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# INSURANCE AND ANTITRUST LAW: THE McCARRAN-FERGUSON ACT AND BEYOND

ALAN M. ANDERSON\*

## I. INTRODUCTION

In 1945, Congress enacted the McCarran-Ferguson Act,<sup>1</sup> permitting states to regulate and tax foreign insurance companies doing business within their borders. The Act also exempts the insurance industry from the federal antitrust laws if the state regulates the industry. For more than thirty years, the exemption led a quiet existence. Between 1945 and 1977, the United States Supreme

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1. 15 U.S.C. §§ 1011-1015 (1976). The Act provides in relevant part:

[§1.] Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

[§2.] (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business. (b) 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 after June 30, 1948, . . . the Sherman Act, and . . . the Clayton Act, and . . . the Federal Trade Commission Act, . . . shall be applicable to the business of insurance to the extent that such business is not regulated by State Law.

[§3.] (a) Until June 30, 1948, . . . the Sherman Act, and . . . the Clayton Act, and . . . the Federal Trade Commission Act, and . . . the Robinson-Patman Anti-Discrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof. (b) Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

[§4.] Nothing contained in this chapter shall be construed to affect in any manner the application to the business of insurance of the . . . National Labor Relations Act, or . . . the Fair Labor Standards Act of 1938, or . . . the Merchant Marine Act, 1920.

Court heard only three cases addressing its scope.<sup>2</sup> Lower courts generally interpreted the exemption expansively, according the insurance industry broad immunity from the federal antitrust laws.

Recently, the exemption has come under increased scrutiny.<sup>3</sup> Within the past five years the Supreme Court has rendered three decisions addressing the scope of the McCarran-Ferguson Act.<sup>4</sup> The decisions have narrowed significantly the scope of the exemption, but lower courts have struggled to understand and implement the new interpretation. The Court also has begun to look outside the McCarran-Ferguson Act and consider the applicability of the antitrust laws to insurer practices beyond the scope of the exemption,<sup>5</sup> a task that lower courts are just beginning to undertake.

This Article develops a comprehensive framework for applying the McCarran-Ferguson Act by analyzing the insurance industry's antitrust exemption and examining antitrust challenges to insurer practices. After briefly reviewing the legislative history and events leading to the passage of the Act, the Article develops a systematic framework for evaluating insurer claims of exemption. This framework then is used to determine whether the insurer practices most frequently challenged in the courts should be exempt under the Act. Finally, the Article examines whether certain practices beyond

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2. See *SEC v. National Sec., Inc.*, 393 U.S. 453 (1969); *SEC v. Variable Annuity Life Ins. Co. of Am.*, 359 U.S. 65 (1959); *FTC v. National Casualty Co.*, 357 U.S. 560 (1958).

3. The increased scrutiny of the exemption is largely in response to new approaches taken by insurers, particularly in the health care field, to control rising claim costs. These new approaches frequently reduce competition among insurers and, consequently, have been challenged under the antitrust laws. Insurers have responded to the challenges by asserting their exemption under the Act. See generally M. THOMPSON, *ANTITRUST AND THE HEALTH CARE PROVIDER* 174-86 (1979); Halper, *The Health Care Industry and the Antitrust Laws: Collision Course?*, 49 *ANTITRUST L.J.* 17 (1980); Rosoff, *Antitrust Laws and the Health Care Industry: New Warriors Into an Old Battle*, 23 *ST. LOUIS U.L.J.* 446 (1979).

4. See *Union Labor Life Ins. Co. v. Pireno*, 102 S. Ct. 3002 (1982); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979); *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531 (1978). Several governmental studies have criticized the Act and have questioned the need for its existence. See 1 *NATIONAL COMM'N FOR THE REVIEW OF ANTITRUST LAWS AND PROCEDURES, REPORT TO THE PRESIDENT AND THE ATTORNEY GENERAL* 225-51 (1979) [hereinafter cited as 1979 REPORT]; U.S. DEP'T OF JUSTICE, *REPORT OF THE TASK GROUP ON ANTITRUST IMMUNITIES* 30 (1977). Moreover, Congressmen have introduced bills seeking to repeal or modify the Act. See, e.g., S. 1710, 95th Cong., 1st Sess., 123 CONG. REC. 19,527 (1977) (modification); H.R. 13,861, 95th Cong., 2d Sess., 124 CONG. REC. 26,000 (repeal); H.R. 7623, 95th Cong., 1st Sess., 123 CONG. REC. 17,557 (1977) (repeal).

5. See *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332 (1982).

the scope of the Act also violate the antitrust laws.

## II. THE EVOLUTION OF THE McCARRAN-FERGUSON ACT

The insurance industry mirrored the rapid growth of the American economy in the early 1800's, and the prospect of large profits attracted many unsophisticated newcomers with minimal capital. This expansion created a heightened need for governmental regulation because large casualties and increased competition threatened the viability of many companies.<sup>6</sup> Each state regulated the insurance industry to some degree, but the regulation proved unsatisfactory. Consequently, the insurance industry sought some type of federal regulation.<sup>7</sup>

Attempts to achieve federal regulation were set back, however, by the United States Supreme Court's decision in *Paul v. Virginia*.<sup>8</sup> In *Paul*, the plaintiff argued that a Virginia statute requiring foreign insurance companies to post a substantial bond and obtain a license prior to doing business in the state constituted an impermissible interference with interstate commerce.<sup>9</sup> The Court

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6. J. DAY, *ECONOMIC REGULATION OF INSURANCE IN THE UNITED STATES* 18 (1971); Kimball & Boyce, *The Adequacy of State Insurance Rate Regulation: The McCarran-Ferguson Act in Historical Perspective*, 56 MICH. L. REV. 545, 546-48 (1958).

7. Note, *The McCarran-Ferguson Act: A Time for Procompetitive Reform*, 29 VAND. L. REV. 1271, 1274 (1976). Although every state regulated the insurance industry, the scope of regulation varied from state to state. See J. DAY, *supra* note 6, at 1-23. Several bills were introduced in Congress in an attempt to achieve federal regulation, but none were enacted. See Rose, *State Regulation of Property and Casualty Insurance Rates*, 28 OHIO ST. L.J. 669, 673 (1967).

Scholars have advanced various reasons for regulating the insurance industry, but the primary rationale is the need to preserve the stability and solvency of insurers. See R. KEETON, *INSURANCE LAW—BASIC TEXT* §8.3, at 554-55 (1971); Kimball & Boyce, *supra* note 6, at 546. An insurance company can provide protection only if an adequate insurance fund is maintained. Competition among insurers, however, could undermine the maintenance of this fund. For example, competition could force some insurers to reduce their rates to attract customers. This, in turn, would diminish the funds available to pay claims and, ultimately, a claim might have to go unpaid. To protect policyholders from such an event, the formation, investments, rates, and accounting practices of insurance companies must be regulated. Brainard & Dirlam, *Antitrust, Regulation, and the Insurance Industry: A Study in Polarity*, 11 ANTITRUST BULL. 235, 237 (1966).

8. 75 U.S. 168 (1868).

9. *Id.* at 173-74. The insurance companies that Paul represented instructed him to violate the law in the hope of obtaining judicial reform in the industry. Indeed, the National Board of Insurance Underwriters furnished Paul with funds and retained two of the best lawyers of the time to argue the case. See Nehemkis, *Paul v. Virginia: The Need for Re-Examination*,

upheld the statute and stated in dictum that “[i]ssuing a policy of insurance is not a transaction of commerce.”<sup>10</sup> Later decisions generally interpreted this proposition to mean that the federal government had no power to regulate the insurance industry under the commerce clause.<sup>11</sup> As a result of this interpretation, no federal regulation of the insurance industry was enacted during the next seventy-five years.

The Supreme Court finally addressed the validity of this interpretation in *United States v. South-Eastern Underwriters Association*.<sup>12</sup> In *South-Eastern Underwriters*, members of an insurance association were indicted on charges of violating the Sherman Act by fixing rates and monopolizing the insurance business in a six-state area.<sup>13</sup> The district court dismissed the indictment on the basis of *Paul* and its progeny, holding that the business of insurance was not commerce.<sup>14</sup> On appeal, the Supreme Court reversed, concluding that *Paul* was not determinative. The Court noted that the question addressed in *Paul* was not whether Congress had the power to regulate the business of insurance under the commerce clause, but rather, whether the commerce clause precluded state regulation.<sup>15</sup> After considering the economic position of the insurance industry, the Court determined that the industry was an ap-

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27 GEO. L.J. 519, 526-28 (1939).

10. 75 U.S. at 183.

11. See, e.g., *New York Life Ins. Co. v. Deer Lodge County*, 231 U.S. 495, 510-12 (1913); *New York Life Ins. Co. v. Cravens*, 178 U.S. 389, 401 (1900); *Hooper v. California*, 155 U.S. 648, 653-54 (1895). None of these cases, however, addressed directly the question of whether the federal government had the power to regulate the insurance industry. These cases instead addressed the validity of state, as opposed to federal, regulatory schemes. See *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533, 534, 544-45 (1944). The validity of federal regulation was not a major concern until Congress passed the Sherman Act in 1890, outlawing “[e]very contract, combination . . . , or conspiracy, in restraint of trade or commerce among the several States.” 15 U.S.C. § 1 (1976). Insurance associations commonly engaged in price-fixing and boycotts as a means of self-regulation. See Carlson, *The Insurance Exemption from the Antitrust Laws*, 57 TEX. L. REV. 1127, 1130 (1979).

12. 322 U.S. 533 (1944).

13. *Id.* at 534-35. The association controlled 90% of the relevant market, fixed premium rates and agents' commissions through concerted action, and utilized boycotts and other acts of coercion and intimidation to injure the businesses of nonmember companies and agents. *Id.* at 535-36.

14. *United States v. South-Eastern Underwriters Ass'n*, 51 F. Supp. 712, 713, 715 (N.D. Ga. 1943), *rev'd*, 322 U.S. 533 (1944).

15. 322 U.S. at 534, 544-45. See *supra* note 11.

propriate subject for federal regulation under the commerce clause. The majority then concluded that the Sherman Act applied to the industry.<sup>16</sup>

The Court's holding "precipitated widespread controversy and dismay. Chaos was freely predicted."<sup>17</sup> Insurance companies, which previously had called for federal regulation, now viewed state regulation as the lesser of two evils.<sup>18</sup> The companies feared that price-fixing and other anti-competitive conduct in which they had engaged with impunity since *Paul* now would be prohibited under the Sherman Act.<sup>19</sup> The Court's decision also troubled the states because they feared that state taxation of insurance companies might be invalid as an undue burden on interstate commerce.<sup>20</sup> Both groups turned to Congress for relief.

Several Congressmen had reacted to the *South-Eastern Underwriters* litigation before the Supreme Court's decision. Following the district court's decision, these Congressmen introduced legislation that would have completely exempted the insurance industry from the antitrust laws.<sup>21</sup> Congress did not enact any of the bills,

16. 322 U.S. at 539-49, 552-53. The dissenting justices argued that Congress did not intend for the Sherman Act to apply to the insurance business. *Id.* at 573-74 (Stone, C.J., dissenting); *id.* at 583-84 (Frankfurter, J., dissenting). The dissenters also argued that federal regulation of insurance would result in the demise of state regulatory and taxing schemes. *Id.* at 581-82 (Stone, C.J., dissenting); *id.* at 590 (Jackson, J., dissenting in part).

17. New York Insurance Dep't, *The Open Competition Rating Law: A Statement of Principles and Procedures* 71, in 111 ANNUAL REPORT OF THE SUPERINTENDENT OF INSURANCE TO THE NEW YORK LEGISLATURE 355 (1969).

18. See *Joint Hearing Before the Subcomm. of the Comm. on the Judiciary on S. 1362, H.R. 3269 and H.R. 3270*, 78th Cong., 1st Sess. 29-30, 61-62 (1943).

19. Carlson, *supra* note 11, at 1133.

20. Kimball & Boyce, *supra* note 6, at 554. See 91 CONG. REC. 1087 (1945) (remarks of Rep. Hancock) ("[T]he taxes imposed on insurance companies in many States may be regarded as burdens on interstate commerce, and, therefore, unlawful."); *id.* at 1090 (remarks of Rep. Gwynne) ("I am afraid some of the taxing policies of some of the States will have to be revamped, because they are probably unreasonably impeding interstate commerce."). Today, this concern is largely unfounded because the Supreme Court "has only rarely held that the Commerce Clause itself pre-empts an entire field from state regulation, and then only when a lack of national uniformity would impede the flow of interstate goods." *Exxon Corp. v. Governor of Md.*, 437 U.S. 117, 128 (1978).

State governments also feared that *South-Eastern Underwriters* would result in the dismantling of state regulatory schemes. The Supreme Court's subsequent decision in *Robertson v. California*, 328 U.S. 440 (1946), holding that states could regulate those aspects of the insurance industry not preempted by federal regulation, dispelled this fear.

21. S. 1362, 78th Cong., 1st Sess. (1943); H.R. 3269, 78th Cong., 1st Sess. (1943); H.R.

although one passed the House and nearly gained Senate approval.<sup>22</sup>

The National Association of Insurance Commissioners (NAIC) subsequently proposed a partial exemption for the insurance industry. Section 2(a) of the proposal stated that the business of insurance is subject to state tax and regulatory laws, and section 2(b) provided that federal law should not "invalidate, impair, or supersede" any state insurance laws. Section 3 completely exempted the business of insurance from the Federal Trade Commission and Robinson-Patman Acts. Section 4 defined the applicability of the Sherman and Clayton Acts to the insurance industry: subsection (a) provided a temporary moratorium during which the Sherman and Clayton Acts would not apply; subsection (b) exempted seven specific activities from the scope of the Sherman Act; and subsection (c) stated that the Sherman Act, even during the moratorium, would apply to any act of boycott, coercion, or intimidation.<sup>23</sup>

Senators McCarran and Ferguson introduced an amended version of this proposal.<sup>24</sup> The bill represented a compromise between those who favored full and immediate application of the antitrust laws and those who favored an absolute exemption. To achieve this compromise, the Senators deleted section 4(b) of the NAIC proposal from their bill. Consequently, the bill did not exempt any specific activities from the Sherman Act. The bill, however, retained section 2(b) of the proposal. Under the bill, therefore, the Sherman and Clayton Acts could not be applied in any manner that would "invalidate, impair, or supersede" any state insurance regulation.<sup>25</sup>

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3270, 78th Cong., 1st Sess. (1943).

22. The House vigorously debated and passed H.R. 3270, known as the Walter-Hancock bill, just seventeen days after the Supreme Court decided *South-Eastern Underwriters*. See 90 CONG. REC. 6449-55, 6524-57, 6559-65 (1944); 89 CONG. REC. 10,532, 10,659-64 (1943). The Senate initially passed the bill, but rejected it on reconsideration. 90 CONG. REC. 8054 (1944). The bills favoring total exemption failed primarily because of an anticipated veto by President Roosevelt, see 91 CONG. REC. 1087 (1945) (remarks of Rep. Hancock), and because only a small segment of the insurance industry supported the bills. Weller, *The McCarran-Ferguson Act's Antitrust Exemption for Insurance: Language, History and Policy*, 1978 DUKE L.J. 587, 592 n.34.

23. The complete text of the NAIC proposal is printed in 90 CONG. REC. A4406 (1944). For a discussion of the NAIC's activities in developing and lobbying for its proposal, see Weller, *supra* note 22, at 593-95.

