S. HRG. 111–458

PROHIBITING PRICE FIXING AND OTHER ANTI-COMPETITIVE CONDUCT IN THE HEALTH INSURANCE INDUSTRY

HEARING

BEFORE THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

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PROHIBITING PRICE FIXING AND OTHER ANTICOMPETITIVE CONDUCT IN THE HEALTH INSURANCE INDUSTRY

WEDNESDAY, OCTOBER 14, 2009

U.S. SENATE,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Committee met, pursuant to notice, at 10:08 a.m., in room SD–226, Dirksen Senate Office Building, Hon. Patrick J. Leahy, Chairman of the Committee, presiding.

Present: Senators Leahy, Kohl, Feinstein, Feingold, Schumer, Durbin, Whitehouse, Klobuchar, Kaufman, Franken, and Hatch.

OPENING STATEMENT OF HON. PATRICK J. LEAHY, A U.S. SENATOR FROM THE STATE OF VERMONT

Chairman LEAHY. Good morning. Today we are going to focus on an issue that has certainly had my attention for a number of years, and that is the insurance industry's exemption from the Federal antitrust laws. This exemption, since it was enacted in 1945, has served the financial interests of the insurance industry, but I do not see where it has helped the consumers at all.

For the past several months, our Nation has debated how best to reform our health care system. Three House Committees and two Senate Committees have spent countless hours trying to answer the question of how best to introduce competition and make health insurance affordable for all Americans. Now, in this debate, it is important to remember that under current law the health insurance industry does not have to play by the same rules of competition as do other industries.

The lack of affordable health insurance plagues families throughout our country. The rising prices that hospitals and doctors pay for medical malpractice insurance drains resources that could otherwise be used to improve patient care. Even in my State of Vermont, where there are very few lawsuits, and virtually no large recoveries on malpractice, the malpractice insurance, you would think you were in California. And the insurance companies will not tell anybody why they have to charge those premiums. Antitrust oversight in these industries would provide consumers with confidence that insurance companies are not colluding to raise prices artificially.

There is no justification for health insurers engaging in egregious anticompetitive conduct to the detriment of consumers. Price fixing, bid rigging, and market allocation are per se violations of our laws

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precisely because there is no procompetitive justification for them. Other companies in all other industries have to follow these rules, and there is no reason why health insurers should be accorded immunity to engage in what would be illegal conduct if being done by any other company. Our bill would fix this anomaly in the law once and for all. I believe it would lead to more competition and lower insurance costs, and basically what it says is that nobody is above the law. If the laws are good for every other company, every other industry, why shouldn't they be good for the insurance industry?

But what has happened, the insurance industry, instead of working to justify this very special exemption, they have used its enormous influence to maintain a special, statutory exemption from Federal antitrust laws and the protections they provide. And while the insurance industry hides behind the exemption, patients and doctors have continued paying artificially inflated prices, as costs continue to rise at an alarming rate.

Now, the cost spiral is just fine for the insurance companies. They make huge profits. But it punishes patients, it punishes American businesses large and small, and taxpayers. And I think while it would be very easy to say there is no justification for the antitrust exemption, they will fight like mad for it because it keeps insurance premiums high. But when we are debating reform efforts to check spiraling costs and expand Americans' access to quality, we should not have this antitrust exemption.

Last month, I introduced the Health Insurance Industry Antitrust Enforcement Act of 2009, and that would repeal the antitrust exemption for health insurance and medical malpractice insurance providers. The Majority Leader is a cosponsor of this legislation, as are six other members of the Committee—Senators Feinstein, Feingold, Schumer, Durbin, Specter, and Franken. It just says we will have the same basic rules of fair competition apply to insurers in the health industry that apply to everybody else.

Last Congress, Senator Trent Lott, the former Senate Republican Leader, and others on both sides of the aisle joined me in introducing a much broader repeal of the insurance industry's antitrust exemption. The one we are introducing now is a scaled-down version of that.

I do not see how somebody can say with a straight face that they should not be subject to the same antitrust laws as everyone else. If they are operating in an appropriate fashion, then they have got nothing to fear.

So I would hope this would be a key part of health programs. There is more, and I will put my full statement in the record.

[The prepared statement of Chairman Leahy appears as a submission for the record.]

Chairman LEAHY. I know we want to hear certainly from Senator Hatch and the Chairman of the Antitrust Subcommittee, Senator Kohl. Go ahead.

Senator HATCH. Do you want to go to Senator Kohl first?

Chairman LEAHY. No. Go ahead.

STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM THE STATE OF UTAH

Senator HATCH. Thank you, Mr. Chairman, and welcome, Assistant Attorney General Varney. We appreciate you.

Thank you, Mr. Chairman. I want to thank the members of this distinguished panel of witnesses for appearing here today, including the Senate Majority Leader and the Assistant Attorney General. These are indeed important issues, and it is my hope that we can have an open and honest discussion.

Throughout this current health care debate, we have seen no small amount of partisan wrangling and disagreement. Now, this is to be expected when we are discussing issues about which Members of Congress have strong philosophical differences and really where one-sixth of the American economy is included. However, despite these differences, I believe that we all want to see the same results—namely, reduction in the cost of health care in America.

None of us are indifferent to those in our Nation who are facing mounting medical costs. We simply disagree as to what is the best role for the Federal Government to play in addressing these costs, and that is what brings us to today's hearing.

Today we are discussing the effect of the antitrust exemptions enjoyed by the insurance industry which were put in place by the McCarran-Ferguson Act. This is not a new debate, and I believe that for most of us past discussions on this topic will inform the current one.

Let me make my position clear. I believe that the essence of capitalism in our free market system is competition. I believe our antitrust laws, if properly and vigorously enforced, enhance this fundamental element of our economic system.

In my mind, there are few exceptions to the notion that when companies compete with one another, consumers benefit. I believe that is true in the insurance industry as in any other. That being the case, I remain open to considering any reform measures that will promote competition in the insurance sector. And while this may include reforms of McCarran-Ferguson to prevent actual abuses of the current system, I have as of yet seen little evidence to justify a complete repeal of the antitrust exemption for the insurance industry.

Now, this is true for a few reasons. First, I believe we need to ensure that small insurance providers and independent agents are able to remain competitive in the insurance market. McCarran-Ferguson has allowed these providers to collaborate in certain areas such as the evaluation-of-loss data, which is vital to setting insurance rates. Smaller providers simply do not have sufficient data on their own to remain competitive in the insurance market. A complete repeal of McCarran-Ferguson would, therefore, result in fewer, smaller competitors, leaving the market for the larger firms.

Second, I believe limited collaboration between even large competitors can result in lower prices for consumers. I think that the data has shown that a ban on collaboration in the insurance industry could result in higher costs for insurers which will undoubtedly be passed on to our consumers. That said, McCarran-Ferguson was put in place to allow some level of collaboration and to ensure that

States play the primary role in regulating the insurance industry, not to exempt insurance companies from the need to compete.

So, in the end, I believe any discussion of repealing the antitrust exemption should be coupled with actual data that the current market is not competitive. I hope that instead of demonizing the insurance industry simply because it is currently unpopular and an easy target will not take precedence over a robust discussion of the actual state of the insurance market.

I would also like to take a minute to discuss this Committee's role in the overall health care debate. Last week, for the first time the Congressional Budget Office released a report addressing the costs of defensive medicine in our health care system and the potential for tort reform to reduce those costs. Defensive medicine, as we all know, are those procedures and treatments which are redundant and often inappropriate that doctors perform not to improve the health of their patients but to avoid malpractice lawsuits. The CBO's letter on this issue came just a few weeks after President Obama mentioned it in the most recent address to Congress, and I am talking about avoiding really wrongful medical liability lawsuits that are brought mainly to get the defense costs, which are extensive in almost every medical liability case.

According to the CBO, tort reform measures would reduce the Federal deficit by $54 billion over 10 years, and the private sector would see even more savings—$11 billion this year alone. These are not insignificant figures, and I believe that there is ample data demonstrating that the savings to our overall health care system would be even larger. Yet it appears that the President and the majority in Congress would rather pay lip service to this issue rather than enact real reforms.

For my part, it is very frustrating, having worked on the health care bills in both the HELP and Finance Committees, hearing time and again from members of the majority that reforming the medical malpractice liability system was a worthy endeavor but outside those committees' jurisdictions. And here we are in the Judiciary Committee, the Committee with jurisdiction on these issues, and the majority has apparently decided to once again pass on the opportunity to address this important matter.

A few weeks ago, former DNC Chairman and physician Howard Dean was speaking at a town hall meeting on health care. In that meeting, he was asked why the House's health care bill did not include any reforms to the medical malpractice system. In a rare moment of candor on this issue, he stated that no such reforms were in the bill because "the people that wrote it did not want to take on the trial lawyers in addition to everyone else they were taking on." He was very frank about it.

I had hoped that, at least with regard to the Senate's health care efforts, this statement would not hold true. But after seeing this Committee literally pay only lip service to the problem, I have to conclude that Governor Dean was speaking for both the House and the Senate. However, I am aware that this is not the subject of today's hearing, and I will not take up any more of the Committee's time discussing that particular issue.

But this is an important hearing. I can only be here a short time, but I appreciate you holding it, Mr. Chairman, and I appreciate our

Chairman of the Subcommittee, Senator Kohl, and, frankly, appreciate virtually everybody on this Committee.

Chairman LEAHY. Well, thank you. And, of course, the reason why malpractice was not in the Finance Committee bill is that it does not have jurisdiction over that issue. We do. I am happy to look at that or any other thing, but——

Senator HATCH. Well, I would like you to do that.

Chairman LEAHY. But I am not going to look at it absent legislation that will give us some honest accounting from the insurance companies. This antitrust exemption really is a significant part of health care legislation, but within our jurisdiction.

Senator Kohl.

STATEMENT OF HON. HERB KOHL, A U.S. SENATOR FROM THE STATE OF WISCONSIN

Senator KOHL. Thank you, Mr. Chairman. We meet today to examine the state of competition in the health insurance market, a topic of great interest to all Americans who are contending with rising health care costs as well as rising health insurance premiums. Ms. Varney, we are particularly pleased to see you here today.

Now, as health care costs continue to rise, consumers face ever increasing premiums. A recent study by the Kaiser Family Foundation found that health insurance premiums have risen by over 120 percent in the past decade. The burden of rising insurance rates is borne by millions of families and individuals all across our country and also by large and small businesses who find it increasingly difficult to offer health insurance for their employees.

Health insurance consolidation has left consumers and businesses with fewer choices, leading to higher prices and to what many believe to be a decline in coverage. There can be no doubt that vigorous competition in the health insurance industry is essential to lower health insurance premiums for consumers as well as businesses.

In this industry, as in all others, a healthy dose of competition is the best remedy for that which ails American consumers. We need to ensure that our antitrust enforcement agencies are paying close attention to competition in this industry and are prepared to take enforcement action where necessary. At the same time, we need to recognize the important role of State regulation in the insurance industry as well as the needs of insurance companies to share information and risk-of-loss data, particularly small companies who rely on this information in order to compete with larger established companies.

I am also glad Ms. Varney is here today because I want to ask her about the state of competition in agriculture, particularly in the dairy industry. Our small dairy farmers are facing increasing consolidation among milk processors, resulting in little choice of whom to sell their milk or at what terms. I am interested to learn what steps, Ms. Varney, you are planning to take to promote more competition in this industry. Again, we thank you for being here today and look forward to your testimony.

Chairman LEAHY. Before we turn to Ms. Varney, I will ask consent to put in the record a letter from the American Hospital Asso-

ciation, which states in the context of health care reform, this bill, the insurance industry bill, "should help to achieve the goal of fair play by eliminating antitrust protection for price-fixing, bid-rigging, and market allocation activities, which would undermine the success of a health insurance exchange and the coverage it promises for millions of Americans."

[The letter appears as a submission for the record.]

Chairman LEAHY. I will also ask consent to put in the record a resolution from the National Association of Attorneys General which represents State Attorneys General throughout the country, and they state that the association supports repeal of the McCarran-Ferguson Act's exemption for the business of insurance from Federal antitrust laws. There have been others that have submitted statements. Those will be put in the record.

[The statement appears as a submission for the record.]

Chairman LEAHY. Ms. Varney is the Assistant Attorney General for the Antitrust Division, United States Department of Justice. Prior to joining the Department of Justice, she was a partner at the Washington, D.C., firm of Hogan & Hartson. She was a member of the Antitrust Practice Group. She was head of the Internet Practice Group. She served as a Commissioner at the Federal Trade Commission from 1994 to 1997, where she was the leading official in a variety of Internet competition issues. She served as a Special Assistant to the President and Secretary of the Cabinet. She received her bachelor's degree from the State University of New York at Albany and her law degree from Georgetown University, which, of course, always makes me happy.

Ms. Varney, please go ahead.

STATEMENT OF CHRISTINE A. VARNEY, ASSISTANT ATTORNEY GENERAL, ANTITRUST DIVISION, U.S. DEPARTMENT OF JUSTICE

Ms. VARNEY. Thank you, Senator. Good morning, Mr. Chairman and members of the Committee. I am pleased to be here today to discuss the McCarran-Ferguson Act's antitrust immunity for the business of insurance.

Chairman LEAHY. Bring your microphone just a little bit closer.

Ms. VARNEY. The McCarran-Ferguson Act was designed to delegate to the States the authority to regulate and tax the business of insurance. It also created a broad antitrust exemption based on State regulation.

Repeal or reform of the broad antitrust exemption currently enjoyed by the insurance companies has been a perennial subject of interest. Most recently, the Antitrust Modernization Commission reviewed whether the McCarran exemption is necessary to allow insurers to collect, aggregate, and review data on losses. The AMC found that the exemption is no longer necessary. The AMC concluded that insurance companies "would bear no greater risk than companies in other industries engaged in data sharing and other collaborative undertakings," and noted like all potentially beneficial competitor collaborations such data sharing would be assessed by antitrust enforcers and the courts under a rule of reason. Such an assessment would fully consider the potential procompetitive ef-

fects of such conduct and condemn it only if, on balance, it was anticompetitive.

The Department is generally opposed to exemptions from the antitrust laws. The antitrust laws reflect our society's belief that competition enhances consumer welfare and promotes our economic and political freedoms. Exceptions from that policy should be—and fortunately are—relatively rare. Those who advocate the creation of a new antitrust exemption, or the preservation of a longstanding exemption such as the McCarran-Ferguson Act, bear a heavy burden in justifying that exemption.

The McCarran exemption has been subject to criticism as to its results. One antitrust treatise notes that under McCarran, the presence of even minimal State regulation, even on issues unrelated to the antitrust suit, is generally sufficient to preserve immunity. Indeed, the case law can be read as suggesting that the Act precludes Federal antitrust action whenever there is a State regulatory scheme, regardless of how perfunctory it may be. It is fair to say that the McCarran exemption is very expansive with regard to anything that may be the business of insurance, including premium pricing and market allocations. As a result, the most egregiously anticompetitive claims, such as naked agreements fixing price or reducing coverage, are virtually always immune from antitrust prosecution.

Concerns over the exemption's effects are especially relevant given the importance of health insurance reform to our Nation. There is a general consensus that health insurance reform should be built on a strong commitment to competition in all health care markets, including those for health and medical malpractice insurance. Repealing the McCarran-Ferguson Act would allow competition to have a greater role in reforming health and medical malpractice insurance markets than would otherwise be the case.

In evaluating the need for an antitrust exemption, the Congress should also consider the flexible nature of the antitrust laws as interpreted in recent cases. These cases allow for a rule-of-reason review. An assertion that particular procompetitive behavior would violate the antitrust laws and, thus, should be exempted fails to take into account the economically sound competitive analysis that is used today to carefully circumscribe per se rules.

The flexibility of the antitrust laws and their crucial importance to the economy argue strongly against antitrust exemptions that are not clearly and convincingly justified.

There are strong indications that the possible justification for the broad insurance antitrust exemption in McCarran when it was enacted in 1945 are no longer valid. To the extent that the exemption was designed to enable the States to continue to regulate the business of insurance, it is no longer necessary. The state action doctrine was undeveloped in 1945. Today that state action doctrine allows a State to immunize what the antitrust laws may otherwise proscribe.

The application of the antitrust laws to potentially procompetitive collective activity has also become far more sophisticated in the 62 years since McCarran was enacted. Some forms of joint activity that might have been prohibited under earlier, more restrictive doctrines are now clearly permissible, or at the very least

analyzed under a rule of reason that takes appropriate account of the circumstances and efficient operation of a particular industry. Thus, there is far less reason for concern that overly restrictive antitrust rulings would impair the insurance industry's efficiency.

In sum, the Department of Justice generally supports the idea of repealing antitrust exemptions. However, we take no position as to how and when Congress should address the issue. In conjunction with the administration's efforts to strengthen insurance regulation and the States' role in setting and enforcing policies, the Department supports efforts to bring more competition to the health insurance marketplace that lowers costs, expands choice, and improves quality for families, businesses, and Government. As you know, the administration has been working closely with the Congress to enact health care reform that lowers costs and offers affordable coverage to all Americans. Yesterday, the Senate Finance Committee became the fifth and final Committee to report out a health reform bill. The President has said that these reforms will greatly benefit Americans from all walks of life, as well as the economy as a whole. We know that you share this goal, and we look forward to working with you and your colleagues in achieving our common objectives.

Mr. Chairman, this concludes my prepared statement. I would be happy to address questions.

[The prepared statement of Ms. Varney appears as a submission for the record.]

Chairman LEAHY. Thank you.

Before we go to questions, Ms. Varney, Senator Reid, the Majority Leader, is here, and I know he is juggling about 12 other things for being here. So I am going to yield to Senator Reid.

STATEMENT OF HON. HARRY REID, A U.S. SENATOR FROM THE STATE OF NEVADA

Senator REID. Mr. Chairman, thank you very much for allowing me to testify. I appreciate the members of the Committee and the Ranking Member for listening to me.

Mr. Chairman, you and I had the good fortune to serve in the Senate with Paul Simon. I had the good fortune of serving with him, the Senator from Illinois. He and I were lieutenant Governors. We served in the House together, and he is one of my favorite people I have ever dealt with in Government. And he had a lot of causes. That is who Paul Simon was. But the one cause that he talked about incessantly was to get rid of the McCarran-Ferguson anticompetitive provision that allows—they have this blanket antitrust exemption. It is something that should have been done a long time ago. I do not know what Pat McCarran had in mind when he lent his name to this, but that is a story for another day.

And, Mr. President—or, Mr. Chairman, I am sorry, one needs only to read the news today and find out what is going on around the country today with the barrage of paid advertisements the insurance industry is doing now to prevent a health care bill from passing. They really are desirous of continuing their monopoly they have in America today.

There is not anything we could do to satisfy them in this health care bill. Nothing. If we did this, they would want that. They are

so anticompetitive. Why? Because they make more money than any other business in America today.

I have received hundreds and hundreds of letters, probably now in the thousands of e-mails, from constituents who are concerned about adequate health care. One of my constituents in Boulder City, Nevada, runs a small business. She is paying a huge amount of money each month for the most basic health care package she could find. Her rates keep going up. No other company will insure her.

Another of my constituents, a psychologist who runs a small practice with a handful of employees, has always paid 100 percent of his workers' health care costs. The insurance company he uses has decided to raise its rates almost 50 percent-46 percent to be exact. He cannot afford this, and he will join the ranks, as will his employees, of the uninsured, because there is no option, public or otherwise.

Free competition is fundamental to our economy and essential to the American character that we have developed in these 200-plus years.

It is one of the most important decisions that we make, and that is, to make sure the insurance industry is playing by the same rules as everyone else and that they are subject to competition.

What a sweet deal they have, Mr. President.

Competition is what allows great ideas to flourish, and it improves prices and quality for consumers. It allows new businesses to enter the market. It gives incentives to entrepreneurs. It fuels innovation.

America's free and open marketplace gives consumers choices and encourages risk taking, and it has been the birthplace of the greatest economy in the history of the world.

That is why we have Federal laws that prohibit price fixing, bid rigging, and collusion between companies within an industry. When companies are forced to compete with one another, the American people benefit. This is not a Democratic Party idea. This first came about with a Republican—Theodore Roosevelt, the trust buster. These are financial trusts, not personal trusts.

Take health insurance as an example.

Providing this blanket exemption for insurance companies to antitrust laws has been anticompetitive and damaging to the American economy, and that is a gross understatement, I repeat. Health insurance premiums have continued to rise at a rapid rate, forcing businesses to cut back on health insurance coverage and forcing many families to choose between health insurance and basic necessities.

Mr. Chairman, employers do not have health insurance because they are cheap or mean. They cannot afford it.

All too often, working families have to forego health insurance. In fact, the primary reason people are uninsured is due to the high and escalating costs of health insurance.

I think it speaks volumes to find out that last year in America three-quarters of a million people filed bankruptcy because of their medical bills. Next year it will be the same, probably more.

The increasing costs impact the costs of Government health programs like Medicare and Medicaid and the costs of providing

health insurance to Federal Government employees. And despite rising costs, insurance companies are underpaying doctors for their services with many of the monopolistic practices they have developed.

Remember the movie—Jack Nicholson was in it, and there was a point in there where they were bashing managed care, and audiences all over America cheered when that part came up in the movie. Why? Because people hate what is happening to them. They have no control.

Insurance companies have become so large they dominate entire regions of the country, and that is what you would expect when you see an industry protected from the antitrust laws. You see, I repeat, insurance companies becoming so large they dominate an entire region of the country. They not only damage general businesses; they prevent insurance companies from starting up.

They have become so dominant that they dictate business practices. They are so influential that they exert tremendous influence over public policy, as seen by the millions of dollars they are spending today in America bashing the health care programs that we are trying to initiate.

In particular, exempting health insurance companies has had a negative effect on the American people, and that is a gross understatement. Health insurance companies have so much authority that they often dictate what course of treatment patients receive.

When you do have health insurance, more than 30 percent of the claims made are turned down. They have armies of people figuring out ways not to pay people for something that happens to them in the way of a medical treatment. Health insurance monopolies should not be making health insurance—I am sorry. Health insurance monopolies should not be making health care decisions for patients—and for doctors. No one should come between a patient and their doctor when it comes to making health care decisions, but in America, the insurance companies come between them millions of times a day.

Patients should be able to choose, just like Members of Congress are able to choose, from a variety of different health care plans. There is no reason why insurance companies should be allowed to form monopolies and dictate health choices.

I so appreciate, Mr. Chairman, your sponsoring this legislation. The minute I saw it, I could not get to my staff quickly enough to make me happy to join with you.

There is no reason why the insurance companies should have exemption from antitrust laws, this blanket exemption. And, you know, they have the audacity to say, "Well, we are subject to the antitrust laws of States." That is laughable.

To the extent insurance companies need to share information to provide their services, let them do what other industries have to do; they are no different than any other business: Seek prior authorization and guidelines from the Department of Justice and others for how they can work together. This guise they have used for decades saying, "Well, we cannot share information if we do not have this monopoly." I am sure that the automobile industry felt the same way. Lawyers feel the same way. Doctors, hospitals all

feel the same way. But they are subject to the law, and so should these insurance companies be.

They should be subject to the same Federal oversight as every other industry. Their price-setting and information-sharing practices should not be permitted to take place out of public view, but should be brought out into the light of day.

So I urge all of my colleagues on this Committee and in the Senate to get this out of Committee as quickly as possible and let us pass it.

Now, the reason they are so upset and the reason they are running these ads is the bill that came out of the Finance Committee chips away at this monopoly that they have, and they hate that. They want to be untouched, as they have been for 60 years. So as far as doing something to help the American people, Mr. President, there are a lot of things we can do. But your sponsoring this bill and getting this out of this Committee sends a tremendous message, an important message to the American people, and the people of Vermont are proud of you, as well they should be, for this and other reasons.

[The prepared statement of Senator Reid appears as a submission for the record.]

Chairman LEAHY. Thank you. Thank you, Mr. Leader. It is interesting. As I said before, your predecessor as Majority Leader, Senator Lott, had been a sponsor of this. You were a sponsor of this. It is a bipartisan—I think it is a nonpartisan thing. Basically what we are saying is everybody should be subjected to the laws. And if you are obeying the law, if you are following the law, if you are not breaking the laws that are set up to protect consumers, you have got nothing to fear. So that is all we are saying.

Unless there is a question of the Leader, I know you have to go back, Senator Reid, so thank you very much for taking the time to be here.

Ms. Varney, I also want to thank you for being here. Did you finish your statement?

Ms. VARNEY. I did. I guess it was not that memorable.

Chairman LEAHY. I know that you offered to yield to Senator Reid.

Ms. VARNEY. I did. He declined.

Chairman LEAHY. He let you go ahead. That prairie way of being sure to give everybody a chance. It sounds like somebody took the cork out of the bottle.

[Laughter.]

Chairman LEAHY. I do appreciate your being here. You know, I have said this to you before privately, and I said it to you in Vermont. But I am glad to see the administration taking antitrust enforcement so seriously. You have announced the intention to be tough on antitrust enforcement. You are showing it.

A few weeks ago, you were in Vermont at a Judiciary hearing to discuss competition issues in the dairy industry. That hearing was very compelling. It was of interest to many of us on this Committee. Having you here is very helpful.

You said that the Antitrust Division is suspect of antitrust exemptions generally. Are there any procompetitive justifications for allowing price fixing, bid rigging, and market allocation to the

health insurance and medical malpractice industries? Is there a reason that would help the consumers to have those exemptions?

Ms. VARNEY. Well, Senator, I think historically there was a view that you had to be able to share risk and loss data over time in order to come up with future projections. I think that concern is largely alleviated now because in many, many industries, as Senator Reid noted, you can absolutely share historical data, and so long as you are sharing it on a blinded basis, you can use it to project future trends.

So I do not think that the reasons that were in existence in 1945 are still very viable to justify this exemption.

Chairman LEAHY. A lot of industries share safety data, for example, do they not?

Ms. VARNEY. Yes, they do.

Chairman LEAHY. The legislation I introduced, the Health Insurance Industry Antitrust Enforcement Act, only repeals the McCarran-Ferguson exemption for what I think we would all agree are egregious violations of the antitrust laws—price fixing and bid rigging and market allocation. Why would somebody object to that?

Ms. VARNEY. I do not know that they would, Senator. I certainly would not.

Chairman LEAHY. The insurance companies apparently do, according to what Senator Reid and others have said.

Ms. VARNEY. Well, again, I think that it is time for everybody to realistically assess how you can share information. We see it in many, many industries. There is no prohibition in the antitrust law on sharing historical data. There is no prohibition on coming up with future trend projections, so long as it is blinded so you cannot tell whose data are whose. And it happens across the board. It happens in the lumber industry, in the paper industry, in the safety industries. Law firms share historical data to project the future. I mean, data sharing is a well-recognized undertaking that, when done appropriately, when you are not talking about fixing price, when you are not talking about allocating markets, is absolutely permissible under the law.

Chairman LEAHY. Your State colleagues, State Attorneys General—I mentioned the resolution which I put in the record from the National Association of Attorneys General, and they have expressed their support for the repeal of McCarran-Ferguson. Now, how do you go about working with them? How does the Federal Government, the Attorney General's office, how do you work with other attorneys general in the States on anticompetitive antitrust matters?

Ms. VARNEY. Well, we work very closely. I was just last week in New York at a meeting of several of the Attorneys General where we were outlining areas that we could beneficially work together. One I think we are all interested in, particularly you, Senator Kohl, is agriculture, and in any area where the State Attorneys General are the front line of what is happening to consumers, that is an area where we can work very closely with them. There is a long tradition of something called "multi-state task force," where several attorneys general can come together and agree with the Department of Justice that we will coordinate an investigation or a prosecution, share data, share resources. Oftentimes, the States

like us to take the lead because we may have more resources. Other times, particular States may have more expertise, and we will support them. But we work very closely with the State attorneys general, and this is an area that we would work closely with them.

Chairman LEAHY. I see a high concentration, I see a lack of competition in the medical insurance market. You cannot look at that today because of the antitrust exemption. If the antitrust exemption was removed, is that something that would at least have inquiry or review by the Department of Justice?

Ms. VARNEY. Yes, Senator, I am also aware that in several regions there is a very high concentration, and as we have talked about before, in any industry where you see significant concentration, whether it is regionally or nationally, you want to look very carefully at what are the competitive effects of such concentration, so yes.

Chairman LEAHY. Thank you.

Senator Kohl.

Senator KOHL. Thank you very much, Mr. Chairman.

Ms. Varney, according to the AMA, in the past 12 years out of 400 health insurance mergers, the Justice Department challenged only two. At the same time, health insurance premiums have risen 120 percent over the past decade. Many industry observers blame sharp industry consolidation for these rising premiums.

Do you believe that antitrust enforcement officials could have done more to prevent health insurance industry consolidation? And what is your view of the record of antitrust enforcement in the health insurance industry in recent years?

Ms. VARNEY. Well, Senator, clearly there is significant concentration in the health insurance market in certain regions. As you know, I have been at the Division just 6 months, and I was not involved in any of the prior reviews of health insurance mergers, so I cannot comment specifically on why they were let through or why they were not challenged.

I can say that as we continue to look in very concentrated markets, there is real cause for concern when you are reducing competition in those markets. On the other hand, there are some geographic markets which are very competitive, where there are multiple players, and you may see a case where you have a smaller insurance company that may not be able to compete effectively where there is robust competition.

So there can be reasons why you might see an acquisition, but certainly particularly in areas of high concentration, I would be very skeptical that there would not be a reduction in competition.

Senator KOHL. Ms. Varney, dairy farmers across our country are facing acute economic pain, as I am sure you are well aware. They are being battered by a "perfect storm" of high input costs and historically low dairy prices. They have lost more than $4 billion in their equity. Their stories are compelling and painful, and we clearly have to find a better system.

As you know, there is a lot of complexity in dairy markets, and there is growing concern that concentration and consolidation on the processor side is hurting dairy farmers a lot.

Some time ago, you and the Secretary of Agriculture announced a series of workshops to look specifically at antitrust in agriculture. I would like an update on your progress and a commitment that at least one of your workshops will delve specifically into dairy issues. Hopefully a workshop of that sort might occur in the State of Wisconsin. I would like some comment from you on that issue as well.

Ms. VARNEY. Absolutely, Senator. Well, we actually went to Vermont a few weeks ago—although Vermont was a field hearing of this Committee, and talked with the dairy farmers there and began to get a real understanding of the reality of their day-to-day life and how difficult it is to maintain their farms.

We are starting our own field hearings early in the spring with the Secretary of Agriculture. This has never been done before that the Department of Justice and the Department of Agriculture have jointly examined concentration in the agriculture industry. We are, of course, looking at dairy. It is at the top of our list. For dairy farmers I met in Vermont, it was so clear to me that they needed action; otherwise, they were not going to be able to stay in business.

So we will be in Wisconsin. We will be looking at dairy. I will keep you fully apprised of what we are finding. And, of course, I cannot comment on whether or not we have any investigations ongoing.

Senator KOHL. Well, it is good to know that you will be out in Wisconsin with a field hearing.

Ms. VARNEY. I will.

Senator KOHL. Ms. Varney, at your confirmation hearing, we discussed my bill to eliminate the wholly unwarranted antitrust exemption enjoyed by the freight railroad industry.

Ms. VARNEY. Right.

Senator KOHL. Because of this exemption, rail shippers have been victimized by the conduct of dominant railroads and have no antitrust remedies. Higher rail shipping costs are passed along to consumers, resulting in higher electricity bills, higher food prices, and higher prices as well for manufactured goods.

I was pleased that you stated at your confirmation that you support the bill, but we have asked the Justice Department for a letter in support of our railroad antitrust bill now for more than a year. Can we expect such a letter from the Department soon?

Ms. VARNEY. Well, as you know, Senator, the administration has not yet taken a position on any particular antitrust exemption bill, and they have not taken a position on the railroad bill. I continue to be very interested in this matter and continue to talk with your staff and the Committee staff about this issue, as well as bring it to the attention of everyone in the administration who is considering these issues.

Senator KOHL. Thank you so much, and thank you, Mr. Chairman.

Chairman LEAHY. Thank you very much.

Senator Feinstein.

Senator FEINSTEIN. Thank you very much, Mr. Chairman. I would like to just indicate my very strong support for your bill.

I am deeply concerned about the medical insurance marketplace. I believe it lacks a moral compass. I believe what has happened in my State is untenable, and let me say a little bit about what I think has happened.

Two large health insurers—namely, Anthem Blue Cross and Kaiser Permanente—now control 58 percent of the market in the entire State. In smaller markets, like Salinas, the top two companies control up to 80 percent of the market. In the last 8 years, profits of the publicly owned medical insurance companies have increased, I understand, around 428 percent while premiums have escalated dramatically, doubling all across the State.

I cannot tell you how many times when I go home people come up to me and say, "I just got a 20-percent increase in my premium. I cannot handle it. Last year I had a 10-percent increase." And the fact of the matter is, you know, as you get older, most people have some condition or another. So premiums are out of hand. I think CEO salaries are out of hand. I think administrative costs, running about 23 percent, are out of hand.

My bottom-line belief is that the health care medical insurance industry should be nonprofit in the United States, and the more I read about other countries, the more this view is supported in my own mind.

To me, this bill is one small step we can take to send a very loud signal to the medical insurance industry that times have got to change. People cannot absorb it, and particularly in my State. I think this bill really is necessary. I think it is a bill whose time has come. I hope we pass it very speedily. And, Ms. Varney, I hope your Department takes a very, very affirmative position.

I can speak for a State that is almost 40 million people now. Health care costs are high. Premium costs are out of sight. And we have got huge unemployment. So it is a highly concentrated market any way you look at it.

So I would just like, Mr. Chairman, without asking any questions, to say I am 100 percent behind this bill, and I thank you.

Chairman LEAHY. Thank you, and if that is a problem in a State as huge as California, you can imagine what it is like in a small State like mine or others.

Senator Feingold is not here. Senator Whitehouse.

Senator WHITEHOUSE. Mr. Chairman, may I yield to the Assistant Majority Leader who is with us?

Senator DURBIN. Go ahead.

Senator WHITEHOUSE. Are you sure? All right.

Chairman LEAHY. That is going to cost you later on, but go ahead.

[Laughter.]

Senator WHITEHOUSE. Ms. Varney, the AMA has calculated that 94 percent of metropolitan areas have a health insurance market that is highly concentrated—which is a term of art—highly concentrated according to Department of Justice standards. In 39 States, two health insurers control at least half of the market, 39 out of 50. You have effectively a duopoly for the majority of the market. And in nine States, a single insurer controls at least 75 percent of the market. Really an effective monopoly.

When you hear those numbers and you measure them against the Department of Justice's standards for what is a competitive versus a noncompetitive market, what is your reaction? And what does having a market be deemed by the Department of Justice to be "highly concentrated" mean?

Ms. VARNEY. Well, Senator, whenever you see concentration numbers like the ones you just mentioned, we are deeply concerned because the higher the concentration, the less competition. When you do not have competition, you do not get the best price, you do not get the best output. So we are always concerned in any industry, including insurance, when you see those levels of concentration.

At the moment it is the State attorneys general and the State insurance commissioners that would have to examine any behavior in a highly concentrated market, and we would welcome them to do that. Should we have the authority, we would, of course, closely examine those markets where there is such high concentration.

Senator WHITEHOUSE. Were you to have the authority, what would it mean that those 94—essentially every metropolitan area in the country is deemed "highly concentrated."

Ms. VARNEY. Well, I think what we would probably do would be work with the State attorneys general and insurance commissioners in those markets where those on the front lines believe that there may be impermissible conduct that is keeping those levels of concentration in place.

Senator WHITEHOUSE. You were—I guess let me ask the question a different way. The best argument that I have heard for the antitrust exemption is that because an insurance company has a hard time entering a market and pricing its product if it does not have claims experience, it has to have a proxy in order to facilitate that market entry, and the proxy is ISO or, in the case of workers' compensation, NCCI, and they provide general information that allows a company that does not have claims experience to become a new entrant and in theory reduces that barrier to entry. And it also helps small insurers make that choice because they do not have the overhead to calculate rates as readily as a great big company does.

That is the best case. I am not sure it is very convincing, but I would like to hear your reaction to it.

Ms. VARNEY. I think, Senator, that is the historic case. In 1945, the state action doctrine and the rule of reason did not really exist. State action doctrine was barely developed. So I think today it is clear in multiple industries across many, many sectors of the economy, there is no prohibition on sharing historic data.

Senator WHITEHOUSE. So long as you engage with the State and get clearance that it is not, in fact, anticompetitive, and that is an established process and procedure.

Ms. VARNEY. You can share historic data as long as you do it carefully, you are not in any small closed rooms setting prices, allocating markets. Many industries—in fact, that is a service that many trade associations offer their members—they take the data in, they strip it of any identification so it becomes blind data. They aggregate it, and get historical data.

You can use that data to project future trends. That is completely permissible under the antitrust laws.

Senator WHITEHOUSE. And when they do that, if they want to come to the Department of Justice to get clearance, do you——

Ms. VARNEY. We give them what is called a "business review letter." We work with them so that they understand the parameters of how they can do this. We then set out our views in what is called a business review letter that explains what they can do.

Senator WHITEHOUSE. And if they rely on the business review letter, they are protected against——

Ms. VARNEY. I would generally protect them against Government enforcement.

Senator WHITEHOUSE. Very good. Thank you very much.

Thank you, Mr. Chairman.

Senator KOHL. [Presiding.] Thank you very much.

Senator Feingold.

Senator FEINGOLD. Thank you, Mr. Chairman. I will make a few comments, and I will just have a question for Ms. Varney.

The antitrust laws enacted in the early 20th century provide essential protections for consumers and businesses, and I also believe that those protections should apply to Americans buying health and medical malpractice insurance. As Congress debates the cost of health care, it is very much worth noting that purchases of these insurance policies are particularly susceptible to industry collusion leading to inflated prices. But under current law, health and medical malpractice insurance providers are exempt from the Federal antitrust regulations. This is because, as we all know, the insurance industry was given a statutory exemption from antitrust laws over 60 years ago by the McCarran-Ferguson Act antitrust laws.

Since McCarran-Ferguson was enacted, it has become clear that health and medical malpractice insurers have abused this exemption to the detriment of patients and doctors everywhere. Industry-specific antitrust exemptions are rarely justifiable. And if there is a good reason to maintain the current exemption for these parts of the insurance industry, I certainly have not heard it.

Simply put, because of the insurance exemption, a competitive market for health and medical malpractice insurance does not exist. In 26 States, a single insurer covers at least half of the population. In 39 States, two insurers control more than half of the insurance market. A recent survey by the American Medical Association found that most metropolitan areas have a highly concentrated commercial market for health insurance.

Now, this lack of competition has hurt both patients and doctors. While market-dominating health insurance companies have made record profits, basic coverage has become unaffordable for millions of Americans. And in Wisconsin, the price of health insurance premiums for families and individuals has doubled over the last 10 years. If current trends hold, family health insurance for a Wisconsin family will consume 46.2 percent of the projected median family income in 2016. In addition, doctors around the country are suffering as medical malpractice insurance providers profit from premiums that are not commensurate with the cost of claims.

Without thorough competition, patients and doctors have little choice but to continue paying whatever premiums the dominant insurers in their market decide to charge, so addressing this problem is crucial to health care reform and does require legislative action

to ensure that health and medical malpractice insurance companies do not engage in anticompetitive behavior.

Although insurance companies have certain informational needs, there is no reason to exempt them from the regulation of the most harmful anticompetitive practices. Without a repeal of the antitrust exemption, insurance companies will continue to have the power to gouge patients and doctors.

So I am also pleased to cosponsor S. 1681, Chairman Leahy's bill, to fix this problem, and I want to commend him for holding this hearing. And I also want to thank Assistant Attorney General Christine Varney for appearing here today and for all her outstanding efforts thus far to revitalize and reinvigorate the Department of Justice's Antitrust Division.

Ms. Varney, you promised me at your confirmation hearing that you would take a very serious look at what has been going on in the agriculture industry, which obviously I have been concerned about for years. You have been true to your word, and I want to personally thank you on behalf of my constituents. I hope the plans by the Departments of Justice and Agriculture for a series of joint workshops next year will be followed by similar partnerships with other agencies that have critical oversight roles, such as the Commodity Futures Trading Commission and the FTC. And, of course, I also can think of no better place for a workshop on dairy than Wisconsin. I am so pleased that Senator Kohl raised this with you and you indicated that there would be one held there.

One question. Given your extensive background in antitrust enforcement, how do the health insurance and medical malpractice insurance industries compare to other industries that you have examined in terms of market concentration? In your view, are there serious imbalances in the marketplace for these products that need to be addressed?

Ms. VARNEY. Well, Senator, we have not undertaken a thorough evaluation of the price effect of concentration. I know many others have, and we carefully monitored those studies. I think it is a logical result that when you have the levels of concentration that you see in the insurance industry, you generally do see prices rising, often at a higher rate, as Senator Feinstein mentioned, than other sectors of the economy.

Senator FEINGOLD. Thank you, and thank you, Mr. Chairman.

Senator KOHL. Thank you very much, Senator Feingold.

Senator Kaufman.

Senator KAUFMAN. Thank you, Senator, and I want to thank Chairman Leahy, first, for putting this bill in and, second, for holding these hearings today. I am pleased to see Ms. Varney here. I think that you are getting a chorus from members here about our unhappiness with what is going on in terms of antitrust over a whole series of years, and I think, as I said at your confirmation, you are a perfect choice for this to get this straightened out. And my feeling is there is a new sheriff in town and we are going to go after a lot of these things that go on, which have been eloquently presented by other members.

Let me ask you a question about how important you think it is that we include an antitrust savings clause in any health care legislation that we pass.

Ms. VARNEY. Well, I think that the administration is working closely with the committees on the details that need to go into any final bill, so I think we need to look at the bill as a whole so we understand what language and what standards will be appropriate.

Senator KAUFMAN. But you think that is important.

Ms. VARNEY. Very important.

Senator KAUFMAN. Good. The second thing is: What have you done to change the deliberative process in the Antitrust Division to let various stakeholders participate in the process?

Ms. VARNEY. Well, we went up to Vermont, to start. We participated in a Senate Judiciary field hearing with the dairy farmers in Vermont. We are undertaking the field workshops with USDA to hear from all sectors of agriculture. We also have announced recently that we are reviewing our merger guidelines, so we will be working with all sectors of industry and consumers on whether or not we are completely transparent in the way that we are doing merger reviews. So we are trying to bring everybody into the process.

Senator KAUFMAN. Great. What is the biggest challenge—I mean, I have not had a chance to ask you this. What is the biggest challenge since you took over the Division?

Ms. VARNEY. Trying to find enough hours in the day to get everything done that we want to get done.

Senator KAUFMAN. Good. And, finally, I know last week the United Kingdom Competition Commission blocked a proposed merger of Live Nation and Ticketmaster, and you have a thing underway. Can we expect a decision somewhat soon in that case?

Ms. VARNEY. You know, we cannot comment on any ongoing investigations, but we take our charge seriously, and when we get to the end, we will get to the end.

Senator KAUFMAN. Great. Thank you.

Thank you, Mr. Chairman.

Senator KOHL. Thank you very much.

Senator Franken.

