



G A O

Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

B-304474

March 4, 2005

The Honorable Michael G. Oxley
Chairman
Committee on Financial Services
House of Representatives

Subject: *Legal Principles Defining the Scope of the Federal Antitrust
Exemption for Insurance*

Dear Mr. Chairman:

The enclosed opinion responds to your request concerning the McCarran-Ferguson Act's exemption from the federal antitrust laws for the insurance industry. In connection with the Committee's examination of the possibility of comprehensive insurance regulatory reform, you asked us to address three issues: (1) the evolution of the exemption and its present-day scope as determined by the courts; (2) the types of insurance-related activities being conducted today which might violate the federal antitrust laws in the absence of the exemption; and (3) the types of antitrust laws currently in effect in the States. As agreed with your staff, this opinion responds to the first question; we are responding to the remaining questions by separate report.

As summarized below, Part I of the opinion provides an overview of the federal antitrust laws and the application of those laws to the insurance industry prior to passage of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.*, in 1945. Part II of the opinion sets forth the Act's provisions relating to the antitrust exemption for insurance activities, which applies only to those practices that: (a) constitute the "business of insurance"; (b) are "regulated by State law"; and (c) do not constitute "an agreement to boycott, coerce, or intimidate, or [an] act of boycott, coercion, or intimidation." Part III of the opinion discusses the courts' considerable narrowing of the exemption over the last 60 years, and includes a detailed review of the key cases that have addressed whether particular activities are the "business of insurance." Courts consider three factors in determining what constitutes the "business of insurance": (1) whether the activity has the effect of transferring or spreading a policyholder's risk; (2) whether the activity is an integral part of the policy relationship between insurer and insured; and (3) whether the activity is limited to entities within the insurance industry. Today, only those activities directly tied to ratemaking and other functions at the core of and unique to the insurance industry, and activities directly related to the relationship between insurer and insured, are deemed to be the business of insurance potentially immune from the federal antitrust

laws (provided they are also regulated by State law and do not constitute an act of boycott, coercion, or intimidation). Although many of the earlier court decisions suggest that additional insurance-related activities qualify for the exemption, it is unlikely that a court would rule the same way today. Attachment A to the opinion lists these “business of insurance” cases from 1959 to the present.

Background

Beginning in the late 19th century, Congress enacted a series of antitrust laws whose purpose was to ensure a competitive business economy—the Sherman Act, 15 U.S.C. §§ 1-7, the Clayton Act, 15 U.S.C. §§ 12-27, and the Federal Trade Commission (FTC) Act, 15 U.S.C. §§ 41-58. The Sherman Act declared contracts, combinations, and conspiracies in restraint of interstate or foreign commerce, as well as monopolies or attempts to monopolize interstate or foreign commerce, to be illegal under certain circumstances. The Clayton Act declared price discrimination, exclusive dealings arrangements, corporate mergers, and interlocking directorates to be illegal under certain circumstances. Finally, the FTC Act created the FTC and empowered it to enforce aspects of the antitrust laws, and prohibited unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.

This same period saw the growth of the fire insurance industry in America, and the increasing tendency of the States to tax fire insurance companies in order to obtain revenue, and to enact laws requiring deposits from out-of-state insurers and imposing heavy taxes on their local operations. To address persistent concerns about insurer insolvency, companies began to pool their loss experience data so they could formulate more accurate and rational insurance rates, and states began to establish administrative bodies to regulate the activities of the insurance industry. After the Civil War, insurers objected to state imposition of discriminatory taxes and to state regulation as a whole, and unsuccessfully challenged the States’ authority to impose such requirements in the Supreme Court case of *Paul v. Virginia*, 75 U.S. (8 Wall.) 168 (1868). The insurers in *Paul* argued that Virginia’s regulation of insurance was an unconstitutional regulation of interstate commerce, but the Supreme Court disagreed, finding that an insurance contract was not an article of commerce within the meaning of the Constitution’s Commerce Clause.

In the aftermath of *Paul v. Virginia*, courts, legislatures, and insurance companies proceeded under the assumption that the insurance industry would be regulated by the States. States began to formally regulate the industry, and many states encouraged collaborative rate-setting to prevent future insurer insolvencies. State regulators also attempted to achieve uniformity of insurance regulation through a coalition of state insurance commissioners, which today is known as the National Association of Insurance Commissioners.

This framework of state regulation was shaken by the Supreme Court’s subsequent decision in *United States v. South-Eastern Underwriters Ass’n*, 322 U.S. 533 (1944). Effectively overruling its decision in *Paul v. Virginia*, the Supreme Court in *South-Eastern Underwriters* held that insurance was, in fact, interstate commerce which Congress could regulate under the Commerce Clause.

In the wake of *South-Eastern Underwriters*, entreaties to Congress by the insurance industry, state regulators, and state legislators to clarify whether and to what extent states could continue to tax and regulate insurers resulted in quick action: Congress passed the McCarran-Ferguson Act in 1945. Although Congress had clear authority to regulate insurance, it determined in McCarran-Ferguson that it would be beneficial, as a matter of public policy, to allow the states to continue regulating and taxing such business in most instances. Consistent with this statutory scheme, the Act also included a limited exemption from the federal antitrust laws for certain insurance-related activities.

The McCarran-Ferguson Act's Antitrust Exemption for Insurance

The McCarran-Ferguson Act gives the insurance industry a very limited exemption from the federal antitrust laws. To qualify for the exemption, an activity must satisfy three prerequisites. It must: (a) constitute the “business of insurance”; (b) be “regulated by State law”; and (c) not constitute “an agreement to boycott, coerce, or intimidate, or [an] act of boycott, coercion, or intimidation.” In determining whether a particular activity qualifies as the “business of insurance,” the Supreme Court has developed three factors to be considered: (1) whether the activity has the effect of transferring or spreading a policyholder’s risk; (2) whether the activity is an integral part of the policy relationship between insurer and insured; and (3) whether the activity is limited to entities within the insurance industry. None of these criteria is dispositive in itself.

