to the other insurance companies. It is thus evident that this selection simply shifts the contribution needs from one company or companies to others without reducing the contribution needs for the whole economy. The result is that the companies that did not, or could not, select have lower surpluses or even sustain losses and would have to charge higher premiums. However, this, in turn, would lead to the fact that the insureds with the indicated criteria would drift away to the selecting company with the lower rates. In practice, in the USA, the insurance companies fight with each other by becoming more selective in their acceptance or retention of risks, the result being that countless loss-free risks can only obtain the mandatory insurance in some assigned risk plan or from a "high-risk insurer" where the insured must pay more for less coverage notwithstanding that he has never had an accident or a traffic violation.

An insurance company which did not react to the selection process initiated by other by using the same rate groupings, or even lower ones, would find itself alone with the group of compulsory insureds who – as a group – have a need for higher contributions. If it were possible, in practice, to predict the need for loss-compensation contributions for the individual driver, the end result of this selection would be that the insureds without need for loss-compensation contribution would not have to make any contribution; conversely, the insureds who did have a need for loss-compensation contribution would be required to pay, besides the cost of the insurance contract, their losses by themselves. Insurance contracts of this kind would, naturally, be nonsensical because the accident-free, who do not pay in any contributions, as well as those who do suffer losses for which they themselves have to pay, are no longer "insureds". Insurance functions only where, in a community made up of those exposed similarly to a peril, those upon whom loss, fortuitously, has not befallen, pay with those upon whom loss has befallen.

It is only the impossibility of predicting in advance the exact amount of loss-compensation money for each individual insured which sets bounds the selection process and the total eradication of the insurance concept. This, also, prevents the unmasking of the character of the insurance contract as perceived by insurance companies which strive for profits from the loss-compensation funds supplied by the insureds. A president for an American insurance "industry" association has said, with typical American frankness; "If we knew, with certainty, who were going to have losses, we would avoid them." The question, then, naturally follows, what sense is there to insurance, particularly, what is the sense of insurance provided by companies which strive for the surpluses arising from the loss pooling funds supplied by the insureds of whom such insurance company wish to accept only the loss-free? The fact is that current selection and rating practices constitute a perversion of the fundamental tenets of insurance.

Even if all companies were required to accept all insureds at the same rates, differing surplus results would arise. Such differences have resulted in Germany because of the historically developed "regional insurers", notwithstanding compulsory acceptance and obligatory rates which, up until about 20 years ago, were the same. These "regional insurers" operated only in specific Federal States of districts, which are principally rural areas with a lower traffic density. Even though a given "regional insurer" has as many, or more, bad drivers as any other company, its need for contributions is still lower because bad drivers in rural areas do not cause as many losses. As a result, certain differences in the contributions needs or surpluses arose within the portfolios of the insurance companies.

Then, the German Federal insurance Supervisory Authority (Supervision Board) made the mistake of allowing a mutual to specialize in the acceptance of State employees. This mutual was exempted to a certain extent from the compulsory acceptance because it was empowered only to accept State employees. This led to a still further contribution-need and profit heterogeneity disparity within the books of business of the insurance companies because State employees, as a group, including even the bad drivers, have a better loss record and a lower need of contributions, because they drive less and cause less losses (like all other drivers who drive little, but who, thus far, are not classified as a group).

Because the German insurance companies could not react to this historically developed and State-sanctioned selection in the light of compulsory acceptance, they asked for a State correction and equality of chance in the selection of business and achieving "profits". In accordance with this request, the German Ministry for Economy (responsible for automobile insurance) in cooperation with the Supervisory Authority and insurance "industry" associations released a "Tariff Order" which allows to all insurance companies the formation of Tariff groups according to residence and profession (farmers, state employees and normal citizens). Consequently, a selective reaction by all companies was made possible in respect to the historical "regional insurers" and the State-sanctioned State-employee selection.

The essentially unregulated selection in the USA naturally led to the vastly greater employment of more selection criteria than in Germany where only a regulated selection on the basis of region and profession occurs. In the USA, practically all companies employ the selection and rating criteria of age, sex, and marital status, based upon the differing loss records and expected loss ratios of the respective groups. These categories really are not groups in any real sense, and they certainly are not insured as groups. Indeed, not a little irony attaches to the fact that in the U.S., where the insuring of fictitious groups is widely prohibited by law, these fictitious groupings by way of age, sex, marital status, etc., are suffered to become the predicates for the selection and/or rating of risks.

Where insurance companies enjoy the essentially untrammled right of underwriting selection, the "selective" aim of each company is to accept the better risks within each classification (it being evident that each classification will contain above average, average, and below average risks). It necessarily follows that where the risk classifications are doubled, trebled, quintupled, etc., the insurance company simply provided that much more scope for the selection process; but regardless how great the expansion of the rating classes may be, within each class the companies will select only what they deem to be the above average risks, leaving what they consider to be the average or below average risks to be handled by the assigned risk plans or the sub-standard insurance mechanism.

The dimensions of the differences in the loss contribution needs of these groups, which are not groups of insureds, is indicated in the Report of the NAIC Advisory Committee of May, 1979, where it is stated:

"The elimination of the present rating criteria implies that approximately 83 percent of the insured motorists (the adult drivers) will have an average increase in liability premiums to compensate for the 39 percent decrease given to the remaining 17 percent of higher risk drivers, specifically, all young single male drivers (10 percent of all insureds), the young, single female drivers (4 percent of all insureds) and the young, married

male drivers (3 percent of all insureds) will have a decrease in their liability premiums of 48 percent, 24 percent, and 17 percent, respectively.

The elimination of the rating criteria of sex and marital status will only affect the youthful drivers as adult insureds are not distinguished by these two factors. Should sex and marital status be eliminated, then the female drivers (25 percent of all youthful insured motorists) and the married male drivers (16 percent of all young insureds) will have an average liability premium increase of 26 percent and 37 percent to effect the 14 percent decrease which the young, single, male drivers would be given.

Should sex be removed from the classification system, then the female drivers, comprising 24 percent of all youthful insured motorists, will have an average liability rate increase of 26 percent; the remaining 76 percent (all young male drivers) will have their rates decreased by 6 percent.

If marital status is removed as a rating classification, then 22 percent of all youthful male insureds, i.e., the married males under 25 years of age, will have an average increase in their liability premiums of 46 percent in order to offset the 8 percent decrease in premiums which would be given to the young, single, male motorists (78 percent of the young, male driving population)."

Over and beyond the above mentioned rating criteria, in the United States even more criteria are utilized for rating or selection purposes, such as territory, occupation, education, number of traffic accidents or violations, distance to and from work, etc. Their residence in higher-rated rating territories, tends to select against Blacks, Hispanics and Indians, while, incident to underwriting by occupation, quite often, the occupation becomes a surrogate for race, thus circumventing the letter of any law prohibiting refusal or cancellation of insurance based upon race.

Because there is no compulsory acceptance of risks by insurance companies in most of the United States, the sort of "competition through selection" has resulted in increasingly large numbers of accident-free, violation free motorists finding it impossible to obtain or afford legally mandated insurance. Accordingly, the States have been forced to establish assigned risk plans, joint underwriting associations, or other residual risk mechanisms in which all are required to participate (the one exception being a State-Fund operated by the State of Maryland). Whatever the name or type of residual risk mechanism, all such mechanisms are characterized by higher rates, inferior coverage, and poorer service. Under the laws or regulations of many states, many of the assigned risk plans are required to be "self-rated", i.e., the rates are based solely upon the loss experience of the occupants of the plan. Since there are obviously large numbers of clearly bad drivers, who are in such plans for cause (drunk driving, reckless driving, manslaughter by vehicle, etc.), the impact of their losses falls heavily upon the clean risks who are in the plan solely because they are refused insurance in the voluntary insurance mechanism.

Notwithstanding the presence of assigned risk plans and other last resort mechanisms in the USA, it is estimated that, as of any given moment, as much as 20 percent of the driving population does not have automobile liability insurance, the latter having been eliminated by the high cost of such coverage. Quite often, for basic limits of liability of \$10,000 per person (\$20,000 per accident), the annual premium may exceed \$2,500. In writing to President Carter in 1977, Supervisor Hahn of Los Angeles County said:

"As a result of the higher premiums, there are more than one million uninsured motorists in Los Angeles County, alone. The nationwide figure may be as high as 25 million. These are people who often are good drivers and are law abiding, solid citizens. Yet, they cannot afford automobile insurance."

The president of the insurance association mentioned earlier has commented that it was a "misfortune" for these people that they live in areas with higher loss records.

The consequences of the current rate structures in Germany and the USA may be considered in the following example:

In Germany:

The Germany study on the regional structure for automobile insurance, ordered by the Ministry for Economy, and performed by the Institute for Traffic Science of the University of Cologne, found that, as to 5 of the 331 car licensing districts, the "normal citizens" have the highest loss record and thus are required to contribute more towards loss contribution fund needs whereas, in these five districts State employees, as a group, have the lowest record (compared to the average of all German drivers). Accordingly, the professors simply propose that in these districts a worker who commences driving (whether young or old) shall pay \$1,200 annually, for a middle class car; a State employee who commences driving the same car in those districts would be called upon to pay only \$750. The worker who drove accident-free for 12 - 16 years would be called upon to pay \$170 per year in those districts, while the State employee, similarly accident-free would pay only \$100 annually. But in those 12 - 15 intervening years of accident-free driving, the ordinary worker pays some thousands of dollars more than the State employee who drove accident-free in exactly the same way, in exactly the same time, in exactly the same area with an identical car. The most extreme difference between accident-free drivers (e.g., an accident-free ordinary worker as a beginner vis-à-vis a long-time, accident-free State employee) would be \$1,200 to \$100, more than 1,000 percent!

In the USA:

In the 1978 Senate Hearing, it was pointed out that, in Los Angeles, car owners in "well to do" areas pay \$580 for car insurance whereas in poorer, inner-city areas, populated heavily by Blacks and Chicanos, car owners with like driving records would be required to pay \$1,383. A female owner in a rural area of Massachusetts paid only \$1.60 for her insurance covering a Malibu, notwithstanding, two recent accidents; whereas a 24 year old worker living in predominantly black area of Boston would be required to pay \$2,512 for the same coverage on the same car, notwithstanding accident-free driving for 7 years - a difference of more than 1,500 percent.

Based upon the rate structure proposed in the State-ordered German study, there would be about 100 boundaries between rating territories with premium differences ranging up to hundreds of dollars. On this subject, in the U.S. Senate Hearing it was asked:

"Does it make sense for an individual in the Newark territory having to pay twice as much as an individual who could be living across the street?"

It is beyond dispute that in both the USA and Germany, like drivers with like cars and like driving records are unfairly discriminated against in the classification and underwriting of their risks based upon the criteria groups; and the financial burdens are placed upon them most unequally and inequitably.

In the USA the "insurance industry" no longer denies the fact of discrimination among the insureds but they dismiss this as valid or "actuarially fair" discrimination which is "necessary for reasons of competition" in general, up to this time, no one has been concerned with the constitutionality of structuring rates in accordance with group criteria or with the consequences to the individual, compulsory insureds flowing from such structuring of rates. The arguments advanced for this structuring of rates are exactly the same as those advanced in the USA – "necessary for competition" – "statistically proved valid".

In 1977, the German Supervisory Authority stated:

"The formation of tariff-groups according to profession is a consequence of competition. But the Supervisory Authority has exerted itself for years to find a way to remove the occupational tariff groups."

Yet, the German Insurance Supervisory Authority did not act consistently in 1980 when it refused to allow a surcharge of about 30 percent for the automobile insurance of foreign workers even though the statistics actually establish a higher loss record for the foreigners as a group. In refusing to grant such requested surcharge, the Supervisory Authority evidently had forgotten that the regional structure and, indeed, the whole current rating structure is based only on statistical differences in the loss records of the various groups.

The German "association of automobile insurers" has stated:

"The regional structure aims at making the statistically proved differences in the regional loss records premium-effective."

To demonstrate the nonsense inherent in this statement, we need only think to example of the income tax rates. According to the conclusion of the German (and American) automobile "insurers", the regional differences in income would need to be made tax-rate-effective, too. Hence, all people in New York, Hamburg, Washington, Los Angeles, etc., would be required to pay a higher "average" tax rate.

### **Arguments for and against the Present System**

The advocates of the current structuring of rates according to group criteria defend this method with all or some of the following arguments:

- It would correspond to the insurance technique to form groups having similar loss records and to have members of the respective groups cover the corresponding money needs for loss compensation contribution.
- This method was based upon "powerful" statistics which show different loss records for the different criteria groups.
- If the statistically demonstrated differences were not made premium-effective, the result would be subsidization between the groups of insureds, and this would be contrary to premium fairness.

- If premium differentiation according to group loss records were no longer permissible out of deference to equal treatment of the individual insureds, in the USA, great numbers of the population would have even more difficulty in obtaining legally compelled insurance because the insurance companies would simply initiate even more intensive underwriting selection of risks, i.e., if youthful rate classifications were abolished or rating territories outlawed, the insurers would simply decline to accept risks with youthful drivers or would accept virtually no risks in territories which they deemed higher risk areas. In Germany, with compulsory acceptance the insurance companies would have unequal surpluses arising out of the loss compensation funds, or as they would, erroneously state it, "unequal profits".
- The method of rating according to group criteria was a consequence of competition and was necessary to provide equality of opportunity in the creation of surpluses or, as the "insurers" would say, the making "profits".
- (Especially in the USA) Rating according to average loss records of groups would correspond to the principle of "cost-based pricing".
- Under like circumstances, equal groups would be treated equally. The discrimination among the individual insureds would be "valid" and "actuarially fair" and would correspond with the insurance technique.

On the other hand, the opponents of the present rating procedures motivated by the extremely uneven treatment of and unequal protection accorded to the individual insureds urge the abolition of these procedures and advance the following arguments in support of such abolition:

- The rating structure does not correspond to the insurance technique of classification according to which every individual insured should pay that contribution toward loss pooling which his individual, inherent chance of involvement and liability demands.
- The statistics proceed from the wrong question and not from the insurance technique; the chance of involvement and liability in any given year of the individual insured can not be determined statistically because the chance of an individual's causing a loss in given year is statistically remote without respect to whether he is a good, bad, or indifferent driver.
- The "loss pooling subsidy" (those upon whom loss has not befallen pay the same as those upon whom loss has befallen) must take place within the statewide group of compulsory insureds – that means: between the insureds of all different rate classes – to be consistent with the insurance technique. Under prevailing classification practices, this subsidy is limited to the single non existing rate classes, which leads to another subsidy a "premium subsidy": Some insureds from a high-rated class pay high premiums while some insureds, equally exposed to risk, pay lower premiums in a low-rated class. The high-rated pay a part of the premiums for equal insureds who are low-rated, and this does not conform to the insurance technique.
- The selection is simply a consequence of the improper structuring of the insurance field which makes it possible for the companies to appropriate to themselves the surpluses arising out of the loss pooling and claim those surpluses as "profits". These surpluses, however, arise solely from the performance of the insureds and cannot properly be classified as profits nor properly claimed by the companies.

- The insurance function – loss spreading and pooling, "subsidy", rating – is not an area suitable for competition and profit but the task and its performance is solely that of the insureds. It is in the area of insurance services, and the price to be paid for those services, alone, that competition can, and must, work. Therefore, the insurance function and the service function; i.e., the contributions toward loss compensation and the service price must be separated. In short, this inevitably requires a breakdown of the premium into those component parts.
- Rating is not price calculation, simply because the cost-free contributions for loss pooling provided by the insureds can never lead to costs.
- The principle of equal treatment or equal protection does not relate to groups, only individuals. Currently, individual insureds are not treated equally, as required by the insurance technique and the principle of equal protection, but, rather are subjected to a rating structure predicated upon criteria for group loss records.

The opponents of the present system propose an alternative under which, after classification of the cars, the contributions of the insureds would be graduated only in accordance with the individual risk of the individual insured which must be objectively determinable with respect to each insured. This takes into consideration social and economical aspects of the problem; owners of the same kinds of cars will pay the same contributions toward loss compensation so long as they remain free of chargeable losses. After one or more chargeable losses, the insureds would be classed for a stipulated period in two or three classes with higher contributions. This, in effect, would constitute a demerit rating system.

Compulsory acceptance would be binding upon all insurance companies although arrangements could be made to accommodate specialized companies to an appropriate extent. However, the surpluses of the companies arising out of the loss pooling, which surpluses cannot be influenced by the performance of the companies (except for selection which is not economical performance and has no effect for the general economy), would be equalized mathematically within the nationwide community of compulsory insureds. The purpose of this is to ensure that an equal coverage for equal contributions and an equal formation of reserves, deductions, and refunding of excess contributions for all compulsory insureds may take place.

The "insurance industry" resists the introduction of a program of equal contributions for equal insureds combined with a demerit rating system because such a system would again lead to different surpluses and "market advantages" for some companies depending upon the composition of their books of business as respects region, profession, etc. However, the argument is negated by the proposal to equalize, mathematically, the surpluses within the nationwide group of compulsory insureds. It must be emphasized that these surpluses arise from the performance of the insureds (loss pooling) and not from the special performance of the company. The companies cannot influence these surpluses through economic measures; they can only shift losses to other companies by selecting the insureds.