Senator FRANKEN. Thank you, Mr. Chairman.

Ms. Varney, there is a recent case in which Anthem Health Plans, a subsidiary of WellPoint, is suing the State of Maine. The company argues that the State must guarantee them a 3-percent profit margin, even though this margin would result in an 18.5-percent premium increase on 12,000 individual policy holders.

I am not aware of any industry that is entitled to any guaranteed margin of profit. Are you?

Ms. VARNEY. No, I am not, Senator.

Senator FRANKEN. OK. The average individual Maine health insurance consumer is paying four times as much today for health care as they did 10 years ago. Do you believe the fact that Anthem controls nearly 80 percent of the insurance market in Maine has fostered this company's I guess brazen behavior at the expense of beneficiaries' pocketbooks?

Ms. VARNEY. Well, Senator, when you do not have to compete, you can get pretty big profit margins so, yes, if you have got that kind of market share.

Senator FRANKEN. Let me ask you something that I do not—it is a good kind of question because I do not know the answer to it.

Sometimes you hear folks say, well, we should open up the insurance market, you should be able to buy insurance in any other State. And I know that in Minnesota, for example, we have basic standards for which, you know, insurance companies have to meet in order to do business in Minnesota, and the danger is that you would get—you know, this would get rid of all the standards, and so you would not know what you were buying.

Ms. VARNEY. Right.

Senator FRANKEN. Does the fact that McCarran basically gives States the jurisdiction over antitrust, does that complicate the issue of if you were to allow people to buy insurance across State lines? Does that make it——

Ms. VARNEY. I do not think, Senator, that it makes it more complicated. I think States can still take and should take a primary role in determining what is required to do business in their State when it comes to offering insurance products. At the same time, that does not need to preclude any insurer's ability to be reviewed under the Federal antitrust laws. I think they are consistent.

Senator FRANKEN. That is not what I am asking. I am saying that if you did not change this, if you kept this the same, would that have any effect over the concept of being able to buy plans from other States? So, in other words, there was no Federal regulation over at least the antitrust part of insurance companies, in addition to all the other issues in terms of what is covered and what is not covered and those kind of standards, does this also complicate that notion of getting insurance products from other States, health insurance products?

Ms. VARNEY. You know, Senator, I am not familiar with the complexities that you are describing. I would like to look into it and maybe get back to your office with a view of how that would work, how it might work.

Senator FRANKEN. OK. I personally hear this a lot about, oh, well, you should be able to buy insurance products from—you know, we should deregulate it so you could buy insurance products from all over the place. But in Minnesota, there is well-baby care. There are other kinds of things—shots for babies that are covered that are not covered in other States. And I just do not want to lower our standards, and any insurance company that operates—that wants to operate in Minnesota can just simply meet our standards. There are no barriers to that.

Ms. VARNEY. And I do not think that what we are talking about today would change that. I think States would still be entitled to and should set the standards for doing insurance business in their State. But let me have a look at it in a little bit more detail.

Senator FRANKEN. Yes, what I am asking is, if you continue McCarran, would it be an argument against buying insurance products from other States, health insurance products.

Ms. VARNEY. Yes, let me get you a thoughtful analysis.

Senator FRANKEN. OK. Thank you. I appreciate that.

Thank you, Mr. Chairman.

Chairman LEAHY. Thank you.

Senator Durbin.

Senator DURBIN. Thank you very much, Ms. Varney. And so when the health insurance industry tells us Monday night, "We are

raising rates; premiums are going up," they can kind of say that with some authority, because if they decide to come together and fix prices, for example, allocate markets, any other company might be brought to court for it saying you have violated antitrust. But a health insurance company under McCarran-Ferguson would not be subject to Federal prosecution, would they?

Ms. VARNEY. They would not, Senator.

Senator DURBIN. It puts it in perspective for a lot of us, incidentally, who support a public option and think that they need real competition to keep them honest on this.

I want to go into the medical malpractice insurance area because it has been a topic during this health care reform debate. And I do not know how familiar you are with this market, but here is an insurance market that I think raises some serious questions.

According to the National Association of Insurance Commissioners, in 2008 medical malpractice insurers had $11.2 billion in direct premiums written, paid out $4.1 billion in losses—in other words, $7.1 billion more in premiums than paid out in tort claims. About $2.1 billion went for defense and cost containment, but that left them $5 billion at the end of the day.

Also, between 2003 and 2008, the same data shows that the total losses paid out by medical malpractice insurers decreased by over 50 percent, from $8.4 billion to $4.1 billion, while premiums, direct premiums charged, actually increased during that period of time from $10.6 billion to $11.2 billion.

Do you believe that lack of competition in the medical malpractice insurance industry is enabling insurers to overcharge policy holders and pocket more money?

Ms. VARNEY. Senator, in any region where there are the levels of concentration we have been talking about today, there is very little incentive to compete on price. So the more competition you can get into those markets, the better price you are going to get and the better quality product you are going to get.

Senator DURBIN. And isn't that at the basis of our antitrust law?

Ms. VARNEY. It certainly is.

Senator DURBIN. Competition.

Ms. VARNEY. Yes, sir.

Senator DURBIN. And this industry has been exempt from that basic requirement. In the next panel, Dr. Powell is going to say that he believes McCarran-Ferguson "increases competition by promoting the characteristics of competitive markets." And he goes on to say, "From all indications, the law has been remarkably successful in achieving this objective."

Ms. Varney, do you have any comment or response?

Ms. VARNEY. I have not seen Dr. Powell's testimony, but in my testimony I have referenced several studies that evaluate the cost impact of McCarran.

Senator DURBIN. Do you believe health and medical malpractice insurance markets in America are competitive?

Ms. VARNEY. I think they are highly concentrated in many geographic regions. In any region where you see the levels of concentration that we have been discussing here today, I certainly do not think they are competitive.

Senator DURBIN. The loss ratio in medical malpractice insurance in 2008 was 36 percent, according to A.M. Best, significantly lower than the loss ratio for major types of property/casualty insurance. For example, in 2008 private auto liability insurance had a loss ratio of 66 percent, homeowners 72 percent, workers' comp 65 percent.

In your opinion, what accounts for the lower loss ratio for medical malpractice insurance?

Ms. VARNEY. Well, it certainly could be lack of competition.

Senator DURBIN. I think so.

Let me ask you this: In the course of this debate on McCarran-Ferguson, I am familiar with what used to exist called the Insurance Services Office. Is that still in existence—ISO?

Ms. VARNEY. I do not know.

Senator DURBIN. Well, this used to be their common meeting place for discussing rates and premiums and market allocations. That is where they came together in violation—what would have violated the antitrust laws for any other company.

Ms. VARNEY. Right.

Senator DURBIN. But an insurance company could exchange that information and parcel out the market and set their prices through their own devices.

And so in this situation, do we do any investigation of that kind of activity by the insurance industry?

Ms. VARNEY. No, we do not. Not the Federal antitrust authorities.

Senator DURBIN. Because of McCarran-Ferguson.

Ms. VARNEY. Because of McCarran.

Senator DURBIN. Well, I would say that there has never been a better time for us to address this, and the health insurance industry has thrown down the gauntlet Monday night and said, "We are going to increase premiums no matter what you do, and we are going to hold you responsible for those." And I think if there is ever a time when we need to confront what is a clear inequity in the law, it is now. Senator Leahy's bill is a good one, and I am glad to cosponsor it.

Thank you.

Chairman LEAHY. Thank you very much.

It is interesting. Somebody asked if I had scheduled this hearing as a response to exactly the ads that you stated, Senator Durbin, when they said they were just going to get together and increase premiums, which would be a violation if any other industry did it. And I said, no, actually it was coincidence. As you know, the notices scheduled this hearing some time previous, and that is why I was surprised at the ad because it makes the point so strongly.

Senator Schumer.

Senator SCHUMER. Well, thank you, Mr. Chairman. Again, I want to thank you for introducing this legislation. Again, I guess the insurance industry is stirring the pot and saying this is retaliation for them being off the reservation. Let me read the date when this legislation was introduced by Senator Leahy for himself, Senators Feingold, Cantwell, Durbin, Schumer, and Feinstein: September 17, 2009. And I believe Senator Leahy has introduced similar legislation in previous Congresses as well.

So this is a longstanding issue, and maybe because the insurance industry blundered so badly on Monday, it gives us a greater opportunity to pass it. But it has long been out there as something we care about.

Now, I remain committed to the notion that only increased competition is going to give insurers the incentive they need to keep the costs down. That is why I have been fighting for a public option to be included in health reform for months, and that is why I am proud to be a cosponsor of the important legislation Senator Leahy has produced.

Removing the insurance companies' antitrust exemption is so important that I think we should all work with Chairman Leahy to make sure that it is part of our health reform bill, the joint bill that Senator Reid will put together, and I for one am committed to helping you, Senator Leahy, make sure it is in that bill to get it done.

Now, back in 1945—this is interesting—when Congress exempted insurers from Federal antitrust laws, the insurance companies argued they needed the exemption because insurers are not engaged in interstate commerce. I want to say that again. The rationale for McCarran-Ferguson was that the insurance companies argued that they were not engaged in interstate commerce.

Well, a lot has changed since 1945. We should not be surprised to learn that 60 years later the insurance industry is one of the most highly concentrated in our economy; 94 percent of insurance markets in the U.S. are now regarded as highly concentrated by the objective definition used by the Justice Department. In nearly 40 States, two insurance companies dominate over half the market. That is not acceptable. We need more competition.

And at the very least, the onus should be on the insurance industry to come forward with real reasons why it is entitled to do things like write policy language in collaboration with so-called competitors. So far I have not seen any.

In fact, after the heavily slanted and really one-sided report that was issued by the insurance industry early this week, you have to conclude they are sort of out of arguments. Let me give an example of what this antitrust exemption does in a State like New York, which, incidentally, is probably more competitive than most of the other States, even though we are not very competitive. I was talking to contractors who hire construction workers. They only have a choice among three firms for that insurance. When there are only three firms, there is never price competition, as you point out.

But we have a for-profit insurer called United Health. It owns the very company that is called Ingenix that determines whether the price of a doctor's visit is reasonable and customary. Ingenix is not an independent group. It is a black box for consumers. And because there is no antitrust regulation, other insurers use Ingenix as well to decide what is reasonable and customary. So let me give an example.

My doctor tells me my visit with her costs $100. But WellPoint, my insurer, will only pay $60 because Ingenix, owned by United Health, tells United Health that is what the reasonable and customary rate is, and WellPoint works with United Health to set the reimbursement rate. The consumer is totally stuck and has to pay

that $40, and it is not—you know, it is clear that it is sort of not fair to have this one company owned by another health insurance company set the rates for everybody. That is one of the reasons health costs have gone up.

So true competition means true choice for consumers. It means innovation and improved service, and I want to work with—(audio failure)—certain a potential antitrust investigation should McCarran-Ferguson be lifted.

Chairman LEAHY. Do you want to respond, Ms. Varney. The red talk button should be on.

Senator SCHUMER. She speaks softly but carries a big stick.

Chairman LEAHY. We seem to—excuse me just a moment. I do want to get this in. We seem to be having some difficulty because the recorder is having trouble getting it. We will just switch machines. It is still not coming through. Hold on just a moment, and we will make sure—this does not come out of Senator Schumer's time.

You are not getting any of this. Is that right? You can hear me, but you are not getting any of the rest. It sounds like we are doing the cell phone ads, but the reporter—hold on just a moment.

Go ahead.

Senator SCHUMER. Thank you. Let me ask this: What are the steps that your Division might be able to do to—well, you have answered that one before. If McCarran-Ferguson is repealed, would there still be other barriers in the way in terms of antitrust law to reduce competition?

Good. So it sort of would be a pretty complete solution. OK. Thank you, Mr. Chairman.

Chairman LEAHY. Thank you very much. We will put other questions for Ms. Varney in the record, and we will take a 5-minute break, and we will switch for the next two witnesses. And I would also ask the staff to double-check those microphones in the meantime.

Ms. Varney, thank you very much. I do want to just note—thank you one more time for coming to Vermont for the hearing. I know that was a very long hearing. Many, many people have taken the time to come up to me in Vermont who were there and say how impressed they were with your understanding of the issues and the fact you listened. They realize you have to make up your own mind on what you are going to do, but they were impressed that you took the time and listened to them. So thank you very much.

Ms. VARNEY. Thank you.

[Recess 11:28 a.m. to 11:33 a.m.]

Chairman LEAHY. We are going to have to move along. The first witness is J. Robert Hunter. Mr. Hunter is the Director of Insurance for the Consumer Federation of America. He serves as a consultant on public policy and actuarial issues. He has extensive experience working on these issues. He served as a Federal Insurance Administrator under Presidents Ford and Carter as well as the Texas Insurance Commissioner. He received the Secretary of Housing and Urban Development's Award for Excellent Service for his work between 1971 and 1977, and the Consumer Federation's Esther Peterson Consumer Service Award for Lifetime Service in 2002.

Mr. Hunter, please go ahead.

STATEMENT OF J. ROBERT HUNTER, DIRECTOR OF INSURANCE, CONSUMER FEDERATION OF AMERICA, WASHINGTON, D.C.

Mr. Hunter. Thank you, Mr. Chairman. Oh, that is working. Good morning. CFA offers our wholehearted support to your legislation, Mr. Chairman, S. 1681, because it is time that health insurers played by the rules of competition as the rest of the commercial enterprises in America do. In fact, we wish you would go beyond it and repeal the antitrust exemption completely for not only health insurance but the entire insurance industry at some point. But this is a great first step.

Consider the following anticompetitive activities:

Cartel-like bureaus, such as ISO, day after day produce price guidance on 70 percent of the rate that many insurers use as the basis for the pricing, including medical malpractice guidance. Rate bureaus manipulate data and project pricing into the future using steps legal experts have told Congress would be illegal absent the McCarran immunity. This is particularly bad for lines of insurance, like medical malpractice, where the bureau rates exacerbate the spikes in prices during hard market periods and generally lead to overpricing.

Rate bureaus have cartel-like control of rate making data. They use it to establish classes and territories that are used to rate people and data are collected in that format, enforcing significant uniformity.

Bid-rigging, market allocation arrangements and hidden kickbacks to brokers were uncovered by then Attorney General Spitzer showing that even the largest, most sophisticated buyers are victims of anticompetitive acts. The potential for such abuses in health insurance must be removed.

But perhaps none of what we have learned recently is as outrageous as the use of claims systems that artificially create "savings" for insurers by underpaying claimants. For example, when patients use non-network doctors, their insurance company agrees to pay 70 percent to 80 percent of the "reasonable and customary" charges for a given medical service in the same geographic area. If the doctor's bill is higher than that rate, the patient must make-up the difference or the doctor must settle for less. The use by many health insurers, like Aetna and United Health, of recommendations produced by Ingenix, a subsidiary of United Health, to place reasonable and customary limits on benefits, led to underpayment of health insurance benefits to claimants in New York state of between 10 and 18 percent, according to findings on the New York Attorney General Cuomo. If health insurers collude on benefit levels, they certainly can collude on price, markets and other aspects of their business.

A computerized claims system called Colossus has underpaid consumers by billions of dollars by allowing insurers to tune their claims payment recommendations to produce "savings" on claims of those with medical injuries from auto accidents. I have forwarded shocking, recently unsealed documentation of this massive, and apparently coordinated, abuse to you, Mr. Chairman. While lawsuits

have begun to mitigate the damage to consumers from Colossus for first party auto claims (like uninsured motorists) for some insurers, the much larger use of the product is in third party bodily injury liability, where the use of the product, we believe, continues unabated.

We urge this Committee to look into the Inginex use by major health insurers and also into Colossus User Groups and other ways that insurers have worked together to create a way to underpay America's insurance consumers billions of dollars in claims. Ingenix costs consumers 10 to 28 percent of claims and Colossus has resulted in underpayments of double digits as well. Certainly antitrust exemptions are not intended to shield this sort of scandalous joint activity.

We heard today that small insurance companies would not be able to obtain historic data for the development of their prices if the antitrust laws were applied to insurance. I have carefully studied this claim for decades (the large insurers always rush forward to protect the small insurers from the free market and save themselves from competition as well) and there is absolutely no evidence for this claim. Legal experts have testified, including today, that procompetitive activities such as collection and dissemination of historic data would be legal under the current antitrust laws. What would end is what they do with the data, which is jointly manipulate it to figure out what the prices are going to be that they will charge in the future.

It is true that some companies might have to hire some additional actuarial service to replace the joint actions, and if a State wanted to replicate some process such as joint trending, it could do so under state action doctrine. But the difference would be that the State would have to be actively involved in regulating it instead of today where all you need is a law on the books and not even effective regulation. This would be a great step forward for consumers since today many States provide very little oversight. It is time, Mr. Chairman, for your bill to be adopted.

[The prepared statement of Mr. Hunter appears as a submission for the record.]

Chairman LEAHY. Thank you very much, Mr. Hunter.

Our next witness, Mr. Powell, holds the Whitbeck-Beyer Chair of Insurance and Financial Services at the University of Arkansas at Little Rock. His primary research interest is the effects of regulation on insurance markets. In addition to his academic pursuits, he serves as Treasurer on the board of Arkansas Mutual Insurance Company, a physician-owned medical professional liability insurance carrier founded in 2008. He has his bachelor's degree from the University of South Carolina and his Ph.D. from the University of Georgia.

Mr. Powell, sorry for all the confusion here, but glad to have you here, sir. Please go ahead.

STATEMENT OF LAWRENCE S. POWELL, PH.D., ASSOCIATE PROFESSOR AND WHITBECK-BEYER CHAIR OF INSURANCE AND FINANCIAL SERVICES, UNIVERSITY OF ARKANSAS-LITTLE ROCK, COLLEGE OF BUSINESS, LITTLE ROCK, ARKANSAS

Mr. POWELL. Thank you, Mr. Chairman and members of the Committee. It is truly an honor to be invited here to discuss these important topics. As you said, my name is Lawrence Powell, and I currently hold the Whitbeck-Beyer Chair at the University of Arkansas-Little Rock. I am also a founding board member of Arkansas Mutual Insurance Company, which is a physician-owned insurer offering medical professional liability coverage.

I want to briefly address two issues relevant to this topic: First, that insurance pricing is an inherently difficult task. Repealing the McCarran-Ferguson Act would further exacerbate this difficulty. And, second, that the limited antitrust exemption provided by McCarran enhances competition in insurance markets. To repeal McCarran would at best maintain the status quo in the near term, but going forward, it would stifle competition to the detriment of consumers.

Pricing insurance is very difficult because the price has to be set before all of the costs are known. And the difficulty is amplified for medical professional liability insurance because of its long claim tail. On average, an insurer does not know the ultimate outcome of a claim until more than 4 years after the potential loss event.

Losses also follow distinct trends over time. The trend of claim frequency has reversed a few times in recent decades, leading to substantial mispricing in certain periods. It is clear and intuitive to recognize this possibility given the time lag between suspicion and confirmation that a trend has reversed. Therefore, these inflection points have brought about infrequent temporary pricing and return anomalies in this line of coverage.

In some years, ultimate losses differ from initial estimates by more than in other years, but overall, the sum of the initial estimates and the ultimate losses are remarkably similar, differing by only 5 percent in the last three decades or so.

In practice, McCarran permits insurers to pool data through independent statistical agents that produce advisory loss costs to eight insurers in the ratemaking process. This benefits consumers by promoting financial strength, efficiency, and competition in insurance markets. The ability to pool loss cost data through independent statistical agents is——

Chairman LEAHY. Excuse me, Mr. Powell. You understand this bill would do nothing to stop removing the McCarran-Ferguson exemption in this context. It would not stop—or prohibit companies from sharing the loss information.

Mr. POWELL. Well, my understanding is that it is currently permitted to be done that way under McCarran and that we have known that for more than six decades.

Chairman LEAHY. But as Assistant Attorney General Varney testified, this kind of sharing, blind sharing, would be allowed.

Mr. POWELL. My understanding—and I am not an attorney. My understanding is that while it could be permitted, the companies would have to file for permission to do so. It would introduce addi-

tional costs as opposed to standing on the precedent that has been around for 60-some years to increase that cost for no benefit. I can come back and address this in the remainder of my remarks.

So as I was saying, I think this benefits consumers by promoting financial strength, efficiency, and competition, and the ability to pool these data are most important for extreme risks. These include very large and infrequent losses and new exposures to loss. So should the underlying distribution of losses change as a result of new medicine, new disease, or new liability, insurers that currently rely largely on their own past loss data would again benefit from advisory loss costs. Any of these scenarios would introduce substantial new uncertainty to insurance markets, increasing the price of insurance.

The current markets enjoy several characteristics that benefit consumers. First, consider the ownership structure of medical professional liability insurers. Approximately 60 percent of U.S. private physicians are insured by physician-owned companies. To believe that these companies are price gouging physicians, we must first reach the flawed conclusion that policyholders are price gouging themselves.

Medical professional liability markets in the United States also exhibit substantial competition, suggesting that additional antitrust measures would not benefit consumers. Nearly 3,000 companies currently sell property and liability insurance in the United States. Of these, a few hundred participate in medical professional liability coverage. While a few hundred insurers are clearly adequate for competition, it is also instructive to consider that more than 2,000 other existing companies could potentially enter the market. Finally, it is also possible to form a new company to compete with existing insurers.

Next, consider the absence of sustained profit we would expect if markets were not competitive. While return for medical professional liability insurers fluctuates substantially over time, the average return is quite modest and has even been negative in several years.

Shifting now to my experience in the industry, I participated in the recent formation of Arkansas Mutual Insurance Company, which entered the medical professional liability insurance market earlier this year. The ability to access industry loss data was paramount in the formation of this new insurance carrier. Without access to loss information, we could not have done it. Therefore, it follows that this bill would have limited competition from Arkansas Mutual and from several dozen similar insurers that formed in recent years.

Since Arkansas Mutual commenced business, I have witnessed firsthand an incredible level of competition in the market. The number of insurers actively underwriting medical professional liability insurance in Arkansas has increased several times over. In the last year, I have seen decreases in premium for some physicians as large as 40 percent, and this aggressive pricing and increasing number of market participants indicates substantial competition to the benefit of consumers.

In light of these observations, the best possible outcome from repealing McCarran is continuation of the status quo. However, it is

also likely that repealing McCarran would have negative consequences for consumers by decreasing competition and accuracy in insurance pricing.

Thank you.

[The prepared statement of Mr. Powell appears as a submission for the record.]

Chairman LEAHY. Thank you. Is there anything in this specific legislation that would prohibit procompetitive functions by the insurance companies? Anything that we prohibit that is actually procompetitive?

Mr. POWELL. The wording of this legislation—and, you know, wording of legislation is not my area of expertise, but it seems that specifically there is not a lot going on. It would be nice to see a lot of the terms defined as to what specifically the legislation——

Chairman LEAHY. Is it stopping any procompetitive activities by any insurance company? Procompetitive activity by the insurance company. Because I could not find any.

Mr. POWELL. Well, just that the idea that it is going to be reconsidered, the idea that if there is—recognizing that the sharing of data to set advisory loss costs is a procompetitive act.

Chairman LEAHY. And we allow the historic loss data sharing.

Mr. POWELL. And to that extent, if it is allowed, if there is not a new consumer of it, if it is not changing at all, then it would, I assume, continue the status quo. There is not anything in this legislation that is not already illegal just by State law as it is. I have not witnessed or found evidence of any of this price fixing and such that it is noted.

Chairman LEAHY. That sounds almost like an endorsement of the legislation, but I will not put those words in your mouth because your employer may not be happy with you if that were the case. Only because of the time I am going to yield to Senator Whitehouse for questions.

Senator WHITEHOUSE. Thank you, Chairman. I have a question for Mr. Powell and then a question for Mr. Hunter.

My question for Mr. Powell is whether in your testimony you cite for the proposition that insurance markets are highly competitive an article by Paul Joskow. Do I have the date of that article correct, it is 1973?

Mr. POWELL. I believe so.

Senator WHITEHOUSE. And so necessarily any of the data on which that article would rely for that conclusion would be pre-1973 data, correct?

Mr. POWELL. For that article, I would suppose it is. There are also some more recent studies cited in——

Senator WHITEHOUSE. But the one you cite is the 1973 article.

Mr. POWELL. I also cite two of my own studies earlier in the testimony that are much more recent.

Senator WHITEHOUSE. Very good.

Mr. Hunter, first of all, thank you for your long efforts on behalf of insurance consumers in these vineyards. I very much appreciate the dedication that you have shown to this issue over so many years of service. One observation that I come across in this is kind of in the category of good for the goose, good for the gander.

In Rhode Island, we have seen situations in which, when doctors try to get together to strategize about how they are going to deal with the dominant insurers in Rhode Island, they are constrained from doing so by the fear or the threat of antitrust litigation being brought against them.

The insurance company, by virtue of being a big corporation with a huge market share, can have anticompetitive conversations about how to deal with the doctors in its own board room, in its own hallways. And when the doctors try to get together to have the exact same conversation about the insurance company strategies and how to respond, for them it is an antitrust violation. For the insurance companies it is not because they are protected by their corporate status. And over and over again there are cases in which insurance companies—here is *Blue Cross and Blue Shield United of Wisconsin* v. *Marshfield Clinic*, and there are many others in which—United Healthcare brought a price-fixing claim against the practices of a large Chicago area health system.

Does it seem incongruous to you that an industry that demands protection from the antitrust laws is so quick to take advantage of those very same antitrust laws that they think should not apply to them when it comes to beating down doctors and trying to make sure that they maximize their competitive advantage in terms of provider negotiations?

Mr. HUNTER. Well, of course, they are going to use whatever they can, but it is awful that they—I have to press the button here. Sorry. It is awful that the insurance companies are operating in a system where they are the only ones essentially that can get together and decide what to do while the people they are going to do it to cannot. And I think that is wrong.

Senator WHITEHOUSE. Just sort of a basic element of plain old fair play, isn't it?

Mr. HUNTER. Exactly. And, amazingly, if you go back—and I gave you the history of the McCarran Act—Claude Pepper got up on the floor when the McCarran Act was passing and said—because it came back from a joint committee. When the Senate sent it over, it was clearly a 2-year moratorium for antitrust enforcement to give everybody a chance to figure out how to deal with it, the States and the industry. So they sent it back to the Senate, and Pepper got up on the floor and said, "Wait a minute. This looks like the language has changed like it is going to be permanent." And McCarran reassured Pepper, "He is in error on his whole premise in the matter." And then Senator O'Mahoney told him why it would be over in 2 years. "Don't worry. It is over in 2 years." And then they voted. And even at that, I think it was like 30 people said, "We are afraid of the language" and voted the other way. And then the courts ruled against what the assurances were. I guess they did not use legislative history too much when they made those rulings.

Senator WHITEHOUSE. Thank you very much.

Chairman LEAHY. Senator Franken, then Senator Durbin, and I would note that the vote has started on the floor.

Senator FRANKEN. Mr. Powell, in your testimony you outlined four characteristics of competitive markets, in your written testimony: one, multiple independent sellers; two, multiple consumers;

three, homogeneous products; four, low barriers to entry and exit into the market.

In numerous States, nearly 90 percent of the health insurance markets are dominated by a single carrier. Do you believe having 90 percent of a market dominated by a single insurer meets your definition of a competitive market?

Mr. POWELL. Well, first I will say that I am not aware of that 90-percent number. I will take your word for it for purposes——

Senator FRANKEN. This is post-1973.

[Laughter.]

Mr. POWELL. Thank you. Thank you. I think something that is instructive that no one has mentioned today as we talk about competition is that market concentration is not necessarily by itself indicative of a lack of competition. It could also be a sign of efficiency. What I have read about the Alabama Blue Cross and Blue Shield having a large market share, they also have some of the lowest expense ratios in running their business of any Blue Cross in the country.

Senator FRANKEN. Would you mind answering my question, though? Do you find that if these companies control 90 percent of the market, it fits your definition of a competitive market?

Mr. POWELL. Well, if they control 90 percent and somebody else is controlling 10 percent and there are hundreds of other companies who come in and take a share if they could do a better job. I am not saying that there is not competition——

Senator FRANKEN. So it does.

Mr. POWELL [continuing]. If the market is concentrated.

Senator FRANKEN. OK. So it does.

In 2007, there were 18 metropolitan areas in which one company held 100 percent of the HMO market. Would those markets meet your criteria for a competitive market?

Mr. POWELL. Are you separating the HMO market from the rest of health insurance?

Senator FRANKEN. I think by definition that question would, yes.

Mr. POWELL. I think that clearly HMOs are competing with PPOs and POS plans and traditional health plans. The fact that there is only one HMO might suggest that the HMO model does not fit very well there, but not that there is a lack of competition.

Senator FRANKEN. OK. You say in your testimony—and, Mr. Hunter, I want you to speak to this. Mr. Powell says in his testimony that "valid evidence of anticompetitive behavior is not observed in insurance markets." That does not seem to comport with your report.

Mr. HUNTER. There is all kinds of anticompetitive behavior. They get together on claims. They get together on pricing. They have rate bureaus that make recommendations for 70 percent of the rate. They do many, many things that would violate the antitrust laws if the antitrust laws were applied to them.

Senator FRANKEN. Yes. It just seemed that your two testimonies were in conflict.

I am a cosponsor of this bill, and I believe that Senator Leahy's legislation in health care companies—health insurance companies' exemption from antitrust laws is a crucial first step to anticompetitive behavior. However, we are on the verge of insuring 46 million

new Americans with significant Federal support, and I am deeply concerned that without additional checks and balances, this expansion will be a windfall for insurance companies, and we will end up with Federal funds going to exorbitant CEO fees, et cetera.

What provisions must we include in any national health reform bill to ensure sufficient competition in health insurance markets and to prevent profiteering by insurance companies?

Mr. HUNTER. Well, first of all, I think you should pass this bill to impose the antitrust laws on the health insurance industry.

Second, you should have a guaranteed competitive player in there. That is why I like the public option. Or if you do not have a guaranteed player like the public option, then you are going to have to have much more regulation to assure that insurance companies—that inefficient costs are not passed through to consumers, like you do with public utilities. Public utilities, you know, will not allow costs through unless they are used and useful. If you do not have a competitive entity to test the market like a public option, then I think you need some kind of utility sort of ratemaking or something to make sure that the prices do not pass through——

Senator FRANKEN. But the alternative to a public option may be more regulation.

Mr. HUNTER. I think it has to be more regulation if not a public option because, otherwise, you—right today no one will stop the insurance companies from passing through the cost of the ads that they are using against you in the health insurance debate to consumers. We will be paying the bill.

Senator FRANKEN. Thank you, Mr. Chairman.

Chairman LEAHY. Thank you very much.

Senator Durbin.

Senator DURBIN. Professor Powell, you have talked about the loss reserve development, and you start your testimony by saying that when it comes to medical professional liability insurance, one of the big problems is the ultimate outcome of a claim may not be known for 4 years.

Mr. POWELL. Right.

Senator DURBIN. Isn't that true for virtually all casualty insurance?

Mr. POWELL. The claim tail is not quite as long in some of the lines. In some lines it could be longer.

Senator DURBIN. It seems to me, if I recall correctly—it has been many years since I did this for a living, but we had a 2-year statute of limitations in Illinois unless there was concealment of extraordinary circumstances. And so you could wait 2 years after an event to file a lawsuit, and it would take a minimum of 1 or 2 years to complete it, even if you were dealing with an automobile accident and an injury from that accident. So I find it hard to understand why this is a unique field of insurance. It appears that most casualty insurance has a long tail before you know what your actual expenditure is going to be for a loss.

Mr. POWELL. Sure, and part of that is that, for example, in Arkansas there are about 5,500 physicians that purchase medical professional liability insurance in a given year, the non-Federal physicians. There are substantially more automobiles and businesses

than that, so you have got a little bit bigger pool to look at, perhaps more data to follow, but also——

Senator DURBIN. And a larger reserve.

Mr. POWELL. Not necessarily. The other part of it——

Senator DURBIN. Automobiles as opposed to physicians?

Mr. POWELL. By reserve, you mean——

Senator DURBIN. The amount that is set aside by the company in anticipation of payouts, losses.

Mr. POWELL. There is certainly a lot more cost to trying and settling a medical malpractice claim based on the cost of the experts and such.

Senator DURBIN. You say you are testifying on behalf of the Physician Insurers Association of America, and there has been a question raised as to what is happening in the area of tort reform. It is my understanding that anywhere from 26 to 40 or maybe more States are involved in some type of tort reform at the moment. And I was wondering if you could, through your association, tell me that there is a correlation between tort reform and the medical malpractice premiums being charged in given States.

Mr. POWELL. There is certainly evidence, from my own academic research and from others, that the effect of certain tort reform laws and tort reform laws in general is to reduce the cost and improve the availability of insurance. That was the reason why they were proposed, and that is indeed what happened in the markets after they were passed.

Senator DURBIN. I do not quarrel with that being the reason they were proposed, but I will ask you, can you provide me through the Physician Insurers Association of America data relative to malpractice premiums that can track specific tort reforms such as caps on non-economic losses to determine whether, in fact, that did result in lower malpractice premiums for the physicians in that State?

Mr. POWELL. I can provide my own academic research that shows that. Yes, I will be happy to.

Senator DURBIN. Would you do that?

Mr. POWELL. Yes.

Senator DURBIN. I appreciate it very much.

[The information referred to appears as a submission for the record.]

Senator DURBIN. And if your premise is that we really get more competition if we ignore antitrust, do you suggest we eliminate antitrust laws for business in general?

Mr. POWELL. No, and the difference is that with insurance you do not know the price of your primary good and service until long after—or you do not know the cost until long after you have set the price. That is the nature of the business, and that is why this exemption is necessary so that the data can be shared and you can have new companies like Arkansas Mutual enter a market where we thought we could do a better job for our doctors.

Senator DURBIN. If I understand Chairman Leahy, there is no prohibition against sharing historical data.

Mr. POWELL. Clearly it is something that would have to be looked at again. Right now you can do it, and there is not a step that has to be taken. It is subject to all of the same antitrust provi-

sions at the State level that there—the idea that there is a bunch of insurance companies sitting around deciding what they are going to do together, I have never observed that. I have been in plenty of places where the companies and their employees go out of their way to not discuss those things because it is illegal.

Senator DURBIN. We just have 2 minutes left. The last question I will ask you is—and this dates me here because it goes back to the time when I was involved in this field. Is there still an Insurance Services Office?

Mr. POWELL. Yes, ISO still exists.

Senator DURBIN. And what do they do?

Mr. POWELL. They take the loss data, and they aggregate it and perform actuarial analysis of trending and all that to produce advisory loss costs.

Senator DURBIN. For price fixing.

Mr. POWELL. It is advisory loss costs. It says this is how much you would expect certain classifications to differ among each other. In medical malpractice, you might see the difficulty in differentiating price across different specialties, and especially at the higher limits of loss where that would be useful for all companies that do not experience losses like that as often as some of the lower levels.

Senator DURBIN. Thanks, Mr. POWELL. Mr. Hunter, I am sorry. We ran out of time.

Chairman LEAHY. I will submit my questions for the record, and we will keep the record open for others.

[The questions appear as questions and answers at the end of hearing.]

Chairman LEAHY. I thank you both, and we are not beating a hasty departure based on your testimony, but based on the fact we have run out of time on the vote on the floor.

[Whereupon, at 12:04 p.m., the Committee was adjourned.]

[Questions and answers and submissions for the record follow.]

QUESTIONS AND ANSWERS

Consumer Federation of America

1620 I Street, N.W., Suite 200 * Washington, DC 20006

WRITTEN QUESTIONS OF SENATOR PATRICK LEAHY "PROHIBITING PRICE FIXING AND OTHER ANTICOMPETITIVE CONDUCT IN THE HEALTH INSURANCE INDUSTRY" OCTOBER 14, 2009 HEARING

QUESTION FOR J. ROBERT HUNTER:

In Mr. Powell's testimony, he stated that a lessened ability to share data would create uncertainty for insurers and also make it very difficult for small insurers assess risk and compete in the market, both resulting in increased prices for consumers. How is this uncertainty different than the uncertainty that companies competing in other industries that are subject to the antitrust laws face every day? Are there ways to exchange this data that do not run afoul of the antitrust laws, so as to enable small insurers to compete?

ANSWER

Over decades, large insurers have raised the "small insurers won't be able to get data" myth to protect their own interests. In fact, antitrust legal experts at every hearing on the issue over decades have said exactly what Hon. Christine Varney said at this hearing, that exchange of historic data would pass muster under full application of the nation's antitrust laws since the exchange of such data would be pro-competitive, not anti-competitive.

What would be stopped, and what the large insurers want to maintain, is not the exchange of historic data but the joint manipulation of such data to project such information into the future for the large companies to jointly use in developing their rates or as indicators of where the market might price the insurance products.

Small insurers can easily access risk without large insurers forcing joint action on pricing matters through the Insurance Services Office (ISO) and other cartel-like ratemaking organizations (e.g., the joint trending of data into the future or use of joint adjustments to reserves called "loss development").

The idea that requiring insurers to compete by price might result "in increased prices for consumers" is laughable. Every industry faces pricing decisions that have future considerations. When contractors bid on the construction of a building in the coming year, they have to price in the costs of labor and materials for next year.

Small contractors must decide for themselves how to bid. There is no Contractor's Services Office (CSO) to fix the price for next year's bricks or labor to "help" small contractors (and provide a signal to large contractors as to the appropriate price). If a CSO did "help" those contractors using such joint information, they would face prosecution.

Beware of large insurers using the supposed situation facing small insurers as an excuse for anticompetitive behavior. Small insurers will do just fine with full antitrust enforcement fully in place and America's insurance consumers will save billions of dollars from the huge inefficiencies and lack of competition that currently permeate the insurance business.

Physician Insurers Association of America

Protecting Healthcare

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United States Senate

Committee on the Judiciary

Senator Patrick J. Leahy, Chairman
Senator Jeff Sessions, Ranking Member

Responses to Committee Questions on

"Prohibiting Price Fixing and Other Anticompetitive Conduct in the Health Insurance Industry"

By

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On behalf of the
Physician Insurers Association of America

November 5, 2009

Responses to Questions Submitted by the Senate Judiciary Committee

1. You testified that data-sharing among insurers is a key tool to permit smaller companies to enter the medical malpractice insurance market, thus improving competition in that market.

a. Can you provide concrete examples of the kind of data being shared, how it is used, and how it promotes competition and new entry into the insurance markets?

When forming Arkansas Mutual Insurance Company (AMIC), actuaries accessed the rate filings of other insurers operating in Arkansas. They used the loss experience of these companies, coupled with expected expenses of AMIC, to set rates. This included overall losses and relativities among classifications and limits.

This promoted competition by allowing another company to enter the Arkansas market for medical professional liability insurance (MPLI). In fact, at least four insurance companies have entered Arkansas since 2007 using the same method. It is important to point out that in practice none of these companies charge exactly the same rate. Each has a different schedule of debits and credits to underlying rates based on the insured's loss experience and risk management practices. Quotes from various insurers to the same prospect often differ across companies by up to 50%.

Another way insurers share data is by reporting claims experience to independent statistical agents, such as the Insurance Services Office. This is an independent agency which provides statistical services to the insurance industry, such as the calculation of loss costs and data trending services. While rating bureau services are important to other lines of insurance, MPLI carriers do not rely heavily on them, as the nature of the data collected is not sufficient for use in this very complex line of insurance. MPLI carriers mainly rely on their own experience, and that of other similar carriers, as indicated above. MPLI carriers do use rating bureau information for a few ancillary services, such as the determination of increased limits factors, which help them price occasional policies issued with high limits of exposure. Given that most MPLI companies are small, they do not have a lot of claims at very high limits of exposure which can be used to price future high limits policies.

b. Is the data-sharing you referred to conducted with the knowledge and consent of the state insurance regulators?

Data were downloaded from the Arkansas Insurance Department website at their suggestion. In many states, carriers are required by law to report to independent statistical agents.

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2. At the hearing, Assistant Attorney General Varney stated that "data-sharing is a well recognized undertaking that, *when done appropriately-when* you're not talking about fixing price, when you're not talking about allocating markets-is absolutely permissible under the law."

a. At the hearing you appeared to argue that the insurance market is "different" from other markets in the role of data-sharing and in its importance to insurer solvency and competition. How is the insurance market different from other products or services markets (e.g. the lumber industry or legal services industry) in its use of such data?

Data sharing is more important to insurance companies given the nature of their operations. Insurers promise to pay uncertain amounts *ex post* in exchange for a certain premium *ex ante*. In other words, they have to set prices before they know all of the costs involved in providing insurance. In the MPLI industry, claims are closed and paid about 4.5 years on average after they happen. For some claims, this lag can be as long as ten years. While all industries face some level of uncertainty, very few are in the business of offsetting uncertainty, and fewer still are capable of legally reducing uncertainty by sharing data with competitors.

b. How clear are the lines in Federal antitrust law on what is an "appropriate" or "inappropriate" form of data-sharing?

Unfortunately, this is not my area of expertise. I operate in the insurance industry, and insurance pricing, or "the business of insurance," has never been subjected to federal antitrust laws. Without observing application of these laws, it is difficult to say how clear it would be in practice. I am not familiar with industries that are allowed to share under the federal law.

c. If the lines are clear for other product or service markets where Federal antitrust law squarely applies, how directly do those lines translate to the conditions and practices of the insurance markets?

Please see the answer to Question 2.b. above.

d. If the lines in Federal antitrust law are not clear, what steps would insurers or potential new entrants to the insurance market be required to take to avoid legal jeopardy?

It is unclear what would need to be done to clarify the risk, but in her testimony, Ms. Varney noted a rule of reason review and a business review letter may be options. I do not know what this involves, or if these measures would protect against private actions under the Clayton Act.

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e. How well-developed are state regulations or standards of conduct designed to ensure competition in the insurance marketplace? Would the superimposition of Federal antitrust law onto existing state legal frameworks produce greater predictability and clarity, or would it produce unpredictability and confusion?

Current law is predictable and stable as a result of many years of developed precedent. The current state regulations have been challenged in courts many times since McCarran Ferguson was enacted in 1945. Insurance is a heavily regulated industry, similar to the banking industry. In addition to annual audits performed by CPA firms, as in all other industries, insurers are also subject to tri-annual audits by state insurance departments. They are also subject to market conduct review, and review of complaints filed by unsatisfied customers with state insurance departments. In all states, insurers must file requested rate changes, and the insurance department has the final say on what insurers can charge their customers.
While some have speculated that the transition to federal regulation would be smooth in this aspect, there is no way to reach legal predictability and stability would likely take many years to develop.

f. Would the possibility of antitrust litigation chill insurers from entering the market or from engaging in certain efficient behaviors, even if the conduct in question were eventually found to be pro-competitive and not barred by Federal law?

In my opinion, as one who formed a new carrier last year, it would. If McCarran were repealed, at the very least, I would need to provide for significant legal costs associated with analyzing antitrust issuers before starting another carrier. This is a significant and unnecessary addition to an already expensive process. My understanding is that the proposed change would also increase the cost of actuarial analysis for new firms, and existing firms that use bureau loss costs.

g. In her testimony, AAG Varney suggested that insurers could seek a Business Review Letter from the U.S. Department of Justice to obtain some assurance about the legality of their activities. Would such letters provide sufficient security to avoid chilling pro-competitive information-sharing in the health or medical malpractice insurance markets? How would the risk of chilling such behavior change if S.1681 were to limit Federal antitrust enforcement to the Department of Justice and the FTC, and exclude private party suits seeking treble damages under the Federal antitrust statutes?

