Consumer Federation of America

TESTIMONY OF

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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.

[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.

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.

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

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.

THE ECONOMIC CYCLE AND RESULTING INSURANCE ISSUES – THE MALPRACTICE EXAMPLE

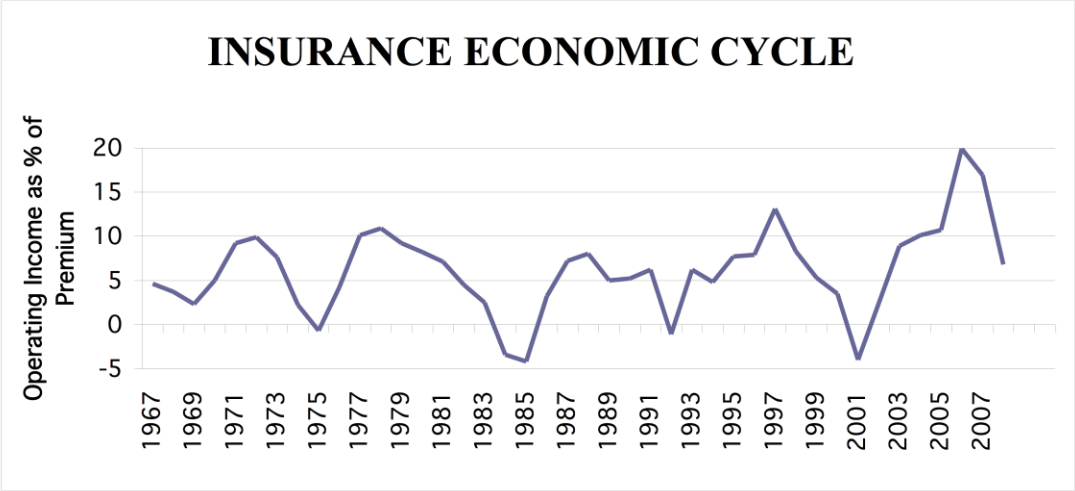
CFA research over several decades convinces us that the lack of antitrust law application to insurance has exacerbated periodic liability insurance cyclical price spikes that occur as insurers return to the "safe harbor" of using rating bureau price levels or pure premium levels during the hard markets.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

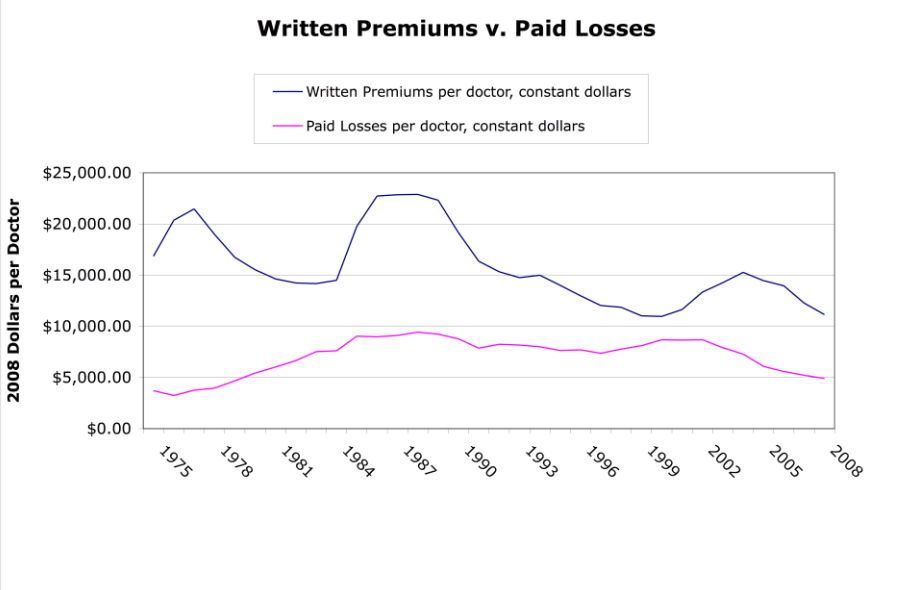
Medical liability insurance is part of the property/casualty sector of the insurance industry. This industry's profit levels are cyclical, with insurance premium growth fluctuating during hard and soft market conditions. This is because insurance companies make most of their profits, or return on net 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.

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

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.

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."

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.

[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.

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.

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

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).

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)

[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.

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

> 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.

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

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]

[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.

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.

