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Much Ado About Possibly Pretty Little: McCarran-Ferguson Repeal in the Health Care Reform Effort

*Chris Sagers**

INTRODUCTION

Since 1945, the McCarran-Ferguson Act¹ (MFA) has shielded the “business of insurance” from antitrust liability, so long as the challenged conduct is “regulated by State Law” and does not constitute “boycott, coercion, or intimidation.”² This law, like the dozens of other statutory antitrust exemptions that still exist for other industries, has more or less always been controversial, and efforts to repeal it date back more than thirty years. Amid the past year’s intense congressional debate over health care reform legislation, a serious repeal effort was once again afoot, and even now it continues. Because they were linked all along to the overall health reform initiative, the repeal bills that have been considered would apply only to carriers in health insurance and medical malpractice insurance (MMI). In addition, depending on events that remain hard to predict, any of them that is adopted may apply to only some of those insurers’ conduct.

If there is consensus on any one issue in antitrust, it is that statutory exemptions are rarely justified and in most cases ought to be repealed. The

* Associate Professor of Law, Cleveland State University. This Essay benefited from comments at an exceptional 2009 conference at the Indiana University, Indianapolis School of Law, cosponsored by the American Antitrust Institute and the Hall Center for Health Law. My thanks to organizers Bert Foer and Max Huffman and conference participants Sydney Arak, William Comanor, John Connor, Ted Frech, Tim Greaney, Cliff Johnson, Paul London, Emily Morris, David Orentlicher, Greg Pemberton, Gayle Reindl and Barak Richman. This Essay began as a written statement on the pending health reform legislation submitted before the House Judiciary Committee, at the request of counsel for the Committee. My thanks to the peerless Anant Raut for feedback on that initial material.

1. 15 U.S.C. §§ 1011-1015 (2006).
2. *Id.* §§ 1012(b), 1013(b).

courts disfavor them and read them narrowly,³ the enforcement agencies have long opposed them,⁴ and they have been criticized for years by the Antitrust Modernization Commission (AMC)⁵ and its many predecessors⁶ and by the American Bar Association (ABA) Section of Antitrust Law.⁷ Other nations generally have converged on similar views, and the European Commission now is preparing to narrow its block exemption for insurance.⁸ Criticism of the MFA itself has been vigorous. Calls for outright repeal from very eminent quarters have become routine.⁹

Still, much doubt remains whether any repeal effort could succeed during the 111th Congress, and events continue to unfold very rapidly. Until January or

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3. See, e.g., *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 126 (1982) (narrowly construing the MFA); *Fed. Mar. Comm'n v. Seatrain Lines, Inc.*, 411 U.S. 726, 733 (1973) (narrowly construing the Shipping Act of 1916); *United States v. McKesson & Robbins, Inc.*, 351 U.S. 305, 316 (1956) (narrowly construing the Miller-Tydings and McGuire Act exemptions for resale price maintenance); *Chi. Prof'l Sports Ltd. P'ship v. NBA*, 961 F.2d 667, 671-72 (7th Cir. 1992) (observing that because "special interest legislation enshrines results rather than principles," the "courts read exceptions to the antitrust laws narrowly, with beady eyes and green eyeshades").
 4. The Federal Trade Commission and the Justice Department's Antitrust Division frequently have urged Congress to repeal or narrow existing exemptions and opposed adoption of new ones.
 5. ANTITRUST MODERNIZATION COMM'N, REPORT AND RECOMMENDATIONS 334-37 (2007), available at http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf.
 6. For histories of the many antitrust study commissions that preceded the AMC and their opposition to statutory exemptions, see Stephen Calkins, *Antitrust Modernization: Looking Backwards*, 31 J. CORP. L. 421 (2006); and Albert A. Foer, *Putting the Antitrust Modernization Commission into Perspective*, 51 BUFF. L. REV. 1029 (2003).
 7. Over many years, the ABA Antitrust Section has made clear its near uniform opposition to all antitrust exemptions by providing testimony to Congress and in other public venues. For a sampling of such statements, see American Bar Association Section of Antitrust Law, Comments of the ABA Section of Antitrust Law, <http://www.abanet.org/antitrust/at-comments/comments.shtml> (last visited July 1, 2010).
 8. E.g., Press Release, European Comm'n, Antitrust: Public Consultation on Revised Draft Block Exemption Regulation for Insurance Sector (Oct. 5, 2009), available at <http://europa.eu/rapid/pressReleasesAction.do?reference=IP/09/1413&forma>.
 9. The committee report accompanying the MFA repeal bill that passed the House this year nicely summarizes this criticism, collecting evidence from an influential 1977 Justice Department report, the President's National Commission report of 1997, the National Association of Attorneys General, and the Antitrust Modernization Commission. See H.R. REP. NO. 111-322, at 4-5 (2009).

February of 2010, the fate of MFA repeal had seemed inextricably entwined with health care reform overall, and it endured a wildly changing and unpredictable several months as a little noticed addendum to that larger fight. It now has been fully extracted from the larger reform bills and will rise or fall as separate, free-standing legislation. But, even now, the repeal effort cannot be understood apart from the history of overall health care reform.

Identical companion bills were introduced in September 2009, that would have repealed the MFA, but only as to health and MMI insurers, and only as to “price fixing, bid rigging, or market allocations.”¹⁰ The House bill was reported favorably out of committee and was included as a part of the comprehensive health reform bill adopted in early November by the full House (the “House Health Bill”).¹¹ The insurance industry, however, voiced predictable opposition,¹² and Senator Reid—though he cosponsored the Senate MFA repeal bill and defended it vehemently before the Senate Judiciary Committee—indicated in November that it was expendable if needed to secure political compromise on the overall health care reform effort.¹³ When the Senate’s comprehensive reform bill (the “Senate Health Bill”) was introduced on November 18, 2009, it did not contain MFA repeal or any other mention of antitrust, except for two miscellaneous savings clauses. The Senate MFA repeal’s principal sponsor, Senator Patrick Leahy, moved its inclusion as a floor

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10. H.R. 3596, 111th Cong. § 2 (2009); S. 1681, 111th Cong. § 2 (2009). At least one other bill has been introduced in this session to repeal the MFA, and it would go much further than the health insurance bills. The Insurance Industry Competition Act of 2009, H.R. 1583, 111th Cong. § 2 (2009), would cause antitrust to apply to the insurance industry regardless of state regulation, subject only to the limit that Federal Trade Commission § 5 unfair competition enforcement would remain available only where the “business of insurance” is not “regulated by State law.” H.R. 1583’s sponsors introduced the same bill in the prior Congress. *See* H.R. 1081, 110th Cong. (2007). Despite the fact that the bill has never received Committee consideration, it appears to have been incorporated partly into the comprehensive House health reform bill by manager’s amendment. *See infra* note 24 and accompanying text.
 11. *See* Affordable Health Care for America Act, H.R. 3962, 111th Cong. § 262 (2009). The House Health Bill passed the House on November 7, 2009.
 12. *See, e.g.*, Press Release, Am. Ins. Ass’n, Health Care Bill Wrongly Targets P/C Insurers Threatening Business Model and Competition (Nov. 9, 2009), *available at* <http://www.aiadc.org/aiadotnet/docHandler.aspx?DocID=329202> (stating industry concerns and including a copy of a November 6 letter sent to House members).
 13. *See* Prescriptions, <http://prescriptions.blogs.nytimes.com/2009/11/08/if-anything-the-senates-task-is-trickier/> (Nov. 8, 2009, 16:33 EST) (“Mr. Reid strongly supports the provision, but has said he will set it aside to win [Senator Ben] Nelson’s support.”).

amendment to the Senate Health Bill,¹⁴ and he had powerful outside support.¹⁵ That effort failed, though, and when the Senate Health Bill was adopted on Christmas Eve of 2009, it contained no MFA repealer.¹⁶ The only remaining hope for repeal seemed to be that the House provision might be included in a conference health bill, but that hope was slim indeed. Democratic Senator Ben Nelson, a former insurance executive and state insurance commissioner, publically had opposed MFA repeal. Winning his probably necessary vote for health care reform apparently called for keeping it out of the bill,¹⁷ and he claimed early in the debate to have “secured assurances” from Senator Reid that he would do so.¹⁸ One final reason that repeal’s future seemed not bright was the suggestion that Democrats pushed it less on its merits than as a tool to pressure insurance industry support for overall health care reform.¹⁹

Since then, everything has changed. Republican Senator Scott Brown’s upset election in January forced Democrats to abandon any hope of securing a conference bill and instead to use a fairly risky and controversial budget reconciliation strategy.²⁰ In some respects, the lack of conference negotiation

14. Press Release, Senator Patrick Leahy, *Leahy To File Antitrust Repeal Amendment on Today* (Dec. 1, 2009).

15. See, e.g., Jesse A. Hamilton, *Ten State Attorneys General Side Against Health Insurers on Antitrust Issue*, A.M. BEST BESTWIRE, Nov. 18, 2009.

16. See Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. (2009). For parliamentary reasons, the vehicle for Senate consideration of health care reform was introduced with a House bill number.