I have no experience with US DOJ Business Review Letters.

Treble damages, potentially sought by private parties under the Clayton Act, would effectively deter insurers from using industry data or providing data to independent statistical agents, without thorough (and expensive) legal review.

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h. Your testimony suggested that S.1681 would raise hurdles for new businesses to enter the medical malpractice insurance market. Please identify those hurdles, other than litigation risk discussed above, and explain how significant the impact of such hurdles might be on competition in the medical malpractice insurance market.

A substantial barrier to entry for new insurance companies is the cost of forming the company. Anything that increases such costs could decrease competition.

In the last four decades, the MPLI industry has experienced a few distinct crises of increasing cost and decreasing availability of coverage. In each of these periods, new companies, and companies expanding from other states have been instrumental in mitigating the shortage of cover. By increasing cost or uncertainty of the process, consumers could be harmed substantially.

3. How effective do you find the current state regulatory systems to be in preventing anticompetitive activities in the insurance markets? Are you aware of any "price fixing, bid rigging or market allocation" or other anticompetitive or collusive behavior in the health or medical malpractice insurance markets that state regulators have been unable or unwilling to prevent or control? Please explain.

State regulators and lawmakers clearly have the authority and means to prevent anticompetitive practices. They periodically review the operations of every insurance company. Activities of regulators supplement market forces to promote competition.

The primary mechanism for preventing such behavior is the market. If some companies collude in an anticompetitive way, another insurer can simply charge less or provide more value than the colluding companies to increase its market share. This is always the most efficient method of consumer protection.

I have never witnessed any anticompetitive behavior in the MPLI industry. I cannot imagine a scenario in which the federal government would do a better job than state government in mitigating such behavior.

4. In a hearing held by the House Judiciary Committee on October 8,2009, a representative of the ABA Section on Antitrust Law stated that the American Bar Association could support S.1681 "only if' the bill were amended to also provide safe harbors to protect specific practices in the insurance markets that are pro-competitive. According to the ABA, such protections would be "necessary amendments" to this legislation.

a. Do you agree that such safe harbors are necessary to prevent S.1681 from harming competition in the insurance markets?

If such safe harbors could be effectively implemented, they would, at best, recreate the environment currently provided by McCarran. My understanding is that there is

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substantial disagreement in the legal community regarding the possibility of drafting adequate safe harbor legislation.

b. Do you believe that a set of "safe harbors," as proposed by the ABA, would be better than the current narrow antitrust exemption provided by the McCarran- Ferguson Act? Why or why not?

Discussion of safe harbors is not new and has been consistently rejected by scholars and policymakers. It is not practical to craft safe harbor provisions that would provide adequate protection for present or future pro-competitive activities and would simply introduce uncertainty into the insurance marketplace and invite costly and protracted litigation. It seems clear that the safe harbor that would be most effective in protecting insurers from anticompetitive antitrust scrutiny is the one that has been in place since 1945—the McCarran-Ferguson Act itself.

There is little doubt that changing the existing insurer antitrust exemption—with or without "safe harbors"—will generate huge legal costs, as MPLI insurers would be forced to contend not only with government lawsuits but hundreds of private actions as well. Given the strong evidence supporting the current federal law, these costs represent inefficient, dead weight imposed on an effective and relatively efficient extant system.

c. In her testimony before the House, the ABA representative predicted that this legislation would "place a greater burden on the insurance industry than on other industries" because it is so broadly-worded that it seems to outlaw activities that courts have found to be pro-competitive. Do you share the ABA's concern? Why or why not?

While I do not fully agree with the conclusions expressed by Ms. Gotts in the House hearing, I share the ABA's concern regarding this aspect of S.1681. The relevant excerpt from that testimony is copied below.

> **Turning back now to H.R. 3596, the American Bar Association would support legislation along the lines of H.R. 3596, but only if it is amended to provide safe harbors that are pro-competitive. The American Bar Association believes that the safe harbor provisions outlined above, that have been included in several other McCarran repeal proposals over the years but are not contained in H.R. 3596, are necessary amendments to the legislation. In addition, while the American Bar Association's view is that the insurance industry should not be subject to an antitrust exemption, it should not be subject to a more rigorous antitrust standard than the rest of American industry either. While I do not believe that the bill's intention is to impose more demanding antitrust standards on the insurance industry than other industries, the bill's broad prohibition on "price fixing," "bid rigging" and "market allocations" could potentially be read to condemn activity that would be otherwise permissible under the antitrust laws. Specifically, some activities that might be characterized as "price fixing" or "market allocation" could**

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have pro-competitive justifications that would make them permissible under current antitrust doctrine. For example, the antitrust laws generally permit manufacturers to set exclusive territories for their downstream distributors, even though such conduct could be construed as a vertical "market allocation." These terms have very specific meanings in the existing case law interpreting the Sherman Act, and it should clearly not be the intent of this legislation to place a greater burden on the insurance industry than on other industries. The safe harbors that the American Bar Association supports help to ensure against this result, but further clarification on this point would also be beneficial.

5. One issue much-debated at the hearing was the degree of competition currently in the health and medical malpractice insurance markets.

a. Please provide your assessment of the competitive environment in these markets. How do these insurance markets compare to other financial services markets? If possible, please provide the Committee with recent studies measuring competition in these markets.

My responses to previous and subsequent questions address this question as well. My responses are limited to the MPLI market. It appears very competitive in practice and from a logical assessment of available data. One point not made elsewhere is the observed lack of sustained profit. If health insurers or MPL insurers exercised monopoly powers, one would expect them to generate huge profits consistently. This is clearly not the case.

The following chart shows profits in MPLI markets compared to other industries. While MPLI profits fluctuate substantially, they do not exhibit the sustained profits we would expect if they exercised monopoly power. In fact, their profits are negative in some years. . See also my attached paper titled "Assessing Financial Performance in Medical Professional Liability Insurance.[1]"

[1] Hoyt, Robert E. and Lawrence S. Powell, 2006. "Assessing Financial Performance in Medical Professional Liability Insurance," *Journal of Insurance Regulation*, v25, n1 (Fall, 2006): 3-13

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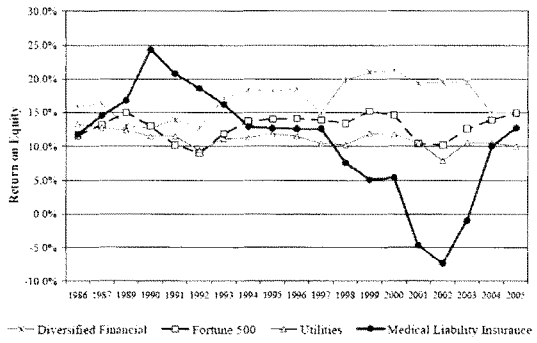
Figure 3: Comparing ROE across Industries, 1986-2005



Source: NAIC Profitability Report, 1995, 2006, and III Fact Book, various years

b. Several Senators argued that the presence of only a few insurers in a given market was proof that the market is not "competitive." Do you agree with this position? Please explain.

I absolutely do not agree. Market concentration does not necessarily indicate collusion or price fixing. In fact, in MPLI it often signals a very different situation. When a few companies have a large market share, it is most likely the result of efficiency (lower prices or greater value) or incentive alignments with consumers.

With regard to MPLI, the majority of the coverage provided to doctors in the United States comes from small physician and other health care provider owned/operated insurers, such as Arkansas Mutual Insurance Company. Many of these companies were founded over thirty years ago by state medical societies because the commercial insurers were leaving the market due to their inability to predict losses and price accurately. In many states, these physician owned carriers, mutuals or reciprocals, are the predominate provider of MPLI insurance. This is because of their dedication to providing a market for physicians, and also because there are few commercial carriers left willing to take large positions in this line of insurance. However, market competition does exist, and in most states, multiple physician owned carriers compete, along with some commercial carriers. For example, in Arkansas, there are four physician owned carriers now in operation, as well as at least three commercial carriers writing any appreciable amount of MPL insurance. During the 1970s when the commercial carriers largely left the market, 28 states formed Joint Underwriting Authorities (JUA), which are essentially government-run insurers. These JUAs were intended to provide a residual market for physicians who could not get coverage from an insurance company. At this point, we are aware of only nine JUAs still in existence (HI, PA, SC, FL, TX, NH, NY, MI, MN). Note that all of these states have multiple

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physican owned and commercial carriers in operation. The disappearance of the JUAs is testimony to the competitiveness of the MPLI market.

Self-insurance is also a prevalent practice in the MPLI market, particularly in the case of large hospital and healthcare institutions. In fact, Conning and Company, a leading industry research firm, estimates that 60% of the MPLI market is now in this self-insured portion of the market.

c. Are there structural factors in the health insurance or medical malpractice insurance markets that discourage monopolistic or oligopolistic behavior by insurers? Please explain.

There are structural factors that prevent monopolistic behavior by MPLI carriers, even if they have a large market share. These factors are primarily the result of ownership structure and organization of market leading companies.

In MPLI markets, 60% of physicians are insured by physician-owned insurance companies. These companies are organized as mutual insurers or reciprocal exchanges. They do not operate to make large profits. If premiums and investment income exceed losses and expenses, the remaining income belongs to policyholders. Profits are used to offset future premiums, or are refunded as policyholder dividends.

Given these two important structural characteristics of insurance markets, it is logical to conclude that increased market share is the result of efficiency and low returns, rather than monopolistic or anticompetitive behavior.

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U.S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

April 12, 2010

The Honorable Patrick J. Leahy
Chairman
Committee on the Judiciary
United States Senate
Washington, D.C. 20510

Dear Chairman Leahy:

Enclosed please find responses to questions for the record stemming from the appearance of Christine Varney, Assistant Attorney General for the Department's Antitrust Division, before the Committee on October 14, 2009, at a hearing entitled "Prohibiting Price Fixing and Other Anticompetitive Conduct in the Health Insurance Industry." We hope that this information is of assistance to the Committee.

Please do not hesitate to call upon us if we may be of additional assistance. The Office of Management and Budget has advised us that there is no objection to submission of this letter from the perspective of the Administration's program.

Sincerely,

Ronald Weich
Assistant Attorney General

Enclosure

cc: The Honorable Jeff Sessions
Ranking Minority Member

Questions for Assistant Attorney General Christine Varney
U.S. Senate Committee on the Judiciary
"Prohibiting Price Fixing and Other Anticompetitive Conduct in the Health Insurance Industry"
October 14, 2009

1. In your testimony you characterized the McCarran-Ferguson antitrust exemption as "broad." But Professors Areeda & Hovenkamp, among the most prominent scholars of U.S. antitrust law and whom you cited in your written testimony, note that the Supreme Court and other courts have "severely reduced" McCarran-Ferguson immunity by tightly circumscribing what activity qualifies as "the business of insurance" and is therefore eligible for the exemption. *See* 1A PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶ 219c, at 4 (3d ed. 2006). On what do you base your assertion that the McCarran-Ferguson antitrust exemption is "broad?"

Answer:

Over the years, the courts have defined what constitutes the "business of insurance" with greater precision. Nevertheless, the McCarran-Ferguson Act exempts from the antitrust laws all activities that the courts find to be the business of insurance. In particular, the Act may exempt many types of conduct that might otherwise violate section 1 of the Sherman Act, including bid rigging, price fixing, and market allocations; section 2 of the Sherman Act, including unlawful monopolization; and section 5 of the Federal Trade Commission Act, including numerous unfair trade practices. Lower courts have held that many activities fall within the exemption. *See generally* 2 SECTION OF ANTITRUST LAW, AM. BAR ASS'N, ANTITRUST LAW DEVELOPMENTS 1440 (6th ed. 2007). Moreover, the case law suggests that the McCarran-Ferguson Act may preclude federal antitrust action whenever there is a state regulatory scheme, regardless of how perfunctory or ineffective it may be. *See, e.g., Ohio AFL-CIO v. Insurance Rating Board*, 451 F.2d 1178 (6th Cir. 1971).

2. In response to several questions from Senators during the October 14th hearing, you argued that immunity from federal antitrust law increases the risk that insurers will engage in anti-competitive behavior. In your written testimony you also criticized the McCarran-Ferguson Act as conferring immunity even where state regulation is "minimal."
   a. Please provide concrete examples of clearly anti-competitive conduct in the health and medical malpractice insurance markets that has been found to qualify for the McCarran-Ferguson exemption to federal antitrust law (or would likely be protected by that exemption) and that state regulators have refused (or been unable) to control.
   b. If anti-competitive behavior occurs, why isn't the better solution to encourage state regulators—who are closer to the consumers who need to be protected, and who have a better grasp of the insurance market dynamics in their states—to be more diligent in regulating the insurers operating in their states?

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Answer:

Firms often take affirmative steps to conceal price fixing, bid rigging, market allocations, and other conduct that is illegal under the antitrust laws, even where the firms are subject to regulatory oversight and where the pertinent regulatory authority has forbidden the particular conduct. For instance, in *In re Workers' Compensation Insurance Antitrust Litigation*, 867 F.2d 1552, 1552–60, 1563–64 (8th Cir. 1989), *cert. denied*, 492 U.S. 920 (1989), workers' compensation insurers in Minnesota fixed prices on their insurance policies even though Minnesota had a law that embodied an explicit state declaration favoring competitive pricing. The court held that the McCarran-Ferguson Act nevertheless precluded the customers' price-fixing claim under federal antitrust law. The Department believes that antitrust and regulation should work together to protect consumers. The antitrust laws are the chief legal protector of the free-market principles on which the American economy is based. Experience has shown that competition among businesses, each attempting to be successful in selling its products and services, leads to better quality products and services, lower prices, and higher levels of innovation. The antitrust laws ensure that businesses will not stifle this competition to the detriment of consumer welfare. Thus, while state regulators may be able to effectively regulate insurers operating in their states, the federal antitrust laws can greatly assist state regulators in their quest to protect consumers.

3. You argue in your testimony that imposing federal antitrust liability on top of existing state regulations will not harm the insurance markets because current business practices that some may claim fall within the literal language of this bill—for example, some types of data-sharing and expected-loss analysis that some object to as inviting "price fixing"—could be found to be pro-competitive and therefore legal under the "rule of reason." In response to a question from Senator Leahy you argued that "data-sharing is a well-recognized undertaking that, *when done appropriately*—when you're not talking about fixing price, when you're not talking about allocating markets—is absolutely permissible under the law."
    a. How do you respond to the concern that the threat of antitrust litigation—and uncertainty about what courts will find is "appropriate" data-sharing—will chill pro-competitive conduct? For example, small insurers may be unwilling to incur the legal risk (or may lack the funds to hire lawyers for years of protracted litigation) to re-establish the precompetitive virtues of activities that state regulators have long considered to be good for the market.
    b. In your testimony, you suggested that insurers concerned about the legality of their practices could request a Business Review Letter from the Department of Justice. You also noted, however, that such letters only provide protection against federal government enforcement. What solace can a Business Review Letter provide to an insurer targeted by competitors or other plaintiffs through private antitrust suits?
    c. Some argue that recipients of Business Review Letters are rarely, if ever, found liable for antitrust violations in private antitrust litigation. Does the Department of Justice have any data to support or refute this claim? If recipients of Business

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Review Letters prevail in private antitrust litigation, at what stage of the litigation have such defendants prevailed?

d. Your argument appeared, at bottom, to be that federal supervision or private antitrust litigation is a better way to control behavior in the insurance markets than state regulatory supervision. Is this in fact your position? Please explain.

Answer:

The application of the antitrust laws to potentially procompetitive collective activity has become far more sophisticated during the 62 years since the McCarran-Ferguson Act was enacted. Some forms of joint activity that might have been prohibited under earlier, more restrictive antitrust doctrines are now clearly permissible, or at the very least analyzed under a rule of reason that takes appropriate account of the circumstances and efficient operation of a particular industry. Thus, there is far less reason for concern that overly restrictive antitrust rulings would impair the insurance industry's efficiency.

In particular, antitrust now recognizes that the vast majority of data exchanges either have no adverse competitive effect or are beneficial to consumers. For instance, the Department has observed that many methods that insurers commonly use to collect, aggregate, and review historical, and even projected, data on losses are procompetitive. *See* DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, Statement 6: Enforcement Policy on Provider Participation in Exchanges of Price and Cost Information, available at www.ftc.gov/bc/healthcare/industryguide/policy/statement6.pdf. To the extent that a compelling case can be made that uncertainty as to the application of the antitrust laws may deter particular procompetitive activity even if such conduct ultimately would be vindicated, the Department is open to affording continued protection to carefully defined conduct that is considered necessary or appropriate to the operation of the insurance industry.

However, if the McCarran-Ferguson antitrust exemption were repealed, it is unlikely that health insurance companies would stop engaging in beneficial, procompetitive data exchanges because of fear of private litigation for a number of reasons. First, research suggests that many insurers, including health and malpractice insurers, no longer engage in the data exchanges that historically raised the greatest concern and served as a justification for the McCarran-Ferguson exemption. *See* Frank A. Sloan et al., Insuring Medical Malpractice 94 (1991); Richard N. Clarke et al., Sources of the "Crisis" in Liability Insurance: An Economic Analysis, 5 YALE J. ON REG. 367 (1988). Second, there is no reason to expect that health insurers will face a multitude of baseless private antitrust suits. As in other areas of law, private parties are unlikely to institute meritless lawsuits and even less likely to be successful in pursuing them. This is especially the case with regard to data exchanges among health insurers, where it can be expected that the courts will take into account the views of the government, including those expressed in the Joint Justice Department-Federal Trade Commission Health Care Policy Statements and any positive business reviews. *See, e.g.*, *Levine v. Cent. Fla. Med. Affiliates*, 72 F. 3d 1538, 1548–49 (11th Cir. 1996). While the Department does not collect data on whether Business Review recipients are later found liable for antitrust violations in private lawsuits, the Department is not aware of any such cases and expects that any defendants that received positive business reviews would request that the

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Department participate as an amicus if the same conduct that was at issue in the business review was under court review.

As noted in the answer to the previous question, while state regulators may be able to effectively regulate insurers operating in their states, the federal antitrust laws can greatly assist state regulators in their quest to protect consumers and regulate insurers. In the Department's experience, the antitrust laws seek to ensure that businesses will not stifle competition to the detriment of consumer welfare. As such, the Department believes that antitrust and regulation should be viewed as complementary.

4. One of the practices discussed at length by several Senators and by one of your fellow witnesses was the reliance by several health insurers on a data-collection and analysis service that issued guidelines on what prices for given medical services are "usual and customary" in a given geographic area. Critics of this practice cited to an "investigation" widely publicized by New York State Attorney General Andrew Cuomo which concluded that the "usual and customary" rate determinations were too low, and that the company providing the analysis may have had a conflict of interest because it was owned by a major national health insurer.
    a. Would you agree that the N.Y. State Attorney General's report did not find, or even allege, that the use of the "usual and customary" rate data by all major health insurers in New York State violated either Federal or state antitrust law?
    b. In the aftermath of his investigation, N.Y. State Attorney General Cuomo has concluded agreements with every health insurer operating in New York State that require all insurers: to discontinue use of the private rate analysis service; to pay over 80 million dollars to fund a new, government-sponsored rate analysis company; and to use, collectively, the rate analysis provided by that new entity to determine "usual and customary" service rates to calculate the insurance companies' reimbursements to their policy holders. *See* *http://www.oag.state.ny.us/bureaus/health_care/HIT2/agreement.html*. Assuming the McCarran-Ferguson exemption were repealed as contemplated in S.1681, do these agreements by all insurers operating within a state to use a single data provider to calculate their reimbursements constitute "any form of price fixing" behavior that might raise any Federal antitrust concerns?
    c. As currently drafted, Section 4 of S.1681 excludes "the information gathering and rate setting activities of any State commission of insurance, or any other State regulatory entity with authority to set insurance rates" from the bill's repeal of McCarran-Ferguson immunity. Do you agree that this language does not protect the state-sponsored data analysis company created by N.Y. State Attorney General Cuomo from antitrust scrutiny? Do you agree that the narrowness of this language might deprive the N.Y. insurers' use of the new rate data analysis company of a "state action" defense, even assuming the N.Y. Attorney General's actions could be viewed as "authorized" to preempt federal antitrust law under *Parker v. Brown*?
    d. In *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982), the Supreme Court held that a "peer review" arrangement in which an insurer relied on the opinions of expert practitioners to determine the "necessity" and "reasonableness" of

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treatments was not the "business of insurance" and was therefore not protected by McCarran-Ferguson immunity. If health insurers were to enter into explicit horizontal agreements (without the coercion of state authorities) to rely on a single "peer review" service to evaluate claims and set reimbursement rates, would they be subject to antitrust scrutiny under the reasoning set forth in the Supreme Court's decision in *Pireno*?

Answer:

New York State Attorney General Andrew Cuomo announced in his press release on the *Ingenix* investigation settlement agreement with UnitedHealth that the industry reforms "will bring crucial accuracy, transparency, and independence to a broken system" and that the settlement "removes the conflicts of interest that have been inherent in the consumer reimbursement system."

To the extent that section 4 of S. 1681 is designed to reflect and maintain intact the state action exemption to the federal antitrust laws, the *Ingenix* settlement would not be affected by this legislation. However, the applicability of the state action doctrine in any given instance turns heavily upon the specific facts of a particular situation. The Department cannot make a determination on the applicability of the state action defense to New York's agreement without further information.

Pireno and *Group Life & Health Ins. Co. v. Royal Drug Co., Inc.*, 440 U.S. 205 (1979), establish as a general proposition that the McCarran-Ferguson Act does not exempt from antitrust scrutiny an insurer's dealings with its providers. Consequently, it is not clear how repeal of the McCarran-Ferguson exemption would impact the applicability of the federal antitrust laws to insurers' agreements to use data from the same vendor when calculating their respective provider reimbursement rates. However, the holding in *Pireno* suggests that the McCarran-Ferguson Act most likely would not exempt from antitrust review health insurers' agreements—without the coercion of state authorities—to rely on a single "peer review" service to evaluate providers' claims and set providers' reimbursement rates.

5. In your testimony, you expressed a general opposition to antitrust exemptions and your support for S.1681 and its repeal of the McCarran-Ferguson exemption for health and medical malpractice insurers. In a hearing held by the House Judiciary Committee on October 8, 2009, the current Chair of the ABA Section on Antitrust Law, Ms. Ilene Knable Gotts, stated that the American Bar Association could support S.1681 "only if" the bill were amended to also provide safe harbors to protect specific practices in the insurance markets that are pro-competitive. According to the ABA, such protections would be "necessary amendments" to this legislation.
    a. Do you agree that such safe harbors are necessary to prevent S.1681 from harming competition in the insurance markets?
    b. Do you believe that a set of "safe harbors," as proposed by the ABA, would be better than the current narrow antitrust exemption provided by the McCarran-Ferguson Act? Why or why not?
    c. In her testimony before the House, Ms. Gotts indicated that the ABA feared this legislation would "place a greater burden on the insurance industry than on other

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industries" because it is so broadly-worded that it seems to outlaw activities that courts have found to be pro-competitive. Do you share the ABA's concern? Why or why not?

Answer:

As stated above, the Department believes that the antitrust laws are more sophisticated and flexible now than when the McCarran-Ferguson Act was adopted over 60 years ago. Thus, even without the proposed safe harbors, the antitrust laws should quickly, accurately, and efficiently sort out conduct beneficial to consumers, like insurers' exchanges of historical loss data, from conduct deleterious to consumers, like agreements among insurers on premiums. Repealing the McCarran-Ferguson antitrust exemption would subject the health and medical malpractice industries to the same treatment under the antitrust laws as virtually every other industry in our nation's economy. At the same time, because the proposed safe harbors would protect conduct that is highly unlikely to be harmful to competition or consumers, they could provide greater clarity to the health insurance industry.

6. One of the most frequent complaints about competition in the health insurance market, expressed in Senator Reid's witness statement and in remarks by several Members of the Committee, is that the industry has become too consolidated. Critics claim that there are too few insurance companies competing in certain markets and that they are therefore able to charge "excessive" premiums.
   a. Has the Department of Justice or the FTC conducted any analysis of the competitive environment in health and medical malpractice insurance markets?
   b. S.1681 speaks of "price fixing, bid rigging, or market allocation," but does not mention monopolization, market power, or consolidation in the health or medical malpractice insurance markets. In response to a question from Senator Leahy you appeared to agree with him that "removing" the antitrust exemption provided by McCarran-Ferguson would enable the Department of Justice to scrutinize what he and others have argued is excessive concentration in the insurance markets. Is it your position that the passage of S.1681 would have this effect, even though market concentration is not mentioned in the bill? Please explain.
   c. In your response to Senator Leahy you also appeared to agree with his suggestion that current law bars the Department of Justice from examining market concentration in the health and medical malpractice industry. The Supreme Court has memorably remarked that the McCarran-Ferguson exemption applies to "the business of insurance," not to "the business of insurers." Is it your view that questions of market concentration or monopoly—which are common to all businesses—constitute "the business of insurance" so as to bar Federal antitrust scrutiny? Please explain.

Answer:

On multiple occasions in recent years, the Department of Justice has investigated proposed mergers in the health insurance industry and allegations concerning the competitive environment in various areas of the medical malpractice insurance industry.

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These inquiries entailed a careful analysis of the competitive dynamics of the particular market in question. In addition, in 2002-03 the Division co-hosted with the Federal Trade Commission comprehensive hearings on competition in the health care industry, including the health insurance industry. Chapters 5 and 6 of the report ensuing from those hearings, FED. TRADE COMM'N AND U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), discusses the factors important to promoting competition in the health insurance industry.

Historically, price fixing, bid rigging, and market allocation cartels have been some of the most effective means for competitors to coordinate their activities, to the detriment of consumers. Repeal of the McCarran-Ferguson antitrust exemption will eliminate the methods most readily available to other industry participants to reduce output, increase prices, and depress innovation.

Supreme Court precedent makes it clear that the Antitrust Division has the authority to challenge an anticompetitive merger of two insurance companies because such an activity is not "the business of insurance." *See SEC v. National Securities Inc.*, 393 U.S. 453 (1969). Whether other particular activities or practices are "the business of insurance" are specific factual questions. Thus, the question in a particular case involving health or medical malpractice insurance would be whether the three criteria of *Pireno* have been satisfied.

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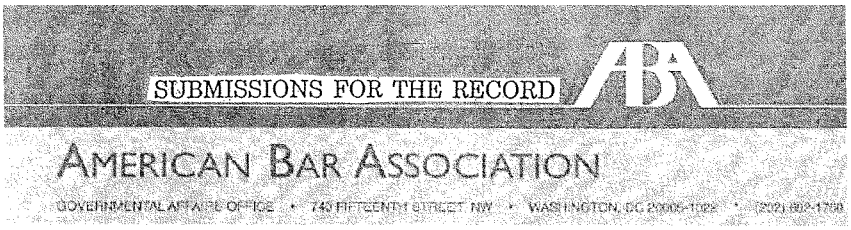

STATEMENT OF ILENE KNABLE GOTTS

Chair, ABA Section of Antitrust Law

Submitted on behalf of the

AMERICAN BAR ASSOCIATION

to the

Committee on the Judiciary

United States Senate

CONCERNING S. 1681, "THE HEALTH INSURANCE INDUSTRY ANTITRUST ENFORCEMENT ACT OF 2009"

October 20, 2009

Mr. Chairman and Members of the Committee:

On behalf of the American Bar Association ("ABA"), which has almost 400,000 members, I appreciate the opportunity to submit to you the ABA's views concerning S. 1681, The Health Insurance Industry Antitrust Enforcement Act of 2009. The Antitrust Law Section has frequently noted its opposition to industry-specific exemptions from the antitrust laws, finding them to be rarely justified. Accordingly, the ABA advocates a repeal of the McCarran-Ferguson exemption, rendering the federal antitrust laws applicable to the insurance industry. However, to deter unwarranted private litigation testing the limits of permissible insurer conduct absent an exemption, the current ABA Policy further recommends that a limited number of "safe harbor" exemptions be created for certain demonstrably procompetitive forms of conduct.

1. The ABA's Views of the McCarran-Ferguson Antitrust Exemption

The ABA believes that the McCarran-Ferguson Act's antitrust exemption should be repealed for the insurance industry and replaced with a series of "safe harbor" protections for certain forms of collective insurer conduct that are unlikely to cause anticompetitive harm to consumers. The underlying rationale for the American Bar Association's position is that the Sherman Act has served the nation well for nearly 120 years because it is a simple and very flexible statement of competition policy that is interpreted by the courts based on the facts and circumstances of each particular case. This flexibility eliminates, in most cases, the need for industry-specific exemptions. Moreover, the benefits of such exemptions rarely outweigh the potential harm imposed on society by the loss of competition resulting from such exemptions, and often are not necessary to limit the risk of deterring procompetitive conduct. In short, the objectives and goals of the McCarran-Ferguson exemption can be achieved in a manner consistent with established antitrust principles and enforcement policy, thus rendering the

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exemption unnecessary, provided "safe harbors" are created, as I explain in more detail in this statement.

Consistent with these general principles, the American Bar Association has supported McCarran-Ferguson reform in the past, most recently in my testimony before the House Judiciary Committee Subcommittee on Courts and Competition Policy that I presented to the Subcommittee on October 8, 2009. In June of 2006, testimony was presented before your Committee by Don Klawiter, the Chair of the Section of Antitrust Law of the ABA at that time. The ABA has consistently expressed the view that the McCarran-Ferguson Act's antitrust exemption should be repealed for the entire insurance industry – not just with respect to the health insurance and medical malpractice insurance industries, as S. 1681 would do – and replaced with a series of "safe harbor" protections for certain forms of collective insurer conduct that were unlikely to cause anticompetitive harm to consumers. To the extent that S. 1681 constitutes a first step in this direction, by repealing the antitrust exemption for these two types of insurance, the American Bar Association would support legislation along the lines of S. 1681, but only if it were amended to provide safe harbors for certain procompetitive conduct as set forth in our attached ABA policy.

As I just indicated, the American Bar Association position on McCarran is not new; over the last twenty years the ABA has consistently maintained that the McCarran-Ferguson Act should be repealed and replaced with certain "safe harbor" protections that I will outline below. See, e.g., Comments to the Antitrust Modernization Commission Regarding the McCarran-Ferguson Act (April 10, 2006), available at http://www.abanet.org/antitrust/at-comments/2006/04-06/Cl-AMC-McCarranFerguson.pdf. The American Bar Association's position – then and now – is that McCarran should be repealed and replaced by a series of safe

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harbor protections for certain insurance industry conduct. For all other conduct, the American Bar Association position is that the insurance industry should be subject to the same antitrust rules as other industries. Before addressing some of the specifics of the proposed bill, I believe that a brief historical review of the origins of the McCarran-Ferguson Act is helpful.

Why do we have an antitrust exemption for the insurance industry? In the latter half of the 19th century, dramatic growth in the fire insurance industry led to increased interest by the states in the regulation and taxation of insurance companies. In response, insurance companies, seeking to avoid such regulation, challenged the states' authority to regulate the insurance industry, contending that such regulation constituted a violation of the Commerce Clause. However, in Paul v. Virginia, 75 U.S. (8 Wall.) 168 (1868), the United States Supreme Court rejected the insurers' position, holding that the Commerce Clause did not preclude the states from regulating insurers.

In the wake of the *Paul* decision, state regulation of insurance increased significantly. Then, in 1944, the United States Supreme Court, in United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533 (1944), effectively overruled *Paul*, holding that insurance was interstate commerce and therefore subject to federal regulation. In response, the very next year, Congress enacted the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, seeking to ensure that the regulation of the insurance industry remained principally the province of the states.

The Act provides the insurance industry generally –not just health insurers and medical malpractice insurers - with a limited exemption from the federal antitrust laws. Specifically, the McCarran-Ferguson Act exempts conduct if that conduct (1) constitutes "the business of insurance" (2) is "regulated by State Law" and (3) does not amount to an "agreement to boycott,

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coerce, or intimidate, or act of boycott, coercion, or intimidation." All three prongs of the McCarran-Ferguson Act must be satisfied for the exemption to attach to an insurer's conduct.

In determining whether conduct qualifies as "the business of insurance" under the McCarran-Ferguson Act's first prong, the courts have considered (1) whether the activity has the effect of transferring or spreading a policyholder's risk; (2) whether the activity is an integral part of the policy relationship between insurer and insured; and (3) whether the activity is limited to entities within the insurance industry. See Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119 (1982); Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979). Notably, no single factor is determinative on this issue.

As to the second prong, courts have held that an activity is regulated by state law if the insurer is subject to general state regulatory standards. In addition, the quality of the regulatory scheme, or its enforcement, does not influence the availability of the exemption. Hartford Fire Ins. Co. v. California, 509 U.S. 794 (1993).

Finally, with respect to the third prong, the Supreme Court held in *Hartford Fire* that a boycott occurs, thus subjecting insurer conduct to the federal antitrust laws, when a refusal to deal is designed to pursue an objective "collateral" to the terms of the transaction in which the refusal to deal occurs.

With this as background, nearly twenty years ago the American Bar Association formed a commission to study, among other things, the important policy issues associated with the application of the U.S. antitrust laws to the business of insurance. Following two years of discussion and debate, the ABA adopted a resolution recommending the repeal of the McCarran-Ferguson exemption to the antitrust laws, to be replaced by a series of safe harbors defining certain categories of exempt conduct. The safe harbors are not intended to alter existing antitrust

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policy; rather, they are intended to serve the important objective of deterring private litigation that might, post-exemption, challenge conduct that, in the unique circumstances of the insurance industry, may actually promote competition. The ABA's recommendation, which is attached to this statement for your convenience, recognizes the benefits of safe harbors for the following conduct by insurance companies:

(1) Insurers should be authorized to cooperate in the collection and dissemination of past loss-experience data so long as those activities do not unreasonably restrain competition, but insurers should not be authorized to cooperate in the construction of advisory rates or the projection of loss experience into the future in such a manner as to interfere with competitive pricing.

(2) Insurers should be authorized to cooperate to develop standardized policy forms to simplify consumer understanding, enhance price competition and support data collection efforts, but state regulators should be given authority to guard against the use of standardized forms to unreasonably limit choices available in the market.

(3) Insurers should be authorized to participate in voluntary joint-underwriting agreements and in connection with such agreements to cooperate with each other in making rates, policy forms, and other essential insurance functions, so long as these activities do not unreasonably restrain competition.

(4) Insurers participating in residual market mechanisms should be authorized in connection with such activity to cooperate in making rates, policy forms, and other essential insurance functions so long as the residual market mechanism is approved by and subject to the active supervision of a state regulatory agency.

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(5) Insurers should be authorized to engage in any other collective activities that Congress specifically finds do not unreasonably restrain competition in insurance markets.

These safe harbors are intended to protect legitimate procompetitive joint activity by insurers while still subjecting the insurance industry to the antitrust rule of law. While much, if not all, of the safe harbor conduct would be permissible or even encouraged under current antitrust precedent, the idea of the safe harbors is to remove all doubt, and hence to discourage private suits challenging such procompetitive conduct.

Turning back now to S. 1681, the American Bar Association would support legislation along the lines of S. 1681, but only if it is amended to provide safe harbors for conduct that is procompetitive. The American Bar Association believes that the safe harbor provisions outlined above, that have been included in several other McCarran repeal proposals over the years but are not contained in S. 1681, are necessary amendments to the legislation.

At the same time, repeal of McCarran without the creation of these safe harbors would not be desirable because it would leave a degree of uncertainty regarding the permissible scope of insurer interaction, potentially causing consumer harm. While Assistant Attorney General Varney testified before your Committee that she believed that activities such as the sharing of historical claims data is well recognized as permissible conduct that would likely not be subject to challenge, that is no guarantee against possible litigation. Because there is no case law on the insurance-related issues that would arise, it is not entirely clear what forms of collective action would be allowed if the McCarran-Ferguson exemption was repealed in all respects. Business review letters from the Department of Justice, while often helpful in providing guidance to the business community, take considerable time to process and, faced with such uncertainty, many companies might avoid collective action that could be procompetitive for fear of criminal or civil

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penalties. Uncertainty will only be removed after expensive litigation and the reconciliation of potentially conflicting judicial interpretations.

In addition, while the American Bar Association's view is that the insurance industry should not be subject to an antitrust exemption, it should not be subject to a more rigorous antitrust standard than the rest of American industry either. While I do not believe that the bill's intention is to impose more demanding antitrust standards on the insurance industry than other industries, the bill's broad prohibition on "price fixing," "bid rigging" and "market allocations" could potentially be read to condemn activity that would be otherwise permissible under the antitrust laws. Specifically, some activities that might be characterized as "price fixing" or "market allocation" could have procompetitive justifications that would make them permissible under current antitrust doctrine. For example, the antitrust laws generally permit manufacturers to set exclusive territories for their downstream distributors, even though such conduct could be construed as a vertical "market allocation." These terms have very specific meanings in the existing case law interpreting the Sherman Act, and it should clearly not be the intent of this legislation to place a greater burden on the insurance industry than on other industries. Accordingly, the language of Section 3 of the bill could be clarified by adding the bold language as follows:

> Notwithstanding any other provision of law, nothing in the Act of March 9, 1945 (15 U.S.C. 1011 et seq., commonly known as the ''McCarran-Ferguson Act''), shall be construed to permit health insurance issuers (as defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91) or issuers of medical malpractice insurance to engage in any form of price fixing, bid rigging, or market allocations **that contravenes federal antitrust law** in connection with the conduct of the business of providing health insurance coverage (as defined in such section) or coverage for medical malpractice claims or actions.

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The American Bar Association believes strongly that competition in the insurance industry can be enhanced, consistent with necessary joint activities, to the benefit of all segments of our society.

Thank you for the opportunity to present the views of the American Bar Association. We would be happy to work with your Committee on the legislation and to answer any questions you might have.

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Resolution Adopted By The

American Bar Association
House of Delegates
February 1989

BE IT RESOLVED, That the American Bar Association adopts the following recommendation:

1) The current McCarran-Ferguson exemption to the antitrust laws should be repealed and replaced with legislation containing the following features:

(1) Insurers should be made subject to general antitrust laws but provided with authorization to engage in specified cooperative activity that is shown to not unreasonably restrain competition in the industry.

(2) Insurers should be authorized to cooperate in the collection and dissemination of past loss experience data so long as those activities do not unreasonably restrain competition but should not be authorized to cooperate in the construction of advisory rates or the projection of loss experience into the future in such a manner as to interfere with competitive pricing.

(3) Insurers should be authorized to cooperate to develop standardized policy forms in order to simplify consumer understanding, enhance price competition and support data collection efforts, but state regulators should be given authority to guard against the use of standardized forms to unreasonably limit choices available in the market.

(4) Insurers should be authorized to participate in voluntary joint underwriting agreements and in connection with such agreements to cooperate with each other in making rates, policy forms, and other essential insurance functions so long as these activities do not unreasonably restrain competition.

(5) Insurers participating in residual market mechanisms should be authorized in connection with such activity to cooperate in making rates, policy forms, and other essential insurance functions so long as the residual market mechanism is approved by and subject to the active supervision of a state regulatory agency.

(6) Insurers should be authorized to engage in such other collective activities that Congress specifically finds do not unreasonably restrain competition in insurance markets.

(7) State regulation of insurance rates should not exempt insurers from the antitrust laws under the state action doctrine, except as specified in Recommendation B.1(1) to B.1(6). Other non – rate regulation by a state should not exempt insurers from the antitrust laws unless that regulation satisfies the requirements of the state action doctrine and the regulation is shown to not unreasonably restrain competition.

2) States should retain the authority to regulate the business of insurance. The federal government should defer to state regulation except in those unusual circumstances where the regulatory objective can only be effectively accomplished through federal involvement.

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ADA American Dental Association®

STATEMENT OF THE

AMERICAN DENTAL ASSOCIATION

TO THE

COMMITTEE ON THE JUDICIARY

UNITED STATES SENATE

ON

"PROHIBITING PRICE FIXING AND OTHER ANTICOMPETITIVE CONDUCT IN THE HEALTH INSURANCE INDUSTRY"

OCTOBER 14, 2009

The American Dental Association ("ADA") is pleased to submit this written testimony for inclusion in the record of the Senate Judiciary Committee's hearing on Prohibiting Price Fixing and Other Anticompetitive Conduct in the Health Insurance Industry, held on October 14, 2009. The hearing addressed the merits of "The Health Insurance Industry Antitrust Enforcement Act of 2009" (S.1681), which would repeal the antitrust exemption created by the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, with respect to health insurers. For the reasons set forth below, the ADA strongly supports this much needed legislation.

I. About the ADA

The ADA is America's leading advocate for oral health. Established in 1859, the ADA today represents approximately 157,000 licensed dentists in the United States. Through its numerous initiatives, the ADA supports programs to improve access to high quality dental care for all Americans and to inform all Americans about their oral health. Consequently, the ADA has a real and abiding interest in promoting a robustly competitive market for health insurance.

II. Repeal of the Health Insurance Industry's Antitrust Exemption

The McCarran-Ferguson Act's antitrust exemption extends to all conduct that constitutes the "business of insurance," not merely the activities of health insurers. Nevertheless, the repeal of the exemption within the health insurance industry is particularly important. As both Senator Reid and Senator Leahy emphasized during the Committee's hearing,[1] the current debate regarding health care reform requires serious consideration of any and all means to introduce competition and make health insurance affordable for all Americans. An important step toward achieving these objectives is eliminating the unwarranted antitrust exemption that grants health

[1] Statement of the Honorable Harry Reid (Oct. 14, 2009), *at* http://judiciary.senate.gov/hearings/testimony.cfm?id=4111&wit_id=7320; Statement of the Honorable Patrick Leahy (Oct. 14, 2009), *at* http://judiciary.senate.gov/hearings/testimony.cfm?id=4111&wit_id=2629.

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insurers special status, and permits them to ignore the competitive rules that apply to every other U.S. business.

A. Antitrust Exemptions Are Disfavored as a General Rule

Even before addressing the merits of the specific antitrust exemption for the insurance industry, it is worth noting that, as a general rule, *all* such exemptions are disfavored. Although a number of industry-specific statutory exemptions remain on the books, no new exemptions have been added in decades. The bipartisan Antitrust Modernization Commission ("AMC") recently concluded that "[t]ypically, antitrust exemptions create economic benefits that flow to small, concentrated interest groups, while the costs of the exemption are widely dispersed, usually passed on to a large population of consumers through higher prices, reduced output, lower quality, and reduced innovation."[2] Consistent with the views of the AMC, the Antitrust Section of the American Bar Association has steadfastly advocated repeal of the specific McCarran-Ferguson Act exemption for the insurance industry for over twenty years.[3]

B. The McCarran-Ferguson Act Is Not Tailored to Unique, Insurance-Industry Needs

Insurers frequently argue that, without the protection of the McCarran-Ferguson Act exemption, they will be unable to engage in procompetitive joint conduct, such as developing standardized policy forms or collecting and disseminating past loss experience data. However, there is little support for these concerns. Firms in other industries routinely carry out these sorts of activities through trade associations and other industry collaborative bodies without fear of undue antitrust enforcement. As the Antitrust Division of the Department of Justice ("DOJ")

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[2] Antitrust Modernization Comm'n, *Report and Recommendations* 335 (Apr. 2007), *at* http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf.

