Chapter 8: Insurance

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CHAPTER 8

Insurance

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§8.1. Life Insurance. In an age when even the most serious statements of public officials can be described as "no longer operative," it should not be surprising that the Supreme Judicial Court should describe its reversal of past precedent by stating "we now disestablish that proposition."1 The "disestablished" proposition occurred during the Survey year in Davis v. Boston Mutual Life Insurance Co.,2 where the Court was faced with the issue of whether public policy still requires that an innocent beneficiary be denied recovery of an ordinary life insurance benefit when the insured was killed while engaging in criminal activity.3

In Davis, plaintiff-beneficiary, who was the insured's mother, was seeking recovery on a life insurance policy providing both an ordinary life benefit and a double indemnity benefit for death caused by accidental means.4 The policy also contained a specific exclusion of the double indemnity benefit for death caused by accidental means "if such death results, directly or indirectly, or wholly or partially ... from committing an assault or a felony ...."5 The insured was shot and killed by a police officer while he was engaged in assault by means of a dangerous weapon and attempt to murder.6 The superior court denied plaintiff-beneficiary recovery of both the ordinary life and double indemnity benefits7 on the basis of a series of prior Massachusetts decisions,8 which had established that "public policy forbids

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3Id. at 1736, 351 N.E.2d at 207-08. For prior cases dealing with this issue, see cases cited in note 8 infra.
5Id. at 1738, 351 N.E.2d at 208, quoting the life insurance policy.
6Id. at 1737, 351 N.E.2d at 208.
7Id.
8In the following cases the Court denied recovery of ordinary life benefits on public policy grounds where the insured died as a result of criminal activity: Molly v. John Hancock Mut. Life Ins. Co., 327 Mass. 181, 97 N.E.2d 422 (1951) (insured killed while
even an innocent beneficiary of a policy of life insurance to recover on the policy where the death of the insured is the result of his own criminal conduct."9

On appeal the Supreme Judicial Court affirmed the superior court's denial of the double indemnity benefit, but reversed its denial of the ordinary life benefit.10 In affirming the denial of the double indemnity benefit, the Court found that recovery was barred by the policy's specific exclusion of such a benefit where death results from committing an assault or a felony.11 More significantly, however, the Court indicated that it would reach the same result so far as double indemnity or other accidental death benefits were concerned, even if such an exclusion were not contained in the insurance contract, on the "grounds of public policy."12 While the Court in Davis did not reexamine the public policy against allowing recovery of double indemnity benefits,13 it did cite two previous decisions14 which reasoned that allowing such recovery could induce criminal behavior.15

As to the ordinary life benefit, the Court in Davis saw it as standing "on a different footing" from the accidental death benefit.16 The Court first pointed out that the policy did not expressly exclude recovery of the ordinary benefit where death resulted from criminal behavior.17 Thus, the plaintiff-beneficiary would be entitled to recover


11 Id. at 1737-39, 351 N.E.2d at 208-09. See text at note 5 supra.


13 Id.


15 1976 Mass. Adv. Sh. at 1739, 351 N.E.2d at 208. Since recovery of the double indemnity benefit for death caused by accidental means was barred by the policy's exclusion clause, see text at note 11 supra, the Court stated that it need not reconsider the position taken in DeMello v. John Hancock Mut. Life Ins. Co., 281 Mass. 190, 196, 183 N.E. 255, 256 (1932), that a person injured while committing a crime did not die by "accidental means" since the death was a foreseeable consequence of his own wrongful act. 1976 Mass. Adv. Sh. at 1739, 351 N.E.2d at 208. See generally R. Keeton, Basic Text on Insurance Law § 5.4(f), at 305 (1971).


17 Id.
unless barred by public policy. Looking to "the great weight of authority in other jurisdictions," the Court overruled the line of cases denying recovery of ordinary life benefits in a case like the present one. This latter limitation appears in its context to be a reference to the beneficiary's status as an innocent party. The Court's holding appears to be based on the fact that modern life insurance policies contain savings and investment features, as well as purely insurance features. Consequently, the Court reasoned that "[f]orfeiture of savings and investment to the insurer may deter crime, but it seems out of harmony with related policies of modern time."