As of now, there has not been conducted anywhere a disinterested scientific, in-depth study which has investigated all of the issues which are critical in the structuring of rates in a compulsory automobile liability insurance environment. Such a study is now being conducted by the international experts of the National Insurance Consumer Organization (NICO) of the USA. In the following pages only the essential points dealing with the subject will be indicated. Much additional documentation has been gathered to buttress legal

attacks upon the rating system and to withstand damage suits against governments and supervisory authorities for derelictions of official duties and denial of civil rights.

### **State and Automobile Liability Insurance:**

For the compensation of automobile traffic victims, all states of the USA and the Federal Republic of Germany, have, through Financial Responsibility and Compulsory Insurance laws, compelled all car owners to conclude automobile liability insurance with fixed, minimum limits of liability. In Germany limits of \$250,000 bodily injury and \$50,000 for property damages are required but, normally, single limit coverage of \$1 million is obtained. In this fashion, the respective governments create a nationwide or statewide group of compulsory insureds who are required to provide the loss pooling and the corresponding contributions for loss compensation.

As the German Supervisory Authority said in 1979:

"By the general insurance obligation, the car owners are grouped together to a danger community. The financial means provided by this community through their contributions must be sufficient, in the interests of the injured traffic victims, to meet the indemnification claims of those victims." (Emphasis added by the author to show the correspondence to the definition of "insurance" by Alfred Manes, see page 10)

The organization of the group of compulsory insureds and the administration of the funds contributed by them was entrusted to private insurance enterprises. These enterprises are supervised by State insurance regulatory authorities.

According to the advocates of the present rating system, the focus of supervision must be directed principally against the possibility of the insufficiency of premiums. This means, according to them, that the regulators must ensure that the companies receive sufficient premium income. The critics of the present system are of the opinion that the proper task of the states and their supervisory authorities is to see to it that the companies not unjustly enrich themselves from any excess in the contributions over the funds needed for loss compensation and that the companies employ these funds efficiently when performing their services.

Because of the legal obligation imposed upon every car owner to conclude insurance, the State has an obligation to see to it that all compulsory insureds are treated fairly and equally in the area of loss pooling and the contribution of loss compensation funds. The measure and guideline for fair and equal treatment is the insurance technique, especially the insurance technique for rating and classification.

The insurance technique for the funding of compensation through the rating and classification of risks is also the beginning point and focus of inquiry in the employment of statistics. Thus, before making statistics, the insurance technique for the classification of risks must be thoroughly investigated to ascertain in which area, and to what extent, statistics can be utilized, especially from which set of tasks and inquiries the statistics must start.

### **The Insurance Technique for Rating and Classification**

Insurance consists of the joint provision of money for a common loss pooling fund. By this, financial risks are eliminated.

The community of insureds is concerned not only with provision of adequate means for the common fund but with the distribution of the contribution burden among the individual insureds.

Over and above the loss compensation fund, there must be provided funds to cover the costs of the companies' services and a reasonable profit commensurate with those services.

Rating, for purposes of determining insureds' contributions takes place in several steps:

- Determination of the contribution needs of the group of insureds based upon loss experience data of the past, modified to consider recognizable trends in that experience.
- Distribution of this contribution needs among all insureds.
- Formation of contribution classes to give consideration to the individual risk which the individual insured brings into the community of insureds.

To these procedures there must be added, as noted above, the calculation of a price to cover the service costs and profits of the companies. The services of the companies and their agents consists of such things as organizing the community of insureds, administration of the common, loss-pooling fund, settlement of claims, etc. But it must be noticed here that classification has nothing to do with these service costs and prices. In the whole dispute on classification this service price must be excluded. This means, when talking about classification, we have to talk only about the contribution for loss pooling (i.e. about that which is now called the "pure premium").

Here you have another argument for the challenge for the premium breakdown: How can you determine the loss pooling contribution without separating it from the premium ? – How can you calculate the service price, costs and profits when not separating this price from the premium ? –

I think everybody recognizes that classification has only to do with the loss pooling contribution but not with an undivided premium, which includes the service price. In reality, the insurance companies actually establish their premiums by these two ways/steps in these two areas by calculating a service price and rating a loss pooling contribution. So why not quote these different premium portions? – The answer is clear: 1. to be able to take in the permanently arising surpluses from the overcharged loss contributions as profits, and 2. to be able to cover costs excesses from the loss pooling surpluses.

In the first stage the total contribution need for all compulsory insureds is ascertained.

In this second stage of the rating process, a social judgment must be made as to what extent loss pooling subsidy shall take place and to what extent, beyond that, distribution of the contribution needs shall be accomplished in accordance with the individual risk of the individual insured. Although insurance rating seems to bring about unequal treatment or subsidization of those who have had losses by those who have not, a moment's reflection will demonstrate that there is no inequality and no subsidization, given the relative infrequency of accident, no one can predict upon whom loss will befall even though the total number of losses

and their approximate cost can be predicted quite closely because of the law of large numbers. Perhaps the more meaningful statistic is not the number who will have losses within the entire insurance community or even within the classification groups, but the number who will not have losses.

It is the very nature and essence of insurance, then, that those upon whom loss has not befallen shall pay the same contribution as those upon whom loss has befallen, for each may properly say: "There but for the grace of God go I." – But a prerequisite must be that only those pay the same contribution to the common fund who are equally exposed to risk. Otherwise there would be a "contribution subsidy". To prevent such a subsidy is the task and aim of classification

### **Classification and Risk Assessment by "Risk Interponents' Criteria"**

In the third step, this classification of the individual insured and the determination of his proper contribution takes place. In the USA, Germany, or elsewhere, the same technical insurance rules are applicable. In Germany, Professor Max Guertler has said:

"Every insured should pay the premium which is suitable to the degree of the risk."

Similarly, in the beginning of the study conducted for the German Ministry of Economy it was stated:

"This means that every insurance technical unit shall be charged that premium rate which corresponds to its individual risk."

In 1976, the Stanford Research Institute observed:

"An insurance pricing system charges all policyholders exactly what their inherent risks demand and spreads the remaining fortuitous risk over the insured population."

This principle of the gradation of contribution according to the individual risk of the individual insured is technically known, in insurance, as the "equivalency principle". This principle of equivalency requires that if contribution gradation takes place, there must be equality within the group of insureds for all with the same risk. It is here that the human right of equal protection must be considered in the environment of the legally compelled conclusion of insurance. It must be remembered that the sole purpose and function of classification, the equivalency principle, is equity or justice, not to promote competition nor increase or equalize "insurer profits". To speak of class equity, as branch spokesmen and some academics do, is surely a contradiction in terms; justice is inherently an individual thing. Thus, a further "contribution subsidy", which goes beyond the natural "pooling subsidy" within the insureds group, has no proper place among insureds with the same risk in a nationwide group of compulsory insured.

At this third step of the classification and rating process, recorded group losses, expected losses, or loss pooling have no further relevance. It must be noted, here, that these statistical procedures have relevance only in the first step of the ratemaking process and only for the insureds as a group; they have neither relevance nor validity for the gradation of premiums based upon the individual risk of the individual insured. This

individual risk of the individual insured cannot possibly be measured by his former loss record, for this would lead to self-payment of losses by the insured.

It is also wrong to believe that contribution classes would have to cover its contribution need by itself and therefore had to be large enough. By a requirement like this all contribution classes would automatically become new and separate group of insureds/insureds' communities.

Stanford Research Institute, 1976: "It is an incorrect view that the essence of classification lies in having large classes to allow pooling of risk within each class."

In other insurance branches it can happen with some insurance companies that there is only one insured risk in one contribution class (for example: industry fire insurance).

According to the better opinion, the individual danger or risk must be shown to have an influence on the cause of loss or its extent and must be demonstrable, objectively, for all insureds.

Risk itself, by nature, is something which is not observable nor recordable; its observation and evaluation can only take place through criteria which make possible prediction of future losses. How such criteria can actually be determined, their influence upon the cause or extent of loss have never been thoroughly investigated nor demonstrated. In the NICO study, such an inquiry is being made for the first time.

The starting point and motive for insurance is that a person with a need for insurance possesses a thing of value which is exposed to certain hazards or perils. In "Insurance and Regulation – Services and Competition", H. D. Meyer, 1979, it is stated:

"It is important to recognize what is frequently overlooked: insurance, danger, risk and damage are connected with capabilities in the widest sense. Only in the second stage, 'things and money', as capabilities in the narrow sense, are insurance objects which get their value by giving capabilities to people. The most important capabilities in connection with things is the ability to use, sell, and value them."

.A car provides the capability to drive. This capability is endangered by the possible loss of the car through theft or fire. The risk from possessing a car and the capability of driving it is, accordingly, exposed to the hazards of theft and fire by the object "automobile". These objects, interposed between risks and capabilities on the one hand and exposed to dangers on the other, may be called risk interponents. These risk interponents render possible the evaluation of the financial risk which is the subject matter of all insurance. The capability of living in a house, for example, is not represented by the actual value of the house but by the cost of reconstruction (the reason that, in Germany, for a long time the insuring of houses has been based upon the reconstruction cost of the house).

Thus, the risk interponent is a crucial criterion in the determination of the risk, a criterion which critically influences the possible extent of loss and, therefore, the amount of the coverage to be obtained. Additionally, certain essentials of the risk interponent assist in the evaluation of risk. If the house is constructed of wood, the risk in relation to the peril of fire is increased in two ways; first, the occurrence of loss is more likely, second, the extent of loss is likely to be greater in the case of frame construction.

These risk criteria clearly differ from selection or group loss-record criteria in that their objective qualities are not only causal in bringing about a contribution increase or decrease within a group of insureds but are causal in relation to the total increase or decrease in the insurance contribution' requirements within the whole economy. It is only when this effect can be established and quantified that a given criterion can properly be employed as a risk criterion for classification of risk and the gradation of contributions. These prerequisites are not met by such selection criteria as occupation, age, residence, sex, and marital status which can bring about only a shifting of the contribution needs within the entire community of insureds but can never bring about a decrease in the contribution needs in a total/as a whole.

Criteria which have an influence on the occurrence and extent of loss can normally be determined and evaluated objectively as to the risk interponent. Accordingly, conclusions are possible with respect to the risk and its intensity.

The danger has interponents, too, which endanger the risk and the risk interponent and of which one finally produces/releases the damage/event of loss (for example: lightning). Thus, the occurrence of loss can be called the "moment of coincidence of danger- and risk-interponent". This moment of co-occurrence is uncertain and unforeseeable, or fortuitous (coincidence in its popular sense). Thus uncertainty as to the future is the dominant factor which has fundamental importance for insurance.

While, in the insuring of goods and objects, the risk area can be evaluated through the risk interponent, it is next to impossible to evaluate the hazard area. In particular, the hazard interponent which causes the loss event is unknown. Nevertheless danger/peril and its intensity can be determined, generally by reference to the risk interponent and its criteria, too. By a direct correlation, risk criteria are also danger criteria – i.e.: no value - no risk - no danger; low value - low risk - low danger; frame construction - higher risk - higher danger.

### **Difficulties in Classification of Automobile Liability Insureds**

In the insurance of property, the determination of the inherent risk creates less difficulty. Thus, in Germany, no property insurance company has ever suggested grouping the inhabitants of a certain region together (as in automobile insurance) for purposes of classification and rating. In the insurance of property, the technical equivalency principle is appropriately employed, according to which every individual risk interponent of the individual insured is evaluated and classified.

Logically, these are storm zones in storm insurance. They are reasonable to a certain extent because all homeowners are exposed to the storm in the same way. In their individual classification they are equally treated. But an automobile liability claim is no regional event or "regional danger" but caused by the misbehavior of an individual driver or the deficiency of his car.

But the matter is quite different in the case of compulsory insurance of car owners, for this is liability insurance. Here, the insured risk is the fortune of the insured in the widest sense of that term. However, the real loss or damage is sustained not by the insured but by the claimant. This loss or damage is caused by a mistake in driving by the driver of a car or a defect in the car. The liability of the car owner in respect to a liability

claim is determined, in Germany, in accordance with Section 7 of the "Road Traffic Law." In his "Compensation of Auto Accident Victims in Europe", M. Pfennigstorf wrote, in connection with Section 7:

"All a claimant has to prove is that his injury or property damage was caused by the operation of a motor vehicle of which the defendant was the keeper. But the keeper is not left without defense. His liability is excluded if he can prove that due to him the accident was an 'unavoidable occurrence'. The law defines as 'unavoidable' any accident caused by the conduct of the injured person or of a person not engaged in the operation of the vehicle, or by an animal, if, at the same time, the driver of the vehicle has exercised every reasonable care due under the circumstances. On the other hand, accidents caused by a defect of 'his vehicle or by a failure of its parts may not be regarded as unavoidable. This so-called 'endanger-liability' shifts the proof of fault/no fault from the claimant to the defendant."

This legal liability of the insured is the basis for the evaluation of risk in automobile liability insurance in Germany as in the USA. The hazard for the fortune of the insured is a liability claim arising out of negligence in driving or a defect in the vehicle. Thus, the driver and the car are the hazard interponents for the risk of the automobile insured.

The risk interponent, which co-determines the occurrence and the extent of the loss incident to the liability claim is completely unknown in advance and is not within the control of the insured. This risk interponent is the car and the person of the claimant. Thus, the question is whether, or to what extent, criteria can be determined which render possible an evaluation of the risk and danger. What is it that happens in the fortuitous co-incident of risk and danger interponents which influences the occurrence and extent of loss in a liability claim?

The extent of the risk in the automobile liability claim is principally governed by circumstances external to the insured. The insured may make hundreds of errors in his driving and yet harm no one if there is no risk interponent; he may drive while intoxicated or tired and overturn in a ditch harming only his own car but escaping a liability claim; his negligent driving may kill a fly, a dog, a child, or a whole family. The risk interponent is not predictable in advance.

But neither can the driver, as a danger interponent who precipitates the accident through his negligence be judged in advance. First, he is generally unknown; second, the danger which flows from his driving, that is, his driving behavior, his reactions, his physical condition at the moment of coincidence with the risk interponent cannot possibly be foretold objectively.

It is just this constellation of uncertainties which precludes useful prediction as to the occurrence and extent of loss with respect to an individual or an individual loss. It is the reason, too, why those responsible for the current rating system have, in resignation, abandoned the insurance technique and have introduced rates based upon group loss records.

In describing the insurance technique, as applied to the classification and rating of insureds, the Stanford Research Institute, (SRI) has said that every insured should be charged what his inherent risk demands

while the remaining fortuitous risk should be spread over the entire insured population. In this same connection it said:

"The crux of the problem is to identify the limit between what is predictable and what is due to chance."

In connection with fire insurance for homes, it is predictable that a frame house is more likely to be burned and to a greater extent than a brick house. Such predictions are impossible with respect to automobile liability insurance; here, virtually nothing is determinable in advance. As the "German Insurance Industry" stated in 1936:

"The danger is determined by several factors. The most important is the personal; these are the qualities of the person who drives the car. But this goes beyond all rating because nobody knows who will drive the car during the insurance period. Even if this was known, it is impossible to rate according to the person of the driver because there is no measure for it."

Similarly, in the 1979 U. S. Report, it was concluded:

"On an individual basis, accident involvement is so infrequent that this random element accidental loss overwhelms and masks the predictable, or expected loss component. It is immediately apparent that there is a complete inability in the real world to measure the expected loss on an individual basis."

The 1978 Senate Hearing a branch spokesman pointed out that:

"No one is capable of predicting exactly what losses each individual will sustain. This is why groupings or classes are necessary."

The present German government study glosses over this problem saying, only at one place, that the challenge to create a premium rate which corresponds to the individual can only be accomplished for risk groups for reasons of administrative efficiency. No word is offered as to how this classification according to individual risk is to work through a classification by groups, based upon group loss records.

### **Selection Led to Classification of Fictitious Groups**

Because of the impossibility of meaningful prediction cited in the reports quoted above, in earlier times in both Germany and the USA, drivers of like cars paid like premiums, this being in accordance with the insurance technique which prohibits a further classification of the individual insureds in the absence of objectively determinable differences.

It was only when the companies were faced with adverse selection and disparities in their rates and "profits" because of the regional or occupational composition of their portfolios of risks that the new rating structure was introduced not for the purpose of achieving greater premium fairness, although that was its pretext, but, rather, for the purpose of achieving rate and "profit" homogeneity in the risk portfolios of the insurance companies.

Under this latter rating method, the risk criteria of the individual insureds are no longer taken into consideration. The compulsory insureds are grouped together in accordance with criteria which have no real influence on the individual liability claim. New groups are formed if they demonstrate a different loss record and contributions needs than other groups. The formation of such groups stems, again, not from consideration of premium fairness or equity, but from the desires of the insurance companies to obtain better selection of risks or avoid a poorer selection.

That the insurance technical equivalency principle and the classification of the individual insured according to his individual risk were totally ignored is demonstrated by the following:

The German study stated:

"In which regional class an insured is classed depends on how the loss record in the respective district develops where the licensing place of his car is situated.