[3] Statement of the ABA Antitrust Section Before the Subcommittee on Courts and Competition Policy, Judiciary Committee, U.S. House of Representatives, Concerning H.R. 3596, "The Health Insurance Industry Antitrust Enforcement Act of 2009" 2 (Oct. 8, 2009), *at* http://judiciary.house.gov/hearings/pdf/Gotts091008.pdf.

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noted in its own testimony before the Committee, antitrust enforcement has changed significantly since 1945. Modern antitrust law is flexible enough that the insurance industry practices at issue, rather than being automatically condemned under the *per se* rule, would now be analyzed under the rule of reason, pursuant to which a particular practice's potential procompetitive benefits are weighed against its potential anticompetitive harms.[4] Reducing the legal uncertainty and business risk still further, DOJ and the Federal Trade Commission ("FTC") have issued detailed joint guidance on the operation of antitrust-compliant industry-wide information exchanges,[5] as well as the structuring of other competitor collaborations.[6] Finally, when even this guidance is insufficient, insurers can request a business review letter from DOJ, or an advisory opinion from the FTC, to assess the antitrust risk associated with a new business practice before implementing it in the marketplace.

C. The McCarran-Ferguson Does Not Benefit Consumers

Both patients and providers have been hurt over the years by the false argument that the McCarran-Ferguson Act exemption protects patients by serving to control the cost of health care. This is simply not the case. Promoting lower prices, greater consumer choice, and increased innovation through robust competition is the role of the antitrust laws. The Supreme Court has characterized the antitrust laws as "the Magna Carta of free enterprise,"[7] and the Sherman Act, 15 U.S.C. §§ 1-7, has proven sufficiently versatile to spur efficiency-enhancing competition in markets spanning the full range of the U.S. economy – largely without the need for industry specific exemptions – for over one hundred years. The McCarran-Ferguson Act, in contrast, was

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[4] Statement of the Antitrust Division of the Dep't of Justice Before the Judiciary Committee, U.S. Senate, Concerning "Prohibiting Price Fixing and Other Anticompetitive Conduct in the Health Insurance Industry" 5 (Oct. 14, 2009), *at* http://judiciary.senate.gov/pdf/10-14-09%20Varney%20Testimony.pdf.

[5] U.S. Dep't of Justice and Fed. Trade Comm'n Statements on Antitrust Enforcement Policy in Health Care, Statement 6 (1996).

[6] U.S. Dep't of Justice and Fed. Trade Comm'n Antitrust Guidelines for Collaborations Among Competitors (2000).

[7] *United States v. Topco Associates*, 405 U.S. 596 (1972).

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intended to protect the insurance industry from a perceived threat of conflicting state and federal regulation – a threat that has proven illusory in the six decades since the legislation's passage.

D. The McCarran-Ferguson Act Chills Needed Antitrust Oversight

Repeal of the McCarran-Ferguson Act will substantially improve, even potentially eliminate, the problem of one-sided federal antitrust enforcement. According to a 2008 study by the American Medical Association, within the 314 metropolitan statistical areas surveyed, 94% of commercial health insurance markets qualified as "highly concentrated" under standards established by DOJ and FTC.[8] Yet, currently, dentists and other health care providers facing monopoly health plans have little recourse. If individual providers or practices band together to increase their negotiating clout, they are likely to trigger an antitrust investigation, if not an enforcement action. For decades, however, when health care providers have brought antitrust concerns regarding insurers to the attention of federal enforcers, agency staff have been reluctant to proceed for fear of crossing the line that McCarran-Ferguson draws. Repeal of the Act would enable both DOJ and FTC to focus their attention on specific anticompetitive practices by insurers that may adversely affect patients and dentists, thereby leveling the playing field and ensuring that providers and health plans are abiding by the same set of competitive rules.

Furthermore, the McCarran-Ferguson Act, by severely limiting federal antitrust enforcement in the insurance industry, places virtually all of the oversight responsibility on state regulators. This allocation of responsibility functions relatively more effectively in those states having better developed and funded regulatory structures, and decidedly less well in the ones that do not. Consequently, repeal of McCarran-Ferguson will lead not only to better, but also to more consistent, antitrust enforcement, as health insurer conduct that is currently subjected to antitrust scrutiny in only some states will be subjected to equivalent scrutiny nationwide.

[8] Emily Berry, *Most Metro Areas Dominated by 1 or 2 Health Insurers*, American Medical News, Mar. 9, 2009.

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E. The McCarran-Ferguson Act Is Outdated

At the time of its passage in 1945, the McCarran-Ferguson Act was intended to resolve a perceived conflict between state and federal regulation of the insurance industry. Prior to the Supreme Court's decision in *United States v. South-Eastern Underwriters Ass'n*,[9] regulation of the insurance industry was regarded as the exclusive province of the states. In *South-Eastern Underwriters*, however, the Court concluded that the insurance industry was within the regulatory reach of the federal government. Under heavy lobbying by the insurance industry, Congress subsequently passed the McCarran-Ferguson Act to return exclusive regulatory authority to the states, thereby eliminating for the decades that followed much of the important federal antitrust scrutiny that has been so highly effective in combating anticompetitive conduct in other industrial sectors. Whatever justification there may have been for the McCarran-Ferguson Act exemption originally, it serves no legitimate purpose today. For example, the possibility of insurers being pulled in different directions by conflicting state and federal regulatory requirements has been vastly reduced in the sixty years since the Act's passage, by the so-called state action doctrine, first articulated by the Supreme Court in *Parker v. Brown*.[10] The doctrine has served well to resolve potential conflicts between state regulation and the federal antitrust laws. Pursuant to it, wherever a state clearly expresses an intention to regulate specific practices or conduct, and such regulation is actively enforced, the federal antitrust enforcement agencies defer. In this light, it becomes apparent that the Act exists today as nothing more than a historical vestige whose complicated terms have resulted in misinterpretation and mischief.

[9] 322 U.S. 533 (1944).
[10] 317 U.S. 341 (1943).

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III. Conclusion

The ADA appreciates the opportunity to participate in the Committee's hearing by submitting this written testimony. We look forward to the opportunity to work with the Committee's members and staff to address the important issues raised by "The Health Insurance Industry Antitrust Enforcement Act of 2009" as the Committee's consideration of the bill moves forward.

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American Hospital
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October 13, 2009

The Honorable Patrick Leahy
Chairman, Senate Judiciary Committee
224 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Leahy:

On behalf of the American Hospital Association's (AHA) more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members we appreciate the opportunity to write in support of the "Health Insurance Industry Antitrust Enforcement Act of 2009" S. 1681. The bill promotes a limited repeal of the McCarran-Ferguson antitrust exemption available for health insurers for price fixing, big rigging and market allocation. AHA believes that the health insurance industry should be governed by the same antitrust laws and policies that apply in other sectors of our economy, including health care. Any exemptions should be narrow and carefully tailored to achieve a procompetitive purpose.

AHA has recently articulated its concern about the abuse of market power in the health insurance industry in a letter and background paper shared with the Department of Justice's Antitrust Division (DOJ) in May. We urged the Division to step up its enforcement against health plan mergers and other anticompetitive conduct because the increase in concentration and increasingly anticompetitive conduct was harming consumers, hospitals and other caregivers and could imperil health care reform.

The recent Kaiser Family Foundation and the Health Research & Educational Trust (HRET) survey confirms that the cost of health insurance premiums continues to outpace inflation and the growth in most American's wages. The survey reported that family health insurance premiums rose about 5 percent this year, which is much more than general inflation (which fell 0.7 percent during the same period). Workers' wages went up 3.1 percent during the same period. Since 1999, premiums have gone up a total of 131 percent, far more rapidly than workers' wages (up 38 percent since 1999) or inflation (up 28 percent since 1999).

We are also concerned about how the insurance industry's market power might impact a health insurance exchange (or multiple exchanges) where consumers will have the opportunity to compare health insurance offerings in a new and robust marketplace. A recent *New York Times*

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article warned that "[w]ithout careful design and adequate rules of fair play . . . the exchange might not actually stimulate new competition among the nation's health insurers."
S.1681 should help to achieve the goal of "fair play" by eliminating antitrust protection for price-fixing, bid rigging and market allocation activities that could undermine the success of a health insurance exchange and the coverage it promises for millions of Americans.

If you have any questions, please feel free to contact Melinda Hatton, the AHA's senior vice president and general counsel at (202) 626-2336 or mhatton@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

America's Health
Insurance Plans

Karen Ignagni
President &
Chief Executive Officer

October 8, 2009

HAND DELIVERED

The Honorable Patrick Leahy
Chairman
Committee on the Judiciary
United States Senate
224 Dirksen Senate Office Building
Washington, DC 20510

The Honorable John Conyers
Chairman
Committee on the Judiciary
United States House of Representatives
2138 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Leahy and Chairman Conyers:

On behalf of America's Health Insurance Plans ("AHIP") and its member companies, we are writing regarding S. 1681 and H.R. 3596, both of which propose to repeal portions of the McCarran-Ferguson Act as they apply to health insurance plans and medical malpractice insurers.

In our view, the two bills under consideration may be based on a misperception of the scope and impact of the McCarran-Ferguson Act on health insurers. The Act does not preclude regulation of insurers but, instead, recognizes that the states play a central role in conducting oversight of health and other insurers. Indeed, the Congressional Research Service (CRS) recently noted that "[t]he McCarran-Ferguson Act prohibits the application of the antitrust laws and similar provisions of the FTC Act to the 'business of insurance' to the extent that it is regulated by state law."[1] In fact, health insurance is one of the most significantly regulated areas of the economy.

CRS also noted that "[t]he scope of the term 'business of insurance' has been narrowly construed by the Supreme Court to include only those activities involving the underwriting and spreading of insurance risk and the insurance companies' relationships with their policy holders." Given this narrow scope, it is inaccurate to describe the exemption as permitting anticompetitive conduct or mergers. CRS noted that "[t]he federal antitrust laws and FTC Act probably still

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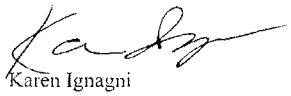
South Building
Suite Five Hundred
Washington, DC 20004
202 7[illegible]

apply to all other activities of insurance companies, including their attempts to merge and some of their negotiated agreements because the McCarran-Ferguson exemption is for the 'business of insurance,' not the 'business of insurers.'"

More generally, AHIP and our members stand on the side both of competition and of meaningful reform. We believe that the federal antitrust enforcement agencies can and do play a meaningful role in making health care markets more competitive, and we encourage initiatives to make them more effective in their missions. Similarly, we have endorsed comprehensive reform proposals for expanding coverage, improving quality, and slowing the growth rate of health care costs.

Thank you for your consideration of our thoughts on this issue. We would be happy to continue to discuss this and other issues with you.

Sincerely,



Karen Ignagni
President and CEO

Cc: The Honorable Jeff Sessions, Ranking Member, Committee on the Judiciary, United States Senate
The Honorable Lamar Smith, Ranking Member, Committee on the Judiciary, United States House of Representatives

[1] Congressional Research Service, Health Care Reform: Selected Antitrust Considerations (Aug. 31, 2009)

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American Insurance Association
Council of Insurance Agents and Brokers
The Financial Services Roundtable
Independent Agents & Brokers of America
National Association of Mutual Insurance Companies
National Association of Professional Insurance Agents
Physician Insurers Association of America
Property Casualty Insurers Association of America
Reinsurance Association of America

October 9, 2009

The Honorable Patrick Leahy
Chairman
Committee on the Judiciary
United States Senate
Washington, DC 2051

The Honorable Jeff Sessions
Ranking Republican
Committee on the Judiciary
United States Senate
Washington, DC 20510

Dear Mr. Chairman and Senator Sessions

The undersigned organizations represent all the segments of the property/casualty insurance industry, from primary insurers to agents, brokers, and reinsurers. We are writing to express our strong opposition to H.R. 3596 and S. 1681, identical bills introduced as the "Health Insurance Industry Antitrust Enforcement Act of 2009." These recently introduced bills would repeal long-standing provisions of the McCarran-Ferguson Act with respect to health and medical malpractice insurance (more appropriately called medical professional liability insurance) issuers. There is no demonstrated need to expand the scope of the healthcare reform debate in this fashion for the reasons below.

The McCarran-Ferguson Act, approved by Congress in 1945, entrusts states with the authority and responsibility for the regulation of the business of insurance. The McCarran-Ferguson Act creates a limited exemption from federal antitrust laws to the extent that the business of insurance – not the business of insurance companies – is regulated by the states; it does not grant insurers blanket immunity from federal antitrust laws, as some have erroneously suggested, and it does not shield insurers from laws that prohibit them from engaging in boycotts, intimidation, or coercion. Courts consistently have narrowly construed McCarran's limited antitrust exemption.

Under the regulatory regime that arose from the McCarran-Ferguson Act, more than 5,000 property/casualty insurers across the country are subject to a comprehensive and pervasive regimen of state-based regulation and antitrust enforcement, including health and medical professional liability insurance covered by H.R. 3596 and S. 1681. States regulate virtually every aspect of insurance, including licensing, market conduct, financial solvency, policy language and underwriting standards. Thus, federal action to repeal or amend the McCarran-Ferguson Act for these or any line of insurance is unnecessary to pursue any allegations of anti-competitive behavior.

Beyond the general disruption to the state regulatory system that these bills propose, the bills appear to have a much broader, but undisclosed agenda. For example:

Section 3 appears to expand the boundaries of antitrust violations in order to encourage attacks on insurers for marketplace behavior that would not otherwise be a violation of federal antitrust laws irrespective of McCarran-Ferguson.

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Section 4 would have the effect of preempting or repealing state laws establishing mechanisms for insurers to gather information and develop actuarially-based rates through organizations that have been (i) created precisely for those purposes, (ii) are licensed and regulated by the states; and (iii) whose availability is critical to the states in carrying out their regulatory responsibilities. Thus, Section 4 would leave the states with only two options for health and medical malpractice insurance: they would either be required to set the prices themselves for health and medical malpractice insurance or be denied the right to have any mechanism for reviewing and regulating the prices established in the marketplace.

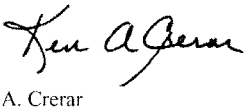
The bill appears designed to deny the affected insurers of standard antitrust defenses, such as the state action doctrine.

In short, the bill is an attempt to radically rewrite the antitrust laws for a certain segment of the insurance business.

We, therefore, urge you to oppose these current bills, as they would bring no consumer benefit while causing enormous marketplace disruption that might have the perverse effect of discouraging new marketplace entrants. It would be ironic indeed if the primary purpose of the federal antitrust laws – promoting competition – was undercut through enactment of either bill.

Sincerely,

Leigh Ann Pusey
President and CEO
American Insurance Association
(AIA)

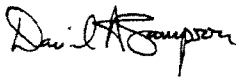


Ken A. Crerar
President
The Council of Insurance Agents and Brokers
(CIAB)

Bob Rusbuldt
President and CEO
Independent Agents & Brokers
of America
(IIABA)

Steve Bartlett
President and CEO
The Financial Services Roundtable
(FSR)

Charles M. Chamness
President and CEO
National Association of Mutual
Insurance Companies
(NAMIC)



Dr. David A. Sampson
CEO
Property Casualty Insurers
Association of America
(PCIAA)

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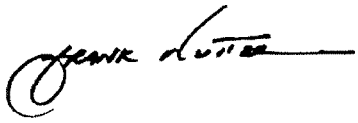
Len Brevik
Executive Vice President & CEO
National Association of
Professional Insurance Agents
(PIA)



Franklin W. Nutter
President
Reinsurance Association of
America
(RAA)

Lawrence E. Smarr
President
Physician Insurers Association
of America
(PIAA)

cc: Members of the Senate Judiciary Committee

Assessing Financial Performance In Medical Professional Liability Insurance*

Robert E. Hoyt, Ph.D.**
Lawrence S. Powell, Ph.D.***

Introduction

In the past few years, significant concerns have arisen over the cost and availability of medical malpractice insurance. In addition,, a great deal of attention has been devoted to the reasons behind these increasing costs. In spite of this interest in and attention to the cost of medical malpractice insurance, surprisingly little analysis of the performance of medical malpractice insurance companies has been conducted. Critics of the medical liability insurance industry, including several consumer advocacy groups, present information regarding medical malpractice insurer performance via formal reports, public letters or testimony before policymakers. Several common elements persist in the information released by these groups. Specifically, the findings include the following: 1) premiums written recently increased more than the amount of claims paid; 2) some insurers increased premiums while expected payouts were decreasing; and 3) insurers increased the nominal amount of surplus they hold.[1]

While we share the view that it is important to consider the performance of insurers when evaluating the cost of medical malpractice insurance, we believe that much of the analysis conducted thus far suffers from errors in methodology, making it difficult to make meaningful conclusions regarding whether

* Financial support for this research was provided by the Health Coalition on Liability and Access, a broad-based group of medical, hospital, insurance and other healthcare organizations (www.hcla.org).

** Dudley L. Moore, Jr., Chair of Insurance, Terry College of Business, University of Georgia; rhoyt@terry.uga.edu.

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1. See Angoff (2005) and AIR (2004a, 2004b). See also discussion in Treaster and Brinkley (2005) and Zimmerman and Oster (2002).

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physicians are being overcharged for professional liability insurance. We believe that careful analysis of objective data regarding insurer financial performance is warranted. In this study, we present evidence regarding the financial performance of the medical malpractice insurance industry. Contrary to the findings of studies and information presented by various industry critics, we find no evidence that medical malpractice insurance is overpriced.

This article first describes the analysis of medical liability insurer financial performance using two appropriate measures. Then, it presents our analysis of the capitalization or surplus position of medical liability insurers, including review of medical liability insurer financial strength ratings information. It concludes with a summary of our findings.

Insurance Company Performance

A firm's performance is often measured by comparing costs to revenues. This task is substantially more complicated for a liability insurance company because costs are uncertain at the time revenue is collected. A proper measure of insurance company performance must consider all costs and all revenues, as well as the timing of the cash flows. Costs include losses, loss adjustment expenses and operating expenses.[2] Revenues include investment earnings and premiums less policyholder dividends.

A substantial amount of time elapses between the time losses are reported to an insurer and when they are paid in full. To illustrate this point, in Appendix A we present the payout pattern for medical malpractice losses calculated by the IRS. Noteworthy in these data is the fact that for occurrence-based policies, by the sixth year following the policy period, only one-half of all claim amounts that will ultimately be paid have actually been paid out by the insurer.[3] For claims-made policies, it is the fourth year following the policy period before more than one-half of all claim amounts have been paid. Further, even at year 10 for claims-made based policies and at year 12 for occurrence-based policies 5% of the ultimate claim amounts remain unpaid. This illustrates the long payout tail that exists in medical liability insurance. An appropriate measure of insurer performance, therefore, should include an estimate of losses incurred in a given year, rather than the amount paid. Also, the measure must account for interest earned on premiums between the time the premium is collected and the loss is paid. This is especially important given the long payout tail in medical liability insurance. Losses must be discounted to present value before performance ratios are analyzed.

2. Loss adjustment expenses include the cost of defending and paying claims such as attorney fees, expert witness fees, claims adjustor compensation, court fees and other miscellaneous costs. Operating expenses include overhead, payroll, employee benefits, underwriting expenses, sales commissions and premium taxes.

3. Approximately 70% of medical liability insurance is written on a claims-made basis, while the remaining 30% is written on an occurrence basis. Appendix A presents the payout pattern for both occurrence and claims-made policies.

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We present two appropriate measures of financial performance in the medical malpractice insurance industry. These measures consider insurer performance from different perspectives. The first measure considers the profitability of a book of insurance policies. The second measure reports return on equity (ROE), which includes performance of insurers' accumulated surplus. It is important to consider both measures, because surplus cannot be accurately segregated by line of business in a multi-line firm (Phillips, Cummins and Allen, 1998). The first measure avoids this problem by measuring the profitability of insurance policies written during the sample period. The second measure, ROE, measures profitability at the firm level, but does not directly represent profitability of insurers exclusively from the medical malpractice line of business.

The first measure is similar in construction to the Economic Loss Ratio (ELR) introduced by Winter (1994) and used in several other academic studies to proxy for the price of insurance.[4] Unlike most derivations of the ELR, our measure includes underwriting and overhead expenses in the numerator to capture insurer performance rather than just the price of insurance. This measure includes the most complete set of costs and revenues reported on insurers' annual financial statements for all companies that reported these data to regulators.[5] Our sample ranges in size from a high of 420 firms in 1996 to a low of 341 firms in 2001. The average number of firms in our sample each year is 391. The measure of profitability that we use discounts incurred losses to present value using the method prescribed by the IRS. This measure, which we call the economic combined ratio (ECR), is presented in Figure 1 below for the period from 1996 to 2004.[6]

4. Berger, Cummins and Tennyson (1992); Cummins and Danzon (1997); Sommer (1996); and others have used the economic loss ratio to proxy for the price of insurance.

5. Our sample is based on all insurers for which data are available on the NAIC data tapes. These data tapes contain the statutory annual statement accounting data that are filed with the NAIC by nearly all insurers in the United States. These data are used with permission of the NAIC. The National Association of Insurance Commissioners does not endorse any analysis or conclusions based on the use of its data.

6. The combined ratio is defined as the ratio of losses and expenses to premiums. It is commonly reported as a measure of underwriting profitability in property-liability insurance. It does not consider the impact of investment earnings. As describe in the text, our measure, the ECR, does consider the time value of money.

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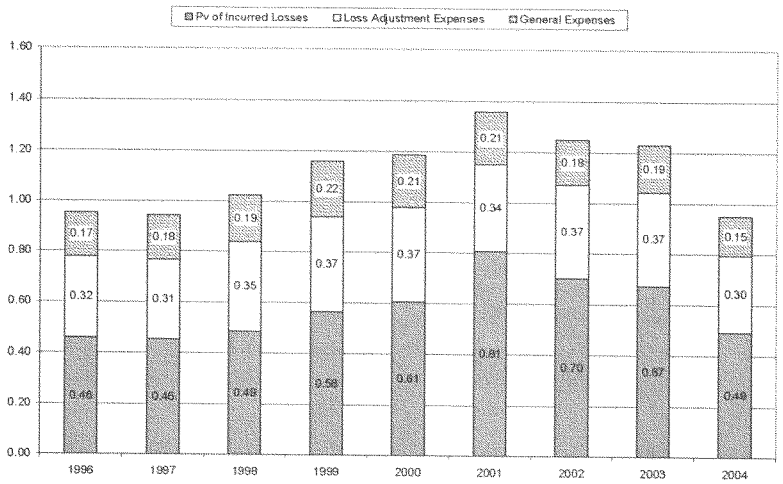
Figure 1
Economic Combined Ratio



Economic Combined Ratio = (Present value of incurred losses + loss adjustment expenses + general expenses)/(premiums earned – policy holder dividends).

Source: NAIC InfoPro Property and Casualty Insurance Data, 1996–2004

Figure 2 displays industry profits and losses in the medical malpractice line calculated using the ECR. Based on this comprehensive analysis of insurer profitability, during the period 1996 to 2004, medical liability insurers, as a group, reported modest profitability in only three years (1996, 1997 and 2004). In contrast, these insurers sustained losses in the medical malpractice line in six consecutive years from 1998 to 2003. The average profit ratio (return on net premiums earned) during the period 1996 to 2004 was −13.0%.[7]

7. This is the geometric mean return. The arithmetic mean was -11.8% and the median return was -16.0%.

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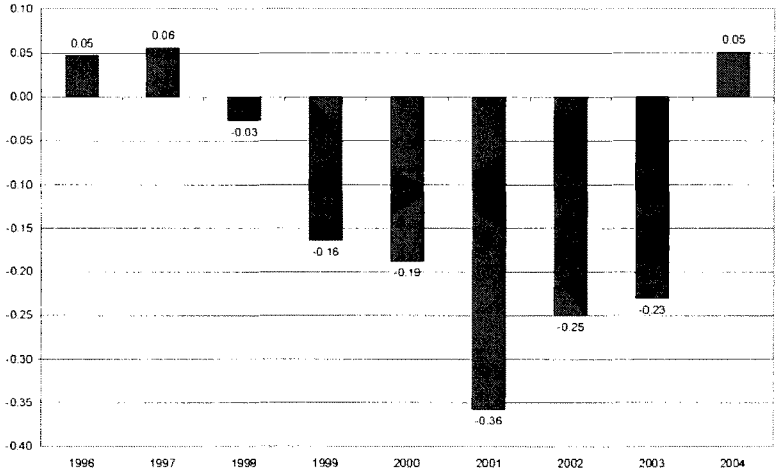
Figure 2
Medical Malpractice Insurance Industry Profit (Loss), 1996-2004



Source: NAIC InfoPro Property and Casualty Insurance Data, 1996-2004

An alternative measure of firm profitability that is often referenced is a firm's return on equity (ROE). This measure includes investment returns not only on an acquired block of policies, but also on the firm's own accumulated capital. Values for average return on equity for medical liability insurers are obtained from the NAIC's *Report on Profitability by Line by State*. The average ROE values for medical liability insurance during the period 1995 to 2003 are presented in Figure 3. For comparison, Figure 3 also reports the average ROE for diversified financial firms, firms in the Fortune 500 and utility firms. Although the ROE values for medical liability insurance are higher in all years than the corresponding ECR values, comparison of returns in medical liability insurance to ROE values for firms in other industries lead to a similar conclusion. Namely, there is no evidence that medical liability insurers have been earning excessive returns. In fact, except for three years when ROE values in medical liability insurance were slightly higher than those earned by utility firms, returns to medical liability insurers have been significantly below those earned by firms in other industries and in the market generally. The comparison between ROE values for diversified financial firms and returns to medical liability insurers is especially dramatic.

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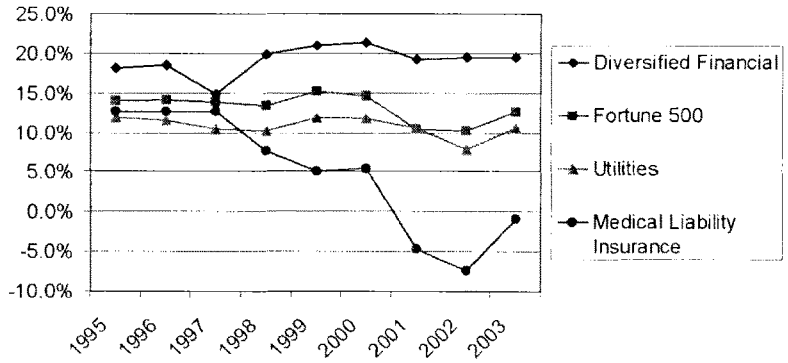
Figure 3
Annual Rate of Return on Equity



Source: *Insurance Information Institute Fact Book*, 2005.

Surplus Analysis

If medical malpractice liability insurers experienced excessive profitability, one likely outcome would be over-capitalization. Instead of returning profits to policyholders as a dividend, insurers could have retained net income by transferring it to surplus. To evaluate the capitalization of medical malpractice insurers, we compared financial strength ratings and the level of risk-based capital (RBC) reported by 12 mono-line medical malpractice insurers to that of the rest of the industry. The median RBC ratio reported by all property-liability insurers for which data were available from the NAIC in 2004 is 833%. Among the mono-line medical malpractice insurers, the highest 2004 RBC ratio was reported by First Professionals Insurance Company, with 592% — more than 200 percentage points less than the industry median in that year. Medical Professional Mutual Insurance Company exhibits the lowest 2004 RBC ratio, with 250%.

Table 1
Analysis of RBC Ratios (2000–2004)

Year	2000	2001	2002	2003	2004
Insurers reporting RBC	2247	2299	2359	2445	2525
Insurers with RBC<300%	167	201	249	219	228
Percentage of insurers with RBC <300%	7%	9%	11%	9%	9%
Insurers with RBC<=200%	53	53	82	69	86
Percentage of insurers with RBC <=200%	2%	2%	4%	3%	3%
Median RBC	923%	888%	813%	805%	833%

Source: NAIC InfoPro Property and Casualty Data, 2004, p. 18 – Five-Year Historical Data

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For qualitative information on medical malpractice insurers' surplus, we looked to A.M. Best, the primary rating agency for insurance companies. A.M. Best's financial strength ratings describe the capitalization of insurance companies. Table 2 displays the breakdown of the A.M. Best ratings for the property-liability insurance industry in 2004. Table 3 describes the A.M. Best ratings for the 15 largest medical malpractice insurers in 2004 and compares those to the rating levels for insurers overall.

Table 2
A.M. Best Ratings (2004)

Rating	No. of Insurers
A++	128
A+	364
A	775
A-	540
B++	213
B+	125
B	103
B-	43
C++	15
C+	8
C	4
C-	4
D	12
E	28
F	9

Source: A.M. Best's *Key Rating Guide*, 2004

The ratings data in Table 3 are not consistent with the notion that these medical liability insurers are earning extraordinary profits or are over-capitalized. In fact, overall, the financial ratings of these companies, from what is arguably the most important independent rating agency of insurers in the United States, suggest that these insurers have average to below average financial strength ratings.

The fourth column of Table 3, labeled "Rating Outlook," lists the rating outlooks assigned to each insurer by A.M. Best in 2003. Rating outlooks indicate the potential future direction of insurers' ratings over an intermediate period. Outlook indications can be positive, negative or stable. Eight insurers in this sample are assigned negative outlooks. Seven are assigned stable outlooks. None are assigned a positive outlook. The lack of positive outlook indications suggests that insurers in this sample are neither overcapitalized, nor excessively profitable. It is also important to note that the ratings for most of these insurers are based on the capitalization of the parent firm, which often serves to bolster the subsidiary insurer's rating.

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Table 3
Description of A.M. Best Ratings
for the 15 Largest Medical Malpractice Insurers

Company Name	A.M. Best Rating	Percentage of Insurers with a Lower Rating	Rating Outlook*	Rating Modifier**
American Physicians Assurance Corporation	B+	9.5%	Negative	none
Continental Casualty Company	A g	46.6%	Negative	g
Evanston Insurance Company	A g	46.6%	Stable	g
First Professionals Insurance Company, Inc.	B++p	14.8%	Stable	p
Health Care Indemnity, Inc.	A-	23.8%	Stable	none
ISMIE Mutual Insurance Company	B+ g	9.5%	Negative	g
Lexington Insurance Company	A++p	94.6%	Stable	p
MAG Mutual Insurance Company	A- g	23.8%	Negative	g
Medical Professional Mutual Insurance Company	A- g	23.8%	Negative	g
NORCAL Mutual Insurance Co.	A g	46.6%	Negative	g
ProNational Insurance Company	A- g	23.8%	Stable	g
State Volunteer Mutual Ins. Co.	A	46.6%	Negative	none
The Doctors Company, An Interinsurance Exchange	B++g	14.8%	Negative	g
The Medical Assurance Co. Inc	A- g	23.8%	Stable	g
The Medical Protective Company	A-	23.8%	Stable	none

*A rating outlook indicates the potential future direction of a company's rating over the next 12 to 36 months. Possible rating outlooks are negative, stable, and positive.

**Rating modifier "g" indicates the rating is based on capitalization of the insurer's parent company. Rating modifier "p" indicates the rating is based on capitalization of companies with which the insurer pools liabilities.

Sources: *A.M. Best's Key Rating Guide*, 2004; *A.M. Best's Company Reports*, 2003.

Conclusions

In the past few years, significant concerns have arisen over the cost and availability of medical malpractice insurance. We present findings on the financial performance of the medical malpractice insurance industry. Contrary to the claims of several industry critics, we find no evidence that medical malpractice insurance is overpriced.

We analyzed two appropriate measures of financial performance in the medical malpractice insurance industry: the economic combined ratio and return on equity. Based on the ECR, during the period 1996 to 2004, medical liability insurers, as a group, reported modest profitability in only three years (1996, 1997 and 2004). In contrast, these insurers sustained losses in six consecutive years from 1998 to 2003. The average profit ratio (return on net premiums earned) during the period 1996 to 2004 was -13.0%. Also, a comparison of

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returns in medical liability insurance to ROE values for firms in other industries leads to a similar conclusion regarding insurer financial performance. Namely, there is no evidence that medical liability insurers have been earning excessive returns.

We also analyzed the capitalization of medical malpractice insurers by comparing the RBC and A.M. Best ratings of 12 mono-line medical malpractice insurers to those of the rest of the industry. The median RBC ratio reported by all insurers in 2004 is 833%, far above the 250% to 592% range reported by the sample of 12 medical malpractice insurance companies. Further, we reviewed the A.M. Best ratings for this sample of insurers. The ratings data are not consistent with the notion that these medical liability insurers are earning extraordinary profits or are over-capitalized. In fact, overall the financial ratings of these companies, from what is arguably the most important independent rating agency of insurers in the United States, suggest that these insurers have average to below average financial strength ratings.

In conclusion, our comprehensive analysis of financial performance in the medical liability insurance industry over the past nine years does not suggest that medical liability insurers are earning extraordinary profits or that they are over-capitalized. We find no evidence that medical malpractice insurance is overpriced.

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Appendix A

Payout Pattern
for Medical Malpractice Losses (Occurrence)

Year	Estimated losses paid each year	Cumulative losses paid	Annual payout for $10,000 loss	Cumulative payout for $10,000 loss
1	0.021	0.021	$ 212	$ 212
2	0.044	0.065	$ 436	$ 648
3	0.091	0.156	$ 912	$ 1,560
4	0.163	0.319	$ 1,631	$ 3,191
5	0.132	0.451	$ 1,319	$ 4,509
6	0.050	0.501	$ 498	$ 5,008
7	0.109	0.610	$ 1,090	$ 6,097
8	0.082	0.692	$ 824	$ 6,921
9	0.037	0.729	$ 365	$ 7,287
10	0.071	0.800	$ 713	$ 8,000
11	0.071	0.871	$ 713	$ 8,714
12	0.071	0.943	$ 713	$ 9,427
13	0.057	1.000	$ 573	$ 10,000

Source: IRS, Internal Revenue Bulletin No. 2000-43, October 23, 2000, page 412.

Payout Pattern
for Medical Malpractice Losses (Claims Made)

Year	Estimated losses paid each year	Cumulative losses paid	Annual payout for $10,000 loss	Cumulative payout for $10,000 loss
1	0.064	0.064	$ 639	$ 639
2	0.176	0.240	$ 1,761	$ 2,400
3	0.187	0.427	$ 1,870	$ 4,270
4	0.154	0.581	$ 1,536	$ 5,806
5	0.116	0.697	$ 1,160	$ 6,967
6	0.059	0.756	$ 594	$ 7,560
7	0.063	0.819	$ 628	$ 8,188
8	0.060	0.879	$ 598	$ 8,785
9	0.017	0.895	$ 167	$ 8,952
10	0.048	0.943	$ 478	$ 9,430
11	0.048	0.991	$ 478	$ 9,908
12	0.009	1.000	$ 92	$ 10,000

Source: IRS, Internal Revenue Bulletin No. 2000-43, October 23, 2000, page 412.

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Consumer Federation of America

TESTIMONY OF

J. ROBERT HUNTER,
DIRECTOR OF INSURANCE,
CONSUMER FEDERATION OF AMERICA

BEFORE

THE COMMITTEE ON THE JUDICIARY
OF THE
UNITED STATES SENATE

REGARDING

PROHIBITING PRICE FIXING AND OTHER ANTICOMPETITIVE CONDUCT IN THE HEALTH INSURANCE INDUSTRY

October 14, 2009

Good morning Mr. Chairman and members of the Committee. Thank you for inviting me here today to discuss the need for the antitrust exemption of the McCarran Ferguson Act, particularly regarding the provision of health insurance. My name is Bob Hunter. I am Director of Insurance for the Consumer Federation of America. CFA is a non-profit association of approximately 300 organizations that, since 1968, has sought to advance the consumer interest through research, advocacy and education. I am a former Federal Insurance Administrator under Presidents Ford and Carter and I have also served as Texas Insurance Commissioner. I am also an actuary, a Fellow of the Casualty Actuarial Society and a member of the American Academy of Actuaries.

As I have told this committee before, CFA wholeheartedly supports completely repealing the antitrust exemption enjoyed by the insurance industry[1] to unleash the Federal Trade Commission (or a new Consumer Financial Protection Agency) to protect insurance consumers. This step is critically needed to overcome the anticompetitive practices of this huge and important industry. It is high-time that insurers played by the same rules of competition as virtually all other commercial enterprises operating in America's economy. We also support significant steps toward that goal, such as your bill, Mr. Chairman, the Health Insurance Industry Antitrust Enforcement Act of 2009 (S. 1681.) This legislation would repeal the antitrust exemption for health and medical malpractice insurance.

The McCarran Ferguson Act is a truly astounding piece of legislation. The Act takes two controversial steps:

1. It delegates the regulation of insurance entirely to the states without providing any guidelines or standards for the states to meet and without mandating any continuing oversight by GAO or other federal entities; and

2. It largely exempts insurance companies from antitrust law enforcement, except for acts involving intimidation, coercion, and boycott.

Both of these provisions are under review by Congress:

- The delegation of regulation to the states is under attack by the insurance industry itself, parts of which seek an optional federal charter and parts of which supports the status quo. Consumer representatives do not care who regulates insurance; they care only about the quality of consumer protections.[2] Both industry-sponsored proposals would accomplish something very hard to do given the overall inadequacy of consumer protection under the current state system – they would reduce these protections; and
- The antitrust exemption has been ripe for repeal for decades, with many businesses and consumers periodically seeking its end.

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[1] CFA supports, for example, H.R. 1583 (DeFazio) to eliminate the federal antitrust exemption for all lines of insurance.

[2] CFA's Principles for a Solid Regulatory System, be it federal or state, are attached to its testimony of October 22, 2003 before the Committee on Commerce, Science and Transportation of the U.S. Senate, available at http://www.consumerfed.org/elements/www.consumerfed.org/file/finance/Insurance%20RegulationSenatetestimony10-03.pdf.

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PERFECT TIMING FOR REPEAL

From 2004 to 2008, the property/casualty insurance industry set several industry profit records. Over that five year period, insurers netted an after-tax profit of more than a quarter of a trillion dollars ($226.1 billion[3]). To put this into perspective, industry profit over this period equates to roughly $714 for every American, or $1,937 per household.[4]

During this time, victims of Hurricane Katrina were having a remarkably hard time getting their claims settled and were, on top of that, losing significant access to homeowners' insurance coverage as insurers pulled out of their area.

Collusive activities by the insurance industry contributed to this "perfect storm" that has harmed consumers. Consider the following anti-competitive activities, which are discussed at greater length below:

- Health insurers used common service providers to underpay health claims through artificially lowering the "usual and customary" amounts paid to doctors and hospitals for providing health services.
- Claims were being settled under the outrageously unfair anti-concurrent-causation clause adopted simultaneously by many insurers. This contract provision prohibits consumers from filing a claim for wind damage if flood damage has occurred during the same period, even if the water damage occurred hours after the wind damage. Courts are still trying to deal with the fallout of this abusive practice.[5]
- Cartel-like organizations, such as the Insurance Services Office (ISO), were signaling to the market that it was time to cut back coverage in certain parts of the coast.
- Many property-casualty insurers used identical or very similar claims processing systems that are designed to systematically underpay claims. Common consultants have frequently recommended these systems.

BACKGROUND[6]

The history of the McCarran Ferguson Act is replete with drama, from an industry flip-flopping on who should regulate it to skillful lobbying and manipulation of Congressional processes in order to transform the bill's short antitrust moratorium into a permanent antitrust exemption in the confines of a conference committee.

In fact, the insurance industry has long-standing anti-competitive roots. In 1819, local associations were formed to control price competition. In 1866, the National Board of Fire

[3] Aggregates and Averages, A. M. Best and Co., 2005 through 2008 editions.
[4] U.S. Census Bureau, Projections of the Number of Households and Families in the United States: 1995 to 2010.
[5] Just last week the Mississippi Supreme Court ruled against an insurer for using the anti-concurrent causation clause in *Corban v. United Services Automobile Association*, No. 2008-IA-00645-SCT.
[6] Much of this material is derived from the Report of the House Judiciary Committee on the Insurance Competitive Pricing Act of 1994 (House Report 103-853) dated October 7, 1994.

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Underwriters was created to control price at the national level, but states enacted anti-compact legislation to control price fixing.

This increased state regulatory activity led insurers to seek a federal approach to preempt the state system. In 1866 and 1868, bills were introduced in Congress to create a national bureau of insurance, but the insurer effort was unsuccessful. Failing in Congress, the industry shifted to a judicial approach.

The case on which rode the industry's hope for court-initiated reform was *Paul v. Virginia*, 75 U.S. (8 Wall) 168 (1868). But the insurance industry's hopes were dashed when the Supreme Court ruled that states were not prohibited by the Commerce Clause from regulating insurance, reasoning that insurance contracts were not articles of commerce in any proper meaning of the word. Such contracts, they ruled, were not interstate transactions (though the parties may be domiciled in different states, the policies did not take effect until delivered by the agent in a state, in this case Virginia). They were deemed, then, local transactions, to be governed by local law.

For the next 75 years insurance regulation remained in the states, despite repeated insurance industry litigation seeking federal preemption. (Ironically, the industry would later adopt the Paul rationale to fend off enhanced federal scrutiny of its activities under the Sherman and Clayton Antitrust Acts).

Until 1944 state regulation of insurance was secure, based on the rationale that insurance was not interstate commerce. But that assumption was repudiated in the 1944 Supreme Court decision *United States v. South-Eastern Underwriters Association*. That case brought the insurance industry's swift return to Capitol Hill to seek exactly the opposite type of relief from what it had previously advocated for so long.

Three months after the Supreme Court denied a motion for rehearing in South-Eastern Underwriters, Senators McCarran and Ferguson introduced a bill that would become the Act bearing their names. The bill was structured to favor continued state regulation of insurance, but also, ultimately, to apply the Sherman and Clayton Antitrust Acts when state regulation was inadequate.

Within two weeks of the bill's introduction and without holding any hearings on the new measure, the Senate had passed it and sent it to the House of Representatives. As it was sent over, the McCarran Ferguson Act provided only a very limited moratorium during which the business of insurance would be exempt from the antitrust laws.

The House Judiciary Committee also approved the bill without holding a hearing. The House floor debate indicates that House Members believed the language of the original bill already comported perfectly with the Senate amendment's stated goal of creating a limited moratorium during which the Sherman and Clayton Acts would not apply to the business of insurance. However, despite the clear intent of both houses not to grant a permanent antitrust exemption, the conference committee proceeded to drastically transform the limited moratorium into a permanent antitrust exemption for the insurance industry. The new language provided that

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after January 1, 1948, the Sherman, Clayton, and Federal Trade Commission Acts "shall be applicable to the business of insurance to the extent that such business is not regulated by State law."

The House approved the conference report without debate. The sole expression of the House's intent regarding the conference report containing the new section 2(b) proviso is the statement of House managers of the conference, which indicates they intended only to provide for a moratorium, after which the antitrust laws would apply. The Senate, in contrast, debated the conference report for two days. After repeated assurances that the proviso was not intended to preclude application of the antitrust laws, the Senate passed the bill and President Roosevelt signed it into law on March 9, 1945.

