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The Federal Medical Loss Ratio: A Permissible Federal Regulation or an Encroachment on State Power?

Meghan S. Stubblebine

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THE FEDERAL MEDICAL LOSS RATIO: A PERMISSIBLE
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INTRODUCTION

The Patient Protection and Affordable Care Act (PPACA) may be the most controversial piece of legislation of the past several decades.¹ The purpose of the PPACA is to provide access to affordable health care for all Americans, to improve efficiency in the health care industry, and to contain rising costs of health insurance.² Although increasing access to health care and other similar goals of the Act are not controversial,³ the PPACA's methods of achieving these goals have created deep rifts within America's political parties.⁴

The controversial nature of the PPACA garnered a constitutional challenge before the Supreme Court in *National Federation of Independent Business v. Sebelius*.⁵ In the majority opinion written by Chief Justice Roberts,⁶ the Court upheld the individual mandate under Congress's power to tax,⁷ but struck down the provision to

1. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). Compare Ron Pollack, *Striking Down the Affordable Care Act Would Be Unconscionable*, U.S. NEWS & WORLD REP. (Mar. 26, 2012), <http://www.usnews.com/debate-club/should-the-supreme-court-overturn-obamas-healthcare-law/striking-down-the-affordable-care-act-would-be-unconscionable> (attacking any future decision to overturn the PPACA), with Rep. F. James Sensenbrenner, *Affordable Care Act Gives Government Permission to Play the Bully*, FOX NEWS (Aug. 1, 2012), <http://www.foxnews.com/opinion/2012/08/01/affordable-care-act-gives-government-permission-to-play-bully/> (calling for support against the PPACA).

2. See DEMOCRATIC POLICY AND COMMUNICATIONS COMMITTEE, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: DETAILED SUMMARY 1 (2010), available at <http://dpc.senate.gov/healthreformbill/healthbill04.pdf>.

3. See Patricia Zengerle, *Most Americans Oppose Health Law but Like Provisions*, REUTERS (June 24, 2012), <http://www.reuters.com/article/2012/06/24/us-usa-campaign-healthcare-idUSBRE85N01M20120624>; see also Ezra Klein, *Poll: Republicans Hate 'Obamacare,' but Like Most of What It Does*, WASH. POST WONKBLOG (June 26, 2012), <http://www.washingtonpost.com/blogs/ezra-klein/wp/2012/06/26/poll-republicans-hate-obamacare-but-like-most-of-what-it-does/>.

4. See Tom Cohen, *Republicans Launch Blitz Against Health Care Law*, CNN.COM (June 29, 2012), <http://www.cnn.com/2012/06/29/politics/health-care/index.html>; Lydia Saad, *Americans Issue Split Decision on Healthcare Ruling*, GALLUP POL. (June 29, 2012), <http://www.gallup.com/poll/155447/americans-issue-split-decision-healthcare-ruling.aspx>.

5. 132 S. Ct. 2566 (2012).

6. See Saad, *supra* note 4.

7. The individual mandate requires people to either purchase insurance or pay a penalty. To clarify, the individual mandate and the federal medical loss ratio are different provisions of the PPACA. The Court's choice to limit Congress's commerce power was not applied to the federal medical loss ratio. See *The Requirement to Buy Coverage Under the Affordable Care*

expand Medicaid because Congress could not order states to regulate in a precise manner.⁸ Not all of the PPACA's legal controversies were brought before the Court in this landmark case.⁹ In particular, the Court did not address the PPACA's requirement that health insurance companies provide rebates to customers if they fail to meet a specified federal medical loss ratio.¹⁰

A medical loss ratio is "[t]he percentage of your premium dollars that an insurance company spends on providing you with health care and improving the quality of your care (as opposed to what it spends on administrative, overhead, [profits,] and marketing costs)."¹¹ Under the PPACA, insurers must issue rebates if payments for medical claims and quality improvement activities account for less than 85% of premium revenue for insurers in a large group market or less than 80% for insurers in a small group or individual market.¹² These requirements of 80% and 85% are the federal government's minimum medical loss ratios. The federal government now limits how much insurance companies may spend of each premium dollar on expenses that are not medical expenses or efforts to improve quality.¹³ The rebate amount is equal to the amount by which the insurance company's expenditures on nonmedical and nonquality improvement costs exceed the minimum medical loss ratio of total premium dollars.¹⁴

Medical loss ratios are not a new concept in governance. States have implemented minimum medical loss ratios for years to rein in

Act, THE HENRY J. KAISER FAM. FOUND. (Mar. 9, 2011), <http://healthreform.kff.org/the-basics/requirement-to-buy-coverage-flowchart.aspx>.

8. See *Nat'l Fed'n*, 132 S. Ct. at 2608.

9. The individual mandate and Medicaid expansion were the primary issues brought before the Court. Other legal issues, though, such as the federal medical loss ratio, were mentioned in briefs. See *infra* notes 54-63 and accompanying text (addressing briefs filed in *National Federation*).

10. See generally *Nat'l Fed'n*, 132 S. Ct. 2566.

11. *Value for Your Premium Dollar*, HEALTHCARE.GOV (Aug. 8, 2011), <http://www.healthcare.gov/law/features/costs/value-for-premium/index.html>; see *Explaining Health Care Reform: Medical Loss Ratio (MLR)*, THE HENRY J. KAISER FAM. FOUND. 1 (Feb. 2012), <http://www.kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/>.

12. See 42 U.S.C. § 300gg-18(b) (Supp. 2012).

13. See *Value for Your Premium Dollar*, *supra* note 11.

14. See *id.*

rising health care costs.¹⁵ However, states almost always set more lenient minimum medical loss ratios than the new federal ratio. Today, thirty-eight states have medical loss ratios below 75% or no medical loss ratios at all.¹⁶ In fact, only California, New York, and Vermont have medical loss ratios that meet or exceed the new federal ratio of 80% for small group or individual carriers.¹⁷ No state has a medical loss ratio that meets the federal medical loss ratio of 85% for large group carriers.¹⁸ Congress only gave states the option of increasing their medical loss ratios above the federal minimum.¹⁹ State regulation decreasing the medical loss ratio is subject to the Secretary of Health and Human Services' approval.²⁰ States may apply for an adjustment if the federal "standard may destabilize the individual market" and "result in fewer choices for consumers."²¹ The decision to set a medical loss ratio is now reserved solely for the federal government, not for the states.

This Note evaluates the constitutional and statutory viability of the PPACA's insurance rebate provision, specifically the federal medical loss ratio. The federal medical loss ratio has received some scholarly attention with respect to its constitutionality. Professor Richard Epstein and practitioner Paula Stannard contend that the ratio is unconstitutional under the Fifth Amendment's Takings Clause because the government has not compensated for regulatory losses after it reduced the health insurance industry's return on investment.²² Professor Epstein also wrote another paper with a

15. See *Medical Loss Ratios: Evidence from the States*, FAMS. USA 3 (June 2008), <http://familiesusa.org/assets/pdfs/medical-loss-ratio.pdf> (showing that approximately one-third of states set medical loss ratios and that nine of these states have ratios below 75%).

16. See *id.*

17. CAL. CODE REGS. tit. 28, § 1300.78 (2011); N.Y. INS. LAW § 3231 (McKinney 2011); VT. STAT. ANN. tit. 8, § 4080 (West 2011).

18. See *Medical Loss Ratios: Evidence from the States*, *supra* note 15, at 3.

19. See 42 U.S.C. § 300gg-18(b) (Supp. 2012) (providing states the option to set a higher medical loss ratio, but not providing an option of a lower medical loss ratio).

20. See § 300gg-18(b), (d).

21. See *State Requests for MLR Adjustment*, CTRS. FOR MEDICARE & MEDICAID SERVS., http://cms.gov/CCIIO/programs-and-initiatives/Health-Insurance-Market-Reforms/state_mlr_adj_requests.html (last visited Sept. 22, 2013).

22. See Richard A. Epstein & Paula M. Stannard, *Constitutional Ratemaking and the Affordable Care Act: A New Source of Vulnerability*, 38 AM. J.L. & MED. 243, 261-65 (2012). Ms. Stannard is also the former deputy general counsel and former acting general counsel of the U.S. Department of Health and Human Services, which is the department in charge of

similar argument prior to the PPACA's passage, arguing that the government's failure to provide a risk-adjusted rate of return or any due process to insurance companies was unconstitutional under the Fifth Amendment's Takings and Due Process Clauses.²³ Judicial clerk Wesley Markham responded to Professor Epstein's concerns by contending that the ratio may be constitutional because insurance companies can still earn a reasonable profit.²⁴ Despite this scholarship, no examination of the medical loss ratio's statutory viability or constitutional viability under the Commerce Clause exists to date. Considering that the Supreme Court could find the federal medical loss ratio to be constitutional under any number of avenues, as it surprisingly found the individual mandate constitutional under the taxation power, it is of vital importance to examine whether the medical loss ratio would be upheld under the federal government's insurance regulatory statute, the McCarran-Ferguson Act.

This Note argues that, although the codification of a federal medical loss ratio may be constitutional under the Commerce Clause, there is no federal statutory basis that permits Congress to preempt state regulation of medical loss ratios. To provide a framework for presenting this argument, the first Part of this Note presents a summary of the PPACA's general goals and resulting litigation. The second Part discusses the history of insurance regulation and its role in the state regulatory sphere. The third Part explains how Congress has the authority to regulate insurance companies' medical loss ratios under the Commerce Clause. The fourth Part demonstrates that although the federal medical loss

administering the federal medical loss ratio.

23. See Richard A. Epstein, MANHATTAN INST., IMPERMISSIBLE RATEMAKING IN HEALTH-INSURANCE REFORM: WHY THE REID BILL IS UNCONSTITUTIONAL, 19-23 (2009), http://www.medicalprogresstoday.com/pdfs/MI_Health_Care_act.pdf. A student note by Rebecca Kopps similarly argues that the federal medical loss ratio violated the Fifth Amendment's Takings Clause because insurance companies cannot earn a competitive rate of return and did not receive compensation for the forced loss. See Rebecca J. Kopps, Note, *Dead on Arrival: The Health Insurance Industry's Bleak Prognosis Due to Unconstitutional Rate-making in the Patient Protection and Affordable Care Act*, 31 N. ILL. U. L. REV. 577, 610-11 (2011).

24. See Wesley D. Markham, *Healthcare Reform's Mandatory Medical Loss Ratio: Constitutionality, Policy, and Implementation*, 46 U.S.F. L. REV. 139, 167-68 (2011) (admitting that the PPACA does allow for occasional unconstitutional circumstances, however, such as when a company sues and is able to prove that it must shut down due to the ratio).

ratio may be constitutional under the Commerce Clause, it is not statutorily permissible under the McCarran-Ferguson Act. This Note concludes by addressing the legal and policy implications of allowing the federal medical loss ratio to continue to exist.

I. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

A. Processes and Goals of the PPACA and Its Medical Loss Ratio

President Obama signed the PPACA into law on March 23, 2010.²⁵ Through over 900 pages of text,²⁶ the Act “put[] in place comprehensive reforms that improve access to affordable health coverage for everyone and protect consumers from abusive insurance company practices.”²⁷ Congress established the federal medical loss ratio and its resulting rebate requirement in order to advance the goal of providing affordable health care to everyone.²⁸ In fact, the Democratic Policy and Communications Committee cited the medical loss ratio as one of the PPACA’s immediate improvements, which “[c]ap[ped] insurance company non-medical, administrative expenditures.”²⁹

The new federal medical loss ratio requires health insurers offering policies to individuals or small groups to spend at least 80% of premiums on direct medical care and efforts to improve the quality of care.³⁰ Insurers selling to large groups of fifty or more employees must spend 85% of premiums on care and quality improvement.³¹ In order for the Secretary of Health and Human Services to assess whether an insurance company must issue a rebate, the PPACA requires insurers to submit data to calculate the medical loss ratio. Specifically, insurance companies must provide the percentage of premium revenues used to pay for “clinical

25. *A More Secure Future: What the New Health Law Means for You and Your Family*, WHITEHOUSE.GOV, <http://www.whitehouse.gov/healthreform/healthcare-overview> (last visited Sept. 22, 2013). See generally Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

26. See 124 Stat. at 119-1025.

27. See *A More Secure Future*, *supra* note 25.

28. See DEMOCRATIC POLICY AND COMMUNICATIONS COMMITTEE, *supra* note 2, at 1.

29. See *id.*

30. See 42 U.S.C. § 300gg-18(b) (Supp. 2012).

31. See *id.*

services and quality improvement.”³² If an insurance company fails to meet the required medical loss ratio, the Secretary of Health and Human Services has mandated that the company send rebates to its consumers.³³ The rebate can be in the form of a check, a reduction in premiums, or a lump sum reimbursement in the insured’s account.³⁴ Reporting by insurance companies began on June 1, 2012 and rebates were sent throughout the summer of 2012.³⁵

B. Litigation Surrounding the PPACA

Parties and amicus curiae mentioned the federal medical loss ratio in briefs submitted in *National Federation*,³⁶ but it was not an issue raised before the Supreme Court.³⁷ Eight federal courts have ruled on other constitutional and statutory challenges to the PPACA.³⁸ Although some aspects of the resulting decisions are no longer good law after the *National Federation* decision, they do show an important trend of how the district and circuit courts rule on challenges to PPACA provisions.

District and circuit court trends appear to favor the constitutionality of federally imposed insurance laws. Five district and circuit courts upheld various provisions of the PPACA, most frequently reviewing challenges targeting the individual mandate.³⁹ These courts collectively stated that the PPACA provisions at issue were created within the lawful power of the Commerce Clause,⁴⁰ lacked

32. See *Medical Loss Ratio*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/CCIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.html> (last visited Sept. 22, 2013).

33. See *id.*

34. See Michael Hash, *Finding Out if Your Health Insurer Is Providing Value for Your Premiums*, INST. FOR HEALTHCARE CONSUMERISM (July 13, 2012), http://www.theihcc.com/en/communities/health_plans_managed_care/finding-out-if-your-health-insurer-is-providing-va_h4pxm023.html.

35. See *id.*

36. See *infra* note 54 and accompanying text.

37. See generally *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

38. See *infra* notes 39-46.

39. See *id.* The individual mandate is a separate provision from the federal medical loss ratio. See *supra* note 7.

40. See *Mead v. Holder*, 766 F. Supp. 2d 16, 33-34 (D.D.C.), *aff'd sub nom.* *Seven-Sky v. Holder*, 661 F.3d 1, 20 (D.C. Cir. 2011); *Thomas More Law Ctr. v. Obama*, 720 F. Supp. 2d 882, 895 (E.D. Mich. 2010), *aff'd*, 651 F.3d 529, 544-45 (6th Cir. 2011), *abrogated by Nat'l*

personal⁴¹ or subject matter jurisdiction⁴² to be challenged, and did not violate the Religious Freedom Restoration Act,⁴³ Free Exercise Clause, or Free Speech Clause.⁴⁴ However, two district courts and a circuit court found the PPACA's individual mandate unconstitutional.⁴⁵ Both district courts and the circuit court held that Congress usurped state power through an unconstitutional extension of the Commerce Clause.⁴⁶

These cases show a trend that district and circuit courts generally view the PPACA as constitutionally permissible, with limited exceptions. The most important decision moving forward, however, is the Supreme Court's review of the PPACA in *National Federation*.

C. Review of the PPACA by the Supreme Court

The Supreme Court reviewed the Eleventh Circuit's decision in *National Federation*. The Eleventh Circuit held that the individual mandate was unconstitutional because it exceeded congressional authority to regulate interstate commerce.⁴⁷ In a five-to-four

Fed'n, 132 S. Ct. 2566.

41. See *Liberty Univ., Inc. v. Geithner*, 671 F.3d 391, 397-98 (4th Cir. 2011) (remanding to dismiss), *vacated*, 133 S. Ct. 679 (2012).

42. See *Virginia ex rel. Cuccinelli v. Sebelius*, 656 F.3d 253, 266 (4th Cir. 2011).

43. See *O'Brien v. U.S. Dep't of Health & Human Servs.*, 894 F. Supp. 2d 1149 (E.D. Mo. 2012) (dismissing a PPACA challenge under the Religious Freedom Restoration Act because the requirement to provide contraception coverage for employees did not violate an employer's religious freedom); *Mead*, 766 F. Supp. 2d at 41-43.

44. See *Liberty*, 753 F. Supp. 2d 611, 618 (W.D. Va. 2010) (dismissing the case because the PPACA did not violate the Free Speech Clause, Free Exercise Clause, equal protection rights, or the Commerce Clause), *vacated*, 671 F.3d 391 (4th Cir. 2011), *vacated*, 133 S. Ct. 679 (2012).

45. See *Florida ex rel. Bondi v. U.S. Dep't. of Health & Human Servs.*, 780 F. Supp. 2d 1256, 1273-95 (N.D. Fla.) (offering one of the most detailed Commerce Clause analyses of the PPACA decisions), *aff'd in part, rev'd in part*, 648 F.3d 1235, 1328 (11th Cir. 2011), *aff'd in part, rev'd in part sub nom. Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012); *Virginia ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768, 781-82 (E.D. Va. 2010) (holding the mandate unconstitutional because the PPACA did not cover commerce as intended by the Constitution).

46. See *Florida ex rel. Att'y Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1328 (11th Cir. 2011) (finding that the mandate could be severed); *Cuccinelli*, 728 F. Supp. 2d at 781-82; *Bondi*, 780 F. Supp. 2d at 1295.

47. See *Florida ex rel. Att'y Gen.*, 648 F.3d at 1328 (holding that the mandate could be severed as well).

decision, the Supreme Court reversed and held that the individual mandate was constitutional under Congress's taxing power.⁴⁸

Although the mandate was constitutional under Congress's taxing power, a majority of the Court also held that the individual mandate exceeded congressional power under the Commerce Clause.⁴⁹ Chief Justice Roberts and the joint dissent⁵⁰ agreed that the Commerce Clause could not justify Congress's creation of the individual mandate because it constituted a penalty against economic inactivity.⁵¹ This constraint limited future congressional authority stemming from the Commerce Clause. The Court further held the expansion of Medicaid unconstitutional because it coerced state action, and thus severed it from the PPACA.⁵²

The legal challenges in *National Federation* did not include challenges to the federal medical loss ratio.⁵³ Because the ratio was not at issue, the Court's rejection of Congress's power to regulate the individual mandate under the commerce power did not extend to the ratio. However, thirteen amicus briefs discussed the ratio, with several raising it as problematic to the health care insurance industry.⁵⁴ Notably, the amicus briefs finding fault with the federal

48. See *Nat'l Fed'n*, 132 S. Ct. at 2601. For a breakdown of the Justices' votes, see Corey Ciocchetti, *The Constitution, The Roberts Court, and Business: The Significant Business Impact of the 2011-2012 Supreme Court Term*, 4 WM. & MARY BUS. L. REV. 385, 458 (2013).

49. See *Nat'l Fed'n*, 132 S. Ct. at 2608.

50. See *id.* at 2642 (Alito, J., Kennedy, J., Scalia, J., Thomas, J., dissenting).

51. See *id.* at 2590 (distinguishing from *Gonzales v. Raich*, 125 S. Ct. 2195 (2005)); *id.* at 2642 (Scalia, J., Kennedy, J., Thomas, J., Alito, J., dissenting).

52. See *id.* at 2608.

53. See generally *id.* (showing no discussion of the insurance rebate requirement).

54. See generally Brief for Petitioners (Minimum Coverage Provision) at 10, *Nat'l Fed'n*, 132 S. Ct. 2566 (No. 11-398); Brief for Petitioners (Severability) at 18-19, *Nat'l Fed'n*, 132 S. Ct. 2566 (Nos. 11-393, 11-400); Brief for Respondents (Severability) at 40, *Nat'l Fed'n*, 132 S. Ct. 2566 (Nos. 11-393, 11-400); Brief for Cato Institute et al. as Amici Curiae Supporting Respondents at 33, *Nat'l Fed'n*, 132 S. Ct. 2566 (Nos. 11-1057, 11-1058); Brief of Chamber of Commerce of the United States of America as Amicus Curiae Supporting Petitioner at 11, *Nat'l Fed'n*, 132 S. Ct. 2566 (Nos. 11-393, 11-400); Brief of Constitutional Law and Economics Professors as Amici Curiae Supporting Petitioners at 12, *Nat'l Fed'n*, 132 S. Ct. 2566 (No. 11-398); Brief for Economists as Amici Curiae Supporting Petitioners at 18, *Nat'l Fed'n*, 132 S. Ct. 2566 (No. 11-393, 11-400); Brief for HSA Coalition et al. as Amici Curiae Supporting Respondents at 19, *Nat'l Fed'n*, 132 S. Ct. 2566 (No. 11-398); Brief of Jewish Alliance for Law & Social Action et al. as Amici Curiae Supporting Petitioners at 35, *Nat'l Fed'n*, 132 S. Ct. 2566 (No. 11-398); Brief of Michigan Legal Services et al. as Amici Curiae Supporting Petitioner at 8, *Nat'l Fed'n*, 132 S. Ct. 2566 (Nos. 11-393, 11-400); Brief for the States of California et al. as Amici Curiae Supporting Respondents at 21, *Nat'l Fed'n*, 132 S. Ct. 2566

medical loss ratio generally attacked it for policy reasons and did not cite direct legal challenges.

