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Scope of the Business of Insurance Provision of the McCarran-Ferguson Act: Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia

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Case Comments

The Scope of the "Business of Insurance" Provision of the McCarran-Ferguson Act: *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*

From 1972 to 1978, Blue Shield of Virginia (the Richmond Plan) and Blue Shield of Southwestern Virginia (the Roanoke Plan) reimbursed policyholders for services rendered by clinical psychologists only if the services were billed through a physician.[1] Although the Richmond and Roanoke Plans claimed that this procedure was necessary to determine whether a psychologist's treatment was medically justified,[2] neither plan required that psychiatrists bill their services through another physician.[3] The Virginia Academy of Clinical Psychologists—the professional organization of clinical psychologists licensed in Virginia—filed suit against the Richmond Plan, the Roanoke Plan, and the Neuropsychiatric Society of

1. Virginia Academy of Clinical Psychologists v. Blue Shield of Va., 624 F.2d 476, 478 (4th Cir. 1980), *cert. denied*, 101 S. Ct. 1360 (1981). The Roanoke Plan had followed this procedure since its inception in 1945, but the Richmond Plan had covered direct payments to psychologists for out-patient psychotherapy between 1962 and 1972. Following a sharp increase in claims for nervous and mental disorders in the late 1960s, the Richmond Plan revised its coverage after consultations with health care provider groups, including the American Psychological Association and the Neuropsychiatric Society of Virginia (NSV). The Richmond Plan adopted the billing policy recommended by the NSV. *See* Virginia Academy of Clinical Psychologists v. Blue Shield of Va., 469 F. Supp. 552, 556-59 (E.D. Va. 1979).

2. Virginia Academy of Clinical Psychologists v. Blue Shield of Va., 469 F. Supp. 552, 561 (E.D. Va. 1979). The standard Blue Shield subscriber contract states that only "medically necessary" services are covered. Blue Cross of Va. v. Commonwealth, 269 S.E.2d 827, 829 (Va. 1980); Group Major Medical Services Certificate-A, form H.MS-14-MM-A-74 (25) (R 6/74), at 1 (on file with the *Minnesota Law Review*). Under the terms of such a contract, services are medically necessary if they are "consistent with the treatment and diagnosis of the patient's condition," follow "standards of good medical practice," are "performed in the least costly setting required by the patient's medical condition," and are not rendered "for the convenience of the patient or the physician." 269 S.E.2d at 829. From Blue Shield's perspective, this billing review policy reduced the chance of unnecessary treatment and expense. Blue Shield applied the same "medically necessary" policy to the services of optometrists and opticians, requiring both to bill their services through a physician. *See id.*

3. Psychiatrists are physicians; psychologists are not. Both, however, may practice psychotherapy under Virginia law. VA. CODE § 54-273 (1978).

Virginia (NSV), claiming that the billing practice violated section 1 of the Sherman Act.[4] The Academy argued that the practice was either a boycott in violation of the Sherman Act[5] and hence not shielded from antitrust scrutiny by the McCarran-Ferguson Act,[6] or a conspiracy in restraint of trade in violation of the Sherman Act and not shielded from antitrust scrutiny by the McCarran-Ferguson Act "business of insurance" provision.[7] The federal district court held that the practice was within the "business of insurance" provision of the McCarran-Ferguson Act and that the practice was neither a boycott nor a conspiracy in restraint of trade.[8] The Court of Appeals for the Fourth Circuit reversed in part,[9] *holding* that the practice of physician review of a psychologist's bills was not the "business of insurance" within the meaning of the McCarran-Ferguson Act, and

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4. 15 U.S.C. § 1 (1976). The Sherman Act makes unlawful "[e]very contract, combination . . ., or conspiracy, in restraint of trade or commerce among the several states." *Id.* Plaintiffs sought injunctive relief pursuant to 15 U.S.C. § 26 (1976). Virginia Academy of Clinical Psychologists v. Blue Shield of Va., 469 F. Supp. 552, 555 (E.D. Va. 1979). In a prior suit, the Richmond and Roanoke Plans had challenged the constitutionality of a "freedom of choice" statute, VA. CODE § 32-195 (1978) (repealed 1979), which had required Blue Shield plans to pay for a psychologist's services directly. In this prior suit, the Plans had been nonsuited. *See* Virginia Academy of Clinical Psychologists v. Blue Shield of Va., 469 F. Supp. 552, 557 (E.D. Va. 1979).

5. A boycott in which "traders at one level . . . seek to protect themselves from competition from non-group members who are competing or seeking to compete at that level . . . by taking concerted action aimed at depriving the excluded [members] of some trade relationship which they would need to compete effectively at that level, L. SULLIVAN, HANDBOOK OF THE LAW OF ANTITRUST, § 83, at 229 (1977), is a per se violation of section 1 of the Sherman Act. *See, e.g.*, United States v. General Motors Corp., 384 U.S. 127, 145-46 (1966); Klor's, Inc. v. Broadway-Hale Stores, Inc., 359 U.S. 207, 212 (1959). *See generally* D. KINTNER, FEDERAL ANTITRUST LAW §§ 10.29-.30 (1980).

6. 15 U.S.C. §§ 1011-1015 (1976) (originally enacted as Act of Mar. 9, 1945, ch. 20, 59 Stat. 33, *amended by* Act of July 25, 1947, ch. 326, 61 Stat. 448, Act of Aug. 1, 1956, ch. 852 § 4, 70 Stat. 908). The relevant portions of the McCarran-Ferguson Act are as follows:

> [T]he Sherman Act, . . . the Clayton Act, . . . [and] the Federal Trade Commission Act . . . shall be applicable to the business of insurance to the extent that such business is not regulated by State Law. . . . Nothing contained in this chapter shall render said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

Id. §§ 1012-1013. For a discussion of the McCarran-Ferguson Act, see notes 13-27 *infra* and accompanying text.

7. Virginia Academy of Clinical Psychologists v. Blue Shield of Va., 469 F. Supp. 552, 562 (E.D. Va. 1979).

8. *Id.* at 563.

9. The circuit court affirmed the district court's judgment that there was no conspiracy between the two Blue Shield plans and the NSV. Virginia Academy of Clinical Psychologists v. Blue Shield of Va., 624 F.2d 476, 479-92 (4th Cir. 1980), *cert. denied*, 101 S. Ct. 1360 (1981).

that the practice was thus not exempt under the Act.[10] Moreover, while the Court of Appeals refused to hold that the practice was a boycott,[11] it did hold that the practice was an unreasonable restraint of trade in violation of section 1 of the Sherman Act.[12] *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 101 S. Ct. 1360 (1981).

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10. 624 F.2d at 483-84.

11. The circuit court said that, although the challenged practice resembled a boycott, the "special considerations involved in the delivery of health services" prevented the court from applying a per se rule of illegality. *Id.* at 484. By refusing to apply a per se rule of illegality, the court implicitly stated that the practice was not a boycott; under the Sherman Act boycotts are treated as per se illegal. *See, e.g.*, Radiant Burners, Inc. v. Peoples Gas Light & Coke Co., 364 U.S. 656 (1961); Klor's, Inc. v. Broadway-Hale Stores, Inc., 359 U.S. 207, 212 (1959).

12. Virginia Academy of Clinical Psychologists v. Blue Shield of Va., 624 F.2d 476, 484-86 (4th Cir. 1980), *cert. denied*, 101 S. Ct. 1360 (1981). After finding a violation of section 1 of the Sherman Act, the circuit court remanded the case to the district court for appropriate relief. 624 F.2d at 486. On remand, the district court ordered the Richmond Plan and Roanoke Plan to give notice that the physician billing practice violated the antitrust laws and to accept, process, and pay all legitimate claims for services rendered by clinical psychologists after January 1, 1972, and covered under a Blue Shield contract. Virginia Academy of Clinical Psychologists v. Blue Shield of Va., No. 78-0496-A (E.D. Va. Dec. 2, 1980).