Thus, Davis is best read as establishing the right of an innocent beneficiary to recover ordinary life insurance benefits where death is the result of the insured's own criminal conduct, except in circumstances where an applicable policy exclusion exists.

§8.2. Liability Insurance. In Ronald Bouchard, Inc. v. Hartford Accident and Indemnity Co., the Supreme Judicial Court was called upon to apply the "completed operations hazard" clause contained in a policy issued by defendant-insurer to the plaintiff, Bouchard. Bouchard installed carpeting at a residence owned by one Charles E. Keene. Thirty-six hours after the installation had been completed an explosion occurred at Keene's home. Keene brought suit against Bouchard alleging that it was negligent in disconnecting, moving, and/or damaging gas pipes while installing the carpet and that this negligence caused the explosion. Bouchard filed suit in superior court seeking a judgment declaring that Hartford was required to defend Bouchard and to pay any judgment against Bouchard up to the policy limit.

18 Id.
20 See the "ordinary life benefit" cases cited in note 8 supra.
22 Id. at 1739-40, 351 N.E.2d at 209.
23 Id. See id. at 1742-43, 351 N.E.2d at 210. Cf. Estate of Draper, 536 F.2d 944 (1st Cir. 1976), where the insurer made no attempt to deny liability after the beneficiary, who was also the policy's purchaser, killed the insured and then killed himself.


Such clauses provide that an insurer's liability ends when the insured's operations are completed. Contractor's liability insurance policies contain such clauses because they define the risk covered as that arising from the insured's principal activity, and they define the time covered as that during which the insured is engaged in such activity. See generally 11 G. COUCH, CYCLOPEDIA OF INSURANCE LAW §§ 44:338, 44:344-45 (2d ed. 1963). Coverage for risks arising out of completed operations is more in the nature of products liability insurance. See id. § 44:345, at 744. See note 18 infra.

4 Id. at 636, 343 N.E.2d at 374.
5 Id.
6 Id.
7 Id. at 633-34, 343 N.E.2d at 373.
Hartford claimed that it was not liable to Bouchard because of the "completed operations hazard" clause contained in the manufacturers' and contractors' liability policy issued to Bouchard. The policy language at issue provided as follows: "This insurance does not apply ... to ... property damage ... arising out of operations ... if ... [the] property damage occurs after such operations have been completed or abandoned ...." The policy also set out a description of when operations shall be considered completed, which included "when all operations to be performed by or on behalf of the named insured under the contract have been completed ...."

Bouchard argued that Hartford could not disclaim liability because (1) the damage did not arise out of "operations," and (2) even assuming that the damages did arise out of operations, the operations were not "complete." Bouchard's first argument was that "operations" referred only to carpeting work because "it would be reasonable for the average businessman to assume that his risk from his operations is limited to his field of expertise." Thus, the "completed operations hazard" exclusion should be limited to damage arising out of some defect or deficiency in the carpet work and should not be extended to other activities, such as the incidental work done on the gas pipes in the process of installation. Bouchard bolstered this first argument with the principle that all ambiguities in insurance policies should be resolved against the insurer. Bouchard's second argument was that the damage was continual and therefore his operations did not end until the explosion occurred thirty-six hours after he had physically left the job site.

The superior court entered a decree in favor of Bouchard. In reversing the superior court, the Supreme Judicial Court, citing the familiar principles that an insurance policy should be viewed as a

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8 Id. at 633, 636, 343 N.E.2d at 373, 374.
9 Id. at 634, 343 N.E.2d at 373 (emphasis omitted).
10 Id. at 635, 343 N.E.2d at 373.
11 Id. at 636-37, 343 N.E.2d at 374.
12 Id.
13 See id. at 637, 343 N.E.2d at 374.
14 Id. at 638, 343 N.E.2d at 374. For an example of the Court's formulation of this principle, see Transamerica Ins. Co. v. Norfolk & Dedham Mut. Fire Ins. Co., 361 Mass. 144, 147, 279 N.E.2d 686, 688 (1972), discussed in Wadsworth, Insurance Law, 1972 ANN. SURV. MASS. LAW § 5.10, at 108-09. The principle that ambiguities should be resolved against the insurer appears to be of particular importance in cases interpreting "completed operations hazard" clauses. Compare, e.g., Glass v. Flowers, 149 So.2d 747, 751-52 (Ct. of App. La. 1963), cert. denied, 244 La. 210, 151 So.2d 689, cert. denied, 244 La. 212, 151 So.2d 690 (1963) ("completed operations hazard" clause bars insurer's liability where court found its language "clear and unambiguous") with Morris v. Western Cas. & Sur. Co., 421 S.W.2d 19, 24 (Mo. Ct. of App. 1967) ("completed operations hazard" clause does not bar insurer's liability where court found its language "ambiguous").
16 Id. at 634, 343 N.E.2d at 373.
whole and that an insurance policy’s words should be given their ordinary significance, found the language clear and unambiguous and excused Hartford from any obligation to defend or to pay in the action between the homeowner and Bouchard.

