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### The Insurance Industry's Antitrust Immunity

Herbert J. Hovenkamp

*University of Pennsylvania Carey Law School*

Author ORCID Identifier:

 [Herbert Hovenkamp 0000-0002-4583-5162](https://orcid.org/0000-0002-4583-5162)

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# THE INSURANCE INDUSTRY'S ANTITRUST IMMUNITY

Herbert Hovenkamp\*

## Introduction

The 1945 McCarran-Ferguson Act provides that federal legislation generally, including the antitrust laws and the Federal Trade Commission (FTC) Act, are “applicable to the business of insurance [only] to the extent that such business is not regulated by State law.”<sup>1</sup> However, federal antitrust law remains fully applicable to insurance “boycotts.”<sup>2</sup> Actions by insurance companies not involving the “business of insurance” are not covered by the exemption. Since 1979 the Supreme Court has severely reduced the immunity by narrowing the definition of “the business of insurance” and broadening the definition of “boycott.” While not reflecting any statutory change, for there has been none, this narrowing does seem to reflect a general view that the immunity had been interpreted too broadly or perhaps even that it has become unnecessary, given the scope of the *Parker* immunity.

The practical questions arising under the insurance statute concern (1) the proper

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\* Ben V. & Dorothy Willie Professor of Law, University of Iowa.

<sup>1</sup>59 Stat. 33 (1945), 61 Stat. 448 (1947), 15 U.S.C. §§1011, 1012. The statute was enacted after *United States v. South Eastern Underwriters Assn.*, 322 U.S. 533 (1944), held that insurance transactions were “interstate commerce” and thus subject to the antitrust laws. That case had in turn undermined the traditional view expressed in *Paul v. Virginia*, 75 U.S. 168, 183 (1868), that insurance was not interstate commerce, but strictly local transactions. The *South Eastern* case followed upon the Supreme Court's decision in *Wickard v. Filburn*, 317 U.S. 111 (1942), which had greatly expanded the reach to relatively local activities of federal statutes passed under the Commerce Clause, and naturally included insurance. On this aspect of the industry's history, see Note, *The Trend of Insurance Regulation*, 35 Geo. L.J. 102 (1946).

By its terms McCarran-Ferguson applies equally to all federal statutes not intended to regulate the insurance industry, including the Federal Trade Commission (FTC) Act. The FTC position that the exemption did not limit its investigatory powers under FTC Act §6 was explicitly rejected by statute. 94 Stat. 375 (1980), 15 U.S.C. §46. But when there is doubt whether activity covered by a subpoena or civil investigative demand is the “business of insurance,” the courts have appeared to give the FTC the benefit of the doubt. *General Finance Corp. v. FTC*, 700 F.2d 366 (7th Cir. 1983); *FTC v. Dixie Finance Co., Inc.*, 695 F.2d 926 (5th Cir. 1983). In *General Finance*, moreover, the court declined to enjoin enforcement at the suit of the insurer, who was left to defend if and when the Commission sought enforcement. Cf. *Highmark, Inc. v. UPMC Health Plan, Inc.*, 276 F.3d 160 (3d Cir. 2001) (McCarran-Ferguson Act does not preempt Lanham Act claim as applied to business of insurance because there is no direct conflict or showing that operation of the federal statute would render enforcement of the state statute ineffective).

Regarding the definition of “state,” see *Arroyo-Melecio v. Puerto Rican American Ins. Co.*, 398 F.3d 56, 66 (1st Cir. 2005) (Puerto Rico is a “state” for purposes of McCarran-Ferguson).

For differing views on the economics of the industry and its susceptibility to anticompetitive practices, see Ian Ayres & Peter Siegelman, *The Economics of the Insurance Antitrust Suits: Toward an Exclusionary Theory*, 63 Tulane L. Rev. 971 (1989); George L. Priest, *The Antitrust Suits and the Public Understanding of Insurance*, 63 Tulane L. Rev. 999 (1989).

<sup>2</sup>59 Stat. 34 (1945), 61 Stat. 448 (1947), 15 U.S.C.A. §1013. See 2 Phillip E. Areeda and Herbert Hovenkamp *Antitrust Law* ¶220 (3d ed. 2006).

definition of the “business of insurance,” particularly in areas such as health care or title insurance, where firms provide both services that serve to spread risk as well as other services or even products that do not; (2) the scope or intensity of state regulation that is sufficient to invoke the exemption; and (3) the scope of the “boycott” exception.

The insurance exemption is said to depend upon the state statute's general regulation of pricing or conduct, not “on the zeal and efficiency displayed by a state in enforcing its laws.”<sup>4</sup> The exemption has been applied when the general language of the state statute was sufficient to embrace the conduct charged in the antitrust complaint without regard to specific statutory language or administrative practice approving the challenged conduct.<sup>5</sup> But mergers have been subjected to federal law when the state statute did not address itself to mergers as such.<sup>6</sup> And federal law remained fully applicable against an insurance firm whose conduct is regulated by its home state but not by the other states that felt the impact of the firm's allegedly false practices.<sup>7</sup>

### The “Business of insurance.”

#### *Insurer Agreements with Providers of Goods or Services*

Under the McCarran-Ferguson Act, the antitrust laws and Federal Trade Commission Act are inapplicable to activities constituting the “business of insurance”—but only “to the extent that such business is not regulated by State law,” and provided that the challenged activity is not “boycott, coercion, or intimidation.”

In *Royal Drug*<sup>8</sup> and later in *Pireno*<sup>9</sup> the Supreme Court identified three criteria for determining whether a practice is part of the “business of insurance”:

*first*, whether the practice has the effect of transferring or spreading a policy holder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured, and *third*, whether the practice is limited to entities within the insurance industry. None of these criteria is necessarily determinative in itself....<sup>10</sup>

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<sup>4</sup>*Lawyers Title Co. v. St. Paul Title Ins. Corp.*, 526 F.2d 795 (8th Cir. 1975). See also *Seasongood v. K & K Ins. Agency*, 548 F.2d 729 (8th Cir. 1977) (dicta: exemption independent of state's effectiveness in regulation or provision of private remedy).

<sup>5</sup>E.g., *Dexter v. Equitable Life Assurance Society*, 527 F.2d 233 (2d Cir. 1975) (alleged tying of creditor life insurance to mortgage lending).

<sup>6</sup>*United States v. Chicago Title & Trust Co.*, 242 F. Supp. 56 (N.D. Ill. 1965); *Maryland Cas. Co. v. American Gen. Ins. Co.*, 232 F. Supp. 620 (D.D.C. 1964).

<sup>7</sup>*FTC v. Travelers Health Assn.*, 362 U.S. 293 (1960) (respondent's home state regulation may not take “from the residents of every other state the protection of the Federal Trade Commission Act”). Compare *FTC v. National Casualty Co.*, 357 U.S. 560 (1958) (prohibiting the FTC from regulating unfair and deceptive insurance practices within states that already regulate such practices).

<sup>8</sup>*Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979).

<sup>9</sup>*Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982).

<sup>10</sup>*Id.* at 129.

These criteria are more easily applied to some situations than to others. For example, the district court in the *Insurance* case had no difficulty concluding that reinsurance as well as primary insurance was part of the “business of insurance.”<sup>11</sup> Reinsurance is insurance that primary insurers purchase in order to even out their own risks. Accordingly, the Supreme Court agreed that alleged agreements between reinsurers and primary insurers not to cover certain risks and agreements among insurers not to provide statistical data covering certain risks both fell within the “business of insurance.”

The Court noted that the “business of insurance” refers to a set of *activities* (including reinsurance) rather than to the entities so acting.<sup>12</sup> For that reason, the Supreme Court disagreed with the Ninth Circuit and concluded that these agreements remained exempt even if the agreeing parties included nonexempt parties. The lower court had held the foreign insurers nonexempt on the ground that they fell outside the state's regulatory jurisdiction.<sup>13</sup> It had relied on the Supreme Court's *Royal Drug* statement that “an exempt entity forfeits antitrust exemption by acting in concert with nonexempt parties.”<sup>14</sup> However, this statement and the earlier cases decided under the Capper-Volstead Act, upon which the *Royal Drug* Court relied,<sup>15</sup> referred to exempt *entities*, not to exempt activities:

The agreements that insurance companies made with “parties wholly outside the insurance industry,” we noted, such as the retail pharmacists involved in *Royal Drug Co.* itself, or “automobile body repair shops or landlords,”...are unlikely to be about anything that could be called “the business of insurance,” as distinct from the broader “business of insurance companies.” The alleged agreements at issue in the instant case, of course, are entirely different; the foreign reinsurers are hardly “wholly outside the insurance industry,” and respondents do not contest the Court of Appeals's holding that the agreements concern “the business of insurance.”<sup>17</sup>

Under these criteria an insurer's agreement with a reinsurer would fall inside the

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<sup>11</sup>*Insurance Antitrust Litig.*, 723 F. Supp. 464 (N.D. Cal. 1989), rev'd on other grounds, 938 F.2d 919 (9th Cir. 1991), rev'd in part and remanded sub nom. *Hartford Fire Ins. Co. v. California*, 509 U.S. 764 (1993).

