

# CRS Report for Congress

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## Medical Malpractice Liability Insurance and the McCarran-Ferguson Act

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### Summary

Volatility in prices and availability of medical malpractice liability insurance and allegations that insurance companies may have colluded in raising current rates are receiving attention from policymakers. In particular, the 108<sup>th</sup> Congress is considering the antitrust exemption for the business of insurance provided under the McCarran-Ferguson Act of 1945. Historically, insurers have relied on the Act's limited exemption from federal antitrust law to engage in cooperative activities that allow them to identify and measure risk, including joint collection, sharing, and analysis of loss cost data, and development of standardized policy forms. Much of the policy debate concerns whether narrowing the exemption from antitrust law would alleviate or aggravate the current problem of high premiums and insurance coverage availability.

On February 11, 2003, Senator Patrick J. Leahy introduced S. 352, the Medical Malpractice Insurance Antitrust Act of 2003, to modify the McCarran-Ferguson Act to ensure that commercial insurers do not engage in anti-competitive rate-making in the medical malpractice insurance market to the detriment of consumers. S. 352 does not address other antitrust laws, but is limited to price-fixing, bid-rigging, and market allocations, and only in connection with the provision of medical malpractice insurance.

This report provides an overview of the current medical malpractice insurance situation and insurance market structure, summarizes the provisions of both S. 352 and the McCarran-Ferguson Act of 1945, and examines arguments for and against modifying the McCarran-Ferguson Act. This report will be updated as developments warrant.

### The Medical Malpractice Insurance Crisis

The U.S. is currently experiencing escalating premiums and reduction in the availability of medical malpractice liability insurance coverage in many states. This problem, however, is not new. During the mid-1970s, and in the mid-1980s, businesses and municipalities experienced sharp price increases and shortages in commercial liability insurance. More recently, physicians, hospitals, and other healthcare providers in a number of states have experienced escalating premium costs and problems of availability.

According to a recent American Medical Association (AMA) survey of 50 states, some 18 states have a serious medical malpractice liability insurance problem.<sup>1</sup> There are a number of alleged causes for the current situation:

- *Litigation* – lawsuits, the rising costs of defending malpractice claims, and excessive jury awards are increasing potential loss severity;
- *The economy* – the “bull” market of the 1990s funded insurers’ market share acquisition and facilitated competition that led to underpricing, and lower returns on investments in a “weak” economy has added to deteriorating financial results;
- *Insurers* – profitability in the medical malpractice insurance line attracted new players seeking revenue growth and the cash flow characteristics of long-term liability lines led to intense price competition and eventual deteriorating financial results; and
- *Physicians* – technological innovations and institutional constraints limited the amount of time doctors spend with patients, and this has contributed to medical errors and more lawsuits.

The search for a solution to the medical malpractice liability insurance problem has been frustrated by a lack of consensus over which suggested causes are more central to the problem, the scarcity and limitations of data, and contradictory results in different empirical studies that seek to examine whether medical malpractice reforms implemented by the states following the liability insurance crises in the 1970s and 1980s have had their intended effects on premiums. At present, however, the medical malpractice insurance debate is focusing on the extent to which instability of the medical malpractice liability insurance market is a result of (1) inherent management problems that are driven by the profitability cycle of the insurance industry, or (2) out-of-control medical litigation, frivolous lawsuits, and high jury awards that have resulted in a dramatic increase in the frequency and severity of paid claims. Both sets of views have strong proponents and very different proposed solutions.

**Profitability Cycle of the Insurance Industry.** Proponents of limiting certain insurance company pricing and accounting practices stress the insurance profitability cycle and the manner in which insurance companies respond to it. They point to “cash flow” characteristics and rising interest rates that attracted new insurers into then-profitable medical malpractice line in the late-1980s and early-1990s. These insurers pursued as much business as they could in order to have more funds to generate investment income. Competition intensified as many insurers were convinced that they could attract only the “good” business at lower prices and make up for any losses with investments that appeared to be steadily rising in value. In this view, competition created an environment of underpricing of the actual risks of the insurance.