While the result in Bouchard seems correct, the Court’s reasoning appears to be unsatisfactory. Rather than considering Bouchard’s two arguments independently, the Court rejected both arguments because it disagreed with “the central assertion that the exclusionary clause in the [policy] ... is ambiguous.” The Court demonstrated the lack of ambiguity by showing that the language clearly limited Hartford’s liability to “accidents occurring during the process of [Bouchard’s] work ....” This finding, while disposing of Bouchard’s argument based on the word “completed,” has little significance for Bouchard’s first argument, which was that the damages caused by the explosion did not arise out of the “operations” of carpet work.

In fact, the Court’s only analysis of Bouchard’s first argument appears to be the general statement that “[w]e ... have no doubt that an insured who read the plain language of the exclusion clause ... would be fully informed that he would have no coverage for an event that occurred in the circumstances here shown.” A more specific response to Bouchard’s “operations” argument can be obtained by focusing on the words “arising out of.” Presumably the explosion occurred as a result of a gas leak that in turn was set in motion by Bouchard’s carpet laying activities. The mere fact that there was an intermediate step between Bouchard’s “operations” and the ultimate damage did not prevent the damage from “arising out of” those “operations.”

§8.3. Automobile Insurance. The process of interpreting the state’s “no-fault” auto insurance law continued during the Survey year


18 1976 Mass. Adv. Sh. at 639, 343 N.E.2d at 375. The Court correctly noted that coverage for completed operations could have been procured. See note 2 *supra*.

19 1976 Mass. Adv. Sh. at 637, 343 N.E.2d at 374. Only Bouchard’s first argument relied expressly on a claim of ambiguity in the policy’s language. See text at notes 11-15 *supra*. Thus, the opinion in Bouchard could be interpreted as addressing only Bouchard’s first argument, based on the word “operations,” and ignoring Bouchard’s second argument based on the word “completed.” A more reasonable interpretation, however, is that the Court, assuming that ambiguity was an element of Bouchard’s second argument as well, analyzed both arguments together. See text at notes 21-22 *infra*.


21 See text at notes 11 & 15 *supra*.

22 See text at notes 11-14 *supra*.


24 For the language of the “completed operations hazard” clause, see the text at note 9 *supra*.
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with a Supreme Judicial Court decision1 with respect to whether an injured employee entitled to recover lost wages under the Workmen's Compensation Act2 is barred from recovering lost wages under “no-fault” by section 34A of chapter 90 of the General Laws.3 Section 34A provides generally that a person injured in an automobile accident may recover medical expenses and lost wages up to $2,000 without regard to fault.4 Section 34A, however, excludes from those people eligible to recover under “no-fault” any person “entitled to payments or benefits under the provisions of chapter one hundred and fifty-two (the Workmen’s Compensation Act) ....”5

2 G.L. c. 152.
3 G.L. c. 90, § 34A, provides in part that the personal injury protection provisions of a motor vehicle liability policy or motor vehicle liability bond must:

[Provide for payment to the named insured in any such motor vehicle liability policy, the obligor of any motor vehicle liability bond, members of the insured's or obligor's household, any authorized operator or passenger of the insured's or obligor's motor vehicle including a guest occupant, and any pedestrian struck by the insured's or obligor's motor vehicle, unless any of the aforesaid is a person entitled to payments or benefits under the provisions of chapter one hundred and fifty-two, of all reasonable expenses incurred within two years from the date of accident for necessary medical, surgical, x-ray, and dental services, including prosthetic devices and necessary ambulance, hospital, professional nursing and funeral services, and in the case of persons employed or self-employed at the time of an accident of any amounts actually lost by reason of inability to work and earn wages or salary or their equivalent, but not other income, that would otherwise have been earned in the normal course of an injured person's employment, and for payments in fact made to others, not members of the injured person's household and reasonably incurred in obtaining from those others ordinary and necessary services in lieu of those that, had he not been injured, the injured person would have performed not for income but for the benefit of himself and/or members of his household, and in the case of persons not employed or self-employed at the time of an accident of any loss by reason of diminution of earning power and for payments in fact made to others, not members of the injured person's household and reasonably incurred in obtaining from those others ordinary and necessary services in lieu of those that, had he not been injured, the injured person would have performed not for income but for the benefit of himself and/or members of his household, as a result of bodily injury, sickness or disease, including death at any time resulting therefrom, caused by accident and not suffered intentionally while in or upon, or while entering into or alighting from, or being struck as a pedestrian by, the insured's or obligor's motor vehicle, without regard to negligence or gross negligence or fault of any kind, to the amount or limit of at least two thousand dollars on account of injury to or death of any one person, except that payments for loss of wages or salary or their equivalent or, in the case of persons not employed, loss by reason of diminution of earning power, shall be limited to amounts actually lost by reason of the accident and further limited (1) in the case of persons entitled to wages or salary of [sic] their equivalent under any program for continuation of said wages or salary or their equivalent to an amount that, together with any payments due under such a program, will provide seventy-five per cent of any such person's average weekly wage or salary or its equivalent for the year immediately preceding the accident ... .]

4 Id.
5 Id.

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In *Flaherty v. The Travelers Insurance Co.*, the plaintiff was operating the insured vehicle as part of his employment when it was involved in a single vehicle accident and overturned. He was out of work eight and one-half weeks and was paid workmen's compensation benefits at the rate of $95 per week. At the time of the accident, the plaintiff's weekly wage was $220 per week. Thus under "no-fault," which pays lost wages at a rate of 75 percent of the injured party's average weekly wage, the plaintiff would have recovered $165 a week.

The plaintiff filed suit in district court against the vehicle's insurer to recover lost wages under "no-fault." The plaintiff argued that section 34A did not deny "no-fault" wage loss benefits to a person entitled to workmen's compensation benefits because the language of the statute, after broadly describing the medical expenses that are recoverable, shifts to a more particular description of the wage loss benefits. Thus the plaintiff argued that while the workmen's compensation proviso to section 34A barred recovery of medical expenses under both "no-fault" and workmen's compensation, it had no effect on an injured party's right to recover lost wages under "no-fault." The district court and the appellate division of the district court rejected the plaintiff's argument and found for the defendant.

On appeal, the Supreme Judicial Court held that section 34A prohibits a person entitled to workmen's compensation benefits from recovering lost wages under "no-fault." The plaintiff raised another argument based on G.L. c. 90, § 34N, which allows recovery of personal injury benefits by persons otherwise having no such benefits. Section 34N, however, excludes "(1) a person entitled to payments or benefits under the [Workmen's Compensation Act and] ... (2) a person who is subject to exclusion from personal injury protection benefits by insurers under [§ 34A] ... of this chapter." The plaintiff argued that interpreting § 34A to bar all recovery by persons eligible for workmen's compensation benefits rendered § 34N's first exclusion a mere repetition of its second exclusion. The Court rejected the plaintiff's argument by pointing out that § 34N's second exclusion refers to persons excludable by the insurer under § 34A where such persons contribute "to their own injury while under the influence of alcohol or drugs or while committing a felony or while intentionally causing injury to themselves or others."
covering lost wages under "no-fault." A reading of the statute by the Court, which yields only to James Joyce in the length of its sentence describing the "no-fault" benefits, makes the plaintiff's argument a plausible one. The wage loss benefit is added to, and in a sense separate from, the medical expense benefit. The Court, however, held that the "root description of the persons entitled to ... ["no-fault" benefits] is shown in only one place in the ... statute [and] ... followed immediately by the exclusion of those entitled to payments or benefits under [the Workmen's Compensation Act]." Thus, such a person is precluded from recovering either medical expenses or wage loss benefits under "no-fault."