<sup>12</sup>The Court noted:

The activities in question here, of course, are alleged to violate federal law, and it might be tempting to think that unlawful acts are implicitly excluded from “the business of insurance.” Yet §2(b)'s grant of immunity assumes that acts which, but for that grant, would violate the Sherman Act, the Clayton Act, or the Federal Trade Commission Act, are part of “the business of insurance.”

509 U.S. at 783 n.10.

<sup>13</sup>509 U.S. at 782-783.

<sup>14</sup>*Ibid.*, referring to *Royal Drug*, 440 U.S. at 231.

<sup>15</sup>7 U.S.C. §291. See 1A Antitrust Law ¶249a.

<sup>17</sup>509 U.S. at 783-784.

exemption even if the reinsurer were a firm geographically outside McCarran-Ferguson's jurisdiction; the same would likely be true of a loss data collection agency or equivalent insurance service firm.

By contrast, an auto insurer's arrangement with repair shops would enjoy no McCarran exemption—not because the repairers are nonexempt under the statute, but because the provision of repair services is not the “business of insurance.” In the *Hartford* case, the reinsurance contracts spread risk between primary and secondary insurers—a purpose central to the “business of insurance” as traditionally defined. Concluding that the primary insurers did not lose their exemption simply by conspiring with the reinsurers, even if the latter were not themselves exempt, the Court had no occasion to decide whether the reinsurers were regulated by state law.<sup>18</sup>

In *Royal Drug* a divided Supreme Court emphasized that “the business of insurance” does not fully embrace “the business of insurers.” In particular, the Court held that a health insurer's agreement with pharmacies on the charges for filling patients' prescriptions—a so-called “provider agreement”—was not the business of insurance, which the Court defined as “underwriting” or “risk spreading” and as centered on the relationship between insurer and insured.<sup>20</sup> To be sure, the provider agreement was related to the insurer's performance of its duties to subscribers, to the insurer's drug costs and thus to its risk exposure, and to premiums charged. The majority was unimpressed by these points, which it viewed as equally applicable to an insurer's dealings with employees or banks; the latter were surely not “the business of insurance.” Provider agreements do not spread risk.<sup>21</sup> The majority even noted, without approval or disapproval, some old lower court decisions that doubted that health plans constituted insurance at all and analoged them to cooperative purchases of medical services.

The four dissenters made a strong case. (1) Of course, the subscriber views its medical plan as insurance protection against serious illness. Policy holders hardly regard themselves as cooperative buyers of medical services that they foresee using constantly. Everyone understands that risks are being pooled. (2) Admitting the parallel between insurer agreements with providers and with banks or employees, the dissenters correctly emphasize the distinction of degree. One may appropriately be regarded as “the business of insurance” without the other being so treated. (3) The

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<sup>18</sup>That question was to be considered on remand. 509 U.S. at 784 n.12. Because the foreign reinsurers were themselves defendants, the McCarran-Ferguson Act protected them only to the extent that their reinsurance business is “regulated by the states.”

<sup>20</sup>Compare *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969) (The “core of the ‘business of insurance’” for purposes of McCarran-Ferguson is “the relationship between the insurance company and the policy-holder”).

<sup>21</sup>Of course, literally, they do. Risk is a function of both the probability that something will occur and of its costs should it occur. An insurance company that is able to procure drugs or medical services more cheaply may not be reducing the probability that such drugs or services will be needed, but it is certainly reducing their cost and thus the overall risk exposure.

One must also distinguish between per unit and “capitized” provisions. For example, if a firm agrees to provide medical services not on a fee-for-service basis, but rather at a rate of \$X per person per month, then it is significantly engaged in risk spreading.

provider agreements contribute significantly to defining the drug risk insured against, thus enabling drugs to be acquired at a lower cost. There is therefore a substantial connection to the underwriting function. (4) Granted that the insurer-insured relationship is an important aspect of the “insurance” idea, it cannot be indispensable.

The majority acknowledged that certain agreements between insurance companies are immunized and therefore must be “the business of insurance” although not between insurer and insured. Such agreements may bear on the insurer-insured relationship, but so does the provider agreement. Furthermore, the majority conceded that the insurer-agent relationship was the focus of the statute’s “boycott” qualification; the existence of that qualification implies that the statutory drafters assumed that the insurer-agent relationship was otherwise immune as “the business of insurance.” (5) Finally, and perhaps most important, “rather than use the technical term ‘underwriting’ to express its meaning, Congress chose ‘the business of insurance,’ a common-sense term connoting not only risk underwriting, but contracts closely related thereto.”<sup>22</sup>

Most subsequent cases simply hold that agreements between insurers and service or goods providers are not immune.<sup>23</sup> But, significantly, once the courts are forced by the absence of immunity to consider the merits, the provider agreements challenged are almost always held lawful under the antitrust laws.<sup>24</sup> Most of these agreements are vertical arrangements not involving regulation of resale prices and thus face lenient

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<sup>22</sup>*Royal Drug*, 440 U.S. at 247.

<sup>23</sup>*Brillhart v. Mutual Med. Ins., Inc.*, 768 F.2d 196, 200 n.3 (7th Cir. 1985) (provider agreement between insurer and physicians; latter agreed to provide medical services to subscribers at price to be determined by insurance company); *St. Bernard Hosp. v. Hospital Serv. Assn., Inc.*, 618 F.2d 1140 (5th Cir. 1980) (contract limiting reimbursement of plaintiff for-profit hospital to average charges of nonprofit hospitals); *Liberty Glass Co. v. Allstate Ins. Co.*, 607 F.2d 135 (5th Cir. 1979) (auto glass repairer challenged insurer’s cost-control arrangements involving other repairers); *Hoffman v. Delta Dental Plan of Minn.*, 517 F. Supp. 564 (D. Minn. 1981) (dental insurance plan created by dentists providing for payment differential between participating and nonparticipating dentists); *National Gerimedical Hosp. & Gerontology Center v. Blue Cross (Kansas City)*, 479 F. Supp. 1012 (W.D. Mo. 1979), ultimately reversed on other grounds, 452 U.S. 378 (1981) (limiting subscribers to 80 percent reimbursement because need for plaintiff hospital not demonstrated); *Arizona v. Maricopa County Med. Socy.*, 1979-1 Trade Cas. ¶62,694 (D. Ariz.), aff’d on other grounds, 643 F.2d 553 (9th Cir. 1980), rev’d on other grounds, 457 U.S. 332 (1982) (agreements among doctors and health plans setting maximum fees; in holding that the maximum price-fixing arrangement at issue was unlawful per se, the Supreme Court implicitly approved the lower court’s conclusion that the arrangement was not immune “business of insurance.”).

<sup>24</sup>E.g., *Royal Drug* on remand, 737 F.2d 1433 (5th Cir. 1984); *Brillhart* case, supra; *Nationwide Mut. Ins. Co. v. Automotive Serv. Councils, Inc.*, 490 F. Supp. 282 (D. Del. 1980) (insurer recommends “preferred” body shops that have demonstrated their willingness to accept insurer’s calculation of reasonable charges as full payment for their work and guarantees customers using those shops that they need pay nothing out of pocket beyond any relevant deductible); *Sausalito Pharmacy, Inc. v. Blue Shield (Cal.)*, 544 F. Supp. 230 (N.D. Cal. 1981), aff’d, 677 F.2d 47 (9th Cir.), cert. denied, 459 U.S. 1016 (1982) (analyzing and rejecting antitrust challenges to provider arrangements of the sort involved in *Royal Drug*); *Human Resources Inst., Inc. v. Blue Cross (Va.)*, 484 F. Supp. 520 (E.D. Va. 1980). See *Proctor v. State Farm Mut. Auto. Ins. Co.*, 675 F.2d 308, 317, 336-339 (D.C. Cir.), cert. denied, 459 U.S. 839 (1982) (rejecting district court conclusion that vertical agreements between insurers and auto repair shops were “business of insurance,” but affirming alternative holding of no antitrust violation).

antitrust treatment.<sup>25</sup> The relatively rare exception is the horizontal agreement among providers that may amount to per se unlawful price fixing or agreement on terms.<sup>26</sup>

Several other courts, limiting *Royal Drug*, have held that the “business of insurance” does embrace such things as (1) a health insurer’s direct provision of services to the insured, (2) an auto insurer’s unilateral recommendation of certain repair facilities observing customary charges, and (3) an alleged horizontal agreement among insurers concerning their respective arrangements with providers. These courts read *Royal Drug* as limited to agreements between the insurer and providers.

Thus, *Klamath-Lake* held that a health insurer’s operation of a pharmacy, in contrast to its arrangement for procurement of drugs from others for its insureds, was the business of insurance.<sup>27</sup> Patients there had the option of having prescriptions filled by the insurer’s pharmacy at a specified \$1 or \$2 charge or having them filled elsewhere with 80 percent reimbursed by the insurer beyond a \$50 deductible. The arrangement involved only the insurer and its insureds, and it “settles the distribution of the risk that insureds will need medical goods and services, including prescription drugs.” The court thus seemed to think that directly providing drugs at its own pharmacy defined the insurer’s risk, transferring or spreading a policy holder’s risk more than the *Royal Drug* plan, which “merely” reduced the insurer’s costs. More significantly, the \$1 or \$2 charge, which presumably did not come close to covering the drugs’ cost, entailed that the drugs were priced through premiums, and thus that the insurer’s risk spreading extended to the provision of the drugs as well as the coverage of medical services.

