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"Proposition 103: A Model for Insurance Regulation"

Testimony of Douglas Heller
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Before the
Committee on Commerce, Science and Transportation
United States Senate
Washington, D.C.
October 22, 2003

Mr. Chairman and Members of the Committee:

Thank you for inviting the Foundation for Taxpayer and Consumer Rights (FTCR) to present its views on insurance regulation and engage in this important discussion on the state of insurance regulation and proposals to improve it.

FTCR is a nonpartisan, nonprofit organization that conducts research, education and advocacy activities on insurance matters and other consumer issues, including healthcare and energy. In particular, FTCR has done extensive work on issues related to auto, home and medical malpractice insurance and has long been an advocate of insurance industry regulation. FTCR's founder, Harvey Rosenfield, is the author of Proposition 103, the California insurance reform initiative that provides the state with the nation's most stringent system of insurance regulation. I am FTCR's senior consumer advocate and insurance specialist.

We would like to thank Chairman McCain for holding this oversight hearing and we appreciate the effort of Senator Hollings, who, in drafting S. 1373, has provided a model for discussing the strength and efficacy of insurance regulation. This proposal reflects many of the provisions of California's Proposition 103, which have provided a stable and affordable insurance market for the past 15 years in California, a stark contrast to the skyrocketing prices and industry turmoil that characterizes the property-casualty marketplace in many other states.

While we believe that insurance regulation should remain the purview of state regulators, lawmakers and courts, we commend Senator Hollings for putting forward a compelling proposal to protect insurance consumers across the nation. Senator Hollings proposal comes at a time when insurance companies are pushing to deregulate the insurance industry at the state level and by proposing an optional federal charter system with rules that would allow insurers to choose their regulator in a manner that will undoubtedly reduce regulatory oversight of the insurance industry.

It is our belief that the most effective way to protect consumers and ensure reasonable insurance rates is through the tools of a prior approval insurance regulation system. Our research has shown that insurance company regulation, when properly implemented, can save consumers billions of dollars and maintain profitability within the insurance industry, thereby providing customers with the most choice in the market. In other words, the regimen of insurance regulation creates the environment that is most conducive to marketplace competition while also affording consumers necessary protection against insurance company profiteering.

In addressing the questions at hand, FTCR would like to present the following thesis:

> Insurance products are such an integral part of the economic life of Americans, that ensuring both the affordability and quality of the products is crucial to the financial security and well-being of American consumers and businesses. Effectively regulating the insurance marketplace is the best way to produce reasonable and stable rates for consumers and appropriate market conduct by carriers

Our reports, analyses and experience have confirmed this thesis time after time over the 15 years since the enactment of Proposition 103 in California. To illustrate the success of and need for a strong regulatory regime for insurance, we bring together a variety of data and analysis in this testimony to make the following points:

I. Proposition 103 has saved California consumers billions of dollars through its prior approval regulatory structure, including more than $62 million saved for doctors and homeowners in the past two months alone as a result of FTCR's rate challenges.

II. Insurance follows an economic cycle inversely related to the nation's financial markets. Aggressive investing practices have created volatility in insurance rates over the past five years, culminating in the massive price spikes and underwriting restrictions that appeared on the heels of the collapse of Enron, Worldcom and declining interest rates.

III. The antitrust exemptions provided to insurers are anti-competitive and allow companies to set prices collusively rather than compete on the insurers' actual abilities to assess and carry risks.

IV. Insurance companies project higher losses in order to push for higher rates and imply a crisis, and then quietly change their data in the years to come.

V. Tort limitations imposed during previous crisess have had no demonstrable effect on insurance rates.

I. PROPOSITION 103 REGULATION SAVES CONSUMERS BILLIONS OF DOLLARS

In 1988, California voters, facing skyrocketing insurance premiums and angry at the failure of tort reform to deliver its promised savings, went to the ballot box and passed Proposition 103, the nation's most stringent reform of the insurance industry's rates and

practices – applicable to all lines of property-casualty insurance, including auto, homeowners, commercial and medical-malpractice.

Proposition 103:

- **Mandated an immediate rollback of rates of at least 20%** – rate relief to offset excessive rate increases by establishing a baseline for measuring appropriate rates.

- **Froze rates for one year**. Ultimately, because of the delay caused by insurance company legal challenges to Proposition 103, rates remained frozen for four years pursuant to decisions by the state's insurance commissioner.

- **Created a stringent disclosure and "prior approval" system of insurance regulation**, which requires insurance companies to submit applications for rate changes to the California Department of Insurance for review before they are approved. Proposition 103 gives the California Insurance Commissioner the authority to place limits on an insurance company's profits, expenses and projections of future losses (a critical area of abuse).

- Authorized consumers to **challenge insurance companies'** rates and practices in court or before the Department of Insurance.

- **Repealed anti-competitive laws** in order to stimulate competition and establish a free market for insurance. Proposition 103 repealed the industry's exemption from state antitrust laws, and prohibited anti-competitive insurance industry "rating organizations" from sharing price and marketing data among companies, and from projecting "advisory," or future, rates, generic expenses and profits. It repealed the law that prohibited insurance agents / brokers from cutting their own commissions in order to give premium discounts to consumers. It permits banks and other financial institutions to offer insurance policies. And it authorizes individuals, clubs and other associations to unite to negotiate lower cost group insurance policies.

- **Promoted full democratic accountability** to the public in the implementation of the initiative by making the Insurance Commissioner an elected position.

A copy of the text of Proposition 103 are submitted as Appendix A.

Insurers spent $80 million in their unsuccessful effort to defeat Proposition 103, including the cost of sponsoring three competing ballot measures that would have enacted "tort reform." Having seen how "tort reform" laws passed at the behest of the insurance industry in 1975 and 1986 had had no effect on premiums, the voters rejected each of the industry's 1988 measures.

Proposition 103 worked. Insurance companies refunded over $1.2 billion to policyholders, including motorists, homeowners and doctors. In the closely studied area of auto insurance, California was the only state in the nation in which auto insurance liability premiums actually dropped between 1989 and 2001, according to NAIC data. A 2001 study by the Consumer Federation of America concluded that the prior approval provision of Proposition 103 blocked over $23 billion in rate increases for auto insurance alone through 2000.

Despite the clear success of Proposition 103, the insurance industry continues to resist regulatory oversight and, instead pushes for less accountability and less intervention.

The industry typically criticizes insurance regulation as slowing down the process of adjusting rates and introducing products that companies want to provide to consumers. Insurers argue for "speed to market" rules that would set a national standard of scrutiny; not surprisingly, that standard is far weaker than the regulatory strictures of Proposition 103 and the prior approval method of insurance ratemaking.

This professed goal of efficiency must be weighed next to the need to protect against high rates and low-quality products. Just as new drugs must be put through a battery of tests to ensure safety prior to being placed on the market, insurance products need to be fully vetted before they are sold to consumers. The prior approval structure of California's Proposition 103 gives the insurance commissioner and the public the ability to ensure that consumers have access to insurance products that provide high quality coverage and are not priced to gouge consumers.

A. Prior Approval and Consumer Participation Allow the Public to Scrutinize Insurers' Books, Hold Firms Accountable

The chief tool necessary to effectively regulate insurance companies is the right of government to approve, deny or alter insurance rates before companies can change consumers' rates. Of course, the quality of the regulator determines, at least in part, the efficacy of the regulation. As a safety valve against an understaffed or unwilling regulator, Proposition 103 provides the public with the opportunity to analyze and challenge rates and industry practices in the courts as well as before the agency in order to offer a competitive perspective on rate changes proposed by insurers. This tool of participation also serves as a way to hold the insurance commissioner accountable to the regulatory structure, by allowing the public to challenge rate hikes or practices that the Commissioner might have otherwise approved.

Proposition 103's prior approval system establishes a set of boundaries for insurance companies to use in setting rates for consumers. The formula includes limits on, or guidelines for administrative expenses, profits, the methods of projecting future losses and other aspects of developing a rate. Effective insurance regulation prohibits insurers from engaging in bookkeeping practices that inflate their claims losses and limits the amount insurers can set aside as surplus and reserves. It also forbids insurers from passing through to consumers the costs of the industry's lobbying, political contributions, institutional advertising, unsuccessful defense of discrimination cases, bad faith damage awards, and fines or penalties.

A prior approval system places the burden on the insurance company to justify its rates in advance, rather than on the consumer or regulator to find inappropriate rates after the fact and only then begin the process of scrutiny. It is our belief that pre-emptive regulation is far more efficient and fair than the alternatives.

A series of recent examples of the power of the prior approval system and the tangible benefit of consumer participation in California follow:

- On August 22, 2003, California Insurance Commissioner John Garamendi ordered the state's second largest medical malpractice insurer, SCPIE Indemnity, and its affiliate American Healthcare Indemnity, to cut it's proposed rate hike for physicians by 36%, in response to a rate challenge brought by FTCR. As part of the challenge, FTCR actuaries and insurance experts opened SCPIE's books to review the company's financial data and actuarial projections. FTCR also interviewed the

firm's actuaries, economists and consultants in order to demonstrate that the insurer's proposed 15.6% rate increase was excessive.

Instead of the company's proposed 15.6% increase that was originally set to go into effect on January 1, 2003, the Commissioner only allowed SCPIE and its affiliate to increase premiums by 9.9% beginning on October 1, 2003. The net impact is a $16 million savings for the insurer's 9,000 physicians in 2003 and an additional $7.2 million of savings in 2004 premiums. (SCPIE has applied for an additional 2004 increase that FTCR will likely challenge.)

According to the decision issued by the commissioner, SCPIE tried to justify its rate hike by claiming that it should not be subject to a strict application of rate regulations and that it did not have the burden of proving its rates were reasonable, despite California's clear regulatory requirements. The Commissioner rejected that argument and, to ensure regulatory compliance by SCPIE and other insurers, officially designated portions of his ruling as legal precedent.