The HSA Coalition's brief, which relied on policy justifications in lieu of legal justifications, argued exclusively against the federal medical loss ratio and the rebate requirement. The brief quoted a study by Milliman, Inc., which performed the only published actuarial study of the federal medical loss ratio.⁵⁵ Milliman found that the "Act and its regulations have taken away an individual's choice in health insurance decisions, and is replacing it with a limited, standardized array of government-approved options."⁵⁶ The HSA Coalition argued that insurance companies with primarily high deductible plans would suffer the most from the high minimum medical loss ratio and may be forced to discontinue such plans due to increased risk while sustaining lower profits.⁵⁷ The Coalition further argued that the federal medical loss ratio's incentive to cut administrative expenses "may create disincentives to offer such lower-cost plans [such as high deductible plans], particularly if the insurer cannot generate reasonable risk margins."⁵⁸ According to the brief, medical loss ratios require lower profits from insurance companies, which is too great of a burden for companies dealing with high risk plans.⁵⁹

Two additional amicus briefs directly expressed disapproval of the federal medical loss ratio. An amicus brief submitted by Virginia Delegate Bob Marshall, among other legislative representatives and research institutions, argued that the federal medical loss ratio allowed the Secretary of Health and Human Services to manage "a quintessential business decision previously left largely to private insurance companies."⁶⁰ The brief argued that such management would influence insurance companies to stop offering Health

(Nos. 11-393, 11-400); Brief for Texas Public Policy Foundation as Amicus Curiae Supporting Respondents on the Individual Mandate at 37, *Nat'l Fed'n*, 132 S. Ct. 2566 (No. 11-398); Brief of Virginia Delegate Bob Marshall et al. as Amicus Curiae Supporting Respondents at 34, *Nat'l Fed'n*, 132 S. Ct. 2566 (No. 11-398).

55. Brief for HSA Coalition et al., *supra* note 54, at 5.

56. *See id.*

57. *See id.* at 19.

58. *See id.* at 19-20 (internal quotations and citations omitted).

59. *Id.*

60. *See* Brief of Virginia Delegate Bob Marshall at 34, *Nat'l Fed'n*, 132 S. Ct. 2566 (No. 11-398).

Savings Accounts (HSA) that offer plans with high deductibles.⁶¹ This is because HSAs are generally used to supplement regular insurance for uncovered treatments and would not count toward medical payments included in a company's medical loss ratio.⁶² Another amicus brief by the Texas Public Policy Foundation argued that the PPACA was a misguided regulation and that the expansion of federal power to establish a minimum medical loss ratio was not within the Framers' original intent.⁶³

Although thirteen amicus briefs mentioned the federal medical loss ratio, including three arguing that the ratio is bad policy, most of the briefs did not offer a strong position for or against the provision. As a result, the Supreme Court has not, to date, addressed any legal challenges of the federal medical loss ratio. The following Parts explore the historical role of Congress in insurance regulation and whether the federal medical loss ratio is likely to be constitutionally and statutorily permissible if the Supreme Court accepts the issue for review.

II. CONGRESS'S HISTORICAL ROLE IN INSURANCE REGULATION

States traditionally regulate minimum standards for insurance companies and their practices.⁶⁴ Standards vary across states, with all states regulating fair claims handling practices⁶⁵ and most regulating access to health care.⁶⁶ With the expansion of insurance sales throughout the country over the past century, however, the nature of regulation has changed. The historical path of health insurance development helps explain the process for determining whether the federal government may constitutionally and statutorily preempt state medical loss ratios. This Part explains how insurance regulation developed as a state issue through 1945, how

61. *See id.*

62. *See id.*

63. Brief for Texas Public Policy Foundation Supporting Respondents on the Individual Mandate at 37, *Nat'l Fed'n*, 132 S. Ct. 2566 (No. 11-398).

64. *See* MILA KOFMAN & KAREN POLLITZ, GEORGETOWN UNIV. HEALTH POLICY INST., HEALTH INSURANCE REGULATION BY STATES AND THE FEDERAL GOVERNMENT: A REVIEW OF CURRENT APPROACHES AND PROPOSALS FOR CHANGE 1 (Apr. 2006), available at <http://www.allhealth.org/briefingmaterials/HealthInsuranceReportKofmanandPollitz-95.pdf>.

65. *See id.*

66. For further discussion on state standards and their variances, see *id.* at 1-4.

the Court expanded Congress's commerce power in insurance regulation, and how congressional actions limited application of the commerce power through passage of the McCarran-Ferguson Act.

A. Pre-1945 Common Law Insurance Regulation

With insurance companies operating locally in the 1850s, states served as the first primary regulators of the insurance industry.⁶⁷ The insurance industry challenged states' regulatory authority in the Supreme Court's first insurance regulation case, *Paul v. Virginia*, in 1868.⁶⁸ In *Paul*, the defendant challenged the Commonwealth's abilities to regulate the issuance of insurance policies and to issue penalties for not obtaining a license to engage in the business of insurance in Virginia.⁶⁹ The Supreme Court held that "[i]ssuing a policy of insurance is not a transaction of commerce" and that Virginia had the authority to regulate insurance.⁷⁰ Speaking for the majority, Justice Field held that insurance "is not commerce in the sense of the Constitution, however convenient and even necessary such insurance may be."⁷¹ As a consequence of the Court's validation of state power in *Paul*, states regulated the insurance industry for decades.

With the expansion of commerce powers after the switch in time in 1937,⁷² the Supreme Court approved of federal insurance regulation via the Commerce Clause in 1944. In *United States v. South-Eastern Underwriters Association*, the Supreme Court held that the insurance industry was within reach of Congress's commerce power and allowed the federal government to prevent

67. See Tom Baker, *The Case for Federal Regulation of Insurance: Should the Tobin Project's Risk Group Care 1*, TOBIN PROJECT (2006), http://www.bipac.net/afc/Tom_Baker_The_Case_for_Federal_Regulation_of_Insurance.pdf; Van R. Mayhall, III, *A Brief Chronicle of Insurance Regulation in the United States, Part I: From De Facto Judicial Regulation to South-Eastern Underwriters Ass'n*, INS. REG. L. (May 16, 2011), <http://www.insreglaw.com/2011/05/brief-chronicle-of-insurance-regulation.html>.

68. 75 U.S. 168, 183 (1868).

69. See *id.*

70. See *id.*

71. *Id.* at 177.

72. See generally Stephen Ganter, *Did United States v. Lopez Turn Back the Clock on the Commerce Clause?*, 21 T. MARSHALL L. REV. 343, 349-53 (1996) (discussing how the "switch in time that saved nine" expanded the use of the Commerce Clause).

insurers from conspiring to fix insurance premium rates.⁷³ Justice Black held, “No commercial enterprise of any kind which conducts its activities across state lines has been held to be wholly beyond the regulatory power of Congress under the Commerce Clause. We cannot make an exception of the business of insurance.”⁷⁴ Through *South-Eastern Underwriters*, the Supreme Court approved of legislative involvement in the insurance industry through the Commerce Clause.

B. The McCarran-Ferguson Act and Its Common Law Progeny

Within one year of *South-Eastern Underwriters*, Congress passed the McCarran-Ferguson Act and “restore[d] the supremacy of the States in the realm of insurance regulation.”⁷⁵ Congress limited federal involvement in the insurance industry because *South-Eastern Underwriters*, which subjected national insurance companies to federal laws, was “widely perceived as a threat to state power to tax and regulate the insurance industry.”⁷⁶ This encroachment on state powers angered several senators, particularly the bill leaders, Senators Pat McCarran of New Mexico and Homer Ferguson of Michigan.⁷⁷

The McCarran-Ferguson Act explicitly states 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.”⁷⁸ The McCarran-Ferguson Act generally allows states to regulate the business of insurance when the federal government elects not to.

Limits on congressional ability to regulate the insurance industry are found in 15 U.S.C. § 1012, which addresses federal laws relating specifically to insurance.⁷⁹ This section states that (1) insurance

73. 322 U.S. 533, 552-53 (1944).

74. *See id.* at 553.

75. U.S. Dep’t of Treasury v. Fabe, 508 U.S. 491, 499-500 (1993).

76. *Id.*

77. *See* Timothy Noah, *Busted Trust*, SLATE (Oct. 14, 2009, 6:52 PM), http://www.slate.com/articles/news_and_politics/prescriptions/2009/10/busted_trust.html.

78. McCarran-Ferguson Act, 15 U.S.C. § 1011 (2006) (emphasis added).

79. *See* 15 U.S.C. § 1012 (2006).

companies are subject to state regulatory laws and (2) Congress may not supersede state law regulating insurance “unless such Act specifically relates to the *business of insurance*.”⁸⁰ Even when federal regulation is considered constitutional under the Commerce Clause, as was the case in *South-Eastern Underwriters*, federal regulation is only statutorily permissible if it regulates the business of insurance. The “business of insurance” is the Act’s most important phrase in this analysis because it determines whether Congress has the right to regulate medical loss ratios. The McCarran-Ferguson Act does not define what constitutes the business of insurance, and the courts have struggled with defining the phrase for years.⁸¹

C. The Common Law Struggle with the “Business of Insurance”

Defining what constitutes the “business of insurance” for regulatory purposes has been left to the courts. Many cases have held that the intent of the McCarran-Ferguson Act was to protect the ability of the states to regulate⁸² by limiting federal preemption of state insurance regulation through the Commerce Clause.⁸³ Most importantly, courts have held that not all business decisions by an insurance company are included in the McCarran-Ferguson Act’s meaning of “the business of insurance.”⁸⁴

The leading case defining the business of insurance is *Group Life & Health Insurance Co. v. Royal Drug Co.*⁸⁵ In *Royal Drug*, a Texas insurance company contracted with a group of pharmacies to offer low cost prescription drugs to its insurance policyholders, while offering more expensive drugs to its policyholders when purchased from nonparticipating pharmacies.⁸⁶ Owners of nonparticipating pharmacies sued the insurance company for violating antitrust laws

80. See *id.* (emphasis added).

81. See Robert P. Rothman, *The Definition of “Business of Insurance” Under the McCarran-Ferguson Act After Royal Drug*, 80 COLUM. L. REV. 1475, 1476-77 (1980) (discussing inconsistent decisions regarding the “business of insurance” across multiple courts).

82. See *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 218-19 (1979).

83. See, e.g., *Am. Ins. Ass’n v. Garamendi*, 539 U.S. 396, 427-28 (2003).

84. *Royal Drug*, 440 U.S. at 216-17.

85. *Id.*

86. See *id.* at 207-08.

under the Sherman Act. The Supreme Court held that the pharmaceutical agreement did not constitute a practice involved in the business of insurance and the insurance company was subject to antitrust laws.⁸⁷

Royal Drug held that the McCarran-Ferguson Act did not intend to include every business decision of insurance companies.⁸⁸ The Court stated that including all business decisions of insurance companies “would be plainly contrary to the language of this chapter” because the “business of insurance” does not include all of the “business of insurance companies.”⁸⁹ *Royal Drug* went on to hold that practices beyond the “business of insurance” are not included in the McCarran-Ferguson Act, even if policyholders are benefited from the insurance company’s improved financial condition.⁹⁰

The Court used a three-prong test to determine whether a practice is the “business of insurance,” and thus whether the federal government can regulate a particular insurance industry practice.⁹¹ This test asks:

First, whether the practice has the effect of transferring or spreading a policyholder’s risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.⁹²

Courts must evaluate all of these factors, but do not need to find that all of the factors are met.⁹³ This three-prong test is known as the McCarran-Ferguson Act test, and must be applied to all federal insurance regulations allowed under the Commerce Clause.

