Health Insurance and Federal Antitrust Law: An Analysis of Recent Congressional Action

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Congress is currently considering several proposals to alter antitrust policy in the health insurance sector, including the Health Insurance Industry Antitrust Enforcement Act of 2009.[1] This legislation would have the effect of altering the McCarran-Ferguson Act's antitrust exemption so that it no longer applies to the business of health insurance. The McCarran-Ferguson Act would remain in effect for other types of insurance (e.g., car insurance or property insurance), thus maintaining a narrowly tailored federal antitrust exemption for certain practices relating to the provision of those types of services.

As the debate over health care reform proposals continues, however, one element of the controversy enjoys broad consensus—that competition in the health insurance and other health care marketplaces is an important element of controlling costs, expanding coverage, and improving quality and services. Yet, the proposed Health Insurance Industry Antitrust Enforcement Act of 2009, if enacted, is unlikely to increase competition or enhance consumer or patient welfare because it is based on a misdiagnosis of the problem—that there is an absence of antitrust and regulatory review of health insurance services. Moreover, the proposal would likely add uncertainty to competition policy in this area, potentially deterring procompetitive insurance practices.

The McCarran-Ferguson Act: History and Key Terms

Historically, the business of insurance was viewed as not falling within interstate commerce and thus was subject to state, not federal, regulation.[2] In 1944, however, the Supreme Court held in *South-Eastern Underwriters Association* that insurance does fall within interstate commerce and was subject to federal regulation, including the federal antitrust laws.[3] In response, in 1945 Congress passed the McCarran-Ferguson Act[4] establishing the states as the primary regulators of insurance and exempting certain insurance practices from federal antitrust laws, including the Sherman Act, Clayton Act, and Federal Trade Commission Act.

Under McCarran-Ferguson, the antitrust exemption is limited to activities that (1) constitute the "business of insurance," (2) are "regulated by State law," and (3) do not constitute an agreement or act "to boycott, coerce, or intimidate."[5] Thus, the activities of companies that provide insurance are not categorically exempt from federal antitrust laws; rather their conduct may be exempt only when meeting each of the three conditions set forth in the Act.

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[1] H.R. 3596, 111th Cong. (2009); S. 1681, 111th Cong. (2009).

[2] Hooper v. California, 155 U.S. 648, 658–59 (1895); Paul v. Virginia, 75 U.S. (1 Wall.) 168 (1868).

[3] United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533 (1944).

[4] 15 U.S.C. §§ 1011–1015.

[5] *Id.* § 1012(b).

The Business of Insurance. The business of insurance does not encompass all activities of insurers. In determining whether conduct constitutes the business of insurance under McCarran-Ferguson, courts consider (1) whether the activity has the effect of transferring a policyholder's risk, (2) whether the activity is an integral part of the policy relationship between insurer and policyholder, and (3) whether the activity is limited to entities within the insurance industry.[6]

A wide range of practices of health insurers do not constitute the business of insurance under this test. For example, health insurance mergers are reviewed by federal antitrust agencies and have been subjected to conditions when the reviewing agency has determined that the merger raised competitive concerns. One of the stranger assertions made with respect to the McCarran-Ferguson Act is that it has played a role with respect to purported consolidation in health insurance markets,[7] which is impossible considering that the exemption has not been applied to insurance mergers.

Even if conduct constitutes the business of insurance and is regulated by state law, the McCarran-Ferguson exemption does not apply to boycotts, coercion, and intimidation.

Bid rigging also has been held not to constitute the business of insurance and thus not within the exemption.[8] Similarly, territorial allocation of Blue Cross Blue Shield-licensees for the marketing and sale of branded health insurance was viewed as not necessarily the business of insurance because it did not directly involve underwriting or risk-spreading activities.[9] Likewise, courts have viewed health insurer reimbursement practices as only indirectly related to risk-spreading. For example, a health insurer's denial of reimbursement for services performed on physician-owned, as opposed to hospital-owned, scanners was held not to constitute the business of insurance.[10]

Regulated by State Law. For the McCarran-Ferguson exemption to apply, there must be regulation by the state in which the challenged conduct is practiced and has impact.[11] The state regulation need not expressly address the challenged conduct. It must, however, reach the conduct. A state law prohibiting unfair competition by insurers and enforceable by the state insurance commission may qualify as state regulation for a range of conduct.