- FTCR challenged a recent 9.9% increase proposal by the state's largest medical malpractice provider, NORCAL Mutual. The ensuing scrutiny by California Department of Insurance regulators, led the company to slash its rate request by 70%, resulting in a $11.6 million savings to NORCAL-insured doctors.

- Using the consumer participation tools of Proposition 103, FTCR recently blocked a 10% rate hike for homeowner's insurance policyholders with the Northern California Auto Club, the state's fourth largest homeowner's insurance provider. This resulted in a $26 million savings for the company's 330,000 policyholders.

- In 1998, FTCR challenged a rate decrease proposal by auto insurer Allstate. The Commissioner allowed the company to reduce rates, but FTCR's analysis indicated that rates should have dropped further. In response to our challenge, Allstate agreed to reduce its auto insurance premium by $43 million in addition to the reductions associated with its initial rate decrease proposal.

To ensure that the public is able to effectively intervene and challenge inappropriate insurance rates and practices, Proposition 103 requires insurers to reimburse consumers or consumer representatives when the group contributes to a decision rendered by the Insurance Commissioner with respect to rates. Pursuant to Proposition 103, consumer groups are also provided funding for participation in all aspects of insurance regulation. This has allowed groups acting on behalf of consumers a reasonable opportunity to enforce the rules set forth in Proposition 103.

B. Auto Insurance: Regulation Protects Consumers From a National Trend

In the years since the implementation of Proposition 103, auto insurance rates in California have defied the national upward trend. The following tables summarize insurance industry data drawn from annual reports published by the National Association of Insurance Commissioners.[1] We provide an analysis of data for the years 1989-2001, encompassing the entire period following the implementation of Proposition 103 for which data is available.

[1] *State Average Expenditures & Premiums for Personal Automobile Insurance* 1993-2001, National Association of Insurance Commissioners

The average auto liability premium dropped 22% in California between 1989 and 2001. Prior to Proposition 103, auto insurance premiums in California rose dramatically each year. Pre-election rate increases by insurance companies in anticipation of Proposition 103's passage, and post-election rate increases taken while Proposition 103 was stayed pending California Supreme Court review, pushed the average liability premium in California to $519.39 by 1989.

According to the latest NAIC data, California's average auto liability insurance premium for 2001 was $404.48 -- 22% less than the 1989 figure. The average premium decrease in California becomes even more striking when adjusted for inflation.[2] The average premium in 1989, in 2001 dollars, was $741.81. In comparison, the average California auto liability premium in 2001 was 45% lower.

Comparison of Average Liability Premiums, 1989-2000

Year	California Premium	California Premium (2001 dollars)
1989	$519.39	$741.81
1990	$501.34	$679.32
1991	$522.95	$679.99
1992	$510.71	$644.67
1993	$512.52	$628.15
1994	$502.76	$600.80
1995	$514.53	$597.92
1996	$508.71	$574.20
1997	$492.31	$543.23
1998	$447.51	$486.22
1999	$405.85	$431.43
2000	$391.24	$402.37
2001	$404.48	$404.48

While auto premiums in California *fell 22%,* premiums throughout the rest of the nation *rose* 30.2%. Another measure of the impact of Proposition 103 is a comparison with average liability premiums in other states. While liability premiums for the rest of the country grew 30.2% since 1989, California's dropped 22%. Tables 2 and 3 below compare California's average premium to the rest of the nation's average.

[2] The Bureau of Labor Statistics Inflation Calculator can be accessed at http://data.bls.gov/cgi-bin/cpicalc.pl.

Comparison of Average Liability Premiums, 1989-2000
Calculation is liability premiums / liability written car-years (

Year	California	Rest of Nation[3]
1989	$519.39	$317.32
1990	$501.34	$338.55
1991	$522.95	$358.82
1992	$510.71	$381.69
1993	$512.52	$400.80
1994	$502.76	$411.40
1995	$514.53	$419.45
1996	$508.71	$431.45
1997	$492.31	$434.17
1998	$447.51	$423.39
1999	$405.85	$402.60
2000	$391.24	$398.44
2001	$404.48	$413.13

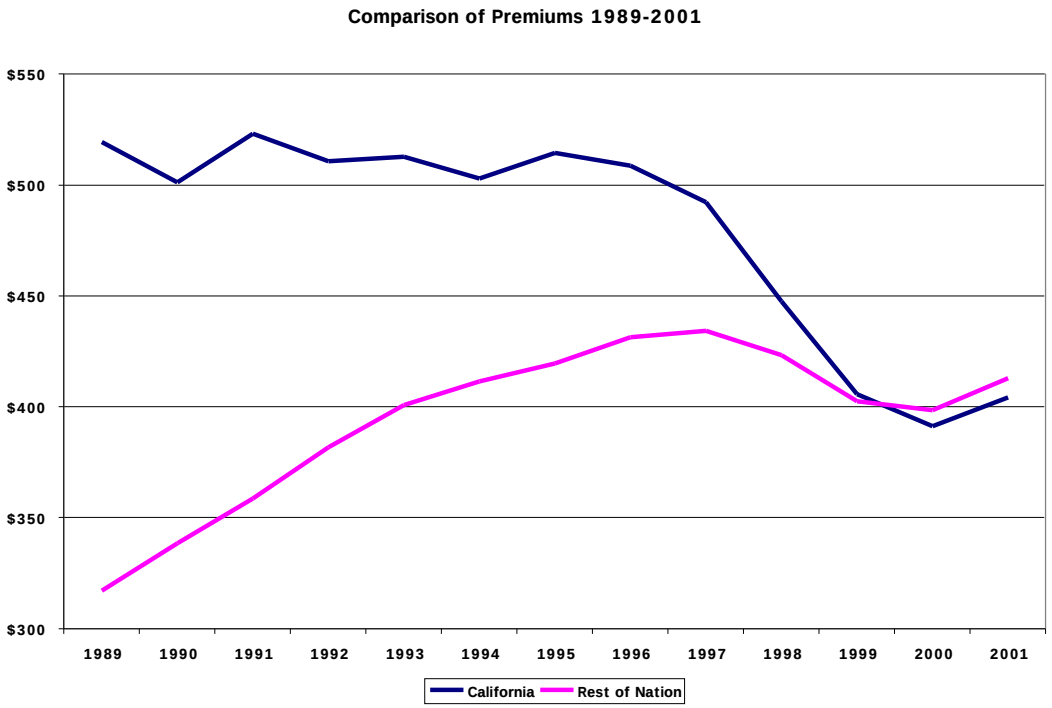
Comparison of Growth/Decline in Average Liability Premiums, 1989-2000

Period	California % Change	Rest of Nation % Change
1989-90	-3.5%	6.7%
1990-91	4.3%	6.0%
1991-92	-2.3%	6.4%
1992-93	0.4%	5.0%
1993-94	-1.9%	2.6%
1994-95	2.3%	2.0%
1995-96	-1.1%	2.9%
1996-97	-3.2%	0.6%
1997-98	-9.1%	-2.5%
1998-99	-9.3%	-4.9%
1999-2000	-3.6%	-1.0%
2000-2001	3.3%	3.7%
1989-2001	-22.1%	30.2%

This sharp drop in California's average premium relative to that of other states brought California's rank down from the 2nd highest rates in the nation in 1989 to 22nd in 2001.

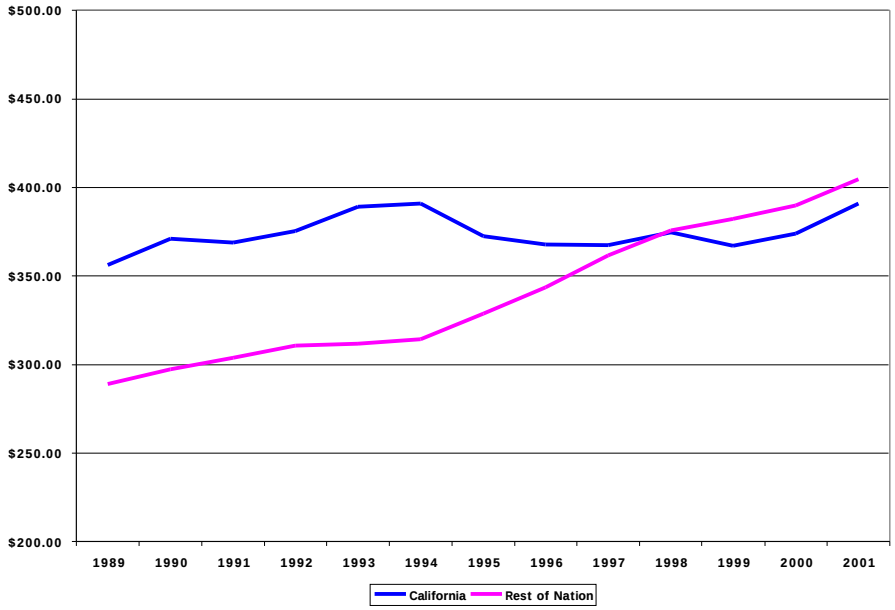
[3] In this table and in subsequent tables, "Rest of Nation" data do not include California data.

Comparison of Growth in Average Liability Premiums, 1989-2000



California's overall post-Proposition 103 premium decline defies national trend toward higher rates. In addition to lowering auto liability premiums, Proposition 103 has slowed premium growth for other types of automobile coverage at the same time that the rest of the nation saw its premiums increase drastically. California's comprehensive premiums have fallen 10% while comprehensive premiums for the rest of the nation have shot up by 40%. Collision premiums in California have gone up 20%, in contrast to the rest of the country's 40%.

