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Repeal of the McCarran Ferguson Act: A Means to an End?

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I. INTRODUCTION

How can we contain health care costs without negatively affecting quality? This is the question that lawmakers continue to struggle with and so far remains unanswered. The healthcare system requires reform but the best method of achieving this reform is uncertain. The Patient Protection and Affordable Care Act (ACA) was the first wave of legislation that resulted in the merging of healthcare entities in an effort to increase collaboration and accountability for patient care among providers. The ACA targeted the healthcare system as a whole, but there are efforts to reform health care by targeting specific areas of the market.

The Health Insurance Industry Antitrust Enforcement Act (the Act) was designed to reform access to health care by increasing competition in the health insurance market.[1] Specifically, the Act is an amendment to the McCarran Ferguson Act (MFA) proposing elimination of exemption from Federal Antitrust law provided to health insurers.[2] Beginning in 2007,[3] Congress has introduced several bills attempting repeal of the MFA but has not gained consensus among the parties to pass any into law, the Act is the newest bill attempting repeal.[4] The first proposals were not able to gain

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1. *See* H.R. 99, 113th Cong. (2013).
2. *Id.* ("Nothing contained in this Act shall modify, impair, or supersede the operation of any of the antitrust laws with respect to the business of health insurance").
3. *Id.*
4. Carl W. Hittinger & John D. Huh, *Health Insurance Antitrust Exemption Temporari-*

enough votes to pass, and later versions of the Act were removed in negotiations for passage of the ACA.[5] However, there is still support for the passage of the Act repealing the MFA exemption by Congress, including the support of President Barack Obama.[6] House Democrats claim repeal of the MFA is the most effective way to prohibit collusion among health insurance companies and effectively contain growing health care costs.[7,8]

This article will focus on the MFA and explain why its implementation is a necessary step towards providing low cost, quality health care by analyzing its purpose, the solution it provides, and the predicted outcome. Section II will provide background information on the exemption under the MFA and why it was implemented. Section III will analyze the MFA and explain why repeal is necessary. Finally, section IV will analyze the expected impact of the MFA repeal and whether it will have any substantial effect on the health insurance industry. The MFA should be repealed in order to effectively reform the health insurance industry and provide quality, low cost health care to consumers by introducing competition and diversity into the insurance market.

II. BACKGROUND

The MFA was passed in 1948 in response to the Supreme Court decision in *United States v. South-Eastern Underwriters Association,* ruling that the business of insurance fell into interstate commerce and was subject to fed-

ly Escapes Repeal, LEGAL INTELLIGENCER (Apr. 5, 2010) (discussing a bill introduced in 2010). Jessica Dye, *Experts Wary of Health Insurance Antitrust Bill*, LAW 360 (Oct. 8, 2009) (discussing a bill introduced in 2009), http://www.law360.com/articles/126202/experts-wary-of-health-insurance-antitrust-bill.

5. *Hittinger & Huh, supra note 4.*

6. *Pelosi Wants Reform Bill To Tackle Insurers' Antitrust Exemption*, INSIDE HEALTH REFORM (Oct. 22, 2009) [hereinafter *Pelosi Wants Reform*].

7. Same Baker, *House Dems Target Insurers' Antitrust Exemption*, THE HILL (Feb. 19, 2013), http://thehill.com/policy/healthcare/283823-house-dems-target-insurers-antitrust-exemption.