Courts also have established parameters for the “regulated by State law” prerequisite. As a general matter, the requirement may be satisfied if an insurer is subject to general regulatory standards, such as when a state statute generally proscribes, permits, or authorizes certain conduct on the part of insurers. The availability of the exemption does not depend on the quality of the state regulatory scheme or on its effective enforcement.

Finally, the Supreme Court has ruled that conduct constitutes a prohibited “boycott” under the McCarran-Ferguson exemption where, in order to coerce a target into certain terms on one transaction, parties refuse to engage in unrelated or collateral transactions with the target. With respect to prohibited “coercion,” this has been interpreted to exclude situations where the allegedly coerced parties retain options to take other actions.

Application of the “Business of Insurance” Test As It Evolved Over Time

A review of cases addressing what constitutes the “business of insurance” shows that the McCarran-Ferguson exemption has been judicially narrowed in the 60 years since its enactment. The cases are highly fact-specific, however, and thus generalities about them are necessarily imprecise and must be applied with caution. Further, because the legal tests under the Act have evolved over time, it is unlikely that all of the earlier rulings would survive today and that a court would rule on the same facts in the same way. Greater reliance therefore should be placed on the most recent cases. With these caveats, the following general conclusions can be drawn:

- **Courts tend to find that activities among insurers involving cooperative ratemaking and related functions constitute the business of insurance. Insurers may enter into agreements or arrangements that do not involve such matters, but the more the arrangements involve functions that are not unique to the insurance business, or whose primary impact is not on the insurance market, the less likely courts are to apply the exemption.**

For example, ratemaking and related activities deemed by courts to constitute the business of insurance have included concerted actions among insurers to set agent commission rates; to fix the rates of various types of insurance pursuant to joint agreements and rating boards; to classify and re-classify risks; to agree to pay damage claims on the basis of agreed-upon labor rates; to limit or refuse to offer certain types of coverage; and to jointly undertake activities to limit risks by, among other things, revising policy language.

By contrast, activities that courts have determined do not constitute the business of insurance include the merger of insurance companies; interlocking directorates between banks or bank holding companies and insurers; arrangements between prepaid healthcare insurers distinguishing between services of different medical providers; competitive market practices that are not limited to the insurance industry; and agreements between insurers to allocate the insurance market in a geographic area.

- **Courts tend to find that activities between insurers and agents involving the terms of their contracts or the termination of their relationships constitute the business of insurance, provided that the activities are closely linked to the insurer/insured relationship and involve the agent's insurance dealings.**

For example, courts have found that the business of insurance includes agency contracts requiring exclusive representation of named insurers; optional agency contract provisions precluding an agent from engaging in another business for remuneration without the insurer's consent; and the termination of an agency contract because the agent would not comply with a limitation on his sales practices. In each of these cases, the courts found that the restrictions were related to the agent's insurance dealings as such.

By contrast, a court has found that the termination of the contract of an agent who serviced both insurance policies and securities, because he refused to sell securities through the insurer's securities affiliate, was not the business of insurance, viewing the practice as a restraint on trading in securities. In addition, activities that interfered with an insurer's ability to do business, such as when one insurer induced the agents of another insurer to stop selling its insurance policies and to use its trade secrets and customer lists, or when an insurer "pirated" its general agent's sub-agents, were found not to constitute the business of insurance because they could be engaged in by any business.

- **Courts tend to find that activities involving the relationship between insurer and insured constitute the business of insurance. If the activity does not involve risk-spreading, however, or if its primary impact on competition is not in the insurance industry, courts are less likely to apply the exemption.**

For example, courts have considered the business of insurance to include “tying” of products, such as an auto insurer’s requirement that policyholders be members of a certain auto club; an insurer’s refusal to offer a health insurance policy that did not include a spouse; and an agreement under which insurers offered medical malpractice insurance only to members of a county medical association. Courts also have considered the business of insurance to include the setting of terms and conditions of the policy, such as funeral service policies that offered smaller cash payments if the family did not choose a designated funeral director; an insurer’s decision to reduce an insured’s monthly disability benefits pursuant to the policy’s terms; a healthcare provider’s requirement that subscribers generally use its pharmacy to take advantage of their prescription drug benefits; and a health insurer’s introduction of its own HMO and its institution of an adverse selection policy of pricing its traditional insurance.

By contrast, a court has found that insurers’ refusal to pay for services rendered by psychologists unless they were billed through a physician were not the business of insurance, because the decision was not whether to underwrite the risk but merely who should be paid. Another court has found that a conspiracy between insured physicians and a medical malpractice insurer to cancel the malpractice insurance of a competitor physician was not the business of insurance, because the attempt to restrain competition targeted the marketplace for maternity services, not medical malpractice insurance.

- **Courts do not find activities involving arrangements between insurers and third-party providers of non-insurance goods and service to constitute the business of insurance, at least since the late 1970s when the current “business of insurance” test was formulated.**

For example, activities which do not constitute the business of insurance include insurer’s agreements with auto glass companies to fix the prices to be paid for glass replacement; agreements between insurers and auto repair shops to perform work at rates agreed upon in advance; activities in private healthcare financing that affect entities beyond the business of insurance; agreements between insurers and various types of medical practitioners to provide services; insurers’ agreements with health planning agencies not to reimburse policyholders for CAT scans performed outside of hospitals; and agreements between insurers and peer review committees for the provision of consulting services.

Please contact Susan D. Sawtelle, Associate General Counsel, at (202) 512-6417, Rachel M. DeMarcus, Assistant General Counsel, at (202) 512-4099, or Tania L. Calhoun, Senior Attorney, at (202) 512-8230, if there are questions concerning this opinion.

Sincerely yours,

A handwritten signature in black ink that reads "Anthony H. Gamboa". The signature is written in a cursive style with a large initial 'A'.

Anthony H. Gamboa
General Counsel

Enclosure



G A O

Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

B-304474

Enclosure

LEGAL PRINCIPLES DEFINING THE SCOPE OF THE
FEDERAL ANTITRUST EXEMPTION FOR INSURANCE

INTRODUCTION AND SUMMARY OF CONCLUSIONS

Under current federal law, the regulation of insurance is primarily the responsibility of the States. This arrangement results, in part, from Congress's decision, in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.*, to exempt certain insurance-related activities from the federal antitrust laws. Congress is in the process of examining whether to undertake comprehensive insurance regulatory reform. As part of that examination, Congress is reviewing the history of the McCarran-Ferguson Act's antitrust exemption, as well as the elements of the exemption and how it is applied in practice today. To assist the Congress in its review, this opinion discusses the historical and legal evolution of the exemption and its present-day scope as determined by the courts.