The Fourth Circuit Court of Appeals disposed of defendants' arguments that their activities were exempt from antitrust scrutiny on the basis of the *Noerr-Pennington* doctrine. Defendants had argued that because they had collaborated in a joint legal action designed to challenge the Virginia "freedom of choice" statute, *see* note 4 *supra*, their collaboration in implementing the billing review procedure was exempt from antitrust scrutiny. 624 F.2d at 481. Implicitly based on the first amendment guarantee to petition the government, the *Noerr-Pennington* doctrine exempts certain types of anticompetitive activities from the strictures of the antitrust laws. Unless a petition is a mere sham, a defendant's deliberate efforts to influence the government to take anticompetitive action cannot be the basis of antitrust liability. *See* UMW v. Pennington, 381 U.S. 657, 669-70 (1965) (lobbying effort designed to induce Secretary of Labor to set minimum wage so high that only larger government contractors could afford to sell coal to the TVA protected by the *Noerr* precedent); Eastern R.R. President's Conference v. Noerr Motor Freight, Inc., 365 U.S. 127, 138 (1961) (misleading advertising campaign designed to influence legislation placing trucking industry at a competitive disadvantage protected by the first amendment). Courts have extended this exemption to protect administrative and judicial litigation. *See* California Motor Transp. Co. v. Trucking Unlimited, 404 U.S. 508, 510-15 (1972) (extending exemption, but also holding that right-to-petition-government exemption does not extend to multiple harrassment suits against competitors).

Because the Richmond and the Roanoke Plans had abandoned the declaratory judgment suit that they had instituted to challenge the statute, *see* note 4 *supra*, the *Virginia Academy* court found *Noerr-Pennington* inapplicable, concluding that the two plans were not exercising first amendment rights. 624 F.2d at 482. Moreover, the court found that the two plans' collaboration over their billing practices "amounted to no more than an agreement to persist in economically restrictive commercial activity in the face of a State law designed to

Congress enacted the McCarran-Ferguson Act in response to the Supreme Court's landmark decision in *United States v. South-Eastern Underwriters Association*,[13] in which the Court held that the business of insurance constituted interstate commerce and as such was subject to federal antitrust laws.[14] Unwilling to deny states the opportunity to regulate the insurance industry,[15] and persuaded that an insurance company's reliable underwriting[16] of risks required cooperation among insurance companies,[17] Congress moved to limit the potential impact of *South-Eastern Underwriters* by providing the insurance indus-

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open up the health care market," and that the collaboration would seriously hamper states' efforts to encourage competition. *Id.*

The circuit court also found that the defendants' collaboration was not exempt from antitrust scrutiny under the doctrine of Parker v. Brown, 317 U.S. 341 (1943), which exempts anticompetitive activity from the antitrust laws if such activity is necessary in order to comply with state regulation. 624 F.2d at 482 n.10. In *Virginia Academy*, the state's regulation forced cooperation between the Richmond and Roanoke Plans in the administration of national accounts, by prohibiting the plans' operations outside of assigned territories. The court noted that, although state regulation of these "national accounts" might have necessitated cooperation, the regulation did not require the plans to administer the specific billing practice in question. *Id.*

13. 322 U.S. 533 (1944).

14. *Id.* at 553-62. Prior to *South-Eastern Underwriters*, the Court had consistently interpreted the leading case of Paul v. Virginia, 75 U.S. (8 Wall) 168, 183 (1868) ("[i]ssuing a policy of insurance is not a transaction of commerce"), to mean that the federal government had no jurisdiction over the insurance industry under the commerce clause. *See, e.g.*, New York Life Ins. Co. v. Deer Lodge County, 231 U.S. 495, 510-12 (1913); New York Life Ins. Co. v. Cravens, 178 U.S. 389, 401 (1900). In the absence of federal authority to regulate the insurance business, every state regulated the insurance business through a state insurance department. *See generally* J. DAY, ECONOMIC REGULATION OF INSURANCE IN THE UNITED STATES 1-23 (1970).

15. Two factors influenced Congress to restrict the potential impact of the *South-Eastern Underwriters* decision: concern that state regulation and taxation of the insurance industry would be found unconstitutional under the commerce clause, *see* E. SAWYER, INSURANCE AS INTERSTATE COMMERCE 46-51 (1945); and fear of a federal takeover of the insurance industry under the activist Roosevelt administration, *see* 1947 NAIC PROCEEDING 69, 74-75 (address of Sen. Ferguson, Dec. 11, 1946).

16. The term "underwriting" originated with the practice at the London coffeehouse of Lloyd's where, from "earliest times," applicants passed proposed policies among the merchants who subscribed or "underwrote" their name for such portion as they wished to assume. 1 G. RICHARDS, THE LAW OF INSURANCE § 11 n.4 (W. Freedman 5th ed. 1971). According to Black, to "underwrite" means to "insure life or property." BLACK'S LAW DICTIONARY 1697 (4th rev. ed. 1968). Modern textbook writers use "underwriter" as a generic term for the insurer, *see, e.g.*, 1 G. RICHARDS, *supra*, § 1, or the process of insuring, *see, e.g.*, R. KEETON, INSURANCE LAW § 1.3(a) (1971).

17. Congress viewed the *South-Eastern Underwriters* decision as potentially prohibiting cooperation among insurance companies in the joint ratemaking and statistical gathering ventures necessarily incident to the accurate underwriting of risks. *See* 91 CONG. REC. 1481 (1945).

try with a qualified exemption from the antitrust laws[18] under the McCarran-Ferguson Act.[19] The Act renders the antitrust laws[20] inapplicable to certain insurance practices that constitute the business of insurance, are regulated by state law, and do not involve intimidation, coercion, or boycott.[21] Of the three requirements, the "business of insurance" requirement has proved the most troublesome to define.[22]

The lower courts initially interpreted the McCarran-Ferguson exemption broadly by applying the "business of insurance" provision expansively.[23] For example, the court in *Dexter v. Eq-*

18. Just seventeen days after the *South-Eastern Underwriters* decision, the House passed the Walter-Hannock Bill, which completely exempted the insurance industry from the antitrust laws. *See* 90 CONG. REC. 6565 (1944). Congress eventually rejected the complete exemption approach, however, and adopted a compromise bill proposed by the National Association of Insurance Commissioners, which exempted from the antitrust laws those "business of insurance" practices that were state regulated and did not constitute intimidation, coercion, or boycott. *See* 15 U.S.C. §§ 1012-1013 (1976). For a discussion of the legislative history of the McCarran-Ferguson Act, see Weller, *The McCarran-Ferguson Act's Antitrust Exemption for Insurance: Language, History and Policy*, 1978 DUKE L.J. 587, 588-608.

19. 15 U.S.C. §§ 1011-1015 (1976).

20. The McCarran-Ferguson Act exemption applies to violations of the Sherman Act, 15 U.S.C. § 1 (1976), the Clayton Act, 15 U.S.C. §§ 12-27 (1976), and the Federal Trade Commission Act, 15 U.S.C. §§ 41-51 (1976). *See* 15 U.S.C. § 1012 (1976).

21. 15 U.S.C. §§ 1012-1013 (1976). For the text of the material portions of the statute, see note 6 *supra*. This Comment deals principally with the "business of insurance" provision of the Act. For brief discussions of the boycott and state regulation provisions, see notes 26-27 *infra* and accompanying text.

22. *See* text accompanying notes 23-63 *infra*. One commentator has noted that most of the McCarran-Ferguson exemption cases concern the "business of insurance" provision. *See* Borsody, *The Antitrust Laws and the Health Industry*, 12 AKRON L. REV. 417, 441 (1979).