8. *Pelosi Wants Reform*, *supra* note 6.

eral regulation.[9] The MFA allows health insurers to escape judicial scrutiny under federal antitrust laws, specifically the Sherman and Clayton Acts.[10] The MFA states that no act of Congress shall supersede any law enacted by any state for the purpose of regulating the business of insurance, and that every person therein is subject to state laws relating to the regulation or taxation of insurance.[11]

The Sherman Act, passed in 1890, prohibits contracts restraining trade and any actions resulting in monopolization, or conspiracy to monopolize.[12] The Clayton Act, passed in 1914, served to strengthen the Sherman Act and prohibits specific acts having anti-competitive effects.[13] That same year, the Federal Trade Commission Act (FTC Act) was passed which broadly encompasses the Sherman and Clayton Acts.[14] Under the FTC Act, parties may bring trade restraint and monopolization cases under the Sherman Act, as well as claims for other activities not formally prohibited by the Sherman Act that have harmed competition, such as unfair or deceptive advertising and consumer fraud.[15]

Before *United States v. South-Eastern Underwriters Association*, the insurance industry was regulated under state law and not considered interstate commerce by the Supreme Court.[16] This case marks the Supreme Court's change of opinion and has caused concern among various states, specifically regarding how state legislation and taxation will be effected by federal regulation and whether federal law would supersede state law.[17] In response

9. *See* United States v. Se. Underwriters Ass'n, 322 U.S. 533, 553 (1944).
10. *Id.*
11. McCarran Ferguson Act, 15 U.S.C.A. § 1012.
12. SARALISA C. BRAU, DAVID MARX JR. & CHRISTINE L. WHITE, ANTITRUST & HEALTHCARE: A COMPREHENSIVE GUIDE 14 (1st ed. 2013).
13. *Id.* at 15.
14. *Id.* at 16-17.
15. *Id.*
16. Kimberly G, Tayner, The Repeal of the McCarran-Ferguson Act & Competition in the Health Insurance Industry 5 (May 2010) (unpublished thesis) (on file with the Loyola University Chicago School of Law Library).
17. *Id.*

to state concerns Congress passed the MFA allowing state laws regulating the business of insurance to supersede federal law.[18] In order for this exemption to apply, the health insurers practices must constitute the business of insurance, be regulated by state law, and must not amount to a boycott, coercion, or intimidation.[19] Practices are considered to be the business of insurance if they have the effect of transferring or spreading risk, are an integral part of the policy relationship between the insurers and insured, and are limited to entities within the insurance industry.[20] The exemption was designed to protect activities that help cope with risk in the industry.[21] However, the exemption does not extend to the "business of insurance companies" such as the purchasing of goods, services, or products that do not relate to the spreading of risk.[22]

As mentioned above, the MFA was passed in response to a sudden change in the Supreme Court's position.[23] The McCarran Ferguson exemption maintained state regulations that were in place before the *United States v. South-Eastern Underwriters Association* decision and prevented uncertainty as to what extent federal regulations would apply.[24] Sixty-six years later, the exemption is broadly interpreted by the judiciary and allows health insurers to merge without implicating federal antitrust laws, which resulted in concentrated markets dominated by large insurance companies.[25] Many of these large companies are labeled as a monopsony or oligopsony,

18. McCarran Ferguson Act, 15 U.S.C.A. § 1012 (West 2014).

19. BRAU ET AL., *supra* note 12, at 539.

20. Chris Sagers, *Much Ado About Possibly Pretty Little: McCarran-Ferguson Repeal in the Health Care Reform Effort*, 28 YALE L. & POL'Y REV. 325, 334 (2010).

21. *Id.*

22. *Id.*

23. See *Se. Underwriters Ass'n*, 322 U.S. at 553 (overturning a previous case holding that insurance did not affect interstate commerce).

24. Tayner, *supra* note 16, at 5-6.

25. *Health Industry Consolidation: Hearing before the H. Comm. on Ways & Means, Subcomm. On Health*, 112th Cong. 1 (Sept. 9, 2011) (statement of David Balto, Senior Fellow, Center for American Progress Action Fund), *available at* http://cdn.americanprogress.org/wpcontent/uploads/issues/2011/10/pdf/balto_testimony.pdf [hereinafter *Hearing on Health Industry Consolidation*].

which dominate the market and negatively impact competition.[26] An oligopsony exists where there is a small group of insurers with a high concentration of power spread among the several insurers.[27] While repealing the MFA and subjecting health insurers to federal antitrust laws cannot change the concentration of the current market, it can help by subjecting future practices to scrutiny to help foster competition and reform in health care.[28] Judicial interpretation of the MFA exempts health insurance practices such as most favored nation agreements that limit competition when used by large health insurers.

