Doctors, Insurers, and the Antitrust Laws

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COMMENTS

Doctors, Insurers, and the Antitrust Laws

The past decade has seen a dramatic change in the ways physicians are compensated for the provision of medical services. For years, physicians have been paid according to the discrete medical procedures they performed during treatment. This method of compensation, known as "fee-for-service," gave physicians an incentive for overtreating patients; the more procedures they performed, the more compensation they received. In order to eliminate the inflationary tendency of fee-for-service compensation, physicians are being placed at financial risk for the costs of medical care. This change is taking place by expanding the unit of payment for health-care services. For example, physicians are frequently reimbursed according to the number of patients they treat. Under such a scheme, a health maintenance organization (HMO) might pay a physician a fixed amount per year for each patient assigned to him. The physician receives the payment whether or not the patients actually require his care. However, if the total costs of treatment exceed the fixed compensation, the physician is forced to incur a loss. Thus, the risks associated with insuring a patient's health care may be shifted from the HMO to the physician himself. The goal of this Comment is to examine whether physicians who are placed at risk in this way deserve the limited antitrust exemption for the "business of insurance" provided by the McCarran-Ferguson Act. This exemption has allowed the insurance industry to engage in some restricted forms of concerted activity, including the joint collection and processing of underwriting data. As physicians take on the role of insurers, they too should be afforded the opportunity to engage in similar, but still restricted, forms of collective activity in order to assess the financial risks they face and the adequacy of the compensation they receive.

I. INTRODUCTION

Traditionally, physicians have been compensated for their services on the basis of the particular medical procedures they perform during a course of treatment.¹ This system of compensation, known as "fee-for-service," relies on the patient's health insurer to reimburse either the

Critics have charged, however, that fee-for-service compensation has contributed to the rapid escalation of health-care costs. The accusation stems from the belief that a physician who is paid according to discrete medical procedures has a clear incentive to increase the quantity of services provided, especially those that are more profitable. Thus, "to the extent that physicians act as 'agents' for patients and can induce additional utilization of services, fee-for-service reimbursement encourages higher costs." In response to the economic effects of fee-for-service compensation, progress has been made toward the establishment of alternative methods of reimbursement intended to create financial incentives for physicians to control utilization of health-care services and, thereby, contain health-care costs. A significant reform has taken place by altering the unit of payment for physician services. Instead of compensating physicians according to the performance of particular medical procedures, the brokers of health-care services, such as the federal government, indemnity health insurers, prepaid health plans, and health maintenance organizations, have begun to

2. Traditional fee-for-service compensation is being rapidly replaced by other forms of physician reimbursement. It is estimated that by 1990, fee-for-service compensation will drop to about 5 percent of the non-government subsidized health-care market; it represented 72 percent of that market in 1985. HOSPITALS, Apr. 5, 1988, at 50.


4. Langwell & Nelson, Physician Payment Systems: A Review of History, Alternatives and Evidence, 43 MED. CARE REV. 5, 23 (1986). Though fee-for-service compensation is often criticized due to its inflationary tendencies, it also provides certain benefits to both the physician and the patient. For example, the physician is not placed at financial risk, and unlike many other forms of alternative compensation, the patient can change providers easily and quickly in the midst of an episode of illness Wilensky & Rossiter, supra note 1, at 137.

5. Id. at 23.

6. The last twenty years have seen a rapid evolution of various medical delivery systems within the health-care industry. The innovations have also caused a proliferation of terminology, some of which deserve at least a brief explanation here. Historically, the most common form of protection against the financial consequences of an illness or accident has been indemnity health insurance, from which patients receive cash reimbursement for the expenses incurred related to medical treatment. A. EASTON, THE DESIGN OF A HEALTH INSURANCE MAINTENANCE ORGANIZATION 9 (1975). Prepaid health plans, on the other hand, represent an alternative to indemnity insurance by contracting directly with physicians and hospitals for the provision of services. Id. at 23. Under a prepaid plan, payments are made directly to the service provider instead of the patient. Id. The most well-known prepaid plans include Blue Cross and Blue Shield. Id.

Health maintenance organizations (HMOs) also contract directly with service providers, but provide various types of financial incentives for physicians to control the utilization of services in order to contain costs. See H. LUFT, HEALTH MAINTENANCE ORGANIZATIONS: DIMENSIONS OF PERFORMANCE 2-7 (1981). Like a prepaid health plan, HMOs are subsidized by their subscribers, who pay a fixed monthly or annual premium. Id. In a staff model HMO, for example, the organization employs physicians who receive a fixed salary. Under such an arrangement, there is no longer the incentive for physicians to take advantage of fee-for-service compensation, since the physician is not
compensate providers according to broader units of payment.7

An example is the way in which hospitals and health care providers are now compensated by the federal government for inpatient hospital services under Medicare's prospective payment program. Prior to 1983, Medicare reimbursed hospitals according to the reasonable costs incurred in providing services to Medicare beneficiaries.8 As with fee-for-service compensation, this type of retrospective payment system created an incentive for hospitals to increase the supply of services: "The more they spent for Medicare allowable costs, the more they received."9

Eventually, Congress responded by adopting a new method of reimbursing hospitals for Medicare-related costs, based on fixed rates representing the average costs of treating a Medicare patient according to the patient's diagnosis.10 Upon discharge from the hospital, patients are assigned to one of several hundred diagnosis-related groups (DRG). Each DRG represents a combination of various patient attributes, including the patient's principal diagnosis, the presence of a complicating condition, patient age, sex, and discharge status.11 Additionally, the assigned DRG may reflect the performance of a surgical procedure. Thus, for example, a hospital will receive a fixed payment for a patient assigned to DRG 222, which is defined to encompass surgical knee procedures for patients under seventy years of age who do not have a complicating medical condition.12 Importantly, if the hospital is able to treat the patient for

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7. Langwell & Nelson, supra note 4, at 5.
9. Id.
10. Id. DRG rates are also adjusted by a wage index for area differences in hospital wage levels compared to the national average hospital wage level. Id. at 5.
12. A. SPEIGEL, supra note 8, at 14.
less than the DRG payment amount, it can retain the savings and, thereby, realize a profit; however, if the treatment costs more, the hospital must absorb the loss.

Thus, by expanding the unit of payment beyond discrete medical procedures, Medicare's DRG-based reimbursement system is intended to create incentives for physicians and hospitals to contain health-care costs by placing them at financial risk for the excessive costs of their services.

Medicare's compensation scheme can be placed on a continuum of reimbursement systems based on the relative aggregation of services, the most disaggregate being compensation per discrete medical procedure under the fee-for-service system. The aggregation of services increases when the unit of payment is the DRG, which may encompass a varying number of medical procedures, depending on the particular episode of treatment. Moving along this continuum in the direction of increasing aggregation, the costs per unit of payment become more difficult to predict. The provider incurs increased financial risk as the payment unit encompasses a longer period of time and, consequently, a greater diversity and quantity of services. At the same time, the provider also receives increased incentive to control utilization of services, since the physician receives a fixed payment per unit and is, therefore, induced to maximize profits by containing the utilization and costs of services.

The economic implications of expanding the unit of payment is, perhaps, the most apparent in the case of capitated reimbursement. When the unit of payment is capitation, a physician receives a fixed rate of payment for agreeing to provide services to an individual patient over a certain period of time, usually a year. Though compensation for services can be adjusted to account for demographic characteristics, such as patient age and sex, the physician may be placed at direct financial risk for the costs of services exceeding the fixed capitated reimbursement rate. The same type of arrangement can be modified so that the physician is also responsible for the cost of specialist referrals and inpatient hospitalization, thereby placing the physician at risk for the entire cost of patient care. Of course, the benefit to the purchaser of services from this type

13. Wilensky & Rossiter, supra note 1, at 133. Though the authors observe that there is a continuum of payment units in terms of aggregation of units and services, it is less clear that cost-savings increase proportionate to the aggregation of services per unit. Id. at 148-53.
15. Id.
16. Id.
17. Id.
18. Id. at 34-35.
of risk-based provider contract is found in a predictable and fixed cost for health services resulting from the shift in financial risk from the purchaser to the provider.\textsuperscript{19} Thus, for example, a health maintenance organization (HMO) can fix a predictable capitation rate for each patient assigned to a contracting physician, leaving the physician to assume the financial risks that usually belong to the insurer. In turn, the HMO will receive a fixed premium from its subscribers in excess of the capitation rates paid to its physician, thereby generating a profit for the HMO. Under such an arrangement, the usual purchaser of health-care services—standing between the patient and the physician—has shifted its traditional role as an insurer onto the physician.\textsuperscript{20}

One response by physicians to this and other types of alternative delivery systems, and to the increasing emphasis on cost containment in general, has taken the form of collective organization. Physicians' unions, for example, have been established as a way for independent providers to attain a position of strength in negotiating with third-party payors.\textsuperscript{21} The recourse to concerted action, however, has met with rigorous scrutiny under federal antitrust legislation. After \textit{Goldfarb v. Virginia}

\begin{itemize}
\item \textsuperscript{19} See infra note 114 and accompanying text.
\item \textsuperscript{20} In a recent federal district court decision involving the McCarran-Ferguson Act, Reazin v. Blue Cross & Blue Shield of Kansas, Inc., 635 F. Supp. 1287 (D. Kan. 1986), the court offered a concise overview of the present trends in the health-care industry that is worth quoting at length:

The distinction between health care providers and insurers is blurring with the rapid development of "brokered" arrangements for the purchase and provision of health services. These brokered arrangements may be sponsored by hospitals, physicians, insurers, or a combination of the three, and may be negotiated through a number of different vehicles, including health maintenance organizations . . . or other direct contract agreements. Whatever their form, these brokered arrangements share three common elements: the sale of health benefits in a wholesale market to group purchasers attempting to obtain health services for less than full retail price; a contractual arrangement between providers and purchasers more narrowly restricting consumer choice to select provider panel; and management systems designed to insure cost effective utilization of health services. . . . The merger of health services and insurance goes beyond the development of brokered arrangements. As a result of a growing market for integrated health care delivery and financing systems, the health care product is being "repackaged" with hospitals and hospital companies integrating into health insurance functions, while insurance companies are developing networks of health care providers. Market forces influencing this integration include: fixed price and capitation programs from government, business and insurance companies; payors assuming the role of purchasers, seeking a package of health services and financing; consumer awareness of, and increased responsibility for, even increasing portions of their health care bills resulting from increasing co-payments and deductibles; and competition and excess capacity leading to provider and insurance company initiatives to improve market position.

