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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
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"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.

[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).

Pricing and Regulation of Medical Professional Liability Insurance (MPLI)

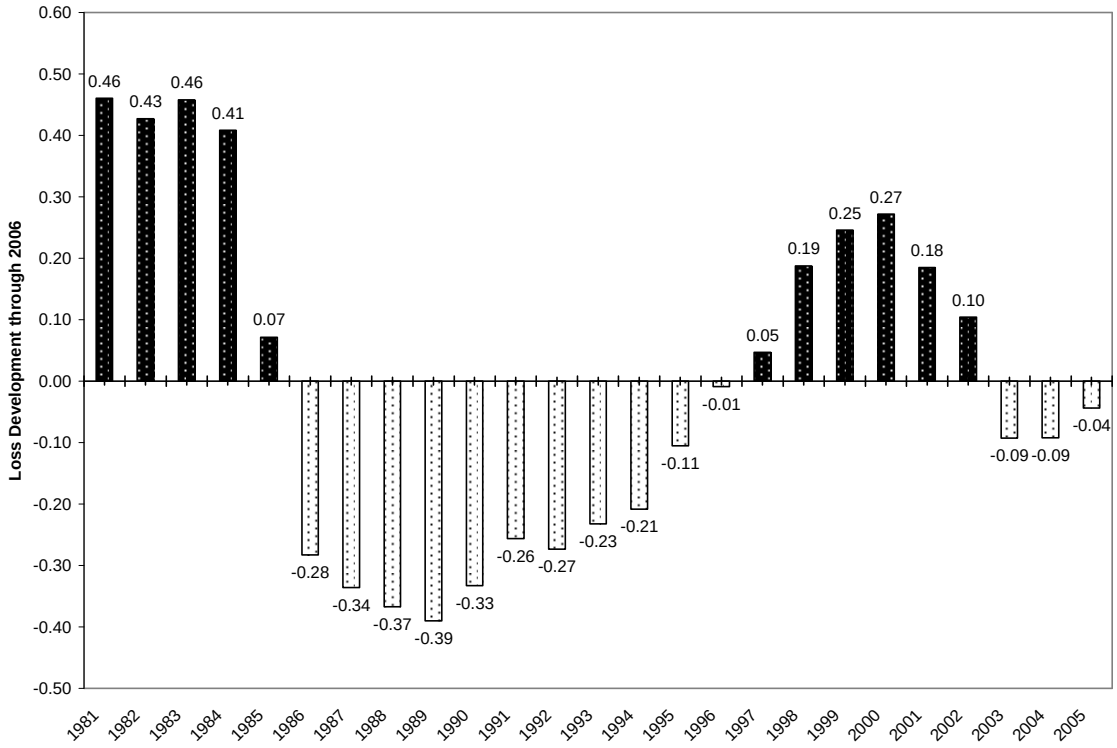
Pricing of insurance is inherently very difficult because the price must be set before all of the costs are known. Difficulty is amplified for MPL insurance because of the long period of time that elapses between the policy period and ultimate settlement of claims. On average, an insurer does not know 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.

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).

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."

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”

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.

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.

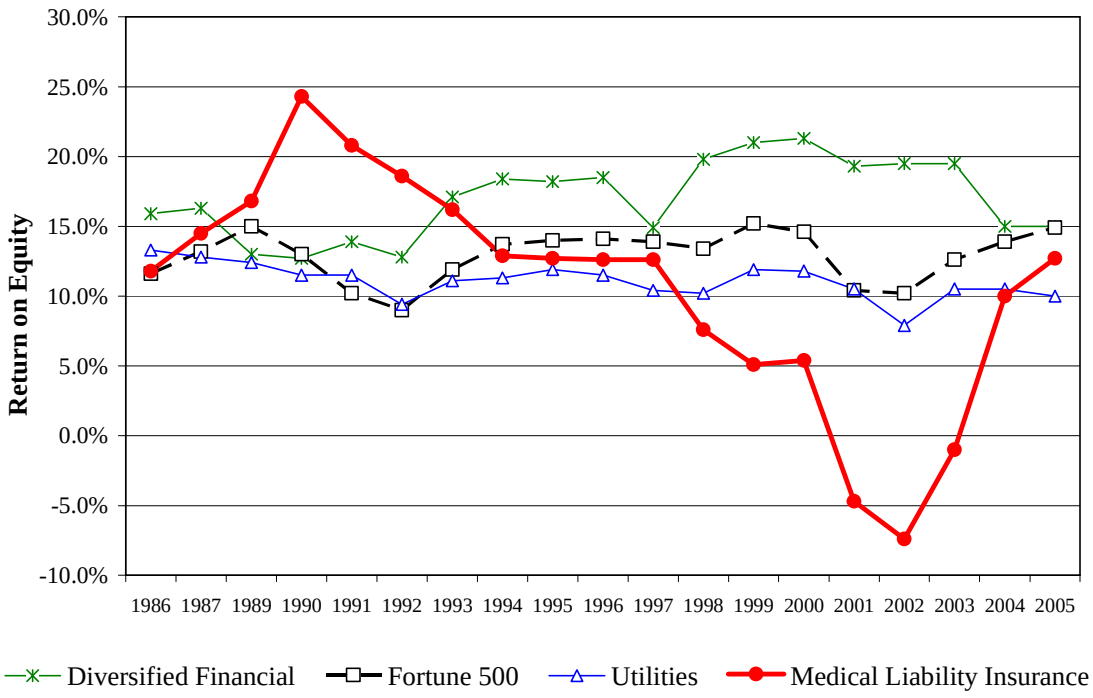
Another potential measure of competition in insurance markets is company performance. If insurers are colluding to raise prices above the competitive equilibrium price, insurance markets should exhibit substantial profits over a lengthy period of time.

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).

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%.

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.

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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