III. REASONS FOR REPEAL OF THE MCCARRAN FERGUSON ACT

A. Lack of State Regulation over Health Insurance Companies

The MFA should be repealed because there is limited enforcement of health insurance regulation on the state level despite state legislative efforts. Regulation in states occurs in multiple ways, including licensing procedures, audits, the processes used to determine how networks are maintained and formed, and how prices are set.[29] States also have laws to regulate anti-competitive effects among health insurance companies. [30] However, very few states actually bring actions against health insurance companies to address practices that may be anti-competitive.[31] Enforcement has been spo-

26. P.E. Hilsenrath & M. Destigter, *Oligoposony, health insurance and antitrust*, 43 MED. GRP. MGMT. J. 52, 53 (1996).

27. FED. TRADE COMM'N & DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), *available at* http://www.justice.gov/atr/public/health_care/204694/chapter6.htm.

28. BRAU ET AL., *supra* note 12, at 15 (explaining that antitrust legislation does not work retroactively and cannot undo monopolies already formed).

29. Michael G. Cowie, *Health Insurance and Federal Antitrust Law: An Analysis of Recent Congressional Action*, ANTITRUST SOURCE 7-8 (Dec. 2009), *available at* http://www.americanbar.org/content/dam/aba/publishing/antitrust_source/Dec09_Cowie12_17f.authcheckdam.pdf.

30. *Id.*

31. David Balto & Stephanie Gross, *Unlocking Competition, The Need to Eliminate the Antitrust Exemption for Health Insurers*, CTR. FOR AM. PROGRESS 2 (Oct. 28, 2009) *available at* http://cdn.americanprogress.org/wp-content/uploads/issues/2009/10/pdf/unlocking_competition.pdf.

radic with few consumer protection actions and no actions against anti-competitive conduct.[32] Even in those states where the concentration of the market is at its highest, no actions against health insurers occurred in the past five years.[33] The MFA requires states to have regulations in place for the exemption to apply, but it does not mandate that states actually take action on the laws that it has in place.[34] Federal case law suggests that, as long as there is a state law in place, the exemption stands even if it is ineffective.[35] A state law that only minimally regulates and touches on the issue of antitrust is sufficient to preserve the exemption under the MFA.[36] This system of enforcement allows insurers to escape scrutiny on the federal level for practices that may negatively affect competition and escape scrutiny on the state level as a result of such relaxed enforcement.[37] Repeal of the MFA solves this problem by eliminating the exemption allowing health insurer practices to escape federal antitrust legislation as long as the practice is regulated under state law.

The McCarran Ferguson exemption should be repealed to implement uniform application of antitrust regulations instead of permitting the degree of restriction to vary from state to state.[38] For instance, an insurer in one state may be able to escape antitrust scrutiny in one state, but not in another because there are no guidelines on how stringent state laws must be for the exemption to apply.[39] This presents an advantage for insurers that are large enough to operate across multiple states and can control a relevant market

32. *Id.*
33. *Id.*
34. BRAU ET AL., *supra* note 12, at 539.
35. Balto & Gross, *supra* note 31, at 3.
36. *Id.*
37. *Id.* (Insurers are exempt from federal law because they are regulated under state law, but there have been limited enforcements in past five years).
38. Tayner, *supra* note 16, at 26 (explaining that state law only extends to the borders of the regulating state, so if an insurer also acts in a non-regulating state, the activities in the non-regulating state are subject to federal antitrust authority).
39. *Id.*

based on how strict the state laws are imposed, if they are imposed at all.[40] An example of this scenario is the health insurance company Blue Cross Blue Shield, which provides coverage for almost fifty percent of the population in many states.[41] Requiring a uniform application of federal antitrust laws may eliminate the varying degree of enforcement under state law and subject all health insurers to the same standard of legislation.