\item \textsuperscript{21} See infra note 29 and accompanying text.
\end{itemize}
State Bar, in which the Supreme Court rejected any "learned profession" exemption from antitrust prosecution under the Sherman Act, the 1970's and early 1980's witnessed a marked increase in antitrust litigation against members of the health care industry. This trend has left some independent physicians in a position of diminished bargaining power relative to the legal and administrative capacities of third-party payors to establish the level of compensation for medical services.

The goal of this Comment is to suggest that health-care providers who are placed at financial risk for the provision of medical services may be entitled to the limited antitrust exemption that is available to the insurance industry through the McCarran-Ferguson Act (Act). Though physicians and other health-care providers should not be given complete immunity from federal antitrust laws, they should be permitted to engage in some restricted forms of concerted activity in return for bearing the economic risks traditionally borne by conventional insurers of health-care services. As is made clear below, the Act's limited exemption should be granted to providers only in those situations where their conduct satisfies the applicable requirements of the Act.

II. PHYSICIAN ORGANIZATION AND THE ANTITRUST RESPONSE

Professional trade associations have traditionally played an important role in the health-care industry as a mechanism for self-regulation. More recently, these organizations, together with broader based profes-
sional unions,29 have begun a process of collectivization as a means to protect private economic and professional interests. The perceived threat comes from outside the medical profession and takes several forms: health care providers are increasingly placed at financial risk for the efficient provision of medical services;30 compensation for services is sometimes linked to a provider's compliance with rigorous utilization and quality assurance programs;31 the presence of a competitive health-care plan within a community can force a physician to choose between a reduction in fees if he joins the plan or a possible decrease in patient load if he does not.32 Not surprisingly, in reaction to the combined emphasis on enhanced competition and cost-containment, independent physicians have resorted to various forms of collective activity. The antitrust response, however, has not been sympathetic.

Despite the complexity of antitrust law a brief, statutory review of the relevant federal legislation is necessary to understand the potential liability that health-care providers may incur as a result of certain collective activities. Generally, federal antitrust laws seek to prevent aggregations of economic power that stifle the opportunity for competition.33 This goal is accomplished through the enforcement of three pieces of federal legislation: the Sherman Act, the Clayton Act, and the Federal Trade Commission Act.

The Sherman Act34 is considered the cornerstone of the antitrust law. Section 1 succinctly declares: "Every contract, combination in the form of trust or otherwise, or conspiracy in restraint of trade or commerce among the several States" is illegal.35 The operative phrase—restraint of trade—has given rise to the basic tenet of antitrust law, known as the rule of reason: "Only those restraints of trade which are unreason-

29. The Union of American Physicians and Dentists, for example, was established by doctors and dentists to assist in negotiations between providers and HMOs. The union has locals in seventeen states and 40,000 members as of March 1987. HOSPITALS, Mar. 5, 1987, at 58.
30. See infra notes 102-119 and accompanying text.
31. For example, a physician who participates in a prepaid health plan may be required to demonstrate the medical necessity of the services proposed or actually performed in order to receive compensation. See D. COWEN, PREFERRED PROVIDER ORGANIZATIONS: PLANNING, STRUCTURE, AND ORGANIZATION 169-77 (1984).
33. See generally E. KINTER, AN ANTITRUST PRIMER (1973) for an accessible overview of a complicated topic.
35. Id.
able have been held to violate the law."\textsuperscript{36} With the exception of certain activities presumed to be illegal, a defendant in an antitrust action has the opportunity to show that the challenged activities are reasonable in view of the pending business conditions and that they do not in fact substantially and adversely impair competition.\textsuperscript{37} To eliminate the need for this inquiry in every instance of antitrust enforcement, however, the courts have developed the rule that "there are certain agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable and therefore illegal"\textsuperscript{38} regardless of the actual harm caused or the defendant's excuse. Examples of per se violations include price-fixing agreements, group boycotts, and agreements to divide markets.\textsuperscript{39} As shown below, independent physicians who undertake concerted activity in order to influence their compensation from third-party payors may be subject to Sherman Act scrutiny under the rule of reason or the standard of per se illegality, depending on the particular conduct.\textsuperscript{40}

Section two of the Sherman Act\textsuperscript{41} prohibits the monopolization or attempted monopolization of markets. It is "primarily concerned with the situation in which a single firm or corporation achieves or seeks to achieve a position of such size and power that it is capable of restraining trade by its own, unaided efforts."\textsuperscript{42} As a general rule, monopoly power has been defined as the ability to control prices or exclude competition from markets,\textsuperscript{43} though federal courts have not established a definitive or consistent means to establish when a firm possesses such power.\textsuperscript{44} Section two liability will arise when a firm engages in restraints of trade, such as boycotts and tying arrangements, in order to obtain its monopoly power.\textsuperscript{45} It has also been held to apply when a firm lawfully obtains its monopoly power through normal, competitive means, and thereafter engages in trade restraints as a way to expand or maintain that power.\textsuperscript{46}

The Clayton Act\textsuperscript{47} was passed by Congress in order to close some of
the gaps left open by the Sherman Act. The substantive offenses under the Clayton Act have primarily to do with the sale of goods and commodities, corporate acquisitions, interlocking directorates, and price discrimination. As such, the Clayton Act is unlikely to have a significant effect in the context of concerted action by the providers of health services. This type of activity more appropriately falls under the Sherman Act's broad sweep.

Lastly, the Federal Trade Commission Act declares that "unfair or deceptive acts or practices" are unlawful. This language encompasses the same anticompetitive standards found in the Sherman and Clayton Acts, but the FTC Act goes further in permitting the Federal Trade Commission to "stop in their incipiency acts and practices, which, when full blown, would violate" the Sherman and Clayton Acts. Thus, the FTC Act is important from an enforcement perspective, because it gives the FTC the capacity to police interstate commerce for anticompetitive conduct. Moreover, the FTC Act established the Federal Trade Commission as an agency designed to protect the public from deceptive commercial practices and protect the competitive structure of the nation's economy.

Returning to the context of health care, the current trend of heightened antitrust scrutiny over concerted activity among professionals can be traced at least as far back as Goldfarb v. Virginia State Bar, in which the Supreme Court held that the use of agreed upon, recommended fee schedules by bar association members was a violation of the Sherman Act. Though Goldfarb was not the first case to apply antitrust standards to professional activities, the Court's firm rejection of a "learned profession" exemption has "opened the door through which many have since marched." That the Court's decision was part of a broader movement to promote competition within the learned professions is supported, in

50. E. KINTER, supra note 33, at 23.
51. Id. at 23.
53. See, e.g., American Medical Ass'n v. United States, 317 U.S. 519 (1943) (considered the first significant application of antitrust principles to health providers).
part, by the enactment of the Health Maintenance Organization Act just two years earlier. In passing the HMO Act, Congress sought to spur economic efficiency within the health care industry by providing financial support and federal guidelines for the creation of competitive health maintenance organizations on a national basis.

After Goldfarb, Arizona v. Maricopa County Medical Society confirmed that the health care industry would be treated as any other in the eyes of federal antitrust law. Maricopa involved a non-profit corporation composed of roughly 1,750 physicians engaged in private practice. The organization was created in order to promote fee-for-service medicine and to provide the community with an alternative to existing health insurance plans by establishing maximum fees for participating providers. Because the providers themselves fixed the maximum fees payable by insurers, the arrangement was held to constitute a per se violation of the Sherman Act. That the Court's ruling on such a complex issue was made on a motion for summary judgment has been described as "troubling" and reminiscent of "times . . . when antitrust cases were decided more by reference to talismanic phrases than careful analysis."

The same criticism might not apply to the Court's approach in FTC v. Indiana Federation of Dentists, in which it refused to apply the per se rule in the context of a group boycott. Like Maricopa, the case is indicative of the response by medical professionals to cost-containment efforts imposed by third-party payors. Specifically, dental health insurers had implemented a cost-containment program whereby the insurer evaluated a provider's services to determine the necessity of treatment. As part of the program, insurers frequently requested dentists to submit, along with insurance claim forms, any dental x-rays that had been taken in the course of treatment. The insurer used the x-rays and other medical information as a basis for approving or disapproving a patient's insurance claim. In response, the Indiana Federation of Dentists (IFD), comprising

56. The Health Maintenance Organization Act of 1973, P.L. 93-222, 87 Stat. 914 (1973) (codified at 42 U.S.C. § 300e (1982), delineates the requirements an HMO must meet to become federally qualified according to organizational structure, health care benefits, and the manner of conducting business. Though federal qualification is not intended to represent that the HMO is financially viable, qualification is necessary to receive federal subsidies under the act and also serves as a means to demonstrate publicly that the HMO has complied with a federally uniform standard.
58. Id. at 341.
approximately eighty-five percent of the practicing dentists in the state, enlisted member dentists to pledge not to submit x-rays as requested.

Though the Court conceded that the IFD’s dealings with the insurers resembled a group boycott, it did not apply the traditional rule that such activities are per se illegal under the Sherman Act. Though this may be considered a step in the direction of leniency for the health care industry, the Court still sustained the FTC’s finding that the Federation’s policy of withholding x-rays was an unreasonable restraint of trade and, therefore, in violation of the Sherman Act.

Similarly, health-care providers will not be allowed to boycott competitors who agree to participate in lower cost health-service agencies, such as HMOs. This was made clear in Feminist Women’s Health Center v. Mohammad, in which a group of physicians undertook concerted action to interfere with the successful operation of a local abortion clinic. In response to the clinic’s advertised price for first trimester abortions at less than half of that charged by area physicians, a group of local doctors attempted to persuade other physicians from associating with the clinic. The conduct was held to be a per se violation under the Sherman Act.

The above cases are representative of how federal antitrust legislation has been employed to prevent collective activity on the behalf of medical professionals in response to cost-containment mechanisms and the promotion of competition within the health-care industry. There are however, some forms of concerted activity among health-care professionals that are not subject to antitrust scrutiny.

In Wilk v. American Medical Association, for example, the court of appeals held that it was “free to modify the rule of reason test in a case involving a certain kind of question of ethics for the medical profession.” Specifically, the court held that a group of defendants would be able to introduce evidence that their collective activity was motivated by a concern for the health and lives of the patients for whom they had accepted responsibility. An application of the “patient care motive,” however, will not be casually approved. The rule “should impose a heavy burden on those who would justify conduct having a significant anti-competitive effect.”

61. Id. at 2018.
62. Id. at 2018-21.
64. Id. at 1264-67.
65. 719 F.2d 207, 226 (7th Cir. 1983).
66. Id.
67. Id. at 227.
Concerted activity is also immune from antitrust scrutiny if it is "clearly articulated and affirmatively expressed as state policy." For example, a court of appeals has held that a hospital staff's review of a physician's medical procedures as required by Indiana law will not give rise to an antitrust violation.