According to the insurance technical equivalency principle, the premium for the insurance of the particular risk group must correspond to the expected losses of this group. Because the expected losses are unknown, it is approximated by the general loss record.

According to the equivalency principle, the premiums for homogeneous subgroups must correspond to their respective loss records."

In 1980, the American Insurance Association (AIA) said:

"Each driver is assigned to a group with similar characteristics and pays a price for insurance based as closely as possible on the losses which past experience indicates will be produced by that group. Auto insurance classifications discriminate among drivers on the basis of statistical evidence – evidence that makes such discrimination not only acceptable, but fair and logical."

The U. S. Report observes:

"This is the classical concept of insurance rating: grouping by objective characteristics and charging the group average to the individual members.

Basically, insurers have used a system which attempts to group people in categories that in the past have shown demonstrably different risk exposure compared to other groups. Insurers establish these groups according to the loss experience that can be anticipated for a group.

This phase of the risk assessment process is the development of a classification scheme where loss data is grouped into cells. The fair price for an individual in the cell would reflect this expected loss.

The use of age, sex, and marital status variables is justified on the basis of their ability to predict losses for groups and, thus, to separate groups from a competitive perspective."

In the course of the U. S. Senate Hearing it was contended by a branch spokesmen:

"It would be unfair discrimination from a statistical standpoint if the classes thus identified were not rated accordingly.

Since ratemaking on an individual basis is not feasible, certain groupings of classifications were developed as a means for the pricing of risks."

In 1979, Heinz Sievers, President of the German Automobile Insurers' Association said:

"The potentials of the insurers who participate in the competition are essentially put on the same basis through the present rate structure. This led not only to the creation of equal competition prerequisites but also to the situation where the average, correctly calculated premiums were also correctly differentiated according to the loss causation of large groups of insureds."

### **Automobile Insureds are not Classified as Individual**

This discrimination and the ignoring of the criteria the individual insured, and the classification of risks according to group records rather than individual risk criteria was the e U. Senate hearing in 1978 during the course of which Senator Metzenbaum, Chairman of the Subcommittee on Citizens and Shareholders' Rights and Remedies said:

"It is my belief that characteristics such as age, sex, occupation, race, territory, and marital status should not be the basis for denying consumers insurance, or for making it available only at very high rates."

In addressing a question to one insurance representative, Senator Metzenbaum asked:

"Do you think that people who are of different emotional make-ups, that is, that somebody ought to be making an evaluation based upon the kind of person that you are? Do you think that anybody is capable of doing that? I don't think anybody argues about the need for the insurance company to make a profit. That is not the thrust and direction of these hearings. The question is this: There is the right of the individual and the ability of the individual to be able to obtain insurance without unfair discriminatory practices that we are asking you to justify. It is the question of occupational discrimination. The question is: Do you think the insurance industry is fairly treating the American people? The question is this: Are you rated as an individual?"

The questions propounded by Senator Metzenbaum are basic questions in the rating problems and issues surrounding compulsory automobile insurance. The real question is:

### **"Is the individual insured rated and classified as an individual?" –**

The critical importance of the question is indicated in the remarks of persons prominent in the insurance field in the United States.

In the National Underwriter it was reported:

"The major issues facing the insurance industry today involve classification, according to Federal Insurance Administrator Gloria Jiminez, who also sees a growing need to emphasize 'individual risk' rather than 'group

risk' in the classification process. Ms. Jiminez said that 'there are some very significant new thoughts on classification which require full and open debate and rethinking of what heretofore were almost sacred insurance procedures'."

Former Massachusetts Insurance Commissioner Stone has said:

"The most difficult lesson for those imbued with traditional post-war insurance thinking is that classification accuracy must be thought of in individual terms rather than group terms. To understand insurance pricing, one must turn away from comparison between classes of drivers.

Professor John W. Pratt is one of the most respected writers in the world on the subject of statistical decision theory. He urged that the notion of class precision be subordinated to the concept of measured degrees of individual pricing accuracy. It is wrong to discriminate against someone for being male."

No one can seriously dispute the fact that, because of the impossibility of evaluating the risk of the individual, compulsory insured, a rating structure was established which no longer classified the individual insured according to his individual risk but, rather, one which classifies groups of insureds, which classifies and rates groups of insureds according to their respective group loss records. Nor can anyone seriously dispute the fact that this method does not correspond with the insurance technique; yet, the American Insurance Services Office (ISO) calls this method the "classical method of insurance rating," and in the German study this method is called the "insurance technical equivalency principle." At the opening of the German study the equivalency principle was interpreted correctly in the statement that: "Every insurance technical unit must be charged that premium rate which corresponds to its individual risk." However, some 150 pages later, the principle is interpreted quite differently in the statement that: "The premiums for homogeneous subgroups must correspond to their respective loss records." There is little need to explain that these two interpretations have nothing in common and that it is sophomoric, almost, to call these very different methods the same principle. In Germany, in no other branch of insurance is this spurious equivalency principle, with its class grouping, employed.

### **Classification Alternatives**

Classification alternatives in order to attain equal treatment for the compulsory insureds, the opponents of the present rating system wish to employ the real insurance technique for classification of risks and return to the true equivalency principle in the making of rates.

One possible criterion for purposes of classification might be the horsepower of the insured car based upon the proposition that the bigger and heavier the car the greater the damage and claim in the event of accident. The automobile type might be an appropriate criterion from a social policy viewpoint in the sense that bigger cars are used more and, thus, the insurance is used more so that the premium might be seen as a sort of "user charge."

Although such a method has nothing to do with the gradation of the premium on the basis of the individual risk of the particular insured, it might be sensed as reasonable by the public.

Mileage, standing alone, is not an appropriate criterion for the gradation of premium according to the individual risk, for the fact is that 5,000 miles driven by a bad driver annually may well be fraught with more danger than 30,000 miles driven by the good driver. Mileage would be meaningful in the gradation of premiums based upon individual risk only after the individual is evaluated as to his likelihood for causing a liability loss. As we have already seen, the relative rarity of accident precludes any such objective assessment of the individual's probability of causing a loss, and this is equally true with respect to good and bad drivers in high-traffic density areas.

Even the individual insureds driving record is not an appropriate criterion for the classification of the individual insured according to the insurance technique. Obviously the driver who caused a liability claim has demonstrated, on that occasion, bad driving behavior or an erroneous reaction to the circumstances then existing, but, unquestionably, there are thousands of drivers whose driving behavior was equally faulty or whose reactions were equally erroneous but who have escaped simply because they were not confronted by a similar risk interponent at the moment of their negligence. To treat all compulsory insureds equally, only those classification criteria can be employed which can be determined for all insureds in the same objective manner and can thus be employed for all insureds.

For a better look at the underlying question, let us analogize with another insurance area. Suppose that the frame construction of houses were not objectively determinable prior to fire loss but could be determined only after loss; would it be appropriate and equitable to call upon only those insureds who have sustained loss to pay the higher premium contribution for frame construction? Both the insurance technique and the principle of equal treatment dictate a negative response to the question.

In the 1979 U.S. Report, it was observed:

"Such a [driving record] rating plan might be successful if there existed a set of low risk drivers and a set of high risk drivers such that the latter could easily be distinguished from the former. Unfortunately, these two groups are not readily identifiable. Any driver may, on occasion, use poor judgment or perform imprudently or be unlucky. In fact, persons who are involved in accidents over a period of several years are not necessarily high risk drivers, nor are those who are accident-free necessarily low risk drivers. On the basis of probability theory, low risk drivers will sometimes go without an accident for a long period of time."

Similarly, in the 1978 Senate Hearing it was said:

"It is not always easy to identify those drivers who are high risk. In reality, the driving record of an individual applicant for automobile insurance often is not a very reliable tool for measuring the risk exposure of that individual. The reason is that auto accidents are relatively rare occurrences for individual drivers."

On the issue of higher charges on an after-the-fact, or retrospective basis, for drivers who have actually demonstrated particularly careless driving behavior in causing a liability claim; the imposition of a demerit rating system surcharge should be viewed in its social aspect of acting as a deterrent so that careless driving does not increase among the body of compulsory insureds.

It is essential that it be understood that classification has nothing to do with statistics and price calculation but it has everything to do with social purposes and a sense of fairness among the community of compulsory insureds. On the basis of these considerations, only two or three contributions classes should be introduced into the scheme of uniform contributions classes for loss-free drivers of like cars.

Incident to the introduction of rate classes with demerit rate surcharges, which are to be paid only after loss, the amount of all loss payments must never be distributed solely on the loss-causing drivers. To attempt to do so would simply destroy the insurance principle whereby "the not befallen pay for the befallen". Thus, the demerit surcharge must be fixed according to the degree of insurance subsidy to be recognized in the rate structure, that is the extent to which the "not befallen" are willing to pay for "the befallen". This, in turn, must be undertaken in the light of the fact that many of those insureds could have caused those same losses under the same or similar circumstances ("There but for the grace of God go I"). It is, then, only the not subsidized portion of the expected losses which is to be distributed among the loss-causing drivers.

The classification and rating of the individual insured should be performed in accordance with the insurance technique and in the steps illustrated below. (Illustrations shown on pp. XX.)

## **DEFECTS OF THE PRESENT CLASSIFICATION SYSTEM**

### **Statistics in the Present System Have a Wrong Underlying Question**

The emphasis upon statistics as the basis of current ratemaking procedure is repeated again and again both in the USA and Germany. Thus, in the USA ratemaking is described as "statistically based and justified", "supported by a body of credible statistical data", or "distinctions backed by powerful statistics." In Germany, similar protestations are heard that rates are "statistically based", "clearly recognized by the statistics that the expected losses for specific drivers (sic) definitely demonstrate regional differences", "statistical investigations have shown that the average loss record of automobile liability insurance contracts demonstrate definite differences if they are grouped according to the residence." (Let us forget that "statistic based pricing" and "cost based pricing" are contradictory in themselves. There is no producer who ascertains his costs by statistics but by costs information.)

All important to decision-making in the use of statistics as the predicate for classification is the posing of the underlying question. If that question is put in the terms: "How can the individual insured be classified according to his individual risk in respect to causing a liability loss?" then every responsible actuary would have to respond that the question cannot be answered on the basis of statistics. However, the underlying question posed by the companies actuaries is quite different, being: "How can the particular company achieve a greater profit, or, at least not a lesser profit, than other through the selection of the insureds?"

The German study concluded:

"By the premium differentiation, which was introduced in accordance with the request of the insurance companies, previously existing competition inequalities between the insurers should be removed."

In the 1978 Senate Hearing it was stated:

"Insurers seek to improve their risk assessment accuracy by identifying a subgroup with a lower risk from a large, uniformly-rated group, and if they can select this subgroup, they can improve their underwriting results."

"Every company, through selection and pricing, will attempt to identify and write the good drivers and avoid the bad drivers. This is the company's response to sound public policy, fair play, and economic realities."

The 1979 U. S. Report put it this way:

"Insurers will continue to experiment with private passenger auto classification plans. Insurers operating in a competitive environment are constantly seeking to identify better than average risks in order to maximize profits."

Based on the foregoing, it is manifest that the statistical underpinnings for the current rating system have nothing to do with classification of the individual compulsory insured according to his individual risk or with individual premium fairness.

We have already seen that the responsible actuary, in answering the fundamental question on the use of statistics, would be obligated to answer that statistics can serve no useful purpose in classifying an individual insured on the basis of his own, individual risk.

If the same responsible actuary were to respond to the basic question, "How can the companies distribute the need for contributions among the group of the compulsory insureds?", he would be obligated to say that this, too, is not a problem in statistics but only a simple mathematical distribution.

In terms of insurance companies quest for equal "profits" or equal opportunity for "profit", the responsible actuary would have to ask himself whether, in the employment of statistics to achieve "profit equity among insurers", such statistics would accord with the insurance technique and whether the statistically based rates would comport with constitutional and civil rights requirements, such as equal protection under the law. The responsible actuary must necessarily conclude that statistically based rates designed to achieve "profit equality" among companies cannot constitute an appropriate classification method for compulsory insurance and that it completely negates the insurance principle since it segregates the compulsory insureds' group into a great number of new insurance groups which would have to cover their respective contributions needs by themselves. The loss spreading over the statewide group of insureds would have been abandoned in favor of spreading loss only among single groups. Compulsory insureds with the same objective characteristics would have been redistributed to a great number of different groups with the consequence that the financial burdens would be most unevenly distributed. Thus, classification aimed at "profit equality" or equal opportunity among companies' results in unfair discrimination among the compulsory insureds.

### **Former Loss Records are no Means to Measure Exposure to Risk**

The responsible actuary must also conclude that the loss record does not provide a suitable basis for the classification of insureds because such classification can only occur on the basis of actually recorded prior losses. Applying the statistical rule that only homogenous groups may be compared, this method would lead

to the classification of insureds into groups of those with losses and those without losses, and, thus, would lead to self-payment of losses by those upon whom loss had, fortuitously, fallen. It is impossible to evaluate future risk solely in terms of a prior loss since this, too, would mean that only those insureds could be classified as "risky" who have actually had a prior loss, whereas, as we have seen, thousands have committed acts of equal or greater negligence with impunity owing to luck, chance, or God's Grace. Indeed, intuitively, one would have to suppose that the average, reasonable insured who has had a loss would be doubly cautious to avoid another.

The essence of casualty insurance lies in the creation of a common fund contributed to by all of those who are exposed to loss from a given peril (such as legal liability for an automobile accident) in order that the few who, fortuitously, actually sustain loss may be compensated. Although, through the law of large numbers (the law of averages), it is possible to predict in advance the number of losses that will occur in the coming year rather precisely, and even to predict the overall cost of compensating the victims, no one can possibly predict which ones will cause losses for which they are legally liable. Thus, insureds need to pool their money into a common fund so that the contributions distributed among all of these may indemnify the relatively few upon whom, by chance, loss befalls. But then, it becomes sheer nonsense to graduate the contributions of the insureds according to the respective loss record, because this process would, in effect, destroy the loss-pooling process, the very sine qua non of insurance. Carried to its logical conclusion, this would mean that those incurring losses would have to pay their own losses. This would be as lacking in sense as graduating the prices for lottery tickets according to the winnings which would mean that only the winners would pay for tickets, the cost of which would wipe out their winnings and thus eliminate the gamble. In like fashion is destroyed loss-pooling, the very essence of insurance.

Insurance and gambling are both based on the uncertainty of the future and have as a prerequisite the grouping of persons – to pay the winners or to pay to those who suffered loss. After knowing this it is a complete nonsense to remove the basis of these procedures by trying to replace the uncertainty of the future by recorded past results. It follows that recorded losses of groups, currently utilized as an instrument of risk classification, is a totally unsuitable means for ascertaining the exposure to danger and risk for an individual insureds and his classification.

The fact is that risk can be determined only on the basis of objective, universally applicable criteria having predictive value, not simply on the basis of prior loss. The companies' actuaries ignore the fact that the contributions needs must be determined for the whole insured group on the basis of the prior loss experience of the entire group and distributed over that entire group of compulsory insureds (Step 1 in rating). The contributions need of the individual insured or a specific group cannot be so determined without violation of the insurance principle. Thus risk determination for the individual insured can only be accomplished through identifying specific criteria which influence risk and loss. A prior loss sustained by an insured is not such a criterion.

### **The Group of Individuals must be a Result, but not the Starting Point of Classification**

The entire group of compulsory insureds should not be segregated into subgroups on the basis of criteria having no relation to the individual's likelihood of causing an automobile liability loss. Indeed, such senseless

groupings can produce different average indications with respect to the different groupings, but such average indications as to contribution needs cannot properly be generalized and assigned to the individual insured. This would lead to a classification of groups but not of individual insureds. Moreover, according to this method, each group would have to cover its own contributions needs. The entire group of compulsory insureds would have become disintegrated and like individuals with like probability of causing a liability loss, would be treated unequally depending upon the subgroup within which they were placed and the average loss record and individual contribution requirements of that subgroup.

To illustrate the fallacy in the present rate structure wherein no individual evaluation of the insured takes place let us consider an analogue from another field:

In the USA, as in Germany, there are nationwide income tax rates. No one can exactly determine, in advance, the exact income of the individual taxpayer; hence, estimated tax payments are collected in advance. After the close of the taxable year, the exact income and tax payable by the taxpayer is computed in accordance with the actual income. The taxpayer with a lower actual income may receive a refund while the one with higher income may be required to supplement the estimated tax. The great probability is that groups of employees or workers in, say, New York, Washington, Hamburg, Los Angeles, or New York, earn more, as a group, than their counterparts in other places. Surely, no one would contend, therefore, that all employees or workers in New York, Washington, Hamburg, Los Angeles, or New York should pay a higher tax rate. To do so would substitute for the individual assessment of each taxpayer a group-based tax rate which would be entirely alien to the actual earnings of individuals within the selected group. Citizens exactly alike and with exactly alike incomes in all other respects would pay widely disparate taxes in accordance with their residence or employment groupings. That this would violate every principle of equal protection of the law is clear. Indeed, since under compulsory automobile insurance, the mandatory conclusion of insurance is widely perceived as being a tax on operating an automobile, this analogy might well be worthy of deep pondering.