87. *See id.* at 231-33. Although antitrust laws are not at issue in this Note, *Royal Drug’s* “business of insurance” rationale applies to the analysis of whether the federal government may preempt state medical loss ratio regulations. For a discussion of the McCarran-Ferguson Act’s impact on antitrust law, see Alan M. Anderson, *Insurance and Antitrust Law: The McCarran-Ferguson Act and Beyond*, 25 WM. & MARY L. REV. 81 (1983).

88. *See Royal Drug*, 440 U.S. at 213-14.

89. *See id.* at 217.

90. *See id.* at 250-51.

91. *See id.* at 217-28.

92. *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982) (original emphasis omitted) (summarizing *Royal Drug’s* three-prong test).

93. *See id.*

D. Roadmap for Testing the Legality of the Federal Medical Loss Ratio

To summarize, the McCarran-Ferguson Act and its resulting common law interpretation expressly limit congressional authority to regulate the insurance industry. The Supreme Court held in *South-Eastern Underwriters* that Congress possessed the right to regulate the insurance industry if it fell within the bounds of the Commerce Clause. However, Congress chose to limit its constitutional authority through the McCarran-Ferguson Act by narrowing the scope of federal regulatory power over the insurance industry to the “business of insurance.” Since passage of the McCarran-Ferguson Act, courts have fashioned the three-prong test cited above to determine whether a particular regulated activity constitutes the “business of insurance.”

This complex history of federal regulation provides a roadmap for determining whether the federal medical loss ratio may be considered legally permissible. The following two Parts evaluate the legality of the federal medical loss ratio under both the Commerce Clause and the McCarran-Ferguson Act. Part III finds that the federal medical loss ratio meets the constitutional requirements of the Commerce Clause.⁹⁴ Part IV concludes that the federal medical loss ratio does not pass the McCarran-Ferguson Act’s three-prong test, and thus is not statutorily permissible.

III. CONSTITUTIONALITY OF THE FEDERAL MEDICAL LOSS RATIO UNDER THE COMMERCE CLAUSE

The first step to determine whether Congress is permitted to regulate medical loss ratios within the insurance industry is to evaluate whether such regulation is permissible under the Commerce Clause. Congress traditionally may regulate any commerce,

94. Although Congress may regulate the insurance industry under the Commerce Clause, the federal medical loss ratio still must be evaluated to determine whether it meets the requirements of the Commerce Clause. For example, the individual mandate was not constitutional under the Commerce Clause in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012). The commerce power may be used to regulate insurance, but that does not make all insurance regulation permissible without meeting the Commerce Clause’s requirements.

including insurance, under three classes of cases. First, Congress may regulate channels of interstate commerce, such as highways, waterways, and railroads.⁹⁵ Second, Congress may regulate instrumentalities of interstate commerce, or persons, goods, or things that move in interstate commerce.⁹⁶ Third, Congress may regulate intrastate activity that substantially affects interstate commerce.⁹⁷ Cases in this third class apply the “substantial effects” test.⁹⁸

Chief Justice Roberts readily admitted in his opinion in *National Federation* that “[t]he path of our Commerce Clause decisions has not always run smooth.”⁹⁹ As a consequence of the inconsistent nature of the Supreme Court’s Commerce Clause rulings, it is sometimes unclear how the Court will rule.¹⁰⁰ Despite inconsistent holdings, the Court always uses one of the three classes of cases noted above to define the scope of activities that Congress is permitted to regulate under the Commerce Clause.

Congress’s attempt to regulate the insurance industry by establishing a federal medical loss ratio may be constitutional under either the second or third classes of Commerce Clause cases. The following two sections analyze whether the medical loss ratio is constitutional under each of these two classes of cases. The first section addresses the constitutionality of the federal medical loss ratio under the second class of commerce cases—cases that involve persons, goods, or things that move in interstate commerce. The second section addresses the constitutionality of the federal medical loss ratio under the third class of commerce cases—cases that involve the substantial effects test.

95. See *Houston, E. & W. Tex. Ry. Co. v. United States*, 234 U.S. 342, 351, 358-59 (1914).

96. See *United States v. Lopez*, 514 U.S. 549, 558 (1995); *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241, 255-57 (1964); *Katzenbach v. McClung*, 379 U.S. 294, 301 (1964).

97. For cases discussing activities that have an economic effect, see *Gonzales v. Raich*, 545 U.S. 1, 17-18, 26-27 (2005); *Wickard v. Filburn*, 317 U.S. 111, 123-25 (1942); and *United States v. Darby*, 312 U.S. 100, 118-20 (1941). For cases evaluating activity that has a noneconomic effect, see *Gonzales*, 545 U.S. at 35-37; *United States v. Morrison*, 529 U.S. 598, 616-18 (2000); and *United States v. Lopez*, 514 U.S. 549, 559-65 (1995).

98. See *Nat’l Fed’n*, 132 S. Ct. at 2586-89.

99. *Id.* at 2585.

100. See Colin Starger, *A Visual Guide to NFIB v. Sebelius: Competing Commerce Clause Opinion Lines 1789-2012*, 2012 CARDOZO L. REV. DE NOVO 316, http://www.cardozolawreview.com/content/denovo/starger_2012_316.pdf.

A. Constitutionality Under the Test for Persons, Goods, or Things that Move in Interstate Commerce

Congress may be able to establish its power to impose a federal medical loss ratio through the line of Commerce Clause cases that deals with persons, goods, or things that move through interstate commerce. In order to determine whether a regulation is constitutional under the second class of Commerce Clause cases, the Court must determine whether (1) the person, good, or thing moved through interstate commerce and (2) whether the regulation meets the rational basis test.¹⁰¹ The Supreme Court has repeatedly re-established this test as the standard for evaluating whether a law constitutionally regulates persons, goods, or things moving through interstate commerce.¹⁰²

Two of the most well-known and frequently cited cases establishing this rule are *Heart of Atlanta Motel v. United States* and *Katzenbach v. McClung*. In *Heart of Atlanta Motel*, Congress used the Commerce Clause to prohibit discrimination at hotels.¹⁰³ Congress justified its use of the Commerce Clause based on the movement of people through interstate commerce and the impact of discriminatory lodging practices on interstate travelers.¹⁰⁴ The Court stated that “the determinative test of the exercise of power by the Congress under the Commerce Clause is simply whether the activity sought to be regulated is commerce which concerns more states than one and has a real and substantial relation to the national interest.”¹⁰⁵

In applying the second half of this test, commonly known as the rational basis test, the Court asked two questions: (1) whether a rational relationship existed between the regulation’s purpose and its means, and (2) whether the regulation supported a legitimate government purpose.¹⁰⁶ The Court similarly employed the *Heart of Atlanta Motel*’s test in *Katzenbach* to prohibit discrimination in

101. See *Heart of Atlanta Motel*, 379 U.S. at 255-57; *Katzenbach*, 379 U.S. at 301.

102. See, e.g., *Lopez*, 514 U.S. at 558 (“Congress is empowered to regulate and protect the instrumentalities of interstate commerce, or persons or things in interstate commerce, even though the threat may come only from intrastate activities.”).

103. See *Heart of Atlanta Motel*, 379 U.S. at 255.

104. See *id.* at 255-56.

105. See *id.* at 255 (internal quotations and citations omitted).

106. See *id.* at 258.

restaurants.¹⁰⁷ In *Katzenbach*, the Court justified Congress's use of the Commerce Clause based on the restaurant's purchase of food from out of state that traveled in interstate commerce.¹⁰⁸ In sum, Congress needs only a rational basis to regulate the movement of people, goods, or things through interstate commerce.

The following three subsections apply this well-established test to determine whether Congress may regulate medical loss ratios under this second class of commerce cases. The first subsection evaluates whether the federal medical loss ratio is subject to federal regulation under the class of cases that deals with goods or things that move through interstate commerce. The next two subsections analyze the federal medical loss ratio under the rational basis test, first by evaluating whether there is a rational relationship between the ratio's purpose and its means, and second by determining whether the ratio has a legitimate government purpose.

1. Persons, Goods, or Things that Move in Interstate Commerce

Congress's regulation of medical loss ratios meets the Commerce Clause's first requirement that the regulated good or thing move in interstate commerce.¹⁰⁹ The regulated thing for the purpose of analyzing the constitutionality of the federal medical loss ratio is the insurance premium. Interstate commerce is impacted by the transfer of premiums between the insurance company, the insured, and eventually medical service providers, all of whom are often in different states. Alternatively, the Commerce Clause requirement is met by the involvement of medical goods, such as medical equipment and prescription drugs, purchased by premiums that cross state lines between insurance companies, health care providers, and the insured.

Two cases aptly demonstrate by analogy how the federal medical loss ratio regulates goods or things that move through interstate commerce. In *Citizens Bank v. Alafabco*, the Court held that Congress could regulate "substantial commercial loan transactions" secured by things moving through interstate commerce because

107. See *Katzenbach v. McClung*, 379 U.S. 294, 305 (1964).

108. See *id.*

109. See 15 C.J.S. Commerce § 23 (2012).

Congress has the ability to regulate purchased things that have moved through interstate commerce.¹¹⁰ In *Katzenbach v. McClung*, the Court held that food purchased by a restaurant out of state qualified as goods moving through interstate commerce as well.¹¹¹ Insurance premiums and medical purchases are goods or things similar to the loan payments in *Citizens Bank* and the foodstuffs in *Katzenbach*. Specifically, regulating insurance premiums that purchase medical goods analogizes to the similar monetary transaction of commercial loans secured by goods in *Citizens Bank*. Because medical goods are purchased with health insurance premiums and such goods cross state lines, they impact interstate commerce.

In addition to the federal medical loss ratio regulating goods or things crossing state lines, these goods or things impact the interstate market. One of the purposes of the federal medical loss ratio is to incentivize insurance companies to reduce administrative costs and premiums.¹¹² The incentive to reduce premiums impacts how much all Americans may spend when purchasing insurance. Because this incentive impacts insurance policyholders across state lines, it impacts interstate commerce. Congressional regulation of the federal medical loss ratio therefore regulates the commerce of the insurance industry and meets the first step of this Commerce Clause analysis.

Given that Congress's regulation of medical loss ratios constitutes regulation of the movement of goods or things through interstate commerce, federal regulation of medical loss ratios falls within the commerce power if the federal ratio also meets the rational basis test. The rational basis test evaluates whether a regulation is rationally related to a legitimate government purpose.¹¹³ The following two subsections evaluate whether there is (1) a rational relationship between the intended purpose of the statute and its

110. 539 U.S. 52, 57 (2003) (citing *Katzenbach*, 379 U.S. at 304-05).