The legislative history shows that the Senate had a serious debate on the antitrust exemption, unlike the House. Senator Claude Pepper contended that the new conference language enabled the states to evade the federal antitrust laws by merely authorizing legislation. Senator O'Mahoney stated that section 2(b) of the conference report simply provided for a moratorium, after which the antitrust laws would "come to life again in the field of interstate commerce." The "state action" doctrine of *Parker v. Brown* would apply fully, he said, so that "no State, under the terms of the conference report, could give authority to violate the antitrust laws." Therefore, he concluded, "the apprehensions which [Senator Pepper] states with respect to the conference report are not well founded." Senator McCarran likewise reassured Senator Pepper that "he is in error in his whole premise in this matter."

Unfortunately, the courts construing the Act did not make these inferences. When presented with the question of what Congress meant by "regulated," the courts found no standard in the text of the statute and, declining to search for one in the legislative history, reached the very conclusion that Senator Pepper had anticipated and vainly struggled to forestall.

The antitrust exemption has been studied on several occasions by federal authorities, each time with the determination that continued exemption was not warranted. For example:

- In 1977, when I was Federal Insurance Administrator under President Ford, the Justice Department concluded, "an alternative scheme of regulation, without McCarran Act antitrust protection, would be in the public interest."[7]
- In 1979, President Carter's National Commission for the Reform of Antitrust Laws and Procedures concluded, almost unanimously, that the McCarran broad antitrust immunity should be repealed.
- In 1983, then FTC Chairman James C. Miller III told the House Subcommittee on Commerce, Transportation and Tourism that he saw no legitimate reason to exempt the insurance industry from FTC jurisdiction.
- In 1994, the House Judiciary Committee issued its report, calling for a sharp cutting back of the antitrust exemption.

[7] Report of the U.S. Department of Justice to the Task Group on Antitrust Immunities, 1977.

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THE ECONOMIC CYCLE AND RESULTING INSURANCE ISSUES – THE MALPRACTICE EXAMPLE

CFA research over several decades convinces us that the lack of antitrust law application to insurance has exacerbated periodic liability insurance cyclical price spikes that occur as insurers return to the "safe harbor" of using rating bureau price levels or pure premium levels during the hard markets. Rate bureau levels are set to assure that the least effective or most inefficient insurers are able to thrive at the suggested price.

Medical liability insurance is part of the property/casualty sector of the insurance industry. This industry's profit levels are cyclical, with insurance premium growth fluctuating during hard and soft market conditions. This is because insurance companies make most of their profits, or return on net worth, from investment income. During years of high interest rates and/or excellent insurer profits, insurance companies engage in fierce competition for premium dollars to invest for maximum return, particularly in "long-tail" lines – where the insurers hold premiums for years before paying claims – like medical malpractice. Due to this intense competition, insurers may actually under-price their policies (with premiums growing below inflation) in order to get premium dollars to invest. This period of high competition and stable or dropping insurance rates is known as the "soft" insurance market.

When interest rates drop, a declining economy causes investment to fall, or cumulative price cuts during the soft market years make profits unbearably low, the industry responds by sharply increasing premiums and reducing coverage, creating a "hard" insurance market. This usually degenerates into a "liability insurance crisis," often with sudden high rate hikes that may last for a few years.

Hard markets are followed by soft markets, when rates stabilize once again. The country experienced a hard insurance market in the mid-1970s, particularly in the medical malpractice and product liability lines of insurance. A more severe crisis took place in the mid-1980s, when most types of liability insurance were affected. Again, from 2001 through 2004, a "hard market" took hold again. Each of these periods was followed by a soft market, as now exists.

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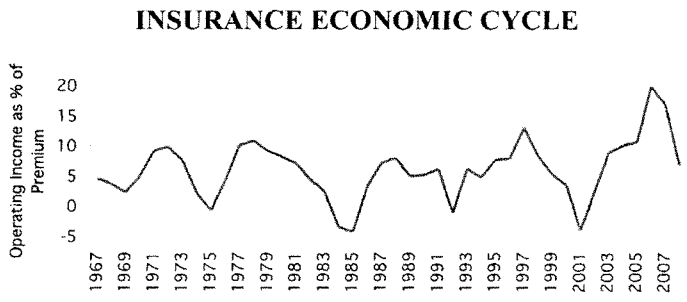
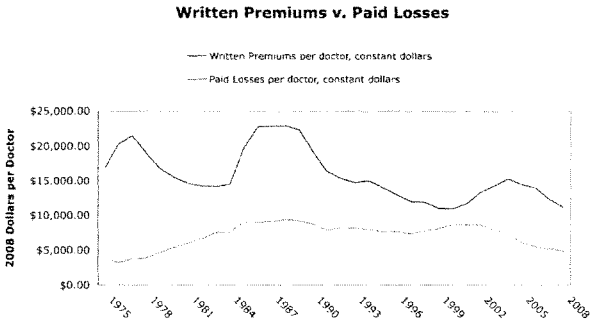
Consider the following 2 charts:





Since 1975, the data show that (in constant dollars, per doctor written premiums) the amount of premiums that doctors have paid to insurers have fluctuated almost precisely with the insurer's economic cycle, which is driven by such factors as insurer mismanagement of pricing during the cycle and changing interest rates. Notably, the amounts were not affected by lawsuits, jury awards, or the tort system. In other words, according to the industry's own data, premiums have not tracked costs or payouts in any direct way.

Clearly, during the early to mid part of this decade, medical malpractice insurance premiums rose much faster than was justified by insurance payouts. These hikes were similar to, although perhaps not quite a severe as, the rate hikes of the past "hard" markets, which occurred

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in the mid-1980s and mid-1970s. None were connected to actual increased payouts.

Our studies over the decades indicate that, during hard markets, rates tend to rise toward the levels of pure premiums set out by the rating bureaus and that during the soft market the bureau's influence is reduced, at least in respect to overall rate levels (they still have significant impact on setting classification differentials).

If antitrust law was applied to insurers, we believe that the economic cycle's amplitudes would be reduced and that periodic crises would be at lease partially mitigated. This is because insurers will be less likely to allow the cycle bottom at the end of the soft market to go so deep as to not know what is the target "safe" pricing level that is now set by the rate bureaus. Correspondingly, insurers will have to be careful about raising the rates too high during the hard phase of the market because they will not know the price levels the other companies will set.

HEALTH INSURANCE CLAIMS COLLUSION

If a patient uses an out-of-network doctor the insurer typically pays a percentage, normally about 75 percent, of the "reasonable and customary" doctor charge for the area of the country in which the procedure was done. A doctor bill or hospital charge that is over that limit is paid not by the insurer but by the insured, the consumer.

As the *New York Times* said in an editorial dated January 17, 2009, "the rub comes in defining what is reasonable and customary." The editorial describes how this key factor has been calculated by Ingenix, "which conveniently is owned by United Health. The whole system is rendered suspect by an obvious conflict-of-interest: If Ingenix pegs the customary rates low, it keeps insurance reimbursements low and shifts more of the costs to the patient."

The editorial was based on a report[8] from the New York Attorney General, Andrew Cuomo, which found that:

- Most health insurers use the Ingenix schedules of reasonable and customary charges, including UnitedHealth, Aetna, Cigna and Wellpoint.
- A conflict-of-interest exists because Ingenix is owned by United Health.
- Insurers hide the way they calculate reasonable and customary charges from insured parties and pretend that an independent group calculates the schedules.
- The Ingenix system is a "black box" for consumers, who do not know, before selecting a doctor, what will be paid by the insurer.
- Health insurers mislead and obfuscate in their policy language.
- In New York, the system understated reimbursement rates by ten to 28 percent, which "translates to at least hundreds of millions of dollars in losses for consumers over the past ten years across the country."

[8] "Health Care Report, The Consumer Reimbursement System Is Code Blue," January 13, 2009.

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While the insurers have agreed to set up a new system, now that Mr. Cuomo caught them, the points that this Committee must take from this report are that:

- Collusive activity exists in health insurance and should be stopped by antitrust law enforcement.
- Collusive activity goes well beyond price fixing and deeply into other aspects of insurance, such as claims settlement practices.

ATTORNEY GENERAL SPITZER'S FINDINGS

The nation was shocked when it learned that New York Attorney General Elliot Spitzer had uncovered remarkable levels of anticompetitive behavior involving the nation's largest insurance companies and brokers. The victims were the most sophisticated insurance consumers of all – major American corporations and other large buyers. Bid-rigging, kickbacks, hidden commissions and blatant conflicts of interest were uncovered. Attorney General Spitzer's findings are, unfortunately, a reflection of the deeply rooted anti-competitive culture that exists in the insurance industry. Only a complete assessment of the federal and state regulatory failures that have helped create and foster the growth of this culture will help Congress understand how to take effective steps to change it.

On the federal side, the antitrust exemption that exists in the McCarran Ferguson Act (and that is modeled by many states) has been the most potent enabler of anticompetitive practices in the insurance industry. Congress has also handcuffed the Federal Trade Commission in prosecuting and even in investigating and studying deceptive and anticompetitive practices by insurers and brokers. On the state side, insurance regulators have utterly failed to protect consumers and to properly regulate insurers and brokers in a number of key respects. Many of these regulators, for example, collaborated with insurance interests to deregulate commercial insurance transactions, which further hampered their ability to uncover and root out the type of practices uncovered by Attorney General Spitzer. Deregulation coupled with an antitrust exemption inevitably leads to disastrous results for consumers.

The Spitzer investigation reveals how easily sophisticated buyers of insurance can be duped by brokers and insurers boldly acting in concert in a way to which they have become accustomed over the long history of insurance industry anticompetitive behavior. Imagine the potential for abuse and deceit when small businesses and individual consumers try to negotiate the insurance marketplace if sophisticated buyers are so easily harmed.[9]

[9] For a complete discussion of the anticompetitive activities uncovered by Attorney General Spitzer, see Statement of J. Robert Hunter before the Senate Committee on Governmental Affairs on November 16, 2004 in the hearing entitled, "Oversight Hearing on Insurance Brokerage Practices, Including Potential Conflicts of Interest and the Adequacy of the Current Regulatory Framework."

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WIDE RATE DISPARITY REVEALS WEAK COMPETITION IN INSURANCE

Consider the wide disparities in automobile insurance rate quotes that a 20-year old married man in Burlington, Vermont, with a clean driving record, would receive.[10] He would pay as much as $5,099 per year from Liberty Mutual Fire Insurance Company or as low as $1,485 from Safeco or GEICO's General Insurance Company of America.[11] Or consider the case of a six-month rate for a 48-year-old woman from Birmingham Alabama with a 16-year-old daughter, both of whom have clean records.[12] She would pay from $610 from United Services Automobile Association to $2,076 from Farmers Insurance Exchange.

Some would say this wide range in price proves a competitive market. It does not. A disparity like this, where prices for the exact same person can vary by a multiple of five, reveals very weak competition in the market. In a truly competitive market, prices fall in a much narrower range around a market-clearing price at the equilibrium point of the supply/demand curve.

There are a number of important reasons why competition is weak in insurance. Several have to do with the consumer's ability to understand insurance:

1. ***Complex Legal Documents.*** Most products are able to be viewed, tested, "tires kicked" and so on. Insurance policies, however, are difficult for consumers to read and understand -- even more difficult than documents for most other financial products. For example, consumers often think they are buying insurance, only to find they've bought a list of exclusions. No where was this more apparent than after Hurricane Katrina...consider ISO's "Anti-concurrent-causation Clause" as a prime example of joint decision making that harmed consumers. This confusing clause was intended, believe it or not, to eliminate covered losses (in Katrina, wind damage) when a non-covered event occurs (flood), even if the non-covered event occurs much later than the covered event. So, the industry colluded to create a clause that no reasonable person could logically understand, to the detriment of consumers and the rebuilding efforts in the Gulf region. An example of how this clause would work would be when wind seriously destroys a home, followed by a much later storm surge finishing off the home. In such a situation, there would be no coverage for wind damage, the industry alleges.

2. ***Comparison Shopping is Difficult.*** Consumers must first understand what is in the policy to compare prices.

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[10] To insure a four-door, 2005 Ford Focus sedan equipped with air bags, anti-lock brakes and a passive anti-theft device for someone who drives to work five miles one way and 12,000 miles annually and seeks insurance for $25,000/$50,000/$5,000 (BI/PD/MP limits), collision with a $250 deductible, comprehensive coverage with a $100 deductible and $50/$100/$10 UM coverage.

[11] Buyers Guide for Auto Insurance. Downloaded from the Vermont Insurance Department website on October 9, 2009. Alabama data is from the website of the Alabama Insurance department, visited on October 9, 2009.

[12] Principal operator is a single female, age 48, no driving violations, drives to work 30 miles roundtrip, 15,000 miles annually, neutral credit score, new business, premium paid-in-full, homeowner who lives with daughter and has no multi-car discount. Daughter is occasional operator, age 16, no accidents or violations, student with 3.5 GPA. They drive a 2002 Toyota Camry LE, 4-door sedan, 4 cylinders in ZIP code 35216 Birmingham, Alabama.

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3. ***Policy Lag Time***. Consumers pay a significant amount for a piece of paper that contains specific promises regarding actions that might be taken far into the future. The test of an insurance policy's usefulness may not arise for decades, when a claim arises.

4. ***Determining Service Quality is Very Difficult***. Consumers must determine service quality at the time of purchase, but the level of service offered by insurers is usually unknown at the time a policy is bought. Some states have complaint ratio data that help consumers make purchase decisions and the NAIC has made a national database available that should help, but service is not an easy factor to assess.

5. ***Financial Soundness is Hard to Assess***. Consumers must determine the financial solidity of the insurance company. They can get information from A.M. Best and other rating agencies, but this is also complex information to obtain and decipher.

6. ***Pricing is Dismayingly Complex***. Some insurers have many tiers of prices for similar consumers—as many as 25 tiers in some cases. Consumers also face an array of classifications that can number in the thousands of slots. Online assistance may help consumers understand some of these distinctions, but the final price is determined only when the consumer actually applies and full underwriting is conducted. At that point, the consumer might be quoted a rate quite different from what he or she expected. Frequently, consumers receive a higher rate, even after accepting a quote from an agent.

7. ***Underwriting Denial***. After all that, underwriting may result in the consumer being turned away.

Other impediments to competition rest in the market itself:

8. ***Mandated Purchase***. Government or lending institutions often require insurance. Consumers who must buy insurance do not constitute a "free-market," but a captive market ripe for arbitrary insurance pricing. The demand is inelastic.

9. ***Producer Compensation is Unknown***. Since many people are overwhelmed with insurance purchase decisions, they often go to an insurer or an agent and rely on them for the decision making process. Hidden commission arrangements may tempt agents to place insured's in the higher priced insurance companies. Contingency commissions may also bias an agent or broker's decision-making process. Elliott Spitzer's investigations showed that even sophisticated insurance buyers could not figure this stuff out.

10. ***Incentives for Rampant Adverse Selection***. Insurer profit can be maximized by refusing to insure classes of business (e.g., redlining) or by charging regressive prices. Profit can also be improved by offering kickbacks in some lines such as title and credit insurance.

11. ***Antitrust Exemption***. Insurance is largely exempt from antitrust law under the provisions of the McCarran Ferguson Act. Repeal of this outdated law is seriously under consideration in Congress.

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Compare shopping for insurance with shopping for a can of peas. When you shop for peas, you see the product and the unit price. All the choices are before you on the same shelf. At the checkout counter, no one asks where you live and then denies you the right to make a purchase. You can taste the quality as soon as you get home and it doesn't matter if the pea company goes broke or provides poor service. If you don't like peas at all, you need not buy any. By contrast, the complexity of insurance products and pricing structures makes it difficult for consumers to comparison shop. Unlike peas, which are a discretionary product, consumers absolutely require insurance products, whether as a condition of a mortgage, as a result of mandatory insurance laws, or simply to protect their home, family, or health.

COMPETITION CAN BE ENHANCED BY REPEAL OF THE ANTITRUST EXEMPTION

The insurance industry, as documented by the history recounted above, arose from cartel roots. For centuries, property/casualty insurers have used so-called "rating bureaus" to make rates for several insurance companies to use. Not many years ago, these bureaus required that insurers charge rates developed by the bureaus (the last vestiges of this practice persisted into the 1990s).

In recent years, the rate bureaus have stopped requiring the use of their rates or even preparing full rates. These developments occurred because lawsuits by state attorneys general after the liability crisis of the mid-1980s demonstrated that the rate increases were caused, in great part, by insurers sharply raising their prices to return to Insurance Services Office (ISO) rate levels. ISO is an insurance rate bureau or advisory organization. Historically, ISO was a means of controlling competition. It still serves to restrain competition as it develops "loss costs" -- the part of the rate that covers expected claims and the costs of adjusting claims-- which represent about 60 to 70 percent of the rate. ISO also makes available expense data, which insurers can use to compare their costs in setting their final rates. ISO also establishes classes of risk that are adopted by many insurers. ISO diminishes competition significantly through all of these activities. There are other such organizations that also set pure premiums or do other activities that result in joint insurance company decisions. These include the National Council on Compensation Insurance (NCCI) and National Independent Statistical Services (NISS). Examples of ISO's many anticompetitive activities are included in Attachment A.

Today, the rate bureaus still produce joint price guidance for the largest portion of the rate. The rating bureaus start with historic data for these costs and then actuarially manipulate the data (through processes such as "trending" and "loss development") to determine an estimate of the projected cost of claims and adjustment expenses in the future period when the costs they are calculating will be used in setting the rates for many insurers. Rate bureaus, of course, must bias their projections to the high side to be sure that the resulting rates or loss costs are high enough to cover the needs of the least efficient, worst underwriting insurer member or subscriber to the service.

Legal experts testifying before the House Judiciary Committee in 1993 concluded that, absent McCarran Ferguson's antitrust exemption, manipulation of historic loss data to project losses into the future would be illegal (whereas the simple collection and distribution of historic

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data itself would be legal – which is why you do not need safe harbors to protect pro-competitive joint activity.) This is why there are no similar rate bureaus in other industries. For instance, there is no CSO (Contractor Services Office) predicting the cost of labor and materials for construction of buildings in the construction trades for the next year (to which contractors could add a factor to cover their overhead and profit). The CSO participants would go to jail for such audacity.

Further, rate organizations like ISO file "multipliers" for insurers to convert the loss costs into final rates. The insurer merely has to tell ISO what overhead expense load and profit load they want and a multiplier will be filed. The loss cost times the multiplier is the rate the insurer will use. An insurer can, as ISO once did, use an average expense of higher cost insurers for the expense load if it so chooses plus the traditional ISO profit factor of five percent and replicate the old "bureau" rate quite readily.

It is clear that the rate bureaus[13] still have a significant anti-competitive influence on insurance prices in America.

- The rate bureaus guide pricing with their loss cost/multiplier methods.
- The rate bureaus manipulate historic data in ways that would not be legal absent the McCarran Ferguson antitrust law exemption.
- The rate bureaus also signal to the market that it is OK to raise rates. The periodic "hard" markets are a return to rate bureau pricing levels after falling below such pricing during the "soft" market phase. This is particularly important in the creation of rate spikes in the so-called "long-tail" lines of insurance such as medical malpractice.
- The rate bureaus signal other market activities, such as when it is time for a market to be abandoned and consumers left, possibly, with no insurance.

CURRENT EXAMPLES OF THE COLLUSIVE NATURE OF INSURANCE – HOME INSURANCE AVAILABILITY AND PRICING IN THE WAKE OF HURRICANE KATRINA

As an example of coordinated behavior that would end if antitrust laws applied fully to insurers, consider the current situation along America's coastlines. Hundreds of thousands of people have had their homeowners insurance policies cancelled and prices skyrocketed.
As to the decisions to non-renew, on May 9, 2006, the ISO President and CEO Frank J. Coyne signaled that the market was overexposed along the coastline of America. In the *National Underwriter* article, "Exposures Overly Concentrated Along Storm-prone Gulf Coast" (May 15, 2006 Edition), the ISO executive "cautioned that population growth and soaring home values in

[13] By "rate bureaus" here, I include the traditional bureaus (such as ISO) but also the new bureaus that have a significant impact on insurance pricing such as the catastrophe modelers (including Risk Management Solutions – RMS), other non-regulated organizations that impact insurance pricing and other decisions across many insurers (credit scoring organizations like Fair Isaac are one example) and organizations that "assist" insurers in settling claims, like Computer Sciences Corporation (using products like Colossus).

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vulnerable areas are boosting carrier exposures to dangerous levels." He said, "The inescapable conclusion is that the effects of exposure growth far outweigh any effects of global warming."

Insurers undertook major pullbacks in the Gulf Coast in the wake of the ISO pronouncement. On May 12, 2006, Allstate announced it would drop 120,000 home and condo policies and State Farm announced it would drop 39,000 policies in the wind pool areas and increase rates more than 70 percent.[14] An update of this information, based on an article in the *Los Angeles Times* follows this testimony as Attachment C.

Collusion appears to be involved in price increases along our nation's coastline as well. On March 23, 2006, Risk Management Solutions (RMS) announced that it was changing its hurricane model upon which homeowners and other property/casualty insurance rates are based. RMS said that "increases to hurricane landfall frequencies in the company's U.S. hurricane model will increase modeled annualized insurance losses by 40% on average across the Gulf Coast, Florida and the Southeast, and by 25-30% in the Mid-Atlantic and Northeast coastal regions, relative to those derived using long-term 1900-2005 historical average hurricane frequencies." This means that the hurricane component of insurance rates would sharply rise, resulting in overall double-digit rate increases along America's coastline from Maine to Texas.

The RMS action interjected politics into a process that should be based solely on sound science. In the aftermath of the unexpectedly high damage caused by Hurricane Andrew, insurers turned to computer catastrophe modelers like RMS for new approaches to setting rates for catastrophe insurance coverage. The new method was a computer simulation model based on either a 1,000 or 10,000-year weather forecast. Consumers were told that the increase in rates resulting from the new computer catastrophe models would lead to greater rate stability. (I was promised this outcome personally when I was Texas Insurance Commissioner.) There would be no need to raise rates after a catastrophic weather event with the use of the new models, insurers said, because these storms would already have been anticipated when rates were set. However, the new RMS model breaks that promise to consumers and establishes rates on a five-year time horizon, which is expected to be a period of higher hurricane activity.

RMS has become the vehicle for collusive pricing. In its report on its new hurricane model, RMS states:

> In developing the new medium-term five-year view of risk, RMS has taken counsel from representatives across the insurance industry in determining that future model output will be for a 'medium-term' five-year risk horizon.[15]
>
> To determine what should be the explicit risk horizon of an RMS Cat model, opinions were solicited among the wider insurance industry from those who both use and apply the results of models to find the duration over which they sought to characterize risk.[16](Emphasis added)

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[14] "Insurers Set to Squeeze Even Tighter," *Miami Herald*, May 13, 2006.
[15] Risk Management Solutions, "U.S. and Caribbean Hurricane Activity Rates," March 2006, page 1.
[16] Risk Management Solutions, "U.S. and Caribbean Hurricane Activity Rates," March 2006, page 4.

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It is clear from the release that insurance companies sought this move to higher rates. RMS's press release of March 23, 2006 states:

> Coming off back-to-back, extraordinarily active hurricane seasons, the market is looking for leadership. At RMS, we are taking a clear, unambiguous position that our clients should manage their risks in a manner consistent with elevated levels of hurricane activity and severity,' stated Hemant Shah, president and CEO of RMS. 'We live in a dynamic world, and there is now a critical mass of data and science that point to this being the prudent course of action.

The "market" (the insurers) sought leadership (higher rates), so RMS was in a competitive bind. If it did not raise rates, the market would likely go to modelers who did. So RMS acted and the other modelers are following suit. According to the *National Underwriter's* Online Service (March 23, 2006): "Two other modeling vendors—Boston-based AIR Worldwide and Oakland, Calif.-based Eqecat—are also in the process of reworking their hurricane models." It is shocking and unethical that scientists at these modeling firms, under pressure from insurers, appear to have completely changed their minds *at the same time* after over a decade of using models they assured the public were scientifically sound.

The RMS model is now coming under increasing scientific and political scrutiny. According to a report in the *Tampa Tribune*,

> Two scientists, Florida State University geologist Jim Elsner and National Oceanic and Atmospheric Administration research meteorologist Thomas R. Knutson, told the Tribune that insurance industry objectives drove the change and faulted the company's scientific justification...'I'm kind of used to deceptive activity as a former attorney general,' (Governor) Crist said. 'But that was rather disturbing to hear about that. We need to get as much information as we possibly can. This much I do know: Insurance companies are making extraordinary profits.'[17]
>
> Other scientists have also expressed concerns about the RMS methodology:
>
> 'It's ridiculous from a scientific point of view. It just doesn't wash well in the context of the way science is conducted,' said Mark S. Frankel, director of the Scientific Freedom, Responsibility & Law Program at the American Association for the Advancement of Science, in Washington. (RMS) mentioned the 'expert elicitation' process RMS conducted in October 2005 - when the company paid the expenses for four scientists to meet in Bermuda and discuss the issue. The company later mentioned the scientists in news releases and included pictures of them in a slideshow on the new model. Last week, two of those scientists told the Tribune they didn't agree with some of the statements RMS has made about the model and noted that they only had a chance to review a portion of the data in

[17] Christ, Sink Seek Storm Model Data, *Tampa Tribune*, January 9, 2007

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> question...'I think that question was driven more by the needs of the insurance industry as opposed to the science,' said Knutson, who also questioned the extent of some of the RMS projections about hurricane landfall.[18]

Insurers often try to position supposedly objective and independent third parties as the public decision-makers when it is insurers themselves who want to increase rates. For decades, the third parties that often performed this function were ratemaking (advisory) organizations such as ISO. At least ISO and other rating organizations were licensed by the states and subject to at least nominal regulation, because of the important impact they had on rates and other insurance tools, such as policy forms.

More recently, insurers have utilized new third party organizations (like RMS) to provide information (often from "black boxes" beyond state insurance department regulatory reach) for key insurance pricing and underwriting decisions, which helps insurers to avoid scrutiny for their actions. These organizations are not regulated by the state insurance departments and have a huge impact on rates and underwriting decisions with no state oversight. RMS is one such organization. Indeed RMS's action, since it is not a regulated entity, may be a violation of current antitrust laws.

POSSIBLE COLLUSION ON CLAIMS PRACTICES

Many concerns have been raised about the poor performance of property-casualty insurers in paying legitimate claims in the wake of Hurricane Katrina. Some have suggested that the lack of attention to individual claims by some insurers may have been the result of the collusion. Consider this startling blog from the President of the Association of Property/Casualty Claims Professionals, James Greer, posted on the web site of the Editor of the National Underwriter:

Posted on January 31, 2007 23:06

James W. Greer, CPCU:
Although I live and work in Florida, my home is on the Mississippi Gulf Coast where I have family spread from one side of the state to the other. I spent six months there leading a team of over 100 CAT adjusters and handling the wind claims for the state's carrier of last resort.

I personally walked through the carnage, saw the people, and felt the sorrow. I climbed the roofs, measured the slabs, and personally witnessed very visible and clear damage caused by both water AND WIND.

I also observed something else that surprised me, and, after 28 years as a claims professional who has carried "the soul" of a bygone industry in my practices and preachings, I was ashamed of those to whom I had vested a lifetime career: An overwhelming lack of claims adjusters on the Mississippi Gulf Coast. The industry simply did not respond.

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[18] Ethicist Questions Insurance Rate Data, *Tampa Tribune*, January 12, 2007.

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The industry appeared as distant to the Miss. Gulf Coast as the federal government was accused of being to New Orleans. *It was as if some small group of high-level financial magnates decided that the only way to save the industry's financial fate from this mega-disaster was to take a total hand's off approach and hide beneath the waves and the flood exclusion.*

While media reps repeatedly quoted, "Each claim is different and will be handled on its own facts and merits," the carriers behaved as one...if there was evidence of water, or you were within a certain geographic boundary, adjusters were largely absent on the coast. (Emphasis added.)

(Actually, State Farm did have one of the largest CAT facilities, located centrally on the coast, but there was little evidence of other carrier presence.)

I personally observed large carriers simply refusing to respond, or even consider arguments of wind involvement...well-rationalized sets of facts, coverage and legal arguments. The silence from industry officials "far from the field" who retained the authority for claim decision-making was deafening.

In an article posted on the Association of Property & Casualty Claims Professionals' Web site shortly after Katrina hit, I described the catastrophe as "Claims Greatest Challenge," and pondered the industry would respond. Now we know.

As a member of an old Aetna family that has been widely dispersed since its demise in the '90's, I remember the day when leaders of that fine company routinely cited, and tried to honor, the social/moral contract the insurance industry had with society. It is clear that, in today's business environment, the soul of the insurance industry is missing, and despite the rhetoric of its PR machine, the industry no longer recognizes such a social/moral obligation.

As a lifetime claims professional, I will never quit writing, teaching and showing those who are interested the way things should be done to serve the best interests of the industry and its customers according to the best practices and behaviors of a bygone claims age. Perhaps someday a change in mindset will once again begin to evolve.

Clearly, for the Mississippi Gulf Coast, the Katrina catastrophe, the animosity and the litigation, it was never really about flood...nor was it about the flood exclusion. It was, and is, about the failure of the insurance industry to keep its promise...a promise that it will respond when loss occurs.

The only thing sold in insurance is peace of mind. The victims of this storm, and certainly those in Mississippi, will never again find peace of mind in insurance.

Actions do speak loudest. On the Mississippi Gulf Coast, the insurance industry simply failed to act. In the end, it will pay dearly for that decision, as will all of society.

James W. Greer, CPCU, President, Association of Property & Casualty Claims Professionals (PCCP)[19]

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[19] Your Own Worst Enemy, Continued, Blog of Sam Friedman, Editor, National Underwriter Magazine, www.property-casualty.com, February 21, 2007. The blog has other interesting posts on this subject.

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There may also be significant antitrust implications to the growing use of claims payment software by insurance companies. Insurers have reduced their payouts and maximized their profits by turning their claims operations into "profit centers" by using computer programs and other techniques designed to routinely underpay policyholder claims. For instance, many insurers are using programs such as "Colossus," sold by Computer Sciences Corporation (CSC).[20] CSC sales literature touted Colossus as 'the most powerful cost savings tool" and also suggested that the program will immediately reduce the size of bodily injury claims by up to 20 percent. As reported in a recent book, "...any insurer who buys a license to use Colossus is able to calibrate the amount of 'savings' it wants Colossus to generate...If Colossus does not generate sufficient 'savings' to meet the insurer's needs or goals, the insurer simply goes back and 'adjusts' the benchmark values until Colossus produces the desired results."[21] In a settlement of a class-action lawsuit, Farmers Insurance Company has agreed to stop using Colossus on uninsured and underinsured motorist claims where a duty of good faith is required and has agreed to pay class members cash benefits.[22] Other lawsuits have been filed against most of America's leading insurers for the use of these computerized claims settlement products.[23]

Programs like Colossus are designed to systematically underpay policyholders without adequately examining the validity of each individual claim. The use of these programs severs the promise of good faith that insurers owe to their policyholders. Any increase in profits that occurs cannot be considered to be legitimate. Moreover, the introduction of these systems could explain part of the decline in benefits that policyholders have been receiving as a percentage of premiums paid in recent years.

Colossus is being used by most major insurance companies, in some cases through the marketing efforts of CSC offering 20 percent savings. McKinsey & Company has also encouraged several companies to use Colossus[24]. "Before the Allstate project in 1992 (called CCPR – Claims Core Process Redesign), McKinsey named its USAA project 'PACE' [Professionalism and Claims Excellence]. At State Farm, McKinsey named its project 'ACE' [Advanced Claims Excellence]."[25]

For example, McKinsey introduced Allstate to Colossus. "McKinsey already knew how Colossus worked having proved it in the field at USAA."[26] This quote was footnoted as follows: "See McKinsey at (PowerPoint slide number) 7341: "The Colossus sites have been extremely successful in reducing severities with reductions in the range of 10% for Colossus-evaluated claims."[27]

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[20] Other programs are also available that promise similar savings to insurers, such as ISO's "Claims Outcome Advisor." These are bodily injury systems but other systems, such as Exactimate, "help" insurers control claims costs on property claims.

[21] "From Good Hands to Boxing Gloves – How Allstate Changed Casualty Insurance in America," Trial Guides, 2006, Berardinelli, Freeman and DeShaw, pages 131, 133, 135.

[22] Bad Faith Class Actions, Whitten, Reggie, PowerPoint Presentation, November 9, 2006.

[23] Ibid.

[24] "...Mc Kinsey & Co. has taught Allstate **and other** insurance companies how to deliver less and less." Berardinelli, Freeman and DeShaw, page 17.

[25] Ibid. Page 57.

[26] Ibid. Page 132.

[27] Ibid.

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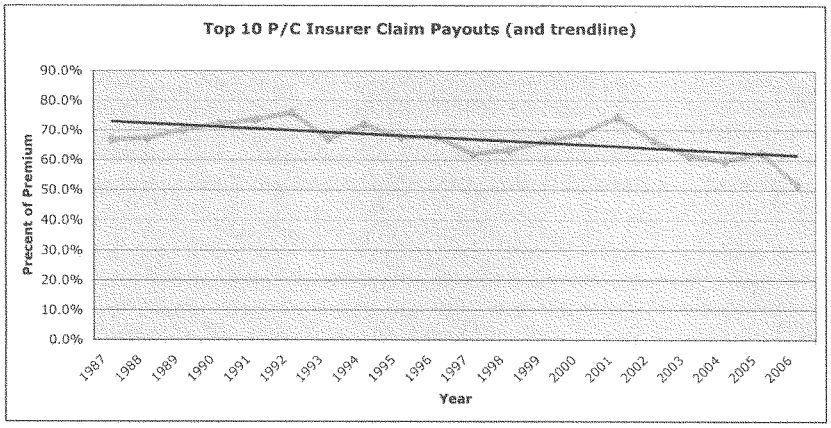
I have been a witness in some of the cases against insurers using the Colossus product and I am covered by a protective order in these cases (I could go on at length about why these Protective Orders are bad public policy, particularly coupled with secrecy provisions in settlements, in that the bad practice that was uncovered, often continues to harm people). I am, therefore, limited in this testimony to what is in the public domain. However, as I describe above, there is public information about the use of common consultants and vendors by insurance companies that have adopted Colossus and similar systems. I strongly urge this committee to probe the question of whether these vendors and consultants have been involved in encouraging and facilitating collusive behavior by insurance companies with these claims systems. I also urge you to investigate whether a similarity in Hurricane Katrina claims payment procedures and actions (or non-actions), as mentioned above, could indicate collusive activity by some insurers.

The use of these products to cut claims payouts may be at least part of the reason that consumers are receiving record low payouts for their premium dollars as insurers reap unprecedented profits. As is obvious in the following graph, the trend in payouts is sharply down over the last twenty years, a period during most state insurance regulators have allowed consumer protections to erode significantly and when Colossus and other claims systems were being introduced by many insurers.[28]



[28] CFA tested this drop in benefits related to premiums to see if it could be attributed to a drop in investment income. Over the time frame studied, there was a three percent drop in investment income. Since insurers typically reflect about half of investment income in prices, CFA believes that the drop in investment income accounts for only 1.5 points of the 15-point drop. That is, investment income explains only about one-tenth of the drop in benefit payouts to consumers per dollar expended in insurance premium.

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It is truly inappropriate for property/casualty insurers to be delivering only half of their premium back to policyholders as benefits.[29]

State insurance departments have been sound asleep on the issue of the negative impact of Colossus and other such models on policyholders' rights to fair, good-faith claims settlements. If the FTC had been empowered to undertake investigations and other consumer protection activities, insurers might have thought twice about engaging in such acts on a national basis.

Recently, certain Colossus materials that were held under seal in legal proceedings have become public. These materials should be of great interest to this committee. We are also sending these materials to the National Association of Insurance Commissioners. We ask that both this Committee and the NAIC carefully review these important documents for possible action to protect America's consumers.

These documents provide evidence that insurers were able to use Colossus to achieve "savings," by selecting target savings for the future and using the system to push adjusters to achieve those targets. The documents further show an attempt to change the terminology from savings to consistency to avoid legal and regulatory concerns.

As an example of evidence that is now public, here is an excerpt from the deposition of a Vice President of CSC, designated as the corporate representative in a lawsuit:

A We show them (insurance companies) how to operate the tuning mechanism but then they make the decision on the tuning.

Q On the percentage of savings?

A Yes

Q So its kind of like a water spigot on the savings, you can turn it up or down depending on what the insurance company wants to do, right?

(Objection from counsel)

A Yes

Thus targeted savings are a part of the Colossus claims system, savings that can be selected by the insurer by simply tuning the system to achieve it.

In a document written by ISO[30], which sells a competing product to Colossus, the savings are discussed:

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[29] Insurers contend that the loss adjustment expense is a benefit to consumers. Obviously, this is a "benefit" that does not go to the consumer or repair cars, doctor bills, etc. But even the loss and LAE ratio itself is at a record low for many decades, at under 70 percent.

[30] "Discussion Paper: The Durability of Savings Produced by Bodily Injury Claim Assessment Products," found at H_ISO-00000803-815 in the documents.

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"The often-quoted savings derived from these products (20%) comes from Colossus results, a mixture of folklore and performance. CSC clearly state (sic) that the performance of Colossus in independently controlled, and measured, pilot operations in many US insurers over the past 8-10 years has delivered savings of approximately 20% on average."

But, ISO notes that these savings do not show up in overall average claims' costs nationally. ISO believes that a key reason is that, while "...initial savings from piloting Colossus measured quite high, almost immediately on the pilot ending the savings began to deteriorate. This has been evident as we have visited Colossus sites with all users citing far lower levels of savings than achieved at pilot. Typically, Colossus users claim savings in the 1-7% range with the odd company registering in the teens. It is clear that some level of savings is sustainable. Give that there is significant additional administrative cost involved in the use of Colossus, if it failed to deliver some level of sustainable savings then many companies would have removed it by now."

ISO says this loss of savings "was first brought to our attention by McKinsey and has been confirmed by several Colossus users."

A prime reason for the slippage, according to ISO, is human behavior. "During the pilot process, adjusters are diligent...During this time, they generally settle within the Colossus nominated range. This combination of product and behavior produces the 20% number. As time passes adjusters learn how to answer the questions asked by Colossus...to get the number they desire...(or) to get the answer that they need to settle the claim...This has been evidenced by McKinsey observing that adjusters run Colossus consultations 8-10 times until they get the number the other side wants, and then the claim is settled."

ISO believes that "diligent management" can slow the loss of savings but that the slippage will still occur. ISO says that the answer is the use of their product, Claims Outcome Advisor, which "keeps a record of every assessment run by adjusters...Should an adjuster run 8-10 assessments attempting to get a higher number, then there is a record of this happening and an Action Item. Can be generated to the particular adjuster's supervisor..."

ISO maintains, "The Claims Outcome Advisor was designed to save insurers 25-50% more than any other product...a strong initial round of savings for the insurer. This is supported by active strategies for maintaining these initial savings, and strategies for developing additional future savings."

The CSC documents forwarded to staff show that they sold the Colossus product to many insurers in the early years of the product touting a 20 percent savings (often they cite projected savings of 19.8 percent) on bodily injury auto settlements. In later years, CSC changed the terminology from "savings" to "consistency," because, as internal documents show, CSC knew that this was a "small twist, but it has large potential legal exposure." The documents show that a top CSC executive "has a concern re any use of the 's-word', as he called it. Concern is, in litigation, we take the position of consistency tool, etc. He is concerned that a savings-related presentation will be introduced to counter that." (CSC document identified as CSCHENSR078-

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000009650.) He asked that, on one document, this change be made: "Colossus users can achieve savings up to 19% through the consistent application of Best Practices should be Colossus users can achieve increased consistency up to 19% through the consistent application of BP." (CSCHENSR078-000008933)

Insurer internal documents show that savings were realized. CNA Insurance found savings of 22 percent in their trial use of Colossus, for example.

A CNA document reveals that the insurer knew what other Colossus users were doing to make the system work to achieve desired savings by monitoring the work of claims adjusters to make sure they stay within the Colossus range:

> **We have been in contact with other companies which use Colossus, and have found that data accuracy is a universal problem. The system can be easily manipulated to provide whatever settlement value the claim rep. desires. The only way to avoid this is to check the files/consultations for accuracy of the data. Some of the other carriers monitor data accuracy solely from the Home Office level by reviewing data obtained from the reporting system which comes with the product. Other carriers conduct periodic file reviews in their branches. There are a few other carriers which have gone with full-time employees dedicated 100% to Colossus for purposes of checking for data accuracy, tracking results, conducting training, etc. These companies are having the best success with Colossus. The most beneficial severity results are obtained when the consultations are reviewed *prior* to negotiations taking place, so the claim rep is forced to attempt settlement within the Colossus recommended range. The original pilot was conducted in July 1995, and the results proved to be impressive.**

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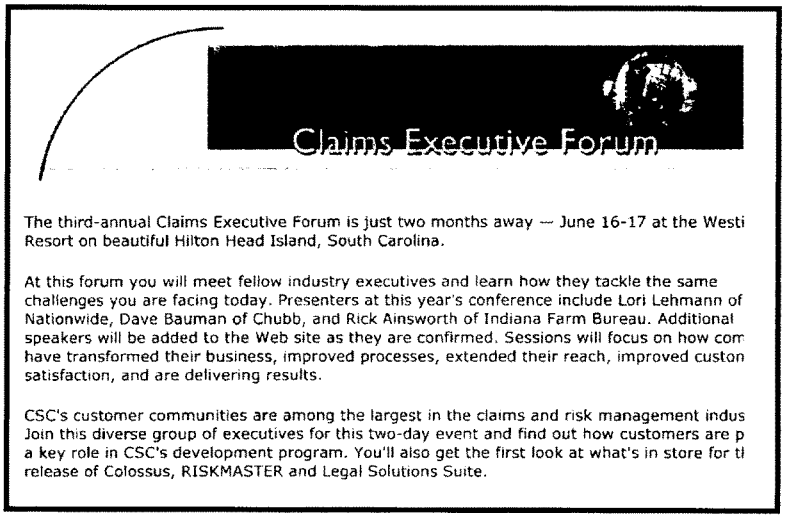
CSC had Advisory Committees and User Groups that met to discuss Colossus issues. Here is part of one agenda:



Claims Executive Forum

The third-annual Claims Executive Forum is just two months away — June 16-17 at the Westi Resort on beautiful Hilton Head Island, South Carolina.

At this forum you will meet fellow industry executives and learn how they tackle the same challenges you are facing today. Presenters at this year's conference include Lori Lehmann of Nationwide, Dave Bauman of Chubb, and Rick Ainsworth of Indiana Farm Bureau. Additional speakers will be added to the Web site as they are confirmed. Sessions will focus on how com have transformed their business, improved processes, extended their reach, improved custon satisfaction, and are delivering results.