Lastly, a group of medical providers may have a defense from antitrust enforcement if it can be shown that the local nature and effect of their conduct is not a sufficient influence on interstate commerce to fall within federal antitrust legislation. However, the availability of this defense has been largely eroded by the Supreme Court's decision in Hospital Building Company v. Rex Hospital Trustees that the purchase of medical supplies from out of state will satisfy the jurisdictional requirements of the Sherman Act.

There are, however, some instances where antitrust enforcement is compatible with the medical profession's process of self-regulation. The following are examples of collective activity by professional trade associations that will not give rise to infraction:

1. disciplining or expelling members of an association for incompetence or dishonesty, or because the member engaged in false or deceptive advertising;
2. sponsoring or participating in peer review of fees and the quality of care provided by professionals when the risk of anticompetitive conduct is minimized;
3. sponsoring or participating in the accreditation of professional schools and certification programs whereby a professional association certifies that its members are trained and qualified in particular areas of specialization.

Additionally, a group of independent physicians other than a trade association may participate in some forms of collective activity provided it does not have an anticompetitive effect. The following are examples of how a union of independent physicians may conduct itself.

1. Representatives for a union can hold meetings with third-party payors in order to present the union members' viewpoints, suggest options and

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73. Jacobs, supra note 72, at 840.
74. Id.
solutions with regard to the relationship between the parties, so long as
the union members do not form an agreement among themselves con-
cerning their conduct with the payor.\textsuperscript{75}

2. The union can disseminate information, such as results of studies hav-
ing to do with third-party payors in order to help members make in-
formed, but independent, decisions.\textsuperscript{76}

3. Union members can engage in non-deceptive publicity and advertising
in order to express individual and joint physician concerns to the
public.\textsuperscript{77}

4. Union members can meet to discuss common problems so long as there
is no conspiracy or agreement reached.\textsuperscript{78}

When physicians are placed at financial risk for the provision of
medical services, these types of collective activity may not go far enough
to protect providers against economic loss, especially during negotiati-
ons with a third-party payor that possesses the financial and administrative
resources to predict expected costs more accurately than the physician.
Moreover, the types of self-regulation found within professional trade as-
sociations are not intended to protect the economic interests of physi-
cians as they enter into bargaining with the purchasers of medical
services.\textsuperscript{79}

As I hope to show below, those physicians who are placed at finan-
cial risk for the provision of medical services may be able to take advan-
tage of the McCarran-Ferguson Act as a means to pursue certain
restrictive forms of collective activity, which go beyond those listed
above, for the purpose of assessing financial risk and determining appro-
priate compensation rates for risk-based provider arrangements. The Act
is not intended to provide a blanket exemption from anticompetitive con-
duct, and it is not the goal of this Comment to suggest that medical prov-
iders should be entirely immune from antitrust legislation. However, as
physicians incur the financial risks associated with the business of insur-
ance, they should be granted the same limited antitrust exemption that is
presently afforded the insurance industry under the McCarran-Ferguson
Act.


\textsuperscript{76} Id.

\textsuperscript{77} Id.

\textsuperscript{78} Id.

\textsuperscript{79} Adding to the potential disparity in the bargaining power is the fact that third-party payors
find themselves in a position of strength due to the growing oversupply of providers. Powers, Allocation of Risk in Managed Health Care, in MANAGED HEALTH CARE: LEGAL AND OPERATIONS
III. THE MCCARRAN-FERGUSON ACT: HISTORY AND BACKGROUND

Any meaningful discussion of the McCarran-Ferguson Act requires some familiarity with the reasons for its enactment.

For over seventy-five years prior to 1945, when the McCarran-Ferguson Act was passed, state insurance departments exercised their authority over the insurance industry without federal oversight or intervention. As early as 1868, the Supreme Court's dictum that "issuing a policy of insurance is not a transaction of commerce" led many to conclude that the federal government was incapable of intervention, since its authority was thus proscribed under the commerce clause.

In 1944, however, the Supreme Court shocked the industry with its landmark decision of United States v. South-Eastern Underwriters Association (S.E.U.A.), in which it held that the insurance industry was subject to federal regulation under the commerce clause. More importantly, the Court held that the same industry was subject to federal antitrust law, specifically, the Sherman Act.

The congressional response to the S.E.U.A. decision was influenced by three concerns of the insurance industry as it reacted to the ruling. First, there was the immediate threat of criminal prosecution felt by those who had for years assumed that their industry was immune from antitrust enforcement. Second, it was feared that state tax and regulatory schemes would be found unconstitutional under the commerce clause. And, third, it was believed that the Court's decision would now make possible a federal takeover of state insurance regulation under the activist Roosevelt administration. The latter concern has been described as "one of the important issues addressed by the McCarran-Ferguson Act."

Though Congress did not accede to proposals for granting the industry complete antitrust immunity, the McCarran-Ferguson Act, as enacted, embodied a compromise between the enforcement of federal an-

4. Id. at 553-62.
5. Weller, supra note 80, at 90.
6. Id. at 91.
7. Id. at 92.
8. Id. at 92-93.
9. The complete-exemption bills were sponsored by the stock insurance industry, which was the most directly affected by the Supreme Court's ruling in S.E.U.A. Weller, supra note 80, at 592.
ANTITRUST EXEMPTION

...titrust law and the preservation of state regulation. Specifically, the Act provides that "the 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." The Act's language reflects the congressional belief that the states were better equipped to regulate the insurance business because of their familiarity with the local industry and because of their prior experience in regulating the same.

Additionally, the statute's exemption is further limited insofar as it is "inapplicable to any agreement to boycott, coerce, intimidate, or act of boycotting, coercion, or intimidating." This provision is intended to sustain an application of the antitrust laws in those circumstances where insurers exceed "the realm of state-supervised cooperative action."

Thus, the Act is not designed to overrule entirely the Court's decision in *S.E.U.A.*, which made the insurance industry subject to antitrust scrutiny. Rather, the congressional response to *S.E.U.A.* represents an accommodation of state and federal interests that is indicative of the federalist process.

IV. THE MCCARRAN-FERGUSON ACT AS APPLIED TO RISK-BASED PROVIDER ARRANGEMENTS

A. Requirement for an Application of the Exemption

An application of the McCarran-Ferguson Act's antitrust exemption turns on three separate inquiries:

1. whether the challenged activity is part of the "business of insurance";
2. whether the activity is regulated by state law; and
3. whether the activity constitutes an agreement or act of boycott, coercion, or intimidation.

The discussion below is intended to test the viability of the Act's limited antitrust exemption in the context of health-care providers who are placed at financial risk for the provision of medical services. I will...
address separately each of the statute’s three principal elements, as described above.

B. The "Business of Insurance"

The Supreme Court has only twice ruled on what constitutes the "business of insurance" under the McCarran-Ferguson Act in the context of antitrust enforcement. Consequently, the lack of statutory definition combined with numerous lower court decisions makes it difficult to apply the Act's exemption with any precision. Still, there is adequate authority, both legislative and judicial, to suggest that providers who are placed at financial risk are engaged in the "business of insurance."

1. Risk-Spreading. The Supreme Court’s reasoning in Group Life and Health Insurance v. Royal Drug is especially apposite, despite the Court’s ruling against exemption in the case. Even in denying protection under the, Act the case sheds important light on the statute’s intended purpose.

The plaintiffs in Royal Drug brought an action against Blue Shield of Texas and three pharmacies with which Blue Shield had contracted under its “Pharmacy Agreement.” The agreement, which was offered on a state-wide basis, provided that Blue Shield would reimburse the acquisition cost for each prescription filled for its policyholders. The pharmacy would retain a $2.00 fee paid by the policyholder upon purchase of the drugs. The plaintiffs alleged that this arrangement constituted a violation of the Sherman Act because the defendants allegedly agreed upon and fixed the price of the drugs, thereby inducing Blue Shield’s policyholders to boycott those pharmacies that had not entered into a similar agreement.

The Court began its discussion by distinguishing the “business of insurance,” which is protected by the Act, from the “business of insurers,” which is not: “Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the ‘business of insurance’ does the statute apply.” Going further, the

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97. 440 U.S. at 207.
98. Id. at 211 (quoting SEC v. National Securities, Inc., 393 U.S. 453 (1972)).
Court explained that the "business of insurance" necessarily entails the spreading and underwriting of risks. The pharmacy agreements in question, however, did not satisfy this requirement, since they were "merely arrangements for the purchase of goods and services by Blue Shield." Thus, the contracts were "legally indistinguishable from countless other business arrangements that may be made by insurance companies to keep their costs low and thereby lower the level of premiums charged to their policyholders."

At first, this treatment of an interindustry agreement between an insurer and its providers would appear to preclude an application of the McCarran-Ferguson Act to similar arrangements between third party payors and health-care professionals. There are, however, important exceptions that arise in the case of physicians who incur the financial risks that have been traditionally borne by indemnity insurers or prepaid health plans, such as Blue Shield in the *Royal Drug* case. With this in mind, the Court's emphasis on risk-spreading is particularly appropriate for those arrangements in which the purchaser of health services, such as an HMO, is able to transfer some or all of its risk to the provider.

It is necessary at this point to examine risk-based provider arrangements in further detail in order to assess the Act's application to risk-spreading activities involving health-care providers.

In the most general terms, the risk-spreading role of physicians is created by expanding the unit of payment for a provider's services beyond the discrete medical procedure, which traditionally has served as the basis for compensation under the fee-for-service system. The expansion of the payment unit can take several forms, depending on the extent to which the unit represents anticipated costs over a greater or lesser period of time. As discussed in Section I above, the alternatives can be placed on a continuum from payment for a particular procedure (fee-for-service) to a rate of compensation based on demographically determined patient attributes (capitation). The following are considered alter-

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99. *Id.* at 211-12. The Court sheds additional light on its understanding of risk spreading with the following quote: "It is characteristic of insurance that a number of risks are accepted, some of which involve losses, and that such losses are spread over all of the risks at a slight fraction of the possible liability upon it." *Id.* (quoting 1 G. COUCH, *CYCLOPEDIA OF INSURANCE LAW* § 1:3 (2d ed. 1959)).

100. *Id.* at 214.

101. *Id.*

native payment units for physician compensation, ordered from discrete to less discrete payment units:

1. medical procedure (fee-for-service),
2. medical case (e.g., office visit or hospital admission),
3. episode of illness (e.g., diagnosis related groups),
4. capitation for ambulatory services only,
5. capitation for all health services, including referrals and inpatient hospitalization.  