23. The courts appeared to regard the business of insurance as any activity in which an insurance company might engage. *See, e.g.*, Addrisi v. Equitable Life Assurance Soc'y, 503 F.2d 725, 726-7 (9th Cir. 1974) (insurer's loan to homeowner conditioned on prospective borrower's purchase of life insurance policy to secure loan found within business of insurance); California League of Independent Ins. Producers v. Aetna Cas. & Sur. Co., 175 F. Supp. 857, 859-60 (N.D. Cal. 1959) (fixing of insurance agent's commissions found within business of insurance). Although the *California League* court found that the fixing of agent's commissions was within the business of insurance, the court implicitly suggested an "effects-on-rates" test that narrowed the "business of insurance" exemption to only those activities "of an insurer that significantly or substantially affect the rate charged policyholders." Nedrow, *The McCarran Controversy: Insurance and the Antitrust Law*, 12 CONN. L.R. 205, 210-11 (1980); *see* California League of Independent Ins. Producers v. Aetna Cas. & Sur. Co., 175 F. Supp. 857, 867 (N.D. Cal. 1959). For example, the settlement of claims was found to be within the business of insurance under the "effects-on-rates" test because such activity had a substantial effect on rate-making. *See* Manasen v. California Dental Servs., 424 F. Supp. 657, 666 (N.D. Cal. 1976). The rationale underlying the "effects-on-rates" test is that any activity having an effect on rates affects the reliable status of insurance companies, *see id.* at 667, the maintenance of

uitable Life Assurance Society[24] held that the business of insurance encompassed an insurer's practice of conditioning loans to homeowners on the homeowners' purchase of life insurance policies as security.[25] Moreover, the lower courts construed both the boycott[26] and state regulation[27] provisions of

such status being an important justification for the McCarran-Ferguson exemption, *see* note 17 *supra* and accompanying text. For representative cases using the "effects-on-rates" test, see, *e.g.,* Doctor's, Inc. v. Blue Cross of Greater Phil., 431 F. Supp. 5, 10 (E.D. Pa. 1975), (Blue Cross' continuing renewal of hospital agreements conditioned on elimination of wasteful practices and services found within business of insurance); *aff'd*, 535 F.2d 1245 (3d Cir. 1976) Traveler's Ins. Co. v. Blue Cross of W. Pa., 481 F.2d 80, 83 (3d Cir.) (test used to find service-provider contracts in issue within business of insurance), *cert. denied*, 414 U.S. 1093 (1973). *But see* Fry v. John Hancock Mut. Life Ins. Co., 355 F. Supp. 1151, 1154 (N.D. Tex. 1973) (insurer's farm loans to prospective borrower conditioned on purchase of irrigation system and/or life insurance found outside the business of insurance). One can argue, however, that the Supreme Court rejected the "effects-on-rates" test in Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979). *See* note 38 *infra* and accompanying text.

24. 527 F.2d 233 (2d Cir. 1975).

25. *Id.* at 235.

26. Under the McCarran-Ferguson Act, activities that constitute a boycott, intimidation, or coercion are subject to the antitrust laws. Because "boycotts" are defined restrictively, however, the Act's coverage is relatively expansive. *See* Comment, Barry v. St. Paul Fire & Marine Ins. Co.: *A Re-Interpretation of the Boycott Exception to the McCarran Act*, 1977 DUKE L.J. 1069, 1069-73. *See, e.g.*, Addrisi v. Equitable Life Assurance Soc'y, 503 F.2d 725, 728-29 (9th Cir. 1974), *cert. denied*, 420 U.S. 929 (1975); Meicler v. Aetna Cas. & Sur. Co., 372 F. Supp. 509, 513-14 (S.D. Tex. 1974), *aff'd*, 506 F.2d 732 (5th Cir. 1975); Transnational Ins. Co. v. Rosenlund, 261 F. Supp. 12, 26 (D. Ore. 1966). The Supreme Court, however, has recently expanded the scope of the boycott exception and thus has narrowed the exemption from the antitrust laws. *See* St. Paul Fire & Marine Ins. Co. v. Barry, 438 U.S. 531, 552-54 (1978) (the term "boycott" is not limited to concerted action against competitors of members of the boycotting group, but includes concerted action against policyholders).

27. The McCarran-Ferguson Act exempts activities from the antitrust laws only if the activities are state regulated. This provision of the Act has been construed so that mere regulatory legislation that deals with insurance company practices, but does not actively regulate a specific practice, is sufficient to satisfy McCarran-Ferguson requirements. *See, e.g.*, FTC v. National Cas. Co., 357 U.S. 560, 564-65 (1958) (state regulation existed even though state insurance statutes prohibiting unfair and deceptive practices were "inchoate" and had not "crystallized into 'administrative elaboration'" of standards of conduct nor been applied in individual cases); Ohio AFL-CIO v. Insurance Rating Bd., 451 F.2d 1178, 1181-83 (6th Cir. 1971), *cert. denied*, 409 U.S. 917 (1972); Schwartz v. Commonwealth Land Title Ins. Co., 374 F. Supp. 564, 575-77 (E.D. Pa.), *enforced*, 384 F. Supp. 302 (E.D. Pa. 1974). Although the courts have allowed almost any state involvement to satisfy the state regulation requirement, commentators have generally favored a test that would require more active state involvement and therefore more accurately reflect the policy considerations underlying the McCarran-Ferguson Act. *See, e.g.*, Comment, *State Regulation Under the McCarran Act*, 47 TUL. L. REV. 1069 (1973); Note, *State Supervision Over Insurance Rate-Making Combinations Under the McCarran Act*, 60 YALE L.J. 160 (1951).

The state regulation requirement of the McCarran-Ferguson Act was not at issue in *Virginia Academy*. It is unclear, however, why the Academy did not

the McCarran-Ferguson Act so as to afford insurance practices substantial protection from the antitrust laws.

The first two major Supreme Court decisions delineating the scope of the "business of insurance" provision were *SEC v. Variable Annuity Life Insurance Co.*[28] and *SEC v. National Securities, Inc.*[29] In *Variable Annuity*, the Court held that an insurer's assumption of investment risk inheres in the concept of insurance.[30] In further defining the scope of the "business of insurance" provision, the Court in *National Securities* held that "[t]he relationship between insurer and insured, the type of policy which could be issued, [and the policy's] reliability, interpretation, and enforcement" were "the core of the 'business of insurance.' "[31] The Court also acknowledged that other activities of insurance companies so strongly related to the companies' status as reliable insurers that those activities would fall within the scope of the "business of insurance" provision.[32]

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raise the state regulation issue. Apparently, the Blue Shield plans' challenge to the "freedom of choice" statute, which prohibited their physician-supervised billing practice, was still active in the Virginia courts when the *Virginia Academy* appeal was argued, thus rendering consideration of the state regulation issue inappropriate.

28. 359 U.S. 65 (1959).

29. 393 U.S. 453 (1969).

30. 359 U.S. at 71-73. A variable annuity contact entitles the purchaser not to a specified income per annum, but to a fluctuating income based on a pro rata participation in investment portfolios. Because the issuer of such an annuity assumes no investment risk, the Court found that the contract was not the business of insurance under the McCarran-Ferguson Act. *Id.*

31. 393 U.S. 453, 460 (1969). The plaintiff charged violations of section 10(b) of the Securities Exchange Act of 1934 and of Rule 10b-5 because the defendant insurance company's proxy materials made allegedly fraudulent representations to stockholders about a merger with a competing firm. The defendant interposed the McCarran-Ferguson Act as a defense. In its analysis, the Court found the insurance aspects of the merger subject to state regulation and other aspects of the merger subject to the Securities Exchange Act. Incident to this analysis, the Court defined the business of insurance for McCarran-Ferguson Act purposes. *See id.*

32. *Id.* The Court listed rate fixing, selling and advertising policies, and licensing companies and their agents as examples of activities that constitute the business of insurance. *Id.*

In the ten years since *National Securities*, the issue of the scope of the business of insurance has arisen in four contexts: (1) tying arrangements, *see, e.g.*, Zelson v. Phoenix Mut. Life Ins. Co., 549 F.2d 62 (8th Cir. 1977); (2) agency relationships, *see, e.g.*, DeVoto v. Pacific Fidelity Life Ins. Co., 516 F.2d 1 (9th Cir.), *cert. denied*, 423 U.S. 894 (1975); (3) insurance company mergers, *see, e.g.*, American Gen. Ins. Co., [1970-1973 Transfer Binder] TRADE REG. REP. (CCH) ¶ 20,163 (F.T.C. Dec. 5, 1972); and, (4) service provider contracts, *see, e.g.*, Traveler's Ins. Co. v. Blue Cross of W. Pa., 481 F.2d 80 (3d Cir. 1973). For a discussion of how courts have narrowed the scope of the business of insurance provision in all four areas, see Nedrow, *supra* note 23, at 213-45. Courts have narrowed the business of insurance provision out of recognition that the McCarran-Ferguson exemption is justified only because of certain unique charac-

In *Group Life & Health Insurance Co. v. Royal Drug Co.*,[33] the Supreme Court re-examined and significantly narrowed the scope of the business of insurance provision.[34] First, the Court identified the "primary elements" of the business of insurance as the underwriting and spreading of a policyholder's risk.[35] Second, the Court described the contractual relationship between insurer and insured as "[a]nother commonly understood aspect of the business of insurance,"[36] and in doing so perhaps demoted this relationship from the status given it in *National Securities* as the "core" of the business of insurance.[37] Further, the Court rejected the argument that the cost-saving impact of insurer agreements with providers of services necessitates a finding that those agreements constitute the

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teristics, *see* notes 17-18 *supra* and accompanying text (joint rate-making), of the insurance industry. *See, e.g.*, DeVoto v. Pacific Fidelity Life Ins. Co., 516 F.2d 1, 3 (9th Cir.), *cert. denied*, 423 U.S. 894 (1975); American Family Life Assurance Co. v. Planned Marketing Assocs., Inc., 389 F. Supp. 1141, 1146-47 (E.D. Va. 1974). Hence, it could be argued that the exemption should not be interpreted to give insurance companies engaging in non-insurance activities the competitive advantage of a federal antitrust exemption. *See, e.g.*, Allied Financial Servs., Inc. v. Foremost Ins. Co., 418 F. Supp. 157, 161-62 (D. Neb. 1976) (insurance company interference with agency relationships does not constitute the business of insurance).