Carve-out for Boycotts, Coercion, and Intimidation. Even if conduct constitutes the business of insurance and is regulated by state law, the McCarran-Ferguson exemption does not apply to boycotts, coercion, and intimidation. For example, the Supreme Court treated the refusal to provide insurance for one type of coverage in order to influence the terms of another type of coverage as a boycott and, thus, conduct not subject to the exemption.[12]

The Proposed Legislation

The Terms of the Pending Bills. H.R. 3596, The Health Insurance Industry Antitrust Enforcement Act of 2009, was introduced in the House and the Senate this past September.[13] According to the sponsors, health insurers "currently enjoy broad antitrust immunity under the McCarran-Ferguson Act" and "this immunity can serve as a shield" for activities that may be detrimental to consumers

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6 Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129 (1982).

7 Health Care For America Now, http://blog.healthcareforamericanow.org/2009/10/15/what-repealing-the-insurer-anti-trust-exemption-would-do/ ("These kinds of market concentrations were caused by years of mergers, mergers that would never have been allowed under normal anti-trust rules.").

8 *In re* Ins. Brokerage Antitrust Litig., 2006 WL 2850607, MDL No. 1663 (D.N.J. Oct. 3, 2006).

9 State of Maryland v. Blue Cross and Blue Shield Ass'n, 620 F. Supp. 907, 917 (D. Md. 1985) (denying motion for summary judgment).

10 Trident Neuro-Imaging Lab. v. Blue Cross & Blue Shield, 568 F. Supp. 1474 (D.S.C. 1983).

11 FTC v. Travelers Health Ass'n, 362 U.S. 293, 299 (1960).

12 Hartford Fire Ins. Co. v. California, 509 U.S. 764 (1993).

13 H.R. 3596, 111th Cong. (2009); S. 1681, 111th Cong. (2009).

and result in higher prices.[14] One of the sponsors' stated objectives in introducing the bill is "to reduce insurance prices for consumers."[15]

H.R. 3596 as proposed, provides that the McCarran-Ferguson Act shall not be construed to permit health insurers or medical malpractice insurers to engage "in any form of price fixing, bid rigging or market allocations in connection with the conduct of the business of providing health insurance coverage . . . or coverage for medical malpractice claims or actions."[16] It contains a carve-out for information gathering and for rate-setting activities of state regulatory agencies.[17] As reported out of the House Judiciary Committee, the bill also included language, from an amendment offered by Representative Lungren "to add safe harbors for collecting and distributing historical loss data, developing a loss development factor, and performing actuarial services that do not involve a restraint of trade."[18]

Another bill, H.R. 3962, the House of Representative's health care reform bill (the Affordable Health Care for America Act), also contains a section entitled "Restoring Application of Antitrust Laws to Health Sector Insurers." This section, which was passed by the House on November 7, would amend McCarran-Ferguson to remove "the business of health insurance or the business of medical malpractice insurance."[19] H.R. 3962 contains carve-outs for insurer collection and distribution of historical loss data, determination of loss development factors, and performance of actuarial services.[20] Thus, those insurance activities would still be evaluated and potentially exempt from federal antitrust law under the McCarran-Ferguson Act, if this bill became law.

Congressional Testimony and Agency Comments. Government agencies and the American Bar Association have provided Congressional testimony on the justifications for and likely impact of any modification to the McCarran-Ferguson exemption for health insurance in response to H.R. 3596. The ABA described the McCarran-Ferguson Act as "a *limited* exemption from the federal antitrust laws."[21] The ABA has taken the position that any repeal should reach all types of insurance, rather than targeting health insurance or malpractice insurance.[22] As stated, the ABA would support the legislation "only if it is amended to provide safe harbors that are procompetitive."[23]

Along with the absence of safe harbors, the ABA also expressed the concern that some of the proposed language prohibiting "price fixing" and "market allocations" could potentially be read

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[14] 155 Cong. Rec. E2,318 (Sept. 17, 2009) (statement of Representative John Conyers, Jr.), *available at* http://www.gpoaccess.gov/crecord; *see also* 155 Cong. Rec. S9,556 (Sept. 17, 2009) (statement of Senator Patrick Leahy) ("As the insurance industry prospers behind its exemption, patients and small businesses suffer."), *available at* http://www.gpoaccess.gov/crecord.