24. S. 340, 79th Cong., 1st Sess., 91 CONG. REC. 330 (1945).

25. See *id.*

Within two weeks after the bill's introduction, the Senate passed the bill with two amendments.<sup>26</sup> One of the amendments expanded former section 4(c) and made the Sherman Act applicable not only to acts involving boycott, coercion, and intimidation, but to agreements to boycott, coerce, or intimidate as well.<sup>27</sup> The second amendment arose out of a perceived conflict between sections 2(b) and 4(a). Some senators argued that, to the extent state regulatory laws conflicted with federal law, section 2(b) made the Sherman and Clayton Acts permanently inapplicable, while section 4(a) made the antitrust laws applicable after the moratorium period.<sup>28</sup> To resolve the potential confusion, the Senate amended section 2(b) to specifically exempt the Sherman and Clayton Acts from the operation of section 2(b).<sup>29</sup> Thus, as passed by the Senate, the McCarran-Ferguson Act contained only a short moratorium during which the antitrust laws would not apply to the business of insurance.

The House, however, did not perceive any conflict between sections 2(b) and 4(a), and passed the bill without either Senate amendment.<sup>30</sup> The House debates suggest, however, that House members interpreted the bill as providing only a limited moratorium during which the Sherman and Clayton Acts would not apply.<sup>31</sup>

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26. *See id.* at 464, 478-88.

27. The Senate Judiciary Committee recommended this change, which did not generate much debate on the floor. *See id.* at 478.

28. I think there is an ambiguity in the bill. . . . In section 4(a) of the bill it is implied that in 1948 the Sherman Act shall again come into force unless something has been done in the meantime. However, in section 2(b) it is implied that even in 1948 the Sherman Act shall not invalidate any State regulatory law. . . . We should straighten out the difference between the two sections.

91 CONG. REC. 485 (1945) (remarks of Sen. Taft). *See also id.* at 484 (remarks of Sen. Taft and Sen. Murdock); *id.* at 486 (remarks of Sen. Murdock); *id.* at 486-87 (remarks of Sen. Ferguson).

29. Section 2(b) then read:

No act except . . . the Sherman Act and/or . . . the Clayton Act 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 so provides.

*Id.* at 486.

30. *See id.* at 1085.

31. *See, e.g., id.* at 1090 (remarks of Rep. Gwynne) ("What the bill does is to grant a moratorium."); *id.* at 1092 (remarks of Rep. Springer) ("This measure seeks only to estab-



The joint conference committee drastically altered the bill. The committee deleted section 3, which had exempted the insurance industry from the Federal Trade Commission and Robinson-Patman Acts.<sup>32</sup> The committee also sought to remove any possible ambiguity between sections 2(b) and 4(a) by adding a proviso to section 2(b). This proviso stated that the Sherman, Clayton, and Federal Trade Commission Acts would apply to the business of insurance after the moratorium period "to the extent that such business is not regulated by state law."<sup>33</sup> The proviso was apparently a compromise measure between a faction in Congress that favored a complete exemption from the antitrust laws and another faction that favored only temporary relief in the form of a moratorium.<sup>34</sup> By this proviso the committee transformed a limited moratorium into a permanent exemption to the extent that states regulated the insurance industry. The conference committee also revived the Senate amendment that would make the Sherman Act applicable to any agreement to boycott, coerce, or intimidate.<sup>35</sup>

The House approved the joint bill without debate;<sup>36</sup> the Senate debated the bill for two days before passing it without change.<sup>37</sup> President Roosevelt then signed the McCarran-Ferguson Act into law on March 9, 1945.<sup>38</sup>

As enacted, the McCarran-Ferguson Act provides in section 1 that state regulation and taxation of the insurance industry is in the public interest, and that congressional silence on these subjects does not impose any barrier on the states. Section 2(a) provides that the business of insurance is subject to state taxing and regulatory schemes. Section 2(b) declares that no federal law shall be construed to "invalidate, impair, or supersede" any state regulation or taxation of the insurance industry unless the federal law

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lish a moratorium. . . ."); *id.* at 1086 (remarks of Rep. Walter) ("This [bill] is merely a moratorium. That is all it is.").

32. H.R. REP. NO. 213, 79th Cong., 1st Sess. 2 (1945). *See* 91 CONG. REC. 1396 (1945).

33. H.R. REP. NO. 213, 79th Cong., 1st Sess. 1-2 (1945). *See* 91 CONG. REC. 1396 (1945).

34. *See* 91 CONG. REC. 1480-81 (1945) (remarks of Sen. Murdock).

35. *Id.* at 1396.

36. *See id.*

37. *See id.* at 1442-44, 1477-89. Only Senator Pepper opposed the bill, arguing strenuously that states should not be given the power to preclude the application of the federal antitrust laws. *See, e.g., id.* at 1443-44.

38. *See id.* at 1992.

specifically relates to the business of insurance. This section furnishes an exception for the Sherman, Clayton and Federal Trade Commission Acts, which are applicable to the extent that the business of insurance is not regulated by state law. Finally, section 3(b) provides that the Sherman Act shall apply to any agreement or act of "boycott, coercion, or intimidation."<sup>39</sup>

### III. THE SCOPE OF THE INSURANCE EXEMPTION: A FRAMEWORK FOR ANALYSIS

The assertion of an exemption under the McCarran-Ferguson Act should be examined in a logical fashion. Unfortunately, courts often fail to do so.<sup>40</sup> In addition, commentators, while recognizing the relevant issues, have failed to develop a systematic analysis for assessing the validity of an insurer's assertion of an antitrust exemption under the McCarran-Ferguson Act.<sup>41</sup> Such an analysis should begin by asking whether the insurer's activity is an ordinary part of the business of insurance. If it is, then the extent to which the activity is regulated by the state must be considered. Finally, one should determine whether the activity involves a form of boycott, coercion, or intimidation. If the activity is not regulated effectively by the state, or if the activity constitutes a form of boycott, coercion, or intimidation, the activity will be subject to close scrutiny under the antitrust laws. The activity, therefore, must satisfy all three steps in the analysis to qualify for an exemption.

#### A. The "Business of Insurance" Requirement

Section 2 of the McCarran-Ferguson Act specifies the first requirement for determining whether an insurer's activity is within the scope of the exemption. The section requires the activity to be part of the "business of insurance." Whether this requirement has been satisfied frequently determines whether an insurer is exempt from the antitrust laws. The issue is difficult to resolve because the Act does not define "business of insurance," and the legislative his-

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39. See *supra* note 1.

40. See, e.g., *Bartholomew v. Virginia Chiropractors Ass'n*, 612 F.2d 812 (4th Cir. 1979), *cert. denied*, 446 U.S. 938 (1980).

41. See, e.g., *Carlson*, *supra* note 11; *Weller*, *supra* note 22; Note, *Qualified Immunity for Insurers Under the McCarran-Ferguson Act*, 46 GEO. WASH. L. REV. 396 (1978).

tory is ambiguous.<sup>42</sup>

Faced with the difficulty of defining "business of insurance," the lower courts initially construed the phrase broadly, maintaining that it included any activity in which an insurance company might engage.<sup>43</sup> In a series of decisions culminating in *Group Life & Health Insurance Co. v. Royal Drug Co.*<sup>44</sup> and *Union Labor Life Insurance Co. v. Pireno*,<sup>45</sup> however, the Supreme Court developed and refined a restrictive three-prong test for determining whether an insurer's activity is within the business of insurance. Problems exist with this test, however—the most serious one being that the test excludes several activities that Congress considered a part of the business of insurance.

### 1. *The Test*

The Supreme Court in *Royal Drug* created a three-prong test for determining whether an insurer's activity is within the business of insurance: the first prong examines whether the activity involves the underwriting or spreading of risk; the second prong focuses on whether the activity involves the insurer-insured relationship; and the third prong, as refined in *Pireno*, asks whether the activity is limited to entities within the insurance industry, thus conforming to the legislative intent of the Act.

#### *a. The Underwriting or Spreading of Risk*

To satisfy the first prong of the test, the activity must involve the underwriting of risk.<sup>46</sup> This part of the test is based upon the Court's ruling in *SEC v. Variable Annuity Life Insurance Co. of America*,<sup>47</sup> the Court's first attempt to define the "business of in-

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42. Compare 91 CONG. REC. 480 (1945) (remarks of Sen. Murdock) (suggesting that the "business of insurance" is synonymous with "insurance companies") with *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 220-21 (1979) (legislative history suggests that Congress equated "business of insurance" with underwriting and spreading of risk).

43. See, e.g., *California League of Indep. Ins. Producers v. Aetna Casualty & Sur. Co.*, 175 F. Supp. 857 (N.D. Cal. 1959); *Professional & Business Men's Life Ins. Co. v. Banker's Life Co.*, 163 F. Supp. 274 (D. Mont. 1958); *Miley v. John Hancock Mut. Life Ins. Co.*, 148 F. Supp. 299 (D. Mass.), *aff'd*, 242 F.2d 758 (1st Cir.), *cert. denied*, 355 U.S. 828 (1957).

44. 440 U.S. 205 (1979).

45. 102 S. Ct. 3002 (1982).

46. *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211 (1979).

47. 359 U.S. 65 (1959).

insurance.”<sup>48</sup> In *Variable Annuity*, the Securities and Exchange Commission sought to compel a seller of variable-annuity insurance contracts to comply with the federal securities laws. The insurer claimed an exemption from those laws under the McCarran-Ferguson Act. A plurality of the Court rejected the insurer’s claim, holding that the sale of variable-annuity contracts was beyond the scope of the business of insurance.<sup>49</sup> The plurality identified the transfer of risk as an essential element of insurance: an activity that does not transfer a significant element of risk from the policyholder to the insurance company is not within the business of insurance.<sup>50</sup>

*Pireno* and *Royal Drug* emphasize that the underwriting of risk must increase the number of policyholders subject to the same

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48. Commentators occasionally cite *FTC v. National Casualty Co.*, 357 U.S. 560 (1958), as the first Supreme Court case construing the phrase “business of insurance”. See, e.g., Comment, *The McCarran Act’s Antitrust Exemption for “The Business of Insurance”*: A Shrinking Umbrella, 43 TENN. L. REV. 329, 338-39 (1976). In *National Casualty*, the Supreme Court considered the validity of an FTC cease-and-desist order prohibiting the interstate shipment of allegedly unfair and deceptive advertising. Because the Court was concerned primarily with whether the state regulation was sufficient to invoke the protection of the McCarran-Ferguson Act, the Court assumed that the activities involved the “business of insurance” and did not attempt to define that phrase.

49. 359 U.S. at 71-73. In a concurring opinion, Justices Brennan and Stewart contended that the sale of variable-annuity insurance contracts should not be exempt under the federal securities laws because the administration of such contracts caused an insurance company to act “in a way totally foreign to the business of a traditional life insurance and annuity company” and involved a “predominant element of the business of an investment company.” *Id.* at 81 (Brennan, J., concurring).

50. Comparing the variable annuities involved with conventional insurance, the plurality stated:

The difficulty is that, absent some guarantee of fixed income, the variable annuity places all the investment risks on the annuitant, none on the company. . . . But we conclude that the concept of “insurance” involves some investment risk-taking on the part of the company. The risk of mortality, assumed here, gives these variable annuities an aspect of insurance. Yet it is apparent, not real; superficial, not substantial. In hard reality the issuer of a variable annuity that has no element of a fixed return assumes no true risk in the insurance sense. . . . We deal with a more conventional concept of risk-bearing when we speak of “insurance.” For in common understanding “insurance” involves a guarantee that at least some fraction of the benefits will be payable in fixed amounts. . . . [Here, t]here is no true underwriting of risks, the one earmark of insurance as it has commonly been conceived of in popular understanding and usage.

*Id.* at 71, 73 (footnotes omitted).

risk.<sup>51</sup> An activity that merely reduces the insurer's liability, and therefore its financial risk, is insufficient. "[U]nless there is some element of spreading risk more widely, there is no underwriting of risk."<sup>52</sup> Furthermore, the spreading of risk must be effectuated by means of the insurance contract between the parties.<sup>53</sup>

An insurance company assumes two risks when it issues a policy. The first risk is the probability that the insured event will occur; the second risk is the magnitude of the payment should the insured event occur.<sup>54</sup> The Court's risk-spreading test apparently encompasses only those activities that affect the first of these two risks. Increasing the number of policyholders subject to the same event will reduce variance, producing a statistically more accurate determination of the insured event's probability. Spreading the risk through an enlarged pool of policyholders, however, does not affect the size of the settlement.<sup>55</sup> Thus, under the first prong of the test, activities calculated to reduce the magnitude of the insurer's liability for a claim are not part of the business of insurance.

#### *b. The Insurer-Insured Relationship*

The second prong of the test requires that the activity relate to the contract between the insurer and the insured.<sup>56</sup> This part of the test arose from the Court's holding in *SEC v. National Securities, Inc.*<sup>57</sup> In *National Securities*, the SEC sought to dissolve a merger between two insurance companies on the ground that the shareholders' approval of the merger was procured through fraud. Applying a different approach from that used in *Variable Annuity*, the Court concluded that the merger was outside the business of insurance. The Court distinguished the insurance business from

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51. *Pireno*, 102 S. Ct. at 3009; *Royal Drug*, 440 U.S. at 211.

52. 440 U.S. at 214 n.12.

53. See 102 S. Ct. at 3009.

54. See *Proctor v. State Farm Mut. Auto. Ins. Co.*, 675 F.2d 308, 323 n.30 (D.C. Cir.), cert. denied, 103 S. Ct. 86 (1982).

55. Both the provider agreement in *Royal Drug* and the peer review committee in *Pireno* affected the size of the settlement and were held to be outside the business of insurance. See *Pireno*, 102 S. Ct. at 3009; *Royal Drug*, 440 U.S. at 214.

56. *Pireno*, 102 S. Ct. at 3008; *Royal Drug*, 440 U.S. at 215-16.

57. 393 U.S. 453 (1969).

the business of insurance, and announced that the "core" of the business of insurance involves the relationship between the insurer and the policyholder.<sup>58</sup> Consequently, to be part of the business of insurance, an activity must pertain to, or affect, that relationship. Activities affecting the insurance policy, its interpretation or enforcement, and other acts related to the insurer's reliability, therefore, are part of the business of insurance; activities affecting the insurance company's relationship with its stockholders are not.<sup>59</sup>

In *Royal Drug* and *Pireno*, the Supreme Court refined the definition of the business of insurance by requiring that the activity directly affect the insurer-insured relationship.<sup>60</sup> Under this refinement, agreements that are not part of the insurance contract and therefore have only an indirect effect upon the insurer-insured relationship, do not qualify as part of the business of insurance, even though such agreements might affect the financial reliability of the company.<sup>61</sup> Thus, to the extent that the Court in *National Securities* held that the business of insurance included "other activities . . . closely [related] to . . . [the] status [of] reliable insurers,"<sup>62</sup> the Court's current formulation of the insurer-insured test is markedly narrower.

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58. The statute did not purport to make the States supreme in regulating all the activities of insurance companies; its language refers not to the persons or companies who are subject to state regulation, but to laws "regulating the business of insurance." Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the "business of insurance" does the statute apply . . . [W]hatever the exact scope of the statutory term, it is clear where the focus [is]—it [is] on the relationship between the insurance company and the policyholder.

*Id.* at 459-60.

59. *Id.* at 460. Following the Supreme Court's decision in *National Securities*, lower federal courts consistently applied the insurer-insured relationship test rather than the risk-spreading test of *Variable Annuity*. See, e.g., *Zelson v. Phoenix Mut. Life Ins. Co.*, 549 F.2d 62 (8th Cir. 1977); *Allied Fin. Servs., Inc. v. Foremost Ins. Co.*, 418 F. Supp. 157 (D. Neb. 1976). Application of the insurer-insured relationship test proved difficult, however, when insurer practices affected policyholders and imposed restraints on other businesses, such as when the insurance was "tied" to another product or when the insurer contracted with providers for benefits promised under the insurance policy. Note, *supra* note 41, at 401-06. Application of the test in the latter situation—provider agreements—presented the Supreme Court in *Royal Drug* with the opportunity to define further the "business of insurance."