The last and most extreme example from this list provides the clearest illustration of how the business of insurance can be combined with the practice of medicine. Under a fully capitated delivery system, physicians receive a periodic payment (usually monthly) for treating a fixed number of patients for a specified period, usually one year. Generally, the physician receives the payment whether or not the patients actually require medical attention. The arrangement frequently involves a contractual relationship between the physician, serving as an independent contractor, and a third-party purchaser of health services, such as an HMO. In turn, the payor is subsidized by its subscribers, their employers, or both, who pay a fixed monthly premium directly to the third-party payor. The payor then contracts with physicians, also at fixed rates, and makes the participating physicians available to the subscriber. Generally, this type of plan provides comprehensive health care without the deductible payments that are frequently associated with indemnity or pre-paid health insurers. Under a fully capitated model, the fixed payment made to a participating physician is intended to cover the entire cost of medical treatment for each patient, including referrals to specialists and even, in some circumstances, inpatient hospitalization. Additionally, the physician may be placed in the role of a “gate-keeper,” making him a guardian of the patient’s health and giving him the responsibility to control the amount of care that his assigned patients receive. The gate-keeper function creates an incentive for the physician to prevent needless and costly hospitalization or referrals to specialists, since she will incur the costs for such, making her practice less profitable. Thus, if

103. Langwell & Nelson, supra note 4, at 22-23.
105. See infra note 111.
107. Langwell & Nelson, supra note 4, at 22-23.
108. See Wilensky & Rossiter, supra note 1, at 144-48.
109. See Paxton, Are Gatekeepers Good for Medicine?, Med. Econ., Dec. 22, 1986, at 60. In 1984, there was a 117 percent increase in the number of independent provider associations, which frequently employ the gate-keeper model. Id. at 62.
the physician on average is able to control the costs of care for the patients assigned to her, she will realize a profit from the balance of the capitation fee paid to her by the third party payor. However, if costs exceed revenue, the physician suffers a financial loss.

The compensation paid to physicians under a capitated plan is determined by actuarial projections of how much it will cost on average to treat a specified number of patients, taking into consideration certain demographic features, such as patient age and sex. The insuring function of the capitated physician is underscored by the fact that payments to the physician are made whether or not the assigned patients use her services.

Some of the financial risk on a provider under this sort of reimbursement system might be alleviated if the provider belongs to a group of physicians who distribute the risk among its members. For example, a group of physicians that contracts as a single entity with an HMO will be in a less vulnerable position if they are able to spread any financial loss among themselves. A single, costly episode, which might ruin an independently capitated physician, may be better absorbed by several practitioners who can offset the financial loss among some of their members with the profits of others. Nevertheless, the risk remains with the physicians, so that the group, instead of a single provider, takes on the insuring function.

Under a fully capitated model, in which the physicians bear the entire costs of medical treatment, the insuring function is shifted entirely from the traditional insuring entity to the health-care providers:

The primary benefit of a capitation system to the HMO is that the risk of providing health services is no longer borne by the HMO. Instead, the risk is shifted directly to the hospital and physicians. As a result, the primary role of a capitated HMO is no longer that of insurer. This role has changed to that of a non-risk bearing intermediary that serves as a broker between

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110. Langwell & Nelson, supra note 4, at 23.
111. Capitation arrangements "share the common characteristics that there is little or no direct relationship between the compensation received by the physician and the quantity of services which he renders." A. Easton, supra note 6, at 39.
112. Langwell & Nelson, supra note 4, at 37-38. See also A. Easton, supra note 6, at 37. Group practice organizations vary widely in size and type of practice. Id. at 37.
113. A. Easton, supra note 6, at 39. Though a group of physicians may possess the administrative and financial resources to better determine adequate compensation for risk-based provider arrangements, the consolidation of physicians as a partnership or professional corporation should not itself prevent an application of the McCarran-Ferguson Act. See infra note 136.
its subscribers and the providers of health care services . . . .114

Though the third-party payor, or "broker" in the above quotation, is not without some administrative responsibilities,115 the "business of insurance" rests entirely with the health-care providers.

The financial risk that is borne by the fully capitated physician, as described above, can be diminished by narrowing the unit of compensation. For example, the physician may bear the risk of primary care services only.116 Under such a plan, the primary care provider accepts fixed payments per patient only for those ambulatory services he actually provides, while the risks associated with referrals to specialists and inpatient hospitalization are borne by the other providers during the course of treatment or by the third-party payor. Such an arrangement entails fewer risks for the physician, since the high cost of referrals and hospitalization fall elsewhere. The result is that the insuring function for all services provided under the plan may be distributed among several entities.

Moving further in the direction of more discrete and, therefore, less risky payment units, the physician may be reimbursed based on any of the following: (1) the patient's specific illness, (2) general categories of medical treatment (such as an office visit or hospital admission), or (3) a particular medical procedure. As the unit of payment is made to encompass fewer medical procedures and a shorter period of time, it becomes easier to predict actual costs associated with each unit of service. Consequently, the financial risk diminishes as the payment unit gets smaller.117 The physician's incentive to contain medical costs, however, also decreases as the unit is made more concise. For example, a physician who is paid for each medical procedure he performs will have an incentive to over-treat his patients; whereas, the fully capitated provider seeks to limit treatment to those services actually required, since she bears the financial risk for any costs in excess of the fixed payment she receives from the third-party payor.118 The rapid increase in the number of HMO's, which

115. These include administrative work relating to the processing of enrollee applications, development of operational policies and procedures, development of management information systems, and management and distribution of capitation fees. Id. at 70.
116. Primary care services generally encompass those basic medical services that a patient receives during his initial contact with the medical system for an injury or illness and includes the coordination of subsequent medical treatment, such as referrals to specialists or inpatient hospitalization. See P. Lee, L. LeRoy, J. Stalcup & J. Beck, PRIMARY CARE IN A SPECIALIZED WORLD 3, 5 (1976).
117. See Wilensky & Rossiter, supra note 1, at 149.
118. See Langwell & Nelson, supra note 4, at 23.
frequently use some form of capitation arrangement, suggests that capitation reimbursement will become common place among health-care delivery systems.\textsuperscript{119}

With this understanding of how the practice of medicine and the business of insurance are being merged, we can now return to the Supreme Court’s emphasis on risk-spreading as an essential element of the McCarran-Ferguson Act’s antitrust exemption.

\textit{Royal Drug} stands for the proposition that the incidental commercial activities of the insurance industry are not entitled to antitrust immunity because they do not properly belong to the "business of insurance." The purchase of goods and services by the insurer are distinct from the risk-spreading that takes place between it and its insureds. But what about those circumstances in which the insuring function is transferred, in whole or in substantial part, to the providers of medical services? For the reasons discussed below, the Act’s antitrust exemption should rest with those whom the Act was intended to protect. Where physicians are, in fact, engaged in the "business of insurance," then the exemption should reside with them.

This argument finds support in the Court’s own understanding of why the business of insurance has been afforded an exemption from the federal antitrust laws. Pointing to the legislative history of the McCarran-Ferguson Act, the Court in \textit{Royal Drug} observed:

Because the widespread view that it is very difficult to underwrite risks in an informed and responsible way without intra-industry cooperation, the primary concern of both representatives of the insurance industry and the Congress was that cooperative ratemaking efforts be exempt from the antitrust laws.\textsuperscript{120}

Thus, passage of the Act was motivated, in part, by a concern for those who would suffer financial loss or demise due to inaccurate underwriting.\textsuperscript{121} In particular, the legislative history reflects a concern for those insurers that may not possess the resources required for accurate underwriting. The Court in \textit{Royal Drug} relied on a report to the Senate Committee submitted by the National Association of Insurance Comm-

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\textsuperscript{119} According to a recent HMO census report, 27.7 million people, or approximately 13 percent of the U.S. population, are enrolled in 654 HMO’s. The HMO industry experienced a growth rate of 20 percent in enrollment and 50 percent in the number of new plans from 1981 to 1985. \textsc{interstudy}, \textit{National HMO Census Report} (1986).

\textsuperscript{120} 440 U.S. at 221.

\textsuperscript{121} See J. \textsc{Day}, \textit{Economic Regulation of Insurance in the United States} 7, 8 (1970) ("Unbridled competition was viewed as a cause of depressed rates and insurance company failures.")
\end{flushleft}
missioners (NAIC), which was influential in shaping the Act's final version. The report emphasized that "smaller enterprises and insurers [may be] unable to underwrite risks accurately" and that the prohibition of "combined efforts for statistical and ratemaking purposes would be a backward step in the development of a progressive business." 122 The NAIC's concern that some insurers may be unable to properly underwrite risks is, perhaps, no longer justified; in fact, some critics argue that the Act is obsolete and should be repealed due to its anticompetitive effects. 123 The NAIC's rationale for cooperative ratemaking activities, however, finds a new and valuable application to the "progressive business" of modern health-care delivery, in which small enterprises—sometimes individual physicians—are assuming the unfamiliar role of insurers, and at times, suffering the financial consequences that motivated the NAIC's call for cooperative underwriting and ratemaking activities. 124

Moreover, the methods used to establish capitation rates for health-care providers are very similar to the methods that insurance companies have used to set premiums. 125 In both cases, the collection and processing of data is essential to an accurate assessment of future costs and appropriate pricing. Under the Act, insurance companies are permitted to

122. 440 U.S. at 221-22.
124. See, e.g., Brown, Why an HMO and its Founding Doctors are Facing Off in Court, MED. ECON., Dec. 8, 1986, at 64 (describing financial loss suffered by capitated physicians as a result of catastrophic clinical event); Cook & Rodnick, Evaluating HMO/IPA Contracts for Family Physicians: One Group's Experience, 26 FAMILY PRACTICE 325 (1988) (fifteen physician primary care group experienced $43,297 loss under capitation arrangement with HMO).
125. Anderson, Steinberg, Holloway & Cantor, Paying HMO Care: Issues and Options in Setting Capitation Rates, 64 MILBANK Q. 548, 555 (1986). The authors explain that insurance companies rely on two methods to set premiums—manual rating and experience rating:

Manual rating uses demographic and other data to calculate payment rates for different classes of enrollees. Published tables provide actuarial adjustments for factors such as age, sex, geographic location, size of insurance plan, etc. Manual rating is generally
engage in cooperative pooling of information as a means to facilitate the underwriting of risks.\textsuperscript{126} Property-liability insurers also participate in rate bureaus that go beyond the collection of data in publishing "bureau rates" based on the information provided by their members.\textsuperscript{127} Though the possible anticompetitive effects of rate bureaus have not gone unnoticed,\textsuperscript{128} the Act's limited antitrust exemption, nevertheless, condones this type of concerted activity.\textsuperscript{129} Until the Act is repealed or amended to restrict collective activity by insurers, health-care providers who are placed at a financial risk should be accorded the same exemption in order that they too may be able to engage in the collection and processing of data used to establish capitation rates. Without this ability, it is likely that capitation rates will continue to be set by third-party payors who possess the resources necessary for the task.\textsuperscript{130} Consequently, risk-based providers who do not by themselves have the financial and administrative resources for determining adequate capitation rates will remain in a po-

used by insurance companies only for small groups or new clients for whom experience rating is not feasible.