[15] 155 Cong. Rec. E2,318 (Sept. 17, 2009) (statement of Representative John Conyers, Jr.) ("Both the House and Senate today have introduced identical language to reduce insurance prices for consumers."), *available at* http://www.gpoaccess.gov/crecord; *see also* 155 Cong. Rec. S9,556 (Sept. 17, 2009) (statement of Senator Patrick Leahy) ("This bill will prohibit the most egregious anticompetitive conduct . . .—conduct that harms consumers and drives up health care costs."), *available at* http://www.gpoaccess.gov/crecord.

[16] H.R. 3596, 111th Cong. (2009); S. 1681, 111th Cong. (2009).

[17] *Id.*

[18] *See* Health Insurance Industry Antitrust Enforcement Act of 2009, H.R. Rep. No. 111-322 (2009), *available at* http://thomas.loc.gov/cgi-bin/cpquery/?&dbname=cp111&sid=cp111KyE9r&refer=&r_n=hr322.111&item=&sel=TOC_24011&.

[19] H.R. 3962, § 262.

[20] *Id.*

[21] Ilene Knable Gotts, Chair, ABA Section of Antitrust Law, Statement on Behalf of the American Bar Association, Before the Judiciary Committee of the U.S. House of Representatives, Concerning HR 3596, The Health Insurance Industry Antitrust Enforcement Act of 2009 at 3 (Oct. 8, 2009) (emphasis added), *available at* http://www.abanet.org/poladv/letters/antitrust/2009oct8_gottstestimonyh_t.pdf.

[22] *Id.* at 2.

[23] *Id.* at 6.

to condemn activity that would be permissible under federal antitrust law that applies to all other sectors.[24] This language differs from the Sherman Act, and could be read to cover vertical relationships that are often procompetitive. The ABA noted that health insurers "should not be subject to a more rigorous antitrust standard than the rest of American industry."[25]

The Congressional Budget Office (CBO) recently "scored," or provided a cost estimate of, implementation of the Health Insurance Industry Antitrust Enforcement Act of 2009. The CBO's findings are consistent with the ABA's legal analysis that McCarran-Ferguson's antitrust exemption is "limited."[26] Any increase in costs associated with greater federal antitrust enforcement or court proceedings "would not be significant" because "of the small number of cases likely to be affected."[27] Because "state laws already bar the activities that would be prohibited under federal law," any change in premiums charged by health insurers "is likely to be quite small."[28]

The DOJ's Antitrust Division recently shifted its positionon the McCarran-Ferguson exemption. Ten years ago, during the Clinton Administration, the DOJ told Congress that "the McCarran-Ferguson Act does not give insurers leverage."[29] It described the exemption as a "limited" one and explained to Congress that "[w]hen the Division learns about exclusionary or collusive activities among health plans, it carefully reviews them, and if necessary, takes appropriate action."[30] In those situations when a health insurer's dealings with providers are in violation of the antitrust laws, the DOJ stated that, "McCarran provides no obstacle to prosecution of such claims either by the affected providers or by state or federal enforcement agencies."[31] In its statement, the DOJ cited examples of enforcement actions against health insurers to support its conclusion that McCarran-Ferguson is a "limited" exemption.[32]

In contrast to its earlier views, the DOJ recently characterized the exemption as "broad" and "very expansive."[33] The DOJ did not, however, refer to any case law supporting the position that the exemption is broad. Nor did it describe any anticompetitive conduct or practices in the industry that have been authorized or allowed as a result of the exemption. How consumers of health insurance might have been harmed in terms of pricing or quality of services is left unsaid.

To support its view that the exemption is "very broad," the DOJ stated that "premium pricing and market allocation" may "fall within 'the business of insurance.'"[34] It is unclear what "premium pricing" refers to or how it would violate federal antitrust law or otherwise harm consumers. As

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[24] *Id.*

[25] *Id.*

[26] *Id.* at 3.

[27] CBO Cost Estimate, HR 3596, Health Insurance Industry Antitrust Enforcement Act of 2009 at 1, Oct. 23, 2009.

[28] *Id.*

[29] Joel I. Klein, Assistant Att'y Gen., Antitrust Div., U.S. Dep't of Justice, Statement Before House Judiciary Comm. on the Quality Health-Care Coalition Act of 1999 at 4 (June 22, 1999), *available at* http://www.justice.gov/atr/public/testimony/2502.htm.