B. Slowing Further Consolidation of Insurance Markets

Repeal of the MFA can help slow consolidation in the health insurance industry and allow for more companies to enter the market.[42] The concentration levels of health insurance markets exceed the threshold amount of the 2,500 points triggering antitrust liability.[43] Ninety-six percent of state health insurance markets are considered highly concentrated.[44] The trend shows that the market will continue to become more concentrated.[45] In fact, four hundred mergers occurred from 1996 to 2010.[46] A 2011 report lists thirty-nine states where two companies control at least fifty percent of the market and demonstrates that in nine states, a single company controls at least seventy-five percent.[47] Repeal of the MFA would increase judicial scrutiny of all future market consolidation that unreasonably restrains competition or allows achievement of market monopolization through insurance company mergers and acquisitions.[48] The application of federal antitrust

40. Hilsenrath & Destigter, *supra* note 26 (discussing Blue Cross Blue Shield as an example of an oligopsony, who in aggregate are large providers of insurance and cover significant percentages of patients in a given area).

41. *Id.*

42. Balto & Gross, *supra* note 31, at 1 ("A tsunami of health insurance mergers has led to high levels of concentration in practically every market to the point where there are only one or two dominant insurers in many states. New companies face substantial entry barriers, and so the local monopoles go unchallenged").

43. Sagers, *supra* note 20, at 338.

44. *Id.*

45. *Id.*

46. *Hearing on Health Industry Consolidation*, *supra* note 25, at 4.

47. *Id.*

48. BRAU ET AL., *supra* note 12, at 14.

law to all insurance companies can help slow market consolidation.[49] This oversight may hinder the ability of large insurers to dominate large portions of the market, removing access barriers for smaller insurance companies and likely resulting in a more diversified insurance marketplace.[50]

The high concentration of health insurance companies within the market also effectively limits competition by preventing other companies from entering.[51] For example, if an insurer wants to enter the Dallas, Texas market as an HMO or HMO-POS, it must dedicate two to three years and costs up to $50 million due to the high concentration of the market.[52] In St. Louis, Missouri, the HMO market is very concentrated and there has been no new insurer entry since the mid-1990s.[53] One of the causes of market domination by a single insurer is that larger companies typically negotiate more effectively with providers and grant consumers prices they believe to be reasonable.[54] In turn, consumers have little incentive to switch to other insurers that may have similar, or more likely, higher prices.[55] Subjecting health insurers to federal antitrust laws, slowing consolidation, and introducing competition provides consumers with more choices among companies and requires insurers to provide the best deal for the consumer by offering a better quality product at a lower price.

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49. *Hearing on Health Industry Consolidation, supra* note 25, at 4 (Concerns over healthcare consolidation should focus on the need to prevent increases in concentration by health insurers. Insufficient focus on this area in the past has given way to a very poorly functioning health insurance market. Few markets are as concentrated, opaque, and conducive to deceptive and anticompetitive conduct).

50. *Id.*

51. Balto & Gross, *supra* note 31, at 1 (explaining that new companies face substantial entry barrier, and so these local monopolies go unchallenged).

52. FED. TRADE COMM'N & DEP'T OF JUSTICE, *supra* note 27, at 6.

53. *Id.* at 7.

54. *Hearing on Health Industry Consolidation*, *supra* note 25, at 4 (discussing how advocates believe markets have several competitors, but in reality the small players are not a competitive restraint on dominant firm and just follow the larger firms' price increases).

55. *Hearing on Health Industry Consolidation*, *supra* note 25, at 4.