CSC's customer communities are among the largest in the claims and risk management indus Join this diverse group of executives for this two-day event and find out how customers are p a key role in CSC's development program. You'll also get the first look at what's in store for tl release of Colossus, RISKMASTER and Legal Solutions Suite.

And here is part of another agenda:

TRACKING ROI	Return on investment is a critical decision factor for evaluating the usage of claims management tools. Join us as we have a panel discussion with CSC team and Colossus customers as we measure ROI over time.

The sharing of information on the savings, or ROI, and how to achieve it is very disturbing, and, as the following document shows, such sharing occurred in significant detail:

Control of COLOSSUS

- St. Paul does not have a maintenance agreement, but they did use CSC to help them do reviews of 4 of their offices. They did re-up with COLOSSUS and are now using this data to help them decide how to handle the use in the future. St. Paul until last year had 2 more than 10 home office persons and then an expert in the branch (this expert also did LAS and helped with large file negotiation and training). Last year they laid off the HO and stopped checking COLOSSUS. Results deteriorated, so they are rethinking how to handle in the future — their time frame is similar to ours —told them I would touch bases with them as they proceed.
- Metropolitan has strong HO and experts in each branch. Most files reviewed before settlement.

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• Westfield will have 5 HO experts — they are based regionally so these people will be hands on for the branches. All files must be reviewed.
• Allstate — Expert in each office they cannot pay over COLOSSUS without file being reviewed and Okayed for payment over.
• Grange — Strong HO — they have files sent to HO to review. The team does training, file reviews both in HO and in field.
• Allied — very strong HO control. • Royal — strong HO control • Basically it came down to two sets of controls either strong HO — that do reviews and then followed up with the branches. These co.'s tended to have no experts in the branches. Other companies have a weaker HO with COLOSSUS person having multiple other functions, but then they have a strong local control with either an expert that does only COLOSSUS. Several had the combination approach where they had report reviewers in HO with a local expert, but the local expert would have other functions also such as training.
• Quite a few companies use their nurse case managers to review the harder claims with impairment ratings — they felt they got more accurate consultations this way.
• No company had done CBA, but it seemed the stronger the controls the greater the savings. Only St. Paul seemed to have felt the cost outweighed the outcome, but now are re-thinking that posture.

Tracking Savings

- The newer companies are still looking at payment to determine savings.
- Some companies have gone to the trending analysis review
- Several companies are looking at severity as a tracking method. This time quite a few companies have talked of severity tracking as a method. They track the severity for an office using the amounts that fall with COLOSSUS evaluations, when an office's severity increases then they send a COLOSSUS team in to see what is causing it —retuning needed, training needed or are they negotiating with COLOSSUS. This seemed to give these companies the best feel for the product and I think they were the most comfortable with their saving numbers.

Thus, insurers did learn from each other how to use Colossus and how to keep adjusters from going over the Colossus recommended claim settlement amounts.

Other documents indicate that some insurers did know the ROI on Colossus for other, non-affiliated insurers. Westfield Insurance Company's notes of a User Group meeting indicate that savings and how to keep adjusters from going over the Colossus recommendation range (e.g., using the "hammer" to get compliance at Motorists Mutual) were discussed. Savings and the "hammer" by Ohio Casualty and other insurers are also discussed in a Westfield document. The "hammer" refers to holding adjusters strictly to the Colossus recommendations through audit or other methods.

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CNA sought opinions from "competitors" on savings and other matters before determining to purchase Colossus:

Reference Survey					
QUESTION	USF & G	RURAL MUTUAL	AMERICAN STATES	IOWA FARM BUREAU	ST. PAUL COMPANIES
3. What is the savings percentage you have realized from using Colossus?	12.5%—very conservative (not willing to be more accurate)	No savings realized yet, or none detected	21% on payment rate, 17 or 18% on medical incurred	Approx 8-10%, also hasn't been measured properly	6-20% based on pilot offices, depends on how good the office is
8 What are some problems your adjusters have encountered using the system?	Resistance from seasoned adjusters, alleviated somewhat with communication: bulletins, white papers, group sessions	Difficult to figure out which injury code to use; backing up & changing; things(could be OS/2 issue); no concept of TM; very conservative on chiropractic.	None given	Management of project (not related to package). Did not have a coordinator initially, understaffed. They almost killed the project through neglect. Some seasoned adjusters don't like it, new adjusters like it, valuable training, identifying injury codes can be difficult.	Training issues, coding, how often system used? continuing issue
Additional comments:	Working with Continuum is like dealing with a business partner, very easy to work with. Invited us out to see their operation after the first of the year if we decide to move forward	Extremely conservative on chiropractic; need to view this as a tool, not a replacement for adjuster experience & common sense (i.e. settlements instead of going to litigation)			Good tool, requires discipline, can't bear its consistency, medical database "interesting project"

These documents show that insurers were using the Colossus product to achieve claims' payment savings and were keeping this ability to achieve savings secret from claimants. They also had "inside" information from other insurers about how they used Colossus and how much they were profiting from Colossus' use in ways that, if antitrust laws were applied in insurance, would have been avoided. Even without antitrust law enforcement in insurance, insurance regulators should have stopped this massive rip-off of America's consumers long ago.

While lawsuits have mitigated the damage from Colossus for first party auto insurance claims (such as uninsured motorist claims) for many insurers, the lawsuits do not mitigate the damage in third party claims (such as bodily injury auto claims). We call on Congress and the state insurance regulators to take action to stop such abuses as soon as possible.

INEFFICIENCY HARMS CONSUMERS

Because of market inefficiencies, exacerbated by the collusion allowed by the McCarran Ferguson antitrust exemption, high-expense insurers with commensurate high prices can charge whatever is needed to cover their inefficient operations or even more and, like Liberty Mutual in Burlington, still retain a significant market share.

Inefficiency abounds in insurance, as documented in Attachment B. If competition were more effective, significant cost savings (savings in the double digits) could be expected. The spreadsheet contains data compiled by AM Best and Co. showing expenses as a ratio of premiums for all major insurers and aggregate expense information for the entire property/casualty insurance industry.

The first three columns of numbers are the expenses for the entire industry. The

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spreadsheet shows, by major line of insurance, the loss adjustment expense and the underwriting expenses and the total of these two expense ratios. The loss adjustment expense is the cost of settling claims, including defense attorney costs, adjusters' costs and other claim-related expenses. The underwriting expense includes the costs of policy writing, agent and broker costs, overhead costs and other business expenses, with the exception of loss adjustment costs.

The next three columns show similar data but for a specific efficient and large (at least one percent of the national premiums in the line of insurance shown) insurance company.

The final two columns are calculations made by CFA to show the potential savings if competition were enhanced. The first of the two columns shows the savings that would occur if the average expense ratio of all insurance companies were lowered to that ratio enjoyed by an efficient insurer. The final column on the spreadsheet shows the savings that would occur if the expense ratio of the inefficient insurer were lowered to the average expense ratio of all insurance companies.

CFA believes that application of antitrust laws to the insurance industry could result in double-digit savings for America's insurance consumers. In some lines, such as medical malpractice, the savings could reach twenty percent or more. Our study shows remarkable potential benefits for consumers if the antitrust exemption is removed and states do a better job of regulating insurers.

ELIMINATING THE ANTITRUST EXEMPTION HAS HELPED CONSUMERS IN CALIFORNIA

The insurance industry would have us all believe that competition and regulation are polar opposites. This is not true. Both competition and regulation seek the same end, the lowest possible prices for consumers consistent with fair profits for the providers of a good or service. They can work together in a complimentary fashion.

The proof that competition and regulation can work together in a market to benefit consumers and the industry is evident in California, which regulates auto insurance under Proposition 103. Indeed, that was the intent of the drafters of Proposition 103. Before Proposition 103, Californians had experienced significant price increases under a system of "open competition." Proposition 103 sought to maximize competition by eliminating the state antitrust exemption, laws that forbade agents to compete, laws that prohibited buying groups from forming, and so on. It also imposed the best system of prior approval of insurance rates and forms in the nation, with very clear rules on how rates would be judged.

As our in-depth study of regulation by the states revealed,[31] California's regulatory transformation – to rely on both maximum regulation and competition – has produced remarkable results for auto insurance consumers and for the insurance companies doing business there. The study reported that insurers realized very substantial profits, above the national

[31] "Why Not the Best? The Most Effective Auto Insurance Regulation in the Nation," June 6, 2000, (www.consumerfed.org).

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average, while consumers saw the average price for auto insurance drop from $747.97 in 1989, the year Proposition 103 was implemented, to $717.98 in 1998. Meanwhile, the average premium rose nationally from $551.95 in 1989 to $704.32 in 1998. California's rank dropped from the third costliest state to the 20th.

I can update this information through 2005.[32] As of 2005, the average annual premium in California was $844.50 (ranked 17th) vs. $829.17 for the nation. Since California transitioned from relying simply on competition -- as promoted by insurers -- to full competition and regulation, the average auto rate went up by 12.9 percent while the national average rose by 50.2 percent -- a powerhouse result for California's consumers! [33]

Removing the antitrust exemption has been a key element in this successful transformation of California's insurance market.

BROOKS HEARINGS

I encourage you to carefully review materials from the last time Congress studied this matter: the hearings and report developed under Chairman Jack Brooks of the House Judiciary Committee in the early to mid 1990s. You will find that a long list of organizations supported reform: from labor to business, from consumer groups to the ABA.

In 1994, the House Judiciary Committee issued its report. A compromise proposal emerged after years of negotiation that both we at CFA and the American Insurance Association (AIA) supported. It would have only controlled trending by insurers where groupings of "rivals" in bureaus like ISO cooperated in the ratemaking process to project pricing into the future. The compromise would have also prohibited joint final price fixing, allowed today. The idea was to end the situation under McCarran where a state law on the books – no matter how weak or unenforced – trumps federal antitrust enforcement. This system, which produces extremely weak consumer protection results, would be replaced by the more normal American system known as the state action doctrine, which would require active supervision by a state that wanted to allow collusive behavior in the insurance market.

That would have been a good step forward in 1994, so we agreed to the compromise. In the intervening years, we have had another hard market made possible by Congressional inaction on McCarran reform. We have had shocking revelations by Attorney General Spitzer of bid rigging and kickbacks, where the most sophisticated insurance buyers were duped. We have the remarkable Katrina related revelations of abusive claims practices, group adoption of anti-concurrent-causation clauses, and the creation of a coastal crisis in the midst of the industries unprecedented prosperity. We have seen reverse competition, where kickbacks to intermediaries have caused extreme increases in prices of title insurance, credit insurance and other lines.

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[32] State Average Expenditures & Premiums for Personal Automobile Insurance in 2005, NAIC.

[33] Insurers have posted excellent profits as well. Over the decade ending in 2007, California insurers enjoyed a return on equity for private passenger auto insurance of 9.2 percent vs. 8.1 percent for the nation (Report on Profitability by Line by State 2007, NAIC).

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Given these new outrages, CFA believes that the compromise we agreed to in 1994 would be too little, too late in 2009. We now believe that only a complete repeal of the antitrust exemption will achieve the reforms that are necessary to end these anticompetitive abuses.

RESPONSE TO INSURER ARGUMENTS AGAINST REPEAL

CFA has heard several concerns from the insurance industry regarding repeal of the McCarran Ferguson Act that do not withstand serious scrutiny.

1. Small insurers would be hurt by the lack of data sharing. There is absolutely no evidence for this claim. As stated above, legal experts have testified that pro-competitive activities, such as the collection and dissemination of historic data, would still be legal under current antitrust laws. It is true that some companies would have to hire actuarial services to replace the joint actions for such anti-competitive steps as trending, but many actuaries are available for hire to do such work. If a state wanted to replicate some process, such as joint trending, it could do so under the state action doctrine. The difference would be that the state would have to be actively involved in regulating such activities. This would be a great step forward for consumers, since many states today provide very little oversight.

2. Small insurers would be hurt by the lack of joint policy language. It is not appropriate to allow cartel-like organizations to write "joint" policy language for adoption by many insurers in a short period of time. Such an approach leads inevitably to the wide adoption of anti-consumer provisions, like the anti-concurrent-causation clause. The financial impact of developing standardized policy language on smaller insurers could be mitigated if state insurance departments promulgate standard forms. However, these regulators would have to ensure that the policy language was fair to consumers, not just friendly to insurers.

3. The antitrust exemption is not an issue in health insurance. As cited above the example of conflicts-of-interest in setting "reasonable and customary" fees demonstrates that this statement is not true. But, if it were true, why would health insurers argue for an exemption that has no impact? To say it does nothing and, simultaneously, fight the change does not make sense. There is a reason health insurers want to retain the exemption.

4. ISO and other cartel-like organizations "facilitate" competition. This claim is patently absurd, as every independent study over the last few decades has shown. (See studies cited above.) If industry-wide collusion to develop prices is pro-competitive, why have Congress and the courts determined that such activity in other industries should send executives to jail?

5. Allowing the FTC to study insurance issues would cause a "lawsuit explosion." The FTC's involvement would likely reduce litigation by uncovering improper practices earlier than under the notoriously inept state "market conduct" review systems. This would allow insurers to correct problems sooner, reducing their financial exposure to litigation at a later date.

6. Repeal of the McCarran Ferguson Act coupled with the application of federal antitrust laws would constitute "dual" federal/ state regulation of insurance. Regulation of the

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business of insurance would remain firmly vested with the states, given that proposals to repeal the antitrust exemption do not alter the first section of the McCarran Ferguson Act that delegates the insurance regulation to the states. These proposals would only empower the FTC and DOJ to help consumers and make sure that antitrust law is not violated. Moreover, state regulators would be in complete control of whether or not federal antitrust intervention in the insurance marketplace occurs. If states do their jobs and implement "active" regulation, as required under the state action doctrine, there would be no need for federal intervention. The problem with state insurance regulation under the McCarran Ferguson Act is, of course, that it allows any form of regulation, no matter how weak,. Unfortunately, for consumers, a number of states have decided that virtually no regulation constitutes an acceptable regulatory regime.

7. Repeal of McCarran Ferguson should only occur in conjunction with federal enactment of an "optional federal charter" (OFC) for insurers. There are several reasons why this is unnecessary and even dangerous to consumers. First, the OFC bills that some insurers have supported would sharply reduce consumer protections at a time when experience with insurance claims (particularly in the wake of Hurricane Katrina) shows that consumer protections need to be enhanced. For instance, under these bills, the federal regulator would have little or no authority to review skyrocketing insurance rates on the coasts or the introduction of anti-consumer contract provisions, such as the anti-concurrent-causation clause. Congress should not reward insurers with their "wish list" of inadequate regulatory controls at any time, particularly in light of concerns about insurance industry practices raised after Hurricane Katrina.

Second, OFC legislation sets up a system of regulatory arbitrage where insurers have the option of selecting the regulator of their choice -- state or federal. Regulators would have to "compete" to bring insurers into their system by lowering consumer protections even further. In contrast, repealing the antitrust exemption alone will require states to enhance their regulatory efforts and improve consumer protections to meet state action doctrine Third, including an OFC proposal as part of repeal would help undermine the positive consumer impact of repeal and create vigorous opposition from consumer organizations, editorial writers, and others. Fourth, the anti-trust exemption was always intended by the drafters to be a stand-alone provision and, indeed, as the legislative history shows, was intended to end in around 1946.

CONCLUSION

Congress should end the long history of insurance industry collusion and anticompetitive behavior and the Health Insurance Industry Antitrust Enforcement Act of 2009 (S. 1681) is an important first step in doing so. Anti-competitive behavior in the insurance market routinely costs consumers more money than a competitive market would, because insurers can cooperate in price setting. Further, collusion in claims handling appears to result in massive underpayment of consumers' claims. The "boom and bust" business cycle of the property/casualty insurance industry is exacerbated by the availability of pure premium and other rate guides the rate bureaus publish. Many insurers do not use these guides during the "soft" market periods but they become a kind of safe harbor when the periodic hard market strikes the commercial property/casualty market. The Katrina experience and the Spitzer revelations show us that collusive insurer behavior has terrible consequences for all buyers, from low-income coastal residents seeking fair claims settlements, up to the most sophisticated Fortune 500 corporations seeking reasonably priced insurance.

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Public and media support for ending this antitrust exemption has been quite strong for a very long time. For example:

- *Business Week* editorialized that "The Insurance Cartel is Ripe for Busting."[34]
- *The Journal of Commerce* called for an "End to McCarran Ferguson."[35]
- *The New York Times* asked Congress to "Bust the Insurance Cartel."[36]
- *The Los Angeles Times* wanted Congress to take "New Action on an Old Proposal to End Cartel-Like Conditions."[37]
- When the House Judiciary Committee last studied eliminating or scaling back the antitrust exemption, there was much support. Consumer groups, small business groups, AARP, the American Bar Association, the American Bankers Association, labor unions, medical groups and others supported the effort. The American Insurance Association participated in lengthy discussions with the Committee staff and consumer advocates to try to determine a way to cut back the exemption.
- Every independent study of the McCarran Ferguson Act's antitrust exemption has concluded that it should end.

It is time to heed the advice of federal studies, consumers, and editorial writers and to repeal the antitrust exemption of the McCarran Ferguson Act.

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[34] April 11, 1988.
[35] May 25, 1988.
[36] May 4, 1991.
[37] June 12, 1991.

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ATTACHMENT A

COLLUSIVE ACTIVITY BY THE INSURANCE SERVICES ORGANIZATION THAT IS ALLOWED BY THE MCCARRAN FERGUSON ANTITRUST EXEMPTION

The ISO website has had extensive information on the range of services they offer insurance companies. The website illustrates the deep involvement that this organization has in helping to set insurer rates, establishing policy forms, underwriting policies and in setting other rules.

Some examples:

- The page "The State Filing Handbook," promises 24/7 access to "procedures for adopting or modifying ISO's filings as the basis for your own rates, rules and forms."

- The page "ISO MarketWatch Cube" is a "powerful new tool for analyzing renewal price changes in the major commercial lines of insurance...the only source of insurance premium-change information based on a large number of actual policies." This price information is available "in various levels of detail – major coverage, state, county and class groupings – for specific time periods, either month or quarter..."

- "MarketWatch" supplies reports "that measure the change in voluntary-market premiums (adjusted for exposure changes) for policies renewed by the same insurer group...a valuable tool for...strategically planning business expansion, supporting your underwriting and actuarial functions..."

- ISO Services are described as follows: "As a **member** or **subscriber**, your insurance company will be eligible to receive ISO products and services, serve on ISO user panels, and have ISO file rules and forms on your behalf. A member or subscriber must be licensed to write at least one ISO line of insurance in at least one jurisdiction or territory of the United States. "As a **service purchaser**, you will be eligible to receive ISO products and services. Insurers and other insurance-related entities that do not wish to be members or subscribers may sign up as service purchasers."

- You must be a member or subscriber to get Filing Authorization Service, which is: "As a filing agent, ISO can handle the intricacies of filings and filing changes associated with ISO programs. You can adopt rule and form revisions — when approved by regulators — that we file on your behalf. Of course, you can also deviate from those filings if you prefer.

  "ISO offers Filing Authorization for rules and forms as allowed by law. ISO does not offer Filing Authorization Service for lines of business now handled by statutory rating organizations in certain states.

  "Subject to all applicable state laws, you may choose to:

  have ISO filings apply on your behalf

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make filings on your own for any line or subdivision of a line (even though you may have authorized ISO to file on your behalf)

use a combination of these approaches

"You must be a member or subscriber to participate for Filing Authorization. You must also participate for State Service rules and/or forms in the states where you want ISO to act as your filing agent."

- "ISO's Actuarial Service" gives an insurer "timely, accurate information on such topics as loss and premium trend, risk classifications, loss development, increased limits factors, catastrophe and excess loss, and expenses." Explaining trend, ISO points out that the insurer can "estimate future costs using ISO's analyses of how inflation and other factors affect cost levels and whether claim frequency is rising or falling." Explaining "expenses" ISO lets an insurer "compare your underwriting expenses against aggregate results to gauge your productivity and efficiency relative to the average..." NOTE: These items, predicting the future for cost movement and supplying data on expenses sufficient for turning ISO's loss cost filings into final rates, are particularly anti-competitive and likely, absent McCarran Ferguson antitrust exemption protection, illegal.

- "ISO Products and Services" is a long list of ways ISO can assist insurers with rating, underwriting, policy forms, manuals, rate quotes, statistics, actuarial help, loss reserves, policy writing, catastrophe pricing, information on specific locations for property insurance pricing, claims handling, information on homeowner claims, credit scoring, making filings for rates, rules and policy forms with the states and other services.

Finally, ISO has a page describing "Advisory Prospective Loss Costs," which lays out the massive manipulations ISO makes to the historic data. A lengthy excerpt follows:

"Advisory Prospective Loss Costs are accurate projections of average future claim costs and loss-adjustment expenses — overall and by coverage, class, territory, and other categories. Your company can use ISO's estimates of future loss costs in making independent decisions about the prices you charge for your policies. For most property/casualty insurers, in most lines of business, ISO loss costs are an essential piece of information. You can consider our loss data — together with other information and your own judgment — in determining your competitive pricing strategies.

"**The insurance pricing problem** –Unlike companies in other industries, you as a property/casualty insurer don't know the ultimate cost of the product you sell — the insurance policy — at the time of sale. At that time, losses under the policy have not yet occurred. It may take months or years after the policy expires before you learn about, settle, and pay all the claims. Firms in other industries can base their prices largely on known or controllable costs. For example, manufacturing companies know at the time of sale how much they have spent on labor, raw materials, equipment, transportation, and other goods and services. But your company has to *predict* the major part of your costs — losses and related expenses — based on historical data gathered from policies written in the past and from claims paid or incurred on those policies. As in all forms of statistical analysis, a large and consistent sample allows more accurate

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predictions than a smaller sample. That's where ISO comes in. The ISO database of insurance premium and loss data is the world's largest collection of that information. And ISO quality checks the data to make sure it's valid, reliable, and accurate. But before we can use the data for estimating future loss costs, ISO must make a number of adjustments, including loss development, loss-adjustment expenses, and trend.

"Loss development ...because it takes time to learn about, settle, and pay claims, the most recent data is always incomplete. Therefore, ISO uses a process called *loss development* to adjust insurers' early estimates of losses to their ultimate level. We look at historical patterns of the changes in loss estimates from an early evaluation date — shortly after the end of a given policy or accident year — to the time, several or many years later, when the insurers have settled and paid all the losses. ISO calculates *loss development factors* that allow us to adjust the data from a number of recent policy or accident years to the ultimate settlement level. We use the adjusted — or developed — data as the basis for the rest of our calculations.

"Loss-adjustment expenses – In addition to paying claims, your company must also pay a variety of expenses related to settling the claims. Those include legal-defense costs, the cost of operating a claims department, and others. Your company allocates some of those costs — mainly legal defense — to particular claims. Other costs appear as overhead. ISO collects data on allocated and unallocated loss-adjustment expenses, and we adjust the claim costs to reflect those expenses.

"Trend –Losses adjusted by loss-development factors and loaded to include loss-adjustment expenses give the best estimates of the costs insurers will ultimately pay for past policies. But you need estimates of losses in the future — when your new policies will be in effect. To produce those estimates, ISO looks separately at two components of the loss cost — claim *frequency* and claim *severity*. We examine recent historical patterns in the number of claims per unit of exposure (the frequency) and in the average cost per claim (the severity). We also consider changes in external conditions. For example, for auto insurance, we look at changes in speed limits, road conditions, traffic density, gasoline prices, the extent of driver education, and patterns of drunk driving. For just three lines of insurance — commercial auto, personal auto, and homeowners — ISO performs 3,000 separate reviews per year to estimate loss trends. Through this kind of analysis, we develop *trend factors* that we use to adjust the developed losses and loss-adjustment expenses to the future period for which you need cost information.

"What you get – With ISO's advisory prospective loss costs, you get solid data that you can use in determining your prices by coverage, state, territory, class, policy limit, deductible, and many other categories. You get estimates based on the largest, most credible set of insurance statistics in the world. And you get the benefit of ISO's renowned team of actuaries and other insurance professionals. ISO has a staff of more than 200 actuarial personnel — including about 50 members of the Casualty Actuarial Society. And no organization anywhere has more experience and expertise in collecting and managing data and estimating future losses."

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CLAIMS OUTCOME ADVISOR

"Bodily injury and workers compensation claims present a complex array of medical, legal, and occupational issues. To manage those issues effectively, you need a comprehensive claims-management system. You need an intelligent database that will help you determine the historical settlement amounts for similar claims. You need ISO Claims Outcome Advisor®.

"ISO Claims Outcome Advisor — or COA™ — will help you evaluate and manage the complex details of each bodily injury or workers compensation claim. COA's database contains more than 18,000 medical conditions — injuries, treatments, complications, preexisting conditions — and 14,000 occupations.

"Take charge of your claims management today Find out more about ISO Claims Outcome Advisor. Follow the links for details on how ISO Claims Outcome Advisor can help you manage bodily injury claims, workers compensation claims, and accident-related comparative-liability claims.

"COA for Bodily Injury. When you use ISO Claims Outcome Advisor to manage your bodily injury claims, you get fair and consistent loss information based on your company's historical data. In addition, COA helps you stay current with the complex medical conditions associated with bodily injury claims.

"COA for Workers Compensation. For each workers compensation claim, ISO Claims Outcome Advisor provides injury-management documents that facilitate communications among the claims handler, the employer, the employee, and medical professionals. In addition, COA develops a return-to-work (RTW) plan unique to each injured person's medical conditions and occupation.

"ISO Liability Advisor™ ISO Liability Advisor™ is a powerful system that helps claims professionals identify and evaluate accident-related comparative-liability claims. ISO Liability Advisor features powerful graphical features, related industry links, and a relational database that helps you report, manage, and track each claim.

For more information... ...about ISO Claims Outcome Advisor, send e-mail"

NOTE: COA is ISO's version of Colossus. ISO has promised potential buyers large claims savings when this product is used.

ISO's activities extensively interfere with the competitive market, a situation allowed by the provisions of the McCarran Ferguson Act's extensive antitrust exemption.

Web site visited on October 9, 2009.

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ATTACHMENT B PAGE 1

	2008 EXPENSE RATIOS					
	AVERAGE FOR ALL INS. COS.			AN EFFICIENT WRITER WITH AT LEAST 1% MARKER SHARE		
LINE OF P/C INSURNCE	Loss adj Expense	Underwriting Expense	Total	Loss adj Expense	Underwriting Expense	Total
FIRE	4.7%	31.7%	36.4%	1.8%	14.1%	15.9%
ALLIED	8.8%	30.7%	39.5%	5.9%	9.1%	15.0%
HOMEOWNERS	11.3%	30.4%	41.7%	7.6%	21.0%	28.6%
CMP NON LIABILITY	6.6%	35.5%	42.1%	1.2%	14.4%	15.6%
CMP LIABILITY	21.7%	32.9%	54.6%	6.2%	29.2%	35.4%
MEDICAL MALPRACTICE	24.3%	18.8%	43.1%	16.8%	13.9%	30.7%
WORK COMP	15.0%	24.7%	39.7%	15.9%	8.7%	24.6%
OTHER LIABILITY	16.9%	27.7%	44.6%	13.3%	22.3%	35.6%
PP AUTO LIABILITY	13.2%	25.2%	38.4%	9.2%	11.8%	21.0%
CC AUTO LIABILITY	12.7%	30.4%	43.1%	8.3%	24.8%	33.1%
PP AUTO PHYS DAMAGE	9.9%	24.6%	34.5%	9.2%	11.6%	20.8%

Source: A. M. Best, Aggregates and Averages, 2009 Edition

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ATTACHMENT B PAGE 2

AN INEFFICIENT WRITER WITH AT LEAST 1% MARKER SHARE			POTENTIAL RATE SAVINGS*	
Loss adj Expense	Underwriting Expense	Total	If Average Became Efficient	If Inefficient Became Average
5.5%	41.9%	47.4%	-24.4%	-17.3%
9.0%	45.0%	54.0%	-28.8%	-24.0%
10.9%	36.2%	47.1%	-18.3%	-9.3%
9.8%	40.2%	50.0%	-31.4%	-13.6%
32.2%	36.2%	68.4%	-29.7%	-30.4%
22.2%	43.5%	65.7%	-17.9%	-39.7%
11.7%	39.9%	51.6%	-20.0%	-19.7%
30.5%	25.0%	55.5%	-14.0%	-19.7%
14.2%	32.9%	47.1%	-22.0%	-14.1%
20.3%	33.0%	53.3%	-14.9%	-17.9%
13.2%	33.1%	46.3%	-17.3%	-18.0%
	AVERAGE SAVINGS		-21.7%	-20.3%

* Calculated as follows: {(1.000- expense ratio of efficient writer)/1.000- expense ratio of average writer)-1.000}

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Attachment C: Reprinted from the Los Angeles Times, November 28, 2006

Insurance company cutbacks have left more than 1 million coastal residents scrambling to land new insurers or learning to live with weakened policies. As insurers retreat, states and homeowners are left to bear the biggest risks.

Massachusetts

During the last two years, six insurers have stopped selling or renewing policies along the coast, especially on Cape Cod, leaving 45,000 homeowners to look for coverage elsewhere. Most have turned to the state-created insurer of last resort. The Massachusetts FAIR Plan, now the state's largest homeowners' insurer, recently received permission to raise rates 12.4 percent.

Connecticut

Atty. Gen. Richard Blumenthal has subpoenaed nine insurance companies to explain why they are requiring thousands of policyholders whose houses are near any water —coast, river or lake —to install storm shutters within 45 days or have their coverage cut or canceled.

New York

Allstate has refused to renew 30,000 policies in New York City and Long Island, and suggested it may make further cuts. Other insurers, including Nationwide and MetLife, have raised to as much as 5 percent of a home's value the amount policyholders must pay before insurance kicks in, or say they will write no new policies in coastal areas.

South Carolina

Agents say most insurers have stopped selling hurricane coverage along the coast. Those that still do have raised their rates by as much as 100 percent. The state-created fallback insurer is expected to more than double its business from 21,000 policies last year to more than 50,000.

Florida

Allstate has offloaded 120,000 homeowners to a start-up insurer and has said it will drop more as policies come up for renewal. State-created Citizens Property, now the state's largest homeowners insurer with 1.2 million policies, was forced to use tax dollars and issue bonds to plug a $1.6- billion financial hole due to hurricane claims. The second-largest, Poe Financial Group, went bankrupt this summer, leaving 300,000 to find coverage elsewhere. The state also has separate funds to sell insurers below-market reinsurance and cover businesses. Controversy over insurance was a major issue in this fall's election campaign, causing fissures in the dominant GOP.

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Louisiana

The state's largest residential insurer, State Farm, will no longer offer wind and hail coverage as part of homeowners' policies in southern Louisiana. In areas where it still covers these dangers, it will require homeowners to pay up to 5 percent of losses themselves before insurance kicks in. In a move state regulators call illegal and are fighting, Allstate is seeking to transfer wind and hail coverage for 30,000 of its existing customers to the state created Citizens Insurance.

Texas

Allstate and five smaller insurers have canceled hurricane coverage for about 100,000 homeowners and have said they will write no new policies in coastal areas. Texas' largest insurer, State Farm, is seeking to raise its rates by more than 50 percent along the coast and 20 percent statewide.

California

The state has bucked the trend toward higher homeowners' insurance rates with three major insurers, State Farm, Hartford and USAA, seeking rate reductions of 11 percent to 22 percent. Regulators have begun to question whether insurers are making excessive profits after finding that major companies spent only 41 cents of every premium dollar paying claims and related expenses. Alone among major firms, Allstate is seeking a 12.2 percent rate hike.

Washington

Allstate has dropped earthquake coverage for about 40,000 customers and will have its agents offer the quake insurance of another company when selling homeowners policies in the state. Nationally, the company has canceled quake coverage for more than 400,000.

Sources: Risk Management Solutions (map); interviews with state insurance regulators

NOTE: Since the Los Angeles Times ran this recap of actions on the coasts, many insurers have cut back or stopped writing insurance along the coasts.

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Statement Of Senator Patrick Leahy (D-Vt.),
Chairman, Senate Judiciary Committee,
Hearing On "Prohibiting Price Fixing And Other Anticompetitive Conduct
In The Health Insurance Industry"
October 14, 2009

Today, we focus on an issue that has had my attention for many years -- the insurance industry's exemption from the Federal antitrust laws. This exemption, since it was enacted in 1945, has served the financial interests of the insurance industry at the expense of consumers.

For the past several months, our Nation has debated how best to reform our healthcare system. Three House Committees and two Senate Committees have spent countless hours trying to answer the question of how best to introduce competition and make health insurance affordable for all Americans. Amid this debate, it is important to remember that under current law the health insurance industry does not have to play by the same rules of competition as do other industries.

The lack of affordable health insurance plagues families throughout our country, and the rising prices that hospitals and doctors pay for medical malpractice insurance drains resources that could otherwise be used to improve patient care. Antitrust oversight in these industries would provide consumers with confidence that insurance companies are not colluding to raise prices artificially.

There is no justification for health insurers engaging in egregious anticompetitive conduct to the detriment of consumers. Price fixing, bid rigging and market allocation are "per se" violations of our laws precisely because there is no procompetitive justification for them. Health insurers should not be accorded immunity to engage in such otherwise illegal conduct. Our bill will fix this anachronism in the law once and for all and should lead to more competition and lower insurance costs.

The insurance industry has used its enormous influence to maintain a special, statutory exemption from Federal antitrust laws and the protections they provide. While the insurance industry hides behind its exemption, patients and doctors have continued paying artificially inflated prices, as costs continue to rise at an alarming rate. The cost spiral is just fine for insurance companies, but it punishes patients, American businesses large and small, and taxpayers. No wonder the insurance companies dearly want to keep their antitrust exemption. But where does an antitrust exemption fit into the picture at a time when we are debating reform efforts to check spiraling costs and expand Americans' access to quality, affordable health insurance? The obvious answer is that it is an anachronism that does not fit into the picture of what the American people want and need their health insurance system to be.

Last month, I introduced the Health Insurance Industry Antitrust Enforcement Act of 2009, which will repeal the antitrust exemption for health insurance and medical malpractice insurance providers. The Majority Leader is a cosponsor of this legislation, as are five other Members of this Committee – Senators Feinstein, Feingold, Schumer, Durbin, and Specter.

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Our legislation will ensure that the basic rules of fair competition apply to insurers in the health industry, as part of the reforms that the larger healthcare bill will enact. Our Nation's antitrust laws exist to protect consumers, and it is vital that the health insurance companies are subject to these laws. These laws promote competition, which ensures that consumers will pay lower prices and receive more choices.

Last Congress, Senator Trent Lott, the former Senate Republican Leader, and others on both sides of the aisle joined me in introducing a much broader repeal of the insurance industry's antitrust exemption. The bill we have reintroduced this year is a scaled-back version directed at health insurance. Surely we can all agree that health insurers should not be permitted to fix prices, allocate markets, or to rig a bid.

Insurers should not object to being subject to the same antitrust laws as everyone else. If they are operating in an appropriate way, they should have nothing to fear. It is time for Congress to stick up for consumers, rather than roll over for the insurance industry.

I feel strongly that we need a public insurance option as part of our health care reform package. I agree with President Obama that a public insurance option would provide competitive pressure on private health care insurers and should have the effect of lowering prices. I also think we need to strengthen our anti-fraud laws and enforcement in connection with health care. However Senators feel about those matters, the initiative we are considering today – eliminating the health insurance industry's immunity from Federal antitrust laws — should move forward as a key element of health care reform. I intend to work with the Senate Majority Leader to provide the opportunity for all Senators to vote against price fixing and market allocation and bid rigging and for fair competition among health insurers.

American families, doctors and hospitals rely on insurance. It is important to ensure that the prices they pay for this insurance are established in a fair and competitive way.

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ABSTAIN: Attorney General Kelly Ayotte
Attorney General Steve Carter
Attorney General J.B. Van Hollen

National Association
of Attorneys General

Adopted

Summer Meeting
June 19-21, 2007
Atlanta, Georgia

RESOLUTION
OPPOSING PREEMPTION OF STATE INSURANCE REGULATION AND SUPPORTING REPEAL OF THE INSURANCE INDUSTRY'S EXEMPTION FROM FEDERAL ANTITRUST LAWS

WHEREAS, the antitrust laws are intended to protect and promote a competitive marketplace, benefit all the citizens of the several states, and promote robust innovation; and

WHEREAS, state Attorneys General represent their states and the citizens of their states in federal antitrust litigation; and

WHEREAS, the insurance industry wrote a total of approximately $1.1 trillion in premiums in 2003, or approximately 10 cents of every dollar of the $11 trillion Gross Domestic Product[1]; and, is a significant part of the U.S. economy; and

WHEREAS, the McCarran-Ferguson Act, 15 U.S.C. §§1011-1015, enacted in 1945, affords the business of insurance a significant exemption from the federal antitrust laws and precludes enforcement of the prohibitions against anticompetitive practices, such as price-fixing, that are almost always unlawful outside the business of insurance; and

WHEREAS, the McCarran-Ferguson Act has hindered the ability of antitrust enforcers to detect, correct, deter and obtain compensation for abuses in the insurance sector; and

WHEREAS, even though state antitrust enforcers achieved significant reforms in the liability insurance industry in *Hartford Fire Insurance Co. v. California*[2], the defendants in that

[1]Insurance Information Institute, *citing* U.S. Department of Commerce, Bureau of Economic Analysis.

[2]509 U.S. 764 (1993)

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case significantly delayed the reforms by raising non-meritorious claims of immunity under the McCarran-Ferguson Act, that ultimately the United States Supreme Court had to resolve against the defendants; and

WHEREAS, recently, a decade after the *Hartford* litigation, state Attorneys General discovered new instances of anticompetitive conduct in the insurance industry that they chose to address under state, rather than federal, law, in part to avoid the delay and uncertainty that might have resulted from the assertion of a McCarran-Ferguson Act defense to a federal antitrust claim; and

WHEREAS, a uniform federal antitrust standard would facilitate antitrust enforcement and benefit plaintiffs and defendants alike, by reducing disparate actions, under different laws, that may yield inconsistent results; and

WHEREAS, the exchange of information among market participants to achieve pro-competitive benefits is not unique to the insurance industry and generally is not prohibited by the antitrust laws; and

WHEREAS, like businesses in virtually all other market sectors, entities engaged in the business of insurance should not be permitted to enter into agreements that unreasonably restrain competition between them; and

WHEREAS, state regulation of the business of insurance covers far more than antitrust considerations, governing insurance operations, reserves, notices to policy holders, forms of policies, and other matters affecting the day-to-day business of insurance; and

WHEREAS, continuation of this state regulatory regime is consistent with application of the antitrust laws; and

WHEREAS, the National Association of Attorneys General consistently has opposed legislation that weakens antitrust standards for specific industries because there is no evidence that such exemptions promote competition or serve the public interest;

NOW, THEREFORE, BE IT RESOLVED THAT THE NATIONAL ASSOCIATION OF ATTORNEYS GENERAL:

1) Opposes preemption of state regulation of insurance; and

2) Supports repeal of the McCarran-Ferguson Act's exemption for the business of insurance from federal antitrust laws.

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Physician Insurers Association of America

Protecting Healthcare

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United States Senate

Committee on the Judiciary

Senator Patrick J. Leahy, Chairman
Senator Jeff Sessions, Ranking Member

Hearing on

"Prohibiting Price Fixing and Other Anticompetitive Conduct in the Health Insurance Industry"

Statement of

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On behalf of the
Physician Insurers Association of America

October 14, 2009

"Prohibiting Price Fixing and Other Anticompetitive Conduct in the Health Insurance Industry"

Chairman Leahy, Ranking Member Sessions, and members of the Committee, I am honored by your invitation to discuss these important topics. My name is Lars Powell, and I earned a Ph.D. in insurance from the University of Georgia, and currently hold the Whitbeck-Beyer Chair of Insurance and Financial Services at the University of Arkansas–Little Rock. I am also a founding board member of Arkansas Mutual Insurance Company, a physician-owned medical professional liability insurance company and member company of the Physician Insurers Association of America (PIAA). I appear on behalf of PIAA in this capacity.

I am an author of several studies relevant to this discussion. My research investigates performance in medical professional liability insurance (MPLI) markets and the role of the McCarran Ferguson Act (McCarran) in promoting competition in the insurance industry, among other topics. I encourage members to read my peer-reviewed publications that inform this discussion.[1] I will be pleased to provide additional research and comments at your request.

I would like to specifically address two issues relevant to the topic of this hearing and consideration of S.1681. First, insurance pricing is an inherently difficult task, especially in the MPLI line. Repealing McCarran would further exacerbate this difficulty. Second, the limited antitrust exemption provided by McCarran enhances competition in insurance markets. To repeal McCarran would at best maintain the status quo; however, it could also stifle competition to the detriment of consumers.

I will also note that the topics of this hearing, price fixing and anticompetitive conduct, are prohibited in insurance markets by existing state and federal law, and valid evidence of anticompetitive behavior is not observed in insurance markets.

While my comments primarily apply to medical professional liability insurance, there is also substantial overlap to health insurance and the business of insurance in general regarding effects of the McCarran Ferguson Act.

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[1] These include Hoyt, Robert E. and Lawrence S. Powell, 2006. "Assessing Financial Performance in Medical Professional Liability Insurance," *Journal of Insurance Regulation*, v25, n1 (Fall, 2006): 3-13; Powell, Lawrence S., 2008. "Assault on the McCarran-Ferguson Act and the Politics of Insurance in the Post-Katrina Era," *Journal of Insurance Regulation*, v26n3: 3-21 (Spring 2008).

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Pricing and Regulation of Medical Professional Liability Insurance (MPLI)

Pricing of insurance is inherently very difficult because the price must be set before all of the costs are known. Difficulty is amplified for MPL insurance because of the long period of time that elapses between the policy period and ultimate settlement of claims. On average, an insurer does not know the ultimate outcome of a claim until more than four years after the potential loss event. Nonetheless, *ex post* criticism of MPL insurance pricing accuracy is common in public policy debates.

As insurers receive new information about open claims, they adjust their estimates of incurred losses. This process is called loss reserve development. MPL insurers have experienced positive and negative loss reserve development in recent decades due to the lag between setting prices and receiving information about litigation outcomes and trends. Loss reserve development experienced from 1981 through 2006 is shown in Figure 1. When loss reserve development is positive, insurers underestimated initial losses. In this case, initial reserves are said to be inadequate. When development is negative, initial estimates were higher than ultimate losses, and reserves are said to be redundant.

The long claim tail is the primary reason for loss development in MPLI. Not only do expected losses change as insurers learn new information, but they also follow distinct trends over time. The trend of claim frequency and paid claim frequency has reversed a few times in recent decades, leading to substantial mispricing in certain periods. It is clear and intuitive to recognize this possibility given the time lag between suspicion and confirmation that a trend has reversed.

In some years, ultimate losses differ from initial estimates by as much as 46 percent, while in other years the difference is much smaller. Overall, the sum of the initial estimates and the ultimate losses are remarkably similar. During the 25-year period, initial estimates sum to almost $116 billion and losses developed through 2006 sum to slightly less than $111 billion; a difference of only 5 percent.