33. 440 U.S. 205 (1979). *Royal Drug* involved an antitrust challenge to agreements between defendant Group Life (a Blue Shield plan) and several co-defendant pharmacies. The agreements, called provider contracts, were part of a prescription drug insurance plan offered by Group Life that allowed its policyholders to obtain prescribed medications for no more than a two dollar deductible payment if they patronized one of the codefendant pharmacies. Group Life then reimbursed the pharmacy for the wholesale cost of the drugs. If policyholders chose to patronize a pharmacy that did not have a contract with Group Life, they would pay the entire out-of-pocket cost and then apply to Group Life for partial reimbursements. Consequently, policyholders found it both less convenient and more expensive to patronize nonparticipating pharmacies. Nonparticipating pharmacies alleged that the agreements caused policyholders to boycott them, were a form of price fixing, and excluded small pharmacies from the market. *Id.* at 207-09.

34. *Id.* at 232-33. At least one commentator has argued that *Royal Drug* effectively limits the McCarran-Ferguson Act exemption to such innocuous activities as statistics gathering, standardization of forms, and joint underwriting. *See* Nedrow, *supra* note 23, at 241-45.

35. 440 U.S. at 211. In finding that the "primary elements" of the business of insurance were the underwriting and spreading of risks, the Court relied upon textbook definitions of the term "insurance," including those from 1 G. COUCH, CYCLOPEDIA OF INSURANCE LAW § 1:3 (2d ed. 1959); R. KEETON, *supra* note 16, § 1.2(a); 1 G. RICHARDS, *supra* note 16, § 2. 440 U.S. at 211.

36. 440 U.S. at 215.

37. For a discussion of *National Securities*, see notes 31-32 *supra* and accompanying text. The impact of *Royal Drug* on *National Securities* is unclear, but courts have continued to rely on the *National Securities* definition of the "core" of the business of insurance. *See* note 55 *infra*.

business of insurance.[38] The Court also warned of the "serious anticompetitive consequences" of exempting provider agreements from the antitrust laws.[39] Applying the *Royal Drug* definition of the business of insurance to the practice at issue, a divided Court[40] held that the contract between Blue Shield of Texas and participating pharmacies for the provision of drugs to policyholders did not constitute the business of insurance.[41]

Although it is clear that *Royal Drug* narrows the business of insurance exemption, it is also apparent that the boundaries of the narrowed exemption are blurred.[42] While the Court in

38. 440 U.S. at 213-14. Although the Court rejected the argument that all cost-savings activities must be included in the definition of business of insurance, the Court did not adopt the view that such conduct is not the business of insurance simply because it reduces risks. *See id.* at 232-33. The Court reasoned that acceptance of the effects-on-rates test raised an insuperable line-drawing problem: "If agreements between an insurer and retail pharmacists are the 'business of insurance' because they reduce the insurer's costs, then so are all other agreements insurers may make to keep their costs under control." *Id.* at 232; *see id.* at 232 n.40.

39. *Id.* at 232 n.40..

40. Justice Brennan, joined by Chief Justice Burger and Justices Marshall and Powell, dissented. Justice Brennan criticized the majority's approach to the elements of the business of insurance because it encompasses only those activities that were included in the concept of the business of insurance when the McCarran-Ferguson Act was enacted, and because it is unrelated to the underlying aims of the McCarran-Ferguson Act or to a common sense understanding of insurance. *Id.* at 239 (Brennan, J., dissenting).

41. *Id.* at 233. *Royal Drug* was the first Supreme Court case to find that a contract between an insurer and a third party to provide services to claimants of the insurer—a provider contract—was not within the scope of the business of insurance. Prior to *Royal Drug*, the Third Circuit Court of Appeals had held that provider contracts were within the business of insurance. *See* Travelers Ins. Co. v. Blue Cross of W. Pa., 481 F.2d 80, 83 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973). In *Travelers Ins. Co.*, an insurance company brought an antitrust action against a nonprofit provider of prepaid medical health care. At issue was the validity of the standard contract Blue Cross had entered into with 101 hospitals that provided services to Blue Cross subscribers. The *Travelers Ins. Co.* court found that the service provider contract was within the scope of the business of insurance and that the practice was shielded from antitrust attack by the McCarran-Ferguson Act. *Id.* at 82-83; *accord*, Frankford Hosp. v. Blue Cross of Greater Phil., 554 F.2d 1253, 1254 (3d Cir.), *cert. denied*, 434 U.S. 860 (1977); Manasen v. California Dental Servs., 424 F. Supp. 657, 666 (N.D. Cal. 1976).

Royal Drug, in finding that insurer-third party provider contracts did not fall within the business of insurance, apparently overruled this substantial body of precedent. The *Royal Drug* Court explicitly reserved, however, the question of whether Blue Shield policyholder contracts were within the business of insurance: "This is not to say that the contracts offered by Blue Shield to its policyholders, as distinguished from its provider agreements with participating pharmacies, may not be the 'business of insurance' within the meaning of the Act." 440 U.S. at 230 n.37.

42. The commentators have had difficulty in determining the scope of the post-*Royal Drug* "business of insurance" provision. *See, e.g.*, Note, Group Life & Health Ins. Co. v. Royal Drug Co.: *The McCarran-Ferguson Act and Health Service Plans*, 5 AM. J. L. & MED. 393, 409-10 (1980); Note, *The Definition of the*

Royal Drug held that a practice must "involve" the "primary elements" of underwriting and spreading of risk to constitute the business of insurance,[43] it did not specify the nature of the required "involvement." Since almost any insurance practice involves the underwriting of risk to some degree, lower courts must determine the precise nature of involvement a practice must have with the underwriting and spreading of risk before that practice constitutes the business of insurance.

In identifying a practice as the business of insurance, the Court in *Royal Drug* also held that the contractual relationship between insurer and insured is a "commonly understood" factor.[44] The *Royal Drug* opinion fails to answer the question of precisely how important the insurer-insured contract—either alone or in relation to the underwriting and spreading of risk—is in the identification of the business of insurance. Thus, lower courts are again left with the task of determining the importance of the insurer-insured relationship in identifying what constitutes the business of insurance.[45]

Two courts have recently confronted claims that the practice of reviewing bills submitted to insurance companies is within the post-*Royal Drug* definition of the business of insurance.[46] In *Pireno v. New York State Chiropractic Association*[47]

"Business of Insurance" Under the McCarran-Ferguson Act after Royal Drug, 80 COLUM. L. REV. 1475, 1478 (1980) [hereinafter cited as Columbia Note].

43. For example, the Court stated that "[t]he Pharmacy Agreements thus do not involve any underwriting or spreading of risk." 440 U.S. at 214.

44. 440 U.S. at 211, 215. The significance of the Court's distinction between "primary elements" and a "commonly understood" factor is unclear.