60. *Pireno*, 102 S. Ct. at 3008; *Royal Drug*, 440 U.S. at 216.

61. *Pireno*, 102 S. Ct. at 3009-10; *Royal Drug*, 440 U.S. at 216-17.

62. 393 U.S. at 460.

*c. Conformity to Legislative Intent*

The Supreme Court developed the final prong of the test in *Royal Drug*. This prong recognizes and attempts to fulfill the congressional intent in enacting the McCarran-Ferguson Act.<sup>63</sup> The primary purpose of Congress in passing the Act was to immunize state regulatory and taxing schemes from attack as unreasonable burdens on interstate commerce.<sup>64</sup> This federalistic purpose is irrelevant, however, when determining the applicability of the anti-trust laws to the insurance industry.<sup>65</sup> Instead, the secondary purpose of the Act, "to give insurance companies only a limited exemption from the antitrust laws," controls in antitrust cases.<sup>66</sup> In *Royal Drug*, the Court asserted that this secondary purpose could be furthered only by construing the phrase "business of insurance" narrowly. Thus, the Court maintained that any uncertainty regarding the applicability of the exemption should be resolved against a

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63. 440 U.S. at 217.

64. Inevitable uncertainties which followed the handing down of the decision in the Southeastern Underwriters Association case, with respect to the constitutionality of State laws, have raised questions in the minds of insurance executives, State insurance officials, and others as to the validity of State tax laws as well as State regulatory provisions; thus making desirable legislation by the Congress to stabilize the general situation.

. . . Your committee believes there is urgent need for an immediate expression of policy by the Congress with respect to the continued regulation of the business of insurance by the respective States. Already many insurance companies have refused, while others have threatened refusal to comply with State tax laws, as well as with other State regulations, on the ground that to do so, when such laws may subsequently be held unconstitutional in keeping with the precedent-smashing decision in the Southeastern Underwriters case, will subject insurance executives to both civil and criminal actions for misappropriation of company funds.

H.R. REP. No. 68, 79th Cong., 1st Sess. 2 (1945). See H.R. REP. No. 143, 79th Cong., 1st Sess. 3, reprinted in 1945 U.S. CODE CONG. & AD. NEWS 670, 671; S. REP. No. 20, 79th Cong., 1st Sess. 1-2 (1945). The Supreme Court recognized the primarily federalistic purpose of the McCarran-Ferguson Act when it upheld the Act against constitutional challenge in *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408, 429 (1946) ("Congress' purpose [in passing the Act] was broadly to give support to the existing and future state systems for regulating and taxing the business of insurance.").

65. 440 U.S. at 218 n.18.

66. *Id.* Congress' consideration and rejection of bills proposing a blanket immunity indicates that Congress intended to provide only a limited exemption. See *supra* notes 21-22 and accompanying text. See also Weller, *supra* note 22, at 598.

grant of antitrust immunity.<sup>67</sup> In *Pireno*, the Court indicated that an activity can escape the antitrust laws only if the activity is confined entirely to the insurance industry.<sup>68</sup> The Court maintained that Congress did not intend to include within the business of insurance agreements or practices that involve parties outside the insurance industry. Consequently, the Court held that such agreements or practices are subject to antitrust regulation.

## 2. *The Problem*

Several difficulties exist with the Court's three-prong test. The most significant problem is that the test excludes cooperative rate-making and pooling of loss data from the business of insurance. The dissent in *Royal Drug* recognized this problem and criticized the majority's approach.<sup>69</sup> Congress clearly intended to include both of these activities within the scope of the exemption as long as the states continued to regulate the industry.<sup>70</sup> The Court's test, however, would exclude these activities because neither cooperative rate-making nor pooling of loss data directly affects the probability of the insured event.<sup>71</sup> Rather, these activities affect only the premium charged for the insurance. Moreover, neither activity directly affects the insurer-insured relationship in the manner prescribed by the Court in *Royal Drug* because the only parties involved in either activity are insurance companies.

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67. See, e.g., *Abbott Laboratories v. Portland Retail Druggist Ass'n, Inc.*, 425 U.S. 1 (1976); *Connel Const. Co. v. Plumbers & Steamfitters Local Union No. 100*, 421 U.S. 616 (1975); *FMC v. Seatrain Lines, Inc.*, 411 U.S. 726 (1973).

68. 102 S. Ct. at 3008-09. See also 440 U.S. at 224 ("There is not the slightest suggestion in the legislative history that Congress in any way contemplated that arrangements . . . , which involve . . . entities outside the insurance industry, are the 'business of insurance.'") (footnote omitted).

69. 440 U.S. at 244 (Brennan, J., dissenting).

70. See 91 CONG. REC. 1481 (1945) (remarks of Sen. Ferguson); 90 CONG. REC. A4405 (1944).

71. Two commentators have argued that because cooperative rate-making and the pooling of loss data lower the premiums that an insurer charges, those activities do spread risk. They observed that the lower premiums created by those activities attract more customers to the insurance company, and the enlarged customer pool, in turn, "spread[s] risk between customers by making the company's actual average payout come closer to the statistically predicted result." Sullivan & Wiley, *Recent Antitrust Developments: Defining the Scope of Exemptions, Expanding Coverage, and Refining the Rule of Reason*, 27 U.C.L.A. L. REV. 265, 283 (1979).



In *Owens v. Aetna Life & Casualty Co.*,<sup>72</sup> the United States Court of Appeals for the Third Circuit implicitly recognized this problem with the Supreme Court's test. The plaintiff in *Owens* alleged that the defendant had conspired with other insurance companies to create a monopoly that would force the plaintiff out of business. One of the questions faced by the Third Circuit was whether cooperative rate-making was within the "business of insurance." After quoting at length from the Supreme Court's discussion of Congress' intent to include such activity within the exemption, the court concluded, "it is clear that at least [cooperative rate-making is within] the business of insurance, either because [it] pertain[s] to risk-spreading or to the contract between the insurer and the insured. . . ."<sup>73</sup> In reaching this conclusion though, the court did not attempt to explain how cooperative rate-making satisfies the *Royal Drug* test.

One commentator has attempted to resolve this problem by reading the risk-spreading test broadly to include insurer activities related to the determination of coverage and premiums.<sup>74</sup> The difficulty with this broad reading is that it renders the insurer-insured relationship test superfluous: an insurer's decision regarding coverage and premiums almost always would affect its relations with current or potential policyholders.<sup>75</sup>

Rather than read the Supreme Court's test more broadly than the Court intended, courts should recognize pooling of loss data and cooperative rate-making as exceptions to the three-prong *Royal Drug* test. The majority's discussion of these two activities, as well as the dissent's interpretation of the majority opinion, is consistent with the creation of such exceptions.<sup>76</sup> Congress clearly intended to include cooperative rate-making and pooling of loss data within the business of insurance.<sup>77</sup> The Court's three-prong

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72. 654 F.2d 218 (3d Cir.), cert. denied, 454 U.S. 1092 (1981).

73. 654 F.2d at 224-25.

74. Note, *The Definition of "Business of Insurance" Under the McCarran-Ferguson Act After Royal Drug*, 80 COLUM. L. REV. 1475, 1479 (1980).

75. *Id.* at 1479 n.26.

76. See 440 U.S. at 221-24; *id.* at 244-45 (Brennan, J., dissenting). In addition, the Court intimated that activities that involve the insurer-agent relationship, but do not fit within the Court's three-prong test of the "business of insurance", might constitute an additional exception. See *id.* at 224 n.32; *infra* notes 161-66 and accompanying text.

77. See *supra* note 70.

test, therefore, should be viewed as a device for determining whether activities not explicitly included by Congress are also within the business of insurance.

A second problem with the Supreme Court's three-prong test for the business of insurance is that it fails to explain the relationship among the three prongs.<sup>78</sup> The Court characterized the spreading of risk as "an indispensable characteristic of insurance,"<sup>79</sup> while describing the insurer-insured relationship as only "[a]nother commonly understood aspect of the business of insurance."<sup>80</sup> The relationship between the business of insurance and the prong that requires the activity to conform to legislative intent is also uncertain.

The Supreme Court's decision in *Pireno* partially ameliorated the problem of understanding the relationship between the three prongs of the test. In *Pireno*, the Court stated that "[n]one of the [three] criteria is necessarily determinative in itself. . . ."<sup>81</sup> Thus, a court must apply each prong of the test in conjunction with the other two.<sup>82</sup> The relative weight accorded to each prong of the test, however, remains uncertain.

### *B. The State Regulation Requirement*

Section 2 of the McCarran-Ferguson Act addresses state regulation of activity within the "business of insurance." In the framework for analyzing insurer claims of antitrust immunity, two requirements must be met. Section 2(b) of the Act establishes the first requirement, defining the extent of state regulation required to exempt insurer activity from the antitrust laws. The second requirement arises from a constitutional limitation on state regulation of insurance.

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78. Sullivan & Wiley, *supra* note 71, at 282 n.77. See also *Proctor v. State Farm Mut. Auto. Ins. Co.*, 675 F.2d 308, 319 (D.C. Cir.), *cert. denied*, 103 S. Ct. 86 (1982).

79. *Royal Drug*, 440 U.S. at 212.

80. *Id.* at 215.

81. 102 S. Ct. at 3009. See also *id.* at 3010.

82. Unfortunately, some courts have considered only one part of the test in reaching a decision. See, e.g., *Pireno v. New York State Chiropractic Ass'n*, 650 F.2d 387 (2d Cir. 1981) (primarily applying risk-spreading test), *aff'd sub nom. Union Labor Life Ins. Co. v. Pireno*, 102 S. Ct. 3002 (1982); *Virginia Academy of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476 (4th Cir. 1980) (applying insurer-insured relationship test), *cert. denied*, 450 U.S. 916 (1981); *Bartholomew v. Virginia Chiropractors Ass'n, Inc.*, 612 F.2d 812 (4th Cir. 1979) (applying insurer-insured relationship test), *cert. denied*, 446 U.S. 938 (1980).

### 1. *The Extent of State Regulation*

Section 2(b) of the Act specifies that the business of insurance is exempt from the antitrust laws only if regulated by the states. To allow the states time to enact regulations, section 3(a) of the Act provided a moratorium during which the antitrust laws would not apply.<sup>83</sup> Although the Act invites state regulation of the insurance industry, this does not mean that state regulation will foreclose application of the federal antitrust laws. The question that must be addressed then is what type of state regulation the Act requires.

One should look initially to the language of the Act. Generally, courts have focused on the proviso of section 2(b) which declares that the antitrust laws "shall be applicable to the business of insurance to the extent that such business is not regulated by state law." One commentator has argued that the "invalidate, impair, or supersede" clause of section 2(b) is equally applicable.<sup>84</sup> The legislative history of the Act, however, contradicts this view. Congress inserted the "invalidate, impair, or supersede" clause to retain authority to legislate further if state regulation proved inadequate. But any supplementary legislation would have to apply specifically to the business of insurance to avoid implicit repeal of the McCarran-Ferguson Act.<sup>85</sup> In addition, the final Senate debate suggests

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83. Carlson, *supra* note 11, at 1137. Shortly after the passage of the Act, the National Association of Insurance Commissioners developed model acts designed to insulate the insurance industry from federal antitrust laws. *Id.* By 1964, most states had adopted one or more of these model acts. See generally J. DAY, *supra* note 6, at 28-31.

84. Weller, *supra* note 22, at 602-05. Weller bases his argument on several statements by Senators O'Mahoney, McCarran, and Murdock that suggest that § 2(b) made the Act stronger than the original Senate version, and that the first clause of § 2(b) applies to the antitrust laws as well. See 91 CONG. REC. 1444, 1478, 1489 (1945). These statements, however, were responses to Senator Pepper, who objected to the proviso clause because he feared that the clause immunized insurance companies from the operation of the antitrust laws. In addition, the conference committee bill was a compromise measure between the Senate version, which provided only a short moratorium, and the House version, which provided a broader exemption. See *id.* at 1480-81 (remarks of Sen. Murdock). The House conferees would not have agreed to a bill that was stronger than the original Senate version. Finally, Weller also states that his interpretation is consistent with the federalistic purposes of the Act. Weller, *supra* note 22, at 605. The federalistic purposes, however, are inapposite to considerations of the McCarran-Ferguson Act and the antitrust laws. See *supra* notes 64-66 and accompanying text. See also *infra* notes 85-87 and accompanying text (further suggesting that Weller's argument is not supported by the legislative history or case law).

85. See 91 CONG. REC. 1487-88 (1945) (remarks of Sens. Ferguson, O'Mahoney, and Barkley).

that the applicability of the federal antitrust laws was to be governed by the proviso, and not by the "invalidate, impair, or supersede" language.<sup>86</sup> Moreover, absent the proviso, the antitrust laws would not be applicable at all, because they are not related specifically to the business of insurance. Indeed, courts have recognized this distinction and have applied the "invalidate, impair, or supersede" clause only when determining whether a state insurance regulation conflicted with a federal non-trade regulatory statute.<sup>87</sup>

The interpretation of the proviso in section 2(b) is critical to a determination of what constitutes sufficient state regulation to preclude application of the antitrust laws. Unfortunately, the Supreme Court has never defined the phrase "to the extent that." In *FTC v. National Casualty Co.*,<sup>88</sup> the Court held that general state legislation was not insufficient per se to satisfy the section 2(b) requirement.<sup>89</sup> The Court suggested, however, that a statutory framework that was a mere pretense would be insufficient.<sup>90</sup>

Lower courts have interpreted section 2(b) more liberally than the Supreme Court did in *National Casualty*, and have maintained that a reasonably comprehensive statutory scheme authorizing state regulation of the business of insurance is sufficient. The standard generally applied by the lower courts is that "a State regulates the business of insurance within the meaning of [section 2(b)] when a State statute generally proscribes . . . or permits or authorizes certain conduct on the part of . . . insurance companies."<sup>91</sup> Thus, the United States Court of Appeals for the Sixth Cir-

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86. See, e.g., *id.* at 1481 (remarks of Sen. Ferguson).

Rules of statutory construction also support the interpretation that the proviso is an exception to the general language of § 2(b). See 1A, 2A C. SANDS, STATUTES AND STATUTORY CONSTRUCTION §§ 21.11, 47.08, 47.09 (4th ed. 1972).

87. See, e.g., *Perry v. Fidelity Union Life Ins. Co.*, 606 F.2d 468 (5th Cir. 1979), cert. denied, 446 U.S. 987 (1980); *Cochran v. Paco, Inc.*, 606 F.2d 460 (5th Cir. 1979); *Spirit v. Teachers Ins. & Annuity Ass'n*, 475 F. Supp. 1298 (S.D.N.Y. 1979), *aff'd in part & rev'd in part*, 691 F.2d 1054 (2d Cir. 1982).

88. 357 U.S. 560 (1958).

89. *Id.* at 564-65.

90. For an analysis that reaches a similar conclusion, see *Crawford v. American Title Ins. Co.*, 518 F.2d 217, 222-24 (5th Cir. 1975) (Godbold, J., dissenting).