In *Ocean State* the First Circuit held Blue Cross’s adoption of a (HMO) health maintenance organization like plan to be part of the “business of insurance.”<sup>29</sup> The plan paid only for services provided by participating physicians and covered such things as drugs and office visits. In addition, Blue Cross followed a policy of not paying a physician any more for a procedure than that physician was currently accepting from another HMO. Finally, Blue Cross was heavily involved in marketing its HMO plan and priced it aggressively so as to compete with other HMOs. As the court noted, a prepaid health care system—even one in which the offeror participates heavily in the provision of services—is nonetheless a risk-spreading device. Since the policy itself was part of the business of insurance, the marketing of the policy qualified as well.

In *Proctor*, an auto insurer was immunized for allegedly agreeing with other insurers to recommend certain auto repair shops observing customary and reasonable charges, while warning insureds that the company would only reimburse the reasonable part of charges by other shops.<sup>30</sup> But the court did not classify as the “business of insurance”

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<sup>25</sup>See 8 Phillip E. Areeda & Herbert Hovenkamp, *Antitrust Law*, ch. 16D (3d ed. 2010).

<sup>26</sup>E.g., *Maricopa*.

<sup>27</sup>*Klamath-Lake Pharmaceutical Assn., v. Klamath Med. Serv. Bureau*, 701 F.2d 1276 (9th Cir. 1983), cert. denied, 464 U.S. 822 (1983).

<sup>29</sup>*Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I.*, 883 F.2d 1101 (1st Cir. 1989), cert. denied, 494 U.S. 1027 (1990).

<sup>30</sup>See also *Quality Auto Body, Inc. v. Allstate Ins. Co.*, 660 F.2d 1195 (7th Cir. 1981), cert. denied, 455 U.S. 1020 (1982) (similar); *Workman v. State Farm Mut. Auto. Ins. Co.*, 520 F. Supp. 610 (N.D. Cal. 1981) (similar). The issue also arises in the distinct context of agreements on the quality of automobile

the alleged vertical agreements between individual insurers and body repair shops on the maximum prices that the shops would charge.<sup>31</sup> This is consistent with the *Ocean State* conclusion that a health insurer's cap on physician reimbursement does not fall within the business of insurance, but that it is not a violation in any event.<sup>32</sup> Of course, one might distinguish for antitrust purposes a health insurer's unilaterally announced maximum reimbursement policy and an auto insurer's "agreement" with body shops about maximum charges, but that question goes to the merits of the antitrust complaint rather than the practice's status as a risk reduction device.<sup>33</sup>

*Proctor* also emphasized that the McCarran-Ferguson immunity was centered on horizontal agreements among insurance companies and therefore held that an alleged agreement among auto insurers concerning their provider arrangements was "the business of insurance." The *Proctor* court did not specify whether the horizontal agreement in question concerned the contents and terms of their respective insurer-insured agreements or whether it concerned the terms on which the insurers would deal with providers in order to implement their several insurance policies. If insurer-provider agreements are not at the core of the insurance relationship, as *Royal Drug* held, it seems doubtful that the horizontal agreement concerned with such vertical arrangements can be the business of insurance. Incidentally, only the last situation involved a reasonably arguable antitrust violation; even without an exemption for the business of insurance, the first two situations do not seem to present any antitrust violation at all.

#### Peer Review

Another effort at cost control is "peer review," by which an insurer seeks the advice of a panel of providers on the reasonableness of the charges or services given by a particular provider. The insurer is usually obligated to reimburse subscribers only a "reasonable" amount for the services of a physician or other provider. Of course, it is often difficult to determine what is reasonable under the circumstances, and so it is understandable that insurers have sometimes turned to a panel of experienced

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replacement parts, which the Eleventh Circuit interpreted as involving interpretation of the insurance contract, which is the "business of insurance."

<sup>31</sup> *Proctor v. State Farm Mut. Auto. Ins. Co.*, 675 F.2d 308, 317, 336-339 (D.C. Cir.), cert. denied, 459 U.S. 839 (1982)

<sup>32</sup> *Ocean State*, 883 F.2d at 1110 (agreement with physicians that they would not charge more than specified amount is not "business of insurance" but not an antitrust violation either).

<sup>33</sup> In any event, even the agreement with body shops stipulating maximum prices is not per se unlawful resale price maintenance, for nothing is being resold. See 8 Antitrust Law ¶1622b. See also *Insurance Brokerage Antitrust Litigation*, 2006 WL 2850607, 2006-2 Trade Cas. ¶75,456 (D.N.J. Oct. 3, 2006) (alleged payments by insurance companies to brokers that were above the usual brokerage payments and denominated "bid-rigging" and "steering" were not part of the "business of insurance"; although these practices take place within the insurance industry, they do not seem to be related to the undertaking or transfer of risk). Cf. *Genord v. Blue Cross and Blue Shield of Michigan*, 440 F.3d 802 (6th Cir. 2006), cert. denied, 549 U.S. 1030 (2006) (RICO claim with no antitrust issues; Michigan statute that regulated physician reimbursement agreements was not intended to regulate the business of insurance and thus did not create a McCarran preemption).

providers for advice.

This was the issue in the *Pireno* case.<sup>34</sup> Because insurers and their medical advisors were frequently unfamiliar with chiropractic services and therefore found it difficult to determine whether the services rendered and fees charged insurance claimants were “usual, customary, and reasonable,” the New York State Chiropractic Association established a peer review committee. When the insurer requested, the committee gave its opinion on the reasonableness of a chiropractor’s treatment and charges in a given case based on information supplied by the treating chiropractor. Although the committee procedure was used primarily by insurers, it was also available to patients, government agencies, and chiropractors themselves. The plaintiff had been the subject of a number of peer review proceedings, and he challenged the arrangement as a violation of the antitrust laws. The defendant stated that the plaintiff treated his patients in a manner calculated to maximize the number of treatments and that his fees were unusually high. The plaintiff contended that he used innovative procedures and that the committee was protecting antiquated techniques. The trial court found that the peer review procedure was immunized as the business of insurance and was not a boycott. The Second Circuit reversed, holding that peer review does not involve the business of insurance.<sup>35</sup>

The Supreme Court affirmed. It found that

[the] peer review arrangement is logically and temporally unconnected to the transfer of risk accomplished by ULL’s insurance policies. The transfer of risk from insured to insurer is effected by means of the contract between the parties—the insurance policy—and that transfer is complete at the time the contract is entered....If the policy limits coverage to “necessary” treatments and “reasonable” charges for them, then that limitation is the measure of the risk that has actually been transferred to the insurer....Petitioner’s argument contains the unspoken premise that the transfer of risk from an insured to his insurer actually takes place not when the contract between those parties is completed, but rather only when the insured’s claim is settled. This premise is contrary to the fundamental principle of insurance that the insurance policy defines the scope of risk assumed by the insurer from the insured.<sup>36</sup>

Once again, one could dispute the Court’s conclusions. When the policy covers only “reasonable” charges, “reasonableness” must be defined for a specific event that necessarily occurs while the policy is in effect—that is, after it has been issued and at the time the claim is made. Determining whether a provider’s charge is reasonable is no

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<sup>34</sup>*Pireno v. New York State Chiropractic Assn.*, 458 U.S. 119 (1982).

<sup>35</sup>See 458 U.S. at 130-132.

<sup>36</sup>*Id.* at 129-131. Post-*Pireno* courts finding peer review outside the “business of insurance” include *Ratino v. Medical Serv. of the Dist. of Columbia*, 718 F.2d 1260 (4th Cir. 1983) (instant peer review arrangement “indistinguishable” from *Pireno*; provider agreement similar to that in *Royal Drug*). The decision overruled *Bartholomew v. Virginia Chiropractors Assn.*, 612 F.2d 812 (4th Cir. 1979), cert. denied, 446 U.S. 938 (1980).

different in principle from determining whether an insured's claim is reasonable under the circumstances—perhaps because he exaggerated the loss or suffered no insured loss at all.

In any event, the exemption question in many such cases is largely mooted by the absence of any cognizable antitrust violation on the part of the insurance company. The insurer is not a competitor of the person being reviewed; rather, it stands in a vertical relationship. As a result, the insurer would ordinarily prefer physicians supplying better service and lower prices and would not be expected to conspire with peer reviewers to exclude a price-cutting rival. By contrast, if the provider being reviewed is behaving in a substandard, fraudulent, or other improper way, then disciplining him is in the interest of both the reviewers and the insurer. Of course, even vertically related firms have an interest in not paying when they can avoid doing so, and unreasonableness might attach to insurers' *collective* and unreasonable refusal to pay for a novel or untested procedure—effectively, a horizontal agreement to reduce the amount of insurance coverage.