The responsible actuary must conclude that, in the classification of individual insureds, to form subgroups, first, and only then to classify the individual insured according to his identification with this subgroup is to "place the cart before the horse". Incident to an individual classification, the group should be the result, not the starting point, of the process.

### **Grouping by Agreement or Experimentation**

The companies' actuaries have never dealt with these issues – at least, they have never publicly expressed themselves on them. They have simply continued their "experimenting" with all potential subgroups that may be identified on the basis of their loss records. In the USA, where insurance is compulsory but acceptance by the companies is not, and where company acceptance is essentially unregulated, the field open to such experimentation is extremely wide.

In Germany, selection is accomplished through classification which, in turn, is limited to region and occupation. Classification was founded upon an agreement between the ministry having responsibility for automo-

bile insurance, the insurance supervisory authority, and the automobile insurance company. As the Germany study has said:

"The determination of the regional units for the K-H [automobile insurance] 1977 tariff was done by agreement, to choose big cities and governmental districts as regions."

But this very formation of groups is the essential problem and subject of risk classification. In Germany, these groups were agreed; in the USA, actuaries "experimented" to achieve them. Whether reached as a result of agreement or experimentation, the actuaries took as their basis prior loss records and compared the respective loss records to evaluate the potential groups. If, on the basis of the class criterion employed, e.g., the region or the occupation, the loss record was different, that criterion was made a class criterion. The identified group was constituted a premium class and the average loss record was made the basis for the group premium under arguments along lines of the following: (This is the wrong argumentation in a circle / vicious argumentation circle)

"If drivers fail especially often in specific traffic areas, if human failure concentrates in specific junctions or roadways, the quality of these places or lines must be jointly causal for the misbehavior." [German study]

"Geography is a factor because more accidents occur in congested traffic conditions. Thus, insurers correctly charge urban motorists more because their exposure to loss is greater." [1978 U.S. Senate Hearing]

Such a method and the results flowing from it violates basic statistical principles. Statistical science consists of the meaningful grouping, comparison, and evaluation of units. For this purpose only initially homogeneous units may be grouped, that is, homogeneity must be the beginning point, not the result, of the grouping.

## **VIOLATION OF STATISTICAL PRINCIPLES**

### **Impermissible Generalization**

If the units were different or if they were taken with initially heterogeneous data into the statistical process, the group result may only be related to the group as a whole in comparing groups, but the transfer of an average result coming from heterogeneous units or data having heterogeneous factors to the individual unit is not valid for this is an impermissible generalization.

It must be concluded, therefore, that this ascertainment of different loss records for selected groups can only have meaning for the particular groups, as groups, but that the average loss indication record of the groups cannot properly be assigned to the individual units of the group as their "expected loss" or "contribution need." As noted earlier, these constituent units have widely differing loss records ranging from no loss for many to several losses for others. Transfer of the group result to the individual units would be tolerable only if all of those insureds, year after year, had losses of the same amount and, had the same, or average, loss record. As former Massachusetts Commissioner Stone said during the U. S. Senate Hearing:

"If you can prove to me that someone is the average person in the group, then it is all right for them to pay the average rate for the group."

Every actuary with a sense of responsibility would refuse to identify groups as being "homogeneous as to the loss record"; yet this is what is done by the companies' actuaries. In fact, there is never homogeneity among insureds as to their loss records; if there were, insurance would become pointless and group compensation superfluous. However, if 10 of 100 insureds have losses totaling \$50,000, no actuary in the world can alter this fact that each of the insureds had a loss of \$500.

### **Statistical Results are no Causation Criteria**

Every responsible actuary must concede the fallacy inherent in identifying as causal every criterion produced by the results of a grouping of heterogeneous units. Let us suppose, for example, that the average age of people is determined by the streets on which they live; if the people on a certain street were found to have a greater average age, surely no one would contend that living on that street was causal for the greater average age. Thus, there would be no merit to the proposition that: "If greater age is concentrated in specific streets, the quality of the streets must be jointly causal for this greater age."

Yet, it is this very naive conclusion which is advanced by the insurance and government actuaries as "proof" that every group criterion must be acknowledged as a valid causation criterion if it leads to different results among the groups compared. Thus, it is deduced that:

"Territorial classification is a valid, proven method of estimating exposure to loss." [U.S. Senate Hearing.]

Based upon the earlier quoted statement of the German actuaries, they would presumably say something to the effect that: "If human failure is concentrated in specific traffic areas, all car owners and drivers who live in, or close to, such areas must be bad and should pay a higher premium." But will actuaries contend that just at the edge of the licensing districts this human failure changes?

It should not require extensive investigations and studies to show that residence, occupation, age, sex, or marital status do not, of themselves, influence the occurrence or the extent of an automobile liability claim and that these criteria are not valid causation or risk criteria. Manifestly, the cause of an automobile liability claim (not accident) can only be negligence of the driver or owner in respect to his driving or the defective condition of the car. Senator Metzenbaum at the U. S. Senate Hearing pinpointed the differences which separate the and their critics when he said:

"The insurance industry suggests that there is statistical justification for the classifications they are using. In fact, such categories have been challenged by industry critics as superficial, with no direct causal relationship to possible losses."

Undoubtedly, various groups of insureds could be shown to have differing loss records and contributions requirements if they were grouped in accordance with various criteria. Perhaps statistics on blue-eyed blonde, married drivers with small feet would indicate that they have a lower loss record. The generally black-haired foreigners would be excluded and only "cool blonde" people insured; young drivers would be excluded and a lot of small-footed women would be included (women, as a group, have a lower loss record than males). Nevertheless, it would be a gross perversion of the statistical method to conclude from the lower loss record of the arbitrarily formed group that everyone who has blue eyes, blonde hair, small feet and

is married is a good driver. To repeat, group criteria can have predictive value for the group as a whole but not for the individual encompassed within the group.

### **A Group Criterion has predictive Value only for the Group – not for Heterogeneous Units**

The group criterion "state employee" suggests that the drivers among this group, in general, drive less, including the bad drivers. Thus, even if there are more bad drivers among the group than among groups characterized by more driving, the state employee group will have a lesser contribution requirement. The same may well be true with respect to the "female sex" criterion.

Conversely, the "youthful age" group criterion suggests that in this group there are more inexperienced and judgmentally immature drivers in the group, even if there are more good drivers with quick reactions than among the more mature groups (investigations in the USA demonstrate that within the youthful driver class there are more good drivers than within the elder). Nevertheless, because of the losses of the inexperienced and immature among the class, together with their greater usage of cars, particularly for night driving, the youthful driver group, as a group, demonstrates a need for higher contributions.

Still, according to the insurance principle and statistical rules, it is not appropriate to transfer this group loss record and average contribution need to the individual insured member of the group and thus charge him the average loss record as his contribution. It is inappropriate because the units composing the group are not homogeneous as to the individual risk.

### **The Present Classification Groups are "Fictitious" and Overlapping**

Actually, under the current method, there occurs only a classification of groups but not of the individuals within the groups. Accordingly, the insurance actuaries have established group premiums for the several groups but the difficulty is that they certainly are not insured as groups. They are, in the words of statutes prohibiting such things, "fictitious groups".

With a statewide compulsory insurance law, it is inadmissible to establish different groups of compulsory insureds for Hamburg or Munich, New York or Buffalo. These subgroups really do not exist. In Germany, the insureds from 45 regional districts (it is proposed to make these 331) are dispersed among about 100 insurers among whom no technical distribution takes place. Additionally, the insureds are randomly distributed among these 100 insurers on the basis of three occupation classes (state employees, farmers, and "normal citizens"), 10 horsepower and 10 driving record classes. According to the argument of the insurance actuaries, each company and even each class must of itself, cover its own contributions needs. The result, however, is an overlapping which itself is a violation of the statistical principle of separation which requires that for each question to be answered there must be established a new and different group of units.

**State of New Jersey, April 1981**

### **"Re-Hearing on Automobile Insurance Classifications and Related Methodologies"**

#### **(Financial Determination – Major Findings and Conclusions)**

## Within-Class Heterogeneity

105. The lack of homogeneity in current classifications is recognized implicitly in the industry's traditional emphasis on the importance of underwriting. Substantial perfection in classification would obviate the application of subjective judgments by agents and underwriters to further screen applicants.

106. The inaccuracies of the system are underscored by direct assessments of heterogeneity within classes. Assuming for the sake of discussion that premiums are an accurate reflection of class-average costs, variations among individuals within classes nonetheless result in measurable overcharges for substantial fractions of class populations. For example, in a representative suburban territory 17-year old single male principal operators who use their cars to drive to work and are ineligible for either good-student or driver-training status pay an average premium of about \$635 for the compulsory coverages. Yet in relation to individual expected costs, this premium is at least \$300 too high for 17 to 25 per cent of the class, depending on computational assumption, and at least \$500 too high for 1 to 4 per cent of the class.

107. The size of the overcharges affecting class members vary in relation to class premiums. For example, if the suburban males above purchase full coverage - the compulsory coverages plus collision and comprehensive - they pay an average premium of about \$1,240. At this premium level 37 to 43 per cent of the class are overcharged at least \$300 and 23 to 31 per cent of class members pay at least \$500 too much.

108. The frequency and magnitude of large overcharges are greatest for individuals in the highest-rated classes within the highest-rated territories. Nonetheless, in the highest-rated classes the fractions of insureds overcharged by large amounts are substantial everywhere. In one of the lowest rated territories in the State no less than 34 per cent of the highest-rated single males are overcharged a minimum of \$300 for full coverage and at least 18 per cent are overcharged \$500 or more.

109. Even the lower-rated youthful classes contain substantial fractions of insureds subject to large overcharges. In a typical suburban territory about 18 to 27 per cent of the highest-rated single females are overcharged at least \$300 and about 2 to 5 per cent are overcharged at least \$500 for full coverage. In the same territory minimum \$300 overcharges are incurred by no less than 28 per cent of the 18-year old single male principal operators who are eligible for good-student and driver-training status and drive only for pleasure. No less than 10 per cent of these males are overcharged at least \$500.

110. Direct assessments of within-class variation also reflect the extent to which individuals in different classes have More in common with each other than with members of their own classes. Overlaps of this sort are characteristic of all classifications to some degree, but the anomalies are greatest in the youthful classes where dollar differences between classes are largest:

(a) No less than 23 per cent of the highest-rated 18-year old male operators have lower expected losses than 24-year old males with otherwise the same rating characteristics; and about 10 per cent of the 24 year olds have greater expected losses than the average for the 18-year old group. The younger group pays average premiums about 66 per cent higher than the 24-year olds. The graph in Figure F-6 illustrates the overlap under full coverage among the highest-rated 18, 21 and 24-year old males in a typical suburban territory.

(b) Between 18 and 29 per cent of the highest-rated 17-year old single males have expected losses below the average for the highest-rated single females, but pay over 80 per cent higher premiums; 7 to 12 per cent of the females have higher expected losses than the average for the males. Similarly, 39 to 44 per cent of the highest-rated class for 17-year old single-male principal operators have expected losses below average for occasional operators with otherwise identical rating about 25 per cent of the occasional operators are above the average of the principal operators. The graph in figure F-7 plots typical overlap among highest-rated male principal, male occasional and female operated under the compulsory coverage. The territory is suburban. Figure F-8 plots comparable overlaps in the highest-rated territory. Figure F-9 provides the same comparisons as F-8 but for full coverage. As the spread in class means increases, within-class heterogeneity and related pricing errors increase dramatically.

(c) About 22 per cent of a representative high-rated class of single male principal operators have lower expected costs than the average for comparable married males, but pay about 70 per cent higher premiums; about 9 per cent of the married males have expected cost above the average for the single-male class. Figure F-10 plots the overlap among 18-year old single males (separately for principal and occasional operators) and 18-year old married males in the representative suburban territory.

(d) About 36 per cent of a representative class of 18-year old single males without either driver-training or good-student status produce expected losses below the average for otherwise identical youths with both qualifications, but pay about 34 per cent more for the same coverages; approximately 22 per cent of the youths with both qualifications have expected losses above the average for the no-discount group. Figure F-11 plots overlaps under full coverage among four classes on 18-year old single males in a typical suburban territory: those without either driver training or good student status; those with driver training only; those with good student only; and those with both driver training and good student. The four classes are almost fully overlapping and each is substantially heterogeneous."

The groups of insureds with the same criteria, which, presumably, are to cover their own needs for contributions, do not exist in the real world. The former Administrator and Chief Actuary of the U. S. Federal Insurance Administration (FIA) found that for the State of Illinois, there were more than 13 million potential rating slots whereas there were only 11 million citizens with 5 million cars.

In fact, in the USA there are billions, and in Germany, millions of insureds' groups each of which, presumably, is large enough to cover its particular contributions need. In accordance with the statistical rule of separation to avoid overlapping, the actuaries would have to ascertain the loss record of every insured as a "group of one" and to transfer the result to him as his "risk criterion" and his "class premium". The result would be an exemption from premium for those without losses and self-payment of losses for those with losses and a total disintegration of the nationwide group of compulsory insureds. It is ironic that the German actuaries suggest that smaller licensing districts be combined into agglomerates if these districts "are too small to make the insurance technical compensation possible." Apparently, they did not see that these districts do not represent a group of insureds because the insureds of these districts are distributed to 100 insurance companies and thousands of premium classes.

### **Surrogate Criteria of Group Classification Lead to Discrimination of the Individual Insured**

In reality, the insurance and government actuaries did not establish the contributions for these fictitious groups of insureds, but they produced "surrogate criteria" for the classification of the insureds which are to be used instead of, and because the lack of, risk criteria, even though these surrogate criteria have no influence on the occurrence and extent of the automobile liability loss. These surrogate criteria for the classification of the individual insured have a distinct influence on the premium income and loss payments, and, thus, on the "profits" of the companies and this is precisely the reason for the employment of such criteria, not premium fairness or equal protection.

Thus, the companies determine their own risk which is exposed to the danger of loss payments. But this is not the risk, which is understood by the insurance technical equivalency principle for classification (the exposure of the individual risk to the insured danger). Hence, the statistical group loss records and group criteria now employed have nothing to do with the insurance technical classification principle. Maybe the reader didn't notice it how the establishment of these group criteria left the equivalency principle for classification of the individual insured. Therefore a summary at this place:

The insurance technical equivalency principle of classification aims at a measurement of the individual insured's exposure to danger or risk by his specific criteria, which objectively indicate the individual risk. But the classification principle of the companies actually aims at a determination of a quite different risk and exposure to danger. They measure their own risk – their own exposure to the danger of loss payments or loss. They actually don't want to determine the individual risk of the individual insured (his exposure to danger), but they determine the risk of their speculative activity (what insurance "produced" by stock companies really is). This risk can be determined by a statistical record of former losses of specific groups. The risk and the exposure to the danger of loss payments is higher when the companies accept clients from groups, which show – as a group – a higher loss record than other groups. But past loss-records of groups don't indicate the future risk of an individual.

The group criteria are, moreover, employed in multifold combinations in the classification of the individual insured. The unfair discrimination which is inherent in the transfer to the individual of the result of even one such group criterion is, thus, multiplied by the combination of five or more group criteria.

Restating the matter for purposes of emphasis: under the present rating method, it is not the individual insureds who are classified but only non-existent groups of insureds. The criteria through which these groupings are made have an influence on the premiums of these groups and "insurer profits" but not on the occurrence or extent of the liability loss. These group criteria, which are surrogates for the unattainable individual risk criteria, are employed in multifold combinations to establish the premium for the individual insured.

Actually, through employment of the surrogate criteria "residence, occupation, age, sex, family status, driving record, etc.," the actuaries are attempting to approximate a combination of the real risk and loss Potential criteria "driving behavior, driving area and mileage", which, even if obtainable, would only make a classification of the individual insured possible according to his individual risk."

### **The Real Criteria Combination "Driving Behavior – Driving area – Mileage" cannot be Ascertained**

Even if driving area and mileage are acknowledged to be risk factors or risk criteria, they may not properly be employed, standing alone, as rating criteria since they have a distinctly different importance in respect to the good driver, the bad driver, and the very bad driver. This means, for example, that the good driver poses no danger in a given driving area even though he has an annual mileage of 30,000 miles; the bad driver poses a danger in that same area, though his annual mileage is only 5,000 miles; the very bad driver poses danger in that area with every mile that he drives.

The meaning of this is that, primarily, the individual driver must be evaluated before, secondarily, it can be determined what importance driving specific mileage in specific areas has for him. However, since the differing driving abilities of the insureds cannot be objectively measured, the subsidiary factor of "driving area" or "mileage" likewise cannot be objectively employed.

The real risk factors of driving behavior, driving area and mileage, which may be employed for the classification of the individual risk only in combinations cannot even be objectively ascertained as to any one factor, still less can they be so ascertained in combination.