As discussed in Part I below, a system of state regulation of the insurance industry developed over the 19th and early 20th centuries. After a 1944 United States Supreme Court decision finding that the federal government had constitutional authority to regulate the insurance industry as "interstate commerce," Congress passed the McCarran-Ferguson Act ("McCarran-Ferguson" or "the Act") in 1945. The Act reflected Congress's judgment that, although the federal government has the authority to regulate insurance, it was preferable, as a matter of public policy, to permit the states to continue to do so in most instances. The Act therefore, among other things, exempts insurance activities from the federal antitrust laws under certain circumstances.

The scope of the Act's antitrust exemption is narrow on its face, as discussed in Part II. The Act exempts only those activities that: (a) constitute the "business of insurance"; (b) are "regulated by State law"; and (c) do not constitute "an agreement to boycott, coerce, or intimidate, or [an] act of boycott, coercion, or intimidation." As discussed in Part III, over time, the courts have limited the exemption even further, principally by narrowing the first prerequisite—what constitutes the "business of insurance." Today, the courts apply a three-factor test in ascertaining whether an activity is the "business of insurance": (1) whether the practice has the effect of transferring or spreading a policyholder's risk; (2) whether the practice is an integral part of the policy relationship between insurer and insured; and (3) whether the practice is limited to entities within the insurance industry. None of these criteria is dispositive in itself.

Applying these three factors, the courts have found that only activities which are directly tied to ratemaking and other functions at the core of and unique to the insurance industry, and activities directly related to the relationship between the insurer and the policyholder, are immune from the federal antitrust laws. Although many of the earlier court decisions suggest that additional insurance-related activities qualify for the exemption, it is unlikely that a court would rule the same way today. Attachment A to this opinion lists the key “business of insurance” cases from 1959 to the present.

ANALYSIS

I. Developments Leading to Enactment of the McCarran-Ferguson Act

A. Overview of the Federal Antitrust Laws¹

The purpose of the federal antitrust laws is to ensure a “competitive business economy.”² In the latter half of the 19th century, the power to “fix prices, to restrict production, to crush small independent traders, and to concentrate large power in the few to the detriment of the many, were but some of the numerous evils ascribed to” trusts and monopolies.³ To address these concerns, Congress enacted three statutes which form the foundation of federal antitrust law: the Sherman Act (in 1890), the Clayton Act (in 1914), and the Federal Trade Commission (“FTC”) Act (also in 1914).⁴ These laws are intended to preserve “free and unfettered competition,” and rest on the premise that “the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress”⁵

The first two sections of the Sherman Act⁶ are its most important. Section 1 states, in relevant part, that:

Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States,

¹ In addition to the federal antitrust laws, many states have enacted their own legislation prohibiting restraints on competition.

² *United States v. South-Eastern Underwriters Ass’n*, 322 U.S. 533, 559 (1944).

³ *Id.* at 553-54.

⁴ The most important amendments to these laws have been the Robinson-Patman Act of 1936 (which rewrote and amended section 2 of the Clayton Act, dealing with price discrimination); the Celler-Kefauver Act of 1950 (which amended section 7 of the Clayton Act, dealing with mergers and acquisitions); and the Hart-Scott-Rodino Antitrust Improvement Act of 1976 (which expanded the power of the Justice Department to investigate antitrust violations, required pre-merger notification and a waiting period by parties to certain mergers, and authorized and established procedures for state attorneys general to sue, as *parens patriae*, for antitrust violations causing injury to state citizens). Many other federal antitrust statutes target specific industries; these are not addressed in this opinion.

⁵ *Northern Pacific Railway Co. v. United States*, 356 U.S. 1, 4 (1958).

⁶ July 2, 1890, ch. 647, 26 Stat. 209, codified as amended at 15 U.S.C. §§ 1-7.

or with foreign nations, is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony

Section 2 states, in relevant part, that:

Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony

The focus of section 1 is on combinations and conspiracies to engage in practices that restrain trade. As such, section 1 requires at least two actors working in concert. The prohibition extends to nearly every type of “horizontal” or “vertical” act or practice that may restrain competition.⁷ In addition, as with any federal regulation of “commerce,” section 1 applies only to acts which restrain interstate trade; regulation of purely intrastate trade is left to the states.⁸ Finally, section 1 prohibits only those restraints found to be unreasonable.⁹

The focus of Sherman Act section 2, by comparison, is on actions of a single firm which has exercised its monopoly power, typically through acts or practices subject to section 1. Monopoly power is usually defined as “the power to control prices or exclude competition.”¹⁰ A prohibited monopoly under section 2 has two elements: the possession of monopoly power in the relevant market and “the willful acquisition or maintenance of that power”¹¹

The Clayton Act¹² was enacted almost a quarter-century after the Sherman Act, in response to that statute’s perceived deficiencies. The Clayton Act declares four types

⁷ “Horizontal” restraints are agreements among rivals, and include cartels and agreements to exclude rivals. “Vertical” restraints are agreements between purchaser and supplier, and include resale price fixing, territorial restrictions, exclusive dealing contracts, reciprocal dealing contracts, and tying arrangements. II Joseph P. Bauer & William H. Page, *Kintner, Federal Antitrust Law*, § 9.2 at 4 (2002). A tying arrangement is an “agreement by a party to sell one product but only on the condition that the buyer also purchase a different (or tied) product, or at least agrees that he will not purchase that product from any other supplier.” *Northern Pacific Railway Co. v. United States*, footnote 5 above, at 5-6.

⁸ The Commerce Clause of the Constitution authorizes Congress only “[t]o regulate Commerce with foreign Nations, and among the several States, and with Indian tribes” U.S. Const., Art. I, § 8, cl. 3.