17. See *supra* note 13.

18. Kristin Jensen, *Senate ‘Horse Trading’ Begins as Democrats Take Up Health Bill*, BLOOMBERG, Nov. 30, 2009, http://www.bloomberg.com/apps/news?pid=20670001&sid_ahNn8gDZiDqY.

19. That argument seems to come in part from the industry, as part of its opposition effort—the argument being that MFA repeal is simply a mean-spirited reprisal for the industry’s opposition to overall health reform. See, e.g., Hamilton, *supra* note 15. But it has been mentioned by others as well. See Ryan Grim, *Insurance Industry Antitrust Fight Headed to Conference Committee*, HUFFINGTON POST, Nov. 24, 2009, <http://www.huffingtonpost.com/2009/11/24/insurance-industry-antitrust>; David Welna, *Democrats Push To End Insurers’ Antitrust Exemption*, NATIONAL PUBLIC RADIO, Oct. 23, 2009, <http://www.npr.org/templates/story/story.php?storyId=114063950>.

20. After months of debate over procedure, it became clear that congressional leadership would use the budget reconciliation process to avoid likely filibuster of a conference bill. Although comprehensive health care reform bills had passed both chambers—and passed in the Senate by a filibuster-proof sixty votes—the two bills sharply diverged on a number of hotly debated issues. Conference negotiations surely would have been contentious, and the Democratic leadership had hoped those discussions would be completed before the State of the Union address in late January. See Shailagh Murray & Paul Kane, *Senate Democrats Vote To Bring Health Bill to Floor for Debate*, WASH. POST, Nov. 22, 2009, at A01.

improved the odds for MFA repeal. A free-standing MFA repealer would have much less opposition than the comprehensive health bills faced, and therefore the opposition of a handful of moderate Democrats to MFA repeal was no longer a meaningful issue. In fact, as of this writing, it is still not an unlikely outcome that free-standing repeal legislation will pass both chambers, possibly by significant majorities. If so, it will apply only to health insurers, but it will contain no exceptions; it will repeal their MFA immunity entirely. On February 22, 2010, after reconciliation had become a likely scenario, two freshmen Democrats and more than seventy cosponsors introduced H.R. 4626, a free-standing MFA repealer.²¹ Their bill would apply only to health insurers but would repeal the exemption as to them totally. Within two days the bill passed the House by an enormous margin.²² Although it remains to be seen whether MFA repeal will fit as well into the Senate leadership's priorities, Senator Leahy and twenty-one cosignatories wrote to Senator Reid on March 3 to urge a Senate floor vote on the new House repealer,²³ and Senator Leahy plainly intends to keep up the fight for a floor vote during this Congress.

Passage of any conference bill, however, seemed surely impossible after Republican Senator Scott Brown won a special election to fill the unexpired term of the late Senator Ted Kennedy. Instead, Democrats argued that conflicts between the bills could be resolved by budget reconciliation—requiring only a simple Senate majority—so long as the discrepancies related only to issues with significant budgetary impacts. As a result of parliamentary ruling, the House was required to pass the Senate bill verbatim, subject to reconciliation corrections, but Democratic leaders believed they had the necessary votes in the House to do so. See Robert Pear, *Democrats Struggle To Finish Health Bill*, N.Y. TIMES, Mar. 12, 2010, at A17; Patrick O'Connor, *Pelosi: 'The Choice Has To Be Made'*, POLITICO, Mar. 11, 2010, http://www.politico.com/news/stories/0310/34294_Page3.html.

21. Health Insurance Industry Fair Competition Act, H.R. 4626, 111th Cong. (2010). The bill was introduced by Representative Tom Perriello of Virginia and (initially) Representative Betsy Markey of Colorado. Cosponsors included the original sponsors of earlier repeal bills, notably Representative Peter DeFazio. See *infra* note 24.
22. The floor vote in the House was 406 for and 19 against. Interestingly, the floor vote on the bill was taken only after a Republican motion to return it to committee, presumably for inclusion of exceptions or safe harbors of the kind that had been included in the earlier House bills. Representative Dan Lungren, who all along had been the chief advocate for safe harbors, also attempted to amend the bill to include safe harbors while it was before the House Rules Committee. See Press Release, Representative Dan Lungren, Lungren Fights for Bipartisan Protection for Health Care Consumers, available at http://lungren.house.gov/index.php?option=com_content&task=view&id=594&Itemid=86.
23. Letter from Senator Patrick Leahy et al., to Senator Harry Reid (Mar. 3, 2010), available at <http://judiciary.senate.gov/resources/documents/111thCongress/upload/030310MembersToReid.pdf>.

This Essay asks two questions: (1) what consequences the pending repeal measures might have if one of them becomes law; and (2) what a close examination of this effort might teach us about the general business of MFA repeal and competition in insurance. Teasing out the consequences is a bit complex, because these industries are complex—health and MMI markets are actually quite different from one another—and because the existing law under the MFA is dense and somewhat unpredictable. In short, however, two points seem true. Any MFA repeal in whole or in part seems desirable, as insurance markets are riddled with competition problems, and whatever justification the MFA ever had expired long ago. But second, the qualifications and provisos with which the pending bills have been studded may generate disappointingly limited results, depending on which version of the language ultimately appears as law. By far the most stunning events in the legislative history so far were the very quiet, little-noticed manager's amendment to the House Health Bill by which the original limitation to "price fixing, bid rigging, or market allocation" was removed completely,²⁴ and the substantially similar repeal that would apply to health insurers under the adopted H.R. 4626. If such broad repeal language actually becomes law, it might represent a major and welcome change with positive competitive consequences. If not—if some version of MFA repeal survives, but Capitol Hill negotiators reinsert limits of the repeal to specific anticompetitive acts—repeal could well have little or no impact on these markets at all.

As to the larger problem of MFA repeal in general, i.e., repeal as to *all* conduct in *all* insurance markets, giving this matter close attention will repay the effort in several ways. The pending repeal bills, however much they may accomplish in and of themselves, have come closer to success than any prior repeal effort, notwithstanding that efforts began more than thirty years ago. Moreover, whether the pending repeal provisions succeed or not, they are an important prelude to the increasingly likely, or even inevitable, general repeal of the MFA. None of the broad antitrust exemptions, most of which date to the

24. The provision as it appears in the final House Health Bill would repeal MFA as to "the business of health insurance [and] the business of medical malpractice insurance." How exactly this happened remains mysterious. Representative Peter DeFazio, Democrat of Oregon who sponsored a different MFA repeal bill, issued a press release shortly before the House Health Bill was adopted that essentially took full credit for the amendment, implying that the DeFazio bill itself had been incorporated rather than H.R. 3596. See Press Release, Peter DeFazio, *DeFazio Language To Repeal Health Insurance Anti-Trust Exemption Included in Health Reform Bill* (Nov. 4, 2009), available at http://www.defazio.house.gov/index.php?option=com_content&view=article&id=527:defazio-language-to-repeal-health-insurance-anti-trust-exemption-included-in-health-reform-bill&catid=60. That claim would be quite misleading, but it is probably fair to say that elements of DeFazio's bill were used to modify the language of H.R. 3596, which forms the core of the repeal provision of the House Health Bill. One can only imagine there was some sort of disagreement among bill proponents and House leadership, and this compromise therefore was reached.

Progressive Era and New Deal years and none of which is now very popular, seems likely to endure. It stands to reason that the MFA will disappear eventually as well. This recent repeal effort, the rhetoric surrounding it, and an examination of the likely consequences of the proposed legislation present an excellent opportunity to explore what will work and what will not in the eventual reform.

Finally, repeal should be adopted even if the best, politically feasible option is a bill with exceptions or safe harbors. All else aside, passage would be symbolic. It would show the legislature's commitment to the matter. It also would establish in effect a pilot program to show that exposure to antitrust will not hurt insurers' ability to perform. But it should have even more concrete benefits. Passage effectively will direct the enforcement agencies to take insurance competition seriously, which they have not done for many years. In that respect, incidentally, the House Health Bill originally included an important restoration of the power of the Federal Trade Commission to undertake industry studies in insurance, complete with the full panoply of its investigatory powers under § 6 of the Federal Trade Commission Act.²⁵

This Essay proceeds in four Parts. Part I lays out useful background regarding the law of antitrust that currently applies to health and medical malpractice insurers, as well as to the current economic circumstances of their markets. Part I asks: (1) whether there is anything important about these markets that singles them out for special antitrust exemption; and (2) whether there is anything different enough about the two markets that dealing with them in the same way, in the same bill, might be somehow unwise (an argument insisted upon by industry lobbyists). Part II surveys in more detail the legislation that has been considered in the 111th Congress to set the stage for the substantive policy analysis that comprises Part III. A brief Conclusion then offers some broader thoughts about the general problem of repealing antitrust exemptions.

I. THE MFA AND THE CURRENT CIRCUMSTANCES OF THE HEALTH INSURANCE AND MMI MARKETS

After a brief précis of existing law, this Essay discusses the factual backgrounds of the two quite different markets for health and medical malpractice insurance. Part I also considers whether the differences between them might favor differing antitrust treatment.