111. See *Katzenbach*, 379 U.S. at 305.

112. See Rex Huppke, *All You Need to Know About Health Insurance Rebates*, CHI. TRIB. (July 23, 2012), [http://articles.chicagotribune.com/2012-07-23/business/ct-biz-0723-work-advice-huppke-20120723_1_health-insurance-insurance-premiums-affordable-care-act;Medical Loss Ratio](http://articles.chicagotribune.com/2012-07-23/business/ct-biz-0723-work-advice-huppke-20120723_1_health-insurance-insurance-premiums-affordable-care-act;Medical%20Loss%20Ratio), OFFICIAL WEB SITE OF SEN. AL FRANKEN, <http://www.franken.senate.gov/?p=issue&id=136> (last visited Sept. 24, 2013).

113. See *Katzenbach*, 379 U.S. at 302 (citing *United States v. Wrightwood Dairy Co.*, 315 U.S. 110 (1942)).

means, and (2) whether there is a legitimate government purpose behind the statute.

2. *Rational Relationship of the Rational Basis Test*

The second step of this particular Commerce Clause analysis requires the federal medical loss ratio regulation to pass the rational basis test.¹¹⁴ The federal medical loss ratio is analyzed first to determine whether the purpose and means are rationally related, and second to determine whether it has a legitimate purpose. This subsection evaluates whether there is a rational relationship.

A law is rationally related if there is a relationship between the government's purpose for a law and the government's means of achieving this purpose.¹¹⁵ In *Railway Express Agency v. New York*, the Supreme Court upheld a city traffic regulation banning advertisements on trucks because the law was sufficiently related to the goal of reducing distractions while driving.¹¹⁶ The under-inclusive fit did not affect the constitutionality of the law because the law was rationally related to the purpose of improving driving safety.¹¹⁷ Similarly in *New York City Transit v. Beazer*, the Supreme Court upheld a law that prohibited hiring methadone users for the state transit system with the stated purpose of improving city safety and efficiency.¹¹⁸ Although the fit of the law was over-inclusive, the Court once again found the fit sufficient because the restriction was rationally related to the law's legitimate government interest.¹¹⁹

These older cases, which stand for the proposition that an over- or under-inclusive fit generally does not impact a rational basis review, are still some of the primary cases that serve as precedent for this issue. For example, in 1997 the majority in *Vacco v. Quill* relied on *Beazer* to uphold a law banning physician-assisted suicide as constitutional because the distinction between withdrawing

114. See *id.* at 303-04.

115. See, e.g., *Eisenstadt v. Baird*, 405 U.S. 438, 447 (1972); see also Note, *Legislative Purpose, Rationality, and Equal Protection*, 82 YALE L.J. 123, 123 (1972).

116. See 336 U.S. 106, 109-10 (1949).

117. See *id.* at 109 ("We do not sit to weigh evidence on the due process issue in order to determine whether the regulation is sound or appropriate; nor is it our function to pass judgment on its wisdom.")

118. See 440 U.S. 568, 593-94 (1979).

119. See *id.* at 592 (1979).

necessary medical treatment and assisting suicide is not so slight so as to fail rational basis review.¹²⁰ Relatedly, Justice Scalia's dissent in *Romer v. Evans* in 1996 used *Beazer's* reasoning to argue that excluding homosexuals from marriage by state constitutional amendment was not unconstitutional just because the fit was imperfect.¹²¹

With regard to the federal medical loss ratio, there is a strong relationship between the means of instituting the medical loss ratio requirement and the government's purpose to incentivize insurance companies to reduce administrative costs and premiums.¹²² Senator Al Franken of Minnesota stated that Minnesota's minimum medical loss ratio contributed to decreasing administrative costs of the State's nonprofit plans to the lowest in the country.¹²³ Although the federal medical loss ratio may cause other effects, such as influencing transparency in insurance companies' spending¹²⁴ or reducing the number of available HSA plans, the purpose of reducing administrative costs is still rationally related to Congress's means.

Critics of the federal medical loss ratio may argue that the ratio is not rationally related to the purpose of reducing administrative costs and premiums. There are two potential arguments suggesting there is no relation. First, the fit between the purpose and the means could be so poor that the federal medical loss ratio could not be rationally related to achieving the government's goals. This seems improbable, however, based on Senator Franken's experience with reducing administrative costs in Minnesota.¹²⁵ A second argument could be that the government did not intend to reduce administrative costs and premiums but actually established the federal medical loss ratio for another purpose. The success of this argument also is unlikely, however, because of the low standard that the government must meet to show a rational basis.¹²⁶ In *FCC*

120. 521 U.S. 793, 800-01 (1997).

121. 517 U.S. 620, 642 (1996) (Scalia, J., dissenting).

122. See *Medical Loss Ratio*, *supra* note 112; see also Huppke, *supra* note 112.

123. See *Medical Loss Ratio*, *supra* note 112 (stating that these plans spend an average of ninety-one cents per premium dollar on health services).

124. See *id.*; see also Huppke, *supra* note 112.

125. See *Medical Loss Ratio*, *supra* note 112.

126. See generally Ashutosh Bhagwat, *Purpose Scrutiny in Constitutional Analysis*, 85 CALIF. L. REV. 297, 303 (1997) (discussing how the rational basis test is applied very leniently in practice).

v. Beach Communications, Inc., the Supreme Court held that “it is entirely irrelevant for constitutional purposes whether the conceived reason for the challenged distinction actually motivated the legislature.”¹²⁷ The Court may find another purpose that rationally relates to the means used even if the purpose is not clearly expressed by Congress.¹²⁸ *Beach Communications* allows the Supreme Court leeway to assume that Congress’s intention to reduce administrative costs is the proper reason, even if the legislative record does not provide clear support for the proposition.

Based on this analysis, the federal medical loss ratio fulfills the rational relation requirement and thus meets the first half of the rational basis test.

3. Legitimate Government Purpose of the Rational Basis Test

The federal medical loss ratio must have a legitimate government purpose in order to satisfy the last requirement under the Commerce Clause. A legitimate government purpose is defined as a purpose that benefits the public and debatably works to achieve the regulation’s goal.¹²⁹ This purpose does not actually have to be effective in achieving its goal under the rational basis test.¹³⁰

The Supreme Court applied this rationale in *Minnesota v. Cloverleaf Creamery*, upholding a state ban on plastic-cased milk for environmental reasons, which did not stand up to scientific scrutiny, because the legislature’s legitimate purpose was only required to be at least empirically debatable.¹³¹ Similarly in *Western and Southern Life Insurance Co. v. State Board of Equalization of California*, the Supreme Court held that a questionable retaliatory tax was rationally related to its purpose because “the courts are not

127. 508 U.S. 307, 315 (1993).

128. See *Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483, 487-88 (1955).

129. See *Heart of Atlanta Motel v. United States*, 379 U.S. 241, 258 (1964).

130. See *Minnesota v. Clover Leaf Creamery Co.*, 449 U.S. 456, 464 (1981) (“States are not required to convince the courts of the correctness of their legislative judgments. Rather, ‘those challenging the legislative judgment must convince the court that the legislative facts on which the classification is apparently based could not reasonably be conceived to be true by the governmental decisionmaker.’”) (citing *Vance v. Bradley*, 440 U.S. 93, 111 (1979)).

131. See *id.* at 463-64 (citing *United States v. Carolene Products Co.*, 304 U.S. 144, 153-54 (1938)).

empowered to second-guess the wisdom of state policies.”¹³² Even though these cases addressed state laws and not federal law, the legitimate government purpose analysis applies to any government action, regardless of whether the law is established at the federal or state level.¹³³

It follows, based on the case law cited above and the prior subsection’s discussion of the government’s purpose in establishing a federal medical loss ratio, that the ratio has a legitimate government purpose. Implementing a cost control to address the nationally recognized problem of rapidly increasing insurance costs is a legitimate purpose. Even if the federal medical loss ratio does not lower premiums or administrative costs, the government’s stated purpose is at least debatably legitimate based on states’ empirical evidence on medical loss ratios.¹³⁴ The federal medical loss ratio therefore passes the rational basis requirement and Congress’s use of the requirement is constitutional under the Commerce Clause.

B. Constitutionality Under the Substantial Effects Test

In the event the Supreme Court holds the federal medical loss ratio to be unconstitutional under the second class of Commerce Clause cases involving persons, goods, or things moving in interstate commerce, the third class of Commerce Clause cases addressing the substantial effects test provides strong support for the proposition that the ratio is constitutional. Congress may regulate medical loss ratios under the third class of Commerce Clause cases, which includes both national and local insurance companies, because both national and local insurance companies substantially affect the interstate commerce of the insurance industry.

132. 451 U.S. 648, 668-70 (1981).

133. See generally Mario L. Barnes & Erwin Chemerinsky, *The Once and Future Equal Protection Doctrine?*, 43 CONN. L. REV. 1059, 1077-78 (2011) (discussing the rational basis test and finding that “few government actions have ever been found unconstitutional under this test”).

134. See *Medical Loss Ratio*, *supra* note 112.

1. *Substantial Effects Test*

Congress should be able to regulate insurance costs through the federal medical loss ratio because the business of all insurance companies, including local insurance companies, substantially affects interstate commerce. Congress possesses the ability to regulate intrastate activity that substantially affects interstate commerce.¹³⁵ This is the test that Chief Justice Roberts applied in *National Federation*.¹³⁶ The substantial effects test is applied in different ways depending on whether the intrastate activity is economic in nature.

If the activity is economic, then the Supreme Court gives broad authority and deference to congressional use of the Commerce Clause.¹³⁷ This approach allows for intrastate economic activity to be aggregated with similar activity that substantially affects interstate commerce.¹³⁸ In *Wickard*, the Court held that the decision to grow wheat for personal consumption, “when considered in the aggregate along with similar decisions of others, would have had a substantial effect on the interstate market for wheat.”¹³⁹ According to Chief Justice Roberts in *National Federation*, “*Wickard* has long been regarded as perhaps the most far reaching example of Commerce Clause authority over intrastate activity.”¹⁴⁰ Although the Roberts Court may not like the broad range of the commerce power, *Wickard* still stands as good law, and the regulation of aggregated goods that substantially affect interstate commerce remains within the commerce power. For example, as recently as 2005, the Court in *Gonzales v. Raich* relied on *Wickard* to uphold congressional regulation of marijuana use and production because

135. See *United States v. Darby*, 312 U.S. 100, 118-19 (1941).

136. See *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2585-86 (2012) (citing *Darby*, 312 U.S. at 118-19).

137. See *Wickard v. Filburn*, 317 U.S. 111, 123-25 (1942) (“The power of Congress over interstate commerce is plenary and complete in itself, may be exercised to its utmost extent, and acknowledges no limitations other than are prescribed in the Constitution.”) (quoting *United States v. Wright Wood Dairy Co.*, 315 U.S. 110, 119 (1942)).