### *Non-physician Limitations*

Several cases have challenged health insurance policies that either excluded patient reimbursement for the service of non-physicians such as chiropractors, podiatrists, or psychologists; or (2) limited such reimbursement to those services sought on the advice of a physician and billed through the physician. The *Virginia Academy* decision denied an insurance exemption.<sup>37</sup> The Fourth Circuit acknowledged that an outright refusal to cover treatment for mental and nervous disorders “might” constitute “an insurance decision—the refusal to underwrite a specific risk.”<sup>38</sup> But once the insurer covered such disorders, its risk-underwriting function was exhausted. Thereafter, the only issue was whether the insurer would make payments for such treatment to psychiatrists alone or to psychologists as well. At that point, for the Fourth Circuit, the insurer's decision was analogous to the non-immune provider agreements of *Royal Drug*—a mere matter of “cost savings obtained by using specific providers....”<sup>39</sup>

The distinction drawn in *Virginia Academy* seems very strained indeed. The nature of the risk insured against is not determined solely by the specification of the ailment (mental disorders) but also by the range of therapists whose services are to be reimbursed—psychiatrists, psychologists, social workers, lay advisors, ministers, phrenologists, etc. The risk insured against cannot be separated from the specification of the professions whose services the insurance policy covers. For these reasons, *Health Care Equalization* held that a health insurer's decision not to cover chiropractic

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<sup>37</sup>*Virginia Academy of Clinical Psychologists v. Blue Shield (Va.)*, 624 F.2d 476 (4th Cir. 1980), cert. denied, 450 U.S. 916 (1981).

<sup>38</sup>*Id.* at 484.

<sup>39</sup>*Id.* The Ninth Circuit has agreed. *Hahn v. Oregon Physicians' Serv.*, 689 F.2d 840 (9th Cir. 1982), cert. denied, 462 U.S. 1133 (1983) (health plan's requirement that insureds receive podiatric services only from medical doctors, refusal to reimburse insureds for podiatric treatments unless visit had been referred by participating physician, and denial of podiatrist's request for membership in the plan were not “business of insurance”).

services was part of the “business of insurance.”<sup>40</sup>

To be sure, the same might be said in *Royal Drug*, as indeed the dissenters argued. However, to accept the majority's characterization of provider agreements with particular drugstores as a mere “cost cutting” arrangement does not dictate that an insurance policy's specification of reimbursable disciplines be treated in the same way. Rather, such limitations seem more analogous to limitations on the scope of coverage, which are almost universally regarded as the business of insurance.

### *Insurer Decisions Concerning Scope of Policy; Complementary Services*

A standardized insurance policy may cover more than one risk or service and therefore arguably “tie” one to the other. For example, the standardized home owner's insurance policy may insure against both burglary and fire, and the insurer may refuse to insure one risk without the other or charge a significantly higher premium for separating the risks. Further, the refusal to sell or the higher premium may be fully justified by higher transaction costs.<sup>41</sup> Although not every array of coverage is inevitable or even customary, the supervision of such policy terms seems especially suitable for regulatory rather than antitrust control—provided, of course, that the regulators are actually controlling it. Moreover, the scope of coverage certainly involves the underwriting function, risk spreading, and the direct insurer-insured relationship. On these grounds, one should normally hold such matters to be the “business of insurance.”<sup>42</sup>

By contrast, if the contract with the insured covers collateral or complementary services, these may not be part of “the business of insurance.” In *Ticor* the Federal Trade Commission found that title insurers' examinations of titles and rendering of opinions as to their quality did not qualify.<sup>43</sup> Although attorneys and abstract companies also examine titles and determine their quality, the title insurers in *Ticor* insisted that search and examination were inherent in risk determination—much as physical examinations enable life or health insurers to determine risks and suitable premiums with respect to customers. Here, however, “the search and examination undertaken prior to the issuance of insurance is intended to provide an accurate search of the public records for title defects, which are to be cured by the insured or excepted from coverage.”<sup>44</sup> In short, the title search was an insurer mechanism for *avoiding* risk, not for quantifying it in order to compute appropriate premiums.<sup>45</sup> Accordingly, “the most significant ‘risk’ that title insurers face is whatever peril attaches to conducting a

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<sup>40</sup>*Health Care Equalization Comm. v. Iowa Med. Socy.*, 851 F.2d 1020 (8th Cir. 1988).

<sup>41</sup>For example, if 95 percent of home owners want protection from both fire and theft, then separating out the two and writing distinct policies for the small number wanting one but not the other could be very expensive.

<sup>42</sup>See *Anglin v. Blue Shield (Va.)*, 510 F. Supp. 75 (W.D. Va. 1981), *aff'd*, 693 F.2d 315 (4th Cir. 1982) (plaintiff seeking health coverage for only himself and son objected that insurer offered only individual or family coverage including spouse).

<sup>43</sup>*Ticor Title Ins. Co.*, 112 F.T.C. 344 (1989).

<sup>44</sup>*Id.* at 451.

<sup>45</sup>“The title insurers strictly require their agents and employees to list all enforceable or even doubtful title defects, liens, and encumbrances in the exceptions schedule.” *Id.* at 452.

competent search examination of the public records. But this 'risk' has nothing to do with the notion of risk as it is commonly encountered in casualty insurance."<sup>46</sup> After remand from the Supreme Court, which had dealt with other issues, the Third Circuit agreed with the FTC's conclusion:

The title search and examination does not itself spread or transfer risk. At most, title searchers identify defects of title. That the insurance policy defines the scope of the risk assumed by the insurer does not logically imply that the person conducting the title search and examination has defined the risk. The two are separate.<sup>47</sup>

The court then concluded that title search and examination are "analogous to the peer review process in *Pireno* and the insurer-pharmacy reimbursement process in *Royal Drug*." The practice itself has "nothing to do with the actual performance of the title insurance contract." This decision was bolstered by the Supreme Court's *Hartford* conclusion that "the business of insurance should be read to single out one activity from others, not to distinguish one entity from another."<sup>49</sup> A dissenter found title searching to be so intrinsic to the business of title insurers that it must be regarded as part of the "business of insurance." One might observe, however, that lawyers and abstract companies, neither of whom generally performs an insurance function, also engage in a great deal of title searching.

The FTC had also concluded that "title insurance rates are not set collectively through rate bureaus in order to facilitate intra-industry cooperation in the pooling of risk information." This risk element was only a small percentage of any insurer's rate. By far the greater part of the charge was for the title searching and reporting services, and these costs were "easily ascertainable" by each insurer acting individually. As a result of the rate bureau activity, "uniform rates are established that apply to all members despite any cost differences the members individually face when conducting searches and examinations."<sup>51</sup>

Similarly, *Title Insurance Rating*<sup>52</sup> held that an agreement among title insurers to fix escrow fees was not exempt because escrow services were offered by many others, such as lawyers and escrow companies. The Ninth Circuit pointed out that price fixing by the title insurers would "distort competition" in a market containing firms not protected by the McCarran-Ferguson Act.<sup>53</sup> The Fifth Circuit agreed, holding that lending money

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<sup>46</sup>Ibid.

<sup>47</sup>*Ticor Title Ins. Co. v. FTC*, 998 F.2d 1129, 1135 (3d Cir. 1993), cert. denied, 510 U.S. 1190 (1994).

<sup>49</sup>*Hartford*, 509 U.S. at 781.

<sup>51</sup>*Ticor*, 112 F.T.C. at 454. Of course, where the insurance rates themselves are fixed, the immunity ordinarily applies. *Bristol Hotel Management Corp. v. Aetna Casualty & Surety Co.*, 1998-2 Trade Cas. ¶172,272 (S.D. Fla.) (agreement among workers' compensation insurers to set rates was part of exempt business of insurance).

<sup>52</sup>*United States v. Title Ins. Rating Bureau of Ariz., Inc.*, 700 F.2d 1247 (9th Cir. 1983), cert. denied, 467 U.S. 1240 (1984).

<sup>53</sup>The contrary suggestion of *Real Estate Title & Settlement Servs. Antitrust Litig.*, 1986-1 Trade Cas. ¶167,149, at 62,933 (E.D. Pa.), aff'd, 815 F.2d 695 (3d Cir. 1987), cert. denied, 485 U.S. 909 (1988), seems wrong. In approving a private settlement of a class action suit, the court commented that title search and

was not part of the business of insurance because many non-insurers also made loans; a restraint among the insurers would distort the market with respect to insurers and non-insurers alike.<sup>54</sup>

As to the type of insurance covered, it might be argued that health insurance lies outside the McCarran-Ferguson exemption. It was not common when that statute was enacted. And health insurance policies that cover regular or routine procedures do not transfer risks in the same way as other insurance policies. Yet such policies do usually include coverage that spreads risks, and in both *Royal Drug* and *Pireno* the Supreme Court appeared to assume that health insurance was part of the “business of insurance.”<sup>55</sup> The lower courts have so held.<sup>56</sup>

Although one of the criteria the Supreme Court gave for including an arrangement within the “business of insurance” was its limitation to entities within the insurance industry, insurance agreements with subscribers or their representatives are clearly part of that “business.” *Feinstein* held that McCarran-Ferguson barred an antitrust challenge to an agreement between insurers and a county medical association to sell medical malpractice insurance to association members.<sup>58</sup> In rejecting a complaint by nonmembers, the Ninth Circuit interpreted the Supreme Court test as questioning only the insurer/non-insurer arrangement that “has the potential to restrain competition in non-insurance markets.”<sup>59</sup> Here, “the only role of the non-insurer is in negotiating the terms of the policy relationship between insurer and insured, and the gravamen of the complaint is lack of competition in the insurance market itself.”<sup>60</sup> Moreover, the arrangement was “demonstrably related to the allocation and spreading of risk.”<sup>61</sup>

Another decision rejected a “market impact” test that would exempt arrangements whose competitive impact was felt entirely within the insurance industry.<sup>62</sup> The *Reazin* court read *Pireno* and *Royal Drug* to deny the insurance exemption to restraints involving an agreement with firms outside the insurance industry and unrelated to the

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examination services were part of the business of insurance “since they are closely related to the issuance of title insurance and have been services historically provided by title insurance companies.” But lawyers and escrow companies compete with title insurers in most states in the searching and examination of titles. As a result any anticompetitive restraint in the business of searching titles would affect competition in a market not exempted by McCarran-Ferguson.