... .

Experience rating, in contrast, relies on other factors to determine premium rates. These include the actual historical health-care costs of a specific group of individuals, as well as a projection of the rate of inflation, an allowance for profits and reserves ... and adjustments for changes in the pool of eligible individuals and the level of coverage from year to year. Experience-rating systems are based upon group rather than individual enrollee experience ... .

Capitation prices are established using modified versions of these two premium-setting methodologies. \textit{Id. See also} D. MACKIE \& D. DECKER, \textit{supra} note 104, at 129-49 (methods of premium determination for HMOs).

\textsuperscript{126} See \textit{Exemptions and Immunities}, \textit{supra} note 123, at 1249. Though the collection and analysis of historical data may not give rise to antitrust violations, the present status of antitrust law "does not permit the collection or trending of prospective costs, which is considered essential to the insurance rate-making process." \textit{Seiler, Should Congress Repeal McCarran-Ferguson?}, 1 \textit{ANTITRUST} 31, 32 (Summer 1987) (summarizing testimony of Mark Horning before Senate hearings on S. 80).

\textsuperscript{127} \textit{Exemptions and Immunities, supra} note 123, at 1250.

\textsuperscript{128} \textit{See, e.g.,} Angoff, \textit{supra} note 123, at 404-15.


\textsuperscript{130} In the case of the insurance industry, competition from smaller insurers is made possible by cooperative rate-making activity because smaller enterprises "have neither the resources nor the underlying credible data to make their own rates." \textit{Seiler, supra} note 126, at 32. Analogously, independent providers or small physician groups that enter into capitation agreements are also likely lack the necessary resources for setting appropriate capitation rates.
sition of diminished bargaining strength when negotiating rates.\footnote{131}{See, e.g., Managed Care: Whoever has the Data Wins the Game, HOSPITALS, Apr. 5, 1988, at 51. The executive director of Central Health Services, a provider group with 140 affiliated physicians, observed that the organization has no way of knowing whether the data provided by insurers is complete or accurate. \textit{Id.} at 51. In response, a national managed care practice director with Price Waterhouse stated, "The HMO is holding all the cards that way. It's not a smart way to do business." \textit{Id.}}

Also under the rubric of risk-spreading, we should consider what would happen to the Act's antitrust exemption if it were not applied to those physicians who take on the role of insurers. \textit{Reazin v. Blue Cross & Blue Shield of Kansas, Inc.}\footnote{132}{663 F. Supp. 1360 (D. Kan. 1987).} provides a clue. The defendant in \textit{Reazin} provided private health-care financing through its subsidiary, HMO Kansas. The defendant HMO employed a capitation reimbursement system in which participating physicians were paid a specified amount for each member choosing that physician as his or her primary care provider. A portion of this fee was paid into a capitation fund to cover the costs of inpatient hospitalization and referrals to specialists. At the end of each year, the capitation fund was distributed to participating physicians on a pro rata share based on the number of patients treated. The defendant sought the protection of the McCarran-Ferguson Act in an antitrust action against it, arguing that its role as a third-party payor belonged to the "business of insurance" under the Act. The court conceded that "the formerly distinct boundaries among hospitals, physicians, and insurers are 'blurring' with the emergence of ... new financing arrangements attempting to obtain health services for less than full retail price ... ."\footnote{133}{\textit{Id.} at 1403.} Still, the exemption was denied. The court reasoned that companies should not be allowed to take advantage of the Act's exemption by "simply diversifying into areas not traditionally considered to be the 'business of insurance.'\footnote{134}{\textit{Id.}} This argument is unpersuasive because it assumes that courts will be unable to distinguish risk-spreading activities from other, general commercial arrangements. The Supreme Court's holding in \textit{Royal Drug} is intended to make possible this very distinction. Whatever the merits of the court's reasoning, the result in \textit{Reazin} is at least consistent with the Supreme Court's emphasis on risk-spreading as an integral part of the business of insurance. From the facts presented, it appears that the capitation system at issue in \textit{Reazin} would have transferred a substantial portion of the financial risk from the defendant HMO to the physicians who participated in the plan. For this reason, and not those
offered by the court, the defendants should not have received antitrust immunity under the Act.

For the purpose of our own analysis, *Reazin* provides at least tentative support for the conclusion that private health-care financing will not be recognized as the business of insurance. If, in turn, federal courts refuse to grant the exemption to physicians who participate in similar plans, then they will have, in effect, achieved a partial repeal of the Act. In a capitated reimbursement plan, such as that discussed in *Reazin*, the insuring function does not disappear. It may be transferred in whole or in part to the participating physicians, but the risk remains. Consequently, if courts are not careful in discerning which party deserves the Act’s exemption, they may end up eliminating it entirely by refusing to grant it to anyone. This is not to deny that there may be cases in which the insuring function is distributed among the parties, so that neither the participating physicians nor the third-party payer bears a substantial portion of the total risk. Still, in those cases in which the providers are the principal

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136. The application of the Act’s antitrust exemption becomes problematic in those situations where the insuring function is split between the participating providers in a plan and the third-party payor, or where the risk is distributed among multiple providers, such as primary care physicians, specialists, and hospitals. See, e.g., Ramsdell, *Physician Reimbursement for Services to HMO-sponsored Patients*, 23 MED. CARE REV. 1315 (1985) (describing capitation arrangement that divided risk for outpatient services between primary care physicians and specialty physicians). For example, a capitated reimbursement scheme may be limited to those services that a participating physician actually provides so that the risks associated with referrals to specialists and inpatient hospitalization may be borne by the third-party payor. Consequently, the total risk for the care provided under the plan is divided between the providers and the purchaser of health services.

Adding to the complexity, physicians frequently organize themselves as partnerships or professional corporations before participating in risk-based provider arrangements; the organization as a whole contracts with the third-party payor so that the risk of financial loss is spread among its members.

A single example of how the allocation of risk may influence the application of the Act is found in *Hoffman v. Delta Dental Plan of Minnesota*, 517 F. Supp. 564 (D. Minn. 1981). *Hoffman* involved an antitrust action brought by a professional corporation against a nonprofit dental service plan, in which 95 percent of the state’s dentists were participating members. The defendant, Delta, served as a third-party payor in purchasing dental services for its group subscribers. The plaintiff charged that Delta’s fee schedules favored its own participating dentists, resulting in a state-wide monopoly of dentistry. The contracts between Delta and its participating dentists provided for a five percent withholding of the dentist’s fees. Though the court did not specify in any detail the terms of the withholding provision, generally, this type of arrangement is created as a way to give health-care providers an incentive to contain utilization of services. A percentage of the provider’s charges—anywhere from five to twenty percent—are withheld by the third-party payor and placed in a reserve account. See Powers, supra note 79, at 279, 292. The third-party payor then establishes certain utilization targets, which the provider is expected not to exceed. The nature of the targets vary, but typically include a fixed limit for the provider’s expenditures in treating his assigned patients. If actual costs exceed the target, then the reserve funds are used to offset the excess costs. Thus, the
risk-spreading in a health-delivery system, courts should not be quick to dismiss the Act’s application simply because physicians are “not traditionally considered” to be in the business of insurance.

Finally, on the topic of risk-spreading, we should note that the Supreme Court’s decision to deny the exemption in *Royal Drug* does not preclude an application of the McCarran-Ferguson Act to physicians placed at financial risk. The “Pharmacy Agreement” at issue in *Royal Drug* did not transfer financial risk from the defendant in that case, Blue Shield, to the participating pharmacies. Under the agreements, Blue Shield’s policyholders paid the pharmacies a fixed $2.00 fee for the purchase of prescription drugs; in turn, Blue Shield paid the pharmacies the acquisition costs of the drugs. Consequently, the participating pharmacies were assured a fixed profit for each prescription filled. Blue Shield, on the other hand, retained the risk that total costs under the program would exceed the premiums collected, which would occur if the demand for prescription drugs exceeded the anticipated use of that benefit. This type of arrangement is clearly distinguishable from those reim-

physicians are at risk for the percentage of the fees withheld. The court in *Hoffman* rejected an application of the Act’s antitrust exemption because the withhold provision had been discontinued, but the court also relies on authority for an argument that a five percent withholding would not suffice to trigger the Act’s exemption, since the arrangement did not place the provider at sufficient risk. 517 F. Supp. at 569 (relying on National Gerimedical Hosp. v. Blue Cross of Kansas City, 479 F. Supp. 1012, 1018 (W.D. Mo. 1979), aff’d, 628 F.2d 1050 (8th Cir. 1980), rev’d on other grounds, 101 S. Ct. 2415 (1982) (provider agreement providing for ultimate reimbursement to providers if funds available for full benefit payment did not result in risks falling on provider). See also *Kartell v. Blue Shield of Mass.*, 542 F. Supp. 782 (D. Mass. 1982) (agreements between participating physicians and medical insurance plan requiring participating physicians to carry some of risk was not sufficient to establish that agreements were business of insurance).

Thus, the result in *Hoffman* is consistent with the proposition that the Act’s exemption should reside with the actual insurer and should not be granted to those parties that carry only a small percentage of the total risk. *Hoffman*, however, does not help in resolving those cases where the risk is more evenly divided among the parties or allocated among different types of providers. A possible solution under the Act may be to grant the exemption to each party but only for those activities that entail the spreading of risk. For example, if a capitation agreement encompasses only a physician’s own services, the exemption could be crafted so that similarly situated physicians who participate in the same plan are able to engage in the sorts of collective activity envisioned by the Act, but only as it pertains to services to be provided under that contract. The same physicians would not be permitted to engage in collective activity involving the provision of services under other non-risk based arrangements.