91. *California League of Indep. Ins. Producers v. Aetna Casualty & Sur. Co.*, 175 F. Supp. 857, 860 (N.D. Cal. 1959). Another court recently observed that "[e]ven if the alleged activities [are] not specifically regulated, the exemption [will] still be effective as long as the mechanism for regulation [is] available. . . ." *Steinberg v. Guardian Life Ins. Co. of Am.*,

cuit in *Ohio AFL-CIO v. Insurance Rating Board*<sup>92</sup> allowed an exemption under the McCarran-Ferguson Act, reasoning that the state sufficiently regulated the insurance industry although evidence indicated that the Ohio insurance commissioner did not enforce the state laws and essentially permitted insurers to regulate themselves.<sup>93</sup>

The legislative history of the Act, however, indicates that Congress intended the exemption to be available only when effective state regulation exists.<sup>94</sup> Otherwise, neither federal nor state law actually would regulate insurer activity, leaving the public unpro-

486 F. Supp. 122, 124 (E.D. Pa. 1980).

92. 451 F.2d 1178 (6th Cir. 1971), *cert. denied*, 409 U.S. 917 (1972).

93. 451 F.2d at 1182-84. Other courts have reached similar results. *See, e.g., Crawford v. American Title Ins. Co.*, 518 F.2d 217 (5th Cir. 1975); *California League of Indep. Ins. Producers v. Aetna Casualty & Sur. Co.*, 175 F. Supp. 857 (N.D. Cal. 1959). The Supreme Court recently intimated approval of the lower federal courts' interpretation of the state regulation requirement. *See St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531, 540 n.9 (1978).

Apparently, only two judges have disagreed with the lower courts' interpretation, adopting the view that only active and effective state regulation will satisfy the requirements of the exemption. *See Ohio AFL-CIO v. Insurance Rating Bd.*, 409 U.S. 917 (1972) (Douglas J., dissenting), *denying cert. to* 451 F.2d 1187 (6th Cir. 1971); *Crawford v. American Title Ins. Co.*, 518 F.2d 217, 221-30 (5th Cir. 1975) (Godbold, J., dissenting).

Recently, the District of Columbia and Second Circuits have intimated that they would require effective state regulation of an insurer's activity before the insurer could qualify under the Act. *See Proctor v. State Farm Mut. Auto. Ins. Co.*, 675 F.2d 308, 316 (D.C. Cir.), *cert. denied*, 103 S. Ct. 86 (1982); *Pireno v. New York State Chiropractic Ass'n*, 650 F.2d 387, 390 n.5 (2d Cir. 1981), *aff'd sub nom. Union Labor Life Ins. Co. v. Pireno*, 102 S. Ct. 3002 (1982). *See also United States v. Crocker Nat'l Corp.*, 656 F.2d 428, 452-55 (9th Cir. 1981) (holding that state law must regulate the specific practices challenged under the federal antitrust law), *cert. granted sub. nom. BankAmerica Corp. v. United States*, 456 U.S. 1005 (1982).

Ineffective state regulation is not uncommon. *See* 1979 REPORT, *supra* note 4, at 226; Kimball & Boyce, *supra* note 6, at 565; Note, *supra* note 7, at 1292-98. For a report concluding that state regulation of the insurance industry is ineffective because of underbudgeting, lack of trained personnel, and other factors, see S. REP. No. 1834, 86th Cong., 2d Sess. 1-8, 239-47 (1960).

94. Commentators have argued for years that effective state regulation is a prerequisite to the availability of the exemption. *E.g., Carlson, supra* note 11, at 1155; Kimball & Boyce, *supra* note 6, at 570-75; Comment, *State Regulation Under the McCarran Act*, 47 TUL. L. REV. 1069, 1084 (1973).

The Supreme Court's recent restrictive interpretations of the exemption also suggest that the lower courts' liberal reading of the state regulation requirement is incorrect. *See Sullivan & Wiley, supra* note 71, at 288-89. Moreover, the use of the term "regulate" in defining the type of state law that will trigger the exemption indicates that the drafters of the Act contemplated effective state regulation. *See Kimball & Boyce, supra* note 6, at 568-69.

tected. Congress intended the proviso of section 2(b) to fill this potential gap by requiring specific state regulation of the activity before allowing an exemption under the McCarran-Ferguson Act.<sup>95</sup>

Because the proviso originated in a conference committee, the only evidence of congressional intent is the Senate's consideration of the committee report. The limited legislative history supports the proposition that Congress intended effective state regulation to be a prerequisite to antitrust immunity. Several senators distinguished state legislation from state regulation, indicating that only the latter would suffice under the Act.<sup>96</sup> In addition, Senator Barkley inquired

whether, where States attempt to occupy the field—but do it inadequately—by going through the form of legislation so as to deprive the [antitrust laws] of their jurisdiction, is it the Senator's interpretation of the conference report that in a case of that kind, where the legislature fails adequately even to deal with the field it attempts to cover, [the antitrust laws] still would apply?<sup>97</sup>

Senator McCarran responded that this was his interpretation of the Act.<sup>98</sup> Furthermore, although President Roosevelt did not purport to declare the intent of Congress, he did announce that the Act required effective state regulation of the insurance industry for the exemption to apply.<sup>99</sup>

The relationship between section 2(b) and the state action doctrine, as expressed in *Parker v. Brown*,<sup>100</sup> further supports the

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95. W. FREEDMAN, RICHARDS ON THE LAW OF INSURANCE 189-90 (5th ed. 1952).

96. See, e.g., 91 CONG. REC. 1443-44 (1945) (remarks of Sens. McCarran, O'Mahoney, Murdock, and White).

97. *Id.* at 1444.

98. *Id.* Senator Barkley later stated that he was voting for the Act on the basis of this interpretation. See *id.* at 1488.

99. Upon signing the Act into law, President Roosevelt stated:

After the moratorium period, the antitrust laws . . . will be applicable in full force and effect to the business of insurance except to the extent that the states have assumed the responsibility, and are effectively performing that responsibility, for the regulation of whatever aspect of the insurance business may be involved.

Press release by President Roosevelt (Mar. 10, 1945), reprinted in Donovan, *Regulation of Insurance Under the McCarran Act*, 15 LAW & CONTEMP. PROBS. 473, 478 (1950) (emphasis added).

100. 317 U.S. 341 (1943). In *Parker*, the Supreme Court held that the Sherman Act did

proposition that the Act requires effective state regulation. In *Parker*, the Supreme Court held that the antitrust laws would exempt anticompetitive activity only if the state clearly articulates, actively supervises, and compels adherence to the regulatory scheme.<sup>101</sup> During the Senate debate, one of the conferees asserted that the proviso clause embodied the *Parker* doctrine.<sup>102</sup> Both the legislative history and the language of the proviso clause support this assertion.<sup>103</sup> Indeed, the NAIC has said that “[s]ection 2(b) is essentially an enunciation of the *Parker v. Brown* decision.”<sup>104</sup> If section 2(b) is the embodiment of *Parker* or simply analogous to it, then courts should require effective state regulation of the activity, in contrast to mere legislation, before allowing an insurer’s claim of exemption under the McCarran-Ferguson Act.<sup>105</sup>

## 2. *The Territorial Limitation on State Regulation*

Even if state insurance law effectively regulates insurer activity, the regulation must be constitutional. In *FTC v. Travelers Health Association*,<sup>106</sup> the FTC sought to prohibit the defendant’s nationwide distribution of deceptive circulars. The United States Court of Appeals for the Eighth Circuit upheld the insurer’s claim of exemption on the basis of a Nebraska statute regulating unfair and deceptive insurance practices.<sup>107</sup> The Supreme Court reversed, holding that “the state regulation which Congress provided should operate to displace [the antitrust laws] means regulation by the

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not invalidate a state program aimed at stabilizing raisin prices because the Sherman Act was not intended to apply to the actions of a state or its officers. *Id.* at 350-52.

101. *Id.* at 346-47.

102. 91 CONG. REC. 1480 (1945) (remarks of Sen. O’Mahoney).

103. See generally Weller, *supra* note 22, at 615-17.

104. NATIONAL ASS’N OF INS. COMM’RS, MONITORING COMPETITION: A MEANS OF REGULATING THE PROPERTY AND LIABILITY INSURANCE BUSINESS 27 n.58 (1974). At least one court has adopted this view. *Allstate Ins. Co. v. Lanier*, 242 F. Supp. 73, 87 (E.D.N.C. 1965) (“Section 2(b) was written into the Act as an enunciation of the *Parker v. Brown* decision.”), *cert. denied*, 385 U.S. 930 (1966).

105. The *Parker* doctrine must be applied as a static concept, of course, not in accordance with its recent interpretations. Otherwise, courts would be giving the doctrine a meaning unanticipated by Congress.

106. 362 U.S. 293 (1960). The decision resolved a question left open in *FTC v. National Casualty Co.*, 357 U.S. 560 (1958)—whether state regulation could be ineffective because of constitutional constraints.

107. 262 F.2d 241, 244 (8th Cir. 1959), *vacated and remanded*, 362 U.S. 293 (1960).

State in which the [insurer's activity] is practiced and has its impact."<sup>108</sup> Thus, effective state regulation exempts from the anti-trust laws only insurer activity that is practiced and has its impact within that state; regulation by a state cannot provide an exemption for insurer activity occurring beyond its borders.

### C. *The Boycott Exception*

Even if insurer activity is within the business of insurance and state law effectively regulates it, the activity is not outside the purview of the Sherman Act if it entails a boycott, coercion, or intimidation. Section 3(b) of the McCarran-Ferguson Act provides that "[n]othing contained in [this Act] shall render the . . . Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or any act of boycott, coercion, or intimidation."<sup>109</sup> The scope of the boycott exception is unclear from the language of the Act. Consequently, a question exists whether the exception applies only to acts against insurance companies and agents or whether policyholders and members of the general public also may take advantage of the exception.

The legislative history of the Act offers little assistance in answering this question. Congress intended the exception to apply to activity such as that found in *South-Eastern Underwriters*.<sup>110</sup> In *South-Eastern Underwriters*, insurance association members attempted to force non-members to join the association by preventing them from reinsuring their risks, by disparaging their services and facilities, and by withdrawing support from independent agencies that represented non-members.<sup>111</sup> The congressional debates, however, do not demonstrate whether Congress intended to limit the exception to such conduct.

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108. 362 U.S. at 298-99. Lower courts have applied this rule without great difficulty. See, e.g., *Seasongood v. K & K Ins. Agency*, 414 F. Supp. 698 (E.D. Mo. 1976), *rev'd on other grounds*, 548 F.2d 729 (8th Cir. 1977); *United States v. Chicago Title & Trust Co.*, 242 F. Supp. 56 (N.D. Ill. 1965).

109. 15 U.S.C. § 1013(b) (1976).

110. See 91 CONG. REC. 1485 (1945) (remarks of Sen. O'Mahoney); *id.* at 1087 (remarks of Rep. Celler). The drafters of the Act apparently derived the "boycott, coerce, or intimidate" language of § 3(b) from the Supreme Court's decision in *South-Eastern Underwriters*. See 322 U.S. 533, 535 (1944).

111. 322 U.S. at 535-36.



On the basis of this meager legislative history, courts initially held that section 3(b) applied only to the boycott, coercion, or intimidation of insurance companies or agents.<sup>112</sup> In *St. Paul Fire & Marine Insurance Co. v. Barry*,<sup>113</sup> however, the Supreme Court held that the boycott exception protected other parties as well. In *Barry*, Rhode Island physicians had refused to accept an unfavorable change in their malpractice insurance policies.<sup>114</sup> The other malpractice insurers in the state refused to insure the physicians, and the physicians brought suit. On review, the Supreme Court reasoned that Congress must have intended the terms "boycott, coercion, and intimidation" to be given their natural meaning within the context of the Sherman Act. After considering several possible definitions of the word "boycott",<sup>115</sup> the Court concluded that the term included concerted refusals to deal with parties who were not competitors. The Court also found that the legislative history of the Act disclosed no congressional intent to limit the "broad and unqualified" language of section 3(b) to boycotts

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112. The first case to interpret the boycott exception was *Transnational Ins. Co. v. Rosenlund*, 261 F. Supp. 12, 26 (D. Or. 1966), which held that Congress' primary purpose in passing § 3(b) was to protect agents from blacklisting. Relying on *Rosenlund*, other courts subsequently held that the boycott exception did not apply to suits brought by policyholders or by the general public. See, e.g., *Meicler v. Aetna Casualty & Sur. Co.*, 506 F.2d 732 (5th Cir. 1975); *Addrisi v. Equitable Life Assur. Soc'y of the United States*, 503 F.2d 725 (9th Cir. 1974), cert. denied, 420 U.S. 929 (1975); *McIlhenny v. American Title Ins. Co.*, 418 F. Supp. 364 (E.D. Pa. 1976); *Mathis v. Automobile Club Inter-Ins. Exch.*, 410 F. Supp. 1037 (W.D. Mo. 1976). For a discussion of this early line of cases, see Note, *Insurance Regulation and Antitrust Exemptions: McCarran-Ferguson, the Boycott Exception, and the Public Interest*, 27 RUTGERS L. REV. 140 (1973).

113. 438 U.S. 531 (1978).

114. The insurer announced that it would no longer offer coverage on an "occurrence" basis, which protects the policyholder from liability for any act done while the policy is in effect, and instead would provide coverage only on a "claims made" basis, which protects the policyholder only against claims made during the life of the policy. See *id.* at 535 & n.3.

115. Among the definitions that the Court quoted were: "a method of pressuring a party with whom one has a dispute by withholding, or enlisting others to withhold, patronage or services from the target," *id.* at 541; "combinations of businessmen to 'deprive others of access to merchandise which the latter wishes to sell to the public,'" *id.* (quoting *United States v. General Motors Corp.*, 384 U.S. 127, 146 (1966)); "'any agreement by a group of competitors to boycott a particular buyer or group of buyers,'" *id.* (quoting *FMC v. Aktiebolaget Svenska Amerika Linien*, 390 U.S. 238, 250 (1968)); and "'concerted refusals by traders to deal with other traders,'" *id.* at 543 (quoting *Klor's, Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207, 212 (1959)).

against competitors.<sup>116</sup> Accordingly, the Court held that section 3(b) encompassed boycotts of policyholders by the insurance companies.<sup>117</sup>

The Court's decision in *Barry*, however, fails to define adequately the scope of the "boycott, coercion, and intimidation" language of section 3(b).<sup>118</sup> Extending the exception to acts against policyholders creates the danger that the exception, if read too broadly, will consume all of the exemption granted in section 2 of the Act. For example, after a state has approved a rate or policy agreed upon by a group of insurers, members of the public could challenge the rate or policy under section 3(b), contending that the insurers implicitly have refused to deal with the general public at other than the agreed upon price.<sup>119</sup>

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116. 438 U.S. at 546-50.

117. The Court also noted that state regulation or compulsion might be "a factor to be considered in the definition of 'boycott' within the meaning of § 3(b)." *Id.* at 554 n.27. The footnote implies that the state action doctrine might shield acts of boycott, coercion, or intimidation. The legislative history of the Act, however, precludes application of the state action doctrine in such a manner. *See* 91 CONG. REC. 481 (1945) (remarks of Sen. Ferguson) ("[I]f . . . State law undertook to authorize a boycott, a coercion or an intimidation, or an agreement to do any one of those three things, then it would be clearly void because Congress would have already spoken. . . ."). *See also id.* at 1443, 1481, 1483 (remarks of Sens. Ferguson, McCarran, and Radcliffe).

Section 3(b) also might apply to suits in which insurers allegedly have boycotted tradesmen. *See, e.g., Proctor v. State Farm Mut. Auto. Ins. Co.*, 561 F.2d 262 (D.C. Cir. 1977), *vacated and remanded on other grounds*, 440 U.S. 942 (1979).