<sup>54</sup>*Perry v. Fidelity Union Life Ins. Co.*, 606 F.2d 468 (5th Cir. 1979), cert. denied, 446 U.S. 987 (1980).

<sup>55</sup>In *Royal Drug*, the Court noted, “This is not to say that the contract offered by Blue Shield to its policyholders, as distinguished from its provider agreements with participating pharmacies, may not be the ‘business of insurance’ within the meaning of the [McCarran-Ferguson] Act.” 440 U.S. at 230 n.37.

<sup>56</sup>See, e.g., *Klamath-Lake Pharmaceutical Assn., v. Klamath Med. Serv. Bureau*, 701 F.2d 1276 (9th Cir. 1983), cert. denied, 464 U.S. 822 (1983).

<sup>58</sup>*Feinstein v. Nettleship Co. of Los Angeles*, 714 F.2d 928 (9th Cir. 1983), cert. denied, 466 U.S. 972 (1984). See also *Owens v. Aetna Life & Cas. Co.*, 654 F.2d 218 (3d Cir.), cert. denied, 454 U.S. 1092 (1981) (same).

<sup>59</sup>714 F.2d at 932, citing *Pireno*, , 458 U.S. at 129.

<sup>60</sup>714 F.2d at 932.

<sup>61</sup>*Ibid.*

<sup>62</sup>*Reazin v. Blue Cross & Blue Shield of Kansas*, 663 F. Supp. 1360 (D. Kan. 1987), aff’d, 899 F.2d 951 (10th Cir.), cert. denied, 497 U.S. 1005 (1990).

spreading of risk.<sup>63</sup> In addition, the court held that providing administrative services to self-insured health programs was not part of the “business of insurance,” for self-insurance did not involve the spreading of risk.<sup>64</sup> Similarly outside the exemption were operating prepaid health care plans such as HMOs because the HMOs performed medical services in addition to assuming and spreading risk.<sup>65</sup>

*Gilchrist* was a consumer class action alleging a conspiracy among automobile insurers to use inferior, non-OEM (original equipment manufacturer) parts for doing body repair work.<sup>66</sup> The arrangement was not a provider agreement because it specified quality of parts, not identity of providers. The court found a McCarran immunity. The district court had denied the immunity, concluding that the agreement lay outside the rate-making process and was thus not part of the “business of insurance.” As the court described the dispute:

the real question in this case is which party has more accurately characterized *Gilchrist's* claim. Are Insurers correct that the claim is clearly about rate-making and performance of the insurance contract? Or does *Gilchrist* correctly describe her claim as attacking a conspiracy, entirely outside the rate-making process, in which Insurers agreed to avoid OEM parts and worked with third parties to disseminate false information about such parts in order to exclude competition from other insurers who would have provided OEM-quality repair policies?<sup>67</sup>

In finding immunity the court reasoned:

*Gilchrist's* claim that Insurers used “inferior, imitation crash parts” in the repair of their policyholders' vehicles “despite their contractual obligation to restore insured vehicles to their pre-loss condition and

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<sup>63</sup>Id. at 1408.

<sup>64</sup>Id. at 1403.

<sup>65</sup>Id. at 1403, relying on *Hahn v. Oregon Physicians Serv.*, 689 F.2d 840 (9th Cir. 1982), cert. denied, 462 U.S. 1133 (1983). See also *Allstate Insurance Co. v. State of South Dakota*, 871 F. Supp. 355 (D.S.D. 1994) (state statute prohibiting insurers from requiring auto policy holder to use particular glass replacement companies not preempted by McCarran, for it was unrelated to risk spreading); and see *King, Inc. v. G. D. Van Wagenen Co.*, 1987 WL 346057 (D. Minn. 1987), which denied the exemption to an insurance company's “collateral monitoring” program to determine whether personal property pledged as loan security had been insured as required in the loan agreement. Under the program, a reminder was sent to borrowers whose insurance had lapsed; if the borrower did not reinstate the insurance, the lender procured insurance, adding the cost to the debt. Although this “service” reduced the lender's risk of loss, the court concluded that the service provider was not assuming and spreading any risk in an insurance sense. *Compare Calico Trailer Mfg. Co., Inc. v. Insurance Co. of North Am.*, 1995-1 Trade Cas. ¶71,022 (E.D. Ark. unpublished) (“loss control service” firm providing safety consulting services is engaged in business of insurance to extent that its service is designed to reduce insured's risk); *Delta Life and Annuity Co. v. Freeman Financial Services Corp.*, 57 F.3d 1076, 1995-2 Trade Cas. ¶71,141 (9th Cir. unpublished) (sale of annuities is exempt “business of insurance,” since annuity contract uses actuarial tables to base future payouts on life expectancy).

<sup>66</sup>*Gilchrist v. State Farm Mutual Automobile Ins. Co.*, 390 F.3d 1327 (11th Cir. 2004).

<sup>67</sup>Id. at 1331.

to use parts of like kind and quality” is an attack on how Insurers perform their contractual obligations to their policyholders. Her claim that “[t]he effect of the conspiracy has been to raise and maintain insurance prices or premiums paid by policy holders above competitive levels for the actual repairs provided” is an indirect allegation of price-fixing and, therefore, a direct attack on the integrity of Insurers' rate-making.<sup>68</sup>

Further,

The heart of Gilchrist's complaint is that Insurers have lowered the quality and cost of repairs by specifying the use of non-OEM parts and not passing along the savings to their policyholders through reduced premiums. Despite Gilchrist's protestation that this claim “does not involve the contract with the insured,” it is precisely that contract that is at issue. Her claim goes to the heart of “the relationship between insurer and insured” and attacks the “reliability, interpretation, and enforcement” of the insurance policy itself.<sup>69</sup>

Gilchrist had attempted to bring her claim within *Royal Drug* by presenting it as involving “cost-cutting arrangements” regarding *selection* of parts. But here there were no third-party provision arrangements with non-insurers:

On the contrary, Gilchrist is a policyholder whose claim is that Insurers have charged excessive premiums for inferior repair work on her automobile. She alleges that Insurers have failed to perform their *obligation* under the insurance policies to provide repair parts of a “like kind and quality.” Unlike an ancillary cost-cutting agreement, a claim that an insurer has not performed its obligations under its contract with an insured goes to the heart of their relationship. As the Court observed in *Royal Drug*:

The fallacy of the petitioners' position is that they confuse the *obligations* of Blue Shield under its insurance policies...and the *agreements* between Blue Shield and the participating pharmacies, which serve only to minimize the costs Blue Shield incurs in fulfilling its underwriting obligations. The benefit promised to Blue Shield policyholders is that their premiums will cover the cost of prescription drugs except for a \$2 charge for each prescription. So long as that promise is kept, policyholders are basically unconcerned with arrangements made between Blue Shield and participating pharmacies.<sup>70</sup>

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<sup>68</sup>Id. at 1332.

<sup>69</sup>Id. at 1331, quoting *National Securities*, 393 U.S. at 460.

<sup>70</sup>*Gilchrist*, 390 F.3d at 1334, quoting *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 213-214 (1979) (emphasis added). See also *Arroyo-Melecio v. Puerto Rican American Ins. Co.*, 398 F.3d 56 (1st Cir. 2005), which reached conclusions similar to those in *Gilchrist*.

The court then concluded that:

*Insurer Agreements with Agencies and Agents*

At first glance one might think that the sale of insurance by agents—who themselves assume no risk in the insurance sense and generally work much like sellers of mutual funds, estate plans, or other financial instruments—is not part of the exempt business of insurance, but rather part of the nonexempt “business of insurers.” Indeed, that view makes some sense, for insurer-agent dealings may not be distinctively different from ordinary relationships with dealers marketing a product or service. In this case, however, the structure of the McCarran-Ferguson Act implies that such relationships are within the immune category; otherwise, there would be little need for the express statutory “boycott” exception. To be sure, the boycott exception could serve other purposes, but the apparent motivation for it was to protect agents from insurer “boycotts”—a protection that would be unnecessary if the “business of insurance” did not embrace insurer-agent arrangements in the first place. As *Royal Drug* noted, the fact that the boycott provision “presumably removes an exemption that, but for its absence, would be conferred...suggests that ‘the business of insurance’ may have been intended to include dealings within the insurance industry between insurers and agents.”<sup>72</sup> Lower courts have so held.<sup>73</sup>

*Horizontal Agreements*

There is no question that the “business of insurance” embraces horizontal agreements among insurance companies on, for example, the assessment of risk.<sup>74</sup> More generally, an agreement among insurers on the policy price, terms, and conditions is exempt. Indeed, one important purpose of insurance regulation is to provide customers with fairly standardized insurance forms permitting easier comparison among the offerings of competing insurers. To a large extent, these forms are promulgated by insurers themselves, although they may be subject to various amounts of scrutiny by

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<sup>72</sup> *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 224-225 & n.32 (1979).