### **The Vicious Argumentation Circle of Actuaries**

If the insurance actuaries would frankly concede that the basis for employment of statistics as described above has in the companies, interest in profits rather than premium fairness for the insureds they would avoid reproach for their misuse of statistics which would then have a more logical predicate. Whatever the basis for employment of the group statistics, the fact remains that the result is unequal treatment to the tune of billions of dollars among insureds legally compelled to buy insurance.

Many of the government actuaries appear to entertain the serious belief that they have observed the insurance technique and equivalency principles, and that they have discovered useful criteria for the classification of the individual insured in accordance with his probability in causing an automobile liability loss. These actuaries must be faulted not only with respect to the gross errors in the area of the insurance technique but also with respect to their own field of statistics because their argument proves to be completely circular. First, they establish a group in accordance with some criteria and ascertain the loss experience and the average loss experience for this group. If this differs from the loss and average loss experience of some different group, the criteria employed in selecting the group are denominated risk criteria, the groups identified as contribution classes, and the average loss experience of the group is claimed to constitute the "fair premium for the individual insured." Finally, the full circle is closed through the assertion that this group must be homogeneous because the same "average loss experience" was ascertained for all units of this group. What is entirely ignored in this statistical circle is that the units were not homogeneous in the beginning, but have been homogenized in the end only through this "statistical mix" and an average result. Using this same method a 100 year old man could be shown to be homogeneous within a group of much younger people because he is of the same average age.

### **Contradictions of the Actuaries**

Moreover, the German government actuaries proceeded contradictorily. First, they agreed that while the insured can be faulted for causing the accident, he cannot be charged with responsibility for its exact consequences which are principally providential, for example, the faulty driver can scarcely be held to foresee that a small cut sustained in a minor accident would prove to be fatal to a hemophiliac in the other car. Then, however, instead of proceeding only on the basis of the number of claims, or accident frequency, of the respective regions, they use the total loss experience which includes all loss payments, which obviously incorporate accident severity, although the actuaries have conceded that severity is essentially providential. It is this inappropriate loss experience which then is made "the starting point" for the premium calculation. While saying that in the differentiation of risks only those criteria may be considered the influences on the insured of which can be ascertained," they also concede that "the ascertainment of single reasons causing the liability loss meets particular difficulties." Notwithstanding all of this, the actuaries designate the residence as a risk criterion and even the occupation of the group, such as "State employees" as an "independent risk factor" statistically ascertained. It is self-evident that these several statements do not tie together.

The German government actuaries profess to have proved the "influence on the insured risk by the risk factors of residence and occupation" in their assertion that "if human failure concentrates in specific traffic areas, the quality of their area must be jointly causal for the failure." This attempt to present localizable accident causes as non-localizable liability loss causes is demonstrated to be a diversionary tactic by the method actually employed which is to allocate the liability loss to the residence of the insured without respect to where the accident actually occurred. The car owners of the little town of Wolfratshausen, 13 miles from Munich, certain do not pay the highest premiums in Germany because the quality of this small town is jointly causal for their "failures" and liability losses, the vast majority of which occur in Munich to which they regularly commute.

This expensive German study, mandated by the Ministry for Economics, with all its scientific mistakes, deficiencies, and diversionary tactics is presented to the compulsory insureds as a joint venture of government, the Insurance Supervisory Authority, and the "insurance industry". It is then left to the helpless insureds, who are unorganized and without means, to ferret out all of these faults, deficiencies, and the unfair discrimination which is their consequence. The faults and deficiencies of this study can be explained to the media only with great difficulty and to the public not at all. Superficial journalists are certain to adopt the false results of a purportedly scientific study which is supported and done by "such responsible institutions".

### **A Wrong "Premium-Subsidy" between Equal Insureds Form differently Rated Groups**

Having shown that this current rating methodology neither corresponds to the insurance principle nor statistical science and validates the equal profit, it remains to demolish the other arguments raised by the protagonists and defenders of that methodology.

Prominent among these arguments is that of "subsidization" through which the advocates of the present system seek to arouse the emotions of "good" drivers and thus win them to the defense of the status quo and group thinking. – Thus, the insured who is at least temporarily benefited under the current method is invited to ask: "Why should we pay for those who cause the most losses? i.e., for the youthful drivers, for the

residents of the big cities, etc.; or why should we, the state employees, pay for the losses which are caused by non-state employees?"

Such arguments seem to have a surface logic for the lay citizen who cannot be expected to realize that through compulsory insurance a statewide group of insureds is established and that these arguments are really addressed to the Balkanization of the overall group into subgroups dependent upon the chance and transitory affiliations of the insureds with these subgroups; for he who is a state employee today may not be tomorrow, or he who lives in Bremen or Milwaukee today may not tomorrow. But let us see who subsidizes whom under the present system.

### Loss Pooling Subsidy

Of 100 insureds, 50 remain without loss over a period of 10 years; 30 have one loss within the period; 20 have two losses and ten have three losses within the period. The average loss is \$5000. The contributions requirement for the entire group is, then, \$500,000. The group of insureds agree on a subsidy of 50 percent, that is, every one of the 100 insureds, whether with or without losses, had to pay a basic premium of \$2,500 in the 10 years. He who suffers a loss must pay over a period of 10 years a surcharge of \$150 per year; he who suffers two losses must pay an annual surcharge of \$500; and he who suffers three losses must pay \$750. This results in the following table:

(simplified example)

		Subsidy contribution	demerit surcharge	total premium p.a.	premium in 10 years	loss payments	need for subsidy	amount of subsidy
A	50 without loss	250		250	125000			125000
B	30 with 1 loss	250	150	400	120000	150000	25000	--
C	20 with 2 losses	250	500	750	150000	200000	50000	--
D	10 with 3 losses	250	750	1000	100000	150000	50000	--

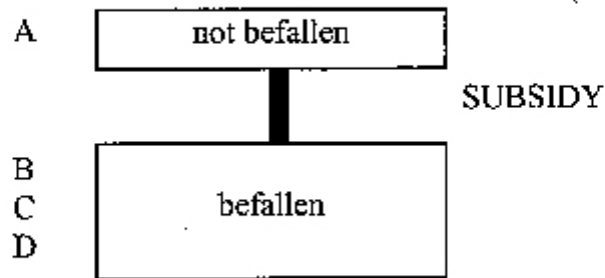
### Premium Subsidy

According to the present rating system used in Germany, the data in column (3) must be changed as follows since differing premiums are applicable to like drivers with like cars and driving records:

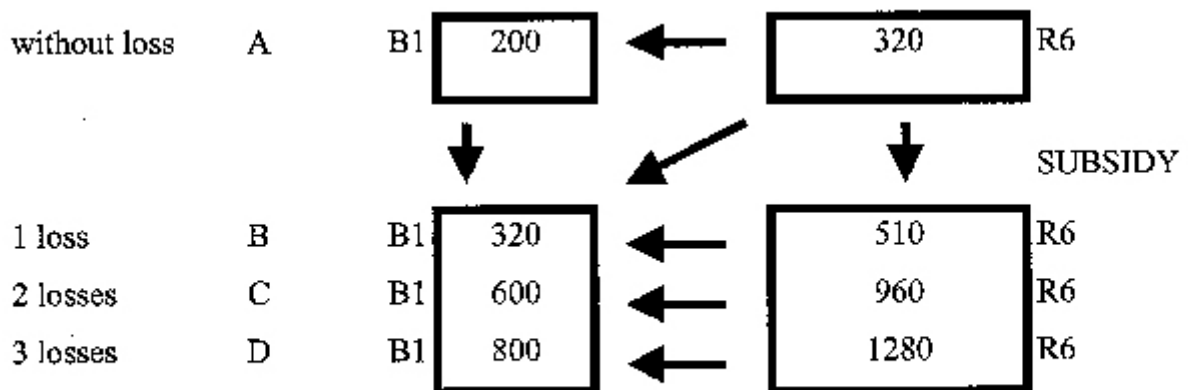
contribution difference	state employee class (B1)		regional class (R6)	
B1 / R6 = 60 %				

without loss	A	B1	200.-	/	320.-	R6
1 loss	B	B1	320.-	/	510.-	R6
2 losses	C	B1	600.-	/	960.-	R6
3 losses	D	B1	800.-	/	1,280.-	R6

While the subsidy in insurance must go from the insureds who had no loss to the insureds who had loss ...



the subsidy according to the present rating system breaks down into the following:



This „premium subsidy” is against the insurance technique.

This presentation shows that it is false to the point of irresponsibility for the protagonists of the current system to induce the public to believe that the drivers among the group with low loss records would have to subsidize the groups with high loss records if the present rate structure were replaced by a rating structure having the same rates for the same cars but modified by a demerit surcharge system. In fact, the opposite is the case: under the current system, the loss-free and even the other drivers of the groups with high loss experience subsidize the drivers with losses in all the other rate classes. This is as valid for the USA, where the above mentioned loss-free young driver from a Black area in Boston, paying \$2,500, subsidizes that old woman in the rural area, who had two losses but pays only \$160 for the same car.

### The Highest "Premium-Subsidy" from Loss-free Young Drivers

Indeed, (this does not even take into consideration) the loss-free beginners, too, must be taken into consideration, who, with their up-to-1000 percent higher contributions, subsidize the entire statewide group of in-

insureds even though they have themselves caused no loss. In the face of this, the German study, oblivious of the insurance principle, the fundamental rules of statistics, and the constitutional principle of equal protection, blithely states:

"According to this statistically proved fact that many young people cause automobile accidents above average, we propose to fix the rate for contracts with beginners according to the effective loss record."

Accordingly, all beginners would have to pay 270 percent of the basic premium without respect to whether they are "good", "bad", or "very bad" drivers. As a result, the annual premium for the beginner with a middle-class car would be \$1,200. If young drivers are prejudged as the "worst" drivers and saddled with unjustifiably high premiums, they are certainly provided no incentive to drive carefully and reasonably.

Would it not be more reasonable to acknowledge that in the "beginner" class there are also "good" drivers (probably more than in the other groups because of their quick responses) who should be classified as all other accident-free drivers so as to avoid unfair discrimination. Those who cause a loss should be retrospectively charged a demerit surcharge as a deterrent. Certainly, the prospect of a higher rate as a consequence of actual wrongdoing would provide the incentive for beginners to drive reasonably and prudently. It is a matter of simple logic that a driver who has been accident-free for 15 years must also have been a good driver when he was a beginner; yet where he was classified as a beginner, he was assumed to be among the "worst" and had to pay the highest premium of all drivers.

### **No "Premium-Fairness" for the Individual**

Along lines of the subsidy argument is that relating to "premium fairness". The defenders of the present system declare: The drivers of regions or occupations with low loss experience should pay correspondingly low premiums, otherwise they would subsidize the drivers of regions or occupations with higher loss experience. The fallaciousness of this group treatment has already been demonstrated: such comparisons completely ignore the single insured as an individual.

### **Removal of the Present System without further Measures Leads to Availability Problems**

In the USA, where compulsory acceptance of risks by the companies is not general, the companies fortify their position by warning that abandonment of the present system could lead to the unavailability of essential insurance for some regions or groups of insureds. It is urged that if the same premiums were charged for like drivers with like cars, the companies would no longer accept insureds from regions and groups having higher loss experience.

In the 1979 U.S. Report, it was stated:

"Territorial rating should not be proscribed as unfairly discriminatory. Direct control of risk assessment has all the negative effects of rate control, including market dislocations, unintended subsidizations and problems of availability of insurance for some groups of consumers."

In this same connection, a German press article in December, 1979, is revealing where, under the caption "Cars of Foreigners Screened", it was said:

"Frankly and freely the second largest German insurer had conceded to having sent cancellations to the houses of Turks, Greeks, and Yugoslavs. The insurer advanced enterprisal necessity as its reason. The Colonia, along with other insurers, had attempted to bring about, through the Supervisory Authority, a premium surcharge for this group of clients. However, since such a surcharge contains discrimination features, the Supervisory Authority declined authorizing it."

(An actual remark: Section # 81e of the German Supervision Law 1994 [National or ethnic classifications]  
"An irregularity as specified in § 81 para. 2 is also deemed to exist if rating rules and premium calculations refer to the nationality of the policyholder or insured or to their being part of an ethnic group."

In the USA, the assigned risk plans would be overcrowded; or, if state operated residual risk mechanisms were established to insure those who were cancelled or refused insurance, and the state was required, by equal protection considerations, to charge the same premiums as the insurance companies, the state would incur heavy losses while the companies were making large profits simply because despite the many good risks in the state mechanisms there would be many truly bad risks.

### **The Basic Conflict "Insurance and Profit-Striving"**

It is just at this point that the basic conflict in the insurance field becomes evident – the conflict between "insurance" or spreading loss and the striving for profit from the loss pooling. This conflict has previously been cited: The interest of the insureds which is simply to provide the money for their joint loss pooling and to have the loss fairly compensated, and the conflicting interest of the insurance companies to retain as much as possible of the insureds money and to pay out as little as possible under the theory that such surpluses represent their "profits". We shall presently scrutinize this conflict more closely.

The quotations which follow clearly demonstrate the dominance of the profit motive as a predicate for the preferences for the status quo:

Typical quotes from the USA are:

"Public policy is not the responsibility of the insurance industry."

"We are profit-seekers operating within a competitive environment. We are in competition for good business with other companies. We like to write pig-iron under water against fire."

"Elimination of rate classifications and the establishment of a simple rate would compel insurers to select risks which offer the least potential for loss."

"The company is picking the 'cream' from the state and leaving the rest scrambling for insurance."

"Thus, competition leads to class grouping."

The foregoing quotations graphically describe the methods of a system of unregulated selection which is regarded by the companies as "competition" and the essence of "free market forces."

In the German study, on the other hand, unregulated selection is regarded as undesirable. In that study, it was said:

"The main target in the shaping of the automobile liability insurance market is the creation of a functional competitive order, but controlled according to specific peculiarities of that branch of insurance. The term, "controlled", implies the opinion that in an\_uncontrolled competition in the automobile liability insurance market, there would be an inherent tendency leading to economically and politically undesirable results."

In the US Report, it was said:

"Given the freedom to contract, it is natural for insurance companies to avoid or price-up buyers who, in their judgment, offer a greater loss potential."

At the same time, however, all studies stress the importance of creating a climate of equality of opportunity for "profit" among companies. Thus, the German study says:

"In summary, it can be stated that the regionally differentiated tariff gives no advantage to any one insurer, but creates for all insurers initial equality."

Thus, it is crystal clear that the real predicate for classification of risks is not equity among the insureds but "competition equity" among the companies. In Germany, the proposed system was designed to enable the insurance companies to protect themselves against historically developed or regionally conditioned adverse selection. Accordingly, the German study conceded:

"The premium differentiation protects the insurer against a negative selection within his insurance portfolio."

"A further reason for maintaining the tariff groups, 'farmers' and 'state employees' is the challenge raised by competition; here, there are similar tendencies in development to those involved in the regional structuring of the automobile insurance tariffs. Here, as there, 'a uniform standard tariff' could lead to the formation of new special insurers. Thus, the recognition of the tariff groups for 'farmers' and 'state employees' makes it possible for the composite insurers to remain competitive with the special insurers. Therefore, an abolition of the occupational tariff group seems to be practicable only if, at the same time, a prohibition of special insurers were ordered."

The last sentence quoted echoes a statement in the U. S. Report that:

"If government forces negate economic pricing methods, government will have to mandate the rules of conduct on a legislated basis to put all insurers on an equal footing."

## **SOLUTION OF THE PRESENT CONFLICT**

Now the study has reached that point, where the two incompatible facts and results of our present classification system bounce together:

When equal insureds pay equal contributions, the companies have different surplus results and ask the State to be "put on equal footing". But when the companies are put on equal footing (like in Germany by the Tariff Order) or when they provide themselves equal feet by "selection – anti-selection", then insureds, who had to pay equal contributions according to the insurance' technique, pay unequal premiums.

Up to now, this problem was and could not be solved, because the decisive question was always asked the wrong way. It is not the question "competition and equal profits-or-equal treatment and equal contributions?". This way of asking is already nonsensical, because competition and profits can never have anything to do with the equal protection clause. Beside that, the challenge for equal profits in connection with competition is schizophrenic.

### **Compulsory Insurance and its State Regulation is "State Action"**

I think, there is no doubt that a compulsory insurance and State regulation of this compulsory insurance is "State action", the prerequisite to provide equal protection. The Michigan Supreme Court confirmed this.

So the legislators, judges and regulators have to decide the question: "Selection and equal chances for embezzling the surpluses from the compulsory insureds' money-or-equal treatment and equal contributions for the individual compulsory insured?." There should be no doubt that after this the vote can only be for equal treatment and equal contributions! –

### **Provision of Equal Treatment by a New "Insurance-/Service-Theory"**

There is nothing else left that "governmental forces" **must** "negate economic pricing methods" as to the contribution to the common fund (a hidden part of the present premium). The reasons are comprehensively explained above, but also stated by the National Association of the Insurance Commissioners:

US Report: "The NAIC is moving forward from the philosophical perspective that the insurance industry needs to be changed that economic pricing is not functioning properly and that regulatory action is needed to change the industry."