Comparison of Average Combined Collision and Comprehensive Premiums, 1989-2001



Combined liability, collision and comprehensive premiums are down 9.2% for Californians, up 35% nationally since Proposition 103

In 1989 Californians paid $875.60 for liability, collision and comprehensive combined coverage on average. Nationwide consumers paid $606.40 for the combined coverage. However, with Proposition 103 in effect, California drivers' fortunes have changed, as combined average premium in California 2001 was $795.36, a 9.2% decline while nationally, motorists paid $817.87, a 34.9% increase

C. Insurance Regulation Has Allowed California To Be A More Profitable Market For Insurance Companies Than The National Average, While Keeping Rates Low

Despite the insurance industry's automatic negative reaction to insurance regulation, California under the strict regulation of Proposition 103 has been a more profitable environment for insurers than the nation as a whole. According to the most recent data available from the National Association of Insurance Commissioners, in the majority of lines of insurance returns are better in California than countrywide.[4]

Whether one compares return on net worth or profit on insurance transactions (both are measures of profitability used by NAIC), the findings consistently show that California is generally more profitable for insurers than the nation as a whole.

Table 7. Insurer Profitability in California vs. Countrywide Average

Return on Net Worth	10 Year Average 1992-2001	
Line of insurance	California	Countrywide
Private Passenger Auto (Total)	13.7%	9.8%
Homeowners Multiple Peril	5.7%	(3.4%)
Commercial Auto (Total)	10.0%	7.2%
Farmowners Multiple Peril	7.3%	0.9%
Medical Malpractice	12.5%	9.6%

Notably, workers compensation has not been as profitable in California as that line has been nationally. Workers compensation insurance, however, was deregulated in California in 1993 and is in crisis currently.

California has been a profitable marketplace for insurers specifically because of the regulatory regime. Regulation serves to restrain the companies from damaging themselves as well as hurting consumers. Insurance regulation is not meant to produce the lowest premiums, it is meant to produce the most appropriate premiums for the risk insured; insurance regulation guards against both excessive and inadequate, as well as unfairly discriminatory rates. As a result, regulated lines of insurance result in more stable rates for customers, even if they are not the lowest prices at certain points in time.

The stable profitability associated with regulatory controls creates an environment in which insurers want to sell in the state. That is why there are so many insurers serving California customers. There are over 200 companies selling auto insurance in California, 150 selling homeowners and almost 50 selling medical malpractice insurance.

[4] *Profitability by Line by State In 2001*, National Association of Insurance Commissioners, December 2002

II. THE INSURANCE CYCLE AND THE IMPACT OF ENRON, WORLDCOM AND LOW INTEREST RATES

Over the last three decades-plus, the nation has experienced three major insurance crises, in the mid-1970s, the mid 1980s and the early 2000s. Each of these crises swept the nation with massive rate increases, insurers pulling or threatening to pull out of local markets and a legislative push for changes to tort laws. Each of these crises also occurred at the same time as a national downturn in the economy that dramatically reduced insurance company investment returns.

A. The Insurance Cycle

The present insurance "crisis" – apparent in homeowners, auto, commercial liability as well as medical and other malpractice lines – constitutes the apogee of a financial cycle to which the insurance industry is constantly subject. As one consumer organization explains:

> Insurers make most of their profits 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. Insurers severely underprice their policies and insure very poor risks just to get premium dollars to invest. This is known as the "soft" insurance market. But when investment income decreases — because interest rates drop or the stock market plummets or the cumulative price cuts make profits become unbearably low — the industry responds by sharply increasing premiums and reducing coverage, creating a "hard" insurance market usually degenerating into a "liability insurance crisis." A hard insurance market happened in the mid-1970s, precipitating rate hikes and coverage cutbacks, particularly with medical malpractice insurance and product liability insurance. A more severe crisis took place in the mid-1980s, when most liability insurance was impacted. Again, in 2002, the country is experiencing a "hard market," this time impacting property as well as liability coverages with some lines of insurance seeing rates going up 100% or more.[5]

Fitch, a Wall Street rating firm, recently began a discussion of the current "crisis" by harkening back to the last one:

> We need to look back at the hard market of the mid-1980s.… The last major hard market turn was in the mid- 1980s, and was inspired greatly by a sharp drop in interest rates. In years prior to the mid-1980s, cashflow underwriting was prevalent in which a significant amount of naive capital was attracted to the property/casualty industry on the lure of making strong investment returns on the premium "float" between the time premiums were collected and claims were paid. Naturally, much of the naive capacity was directed at long-tail casualty and liability lines at both the primary and reinsurance levels in order to maximize the float. In the early 1980s, nominal interest rates were running in the mid-teens. When interest rates dropped off and significant reserve deficiencies were simultaneously detected, many insurers suffered large losses to both earnings

[5] "Medical Malpractice Insurance: Stable Losses/Unstable Rates," Americans for Insurance Reform, October 10, 2002

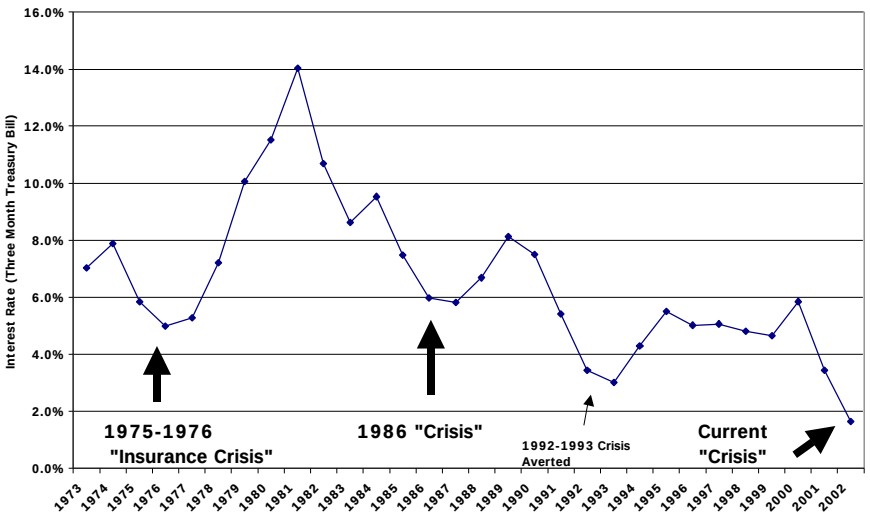
and capital. The result was a sharp turn in the market, especially in long-tail lines, and the emergence of a so-called "liability insurance crisis." The liability insurance crisis included a sharp drop in availability of coverages, and huge price increases (in many cases several-fold).[6]

Indeed, by early 2002, insurers had already begun licking their chops as they looked forward to an infusion of profits from the latest "crisis." In its "Groundhog Forecast 2002," the Insurance Information Institute projected a 14.7% increase in premiums, the industry's "fastest pace since 1986" – the last crisis.[7] The Auto Insurance Report proclaimed, "The Stars Are Lining Up for Solid Profits in '02-'03."[8] "How Much longer to P-C Nirvana?" asked the National Underwriter, saying, "Like kids on a long car trip headed for summer vacation, many insurance company employees and the agents that represent them have found themselves wondering just how much longer this trip to property-casualty nirvana can last."[9] Said an industry executive: "This manic behavior leads our customers to believe we don't know what we're doing, and I think they have a point. This is a generation of insurance professionals who need to learn how to be successful with something other than low premiums."[10]

B. Interest Rates and the Cycle

The current push for higher insurance rates is driven in part by the historically low interest rates. There is an inverse relationship between interest rates and insurance rates and, as the graph below illustrates, when interest rates go down a crisis ensues and, inevitably, rates increase.

When Interest Rates Fall, A Crisis Ensues



"Selected Interest Rates: 1970-2002," prepared by Michigan Legislature Senate Fiscal Agency. http://www.senate.state.mi.us/sfa/Economics/SelectedInterestRates.PDF

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[6] Fitch Ratings, Inc., Insurance Special Report Review & Outlook: 2001/2002: U.S. Property/Casualty Insurance,
January 17, 2002, p. 19-20.
[7] www.iii.org/media/industry/financials/groundhog2002/ visited 11/21/02.
[8] Auto Insurance Report, May 13, 2002, p. 1.
[9] National Underwriter, July 22, 2001, p. 26.
[10] "Liability Insurers Urged to Take Long View for Industry's Financial Health," Orlando Business Journal, November 26, 2002 at
http://orlando.bizjournals.com/orlando/stories/2002/11/25/daily25.html?t=printable.

Over the past three decades, there has been an insurance crisis and a concurrent spike in insurance premiums each time the nation has experienced a major decline in interest rates. The notable exception to this is when interest rates dipped in 1992. Still reeling from California's adoption of Proposition 103 after the 1980s crisis, the insurance industry aborted another run-up in prices in 1992 and 1993 despite the declining economy and interest rates. As one insurance executive explained, "The last soft market was driven purely by the need for cash to invest. . . . We all know we can't do the dumb things we did last time. . . . We will not see a repeat of 1985-86."[11] Arguing against a push to raise rates, a senior officer at the Insurance Services Office, an industry data provider, said: "Remember the fallout from the last recovery: California's Proposition 103 and other price-suppression laws, threats to the industry on the antitrust front, and virulent consumer hostility."[12]

Despite its apparent awakening after the passage of Proposition 103, the insurance industry has fallen into its old ways in recent years, as the most recent insurance-cycle crisis and the ensuing rate increases have been particularly aggressive.

In this crisis as with previous crises, insurers have made it difficult for consumers to obtain and maintain coverage. After the very liberal underwriting practices of the mid 1990s, in which obtaining coverage was not particularly difficult for consumers and businesses, the trend over the past two years has been to shut consumers out of the insurance market by implementing very restrictive underwriting guidelines.