45. Lower courts have experienced further difficulty because of *Royal Drug*'s inconsistent use of definitional terms. *See* Bartholomew v. Virginia Chiropractors Ass'n, 612 F.2d 812, 817 (4th Cir. 1979), *cert. denied*, 446 U.S. 938 (1980); Pireno v. New York State Chiropractic Ass'n, [1979] 2 TRADE CASES 78,373 (S.D.N.Y. Mar. 16, 1979). The *Royal Drug* Court initially stated that the primary elements of an insurance contract, not the business of insurance, are the underwriting and spreading of risk. 440 U.S. at 211. Unless the Court was using "insurance contract" to mean "business of insurance," it could be argued that the primary elements of the business of insurance and an insurance contract are not identical. Because the Court elsewhere speaks of the primary elements of the business of insurance (as opposed to an insurance contract), perhaps the Court did mean to associate the two.

Moreover, the sources the Court relied on in *Royal Drug* to identify the elements of the business of insurance state that the elements are the transfer and distribution of risk, rather than the underwriting and distribution of risk. *See* 1 G. COUCH, *supra* note 35, § 1:3; R. KEETON, *supra* note 16, § 1.2(a); 1 G. RICHARDS, *supra* note 16, § 2. Again, perhaps the *Royal Drug* Court used "underwriting" to mean "transfer." Because the Court gives no indication of why its substitutes "underwriting" for "transfer," courts and commentators are left to conjecture what this substitution means.

46. Another recent case, State v. Maricopa County Med. Soc'y, [1979] 1

and *Bartholomew v. Virginia Chiropractic Association*,[48] the challenged practices, like those in *Virginia Academy*,[49] were billing procedures allegedly used to review the need for and cost of a provider's services.[50] Further, the practices were factually similar to the practices examined in *Royal Drug* in that a third party provider was involved in delivering health care and an insurance company was attempting to impose cost constraints on the third party's delivery of such services.[51]. The practices were different in that they were not specified in a contract between an insurer and a provider of health care.[52]

The courts in both *Pireno* and *Bartholomew* found that the function of the committee that reviewed policyholders' bills[53] was to interpret the rights of the policyholder under the contract.[54] The key step in both courts' analyses was to identify

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TRADE CASES (CCH) 77,893 (D. Ariz. June 5, 1979), involved the question of whether maximum payment schedules, approved by a physician association and followed by private insurance companies that participated in so-called foundation plans, constituted the business of insurance under *Royal Drug*. The court held that the fee schedules acted only to reduce the risk that the insurers had underwritten and did not directly involve the underwriting of risks. *Id.* at 77,894. Thus, the *Maricopa* court found the maximum payment practices outside the scope of the "business of insurance" provision of the McCarran-Ferguson Act. *Id.* The principal cases under discussion, however, *see* notes 46-73 *infra* and accompanying text, deal with whether different types of fee and service review practices constitute the business of insurance under the Act.

47. [1979] 2 TRADE CASES (CCH) 78,373 (S.D.N.Y. Mar. 16, 1979).

48. 612 F.2d 812 (4th Cir. 1979), *cert. denied*, 446 U.S. 938 (1980).

49. *See* 624 F.2d at 485; notes 1-3, 59 *infra* and accompanying text.

50. Bartholomew v. Virginia Chiropractors Ass'n, 612 F.2d 812, 814 (4th Cir. 1979), *cert. denied*, 446 U.S. 938 (1980); Pireno v. New York State Chiropractic Ass'n, [1979] 2 TRADE CASES (CCH) 78,373, 78,374 (S.D.N.Y. Mar. 16, 1979).

51. *See* Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 209 (1979); Bartholomew v. Virginia Chiropractors Ass'n, 612 F.2d 812, 814 (4th Cir. 1979), *cert. denied*, 446 U.S. 938 (1980); Pireno v. New York State Chiropractic Ass'n, [1979]. 2 TRADE CASES (CCH) 78,373, 78,374-75 (S.D.N.Y. Mar. 16, 1979).

52. *See id.*

53. In both *Pireno* and *Bartholomew*, insurance companies employed peer review boards composed of chiropractors who reviewed chiropractic bills submitted by policyholders to their insurance companies for payment and then, after investigating the circumstances surrounding the service and after referring to a schedule of "usual and customary" fees, made a nonbinding recommendation for payment. The insurance companies reimbursed their policyholders accordingly. In both cases, chiropractors who were not members of the state chiropractic association administering the review board brought suit alleging that the insurance companies and the state chiropractic association conspired to fix prices. Defendants successfully interposed a McCarran-Ferguson Act defense. Bartholomew v. Virginia Chiropractors Ass'n, 612 F.2d 812, 813-17 (4th Cir. 1979), *cert. denied*, 446 U.S. 938 (1980); Pireno v. New York State Chiropractic Ass'n, [1979] 2 TRADE CASES (CCH) 78,373, 78,374-78 (S.D.N.Y. Mar. 16, 1979).

54. Bartholomew v. Virginia Chiropractors Ass'n, 612 F.2d 812, 817 (4th Cir. 1979), *cert. denied*, 446 U.S. 938 (1980); Pireno v. New York State Chiropractic Ass'n, [1979] 2 TRADE CASES (CCH) 78,373, 78,377 (S.D.N.Y. Mar. 16, 1979).

the relationship between insurer and insured as the "core" or the "essence" of the business of insurance.[55] Moreover, the federal district court in *Pireno*, unlike the Court of Appeals for the Fourth Circuit in *Bartholomew*, went on to analogize the committee to an agent of the insurance company akin to a licensed adjuster.[56] The *Pireno* court also found that the committee's decision involved the spreading of risk in the same sense that the licensed adjuster's decisions involved the spreading of risk: each determined whether loss would remain with the insured or would pass to the insurer and be distributed to the policyholders through higher premiums.[57]

The Fourth Circuit's opinion in *Virginia Academy* represents the most recent attempt to define the business of insurance in the antitrust context. In contrast to its decision in *Bartholomew*,[58] the court in *Virginia Academy* found the bill-

55. Bartholomew v. Virginia Chiropractors Ass'n, 612 F.2d 812, 817 (4th Cir. 1979), *cert. denied*, 446 U.S. 938 (1980); Pireno v. New York State Chiropractic Ass'n, [1979] 2 TRADE CASES (CCH) 78,373, 78,377 (S.D.N.Y. Mar. 16, 1979). In so doing, both courts quoted *National Securities*. *See* SEC v. National Securities, Inc., 393 U.S. 453, 460 (1969). For a discussion of *National Securities*, see notes 28-32 *supra* and accompanying text. The courts' analytical treatment of the insurer-insured contract suggests that they have not accepted the argument that the relationship between insurer and insured has been changed by *Royal Drug*'s treatment of the component parts of the business of insurance. *See* notes 36-37, 44-45 *supra* and accompanying text.

56. [1979] 2 TRADE CASES (CCH) at 78,377.

57. *Id. Pireno*, consistent with *Royal Drug*, *see* note 45 *supra*, apparently used the term "spreading" to mean "underwriting." For a discussion of the underwriting of risks, see note 16 *supra*. Moreover, the process that *Pireno* describes as the spreading of risk is in fact the transfer and distribution of loss. According to *Pireno*, the peer review committee determines "the extent to which an individual insured must bear the full cost of chiropractic services, or instead have that cost borne by the insurer (and, through higher premiums, his fellow insureds)." *Id.* The committee thus determines whether the loss (cost) is transferred (borne by insurer or insured), and that decision determines whether the loss is distributed to the policyholders through higher rates.