⁹ The “unreasonableness” requirement stems from the Supreme Court’s decision in *Standard Oil Co. of New Jersey v. United States*, 221 U.S. 1, 60 (1911). Except for certain classes of restraints considered to be *per se* unreasonable, the “rule of reason” requires consideration of the relevant circumstances to ascertain whether the conduct, taken as a whole, promotes or suppresses competition. *See, e.g., Board of Trade of the City of Chicago v. United States*, 246 U.S. 231, 238 (1918).

¹⁰ *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 391 (1956).

¹¹ *United States v. Grinnell Corp.*, 384 U.S. 563, 570-71 (1966).

¹² Oct. 15, 1914, ch. 323, 38 Stat. 730, codified as amended at 15 U.S.C. §§ 12-27.

of practices to be illegal under certain circumstances: direct and indirect price discrimination, exclusive dealings arrangements, corporate mergers, and interlocking directorates. The illegality of the first three practices is premised on a finding that the practice may lessen competition substantially or that it tends to create a monopoly.¹³ As such, the Clayton Act tends to look to the future, to predict the probable anticompetitive effect of a given activity or practice, rather than to the past, to determine whether anticompetitive effects already have occurred.

The FTC Act,¹⁴ a trade regulation law passed the same year as the Clayton Act, created the FTC and empowered it to enforce certain portions of the antitrust laws.¹⁵ Section 5(a)(1) of the Act prohibits “unfair methods of competition in or affecting commerce, and unfair or deceptive acts or practices in or affecting commerce.” Unfair methods of competition include any conduct that would violate the Sherman Act.¹⁶ The FTC Act defines unfair practices as those that “cause[] or [are] likely to cause substantial injury to consumers which is not reasonably avoidable by consumers themselves and not outweighed by countervailing benefits to consumers or to competition.”¹⁷

The Department of Justice is responsible for enforcing the Sherman Act, and shares responsibility with the FTC for enforcing the Clayton Act. The Department of Justice can seek an injunction or civil money damages under either statute, and can seek criminal penalties for Sherman Act violations. Private parties may also enforce sections 1 and 2 of the Sherman Act and may seek redress under the Clayton Act. The FTC has exclusive authority to enforce section 5 of the FTC Act, and can use section 5 to take action against parties that violate the Sherman Act. The FTC typically acts administratively, through judicially enforceable cease-and-desist and similar orders.

B. Applicability of the Antitrust Laws to the Insurance Industry Prior to the McCarran-Ferguson Act

1. The Insurance Industry in the 1800’s

As one commentator has noted, the history of the relationship between the federal government, the states, and the business of insurance is largely the story of fire

¹³ 15 U.S.C. §§ 13, 14, 18.

¹⁴ Sept. 26, 1914, ch. 311, 38 Stat. 717, codified as amended at 15 U.S.C. §§ 41-58.

¹⁵ While the FTC may use its authority to examine antitrust actions of insurers that do not fall under the McCarran-Ferguson Act’s exemption, under section 5 of the FTC Improvements Act of 1980, Pub. L. No. 96-252, 94 Stat. 374 (1980), the FTC may study an insurance issue only upon a specific request by a majority of either the Senate or House Commerce Committees. Congress imposed this limitation on the FTC because it believed the Commission was misconstruing its jurisdictional limitations set forth in the McCarran-Ferguson Act with respect to the business of insurance. S. Rep. No. 96-500, at 13 (1980), reprinted in 1980 U.S.C.C.A.N. 1073, 1114.

¹⁶ See *FTC v. Cement Institute*, 333 U.S. 683, 689-94 (1948).

¹⁷ 15 U.S.C. § 45(n).

insurance in America.¹⁸ In the 1800's, the property and casualty insurance industry was dominated, both economically and politically, by fire insurance.¹⁹ As the 19th century progressed, and the power and profitability of the fire insurance industry grew, state governments began taxing fire insurance companies, as a means of obtaining revenue, and enacting laws requiring deposits from out-of-state insurers and imposing heavy taxes on their local operations, as a means of protecting local insurers.²⁰

Concerns about the solvency of the fire insurance industry also arose throughout the 19th century. In years with few fires, insurers were profitable and competitive, and could offer lower prices. In years when major fires occurred, many insurers had insufficient reserves to pay losses.²¹ Insurers also competed vigorously for the business of independent agents who sold their products, and these agents, who had no incentive to avoid bad risks, competed with each other. The resulting price competition exacerbated the threat to insurer solvency.²² To reduce these risks, insurers began to set agent commissions collectively and to pool loss experience data, in order to obtain sufficient information to determine rational and more accurate insurance rates. This was of particular benefit to smaller insurers, who had limited loss experience data of their own.²³

At the same time, states began to establish administrative bodies to regulate the activities of the insurance industry.²⁴ After the Civil War, insurers began to object to the states' imposition of discriminatory taxes and to state regulation generally, and in 1866, as discussed below, they unsuccessfully challenged states' authority to impose such measures.

¹⁸ Richard A. Wiley, *Pups, Plants and Package Policies—Or The Insurance Antitrust Exemption Re-Examined*, 6 Vill. L. Rev. 281, 286 (1961).

¹⁹ Kenneth J. Meier, *The Political Economy of Regulation: The Case of Insurance* 50 (1988). Most marine underwriting was done by foreign firms prior to World War I; life insurance was a separate industry; and health insurance was a minor portion of the industry at the time. *Id.*

²⁰ *Id.*

²¹ *Id.* at 51-52; see also Spencer L. Kimball and Ronald L. Boyce, *The Adequacy of State Insurance Rate Regulation: The McCarran-Ferguson Act in Historical Perspective*, 56 Mich. L. Rev. 545, 547-49 (1958).

²² D.T. Armentaro, *Antitrust and Insurance: Should the McCarran Act Be Repealed?*, Cato Journal, Winter 1989, at 729, 730; Meir, footnote 19 above, at 52.

²³ See Armentaro, footnote 22 above, at 730, 736.

²⁴ Meir, footnote 19 above, at 51-52.