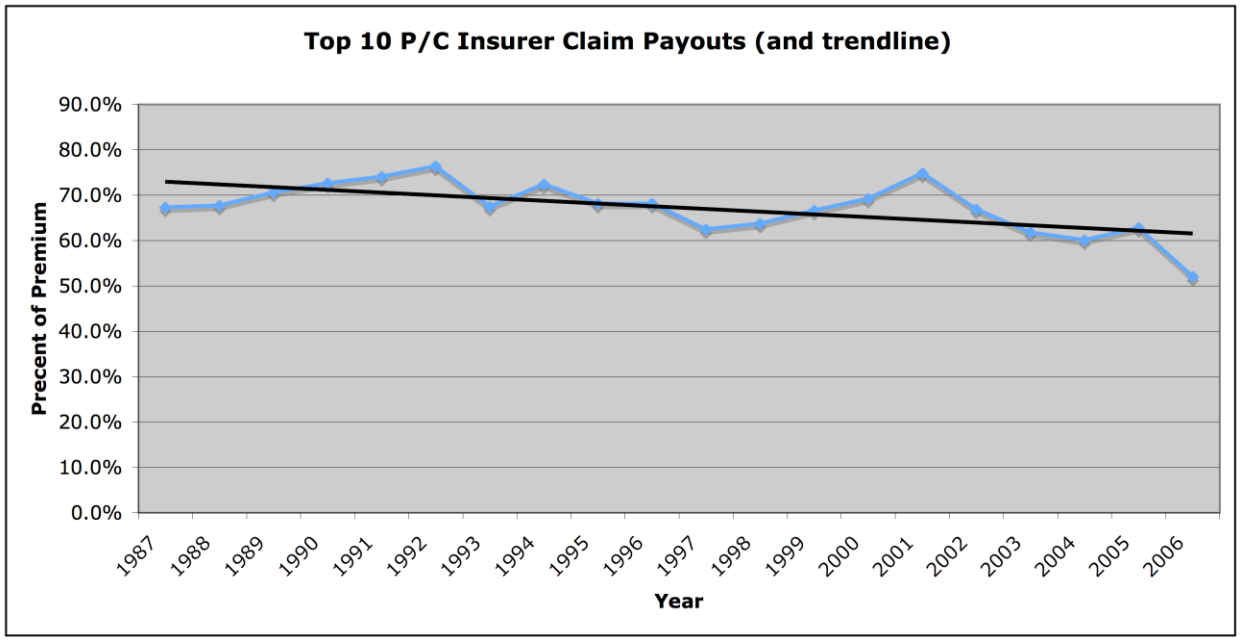
[25] Ibid. Page 57.

[26] Ibid. Page 132.

[27] Ibid.

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.

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.

"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-

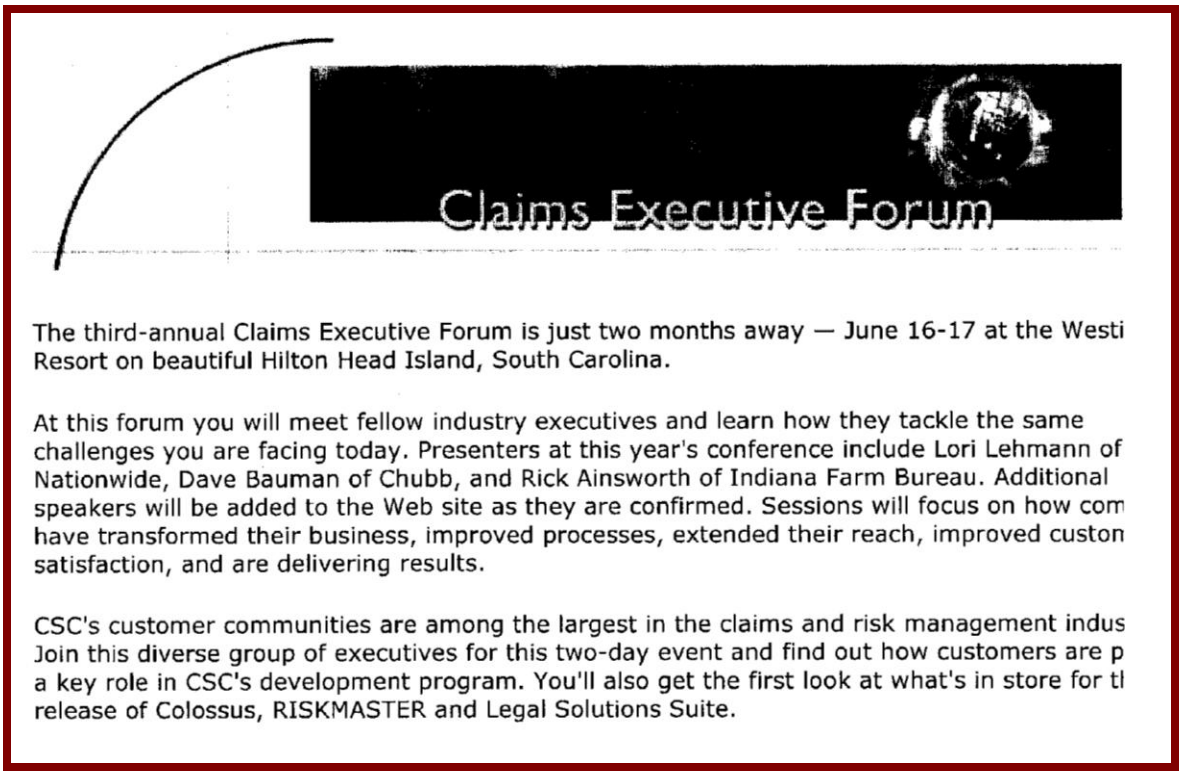
000009650.) He asked that, on one document, this change be made: "Colossus users can achieve savings up to 19% through the consistent application of Best Practices should be Colossus users can achieve increased consistency up to 19% through the consistent application of BP." (CSCHENSR078-000008933)

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.**

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



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.

• 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.

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 TMJ, 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 beat 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

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).

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.

[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).

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

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.

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.

[34] April 11, 1988.
[35] May 25, 1988.
[36] May 4, 1991.
[37] June 12, 1991.

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

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

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."

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.

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

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}

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.

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.