Nor should the exemption be denied in those cases where physicians are organized into single entities and thereby contract with third-party payors. Under these circumstances, the group of physicians becomes the insuring entity and is likely to provide medical care to a greater number of patients, thereby increasing the risk that would otherwise fall on a single, independent practitioner. The exchange of actuarial and underwriting information, as envisioned by the Act, would permit physician groups to better assess the adequacy of reimbursement for their participation in such a plan.
bursement schemes in which physicians receive a fixed rate of compensation while assuming the economic risk of providing comprehensive medical care to a group of patients.

2. The Insurance Contract. In addition to risk-spreading, the Supreme Court in Royal Drug found a second, essential element of the "business of insurance" within the contract between the insurer and its policyholders:

The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the "business of insurance." Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. But whatever the precise scope of the statutory term, it is clear where the focus was—it was on the relationship between the insurance company and the policyholder.137

The Court held that the pharmacy agreements in Royal Drug did not satisfy this requirement because they involved separate contractual arrangements other than those between the insurer and its policyholders. Alternatively, the Court rejected the petitioner's argument that the agreements, because they influence the cost of insurance to policyholders, had a sufficient impact on the insurance contract to fall within the Act's exemption.138 The Court reasoned that such an interpretation would prove overly broad, since it would encompass every decision by an insurer intended to contain the premiums charged to its policyholders.139

This conclusion would appear to preclude an application of the Act to risk-based provider arrangements because, like the pharmacy agreements in Royal Drug, they entail the purchase of services by the insurer with the goal to minimize costs. Moreover, any attempt to place the provider of services under the Act would not depend on the insurance contract between the purchaser of those services, such as an HMO, and its subscribers. There are, however, several responses to the Court's analysis—some factual, some legal—all of which would accommodate the Court's reasoning.

First, the transfer of economic risk from a third-party payor to the provider places the physician among those "other activities" that "relate so closely to [the insurer's] status as a reliable insurer" that they qualify for exemption. Generally, in most risk-based provider arrangements, the

138. Id.
139. Id. at 216-17.
physician is given substantial control and discretion over the extent of care his patients will receive under the insurance contract. This is readily apparent in the case of a physician who is placed in the role of a gatekeeper:

The gatekeeper is a designated health professional who serves as the patient's 'primary physician' and refers the patient to specialist services, as needed, as a condition of third-party payment for such services. While capitation is an appropriate method of paying for the gatekeeper function, other methods are also acceptable, provided the rates are for a defined period of time.\textsuperscript{140}

Under such an arrangement, "physicians become both clinical and financial managers responsible for the total care of their patients."\textsuperscript{141} More importantly, for the purposes of the McCarran-Ferguson Act, the effects of the gate-keeper system on the patient are significant and arise directly from the insurance contract. The system places substantial restraints on the patient's freedom of choice in deciding when to see a specialist or undergo inpatient hospitalization, since these decisions must be authorized by the primary care physician in order to be covered under the plan. If the patient attempts to circumvent the system, he becomes liable for the costs of any unauthorized services.\textsuperscript{142} In effect, the physician controls the allocation of benefits under the insurance contract—a function that would otherwise be performed by the traditional health insurance company through the claims review process. The patient is no longer reimbursed for the services received; instead, the patient receives his benefits in the form of the services themselves, obtained directly from the physician, who rations the extent of care provided and oversees the patient's well-being. Returning to the language of \textit{Royal Drug}, the "reliability, interpretation, and enforcement" of the insurance contract are placed largely, if not exclusively, within the physician's discretion.\textsuperscript{143}

A second response to the Court's emphasis on the relationship between the insurer and the insured is found in \textit{Travelers Insurance Company v. Blue Cross of Western Pennsylvania.}\textsuperscript{144} In \textit{Travelers}, a private insurer brought an action against a non-profit hospitalization insurer,
charging the latter with a restraint of trade in connection with its contracts for reimbursing hospitals.\textsuperscript{145} Despite the fact that the case involved the contractual relationship between the insurer and its providers, as opposed to its policyholders, the court of appeals held that "the interrelationship of hospital payments and subscribers' rates was such that Blue Cross's arrangement with hospitals should be considered part of the 'business of insurance.' "\textsuperscript{146} This conclusion is based, in part, on the financial impact that the hospital contracts had on the premiums paid by Blue Shield's policyholders.\textsuperscript{147} An additional factor, having to do with the state's regulation of the relationship between Blue Shield and the hospitals, is discussed below.\textsuperscript{148} Thus, \textit{Travelers} seems to indicate that the McCarran-Ferguson Act has a valid application in those cases where the challenged antitrust activity arises from the relationship between the insurer and its providers and where the same relationship substantially influences the premiums paid by policyholders.\textsuperscript{149} In the case of physicians placed at financial risk, the fees paid to service providers will significantly influence the premium rates that are passed on to subscribers through a third-party payor, since a substantial portion of the premium is devoted to compensating providers.\textsuperscript{150} Consequently, \textit{Travelers} lends further support to the argument that risk-based provider arrangements belong to the business of insurance.

3. \textit{Prepaid Health Care Versus Indemnity Health Insurers.} Apart from risk-spreading and the insurance contract, the Court discerned a third and final attribute belonging to the "business of insurance" having to do with the Act's application to prepaid health-care organizations as

\textsuperscript{145} The plaintiff objected to a standard contract that Blue Cross had with 101 hospitals in the area, prescribing the amounts and terms under which it would pay for services rendered by its subscribers.

\textsuperscript{146} 481 F.2d at 83. Importantly, the court in \textit{Travelers} relies on precisely the same language from SEC v. National Securities, Inc., 359 U.S. 453 (1972), that the Supreme Court used in \textit{Royal Drug}. \textit{See supra} note 137 and accompanying text.

\textsuperscript{147} A witness in the \textit{Travelers} case made the following observation regarding the financial impact of the provider contracts on the policyholders' premiums: "[T]hese two things are really indivisible aspects reflecting the same economic forces. If you do not have a sound contract between Blue Cross and the hospitals that controls costs and quality then the Blue Cross rate to the subscriber is going to be unreasonable." 481 F.2d at 83.

\textsuperscript{148} \textit{See infra} Section IVC.

\textsuperscript{149} It is not clear to what extent \textit{Travelers} is still valid in light of the Supreme Court's holding in \textit{Royal Drug} that the business of insurance did not extend to contracts between an insurer and its providers.

\textsuperscript{150} \textit{See} D. \textsc{Mackie} & D. \textsc{Decker}, \textit{supra} note 104, at 129-134 (actuarial method of determining premium based on average utilization per service per month multiplied by average cost of service).
opposed to indemnity health insurers.\textsuperscript{151}

The distinction between prepaid health care plans and traditional indemnity insurance rests primarily on two features: (1) the budgeting technique used to satisfy claims or subsidize health-care costs, and (2) the relationship between the insuring entity and the providers of health care. Indemnity insurers are generally divorced from the actual delivery of health care; the payment of claims is made directly to the patient as opposed to the provider.\textsuperscript{152} In contrast, prepaid plans, such as Blue Cross and Blue Shield, reimburse providers directly and frequently have some form of contractual relationship with physicians and hospitals.\textsuperscript{153} More significant to an application of the McCarran-Ferguson Act is the difference in financing mechanisms between the two. Insurance can be described as a "device for accumulating funds to meet losses through the transfer of individual risks to a large number of persons."\textsuperscript{154} Insurance is probabilistic in nature and operates on the law of large numbers. Though the "fortuitous needs of a particular individual cannot be predicted accurately, the needs of a large group can."\textsuperscript{155} The financing of health-care costs under a prepaid plan, in contrast, can be seen as a "forced savings plan."\textsuperscript{156} Subscribers make payments to the plan in return for a fixed bundle of medical services, the cost for which is spread out over time prior to the use of such services.\textsuperscript{157}

In \textit{Royal Drug}, the Court relied on the distinction between indemnity insurance and prepaid health plans for its argument that the pharmacy agreements in question did not qualify for the Act's antitrust exemption. The Court's distinction, however, was based primarily on a different set of factors than the two discussed above. Specifically, it relied on: (1) the absence of state insurance regulation over prepaid health service plans at the time of the Act's passage;\textsuperscript{158} (2) legislative history showing that Congress did not intend the "business of insurance" to be broader than its commonly understood meaning;\textsuperscript{159} (3) judicial precedent from 1939 to the effect that such plans are concerned primarily with the

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{151} 440 U.S. at 226.
\item \textsuperscript{152} A. EASTON, supra note 6, at 23.
\item \textsuperscript{153} \textit{Id.}
\item \textsuperscript{154} \textit{Id.} at 10.
\item \textsuperscript{155} \textit{Id.} at 10-11.
\item \textsuperscript{156} Feigenbaum, supra note 102, at 122.
\item \textsuperscript{157} \textit{Id.}
\item \textsuperscript{158} 440 U.S. at 226.
\item \textsuperscript{159} \textit{Id.} at 230.
\end{enumerate}
\end{footnotesize}
provision of medical services and not with risk-spreading; 160 (4) efforts by Blue Cross and Blue Shield organizations to escape state insurance regulation; 161 and (5) the exclusion by state insurance codes of such plans from the business of insurance at the time of the Act's passage. 162 This argument has important implications for our own discussion, since risk-based delivery systems are generally classified as a type of prepaid health care plan. 163

The Court's argument and all of its attendant support, failed to acknowledge the recent steps taken by state legislatures to bring prepaid health plans within the scope of insurance regulation. 164 Consequently, the Court ignored the broader purpose of the McCarran-Ferguson Act to preserve state control over the insurance industry. As the legislative history clearly indicates and as the Supreme Court conceded, "The primary concern of Congress in the wake of [the S.E.U.A.] decision was in enacting legislation that would ensure that the states would continue to have the ability to tax and regulate the business of insurance." 165 The Court's historical emphasis on the fact that prepaid health plans were not regulated at the time of the Act's passage was surely misplaced. It is hard to believe that Congress did not anticipate the possible expansion or contraction of state regulatory control over the insurance industry as it evolved. In fact, the legislative history clearly reflects the contrary expectation. 166 The Court's rather firm conclusion that prepaid plans do not belong to the "business of insurance" has the effect of diminishing state authority under the Act as the exemption itself is narrowed. Thus, the Court threatens to disturb the balance between state and federal interests that the Act was intended to achieve and sustain over time.