Increasingly, companies are punishing policyholders – especially in the homeowners insurance market – for having filed legitimate claims. In fact, during this crisis, insurers have begun to drop customers simply for inquiring with their insurer about a possible claim, even if they do not file a claim. Additionally, using the national claims database known as the Comprehensive Loss Underwriting Exchange (CLUE), insurers have been denying policies to consumers who have previous claims or even mere inquiries, regardless of the nature of the claim.

C. The Role of Enron, Worldcom and the Corporate Scandals of 2001-2002

While internally acknowledging the insurance cycle and the role of investments, particularly in mandatory financial filings, the insurance industry has largely blamed factors such as higher medical bills, increased labor costs, litigation costs and jury awards when it presents its view of the insurance market to lawmaers and the public generally. The industry does not, unfortunately, blame Enron and WorldCom for rate hikes. More importantly, the companies do not blame themselves and the insurance executives who decided to risk a growing percentage of policyholder premiums on investments in Enron, WorldCom and other corporations. They should. And insurance commissioners should hold insurance companies accountable for the billions of policyholder premium dollars that have been squandered as a result of risky investment practices.

Ten property and casualty insurance companies reviewed by FTCR lost a combined $274.1 million in 2001-2002 as a result of investments in *the big five frauds* – WorldCom,

[11] Business Insurance, July 13, 1992, p. 55
[12] Insurance Week, Oct. 19, 1992, p.15

Enron, Adelphia, Global Crossing and Tyco.[13] State Farm, for example, lost more than $74 million as a result of that company's investments in Enron and WorldCom alone.

1. Americans are more exposed to corporate corruption than they think

With the excitement surrounding the stock market bubble of the 1990s, insurance companies increasingly invested in private corporations. Typically, insurance industry executives assert that company portfolios are largely tied up in municipal and other government bonds, with only limited exposure to corporate America. However, by 2001, the particularly disgraced energy, high-tech and telecom sectors figured heavily in insurance companies' portfolios. As a result of this indulgence in higher risk investments, the spate of recent corporate scandals and the insurers' investment follies significantly impacted consumers, whose premium dollars have been placed in insurance company portfolios replete with stocks and corporate bonds.

In a 2002 study, FTCR identified billions of premium dollars lost as a result of changes in property and casualty insurers' investment strategies.[14]

Among FTCR's findings:

- State Farm Mutual Auto lost $60.7 million on ***WorldCom*** investments in 2002 and $42.6 million associated with its ***Tellabs*** holdings.

- Allstate lost $23.3 million when it shed several hundred thousand shares of ***Tyco*** stock as the public became aware of Tyco CEO Dennis Kozlowski's alleged criminal fraud in the first half of 2002. The insurer also lost $11.7 million when it discarded ***Qwest Communications*** stock, another firm investigated by the SEC for its accounting practices.

- Fireman's Fund wrote off the entire cost of its ***Winstar*** stocks and bonds – $85.4 million –after that wireless communications company filed for bankruptcy in April 2001. Additionally, the insurer took a $28.6 million hit on ***WorldCom***.

The Enron factor:

- ***Enron***, the company whose fraudulent accounting and subsequent bankruptcy inaugurated the current era of corporate scandals, was held by many of the insurers reviewed for this analysis. In 2001, Enron losses cost State Farm Mutual Auto $13.5 million, Farmers $9 million, Fireman's Fund $6.2 million, Northern California Auto Club $4.4 million, United Services Automobile Association $4.3 million and Allstate $3.6 million. Fireman's Fund continued to hold $5 million dollars in Enron bonds into 2002.

[13] The companies reviewed include: Allstate Insurance Company, Auto Club of Northern California, Auto Club of Southern California, Farmers Insurance Exchange, Fireman's Fund, Liberty Mutual Insurance Company, Mercury Casualty Company, Nationwide Mutual Insurance Company, State Farm Mutual Auto, United Services Automobile Association.

[14] All data are based on Annual Statements of insurers filed with the California Department of Insurance. Calculations of stock and bond holdings are based on the actual cost of the investments (see also footnote 8).

2. Insurers Change Investment Strategies in the late 1990s

FTCR studied investment data for ten major insurers between1998-2001. The study also examined available 2002 data, and reviewed data going back to 1994 for four companies exhibiting the riskiest investment behavior.

For this analysis, FTCR reviewed public filings to measure the percentage of an insurer's portfolio that is invested in stocks (both common and preferred) and corporate bonds.[15] Real estate holdings, which are reported separately from stock and bond holdings, were not reviewed.

Nine of the ten companies reviewed increased their level of investment in the corporate sector between 1998 and 2001. The companies' holdings in 1998 consisted on average of 48% stocks and corporate bonds combined, with the rest invested in government bonds. By 2001, the average percentage invested in corporate America was up to 57% -- a 19% increase in the size of insurers' corporate investments relative to their overall portfolios. At the end of 2001, seven of the 10 companies for which FTCR obtained data had over 50% of their investments in stocks and corporate bonds.

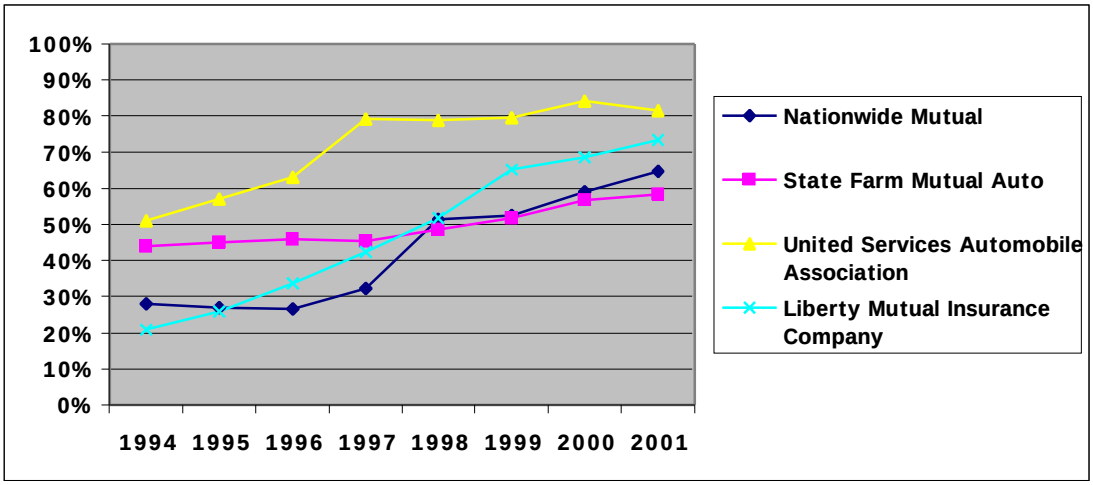
For four of the companies that had most heavily invested in the stock and corporate bond markets in 2001 – USAA, Liberty Mutual, State Farm and Nationwide – FTCR analyzed portfolios for an extended period, 1994-2001, and found that the companies had greatly increased investments in the corporate sector relative to their overall investments.

- In 2001 United Services Automobile Association had more than four-fifths of its entire portfolio – 82% – invested in the corporate sector. This represents a 61% increase in the companies' investments in corporations since 1994.
- Corporate investments accounted for 73% of Liberty Mutual's portfolio in 2001, representing a 248% increase over the insurer's 1994 corporate investments, which accounted for 21% of its portfolio
- State Farm Mutual Auto's percentage was 58% in 2001, a 32% increase over its level of corporate investing before the company jumped into the nineties stock bubble.
- Nationwide Mutual's ratio of corporate investments to its overall holdings jumped 37 percentage points over this period to 65% – a 132% increase.

[15] This percentage was calculated using the actual cost of insurers' investments, also known as the purchase price. The purchase price of the insurance companies' stock and bond holdings in a given year remains constant, while other measures – such as book value – may fluctuate. Moreover, the actual cost of the investments is useful in that it shows how the companies in this study chose to allocate their investment dollars over the years. In other words, if a given company's level of investment in corporations grew over the period of the study, it was not due to rising values of previously purchased stocks and corporate bonds. The use of the actual cost value is also consistent with the losses on stock and bond sales and write-offs listed below, which are calculated based on the initial purchase price of the investments.

The following graph shows the rise in the percentage of these companies' portfolios tied up in corporate sector investments.

Corporate Investment as a % of Investment Portfolio 1994-2001



3. Heavy in Stocks

It is important to note that a large portion of corporate holdings is invested in stocks and not in the generally more stable corporate bonds.

The stock investments of the ten companies reviewed averaged 37% of their overall investments in 2001, eight percentage points more than 1998 levels. United Services Automobile Association invested more than half of its portfolio –57% – in stocks alone (up from 40% in 1994). Nationwide Mutual was close behind with 46% (the company invested only 25% in stocks in 1994), and State Farm Mutual Auto's stock holdings represented 43% of its portfolio (compared to 27% in 1994). 42% of Liberty Mutual's holdings were in stocks in stocks in 2001, up from 10% in 1994.

4. Insurers' Major Losses

Insurance portfolios are replete with corporate stock and bond picks that chronicle the recent bankruptcies, earnings restatements and fraud indictments. A glance at stock and bond transactions in 2001 for a handful of big insurance companies illustrates why investment income fell dramatically by remaining too heavily invested in the stock and corporate bond markets.

The 2001 figures below represent the sum of the amounts lost by a given insurer on all transactions of a given company's stocks and bonds for the entire year, 2001.