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<sup>1</sup> These 18 states are Arkansas, Connecticut, Florida, Georgia, Illinois, Mississippi, Missouri, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, and West Virginia. This survey is available at <http://www.ama-assn.org/ama/pub/article/9255-7341>, visited March 4, 2003.

From this scenario has come the argument that the problems of availability and affordability in the medical malpractice insurance segment are attributable to poor investments and that insurers are now employing certain alleged anti-competitive practices to force premiums up and recover investment as well as insurance losses. These practices, ranging from the methods of setting rates in the industry (i.e., price-fixing) to collectively withdrawing capacity (i.e., restricting supply), are allegedly made possible by the industry's antitrust exemption provided under the McCarran-Ferguson Act of 1945.<sup>2</sup> As a result, some observers have called for a modification of the insurance industry's federal exemption from antitrust laws.

**Medical Litigation.** Another approach that is supported by insurance industry representatives and physician groups is based on the proposition that the current medical malpractice liability insurance crisis is caused by out-of-control medical litigation, frivolous lawsuits, and high jury awards that have resulted in a dramatic increase in paid claim severity – i.e., the average amounts paid in indemnity to plaintiffs on behalf of individual physicians. At the core of the argument is the belief that the tort system functions unevenly and inequitably in resolving medical negligence cases.<sup>3</sup> Medical litigation, they argue, needs a predictable and consistent context. Supporters of this argument view tort reform as the solution, and they want the medical litigation process to be simplified, procedural laws streamlined, incentives to protracted and complicated litigation eliminated, improvements to the courts' case management role with regard to complex multi-party litigation, and the implementation of alternatives to litigation, such as arbitration, mediation, and a no-fault compensation system coupled with medical review boards to regulate quality of care.

Proponents of the "litigation explosion" argument state that medical malpractice insurers do not jointly set rates;<sup>4</sup> thus, they argue, the assertion that insurers benefit from the McCarran-Ferguson's exemption to collude in the setting of rates is simply not correct.<sup>5</sup>

## **Medical Malpractice Liability Insurance Market Structure**

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<sup>2</sup> 15 U.S.C. §§ 1011-1014, P.L. 79-15.

<sup>3</sup> Donald Palmisano, "A Special Medical Liability Monitor Report: Examining Today's Malpractice Problem – The Controversial Search for Solutions," *Medical Liability Monitor*, Aug. 2002, p. 6.

<sup>4</sup> According to the Head Actuary in the Department of Insurance for the District of Columbia, the joint development of rates does not apply to most medical malpractice insurers because these firms tend to rely on their own company's statewide or national loss cost data to support their actuarial estimates and rate request submissions in a state, and do not rely on the loss cost data of other insurers or rating agencies like Insurance Services Office (ISO) to pool historical loss data in order to derive a pure premium. Insurers argue that this is prima facie evidence that medical malpractice insurers do not collude in the setting of rates. (Discussion, February 25, 2003)

<sup>5</sup> For many insurable lines, insurers rely on information from the ISO which pools, forecasts, and make results available to companies at cost for use as they see fit. It does not, however, apply to medical malpractice.

The medical malpractice insurance market consists of three separate types of insurers: (1) traditional commercial multi-line property-casualty insurers that seek to earn profits; (2) hospital-and physician-owned insurers (including multi-state physician malpractice groups like PHICO in Pennsylvania and PIE Medical Mutual in Ohio that started in the mid-1990s and expanded their business outside their state of domicile) that focus on long-term market stability and affordably priced coverage; and (3) alternative risk transfer entities that include self-insurance and pooling, captives, and risk retention groups that provide coverage as a service to their parent organizations. The market in which medical malpractice insurers operate is composed of five separate customer markets: physicians, hospitals, managed care organizations, nursing homes, and allied health care (i.e., non-M.D. practitioners).