Lower courts, in fact, have already refused to accept the conclusion that the Act does not have any force in those cases involving prepaid health plans that provide insurance for their subscribers as well as the services for which the subscriber has paid. 167 Such a rule is consistent

160. Id. at 220.
161. Id. at 228-29.
162. Id. at 230 n.38.
163. See A. EASTON, supra note 6, at 38.
164. See infra Section IV.C.
166. In explaining the overall purpose of the Act, Senator Ferguson's language clearly indicates that the states were expected to modify their control over the insurance industry, and that the Act would accommodate such changes: "We believe that there is some wisdom left in the legislatures of the various states, and that they should exercise their judgment and regulate insurance, except in the respects which we have enumerated." 91 CONG. REC. 1481 (1945).
167. See, e.g., Klamath-Lake Pharmaceutical Ass'n v. Klamath Medical Service Bureau, 701
with the reality that prepaid plans, including HMOs,\textsuperscript{168} do engage in some form of risk-spreading though the use of a community rating system. Under such a system, subscribers are charged a uniform "community" premium irrespective of their actual use of medical services.\textsuperscript{169} Because all subscribers are charged the same rates regardless of risk, poor risks are subsidized by good risks.\textsuperscript{170} Moreover, it is only when a subscriber can precisely predict his actual future medical costs that he has engaged strictly in a prepayment plan for future medical services, by paying a premium roughly equal to the cost of future treatment.\textsuperscript{171} When a subscriber cannot predict future costs, which is typically the case, he in fact purchases insurance against the risk of requiring medical services,\textsuperscript{172} whether the insuring entity is an indemnity insurer, a prepaid health plan, or an HMO. Thus, the distinction between indemnity insurers and prepaid health plans is not as clear as the Court would like to believe. For purposes of the McCarran-Ferguson Act, the distinction should not preclude an application of the Act to providers placed at financial risk.

4. \textit{Summary.} Physicians or health-care providers in general who insure the costs of medical treatment in conjunction with their medical practice are engaged in the "business of insurance" as defined by the McCarran-Ferguson Act. These providers participate in the risk-spreading activity that traditionally has belonged to the indemnity insurer or the prepaid health plan. Moreover, the physician’s discretion over what benefits are actually received by the patient under such a plan, combined with the financial impact that the physician has on the subscriber’s premiums, gives the physician an integral role in shaping, enforcing, and regulating the insurance contract.

C. \textit{State Regulation}

The second element under the McCarran-Ferguson Act requires that the challenged activity be regulated by the state. As explained above,\textsuperscript{173} this provision of the statute is intended to preserve state regula-

\begin{itemize}
\item F.2d 1276 (9th Cir. 1983) (upholding McCarran-Ferguson exemption in context of Blue Shield pharmacy benefit provided by insurer).
\item Federal qualification under the HMO Act calls for rates based on the community rating system. 42 U.S.C. § 300e (1982).
\item Fegenbaum, supra note 102, at 134.
\item A. EASTON, supra note 6, at 23.
\item Fegenbaum, supra note 102, at 123.
\item Id.
\item Supra notes 87, 91-93 and accompanying text.
\end{itemize}
tory authority over the insurance industry.

The applicable test for this element of the Act is succinctly expressed in *California League of Independent Insurance Producers v. Aetna Casualty Surety Company*: "[I]f a state has generally authorized or permitted certain standards of conduct, it is regulating the business of insurance."\(^{174}\) In *California League*, the plaintiffs were insurance agents who accused various insurance companies of fixing commission rates. Though the state statute prohibited insurance companies from agreeing on rates, the court nevertheless held that the regulation requirement under the Act was satisfied. Thus, actual compliance with state law is not required.

Other courts have gone so far as to state that "the fact that no statute specifically deals with the practice here in question is irrelevant" to the issue of state regulation.\(^{175}\) Alternatively, if a controlling statute or regulation does exist, the availability of exemption "is not affected by . . . whether or not the state enforces its regulations or whether such enforcement is effective."\(^{176}\) Consequently, even remote and imprecise regulation of an activity may satisfy this element of the Act.\(^{177}\)

State regulation of prepaid health service plans is likely to satisfy these requirements in the case of risk-based provider agreements. For example, California's Knox-Keene Health Care Service Plan Act,\(^{178}\) though it does not belong to California's insurance law, provides a comprehensive regulatory scheme intended to protect the interests of both consumers and health-care providers who participate in various health service plans.\(^{179}\) The Act's broad definition of a health service plan brings within its scope those organizations that arrange for the provision of health services to their subscribers in return for a prepaid fee.\(^{180}\) The organizations that fall within the Act are likely to include those that em-


\(^{177}\) But see Weller, *supra* note 80, at 607-18 (legislative history suggests that Act requires specific state regulatory authority over activity in question).

\(^{178}\) *CAL. HEALTH & SAFETY CODE* § 1340-1399.64 (West Supp. 1988). *See also* N.Y. INS. LAW § 4301-4315 (McKinney Supp. 1988). This article of New York's insurance law provides an extensive regulatory scheme applicable to prepaid health plans, which generally offer capitation arrangements with independent providers.


\(^{180}\) *CAL. HEALTH & SAFETY CODE* § 1345 (West Supp. 1988) states: "'Health care service plan' means any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for such services, in return for a prepaid or periodic charge paid by or on behalf of such subscribers or enrollees."
ploy independent physicians or other health-care providers on a contract-
tual basis. Generally, risk-based provider agreements, because they rely
on a third party serving as a broker for health services between the sub-
scriber and the physician, are likely to fall within the variety of regula-
tions belonging to the act at least for purposes of satisfying the state
regulation requirement of the McCarran-Ferguson Act. Moreover, courts already have acknowledged that the Knox-Keene legislation satisfies the requirement for state regulation under the Act.

Existing state insurance law may also regulate the contractual rela-
tionship between the third-party purchaser of health services and the
provider. California’s insurance law, for example, provides that compre-
hensive health care programs “may, subject to the approval of the com-
missioner . . . enter into agreements with individual physicians or
groups thereof for the rendering of services to subscribers . . . or such a
program on a fee-for-service or prepaid capitation basis.” This type of
express statutory regulation would likely satisfy the requirements for
state oversight under the Act.

Frequently, enabling legislation for prepaid health plans, such as
HMOs, also provides a source for state regulation. For example, in New
York, the state’s Health Maintenance Act governs the financial aspects
of provider contracts.

Where these types of statutory schemes are available, the require-
ments for state regulation under the McCarran-Ferguson Act would
likely be satisfied.

D. Boycott, Coercion, or Intimidation

The third and final element of the McCarran-Ferguson Act disal-
lows an exemption for anticompetitive activity under the Act for any
agreement to or act of boycott, coercion, or intimidation. This element
of the legislation is intended to preserve the application of federal anti-
trust law in those instances where the challenged activity goes beyond the

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181. See supra note 114.
182. See Manasen v. California Dental Services, 424 F. Supp. 657 (1976), rev’d on other grounds, 638 F.2d 1152 (9th Cir. 1979).
184. See, e.g., N.Y. PUB. HEALTH LAW § 4402 (McKinney Supp. 1988), which requires that the Commissioner of Public Health will not issue a certificate of authority to establish an HMO unless the applicant demonstrates that the “prepayment mechanism of its comprehensive health care services plan, the bases upon providers are compensated . . . is conducive to the use of ambulatory care and the efficient use of hospital services.”
types of cooperative conduct envisioned by the Act. Though the statute is
designed to acknowledge the exclusive role of state insurance regulation,
the exemption from antitrust scrutiny will not extend to those who com-
mit egregious violations of federal antitrust law. To achieve this compro-
mise, the Act excludes from its antitrust exemption certain statutorily
defined types of anticompetitive conduct, which federal courts have
struggled to interpret consistently.

The Supreme Court, in *St. Paul Fire & Marine Insurance Co. v. Barry*, 186
held that the restriction on the types of collective activity per-
mitted under the Act is intended to evoke the body of judicial decisions
interpreting the Sherman Act. 187 With the Sherman Act in mind, the
Court provided the general rule that "the generic concept of boycott re-
fers to a method of pressuring a party with whom one has a dispute by
withholding, or enlisting others to withhold, patronage or services from
the target." 188 Responding to a dissenting opinion by Justice Stewart, in
which the majority is accused of broadening the notion of "boycott" be-
yond its intended scope, the Court added to this definition an important
qualification:

Whatever the precise reach of the terms "boycott," "coercion," and "intim-
idation," the decisions of this Court do not support the dissent's suggestion
that they are coextensive with the prohibitions of the Sherman Act. In this
regard, we are not citing to any decision illustrating the assertion that price-
fixing, in the absence of any additional enforcement activity, has been
treated as a "boycott" or "coercion." 189

This suggests that price-fixing among competitors is permissible under
the McCarran-Ferguson Act provided that the participants do not com-
bine their collective actions with some type of "enforcement activity"
that would compel others to abide by the terms of their own accord.
Applying this standard to the facts in *Barry*, an agreement among three
insurers not to insure the customers of a forth insurer was held to consti-
tute a boycott. The Court explained:

St. Paul induced its competitors to refuse to deal on any terms with its
customers. This arrangement did not simply fix rates or terms of coverage;
it effectively barred St. Paul's policyholders from all access to alternative
sources of coverage and even from negotiating for more favorable terms
elsewhere in the market. 190

187. Id. at 541.
188. Id.
189. Id. at 545 n.18.
190. Id. at 544.
The Court's emphasis on the defendant's refusal to deal on any terms suggests that a refusal to deal on certain, specified terms may be permissible conduct under the Act. As one commentator has observed, the Court sets forth contradictory signals as to what constitutes a boycott for purposes of the McCarran-Ferguson Act: "The fact that there was an absolute refusal to deal was repeatedly emphasized by the Barry Court. . . . However, the Court at the same time hinted that conduct not involving an absolute refusal to deal, such as a price fixing agreement involving enforcement activity, may fall within the 'boycott' term."\(^{191}\)

Lower courts relying on Barry have picked up this apparent distinction between a concerted refusal to deal on any terms and a concerted refusal to deal on certain, specified terms.\(^{192}\) A recent example involving the health-care industry is Feinstein v. Nettleship Company of Los Angeles.\(^{193}\) In Feinstein, plaintiff physicians brought an antitrust action against a county medical association and the medical malpractice insurer that had issued a master policy to the association. Physicians who wanted to take advantage of the insurance offered through the association were required to become members. The plaintiffs alleged that the arrangement involved a conspiracy to monopolize, tied sales, and a boy-


Importantly, the Court in Barry did not decide whether state regulation of a particular activity is a factor in determining its legality under the Act:

[W]hile we give force to the congressional intent to preserve Sherman Act review for certain types of private collaborative activity by insurance companies, we do not hold that all concerted activity violative of the Sherman Act comes within § 3(b) [which contains the boycott exception]. Nor does our decision address insurance practices that are compelled or specifically authorized by state regulatory policy. 438 U.S. at 555. Thus, it remains unclear whether the presence of express regulatory authority over a challenged activity will affect the availability of the exemption under the Act. This may become an issue where there exists a direct conflict between state regulation and those type of collective conduct that are prohibited under the Act. See Coughlin, supra, at 1285. Because risk-based provider arrangements may be closely regulated by state insurance or public health law, this issue may bear importantly on the possible application of the Act, where in fact such a conflict in the law exists.