118. *See* Carlson, *supra* note 11, at 1167-68; Note, *Policyholder Standing Under the Boycott Exception to the McCarran-Ferguson Act*, 10 CONN. L. REV. 419, 438 (1978) [hereinafter cited as Note, *Policyholder Standing*]; Note, *Barry v. St. Paul Fire & Marine Insurance Co.: A Re-Interpretation of the Boycott Exception to the McCarran Act*, 1977 DUKE L.J. 1069 [hereinafter cited as Note, *A Re-Interpretation*].

The Court also did not define "coercion" or "intimidation." Courts generally have not differentiated between the three terms used in section 3(b). *See, e.g., Proctor v. State Farm Mut. Auto. Ins. Co.*, 561 F.2d 262, 275 (D.C. Cir. 1977), *vacated and remanded on other grounds*, 440 U.S. 942 (1979); *Black v. Nationwide Mut. Ins. Co.*, 429 F. Supp. 458, 462 (W.D. Pa. 1977), *aff'd mem.*, 571 F.2d 571 (3d Cir. 1978). *But see Travelers Ins. Co. v. Blue Cross of W. Pa.*, 481 F.2d 80, 84 (3d Cir.) (economic pressure on hospitals to sign with Blue Cross does not amount to "coercion"), *cert. denied*, 414 U.S. 1093 (1973). *Cf. Card v. National Life Ins. Co.*, 603 F.2d 828, 834 (10th Cir. 1979) (summary dismissal of alleged conspiracy to terminate insurance agent's contract affirmed because "there was not present the allegation of coercion").

119. Carlson, *supra* note 11, at 1168; Note, *Policyholder Standing, supra* note 118 at 438. Such a challenge already has occurred. *See Anglin v. Blue Shield of Va.*, 510 F. Supp. 75 (W.D. Va. 1981), *aff'd*, 693 F.2d 315 (4th Cir. 1982). In addition, two Circuits have noted that an expansive interpretation of § 3(b) would undermine the exemption granted in § 2.

Because of this potential danger, commentators have suggested several approaches to narrow the scope of the boycott exception. One writer has suggested that courts distinguish between concerted refusals to deal at all and concerted refusals to deal except on particular terms.<sup>120</sup> Although this proposal finds some support in the majority opinion in *Barry*,<sup>121</sup> the Court apparently has rejected it.<sup>122</sup> Such a distinction also would foster proliferation of conditional refusals to deal.<sup>123</sup> Another commentator has argued that the boycott exception should cover only those concerted activities of insurers that do not further the legitimate purposes of the Act.<sup>124</sup> This proposal is too vague, however, and would require the courts to speculate whether the activity furthered the goals of the Act, without adding any certainty to the scope of the exception.

Instead of narrowing the boycott exception, courts should read it broadly.<sup>125</sup> The various definitions cited by the Court in *Barry* suggest that a broad reading of section 3(b) is appropriate.<sup>126</sup> A broad reading also is consistent with Congress' intention to use section 3(b) as a method to prevent coercive insurer activities that would otherwise be protected by section 2.<sup>127</sup> Finally, Congress clearly intended to allow insurers to establish rates and policies on a collec-

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*See Meicler v. Aetna Casualty & Sur. Co.*, 506 F.2d 732, 734 (5th Cir. 1975); *Addrisi v. Equitable Life Assur. Soc'y of the United States*, 503 F.2d 725, 729 (9th Cir. 1974), *cert. denied*, 420 U.S. 929 (1975).

120. Carlson, *supra* note 11, at 1168.

121. The majority stated several times in the opinion that the facts of the case constituted a refusal to deal on any terms. *See* 438 U.S. at 533, 535, 540, 544, 552, 553. In addition, the Court noted that its holding should not be read to mean "that all concerted activity violative of the Sherman Act comes within § 3(b)." *Id.* at 555.

122. *See id.* at 542. Commentators developed the distinction between "refusals to deal on any terms" and "refusals to deal except on certain terms" to distinguish between boycotts that warrant per se illegality and those that do not. This distinction is not relevant to a consideration of the scope of § 3(b) because the legality of the insurer's activity is considered apart from whether the activity comes within the boycott exception. *See Sullivan & Wiley, supra* note 71, at 277-78.

123. Note, *Policyholder Standing, supra* note 118, at 443.

124. Note, *A Re-Interpretation, supra* note 118, at 1083-85.

125. *Accord Sullivan & Wiley, supra* note 71, at 278-80; Note, *Policyholder Standing, supra* note 118, at 445-46. Sullivan and Wiley argue that the boycott exception of the Act should apply to "the employment of substantial unregulated economic power by insurance industry members." Sullivan & Wiley, *supra* note 71, at 279 (emphasis deleted). Courts also should read "coercion" and "intimidation" broadly.

126. *See supra* note 115.

127. *See* 438 U.S. at 549 (quoting 91 CONG. REC. 1483, 1486 (1945)).

tive basis, as long as the states regulated such activity.<sup>128</sup> Courts, therefore, should heed the legislative intent and not allow the public to challenge rate and policymaking activity under the boycott exception.

#### IV. APPLYING THE McCARRAN-FERGUSON ACT TO INSURER ACTIVITIES

The McCarran-Ferguson Act has been applied principally to protect concerted rate-making by insurers where the necessary state regulation exists. The majority of antitrust cases involving the exemption have concerned intra-industry trade restraints within the business of insurance. With increasing frequency, however, courts are being asked to apply the exemption to cases involving inter-industry restraints.

This section of the Article applies the framework developed in the previous section to those insurer activities that frequently are challenged in the courts, and determines whether those activities fall within the scope of the exemption. Four broad categories encompass the practices under consideration: provider arrangements; benefit and "usual, customary, and reasonable" fee schedules; tying arrangements; and activities concerning the insurer-agent relationship.<sup>129</sup> The first two practices involve inter-industry restraints that insurers have developed to contain costs. The third and fourth practices involve primarily intra-industry restraints that traditionally have been considered within the exemption. A review of the status of these practices under the exemption is needed, however, in light of the Supreme Court's recent decisions construing the scope of the McCarran-Ferguson Act. Application of the framework to each of these four categories indicates that the McCarran-

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128. See 91 CONG. REC. 1481 (1945) (remarks of Sen. Ferguson); *id.* at 1483 (remarks of Sen. Radcliffe). At least one court has held that rate-setting by an insurer falls within the exemption. See *Thomsen v. Sun Co.*, 498 F. Supp. 1109, 1111-12 (E.D. Pa. 1980).

129. Other insurer activities have been challenged, but those activities are so far beyond the scope of the exemption that they were not considered within the business of insurance even before *Royal Drug*. See, e.g., *United States v. Crocker Nat'l Corp.*, 656 F.2d 428 (9th Cir. 1981) (dictum) (interlocking directorates); *American Gen. Ins. Co. v. FTC*, 359 F. Supp. 887 (S.D. Tex. 1973) (mergers between insurance companies), *aff'd*, 496 F.2d 197 (5th Cir. 1974); *DeVoto v. Pacific Fidelity Life Ins. Co.*, 354 F. Supp. 874 (N.D. Cal. 1973) (customer list agreements), *rev'd on other grounds*, 516 F.2d 1 (9th Cir.), *cert. denied*, 423 U.S. 894 (1975).

Ferguson Act offers only a limited exemption from the antitrust laws. The exemption is limited primarily because of the Supreme Court's restrictive tests for determining whether an activity is within the "business of insurance."

### A. Provider Arrangements

Provider arrangements generally are contractual agreements between an insurer and third parties for the provision of goods and services to the insurer's policyholders.<sup>130</sup> The agreement allows the policyholder to receive specified goods or services from the provider, usually at a nominal fee. The insurer then pays the provider any remaining cost.

Provider arrangements are either closed-panel or open-panel. Under a closed-panel arrangement, the policyholder must go to a participating provider to receive the benefit of the provider agreement. If the policyholder goes to a non-participating provider, he will have to pay the full price for the goods or services and will not receive reimbursement from the insurer. In contrast, under an open-panel arrangement, the policyholder may choose whether to go to a participating provider. If he goes to a non-participating provider, he must pay the full price for the goods or services. The policyholder then files a claim with the insurer to obtain reimbursement, usually in an amount less favorable than if the policyholder had gone to a participating provider.<sup>131</sup>

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130. Provider arrangements also may be informal, with the insurer simply referring claimants to certain providers. See e.g., *Quality Auto Body, Inc. v. Allstate Ins. Co.*, 660 F.2d 1195 (7th Cir. 1981), cert. denied, 455 U.S. 1020 (1982). The informal nature of the arrangement does not alter the applicability of the McCarran-Ferguson Act. See Note, *supra* note 74, at 1485-86.

131. The operation of an open-panel provider arrangement is illustrated by the following example:

Suppose the usual and customary retail price for a quantity of Drug X charged by both "participating" Pharmacy A and "non-participating" Pharmacy B is \$10.00, and the wholesale price (or acquisition cost) to both is \$8.00. If an insured buys Drug X from Pharmacy A, the insured pays \$2.00. Pharmacy A receives \$2.00 from the insured and \$8.00 from Blue Shield, or \$10.00 total. If an insured buys Drug X from Pharmacy B, the insured pays Pharmacy B \$10.00, and receives \$6.00 (75 percent of the difference between the retail price and \$2.00) from Blue Shield. While Pharmacy B receives the same as Pharmacy A, the insured must pay \$4.00 for the drug and also must take steps to obtain reimbursement.

Before 1979, courts consistently held that the McCarran-Ferguson Act exempted provider arrangements from the antitrust laws.<sup>132</sup> In *Group Life & Health Insurance Co. v. Royal Drug Co.*,<sup>133</sup> however, the Supreme Court held that an open-panel provider arrangement between an insurer and pharmacies was not within the "business of insurance." In reaching this conclusion, the Court noted that provider arrangements "do not involve any underwriting or spreading of risk, but are merely arrangements for the purchase of goods and services by [the insurer]."<sup>134</sup> Such arrangements may enable the insurer to minimize its costs and thereby reduce premiums, but that affects only the magnitude of an insurer's potential payment, not the probability of payment which is an essential element of the risk-spreading requirement.<sup>135</sup> Furthermore, provider arrangements do not affect the insurer-insured relationship directly because the arrangements are distinct from the insurer's contract with its policyholders. Although the cost savings produced by such arrangements may have an indirect effect upon the insurer-insured relationship, virtually every business decision made by an insurer has an indirect effect upon the policyholder. Finally, because provider arrangements are inter-industry in character, Congress did not intend the arrangements to be exempt under the Act. Accordingly, lower courts since *Royal Drug* have held that the McCarran-Ferguson Act exempts neither closed-panel nor open-panel provider arrangements from the antitrust laws.<sup>136</sup>

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If the pharmacy's acquisition cost for the drug is \$5.00 rather than \$8.00, the situation of Pharmacy B and the insured are unchanged. But now Pharmacy A will receive only \$5.00 from Blue Shield, for a total of \$7.00.

*Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 209 n.3 (1979) (quoting from the brief for the United States as *amicus curiae*).

132. See, e.g., *Doctors, Inc. v. Blue Cross of Greater Philadelphia*, 431 F. Supp. 5 (E.D. Pa. 1975), *aff'd per curiam*, 557 F.2d 1001 (3d Cir. 1976); *Holly Springs Funeral Home, Inc. v. United Funeral Serv. Inc.*, 303 F. Supp. 128 (N.D. Miss. 1969); *Hill v. National Auto Glass Co.*, 293 F. Supp. 295 (N.D. Cal. 1968).

133. 440 U.S. 205 (1979).

134. *Id.* at 214.

135. See *supra* notes 54-55 and accompanying text.

136. See, e.g., *Proctor v. State Farm Mut. Auto. Ins. Co.*, 675 F.2d 308 (D.C. Cir.), *cert. denied*, 103 S. Ct. 86 (1982); *Quality Auto Body, Inc. v. Allstate Ins. Co.*, 660 F.2d 1195 (7th Cir. 1981), *cert. denied*, 455 U.S. 1020 (1982); *United States v. Title Ins. Rating Bureau of Ariz.*, 517 F. Supp. 1053 (D. Ariz. 1981). *But see* *Hahn v. Oregon Physicians' Serv.*, 508 F.

### B. Benefit and "Usual, Customary, and Reasonable" Fee Schedules

Some insurance policies provide that policyholders will be indemnified according to a schedule of payments. The benefit schedule usually is fixed by the insurer and minimizes claim costs by establishing maximum prices for provider services. Similarly, under a "usual, customary, and reasonable" (UCR) fee schedule, insurers indemnify policyholders only for the reasonable costs arising out of an insured event, rather than the entire loss. Typically, a "peer review" committee implements the UCR fee schedule by determining whether the fees charged by a provider are reasonable.<sup>137</sup>

Immediately following *Royal Drug*, two United States Circuit Courts of Appeal considered for the first time the applicability of the McCarran-Ferguson Act to peer review and the UCR fee schedules. Focusing solely upon the insurer-insured relationship test of *Royal Drug*, the Fourth Circuit concluded that the Act shielded such activity from scrutiny under the antitrust laws.<sup>138</sup>

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Supp. 970, 974 (D. Or. 1981), *rev'd*, 689 F.2d 840 (9th Cir. 1982). The court in *Hahn* distinguished the case before it from *Royal Drug* on the basis that the provider arrangement involved was a part of the insurance contract. The Supreme Court's subsequent decision in *Union Labor Life Ins. Co. v. Pireno*, 102 S. Ct. 3002, 3009 (1982), may provide some support for this approach. Provider arrangements that are a part of an insurance contract, however, satisfy only one of the tests used to define the business of insurance. Those arrangements satisfy the insurer-insured relationship test, but fail to satisfy either the spreading of risk or the conformity to legislative intent tests. *See supra* text accompanying notes 46-68.

137. *See generally* Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act*, 1978 DUKE L.J. 645. These two types of fee schedules are tied closely to provider arrangements and are typically included in them.

Peer review may be requested by an insurer or compelled by law. In either event, a group or committee of providers conducts the review. *See, e.g.*, 42 U.S.C. § 1395(f) (1976 & Supp. III 1979); *id.* at § 1396(a)(3) (1976); N.Y. WORK. COMP. LAW §§ 13-a, 13-g (McKinney 1965 & Supp. 1981); N.Y. INS. LAW § 678 (McKinney 1966 & Supp. 1981). Only voluntary peer review presents potential antitrust problems. Mandatory peer review is exempt from the antitrust laws under both the state action doctrine and the doctrine of implied repeal. *See* Borsody & Tiano, *Peer Review and the Antitrust Laws: An Analysis and A Proposal*, 26 ST. LOUIS U.L.J. 511, 513-17 (1982).

138. *Bartholomew v. Virginia Chiropractors Ass'n*, 612 F.2d 812 (4th Cir. 1979), *cert. denied*, 446 U.S. 938 (1980). The defendant maintained a peer review committee which reviewed claims submitted to various insurers for chiropractic services. The committee determined the usual and customary fees for such services, and the insurer then reimbursed the policyholder for that amount. The court held that because "the sole parties to the system were the insured and the insurer," the review procedure "touched upon 'the business of insurance,'" and therefore was within the scope of the McCarran-Ferguson Act. *Id.* at 817.

The Second Circuit, however, focused primarily on the underwriting or spreading of risk requirement and reached the opposite conclusion, holding that the Act does not exempt such activity.<sup>139</sup>

On review of the Second Circuit's decision, the Supreme Court in *Union Labor Life Insurance Co. v. Pireno*<sup>140</sup> resolved the conflict. The Court held that the peer review used to implement UCR fee schedules is not within the business of insurance. Applying the three-prong *Royal Drug* test, the Court first observed that such activity did not underwrite or spread risk. Rather, the insurance policy itself had already effected the transfer of risk. Moreover, the Court noted that peer review does not transfer the risk of unreasonable charges back to the insured because the risk was never transferred to the insurer.<sup>141</sup> The Court, therefore, concluded that the review process failed to satisfy the risk-spreading requirement. The Court also found that the activity did not satisfy the insurer-insured relationship requirement because the procedure was distinct from the insurance contract between the insurer and its poli-

See *Ratino v. Medical Serv. of D.C.*, 1981-1 Trade Cas. (CCH) ¶64,144 (D. Md. 1981) (holding on the basis of *Bartholomew* that a UCR system was within the business of insurance).