2. The Supreme Court's Decisions in *Paul v. Virginia*²⁵ and *United States v. South-Eastern Underwriters Association*

In 1866, the Virginia legislature passed a statute requiring insurance companies not incorporated under Virginia law to obtain a license before doing business in Virginia. The license could be obtained only upon payment of a bond. A subsequent statute provided that no person without a license could act as an agent for an out-of-state insurer, and anyone offering to issue an insurance policy for an out-of-state insurer would be considered an agent of that firm. Samuel Paul, a Virginia resident, was appointed as the agent for fire insurers incorporated in New York. He applied for a license to act as their agent in Virginia, and complied with every requirement except for the bond. His request for a license was rejected, but he nonetheless issued an insurance policy to a citizen of Virginia. He was indicted and convicted for this offense, and the case was ultimately appealed to the United States Supreme Court.

Mr. Paul's argument before the Supreme Court was rooted in the Commerce Clause of the Constitution which, as noted above, authorizes Congress to regulate interstate commerce.²⁶ In arguing that insurance was interstate commerce that could only be federally regulated, Mr. Paul asserted that the term "commerce" was broad enough to include the "business of insurance." The fact that the New York corporations sent an agent to Virginia made the transaction interstate commerce, he argued, and thus the Virginia statute constituted improper state regulation of interstate commerce.

The Supreme Court rejected this argument in *Paul v. Virginia*, 75 U.S. (8 Wall.) 168 (1868). Focusing on the character of the insurance business, the Court ruled that an insurance contract was not an article of "commerce" within the meaning of the Commerce Clause:

Issuing a policy of insurance is not a transaction of commerce. The policies are simple contracts of indemnity against loss by fire, entered into between the corporations and the assured, for a consideration paid by the latter. These contracts are not articles of commerce in any proper meaning of the word. . . . Such contracts are not inter-state transactions, though the parties may be domiciled in different States. The policies do not take effect—are not executed contracts—until delivered by the agent in Virginia. They are, then, local transactions, and are governed by the local law. They do not constitute a part of the commerce between the States any more than a contract for the purchase and sale of goods in Virginia by a citizen of New York whilst in Virginia would constitute a portion of such commerce.

Id. at 183.

In view of the Court's conclusion that insurance contracts were "local transactions, governed by local law," courts, legislatures, and insurance companies proceeded

²⁵ A full discussion of the background of this decision is contained in Peter R. Nehemkis, Jr., *Paul v. Virginia: The Need for Re-Examination*, 27 Geo. L. J. 519 (1939).

²⁶ See footnote 8 above.

under the assumption that the insurance industry would be regulated by the states, not the federal government. As the Supreme Court later observed, “on the rationalization that insurance was not commerce, yet was business affected with a vast public interest, the states developed comprehensive regulatory and taxing systems. And litigation of their validity came to be freed of commerce clause objections”²⁷

Meanwhile, beginning in the 1850s, states established boards and administrative agencies to regulate the insurance business, with the scope of regulation varying from state to state. Many states encouraged collaborative rate-setting for fire insurers, through rate-setting boards or bureaus, to prevent insolvencies. State regulators also attempted to achieve uniformity of insurance regulation by forming a coalition of state insurance commissioners. This coalition ultimately became known as the National Association of Insurance Commissioners (“NAIC”). For almost 75 years, the states relied on the NAIC’s efforts in developing uniform practices and model laws, and continued their regulatory practices without federal intervention.²⁸

Beginning in the 1920s, the state of Missouri attempted to address the problem of rate-fixing combinations by fire insurers under its state laws, with little success. In 1942, apparently at the behest of the Missouri Attorney General,²⁹ the Department of Justice indicted the South-Eastern Underwriters Association and its membership of nearly 200 private fire insurance companies, along with 27 individuals, for alleged violations of the Sherman Act. The indictment alleged two conspiracies. The first, in violation of Sherman Act section 1, was to restrain interstate trade and commerce by fixing and maintaining arbitrary and non-competitive premium rates on fire and other lines of insurance in several states. The second, in violation of Sherman Act section 2, was to monopolize trade and commerce in the same lines of insurance in the same states. The insurers’ defense was that the Sherman Act applied only to interstate commerce; that, under *Paul v. Virginia*, insurance activity was not interstate commerce; and that the Sherman Act therefore did not apply to them.

The Supreme Court rejected this argument in *United States v. South-Eastern Underwriters Ass’n*, 322 U.S. 533 (1944). Effectively overruling its decision in *Paul v. Virginia*, the *South-Eastern Underwriters* Court found that the federal government did, in fact, have jurisdiction over the insurers, because insurance clearly was “interstate commerce” which Congress could regulate under the Commerce Clause. Although Congress had not specifically acted to regulate insurance, said the Court, it certainly had the power to include insurers within the scope of the antitrust laws. Insurance should be treated no differently than any other business affecting interstate commerce, the Court explained:

²⁷ *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408, 415-16 (1946). The Supreme Court followed *Paul v. Virginia* in several subsequent cases. See *Hooper v. California*, 155 U.S. 648, 655 (1895) (“The business of insurance is not commerce. The contract of insurance is not an instrumentality of commerce.”); *New York Life Ins. Co. v. Deer Lodge County*, 231 U.S. 495, 510 (1913) (“contracts of insurance are not commerce at all, neither state nor interstate.”).

²⁸ See Meier, footnote 19 above, at 54-61.

²⁹ Wiley, footnote 18 above, at 288 n.23.

No commercial enterprise of any kind which conducts its activities across state lines has been held to be wholly beyond the regulatory power of Congress under the Commerce Clause. We cannot make an exception of the business of insurance.

Id. at 553.

The Court also rejected the argument that, in the Sherman Act, Congress did not intend to exercise its power over interstate insurance. As the Court explained:

Whether competition is a good thing for the insurance business is not for us to consider. Having power to enact the Sherman Act, Congress did so; if exceptions are to be written into the Act, they must come from the Congress, not this Court.

Id. at 561.