A. *The Law as It Exists*

The MFA was born at a time when “destructive competition” theory still was taken seriously,²⁶ and associationalism²⁷ remained an article of faith in

25. See *infra* notes 83-86 and accompanying text.

26. By the late nineteenth century, a remarkable consensus began to emerge among economists that, in many sectors of the rapidly industrializing economy, very high

American business;²⁸ confidence in them had just begun to wane in government.²⁹ By the time of the MFA's adoption, those trends already had led

fixed costs would make it impossible for more than one firm to produce goods profitably. This was of course most commonly thought to afflict the railroads, utilities, and other markets with very high fixed costs that are now sometimes thought to be natural monopolies, but many economists were convinced that similar problems would inhere through all sorts of industries. See generally NAOMI R. LAMOREAUX, *THE GREAT MERGER MOVEMENT IN AMERICAN BUSINESS, 1895-1904* (1985) (recounting the rise of destructive competition theory).

27. Associationalism refers to the notion that social problems can and should be handled by coalitions of private persons or entities, rather than by government. Even though sentiments of that nature surely persist now, they were much more pronounced during the late nineteenth and early twentieth centuries. For general background, see Ellis W. Hawley, *Herbert Hoover, the Commerce Secretariat, and the Vision of an "Associative State," 1921-1928*, 61 J. AM. HIST. 116, 117-19 (1974).
28. Businesses had cartelized the American economy significantly in a variety of sectors throughout the late nineteenth century. In particular, "pooling agreements" and output-limiting cartels were common in the railroad and ocean shipping industries. The psychological commitment of businesspeople to associationalism had become well-entrenched at least as early as the legislative consideration of the 1914 antitrust amendments: the Clayton Antitrust Act of 1914, Pub. L. No. 63-212, 38 Stat. 730 (codified as amended at 15 U.S.C. §§ 12-27 (2006)) and the Federal Trade Commission Act of 1914, Pub. L. No. 63-203, 38 Stat. 717. Famously, the "Gary dinners," informal gatherings of steel industry executives to coordinate business affairs arranged by Elbert Gary, had begun in 1907 and were well-known to the public at that time. See JOHN D. CLARK, *THE FEDERAL TRUST POLICY* 215 (1931). Likewise, a theoretical work by the antitrust lawyer Arthur Eddy, which was nothing short of a blockbuster and lay the intellectual foundations for the associationalist movement that culminated in the National Industrial Recovery Act, ch. 90, 48 Stat. 195 (1933) (codified as amended at 15 U.S.C. § 703 (2006)), was published and widely read in 1912. See ARTHUR JEROME EDDY, *THE NEW COMPETITION* (1912). See generally H.R. Tosdal, *Open Price Associations*, 7 AM. ECON. REV. 331 (1917) (describing Eddy's book and the impact it had on businesspeople's thinking).

In any event, testimony surrounding the 1914 antitrust amendments involved a fair bit of such thinking and included explicit requests that any modifications to the Sherman Act permit either open freedom to fix prices or at least provide for a regulatory agency that could preapprove some forms of cartel agreement. See CLARK, *supra*, at 139-64. The influence of these trends on the coming wave of antitrust exemptions in the "regulated industries," including insurance, cannot be overstated.

29. Throughout the late nineteenth and early twentieth centuries, government supported cartelization in a variety of ways. The most significant and visible policy, aside from the antitrust exemptions adopted in the heavy infrastructure industries, was the official support given trade associations under the Commerce Secretariat of Herbert Hoover. See ROBERT F. HIMMELBERG, *THE ORIGINS OF THE NATIONAL RECOVERY ADMINISTRATION: BUSINESS, GOVERNMENT, AND THE TRADE ASSOCIATION ISSUE, 1921-1933*, at 26-53 (1993); Hawley, *supra* note 27, at

to rate-and-entry regulation in markets throughout the United States economy, complete with broad antitrust exemptions.³⁰ Accordingly, while the MFA was founded on insolvency problems unique to the insurance industry,³¹ it was but the latest in a string of federal interventions shielding industries from competition. The Act was just one part of a larger economic consensus dating back decades, which only then had begun to unravel.

Still, the policy was more or less always controversial. It came under fire from subsequent Congresses as early as 1961,³² and agitation for actual repeal began as early as the general deregulatory fervor of the 1970s.³³ Interestingly,

122-39. This “associationalist” policy culminated in the abortive National Industrial Recovery Act of the early 1930s, but its influence by no means died with that statute.

As to the government’s growing disenchantment with associationalism and regulated cartels, in addition to the replacement of those policies with a commitment to antitrust and competition, see SPENCER WEBER WALLER, THURMAN ARNOLD: A BIOGRAPHY 78-82 (2005).

30. See generally AM. BAR ASS’N, SECTION OF ANTITRUST LAW, FEDERAL STATUTORY EXEMPTIONS FROM ANTITRUST LAW (2007) [hereinafter ABA EXEMPTIONS MONOGRAPH] (describing the history and politics of statutory antitrust exemptions); Joseph D. Kearney & Thomas W. Merrill, *The Great Transformation of Regulated Industries Law*, 98 COLUM. L. REV. 1323 (1998) (same); Robert L. Rabin, *Federal Regulation in Historical Perspective*, 38 STAN. L. REV. 1189 (1986) (same).
31. Spectacular failures occurred among fire insurers throughout the nineteenth century, and life insurers suffered severe economic strains as well. In retrospect it is clear that these failures reflected inadequacies of the then-current state of actuarial science and underwriting standards and that those problems have been improved significantly. By the time of the MFA, however, insurers had responded to those problems mainly through horizontal price-fixing conspiracy, meant to avoid destructive rate wars. See *infra* notes 47-50 and accompanying text. They did so quite openly because, until 1944, insurance had been deemed outside the scope of interstate commerce, *Paul v. Virginia*, 75 U.S. (8 Wall.) 168 (1868), and therefore not subject to antitrust regulations. *Paul* was reversed in *United States v. South-Eastern Underwriters Association*, 322 U.S. 533 (1944), and it was directly in response to *South-Eastern Underwriters* that Congress adopted the MFA.
32. See S. REP. NO. 87-831 (1961) (criticizing state rate regulation regimes and encouraging the adoption of less restrictive “file-and-use” systems).
33. See FEDERAL-STATE REGULATION OF THE PRICING AND MARKETING OF INSURANCE (Paul W. MacAvoy ed., 1977) [hereinafter FEDERAL-STATE REGULATION] (casting doubt broadly on the need for antitrust exemption as to property/casualty insurers and proposing a new system of optional federal chartering without exemption). The report appeared during the massive deregulatory efforts of the Carter Administration. By then, economic opinion resoundingly rejected destructive competition theory, and overwhelming evidence had been amassed of the costs of rate-and-entry regulation. Those deregulatory efforts have continued to this day. For the most part, rate-and-entry regulation

though, no serious effort at repeal legislation seems to have predated 1987.³⁴ Efforts began that year following a serious crisis in the pricing and availability of liability insurance, especially among doctors, charities, and municipal governments. The politics of that time, though, seem to have reflected not just a desire for competitive insurance markets. They also reflected a range of parochial interests throughout the financial sector and possibly spurious business community interests that continue to drive tort reform rhetoric even now.³⁵

Under the MFA, antitrust applies to “the business of insurance” only “to the extent that [it] is not regulated by State law.”³⁶ In other words, for particular conduct by insurers to enjoy exemption from antitrust, it must constitute “the business of insurance” within the meaning of the statute, *and* it must be regulated under state law. Conduct is “the business of insurance” to the extent (1) that it “has the effect of transferring or spreading a policyholder’s risk”; (2) that it “is an integral part of the policy relationship between the insurer and the insured”; and (3) that it “is limited to entities within the insurance industry.”³⁷ Because this test is meant to exclude the “business of insurance *companies*,”³⁸ it does not cover their dealings with parties that are outside the insurance contract, and it does not cover the purchasing of goods or the provision of services or products that do not involve the spreading of risk. At its center, the McCarran-Ferguson exemption is meant most importantly to protect “intra-

has been removed from most industries, though vestiges of it remain in various sectors. Insurance remains the industry probably most broadly shielded from competition. See generally ABA EXEMPTIONS MONOGRAPH, *supra* note 30 (recounting the history of deregulatory efforts); Kearney & Merrill, *supra* note 30 (same).