*Flaherty* is of interest because in addition to its rejection of the plaintiff's argument that the "no-fault" benefits should be parsed into two parts, one referring to medical expenses and the other referring to reimbursement for lost wages, the Court used the case to clarify the tort rights that survive as a result of the unavailability of a "no-fault" benefit. As is the case in any situation where a person has no right to a "no-fault" benefit, his tort rights against a negligent third party are unaffected by the statute's tort exemption. Though apparently not directly at issue in *Flaherty*, where the plaintiff was involved in a single car accident, the Court used its decision to remind the bar that such a party has the right to sue for and recover all special damages.

§8.4. Rate Regulation. In *Attorney General v. Commissioner of Insurance*, [hereinafter cited as *Rate case*] the Supreme Judicial Court faced a broad challenge to the automobile insurance rates for the year 1976 as fixed and established by the Commissioner of Insurance in accordance with the provisions of section 113B of chapter 175 of the General Laws. Following hearings, the Commissioner established industry-wide rates for bodily injury and property damage coverage

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17 Id. at 104, 340 N.E.2d at 891.
18 Note 3 *supra* sets out only a portion of the sentence in G.L. c. 90, § 34A describing the "no-fault" benefits.
19 See note 3 *supra*.
21 See text at notes 12-15 *supra*.
23 See text at note 7 *supra*.

2 G.L. c. 175, § 115B, provides in general that "[t]he commissioner shall, annually on or before September fifteenth, after due hearing and investigation, fix and establish ... just, reasonable and nondiscriminatory premium charges to be used and charged by companies in connection with the issue or execution of motor vehicle liability policies or bonds ... for the ensuing calendar year . . . ."
3 On August 4, 1976, the Governor approved Acts of 1976, c. 266, which created a new G.L. c. 175E. Under the new chapter 175E, industry-wide rates established by the Commissioner have been replaced by individualized rates established by the insurers based in part on competition. See *Rate* case, 1976 Mass. Adv. Sh. at 2068 n.2, 353

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based on three components: an allowance for losses, an allowance for expenses, and an allowance for profits. Petitions for review were filed with the Supreme Judicial Court by both the Attorney General, who challenged the rates as being too high, and the insurers, who challenged the rates as being too low. The Court upheld the rates

N.E.2d at 749 n.2; Griffin & Hillman, Auto Insurance Reform Law, 61 Mass. L. Q. 211, 214-15 (1977). The Supreme Judicial Court’s discussion of the Commissioner’s ratemaking efforts in the Rate case, 1976 Mass. Adv. Sh. 2068, 353 N.E.2d 745, will retain significance under the new law for two reasons. First, G.L. c. 175E, § 5 empowers the Commissioner to “fix and establish” rates under G.L. c. 175, § 113B where he discovers that “competition is either (i) insufficient to assure that rates will not be excessive, or (ii) so conducted as to be destructive of competition or detrimental to the solvency of insurers . . . .” Second, G.L. c. 175E, § 7 requires insurers to file rate changes with the Commissioner for review. G.L. c. 175E, § 4 states that the standards against which these rates should be judged include, in addition to competition, the insurer’s losses, expenses, and profits—the same elements under discussion in the Rate case. See text and notes at notes 4-6 infra.

4 The loss allowance is that part of each premium which will be used by the insurers to pay the claims of their insureds. The allowance is determined by first calculating the “Raw Pure Premium” for the most recent year for which there is reasonably complete data. The “Raw Pure Premium” is arrived at by dividing the total claims arising from the base year policies by the total insurance exposure for the base year. The “Raw Pure Premium” is then adjusted by various multiplicative factors to account for the facts that the data arising from the base year is not complete and that the experience during the current year will differ in predictable ways from the base year. See Rate case, 1976 Mass. Adv. Sh. at 2070-73, 353 N.E.2d at 750-51. The loss allowance disputes in the Rate case concerned the appropriate size of the multiplicative factors. See id. at 2073-86, 353 N.E.2d at 751-57.

5 The expense allowance is that part of each premium which will be used by the insurer to pay costs such as those associated with the investigation and adjustment of claims, the acquisition of new customers, and the maintenance of administrative facilities. As with the loss allowance, the expense allowance is determined by first calculating the “Expense Pure Premium” for the base year. The “Expense Pure Premium” is then adjusted by various multiplicative expense factors. See id. at 2087-88, 353 N.E.2d at 757-58. The expense allowance disputes in the Rate case centered on the multiplicative factors. See id. at 2088-92, 353 N.E.2d at 758-59.