A Selection of Insurers' Major Stock and Bond Losses in 2001[16]:

Allstate	**Fireman's Fund**
· Adelphia: $1.1 million[17] · AOL / Time Warner: $2.2 million · Cisco: $6.9 million · Enron: $3.6 million · Global Crossing: $5.9million · Qwest: $11.7 million · WorldCom / MCI: $2.4 million	· Broadcom: $31.2 million · Cisco: $26.3million · Enron: $6.2 million · WorldCom / MCI: $28.6 million · Winstar: $85.4 million
Farmers	**Nationwide**
· Enron: $9 million · Dynegy: $1.1 million	· Enron: $734,513 · EMC Corp.: $4 million · Compaq: $1.2 million
State Farm	**USAA**
· Enron: $13.5 million · Level 3 Communications Inc: $55 million · Bank of America: $29.1 million · XO Communications Inc.: $19.8 million · Battle Mountain Gold: $9.9 million	· Enron: $4.3 million · JDS Uniphase (telecom supplier): $7.6 million · USAA emerging markets fund: $63.6 million (fund heavily invested in international energy and telecommunication stocks)

The data reviewed for the first two quarters of 2002 show equally precipitous declines in the portfolios of major insurers with particularly dramatic losses resulting from WorldCom and Tyco holdings.

The investment losses and other data detailed above are not meant to be exhaustive. They paint a picture, rather, of the sort of investment failures that have cut into insurance companies' profitability in recent years and led to a national run-up in insurance rates.

In light of these findings, it is useful to review the preamble to the International Association of Insurance Supervisors' "Supervisory Standard on Asset Management by Insurance Companies," which reads:

> In order to ensure that an insurer can meet its contractual liabilities to policyholders, such assets must be managed in a sound and prudent manner taking account of the profile of the liabilities held by the company and, indeed, the complete risk-return profile.[18]

Instead of following these standards, we have found that insurance companies ignored their responsibility and jumped headlong into the stock market bubble — only to fall hard when it burst with the string of frauds and bankruptcies that decimated the Dow and NASDAQ.

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[16] All of a given company's publicly traded units are grouped for the purposes of this report. For example, "WorldCom" includes MCI and WorldCom, "AOL / Time Warner" includes AOL and Time Warner, etc. "Williams" includes Williams Cos. and Williams Communications Group, due to the Energy company having been the owner of the Communications subsidiary during a portion of the period covered by this report and the continuing close affiliation between the two companies.

[17] Figures for stock and bond losses are based on total net gain / loss from all transactions of the given issuer's stocks and bonds, and / or basis adjustments for bonds, for each insurer.

[18] "Supervisory Standard on Asset Management by Insurance Companies,"International Association of Insurance Supervisors. Approved December 1999

The mismanagement of policyholder premium, however, has been largely ignored as companies simply replenish the dissipated investments through rate hikes.[19] As a result of insurers' increased exposure to corporate risk during this insurance cycle, the impact of corporate fraud on companies and, in turn, policyholders was far greater than should ever have been expected.

Not surprisingly, with the recent rebounding of the stock market, it is becoming evident that insurers wish to start selling more policies in order to gain investment capital. Companies that earlier this year had committed to reducing exposure and refusing to sell insurance are once again entering the market and selling new policies. If the stock market continues this expansion, and especially if interest rates increase, a loosening of the insurance market – a stabilizing and possibly lowering of rates as well as a liberalizing of underwriting practices – is inevitable.

It is not, however, good public policy to allow insurers to foist these economic cycles onto individual consumers and business consumers of insurance by allowing the rating and underwriting chaos that consumers have endured in recent years. Unregulated, or loosely regulated insurance companies will invest recklessly, knowing that the firms can simply pass through their investment mistakes and troubles.

Under this system, individuals and businesses face unnecessary premium volatility as rates follow the investing cycles: when insurers' investment returns are high rates will drop and when investment returns drop, rates increase, and when the stock market, bond market and interest rates all collapse at once rates will skyrocket. Furthermore, without regulatory oversight to enforce more responsible practices, consumers bear much more of the burden of bad economic times than they gain in benefits during the good times.

III. THE INSURANCE INDUSTRY SHOULD BE SUBJECT TO ANTITRUST LAWS

In 1945 the McCarran-Ferguson Act exempted the insurance industry from federal antitrust laws and in subsequent years the insurance industry won antitrust exemptions from virtually every state. As a result, insurer-controlled "rating bureaus" freely distribute proposed pricing data, including projected losses, expenses, profits, and overhead charges, to all insurers who wished to obtain the information, allowing tacit price collusion.

As a result of this exemption, insurers are able to fix rates through the use of advisory rates established by an insurance industry owned organization, the Insurance Services Office (ISO). The ISO projects loss trends, allowing insurers to share data and projections for pricing rather than requiring companies to develop product pricing competitively. As a result of the anti-competitive environment, insurers know that they can price insurance too low when, for example, investment returns are high, because the companies know that the industry can act in concert to raise prices at a future date. Without the antitrust exemption, insurers would need to price more responsibly and based on their actuarial needs because they would not be assured of the higher future prices that collusion allows.

[19] Insurance companies maintain significant surplus, beyond what is reserved to pay losses, that could be tapped to cover claims if there is a shortfall due to failed investments of policyholder premium.

Proposition 103 repealed the insurance industry's exemption from the antitrust laws in California and prohibited the operation of "rating" and "advisory" organizations set up by the industry to circulate pricing and policy information to insurance companies. There is no reason to maintain this exemption from the nation's antitrust laws elsewhere, as there is no reason to provide the industry with anti-competitive tools that allow it to act collusively against the interest of consumers. The antitrust exemption should be repealed.

IV. INSURANCE COMPANIES' LOSS ESTIMATES ARE INFLATED

The insurance industry bases rates on a series of actuarial analyses and calculations. A key data set in these calculations is the incurred losses that insurers report on an annual basis. Incurred losses represent the projected payments a company will make for claims filed in a given year. These projections are based on a combination of the assessed value of those claims that have been filed as well as those that have not yet been filed, but the insurer expects, known as "incurred but not reported" losses. In short, the data reported annually as "incurred losses" are estimates of losses that are meant to be an insurer's best guess as to their liabilities for the year.

The "best guess" data are used to assess a company's financial condition, to develop new rates and, often, the data are used as fodder for legislative efforts to push changes in tort law. FTCR has recently analyzed fifteen years of loss projections in the field of medical malpractice insurance and found that companies dramatically and consistently exaggerate incurred losses initially, only to adjust the losses downward in future years.

According to the data (we have reviewed reported losses since the beginning of the last insurance crisis in 1986), malpractice insurance companies have historically inflated their loss projections and then revised their reported losses downward in subsequent years. The research shows that the "incurred losses" that medical malpractice insurance companies initially report for policies in effect in each of the years examined were, on average, 33% higher than the amount they actually paid out on those policies.

We have also found that insurers' reported losses were significantly inflated during the "insurance crisis" of the late 1980's. In 1989, for example, medical malpractice insurers' loss estimates were overstated by 40%. Based on this investigation, the "incurred loss" data reported by medical malpractice insurers do not represent, or even approximate, the actual losses a company will sustain as a result of claims against its policyholders.

It is, therefore, our view that policymakers must not rely upon the insurance industry's current loss projections, because those figures are not based on hard or otherwise reliable data. In order to protect the public from the abuse of unreliable accounting practices, new regulatory and accounting reforms are needed. Additionally, regulators and law enforcement officials should seek to resolve the outstanding question as to whether insurance companies have simply failed to find accurate tools for projecting losses or are intentionally inflating their reported losses.

A. Incurred Losses vs. Actual Losses

The distinction between "incurred" and actual losses, commonly known as "paid losses," is central to understanding an insurance company's true financial condition and to

evaluate the losses insurers report. It is a distinction insurers do not often make in public debate.

Insurers calculate their rates for a given year based on their "incurred losses" for that year. When insurers say they have an "incurred loss" of a certain amount in a given year, however, they do not mean that they have actually paid out that amount in that year. Rather, they mean that they estimate that they will ultimately pay out that amount on claims they predict they will receive that are covered by policies in effect in that year. In other words "incurred losses" represent projected losses. Thus, if an insurer reports in 2003 that its "incurred losses" for 2002 were $100, the insurer has not paid out $100 for 2002 claims. Rather, the insurer estimates that it will ultimately pay out – over a period of several years – $100 for claims covered by policies in effect in 2002.

An insurer's "incurred losses" are, therefore, by definition, a guess. Statistical and mathematical methodologies have been developed which, using standard actuarial techniques, can be applied to make that guess an educated one. However, absent a regulatory formula that both mandates the use of such techniques and reviews insurers' compliance, insurers have enormous discretion in determining incurred losses.

Each year, the insurer receives more information about the "incurred losses" it had guessed it would ultimately pay for claims covered by policies in effect in a previous year. As time goes on new claims are reported to the insurer, the insurer receives more details about existing claims, and the insurer ultimately pays a specific amount – or no amount – on each claim. As it receives this new information, the insurer adjusts the original guess it made. The more time that elapses, therefore, the less guesswork is involved and the more accurate an estimate for a previous year becomes.

In medical malpractice, the average claim is paid approximately 5 and 1/2 years after the claim arises; most claims are paid within 10 years. An insurer's estimate of its true liability for claims it guesses it has incurred in a given year is therefore substantially accurate after 10 years.

Projecting the number of claims an insurance company must pay out, and the amount of those claims, and setting rates based on these guesses, is inherent in the nature of the insurance business. In exchange for a premium an insurer receives from an insured in the present, the insurer agrees to pay claims against that insured in the future; there is no way for the insurer to know at the time it receives the premium exactly how much it will pay for claims against the insured, nor even whether there will be any claims against that insured at all.

Insurers therefore may not fairly be criticized for estimating their future losses and changing those estimates every year--that is the nature of the business.[20]

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20 Indeed, insurance companies employ their own "statutory accounting principles" (SAP) – a departure from the "generally accepted accounting principles" applicable to all other industries in the United States – in recognition of their need to make loss projections. Under SAP accounting practices, insurers not only report incurred losses to regulators for purposes of justifying rate increases and decreases. They are also permitted to treat incurred losses as real losses for tax purposes. Although the IRS theoretically has the authority to impose penalties for grossly overstated loss reserves, as a practical matter it never imposes such penalties. See, e.g., K. Logue, Toward a Tax-Based Explanation of the Liability Insurance Crisis, 82 Va. L. Rev. 895, 917-18; R. Morais, Discounting the Downtrodden, Forbes, Feb. 25, 1985, at 82-83 ("It is virtually impossible on a case-by-case basis to prove reserve redundancy") (quoting Larry Coleman, analyst for National Association of Insurance Commissioners).