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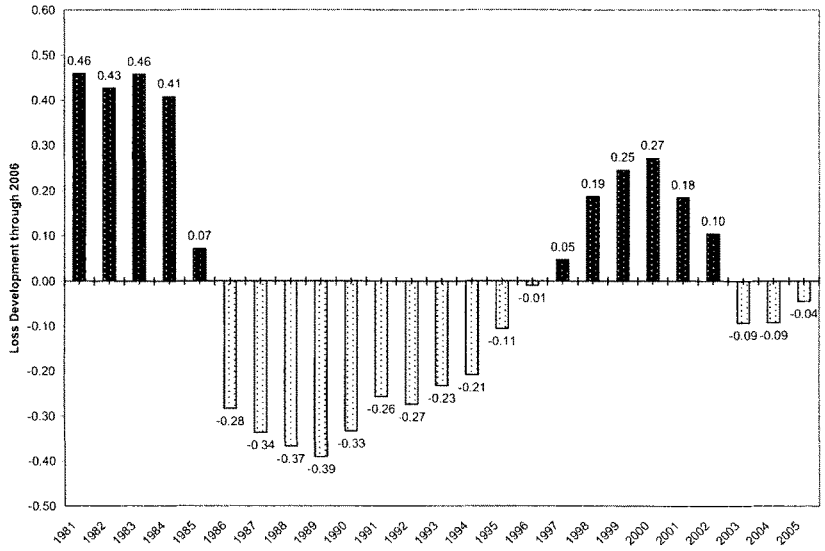
Figure 1: MPL Insurance Loss Development through 2006



Note: Ten-calendar-year loss development shown for losses incurred in years 1981-1997. Development through 2006 is shown for subsequent years.
Source: NAIC InfoPro Database, 1990-2006

The McCarran Ferguson Act of 1945

The 79th Congress enacted Public Law 15, better known as the McCarran-Ferguson Act of 1945.[2] The Act provides a narrow exemption from federal antitrust laws, and pertains only to activities that (1) constitute the "business of insurance," (2) are "regulated by State law," and (3) do not constitute "an agreement to boycott, coerce or intimidate or an act of boycott, coercion or intimidation."

In practice, McCarran permits several activities conducted by insurance companies that would otherwise be prohibited or subjected to scrutiny under the federal antitrust laws. Perhaps the most significant consequence of the Act is that it permits insurers to pool data through independent statistical agents that produce advisory loss

[2] McCarran-Ferguson Act, 59 Stat. 33,34 (1945), U.S.C.A. §1012 (1958).

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costs to aid insurers in the ratemaking process.[3] It also allows standardization of risk classification and policy forms, and joint underwriting ventures.[4] Each of these functions benefits consumers by promoting financial strength, efficiency and competition in insurance markets.

If policymakers repeal McCarran, consumers will suffer substantial negative consequences resulting from a combination of weakened competition in the insurance industry and myriad regulatory, legal and operational problems, creating costs that the consumers themselves must ultimately bear.

Advisory loss costs provided by statistical agents are available to insurers for a fee. However, the benefits of advisory loss costs vary inversely with market share, company size and age of insurers. Small and new insurers have less in-house data to analyze than do large insurers. Also, even if statistical agents provided raw historic loss data for insurers to analyze, the cost of analyzing loss data represents a much larger proportion of a small insurer's revenues than that of a large insurer. Experts claim these costs would be prohibitive for small insurers, effectively eliminating the important competition they bring to markets.[5] Indeed, empirical evidence suggests that when McCarran became law in 1945, its effects differed across insurers based on the types of insurance they underwrote and company size. Current analysis by Randy Dumm, Rob Hoyt and I shows that enactment of McCarran increased the value of small property/casualty insurers and decreased the value of large insurers (Dumm, Hoyt and Powell, 2007).

Some have noted that MPLI carriers and health insurers rely less on aggregate loss information than do insurers in other lines. To this end, S.1681 would have less

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[3] Statistical agencies include the Insurance Services Office (ISO – www.iso.com), Surety and Fidelity Association of America (SFAA – www.surety.org), and the National Council on Compensation Insurance (NCCI – www.ncci.com).

[4] Five independent statistical agents prepare data for the property and casualty industry. They include: Insurance Services Office (ISO), the Independent Statistical Service (ISS), the National Independent Statistical Service (NISS), the American Association of Insurance Services (AAIS) and the Mutual Service Office (MSO).

[5] See testimony of Kevin B. Thompson, FCAS, MAAA before the U.S. Senate Committee on the Judiciary, June 20, 2006 Hearing on the McCarran-Ferguson Act: Implications of Repealing the Insurers' Antitrust Exemption; and testimony of James D. Hurley, ACAS, MAAA before the U.S. House of Representatives Committee on the Judiciary, October 8, 2009, hearing on: H.R. 3596, the "Health Insurance Industry Antitrust Enforcement Act of 2009."

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effect in the current market environment than in other conceivable scenarios. However, it is important to consider not only the current market and the larger market share of existing carriers, but also potential changes in these markets and insurers going forward.

The ability to pool loss cost data through independent statistical agents is most important for extreme risks. These include very large losses and new exposures to loss. Should the underlying distribution of losses change, as a result of new medicine, new disease, or new liability, insurers that currently rely largely on their own past loss data would again benefit from advisory loss costs. Any of these aforementioned scenarios would introduce substantial new uncertainty to insurance markets. The undeniable result of increasing uncertainty in insured outcomes is increased prices for insurance.

In the context of health insurance, these increased prices would occur, but be less pronounced for large group insurance that is effectively experience rated. Rather, the most vulnerable set of consumers – those who purchase insurance as individuals and small groups – would shoulder the bulk of this price increase. The uncertainty causing price increases could be mitigated, at least in part, by data sharing to produce advisory loss costs that is currently permitted by McCarran.

Markets for Medical Professional Liability Insurance

MPLI markets in the United States currently exhibit substantial competition, suggesting that additional antitrust measures would not benefit consumers. I present evidence from two perspectives. First, I develop the concept of market competition and present analysis of market data consistent competition in MPLI markets. Second, I share my recent experience as a board member and consultant for Arkansas Mutual Insurance Company.

In addition to the discussion that follows, it is instructive to consider ownership structure of MPL insurers. Approximately sixty percent (60%) of U.S. private physicians are insured by physician-owned and directed insurance companies. Many of these companies are organized as mutual insurers or reciprocal exchanges, which are owned by policyholders. Others are organized as stock insurers, which are typically "for-profit"

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entities; however, these are owned by physicians or medical associations and, like mutual companies, operate for the benefit of policyholders.

If one is to assume these MPLI companies are price gouging physicians, we must reach the flawed conclusion that policyholders are price-gouging themselves. Clearly, this outcome defies logic and should be dismissed without further comment.

Consumers desire insurance premiums that are adequate, but not excessive. If premiums are too low (i.e., not adequate), the insurer will not have enough money to pay the insured's claims or provide other services such as loss control and claim processing. If premiums are excessive, consumers' economic disadvantages are obvious. In other words, consumers are best served by insurance coverage at the "fair-market premium."[6]

The fair-market premium is the premium that will be offered and accepted in a competitive market. It includes the present value of expected claim payments, expected administrative and operating costs (including distribution costs, taxes and regulatory fees), and capital costs, also known as a fair profit. These elements ensure that the company will have enough money to pay claims and provide services, and create an adequate incentive for participation in insurance markets.

Competitive markets commonly exhibit four characteristics.[7] First, they include multiple independent sellers with low to moderate market shares. Second, there are multiple consumers with enough information to determine the value of the product. Third, the product is relatively homogeneous, allowing consumers to differentiate value across offered prices. Finally, barriers to entry and exit are low, allowing new suppliers to enter the market if prices rise above the fair-market price, or exit the market if they cannot produce the product at the fair-market price.

Competition among sellers is often considered the most important safeguard for consumers of any product, including insurance.[8] When consumers have choices among insurance carriers, the carriers are forced to compete for consumers' business. For example, assume two insurers, Company A and Company B, offer the same insurance policy to identical consumers. If Company A charges more than Company B, consumers

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[6] See Harrington and Niehaus (2001) Chapter 8 for a thorough development of fair insurance premiums.

[7] Competition is defined as "workable competition" in the sense suggested in Clark (1940).

[8] Some might argue that mutual ownership provides equal if not superior protection for consumers.

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will buy from Company B.[9] Company A must either lower its price or exit the market. If insurers in a given market were to collude and fix prices at a level above the fair premium, a new company could enter the market, charge the fair-market price, and take away the colluding insurers' market share.

Insurance markets are competitive

The role of the limited antitrust exemption provided by the McCarran Ferguson Act is to ***increase*** competition by promoting the characteristics of competitive markets described above. From all indications, the law has been remarkably successful in achieving this objective. Numerous studies conducted by academic and government researchers find that insurance markets are highly competitive (e.g., Joskow, 1973).

More than 2700 companies current sell property and liability insurance in the United States. Of these, a few hundred participate in MPLI coverage. While a few hundred insurers are clearly adequate to suggest markets are competitive, it is also instructive to consider that more than 2000 other existing companies could potentially enter the market if presented with a profitable opportunity. Finally, it is also possible to form a new company – a process in which I recently participated – making the potential number of competing firms theoretically infinite.

Another potential measure of competition in insurance markets is company performance. If insurers are colluding to raise prices above the competitive equilibrium price, insurance markets should exhibit substantial profits over a lengthy period of time.

A valid measure of insurer financial performance is return on equity (ROE). It is calculated by dividing estimated net income from the MPL line by insurer capital. These data are obtained from the NAIC's *Report on Profitability by Line by State.* Over the last decade MPL insurers averaged just over five percent ROE. In three of these years ROE was negative. These results contrast with the preceding decade that produced somewhat

[9] Of course, consumers should also consider service and financial strength of the insurer, but this stylized example assumes all other characteristics are equal. It may help to think of the price of insurance as the difference between cost and expected benefits (including service and probability of continuing insurer financial strength).

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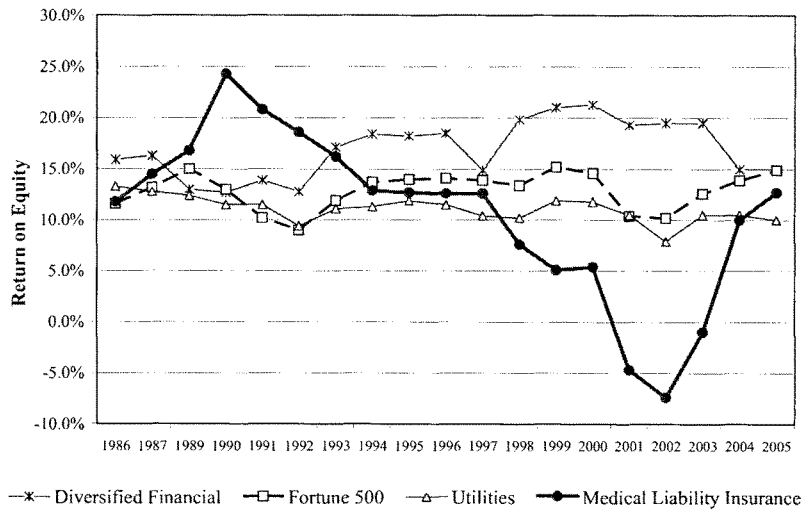
higher returns.[10] Figure 2 displays ROE for MPL insurers and compares it to that of other industries.

Figure 2: Comparing ROE across Industries, 1986-2005



Source: NAIC Profitability Report, 1995, 2006; and III Fact Book, various years

The difference in return volatility between MPL insurers and other industries also is striking. The standard deviation of annual MPL insurer returns is more than four times that of the Fortune 500 index. The high volatility of returns suggests MPL insurer returns should exceed that of other industries with less volatile returns; however, returns have consistently fallen short of other industries for over a decade. The combination of high volatility and low returns suggests it is difficult to price this type of insurance accurately.

In summary, it seems clear that if MPL insurers are price gouging their policyholders, they are doing a very poor job.

[10] The arithmetic average ROE from 1996 to 2005 was 5.5%. From 1986 to 2005, average ROE was 10.1%.

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Arkansas' Market for MPLI – A Case Study in Competition

In May of 2007, I joined a team of physicians and insurance professionals in an effort to create a single-state MPL insurance company for Arkansas physicians. At the time, one carrier underwrote a substantial share of the market. Our effort was motivated more by desire for local control than by identified serious shortcomings in existing carriers. Arkansas Mutual Insurance Company entered the market as an admitted carrier in January of 2009.

The ability to access industry loss data was paramount to formation of this new insurance carrier. Without access to loss information, we would not have been able to form a new company to compete for business from Arkansas' physicians. Therefore, it appears that S.1681 would have limited competition. Moreover, extrapolating from my experience in Arkansas, several dozen MPL insurers that formed in recent years would also be prevented from entering the market.

Since Arkansas Mutual commenced business, in my role as a consultant and executive board member, I have witnessed first hand an incredible level of competition in this market. To put this in perspective, Arkansas is a relatively small state with population of approximately 2.8 million and about 5,500 physicians who purchase MPLI. From 2003 to the present, the number of insurers actively underwriting MPLI in Arkansas has increased from one or two to six or seven. This does not include several surplus lines carriers who insure non-standard physicians.

In marketing efforts, Arkansas Mutual has seen one-year decreases in premium for some physicians as large forty percent (40%). This aggressive pricing and increasing number of market participants indicates substantial competition to the benefit of consumers.

Conclusions

The impetus of this hearing is S.1681, thus, it is important to consider the expected effects of this bill on the current regulatory framework and outcomes of the industry. To summarize my opinion, all of the behaviors this bill seeks to curtail (price fixing, bid rigging, and market allocation) are neither apparent in the market, nor permitted by current law.

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In fact, reality is quite to the contrary. Markets for MPLI exhibit characteristics and outcomes consistent with vigorous competition to provide a product that is inherently difficult to price. In certain short periods, this market has incurred substantial losses or profits, but over time, the outcomes sum to reflect a balanced competitive market with only modest returns. Moreover, because physician-owned mutual insurance companies cover a large portion of United States physicians, it is far fetched to suggest price gouging occurs in this segment of the market.

In light of these observations, the best possible expected outcome from repealing McCarran is continuation of the status quo. However, it is also likely that repealing McCarran could have negative consequence for consumers. Because McCarran currently enhances competition in insurance markets, repealing McCarran would naturally reduce competition. It could also increase uncertainty in insurance pricing, which leads to price increases.

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The Assault on the McCarran-Ferguson Act and the Politics of Insurance in the Post-Katrina Era*

Lawrence S. Powell, Ph.D.[1]

Introduction

> So for more than six decades, the insurance industry has operated largely beyond the reach of federal competition laws. I truly believe that the McCarran-Ferguson Act's antitrust exemption has allowed insurers to engage in anticompetitive conduct, and I can find no justification to exempt the insurance industry from federal government oversight. Such oversight could help make certain that the industry is not engaging in anticompetitive conduct such as price fixing, agreements not to pay, and market allocations.
>
> —Sen. Trent Lott (R-Miss.)
> Statement before the U.S. Senate Committee on the Judiciary
> "The McCarran-Ferguson Act and Antitrust Immunity: Good for Consumers?"
> March 7, 2007

* The author thanks the National Association of Mutual Insurance Companies (NAMIC) for financial support. Robert Detlefsen, David Reddick and other NAMIC staff provided helpful suggestions. The author is responsible for all remaining errors.

1. Whitbeck-Beyer Chair of Insurance and Financial Services, University of Arkansas-Little Rock, College of Business, Department of Economics and Finance.

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The 110th Congress is considering legislation that would repeal a provision of the McCarran-Ferguson Act (hereafter referred to as "McCarran") that gives insurers a narrowly targeted limited exemption from federal antitrust laws.[2]

This study examines the effort to repeal the limited insurance antitrust exemption as part of a broader political movement to "reform" the business of insurance, largely in response to contentious issues arising from the catastrophic hurricane season of 2005. In addition to the McCarran repeal initiative, the movement has spawned a variety of government proposals intended to expand the scope of property insurance coverage in catastrophe-prone areas, while at the same time increasing the supply and reducing the cost of insurance in these areas.[3] Because insurance regulation in the United States is highly decentralized, the movement is being driven by a diverse group of actors that includes members of Congress, state legislators, governors, insurance commissioners, state attorneys general, judges and consumer activists.

Congress has considered legislation to repeal or modify the McCarran-Ferguson Act's insurance antitrust exemption on at least two other occasions since the law was enacted in 1945.[4] Then, as now, the repeal effort was triggered by a perceived crisis in the property-casualty insurance industry that critics claimed was the result of anticompetitive insurer collusion facilitated by the industry's exemption from federal antitrust rules. Proponents of the current repeal effort have asserted that, in the aftermath of hurricanes Katrina, Rita and Wilma, insurers colluded with respect to price, market allocation and claim settling practices under the protection from antitrust scrutiny afforded by the Act.

Today, insurers are facing the formidable challenge of assessing risk in an era of increased coastal development and heightened climate volatility. The powerful

2. See "Insurance Industry Competition Act of 2007" (H.R. 1081/S. 618).

3. Catastrophe insurance-related proposals introduced in the 110th Congress as of this writing include H.R. 3355, which would create a National Catastrophe Risk Consortium that states could join for the purposes of transferring catastrophe risk through the issuance of risk-linked securities or through reinsurance contracts; H.R. 3121, which, as drafted initially, contained provisions to increase the borrowing authority of the National Flood Insurance Program (NFIP) as well as funding for mitigation and updating maps, but now contains a provision that would include windstorm coverage as part of the NFIP; and S. 292, which would establish a bipartisan commission on natural disasters and would require the commission to present a report and recommendations to Congress by December 2008.

4. Proposals to repeal the McCarran-Ferguson Act surfaced in the mid-1980s during the so-called liability insurance "crisis," amid allegations that insurers collusively set prices above competitive levels. While the uproar did not result in any substantive legislative proposals, the Insurance Services Office in 1990 ceased publishing advisory rates and instead began publishing loss costs only. This left each insurer to add a mark-up for expenses and return on capital to arrive at a final rate. In 1991, Rep. Jack Brooks (D-Texas) introduced H.R. 9, the "Insurance Competitive Pricing Act," which attempted to trade the general McCarran antitrust exemption for a set of targeted "safe harbor" antitrust exemptions. Negotiations on the issue continued over three years and eventually resulted in an agreement in the summer of 1994. H.R. 9 was reported favorably out of the House Judiciary Committee, but the effort ultimately stalled when control of the House shifted in that year's mid-term elections. For a concise history of the McCarran-Ferguson Act, see Danzon (1992) and Berrington (2007)

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statistical tools they use to meet this challenge require large amounts of accurate historical data. For several decades, insurers have been allowed to share loss data through third-party statistical agents for estimating future losses. In these circumstances, applying the federal antitrust laws to insurers could threaten the very cooperative behavior that makes it possible for companies to compete in catastrophe-prone insurance markets. The McCarran repeal effort could thus produce a result that is the opposite of what its proponents intend.

This study develops and presents evidence supporting four important conclusions regarding the proposed repeal of McCarran: 1) Insurance markets currently exhibit healthy and vigorous competition; 2) The limited antitrust exemption does not lead to collusion among insurers that is harmful to consumers; 3) Repealing McCarran would impede competition and the operation of insurance markets to the detriment of consumers; and 4) There are several viable options that policymakers could pursue to increase the availability and lower the price of property-casualty insurance that do not involve repealing McCarran.

Background and Context

The McCarran-Ferguson Act of 1945

The history of insurance regulation has been shaped by several landmark court decisions and legislative acts. In 1869, the U.S. Supreme Court decided in *Paul vs. Virginia*[5] that insurance was not interstate commerce and should be regulated at the state level. However, the Court overturned the *Paul* decision in 1944, ruling in *United States vs. South-Eastern Underwriters Association*[6] that the business of insurance constitutes interstate commerce and is therefore subject to federal jurisdiction under the U.S. Constitution.[7] Among other things, the ruling effectively meant that federal antitrust laws, including the Sherman Act,[8] the Clayton Act[9] and the Federal Trade Commission Act,[10] would henceforth be applied to the insurance industry.[11]

Congress immediately recognized that application of the antitrust laws would prevent insurers from jointly collecting and disseminating information that is necessary to facilitate competitive ratemaking. Thus, in the year following the *South-Eastern Underwriters* decision, the 79th Congress enacted Public Law 15, better known as the

5. Paul v. Virginia, 75 US 168 (1868).

6. United States v. South-Eastern Underwriters Association, 322 U.S. 533, 64S.Ct. 1162, 88 L.Ed. 1440 (1944) rehearing denied 323 U.S. 811, 65 S.Ct. 26, 89 L.Ed. 646 (1944).

7. Constitution of the United States, Article 1, Sec. 8

8. Sherman Act, 15 U.S.C. §§ 1-7 (1890).

9. Clayton Act, 15 U.S.C. §§ 12, 13, 14-19, 20, 21, 22-27 (1914).

10. Federal Trade Commission Act, 15 U.S.C. §§ 41-58.

11. The Sherman Act prohibits restraint of trade and monopolistic practices. The Clayton Act prohibits anti-competitive practices; the Robinson-Patman Act (an amendment to the Clayton Act) prohibits price discrimination among customers who compete against each other. The Federal Trade Commission Act prohibits unfair methods of competition and deceptive practices.

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McCarran-Ferguson Act of 1945.[12] The Act provides a narrow exemption from federal antitrust laws, and pertains only to activities that (1) constitute the "business of insurance," (2) are "regulated by State law," and (3) do not constitute "an agreement to boycott, coerce or intimidate or an act of boycott, coercion or intimidation."

In practice, McCarran permits several activities conducted by insurance companies that would otherwise be prohibited or subjected to scrutiny under the federal antitrust laws. Perhaps the most significant consequence of the Act is that it permits insurers to pool data through independent statistical agents that produce advisory loss costs to aid insurers in the ratemaking process.[13] It also allows standardization of risk classification and policy forms, and joint underwriting ventures.[14] Each of these functions benefits consumers by promoting financial strength, efficiency and competition in insurance markets.

Catastrophic Risk and the McCarran Antitrust Exemption

The devastating hurricane season of 2005 has greatly increased the level of interest in insurance regulatory reform among policymakers at both the state and federal levels. With notable exceptions, however, the "reforms" have been limited and targeted in nature.[15] The outlier is Florida, where lawmakers meeting in special session in January voted for rate rollbacks and further rate suppression, more extensive coverage mandates, and further displacement of the private insurance market by state-subsidized insurance and reinsurance entities.[16]

12. McCarran-Ferguson Act, 59 Stat. 33,34 (1945), U.S.C.A. §1012 (1958).

13. Statistical agencies include the Insurance Services Office (ISO – www.iso.com), Surety and Fidelity Association of America (SFAA – www.surety.org), and the National Council on Compensation Insurance (NCCI – www.ncci.com).

14. Five independent statistical agents prepare data for the property and casualty industry. They include: Insurance Services Office (ISO), the Independent Statistical Service (ISS), the National Independent Statistical Service (NISS), the American Association of Insurance Services (AAIS) and the Mutual Service Office (MSO).

15. Two states that did not follow the regulatory status quo this year were Louisiana and South Carolina. In Louisiana, lawmakers enacted HB 678, which creates a $100 million incentive program for property insurers that commit new capital to write in the state and to take policies out of the Louisiana Citizens Property Insurance Corporation. South Carolina lawmakers, meanwhile, enacted HB 3820, which provides incentives to insurance companies that provide coverage within the state's wind pool territory and tax incentives for consumers who set up Catastrophe Savings Accounts or retrofit their homes.

16. House Bill 1a, which took effect January 25, 2007, contains several provisions that many industry observers consider punitive. They include a provision prohibiting formation of new Florida domestic subsidiaries of a national company (commonly called a "pup company"); prohibiting insurers from writing auto insurance in Florida if the insurer writes property insurance in another state but does not write property insurance in Florida; requiring the Insurance Consumer Advocate to provide an annual report card for each property insurer using a letter grade; and requiring an insurer's senior officer for Florida business to sign a sworn statement of certification under oath, with penalty of perjury, for rate filings.

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Meanwhile, federal judges presiding over lawsuits involving Katrina-related coverage disputes invoked the "ambiguity doctrine" to void anti-concurrent causation clauses in insurance contracts, effectively forcing insurers to provide retroactive coverage for which they collected no premium.[17] It was against this backdrop that key members of the U.S. House and Senate introduced the "Insurance Industry Competition Act" (H.R. 1081/S. 618).[18]

Homeowners and their insurance carriers faced substantial challenges in the wake of back-to-back active hurricane seasons in 2004 and 2005. Seven of the ten most costly hurricanes in U.S. insurance history occurred in the 14 months from August 2004 to October 2005: hurricanes Katrina, Rita, Wilma, Charley, Ivan, Frances and Jeanne. Insured losses for the seven storms totaled $79.1 billion.[19] Nonetheless, insurance companies responded with incredible efficiency and effectiveness. Approximately 99% of the 1.2 million homeowners insurance claims from Hurricane Katrina, including those in hard-hit Louisiana and Mississippi, have been settled. Claims payments to homeowners in affected states exceeded $16 billion, approximately 93% of which went to Katrina victims in Louisiana and Mississippi.

In Louisiana, approximately 688,000 homeowners claims, totaling $10.8 billion, have been settled. In Mississippi, more than 350,000 homeowners claims, totaling $5.4 billion, have been settled. Effectively all of the nearly 350,000 claims from damaged vehicles, totaling $2.2 billion, have been settled.

Perceived customer service problems were exacerbated by the volume of claims and pervasive misunderstanding of flood peril coverage. At the same time, insurance prices increased due to a shift in the distribution of expected losses caused by the storms. The combination of increased premiums, availability issues and consumer satisfaction impediments thrust insurance regulation into the political arena.

Policymakers at the state and federal levels are now trying to implement legislation they hope will improve consumer satisfaction related to insurance. However, the proposal to repeal the McCarran-Ferguson Act threatens the viability of competition in insurance markets—the opposite of its intended effect. Further, the repeal of McCarran would generate huge legal costs regarding whatever new, untested legislation replaces McCarran, while doing nothing to increase the

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17. See, e.g., Tuepker v. State Farm Fire & Cas. Co., 2006 WL 1442489 (S.D. Miss.); Leonard v. Nationwide Mutual Insurance, 2006 No. 1:05CV475 (S.D. Miss.); and Broussard v. State Farm Fire & Cas. Co. 2006 No. 1:06cv6-LTS-RHW (S.D. Miss.) All three cases were heard by U.S. Federal District Court Judge L.T. Senter, Jr.

18. The "Insurance Industry Competition Act" (H.R. 1081/S. 618) was introduced on February 15, 2007. Sen. Patrick Leahy (D-Vt.), who chairs the Senate Judiciary Committee, is the bill's chief sponsor. Co-sponsors include: Senate Majority Leader Harry Reid (D-Nev.); Sen. Mary Landrieu (D-La.); Senate Minority Whip Trent Lott (R-Miss.), and Sen. Arlen Specter (R-Pa.). Rep. Peter A. DeFazio (D-Ore.) introduced the House version, H.R. 1081. Its six co-sponsors include Rep. Rodney Alexander (R-La.), Rep. Bobby Jindal (R-La.), Rep. Charlie Melancon (D-La.), Rep. Bruce Braley (D-Iowa), Rep. Walter B. Jones, Jr. (R-N.C.), and Rep. Gene Taylor (D-Miss).

19. Insurance Information Institute, Katrina Fact File.

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availability and affordability of property insurance. It is therefore imperative that lawmakers understand the real causes of insurance problems, while recognizing the salutary effects of the limited insurer antitrust exemption afforded by McCarran.

This section develops the following conclusions:

1.) **Insurance markets are competitive.**

2.) **The limited antitrust exemption provided by McCarran does not lead to collusion among insurers that is harmful to consumers.**

3.) **Repealing McCarran would impede competition and the operations of insurance markets to the detriment of consumers.**

Market Competition

Consumers desire insurance premiums that are adequate, but not excessive. If premiums are too low (i.e., not adequate), the insurer will not have enough money to pay the insured's claims or provide other services such as loss control and claim processing. If premiums are excessive, consumers' economic disadvantages are obvious. In other words, consumers are best served by insurance coverage at the "fair-market premium."[20]

The fair-market premium is the premium that will be offered and accepted in a competitive market. It includes the present value of expected claim payments, expected administrative and operating costs (including distribution costs, taxes and regulatory fees), and capital costs, also known as a fair profit. These elements ensure that the company will have enough money to pay claims and provide services, and create an adequate incentive for participation in insurance markets.

Competitive markets commonly exhibit four characteristics.[21] First, they include multiple independent sellers with low to moderate market shares. Second, there are multiple consumers with enough information to determine the value of the product. Third, the product is relatively homogeneous, allowing consumers to differentiate value across offered prices. Finally, barriers to entry and exit are low, allowing new suppliers to enter the market if prices rise above the fair-market price, or exit the market if they cannot produce the product at the fair-market price.

Competition among sellers is the most important safeguard for consumers of any product, including insurance. When consumers have choices among insurance carriers, the carriers are forced to compete for consumers' business. For example, assume two insurers, Company A and Company B, offer the same insurance policy to identical consumers. If Company A charges more than Company B,

20. See Harrington and Niehaus (2001) Chapter 8 for a thorough development of fair insurance premiums.

21. Competition is defined as "workable competition" in the sense suggested in Clark (1940).

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consumers will buy from Company B.[22] Company A must either lower its price or exit the market. If insurers in a given market were to collude and fix prices at a level above the fair premium, a new company could enter the market, charge the fair-market price, and take away the colluding insurers' market share.

Insurance Markets Are Competitive

The role of the limited antitrust exemption provided by the McCarran Ferguson Act is to ***increase*** competition by promoting the characteristics of competitive markets described above. From all indications, the law has been remarkably successful in achieving this objective. Numerous studies conducted by academic and government researchers find that insurance markets are highly competitive (e.g., Joskow, 1973).

The number of sellers in the insurance market is consistent with vigorous competition. In 2006, there were 2,783 companies licensed to sell property and liability insurance in the United States.[23] Of these, 928 underwrote homeowners insurance.[24] Furthermore, insurer formation and expansion activity shows that barriers to entry are not excessive. Figure 1 displays the annual average number of companies entering each state's market for homeowners insurance from 1996 to 2005. The averages range from three companies per year in Alaska to about 14 per year in Illinois.

22. Of course, consumers should also consider service and financial strength of the insurer, but this stylized example assumes all other characteristics are equal. It may help to think of the price of insurance as the difference between cost and expected benefits (including service and probability of continuing insurer financial strength).

23. This sample is based on all insurers for which data are available on the National Association of Commissioners (NAIC) Data Tapes. These data tapes contain the statutory annual statement accounting data that are filed with the NAIC by virtually all insurers in the U.S. These data are used with permission of the NAIC. The NAIC does not endorse any analysis or conclusions based upon the use of its data.

24. Some companies are affiliated with other companies in a holding company structure. Combining affiliated carriers yields 217 unaffiliated entities writing homeowners insurance.

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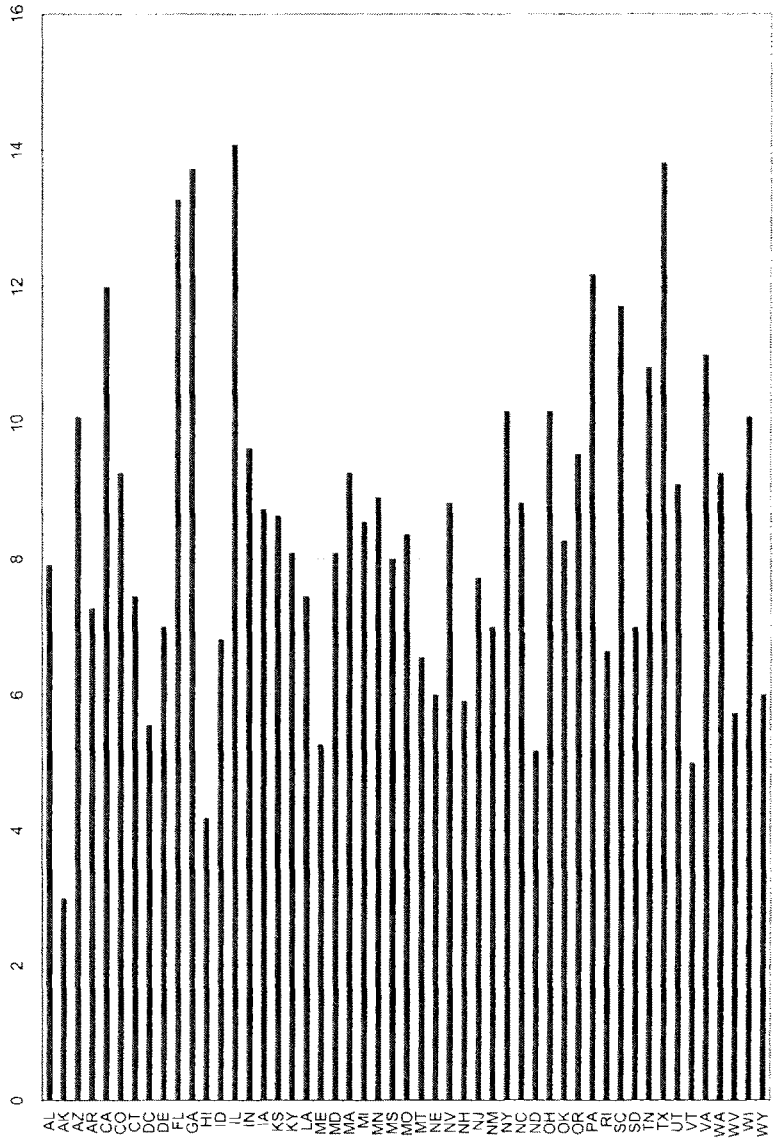
Figure 1: Average Annual Market Entries by State, 1996 – 2006



Note: New market entry defined as a company selling homeowners insurance in a state where it did not sell this cover in the preceding year.
Source: NAIC InfoPro Property and Casualty Database, 1996–2006.

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These numbers leave little room for doubt that insurance markets are competitive. Even if the 928 carriers writing homeowners insurance somehow managed to agree to an artificially high price in a state or region, observed behavior shows that no excessive barrier prevents other companies from entering the region. However, without the limited antitrust exemption provided by McCarran, carrier formation and expansion would be all but impossible because they would not have access to prior loss data. Commercial lines of insurance, especially those covering small businesses, would also be affected similarly, given the heavy reliance of most carriers on advisory loss costs in these lines.

Legal Cooperation Among Insurers Does Not Harm Consumers

Insurance companies share information via statistical agents for the purpose of ratemaking. Therefore, it is correct to say that insurance companies cooperate in estimating loss costs. However, the economic implications of this cooperation are either misunderstood or deliberately misrepresented by some insurance industry critics.

If an industry is colluding to hold prices above the fair-market price, we should expect it to exhibit extraordinarily high returns when compared to other, more competitive industries. This is certainly not the case for property/casualty insurance companies. To the contrary, insurance industry returns are substantially lower than those of the banking industry and a composite index. Figure 2 compares U.S. property/casualty insurance industry return on equity (ROE)[25] to that of U.S. banks and a composite index created by averaging industrial and service sector returns reported in *Fortune* magazine. Insurance industry ROE averaged less than 8% from 1996 to 2006. During the same period, commercial banking ROE averaged 16%, and a composite index of ROE for multiple industries averaged almost 14%—roughly twice that of insurers. If insurers are colluding to raise prices unfairly, they are doing a very poor job. Of course, the more logical conclusion is that insurance markets are competitive, and onerous regulation suppresses insurance industry returns.

25. Return on equity is equal to net income after tax, divided by the net worth of the firm (assets – liabilities). It is a common measure of performance.

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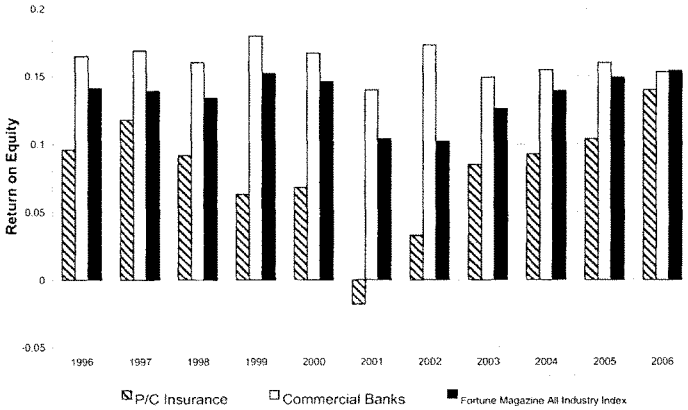
Figure 2: Comparing Return on Equity Across Industries, 1996-2006



Sources. Insurance Information Institute. Fortune Magazine

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The McCarran-Ferguson Act and Market Conduct of Insurers

Perhaps the most perplexing accusation recently brought against insurance carriers is that the limited antitrust exemption provided in McCarran somehow facilitates unethical market conduct in claim settlement. For example, in testimony before the U.S. House of Representatives Committee on Financial Services, Rep. Gene Taylor (D-Miss.) declared:

> I'd like you to look into the antitrust. Again, they are exempt from the antitrust laws, so is it really fair that State Farm can call up Allstate and call up Nationwide and call up USAA and say, "You know what, if you don't pay claims, and you don't pay claims, then I won't have to pay claims." Under the existing law, that is allowed. It's wrong as all get out, and it should be illegal.[26]

No one would deny that such behavior is wrong, which probably explains why it is currently illegal in every state.[27]

In fact, McCarran does not protect such behavior in the claims handling process, as it does not shield insurers from actions against unfair and deceptive trade practices. In addition, Unfair Claims Practice statutes exist in every state.[28] These laws give the state's insurance regulator and attorney general complementary and mutually supportive authority to monitor, investigate and punish insurers that fail to pay valid claims. States also have market conduct regimes where regulators examine the behavior of insurers and take corrective action if needed. In addition, consumer protection laws in every state apply to insurance transactions. Furthermore, federal consumer protection statutes, including the Fair Credit Reporting Act, also apply to insurance companies (Mirrel, 2008).

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26. "Insurance Claims Payment Process in the Gulf Coast After the 2005 Hurricanes," Hearing Before the Subcommittee on Oversight and Investigations of the Committee on Financial Services, U.S. House of Representatives, 110th Congress, First Session, February 28, 2007. Printed for the use of the Committee on Financial Services Serial No. 110–7, U.S. Government Printing Office, available from bookstore.gpo.gov. Statement of the Rep. Gene Taylor (D-Miss.).

27. The crime of "collusion" involves (i) a secret agreement among two or more persons, and (ii) the committing of a fraudulent act. Collusion is an actionable offense under federal and state deceptive and unfair trade practices laws.

28. Current information on state unfair claims practices settlement laws can be found at www.namic.org/compliance/ClaimsSettlement.pdf.

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Repealing McCarran Would Harm Consumers

If policymakers repeal McCarran, consumers will suffer substantial negative consequences resulting from a combination of weakened competition in the insurance industry and myriad regulatory, legal and operational problems, creating costs that they must ultimately bear.

Advisory loss costs provided by statistical agents are available to insurers for a fee. However, the benefits of advisory loss costs vary inversely with market share, company size and age of insurers. Small and new insurers have less in-house data to analyze than do large insurers. Also, even if statistical agents provided raw historic loss data for insurers to analyze, the cost of analyzing loss data represents a much larger proportion of a small insurer's revenues than that of a large insurer. Experts claim these costs would be prohibitive for small insurers, effectively eliminating the important competition they bring to markets.[29] Indeed, empirical evidence suggests that when McCarran became law in 1945, its effects differed across insurers based on the types of insurance they underwrote and company size. Current analysis by Randy Dumm, Rob Hoyt and the author shows that enactment of McCarran increased the value of small property/casualty insurers and decreased the value of large insurers (Dumm, Hoyt and Powell, 2007).

Competition from insurers with relatively small market shares appears especially important in the homeowners insurance line. Collectively, insurers writing less than $5 million[30] direct premiums in a given state hold market share that varies substantially across states. In 2006, the market share of smaller insurers varied from less than 1% of homeowners insurance in California[31] up to 37% in South Dakota. Because smaller insurers rely more heavily on advisory loss costs than do larger insurers, repealing McCarran poses a substantial threat to states where a large percentage of its insurance market would face substantial increases in cost.

Benefits of Pooling Loss Data, Standardizing Forms

McCarran permits several activities conducted by insurance companies that would otherwise be prohibited or subject to costly litigation under federal antitrust laws. Perhaps the most important of these is to permit insurers to pool data via statistical agents that produce advisory loss costs to aid insurers in the ratemaking process. Insurers are often required by states to report loss information for this

29. See testimony of Kevin B. Thompson, FCAS, MAAA before the U.S. Senate Committee on the Judiciary, June 20, 2006 Hearing on the McCarran-Ferguson Act: Implications of Repealing the Insurers' Antitrust Exemption.

30. The $5 million figure is consistently adjusted to real 2006 dollars over the 12-year sample period using the Consumer Price Index (CPI).

31. It is noteworthy that California exhibits such low levels of small company participation, given Proposition 103 substantially narrowed exemptions provided by the McCarran Act for California insurers in 1988

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purpose because advisory loss costs promote competition in insurance markets. Without advisory loss costs, credible ratemaking information would not be available to many small to mid-size insurers whose own loss experience is not adequate for estimating loss distributions. Of course, this argument can be extended to start-up insurance companies, or companies entering new markets or lines of coverage, as well. With no loss data of their own, these companies would have limited means by which to responsibly enter the market and compete for premiums.

A related function of the limited antitrust exemption is to allow standardization of risk classification and policy language. The broad use of standard policy forms serves at least four functions that benefit consumers. First, it ensures that data reported to statistical agents are consistent across insurance companies and can thus be accurately pooled to create advisory loss costs. This reduces insolvency risk and encourages competition from small and new companies. Second, consistent policy language simplifies price comparison for consumers, creating a more competitive market. Third, standardization makes coverage more reliable by facilitating uniformity in judicial interpretation of policy contracts. If all insurance contracts differed substantially, there would be more uncertainty for insurers and consumers regarding the outcomes of coverage disputes. This would reduce market efficiency and increase the cost of insurance. Finally, it would increase the cost of regulatory compliance related to approval of policy forms required in most states.

Absent McCarran, joint underwriting arrangements among insurers would be subject to antitrust scrutiny. This would affect several common insurer practices. Currently, insurers are allowed to form intercompany pools or syndicates in which multiple insurers combine to underwrite very large exposures. This function increases market capacity for large risks such as commercial property. It also fosters competition by allowing smaller insurers to underwrite sections of large accounts that would otherwise face a very thin market.

Residual market mechanisms represent another form of joint underwriting arrangement. The purpose of involuntary (or residual) markets is to make insurance coverage available to individuals who cannot obtain coverage in the voluntary market. Residual markets are often formed via regulation for coverage required by law or common contracts (e.g., automobile liability, workers' compensation or property insurance).[32] It is not clear that antitrust laws would permit this practice in the absence of McCarran.

Participation in guaranty funds would also be threatened if McCarran were repealed. Guaranty funds exist in every state to protect consumers when an insurer becomes insolvent. If an insurer does not have the financial capacity to pay claims, the state takes control of the insurer to guide it through liquidation—the process of dividing the insurer's assets among claimants. Once the insurer's assets are

32. Residual markets are mostly the result of ill-advised rate regulation. Without the burden of rate regulation, residual markets would affect far fewer consumers; however, their purpose would be more easily justified.