[30] *Id.*

[31] *Id.*

[32] *Id.* at 3–4.

[33] Christine A. Varney, Assistant Att'y Gen., Antitrust Div, U.S. Dep't of Justice, Statement Before Senate Judiciary Comm. Hearing on Prohibiting Price Fixing and Other Anticompetitive Conduct in the Health Insurance Industry at 2–3 (Oct. 14, 2009) ("It also created a broad antitrust exemption based on state regulation. . . Repeal or reform of the broad antitrust exemption currently enjoyed by the business of insurance has been a perennial subject of interest. . . . It is fair to say that the McCarran-Ferguson Act antitrust exemption is very expansive with regard to anything that can be said to fall within 'the business of insurance,' including premium pricing and market allocation."), *available at* http://www.justice.gov/atr/public/testimony/250917.htm.

[34] *Id.* at 3.

noted before, we think it is unlikely that "market allocation" (or "bid rigging" for that matter) would constitute "the business of insurance" subject to the McCarran-Ferguson exemption. Such market allocation would also be illegal under state antitrust law.[35]

The DOJ stated that "'the most egregiously anticompetitive claims, such as naked agreements fixing price or reducing coverage, are virtually always found immune.'"[36] The statement contained no references to cases, instead citing a treatise that itself refers to a single case involving car insurance.[37] However, the challenged conduct in the car insurance case cited in the Areeda-Hovenkamp treatise qualifies as "egregiously anticompetitive" or "naked agreement[s] fixing price."[38] In that case, insurers formed a standard-setting body establishing guidelines or standards for car insurers when authorizing replacement parts.[39] A private plaintiff filed an antitrust suit challenging the industry standard allowing for use of non-OEM car parts—parts manufactured by a company other than the original equipment manufacturer.[40] The Eleventh Circuit found that these allegations concerned performance of car insurers' duties to policyholders, thus implicating the business of insurance.[41] The court also found that state agencies already regulated the use of non-OEM parts by car insurers and in some situations even required their use.[42]

The proposed legislation serves only to remedy a phantom problem—that health insurance practices have been escaping competition law scrutiny.

Thus, the referenced treatise and case do not support a conclusion that McCarran-Ferguson has authorized anticompetitive conduct in the health care industry. Critics of McCarran-Ferguson have pointed to no court decisions allowing anticompetitive conduct. Nor have they cited actual anticompetitive marketplace behavior by health insurers that has been enabled by McCarran-Ferguson.[43]

Lack of Justification for Legislation

The proposed legislation serves only to remedy a phantom problem—that health insurance practices have been escaping competition law scrutiny. Federal antitrust law, enforced by the federal antitrust authorities and by private plaintiffs, covers a wide array of health insurer practices. Likewise, health insurers have faced close scrutiny under state law.[44] There are no big holes to fill.

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[35] *See, e.g.*, The Donnelly Act, N.Y. Gen. Bus. Law § 340 et seq.

[36] Varney, *supra* note 33, at 3. (quoting PHILIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW ¶ 219d (3d ed. 2009).

[37] AREEDA & HOVENKAMP, *supra* note 36, ¶ 219d.

[38] *Id.*

[39] Gilchrist v. State Farm Mutual Auto. Ins. Co., 390 F.3d 1327, 1330 (11th Cir. 2004).

[40] *Id.* at 1332.

[41] *Id.*

[42] Id. at 1334–35.

[43] Indeed, Iowa Insurance Commissioner Susan Voss wrote that "[t]he notion that McCarran-Ferguson is the cause of high health insurance premiums is not based on fact." *Democrats Push to Strip Insurers of Antitrust Protections*, DES MOINES REGISTER, Oct. 24, 2009, *available at* http://m.desmoinesregister.com/BETTER/news.jsp?key=543981&rc=bn&p=1. Similarly, Colorado Insurance Commissioner Marcy Morrison, recently said she is "'comfortable' that the industry is regulated appropriately and that it's unlikely price-fixing or bid-rigging has taken place." Jennifer Brown, *Health Insurers' Antitrust Exemption Becoming a Focus of Reform Debate*, DENVER POST, Nov. 12, 2009, *available at* http://www.denverpost.com/headlines/ci_13767249.