II. The McCarran-Ferguson Act's Antitrust Exemption for Insurance Activities

The Supreme Court's *South-Eastern Underwriters* decision caused great concern among insurers, state regulators, and state legislators, and uncertainty about whether and to what extent states could tax or regulate insurers.³⁰ It was also unclear whether insurers could continue to engage in cooperative activities such as ratemaking. Entreaties to Congress to clarify the matter resulted in quick action. After rejecting bills that would have completely exempted the insurance industry from the Sherman and Clayton Acts, Congress adopted a variation of an approach offered by the NAIC and enacted it as the McCarran-Ferguson Act.³¹

As articulated in its statement of policy, McCarran-Ferguson declared that “the continued regulation and taxation by the several States of the business of insurance is in the public interest, and . . . silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.” 15 U.S.C. § 1011. The remaining sections of the Act implement that policy, by generally allowing the States to regulate insurance and, where States have acted, by partially exempting insurance from the federal antitrust laws:

- Section 2(a) ensures that the absence of federal regulation of interstate insurance transactions shall not be construed as barring State regulation, by providing that

³⁰ Chief Justice Stone's dissent in *United States v. South-Eastern Underwriters* was one expression of these concerns. As Justice Stone stated, “[c]ertainly there cannot but be serious doubt as to the validity of state taxes which may now be thought to discriminate against the interstate commerce, . . . ; or the extent to which conditions may be imposed on the right of insurance companies to do business within a state; or in general the extent to which the state may regulate whatever aspects of the business are now for the first time to be regarded as interstate commerce.” 322 U.S. at 581-82.

³¹ Pub. L. No. 79-15, ch. 20, 59 Stat. 33, codified as amended at 15 U.S.C. §§ 1011-1015. An extensive discussion of the legislative history of the McCarran-Ferguson Act can be found in Charles D. Weller, *The McCarran-Ferguson Act's Antitrust Exemption for Insurance: Language, History and Policy*, 1978 Duke L.J. 587, 589-98 (1978).

the business of insurance is subject to the laws of the States relating to the regulation or taxation of such business:

The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

15 U.S.C. § 1012(a).

- The so-called “first clause” of section 2(b) addresses the concern that other federal statutes might be read to displace state insurance regulation, by providing that no Act of Congress shall invalidate State laws regulating or taxing the business of insurance unless it specifically relates to the business of insurance. This “reverse preemption” of state law over federal law provides:

No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance

15 U.S.C. § 1012(b).

- The so-called “second clause” of section 2(b) supports this reverse preemption, by exempting the “business of insurance” from the federal antitrust laws beginning three years after enactment,³² but only where States have regulated. The second clause provides:

. . . *Provided*, That after June 30, 1948, the . . . Sherman Act, and 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.

15 U.S.C. § 1012(b).³³

³² Section 3(a) provides that “[u]ntil June 30, 1948, the . . . Sherman Act, and the . . . Clayton Act, and the . . . Federal Trade Commission Act . . . and the . . . Robinson-Patman Anti-Discrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof.” 15 U.S.C. § 1013(a). A 1947 amendment, July 25, 1947, c. 326, 61 Stat. 448, substituted “June 30, 1948” for “January 1, 1948” in sections 2(b) and 3(a).

³³ Your request and this opinion focus on section 2(b)’s “second clause” antitrust exemption. Our opinion does not address section 2(b)’s “first clause” reverse preemption, which concerns issues beyond antitrust and which is “not so narrowly circumscribed.” *United States Dep’t of Treasury v. Fabe*, 508 U.S. 491, 504 (1993); *see also Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 218 n. 18 (1979) (“the *primary* purpose of the McCarran-Ferguson Act was to preserve state regulation of the activities of insurance companies, as it existed before the *South-Eastern Underwriters* case . . . the quite different *secondary* purpose . . . [was] to give insurance companies only a limited exemption from the antitrust laws.”) (emphasis in original).

- Finally, section 3(b) limits the scope of section 2(b)'s antitrust exemption even further, by providing that the Sherman Act's boycott, coercion, and intimidation provisions continue to apply to insurance activities:

Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

15 U.S.C. § 1013(b).

After passage of the McCarran-Ferguson Act, the NAIC developed a model state law on insurance rating to implement the Act's "reverse preemption" of federal law. Within a year, 37 states had enacted statutes patterned on the NAIC's model, and by 1951, all states had enacted laws to regulate property-casualty insurance rates. In 1947, the NAIC proposed a model law intended to preempt application of the FTC Act to the business of insurance; every state eventually adopted this model act.³⁴

III. The Courts' Interpretation of the McCarran-Ferguson's Antitrust Exemption

As is clear from the above-quoted provisions, McCarran-Ferguson gives the insurance industry only a limited exemption from the federal antitrust laws.³⁵ To qualify for the exemption, an activity must satisfy three prerequisites. It must: (a) constitute the "business of insurance"; (b) be "regulated by State law"; and (c) not constitute "an agreement to boycott, coerce, or intimidate, or [an] act of boycott, coercion, or intimidation." Moreover, like all exemptions from the antitrust laws, this exemption is to be construed narrowly.³⁶ It is important to remember, however, that non-exempt insurance activities do not necessarily violate the antitrust laws; it is "axiomatic that conduct which is not exempt from the antitrust laws may nevertheless be perfectly legal." *Pireno*, footnote 36 above, 458 U.S. at 126, citing *Royal Drug*, footnote 33 above, 440 U.S. at 210 n.5.

The courts' interpretation of these prerequisites is discussed in the remainder of this opinion. Because the vast majority of cases have focused on the "business of insurance" prerequisite, it is given the most extensive treatment here and, for

³⁴ Meier, footnote 19 above, at 75-76. Since the Act's passage, Congress has exercised its authority to regulate insurance in certain areas: healthcare insurance, liability insurance, flood insurance, crop insurance, and terrorism risk insurance. *See generally Optional Federal Chartering for Insurers: History and Background of Insurance Regulation* (Congressional Research Service CRS RL31982, June 3, 2003), at CRS-13 to CRS-15.

³⁵ Two doctrines beyond the scope of this opinion can also affect the antitrust liability of insurers. First, under the state action doctrine of *Parker v. Brown*, 317 U.S. 341 (1943), a state's decision that competition should yield to some sort of regulation or control will, in certain circumstances, result in immunity from antitrust prosecution. Second, under the *Noerr-Pennington* doctrine, the Sherman Act does not apply to joint efforts by groups seeking to exercise their First Amendment right to petition the government. *See Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127 (1961); *United Mine Workers of America v. Pennington*, 381 U.S. 657 (1965); *California Motor Transport Co. v. Trucking Unlimited*, 404 U.S. 508 (1972).