Great words – but no action ! –

To find the right framework for a solution of the moribund controversy over wrecked theories, it was necessary to start from the contradictions raised by these legal and economic conceptions and by the present insurance system in the face of our legal and economic system.

First there was the legal framework within which hitherto unresolved legal questions had to be posed, such as no counter performance for the not befallen – no mutuality of performance – no transmission of title -no justification for profit taking» Then> there was the economic framework, posing unsolved problems along lines of economic questions such as incompatibility with the National Accounts – no price quotation -no com-

petition prerequisites – no object factor of the companies' services – the fact that cost-free money provided by the insureds for loss payments can never constitute a production factor and lead to costs for the insurance companies.

The starting point for a solution, is the analysis of the economic processes in the insurance field, Here, the National Accounts record two separate processes: a money provision aimed at a redistribution of income (insurance)., and the organization of the redistribution process (companies services). The first process is performed by the group of insureds., the second by the companies. It is in the breakdown of these two insurance processes until now erroneously considered as a unit, that solution of the outstanding theoretical and practical problems in the insurance field is to be found. Through a separation of these performances and their allocation, respectively, to the insureds and the companies correspondence with the handling of the National Accounts is achieved.

Such a separation of the economic processes naturally requires a breakdown of the insurance contract, which also has hitherto been seen as a unit, into two contracts., that is, the actual insurance contract between the single insured and the group of insureds (the real insurer) and a "remunerated provision of service contract" which is concluded between the single insured and the insurance company and which has, as its object, the administration and redistribution of the insurance contributions for loss pooling.

In this fashion there arises a mutual contract between the insurance company and every insured. For every insured, even those who do not receive an "insurance performance" (loss payment) there is a counter performance rendered by the company, the service of concluding the insurance contract, organizing the group of insureds, and administering, redistributing, and investment of the funds provided by the insured for loss pooling. This money is the, hitherto lacking, object factor of the companies' services upon which the service is performed.

The premium must be broken down, accordingly, into its components. The insurance companies must be required to quote a price for their services, which will obviate the necessity of estimating the value of those services for the purposes of ascertaining the GNP. In this fashion, too, there is compliance with the requirements of the Price Quotation Law as well as fulfillment of the prerequisites for effective competition. It is the service price alone which becomes the absolute property of the insurance companies, and the companies are entitled to profit only from surplus arising out of these service prices. In addition to the service price, an insurance contribution must be charged which is rated jointly With representatives of the insureds, and the resulting common fund must be administered, invested, and accounted for as the property of the insureds.

The strained relationship between State supervision and competition would be resolved through a separation of the insurance field into a supervised insurance area and an uncontrolled competition area relating to company services.

Such a system abolishes the anomalous situation in the claim settlement process whereby the avoidance, delay, or diminution of payments automatically lead to increased profits for the insurance companies. The insurance companies would no longer be concerned with surpluses., differing from company to company, arising from loss pooling in connection with compulsory automobile liability insurance. Regional and occupa-

tional classes (and all other group-criteria-based classes) could be abolished so that like compulsory insureds could be treated equally, as required by the constitution.

### **Equal Protection Systems in other Countries**

Interestingly, in Japan and the Philippines, this premium separation is indirectly accomplished to secure equal treatment of the insureds and secure universal availability of the required insurance. The 1974 FIA Study explains:

"Compulsory automobile liability insurance was introduced in Japan in 1955-56. At that time, both the Japanese Government and the insurance industry foresaw the probability of the development of a residual risk problem and moved to preclude such development."

"All insurers must accept all eligible applicants for the compulsory coverage. The agents are paid a uniform commission."

"The compulsory coverage, all of which is written at a uniform premium rate, is 100 percent reinsured (net of a fixed percentage expense loading), 60 percent of the risk being ceded to the Ministry of Transportation of Japan and 40 percent to a pool in which all Japanese automobile insurers participate."

"Under the Japanese system, all who are required by law to carry the liability coverage are assured of its ready availability, and, since all are afforded coverage on the same terms, there is no need for concern regarding access to insurance or with unfair, discriminatory, or inequitable treatment of any segment of the market."

In a letter of May, 1980, to the author, Gregoria Cruz Arnaldo, Insurance Commissioner of the Philippines wrote:

"To insure that the insurance industry may adequately provide the compulsory insurance coverage and at the same time meet the losses arising there from, a pool, known as the Philippine Motor Vehicle Liability Pool (PMVLP), composed of all insurance companies writing casualty or motor car risks, was organized following the signing and approval of a Pool Agreement. The PMVLP is licensed by this Commission. It was conceived to serve as a "clearing house" for the member companies in effecting a redistribution of the compulsory motor vehicle liability insurance (CMVLI) business as well as the losses on an equal sharing basis among its members. As provided for in the Pool Agreement, the member companies are to:

- directly write the CMVLI policies
- cede all their writings on CMVLI business on a 100 percent reinsured basis to the Pool
- accept their equal shares of the CMVLI business written
- effect immediate remittance of premiums
- undertake settlement of claims and losses on account of their policies
- report claims and losses."

**In one state in the USA (South Carolina) a true premium separation attempt was introduced but failed in the legislature where "the lobby was in control". It is reported by the FIA:**

**"The Federal Insurance Administration has worked on model legislation in 1974 which would have separated the premium into a price for company services (which would have been competitively established) and into a contribution for loss pooling (which would have been established by the State Rating Bureau for all insurers). It failed in the legislature."**

With either a direct or indirect separation of the premium, the interest of the insurance companies in the surpluses arising out of the loss pooling will end and with that will end selection among the compulsory insureds. Then, for the first time, among the statewide group of compulsory insureds there can be effected an equalization of the different surpluses, arising despite equal contributions for loss pooling and varying from company to company, in order that there may be equal treatment of the insureds as to their contributions, the surpluses arising from them and the use to which those surpluses are put, whether by way of reserving them for future deficits or repaying them to the insureds. Along with the benefit of equal contributions for like drivers of like cars, there would result consumer benefit from free competition among insurance companies which could charge different service prices for their differing services. Such competition would bring about performance increases and cost decreases, all without government intervention.

#### **Rating and Classification by State Rating Bureaus and Insureds' Representatives**

It is not so much the question, how the rates for the contributions and the classification scheme should be done, but the question is: who shall do it? – This study made clear that insurance, providing the common fund and all respective procedures are the task of the insureds. But they are not organized. And it is impossible to organize hundred millions of people. Nearly every citizen is an insured. And thus, the task of the insureds should be performed by the State, by State regulatory authorities, representing the insureds. \* These State Rating Bureaus should fix the rates and the classification scheme. One of the greatest benefit of this system would be that the huge costs for the present ratemaking mechanism can be saved, because the contributions can be fixed generously, since the insureds get back the overcharged surpluses and nobody can embezzle them any longer "as profits".

To find out if the State Rating Bureaus and Supervisory Authorities should fulfill the task of representing the insureds quite alone or if it is better to give them some assistance and control by consumer representatives let us have a look into the "Report To The Congress Of The United States" about "Issues And Needed Improvements In State Regulation Of The Insurance Business (Executive Summary)" by the Comptroller General, US General Accounting Office, October 9, 1979:

"There are serious shortcomings in State laws and regulatory activities which respect to protecting the interests of insurance consumers in the United States. In particular, most systematic procedures to determine whether insurance consumers are being treated properly with respect to such matters as claims payments, rate-setting, and protection from unfair discrimination."

"Despite the many allegations of redlining and other unfair discriminatory practices, most insurance departments have not investigated the problem nor do they collect the data necessary to monitor insurance availability."

"Despite serious questions that have been raised about the accuracy and fairness of these plans, most State insurance departments have unquestioningly accepted pricing systems that are convenient for insurance companies rather than effectively protecting the legal rights of citizens."

### **Independence of the NAIC**

"Some critics have alleged that the NAIC is, on balance, oriented more toward the welfare of the insurance industry than its consumers, and that it is heavily dependent on the industry. One manifestation of this dependence is the alleged industry domination of the various committees and task forces that study insurance issues and help formulate NAIC model laws and regulations. Until 1977, these advisory committees were officially known as "industry advisory committees," and, apparently, were composed exclusively of insurance industry representatives. The NAIC Central Office reported that it did not maintain a list of advisory committees, but we did obtain information on the composition of a number of committees convened since an NAIC rules change providing for voluntary consumer representation on advisory committees. Most committees still had no consumer representatives, and the others were almost exclusively composed of industry members. Moreover, nearly the entire body of NAIC model regulations and statutes were developed under system with no consumer participation in the process by which the advisory committees worked with the regulators in developing those model laws."

"Industry representatives also are numerically dominant at NAIC meetings and provide 'hospitality suites', meals and other entertainment to insurance commissioners."

"We do not conclude that the insurance regulatory system is completely dominated by the insurance industry, but the system in general is not characterized by an arms-length relationship between the regulators and the regulated."

I think, further comment is not necessary – only one hint to the "revolving door" (some insurance commissioners come from the "industry" and they behave in a way that the backdoor remains open to go back to the "industry"). This is the reason that commissioners make great words and fine speeches in the consumers' interest, but act – or better: don't act – in the "industry's" interest.

The challenge for consumer representatives, elected by consumer associations and consumer politicians, in the State regulatory and supervisory authorities is not rejectable.

### **A Uniform System and Equal Protection only by "State Action"**

To underline the necessity for "State action" let us now explore a final argument raised by the insurance industry against the industry against the proposed model. In November, 1980, Georg Buechner, president of the German Insurance Industry Association, said:

"Let us give the word to the market theoretician. He would object that, if this new concept would work, the market would actually have produced it somewhere. Indeed, since our friends expect such considerable consumer advantages from their model, not only through price transparency but through price decrease, one must ask himself why somebody like this does not yet exist."

"Let us make a last attempt and ask our opponents why they don't try their fantastic model themselves. One must expect that this question would not be allowed by them because one who is a righteous opponent is accustomed to sweep such requests from the table with the same 'light hand that deals with calls for law and order. But here we are disappointed by our friends in a most pleasant way. One would like to do it, it is whispered, behind the hand raised to the mouth, but one would see that a single insurer could not realize this model. Only if the state could prescribe it for all insurers and assume the risk in the event that the cash-box would not be large enough for loss compensation, only then could this be done."

The quoted remarks not only contain untrue assertions (no one suggests a takeover of risk by the State), but they also indicate that the president of the German Insurance Industry Association does not actually understand the sense and mechanic of insurance.

In the first place, it should be pointed out that, even now, compulsory insurance does not function without government intervention. In the USA, assigned risk plans, or other residual risk mechanisms, had to be established to make compulsory insurance available to those cancelled or refused insurance by the voluntary insurance market. Despite this, great numbers of American drivers, even though they are "clean", i.e., without accidents or violations, are without insurance because they cannot afford it. In Germany, the Government had to allow the use of residence and occupation as tariff criteria through its Automobile Insurance Tariff Order in order to bring about that, "chance equality in surplus employment" which the companies could not achieve by themselves.

In any event, as Mr. Buechner well knows, the German Supervisory Authority could not license an insurance company which would not employ the present, legally prescribed rating structure. The current German Tariff contains a scale of rates from 35 percent to 270 percent which is even extended to 350 percent through a 30 percent surcharge for all non-state employees. The "New Insurance" might offer, for example, a tariff which contained a contribution rate for all loss-free drivers of 80 percent according to the present scale. Then, all loss-free drivers of the other companies who were paying more, especially the beginners, would flock to the "New Insurance". While it is certainly true that, within this group, there are many good, quick-reacting, loss-free drivers, it is also true that there are many inexperienced drivers who will cause losses. Since the subsidy provided by the long-time, loss-free drivers who stay with the other companies is ended, the young, loss-free drivers having the "New Insurance" will, alone, have to subsidize their contemporaries. An equalization within the statewide group of insureds does not take place. Moreover, the loss-free drivers would leave the "New Insurance" just as soon as they could meet the requirements to obtain a contribution rate of less than 80 percent from the other companies. In other words, the "New Insurance" must either adapt its tariff to those of the other companies or "go broke". The same is valid for a company that would try to introduce a fair allocation of administration expenses not as a percentage of the premium (which nowadays is a double-discrimination against the high-rated insureds), but according to a real cost calculation of the single contract.

It is not necessary to explain extensively/that such processes in the field of insurance have nothing whatsoever to do with economic performance or activity by the other companies nor with competition and the market. They are the consequence of the subsidy process in insurance which can only function in one way. This is also proved by the above mentioned State mandated systems in Japan and Philippines.

Insurance is inherently subsidy in the sense that those upon whom loss has not befallen pay the losses for those upon whom loss has, fortuitously, befallen. At that moment when insurance companies break out groups which have a lower loss record and contribution requirement, this subsidy collapses and a great number of new subsidy processes come into being. The loss-free drivers, now dispersed among a great number of groups now have to subsidize in differing ways and in differing amounts the loss drivers, in their respective groups. The result of this is that, in a statewide group of compulsory insureds, there are millions of loss-free drivers who pay, depending upon their group allocation, up to 1500 percent (USA) or 1000 percent (Germany) higher subsidy contributions. From this it follows that, under a system of compulsory insurance, only a uniform subsidy system can function; the state must prescribe it, and, in so doing, must see to it that the compulsory insureds receive equal treatment befitting their particular cars and driving records. Those who do not recognize this really do not understand "insurance".

## **OTHER RELATED ABUSES**

### **The Commission System and Expense Allocation, and a State Guaranteed "Profit" of about 20 Percent**

Finally, two other abuses in the compulsory automobile insurance system must be pointed out:

1. the totally improper commission system and expense allocation.
2. a State guaranteed profit for the insurance companies amounting to 20 percent of the expense component of the premium.

As to the first: In the USA, as in Germany, the commissions of the insurance agents are calculated as a percentage of the premium amount. In Germany, the commission for automobile insurance may not exceed 11 percent of the premium. In the USA, commission rates of up to 20 percent are paid. In Japan, the agents receive a uniform commission for each application. In a 1971 Memorandum discussing the allocation of expenses as a percentage of premium, J. Robert Hunter of the Federal Insurance Administration wrote:

"I think it is philosophically logical to suggest that certain expenses in ratemaking should not be varied as a percentage of premium. This practice varies all expenses on the basis of loss potential. In other words, using automobile insurance as an example, the youthful operator pays three times the commission, general expenses, etc., as does the adult operator. The city resident pays more than the rural resident, and so forth. If losses show a sharp jump, the expenses tag along. The apparent inequities have been pointed out by many prominent actuaries."

The 1979 U. S. Report said:

"Currently, expenses and the profit allowances are allocated to policies in proportion to pure premiums, that is, expected claim costs. Thus, the person whose pure premium is \$1,000 pays ten times the agent commission and share of company expenses than is paid by the individual whose pure premium is \$100. Some critics have complained that there is insufficient reason for such a cost assessment."

Thus, here too, additional financial discrimination against compulsory insureds has taken place for years, even decades, under the eyes of government and supervising authorities.

In Germany, as regards compulsory automobile liability insurance, the insurance companies are allowed to retain three percent of the total premium and its investment yields as "profit". At first glance, this three percent does not appear to be extraordinary, but keeping in mind the Gross National Product computation, which credits the insurance companies with only the administrative expenses and profit portion of the premiums, and keeping in mind the statement of the president of the German Automobile Insurers Association that this portion approximates 15 percent of the premiums, it will be seen that the three percent of premiums and investment yield amounts to a turnover yield of more than 20 percent which is state sanctioned if not guaranteed.

## **FINAL REMARKS**

As a sort of epilogue, the author would like to quote from an article which was received just as he was concluding this in "Insurance", appearing work. The article, "System changers in Insurance", appearing in December, 1980, in the independent "Magazine of Insurance", and written by Arno Surminski, a noted German journalist specializing in economic and insurance affairs stated:

"Dr. Buechner dealt in great detail, in his principal speech before the German Insurance Industry Association, with new insurance ideologies which ultimately aim at an including of the money claimed by the insurance companies in the redistribution process. Simply stated, this question is at stake: 'To whom belongs the money in the companies?'

While the system changers regard this money as the common property of the insureds, which the companies administer only fiduciarily, the president of the association rejected this view."

"He who means well for the insurance industry should urgently dissuade it from carrying on this discussion. The arguments of Dr. Buechner, for and against the new ideology, by no means appeared to be of that kind that the system changers were identified as unrealistic "spinners" ignorant of the world. Disinterested persons and the largest part of the journalists must be accounted as being those – certainly received the impression that there is something in these new ideas. The insurance industry itself, through its behavior in recent decades has also moved in this direction. In innumerable press releases, business reports and speeches, it has been pointed out that one would operate with the savings capital of insureds and would achieve profit for the insureds through a fiduciary administration. A further discussion on the question to whom the insurance money belongs can only lead, at best, to an 'undecided'. It is impossible for the insurance industry to win on this question."

The "undecided" vote is not enough on the question of the ownership of 650 billion dollars nor on the question of the unequal treatment of millions of compulsory insureds. The study on which this summary is based will very soon assist the courts in deciding these questions. The hope remains that all the responsible persons and institutions will, either now or after the court decisions, draw the corresponding conclusions.