[44] Thus, in a letter to Congress, the National Association of Insurance Commissioners noted that it was "concerned about statements made at the hearings that seemed to imply that collusion among health insurance or among medical malpractice companies is permitted under state law and that the McCarran-Ferguson Act somehow protects these practices. This is not true. The McCarran-Ferguson antitrust exemption for insurance does not allow or encourage conspiratorial behavior, as some have characterized it. The exemption simply leaves oversight of insurance, including health insurance and medical malpractice insurance, to the states and, as stated earlier, state laws do not allow collusion." Letter of Roger Sevigny, N.H. Ins. Comm'r and President, Nat'l Ass'n of Ins. Comm'rs, to Senator Patrick Leahy and Representative John Conyers, Jr. (Oct. 21, 2009), *available at* http://rsc.tomprice.house.gov/UploadedFiles/McCarran_Final_Letter_Oct_21_2009.pdf [hereinafter NAIC Letter].

Enforcement of Federal Antitrust Law. Proponents of the Health Insurance Industry Antitrust Enforcement Act of 2009 have portrayed McCarran-Ferguson as a broad shield from federal antitrust law, but have not shown that there has been less federal antitrust law enforcement in this industry sector compared to others. It is very difficult to compare federal antitrust law enforcement data by industry sector and draw conclusions about the relative magnitude of enforcement by sector. However, the available information on both federal government enforcement and private enforcement of federal antitrust law suggests extremely active federal antitrust oversight. On top of this, there is relatively intensive state regulatory oversight of health insurers.

Over the years, the DOJ has conducted many antitrust investigations focusing on health insurers. According to a former Assistant Attorney General, the Antitrust Division "carefully scrutinizes mergers and other activities among health plans that may harm consumers."[45] It has challenged health insurer mergers on the grounds that the merger would lead to higher insurance rates.[46] This has included mergers raising concerns of an increase in rates for traditional commercial health plans and for Medicare Advantage plans.[47] It has also challenged health insurer mergers on the grounds that the merger may result in a reduction of prices paid to physicians.[48]

Federal antitrust enforcement in the health insurance industry has also focused on non-merger conduct, such as health insurer contracting. For example, the DOJ has "aggressively challenged contractual provisions imposed by payers on Rhode Island dentists . . . and Cleveland area hospitals."[49] It has noted that health insurer use of most-favored-nation clauses may create disincentives for providers to lower rates.[50] Federal antitrust investigations have also covered the use of "all-product clauses."[51]

While federal antitrust investigations are typically non-public, and data on investigations are unavailable, there are no facts indicating that the DOJ has been less aggressive in investigating health insurers relative to other sectors. The statements of DOJ officials suggest the opposite—that health insurer conduct has been among the highest enforcement priorities.[52]

The McCarran-Ferguson exemption also has not stopped private plaintiffs from enforcing federal antitrust law and bringing lawsuits, including class action lawsuits, against health insurers. In the past five years, private plaintiffs have brought over twenty-five federal antitrust lawsuits against

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[45] Klein, *supra* note 29, at 3.

[46] Complaint, United States v. UnitedHealth Group, Inc. (D.D.C. Feb. 25, 2008); Complaint, United States v. UnitedHealth Group Inc. (D.D.C. Dec. 20, 2005); Complaint, United States v. Aetna Inc. (D.D.C. June 21, 1999).

[47] Complaint, United States v. UnitedHealth Group, Inc. (D.D.C. Feb. 25, 2008); Complaint, United States v. UnitedHealth Group Inc. (D.D.C. Dec. 20, 2005); Complaint, United States v. Aetna Inc. (D.D.C. June 21, 1999).

[48] Complaint, United States v. UnitedHealth Group Inc. (D.D.C. Dec. 20, 2005); Complaint, United States v. Aetna Inc. (D.D.C. June 21, 1999).

[49] Klein, *supra* note 29, at 4.

[50] Press Release, Justice Department Challenges Rhode Island Dental Group's Agreements that Discourage Discounting (Feb. 29, 1996), *available at* http://www.justice.gov/atr/public/press_releases/1996/0556.htm.

[51] Deborah Platt Majoras, Dep. Assistant Att'y Gen., Antitrust Div., U.S. Dep't of Justice, Address to Health Care and Competition Law and Policy Workshop 2 (Sept. 9, 2002), *available at* http://www.justice.gov/atr/public/speeches/200195.pdf.