IV. EXPECTED IMPACT OF THE REPEAL OF THE MFA EXEMPTION

A. Effect on Competition in the Market

Repeal of the MFA will have little impact unless the courts change how they view health insurers' price setting practices. The courts have granted health insurers great latitude when evaluating whether their practices are in violation of the Sherman Act.[56] For example, practices such as banning balance billing, most favored nation (MFN) clauses, and reimbursement caps were found not to harm competition in many cases.[57]

One of the restrictions imposed by insurers is a ban on balancing billing which prohibits providers from billing the patient for any additional payments beyond what the insurer has set as the reimbursement amount for services rendered.[58] If the provider decides not to participate by refusing the health insurers' reimbursement as payment in full, the provider can be precluded from receiving any payments from the insurer and banned from treating patients of that insurer.[59] Another device used in the practice of insurance, the MFN clause, is a contractual agreement between insurer and provider that requires the provider to sell to the insurer on pricing terms that are at least as favorable as the pricing terms given to any other insurer.[60] This requires the provider to charge all insurers similar prices and offer similar discounts, regardless of the customer base.[61] Finally, insurers often use reimbursement caps to limit the amount paid to a provider for services rendered.[62] An insurer contracts with providers on this reimbursement amount, but if a provider outside of this contract renders services, they will receive a

56. Hilsenrath & Destigter, *supra* note 26, at 55.
57. *Id.* at 55-57.
58. *Id.*
59. *Id.*
60. FED. TRADE COMM'N & DEP'T OF JUSTICE, *supra* note 27, at 13.
61. *Id.*
62. Hilsenrath & Destigter, *supra* note 26, at 57.

lower reimbursement compared to contracted providers.[63] This practice compels patients to see only contracted providers to insure that the services will be covered and there will be limited out-of-pocket expense.[64]

The ban on balance billing works to keep prices low for consumers but stifles competition by preventing providers from charging different rates.[65] If the insurer has market power, the provider will accept the reimbursement amount offered by the insurer rather than lose access to the large percentage of patients covered by the insurer.[66]

MFN clauses work to prevent providers from charging smaller insurers less because providers cannot sustain business if the largest amount of their patient population and source of revenue is being cared for at a low market rate.[67] Providers cannot terminate contracts with large insurers because of the large percentage of beneficiaries that they cover.[68] As a result, providers are forced to charge a blanket rate to all insurers and many small insurers may not be able to compete.[69]

A ban on balance billing is a positive business strategy, but with the market power of large contracting insurers, anti-competitive effects are likely.[70] A ban on balance billing and MFN clauses alone are not anti-competitive, however, when combined with market power they can effectively limit competition by setting reimbursements at levels beneficial to the

63. *Id.*
64. *Id.*
65. *Id.*
66. *Id.* at 55 (discussing how those providers who do not agree to the insurers reimbursement rate are not allowed participatory status and may be precluded from receiving payment whatsoever from treating patients of the insurer).
67. FED. TRADE COMM'N & DEP'T OF JUSTICE, *supra* note 27 (discussing that a MFN clause may harm competition either by substantially raising costs of the insurer's rivals or reducing provider discounting in the particular market).
68. BRAU ET AL., *supra* note 12, at 467.
69. *Id.*
70. *Id.* at 56 (discussing the unlimited rights of a buyer to set its own terms and bargain for the best price, and that discriminatory reimbursement constitutes hard bargaining rather than anticompetitive conduct).

insurer but not to the provider.[71]

Similarly, repeal of the McCarran Ferguson exemption will have little effect unless courts change how federal antitrust laws apply to health insurers' practices.[72] In previous cases, many of the practices that harm competition have been found to be lawful under the Sherman Act.[73] This will not change with repeal of the exemption. However, these activities may fail if scrutinized under the FTC Act.[74] The FTC Act applies much more broadly and does not point to specific practices or activities that are illegal, allowing for general practices that restrain trade or harm competition to be challenged.[75] But interpretation of section six of the FTC Act suggests the FTC does not have authority to investigate health insurance without Congressional approval.[76] Section six states the FTC has the power to investigate persons and corporations whose business affects commerce but the power to investigate violations of antitrust statues exists when commanded by the President or either House of Congress. Clarification of this limitation by Congress would allow the FTC to bring cases based on competition and consumer protection that were previously ruled unlawful under the Sharman Act.[77] Because many of the anti-competitive practices were previously ruled legal under the antitrust laws, repeal of the exemption without further action will change very little in the context of challenging insurers' practices.