\(^{192}\) In California League of Indep. Ins. Producers v. Aetna Casualty and Surety Co., 179 F. Supp. 65 (N.D. Cal. 1959), the court rejected the distinction between an absolute refusal to deal and a refusal to deal except on certain terms, arguing that the Act's plain meaning did not support the distinction. The court conceded, however, that such a rule renders the Act's exemption meaningless, since a party that complies with the Act's remaining elements does not have the capacity to enforce a collective agreement by refusing to accept from a purchaser any terms other than those offered. Id. at 66; see also Coughlin, supra note 191 at 128.

\(^{193}\) 714 F.2d 928 (9th Cir. 1983); see also Klamath-Lake Pharmaceutical Ass'n v. Klamath Medical Serv. Bureau, 701 F.2d 1276 (9th Cir. 1983) (requirement by nonprofit provider of health insurance and health care services that insureds' use of provider's pharmacy did not constitute boycott).
The court of appeals, however, held that the defendant's conduct fell within the antitrust exemption. On the issue of whether or not a boycott existed, the court held that because the plaintiffs were free to purchase insurance from other carriers, the defendant's conduct did not amount to a "boycott, coercion, or intimidation" under the Act.

In sum, the defendants had not engaged in an absolute boycott of the plaintiffs, but refused to deal with them except on certain terms; namely, that they become members of the association in order to participate in the insurance plan. Moreover, members of the association were not compelled to purchase through the association. The court further held that plaintiffs could not assert a section two monopolization claim unless they were able to show some additional act or agreement amounting to boycott, coercion, or intimidation.

Cases such as Feinstein, however, do not resolve whether cooperative pricing activity combined with a refusal to deal on specific terms would fall under the Act's boycott exception. This is a crucial issue for our discussion, since a group of independent physicians, assuming they satisfied the remaining elements of the Act, would likely seek to engage in some form of cooperative pricing activity as a means to protect or assert their economic interests. Though the exchange and collective use of pricing information is permitted under the Act, and although such activities may certainly be valuable to physicians placed at financial risk, the ability to engage in some form of concerted refusal to deal would make it possible to carry out a cooperative pricing policy.

The available case law suggests that entities possessing substantial market power will not be allowed to engage in price-fixing activity despite their compliance with the remaining provisions of the Act. In re Worker's Compensation Litigation, for example, involved a price-fixing action brought against underwriters of worker's compensation insurance and the state worker's compensation insurance rating association. The plaintiff employers alleged that the defendants had entered into a cooperative agreement not to charge less than the maximum lawful rate set by the state's insurance commissioner. Though the court of appeals acknowledged that "mere price fixing, i.e., a refusal to deal except at a specified price, without more, is not within the confines of the term boycott," it reversed the defendant's summary judgment below on grounds that the record contained certain enforcement activity that may

194. See supra notes 123-31 and accompanying text.
196. Id.
bring the defendant within the boycott exception. Among other things, this conduct included acts of intimidation to maintain uniform rates by all worker's compensation carriers and exclusionary practices that prevented non-members of the association from underwriting insurance.

The question remains what constitutes "mere price fixing" of the type described in the above case. Perhaps the best clue is found in cases such as *Feinstein*, which rely on a plaintiff's ability to deal freely with third parties despite the defendant's exclusionary conduct. The difference between *Feinstein* and *In re Worker's Compensation Litigation* rests primarily on the defendant's conduct in the latter case to coerce and intimidate other insurance carriers in order to ensure their participation in the defendant's price-fixing arrangement. This, coupled with the threat of expulsion for failure to comply with established pricing policies, would largely eliminate an employer's opportunity to deal freely with carriers who refused to belong to the association.

This type of coercive and exclusionary conduct is not present in circumstances in which a cooperative association does not possess monopoly or near monopoly power and does not coerce members to join its ranks. If, however, an association of providers that possess monopoly power could not engage in a permissible boycott, since a purchaser of such services is left without recourse to other market participants. If the providers' conduct, however, does not foreclose access to the remaining market, then a purchaser of services retains the opportunity to deal with those providers who have chosen not to participate in concerted activity. Moreover, the association of providers cannot engage in conduct intended to coerce non-members into joining, since such conduct amounts to a coercive boycott of the type found in *Barry* and is intended to eliminate that portion of the market to which a purchaser would turn if it chose not to deal with the association.

If in fact, this is the proper understanding of "mere price-fixing," as opposed to an impermissible boycott, the result is consistent with the proposal that a price-fixing agreement without substantial market power

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197. Though a price-fixing agreement may have some anticompetitive effects despite a lack of market power, the boycott exceptions under the McCarran-Ferguson Act are not coextensive with prohibitions of the Sherman Act. *Barry*, 430 U.S. at 545. Consequently, what is impermissible collective activity under the antitrust laws may be permissible under the Act.

198. The rating bureau cases, see, e.g. supra note 129, in which courts have condoned concerted price-fixing by numerous insurers provides some support for the conclusion that market power is irrelevant in defining a boycott under the Act. Nevertheless, it remains unclear whether the possession and use of market power in the context of a conditional boycott is a determining factor for the type of "enforcement activity" intended by the Supreme Court in *Barry*. 
may have a limited anticompetitive effect, or perhaps no effect at all.\textsuperscript{199} Conversely, physicians who seek to engage in "mere price fixing" may discover that their concerted activity has little economic force, since a purchaser of health-services will have access to the unassociated portion of the market. Nevertheless, an association of physicians that complies with the dictates of the McCarran-Ferguson Act may still find some practical value in being able to engage in cooperative rate-making activity similar to that practiced by indemnity insurers, since doing so will provide access to a larger body of actuarial data, which, in turn, may provide for more accurate underwriting of the economic risks that providers face.\textsuperscript{200}

V. POLICY IMPLICATIONS OF THE MCCARRAN-FERGUSON EXEMPTION AS APPLIED TO PROVIDERS

Beyond the formal elements of the McCarran-Ferguson Act, there lies the broader policy issues that may ultimately determine the scope of its application in the health-care context. The emerging emphasis in the health-care industry on the efficient and cost-effective use of services is taking place in response to the rapid escalation of health-care costs in the United States.\textsuperscript{201} In light of the present, competitive atmosphere that surrounds the health-care industry, it may seem contrary to public policy to suggest that physicians and other health-care providers should be given even a limited exemption from federal antitrust legislation. In response to this legitimate concern, I offer the following tentative response.

To begin with, it bears repeating that the McCarran-Ferguson Act does not provide a blanket exemption from the antitrust laws. As discussed above, a party engaged in the "business of insurance" cannot resort to concerted "boycott, coercion, or intimidation" in order to win concessions in the bargaining process. The Act is designed to permit collective activity among competitors but only to the extent of formulating contract terms to be negotiated and enforced on a relatively independent basis.

The Act's intended restrictions on concerted conduct, however, may

\textsuperscript{199} See H. Hovenkamp, Economics and Federal Antitrust Law, 84 (1985); Id. at n.2; \textit{cf.} R. Bork, The Antitrust Paradox: A Policy at War With Itself 268-69 (1978).

\textsuperscript{200} See supra notes 123-31 and accompanying text.

\textsuperscript{201} In 1987, national health care expenditures topped $500 billion, an increase of 9.8 percent from 1986. Letsch, Levit & Waldo, National Health Expenditures, 1987, 10 Health Care Financing Rev. 109 (Winter 1988). National health care expenditures, as a share of gross national product, increased to 11.1 percent in 1987, up from 10.7 percent in 1986, and nearly double what it was in 1965. Id.
not have prevented anticompetitive effects in the insurance industry, since collusive boycotts may go undetected. As one commentator has observed, "Finding a 'smoking gun' agreement not to underwrite insurance ... is rather unusual." The industry's reliance on joint rate bureaus, which promulgate "advisory" rates, makes it possible to engage in collusive conduct without recourse to express and concerted refusals to deal. Without a smoking gun, "courts have been forced to dismiss cases involving either price fixing or any other type of collusion falling short of a complete refusal to deal on any terms." While the same conscious parallelism may occur between health-care providers if allowed to engage in joint pricing activity under the Act, the potential anticompetitive effects of the Act should be weighed against other factors that militate in favor of the Act's application to health-care providers.

First, in defense of the McCarran-Ferguson Act, representatives of the insurance industry, as well as the Justice Department, have suggested that the Act has helped to create an unconcentrated insurance industry with low entry barriers. The lack of concentration, in turn, makes it extremely difficult to enforce uniform rates, since many firms have a strong incentive to undercut inflated bureau rates in order to attract a larger market share. Arguably, one could expect the same result among health-care providers, despite concerted pricing activity. The ability to collect and process pricing information on a cooperative basis may reduce the need for providers to organize themselves into larger entities, and the resulting unconcentrated market would make it difficult to engage in a successful price fixing arrangement.

Finally, there is also the concern that physicians are frequently placed in a position of diminished bargaining strength because they lack the resources and expertise necessary to evaluate the reimbursement rates proposed by a third-party payor. This disparity in bargaining power

202. Angoff, supra note 123, at 403
203. Id. at 403-404.
204. Id.
207. An observer to the bargaining process between providers and third-party payors has described what sometimes takes place: "Too frequently, the brute force negotiating approach is used.
may be reduced if providers are allowed to pool resources and data, without the threat of antitrust liability, in order to establish adequate levels of compensation for their services. The McCarran-Ferguson Act would provide the vehicle to accomplish this end.

FRANK T. HERDMAN

Under this approach, the plan makes an offer and providers must accept or reject it without adequate documentation or explanation.” Axene & Mulet, Negotiating Provider Contracts Actuarial Style, in NEW HEALTH CARE SYSTEMS HMO’s & BEYOND 353 (Group Health Institute 1986). The same observer lends some insight as to why health service plans are able to resort to such a forceful approach:

Idealistically, providers might be expected to accept the utilization and reimbursement levels developed by the plan. Realistically, providers frequently do not agree with the managed care utilization levels used by the plan. Providers are at a decided disadvantage in making their assessments. Providers see only the user side of health care. They usually lack adequate data to convert it into utilization rates for an average covered member.

Id. at 354.