Insurers may fairly be criticized, however, when they mischaracterize these estimates of future losses as actual losses – which they do frequently. For example, the most commonly used measure of success in the insurance industry is the loss ratio: the ratio of an insurer's incurred losses in a given year to its earned premiums in that year. While the earned premium number is a hard number and does not meaningfully change over time, the incurred loss number is a guess. Yet insurers discuss the loss ratio as if each number were a hard number. For example, if an insurer reports a loss ratio for 2002 of, say, 110, it typically characterizes itself as actually paying out $1.10 for each premium dollar it takes in in 2002. The implication is that the company is losing money. In fact, it has not paid out $1.10 in 2002, but only guessed that when a final accounting of 2002 claims is completed years later, it will have paid out $1.10.

For example, here is how the Florida coalition of insurance companies, hospitals and the medical lobby characterize the industry's financial status:

> In 2001, medical liability insurers nationally paid out $1.40 for every $1.00 they received in premiums.[21]

In fact, this dire portrayal is based on incurred losses, and is, by definition, only an estimate of what insurers will pay out in the future. Yet the statement expressly – and falsely -- states that that amount was paid out.

Similarly, the North Carolina Access to Quality Healthcare Coalition discussed North Carolina's medical malpractice incurred loss ratio of 113 for 2001 as follows:

> "In 2001, according to NAIC data, North Carolina professional liability insurers paid $1.13 in claims for every $1 in premiums they received." (Emphasis in original). (Fact sheet, N.C. Access to Quality Healthcare Coalition).

Again, the numbers are referring to incurred losses, and insurers only estimated that they will pay out $1.13. Again, the insurance industry incorrectly states that that amount was paid out.

The description of projections as actual payments is false, and it is a misrepresentation that has misled policymakers, the news media and the public.

The difference between an insurer's initial estimate of its incurred losses for a given year's policies and the amount of its actual losses on that year's policies has important implications for the current medical malpractice insurance debate. This is because the rates an insurer charges for a given year are necessarily based on its incurred loss estimates for claims covered by that year's policies, not on its ultimate paid losses on that year's policies. Thus, if the amount an insurer ultimately pays out for claims covered by a given year's policies is less than the amount the insurer initially estimated it would pay out for claims covered by those policies, the insurer's rate (and the premiums paid by policyholders) for that year would have been too high. Similarly, if the amount the insurer ultimately pays out is more than the amount the insurer initially guessed it would pay out, the insurer's rate for that year would have been too low.

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21 Heal Florida's Health Care, fact sheet available at http://www.healflhealthcare.org/heal_FLhealthcare/homepage.html.

It should be obvious that in a weakened economy such as today's, insurance companies stand to gain by reporting sudden and substantial increases in incurred losses. Such increases are used to justify sudden spikes in premiums, such as those in the current malpractice marketplace. They also provide tax breaks for insurers. And the increased estimates of incurred losses are the foundation of the industry's argument that only by enacting tort reform will premiums go down.

Whether the insurer charged a rate that was too low or too high, and the amount by which that rate was too low or too high, cannot be known with confidence until 10 years after the insured pays the premium. Whether the rates doctors are being charged in 2003 for medical malpractice insurance are too low or too high, therefore, will not be known for certain until 2012.

Unfortunately, there is no opportunity to go back ten years and lower rates that, in hindsight, proved to be too high.

Nor is there any way to retroactively repeal the application of tort law restrictions put in place at the behest of the industry based on loss estimates that turned out to be far in excess of reality.

B. Data Show Companies Overestimated Losses

After 10 years of claims information being reported to insurers and incurred losses being restated, the initial incurred loss estimated for each year from 1986 through 1992 by the medical malpractice insurance industry has proved to be at least 26% overstated. (Except where stated, these figures reflect an analysis of “claims made coverage” a common form of medical malpractice insurance.)

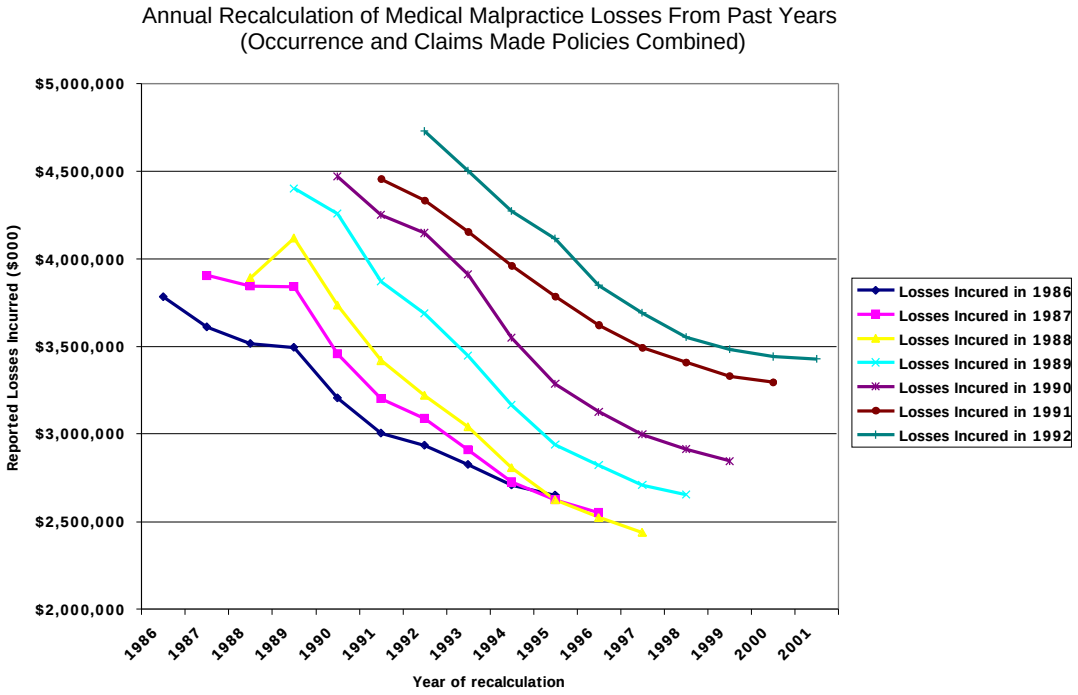
• During the key crisis years – 1986 through 1990 – incurred losses were initially estimated to reach $10.7 billion. Ten years later the reported losses for that period totaled $7.1 billion, meaning that original loss estimates during the crisis were 34% higher than the actual losses reported ten years later.

• The initial incurred loss estimate for 1988 – the apogee of the crisis -- has proved to be 37% overstated.

• In total, for the 7 years 1986 through 1992, malpractice insurers' initial incurred loss estimates were $16.8 billion; they reported incurred losses of $11.6 billion for those years 10 years after the initial estimates, for a total overstatement of $5.2 billion, or 31%.

• Initial incurred loss estimates for “occurrence coverage” policies for the years 1986-92 totaled $12.9 billion, but the reported incurred losses for these years was corrected to $8.3 billion ten years later, a total overstatement of $4.6 billion, or 35%.

The graph below illustrates the change in the combined (occurrence and claims-made policies) incurred losses, as reported by the nation's medical malpractice. providers over the course of ten years. The graph shows that the losses insurers initially reported are far higher than the restated losses that are reported ten years later. Even after revising the original 1988 projections upward in 1989, that year's losses, along with every year's losses, eventually fell precipitously as the incurred loss estimates were refined over time.



The data indicate that medical malpractice insurers overstated their anticipated losses for each of the years analyzed for this study. Additionally, it appears that the losses reported during the insurance crisis of the mid- to late-1980s were more inflated than those of the mid-1990s – although fewer years of restated loss data are available for the mid-1990s.

According to the data (claims made and occurrence policies combined):

- In 1989, medical malpractice insurers announced losses for that year of $4.4 billion; by 1998, that number had been revised downward to $2.7 billion in losses.
- For the years 1986 through 1990, insurers' initial incurred loss estimates were overstated by an average of 36%.
- During the following four years (1991-1994), initial incurred loss estimates appear to have been overstated by 24%.[22]

C. Reported Losses and the Present Crisis

The current crisis is roughly two years old; there is no data to assess the accuracy of the insurers "incurred loss" reports for recent years. In contrast to the previous years' data, because we have fewer than five years of restated incurred loss estimates for each year beginning with 1997, we cannot yet know what the ultimate payouts will be for claims incurred in those years with any reasonable degree of accuracy.

[22] For 1991 and 1992, ten years of incurred loss estimates are available; for 1993, only nine years are available, and for 1993, only eight years are available.

We can, however, examine the recent incurred loss reports to determine whether the insurers have reported a sudden spike in incurred losses, following the pattern of the 1980s crisis.

As revealed in the table below, there is a noteworthy and sudden increase in reported incurred losses between 2000 and 2001, the beginning of the current crisis. After four years during which total malpractice incurred losses hovered between $5.09 to $5.27 billion, the estimate for 2001 jumped 17% to nearly $6 billion.

Initial Incurred Loss Estimate Past Five Years Medical Malpractice (Claims Made and Occurrence Policies Combined)

Year	Insurers' initial estimates of incurred losses for year
1997	$ 5,273,973,000
1998	$ 5,217,410,000
1999	$ 5,093,117,000
2000	$ 5,116,965,000
2001	**$ 5,985,382,000**

Loss inflation during the last insurance crisis – when insurers had multiple motives to show greater losses – was pronounced compared to the years which immediately followed. That said, for those non-crisis years in which at least five but less than 10 years of claims information is now available, insurers' initial incurred loss estimates also appear to be substantially overstated.