[52] *See, e.g.*, J. Bruce McDonald, Dep. Assistant Att'y Gen., Antitrust Div., U.S. Dep't of Justice, Before Senate Judiciary Comm., Examining Competition in Group Health Care 2 (Sept. 6, 2006) (referring to health insurer collusion as one of "the kinds of anticompetitive restrictions we are on the lookout for as we monitor health care markets"); Klein, *supra* note 29 ("Thus, federal antitrust enforcement must ensure that neither health insurance plans nor health care professionals utilize anticompetitive means to distort the competitive outcome in the health care industry. The Antitrust Division has been active in pursuing that important role.").

the leading health insurers.[53] This number understates the magnitude of federal antitrust litigation in this sector because it omits cases classified based on a different type of lead claim (e.g., RICO), as well as antitrust counterclaims brought against health insurers.

Enforcement of State Law. The McCarran-Ferguson antitrust exemption explicitly depends upon the regulation of insurance by the states. More precisely, the Sherman, Clayton, and Federal Trade Commission Acts "shall be applicable to the business of insurance to the extent that such business is not regulated by State Law."[54] It is not possible to understand the context of the McCarran-Ferguson exemption without understanding this regulatory scheme. Therefore, it seems fair to ask whether such business is regulated by state law and, if so, in what manner, and to what extent.

The answer is that the business of insurance in general, and of health insurance in particular, is regulated in a manner that is detailed, thorough, and constant.[55] State regulation of health insurers begins with the licensure process, and includes, among other things, ongoing oversight, audits, filing requirements, and solvency standards. State laws and regulations also cover a wide range of health insurer conduct—from what must be covered, to how their networks are formed and maintained, to how their products are priced. These rules often are enforced by the state insurance department, but other state agencies (such as the treasurer, the labor department, the health department, the secretary of state, and the attorney general) also can have oversight responsibilities and enforcement authority.

Any consideration of the relevance of federal and state antitrust laws to state insurance markets must take note of the detailed nature of this regulation.[56] A good example can be found in state regulation of "pricing" in small group markets.[57] Price is a key concern of antitrust law and a vital area of competition in any industry. In health insurance, however, state regulation of premium rates and rating means that competition is not the sole determinant of prices in such markets. States have used a variety of approaches to regulating premiums, including community rating, adjusted community rating, and rate bands. Thus, insurers must charge policyholders the same rate, subject to variations based on certain defined factors, or must set initial premiums within a certain percentage above or below an index.[58] Any antitrust activities in this area must be informed by, and should not undermine, the state's regulatory goals.

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[53] I identified the ten largest health insurers from an industry trade publication. *See* AIS Market Data, Health Plan Enrollment, http://www.aishealth.com (top 25 U.S. health plans by medical enrollment). The source for the federal court lawsuits is LexisNexis Courtlink for the time period 2004 to the current. Lawsuits are classified as antitrust based on the plaintiff's completion of a civil docket sheet form (JS 44) approved by the U.S. Judicial Conference. This form requires plaintiffs to identify the "nature of suit," selecting a single type of suit (e.g., RICO, antitrust, employment, bankruptcy, etc.).

[54] 15 U.S.C. § 1012.

[55] In arguing against current repeal efforts, Iowa Commissioner Susan Voss noted that "all 50 states have rules regulating health insurance carriers, and states require them to justify rates based upon rating factors and experience." She wrote that "[f]or example, in the state of Iowa, there are statutes which specifically outline the rate guidelines and restrictions allowed by health insurance providers." *Democrats Push to Strip Insurers of Antitrust Protections*, *supra* note 43.

[56] The NAIC letter to Congress noted that "insurance companies are different than other businesses in terms of current state oversight. The rates insurance companies charge are typically reviewed by the insurance commissioners, which is very different from other business sectors. If an insurance rate is not justified by claims experience, it is not permitted. As to other business sectors, they set their rates without any oversight." NAIC Letter, *supra* note 44.

[57] Small groups typically consist of 2–50 individuals.