<sup>73</sup> E.g., *Owens v. Aetna Life & Cas. Co.*, 654 F.2d 218 (3d Cir.), cert. denied, 454 U.S. 1092 (1981) (business of insurance includes insurer's authorization of agents to solicit individual or group policies and decision to accept or reject coverages tendered by brokers); *Weatherby v. RCA Corp.*, 1988-1 Trade Cas. ¶68,077 (N.D.N.Y.) (insurer's decision to refuse to write new insurance and to terminate its relationship with plaintiff part of “business of insurance”); *Steinberg v. Guardian Life Ins. Co.*, 486 F. Supp. 122 (E.D. Pa. 1980). *Mackey v. Nationwide Ins.*, 724 F.2d 419 (4th Cir. 1984) (McCarran-Ferguson Act bars allegation that a black insurance agent was terminated by defendant insurer as part of defendant's “redlining” scheme against insuring buildings in predominantly black neighborhoods; civil rights claims accepted).

<sup>74</sup> See *Royal Drug*, 440 U.S. at 221, 224 n.32. Of course, there is no immunity without state regulation. See *First Am. Title Co. v. South Dakota Land Title Assn.*, 541 F. Supp. 1147 (D.S.D. 1982), aff'd on other grounds, 714 F.2d 1439 (8th Cir. 1983), cert. denied, 464 U.S. 1042 (1984), denied an exemption for alleged price fixing among competing title insurers not authorized by state law. Further, horizontal agreements among providers are not exempt. *Hahn v. Oregon Physicians' Serv.*, 860 F.2d 1501 (9th Cir. 1988), cert. denied, 493 U.S. 846 (1989) (McCarran-Ferguson does not exempt fee fixing among physicians with independent practices who were board members of an insurer providing prepaid health plan).

insurance regulators in the various states.<sup>75</sup> However, as *Gilchrist* found, even an agreement to use non-OEM repair parts, which was not specified as part of the common insurance form, was the exempt “business of insurance.”<sup>76</sup>

In *Owens* the Third Circuit declared that the business of insurance embraces individual or collective (1) preparing and filing of a rating schedule and (2) deciding upon rating classification differences between individual policies and group marketing plans.<sup>77</sup> In *Workers Compensation* the Eighth Circuit found concerted rate setting for workers' compensation insurance to be part of the “business of insurance,”<sup>78</sup> as did the Eleventh Circuit for an agreement among workers' compensation insurers to charge higher rates on “assigned risk” policies for temporary workers, where risks were apparently both higher and more difficult to measure.<sup>79</sup>

*Royal Drug's* category of immune “intraindustry” arrangements—which it used to distinguish insurer-agent arrangements from insurer-provider arrangements—would seem to save virtually all horizontal agreements. On the other hand, the *Royal Drug* holding that purely vertical provider agreements are not the business of “insurance” might also imply that such agreements are not “insurance” when the subject of a horizontal agreement among insurers. That is, one might immunize only those

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<sup>75</sup>See generally 1 Lee R. Russ & Thomas F. Segalla, *Couch on Insurance*, ch. 2 (3d ed. 1997 & 1999).

<sup>76</sup>*Gilchrist v. State Farm Mutual Automobile Ins. Co.*, 390 F.3d 1327 (11th Cir. 2004). The relevant language required the insurer to restore vehicles to their prior condition with “like” parts, and the court found this agreement to be part of the “business of insurance”:

The heart of *Gilchrist's* complaint is that Insurers have lowered the quality and cost of repairs by specifying the use of non-OEM parts and not passing along the savings to their policyholders through reduced premiums. Despite *Gilchrist's* protestation that this claim “does not involve the contract with the insured,” it is precisely that contract that is at issue. Her claim goes to the heart of “the relationship between insurer and insured” and attacks the “reliability, interpretation, and enforcement” of the insurance policy itself.

*Id.*, 390 F.3d at 1333 (citations omitted).

<sup>77</sup>*Owens v. Aetna Life & Cas. Co.*, 654 F.2d 218 (3d Cir.), cert. denied, 454 U.S. 1092 (1981).

<sup>78</sup>*Workers Compensation Insurance*, 867 F.2d 1552 (8th Cir.), cert. denied, 492 U.S. 920 (1989). The court concluded that

fixing of rates by the compensation carriers, whether by private or by state-approved rate setting, is integral to the price charged to policy holders and to the contractual relationship with the insured. Although a price fixing agreement may maximize profit, it is axiomatic that the fixing of rates is central to transferring and spreading the insurance risk.

*Id.* at 1556, citing Lawrence Sullivan & John Wiley, *Recent Antitrust Developments: Defining the Scope of Exemptions, Expanding Coverage, and Refining the Rule of Reason*, 27 *UCLA L. Rev.* 265, 283 (1979). See also *Uniforce Temporary Personnel, Inc. v. National Council on Compensation, Inc.*, 892 F. Supp. 1503 (S.D. Fla. 1995), *aff'd*, 87 F.3d 1296 (11th Cir. 1996) (alleged conspiracy among insurers and rate-making organization to make temporary employee services pay higher workers' compensation rates was exempt business of insurance).

<sup>79</sup>*Uniforce Temporary Personnel, Inc. v. National Council on Compensation, Inc.*, 87 F.3d 1296 (11th Cir. 1996).

horizontal agreements that concern matters that would constitute the “business of insurance” when unilaterally pursued by an insurer.<sup>80</sup> Otherwise one gets the unappealing result that a decision involving a single insurer and its providers limiting the latter’s charges falls outside the “business of insurance,” while a horizontal agreement among insurers imposing the same restraint falls inside.

Nevertheless, the *Proctor* decision, later than *Royal Drug*, immunized an alleged horizontal agreement among automobile insurers that they would pay only “prevailing” rates for repairs rather than the rate each particular body repair shop chose to bill. The court emphasized that Congress’s purpose in passing the McCarran-Ferguson Act was “to protect cooperative ratemaking,” and thus “wholly intra-industry [horizontal] agreements” should be regarded as the “business of insurance” even though they concerned claims procedures and payments to insureds or their providers.<sup>81</sup>

All of the cases after *Royal Drug* differ less in their logic than on the policy question of how narrow the insurance exemption ought to be. *Royal Drug* itself adopts a narrow construction of the statute. Cases like *Pireno* and *Virginia Academy* in turn provide a narrow reading of *Royal Drug*. The narrowing process might continue until nothing is left of the insurance exemption except (1) the insurer-insured agreement itself, perhaps only in its rate and class-of-coverage provisions, and (2) the horizontal agreement concerning rates and risks among insurance companies. Such a reading might please those of us who favor repeal of the McCarran-Ferguson Act, but query whether it is true to congressional intent.

### “Regulated by State Law”

The McCarran-Ferguson Act exempts the “business of insurance” from federal antitrust scrutiny only to the extent that it is “regulated by state law.” The relevant text reads:

No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That...[the antitrust laws and FTC Act] shall be applicable to the business of insurance to the extent that such business is not regulated by State law.<sup>82</sup>

Except in a few non-antitrust decisions, the courts have not scrutinized the nature

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<sup>80</sup>Cf. *American Standard Life & Accident Ins., Inc. v. U.R.L., Inc.*, 701 F. Supp. 527 (M.D. Pa. 1988) (alleged conspiracy among insurers and agents to use misrepresentations to induce competitor’s policy holders to switch insurance carriers not part of “business of insurance”).

<sup>81</sup>See *Proctor v. State Farm Mut. Auto. Ins. Co.*, 675 F.2d 308, 317, 336-339 (D.C. Cir.), cert. denied, 459 U.S. 839 (1982). The Justice Department took the same position as amicus curiae in *Royal Drug*, arguing that “wholly intra-insurance industry agreements concerning the extent to which particular claims would be paid” should be exempt under McCarran-Ferguson. Brief for the United States as Amicus Curiae 31. To the same effect is *Quality Auto Body, Inc. v. Allstate Ins. Co.*, 660 F.2d 1195 (7th Cir. 1981), cert. denied, 455 U.S. 1020 (1982) (dicta).

<sup>82</sup>15 U.S.C. §1012b.

and intensity of state regulation very closely. The first portion of the statute limits the coverage of general acts of Congress that might “invalidate, impair, or supersede” an extant state law. The second portion then adds that the federal antitrust laws “shall” be applicable “to the extent” that state regulation is absent. While hardly a model of clarity, the final sentence thus suggests that there may be broader room for application of the antitrust laws than for other federal laws not intended to regulate the insurance industry.