58. It appears that the composition of the Fourth Circuit court, rather than the facts of the two cases, distinguishes *Virginia Academy* from *Bartholomew*. In *Bartholomew*, argued and decided approximately ten months before *Virginia Academy*, Federal District Judge D. Dortch Warriner, sitting by designation, and Senior Circuit Judge Albert V. Bryan joined to form a two to one majority over Circuit Judge K.K. Hall, who concurred in part, but dissented to the majority's finding that the McCarran-Ferguson Act exempted the defendant's activity from the antitrust laws. Bartholomew v. Virginia Chiropractors Ass'n, 612 F.2d 812, 818 (4th Cir. 1979), *cert. denied*, 446 U.S. 938 (1980). In the *Virginia Academy* district court decision, Judge Warriner was the presiding judge. 469 F. Supp. 552, 554 (E.D. Va. 1979). At the circuit level, Judge Hall, who had dissented in *Bartholomew*, authored the opinion reversing Judge Warriner, and was joined by Circuit Judge D. Phillips and District Judge Joseph C. Howard, sitting by designation. 624 F.2d at 478. The majority in *Virginia Academy* cites *Bartholomew* for the proposition that the "essence of the business of insurance is the relationship between the insurance company and its policy-

ing review practice outside the business of insurance as defined in *Royal Drug*. In determining whether physician review of a psychologist's bills[59] fell within the "business of insurance" exemption, the court of appeals interpreted the definition of the business of insurance narrowly and refused to extend McCarran-Ferguson immunity to the defendant's activities.[60] The *Virginia Academy* court reasoned that the physician billing practice did not involve the underwriting or distribution of any specific risk because underwriting involves only the initial decision to cover a disorder, and the Richmond and Roanoke Plans' policies had covered nervous disorders for ten years prior to the initiation of the billing review procedures.[61] The court found that the practice resulted from a decision to use certain providers of health care for the purpose of effecting a cost savings—the same type of decision involved in *Royal Drug*[62]—and thus, did not constitute the business of insurance. More generally, the court's narrow construction of the McCarran-Ferguson exemption reflected its concern about the anticompetitive effects of physician dominance of group health plans.[63]

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holder," but ignores the factual similarities in the cases and, without specifically overruling *Bartholomew*, comes to the opposite conclusion concerning these facts. *Id.* at 483.

59. *See* notes 1-3 *supra* and accompanying text. In addition to reviewing the psychologist's bill, the physician could also treat the policyholder and/or supervise the psychologist's treatment. Virginia Academy of Clinical Psychologists v. Blue Shield of Va., 469 F. Supp. 552, 556 (E.D. Va. 1979).

60. 624 F.2d at 480, 484. The district court, on the other hand, identified the "core of the business of insurance" as the relationship between insurer and policyholder. 469 F. Supp. 552, 562 (E.D. Va. 1979). The district court then reasoned that since the billing practice was specified in a provision of the contract between the insurer and the policyholder, the practice was squarely within the business of insurance. *Id.*

As in *Pireno* and *Bartholomew*, the *Virginia Academy* district court invoked *National Securities* for the definition of the core of the business of insurance. *See generally* text accompanying note 31 *supra*. The court also used footnote 37 of the *Royal Drug* opinion ("[t]his is not to say that the contracts offered by Blue Shield to its policyholders, as distinguished from its provider agreements with participating pharmacies, may not be the 'business of insurance' within the meaning of the Act") to distinguish *Virginia Academy* from *Royal Drug*. *See* 624 F.2d at 562. For a discussion of *Royal Drug's* footnote 37, see note 41 *supra*.

61. 624 F.2d at 480, 484.

62. *See id.*; note 38 *supra* and accompanying text.

63. *See id.* at 479 n.2, 480. In discussing this concern, the court cited footnote 40 of the *Royal Drug* opinion. *Id.* at 479 n.2. The *Royal Drug* footnote noted the "serious anticompetitive consequences" that might follow from physician domination. 440 U.S. at 232 n.40.

The *Virginia Academy* appellate court used provider dominance not only to justify finding a conspiracy within the reach of the Sherman Act, 624 F.2d at 479-81, but also to justify interpreting the McCarran-Ferguson exemption narrowly. *Id.* at 483-84. In finding an antitrust violation, the circuit court agreed

The *Virginia Academy* court failed to interpret correctly the *Royal Drug* definition of the business of insurance. The Court in *Royal Drug* merely indicated that exemptions from the antitrust laws should be construed narrowly,[64] not that they should be eliminated entirely.[65] Presumably, the theoretical limits beyond which an exemption cannot be narrowed are determined by reference to the policy concerns that justified the exemption originally.[66] In passing the McCarran-Ferguson exemption, Congress attempted to foster state regulated insurance company practices that furthered the interest of insurer stability and solvency by protecting these practices from antitrust scrutiny.[67] By narrowly circumscribing the argument that the cost-saving impact of provider agreements justifies exempting those agreements from the antitrust laws,[68] the Court in *Royal Drug* seemed to suggest that the underlying policy of insurer solvency should provide only limited guidance to courts in interpreting the statute.[69] Thus, *Royal Drug* indicates that courts should determine whether a specific practice is exempt by applying the formal definition of the business of insurance articulated in the case.[70] Because this definition is unclear and because courts interpret the McCarran-Ferguson exemption narrowly,[71] courts are likely to narrow this definition even further than the *Royal Drug* Court did.

Although the *Virginia Academy* court followed *Royal*

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with the lower court that a rule of reason approach was appropriate and refused to characterize the practice as an illegal per se boycott. *Id.* at 484-85. The circuit court disagreed, however, with the lower court's finding that the practice was justified and that psychiatrists and psychologists were not in competition. *Id.* at 485.

64. 440 U.S. at 231. *See generally* 2A J. SUTHERLAND, STATUTES AND STATUTORY CONSTRUCTION § 47.03-.13 (4th ed. 1973) (discussing rules of statutory construction of exceptions, provisos, savings clauses, and savings statutes); Mintz, *The Standard of Patentability in the United States—Another Point of View*, 1977 DET. C. L. REV. 755, 774-77, 785-88 (examines Court's hostility toward patent laws because of those laws' anticompetitive effects).

65. One commentator has stated that the "older rule" favors strict interpretation of exceptions, provisos, savings clauses, and savings statutes. 2A J. SUTHERLAND, *supra* note 64, § 47.11. Another view favors determining the effects of such provisions by reference to their underlying policy justification without reference to artificially narrowing presumptions. *Id.* The Supreme Court, however, adheres to the "older rule" of strict construction of statutory exemptions from the antitrust laws. *See, e.g.*, United States v. McKesson & Robbins, Inc., 351 U.S. 316, 319-20 (1956).

66. 2A J. SUTHERLAND, *supra* note 64, § 47.11.

67. *See* notes 13-19 *supra* and accompanying text.

68. *See* note 38 *supra* and accompanying text.

69. *See* 440 U.S. at 216-17.

70. *See id.* at 215-17.

71. *See* note 64 *supra*.

Drug's formalistic approach[72] in determining the scope of the business of insurance, the court should also have analyzed the practical realities of the insurance industry in making its determination. Rather than comparing the billing review procedures to the third-party provider agreements that had been held not to constitute the business of insurance in *Royal Drug*, the *Virginia Academy* court should have rigorously developed the insurance adjuster analogy advanced in *Pireno*.[73]

An insurance claims adjuster, normally a representative of either the insurance company or the policyholder, determines the obligations of the insurer and insured based upon his or her investigation of the claim.[74] In the settlement of claims, the

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72. By adopting an essentially formal approach towards determining the scope of an exemption from the antitrust laws instead of a policy-based approach, the Court in *Royal Drug* echoed the style of argument that the Court had used in United States v. McKesson & Robbins, Inc., 351 U.S. 305 (1956). The issue in *McKesson & Robbins* was whether price-fixing agreements fell within the so-called "fair-trade" provisions of the Miller-Tydings Act or McGuire Act exemptions from the antitrust laws. The opposing parties argued that the scope of the exemptions should be set with reference to the economic considerations underlying the statutes, *id.* at 315, but the Court's response was simply that "[w]e need not concern ourselves with such [economic] speculation. Congress has marked the limitations beyond which price fixing cannot go." *Id.* at 316-17. The Court's ensuing construction of the two exemptions was termed "verbalistic," "arbitrary," and overly subtle by Justices Harlan, Frankfurter, and Burton in dissent. *Id.* at 316, 318-20 (Harlan, J., dissenting). For Justice Brennan's essentially similar response in dissent to the majority's construction of the McCarran-Ferguson exemption in *Royal Drug*, see note 40 *supra*. The message of *Royal Drug* and *McKesson & Robbins* is apparently that the Court will eschew economically-based policy arguments in favor of formal arguments as the preferred method of fixing the boundaries of exemptions from the antitrust laws. This formal approach presumably reflects the Court's longstanding aversion to becoming embroiled in judging the merits of complex economic arguments. *See, e.g.*, Illinois Brick Co. v. State, 431 U.S. 720, 737-44 (1977); Hanover Shoe, Inc. v. United Shoe Machinery Corp., 392 U.S. 481, 492-94 (1968). *But see* United States v. E.I. duPont de Nemours & Co., 351 U.S. 377, 399-404 (1976) (Supreme Court engaged in extensive analysis of relevant competing markets).