34. See H.R. REP. NO. 111-322, at 6-7 (2009) (recounting prior efforts at MFA repeal).
35. See JONATHAN R. MACEY & GEOFFREY P. MILLER, *COSTLY POLICIES: STATE REGULATION AND ANTITRUST EXEMPTION IN INSURANCE MARKETS* 2-4 (1993) (arguing that the MFA was not especially contentious until after the crisis of the mid-1980s and that major agitators for MFA repeal included banks and other institutions that wanted to sell insurance); Jay Angoff, *Insurance Against Competition: How the McCarran-Ferguson Act Raises Prices and Profits in the Property-Casualty Insurance Industry*, 5 YALE J. ON REG. 397, 398-402, 412-14 (1988) (claiming that the recurrent crises in liability insurance, which have driven the politics of MFA repeal, were distorted by insurance industry lobbying creating a false sense of crisis in tort liability and that cyclical crises in premiums and availability are unrelated to changes in liability claims).
36. 15 U.S.C. § 1012(b) (2006).
37. *Union Lab. Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982).
38. *Id.* at 132 (quoting *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 217 (1979)) (emphasis added).

industry cooperative or concerted activities” intended to help insurers cope with risk.³⁹

Insurer conduct is usually said to be regulated by state law, for purposes of the exemption, merely when there is some regime of state oversight generally relating to the conduct in question. The courts ordinarily do not inquire into the adequacy of that regulation.⁴⁰ The law in this area, however, is fairly confused. Although it often is said that even very general state laws only tangentially touching the challenged conduct may be enough,⁴¹ the cases are hard to harmonize, and courts frequently inquire whether specific state laws alleged to regulate insurer conduct actually could do so. This fact has some relevance to assessing MFA repeal, especially if targeted conduct remains limited to price-fixing. By and large, only property/casualty insurers like MMI firms have ever been formally authorized to fix prices, and price-fixing by health insurers is subject to regulation in many states only through the jurisdiction’s general antitrust statute.⁴²

B. Health Insurance Versus MMI

One peculiarity of the original MFA repeal bills was their joinder of health insurance and MMI in the same bill. It may seem to have made sense in that repeal was part of an overall effort to reduce the cost of health care. It also may have reflected a desire to appease doctors’ groups, given their initial efforts to make tort reform a significant part of the recent health care reform push. Or, it may have reflected merely the 2003 introduction of an MFA repealer for MMI insurers alone, which had followed a perceived MMI crisis in the early 2000s.⁴³ But, in any case, the two industries differ economically in ways that are arguably relevant to antitrust treatment and may be significant. The issue was not explored extensively in the legislative history, such as it is,⁴⁴ and Republicans

39. *Royal Drug*, 440 U.S. at 222.

40. See AM. BAR ASS’N, SECTION OF ANTITRUST LAW, *INSURANCE ANTITRUST* 25-28 (2d ed. 2006) [hereinafter ABA *INSURANCE HANDBOOK*].

41. See, e.g., 1A PHILLIP E. AREEDA & HERBERT HOVENKAMP, *ANTITRUST LAW* ¶ 219C, at 24-29 (2006).

42. Courts are split as to whether a general state antitrust statute is the “regulation of insurance at state law.” See *id.* ¶ 219C & n.86.

43. See, e.g., Medical Liability Insurance Crisis Response Act of 2002, H.R. 5253, 107th Cong. (2002).

44. The Committee report accompanying H.R. 3596 nicely summarizes the MFA’s history and competitive problems in insurance generally. But as to the limitation to health and MMI, it says only that it is “timely . . . as Congress considers other measures to reform the health insurance marketplace.” H.R. REP. NO. 111-322, at 5 (2009).

pointed to it as a criticism of the repeal bills.⁴⁵ The consequences of repeal for these two markets, however, call for some consideration of their differences.

On the most basic level, insurers in the two markets insure different kinds of risk. MMI insurers are in the so-called “property/casualty” business—they indemnify insureds when they incur liabilities to third parties. Health insurers are not. As will be explained,⁴⁶ property/casualty insurers face economic problems that health insurers do not, mainly reflecting the greater uncertainty of future liability risks, as compared with future health care costs.

Next, there are differences in the ways that insurers in these two markets cooperate and differences in the ways the law treats their cooperation. Price-fixing is a very old tradition in insurance, but it has existed in legally sanctioned form mainly among property/casualty insurers.⁴⁷ As late as 1945, price-fixing and extensive information-sharing were prominent only in property/casualty markets. Thereafter, price-fixing was sanctioned legally by the states (and therefore exempt under the MFA) almost exclusively in those lines. By contrast, while health insurers always have collaborated to some extent in sharing information—mainly as to historic loss experience and individual medical histories—they have not often openly fixed their prices. At present, the only state-sanctioned insurer price-fixing is for property/casualty lines of business.⁴⁸

Moreover, even in property/casualty lines, overt price-fixing has lost some of its effectiveness. Like other property/casualty insurers, MMI carriers were at least traditionally heavy users of shared historic loss data and shared prospective loss calculations. At one time—for about the first fifteen years after adoption of the MFA—this collaborative network amounted to an unusually effective price-fixing regime. Though the early solvency concerns that led to the MFA seem to have been sincere, in its heyday legally sanctioned price-fixing caused the price of insurance to increase dramatically.⁴⁹ There is reason to believe that the

45. See *id.* at 11-13 (additional views of Rep. Lamar Smith et al.).

46. See *infra* notes 57-70 and accompanying text.

47. In this country the practice dates at least to the early nineteenth century and has even earlier English antecedents. It was justified by apparently quite sincere concerns about insurer solvency. The fear was that unrestrained price competition would push premiums below the level that would guarantee adequate insurer reserves to cover expected claims. Solvency was a problem particularly among fire insurers, who suffered strings of dramatic and very visible failures during the nineteenth and early twentieth centuries. Accordingly, fire insurers were among those most involved in collaboration and of most concern in early insurance regulation. See generally 1 JON S. HANSON ET AL., NAT'L ASS'N OF INS. COMM'RS, MONITORING COMPETITION: A MEANS OF REGULATING THE PROPERTY AND LIABILITY INSURANCE BUSINESS (1974); ABA EXEMPTIONS MONOGRAPH, *supra* note 30, at 133-60; Tim Wagner, *Insurance Rating Bureaus*, 19 J. INS. REG. 189 (2000).

48. See ABA INSURANCE HANDBOOK, *supra* note 40.

49. See Wagner, *supra* note 47, at 192-93.

effectiveness of the system began to wane around 1960. Insurers continued to share various kinds of information and therefore collaborate, but the traditional bureau system through which they constrained their markets largely dissolved. It has evolved into one in which a few centralized advisory organizations aggregate historic loss data, mostly for property/casualty and workers compensation insurers, and provide some other services.⁵⁰

Thus, the current state of play is that most insurers collaborate at least to the extent of sharing historic loss information, and property/casualty insurers sometimes engage in state-sanctioned price coordination or some actual price-fixing. Theoretically, while health insurers cannot engage in price-fixing or price coordination legally, both kinds of insurers can share a range of information that will vary greatly in the degree of its competitive sensitivity and the likelihood that the collaboration would be illegal were it subject to antitrust regulation. There is one other completely separate context in which insurers collaborate: joint underwriting arrangements, i.e., arrangements in which a pool of insurers jointly insure some risk. Oftentimes, joint underwriting arrangements are required by state regulators to secure coverage of high-risk insureds.

Finally, the health insurance business is also quite a bit more complex than the MMI business. In particular, while some health insurance fits the simple “indemnity” model of traditional lines like property/casualty—that is, it will reimburse the insured when expenses are incurred—many payors of health care costs are engaged in lines of business that are fairly different. This is especially true of the various models of prepaid or managed health care, which are less like the spreading of uncertain risk and more like the provision of a service for a fee. There remains persistent doubt that lines of business such as these constitute “the business of insurance,” and that fact has some significance in predicting the impact of MFA repeal.⁵¹

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50. Traditionally both the fixing of prices and the sharing of information were coordinated by a private entity usually called a rating bureau, a rating organization, or an advisory organization. These entities often were required to be licensed under state law and were subject to some state regulatory oversight, especially when they engaged in actual price-fixing. Traditionally there were many such entities, but, beginning in the 1960s, most of them were merged into one of the few, now national advisory organizations. The most important are two entities that serve property/casualty insurers, the Insurance Services Office and the American Association of Insurance Services, and another that serves workers compensation insurers, the National Council on Compensation Insurance. Each of these entities is organized separately from their insurer clients and sells its services to them. See Wagner, *supra* note 47, at 198-200. Health insurers, too, have made use of either public loss-related information or medical history and loss information shared by insurers through “medical information bureaus,” but they have not engaged generally in open rate-fixing or advisory pricing.
51. Again, MFA repeal during the 111th Congress aims to contribute to overall health care reform. But it will have no effect on those aspects of prepaid, managed, or other health care products provided by insurance companies that do not involve

C. *The Character of Health Insurance Markets*

Although there is some small debate regarding competitiveness in health insurance—in particular over the concentration evidence—no one seems to question seriously that the market circumstances are deplorable. By most accounts, health insurance markets are severely concentrated: Ninety-six percent of all health insurance markets are “highly concentrated,” at levels often far exceeding the thresholds that trigger antitrust concerns. And if any change is likely, it is only that they will become more concentrated. There have been more than 400 mergers among health care insurers in the past 14 years.⁵² Trends in affordability and availability of health insurance also have come to pose serious problems of income disparity.⁵³

As one might guess, given severe concentration and antitrust exemption, there also is evidence of serious collusion. First, there has been significant market allocation, most prominently the decades-old, nationwide system imposed by the Blue Cross and Blue Shield Association (BCBSA) on its member plans. BCBSA has acknowledged the system’s existence and that it includes agreements between BCBSA entities and third-party insurers that they will not compete, as well as that it divides up insurance markets across the country.⁵⁴ Second, as evidenced by frequent litigation, there apparently has been substantial collusion as to price, services, and terms, some of it held to be MFA-immune, but some outside of any likely MFA protection. Finally, profits among

the spreading of risk and therefore do not constitute “the business of insurance.” As to doubts whether prepaid or managed care constitutes “the business of insurance,” see ABA INSURANCE HANDBOOK, *supra* note 40, at 23-24. “