Nevertheless, the courts have interpreted the final clause of the statute as restricting rather than expanding the reach of the antitrust laws. That is, if the state's insurance industry is “regulated by state law,” then the antitrust laws simply do not apply, notwithstanding that the application of antitrust law in the particular case in no way “invalidate[s], impair[s], or supersede[s]” state law and may even be consistent with it. To illustrate, suppose that the state has insurance regulation in place whose general tenor is to oppose horizontal agreements fixing insurance premiums. In such a case one might say that a Sherman Act complaint alleging unlawful price fixing would be in furtherance of rather than inconsistent with the state's regulatory policy respecting insurance. Nevertheless, the courts generally agree that the Sherman Act complaint is preempted. Although state insurance regulation is not invalidated or impaired, the mere presence of the regulation is sufficient to oust the federal antitrust claim. This treatment of the two clauses is odd. While the debates themselves are ambiguous, they indicate that in drafting the McCarran-Ferguson Act Congress chose its language because it wanted to leave more room for antitrust enforcement against the insurance industry than for the application of other laws not explicitly directed at the insurance industry.<sup>83</sup>

Nevertheless, when the federal action in question is not one under the antitrust laws, the courts consider the extent of actual conflict between the federal action and the state regulatory scheme. For example, the Supreme Court's non-antitrust *Humana* decision held that McCarran-Ferguson did not preclude an action under the Racketeer Influenced and Corrupt Organizations Act (RICO)<sup>84</sup> when such a suit would not impair the operation of Nevada's state regulatory scheme for insurance.<sup>85</sup> The court defined a federal law or action as “impairing” the state business of insurance when there is a direct conflict between the federal and state law or when application of the federal law would frustrate a declared state policy. In this case, the RICO action seemed to be consistent with the state policy of combatting insurance fraud.

By contrast, in an antitrust case the presence of even minimal state regulation, even on an issue unrelated to the antitrust suit, is generally sufficient to preserve the immunity. The courts have generally been satisfied with the existence of a state regulatory scheme and rather superficial indicators of supervision, without much regard for the actual intensity of state regulation.<sup>86</sup>

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<sup>83</sup>See, e.g., 91 Cong. Rec. 1444 (remarks of Senator Pepper), *id.* at 1484 (Senator Murdock).

<sup>84</sup>18 U.S.C. §§1961 -1968.

<sup>85</sup>*Humana v. Forsyth*, 525 U.S. 299, 310-311 (1999).

<sup>86</sup>See *Crawford v. American Title Ins. Co.*, 518 F.2d 217, 220 (5th Cir. 1975) (Alabama statute prohibiting “all unfair methods of competition” sufficient regulation to create McCarran immunity); *Ohio AFL-CIO v. Insurance Rating Bd.*, 451 F.2d 1178, 1184 (6th Cir. 1971), *cert. denied*, 409 U.S. 917 (1972) (“there is nothing in the language of the McCarran Act or in its legislative history to support the thesis that the Act does not apply when the state's scheme of regulation has not been effectively enforced”). See

For example, some courts have suggested that the mere existence of a state agency or official who oversees insurance practices invokes the McCarran-Ferguson exemption.<sup>87</sup> If the state has passed a legislative scheme that purports to regulate the insurance industry and which has jurisdiction over the challenged practice, then the requirement is met.<sup>88</sup> In *Freier* the fact that a statute required an insurance commissioner to approve all policies was sufficient.<sup>89</sup> Moreover, most courts hold that state regulation of the general class of activities into which the challenged practice falls immunizes the practice, even though the state did not authorize the particular activity being challenged.<sup>90</sup> In *Klamath-Lake*,<sup>91</sup> the Ninth Circuit even applied the McCarran-Ferguson Act to an insurer's direct provision of prescription drugs to insureds seeking maximum reimbursement by citing state statutes that banned unfair or deceptive practices in the health insurance industry and prohibited insurers from doing "anything which is detrimental to free competition in the business or injurious to the insuring public."

In the *Workers Compensation* decision,<sup>93</sup> the state set maximum insurance rates but left insurers free, individually or in concert, to set lower rates. The state retained the power to "investigate" rates or unfair methods of competition, but apparently such investigations were rare. The Eighth Circuit held this degree of regulation sufficient for McCarran-Ferguson purposes in a case in which below-maximum rates were not in issue.<sup>94</sup>

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also *Gilchrist*, 390 F.3d at 1334 (finding immunity for alleged insurer agreement reducing quality of repair parts; noting that Florida, the most relevant state, regulated the general industry intensely and that many states also regulate the use of non-OEM repair parts).

However, some decisions find the regulation requirement not to be met when the regulatory statute at issue is not directed at the insurance industry as such, but is of a more general nature. See, e.g., *Ohio v. Ohio Medical Indem., Inc.*, 1976-2 Trade Cas. ¶61,128 at 70,113 n.1 (S.D. Ohio 1976) (state antitrust statute not sufficiently explicit regulation of insurance); contra, *Maryland v. Blue Cross & Blue Shield Assn.*, 620 F. Supp. 907, 920-921 (D. Md. 1985) (state antitrust law is sufficient insurance regulation).

<sup>87</sup>For example, *National Casualty*, 357 U.S. at 564-565, refused to inquire into how state regulatory provisions were applied, with the possible exception where the regulation was a "mere pretense."

<sup>88</sup>*Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I.*, 883 F.2d 1101, 1108-1109 (1st Cir. 1989), cert. denied, 494 U.S. 1027 (1990).; *Workers' Compensation*, 867 F.2d at 1557-1558; *Health Care Equalization*, 851 F.2d at 1029; *Mackey*, 724 F.2d at 420-421; *Feinstein*, 714 F.2d at 933; *Klamath-Lake*, 701 F.2d at 1287 & n.10.

<sup>89</sup>*Freier v. New York Life Ins. Co.*, 679 F.2d 780, 782 (9th Cir. 1982). See also *Proctor*, 675 F.2d at 317 (not disturbing district court finding that virtually any regulation specifically mentioning insurance industry will suffice).

<sup>90</sup>See, e.g., *Addrisi v. Equitable Life Assurance Socy. of the U.S.*, 503 F.2d 725, 728 (9th Cir. 1974), cert. denied, 420 U.S. 929 (1975) (simple statute regulating unfair practices in insurance industry sufficient, regardless of "whether the ... laws proscribe or permit the alleged acts of economic coercion in the issuance of insurance policies" challenged in this case).

<sup>91</sup>*Klamath-Lake Pharmaceutical Assn., v. Klamath Med. Serv. Bureau*, 701 F.2d 1276 (9th Cir. 1983), cert. denied, 464 U.S. 822 (1983).

<sup>93</sup>*Workers Compensation Insurance*, 867 F.2d 1552 (8th Cir.), cert. denied, 492 U.S. 920 (1989).

<sup>94</sup>One judge objected: "Given Minnesota's intentional deregulation of workers' compensation rates, I would find that Minnesota does not 'regulate' these rates for purposes of ... McCarran-Ferguson. While

By contrast, such general authority or nondeliberative and passive acceptance by state regulators of the regulated firm's position is usually not sufficient to confer *Parker* immunity.<sup>95</sup> Furthermore, *Parker* immunity also requires a state's manifested intention to intervene in the market, thus displacing the antitrust laws<sup>96</sup> and "active supervision" of any private conduct.<sup>97</sup> In sum, the prerequisites to *Parker* immunity are significantly more stringent than those satisfying the McCarran-Ferguson "regulation" requirement.

Of course, the latter requirement might itself be tightened up to reflect judicial thinking about the antitrust significance of state regulation in the *Parker* context. After all, the insurance statute's regulation requirement is not self-defining, and it could be reinterpreted in the light of *Parker* developments. If the insurance statute's regulation requirement were to coalesce with the *Parker* requirements, the scope of the McCarran-Ferguson Act would be largely irrelevant as a practical matter. As a matter of policy, moreover, the rationale for the sensible limits on *Parker* immunity apply at least equally to an insurance immunity.

Indeed, there is one powerful argument for giving *less* immunizing power to the states in insurance matters than in most of the areas to which *Parker* immunity has been applied. In large part, the McCarran-Ferguson notion that insurance regulation is a special prerogative of the state is a historical relic of the nineteenth century. Insurance originated in largely local risk-sharing transactions among businesspersons within the same city or state. As a result, the industry was initially heavily intrastate and largely subject to severe state limitations on extraterritorial business. Today, by contrast, most parts of the insurance market are national rather than local, and insurers in one state typically sell insurance to buyers in numerous states or even in all of the states. By contrast, many of the markets to which *Parker* applies are relatively local, such as taxicab fares, land use, waste disposal, and the like. To the extent that deference to the regulatory prerogatives of the states is the grounds for the federal antitrust immunity, the case would seem to be far stronger in these other areas than in insurance. Indeed, a system that permits antitrust intervention into a municipality's development of its own cable television system through a political process entirely answerable to voters,<sup>98</sup> while denying federal antitrust intervention into something as national as insurance seems quite irrational.