138. See *Wickard*, 317 U.S. at 127-28; see also *Nat'l Fed'n*, 132 S. Ct. at 2586 (2012).

139. See *Nat'l Fed'n*, 132 S. Ct. at 2588; *Wickard*, 317 U.S. at 127-29.

140. *Nat'l Fed'n*, 132 S. Ct. at 2588 (internal quotations omitted); see also *id.* at 2643 (Alito, J., Kennedy, J., Scalia, J., & Thomas, J., dissenting); *United States v. Lopez*, 514 U.S. 549, 560 (1995).

of its effect on interstate commerce.¹⁴¹ The Court also expanded the scope of regulable activity to include production, consumption, and distribution of a good.¹⁴²

If the regulated activity is noneconomic, then the Court takes a strict approach to analyzing the role of the Commerce Clause and does not allow for aggregation of similar local activities throughout the country.¹⁴³ This approach to the substantial effects test does not apply to the federal medical loss ratio, however, because the medical loss ratio regulates activity of insurance companies that is economic in nature.¹⁴⁴

Based on the most recent interpretation of the substantial effects test as applied to economic activity in *National Federation*, the federal medical loss ratio fully meets the necessary elements. As stated previously, the federal medical loss ratio regulates activity that is economic in nature. In fact, the economic activity at issue with the federal medical loss ratio may exceed the level of economic activity in *Wickard* and *Raich*. Both *Wickard* and *Raich* involved goods that were not sold on the market, but were instead used only personally.¹⁴⁵ Insurers and insurance policyholders exchange premiums and medical goods throughout the local and national insurance market, not just among private individuals for personal use.

The federal medical loss ratio certainly substantially affects interstate commerce as well. The regulated activities in both *Wickard* and *Raich* met the substantial effects test although involving only a fraction of the U.S. population.¹⁴⁶ The number of personal wheat and marijuana growers is far less than the number of people and companies participating in the insurance industry.

141. See *Gonzales v. Raich*, 545 U.S. 1, 17-22 (2005).

142. See *id.* at 17-19.

143. See *id.* at 22 (holding that Congress can regulate if failure to regulate undermines a broader regulatory scheme); *United States v. Morrison*, 529 U.S. 598, 615-19 (2000) (holding that gender violence that injures commerce is not economic and has no substantial effect); *Lopez*, 514 U.S. at 600-01 (Thomas, J., concurring) (arguing that possessing guns near schools does not substantially affect interstate commerce).

144. See *supra* notes 11-21 and accompanying text (explaining medical loss ratio).

145. See *Wickard v. Filburn*, 317 U.S. 111, 128-29 (1942); see also *Raich*, 545 U.S. at 18-19.

146. The large majority of the population presumably is not growing wheat or marijuana for personal use.

Approximately 256.2 million Americans were insured in 2010.¹⁴⁷ Only 16.3% of Americans were uninsured.¹⁴⁸ Aggregated across the population, the impact of the federal medical loss ratio's ability to lower premiums and administrative costs affects a supermajority of the U.S. population. The federal medical loss ratio and its insurance rebate requirement meet the substantial effects test.

2. *Rational Basis Test*

Just as with the persons, goods, or things moving in interstate commerce analysis presented above, the substantial effects test as applied under the third class of Commerce Clause cases requires only that the federal medical loss ratio be rationally related to achieving a legitimate government purpose.¹⁴⁹ Without repeating the previous analysis, the federal medical loss ratio passes the rational basis test.¹⁵⁰ In short, there is a strong rational relationship between Congress's use of a minimum medical loss ratio and its legitimate purpose of incentivizing insurance companies across the country to reduce administrative costs and premiums.¹⁵¹

The federal medical loss ratio is a constitutionally valid regulation under two of the three classes of Commerce Clause cases. Although the regulation is constitutionally permissible under the Commerce Clause, this conclusion represents only one of two steps necessary to determine whether the ratio is legally valid. The federal medical loss ratio must still be statutorily permissible under the McCarran-Ferguson Act.

147. See Emily Smith & Caitlin Stark, *By the Numbers: Health Insurance*, CNN.COM (June 28, 2012), <http://www.cnn.com/2012/06/27/politics/btn-health-care/index.html>.

148. See *id.*

149. See Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2649 (2012) (Alito, J., Kennedy, J., Scalia, J., & Thomas, J., dissenting); see also Katzenbach v. McClung, 379 U.S. 294, 303-04 (1964).

150. See *supra* notes 112-34 and accompanying text (applying the rational basis standard to the insurance rebate requirement).

151. See *id.*

IV. PERMISSIBILITY OF THE FEDERAL MEDICAL LOSS RATIO UNDER THE McCARRAN-FERGUSON ACT

The federal medical loss ratio is statutorily permitted to preempt state law under the McCarran-Ferguson Act if the practice of setting medical loss ratios is part of the “business of insurance.” The practice of setting medical loss ratios involves determining how much premium revenue an insurer expends on noncare related expenses. The practice of setting medical loss ratios is considered part of the “business of insurance” under the McCarran-Ferguson Act and therefore subject to federal regulation if it (1) transfers or spreads the policyholder’s risk, (2) is an integral part of the relationship between the insurance company and the insured policyholder, and (3) only impacts entities within the insurance industry.¹⁵² This Part explains the elements of the McCarran-Ferguson Act test and how each element applies to an analysis of the federal medical loss ratio. This Part ultimately finds that the federal medical loss ratio is not permissible under the McCarran-Ferguson Act.

A. Elements of the McCarran-Ferguson Act Test in Practice

Although the McCarran-Ferguson Act has only three elements, application of the test has baffled courts since Congress passed the statute.¹⁵³ *Royal Drug* suggested that the first element, requiring a

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

153. The Supreme Court recognized in *Kentucky Ass’n of Health Plans v. Miller* that the McCarran-Ferguson Act test can lead to divergent results and established a new two-prong test for cases involving claims under the Employee Retirement Income Security Act (ERISA). See 538 U.S. 329, 340-42 (2003). The new test requires only that (1) the state law is directed at insurers and (2) the state law “substantially affect[s] the risk pooling arrangement between the insurer and the insured.” *Id.* at 341-42. This test sidestepped two of the McCarran-Ferguson Act’s major problems—the difficulty of determining how many of the three elements needed to be fulfilled and “whether the *state law itself* or the *conduct regulated by that law* is the proper subject to which one applies the McCarran-Ferguson factors.” See *id.* at 340-41. The Court made a clean break from applying the three-prong test to ERISA cases because its “factors were developed in cases that characterized *conduct* by private actors, not state laws.” *Id.* Even if the Court had not limited this two-prong test to ERISA cases, the traditional three-prong test is still more applicable in this Note because a statutory challenge to the federal medical loss ratio would be directed at *how state laws* regulate the medical loss ratio. The

risk transfer, may be the most important, explaining, “The primary elements of an insurance contract are the spreading and underwriting of a policyholder’s risk.”¹⁵⁴ *Union Labor Life Insurance Co. v. Pireno*, which employed *Royal Drug’s* test, stated that this first element involved a transfer of risk between the insurer and the insured.¹⁵⁵ *Pireno* elaborated that “[t]he transfer of risk from insured to insurer is effected by means of the contract between the parties—the insurance policy—and that transfer is complete at the time that the contract is entered.”¹⁵⁶

The second element requires the practice to be an integral part of the relationship between the insurer and the insured. This element is not met if the relationship involves insurance companies’ arrangements and practices with parties that are not the insured.¹⁵⁷ *Royal Drug* held that the practice must involve a direct relationship between the insurer and the insured.¹⁵⁸ Specifically, both *Royal Drug* and *Pireno* stated that the practice must do more than “closely affect the ‘reliability, interpretation, and enforcement’ of the [policyholder’s] insurance contract.”¹⁵⁹ In sum, this practice must occur directly between the insurer and the insured.

The third and final element is that the regulated practice must address only parties within the insurance industry.¹⁶⁰ For example, the pharmacies’ relationship with the insurance company in *Royal Drug* did not meet this third element because agreements with pharmacies were not within Congress’s intended meaning of the “business of insurance.”¹⁶¹ In *Pireno*, the Court held that this element was not met because the practice of peer reviews involved chiropractors who were not in the insurance industry.¹⁶² The key point is that the practice subject to regulation must involve parties that are within the insurance industry.

conduct itself would not be challenged because states have regulated insurance companies’ conduct through state medical loss ratios for years.

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

155. *See Pireno*, 458 U.S. at 130 (quoting *Royal Drug*, 440 U.S. at 211).

156. *Id.* (citing 9 G. COUCH, CYCLOPEDIA OF INSURANCE LAW §§ 39:53, 39:63 (2d ed. 1962)).

157. *See Pireno*, 458 U.S. at 131.

158. *See id.*

159. *Id.* at 132 (quoting *Royal Drug*, 440 U.S. at 216).

160. *See id.* at 129.

161. *See Royal Drug*, 440 U.S. at 224, 231.

162. *Pireno*, 458 U.S. at 132.

1. *First Prong*

To satisfy the first prong of the McCarran-Ferguson Act test, a practice must involve the transfer or spreading of risk between the insurance company and the insured. The setting of medical loss ratios does not appear to involve a transfer or spreading of risk. Risk is defined as the “uncertainty of a result, happening, or loss [or] the chance of injury, damage, or loss.”¹⁶³ As explained in *Pireno*, risk transfer for insurance occurs when the policyholder agreement is finalized.¹⁶⁴ A policyholder agreement is finalized when a policyholder purchases a policy.¹⁶⁵ The risk transfer that occurs upon a policyholder’s purchase of a policy is not altered by future rebates calculated after the purchase of a policy. Even if *Pireno* did not explicitly hold that there can be no risk transfer after the purchase of a policy, all of the risk that an insurance company accepts is realized¹⁶⁶ by the end of the policy term and there is no risk transfer remaining to be altered by rebates.

In employing the federal medical loss ratio, the federal government evaluates only whether insurance companies have met the medical loss ratio upon the conclusion of policyholder agreements. The federal government’s federal medical loss ratio does not and cannot involve risk transfer because the government requires rebates to be paid only after all risk has been realized. With the expiration of the policy period, all risk has been realized and there is no risk to transfer.¹⁶⁷ The practice of determining the amount of premium revenue to expend on nonmedical care related costs—establishing medical loss ratios—has nothing to do with risk transfer.

One may try to argue that the transfer of money from an insurance company back to an insured at the end of an insurance

163. BLACK’S LAW DICTIONARY 1353 (8th ed. 2004).

164. *See Pireno*, 458 U.S. at 130.

165. *See id.*

166. BLACK’S LAW DICTIONARY 1292 (8th ed. 2004) (defining realization as the “[c]onversion of noncash assets into cash assets”).

167. Insurance companies may not request a rebate from their clients for years in which they pay out more medical expenses than the medical loss ratio requires. However, insurance companies may build in higher rates later to recover losses. This further shows that there is no transfer of risk between the insurer and insured.

policy's term could be a form of risk transfer. For example, the insured may believe there is less risk in purchasing a policy because, if the insurance company does not allot its premiums appropriately to medical expenses, the insured will receive a rebate for a portion of the premium she paid for her policy. The insured may therefore view the prospect of purchasing insurance as "less risky." However, this argument fails by definition. "Less risk" under such an argument is mistakenly associated with an insured's belief or expectation that she will receive money back if the insurance company engages in an unfair practice. The "risk" that is the correct focus of the first prong of the McCarran-Ferguson Act is the risk associated with unknown future health care costs—not a potential for a premium rebate. The insured has no assurance that she will receive a rebate at the end of the policy's term. She could easily pay the same amount without any rebates for years. More importantly, the rebate of policy premiums occurs, if at all, after the end of the policy term when the true risk of unknown future medical expenses has been realized—and no further risk remains to be transferred. As a consequence, the counterargument fails by definition. The practice of establishing a federal medical loss ratio, therefore, fails the first prong of the McCarran-Ferguson Act test.