52. See generally AM. MED. ASS’N, COMPETITION IN HEALTH INSURANCE: A COMPREHENSIVE STUDY OF U.S. MARKETS, 2007 UPDATE (2007) (discussing competitive circumstances in health insurance markets); COMMON DREAMS.ORG, STUDY: HEALTH INSURERS ARE NEAR MONOPOLIES (2006), available at <http://www.commondreams.org/headlines06/0418-09.htm> (same); HEALTH CARE FOR AM. NOW, PREMIUMS SOARING IN CONSOLIDATED HEALTH INSURANCE MARKET: LACK OF COMPETITION HURTS RURAL STATES, SMALL BUSINESSES 7-8 (2009) [hereinafter HCAN REPORT], available at http://hcfan.3cdn.net/dadd15782e627e5b75_g9m6isl1.pdf (same).
53. See Byron G. Auguste, Martha Laboissière & Lenny T. Mendonca, *How Health Care Costs Contribute to Income Disparity in the United States*, MCKINSEY Q., March 2009, at 1 (presenting evidence that the poor are drastically more likely to lack insurance and that, when they have it, their coverage is much less desirable and the portion of their income they must pay to secure it is much larger than for the wealthy).
54. The history of this conspiracy is recounted in *Maryland v. Blue Cross & Blue Shield Ass’n*, 620 F. Supp. 907 (D. Md. 1985).

the largest health insurers have increased dramatically—more than 400 percent since 2000—and executive compensation is also very high.⁵⁵

D. Markets for MMI

The discussion in this Section takes a somewhat deeper look at MMI, as health markets are understood better than MMI and because MMI markets pose certain economic problems not felt by health insurers. Still, though, the point ultimately will be that for antitrust purposes the details should not really matter. Those problems that do exist in MMI, and that may be different than those faced by health insurers, would seem poorly addressed through any sort of industry collusion requiring antitrust immunity. In other words, although there is something special about MMI and other property/casualty lines, that unique status is no justification for antitrust immunity.

1. Special Problems in the Market

Nearly all health care providers (including hospitals and other institutions) purchase MMI, as it ordinarily is required by professional ethical rules and hospital privileges requirements.⁵⁶ But the history of this market, especially in the past forty years, has involved substantial volatility and change. As a result of the so-called “insurance cycle” or “underwriting cycle,” which is observed in all property/casualty lines, these markets are prone to extreme variability in both the premiums charged and the insurers’ economic performance.⁵⁷ Interestingly, the insurance cycle in MMI follows closely the overall cycle of all liability insurance, but its peaks and valleys are more extreme.⁵⁸

55. See HCAN REPORT, *supra* note 52, at 7-8.

56. MICHELLE MELLO, ROBERT WOOD JOHNSON FOUND., UNDERSTANDING MEDICAL MALPRACTICE INSURANCE: A PRIMER 1 (2006), available at <http://www.rwjf.org/files/research/no8primer.pdf>.

57. The insurance cycle is the oscillation over time between “soft” and “hard” markets. In soft periods, insurers enjoy comparatively good investment returns and compete vigorously for insureds by lowering premiums. Soft markets are followed by hard markets, in which insurers compensate for worsening conditions (increasing expected losses or decreasing expected investment returns) by raising premiums, tightening underwriting standards, and restricting availability. See Tom Baker, *Medical Malpractice and the Insurance Underwriting Cycle*, 54 DEPAUL L. REV. 393, 394 (2005) (“A ‘hard’ turn in an insurance underwriting cycle comes when insurers collectively respond to the fact that the prevailing premiums cannot support future claims payments, whether because claims costs have been higher than projected or investment income has been lower than projected, or some combination of the two.”).

58. GOV’T ACCOUNTABILITY OFFICE, MEDICAL MALPRACTICE INSURANCE: MULTIPLE FACTORS HAVE CONTRIBUTED TO INCREASED PREMIUM RATES 33 (2003)

Volatility in MMI has led to three significant “crisis” periods in recent decades, during which premiums rose sharply, and the availability of coverage dried up: the mid-1970s, the mid-1980s, and the early 2000s. Each of these periods witnessed dramatic incidences of insurer failure or withdrawal from malpractice lines. Physicians’ mutuals—nonprofit malpractice insurance companies owned by doctors—primarily have taken their place. Mutuals now insure about sixty percent of all physicians in private practice. Likewise, many hospitals and groups of hospitals or doctors now self-insure.⁵⁹ In any case, we are arguably in the midst of one continuing “crisis” right now. Malpractice insurers’ loss costs began rising significantly in the late 1990s, and premiums have increased dramatically since a sharp spike that occurred in 1999 and 2000. There is extraordinary variation, however, across states in the degree of both of these increases; no one is quite sure why.⁶⁰

No one can say yet what causes the insurance cycle or even how much of the variability in premiums and profits it explains. The cycle might arguably have antitrust relevance, because one persistent explanation for its existence is in effect a destructive competition argument. During the “soft-market” period of the cycle, the argument goes, comparatively good circumstances for insurers cause them to compete by *excessive* price-cutting—which they find for whatever reason irresistible—the result being premiums that are too low given expected loss costs.⁶¹ The problem is exacerbated by special traits of MMI risks that render MMI products harder to price even relative to other property/casualty products. MMI risks are uncommonly “long tailed”; resolution of claims requiring actual payout takes on average five years from occurrence and may take as long as ten.⁶² Also, the claims themselves are both uncommonly variable and are the subject of much smaller datasets than is common in most other

[hereinafter GAO, MULTIPLE FACTORS], *available at* <http://www.gao.gov/new.items/do3702.pdf>.

59. *Id.* at 6.

60. *See id.* at 18-21. Ordinary increases in the value of claims would be expected as the cost of medical care itself rises and as the value of lost wages rises. But the increase in loss costs in some states has far outpaced this inflation. Possible, but so far uncorroborated, explanations include increased propensity to sue, an aging population, or decreasing quality of medical care. *See id.* at 24.

61. A persuasive theoretical basis for the proposition that “hard” turns in MMI markets are uncommonly “hard” and therefore tend to call for sudden, unexpected, and large requirements to acquire new capital reserves is set out in Baker, *supra* note 57, at 399-401; and Anne Gron & Andrew Winston, *Risk Overhang and Market Behavior*, 74 J. Bus. 591 (2001). *See also* Scott E. Harrington, Patricia M. Danzon & Andrew J. Epstein, “Crises” in *Medical Malpractice Insurance: Evidence of Excessive Price-Cutting in the Preceding Soft Market*, 32 J. BANKING & FIN. 157 (2008) (explaining the argument and adducing limited evidence).

62. The somewhat nonintuitive consequences of this problem are explained very nicely in Baker, *supra* note 57, at 399-401; and Gron & Winston, *supra* note 61.

property/casualty lines.⁶³ The datasets are so small and unpredictable, in fact, that insurers do not even bother with experience-rated premium adjustments for individual practitioners.⁶⁴ In any case, there is some limited empirical and anecdotal evidence said to be consistent with the destructive competition view.⁶⁵ This imprudent competition at least conceivably might be softened by industry cooperation, which in turn might require antitrust exemption.

Other factors, though, cast doubt on this view. First, it may well be that prospective medical malpractice losses are uncommonly hard for actuaries to estimate. But deliberate pricing likely to produce severe market turns, with the associated likelihood of insolvency, is still difficult to explain without assuming some significant, systematic irrationality throughout MMI markets. Though a large appetite for risk is not in itself irrational, that appetite should be moderated by a more or less random distribution of risk aversion across insurance executives. There is no reason to expect, especially among publicly traded stock-company MMI firms, a distribution different from that of the population at large. Moreover, while predicting the actual timing and severity of hard-market turns is impossible, insurers surely know they are coming; they often have the benefit of decades of experience and a huge empirical and theoretical literature. Accordingly, if one firm is driving prices too low by excessive risk-taking, we should then see exits from the market *before* hard-market turns. Instead, we observe quite the opposite. Thus, most observers acknowledge that the mere facts of long tails and loss cost volatility should not in themselves produce a *cycle*, as opposed to conservative pricing. They also acknowledge that the actual explanation for the cycle remains unknown.⁶⁶

Moreover, there is plenty of reason to believe that rational but not procompetitive behaviors contribute to cycle problems. Some of this phenomenon may be explained by income-smoothing accounting gimmickry.⁶⁷ There also is a straightforward collusive explanation. MMI insurers know that, because of the MFA and laws in many states that allow property/casualty price coordination, they can regroup following a soft-market period of competitive expansion and protect themselves by collusive price increases. Evidence exists to

63. See GAO, *MULTIPLE FACTORS*, *supra* note 58, at 8.

64. See MELLO, *supra* note 56, at 1. “Experience rating,” which is common in automobile, homeowners, and some other insurance lines, is the process by which loss estimates as to a particular insured class are changed on the basis of claims made by that class over time.