## **OUTLOOK**

From the statements outlined above, there results a clear challenge for a complete investigation and total reform of the present insurance system which must occur if there is to be achieved a correspondence with the principles surrounding the legal and economic systems. No one should any longer refer to existing laws and the permanence of these laws and the present insurance system. These laws and the present practices clearly violate the Constitution (property guarantees and equal protection) as well as generally accepted legal and economic principles. Nor does an appeal to state supervision offer any promise of assistance. The State Supervisory Authority has never done what it should have done under existing circumstances namely prevent an improper expense and profit expropriation from the money supplied by the insureds for loss pooling. Nor has it rectified the lack of competition or required distinction between the property rights of the insureds and of the insurance companies. No one has seen the fact that it is precisely because of the, wrong structure of the insurance field, with all its attendant invitations to arbitrary expense and Profit expropriations from fiduciary funds, that government supervision was demanded and created.

Up until this time, the courts have not addressed their issues, but since those charged with responsibility have been informed Of these manifest abuses for years, and have done nothing looking toward their abolition or redress, it would appear likely that constitutional and/or civil rights issues will be raised or suits seeking damages from State or public officials for derelictions of their official duties may be filed requiring the courts to deal with these questions which could involve judgments of imponderable amounts.

## **EXECUTIVE SUMMARY OF FINDINGS AND CONCLUSIONS**

In the United States, as in Germany, car owners are generally compelled by law to maintain liability insurance. Thus a nationwide group of compulsory insureds is developed. The relevant government must, therefore, ensure that all such insureds receive fair treatment and equal protection. Such requirement relates particularly to the pure premium component of the premium dollar, that is, the portion of the premium which goes to the payment of losses and the expenses incident to the settlement, defense, or payment of claims. The other portion of the premium dollar, the expense component, covers the underwriting and general company expenses incident to the services which the private insurance companies offer and perform with respect to the compulsory insurance. It is in the latter area that insurance service companies should and must, compete for the favor of the insureds by offering better, and more efficient and economical services to the end that such companies may be more attractive to present and prospective customers in view of the price which they charge for the services and, of course, in order that they may make a profit commensurate with the value of such services.

Equal treatment in the insurance, or pure premium, area must, necessarily, accord with sound insurance principles. This means that only those classifications may be established which take into consideration the

individual loss producing element faced by each individual insured. According to the motor vehicle traffic law, this loss producing factor consists of either negligence of the operator or the defective condition of the car. In Germany, the owner of a defective vehicle is liable without regard to fault since the car is considered an inherently dangerous instrumentality. In the United States, the owner or driver of a defective vehicle is not generally liable unless he knew or reasonably should have known that it was defective.

As regards risk classification, differentiation in the treatment accorded insureds is permissible only on a reasonable basis. The current classification structure is not in accordance with insurance principles and is not reasonable because the classes are predicated upon extraneous factors having nothing to do with the loss producing factor which threatens the individual insured. Moreover, the criteria used for classification purposes (such as residence or occupation in Germany, or, in the U. S., age, marital status, etc.) clearly do not have any influence on the causes or extent of a liability claim, since the fact that one is a bank president or a bartender has no bearing on whether or not he was negligent or his car was defective as respects an automobile claim which that driver caused. Equally clearly, the fact that one is married or divorced, young or old does not, of itself, cause a loss.

The use of the now prevailing criteria which were developed through false statistics according to previous losses of not existing groups leads to unequal protection for individual insureds. Compulsory insureds, with unblemished driving records, who should only be called upon to pay an equal premium on the basis of true insurance principles, now are required to pay premiums of up to 1,000 percent more than others in Germany or even up to 1,500 percent more in the U.S., depending upon the group to which they are consigned by irrelevant factors over which they have no control. Indeed, many claim-free drivers currently pay a multi-fold higher premium than others who are not claim-free, as, for example, where the claim-free but high-rated youthful driver pays a premium many times higher than the low-rated adult driver who has had an accident or two.

Manifestly, this current unequal treatment of compulsory insureds is contrary to sound insurance principles and is not based upon rational or reasonable considerations. The ineluctable fact is that this unequal protection stems solely from the self-interest of the insurance companies; to the end that, in Germany, they may all have the same opportunity to obtain (and pocket as profits) the surplus arising from the loss component of the premium dollars. In the United States where, unlike Germany, the companies are generally legally privileged to select which compulsory insureds they will deal with, the classification system now prevailing assists insurance companies in maximizing profits through the selection process.

These surpluses arising out of the loss component of the premiums are influenced, or can be influenced, by the mix of the portfolio of business. They cannot properly be designated as profits because they do not arise out of the economic performance of the companies; to the contrary, these surpluses arise out of the performance of the compulsory insureds and belong to them unless, or until, the surpluses are used to pay losses.

In order to achieve fair treatment and equal protection for compulsory insureds, the premiums must be separated into (1) a contribution toward the loss compensation fund, and (2) the price for the services of the companies and agents. Not only would this accord with all economic and legal principles, but it would accord with

the manner in which the Gross National Product (GNP) is now computed with respect to the financial transactions of insurance companies. Even now, in the computation of the GNP, the losses are deducted from premiums, from which it necessarily follows that wealth is increased solely by the services of the insurance companies. In short this should lay to rest the myth that "insurance" is a product brought into being by the companies.

As regards the price for services performed by companies complete freedom of competition must not only be allowed but enforced through the antitrust laws and other laws prohibiting price fixing and restraint of trade. However, the contributions toward the loss contribution fund must be rated equally for all equal insureds. The accomplishment of the latter cannot be left to the regulators alone, they having been quite remiss in this area, but should be accomplished through a Federal Commission for insureds or through state consumer advocates. These insurance consumer advocates, acting jointly with the regulatory authorities and companies, should develop the classification and rate structures and should generally supervise control over the funds contributed by the policyholders for the compensation of losses.

In the structuring of the rates, only the size, type of car, and prior loss experience of the motorist should be taken into consideration. Although the likelihood of an individual insureds being legally responsible for an loss in which he might be involved cannot be predicted – not even in the light of a previous claim – there should be a retrospective surcharge for an at fault loss to act as an incentive to safe driving or a deterrent to bad driving. Since, as envisaged here, the insurance companies can have no interest in the loss-contributions fund, it could not be said that these retroactive surcharges would simply line the pockets of companies rather, they would reduce the amounts necessary to be paid as contributions to the loss funds.

The drivers causing "at fault" claims might properly be classified into 2 or 3 classes with surcharges for periods of several years, depending upon the gravity of their misconduct, with, perhaps, a surcharge of 80 percent for one claim, 200 percent for two claims and 300 percent for three or more claims. On such a basis, the annual basic rates for claim-free drivers could be as little as 300-600 DM in Germany, depending on the horsepower of the car. To the contribution to the loss compensation fund made by each individual there would be added the specifically quoted service price of the particular company.

In the compulsory insurance, insurance companies must be compelled to accept all comers, what they can do without economic disadvantage.

The differing pure loss results of the individual companies are arithmetically equalized on a nationwide basis and must be taken into consideration in the making of rates and/or ratably refunded to insureds as excess in the loss contribution funds. Only then can the equal treatment of all compulsory insureds be made certain. Any remaining excess in the loss contribution fund could be left with the companies relative to their portfolios to be invested as a safety reserve for the nationwide group of compulsory insureds.

### **Need for Investigations of Competition in Automobile Liability Insurance (October 1999)**

The present situation in the automobile liability insurance in Europe makes it necessary to investigate, if competition in this area is functioning:

- Five years after deregulation, no European insurance company offers automobile insurance for foreigners, driving their cars in their home countries.
- There is a wide range of offers available in the Community, but they are based on such different and complicated tariffs, that no car-owner is able to find and choose the best contract (most Europeans - like Germans - cannot even find it in his own country).
- The best driver in Europe cannot get insurance for the lowest premium, because not his individual criteria, to cause a liability claim, determines his premium, but a lot of criteria, by which the companies select certain groups of car-owners and which the individual insured cannot influence, i.e. age, sex, residence, profession, nationality ...

These facts have a circumstantial evidence, that there is no European automobile insurance market. They indicate, that the tariffs, used in the European countries, might not be the result of competition and insurance technique and could even be unconstitutional in a compulsory insurance because having symptoms of discrimination: a lowest-risk driver has to pay a multiple higher premium than car-owners with accidents (i.e. because he is young, no official and living in a large city). In the USA he could even get no coverage, if he was living in a "black" residential area. All these particularities require an investigation of their reasons.

There are different opinions about competition in automobile liability insurance:

1. There is intense competition, because there are a lot of companies and a lot of different offers with very different premiums. Advocates of this opinion don't see a need for investigation.
2. There are deficiencies in competition because there is a lack of transparency by reason of the different tariff-systems with very different tariff-criteria. Advocates of this opinion see a need of investigation, how to bring about or conserve a certain degree of transparency (i.e. by harmonisation of the tariff systems to a basic Pan-European structure).
3. There cannot be any competition, because insurance (as a money providing and distributing procedure) is no competition area and because there is no price quotation in the one and only competition area: the companies' services. Selection of car-owner groups is no measure of competition, because it does not reduce the total loss payments, but only shifts them within the different groups (with the result of discrimination against loss-free drivers). Advocates of this opinion see a need to investigate, what insurance is, what competition and the competition area in the insurance field is and if the selection of groups is a means of competition.

These different opinions justify an investigation, especially because there is a serious proof for the necessity to separate insurance from the companies' services in the way the Gross National Product (GNP) is computed all over the world. Professor Werner Mahr has written on this subject in the "Insurance Economics Studies":

"The services performed by the insurance companies are valued through the administrative costs portion separated from the premium income. The risk portion, contained in the gross premiums, are not taken into

consideration when measuring the value of the service of an insurance company because these are performances which other economic units, namely, the insureds, have provided. The risk portion included in the premiums stem from the income yielded by the insureds and is transmitted through the so-called 'insurance performance' to the economic units upon which the insurance loss has befallen. The organisational service, which the insurance companies contribute to this process, is expressed in the remuneration paid for it; this is the administrative costs portion of the premium income. Thus, it is not the total premium income which characterises the contribution of the insurance companies to the domestic Gross National Product but only the administrative costs portion of the total premium income assessed according to the balance sheets presented. In its characteristic features, the accounting for the procedures connected with private insurance occurs as follows:

1. The administrative costs portion of the premium is accounted for in the 'Accounts 1 – Production and its Employment' as the expression of the services of the insurance companies. The insurance companies sell these services to the economic units.
2. The risk portions in the premiums for all insurance is regarded as current transfer. The risk premium is accounted on the 'Accounts 4 – Income Redistribution'.

The integration of the so-manifold insurance in the general scheme of the National Accounts requires complicated bookings if the National Accounts is to provide information on the origin and employment of performances, who ultimately performs them, and to whom they must be assigned. Insurance science has not given the necessary attention to these problems."

Interestingly, in other countries a premium separation is indirectly accomplished to secure equal treatment of the insureds and secure universal availability of the required insurance. The Report of the US Federal Insurance Administration "Full Insurance Availability" explains:

"Compulsory automobile liability insurance was introduced in Japan in 1955-56. At that time, both the Japanese Government and the insurance industry foresaw the probability of the development of a residual risk problem and moved to preclude such development. All insurers must accept all eligible applicants for the compulsory coverage. The agents are paid a uniform commission. The compulsory coverage, all of which is written at a uniform premium rate, is 100 percent reinsured (net of a fixed percentage expense loading), 60 percent of the risk being ceded to the Ministry of Transportation of Japan and 40 percent to a pool in which all Japanese automobile insurers participate. Under the Japanese system, all who are required by law to carry the liability coverage are assured of its ready availability, and, since all are afforded coverage on the same terms, there is no need for concern regarding access to insurance or with unfair, discriminatory, or inequitable treatment of any segment of the market."

The computation of the GNP as well as the Japanese pool are hints, that only the companies' services could be a competition area, but not insurance itself (as a distribution procedure, like competition has nothing to do with the distribution of letters, parcels or giro-money. Nobody would say, that parcels, letters or the payments of bills are produced by banks or post offices).

The statistical method, to classify groups of car-owners by criteria like age, sex, profession, residence or nationality, could proceed from the wrong statistical question, what groups are good risks for the danger of an entrepreneurial loss, and not from the right question, which is the inherent risk of an individual person to cause a liability claim. In Germany it is seen as an abuse if nationality is used as a tariff-criterion (§ 81e Supervision Law, VAG), although the group statistics show, that foreigners – as groups – cause higher loss payments.

So the main questions of every investigation should be:

Does the European Law allow the development and enforcement of Pan-European tariff-structures in the automobile liability insurance? - That leads to the economical questions: Is insurance a product of the companies or a performance of the insureds? - Is the risk portion of the premium a price or part of a price for a product or a contribution for a distribution procedure? – Can competition exist as to insurance, a money providing and distributing procedure, or only as to the companies' services? – Can competition exist as to the services, when the companies mix them up with insurance and don't quote a price? - How have ratemaking and classification to be handled according to the insurance-technique? - Are there statistically proved and valid data, which characteristics are suitable risk-criteria with regard to causing a liability claim?

Such investigations could lead to the result, that insurance (money providing as a performance of the insureds) and all measures around insurance (i.e. tariffs, which classify equal individuals equally) have to be re-regulated and that the companies' services finally have to be deregulated by separating them from insurance and leaving them to competition by quoting prices for their services and making profits only in this area (not in the money-distribution area).

Hans Dieter Meyer

Contact <mailto:hansdmeyer@versanet.de>

---

**Sozialdemokratischer Pressedienst WIRTSCHAFT**

35. Jahrgang/88/18. November 1980/Seite 6

## **Rosinenpicker zerstören Solidargemeinschaft der Versicherten**

-----  
Regionalstruktur der Kfz-Haftpflichtversicherung

Von Dr. Anke Martiny MdB

Die Klagen über die Ungerechtigkeiten der Regionalstruktur in der Kfz-Haftpflichtversicherung haben die Bundesregierung dazu veranlaßt, dem Institut für Verkehrswissenschaft an der Universität Köln einen Forschungsauftrag zu erteilen. Die Untersuchung dieses Instituts liegt nunmehr vor. Die Ergebnisse werden in der Öffentlichkeit schon als wahrscheinliche Tarifänderung zum 1. Juli 1981 unter dem Slogan: Mehr Regionalklassen sollen eine gerechtere Prämie garantieren, diskutiert. Ob dies wirklich der Weisheit letzter Schluß ist?

Der Bundesregierung wäre anzuraten, sich nicht zu schnell auf eine Reform der Regionalstruktur einzulassen. Zunächst muß es darum gehen, die grundsätzlichen Fragen zu klären, die hinter den Klagen über die Ungerechtigkeiten verborgen sind.

Wenn man weiß, daß die Regionalstruktur der Kfz-Haftpflichtversicherungsprämien nur eingeführt wurde, um die Gewinne von Regionalversicherern denen der Universalversicherungen anzupassen, muß man daran zweifeln, daß durch eine verfeinerte Tarifstruktur mit noch mehr Regionalklassen die grundsätzliche Ungerechtigkeit einer unterschiedlichen Belastung gleich guter Fahrer in verschiedenen Wohngebieten aus der Welt geschafft wird. Versicherer, die sich die guten Risiken als Rosinen aus dem großen Kuchen der Versicherungsgemeinschaft herausuchen, werden immer höhere Gewinne machen als die Versicherer, die alle Kraftfahrer versichern, ohne nach ihrem Wohnort, ihrer Haarfarbe, beziehungsweise ihrer Staatsangehörigkeit, ihrem Geschlecht, Alter oder Beruf zu fragen. Schwarzhäarige, junge, ausländische Fabrikarbeiter werden nach der Statistik immer höhere Schäden verursachen als blonde, verheiratete im öffentlichen Dienst angestellte Frauen und sei es nur aus dem simplen Grund, daß letztere weniger fahren als erstere. Es ist einfach ungerecht, einen guten Kraftfahrer (oder eine gute Kraftfahrerin), nur weil er oder sie in einem Gebiet mit hohem Schadenbedarf wohnt oder nicht im öffentlichen Dienst beschäftigt oder kein Landwirt ist oder mit einem solchen auch nicht verheiratet ist, mit höheren Prämien zu belasten als einen gleich guten Fahrer, der auf dem Land wohnt und Beamter ist. Und dies alles nur, damit alle Versicherungsunternehmen die selben Chancen bekommen, aus der Schadenabwicklung halbwegs gleich hohe Gewinne zu machen.

Es wäre doch einmal grundsätzlich zu prüfen, ob das Auftreten von Regionalversicherern und speziellen Berufsversicherungen mit dem Charakter einer allgemeinen Haftpflichtversicherung vereinbar ist. Das Herausuchen von Kraftfahrern mit geringem Schadenbedarf aus der Solidargemeinschaft aller Kraftfahrer widerspricht dem Prinzip der Versicherung, nach dem alle Nichtbetroffenen für die vom Versicherungsfall Betroffenen zahlen. Wenn man den Rosinenpickern ihr Auftreten am Markt nicht verbieten will, sollte man die Möglichkeit prüfen, die aus der Schadenabwicklung entstehenden Überschüsse über einen Pool unter den Versicherungsunternehmen gleichmäßig zu verteilen, um auf diese Weise die Solidargemeinschaft wieder herzustellen.