But Congress has spoken by creating an express immunity for state insurance regulation, while these other markets depend on the judicially created *Parker* immunity. The question is thus one of legislative intent. If Congress is to be understood as requiring rather little supervision to satisfy its "state regulation" requirement, then that decision binds the courts regardless of their policy judgment on the appropriate limits of the *Parker* state action immunity.

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the state did maintain a general regulatory presence in the field, there was no specific regulation targeted at the alleged practices at issue. ..." Id. at 1569. In any event, a nonexempt boycott was found.

<sup>95</sup>See 1A Antitrust Law ¶224.

<sup>96</sup>See id.

<sup>97</sup>See id., ¶226.

<sup>98</sup>See *Community Commun. Co., Inc. v. City of Boulder*, 455 U.S. 40, 65 n.2 (1982), discussed in 1A Antitrust Law ¶223c.

The Ninth Circuit found the mere power to control insufficient in the *Insurance* litigation.<sup>99</sup> The agreeing parties were several domestic insurers and several British reinsurers. Although all were in the “business of insurance,” state regulation did not extend to the bulk of international insurance transactions.<sup>100</sup> Indeed, a “state’s regulation of insurance does not have extraterritorial effect within the United States”<sup>101</sup> and thus has no effect outside the United States as well. Accordingly, said the court, the foreign firms were not immune. The court then held that regulated domestic insurers agreeing with each other lost the immunity they would otherwise have because they also agreed with non-immune foreign firms.<sup>102</sup> Either the court thought that the state regulators lacked power to control the international reinsurance contracts of domestic insurers or that such potential control was insufficient.

There is one important respect in which the mere availability of state insurance regulation—as distinct from actual and deliberate state approval pursuant to an intention to displace the antitrust laws—might be thought sufficient for an insurance exemption though not for the *Parker* immunity. The distinguishing factor is the relative competence of the antitrust court and of the state insurance regulatory agency.

Consider the recurring health insurance controversies over provider agreements, peer review, or the various policies excluding non-physicians such as chiropractors from insurance coverage. Most of these are presumably intended by insurers to control either costs or the quality of service to be delivered. Provider agreements are typically contested by providers who object to the insurer’s efforts to pay less than the plaintiff wishes to charge. The peer review agreements are typically challenged by non-physicians such as chiropractors or psychologists, who complain that the insurer fails to provide the patient with coverage for their services or that such coverage is limited in ways that subject them to control or supervision by physicians.

Without deciding whether such arrangements violate the antitrust laws, we should ask whether an antitrust court or a state insurance regulatory agency is better situated to investigate and appraise the impact and reasonableness of such practices. A health care policy must necessarily define the risks insured against and the services to be reimbursed. Limitations on non-physician providers might in some circumstances be unwise, but a regulatory agency may be better qualified to make the necessary investigations, to draw the necessary lines, and to supervise actual administration.

### **Conclusion: Implications of McCarran-Ferguson Repeal**

The McCarran-Ferguson Act is rooted in a history in which the states were thought to be the principal regulators of the insurance industry, and Congress ought generally to

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<sup>99</sup>*Insurance Antitrust Litig.*, 723 F. Supp. 464 (N.D. Cal. 1989), rev’d on other grounds, 938 F.2d 919 (9th Cir. 1991), rev’d in part and remanded sub nom. *Hartford Fire Ins. Co. v. California*, 509 U.S. 764 (1993).

<sup>100</sup>The court gave no weight to the plaintiffs’ own allegation that all the defendants violated state insurance laws—thereby implying that the practices were in fact subject to state oversight and thus “regulated”—perhaps because alternative facts and theories are often claimed.

<sup>101</sup>*Id.* at 928, citing *FTC v. Travelers Health Assn.*, 362 U.S. 293, 298-299, 302 (1960).

<sup>102</sup>938 F.2d at 928-929. While the court relied on *Royal Drug*, in that case the Supreme Court had held that the subject matter of the challenged agreements was not the “business of insurance.”

take a hands-off policy.<sup>103</sup> Today the reality is quite different, and the McCarran-Ferguson Act seems to operate mainly to insulate anticompetitive restraints from effective antitrust scrutiny. Indeed, the case law on “business of insurance,” as discussed above, has been perverse, as it tends to insulate horizontal agreements such as forms development and price fixing where the threat to competition is high, but to find no immunity for vertical arrangements such as health insurer provider agreements where the threat to competition is small or nil.

Congress has often discussed repealing the McCarran-Ferguson Act but has never done so.<sup>104</sup> Repeal need have no enormous impact on insurance practices—for three reasons. *First*, many of those practices are already subject to the antitrust laws because they are insufficiently regulated by the states, too “interstate” in character to be subject to regulation by any one state, or an undoubted boycott.<sup>105</sup> *Second*, many, perhaps most, of the challenged practices need no immunity because they do not violate the antitrust laws. *Third*, to the extent that the insurer's practices are actively supervised by state regulators pursuant to a state policy to substitute regulation for market competition, the insurer would enjoy a “state action” immunity under the *Parker* doctrine.

To the extent these three reasons do not apply to a practice, repeal seems desirable, for the effective impact of McCarran-Ferguson is to immunize activities that (1) would normally be antitrust violations when engaged in by private parties, (2) where there is inadequate public supervision to qualify for *Parker* supervision. Thus the residual impact of repeal would be to force states either to regulate more actively themselves or else leave provable antitrust violations to the antitrust tribunals rather than the unsupervised discretion of private firms.

The recent *Gilchrist* decision is a good example. The case involved an alleged agreement among insurers to use lower-quality crash parts in automobile repair than were apparently specified in insurance contracts.<sup>106</sup> In such a case open competition furthers transparency and thereby forces individual insurers to compete on both rates and the quality of repair parts. By contrast, the alleged agreement itself seems to be nothing more than a naked restraint of trade. To be sure, using cheaper parts reduces insurers' costs, but antitrust policy supports the proposition that the quality of a product as well as its price is an element of competition, and every firm can reduce short-run costs by using cheaper components.

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<sup>103</sup>See Note, The Basis for State Control of Insurance, 58 Mich. L. Rev. 559 (1960), which traces the history of state insurance regulation back to the early nineteenth century; and see M.F. Brinig, Politics, Economics and the McCarran-Ferguson Act, 73 Public Choice 371 (1992), which examines the history of state interest groups and the insurance industry.

<sup>104</sup>In 1989 the ABA recommended repeal after concluding that the statute “permits insurers to collusively manipulate the insurance mechanism and the price of insurance coverage.” ABA, Report of the Commission to Improve the Liability Insurance System 66 (1989); and see Brinig, *id.* See also Susan Randall, Insurance Regulation in the United States: Regulatory Federalism and the National Association of Insurance Commissioners, 26 Fla. St. U. L. Rev. 625 (1999). On current proposals for repeal or reform, see John A. Knapp & Michael J. Rothman, Recent Developments in Insurance Regulation, 39 Tort Trial & Ins. Prac. L.J. 511 (2004).

<sup>105</sup>On the boycott exception to McCarran-Ferguson, see 1A Antitrust Law ¶220.

<sup>106</sup>*Gilchrist v. State Farm Mutual Automobile Ins. Co.*, 390 F.3d 1327 (11th Cir. 2004).

Indeed, one of the abiding problems of the McCarran-Ferguson Act is that the most egregiously anticompetitive claims, such as naked agreements fixing price or reducing coverage, are virtually always found immune. By contrast, ancillary agreements with a significant efficiency-creating potential, such as peer review agreements, provider agreements, and the like, often lose the immunity because they are found to fall outside the “business of insurance.” As a result, from a competition perspective the statute does a fair amount of social harm and not very much good. Of course, whether price fixing of this sort is common outside of the regulation context is a different matter.

Short of repeal, competition would be served by legislative or judicial revision making clear that the antitrust immunity applies only when application of the antitrust laws would “invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance....”<sup>107</sup> Such an interpretation would still create a greater immunity than *Parker* creates: it would serve to immunize activities that are clearly “authorized” by state law even though private conduct is not actively supervised.<sup>108</sup>

With some exceptions, insurance markets are not particularly prone to collusion or other anticompetitive practices. Again, with some exceptions, entry is easy and common and insurers are numerous. One cannot rule out the possibility that pockets of insurers who are isolated by either geography or subject matter will attempt to fix prices or divide markets, but risks of this sort exist in even the most competitive of markets.

One consequence of the McCarran-Ferguson antitrust immunity is that the federal courts have acquired very little experience in evaluating substantive antitrust claims in insurance markets. This shortcoming is particularly important in rule of reason cases, which depend heavily on the court's knowledge about a market's workings. If McCarran-Ferguson were repealed courts would be writing on a relatively clean slate, a state of affairs that often leads to judicial refusals to dismiss a case or grant summary judgment, hoping that further development of the record will reveal more, or that a trial will shift part of the decision burden to a jury. This uncertainty will almost certainly provoke a certain measure of overdeterrence.

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<sup>107</sup> 15 U.S.C. §1012b.

<sup>108</sup> On these requirements of the *Parker* immunity, see 1A Antitrust Law ¶¶224-226.