65. See GAO, *MULTIPLE FACTORS*, *supra* note 58, at 30-31 (collecting anecdotal views of industry participants); Harrington et al., *supra* note 61 (reporting empirical results arguably consistent with excessive soft-market price cutting but admitting the severe limitations of available data and acknowledging that most premium variation is probably explained by ordinary competitive market factors).

66. See, e.g., MELLO, *supra* note 56, at 11-12. Again, a very careful elaboration of the problem is in Baker, *supra* note 57, at 402-04.

67. See Baker, *supra* note 57, at 402-03 & n.29.

corroborate this pattern, precisely at the beginnings of even recent hard-market turns.⁶⁸

Likewise, a factor that has not yet been incorporated sufficiently in the insurance-cycle literature is that MMI and other property/casualty lines remain among the most heavily rate-regulated insurance lines.⁶⁹ The influence of rate regulation on insurer performance seems supported by the fact that both premiums and insurer profitability are highly variable from state to state.

Finally, a fact arguably at odds with the destructive competition theory is the general agreement that MMI premiums mostly reflect those forces one would expect in functional competitive markets. Variation in premiums is explained mostly by changing predictions of future loss based on loss experience and the discount rate reflecting expected investment income.⁷⁰

2. Competitive Problems

It is generally thought that property/casualty markets are fairly competitive and, in any case, should be more competitive than health care markets have been.⁷¹ But MMI markets still display competitive problems and possibly worse ones than in other property/casualty sectors. First, MMI markets have been prone at various times to significant concentration. This outcome may reflect in part the fact that they suffer more volatile hard-market swings, which are followed by insolvencies and exits, leaving remaining incumbents with larger market share and other competitors that are capacity-constrained by solvency regulation.

Moreover, even though the strength of the traditional price-fixing system has faded,⁷² there is reason to believe that mere information-sharing could dampen competition in MMI markets. Insurer advisory organizations still

68. See Angoff, *supra* note 35, at 406-08.

69. Importantly, insurers must reflect expected investment income in premiums, i.e., they must reduce premiums when returns are expected to be high, but cannot raise premiums to reflect lower than expected returns in the past. See GAO, MULTIPLE FACTORS, *supra* note 58, at 26. Insurers also are capacity-constrained, because regulators set a maximum amount of insurance they can write according to their reserves. So if, as often happens, some insurers exit following a period of declining profits, remaining insurers not only enjoy decreasing competition as a result of exit, they also are artificially protected from supply substitution. See *id.* at 31.

70. Harrington et al., *supra* note 61, at 168. In competitive markets with low transaction costs, insurance premiums should equal the risk-adjusted discounted value of expected loss, plus the costs of sales and underwriting, taxes, and other costs, and, in the case of for-profit stock insurers, a competitive return on capital. See *id.* at 160.

71. See, e.g., Angoff, *supra* note 35.

72. See *supra* notes 47-50 and accompanying text.

aggregate property/casualty loss data and still develop prospective pricing aids, including techniques such as shared “loss development factors” and “trending” formulas. Such tools might be effective price coordination aids, especially during the immediate shock of a hard-market turn and during the less competitive hard-market phase of the insurance cycle. These tools also might well be illegal in the absence of exemption, under cases like *American Column & Lumber Co. v. United States*.⁷³

II. THE PENDING LEGISLATION

As originally introduced in identical versions as House Bill 3596 and Senate Bill 1681, the MFA repealer of 2009 was a very short bill. It would have repealed the MFA for health and MMI insurers but only as to “price fixing, bid rigging, or market allocations.”⁷⁴ The limitation to specified kinds of conduct has a long lineage, dating to bills of the late 1980s and 1990s associated with House Judiciary Committee Chairman Jack Brooks. But, as initially introduced, the current bill’s specified types of conduct would have been narrower than in those earlier bills.⁷⁵ In any case, the 2009 bill included two other brief sections, one of which specified that its purpose was to prevent conduct “to the detriment of competition and consumers,”⁷⁶ the other clarifying that it would have no effect on the immunity of state government insurance regulators.

73. 257 U.S. 377 (1921). In *American Column*, the Court found per se illegal a trade association arrangement under which the association collected detailed historic data from members and then distributed forward-looking price predictions that the Court decided were price-coordination tools. See Angoff, *supra* note 35, at 404-06, for a description of how the sharing of historic loss data and the development of forward-looking pricing formulas could be used to coordinate prices as effectively as the arrangement in *American Column*.

74. H.R. 3596, 111th Cong. § 2 (2009); S. 1681, 111th Cong. § 2 (2009).

75. Brooks, a socially liberal Democrat from Texas, served in Congress for more than forty years before losing his seat during the Republican uprising of 1994. He chaired the House Judiciary Committee from 1989 until his failed reelection bid. An MFA repealer had been introduced in the immediately prior Congress but did not leave the House committee. See Fairness in Insurance Act of 1987, H.R. 2727, 100th Cong. (1987). Brooks introduced substantially identical repeal language in the next three Congresses, and in 1993 this bill finally was reported to the full House and incorporated into the Clinton Administration’s health care reform effort. See Health Security Act, H.R. 3600, 103d Cong. (1994). Each time, the Brooks bill would have repealed the MFA only for specified conduct. The kinds of conduct identified, however, would cover most insurer conduct that could result in antitrust liability: price-fixing, market allocation, tying of insurance to other products, and monopolization. Brooks’s bills also would have repealed the MFA for all insurers. See Insurance Competitive Pricing Act of 1993, H.R. 9, 103d Cong. (1993); Insurance Competitive Pricing Act of 1991, H.R. 9, 102d Cong. (1991); Insurance Competitive Pricing Act of 1989, H.R. 1663, 101st Cong. (1989).

76. H.R. 3596 § 2.

The bill passed out of the House Judiciary Committee only after an amendment offered by a conservative Republican from the Sacramento area, Representative Dan Lungren. Nominally, the Lungren Amendment did no more than harmonize House Bill 3596 with the Brooks bills; it was introduced at the end of a brief markup hearing, where it merely incorporated verbatim protections that had been thought important in those bills,⁷⁷ and it aroused no opposition. Oddly enough, Representative Lungren's addition seemed to have been defended as a tribute to Brooks's memory.⁷⁸ In any case, its sole modification was to add three "safe harbors" for specified insurer conduct: (1) the sharing of historical loss data; (2) determining a "loss development factor" applicable to historical loss data; and (3) performing actuarial services.⁷⁹

The House Judiciary bill was incorporated by Speaker Nancy Pelosi, acting as floor manager, into the House Health Bill. As mentioned, that incorporation was the most significant event to occur in the legislative history, as it included a manager's amendment that modified the coverage of the repealer. Whereas it originally repealed the MFA only with respect to "price fixing, bid rigging, and market allocation," the amended version applied to all of "the business of health insurance, . . . [and] the business of medical malpractice insurance."⁸⁰ In other words, it would repeal the MFA entirely within those markets, subject only to the safe harbors introduced by the Lungren Amendment.⁸¹ Though the details

77. Hearing Transcript, Full Committee Markup of H.R. 3596, at 43:00-47:45 (Oct. 21, 2009) (statement of Rep. Daniel Lungren), *available at* http://judiciary.house.gov/hearings/mark_091021.html (describing the amendment as "exactly the same" as prior legislation and meant merely to avoid "the law of unintended consequences" and harm to small insurance companies).

78. *See Full Committee Markup of H.R. 3596: Hearing Before the H. Comm. on the Judiciary*, 111th Cong. 30-31 (2009) (statement of Rep. Daniel Lungren, Member, House Comm. on the Judiciary).

79. H.R. 3596 § 5.

80. Affordable Health Care for America Act, H.R. 3962, 111th Cong. § 262(b) (2009).

81. As it appears in the House Health Bill, the repealer would add a subparagraph to § 3 of the McCarran-Ferguson Act, 15 U.S.C. § 1013 (2006), providing in full as follows:

(c)(1) Except as provided in paragraph (2), nothing contained in this Act shall modify, impair, or supersede the operation of any of the antitrust laws with respect to price fixing, market allocation, or monopolization

(2) Paragraph (1) shall not apply to—

(A) collecting, compiling, classifying, or disseminating historical loss data;

(B) determining a loss development factor applicable to historical loss data; or

(C) performing actuarial services if doing so does not involve a restraint of trade.

. . .

remain undisclosed, the resulting product appears to have merged the language and structure of H.R. 3596, as it was voted out of the House Judiciary Committee, with language from a comprehensive MFA repeal bill introduced by Representative Peter DeFazio.⁸² The bill, with that manager's amendment, passed the House on November 7, 2009.

The House Health Bill included a few other antitrust improvements. Section 262 added two provisions, one that would clarify new powers of the Federal Trade Commission (FTC) over health and MMI insurers and a second that includes a general antitrust savings clause.⁸³ Rather more important, one separate section of the bill, not included in the original Judiciary bill, would restore some of the FTC's authority to "conduct studies and prepare reports"

(3) For purposes of this subsection—

(A) the term 'antitrust laws' has the meaning given it in subsection (a) of the first section of the Clayton Act, except that such term includes section 5 of the Federal Trade Commission Act to the extent that such section 5 applies to unfair methods of competition;

(B) the term historical loss data means information respecting claims paid, or reserves held for claims reported, by any person engaged in the business of insurance; and

(C) the term loss development factor means an adjustment to be made to the aggregate of losses incurred during a prior period of time that have been paid, or for which claims have been received are being held, in order to estimate the aggregate of the losses incurred during such period that will ultimately be paid.