In *Virginia Academy of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476 (4th Cir. 1980), cert. denied, 450 U.S. 916 (1981), the Fourth Circuit retreated somewhat from its position in *Bartholomew*. In *Virginia Academy*, the insurer required that psychologists submit their bills to physicians. If the reviewing physician deemed the charges reasonable, the insurer would pay the psychologist directly. In reviewing this procedure, the court, as in *Bartholomew*, focused on the insurer-insured relationship, but found that the procedure was "only tangential to that relationship in that it does not affect the benefit conferred upon the [insured]." *Id.* at 483. The court held that because the insurer did not deny coverage for psychological treatment, as opposed to psychiatric treatment, and therefore had not decided against underwriting psychological treatment, any cost savings arising out of the review procedure were not sufficiently a part of the insurer-insured relationship. *Id.* at 484. The court indicated that *Bartholomew* simply held that the essence of the business of insurance is the insurer-insured relationship, *id.* at 483, but did not overrule that decision specifically. Judge Hall, who dissented in *Bartholomew*, authored the opinion in *Virginia Academy*.

139. *Pireno v. New York State Chiropractic Ass'n*, 650 F.2d 387 (2d Cir. 1981), *aff'd sub nom. Union Labor Life Ins. Co. v. Pireno*, 102 S. Ct. 3002 (1982). The Second Circuit stated that the review process does nothing more than

determine whether the risk of the entire loss . . . has been transferred to the insurer—that is, whether the insured's loss falls within the policy limits. Peer review is thus not a means of transferring risk from insured to insurer. At most, it is an aid in determining the scope of the transfer after it has been made.

650 F.2d at 393.

140. 102 S. Ct. 3002 (1982).

141. *Id.* at 3009.



cyholders. Like provider arrangements, the practice only affects an insurer's potential costs and the magnitude of its potential payments. Finally, peer review procedures involve parties outside the insurance industry, and are therefore beyond the scope of congressional intent.

Only one court has considered whether fixed-benefit schedules are within the business of insurance. In *Arizona v. Maricopa County Medical Society*,<sup>142</sup> the defendant set maximum fees that physicians could receive for services rendered to policyholders. The district court held that the McCarran-Ferguson Act was inapplicable on the ground that the benefit schedule did not underwrite or spread risk. The court stated that "[m]erely because an insurance company acts to reduce the risk that it has underwritten does not directly further underwrite or spread the risk that the policyholders sought to insure against."<sup>143</sup>

The analysis used by the Court in *Pireno* confirms that fixed-benefit schedules are not within the business of insurance and that the decision in *Maricopa County* is correct. Like a UCR fee schedule, a fixed-benefit schedule affects only the magnitude of the insurer's risk—not its probability. Moreover, benefit schedules are separate from the insurance contract and thus do not affect the insurer-insured relationship directly. Finally, because benefit schedules involve parties outside the insurance industry, Congress could not have intended to exempt the schedules under the McCarran-Ferguson Act.

Despite the above analysis, not all benefit schedules are subject to the antitrust laws. If the risk being insured against is other than the risk of having to pay a provider for his services, then the benefit schedules associated with such a policy are within the business of insurance. For example, automobile liability insurance insures against the risk of a judgment against the policyholder arising out of the use of a car, and typically sets an upper limit on the coverage for various types of accidents.<sup>144</sup> Generally though, the McCarr-

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142. 1979-1 Trade Cas. (CCH) ¶62,694 (D. Ariz. 1979), *aff'd*, 643 F.2d 553 (9th Cir. 1980), *rev'd on other grounds*, 457 U.S. 332 (1982). In *Kartell v. Blue Shield of Mass., Inc.*, 592 F.2d 1191 (1st Cir. 1979), the court did not decide the applicability of the Act to a fee schedule because of pending state cases that could affect its decision.

143. 1979-1 Trade Cas. (CCH) ¶62,694, at 77,894.

144. Note, *supra* note 74, at 1489. Other examples include life insurance and disability

ran-Ferguson Act does not exempt fixed-benefit and UCR fee schedules from the antitrust laws.

### C. Tying Arrangements

A tying arrangement exists whenever a seller stipulates that he will sell a product or service—the tying product—only on the condition that the consumer also purchase another, often less desired, product or service—the tied product. These arrangements violate the Clayton and Sherman Acts if: the tying and tied products are distinct; the seller possesses an appreciable degree of power in the market for the tying product; and the arrangement affects more than an insubstantial amount of commerce in the tied product.<sup>145</sup>

Tying arrangements involving insurance can be grouped into three categories. The first category ties one type of insurance to another. The second category ties insurance to a non-insurance product, while the third category ties a non-insurance product to insurance.

Prior to *Royal Drug*, only one court had examined the tying of insurance to another insurance product. In *McIlhenny v. American Title Insurance Co.*,<sup>146</sup> the defendant tied the purchase of mechanic's lien insurance to the purchase of title insurance. The court held that this practice was part of the business of insurance, noting that the tying arrangement went to the "very heart of the relationship between the insurance company and the policyholder"<sup>147</sup> because, unless the plaintiff agreed to buy both mechanic's lien insurance and title insurance, the defendant would not insure him.

No court has examined this type of tying arrangement since *Royal Drug*.<sup>148</sup> The arrangement, however, appears to be within the business of insurance. It indicates that the insurer has decided

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insurance.

145. See *Siegel v. Chicken Delight, Inc.*, 448 F.2d 43 (9th Cir. 1971), cert. denied, 405 U.S. 955 (1972). See generally *United States Steel Corp. v. Fortner Enters.*, 429 U.S. 610 (1977); *International Salt Co. v. United States*, 332 U.S. 392 (1947).

146. 418 F. Supp. 364 (E.D. Pa. 1976).

147. *Id.* at 369.

148. In *Portland Retail Druggists Ass'n v. Kaiser Found. Health Plan*, 662 F.2d 641 (9th Cir. 1981), the plaintiff alleged that the defendant had tied the purchase of its drug insurance plan to the purchase of its health insurance plan. The district court held that this arrangement was within the business of insurance. The Ninth Circuit, however, vacated and remanded the case to the district court for reconsideration in light of *Royal Drug*. *Id.* at 647.

to cover only a broad class of risks insured by two insurance products, rather than a narrow class insured by a single insurance product. As such, it represents a spreading of risks that affects the probability of the insurer having to make a payment.<sup>149</sup> As the court in *McIlhenny* noted, the arrangement directly affects the insurer-insured relationship. Finally, because the arrangement ties one insurance product to another, it is entirely intra-industry in character, thus conforming to congressional intent.<sup>150</sup>

Most courts that considered the tying arrangements in the second and third categories before *Royal Drug* held that the arrangements were within the business of insurance. For example, in *Adrisi v. Equitable Life Assurance Society of the United States*,<sup>151</sup> the Ninth Circuit held that the practice of tying life insurance to mortgage loans was within the business of insurance. Similarly, the court in *Mathis v. Automobile Club Inter-Insurance Exchange*<sup>152</sup> held that the practice of tying automobile club membership to the issuance of auto insurance was exempt under the McCarran-Ferguson Act. Courts generally had agreed that such arrangements were activities affecting the insurer-insured relationship and, therefore, within the business of insurance.<sup>153</sup>

Tying arrangements in these two categories, however, fail two of the three stringent requirements announced in *Royal Drug*. Because the insurer will not insure anyone who does not agree to the tying arrangement, the arrangement has a direct effect upon the insurer-insured relationship, satisfying one prong of the *Royal Drug* test. Such arrangements, however, fail the remaining two prongs because they necessarily involve parties outside the insurance industry, and because they do more than spread risk.<sup>154</sup> Tying

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149. See Note, *supra* note 74, at 1490.

150. A court should consider the particular facts of each case in determining whether the state has regulated the tying arrangement effectively and whether the arrangement falls within the § 3(b) exception.

151. 503 F.2d 725 (9th Cir. 1974), *cert. denied*, 420 U.S. 929 (1975).

152. 410 F. Supp. 1037 (W.D. Mo. 1976).

153. See, e.g., *Dexter v. Equitable Life Assur. Soc'y of the United States*, 527 F.2d 233 (2d Cir. 1975); *Schwartz v. Commonwealth Land Title Ins. Co.*, 374 F. Supp. 564 (E.D. Pa.) (court deferred granting motion for summary judgment), 384 F. Supp. 302 (E.D. Pa. 1974); *Seasongood v. K & K Ins. Agency*, 414 F. Supp. 698 (E.D. Mo. 1976), *rev'd on other grounds*, 548 F.2d 729 (8th Cir. 1977).

154. See Note, *supra* note 74, at 1490-91.

arrangements in these two categories include the sale of a non-insurance product, and thus involve more than just an agreement to assume a class of risks in return for the payment of a premium, or a decision by an insurer to cover only a certain class of risks. Both types of tying arrangements, therefore, are outside the business of insurance and may be scrutinized under the antitrust laws.

#### *D. Activities Concerning the Insurer-Agent Relationship*

Before *Royal Drug*, courts were divided on the issue of whether activities involving the insurer-agent relationship were within the scope of section 2(b) of the McCarran-Ferguson Act. Such activities include employment or agency contracts and the fixing of commissions. Some courts had held that these activities were exempt from antitrust scrutiny;<sup>155</sup> other courts had focused on the insurer-insured relationship test of *National Securities* and concluded that the insurer-agent relationship was outside the business of insurance.<sup>156</sup>

The Supreme Court in *Royal Drug* considered, but did not decide, whether the insurer-agent relationship is within the business of insurance.<sup>157</sup> Several lower courts, however, have addressed the issue. In *Thompson v. New York Life Insurance Co.*,<sup>158</sup> an insurance agent asserted that his employment contract violated the antitrust laws because the contract prohibited him from engaging in any other occupation for remuneration without the written consent of his employer. The court focused on the insurer-insured relationship test and found that, because the defendant did not force the plaintiff to engage in activities unrelated to insurance, the contract sufficiently affected the insurer-insured relationship to fall within the business of insurance.<sup>159</sup> In *Mac Adjustment, Inc. v. General*

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155. See, e.g., *Lawyer's Realty Corp. v. Peninsular Title Ins. Co.*, 428 F. Supp. 1288 (E.D. La.), *aff'd per curiam*, 550 F.2d 1035 (5th Cir. 1977); *California League of Ind. Ins. Providers v. Aetna Casualty & Sur. Co.*, 175 F. Supp. 857 (N.D. Cal. 1959).

156. See, e.g., *Ray v. United Family Life Ins. Co.*, 430 F. Supp. 1353 (W.D.N.C. 1977); *Allied Fin. Servs., Inc. v. Foremost Ins. Co.*, 418 F. Supp. 157 (D. Neb. 1976).

157. 440 U.S. at 224 n.32.

158. 644 F.2d 439 (5th Cir. 1981).

159. *Id.* at 442-44. Other courts have reached similar results based on the insurer-insured relationship test. See, e.g., *Card v. National Life Ins. Co.*, 603 F.2d 828 (10th Cir. 1979). See also *Steinberg v. Guardian Life Ins. Co. of Am.*, 486 F. Supp. 122 (E.D. Pa. 1980) (relying on *Black v. Nationwide Mut. Ins. Co.*, 429 F. Supp. 458 (W.D. Pa. 1977), *aff'd*, 571 F.2d 571 (3d

*Adjustment Bureau, Inc.*,<sup>160</sup> the court reached a contrary result. In *Mac Adjustment*, an insurance adjuster brought suit, alleging that the defendant insurance companies had conspired to force him out of business. In an unreported opinion, the district court concluded that the relationship between the adjuster and the insurer was not within the business of insurance for the purpose of asserting an exemption under the McCarran-Ferguson Act. Although this aspect of the judgment was not appealed, the United States Court of Appeals for the Tenth Circuit implicitly questioned the soundness of the lower court's conclusion.

Decisions holding that the insurer-agent relationship is within the business of insurance are inconsistent with the Supreme Court's analysis in *Royal Drug*. Although such activity may be necessary to conduct the business of insurance companies, the insurer-agent relationship generally does not involve the underwriting or spreading of risk.<sup>161</sup> Furthermore, the type of employment contract or commission schedule that an agent has affects only the expenses of the insurer. This type of indirect effect upon the insurer-insured relationship is insufficient under *Royal Drug*.

Decisions that place the insurer-agent relationship outside the business of insurance, however, appear to be inconsistent with congressional intent. The NAIC proposal and bills introduced before the *South-Eastern Underwriters* decision specifically exempted activities involving the insurer-agent relationship.<sup>162</sup> Although the exemption as enacted did not mention explicitly the insurer-agent relationship, the language of section 3(b) supports inclusion of the relationship within the exemption.<sup>163</sup> If sections 2 and 3(b) are read together, one can infer that, by including the insurer-insured relationship within section 3(b), Congress also must have considered the insurer-agent relationship to be within the business of

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Cir. 1978)).

160. 597 F.2d 1318 (10th Cir.), cert. denied, 444 U.S. 929 (1979).

161. Two exceptions that the courts have recognized are the authorization of agents to solicit individual or group policies, and the acceptance or rejection of coverage tendered by brokers. See *Owens v. Aetna Life & Casualty Co.*, 654 F.2d 218 (3d Cir.), cert. denied, 454 U.S. 1092 (1981). Such activity also must satisfy the state regulation and non-boycott requirements to fall within the scope of the exemption.

162. See H.R. 444, 78th Cong., 2d Sess. (1944); 90 CONG. REC. A4406 (1944).

163. See *supra* notes 110-11 and accompanying text.

insurance.

The majority in *Royal Drug* apparently recognized this argument<sup>164</sup> and intimated, as the dissent pointed out, "that such transactions, between insurers and agents, might fall within the 'business of insurance,' despite the inconsistency with the [majority's] theory."<sup>165</sup> Recognition of such an exception to the Court's three-prong test would not render section 3(b) superfluous with regard to activities involving the insurer-agent relationship. Moreover, such an exception would be consistent with the broad reading of section 3(b) suggested earlier.<sup>166</sup> Therefore, courts should consider the insurer-agent relationship to be within the business of insurance as an exception to the *Royal Drug* test. Courts should not attempt to fit this activity within the three criteria, lest they unwittingly broaden the test's narrow scope.

#### V. ANTITRUST SCRUTINY OF INSURER ACTIVITIES BEYOND THE SCOPE OF THE McCARRAN-FERGUSON ACT

Courts faced with activities beyond the scope of the McCarran-Ferguson Act still must determine the legality of those activities under the antitrust laws. This section examines the problem by focusing on the legality of fixed-benefit and UCR fee schedules and provider arrangements. Because these schedules and arrangements are recent developments, the appropriate standard of antitrust review is unsettled. In contrast, tying arrangements and activities involving the insurer-agent relationship that do not fall within the scope of the Act are fairly traditional from an antitrust perspective, and so may be scrutinized using the appropriate standards of review.

##### A. Antitrust Scrutiny of Fee Schedules

For purposes of antitrust scrutiny, fee schedules may be classified into two categories depending upon whether provider domination of the insurer exists. In the first category, the providers that supply the goods or services to which the fee schedule pertains also

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164. See 440 U.S. at 224 n.32.

165. *Id.* at 245 (Brennan, J., dissenting).