B. Effect on Information Sharing in the Health Insurance Market

Information sharing among insurance companies will likely not be tar-

71. Hilsenrath & Destigter, *supra* note 26, at 55 ("[I]n these cases, rather than bargaining with providers for a contract price, the powerful payor may have the ability to unilaterally set reimbursement below market levels.").

72. *Hearing on Health Industry Consolidation, supra* note 25, at 12 (The FTC should scrutinize anticompetitive conduct by health insurers and providers).

73. *Id.*

74. *Id.*

75. BRAU ET AL., *supra* note 12, at 16 (The FTC Act broadly declares unlawful unfair methods of competition in or affecting commerce).

76. *Hearing on Health Industry Consolidation, supra* note 25, at 12.

77. *Id.*

geted by repeal due to its pro-competitive effect and because it is subject to state regulation and therefore exempt under the MFA.[78] Health insurers expressed concern that sharing loss information will be scrutinized if the MFA is repealed, impeding the ability to predict costs.[79] Sharing loss information allows insurers to predict costs incurred in a given year before they actually realize the costs.[80] Loss information is used by actuaries and analyzed to set premiums at a rate that is attractive to consumers and protects the insurer from insolvency.[81] Scrutinizing insurers' practice of sharing loss data under federal antitrust law is unlikely because the price sharing and historical loss information currently shared is not detailed enough to raise anti-competitive concerns.[82] The legality of the aggregation and dissemination of this data rests largely on whether client-identifying information is present; if identifiers are removed, then this practice likely remains legal. .[83]

However, this may not have a negative effect on large insurance companies because even if this practice is subject to scrutiny under federal antitrust laws, these insurance giants have enough historical data to accurately predict their costs.[84] A ban on information sharing in the insurance marketplace will only affect small insurers attempting to enter the market due to their inability to gather loss information on a large scale.[85] Imposing a limit on information sharing will fail to achieve the desired result of increasing competition and instead will serve to stifle it by preventing smaller insurers from competing with the larger insurers in the market place.

78. Sagers, *supra* note 20, at 347.

79. Repeal of Antitrust Exemption Would Not Hurt Insurance Industry, 23 CORP. CRIME REP. 42(14) (Oct. 30, 2009), *available at* http://corporatecrimereporter.com/stutz 103009.htm.

80. *Id*.

81. *Id*.

82. Sagers, *supra* note 20, at 348.

83. *Id*.

84. Jenny Gold, *The Antitrust Exemption For Health Insurers: Meaningful Or Not?*, KAISER HEALTH NEWS (Feb. 24, 2010), http://www.kaiserhealthnews.org/stories/2010/february/05/antitrust-health-insurance.aspx.

85. Hittinger & Huh, *supra* note 4.

V. CONCLUSION

Repeal of the MFA is a necessary step toward improving the healthcare system by exposing health insurers to uniform federal antitrust liability. Currently, differing legislation among the states results in a variation of enforcement and regulation across the country. Repeal would expose health insurers to a high level of judicial scrutiny when attempting to consolidate when there is a potential for negative impact on competition in a specific insurance market. Scrutinizing all transactions under the Sherman and Clayton Acts imposes the same level of federal regulation, decreasing the amount of transactions that have anti-competitive effects or restrain trade. This allows smaller insurers easier entry into the market and increases diversity.

While repeal cannot retroactively undo the high level of market concentration, it is the first step in reducing the barrier to market entry by diminishing the ability of large insurers to consolidate and control a majority of the population in a given area. Significantly, removing the McCarran Ferguson exemption will have minimal immediate impact without a further change in the way courts evaluate insurer practices and implement federal antitrust laws, but over time, repeal of the exemption could help to improve and reform the health insurance market.