6 The profit allowance is that part of each premium which will go to the insurer as profit. The most significant disputes in the Rate case concerned the Commissioner’s innovative method of calculating the profit allowance. See id. at 2092-2106, 353 N.E.2d at 759-65. For a further discussion of the profit allowance, see text and notes at notes 19-38 infra.

7 G.L. c. 175, § 113B, provides in part:

Any person or company aggrieved by any action, order, finding, or decision of the commissioner under this section may, within twenty days from the filing of such memorandum thereof in his office, file a petition in the supreme judicial court for the county of Suffolk for a review of such action, order, finding, or decision.


9 Insurers’ interests were represented by individual insurance companies and by the Massachusetts Automobile Rating and Accident Prevention Bureau, an unincorporated association of automobile insurers. Id. at 2068-69, 353 N.E.2d at 749.

10 See, e.g., id. at 2073, 2079-80, 353 N.E.2d at 751, 754. The insurers also argued that the Commissioner erred in failing to increase the 1976 bodily injury and property damage rates pursuant to the “second look” statute. Id. at 2106-13, 353 N.E.2d at 765-68. The “second look” statute, inserted in G.L. c. 175, § 113B by Acts of 1971, c.
In upholding the Commissioner's method of establishing the allowances for losses and expenses,\textsuperscript{12} the Court's opinion followed predictable patterns that flow from its limited scope of review in rate-making cases.\textsuperscript{13} In general, when reviewing rate-making questions, the Court, rather than substituting its judgment for the Commissioner's, is to decide whether the rates set by the Commissioner have "reasonable support in the evidence."\textsuperscript{14} On this basis, the Court disposed of most questions by favoring the choices between competing theories and facts made by the Commissioner. For example, when rejecting one of the numerous challenges to the allowance for losses,\textsuperscript{15} the Court simply stated: "On the whole we cannot conclude that the choice [made by the Commissioner] ... was wrong."\textsuperscript{16} Similarly, when upholding the Commissioner's allowance for expenses,\textsuperscript{17} the Court stated: "[W]e cannot say he was wrong."\textsuperscript{18}

In relation to the allowance for profits, however, the Court strained its scope of review by reaching for evidence not relied upon, and in fact apparently criticized by the Commissioner, to uphold the result he had reached on separate grounds.\textsuperscript{19} For the first time, the Commissioner attempted to consider the insurers' investment income in establishing the allowance for profits.\textsuperscript{20} This investment income is generated by investing the fund created through the excess of premiums, which are received early in the policy year, over claims, which are paid over several years.\textsuperscript{21} The Commissioner's goal was to establish an

\textsuperscript{12} Id. at 2070-86, 353 N.E.2d at 750-57 (upholding allowance for losses); id. at 2087-92, 353 N.E.2d at 757-59 (upholding allowance for expenses).
\textsuperscript{13} Id. at 2069 n.4, 353 N.E.2d at 750 n.4.
\textsuperscript{15} For the nature of the challenges to the loss allowance, see note 4 \textit{supra}.
\textsuperscript{17} For the nature of the challenges to the expense allowance, see note 5 \textit{supra}.
\textsuperscript{19} See id. at 2098-2103, 353 N.E.2d at 762-64.
\textsuperscript{20} Id. at 2093-94, 353 N.E.2d at 760.
\textsuperscript{21} Id. at 2093, 353 N.E.2d at 760. See generally Birkinsha, Investment Income and Underwriting Profit: "And Never the Twain Shall Meet?", 8 B.C. IND. & COM. L. REV. 713 (1967).
allowance for profits which, together with investment income, would allow the average insurer "a rate of return on [shareholders'] invested capital roughly equal to that earned by businesses with similar riskiness in the unregulated, competitive sector of the economy." 22