To provide an alternative to traditional commercial insurers following the difficult insurance cycles of the 1970s and 1980s, a number of states have created medical malpractice insurance joint underwriting associations (JUA's). A JUA is a private, non-profit consortium of insurers operating under the aegis of state authority that jointly offers coverage to medical practitioners licensed by the state. It is an "insurer of last resort" in that JUAs provide coverage to physicians and other healthcare providers who cannot otherwise obtain coverage. JUAs are designed to be self-supporting through premiums collected and, in the eventuality of a deficit, assessments on any company authorized to underwrite casualty insurance in the state. In states without JUA's, substandard writers or "surplus lines" – insurers that underwrite high-risk physicians at rates commensurate with those risks – often fill the void.

Some states have also established patient compensation funds to provide coverage to physicians in excess of the coverage limits of a malpractice insurance policy. Physicians can be assured that in the event their coverage limits are exceeded, there will be money available for damages in medical liability cases. These funds are administered by the state insurance department; others are administered by a quasi-legislative entity. The fund is financed through fees or surcharges levied on all healthcare providers, but in some states, like New York, the fund receives money from the state budget. Additionally, self-insurance trust funds are often used by large hospitals and health maintenance organizations (HMOs) to self-insure all or part of their risk; and, the Product Liability Risk Retention Act of 1981 was enacted to permit the creation of risk retention groups (a corporate entity) and purchasing groups that provide or obtain liability insurance for the owners of the group. In terms of market share, physicians and hospital captives account for roughly 50% to 60% of the malpractice insurance business, commercial insurers account for 30%, and JUA's and other arrangements account for the remaining 10%.

## **The McCarran-Ferguson Act of 1945**

In 1944, the U.S. Supreme Court reversed itself in the landmark case of *United States v. South-Eastern Underwriting Association*<sup>6</sup> when it held that the sale of insurance across state lines was interstate commerce and therefore subject to the federal antitrust laws. The 1944 decision meant that insurance sales, underwriting, rate-making, and investment practices were subject to federal antitrust laws, and to any other federal laws that conflicted with state insurance regulation. Realizing that appropriate underwriting and risk-assessment for the business of insurance depended upon legitimate joint activities,

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<sup>6</sup>*United States v. South-Eastern Underwriters Association* (322 U.S. 533 (1944)).

such as the collection of industry-wide loss data, residual market mechanisms, and pools for jumbo risks that might have been challenged under federal antitrust laws, Congress enacted the McCarran-Ferguson Act. (The Act did not reference any particular industry segment; it referred generally to the business of insurance.)

The McCarran Act did three things: Section 1 of the Act reaffirmed the power of the states to tax and regulate the business of insurance. Section 2 declared that Acts of Congress, except those specifically relating to the business of insurance, did or would not invalidate state laws regulating or taxing the business of insurance, and that the federal antitrust laws – specifically, the Sherman Act, the Clayton Act, and the Federal Trade Commission Act – did not apply to the business of insurance as long as such business was regulated by state law. Section 3(b) declared, however, that boycotts and acts of coercion or intimidation remained subject to federal antitrust law. Thus, under current law, the regulation of the business of insurance in the United States is carried out at the state level, the business of insurance is substantially exempt from federal antitrust statutes, and collective activities may qualify for an antitrust exemption, but the activity in question must not be an act or agreement to boycott, coerce or intimidate.

## **Medical Malpractice Insurance Antitrust Act of 2003**

On February 11, 2003, Senator Patrick J. Leahy introduced S. 352, the Medical Malpractice Insurance Antitrust Act of 2003, to amend the McCarran-Ferguson Act to ensure that commercial insurers do not engage in anti-competitive rate-making in the medical malpractice insurance market to the detriment of consumers. S. 352 does not address other antitrust laws, but is limited to price-fixing, bid-rigging, and market allocations, and only in connection with the provision of medical malpractice insurance. Some observers are concerned that because S. 352 does not define what activities constitute price-fixing, bid-rigging, and market allocation that would be subject to federal antitrust laws, the bill could bring uncertainty to the state regulatory environment.<sup>7</sup> For example, joint activities by insurers involving insurance “pools”, such as JUAs, joint reinsurance associations, and residual market mechanisms that have developed to address market conditions in some states, might be vulnerable to an antitrust lawsuit.