2. *Second Prong*

The second prong of the McCarran-Ferguson Act test examines whether the practices sought to be regulated by the insurance rebate requirement are an integral part of the policy relationship between the insurer and the insured.¹⁶⁸ By definition, "integral" requires the practice to be necessary or essential to the relationship.¹⁶⁹ The practices sought to be regulated by the federal medical loss ratio involve determining the amount of premium revenue to be expended on nonmedical care related costs.

Determining the amount of premium dollars to be spent on nonmedical expenses, such as administrative costs, overhead, and

168. See *Pireno*, 458 U.S. at 129.

169. See *Integral Definition*, MERRIAM-WEBSTER DICTIONARY, <http://www.merriam-webster.com/dictionary/integral> (last visited Sept. 22, 2013); see also *Integral Definition*, DICTIONARY.COM, <http://dictionary.reference.com/browse/integral> (last visited Sept. 22, 2013).

profits, is not an integral part of the policy relationship between the insurer and the insured. The relationship between an insurance company and its insured consists of the insurance company providing health insurance to the insured and the insured paying a premium to the company. The amount of the premium an insurance company dedicates towards paying for various expenses does not impact whether the insurance company continues to pay for the insured's medical expenses or whether the insured pays her premium.¹⁷⁰ In further support, states have set medical loss ratios and limited insurance companies' profits for years without changing the relationship between insurance companies and their insured.¹⁷¹ Even if insurance companies reduced premium rates, this still would not impact the exchange of services for premiums that is the key to this relationship. Regardless of whether an insurance company limits the amount of premium dollars it spends on nonmedical expenses, or later issues premium rebates, the fundamental insurer-insured relationship remains the same: insuring health risks and paying for the insured's medical expenses.

One could argue that any exchange of money between an insurance company and an insured is integral to the policy relationship. Exchanging money certainly is important, from the perspective of both the insurance company losing some of its profit and the insured receiving a rebate of her premium. However, the insurance company will continue to issue insurance and collect premiums regardless of whether the federal medical loss ratio exists, and in

170. A Gallup poll measuring the rate of uninsured people in the first half of 2012 supports this contention. Insurance companies were subject to the federal medical loss ratio's requirements as of the summer of 2011. Gallup found that from that point uninsured rates remained stable both at the state level and nationwide. See *In U.S., Uninsured Rate Stable Across States So Far in 2012*, GALLUP, INC. (Aug. 24, 2012), <http://www.gallup.com/poll/156851/uninsured-rate-stable-across-states-far-2012.aspx>. The lack of change suggests that the ratio does not regulate an integral practice.

171. See *supra* notes 15-18 and accompanying text. The rates of total uninsured per state do not appear to vary based on state medical loss ratios. The middle thirty states in a national survey of uninsured rates all fell in a tight range between 11% and 18%. See *Health Insurance Coverage of the Total Population*, THE HENRY J. KAISER FAM. FOUND. (2011), <http://www.statehealthfacts.org/comparebar.jsp?typ=2&ind=125&cat=3&sub=39&show=156&cha=156&o=a>. For example, New Jersey and New York, which had state medical loss ratios, possessed uninsured rates of 16% and 14%, respectively. In comparison, Virginia and Idaho, which did not have state medical loss ratios, possessed similar uninsured rates of 14% and 18%, respectively. See *id.*

almost all cases the insured will continue to purchase insurance regardless of the ratio. Given that the relationship would continue in a similar manner regardless of the ratio, it is likely that such an “exchange of money” argument would fail even the “affecting the reliability, interpretation, or enforcement of an insurance contract” standard that was considered and rejected as insufficient to prove that a practice was an integral part of a policy in *Royal Drug* and *Pireno*.¹⁷² As such, an insurer’s practice of determining the amount of premium revenue to expend on nonmedical care related expenses does not constitute an integral part of the insurer-insured relationship, and therefore fails the second prong of the McCarran-Ferguson Act test.

3. Third Prong

The third and final prong of the McCarran-Ferguson Act test examines whether the practices sought to be regulated by the federal medical loss ratio are limited to entities within the insurance industry.¹⁷³ These practices include determining the amount of premium revenue to be expended on noncare related costs. It is unclear whether the Supreme Court would hold that the practice of determining how an insurance company spends its revenue is a practice limited to entities within the insurance industry.

The government could argue that the practice of how an insurance company spends its premiums is limited only to insurance companies. Specifically, the government could contend that insurance companies make internal decisions on how to spend premium revenue and do not involve outside parties in the decision-making process. If this is the case, then the third prong would be met. However, there is a counterargument that the regulated practices are not limited to entities within the health insurance industry and in effect involve health care providers. Insurance companies’ new practices would require insurance companies to spend a larger portion of their overall revenues on health care providers’ services. As seen in *Royal Drug*, outside parties, such as

172. *Pireno*, 458 U.S. at 132 (quoting *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 221 (1979)).

173. *See id.* at 129.

pharmacies and chiropractors, are not considered part of the insurance industry.¹⁷⁴ Additionally, a broader counterargument could contend that all businesses engage in the practice of how to spend their revenue and therefore such a practice is not limited to entities within the insurance industry.

Because the arguments on both sides of this issue appear compelling, it is unclear whether the federal medical loss ratio would pass or fail the third prong of the McCarran-Ferguson Act test. However, even if the federal medical loss ratio satisfied the third prong of the McCarran-Ferguson Act test, its failure to pass the prior two prongs suggests that the Court would not hold the federal medical loss ratio to be statutorily permissible.

B. State Medical Loss Ratios Cannot Be Statutorily Preempted

Under the McCarran-Ferguson Act analysis, state laws governing medical loss ratios should be exempt from federal regulation. As discussed above, the practice of determining the amount of revenue an insurer will spend on certain types of expenses (i) does not transfer risk between the insurer and the insured, and (ii) is not an integral part of the insurer-insured relationship. Without effectuating a risk transfer or becoming an integral part of the insurer-insured relationship, the federal medical loss ratio fails the first two prongs of the McCarran-Ferguson Act analysis. The only prong of the test that the federal medical loss ratio could arguably meet is the third prong, which requires that the practice be limited to entities within the insurance industry. The federal government would be unable to prove at least two of the three prongs establishing the “business of insurance.” It is therefore very probable that setting a federal medical loss ratio does not constitute regulation of the “business of insurance” under the McCarran-Ferguson Act.

In sum, Congress’s federal medical loss ratio appears constitutional under the Commerce Clause. However, even though the ratio is constitutional, it remains statutorily impermissible under the McCarran-Ferguson Act. Unless Congress repeals the McCarran-Ferguson Act, which both the Senate and the House attempted to do

174. See *Royal Drug*, 440 U.S. at 231-33.

in October 2009¹⁷⁵ and March 2012,¹⁷⁶ respectively, federal regulation of insurance rebate requirements through a medical loss ratio is statutorily impermissible. As the regulation stands, the policy implications have a negative impact on the legal community, but potentially a positive long-term impact on the general populace.

V. POLICY IMPLICATIONS OF THE FEDERAL MEDICAL LOSS RATIO

The legally impermissible federal medical loss ratio remains unchallenged and thus good law. The implementation of the ratio led to insurance companies sending over \$1 billion in rebates to 12.8 million Americans during the summer of 2012.¹⁷⁷ Congress legislated this significant shift of money from insurers to the insured in order to lower administrative costs and premiums.¹⁷⁸ The impact of the federal medical loss ratio, however, is heavily debated.

Advocates of the federal medical loss ratio argue that the ratio benefits consumers. Blake Hutson of Consumers Union, a health care advocacy nonprofit organization, stated that the federal medical loss ratio “encourage[s] insurance companies to operate more efficiently.”¹⁷⁹ This push for efficiency is probably necessary based on a recent report by the Commonwealth Fund, which found that insurance premiums for families jumped by 50% nationally from 2003 to 2010. Evidence suggests that the federal medical loss ratio may be instigating greater efficiency. The Department of Health and Human Services announced in June 2013 that the health care law caused more insurance companies to enter the market, which created greater competition in the industry.¹⁸⁰ The

175. See Noah, *supra* note 77.

176. See *House-Passes Bill Proposes Repeal of McCarran-Ferguson Antitrust Exemption for Health Insurance*, NAT'L ASS'N INS. & FIN. ADVISORS (Mar. 22, 2012), http://www.naifa.org/advocacy/GovWatch/2012/20120322_repealmccarranferguson.cfm.

177. Parija Kavilanz, *Consumers to Get \$1B in Health Insurance Rebates*, CNN MONEY (June 21, 2012, 4:02 PM), <http://money.cnn.com/2012/06/21/pf/health-care-rebates/index.htm>.

178. See *supra* notes 122-24 and accompanying text.

179. Jeffrey Young, *Health Care Reform Rebates for Health Insurance Costs Rolling In*, HUFFINGTON POST (July 16, 2012, 4:33 PM), http://www.huffingtonpost.com/2012/07/16/health-care-reform-rebate_n_1676964.html.

180. See Robert Pear, *Health Law is Fostering Competition, U.S. Says*, N.Y. TIMES (May 30, 2013), <http://www.nytimes.com/2013/05/31/health/health-law-is-fostering-competition-administration-says.html?hp&r=0>.

Department reported that 77.8 million consumers saved \$3.4 billion in premium payments.¹⁸¹

Evidence from state medical loss ratios seems to support this argument as well. As previously noted, Minnesota leads the nation in low administrative costs for nonprofit health care plans¹⁸² due to its medical loss ratio of 82% for large group carriers.¹⁸³ New Jersey's 75% medical loss ratio similarly has controlled premiums, with \$11.6 million returned in refunds between 1993 and 2006.¹⁸⁴ In addition to individual consumers, small businesses benefit from minimum medical loss ratios. For example, 37,000 small businesses in New York received refunds of \$50 million in 2008 alone.¹⁸⁵ Beyond being consumer friendly, the PPACA's medical loss ratio employs calculations that are more favorable to insurance companies than many states' medical loss ratio models. Traditional medical loss ratios account only for health care claims and premiums.¹⁸⁶ The PPACA's medical loss ratio, however, includes accounting for quality improvement expenses and fees for taxes, licensing, and regulatory issues.¹⁸⁷

Critics, on the other hand, counter that the new federal requirement will be detrimental to the insurance market. Health insurance companies argue that the medical loss ratio will not achieve the intended policy goal. According to a statement by America's Health Insurance Plans (AHIP),¹⁸⁸ the federal medical loss ratio does not address the true problem of high medical care costs.¹⁸⁹ AHIP argues that "coverage disruptions and other unintended consequences of imposing a new arbitrary federal cap on health plan administrative

181. See *80/20 Rule Delivers More Value to Consumers in 2012*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2012-medical-loss-ratio-report.pdf> (last visited Sept. 22, 2013).