³⁶ *See, e.g., Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 126 (1982).

organizational purposes, is discussed last. The other two prerequisites are discussed first.

A. The Activity Must Be “Regulated by State Law”

The Act exempts the business of insurance from the federal antitrust laws only to the extent such business is “regulated by State law,” but the statute does not define this term. It has been left to the courts to ascertain the parameters.

In order to find that an insurance activity is regulated by state law, the courts have not required uniformity of regulation among states. As the Supreme Court concluded in *Prudential Ins. Co. v. Benjamin*, above, 328 U.S. at 430, in enacting McCarran-Ferguson, Congress must have known that state systems of regulation differed greatly in scope and character, and its purpose was “evidently to throw the whole weight of its power behind the state systems, notwithstanding these variations.” *See also Ohio AFL-CIO v. Ins. Rating Bd.*, 451 F.2d 1178, 1183 (6th Cir. 1971), *cert. denied*, 409 U.S. 917 (1972) (“We are confident that Congress in enacting the McCarran Act did not intend to impose a uniform standard of regulation upon all of the states. It is our view that the congressional intent was to leave to the judgment of each state the specifics of regulation which it should see fit to adopt.”).

Thus, early on, the Supreme Court suggested the “state law” requirement would be satisfied if the insurer were subject to general regulatory standards. In *FTC v. National Casualty Co.*, 357 U.S. 560 (1958), the FTC sought to stop insurers in several states from engaging in unfair and deceptive acts and practices. The Court found that the FTC’s authority to regulate these practices had been withdrawn by McCarran-Ferguson in states that were regulating the practices under their own laws, and rejected the FTC’s argument that it had regulatory authority where these state laws were ineffective or general:

Each State in question has enacted prohibitory legislation which proscribes unfair insurance advertising and authorizes enforcement through a scheme of administrative supervision. [The FTC] does not argue that the statutory provisions here under review were mere pretense. Rather, it urges that a general prohibition designed to guarantee certain standards of conduct is too “inchoate” to be “regulation” until that prohibition has been crystallized into “administrative elaboration of these standards and application in individual cases.” However, . . . nothing in the language of [the McCarran-Ferguson Act] or its legislative history supports the distinctions drawn by [the FTC].”

Id. at 564-65.³⁷

³⁷ In *National Casualty*, the insurers shipped their advertising material in bulk to independent agents in various states who distributed the material locally. The FTC argued that McCarran-Ferguson should be construed to authorize federal regulation in these cases because there were territorial limitations on the power of the states to regulate an interstate business and Congress could not have intended, in McCarran-Ferguson, to foreclose federal regulation of interstate insurance as a supplement to state action. However, the court found that the insurers’ advertising programs required distribution by their

Since *National Casualty*, courts have generally found “state law” to exist if there is a state regulatory scheme and minimal indicia of supervision. For example, the court in *California League of Independent Ins. Producers v. Aetna Cas. & Surety Co.*, 175 F. Supp. 857, 860 (N.D. Cal. 1959), found that a state “regulates the business of insurance . . . when a State statute generally proscribes . . . or permits or authorizes certain conduct on the part of the insurance companies.” (Citation omitted.)³⁸

The availability of the antitrust exemption does not depend on the quality of a state’s regulatory scheme, or its effective enforcement. Rather, a court is only to determine “whether the State . . . has regulated the business of . . . insurance, and not to determine whether this regulation could be better and more effectively done.” *Mitgang v. Western Title Ins. Co.*, 1974-2 Trade Cas. (CCH) ¶ 75,322 (N.D. Cal. 1974), citing *Commander Leasing Co. v. Transamerica Title Ins. Co.*, 477 F.2d 77, 84 (10th Cir. 1973); *Ohio AFL-CIO v. Ins. Rating Bd.*, above, 451 F.2d at 1184 (nothing in McCarran-Ferguson or its legislative history supports the thesis that the Act does not apply when a state’s scheme of regulation has not been effectively enforced). Moreover, at least one court has even found it unnecessary to find a state statute expressly approving a particular practice; “it is sufficient that a state regulatory scheme possess jurisdiction over the challenged practice.” *Feinstein v. Nettleship Co. of Los Angeles*, 714 F.2d 928, 933 (9th Cir. 1983), *cert. denied*, 466 U.S. 972 (1984).³⁹

Finally, the courts have ruled that insurers’ “state law”-based immunity extends only as far as the borders of the regulating state. If an insurer also acts in a non-regulating state, those activities remain subject to antitrust scrutiny. Thus in *FTC v. Travelers Health Ass’n*, 362 U.S. 293 (1960), a Nebraska insurer conducted business by mail with residents of every state. The FTC sought to prohibit the insurer from making

local agents, and there was no question but that the states had ample means to regulate this advertising within their respective boundaries. 357 U.S. at 564.

³⁸ See also *Ocean State Physicians Health Plans, Inc. v. Blue Cross & Blue Shield of Rhode Island*, 883 F.2d 1101, 1109 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990) (“A body of state law which proscribes unfair insurance practices and provides for administrative supervision and enforcement satisfies the state regulation requirement of the exemption.”) (quoting *Mackey v. Nationwide Ins. Cos.*, 724 F.2d 419, 421 (4th Cir. 1984)). However, the court in *Escrow Disbursement Ins. Agency, Inc. v. American Title and Ins. Co.*, 550 F. Supp. 1192 (S.D. Fl. 1982), was troubled by the notion that the requirement could be summarily satisfied. The court cited the dissent in *Crawford v. American Title Ins. Co.*, 518 F.2d 217 (5th Cir. 1975), which reviewed the legislative history and found that “the Act was never intended to preempt federal antitrust laws in the face of superficial, ineffective state regulation.” *Id.* at 1198 (emphasis in original) (citing *Crawford v. American Title Ins. Co.*, 518 F.2d at 235-36). Referring to the Supreme Court’s statement in *FTC v. National Casualty Co.* that the FTC had not argued “the statutory provisions . . . under review were mere pretense,” *id.* at 560, the *Escrow* court said this “strongly suggests that some sort of inquiry into the adequacy of the state regulation is appropriate.” 550 F. Supp. at 1198.