166. See *supra* notes 109-128 and accompanying text.

comprise or dominate the insurer. This arrangement may arise when the insurer is a Foundation for Medical Care (FMC)<sup>167</sup> or Blue Cross/Blue Shield,<sup>168</sup> both of which are either comprised of, or dominated by, providers. In contrast, under independent insurer fee schedules, an independent insurer fixes either a benefit or UCR fee schedule and obtains provider adherence to the schedule; providers do not dominate or control the insurer.

### 1. *Provider-Dominated Fee Schedules*

The establishment of a benefit or UCR fee schedule by an insurer dominated or controlled by a provider is a classic example of horizontal price-fixing. The prices being fixed, however, are maximum prices, not minimum prices. Despite this distinction, the Supreme Court recently held in *Arizona v. Maricopa County Medical Society*<sup>169</sup> that such fee schedules are illegal per se.

In *Maricopa County*, Arizona challenged a benefit schedule fixed by Maricopa, an FMC, as illegal per se. Both the district court and the Ninth Circuit, however, concluded that the activity should be evaluated under the rule of reason.<sup>170</sup> In a split decision, the Supreme Court reversed the lower courts, noting that the Court previously had declared that maximum price-fixing agreements were

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167. Medical societies manage or sponsor FMCs which provide prepaid health care. The member providers offer a complete line of medical services to subscribers on the basis of an annual participation fee. See Kallstrom, *supra* note 137, at 680.

168. Blue Cross/Blue Shield plans historically have maintained close ties with the medical profession. *Id.* at 682. Indeed, the medical profession originally sponsored the development of Blue Cross/Blue Shield. See Millman, *Cost Containment Efforts by Private Health Insurers: Antitrust Implications and A Proposal for Legislative Reform*, 31 FED. INS. COUNS. 361, 363 (1981). Providers of medical care frequently dominate the governing bodies of Blue Cross/Blue Shield. The Blue Cross/Blue Shield programs thus are quite similar to FMCs.

169. 457 U.S. 332 (1982). Prior to *Maricopa County*, the Supreme Court and Congress had expressed concern over the anticompetitive potential of provider-dominated fee schedules. See *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 232 n.40 (1979); *Hearings Before the Subcomm. on Oversight and Investigations of the House Comm. on Interstate and Foreign Commerce, Skyrocketing Health Care Costs: The Role of Blue Shield*, 95th Cong., 2d Sess. 4-34 (1978).

170. See 1979-1 Trade Cas. (CCH) ¶62,694 (D. Ariz. 1979), *aff'd*, 643 F.2d 553 (9th Cir. 1980), *rev'd*, 457 U.S. 332 (1982). The Ninth Circuit reasoned that because fee schedules were such a recent development, the full effect of those schedules had not been determined sufficiently to label them illegal per se. 643 F.2d at 556-58. See *infra* text accompanying note 187.

unlawful per se.<sup>171</sup> Although the Court recognized that its previous decisions involved primarily vertical maximum price-fixing, the Court reasoned that those cases involved a sufficient degree of horizontal price-fixing to include Maricopa's fixed-benefit schedule.<sup>172</sup> Thus, the Court's prior "decisions foreclose[d] the argument that the agreements at issue escape *per se* condemnation because they are horizontal and fix maximum prices."<sup>173</sup>

The Supreme Court reached a correct conclusion in *Maricopa County*.<sup>174</sup> Fee schedules established by provider-dominated insurers easily fall within the Court's per se prohibition of horizontal price-fixing. Furthermore, an anticompetitive potential exists with provider-dominated benefit and UCR fee schedules because the maximum price ceilings may become minimum prices.<sup>175</sup> Providers, however, may be encouraged to set their charges at the maximum price fixed in the fee schedule.<sup>176</sup> Although ostensibly serving as a maximum price ceiling, the fee schedule easily could become a minimum price floor that allows providers to raise prices each time

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171. 457 U.S. at 346-47 (citing *Albrecht v. Herald Co.*, 390 U.S. 145 (1968) and *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211 (1951)). This conclusion followed from the Court's decision in *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 223 (1940) (any "combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing . . . price[s] . . . is illegal per se"). See also *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980) (per curiam) (reaffirming the Court's position that horizontal price-fixing is illegal per se).

172. 457 U.S. at 348 n.18.

173. *Id.* at 348. The Court also rejected the following arguments: that the defendants' professional status should influence the outcome of the case, *id.*; that the Court should not apply a per se rule because the judiciary has little experience in the health care industry, *id.* at 349 (noting that the type of restraint challenged—horizontal price-fixing—was well known to the courts); and that the fee schedules involved price-fixing only in the literal sense, *id.* at 356-57.

The dissent criticized the majority for holding illegal per se a plan that appeared to be in the public interest and which, on the basis of the incomplete record before the Court, could not be shown to reduce competition. The dissenters also questioned the propriety of the majority's conclusion that the fee schedules involved something more than price-fixing in the literal sense. See *id.* at 357-67 (Powell, J., dissenting).

174. See also *Kallstrom, supra* note 137, at 683 (arguing that provider-dominated fee schedules should be illegal per se). But see *Easterbrook, Maximum Price Fixing*, 48 U. CHI. L. REV. 886 (1981) (arguing that not all maximum price-fixing should be considered unlawful per se).

175. *Kallstrom, supra* note 137, at 650-52, 682-83. See *Easterbrook, supra* note 174, at 900-04. Prof. Easterbrook effectively refutes other allegedly anticompetitive effects of maximum price-fixing. See *id.* at 904-08.

176. *Kallstrom, supra* note 137, at 650.



the fee schedule is revised. Evidence exists that this has happened with some Blue Shield plans.<sup>177</sup> Because the provider controls or dominates the insurer, no real incentive exists to hold down fees. Although the practice may result in the loss of some policyholders, the price-insensitive nature of health care should easily offset the losses. As the Supreme Court stated, "[e]ven if a fee schedule is [otherwise] desirable, it is not necessary that the [providers] do the price fixing."<sup>178</sup>

Finally, parties also have challenged the peer review procedures used to implement UCR fee schedules as violations of the antitrust laws.<sup>179</sup> This issue was not before the Supreme Court in either *Pireno* or *Maricopa County*.<sup>180</sup> Like the UCR fee schedule itself, provider-dominated peer review procedures also should be unlawful per se because they are used to implement the fee schedule. In addition, if a plaintiff could show that the providers used the peer review procedure as part of a conspiracy to boycott, coerce, or intimidate the plaintiff, the review procedure would be illegal per se as a group boycott.<sup>181</sup>

## 2. Independent-Insurer Fee Schedules

The setting of a benefit or UCR fee schedule by an independent insurer is not a form of horizontal price-fixing because no horizontally concerted action occurs. Rather, such practices constitute ver-

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177. See *Hearings Before the Subcomm. on Oversight and Investigations of the House Comm. on Interstate and Foreign Commerce, Skyrocketing Health Care Costs: The Role of Blue Shield*, 95th Cong., 2d Sess. 4-34 (1978).

178. 457 U.S. at 352.

179. See, e.g., *Pireno v. New York State Chiropractic Ass'n*, 650 F.2d 387, 389 (2d Cir. 1981), *aff'd sub nom. Union Labor Life Ins. Co. v. Pireno*, 102 S. Ct. 3002 (1982); *Virginia Academy of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981).

180. *Pireno*, 102 S. Ct. at 3007 ("in deciding this case we have no occasion to address the merits of respondent's Sherman Act claims."); *Maricopa County*, 457 U.S. at 340 ("No challenge is made to [the defendant's] peer review. . .").

181. See *Klor's, Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1959); *Fashion Originators' Guild of Am., Inc. v. FTC*, 312 U.S. 457 (1941). Lower courts, however, have applied the per se rule only when the evidence establishes that the defendant intended to boycott, coerce, or intimidate. See, e.g., *Worthen Bank & Trust Co. v. National Bankamericard, Inc.*, 485 F.2d 119 (8th Cir. 1974); *E.A. McQuade Tours, Inc. v. Consolidated Air Tour Manual Comm.*, 467 F.2d 178 (5th Cir. 1972), *cert. denied*, 409 U.S. 1109 (1973); *Chastain v. American Tel. & Tel. Co.*, 401 F. Supp. 151 (D.D.C. 1975).

tical price-fixing. The Supreme Court in *Maricopa County* did not determine the validity of independent insurer-instituted fee schedules.<sup>182</sup>

Insurer-instituted fee schedules parallel the activity involved in *Albrecht v. Herald Co.*<sup>183</sup> and *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*<sup>184</sup> In those cases, the Supreme Court declared that maximum resale price maintenance was illegal per se.<sup>185</sup> Insurer-instituted fee schedules resemble maximum resale price maintenance in that the insurer sets the maximum price that providers can charge for their services. Providers, however, are not forced to charge the maximum price. In exchange, the providers receive additional business from the insurer's policyholders.

As in *Maricopa County*, the Court may feel bound by its established rule that vertical maximum price-fixing is illegal per se. The Court, however, should distinguish independent-insurer fee schedules from provider-dominated fee schedules and apply the rule of reason because "[m]aximum [vertical] price fixing has none of the potential anticompetitive consequences of horizontal maximum price fixing. . . ."<sup>186</sup>

Under the rule of reason, courts must balance the anticompetitive and procompetitive effects of the restraint on trade to determine the restraint's legality.<sup>187</sup> Although the restraint may be in-

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182. 457 U.S. at 352 n.26.

183. 390 U.S. 145 (1968).

184. 340 U.S. 211 (1951).

185. *Albrecht*, 390 U.S. at 153; *Kiefer-Stewart*, 340 U.S. at 213. Neither decision explicitly enunciated a per se rule, although the Court's language and approach in both cases suggested such a rule. See also *Maricopa County*, 457 U.S. at 346-47 (stating that maximum price-fixing is illegal per se). Commentators have argued that neither *Albrecht* nor *Kiefer-Stewart* should be read as holding that maximum price maintenance is unlawful per se. See generally Kallstrom, *supra* note 137, at 665-68. The Supreme Court in *Continental T.V., Inc., v. GTE Sylvania, Inc.*, 433 U.S. 36, 51 n.18 (1977), however, reaffirmed the per se illegality of vertical price restraints.

186. Easterbrook, *supra* note 174, at 890 n.20. The Supreme Court also has indicated that *Albrecht* and *Kiefer-Stewart* need to be reexamined. See *Maricopa County*, 457 U.S. at 352 n.26; *Royal Drug*, 440 U.S. at 210 n.5. *Maricopa* and *Royal Drug* did not determine the legality of maximum price-fixing arrangements instituted by independent insurers. See also *infra* notes 206-09 and accompanying text (suggesting several distinctions between provider arrangements and resale price maintenance).

187. See *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679, 688-92 (1978). The classic statement of the rule of reason is:

The true test of legality is whether the restraint imposed is such as merely

tended to serve a laudable purpose, such as providing low-cost medical care, the intent is irrelevant.<sup>188</sup> Under this analysis, insurer-instituted fee schedules should not be considered unlawful because the schedules are not anticompetitive, and actually have several procompetitive effects.

Vertical maximum price-fixing reduces search costs by allowing consumers and insurance companies to identify low-price sellers.<sup>189</sup> Because of the high costs involved in consulting various doctors, health care consumers rarely attempt to determine who will provide care at the lowest cost. Identification of low-cost providers, therefore, should increase competition among health care providers, reducing the cost of medical services. Vertical maximum price-fixing also reduces transaction costs.<sup>190</sup> Consumers generally are unable to negotiate with health care providers over the cost of services. Fee schedules allow insurers to negotiate impassionately with providers and set reasonable prices for health care. Fee schedules also can "create a new product" by eliminating any incentive for providers to supply unwarranted or costly services to naive consumers.<sup>191</sup>

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regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition. To determine that question the court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be attained, are all relevant facts. This is not because a good intention will save an otherwise objectionable regulation or the reverse; but because knowledge of intent may help the court to interpret facts and to predict consequences.

Chicago Bd. of Trade v. United States, 246 U.S. 231, 238 (1918).

188. See National Soc'y of Professional Eng'rs v. United States, 435 U.S. at 696; Comment, *Prepaid Prescription Drug Plans Under Antitrust Scrutiny: A Stern Challenge to Health Care Cost Containment*, 75 Nw. U.L. REV. 506, 527 (1980). *But cf.* Havighurst & Kissam, *The Antitrust Implication of Relative Value Studies in Medicine*, 4 J. HEALTH POL., POL'Y & L. 48, 67 (1979); Horan & Nord, *Application of Antitrust Law to the Health Care Delivery System*, 9 CUM. L. REV. 684, 686 (1979) (both articles attempt to weigh the importance of health care policies served by provider arrangements in the balancing test that is used to determine reasonableness).

189. Easterbrook, *supra* note 174, at 892-95. See also Rosoff, *supra* note 3, at 447.

190. Easterbrook, *supra* note 174, at 895-98. See also *Broadcast Music, Inc. v. Columbia Broadcasting Sys.*, 441 U.S. 1, 20-22 (1979) (pointing out that a blanket licensing system reduced transaction costs).

191. Easterbrook, *supra* note 174, at 898-900. For a discussion of other procompetitive

Independent insurers, unlike provider-dominated insurers, have an incentive to keep maximum prices down. By lowering the fees paid for provider services, the insurer will lower its benefit payments and increase its profits. Policyholder premiums also may decrease. In addition, independent insurers do not force the provider to charge a certain price. The provider may charge any price so long as it is at or below the maximum established by the insurer. These factors mitigate against maximum fees becoming minimum prices.<sup>192</sup>

Challenges to the peer review procedures instituted with UCR fee schedules also must be considered. If the peer review committee members are all competitors, and if their determination of what constitutes a reasonable fee is binding, then the review procedure qualifies as horizontal maximum price-fixing.<sup>193</sup> *Maricopa County* indicates that the procedure is unlawful per se. If the peer review procedure is voluntary, however, and the committee's recommendations are not binding on any of the parties involved, then the procedure could not be challenged as an unlawful form of price-fixing. Indeed, a business review letter by the United States Department of Justice and a recent decision by the Second Circuit have suggested that a nonbinding voluntary procedure would be lawful.<sup>194</sup> Finally, if a plaintiff can show that the peer review procedure is part of a concerted refusal to deal, the procedure would be unlawful.<sup>195</sup>

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effects of vertical price-fixing, see R. BORK, *THE ANTITRUST PARADOX* 435-39 (1978); R. POSNER, *ANTITRUST LAW: AN ECONOMIC PERSPECTIVE* 158 (1976).

192. Adoption of the rule of reason in cases of fee schedules instituted by independent insurers does not mean that such fee schedules are lawful per se. If a plaintiff can show that the maximum price fee schedule is actually a guise for minimum price-fixing, the fee schedule should be invalidated as an unreasonable restraint of trade. For a discussion of the ways this can be proven, see Easterbook, *supra* note 174, at 901-03.

193. See Borsody & Tiano, *supra* note 137, at 524.

194. The Antitrust Division approved a peer review procedure that was performed at the request of insurance companies and was not binding on any party. The Antitrust Division emphasized the advisory nature of the peer review process. See Antitrust Division, U.S. Dep't of Justice, Business Review Letter to the International Chiropractors Association (Mar. 2, 1977). The Second Circuit modified a Federal Trade Commission order against the American Medical Association so as to exempt from the order "professional peer review of the fee practices of physicians." *American Medical Ass'n v. FTC*, 638 F.2d 443, 453 (2d Cir. 1980), *aff'd*, 455 U.S. 676 (1982). See also *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 781 (1975) (suggesting that "a purely advisory fee schedule" might be lawful).