73. *See* [1979] 2 TRADE CASES (CCH) 78,373, 78,377 (S.D.N.Y. Mar. 16, 1979); text accompanying notes 56-57 *supra*.

74. 16 J. APPLEMAN, INSURANCE LAW AND PRACTICE § 8646, at 77 (rev. ed. 1968). There are four tyes of adjusters. Bureau or company adjusters work for insurance company-owned adjustment organizations. W. MOORE, A PRIMER ON ADJUSTMENTS 12-16 (5th ed. 1963). Staff adjusters work directly for insurance companies. *Id.* Independent adjusters, who may be affiliated with an adjustment organization, work for insurance companies. *Id.* Finally, public adjusters work for policyholders. *Id.* at 16-17. In addition, insurance brokers, insurance agents, and attorneys may work incidentally to adjust claims, but are not permitted to advertise their services as public adjusters. E. PATTERSON, ESSENTIALS OF INSURANCE LAW § 8, at 47 (2d ed. 1957). For a discussion of which types of adjusters are used to investigate different types of insurance claims, see W. MOORE, *supra*, at 49-51. Since the adjuster's practices are the same regardless of employment status, the question of whether an adjuster's practices constitute the business of insurance under the McCarran-Ferguson Act is unrelated

adjuster is the decision maker with the greatest authority to fix liability.[75] Thus, the adjuster is commonly considered the most powerful and visible representative of the insurer in the day-to-day operation of claims settlement.[76]

Claims adjusting is within the *Royal Drug* definition of the business of insurance because the decisions of the adjuster determine who shall bear the loss. Hence, the adjuster's decisions "involve" the underwriting of risk in a fundamental way: they are a culmination of routine practices expressly designed to determine whether the loss falls within the class of risks that the insurer underwrote on the issuance of the policy.[77] Moreover, claims adjusting is the business of insurance because the adjuster's decisions interpret the contractual obligations of insurer and insured[78] by determining the extent of the insurer's liability.[79] Such decisions intimately affect the contractual relationship between the two parties, thus satisfying the second aspect of the business of insurance under *Royal Drug*.[80]

The billing review practice that was at issue in *Virginia Academy*[81] is within the business of insurance provision because the practice is a special type of adjusting practice. In effect, the billing reviewer is an adjuster whose task is limited to investigating the justifications of a bill for services about which the reviewer has expert knowledge.[82] In executing the review

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to the question of who employs the adjuster. An argument can be made that an adjuster may tend to favor his or her employer in ambiguous cases, but such a potential bias is a separate issue from whether the adjuster is engaged in the business of insurance, unless such bias is so extreme that the adjuster analogy fails entirely. *See* text accompanying notes 90-101 *infra*.

75. *See, e.g.*, H. ROSS, SETTLED OUT OF COURT: THE SOCIAL PROCESS OF INSURANCE CLAIMS ADJUSTMENTS 18 (1970) (the adjuster is the "key figure . . . [who is] the front-line representative of the insurance company . . . [and who] occupies the most powerful role in settlement"); Gilman, *Claims Administration in Life and Health Insurance*, in LIFE AND HEALTH INSURANCE HANDBOOK 1042, 1043-44 (2d ed. D. Gregg 1964).

76. *See* H. ROSS, *supra* note 75, at 18; Gilman, *supra* note 75, at 1042-44.

77. *See* notes 36, 44 *supra* and accompanying text; *cf.* Pireno v. New York State Chiropractic Ass'n, [1979] 2 TRADE CASES (CCH) 78,373, 78,377 (S.D.N.Y. Mar. 16, 1979) (court noted that peer review committee "serve[d] to define the precise extent of [the insurer's] contractual obligations to its insureds under their policies").

78. *See* notes 37-38, 45-46 *supra* and accompanying text.

79. *Cf.* Pireno v. New York State Chiropractic Ass'n, [1979] 2 TRADE CASES (CCH) 78,373, 78,377 (S.D.N.Y. Mar. 16, 1979) (court noted that review committee "determine[d] the extent to which an individual [bore] the . . . cost of . . . services, or instead [had] the cost borne by the insurer"). *See generally* Gilman, *supra* note 75, at 1045-46.

80. *See* notes 36-37, 44-45 *supra* and accompanying text.

81. *See* notes 1-3 *supra* and accompanying text.

82. There are four basic steps to any claims examination procedure: iden-

practice examined in *Virginia Academy*, the insurer found the physician (not the psychologist) adequately trained to diagnose the physical and nervous causes of psychological disorders.[83] Since the insurance policy in question explicitly limited coverage to medically necessary treatment,[84] it was the function of the physician-reviewer to determine if a physician's or a psychologist's treatment was medically necessary and hence within the coverage of the insurance policy.[85] If either type of treatment was merited, the physician-reviewer "interpreted" the contractual relationship of insurer and insured and found that the patient's ailment fell within the class of risks—disabilities for which the treatment of a physician or psychologist is medically necessary—underwritten by the policy. Thus, the billing review practice examined by the court in *Virginia Academy* satisfied the *Royal Drug* definition of the business of insurance.[86]

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tification of the insured; determination of benefits claimed; determination of policy status; and determination of the extent of liability. *See* Gilman, *supra* note 75, at 1045-46. For a short explanation of the mechanics of claims adjustment, see W. MOORE, *supra* note 74, at 53-78. For an analysis of the legal and sociological ramifications of claims adjusting, *see generally* H. ROSS, *supra* note 75.

83. *See* 624 F.2d at 484-85.

84. *See* note 2 *supra*.

85. *See* notes 1-2 *supra* and accompanying text.

86. Although any billing review practice that is substantially similar to claims adjusting would satisfy the *Royal Drug* definition, the billing practice will not be within the McCarran-Ferguson exemption, *see* notes 6, 13-21 *supra*, if it involves intimidation, coercion, or boycott. *See* 15 U.S.C. § 1013 (1976). The exemption permits courts to withhold McCarran-Ferguson protection from illegitimate billing review practices even though the practices satisfy the *Royal Drug* test for the business of insurance under the adjuster analogy rationale. Further regulation of review practices is provided by the state provision of the McCarran-Ferguson Act, which must be satisfied before a practice is shielded from antitrust scrutiny. *See* note 27 *supra* and accompanying text. In *Virginia Academy*, the court determined that the review practice was not a boycott, *see* 624 F.2d at 484, but did not reach the issue of whether the state statute prohibiting the billing practices satisfied the state regulation provision. *See* note 27 *supra*.

It has also been argued that under *Royal Drug* any practice which has a "risk-reducing" effect is not the business of insurance. *See* Columbia Note, *supra* note 42, at 1487. *Royal Drug* Court merely stated that risk-reducing is not, ipso facto, determinative of whether a practice is the business of insurance. *See* 440 U.S. at 214; note 38 *supra*. Even if one assumes that the argument concerning the relationship between risk-reduction and the business of insurance is correct, the review practice at issue in *Virginia Academy* is still the business of insurance. In *Virginia Academy*, the physician-reviewer decided, in essence, whether a patient's ailments fell within the class of risks—illness for which a physician's or psychologist's services was medically necessary—covered by the policy. *See* notes 81-86 *supra* and accompanying text. Thus, the risk-reducing analysis is irrelevant to the adjuster analogy as applied to the facts of *Virginia Academy*.

The circuit court's reasoning—that because the Richmond and Roanoke Plans' policies covered nervous and mental disorders from 1962 to 1972, the billing review practice instituted in 1972 did not involve the underwriting of risks[87]—is simply a non sequitur. The risk covered by Blue Shield policies from 1962 to 1972 was the risk of nervous or mental disorders. The risk covered after 1972 was the risk of nervous or mental disorders for which the services of a physician or a psychologist were medically necessary.[88] Because the physician-reviewer determined whether treatment was medically necessary, the physician-reviewer decided whether the patient's illness fell within the class of risks that Blue Shield had underwritten.[89]

The validity of the adjuster analogy depends in part on the neutrality of the physician-reviewer. If the reviewer is a competitor[90] who might employ an exclusionary course of conduct toward clinical psychologists or engage in a scheme of horizontal price fixing, the adjuster analogy is inappropriate. A determination of the reviewer's status is usually made only after the court makes the threshold determination that the practice at issue involves the business of insurance.[91] Yet the neutrality of

87. *See* text accompanying note 61 *supra*.