H.R. 3962 § 262(a).

82. See DeFazio, *supra* note 24.

83. To wit they provide:

(b) Related Provision—For purposes of section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition, section 3(c) of the McCarran-Ferguson Act shall apply with respect to the business of health insurance, and with respect to the business of medical malpractice insurance, without regard to whether such business is carried on for profit, notwithstanding the definition of 'Corporation' contained in section 4 of the Federal Trade Commission Act.

(c) Related Preservation of Antitrust Laws- Except as provided in subsections (a) and (b), nothing in this Act, or in the amendments made by this Act, shall be construed to modify, impair, or supersede the operation of any of the antitrust laws. For purposes of the preceding sentence, the term 'antitrust laws' has the meaning given it in subsection (a) of the first section of the Clayton Act, except that it includes section 5 of the Federal Trade Commission Act to the extent that such section 5 applies to unfair methods of competition.

H.R. 3962 § 262(b)-(c).

concerning “the business of insurance.”⁸⁴ The Commission’s power in this respect had been curtailed through uncommonly surgical amendments by a fairly hostile Congress in 1980.⁸⁵ In effect this provision would give back the FTC’s significant *sua sponte* equitable power to require information reporting in health and MMI markets.⁸⁶ Because these FTC provisions did not appear in the Senate Health Bill, however, and because they would not affect the federal budget substantially, they could not be added to the Senate Health Bill through reconciliation. They are therefore presumably dead.

In any case, the event even more significant than Speaker Pelosi’s manager’s amendment was the introduction of the free-standing H.R. 4626 by Representatives Perriello and Markey. This bill would repeal the MFA entirely, with no exceptions or safe harbors, though it would apply only to health insurers.⁸⁷

Action in the Senate on MFA repeal has been much more restrained. The original Senate companion MFA bill, S. 1681, was the subject of a Judiciary Committee hearing, but it saw no other action until early December 2009, when Senator Leahy proposed it as an amendment to the Senate Health Bill.⁸⁸ The Senate Health Bill was passed without that amendment, however, and so far there has been no Senate consideration of H.R. 4626. Still, one supposes that given the overwhelming House support for H.R. 4626—it passed by a vote of

84. Under the amendment to be made in the House Health Bill, the FTC would have authority to conduct studies:

and prepare reports, and to share information under clauses (f) [authorizing public reporting of information that is “in the public interest”] and (k) [authorizing referral of evidence for criminal prosecution], relating to the business of insurance. Notwithstanding section 4, such authority shall include the authority to conduct studies and prepare reports, and to share information under clauses (f) and (k), relating to the business of insurance, without regard to whether the entity or entities that is the subject of such studies, reports, or information is a for-profit or not-for-profit entity.

H.R. 3962 § 260.

85. See Federal Trade Commission Improvements Act of 1980, Pub. L. No. 96-252, § 5(a), 94 Stat. 374, 375 (drastically limiting such investigations, allowing them only when requested by either the House or Senate Commerce Committees or under a few other circumstances.); 6 EARL W. KINTNER & WILLIAM P. KRATZKE, *FEDERAL ANTITRUST LAW* § 43.44 (1986).

86. Section 6 gives the Commission broad investigatory powers, which can be used either to support an enforcement action against a particular entity or to require periodic industry reporting. See generally *United States v. Morton Salt Co.*, 338 U.S. 632 (1950) (laying out the Court’s view of the Commission’s statutory powers of investigation); KINTNER & KRATZKE, *supra* note 85, §§ 45.23-45.24 (surveying case law and the statutory bounds of Commission’s investigatory powers).

87. See *supra* notes 20-23 and accompanying text.

88. See *supra* note 14 and accompanying text.

406 to 19—and given the general unpopularity of broad antitrust exemptions, the bill's prospects have at least become brighter.

III. ANALYSIS

The main question for the future is whether any repeal provision likely to be adopted will really generate any change. As it turns out, that question is really not one of examining the purportedly peculiar economics of health care, or even the special problems of the insurance cycle. It takes just a close analysis of the actual language likely to be adopted and how it would affect conduct that insurers actually undertake. On the one hand, it seems *extremely* unlikely that exposure to antitrust under the language of any likely MFA repealer would impede useful behavior. Although it is true that all insurers collaborate to some degree—a fact they stress at great length in opposing any MFA repeal—most of their collaboration would not pose even trivial risk of antitrust liability. Sharing of retrospective loss information is by wide consensus procompetitive and unlikely ever to face antitrust challenge. But on the other hand, the limited amount of additional antitrust exposure under many of the proposed repeal bills probably would not do much good. This conclusion is warranted for two reasons. First, because repeal may be limited to some set of specified anticompetitive practices, other anticompetitive problems—some of which appear to be quite serious—will remain exempt from antitrust scrutiny. Second, some of the specified conduct to which repeal *would* apply is in fact not immune under current law.

A. *Undue Antitrust Risks?*

The industry's lobbying response is familiar from many prior legislative struggles, concerning repeal not only of the MFA but also of the various other antitrust exemptions. The major argument appears to be that increased exposure to liability will chill procompetitive arrangements.⁸⁹ Whatever its merits, this argument probably is taken least seriously by most observers, including members of Congress from both parties. Doubts about chilled competition are familiar, and, in the case of insurance, the skepticism dates at least to a careful Justice Department study undertaken in 1977.⁹⁰

In its most plausible form, the argument is that insurers need access to the largest possible pool of historic loss data to make better actuarial predictions and that in property/casualty lines the lack of such information can have disastrous consequences. The argument is given a competitive tone in that access to large pools of data is said to limit what otherwise could be significant entry barriers for small entrants.

89. See sources cited *supra* note 12.

90. FEDERAL-STATE REGULATION, *supra* note 33, at 91-145.

It is true that MFA repeal would expose some conduct that is currently exempt to antitrust scrutiny. As mentioned, health and medical malpractice insurers engage in a fair amount of information-sharing and also underwrite some risk through joint underwriting arrangements.⁹¹ Because underwriting is pervasively state-regulated, all such conduct is currently exempt from antitrust under the MFA. The problem is that information-sharing of this variety is very unlikely to be illegal even without antitrust immunity. The least sensitive and most obviously procompetitive information-sharing involves historic loss data for better actuarial estimation. It is extremely unlikely under *United States v. Container Corp. of America*⁹² or the Supreme Court's other information-sharing case law that any such conduct could be held illegal. The sharing of historic price data is also probably not illegal, especially if it is not very detailed, and especially if it is simply aggregated and then disseminated without client-identifying information by some advisory organization or trade group.⁹³ It also may be permissible, when insurers create arrangements for sharing these kinds of information, to establish reasonable membership rules that would exclude some competitors from accessing their information.⁹⁴

The sharing of prospective price information would of course pose more legal risk. This would be true of agreements to aggregate "prospective loss cost" predictions, wherever those predictions could be used by insurers to calculate each other's future prices in facilitation of a price-fixing conspiracy. But it hardly would be an adverse result to scrutinize such conduct more closely.

Moreover, no matter how procompetitive information-sharing might be, there is no plausible narrative by which any insurer collaboration could be defended as necessary to solve insurance-cycle problems. That is, to the extent it were argued that MMI insurers need antitrust exemption to deal with the insurance cycle, the argument is weak at best. Even if there is some dysfunction in these markets—as would be suggested by destructive competition theories of the insurance cycle or by theories of information failure—it is unlikely that any sort of industry collaboration is the solution. The MFA and state regulations have given MMI insurers sixty years during which to collaborate, including in

91. See *supra* note 50 and accompanying text.

92. 393 U.S. 333 (1969). *Container Corp.* held that where the characteristics of some particular market would tend to favor oligopoly interdependence, an agreement to exchange information that could facilitate oligopoly pricing might be illegal under the rule of reason. *Id.* at 334-35.

93. Compare *American Column & Lumber Co. v. United States*, 257 U.S. 377 (1921) (enjoining a trade association's "open price plan," under which the association collected extensive price information and disseminated detailed, prospective reports to its members *predicting* future prices), with *Maple Flooring Mfrs. Ass'n v. United States*, 268 U.S. 563 (1925) (reversing an injunction against a trade association that merely collected historic price data and disseminated to members aggregated, nonspecific, and retrospective reports of price trends).

94. See *Nw. Wholesale Stationers, Inc. v. Pac. Stationery & Printing Co.*, 472 U.S. 284 (1985).

some states through freedom for outright horizontal price-fixing. Their experience nevertheless has been very poor.

B. The Limitations to Specific Conduct: Price-Fixing, Bid Rigging, or Market Allocation

Again, the MFA repeal adopted by the House, following a significant manager's amendment, is total—it would repeal all immunity as to the “business of health insurance [and] the business of medical malpractice insurance.”⁹⁵ The same consequence would follow from the Perriello-Markey bill (H.R. 4626), though it would apply only to health insurers. Yet there remains some serious possibility that language of this breadth will not survive even if some repeal bill becomes law because of the Senate's apparently more limited interest in repeal. No repealer was included in the final Senate Health Bill, despite significant efforts to include one, and no Senate consideration has been given to the Perriello-Markey bill.