195. See *supra* note 181 and accompanying text.

## B. Antitrust Scrutiny of Provider Arrangements

The Supreme Court in *Royal Drug* noted that the legality of provider arrangements was not before the Court.<sup>196</sup> Subsequent lower court decisions, however, have addressed the issue. Like fee schedules, provider arrangements may be classified into two categories for the purpose of antitrust scrutiny, depending upon whether provider domination of the insurer exists.

### 1. Provider-Dominated Provider Arrangements

Whenever the providers supplying the services under the provider arrangement dominate or control the insurer, the arrangement may be challenged as a form of horizontal maximum price-fixing, because concerted action among horizontal competitors exists.<sup>197</sup> The prices being fixed are the fee that the insured must pay and the provider's cost for the goods or services.<sup>198</sup>

The Court's holding in *Maricopa County* may be applicable to this type of arrangement. Prior to *Maricopa County*, the Virginia Supreme Court in *Blue Cross of Virginia v. Virginia*<sup>199</sup> held that a provider arrangement was illegal per se as a horizontal price-fixing conspiracy because evidence existed that the insurer had consulted with the providers about the "acceptability" of the arrangement.

An individual also can challenge the arrangements on the ground that they constitute a conspiracy to boycott because the arrange-

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196. 440 U.S. at 210 & n.5.

197. See *Hoffman v. Delta Dental Plan of Minn.*, 517 F. Supp. 564, 571 (D. Minn. 1981).

198. See *Sausalito Pharmacy, Inc. v. Blue Shield of Cal.*, 1980-81 Trade Cas. (CCH) ¶63,695 at 77,723 (N.D. Cal. 1980), *aff'd per curiam*, 677 F.2d 47 (9th Cir.), *cert. denied*, 103 S. Ct. 376 (1982).

199. 211 Va. 180, 189-92, 176 S.E.2d 439, 443-46 (1970). The decision is reviewed favorably in Comment, A "Fix" at the Local Drug Store—*Blue Cross Runs Afoul of the Sherman Act*, 57 VA. L. REV. 315 (1971), and criticized in Oppenheim, *Antitrust Policy and Third-Party Prepaid Prescription Drug Plan*, 40 GEO. WASH. L. REV. 244, 246-66 (1971). See also *General Glass Co. v. Globe Glass and Trim Co.*, 1980-2 Trade Cas. (CCH) ¶63,531 (N.D. Ill. 1980) (reserving for trial the question of whether the insurer had participated in an illegal horizontal price-fixing conspiracy where the evidence included discussions among providers about the insurer's prices). See generally *Problems of Third Party Prepaid Prescription Programs: Hearings Before the Subcomm. on Environmental Problems Affecting Small Business of the House Permanent Select Comm. on Small Business*, 93d Cong., 1st Sess. 51-79 (1973) (an insurer should avoid any activities that might support an inference of collusion between the insurer and providers).

ments involve concerted action.<sup>200</sup> The boycott stems from the refusal of the insurer and its providers to deal with other providers except on coercive terms. Although group boycotts generally are considered illegal per se,<sup>201</sup> lower courts have applied the per se rule only when the evidence established that the parties intended to boycott, coerce, or intimidate other providers.<sup>202</sup> Therefore, the per se rule should apply only when a provider-dominated insurer intends to boycott nonparticipating providers; otherwise, the rule of reason is the proper approach.

Under the rule of reason, an open-panel provider arrangement that is instituted by a controlled or dominated insurer should not constitute an illegal boycott because the arrangement does not preclude policyholders from using nonparticipating providers. Furthermore, the pressure exerted on nonparticipating providers to lower their prices and to participate in the arrangement should foster competition and, therefore, would not protect inefficient providers.

If the provider arrangement is essentially a closed-panel arrangement, courts should find that the arrangement is illegal as an unreasonable restraint of trade.<sup>203</sup> Rather than foster competition, this type of arrangement forecloses competition by precluding nonparticipating providers from competing with participating providers. Open-panel arrangements provide a more competitive alternative, allowing nonparticipating providers to compete at least on the basis of nonprice factors such as service.<sup>204</sup>

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200. See *Hoffman v. Delta Dental Plan of Minn.*, 517 F. Supp. 564, 573 (D. Minn. 1981) (upholding a boycott charge against an FMC-initiated provider arrangement).

201. See *Klor's, Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1950); *Fashion Originators' Guild of Am., Inc. v. FTC*, 312 U.S. 457 (1941).

202. See *supra* note 181.

203. See *Virginia Academy of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981). In determining that the insurer's practices were not exempt under the Act, the court emphasized that the insurer had failed to offer equal terms of reimbursement to psychologists, who could obtain reimbursement only if they billed for their services through a physician. *Id.* at 484. *But see Klamath Lake Pharmaceutical Ass'n v. Klamath Medical Serv. Bureau*, 507 F. Supp. 980, 983-84 (D. Ore. 1981) (upholding a closed-panel arrangement because the policyholders could go to nonparticipating providers "in an emergency" or when the insurer-owned pharmacy was closed).

204. Nonparticipating providers generally are placed at a cost disadvantage by the provider arrangement. See *supra* note 131 and accompanying text.

## 2. *Independent-Insurer Provider Arrangements*

If an independent insurer arranges with a provider to supply goods or services, the arrangement may be challenged as a form of vertical price-fixing. Such arrangements facially resemble maximum resale price maintenance, which is illegal per se.<sup>205</sup> Like a distributor that agrees to sell products at the price established by the manufacturer, a provider that chooses to participate in a provider arrangement agrees to charge no more than the insured's deductible amount, and to accept a fixed reimbursement from the insurer. Several differences, however, suggest that courts should not find independent-insurer provider arrangements illegal per se.

First, maximum resale price maintenance is bilateral, while provider arrangements create a trilateral relationship between the insurer, the provider, and the insured.<sup>206</sup> Second, provider arrangements do not involve the resale of any goods or services. The insured is simply a buyer who partially reimburses a provider for his services. If an insurer is a purchaser, then the insurer should have the right to negotiate the most favorable bargain possible. Indeed, in examining the legality of an arrangement similar to that in *Royal Drug*, the United States Court of Appeals for the Third Circuit commented: "In its negotiating with hospitals, [the insurer] has done no more than conduct its business as every rational enterprise does, i.e., get the best deal possible."<sup>207</sup> The Court in *Royal Drug* implicitly agreed with this analysis by characterizing provider agreements as mere "arrangements for the purchase of goods and services by [the insurer]."<sup>208</sup> Finally, the restraint imposed in a provider arrangement flows from the consumer, on whose behalf the insurer is acting, up to the provider; in resale price maintenance, the restraint flows down from the manufacturer to the distributor.<sup>209</sup> Independent-insurer provider arrangements,

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205. See *supra* notes 183-85 and accompanying text.

206. Comment, *supra* note 188, at 513.

207. *Travelers Ins. Co. v. Blue Cross of W. Pa.*, 481 F.2d 80, 84 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973).

208. 440 U.S. at 214.

209. Comment, *supra* note 188, at 514. In addition, per se rules are appropriate only when the activity in question is "plainly anticompetitive," *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679, 692 (1978), and "lack[s] any redeeming virtue," *Northern Pac. Ry. v. United States*, 356 U.S. 1, 5 (1958). Furthermore, courts should apply a per se rule

therefore, should pose no antitrust problems.

Courts have recognized these differences and have refused to apply a *per se* rule,<sup>210</sup> preferring instead to examine provider arrangements under the rule of reason. Under this analysis, provider arrangements clearly pass muster.<sup>211</sup> An insurer with many policyholders may be able to overcome the price insensitivity typical in the health care field by using its position to force providers to supply services at more competitive prices.<sup>212</sup> The inability of some inefficient providers to participate in the arrangement is a desirable ancillary effect. The antitrust laws encourage vigorous competition and do not shelter inefficient competitors or antiquated modes of competition that no longer meet the needs of consumers.<sup>213</sup> Thus, absent other factors that indicate an anticompetitive purpose or effect, independent insurer-instituted provider arrangements do not violate the antitrust laws.<sup>214</sup>

Plaintiffs also have challenged independent insurer-instituted

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only after determining the full effect of the activity in question. *National Soc'y of Professional Eng'rs*, 435 U.S. at 692. *Accord* *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Conn.*, 675 F.2d 502, 505-06 (2d Cir. 1982) (per curiam).

210. *See, e.g.*, *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Conn.*, 675 F.2d 502 (2d Cir. 1982) (per curiam); *Quality Auto Body, Inc. v. Allstate Ins. Co.*, 660 F.2d 1195 (7th Cir. 1981), *cert. denied*, 455 U.S. 1020 (1982); *Manasen v. California Dental Serv.*, 1981-1 Trade Cas. (CCH) ¶63,959 (N.D. Cal. 1980); *Sausalito Pharmacy, Inc. v. Blue Shield of Cal.*, 1980-81 Trade Cas. (CCH) ¶63,695 (N.D. Cal. 1980), *aff'd per curiam*, 677 F.2d 47 (9th Cir.), *cert. denied*, 103 S. Ct. 376 (1982).

211. *Accord* Comment, *supra* note 188, at 536-37. Indeed, no court that has reviewed insurer-initiated provider arrangements has declared them illegal as a form of vertical price-fixing. *See, e.g.*, *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Conn.*, 675 F.2d 502 (2d Cir. 1982) (per curiam); *Proctor v. State Farm Mut. Auto. Ins. Co.*, 675 F.2d 308 (D.C. Cir.), *cert. denied*, 103 S. Ct. 86 (1982); *Quality Auto Body, Inc. v. Allstate Ins. Co.*, 660 F.2d 1195 (7th Cir. 1981), *cert. denied*, 455 U.S. 1020 (1982); *Sausalito Pharmacy, Inc. v. Blue Shield of Cal.*, 1980-81 Trade Cas. (CCH) ¶63,695 (N.D. Cal. 1980), *aff'd per curiam*, 677 F.2d 47 (9th Cir.), *cert. denied*, 103 S. Ct. 376 (1982); *Chick's Auto Body v. State Farm Mut. Auto. Ins. Co.*, 168 N.J. Super. 68, 401 A.2d 722 (1979), *aff'd per curiam*, 176 N.J. Super. 320, 423 A.2d 311 (1980).

212. *See* Comment, *supra* note 188, at 518-23.

213. *See* *Brown Shoe Co. v. United States*, 370 U.S. 294, 320 (1962); *Hanson v. Shell Oil Co.*, 541 F.2d 1352, 1358-59 (9th Cir. 1976), *cert. denied*, 429 U.S. 1074 (1977).

214. The Antitrust Division of the U.S. Department of Justice agrees with this position, maintaining that provider arrangements initiated by independent insurers do not create antitrust problems. *See* Business Review Letters from the Justice Dep't cited at [1973] ANTITRUST & TRADE REG. REP. (BNA) No. 619, at A-7; [1975] ANTITRUST & TRADE REG. REP. (BNA) No. 744, at A-14; Brief for the United States as Amicus Curiae at 11, 32-33, *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979).



provider arrangements as illegal forms of horizontal price-fixing. When an independent insurer arranges individually with providers to supply services, no horizontal agreement exists as required by the Sherman Act.<sup>215</sup> Nor may an agreement between the providers be inferred from their independent decisions to participate in the arrangement; the insurer's offer may be attractive to an individual provider regardless of the decisions of other providers.<sup>216</sup> Likewise, allegations that independent insurer-instituted provider arrangements constitute illegal boycotts would fail because no concerted action exists.<sup>217</sup> An individual insurer may unilaterally refuse to deal with any provider.<sup>218</sup>

Finally, plaintiffs have challenged provider arrangements as violative of section 2 of the Sherman Act. The allegations involve attempts by insurers to monopolize an insurance market or a provider market, or to use insurer buying power to coerce provider participation.<sup>219</sup> Courts have rejected these allegations. No violation exists as long as the arrangements do not preclude providers from entering into agreements with other insurers, do not prohibit policyholders from patronizing nonparticipating providers, and are offered on equal terms to all providers.<sup>220</sup> Furthermore, as long as insurers do not use their buying power to coerce the participation of providers or engage in predatory pricing in an effort to drive nonparticipating providers out of business, courts should uphold

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215. See *Quality Auto Body, Inc. v. Allstate Ins. Co.*, 660 F.2d 1195, 1200 (7th Cir. 1981), *cert. denied*, 455 U.S. 1020 (1982). Evidence of an agreement among providers, of course, would present a different situation. See *supra* note 199 and accompanying text.

216. See *Theatre Enter., Inc. v. Paramount Film Distrib. Corp.*, 346 U.S. 537 (1954); *Third Party Prepaid Prescription Programs: Hearing Before the Subcomm. on Environmental Problems Affecting Small Business of the House Select Comm. on Small Business*, 92d Cong., 1st Sess. 230-31 (1971).

217. See *Quality Auto Body, Inc. v. Allstate Ins. Co.*, 660 F.2d 1195, 1206 (7th Cir. 1981), *cert. denied*, 455 U.S. 1020 (1982).

218. See *United States v. Colgate & Co.*, 250 U.S. 300 (1919).

219. See, e.g., *Travelers Ins. Co. v. Blue Cross of W. Pa.*, 481 F.2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973); *Hoffman v. Delta Dental Plan of Minn.*, 517 F. Supp. 564 (D. Minn. 1981); *Anderson v. Medical Serv. of the D.C.*, 1976-1 Trade Cas. (CCH) ¶60,884 (E.D. Va. 1976), *aff'd*, 551 F.2d 304 (4th Cir. 1977).

220. *Rankin & Wilson, Sausalito Pharmacy and the Antitrust Consequences of Insurer-Imposed Maximum Limitations on Fees*, 26 St. Louis U.L.J. 601, 621 (1982). Of course, a plaintiff would have to establish the other elements of a violation under § 2 of the Sherman Act.

the arrangements against antitrust challenges.<sup>221</sup>

## VI. CONCLUSION

To assure the ability of states to regulate and tax insurance companies, Congress provided the insurance industry with a limited exemption from the antitrust laws through the McCarran-Ferguson Act. Lower courts, however, initially construed the exemption broadly. In several recent decisions, the Supreme Court has narrowed significantly the scope of the exemption and has looked beyond the Act to consider the legality of insurer activities outside the exemption. Interpretation and application of the Supreme Court's holdings have resulted in confusion among the lower courts.

This Article has organized and outlined a framework, consistent with the recent Supreme Court decisions, for determining whether the McCarran-Ferguson Act immunizes an insurer's activity from the antitrust laws. Application of this framework to frequently challenged insurer activities indicates that many practices, both new and old, do not qualify for exemption from the antitrust laws. This is due primarily to the Supreme Court's restrictive interpretation of the phrase "business of insurance."

The failure of frequently challenged insurer activities to fall within the scope of the exemption, however, does not mean that all such activities are illegal. Indeed, antitrust scrutiny of recently adopted cost containment measures—provider arrangements and fee schedules—indicates that courts should distinguish between activities instituted by provider-dominated or provider-controlled insurers and those instituted by independent insurers. Activities in the former category should be considered illegal per se. Application of the rule of reason to activities in the latter category suggests that these activities ordinarily are lawful. Thus, the recent Supreme Court decisions construing the scope of the McCarran-Ferguson Act, although greatly narrowing the Act's scope, have not

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221. See *Travelers Ins. Co. v. Blue Cross of W. Pa.*, 481 F.2d 80, 84-85 (3d Cir.), cert. denied, 414 U.S. 1093 (1973). Cf. *United States v. New York Great A&P Tea Co.*, 173 F.2d 79, 83 (7th Cir. 1949) (buyer abused dominant position by employing boycotts and other forms of coercion to obtain favorable terms from sellers).

foreclosed the continued use of various cost containment measures by insurance companies.