[58] "Community rating" means that each policyholder is charged the same rate, with adjustments only for family size, benefit plan design, and possibly geographic location. "Adjusted community rating" means that no variation is allowed for health status, claims experience, or duration of coverage, but variation is allowed for demographic or other objective factors. "Rating bands" allow the use of health status and claims experience, but limit the impact of such factors to a set percentage above or below an index rate for initial premiums. In addition to renewal of initial rates, many states regulate renewal rate increases.

Health insurance is an industry in which the government, or more precisely various state governments, have made numerous decisions to displace competition with regulation. This complicates the role of antitrust, particularly when the source of the antitrust law is outside of the state scheme.[59] Within the state scheme, however, state antitrust and other law enforcement has been tailored to complement, rather than supplant, state regulatory authority with respect to insurance.[60] For example, Nevada reached a settlement with respect to the United-Sierra merger, imposing additional conditions to those imposed by the DOJ.[61] In the area of conduct, a review of the National Association of Attorneys General Web site reveals a significant number of bid-rigging antitrust cases bought by state attorneys general against insurance companies.[62] In addition, state attorneys general do not limit their activities to antitrust laws per se, but engage in a broader range of oversight of conduct of health and other insurers.[63] Such "enforcement" activities are not limited to state attorneys' general, but can also include state insurance commissioners.[64]

Health insurance is an industry in which the government, or more precisely various state governments, have made numerous decisions to displace competition with regulation.

States do engage in antitrust enforcement and related activities with respect to health insurers. In addition, however, states maintain detailed and reticulated regulatory schemes with respect to health insurers, reflecting, at times, a decision to displace "pure" competition with regulation. As with other industries in which such regulation exists and such a decision has been made, there is a logic to ensuring that antitrust laws and regulatory schemes are not at cross-purposes—logic that is reflected in the McCarran-Ferguson Act itself.

Potential Consequences from Health Care Legislation

Repeal of the McCarran-Ferguson antitrust exemption for health insurance may have unintended consequences. Specifically, repeal may increase legal and regulatory uncertainty and consequently chill interest in, or limit the scope of, new initiatives and activities that could reduce costs, improve quality, and otherwise benefit consumers.[65] While such procompetitive initiatives likely could be pursued even in the absence of McCarran-Ferguson, replacing settled law and policy

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[59] Thus, the NAIC noted to Congress that, "[u]nder McCarran-Ferguson, state regulation of insurance has proven effective and beneficial for consumers. State regulators are more familiar with the activities of the insurance companies they license and are closer to the consumers. They better understand the state-based markets and have the resources to conduct investigations should the need arise. Insurance regulators across the country have the authority to review rates and market conduct and they constantly monitor insurance company practices to ensure state laws are followed and consumers are protected." NAIC Letter, *supra* note 44.

[60] The protection afforded by this complementary scheme was summed up by Colorado Insurance Commissioner Marcy Morrison, who, as noted earlier, said she is "'comfortable' that the industry is regulated appropriately and that it's unlikely price-fixing or bid-rigging has taken place." Brown, *supra* note 43.

[61] Press Release, Nevada Office of Attorney General, Masto Announces Divestiture and $15 Million Charitable Contribution in the Proposed Acquisition of Sierra Health Services, Inc. by United Health Group Incorporated (Feb. 25, 2008), *available at* http://www.naag.org/assets/files/pdf/antitrust.NV.UnitedHealthPressRelease.pdf.

[62] National Association of Attorneys General, Antitrust Press Releases, http://www.naag.org/press_releases.php.

[63] For example, New York Attorney General Andrew Cuomo has a Healthcare Industry Task Force that has focused on various issues related to health insurers. *See* New York Office of the Attorney General, About the Health Care Industry Taskforce, http://www.oag.state.ny.us/bureaus/health_care/HIT2/about.html.

[64] Thus, Pennsylvania's Insurance Commissioner announced plans to examine whether certain health plans violated Pennsylvania's Unfair Trade Practices Act. *See, e.g.*, Bill Toland, *State to Probe Blue Cross, Blue Shield Insurance*, PITTSBURGH POST-GAZETTE, July 18, 2009, *available at* http://www.post-gazette.com/pg/09199/984765-28.stm.