Die Versicherungsunternehmen würden dann nur noch aufgrund ihrer Dienstleistungen miteinander konkurrieren. Die Höhe der Rückzahlung der zu hoch kalkulierten Prämienanteile an die Versicherten wäre nicht mehr von der Auswahl der Versicherten durch die einzelnen Versicherungsunternehmen abhängig. Insgesamt sollten bei den Überlegungen einer Änderung der Regionalstruktur die Interessen der Versicherten stärker Berücksichtigung finden als bisher. Die mit Hilfe der Versicherungsunternehmen eingeführte Regio-

nalstruktur und die Ergebnisse der jetzt veröffentlichten Untersuchung sind daher noch einmal grundsätzlich auf ihre Zulässigkeit hin zu überprüfen. Alternativen sollten nicht von vorneherein als nicht erwägenswert abgelehnt werden.

---

### **In the following actual remarks in German:**

*Pohlhausen* (Vom Wesen des Versicherungswesens und vom Klimawechsel in der Versicherungswissenschaft, in: Neue Wege des Versicherungsmanagements, Festschrift für Günter Schmidt, Karlsruhe 1997) über das wissenschaftliche Bemühen, das Wesen von Versicherung zu deuten, zum Fehlen methodischer Konturen und zur Resignation und ausbleibenden Resonanz auf den Versuch des Deutschen Vereins für Versicherungswissenschaft, im Jahre 1966 in quasi-parlamentarischer Debatte und Abstimmung eine Definition des Versicherungsbegriffes zu verabschieden. Als falschen Ansatz sieht *Pohlhausen* den Versuch von *Hans Möller* und seiner Kollegen, etwas Gegebenes in ein System einordnen zu wollen. *Pohlhausen* zitiert *Goldschmidt* (siehe oben) und führt dazu aus (a.a.O. Seite 97 f.):

"Es ist lohnend, diese Spur von *Goldschmidt* nicht nur wegen ihrer Bedeutung für die spätere Literatur, sondern auch wegen ihrer Methodik weiter zu verfolgen. Mit welcher Methodik er seinen handelsrechtlichen Rechtsstoff bearbeitet, erläutert er in der Einleitung der ‚Universalgeschichte‘. Neben der Berücksichtigung vorhandener Rechtsquellen stellt er den wichtigen Einfluß einer ‚wirtschaftlichen Anschauung‘ bei Bearbeitung und Bildung des Verkehrsrechts heraus (S. 40 f.). Sodann wirft er die Frage auf, welche Bedeutung die geschichtlichen Wurzeln der Rechtsinstitute haben. Er äußert sich gegen eine ‚dogmatisch-logische‘ Methodik, die bestehendes, zumal ‚kodifiziertes Recht als fertiges Ganzes‘ auffasse, und für eine Zurückverfolgung der geschichtlichen Wurzeln aus *aktuellem* Rechtsinteresse. Wie die geschichtlichen Wurzeln der Rechtsinstitute zu verfolgen sind, legt *Goldschmidt* in seiner einleitenden Methodik gerade unter Bezugnahme auf das Beispiel des Assekuranzrechts dar.

Es ist nicht unbeeindruckend zu sehen, wie durch diese ‚genetische Methode‘ sich die zu Anfang von ihm gegebene Definition geradezu zwangsläufig als Ergebnis eines geschichtlichen Prozesses darstellt. Das Rechtsinstitut ergibt sich ‚von selbst‘ aus geschichtlicher Betrachtung. Wir befinden uns ganz auf dem Boden der ‚strengen historischen Methode‘, die *Savigny* 1814 in seiner berühmten Programmschrift ‚Über den Beruf ...‘ (Vom Beruf unserer Zeit für Gesetzgebung und Rechtswissenschaft, Nachdruck der 2. Aufl., Hildesheim 1967, S. 117 f.) mit dem Bestreben umschreibt,

; ... jeden gegebenen Stoff bis zu seiner Wurzel zu verfolgen, und so sein organisches Prinzip zu entdecken, ...‘

Auf geheimnisvolle Weise werden aus dem geschichtlichen Prozeß also die tragenden Elemente eines Rechtsinstitutes herausgefiltert und abstrahiert."

*Pohlhausen* (a.a.O. S. 102) sieht es als Fehler an, gesetzesbezogen positivistisch zu argumentieren. *Pohlhausen* (a.a.O. Seite 106) kritisiert Autoren, die Begriffe unter dem Gesichtspunkt der Zweckmäßigkeit erar-

beiten. Es gehe dann nicht um Wahrheit, sondern um angemessene Problemlösungen im Rahmen geltender Dogmatik. *Pohlhausen* stellt zusammenfassend fest:

"1. Im Deutschen Verein für Versicherungswissenschaft fand zwischen 1959 und 1966 der vorerst letzte Versuch statt, eines der ‚Hauptprobleme‘ der deutschen Versicherungswissenschaft zu einem positiven Ergebnis zu bringen, nämlich einen Begriff für das Wesen von Versicherung zu finden. Im Anschluß daran vollzog sich nahezu stillschweigend eine Abwendung der Forscher von diesem Themenkreis. ... 3. Anders als bei der historischen Rechtsschule und der darauf aufbauenden Handelsrechtswissenschaft der zweiten Hälfte des 19. Jahrhunderts hatte der historisch-dogmatische Teil der Diskussion im Verein jedoch keinerlei aufbauend-systembildende, konstruktiv-gesetzesersetzende Züge. Die Begriffsbildung im Verein vor dem Hintergrund eines festen kodifikatorischen Gefüges und funktionierender Problembewältigung durch Rechtsprechung wirkt daher inhaltsleer und funktionslos."

Es gibt also keine gesetzlichen Regelungen, keine Rechtsprechung und keine herrschenden Meinungen zum Wesen von Versicherung und zur Rechtsnatur des Versicherungsvertrages. Der nunmehr 150jährige Theorienstreit wurde vor etwa 30 Jahren ergebnislos abgebrochen. *Schmidt-Rimpler* (Die Gegenseitigkeit bei einseitig bedingten Verträgen, 1968, Seite 52) spricht von einem Theorienstreit, der nach einem Absterben des Interesses ein "Friedhofsende" gefunden hat. *Pohlhausen* (a.a.O. Seite 93) beantwortet die Frage "Wie reagiert eine Zunft, der bei einem ihrer Lieblingsthemen die Grundlage entzogen wird?" mit "Man regelt das Problem am besten durch Schweigen" (unter Hinweis auf *Rückert*, Zur Erkenntnisproblematik materialistischer Positionen in der rechtshistorischen Methodendiskussion, in: Zeitschrift für Historische Forschung, Bd. 5, 1978, S. 257, aus gesichtetem *Savigny*-Material).

Das Wesen der Versicherung und die Rechtsnatur des Versicherungsvertrages sind nach wie vor ungeklärt - für die Schweiz: *Alfred Maurer*, Schweizerisches Privatversicherungsrecht, 3. Auflage, Bern 1995, S. 212; für Österreich: *Martin Schauer*, Das österreichische Versicherungsvertragsrecht, 3. Aufl., Wien 1995, S. 43; für Frankreich: *Yvonne Lambert-Faivre*, Droit des assurances, 9. ed., Paris 1991, S. 186, Rdnr. 211; für Spanien: *Fernando Sanchez Calero*, in Comentarios al Código de Comercio, Tomo XXIV, Ley de Contrato de Seguros, Vol. 1-3, Madrid 1990, Art. 1, S. 24).

*Schünemann* in: Karten/Werber/Winter, Lebensversicherung und Geschäftsbesorgung, Verlag Versicherungswirtschaft 1998), *H. D. Meyer* in ZRP 1990, 424; *ders.* VersWissStud Bd. 2, 203 ff., und Bd. 6, 69 ff.; *Dr. Kilian Rudolf Bälz*, Versicherungsvertragsrecht in den Arabischen Staaten, VVW 1997, Heft 99 der "Kölner Reihe", ISBN 3-88487-665-1, ISSN 0522-6236 (62 DM; Anmerkung: Nach islamischen Recht ist nur die genossenschaftliche Versicherung zulässig, bei der der Versicherer (nur) ein "Geschäftsführer" ist, der einen "Solidaritäts-/ Versicherungsfonds im Interesse der Versicherungsnehmer verwaltet". Auch die Grundansätze in Islam - "das Phänomen Versicherung in seinen wirtschaftlichen und sozialen Bezügen würdigen" - und die Begründungen - "kein Synallagma = Versicherung ist unentgeltliche gegenseitige Hilfe" - entsprechen der Geschäftsbesorgungstheorie. - Siehe zu allem auch *Lehmann* und *Rückle* in VersWissStud Bd. 5 und *Schünemann*.

## Zu den betriebswirtschaftlichen Aspekten der Fragestellung

Lehmann/Rückle in: VersWissStud Bd. 5

**Reimer Schmidt** (Versicherungswirtschaft 1982, 804):

"Versicherung ist ein **primär ökonomisches** Phänomen, das noch der juristisch einwandfreien Ausformung bedarf."

Derselbe in Handwörterbuch der Versicherung, HdV, Seite 1116:

**"Die gedankliche Funktion eines Aufbereiters der großen Fragen der Privatversicherung ist von den Juristen auf die ökonomischen Wissenschaften übergegangen, besonders auf die Betriebswirtschaftslehre."**

Derselbe in Handwörterbuch der Versicherung, HdV, Seite 1246:

**"Der Aufbau der modernen Versicherungswirtschaft vollzog sich, ohne daß es wesentliche ökonomisch-wissenschaftliche Vorarbeiten gab und ohne daß die Gesetzgeber nennenswert mitwirkten."**

Derselbe, Weitere Gedanken zum Versicherungsbegriff, in: Risiko und Markt, Festschrift für Walter Karten, Karlsruhe 1994, Seiten 3 ff.:

"Der vorliegende Beitrag geht natürlich von dem Sockel der Grundsatzdiskussion über das Verhältnis der Wirtschaftswissenschaft zur Rechtswissenschaft und der vor allem von *Coase* und *Posner* in den USA begründeten ökonomischen Analyse des Rechts aus (zur Konzeption und Methode insbes. *P. Behrens*, Die ökonomischen Grundlagen des Rechts, Politische Ökonomie als rationale Jurisprudenz, 1986), die als solche - zitiert oder nicht genannt - heute große Bedeutung vor allem für die Rechtspraxis des Alltags hat (vgl. hier nur *R. Posner*, Economic Analysis of Law, 1973, 3. Aufl. 1986). Die vorliegende kleine Studie ... versucht, ‚von der anderen Seite‘ den vom Recht zugrunde zu legenden Sachverhalt, die rechtlich relevanten Tatsachen, von denen die juristische Beurteilung auszugehen hat, mit Mitteln der Wirtschaftswissenschaften in ihren Funktionen zu verstehen und dies zur Rechtsanwendung nutzbar zu machen." - (Anmerkung: *Schmidt* kommt allerdings zu traditionell falschen Ergebnissen und bezeichnet "Versicherung" bzw. "Gewährung von Versicherungsschutz" als Dienstleistung. (Seite 8), wobei er nicht hinterfragt, was eine Dienstleistung ist, siehe hierzu Lehmann in VersWissStud Bd. 5, S.

*Leverenz* (VersR 1997, 655: "Die Prämien sind das Entgelt des Versicherungsnehmers für die Pflicht des Versicherers, bei Eintritt des Versicherungsfalls die vertraglich zugesagten Leistungen zu erbringen.") zeigt in nicht zu überbietender Deutlichkeit den Fehler vieler Juristen, nicht zwischen schuldrechtlichen und wirtschaftlichen "Leistungen" zu unterscheiden und zu übersehen, daß eine Zahlung nur dann ein "Entgelt" ist, wenn sie den Erhalt einer Leistung abgilt, die das Ergebnis einer leistungswirtschaftlichen Aktivität ist.

Zu den - sich aus der betriebswirtschaftlichen Analyse ergebenden - wettbewerblichen Aspekten (Einordnung in allgemeingültige wettbewerbliche Rahmenbedingungen = Frage nach der Erfüllung von Wettbe-

werbsvoraussetzungen - z.B.: Ist die Angabe der KH-Versicherungsprämie die Angabe eines Preises? - oder: Welchen volkswirtschaftlichen Nutzen hat Selektion? – Wettbewerbssanktionen?)

*Schünemann* in *Jacobs/Lindacher/Teplitzky*, UWG Großkommentar, 1994, Einl., Rdnr. D 48:

"Gegenüber mancherlei Manifestationen wohl doch wettbewerbswidrigen Verhaltens von bereits volkswirtschaftlichen Dimensionen in diesem Wirtschaftssektor ist bislang keinerlei Sensibilität der Wettbewerbsrechtsdogmatik erkennbar geworden (grundsätzliche Denkanstöße bei *H. D. Meyer* ZRP 1990, 424 ff.)."

*Farny* (ZVersWiss 1979, 66): "Eine optimale *Verbindung zwischen marktwirtschaftlichem Sanktionsmechanismus und dem Gläubigerschutz* der Versicherungsnehmer würde darin bestehen, die Eigentümer und Unternehmensleiter für ihre Fehlentscheidungen zu bestrafen, zugleich aber die Gläubigerrechte der Versicherungsnehmer zu erhalten. Praktikable Modelle für eine solche Lösung sind jedoch *bisher nicht entdeckt* worden." - (Ähnlich *Gottfried Claus*, Aktuelle Probleme der Lebensversicherung, VerBAV 1980, 22 ff, 25; ähnlich *Bundestags-Drucksache* 9/1493, Begründung S. 27: "Zur Wahrung der Belange der Versicherten müssen die anfallenden Überschüsse aus dem Risikoverlauf ... den Versicherten möglichst ungeschmälert gutgebracht werden.")

### **Zu allem zusammenfassend**

*H. D. Meyer* in *VersWissStud* Bd. 1, 149 ff. und Bd. 2 S. 221 ff.) mit Hinweisen auf das Gesetzgebungsverfahren in 1993 zur Umsetzung der 3. Richtlinien, zum Urteil des BVerwG (VerBAV 1988, 367 ff.), zu § 81e VAG, zu Vorgängen in Japan und den Philippinen:

Es geht primär um die Frage, ob und warum Eingriffe zulässig sind (und welche Eingriffe es bereits gibt)

- primär eine betriebswirtschaftliche Frage (ist die Prämie ein Preis?)
- sekundär eine wettbewerbstheoretische Frage (Preisangabe, Selektion)
- tertiär eine (verfassungs-/gemeinschafts)rechtliche Frage (Eingriff in Wettbewerb und Markt, Eingriff in Versicherungs- oder Unternehmensbereich?)

Weil Eingriffe zumindest nach der in die Untersuchung einzubeziehenden Prämientrennungstheorie (möglicherweise auch aus anderen Gründen) zulässig wären, müsste sekundär die Frage beantwortet werden, warum Eingriffe erforderlich sind bzw. welche Folgen Nicht-/ Eingriffe (a) für den einzelnen Versicherten und (b) für den gemeinschaftlichen Markt der (Dienst)Leistungen von Versicherungsdienstleistungsunternehmen haben.

(a) Erst hier geht es um (allgemein) versicherungstechnische und statistische Fragen, insbesondere um die Frage der Beitragsfestsetzung und Beitragsklassenbildung (die - gemäß dem versicherungstechnischen Äquivalenzprinzip und dem Begünstigungsverbot - von gleichen Beiträgen für gleiche Risiken ausgeht), wobei für die Folgen von Nicht-/Eingriffen in die KH-Tarife letztlich vor allem die Kernfrage interessiert:

In welchen / wievielen Gruppen mit welchen Beitragsunterschieden befinden sich - durch welche Differenzierungen - jeweils wieviele Fahrzeughalter gleicher Fahrzeuge mit gleicher Fahrvergangenheit und gleicher

Fahrzeugnutzung (die nach dem versicherungstechnischen Äquivalenzprinzip in einer gesetzlichen Pflichtversicherung eigentlich einen gleichen Risikobeitrag zahlen müßten) ?

Die Antwort, daß Fahrzeughalter unter insgesamt gleichen Voraussetzungen durch ihre Verstreuung auf viele Gruppen sehr unterschiedliche Risikobeiträge zahlen, ist vorauszusagen (ein schadenfreier Leipziger zahlt mehr Beitrag als ein Schadenfahrer aus Goslar). Interessant ist die Frage, in welchem Umfang (von der Zahl der Fahrzeughalter und vom Beitrag her) die "finanzielle Diskriminierung" versicherungstechnisch gleicher Risiken stattfindet.

(b) Daß weder der gemeinschaftliche noch der nationale Markt (für Versicherungsdienstleistungen) ohne Eingriffe funktioniert, beweist die gegenwärtige Situation in Deutschland.

Tertiär geht es um die Frage, wie die Eingriffe versicherungstechnisch/statistisch und rechtlich aussehen aussehen müßten / dürften / könnten.