As noted, insurance companies have a financial incentive to overstate losses during periods when their investments are performing poorly. By contrast, in periods of economic growth, such as the mid-1990s, insurers seek to maximize their investment income during such periods by lowering prices in order to attract capital and to expand market share. They have nothing to gain by overstating losses at such times; indeed, inflating losses would reduce insurers' authority under state laws to write additional policies.

In view of this data, it is to be expected that insurers' incurred loss estimates for 2001, 2002 and 2003 – and thus their proposed rates for coming years – are inaccurate. We have clear evidence that the malpractice rates insurers charged during the last insurance crisis and the years following it were grossly excessive – by an average of between 31% (for claims-made coverage) and 35% (for occurrence coverage). We should not be surprised to discover in the future that the incurred loss estimates medical malpractice insurers are reporting today, and the resultant rates that companies are charging, have been similarly inflated.

These results should raise a red flag for insurance regulators and lawmakers. The information presented here suggests that the industry's accounting practices are in need of revision, including far greater scrutiny by insurance and financial regulators.

V. LIMITING LIABILITY AND RESTRICTING CONSUMER RIGHTS DOES NOT REDUCE RATES BUT DOES REDUCE THE QUALITY OF THE INSURANCE PRODUCT

The insurance industry, in every state legislature and in Congress, proposes restricting the rights of policyholders or those injured by policyholders as the best way to restrain rates. Rather than regulate insurance companies' actuarial practices, administrative costs and profits, the insurance industry typically calls on government to regulate the ability of consumers to be compensated for an injury. The failure of these proposals is borne out in the data that clearly shows that there is no correlation between rates and legal liability.

The fallacy of the efficacy of tort restrictions lies in the belief that insurers will automatically reduce rates if they are relieved of liability. In fact, without the requirements of regulation, insurers do not and will not reduce rates regardless of whether or not the law limits the rights of policyholders or other claimants.

A. Limits on Third Party Bad Faith Lawsuits Does Not Reduce Insurance Rates

A 1999 study by FTCR found that states that ban injured victims of auto accidents to sue the driver's insurance companies for low-balling or unfairly denying or delaying claims payments actually have faced greater rate increases than states that allow the suits, known as third party bad faith suits. The data directly contradict the insurance industry assertion that banning a third party bad faith cause of action will lower rates.

The insurance industry has suggested that limiting the right to sue brings premiums down and that the converse is also true: allowing such suits raises premiums. Data from the National Association of Insurance Commissioners, however, shows no relationship between the right of third parties to sue and premium levels. According to the study, which reviewed premiums from 1989-1996, California was the only state with a ban on third party suits that saw a reduction in premiums and, other than Pennsylvania, consumers in all states with these tort restrictions saw rate increases of more than 25%, with most states above the national average of 35.8% for this time period. Of course, California was the only state with the regulatory structure of Proposition 103 in place to restrain rates.

According to the data, a limitation on third party bad faith liability has not resulted in lower premiums as insurers promise. A copy of this study is available at http://www.consumerwatchdog.org/insurance/rp/rp000156.pdf.

B. Medical Malpractice Caps Do Not Reduce Insurance Rates

A March 2003 report by FTCR compared the impact on premiums of the tort restrictions of California's Medical injury Compensation Reform Act of 1975 (MICRA) with the regulatory strictures of Proposition 103. The study found that physicians' premiums increased by 450% over the first 13 years with the malpractice caps contained in MICRA and declined after the passage of Proposition 103. A copy of that study is available at http://www.consumerwatchdog.org/healthcare/rp/rp003103.pdf.

Despite the allegation that caps will lower rates, the reality is that even under California's MICRA law insurers have sought major increases in recent years. A major malpractice insurer, SCPIE, has increased rates by 23% since 1999 and the state's largest

medical malpractice insurer, NORCAL Mutual, has increased rates by 26% since 2001. Indeed, during the aforementioned Proposition 103 rate challenge, SCPIE stated that California's strict malpractice caps law did not hold down insurance rates. In written testimony, SCPIE's actuary and Assistant Vice President James Robertson stated:

> "While MICRA was the legislature's attempt at remedying the medical malpractice crisis in California in 1975, it did not substantially reduce the relative risk of medical malpractice insurance in California."

This is not dissimilar to filings by Aetna and St. Paul Companies in the mid-1980s in which the companies refused to lower rates in Florida after that state imposed a liability cap. According to St. Paul Fire & Marine Insurance Company's 1987 filing with the Florida Department of Insurance:

> "The conclusion of the study is that the noneconomic cap of $450,000, joint and several liability on the noneconomic damages, and mandatory structured settlements on losses above $250,000 will produce little or no savings to the tort system as it pertains to medical malpractice."

In short, liability caps reduce an insurers exposure without any mandatory impact on rates, while insurance regulation necessarily impacts rates as it is, by definition, a mechanism for controlling rates.

C. Regulating Rates Not Rights Makes the Difference

Throughout the country, lawmakers have experimented with a host of liability-limiting tools ostensibly imposed to keep rates down. These restrictions, which include the approaches discussed above, as well as no-fault insurance and a variety of others such as periodic payments and elimination of the collateral source rule, fail to restrain rates because they do not address rates. The flaw in the promise of tort restrictions is that it depends upon insurers to reduce rates without requiring the companies to do so. It should be noted that a more important flaw in these programs is the injustice of barring a victim from access to their rights to compensation for their injuries.

The insurance industry presses for tort restrictions with the promise that rates will go down, but the industry never agrees to mandatory rate decreases and regulatory oversight of the companies. The insurance industry has invested millions of dollars to promote the notion that lawsuits are the sole barrier to affordable insurance, yet after the industry successfully shields itself from lawsuits, there is no commensurate rate decrease.

The lesson from decades of legislation restricting victims' and consumers' rights is that the insurance crises keep happening and rates continue to cycle higher and higher unless lawmakers address the real problem by regulating rates.

VI. CONCLUSION

In this testimony we have presented the view that the preeminent public interest in protecting insurance consumers requires that insurance rates and practices are subject to a strong and thorough regulatory regime that promotes accountability.

- First and foremost, insurance companies should be subject to strict prior approval system of rate regulation to ensure that consumers neither pay excessive premiums nor shoulder the unmitigated swings of the insurance cycle. Insurers should be required to justify rates and products (demonstrating, for example, the quality of the coverage to be offered) in advance of placing insurance products in the marketplace. As part of the regulatory process, insurers' books should be subject to an additional layer of regulatory accountability by giving the public an independent right to challenge rate hike proposals and other regulatory actions.

- Insurance companies, which are currently exempt from antitrust laws, are able to collude through the sharing of data in a manner that leaves consumers without a competitive market for insurance products. The industry should be stripped of this unique exemption from the nation's laws against anticompetitive practices.

- Insurance companies use loss projection techniques that are demonstrably inaccurate and possibly intended to inflate companies' apparent losses. These projections, at least for the medical malpractice line of insurance, are consistently higher than the actual losses insurers pay out over time and should be viewed skeptically by insurance regulators. Similarly the data should not be accepted as grounds for changing tort laws.

- The insurance industry alternative to rate regulation, dubbed "tort reform" by insurers, has not achieved its promised goal of reducing insurance rates. Statutory changes that have limited the legal rights of policyholders and insurance claimants over the past thirty years have consistently failed to produce savings specifically because these laws never limit the rates insurers can charge.

Although the insurance industry will argue for deregulation, much in the same way private energy companies argue for deregulation, the path of strict rate regulation and market conduct enforcement will provide the most security in the most fair and public manner for consumers and insurers. As with energy deregulation, in which many of the major firms either filed for bankruptcy or fell to penny-stock status in the wake of deregulation, a move to further undermine or overturn the insurance regulatory regime would be at the peril of consumers and the insurers.

The model for reforming the insurance industry is California's voter-approved ballot initiative Proposition 103. The initiative has produced a stable and competitive insurance market for fifteen years in California, with above average profits for insurers and below average premiums for consumers.

Appendix A

Complete Text of Proposition 103

I. Complete Text Of Proposition 103 As Approved By The California Electors, November 8, 1988

Insurance Rate Reduction and Reform Act

Section 1. Findings and Declaration.

The People of California find and declare as follows:

Enormous increases in the cost of insurance have made it both unaffordable and unavailable to millions of Californians.

The existing laws inadequately protect consumers and allow insurance companies to charge excessive, unjustified and arbitrary rates.

Therefore, the People of California declare that insurance reform is necessary. First, property-casualty insurance rates shall be immediately rolled back to what they were on November 8, 1987, and reduced no less than an additional 20%. Second, automobile insurance rates shall be determined primarily by a driver's safety record and mileage driven. Third, insurance rates shall be maintained at fair levels by requiring insurers to justify all future increases. Finally, the state Insurance Commissioner shall be elected. Insurance companies shall pay a fee to cover the costs of administering these new laws so that this reform will cost taxpayers nothing.

Section 2: Purpose.

The purpose of this chapter is to protect consumers from arbitrary insurance rates and practices, to encourage a competitive insurance marketplace, to provide for an accountable Insurance Commissioner, and to ensure that insurance is fair, available, and affordable for all Californians.

Section 3: Reduction and Control of Insurance Rates.

Article 10, commencing with Section 1861.01 is added to Chapter 9 of Part 2 of Division 1 of the Insurance Code to read:

Insurance Rate Rollback

1861.01.(a) For any coverage for a policy for automobile and any other form of insurance subject to this chapter issued or renewed on or after November 8, 1988, every insurer shall reduce its charges to levels which are at least 20% less than the charges for the same coverage which were in effect on November 8, 1987.