[65] For example, a recent article quoted experts as indicating that "[t]here would be quite a bit of confusion and legal action on the state and federal level as regulators try to figure out who's responsible for regulating what" and that a repeal of the McCarran-Ferguson exemption for health insurance "doesn't seem like it has been thoroughly thought through." Esmé E. Deprez, *Reviving an Old Threat in Health-Insurance Battle*, BUS. WK., Oct. 19, 2009, *available at* http://www.businessweek.com/bwdaily/dnflash/content/oct2009/db20091019_699982.htm.

with uncertain and potentially shifting boundaries of legal analysis and regulatory authority may slow, limit, or unfavorably alter such efforts.[66]

The ABA has recommended adopting certain safe harbors "to serve the important objective of deterring private litigation that might, post-exemption, challenge conduct that, in the unique circumstances of the insurance industry, may actually promote competition."[67] Similarly, even proposed repeal legislation implicitly recognizes the potential for chilling beneficial activities by including carve-outs for the sharing of loss data, an activity that the DOJ suggested could be pursued in the absence of the McCarran-Ferguson exemption.[68]

Current ongoing federal efforts to reform the health care system may create a uniquely inappropriate environment for repealing the McCarran-Ferguson exemption. Two clear by-products of health care reform are change and uncertainty, including new relationships between federal and state regulators, new approaches to the delivery of health care, and new structures for the delivery of health insurance.[69] Until these are settled, the risk of unintended consequences from repeal increases because of the uncertainty about just what health care and health insurance markets will emerge from reform and what types of goals the McCarran-Ferguson exemption would further in such an environment.

While the specific procompetitive activities that the McCarran-Ferguson repeal bills could chill may require a crystal ball, certain areas are more likely to raise concern. The ABA has focused on four specific areas of activities as appropriate for "safe harbor treatment" because of their procompetitive nature. Broadly speaking, those areas relate to: (1) past loss-experience data, (2) standardized policy forms, (3) voluntary joint-underwriting arrangements, and (4) residual market mechanisms.[70] For example, the sharing of past loss-experience data can both make smaller companies more effective competitors and facilitate entry, by providing smaller companies and new entrants data that allow them to price their products appropriately.

Until the dust has settled on health care reform, it is hard to know whether these risks will materialize. I believe that the clearest way to avoid such unintended consequences would be to leave the McCarran-Ferguson exemption in its current form or, at least, to await completion of the current health care reform process to better understand the specific impact of a McCarran-Ferguson repeal for health insurance. A less preferable approach, but one that may have some benefits, could be to empower the federal antitrust agencies to establish "safe harbors" for certain activities by health insurance companies.[71] This may mitigate, but not eliminate, concerns about increased uncertainty and is consistent with an approach the federal agencies have utilized in the

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[66] Depending on the structure of the initiative, and the particular state legal and regulatory environment, the conduct may fall within the protections of the state action doctrine or the conduct may be determined to be procompetitive under rule of reason analysis.

[67] Gotts, *supra* note 21, at 4.

[68] Varney, *supra* note 33, at 5 ("Some forms of joint activity that might have been prohibited under earlier, more restrictive doctrines are now clearly permissible, or at very least analyzed under a rule of reason that takes appropriate account of the circumstances and efficient operation of a particular industry.").

[69] For example, health care reform contemplates new delivery mechanisms, such as exchanges, and a wide range of new rules related to health insurance.

[70] Gotts, *supra* note 21, at 4–5. The ABA also suggests the possibility that Congress may identify other areas appropriate for safe harbor treatment.

[71] *See, e.g.*, S. 618, 110th Cong., *available at* http://www.thomas.gov/cgi-bin/query/z?c110:S.618. (indicating that "[t]he Department of Justice and the Federal Trade Commission may issue joint statements of their antitrust enforcement policies regarding joint activities in the business of insurance").

past with respect to other markets.[72] Finally, safe harbors, which Congress is considering, may make it easier for certain procompetitive proposals to proceed.

Conclusion

The proponents of altering competition law should carry the burden of explaining how existing law has failed consumers, leading to low quality or high prices. However, the proponents of the Health Insurance Industry Antitrust Enforcement Act of 2009 and similar bills have not provided any empirical evidence showing that existing law has led to any anticompetitive outcomes despite over sixty years of experience with the McCarran-Ferguson Act. While there may be many effective methods of reforming health care in our country, this proposed change in antitrust policy should not be undertaken given the absence of sound empirical support. ●

[72] *See, e.g.*, U.S. Department of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care (1996), *available at* http://www.justice.gov/atr/public/guidelines/0000.htm.