182. See *Medical Loss Ratio*, *supra* note 112.

183. See MINN. STAT. § 62A.021 (2007).

184. See MEDICAL LOSS RATIOS: EVIDENCE FROM THE STATES, *supra* note 15, at 2.

185. See *id.*

186. See *Explaining Health Care Reform: Medical Loss Ratio (MLR)*, *supra* note 11, at 2.

187. See *id.*

188. AHIP is the national trade association for health insurance companies. *About Us*, AMERICA'S HEALTH INSURANCE PLANS (last visited Sept. 24, 2013, 1:00 AM), <http://www.ahip.org/about/>.

189. See Press Release, America's Health Insurance Plans, AHIP Statement on the Medical Loss Ratio Requirement (April 26, 2012), <http://www.ahip.org/News/Press-Room/2012/AHIP-Statement-on-the-Medical-Loss-Ratio-Requirement.aspx>.

costs are likely to outweigh any benefit these rebates will provide to consumers.”¹⁹⁰

Reports by the actuarial firm Milliman support this concern. The firm found that insurance companies’ solvency may be seriously harmed due to their inability to “shore up reserves” during successful years with high profits.¹⁹¹ This may eventually harm policyholders by decreasing the total number of insurance companies, and thus providing fewer alternatives. Milliman also found that the detrimental impact of the medical loss ratio will be much greater on high deductible health plans.¹⁹² The amicus brief by the HSA Coalition submitted in support of striking down the PPACA similarly voiced concerns that high deductible health plans, particularly health savings accounts, will be negatively impacted by the ratio.¹⁹³ In addition to Milliman’s reports, at least one study cited concerns that rebates will be paid based on simple statistical variation in medical costs.¹⁹⁴ Beyond harm to insurance companies, Senator Tom Coburn of Oklahoma argues that states will be harmed by destabilized insurance markets across the country and that policyholders will be harmed by increased premiums.¹⁹⁵

Regardless of whether these rebates are a net positive or negative, most insurance policyholders will not notice changes from the regulation in the short term. After the first rebate in the summer of 2012, individuals received \$127 in rebates on average,

190. *See id.*

191. *See* JOHN COOKSON, MILLIMAN, INC., HEALTHCARE REFORM’S MINIMUM MEDICAL LOSS RATIOS 2 (May 2011), <http://publications.milliman.com/publications/healthreform/pdfs/health-care-reform-minimum-medical.pdf>.

192. *See* MILLIMAN, INC., IMPACT OF MEDICAL LOSS RATIO REQUIREMENTS UNDER PPACA ON HIGH DEDUCTIBLE PLANS/HSA’S IN INDIVIDUAL AND SMALL GROUP MARKETS (Jan. 6, 2012), <http://www.hsacoalition.org/wp-content/uploads/2012/02/report-ABAImpactofMedicalLossRatioRequirements.pdf>.

193. *See* Brief for HSA Coalition et al. as Amici Curiae Supporting Respondents at 3, Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012) (No. 11-398).

194. *See* Scott E. Harrington et al., Medical Loss Ratio Regulation Under the Affordable Care Act 35 (Oct. 31, 2012) (unpublished manuscript), *available at* <http://ssrn.com/abstract=2180965>.

195. *See Re-examining PPACA’s Federally-Mandated Medical Loss Ratios*, OFFICIAL WEB SITE OF SEN. TOM COBURN, M.D., http://www.coburn.senate.gov/public/index.cfm/rightnow?ContentRecord_id=8b873136-06e9-4820-8f7b-e9b3828e33a4&ContentType_id=b4672ca4-3742-49c-bffc-fa099b51c966&Group_id=00380921-99d-40f6-a8e3-470468762340 (last visited Sept. 22, 2013).

with the largest rebates being sent to Texas and Florida.¹⁹⁶ Only 13 million Americans received these rebates.¹⁹⁷ This is only 6.6% of the 195.9 million people who have private insurance.¹⁹⁸ Policyholders most benefited by the rebate were people who individually purchased health insurance, with more than 30% receiving a rebate.¹⁹⁹

However, these are only short term statistics. The policy purpose of instituting the federal medical loss ratio was to reduce administrative costs. State statistics supporting this policy are still the most telling evidence. Further, the Congressional Budget Office recently released figures showing that the rising costs of health care slowed significantly in 2012.²⁰⁰ Health care experts do not know what is causing this slow down,²⁰¹ but it is possible that the threat and subsequent implementation of the federal medical loss ratio is beginning to positively impact the cost of health care. If this health care cost slowdown is partially attributable to the federal medical loss ratio, this could be a very effective policy in reducing health care costs while only having a marginal impact on the multitrillion dollar insurance industry.²⁰²

Beyond the potentially significant impact on health care costs, the legal community may be greatly impacted as well. The primary plaintiffs in a suit against the federal government for establishing the medical loss ratio are insurance companies and states. Although insurance organizations such as AHIP and the HSA Coalition have advocated against the federal medical loss ratio, no lawsuits have been filed to strike the provision from the PPACA. The cost of initiating another PPACA lawsuit, especially before a Court which has already shown some support for the Act, may be too great a

196. See Press Release, The Henry J. Kaiser Family Found., Kaiser Analysis: Estimated Health Insurance Rebates Under the Health Reform Law Total \$1.3 Billion Dollars in 2012 (April 26, 2012), <http://www.kff.org/healthreform/hr042612nr.cfm>.

197. See Huppke, *supra* note 112.

198. See Smith & Stark, *supra* note 147.

199. See Young, *supra* note 179.

200. See Annie Lowrey, *Slower Growth of Health Costs Eases U.S. Deficit*, N.Y. TIMES (Feb. 11, 2013), www.nytimes.com/2013/02/12/us/politics/sharp-slowdown-in-us-health-care-costs.html?hpw.

201. See *id.*

202. See Julie Rovner, *Insurers Wait for Verdict on Health Care Law and Their Bottom Line*, NPR (June 15, 2012, 12:03 PM), <http://www.npr.org/blogs/health/2012/06/15/155097061/insurers-wait-for-verdict-on-health-care-law-and-their-bottom-line> (estimating the health insurance industry to be valued at \$2.5 trillion).

burden for an insurance company to bear in comparison to the small cost of reducing administrative expenses and issuing rebates amounting only to \$1.1 billion per year across the industry. Considering that health care lobbyists already spent over \$100 million in a yearlong campaign against the PPACA prior to the lawsuit²⁰³ and more than \$1 billion prior to the passage of legislation,²⁰⁴ the insurance industry may be gun shy to file another major lawsuit that would involve campaigning the public, paying legal fees, and potentially facing another public loss in court. The significant cost of litigation may prevent the insurance industry from challenging the federal medical loss ratio.

States may be the only realistic challengers of the federal medical loss ratio. If anyone is in a worse position to take on needless lawsuits than the insurance industry, however, it is state governments. In the summer of 2012 alone, thirty-one states across the country attempted to find \$55 billion in order to close budget gaps.²⁰⁵ Over the past four years, there have been more than \$540 billion in state budget shortfalls.²⁰⁶ States on the whole are not in a position to fight this battle and, more importantly, probably would not want to put up a fight due to the benefits they receive. As mentioned previously, millions of dollars are coming back into state economies via rebates to companies.²⁰⁷ As a consequence, states will not complain about the extra income and most likely will not try to stop the new revenue with an expensive lawsuit.

Without a group that has standing, the funds to litigate, and the motive to proceed in court, the federal medical loss ratio will almost certainly remain on the books. This is unsettling for legal reasons beyond the mere fact that the federal medical loss ratio is statutorily impermissible under the McCarran-Ferguson Act. Several legal scholars have found the federal medical loss ratio legally controversial,

203. See Rick Ungar, *Busted! Health Insurers Secretly Spent Huge to Defeat Health Care Reform While Pretending to Support Obamacare*, FORBES (June 25, 2012, 8:37 PM), <http://www.forbes.com/sites/rickungar/2012/06/25/busted-health-insurers-secretly-spent-huge-to-defeat-health-care-reform-while-pretending-to-support-obamacare/>.

204. See Lindsay Renick Mayer et al., *Diagnosis: Reform*, CTR. FOR RESPONSIVE POLITICS (June 17, 2009, 5:18 PM), <http://www.opensecrets.org/news/2009/06/diagnosis-reform.html>.

205. See Phil Oliff et al., *States Continue to Feel Recession's Impact*, CTR. ON BUDGET & POL'Y PRIORITIES (June 27, 2012), <http://www.cbpp.org/cms/index.cfm?fa=view&id=711>.

206. See *id.* at 2.

207. See MEDICAL LOSS RATIOS: EVIDENCE FROM THE STATES, *supra* note 15, at 2.

specifically finding the ratio unconstitutional under the Fifth Amendment's Takings and Due Process Clauses.²⁰⁸ This Note addressed the legality of the federal medical loss ratio only under the Commerce Clause, not under other constitutional frameworks. However, with the multitude of avenues available to challenge the federal medical loss ratio, this is a legal question that should be addressed by the courts.

Even if the law found a challenger to bring it to the courts, however, many legal scholars think that the Supreme Court will not want to hear another PPACA case so soon after *National Federation*.²⁰⁹ The federal medical loss ratio may be good law for now, but it offends the rule of law to permit Congress to promulgate a statute that may be unconstitutional under the Takings and Due Process Clauses and statutorily impermissible under the McCarran-Ferguson Act.

CONCLUSION

The insurance industry is traditionally state regulated. Through the McCarran-Ferguson Act, however, the federal government is empowered to regulate practices involved in the "business of insurance." The federal medical loss ratio is a textbook example of when the federal government oversteps its regulatory powers. Under the Commerce Clause, the federal medical loss ratio is arguably a constitutional regulation based on two of the three applicable classes of Commerce cases: (1) persons, goods, or things moving in interstate commerce, and (2) intrastate activity substantially affecting interstate commerce. However, although the federal medical loss ratio may be constitutionally permissible under the Commerce Clause, the ratio is statutorily impermissible as a result of Congress's self-imposed limitations under the McCarran-Ferguson Act.

After only two years, the policy implications of the federal medical loss ratio are unclear. State evidence suggests that insurance

208. See *supra* notes 23-24 and accompanying text (discussing scholarly research about the constitutionality of the federal medical loss ratio).

209. See Rick Ungar, *The U.S. Supreme Court Allows New Challenge to Obamacare to Go Forward*, FORBES (Nov. 26, 2012, 12:59 PM), <http://www.forbes.com/sites/rickungar/2012/11/26/the-u-s-supreme-court-allows-new-challenge-to-obamacare-to-go-forward/>.

policyholders benefit from lower administrative costs, but insurance companies appear adamant that the health insurance industry will be negatively impacted and insurance market instability will result. Beyond a legal assessment of the permissibility of the federal medical loss ratio, policymakers will have to track the effectiveness of this federal requirement to determine whether it is good policy. Lawmakers similarly will have to track whether good policy is worth the cost of bad law.

*Meghan S. Stubblebine**

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