88. *See* notes 1-2 *supra*.

89. *See* notes 2, 86 *supra* and accompanying text.

90. The *Virginia Academy* court apparently treats Blue Shield plans as inherent violations of the antitrust laws. *See* 624 F.2d at 479-81. The court explicitly stated that there was sufficient physician control to bring the Richmond Plan "within the purview of Section 1 of the Sherman Act." *Id.* at 481. Nevertheless, the relationship between the Blue Shield plans' status vis-a-vis the antitrust laws and the antitrust status of the specific billing review practice in question is unclear.

The district court record indicates that the Richmond Plan and the Roanoke Plan had established no clear policy concerning the indemnification of a psychologist's services. *See* 469 F. Supp. 552, 558 (E.D. Va. 1979). Hence, the billing practice enabled the Blue Shield plans to extend coverage to psychological services, while simultaneously ensuring that either a physician's or a psychologist's services was "medically necessary" and thus within the terms of the policy contract. *See* note 2 *supra*.

The billing practice, then, appears to have encouraged—not discouraged—competition; before the practice, Blue Shield policies covered only psychological services rendered by a psychiatrist, whereas after the practice was adopted Blue Shield policies covered psychological services rendered by potentially competing groups: psychiatrists and psychologists. Petitioner's Brief for Certiorari at 10, Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia, 101 S. Ct. 1360 (1980).

91. *See, e.g.*, Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 210 (1979); Bartholomew v. Virginia Chiropractors Ass'n, 612 F.2d 812, 816 (4th Cir. 1979), *cert. denied*, 446 U.S. 938 (1980); State v. Maricopa County Med. Soc'y, [1979] 1 TRADE CASES (CCH) 77,893 (D. Ariz. June 5, 1979); Pireno v. New York State Chiropractic Ass'n, [1979] 2 TRADE CASES (CCH) 78,373 (S.D.N.Y. Mar. 16, 1979).

the adjuster is also relevant when analyzing the validity of the adjuster analogy itself.[92]

In assessing the potential for harm to the competitive delivery of mental health services, the *Virginia Academy* court should have determined whether psychologists and physicians together or psychologists alone form the relevant market arena,[93] and whether physicians and psychiatrists act together to exclude psychologists from entering a particular market for mental health services or to control the prices of such services. If, as the district court in *Virginia Academy* assumed,[94] physicians and psychologists together compete with psychiatrists, and physicians do not engage in concerted efforts to direct patients to psychiatrists, the adjuster analogy is appropriate.[95] If, however, psychiatrists tell physicians who review psychologists' bills that they will not deal with the physicians if the physicians continue to approve psychologists' bills as medically necessary, and the physicians acquiesce to those threats, the reviewing physicians more closely resemble competitors engaged in a group boycott than they do insurance adjusters.[96] Moreover, if physicians refuse to approve all psychologists' treatment as medically necessary, and instead funnel the most lucrative cases to psychiatrists or refused to approve bills that failed to maintain minimum prices for services, the physicians again appear more like competitors engaged in an illegal boy-

92. The *Pireno* court failed to develop fully the analogy, and thus did not consider these issues. *See* text accompanying note 73 *supra*. *See generally* note 74 *supra*.

93. The court was not clear whether it viewed psychologists' competitors to be psychiatrists or physicians. The court repeatedly compared psychologists and psychiatrists as providers of psychological services, *see* 624 F.2d at 484-86, leading the reader to believe that the court viewed those two groups as competitors. The extensive treatment that the court gave to the anticompetitive effects of physician domination of Blue Shield plans, however, leads the reader to view physicians as psychologists' competitors.

94. 469 F. Supp. at 560-61.

95. Even if the adjuster analogy is appropriate and a court were to find the questioned practice within the business of insurance, the court would still have to analyze whether the remaining two provisions of the McCarran-Ferguson Act have been satisfied. *See* notes 26-27 *supra* and accompanying text.

96. *See, e.g.*, Klor's, Inc. v. Broadway-Hale Stores, Inc., 359 U.S. 207, 212 (1959) (defining group boycotts as "concerted refusals by traders to deal with other traders"). Whether an actual group boycott existed would depend on whether the plaintiff could demonstrate an effect on interstate commerce and an injury to some segment of the public. *See, e.g.*, Riggall v. Washington County Med. Soc'y, 249 F.2d 266, 268 (8th Cir. 1957), *cert. denied*, 355 U.S. 954 (1958); Bauer, *Per Se Illegality of Concerted Refusals to Deal: A Rule Ripe for Reexamination*, 79 COLUM. L. REV. 685, 689-692 (1979); Borsody, *supra* note 22, at 447-55; Stewart & Roberts, *Viability of the Antitrust Per Se Illegality Rules: Schwinn Down, How Many to Go?*, 58 WASH. U.L.Q. 727, 745-49 (1980).

cott[97] or in horizontal price-fixing[98] than like adjusters.

To determine the validity of the adjuster and competitor analogies, the *Virginia Academy* court should have conducted a thorough analysis of the relevant market, considering the market power or dominance of each health care provider.[99] In addition, the court should have examined any policies or systems that tended to insure compliance with group anticompetitive activity[100] or to promote objective evaluation of psychologists' claims. Finally, the court should have examined any tendencies of the billing review system to promote a future takeover of the market by one group of providers.[101] If, after examining these factors, the *Virginia Academy* court had concluded that the district court was correct in finding that the billing review practice merely represented a formal standard medical procedure and did not create any significant anticompetitive effects,[102] the court should have invoked the adjuster analogy to satisfy the "business of insurance" provision of the McCarran-Ferguson Act.

Thus, by failing to apply rigorously the adjuster analysis to the billing review practice in issue, the *Virginia Academy* court failed to forward a useful interpretation of the *Royal Drug* definition of the business of insurance for McCarran-Ferguson Act purposes. Moreover, by finding the billing review practice to be

97. *See, e.g.*, Radiant Burners, Inc. v. Peoples Gas Light & Coke Co., 364 U.S. 656 (1961) (mandatory approval of heating equipment by association of utilities and heating equipment manufacturers was illegal boycott).

98. *See, e.g.*, United States v. Socony-Vacuum Oil Co., 310 U.S. 150 (1940) (price stabilization, even if beneficial to the market, illegal per se under § 1 of the Sherman Act).

99. *See, e.g.*, Standard Oil Co. of Calif. v. United States, 337 U.S. 293, 295-97 (1949). Such a market analysis is admittedly complex in the mental health context. *Compare* Dörken & Webb, *1976 Third-Party Reimbursement Experience: An Interstate Comparison by Insurance Carrier*, 35 AM. PSYCH. 355, 362 (1980) (noting anticompetitive and monopolistic obstacles sometimes faced by psychologists because of Blue Shield practices and describing evidence gathered by the Association for the Advancement of Psychology (AAP) and submitted in 1978 to the Federal Trade Commission) *with FTC Says Doctors Can Control Policy of Blue Shield Plans*, Wall St. J., Apr. 24, 1981, at 6, col. 1 (noting FTC decision not to bar doctors from sitting on policymaking boards of Blue Shield because variety of programs and practices makes generalization about anticompetitive effects difficult).

100. *See, e.g.*, Fashion Originators' Guild v. FTC, 312 U.S. 457, 462-63 (1941).

101. *See, e.g.*, Klor's, Inc. v. Broadway-Hale Stores, Inc., 359 U.S. 207, 213 (1959).

102. The district court in *Virginia Academy* said, "[p]laintiffs themselves acknowledge that the best practice for clinical psychologists to follow before psychotherapy is referral to a physician for a physical examination. This is unanimously agreed to be necessary so as to rule out a physicial cause of the nervous or mental problem." 469 F. Supp. 552, 560 (E.D. Va. 1979).

a violation of the Sherman Act, the *Virginia Academy* court may have distorted the anticompetitive impact of the practice. In the future, courts should more thoroughly analyze the relevant market factors in determining the propriety of adopting the adjuster analogy. Such an analysis will provide a more solid basis for deciding whether the questioned activity fits within the "business of insurance" provision of the McCarran-Ferguson Act.