## **Arguments In Support of Modifying The Act**

Insurance consumer advocacy groups have argued that insurers have taken advantage of the McCarran-Ferguson Act to raise prices and restrict coverage, as well as engage in other anti-competitive activities (except boycotts) that would be considered unlawful in any other industry. When profitability is good, insurers actively compete by lowering rates and expanding coverage in order to increase premium and investment income or retain market share. But, when times are bad, the antitrust exemption allows insurers to collectively raise premiums without fear of prosecution. Legal challenges involving alleged price-fixing by insurers are typically dismissed by the courts because of the industry’s special exemption from the antitrust laws.

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<sup>7</sup> See statement of Lawrence E. Smarr, President of Physician Insurers Association of America, before the U.S. Senate, Judiciary Committee and Health, Education, Labor, and Pensions Committee, “Patient Access Crisis: The Role of Medical Litigation,” 108<sup>th</sup> Congress, 1<sup>st</sup> sess., February 11, 2003.

Supporters of McCarran-Ferguson reform point to congressional testimony relative to the “liability crisis” of the mid-1980s as evidence that the industry’s antitrust exemption has allowed insurers to engage in collusion with respect to rate-making.<sup>8</sup> In 1991 congressional testimony regarding the liability crisis of the mid-1980s, the then-assistant attorney general of New York indicated that insurers had engaged in a wide range of price-fixing schemes, and concluded that “the sharp swings within the industry as a whole were not the result of mere coincidence, but rather evidence of a lockstep mentality and an absence of real competition.” Furthermore, he stated “although there were thousands of insurers in the market, the direction of the market was set by only a few companies...and the smaller insurers followed the price increases and market withdrawals of the largest competitors.” Some Members of Congress have noted that the median market share of the top two medical malpractice writers within a state totals 59.2%, on average, and inferred the continuing relevance of the 1991 statement.<sup>9</sup> They support a modification of the Act to ensure that insurers do not engage in price-fixing, bid-rigging, or market allocation.

## Arguments Against Modifying the Act

Insurance industry representatives and most state regulators oppose modification of the Act, arguing that the factors that precipitated the malpractice insurance crisis – i.e., litigation, the economy, insurers, and physicians – have nothing to do with the industry’s limited exemption from federal antitrust law, and that modifying the Act will not lead to reductions in the price of insurance or an expansion of coverage. If anything, they argue, modifying the Act would only create uncertainty for insurers and regulators about what types of joint activities are permissible. It could, for example, threaten insurers’ ability to pool historical loss cost data, which is necessary to actuarially sound pricing. In addition, they contend disagreements over what price-fixing is and when it is illegal could lead to massive litigation. Regulators note that medical malpractice insurance rates are subject to state prohibitions on excessive, inadequate, or unfairly discriminatory rates. The National Association of Insurance Commissioners (NAIC) has stated that “no state insurance regulator has seen evidence that suggests medical malpractice insurers have engaged or are engaging in price fixing, bid rigging, or market allocation.”<sup>10</sup>

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<sup>8</sup> Statement of George W. Sampson, Assistance Attorney General of the State of New York on behalf of Robert Abrams, Attorney General of New York, before the U.S. House of Representatives, Committee on the Judiciary, Subcommittee on Economics and Commercial Law, “H.R. 9: A Bill to Modify the Antitrust Exemption Applicable to the Business of Insurance,” 102<sup>nd</sup> Congress, 1<sup>st</sup> sess., June 13, 1991, (Washington: GPO, 1991), p. 20.

<sup>9</sup> Blair E. Sanford, “Medical Malpractice: Pain Before the Gain,” *National Underwriter: Property & Casualty/Risk & Benefits Management Edition*, May 6, 2002, p. 22.

<sup>10</sup> In a letter from the National Association of Insurance Commissioners (NAIC) to the Senate Committee on Health, Education, Labor, and Pensions, dated February 7, 2003, as part of a hearing on S. 352.