If repeal is limited to “price fixing, bid rigging, or market allocation,” it would not change antitrust exposure much, especially in health markets. Health insurers are not now—and for the most part never have been—legally sanctioned to fix their prices. Therefore, they are already subject to some federal antitrust for price-fixing. In fact, there are even now pending several price-fixing suits against WellPoint, Inc. and other major health insurers.⁹⁶ For this reason—that MFA repeal only regarding price-fixing would not outlaw any conduct that is not already illegal—the Congressional Budget Office cost estimate accompanying H.R. 3596 suggested that the bill likely would have little effect on premiums or insurers' costs.⁹⁷

Second, the chief problem in health insurance now is not obviously conspiracy, but rather may be monopoly and interdependent oligopoly behavior. Although the evidence is in some dispute, there is no serious doubt that health insurance markets are concentrated and growing more so. Powerful incumbents in such markets might take unilateral action to exclude new competitors, but under McCarran-Ferguson such actions will at least

95. Affordable Health Care for America Act, H.R. 3962, 111th Cong. § 262(b) (2009).

96. These disputes are known as the so-called “Ingenix” litigation. The defendant health insurers are accused of using of a database maintained by one of them to set their permissible reimbursement levels for services received from “out-of-network” doctors. The plaintiffs allege that the defendants agreed simply to falsify data in the Ingenix database to keep those reimbursements artificially low. These cases have been consolidated by the Judicial Panel on Multidistrict Litigation in the U.S. District Court for the Central District of California. The plaintiffs are the American Medical Association, regional medical associations, and individual physicians. *See In re WellPoint, Inc., Out-of-Network “UCR” Rates Litigation*, 652 F. Supp. 2d 1375 (J.P.M.L. 2009).

97. H.R. REP. NO. 111-322, at 10 (2009).

sometimes be immune from Sherman Act § 2 challenge.⁹⁸ The conduct-specific repeal bills would not correct that problem. Specifically, incumbent insurers might take “exclusionary” steps akin to the maligned most-favored-nation clauses in provider contracts or exclusive agreements with agents and providers. There is limited case law on whether such conduct is the “business of insurance,” but at least some of it surely is.⁹⁹ Accordingly, under several of the bills that have been proposed, many or all of these practices would remain immunized even after repeal.

Finally, there might be some information-sharing arrangements among insurers that are in fact anticompetitive¹⁰⁰ and that might violate antitrust were there no immunity. It would seem beneficial if antitrust law were available to curb that conduct. But if an MFA repealer is made applicable only to price-fixing or the other enumerated practices that have appeared in various bills, such anticompetitive conduct might still be immune under the remaining MFA immunity. A court would have to decide whether in any particular case insurers sharing too much information were truly engaged in (1) some sort of conspiracy that actually fits within one of the specified kinds of sanctioned conduct; or (2) a mere agreement to share excessive amounts of sensitive information. If only the latter, it might still have been illegal under *Container Corp.* and the Court’s other information-sharing cases but probably would be immune under the MFA and any MFA repealer. In other words, there may be some anticompetitive information-sharing among insurers that is exempt now *and would remain exempt* under some versions of MFA repeal.

C. The Safe Harbors

One separate problem has persisted throughout the debate; there have been repeated efforts to include in any MFA repealer some set of safe harbors for specified types of information-sharing. For example, under the broad repeal provision included by manager’s amendment in the House Health Bill, antitrust

98. 15 U.S.C. § 2 (2006).

99. Strictly speaking, in order for insurer conduct to be exempt under McCarran-Ferguson, it must not only be “the business of insurance” but also must not constitute “boycott, coercion, or intimidation.” *Id.* § 1013(a)-(b). Some exclusionary conduct by insurers might constitute “boycott, coercion, or intimidation,” and indeed that phrase is sometimes (incorrectly) said to have been interpreted broadly. But it appears that this exception to the MFA exemption applies only to *concerted* conduct among two or more insurers. Moreover, the conduct must involve collective refusal to deal with some third party on a transaction that is *separate* from “the terms of the primary insurance [transaction].” *Hartford Fire Ins. Co. v. California*, 509 U.S. 764, 806-07 (1993). See generally ABA INSURANCE HANDBOOK, *supra* note 40, at 28-31.

100. For example, insurers might not only aggregate historic loss data, they might also exchange forward-looking price-sensitive information or pricing formulas that could allow price coordination.

law would have applied to the entire “business of health insurance [and] the business of medical malpractice insurance,” but it would *not* apply to: (1) aggregation of historical loss data; (2) sharing of a loss development factor (LDF); or (3) performing actuarial services. Safe harbors might seem to make sense, given the consensus that some insurer information-sharing is procompetitive. Indeed, the American Bar Association (ABA) historically has advocated replacing the MFA with a series of safe harbors rather than full MFA repeal, and the House of Delegates long ago adopted a recommended list of them.¹⁰¹ The safe harbors in the House Health Bill, however, were quite different than the ABA version, which is couched in cautionary language. Notably absent from the House provision is the following principle from the ABA document:

Insurers should be authorized to cooperate in the collection and dissemination of past loss experience data so long as those activities do not unreasonably restrain competition *but should not be authorized to cooperate in the construction of advisory rates or the projection of loss experience into the future in such a manner as to interfere with competitive pricing.*¹⁰²

Accordingly, the LDF provision seems troubling. LDF is defined in the House Health Bill as:

an adjustment to be made to the aggregate of losses incurred during a prior period of time that have been paid, or for which claims have been received and reserves are being held, in order to estimate the aggregate of the losses incurred during such period that will ultimately be paid.¹⁰³

Again, though insurer advisory organizations have become much less restrictive than in the days of the “bureau” system,¹⁰⁴ it seems conceivable that aggregation of historic data and the sharing of a properly designed LDF could be used to coordinate future prices.¹⁰⁵ Such a scheme might be illegal if it were not for the remaining MFA immunity left under the House Health Bill.

101. See *The Health Insurance Industry Antitrust Enforcement Act of 2009, Hearing on H.R. 3596 Before the H. Subcomm. on Courts and Competition Policy of the H. Comm. on the Judiciary* 8 (2009) (statement of Ilene Knable Gotts, Chair, ABA Section of Antitrust Law) (quoting American Bar Association House of Delegates Resolution (Feb. 1989)), available at <http://judiciary.house.gov/hearings/pdf/Gotts091008.pdf>.

102. *Id.* (emphasis added).

103. Affordable Health Care for America Act, H.R. 3962, 111th Cong. § 262(a) (2009).

104. See *supra* notes 47-50.

105. Angoff, *supra* note 35, at 405-06, explains very nicely just how this could be accomplished.

CONCLUSION

Health insurance reform without some major effort to constrain monopoly and collusion seems likely to fail. A broad repeal provision like the one in the House Health Bill or the Perriello-Markey bill could go some way toward preventing that failure. Repeal of the McCarran-Ferguson Act could lead to at least three predictable changes. First, any current, outright price-fixing should end (except those practices that become covert). Second, both health and medical malpractice insurers would be more cautious about how they handle themselves when sharing information. Their legitimate information exchanges almost certainly would still be legal. They would, however, be aware that their behavior in collaborative joint underwriting deals and their exchanges of purportedly legitimate underwriting data might be scrutinized more closely for antitrust violations. Insurers might therefore be more careful not to engage in information dissemination that could violate the rule of reason under *Container Corp.* Finally, both kinds of insurers would be more concerned about their own unilateral conduct that could be found “exclusionary.” The reason is that some exclusionary conduct is probably immune under the MFA as it currently exists; that conduct probably constitutes “the business of insurance” and is regulated by some states. Therefore, a partial, conduct-specific repeal provision might leave this sort of conduct still immune.

Although only time will tell, in the event that any repeal language is adopted, it still might be rewritten to apply only to specified sorts of conduct. If language is chosen like that in the original repeal bills of September 2009, then repeal may fail altogether. It would not much affect the behavior of health insurers, and, though it could constrain extant legally sanctioned MMI price-fixing, the most likely bill to pass (the Perriello-Markey bill) would not apply to them either. Even then, it probably would have little effect on the prices of their products.

In one final sense, the most important lesson from this complicated political drama relates to the general business of MFA repeal. Like the other classic antitrust exemptions, the MFA seems fated eventually to disappear entirely. If history is any guide, it will fade gradually, and the industry will kick and scream through the entire process. But at least two points are clear in light of the health and MMI repeal effort. First, there are important differences among different kinds of insurers, and some consideration must be given to whether those differences justify differential antitrust treatment. Insurers will argue that they do, and, at a minimum, ferreting out the consequences will be complex. The analysis in this Essay suggests that although those differences exist, they call for no special treatment. Second, if repeal is phrased with qualifications, provisos, and other statutory nooks and crannies—an approach that often seems designed only for political palatability—the consequences are complicated and very difficult to predict. Ordinarily, such semantic tinkering would dampen the beneficial effects of repeal. The much better course is simply a wholesale repeal of the MFA, and that result is warmly supported by just about everyone except for the insurers themselves.