(b) Between November 8, 1988, and November 8, 1989, rates and premiums reduced pursuant to subdivision (a) may be only increased if the commissioner finds, after a hearing, that an insurer is substantially threatened with insolvency.

(c) Commencing November 8, 1989, insurance rates subject to this chapter must be approved by the commissioner prior to their use.

(d) For those who apply for an automobile insurance policy for the first time on or after November 8, 1988, the rate shall be 20% less than the rate which was in effect on November 8, 1987, for similarly situated risks.

(e) Any separate affiliate of an insurer, established on or after November 8, 1987, shall be subject to the provisions of this section and shall reduce its charges to levels which are at least 20% less than the insurer's charges in effect on that date.

Automobile Rates & Good Driver Discount Plan

1861.02. (a) Rates and premiums for an automobile insurance policy, as described in subdivision (a) of Section 660, shall be determined by application of the following factors in decreasing order of importance:

(1) The insured's driving safety record.

(2) The number of miles he or she drives annually.

(3) The number of years of driving experience the insured has had.

(4) Such other factors as the commissioner may adopt by regulation that have a substantial relationship to the risk of loss. The regulations shall set forth the respective weight to be given each factor in determining automobile rates and premiums. Notwithstanding any other provision of law, the use of any criterion without such approval shall constitute unfair discrimination.

(b) (1) Every person who (A) has been licensed to drive a motor vehicle for the previous three years and (B) has had, during that period, not more than one conviction for a moving violation which has not eventually been dismissed shall be qualified to purchase a Good Driver Discount policy from the insurer of his or her choice. An insurer shall not refuse to offer and sell a Good Driver Discount policy to any person who meets the standards of this subdivision. (2) The rate charged for a Good Driver Discount policy shall comply with subdivision (a) and shall be at least 20% below the rate the insured would otherwise have been charged for the same coverage. Rates for Good Driver Discount policies shall be approved pursuant to this article.

(c) The absence of prior automobile insurance coverage, in and of itself, shall not be a criterion for determining eligibility for a Good Driver Discount policy, or generally for automobile rates, premiums, or insurability.

(d) This section shall become operative on November 8, 1989. The commissioner shall adopt regulations implementing this section and insurers may submit applications pursuant to this article which comply with such regulations prior to that date, provided that no such application shall be approved prior to that date.

Prohibition on Unfair Insurance Practices
1861.03 (a) The business of insurance shall be subject to the laws of California applicable to any other business, including, but not limited to, the Unruh Civil Rights Act (Civil Code Sections 51 through 53), and the antitrust and unfair business practices laws (Parts 2 and 3, commencing with section 16600 of Division 7, of the Business and Professions Code).

(b) Nothing in this section shall be construed to prohibit (1) any agreement to collect, compile and disseminate historical data on paid claims or reserves for reported claims, provided such data is contemporaneously transmitted to the commissioner, or (2) participation in any joint arrangement established by statute or the commissioner to assure availability of insurance.

(c) Notwithstanding any other provision of law, a notice of cancellation or non-renewal of a policy for automobile insurance shall be effective only if it is based on one or more of the following reasons: (1) non-payment of premium; (2) fraud or material misrepresentation affecting the policy or insured; (3) a substantial increase in the hazard insured against.

Full Disclosure of Insurance Information
1861.04. (a) Upon request, and for a reasonable fee to cover costs, the commissioner shall provide consumers with a comparison of the rate in effect for each personal line of insurance for every insurer.

Approval of Insurance Rates
1861.05. (a) No rate shall be approved or remain in effect which is excessive, inadequate, unfairly discriminatory or otherwise in violation of this chapter. In considering whether a rate is excessive, inadequate or unfairly discriminatory, no consideration shall be given to the degree of competition and the commissioner shall consider whether the rate mathematically reflects the insurance company's investment income.

(b) Every insurer which desires to change any rate shall file a complete rate application with the commissioner. A complete rate application shall include all data referred to in Sections 1857.7, 1857.9, 1857.15, and 1864 and such other information as the commissioner may require. The applicant shall have the burden of proving that the requested rate change is justified and meets the requirements of this article.

(c) The commissioner shall notify the public of any application by an insurer for a rate change. The application shall be deemed approved sixty days after public notice unless (1) a consumer or his or her representative requests a hearing within forty-five days of public notice and the commissioner grants the hearing, or determines not to grant the hearing and issues written findings in support of that decision, or (2) the commissioner on his or her own motion determines to hold a hearing, or (3) the proposed rate adjustment exceeds 7% of the then applicable rate for personal lines or 15% for commercial lines, in which case the commissioner must hold a hearing upon a timely request.

1861.06. Public notice required by this article shall be made through distribution to the news media and to any member of the public who requests placement on a mailing list for that purpose.

1861.07. All information provided to the commissioner pursuant to this article shall be available for public inspection, and the provisions of Section 6254(d) of the Government Code and Section 1857.9 of the Insurance Code shall not apply thereto.

1861.08. Hearings shall be conducted pursuant to Sections 11500 through 11528 of the Government Code, except that: (a) hearings shall be conducted by administrative law judges for purposes of Sections 11512 and 11517, chosen under Section 11502 or appointed by the commissioner; (b) hearings are commenced by a filing of a Notice in lieu of Sections 11503 and 11504; (c) the commissioner shall adopt, amend or reject a decision only under Section 11517 (c) and (e) and solely on the basis of the record; (d) Section 11513.5 shall apply to the commissioner; (e) discovery shall be liberally construed and disputes determined by the administrative law judge.

1861.09. Judicial review shall be in accordance with Section 1858.6. For purposes of judicial review, a decision to hold a hearing is not a final order or decision; however, a decision not to hold a hearing is final.

Consumer Participation
1861.10. (a) Any person may initiate or intervene in any proceeding permitted or established pursuant to this chapter, challenge any action of the commissioner under this article, and enforce any provision of this article.

(b) The commissioner or a court shall award reasonable advocacy and witness fees and expenses to any person who demonstrates that (1) the person represents the interests of consumers, and, (2) that he or she has made a substantial contribution to the adoption of any order, regulation or decision by the commissioner or a court. Where such advocacy occurs in response to a rate application, the award shall be paid by the applicant.

(c) (1) The commissioner shall require every insurer to enclose notices in every policy or renewal premium bill informing policyholders of the opportunity to join an independent, non- profit corporation which shall advocate the interests of insurance consumers in any forum. This organization shall be established by an interim board of public members designated by the commissioner and operated by individuals who are democratically elected from its membership. The corporation shall proportionately reimburse insurers for any additional costs incurred by insertion of the enclosure, except no postage shall be charged for any enclosure weighing less than 1/3 of an ounce. (2) The commissioner shall by regulation determine the content of the enclosures and other procedures necessary for implementation of this provision. The legislature shall make no appropriation for this subdivision.

Emergency Authority
1861.11. In the event that the commissioner finds that (a) insurers have substantially withdrawn from any insurance market covered by this article, including insurance described by Section 660, and (b) a market assistance plan would not be sufficient to make insurance available, the commissioner shall establish a joint underwriting authority in the manner set forth by Section 11891, without the prior creation of a market assistance plan.

Group Insurance Plans
1861.12. Any insurer may issue any insurance coverage on a group plan, without restriction as to the purpose of the group, occupation or type of group. Group insurance rates shall not be considered to be unfairly discriminatory, if they are averaged broadly among persons insured under the group plan.

Application
1861.13. This article shall apply to all insurance on risks or on operations in this state, except those listed in Section 1851.

Enforcement & Penalties
1861.14. Violations of this article shall be subject to the penalties set forth in Section 1859.1. In addition to the other penalties provided in this chapter, the commissioner may suspend or revoke, in whole or in part, the certificate of authority of any insurer which fails to comply with the provisions of this article.

Section 4. Elected Commissioner

Section 12900 is added to the Insurance Code to read:

(a) The commissioner shall be elected by the People in the same time, place and manner and for the same term as the Governor.

Section 5. Insurance Company Filing Fees
Section 12979 is added to the Insurance Code to read:

Notwithstanding the provisions of Section 12978, the commissioner shall establish a schedule of filing fees to be paid by insurers to cover any administrative or operational costs arising from the provisions of Article 10 (commencing with Section 1861.01) of Chapter 9 of Part 2 of Division 1.

Section 6. Transitional Adjustment of Gross Premiums Tax

Section 12202.1 is added to the Revenue & Taxation Code to read:

Notwithstanding the rate specified by Section 12202, the gross premiums tax rate paid by insurers for any premiums collected between November 8, 1988 and January 1, 1991 shall be adjusted by the Board of Equalization in January of each year so that the gross premium tax revenues collected for each prior calendar year shall be sufficient to compensate for changes in such revenues, if any, including changes in anticipated revenues, arising from this act. In calculating the necessary adjustment, the Board of Equalization shall consider the growth in premiums in the most recent three year period, and the impact of general economic factors including, but not limited to, the inflation and interest rates.

Section 7. Repeal of Existing Law

Sections 1643, 1850, 1850.1, 1850.2, 1850.3, 1852, 1853, 1853.6, 1853.7, 1857.5, 12900, Article 3 (commencing with Section 1854) of Chapter 9 of Part 2 of Division 1, and Article 5 (commencing with Section 750) of Chapter 1 of Part 2 of Division 1, of the Insurance Code are repealed.

Section 8. Technical Matters

(a) This act shall be liberally construed and applied in order to fully promote its underlying purposes.

(b) The provisions of this act shall not be amended by the Legislature except to further its purposes by a statute passed in each house by roll call vote entered in the journal, two-thirds of the membership concurring, or by a statute that becomes effective only when approved by the electorate.

(c) If any provision of this act or the application thereof to any person or circumstances is held invalid, that invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.