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exhausted, the guaranty fund assesses the remaining insurers in the state to cover remaining unpaid losses.

In response to these concerns, some policymakers have suggested so-called safe harbors in federal antitrust laws to permit pro-competitive cooperative activities. Discussion of safe harbors is not new and has been consistently rejected by scholars and policymakers. It is not practical to craft safe harbor provisions that would provide adequate protection for present or future pro-competitive activities and would simply introduce uncertainty into the insurance marketplace and invite costly and protracted litigation. In light of the information presented in this study, it seems clear that the safe harbor that would be most effective in protecting insurers from anticompetitive antitrust scrutiny is the one that has been in place for the last 62 years—the McCarran-Ferguson Act itself. There is little room for doubt that changing the existing insurer antitrust exemption—with or without "safe harbors"—will generate huge legal costs, as insurers would be forced to contend not only with government lawsuits but hundreds of private actions as well. Given the strong evidence supporting the current federal law, these costs represent inefficient, dead weight imposed on an effective and relatively efficient extant system. Some large insurers could regard the costs as prohibitive, giving them a powerful incentive not to report data or participate in other cooperative activities that facilitate competition.

Regulation of Insurance Markets: Reform is Key to Increasing Availability and Affordability

Meier (1991) makes the following observation:

> Insurance is a highly complex industry; many politicians are unwilling to invest their own personal resources to learn the nuances of insurance regulation. Although there are ways to reduce such information costs, the politician has a variety of issues to choose from and, as a result, issues other than insurance are likely to be more attractive to most politicians.

As Meier suggests, lack of insurance expertise on the part of policymakers explains, at least in part, the prevailing misconceptions about the McCarran-Ferguson Act's effect on insurance markets. It also contributes to the creation and persistence of misguided laws and regulations governing the business of insurance. But other factors play a role as well. The economic principles of insurance regulation are riddled with idiosyncrasies differentiating public policy related to insurance from that of other industries. In terms applied specifically to insurance by Meier, insurance is a "complex" product that is infrequently "salient." Gormley (1986) offers the following definitions of salience and complexity in the context of regulation:

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> A highly salient issue is one that affects a large number of people in a significant way. Expressed a bit differently, salience is low unless the scope of conflict is broad and the intensity of conflict is high. In contrast, a highly complex issue is one that raises factual questions that cannot be answered by generalists or laypersons. High complexity does not necessarily mean that technical considerations are paramount or that political considerations are unimportant. It does mean that specialized knowledge and training are needed if certain factual questions are to be satisfactorily addressed.

Insurance is complex in that it is difficult for laypersons to understand the process of setting insurance prices. While insurance consumers are quick to notice when prices are increasing, only a small number of individuals are able to express an informed opinion as to whether observed insurance prices are truly excessive (or inadequate). Insurance tends to be salient to consumers only when they experience an upward spike in premiums and/or a downward spike in availability. Because neither of these events occurs frequently, salience is intermittent, while complexity remains constant. The result is that the factors that influence insurance prices are ignored or misunderstood by most people outside of the insurance industry. Policymakers, for their part, have powerful incentives to acquiesce in the populist call to "do something" about the rising cost of insurance.

Unfortunately, the outcome can be to improperly address complexity with over-simplified assumptions or overly broad legislative proposals that do little to address the fundamental issue at hand.

The public statements of leading senators in support of the "Insurance Industry Competition Act" are consistent with the behavior predicted by the model described above. For example, according to Sen. Patrick Leahy (D-Vt.), Chairman of the Senate Judiciary Committee and sponsor of the Senate version, the bill would "simply give the Department of Justice and the Federal Trade Commission the authority to apply the antitrust laws to anticompetitive behavior by insurance companies." Like the bill's co-sponsors, Sen. Leahy emphasized the linkage between the McCarran antitrust immunity and "concerns that insurers have been too often denying claims and delaying payouts to residents along the Gulf Coast instead of honoring their contractual commitments to their customers and helping rebuild that region."[33]

Sen. Arlen Specter (R-Pa.) cited "the collusive atmosphere that exists in the insurance industry" as the reason why "too many consumers are paying too much for insurance." This cost-inflating collusion, he averred, "has become a particular problem along the Gulf Coast, where insurers have shared hurricane loss projections, which may result in double-digit premium increases for Gulf Coast

32. See Statement of Senator Patrick Leahy (D-Vt.) before the U.S. Senate Committee on the Judiciary, June 20, 2006 Hearing on the McCarran-Ferguson Act: Implications of Repealing the Insurers' Antitrust Exemption.

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homeowners."[34] Senate Minority Whip Trent Lott (R-Miss.) described his amazement at discovering, upon "coming out of Katrina," that "the insurance industry is not subject to antitrust laws," and that "price fixing in this industry [is] not covered by the federal government."[35]

Accusations of collusion to affect price fixing and unfair claim outcomes follow exactly Meier's model of misinformed policymakers promoting populist opinions about insurance pricing at a time when insurance becomes salient. However, upon closer inspection, there is neither evidence supporting, nor even a valid reason to suspect, harmful collusion on the part of insurers.

It is time to break this pattern of subjecting insurers—and ultimately, consumers—to additional unnecessary and onerous regulation when markets react to substantial new information such as catastrophic property damage from natural or manmade disasters.

Policy Recommendations

While insurance markets are made more efficient and competitive by the McCarran-Ferguson Act, other laws and regulations governing insurance markets are less benign. For years, insurance economists and other industry experts have made a consistent and persuasive case for changing the way insurance markets are regulated in the United States. In dozens of books and articles, these analysts have argued that rate regulation, coverage mandates and restrictions on the use of risk-based underwriting criteria distort insurance markets to the detriment of most consumers. Modern property-casualty insurance markets, they repeatedly point out; exhibit none of the characteristics that warrant the market interventions endemic in the insurance regulatory framework of most states. To the contrary, insurance markets are characterized by robust competition and relative ease of entry and exit. Shortages in the supply of insurance and lack of product innovation, where they occur, are direct consequences of the inefficiencies wrought by excessive regulation (Cummins, 2002; Harrington, 2000).

34. See Statement of Senator Arlen Specter (R-Pa.) before the U.S. Senate Committee on the Judiciary, June 20, 2006 Hearing on the McCarran-Ferguson Act: Implications of Repealing the Insurers' Antitrust Exemption.

35. See Statement of Senator Trent Lott (R-Miss.) before the U.S. Senate Committee on the Judiciary, March 7, 2007. Lott became infuriated with the property and casualty insurance industry after State Farm, Lott's insurer, determined that the homeowner's policy covering his home in Pascagoula, Miss., covered only wind damage and not flood damage. As a result, Lott enlisted his brother-in-law, Dickie Scruggs, a trial attorney, to file a lawsuit against State Farm. When Lott made his comments before the Judiciary Committee, his lawsuit had not yet been resolved. To learn more about Lott's animosity towards the insurance industry, see Strassel (2007).

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Yet progress toward market-based regulatory reform has been modest at best, particularly in several of the most populous states.[36] Frustration over the apparent inability or unwillingness of many state legislatures and insurance regulators to effect meaningful reform has produced a schism among opponents of excessive regulation, with some favoring a partial transfer of insurance regulatory authority to the federal government from the states, where it has traditionally resided. Members of Congress have introduced legislation to create an optional federal charter that would allow insurers to choose to be regulated by a newly-created federal insurance regulator, thereby escaping the debilitating effects of hyper-regulation by the states.[37] Skeptics of this approach doubt that federal regulation would produce the desired reforms, and warn that an "optional" charter could eventually metastasize into a comprehensive national regulatory regime every bit as burdensome and dysfunctional as those in the most problematic states.[38] Yet despite their disagreement over means, proponents of insurance regulatory reform share the common goal of greater market freedom, enhanced competition and increased consumer choice.

A complete litany of measures that policymakers could take to mitigate current regulatory shortcomings is beyond the scope of this study. However, certain reforms would directly advance an agenda of enhanced competition, greater availability of insurance coverage, and more consumer choice. They include deregulation of insurance rates and risk-based underwriting practices, making cross-subsidies transparent and explicit, and spurring regulatory competition among states to improve states' regulatory environments.

Following nearly every significant ***loss-related*** event affecting insurance markets, proposed regulatory responses have involved changes in rating and underwriting practices, rather than addressing the underlying element that affects affordability and availability of insurance—***losses***. In many instances, regulation of underwriting and rating practices actually has the unintended effect of exacerbating problems of affordability and availability of insurance. Only recently have some states begun to address the underlying problems leading to affordability and availability issues. These include the factors driving the cost of losses, such as coastal development and building codes, and the factors hampering the speed with which insurers can respond to major events, such as rate regulation and underwriting restrictions.

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36. The difficulty in getting states to consider more market-based regulatory reforms may best be exemplified by the actions of Florida lawmakers. In 2006, they enacted HB 1980, a comprehensive property insurance package which, beginning July 1, 2007, would allow insurers to increase or decrease rates by up to a 5% statewide average, or 10% for any territory, without approval by the Office of Insurance Regulation as long as the rate was not excessive or unfairly discriminatory. However, with the election in November 2006 of Charlie Crist as Governor and his relentless campaign to blame insurers for the state's insurance woes, the flex-band provision was rescinded during a special legislative session in January 2007.

37. S. 40, introduced 5/24/2007 by Sen. John Sununu (R-N.H.) and Sen. Tim Johnson (D-S.D.). H.R. 3200, introduced 7/26/2007 by Reps. Melissa Bean (D-Ill.) and Ed Royce (R-Calif.).

38. See, for example, National Association of Professional Insurance Agents (2007).

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Insurance rates and underwriting practices are currently regulated to varying degrees in most states. The stated purpose of this regulation is to ensure that rates are not inadequate, excessive or unfairly discriminatory. In practice, inadequacy is largely ignored, and the operative definitions of "excessive" and "unfairly discriminatory" often are arbitrarily based on interest group pressure rather than objective evidence. In a competitive market, excessive premiums are not feasible, and discrimination will only occur based on objective risk measures, making them, by definition, fair.

One problem caused by rate regulation is sometimes referred to as "sticky" rates because regulation prevents insurers from changing rates to match expected costs. Insurers in some states where prior approval rate regulation is especially stringent are not able to respond swiftly to changes in expected losses and economic conditions. When expected loss costs decrease, they are inhibited from lowering rates because they reasonably fear that regulators will not allow them to raise rates when loss costs rise above levels that lower rates would support.

Suppression of insurance rates via regulation for some high-risk classes also has unintended negative consequences. Because insurance companies must price coverage to pay for all expected losses out of premiums they collect, they are forced to charge low-risk insureds a higher premium than their expected costs warrant to make up for the deficits from insufficient rates charged to high-risk insureds. Not only is this scenario inherently unfair, it decreases low-risks' incentives to purchase insurance, and decreases high-risks' incentives to take care, further exacerbating the problem. Regulatory reform aimed at enhancing underwriting and pricing freedoms will change insurance markets in ways that benefit consumers and society. Specifically, such regulatory changes will result in optimal levels of risky activity (i.e., coastal development, safety enhancements and driving) and insurance prices reflecting insureds' true expected loss costs. If policymakers' intent is to subsidize some (generally high-risk) insurance consumers that complain about high prices, this should be made clear in the law and to voters.

Summary and Conclusion

The McCarran-Ferguson Act of 1945 was enacted to protect certain activities in the insurance industry that enhance market competition and financial strength. Insurers have traditionally become a popular target for the anger and frustration of consumers when prices increase or availability becomes more limited. Such irritation increased following the hurricanes of 2004 and 2005. Some members of Congress have responded in part by mounting a well-intentioned albeit misguided effort to repeal the McCarran-Ferguson Act and subject insurers to further federal antitrust scrutiny.

The evidence presented in this study supports the conclusion that McCarran benefits insurance consumers, and that repealing it would harm consumers. It shows that insurance markets are characterized by vigorous competition, and

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moreover, that insurance companies are not earning excessive returns as would an industry that successfully colludes to inflate prices. In fact, insurers exhibit quite small returns when compared to other industries. Finally, this study describes the operational obstructions and prohibitive legal costs associated with repealing McCarran. The proposal to repeal McCarran appears to stem from a fundamental misunderstanding of insurance markets and insurance regulation.

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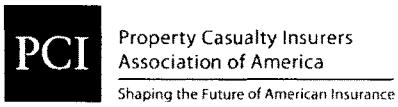

Testimony
Property Casualty Insurers Association of America (PCI)

S. 1681, the "Health Insurance Industry Antitrust Enforcement Act of 2009"

Committee on the Judiciary
United States Senate
October 14, 2009

The Property Casualty Insurers Association of America (PCI) is pleased to offer testimony on the impact of S. 1681, the Health Insurance Industry Antitrust Enforcement Act of 2009, which would amend the McCarran-Ferguson Act as it applies to health and medical malpractice insurers. PCI is the leading property-casualty trade association representing more than 1,000 insurers, the broadest cross-section of insurers of any national trade association. Our members are leading providers of home, auto and business insurance, including providing protection for doctors, hospitals and other medical providers against lawsuits for professional liability. Our testimony briefly highlights some of the unintended consequences that S. 1681 would have in reducing competition for consumers in the medical malpractice insurance market.

S. 1681 would expressly outlaw price fixing, bid rigging, and market allocations for health and medical malpractice insurers. However, the National Association of Insurance Commissioners (NAIC) opined on an earlier version of the bill several years ago that "no state insurance regulator has seen evidence that suggests medical malpractice insurers have engaged or are engaging in price fixing, bid rigging, or market allocation." We are not aware of any credible contrary evidence that would justify the amendments proposed in S. 1681.

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S. 1681 is a solution in search of a problem and in fact would reduce competition by increasing trial lawyer suits and making it more difficult for insurers to enter into new markets or new insurers to be created.

Background on McCarran-Ferguson

The McCarran-Ferguson antitrust exemption was enacted by Congress in 1945 in response to a Supreme Court decision that preempted state control and governance of insurance. McCarran provides that:

> "No Act of Congress shall be construed to invalidate, impair or supersede any law enacted by any State for the purpose of regulating the business of insurance" (15 U.S.C. 1012(b), 1013(b) (1976)).

McCarran does not give insurers a blanket exemption from antitrust laws. In fact, every state has laws governing insurer information sharing and rates to foster a stable and competitive marketplace. Rather, Congress passed McCarran recognizing that insurance is a local issue with very different regional risks and tort laws, and that the states are better equipped to respond to local competitive needs than the federal government. In addition to state antitrust and insurance law, federal antitrust law will apply unless:

(1) The activity is the business of insurance,

(2) The activity is regulated by state law, and

(3) The activity does not involve boycott, coercion or intimidation.

Insurance is relatively unique in that it is one of the few industries that must price its product before it knows the costs of providing the products, which are known as "loss costs." Therefore, insurers must have a reliable way of projecting those loss costs in order to price their products in a sound manner. McCarran-Ferguson and the delegation of antitrust supervision of insurers to the states was enacted to facilitate the pooling of historical loss cost data necessary for sound underwriting, residual market mechanisms, risk pools, assessment allocation, forms uniformity, and a number of other areas that Congress and the

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states have agreed promote competition. Many larger medical malpractice insurers, including many PCI members, do not rely heavily on industry-wide prospective loss costs to support their ongoing medical liability products because they write enough business to have a statistically significant base of information without need to use industry-wide data. However, start-ups and many medium and smaller insurers need such information on an ongoing basis. Even large insurers of any size seeking to enter new states, markets, classes of business, or product lines depend upon industry wide data that is available to them only because of the McCarran antitrust exemption. Repealing the McCarran antitrust delegation would affect the marketplace only by imposing a massive barrier to entry for new competition and smaller insurers, raising costs and further reducing choices for consumers.

Pooling of Loss Information Is Critical for Small Insurers to Compete

Many small and medium-sized "Main Street" insurers rely heavily on organizations such as the Insurance Services Office (ISO), which collect industry-wide data and develop prospective loss costs. This pooling of loss information enables these insurers to be able to more accurately predict their own projected costs, compete on coverage underwriting with an actuarially based price, and determine their necessary surplus to set aside for solvency. Without state governed loss pooling, insurers who do not dominate a particular market would have too little data to develop actuarially reliable rates, would have to charge consumers an extra risk premium, and would be more prone to insolvency. Research by the Wharton School of the University of Pennsylvania confirmed that repeal of McCarran Ferguson would likely reduce competition, increase the cost of insurance and reduce availability for some high-risk coverages, because the threat of antitrust litigation would make insurers unwilling to engage in efficiency-enhancing cooperative activities. [1]

[1] Patricia M. Danzon, the Wharton School of the University of Pennsylvania, *The McCarran Ferguson Act Anticompetitive or Procompetitive?*, Regulation - The Cato Review of Business and Government, 1991.

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ISO also helps standardize coverage language to reduce legal uncertainty and enable consumers to compare policies and shop for rates. ISO and related statistical organizations do not publish joint rates – only prospective loss costs that are so critical for many insurers. Prospective loss costs are only one component of the final premium an insurer will charge – others include expenses, risk considerations, underwriting standards and the target rate of return. The Department of Justice has previously determined that ISO's activities fall within the McCarran-Ferguson exemption because it is part of the business of insurance regulated by state law.

Price fixing, bid rigging, and market allocations are generally illegal under state antitrust laws, but in any event, insurers do not use the McCarran-Ferguson antitrust exemption to engage in those anti-competitive practices. Insurers, including medical malpractice insurers, do use the exemption for the *pro-competitive* purpose for which the Congress adopted it in 1945, *i.e.*, to collect and use industry-wide prospective loss cost data that will assist them *not in price-fixing, but in making their own, independent actuarially sound decisions about pricing their products*. Abuses are not permitted under state insurance law. All states have laws governing rates and insurance conduct, generally prohibiting any rates that are excessive, inadequate, or unfairly discriminatory.

The McCarran antitrust exemption was particularly useful in helping to resolve the availability and affordability "crisis" that existed in the medical liability insurance market in the 1980s. In response to that, a number of doctor-owned mutual insurance companies were formed to provide medical liability coverage to the doctors who owned the companies. This helped fill the gap that had developed in the medical liability insurance market. But without aggregate loss information, many of the doctor-owned medical malpractice insurers would not have been able to enter the business when they were so sorely needed. And the absence of that aggregate data today would be a barrier to market entry for all new start-up insurers in the medical malpractice market. Over time, it could

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threaten the small company franchise, prevent new entrants into the insurance industry, and have a chilling effect on the ability of existing insurers *of all sizes* to expand into new markets, classes of business, or new product lines.

Background on Medical Malpractice Insurance

According to the Congressional Research Service (CRS), most malpractice insurers are currently provider-owned companies.[2] In fact, the American Hospital Association has indicated that 40% of its member hospitals are self-insured. For physicians who cannot find coverage, many states have established joint underwriting residual markets, underwriting associations, and excess liability funds. CRS reports that 30 years ago, medical malpractice was largely provided by large diversified insurers. However, these providers were unable to obtain an adequate rate of return on capital and exited the marketplace. The remaining smaller insurers, and even geographically concentrated medium-sized insurers seeking to expand into additional markets, are now more reliant than ever on pooled loss information to increase competition.

Costs are Driven by Trial Lawyer Lawsuits

CRS listed as the top cause of increasing medical malpractice costs the "Tort System: 'Frivolous' Lawsuits and High Damage Awards", noting that insurance premiums have increased as a matter of course with claims from settlements and awards skyrocketing. CRS noted that a Joint Economic Committee study in 2003 reached the same conclusion that the tort system is the root of the problem, and that the Congressional Budget Office in 2004 cited "increased payments of claims as a major factor in driving medical malpractice insurance costs" (with other market forces also contributing).[3] A comprehensive Government Accountability Office (GAO) study found that "Increased losses on

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[2] Congressional Research Service, *Medical Malpractice: An Overview*, RL 33358, May 5, 2006 (CRS).
[3] CRS, pp.11-12

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claims are the primary contributor to higher medical malpractice premium rates."[4] GAO found that return on net worth for medical malpractice insurers declined precipitously from 1990 to 2001, generating significant and increasing net losses over time. GAO concluded that

> This declining profitability has caused some large insurers either to stop selling medical malpractice policies altogether or reduce the number they sell... [additional funds could be obtained] through capital markets, but even then, convincing investors to invest funds in medical malpractice insurance when profits are falling can be difficult.[5]

Since state laws reining in tort costs vary widely, GAO noted that medical malpractice loss experiences vary dramatically across their sampled states, with wide variations in premium rates, but that states are passing laws to reduce pressure on malpractice costs, mostly by "limiting the number of claims filed, the size of awards and settlements, and the time and costs associated with resolving claims."[6]

Conclusion

Because medical malpractice insurers do not engage in price fixing, bid rigging, or market allocations, adding an express prohibition on those practices to the existing McCarran exemption would have no benefit, but would pose a serious danger. Courts are likely to assume that the Congress passed the bill for a reason and might infer that the Congress intended to prohibit activities the exemption now protects – and the only things it protects now are the pro-competitive activities described above. Thus, by passing S. 1681, the Congress would jeopardize those pro-competitive activities, the absence of which could bar new entrants into the market and complicate the efforts of some existing medical malpractice insurers to price their products responsibly. Moreover, Section 3 of

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[4] U.S. General Accounting Office, *Medical Malpractice Insurance, Multiple Factors Have Contributed to Increased Premium Rates*, p. 15 and 43, GAO-03-702, June 2003 (GAO).
[5] GAO, p.31
[6] GAO, Highlights and p.41.

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the bill would appear to single insurers out by denying to them standard antitrust defenses that are available to others, including the defense that actions undertaken pursuant to a state mandate are exempt from federal antitrust laws (state action doctrine).

The Congress is justifiably concerned about the rising cost of health care, and we share that concern. We are encouraged that President Obama recognized the role that medical malpractice costs play in increasing health care costs when he suggested a willingness to support tort reforms as part of the health insurance reform package now being considered in the Congress. He recognizes that our extraordinarily litigious society is contributing to spiraling health care costs and he has correctly identified the key elements – the practice of defensive medicine (increasing health care costs) and numerous malpractice suits and excessive awards (increasing insurance premiums, and thus health care costs). Reducing abusive litigation will help bring down insurance costs and will help ameliorate the impact those costs have on overall health care costs. Amending McCarran-Ferguson in a way that will jeopardize the pro-competitive activities that permit small and medium "Main Street" insurers to compete in the medical malpractice market and all insurers to enter new markets will have exactly the opposite effect on costs and consumer choice.

We appreciate the opportunity to offer our thoughts on the negative impact this bill could have on the medical malpractice insurance market, and we would be pleased to provide any further assistance the Committee may require.

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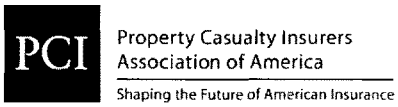

Testimony
Property Casualty Insurers Association of America (PCI)

S. 1681, the "Health Insurance Industry Antitrust Enforcement Act of 2009"

Committee on the Judiciary
United States Senate
October 14, 2009

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S. 1681 would expressly outlaw price fixing, bid rigging, and market allocations for health and medical malpractice insurers. However, the National Association of Insurance Commissioners (NAIC) opined on an earlier version of the bill several years ago that "no state insurance regulator has seen evidence that suggests medical malpractice insurers have engaged or are engaging in price fixing, bid rigging, or market allocation." We are not aware of any credible contrary evidence that would justify the amendments proposed in S. 1681.

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> "No Act of Congress shall be construed to invalidate, impair or supersede any law enacted by any State for the purpose of regulating the business of insurance" (15 U.S.C. 1012(b), 1013(b) (1976)).

McCarran does not give insurers a blanket exemption from antitrust laws. In fact, every state has laws governing insurer information sharing and rates to foster a stable and competitive marketplace. Rather, Congress passed McCarran recognizing that insurance is a local issue with very different regional risks and tort laws, and that the states are better equipped to respond to local competitive needs than the federal government. In addition to state antitrust and insurance law, federal antitrust law will apply unless:

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[1] Patricia M. Danzon, the Wharton School of the University of Pennsylvania, *The McCarran Ferguson Act Anticompetitive or Procompetitive?*, Regulation - The Cato Review of Business and Government, 1991.

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threaten the small company franchise, prevent new entrants into the insurance industry, and have a chilling effect on the ability of existing insurers *of all sizes* to expand into new markets, classes of business, or new product lines.

Background on Medical Malpractice Insurance

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[2] Congressional Research Service, *Medical Malpractice: An Overview*, RL 33358, May 5, 2006 (CRS).
[3] CRS, pp.11-12

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claims are the primary contributor to higher medical malpractice premium rates."[4] GAO found that return on net worth for medical malpractice insurers declined precipitously from 1990 to 2001, generating significant and increasing net losses over time. GAO concluded that

> This declining profitability has caused some large insurers either to stop selling medical malpractice policies altogether or reduce the number they sell… [additional funds could be obtained] through capital markets, but even then, convincing investors to invest funds in medical malpractice insurance when profits are falling can be difficult.[5]

Since state laws reining in tort costs vary widely, GAO noted that medical malpractice loss experiences vary dramatically across their sampled states, with wide variations in premium rates, but that states are passing laws to reduce pressure on malpractice costs, mostly by "limiting the number of claims filed, the size of awards and settlements, and the time and costs associated with resolving claims."[6]

Conclusion

Because medical malpractice insurers do not engage in price fixing, bid rigging, or market allocations, adding an express prohibition on those practices to the existing McCarran exemption would have no benefit, but would pose a serious danger. Courts are likely to assume that the Congress passed the bill for a reason and might infer that the Congress intended to prohibit activities the exemption now protects – and the only things it protects now are the pro-competitive activities described above. Thus, by passing S. 1681, the Congress would jeopardize those pro-competitive activities, the absence of which could bar new entrants into the market and complicate the efforts of some existing medical malpractice insurers to price their products responsibly. Moreover, Section 3 of

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[4] U.S. General Accounting Office, *Medical Malpractice Insurance, Multiple Factors Have Contributed to Increased Premium Rates*, p. 15 and 43, GAO-03-702, June 2003 (GAO).
[5] GAO, p.31
[6] GAO, Highlights and p.41.

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the bill would appear to single insurers out by denying to them standard antitrust defenses that are available to others, including the defense that actions undertaken pursuant to a state mandate are exempt from federal antitrust laws (state action doctrine).

The Congress is justifiably concerned about the rising cost of health care, and we share that concern. We are encouraged that President Obama recognized the role that medical malpractice costs play in increasing health care costs when he suggested a willingness to support tort reforms as part of the health insurance reform package now being considered in the Congress. He recognizes that our extraordinarily litigious society is contributing to spiraling health care costs and he has correctly identified the key elements – the practice of defensive medicine (increasing health care costs) and numerous malpractice suits and excessive awards (increasing insurance premiums, and thus health care costs). Reducing abusive litigation will help bring down insurance costs and will help ameliorate the impact those costs have on overall health care costs. Amending McCarran-Ferguson in a way that will jeopardize the pro-competitive activities that permit small and medium "Main Street" insurers to compete in the medical malpractice market and all insurers to enter new markets will have exactly the opposite effect on costs and consumer choice.

We appreciate the opportunity to offer our thoughts on the negative impact this bill could have on the medical malpractice insurance market, and we would be pleased to provide any further assistance the Committee may require.

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Testimony of

The Honorable Harry Reid

U.S. Senator
Nevada
October 14, 2009

STATEMENT OF SENATOR HARRY REID
Senate Judiciary Committee Hearing
on

"Prohibiting Price Fixing and Other Anticompetitive Conduct in the Health Insurance Industry"

October 14, 2009

Mr. Chairman and members of the Judiciary Committee, thank you for inviting me to testify at this hearing.

Since 1945, the insurance industry has enjoyed exemption from federal antitrust laws because of the McCarran-Ferguson Act.

Pat McCarran, who was the senior Senator from Nevada at the time, lent his name to this piece of legislation. Although we're both Nevadans, I'm not sure what Pat McCarran had in mind when he pushed this bill.

And if Pat were around today, he couldn't be happy with the state of the insurance industry.

I've received hundreds of letters from constituents who are struggling to find adequate and affordable health care.

One of my constituents in Boulder City runs a small business. She's paying well over $1000 per month for the most basic health care package she can find, her rates keep going up, and there's no other company that will insure her.

Another of my constituents, a psychologist who runs a small practice with just a few employees, has always paid 100% of his workers health care costs. The insurance company he uses has decided to raise his rates by over 46 percent. He won't be able to afford to cover his employees for much longer, and they will join the ranks of the uninsured. And they have no options.

Free competition is fundamental to our economy and essential to the American character.

It is of the upmost importance that we make sure the insurance industry is playing by the same

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rules as everyone else, and that they are subject to competition.

Competition is what allows great ideas to flourish, and it improves prices and quality for consumers.

It allows new businesses to enter the market.

It gives incentives to entrepreneurs, and it fuels innovation.

America's free and open marketplace gives consumers choices and encourages risk taking, and it has been the birthplace for the greatest economy in the history of the world.

That is why we have federal laws that prohibit price-fixing, bid rigging and collusion between companies within an industry. When companies are forced to compete with one another, the American people benefit.

Providing an exemption for insurance companies to antitrust laws has been anticompetitive and damaging to the American economy.
Health insurance premiums have continued to rise at a rapid rate, forcing businesses to cut back on health insurance coverage and forcing many families to choose between health insurance and basic necessities.
All too often, working families have to forego health insurance. In fact, the primary reason people are uninsured is due to the high and escalating costs of health insurance.
The increasing costs also impact the costs of government health program like Medicare and Medicaid and the costs of providing health insurance to federal government employees.
And despite rising costs, insurance companies are accused of underpaying doctors for their services.
And we've seen exactly what you would expect to see when you protect an industry from antitrust laws:

Insurance companies have become so large they dominate entire regions of the country.

They have become so powerful they block start up businesses from entering the market, and they put smaller companies out of business.

They have become so dominant that they dictate business practices.

They are so influential that they exert tremendous influence over public policy.

In particular, exempting health insurance companies has had a negative effect on the American people.

Health insurance companies have so much authority that they often dictate what course of treatment patients will receive.

Health insurance monopolies shouldn't be making health care decisions for patients. No one

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should come between a patient and their Doctor when it comes to making health care decisions.

Patients should be able to choose, just like members of Congress are able to choose, from a variety of different health care plans.

There is no reason why insurance companies should be allowed to form monopolies and dictate health choices.

There is no reason why the insurance companies should have exemption from antitrust laws. To the extent insurance companies need to share information to provide their services, let them do what other industries have to do – seek prior authorization and guidelines from the Department of Justice for how they can work together.

They should be subject to the same federal oversight as every other industry. Their price-setting and information sharing practices should not be permitted to take place out of public view, but should be brought out into the light of day.

I urge all of my colleagues to join me in supporting the Health Insurance Industry Antitrust Enforcement Act. Thank you.

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DEPARTMENT OF JUSTICE

Statement of

Christine A. Varney
Assistant Attorney General
Antitrust Division
U.S. Department of Justice

Before the

Committee on the Judiciary
United States Senate

Hearing on

"Prohibiting Price Fixing and Other Anticompetitive Conduct in the Health Insurance Industry"

October 14, 2009

Good morning, Mr. Chairman and members of the Committee. I am pleased to be here today to present the views of the Department of Justice on the Committee's reconsideration of the McCarran-Ferguson Act's antitrust immunity for the business of insurance.

Prior to 1944, regulation of the business of insurance was seen as the exclusive province of the states. In that year, the Supreme Court held in *United States v. South-Eastern Underwriters Association*[1] that the insurance business was within the regulatory power of Congress under the Commerce Clause, and thus was subject to the antitrust laws. This decision was perceived to threaten state authority to regulate and tax the business of insurance. The McCarran-Ferguson Act was designed to return the legal climate to that which existed prior to *South-Eastern Underwriters* by specifically delegating to the states the authority to continue to regulate and tax the business of insurance. It also created a broad antitrust exemption based on state regulation. This antitrust exemption applies where three basic requirements are met: (1) the challenged activity must be part of the "business of insurance," (2) that business must be regulated by state law, and (3) the activity must not constitute boycott, coercion, or intimidation.

Repeal or reform of the broad antitrust exemption currently enjoyed by the business of insurance has been a perennial subject of interest. In 1977, a Justice Department study concluded that the insurance industry could function competitively without the protection of the McCarran-Ferguson Act. The National Commission for the Review of Antitrust Laws and Procedures recommended in 1979 that the broad exemption in the Act be replaced by narrowly drawn legislation adopted to affirm the lawfulness of a limited number of collective activities under the antitrust laws. The 1989

[1] 322 U.S. 533.

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report of the American Bar Association Commission to Improve the Liability Insurance System contained a generally similar recommendation.

The Antitrust Modernization Commission recently reviewed whether the McCarran-Ferguson Act is necessary to allow insurers to collect, aggregate, and review data on losses so that they can better set their rates to cover their likely costs. The AMC found that it was not. The AMC said that insurance companies "would bear no greater risk than companies in other industries engaged in data sharing and other collaborative undertakings." In particular, the AMC said, "[l]ike all potentially beneficial competitor collaboration generally … such data sharing would be assessed by antitrust enforcers and the courts under a rule of reason analysis that would fully consider the potential procompetitive effects of such conduct and condemn it only if, on balance, it was anticompetitive."[2] Significantly, the AMC added that "[t]o the extent that insurance companies engage in anticompetitive collusion … then they appropriately [should] be subject to antitrust liability."[3]

In addition to these reviews, this Committee and other bodies of Congress have held several hearings on the McCarran-Ferguson exemption over the years, and have introduced various bills that would eliminate the current exemption or replace it with a narrower one affording continued protection to certain procompetitive activities. The pros and cons, as well as the particulars, of legislative reform of the McCarran-Ferguson antitrust exemption have thus been thoroughly and carefully debated.

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[2] ANTITRUST MODERNIZATION COMM'N, REPORT AND RECOMMENDATIONS 351 (2007) (footnotes omitted), *available at* http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf.

[3] The American Bar Association of Antitrust Law shares these views, concluding recently that the "historic justification for the McCarran-Ferguson Act's antitrust exemption appears to have lost most or all of its former appeal." SECTION OF ANTITRUST LAW, AM. BAR ASS'N, FEDERAL STATUTORY EXEMPTIONS FROM ANTITRUST LAW 159 (2007).

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The Department is generally opposed to exemptions from the antitrust laws, whether they be industry-specific or general, in the absence of a strong showing of a compelling need. The antitrust laws reflect our society's belief that competition enhances consumer welfare and promotes our economic and political freedoms. Exceptions from that policy should be—and fortunately are—relatively rare. Those who advocate the creation of a new antitrust exemption, or the preservation of a longstanding exemption such as that contained in the McCarran-Ferguson Act, rightfully bear a heavy burden in justifying the exemption.

The exemption has been subject to criticism as to its results. One antitrust treatise notes that under the McCarran-Ferguson Act "the presence of even minimal state regulation, even on an issue unrelated to the antitrust suit, is generally sufficient to preserve the immunity."[4] Indeed, the case law can be read as suggesting that the Act precludes federal antitrust action whenever there is a state regulatory scheme, regardless of how perfunctory or ineffective it may be.[5] It is fair to say that the McCarran-Ferguson Act antitrust exemption is very expansive with regard to anything that can be said to fall within "the business of insurance," including premium pricing and market allocations. As a result, "the most egregiously anticompetitive claims, such as naked agreements fixing price or reducing coverage, are virtually always found immune."[6]

Concerns over the exemption's effects are especially relevant given the importance of health insurance reform to our nation. There is a general consensus that health insurance reform should be built on a strong commitment to competition in all health care markets, including those for health and medical malpractice insurance.

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[4] 1A PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶ 219c, at 25 (3d ed. 2006).
[5] See, e.g., Ohio AFL-CIO v. Insurance Rating Board, 451 F.2d 1178 (6th Cir. 1971).
[6] AREEDA & HOVENKAMP, supra note 2, ¶ 219d, at 31.

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Repealing the McCarran-Ferguson Act would allow competition to have a greater role in reforming health and medical malpractice insurance markets than would otherwise be the case.

In considering any alleged need for an antitrust exemption, the flexible nature of the antitrust laws as interpreted in such recent cases as *General Dynamics*,[7] *GTE Sylvania*,[8] *Broadcast Music*,[9] *Northwest Wholesale Stationers*,[10] and *Dagher*[11] must be recognized. Allegations that particular procompetitive behavior would violate the antitrust laws and thus should be exempted from their application can fail to take account of the economically sound competitive analysis that is used today to carefully circumscribe *per se* rules and fully analyze other conduct under the rule of reason. Congress has occasionally recognized a need for clarification of a proper antitrust standard or adjustment of antitrust remedies, but the flexibility of the antitrust laws and their crucial importance to the economy argue strongly against antitrust exemptions that are not clearly and convincingly justified.

There are strong indications that possible justifications for the broad insurance antitrust exemption in the McCarran-Ferguson Act when it was enacted in 1945 are no longer valid today. To the extent that the exemption was designed to enable the states to continue to regulate the business of insurance, it is no longer necessary. The "state action" defense, which had been announced by the Supreme Court in *Parker v. Brown*[12] in 1943, but was undeveloped in 1945 when the McCarran-Ferguson Act was enacted,

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[7] United States v. General Dynamics Corp., 415 U.S. 486 (1974).
[8] Continental T.V., Inc. v. GTE Sylvania, Inc., 433 U.S. 36 (1977).
[9] Broadcast Music, Inc. v. Columbia Broadcasting Sys., Inc., 441 U.S. 1 (1979).
[10] Northwest Wholesale Stationers, Inc. v. Pacific Stationary and Printing Co., 472 U.S. 284 (1985).
[11] Texaco Inc. v. Dagher, 547 U.S. 1 (2006).
[12] 317 U.S. 341.

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has now been the subject of many Supreme Court opinions. This defense allows a state effectively to immunize what the antitrust laws otherwise may proscribe by clearly articulating and affirmatively expressing a policy to displace competition, and by actively supervising any private conduct that might be involved.

Moreover, the application of the antitrust laws to potentially procompetitive collective activity has become far more sophisticated during the 62 years since the McCarran-Ferguson Act was enacted. Some forms of joint activity that might have been prohibited under earlier, more restrictive doctrines are now clearly permissible, or at very least analyzed under a rule of reason that takes appropriate account of the circumstances and efficient operation of a particular industry. Thus, there is far less reason for concern that overly restrictive antitrust rulings would impair the insurance industry's efficiency.

In sum, the Department of Justice generally supports the idea of repealing antitrust exemptions. However, we take no position as to how and when Congress should address this issue. In conjunction with the Administration's efforts to strengthen insurance regulation and states' role in setting and enforcing policies, the Department supports efforts to bring more competition to the health insurance marketplace that lower costs, expand choice, and improve quality for families, businesses, and government. As you know, the Administration has been working with the Congress to enact health care reform that lowers costs and offers affordable coverage to all Americans. Yesterday, the Senate Finance Committee became the fifth and final committee to report out a health reform bill. The President has said that these reforms "would greatly benefit Americans from all walks of life, as well as the economy as a whole." We know that you share this

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goal, and we look forward to working with you and your colleagues in achieving our common objectives.

Mr. Chairman, this concludes my prepared statement. I would be happy to address any questions that you or the other members of the Committee may have.

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STATE OF IOWA

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

SUSAN E. VOSS
COMMISSIONER OF INSURANCE

October 13, 2009

The Honorable Charles E. Grassley
United States Senator
135 Hart Senate Office Building
Washington, D.C. 20510
Sent Via Email

Re: McCarran-Ferguson Act/Health Insurance

Dear Senator Grassley:

I want to thank you for the opportunity to write to you on a topic for which I am quite familiar. Please note that the views expressed in this letter are my own views. I am not representing any other insurance commissioner or the National Association of Insurance Commissioners. For the past five years, I have been the Iowa Insurance Commissioner. One of my duties as Commissioner is to regulate health insurance carriers licensed to write business in Iowa including the review and approval of the health care premiums charged by insurance carriers and sold to Iowans.

I am writing to respond to recent statements made concerning the McCarran-Ferguson Act. It has been reported that some members of the United States Senate believe that the McCarran-Ferguson Act allows insurance carriers to "collude and conspire" regarding rates and the pricing of health insurance and that they can meet in the same room and decide the rates for insurance premiums. Further, it has been suggested that there is no oversight of how health insurance carriers set rates.

I want to inform you that such an opinion is incorrect. In fact, McCarran-Ferguson, which provides for the state regulation of insurance does not allow for any type of collusion. Each state is authorized under this Act to regulate insurance including the rates set for insurance premiums. For example, in the state of Iowa, there are statutes which specifically outline the rate guidelines and restrictions allowed by health insurance carriers. These statutes provide guidance on what type of rating factors an insurance carrier may use in formulating its rates. For individual health insurance rates carriers must get pre-approval from the state insurance commissioner before charging a certain premium rate. And in fact, there are many instances where our office has denied premium rate requests by insurance carriers because we do not believe the experience of the carrier justifies the rate requested.

It is my understanding that all 50 states, the District of Columbia and the territories all have similar laws and regulations which provide for oversight of the health insurance carriers selling health insurance coverage within their jurisdictions. State laws vary from state to state, but essentially, they all require some form of review of the rates set by carriers and require the insurance carrier to justify these rates based upon rating factors and experience. The National Association of Insurance Carriers has worked

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http://www.iid.state.ia.us/

closely with state insurance regulators to produce model laws and regulations that provide guidelines for setting rates that are adequate and based upon the unique experiences of individual carriers.

State insurance department staff actuaries and other regulatory personnel closely review the documents filed by the carriers to determine if the rates follow state guidelines. It is not uncommon for state insurance departments to deny rate increase requests. This happens frequently and carriers are required to make changes and lower rates according to state guidelines.

I would add that there are many other health care delivery systems not regulated by state insurance departments where costs continue to increase with no restrictions or oversight on premiums. For example, ERISA-based self-funded health care plans are regulated by the U.S. Department of Labor. I am unaware of any rate restrictions that the federal government has placed on these plans. In addition, Medicaid and Medicare do not have the same type of rate restrictions, review and oversight that state-regulated health insurance plans must meet. In short, state insurance regulators because of McCarran-Ferguson are protecting consumers by a strong system of rate review.

The notion that McCarran-Ferguson is the cause of high health insurance premiums is not based upon fact. There are many factors that cause rates to increase including high utilization, underlying health care delivery costs, and plan design to name just a few. State insurance commissioners and their departments constantly monitor the increasing cost of health insurance. Working in concert with their state legislators and Governors, insurance commissioners are seeking ways to ease the pressure of high premiums costs. We take our role seriously.

Please know that we stand ready to assist you in your goal to find greater access and affordability of health care coverage for all Americans. We understand the concerns of our state citizens and work with them every day to answer their questions and help them solve problems. They deserve our coordinated efforts in this area.

Thank you for allowing me this opportunity to express my concerns about the McCarran-Ferguson Act. This federal law has provided states the ability to protect their consumers. I also believe it's a law worth preserving.

Sincerely,

Susan E. Voss

Susan E. Voss
Commissioner