An essential element of the Commissioner's allowance for profits was the creation of a target rate of return for insurers based on rates of return in unregulated industries. 23 The Commissioner set the target rate of return at ten percent by comparing the rates of return for 850 of the largest domestic corporations. 24 The Court found, however, that the Commissioner's reasoning was "open to question" 25 because he failed to consider at least three elements of risk that would lead potential shareholders to demand a higher rate of return from liability insurers. First, the Commissioner did not consider that losses in some lines of liability insurance are more unpredictable than in others. 26 Second, the Commissioner made no allowance for the riskiness of the insurer's own investment policy. 27 Finally, the Court pointed out that the Commissioner failed to consider the risk created by the ratio which the insurer adopts between premium volume and capital. 28 Thus, the Court concluded that "[a]n assessment of these risks, and perhaps others, that characterize the model insurer and a comparison with the risk-return relationship of unregulated enterprises may be thought necessary if the target return of the model insurer is to be properly determined." 29

23 Id. at 2096, 353 N.E.2d at 761. In addition to the creation of a target rate of return, the Commissioner's procedure for calculating the allowance for profits had four other steps. A simplified version of those steps follows:
1). A determination of how much income a given investment dollar would yield based on "risk-free" Treasury securities;
2). A determination of how many dollars would be made available for investment by the excess of premiums over claims for each line of insurance;
3). A determination of how many dollars would be made available for investment through shareholder-contributed capital;
4). A determination of what profit allowance should be included in each premium to allow the insurer's total return to equal the target rate of return.
See id. at 2094-97, 353 N.E.2d at 760-61.
24 Id. at 2098, 353 N.E.2d at 762. The actual target rate of return was increased to 11.5% for bodily injury insurance to compensate for the greater impact of inflation on that line of insurance. Id.
25 Id. at 2099, 353 N.E.2d at 762.
26 Id. at 2099-2100, 353 N.E.2d at 763.
27 Id. at 2100, 353 N.E.2d at 763.
28 Id. This third risk results from the fact that insurers need capital to pay the claims of their insured. If an insurer with large potential liability (i.e., premium volume) and relatively little retained capital (a high-ratio insurer) experiences heavy losses, it may have to sell investments to pay claims. On the other hand, the high-ratio insurer will return a greater profit, through its greater investment, if it experiences lighter losses. Thus, the potential investor will require a larger rate of return from a high-ratio insurer than from a low-ratio insurer. See id. at 2100, 353 N.E.2d at 763.
29 Id.
Rather than remanding for the creation of a new target rate of return however, the Court engaged in an independent review of the record before the Commissioner. Three experts had testified that a prospective investor would demand a rate of return of at least fifteen percent from a real-world liability insurer. The model insurer, however faced fewer risks than a real-world insurer because it maintained a "risk free" investment policy and a low ratio of premium volume to capital. On this basis, two of the three experts claimed that the potential investor would accept a ten percent rate of return in the model insurer. Since the Commissioner employed the same target rate of return, arrived at through a different method, the Court affirmed the allowance for profits, even though the Commissioner criticized the experts' figures as "loose estimates," and the experts themselves claimed that "more careful analysis would be needed to reach a precise figure...." As if to excuse this application of the maxim that "hard cases make bad law," the Court said: "In reaching this result we are mindful that the Commissioner's approach to the profit allowance is not only novel but complicated, and that somewhat greater imprecision must be tolerated in its initial application than might be acceptable in later years."

Overall the Rate case is not an endorsement of the methods used by the Commissioner in calculating the allowance for profits in the 1976 automobile insurance rates. It stands instead as a starting point for a more careful articulation of how profit allowances should be determined in insurance rate cases. In a pragmatic sense, the case accomplished something for all parties. The Commissioner, ignoring the Court's criticism of a central part of his method, has been left to claim victory. Insurers, on the other hand, finding strong sympathy for their contentions as to the proper way to proceed, are left with the hope that a future case will establish their proposed method as the proper one.

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30 See id. at 2101-02, 353 N.E.2d at 763-64.
31 Id. at 2101, 353 N.E.2d at 763.
32 Id. at 2102, 353 N.E.2d at 763. See note 23, at step 1 supra.
33 1976 Mass. Adv. Sh. Id. at 2101-02, 353 N.E.2d at 763. The model insurer retained one dollar of capital for every two dollars of potential liability. Real insurers would retain one dollar of capital for every three or more dollars of potential liability. Id. See note 28 supra.
35 See text at note 24 supra.
37 Id.
38 Id. at 2102-03, 353 N.E.2d at 764.