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Locke Lord QuickStudy: Eliminating McCarran-Ferguson Immunity for Health Insurers – Higher Prices and ?Compliance Burdens

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For decades, politicians of both stripes routinely promised that they would do something about the relentless rise in health insurance costs by repealing the McCarran-Ferguson Act. Now that Congress passed and former President Trump signed into law The Competitive Health Insurance Reform Act of 2020, H.R.1418, health insurers are subject to the federal antitrust laws on much the same terms as every other private business. While the repeal of the McCarran-Ferguson Act for health insurers has attracted substantial interest, few of the actors in the political drama demonstrated a practical understanding of how courts applied the Act in real world cases. Nor did these actors make even the slightest convincing explanation for **exactly** how the partial repeal of the McCarran-Ferguson Act would measurably decrease the cost of health insurance to consumers, especially given that health insurers were already subject to state antitrust laws and regulation. Rather, a desire for headlines seems to have largely driven the entire repeal process, not a desire for serious-minded antitrust or healthcare reform. While it is at best dubious that the repeal will measurably restrain the cost of health insurance, the repeal will create additional opportunities for litigation challenging insurer's efforts to restrain increases in provider prices. From a policy perspective, in this case, the cure may well be worse than the supposed disease.

The McCarran-Ferguson Act provided a limited immunity to health insurers from federal antitrust law for ?collective conduct that was the "business of insurance," regulated by the states and not a boycott or ?coercive.? Limiting the exemption to the "business of insurance" had teeth, particularly in the health care context, placing many critical market activities outside McCarran-Ferguson's scope of protection. Collusive agreements among or between health insurers to fix prices or allocate markets or customers did not qualify for immunity. Immunity did not cover negotiations and practices for reimbursing health care providers, an area at the forefront of private health care antitrust litigation. (The class action plaintiffs' bar for providers had learned how to plead around immunity.) Nor did immunity restrict federal antitrust enforcers from challenging mergers of health insuring entities under Section 7 of the Sherman Act. Indeed, enforcement agency investigations and litigation have derailed many a merger of health insurers or imposed substantial conditions including divestiture to limit the anticompetitive effect of such mergers. Tellingly, the US Department of Justice offered the repeal only the faintest of praise, writing that it would "end distracting arguments" and allow the Department to "spend resources more efficiently." Justice Department Welcomes Passage of The Competitive Health Insurance Reform Act of 2020, Jan. 13, 2021. Notably absent is reference to specific, ongoing anticompetitive business practices that the repeal will end.

Congressional repeal of McCarran-Ferguson immunity for health insurers will initiate a natural experiment. The repeal is most likely to foster increased risk and scrutiny of joint conduct among health insurers to reduce provider prices, precisely when costs of reimbursing providers are the overwhelming driver of claims expenses and therefore health insurance premiums. There is an obvious contradiction between the promises of repeal and its likely effects. In policies and health plan documents, insurers sometimes exclude certain drugs, procedures, devices and so forth from reimbursement Insurers, which are subject to regulation requiring that rates be adequate to ensure solvency and not excessive, must set their rates in reliance on those restrictions. Previously, exclusions set forth in policy and plan documents usually qualified as the "business of insurance" and were exempt from federal antitrust attack. With the repeal, so long as disappointed providers can conjure some theory of concerted action or monopoly, every provider aggrieved that it is not being reimbursed or reimbursed at the level it prefers can pursue litigation claiming that insurer practices restrain trade. We can soon test whether increasing the opportunity for and potential consequences of treble damages litigation will lead to reductions in consumer costs.

While failing to recognize the full range of consumer benefits from McCarrran-Ferguson immunity, Congress ?appropriately showed some appreciation that cooperative undertakings in health insurance can be ?procompetitive. Congress wisely preserved federal antitrust immunity for essential joint conduct at the core of ?ratemaking. It is a basic insurance principle that sound ratemaking is dependent on the law of large numbers. ? Health insurers depend on access to industry loss cost data to develop actuarially-credible rates. Access to ?aggregated historical loss cost data is particularly critical for smaller insurers to compete effectively, remain ?solvent, and grow. As "safe-harbors," the repeal statute preserves antitrust immunity for agreements among ?health insurers to: (1) gather and report historical loss cost data; (2) create loss development factors (which ?adjust amounts initially reserved to pay claims to their final expected value) for historic loss cost data; (3) provide ?actuarial services; and (4) create standardized policy forms. While these protections are welcome, we foresee ?that private antitrust provider plaintiffs will creatively plead around the safe-harbors. Predictably, cases will be ?brought with contrived allegations that collective insurer practices exceeded the boundaries of the safe-harbors, ?or that cooperation on legitimate subjects provided a supposedly irresistible "opportunity to conspire" on rates or ?provider reimbursements. We see little prospect that fomenting litigation by parties interested in increasing their ?share of health insurance premium dollars will benefit consumers.?

A federal district court's very recent application of McCarran-Ferguson immunity to dismiss a provider's antitrust suit against the Blue Cross Blue Shield Association and certain member plans exposes the false promises behind the McCarran-Ferguson repeal. In *Lifewatch Services, Inc v. Highmark, Inc.*, No. 12-5146, E.D. Pa., a cardiac monitoring service alleged that defendants conspired to deny insurance coverage of telemetry services. (We omit a tortuous prior history to the case.) The district court, in an opinion dated December 28, 2020, found that the defendants' agreement with their insureds to exclude coverage for telemetry services satisfied all criteria for McCarran-Ferguson immunity and dismissed the provider's antitrust claims. The provider filed an appeal to the Third Circuit. Post-repeal, the motion to dismiss would go the other way. The provider plaintiff's interests in this case are not congruent with consumer interests in lower prices for care – the plaintiff wants to compel the defendant plans, in addition to paying for all-other covered services, to pay for still another service. Decisions about essential insurance coverages should not be left to the vagaries of federal juries. Health policy decisions are the proper domain of legislation (the Affordable Care Act created a menu of required coverages, as do many state statutes) or administrative bodies with subject matter expertise, such as state Departments of Insurance, which regulate both coverages and premium rates.

The repeal of McCarran-Ferguson immunity in health insurance opens a new front for medical providers to attack insurance industry cost-control initiatives as restraints of trade. In such cases, fewer dispositive motions will succeed, materially changing the burden of defending against antitrust claims. More cases are likely to advance to fulsome discovery. With increased scrutiny, the stakes in appropriate compliance training for health care insurers have increased. Health care insurers must anticipate and be prepared to persuade courts that their collective actions are not inherently anticompetitive (thus not subject to *per se* condemnation). Health insurers must be prepared to adduce the evidence necessary to present a full-throated rule of reason justification for collective actions that providers can attempt to paint as anticompetitive restrictions on the scope and amount of health care coverage.

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