³⁹ A variation on the “state law” requirement can be found in *In re Workers’ Compensation Ins. Antitrust Litigation*, 867 F.2d 1552 (8th Cir.), *cert. denied*, 492 U.S. 920 (1989). It was argued there that an amendment to state law withdrew regulation of rate-fixing by stopping uniform rate-setting by the state insurance commissioner. The court concluded that because the commissioner retained the general power to regulate rates, the regulatory scheme passed muster under McCarran-Ferguson.

certain statements in its mailings, and the question was whether a Nebraska state regulation was sufficient “state law” to bar the FTC from acting in states other than Nebraska. Noting that it had left this issue undecided in *National Casualty*, the Supreme Court in *Travelers Health Ass’n* ruled that Nebraska law was not the “protective legislation” of the other states whose citizens were the targets of the advertising practices, and thus did not bar the FTC from acting in these other states. As the Court explained, “[i]n our opinion the state regulation which Congress provided should operate to displace this federal law means regulation by the State in which the deception is practiced and has its impact.” *Id.* at 298-99.⁴⁰

B. The Activity Cannot Constitute an Agreement to Boycott, Coerce, or Intimidate, or an Act of Boycott, Coercion, or Intimidation

The second prerequisite to insurance immunity from the federal antitrust laws under McCarran-Ferguson is that the activity may not constitute an “agreement to boycott, coerce or intimidate,” or an “act of boycott, coercion or intimidation.”⁴¹ The “generic concept of boycott refers 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.” *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531, 541 (1978). McCarran-Ferguson’s legislative history shows that the boycott exception was seen as an “important safeguard against the danger that insurance companies might take advantage of purely permissive state legislation to establish monopolies and enter into restrictive agreements falling outside the realm of state-supervised cooperative action.” *Id.* at 547.

Before 1978, the lower courts disagreed as to whether the boycott exception extended beyond targets in the insurance industry—such as insurers and insurance agents—to include policyholders. For example, in *Meicler v. Aetna Cas. and Surety Co.*, 372 F. Supp. 509 (S.D. Tex. 1974), *aff’d*, 506 F.2d 732 (5th Cir. 1975), the court rejected the argument that insurance companies were illegally refusing to issue policyholders a policy unless they submitted to a reclassification of their risk. The court found that the boycott exception was designed primarily to deal with conspiracies of insurers or agents to boycott other insurers or agents.⁴² By contrast,

⁴⁰ See also *Travelers Health Ass’n v. FTC*, 298 F.2d 820, 823 (8th Cir. 1962) (on remand from *FTC v. Travelers Health Ass’n*, above) (to the extent a state must depend on the provisions of another state, the activity cannot be held to be “regulated by state law”). Cf. *Hartford Fire Ins. Co. v. California*, 509 U.S. 764, 784 (1993) (domestic insurers not stripped of McCarran antitrust protection simply because they agreed or acted with foreign reinsurers that presumably were “not regulated by State Law.”).

⁴¹ Most case law focuses on the boycott, not the coercion or intimidation component of the exemption. *Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of Rhode Island*, above, 883 F.2d at 1109 n.9. As a general matter, coercion does not occur where the allegedly coerced parties have retained options, “even though such options may have been made more expensive.” *Id.*, citing *Klamath-Lake Pharm. Ass’n v. Klamath Medical Servs. Bur.*, 701 F.2d 1276 (9th Cir.), *cert. denied*, 464 U.S. 822 (1983); *Feinstein v. Nettleship Co. of Los Angeles*, above, 714 F.2d 928.

⁴² See also, e.g., *Frankford Hosp. v. Blue Cross of Greater Philadelphia*, 417 F. Supp. 1104 (E.D. Pa. 1976), *aff’d*, 554 F.2d 1253 (3d Cir.), *cert. denied*, 434 U.S. 860 (1977); *Black v. Nationwide Mut. Ins. Co.*, 429 F. Supp. 458 (W.D. Pa. 1977), *aff’d*, 571 F.2d 571 (3d Cir. 1978). Some decisions have read the exception more narrowly, limiting it specifically to insurance company “blacklisting” of agents and other insurers. See, e.g., *Transnat’l Ins. Co. v. Rosenlund*, 261 F. Supp. 12, 26-27 (D. Or. 1966).

the court in *General Glass Co. v. Globe Glass and Trim Co.*, 1978-1 Trade Cas. (CCH) ¶ 61,998 (N.D. Ill. 1978), read the exception more narrowly, potentially covering third-party provider glass replacement shops as boycott targets.⁴³

The Supreme Court resolved this question in its 1978 decision in *St. Paul Fire & Marine Ins. Co. v. Barry*, above. In *Barry*, physician-policyholders and their patients alleged that three of four firms who wrote medical malpractice insurance in their state had engaged in a prohibited boycott, by refusing to deal with policyholders of the fourth insurer as a way to compel them to submit to that insurer's preferred ground rules. The Court noted that when Congress used the term "boycott" in McCarran-Ferguson, it evoked the meaning of the same term as used in Sherman Act decisions.⁴⁴ The Court reviewed the legislative history of McCarran-Ferguson and found that if Congress had intended to limit the scope of the exception to boycotts of competing insurance companies or agents, and to preclude all Sherman Act protection for policyholders, it would have said so explicitly. Thus the term boycott was "not limited to concerted activity against insurance companies or agents or, more generally, against competitors of members of the boycotting group," but extended to customers of some or all of those engaged in the boycott. *Id.* at 552. Applying that statutory interpretation to the facts, the *Barry* Court concluded there was a prohibited boycott.

Noting that boycotts are not a "unitary phenomenon," *id.* at 543, the *Barry* Court had offered a variety of definitions for this term. Fifteen years later, however, the Supreme Court narrowed the concept of a prohibited boycott in *Hartford Fire Ins. Co. v. California*, 509 U.S. 764 (1993). In that case, the Court ruled there might be a boycott where primary insurers, reinsurers, and trade associations conspired to force certain other primary insurers to change the terms of their standard domestic commercial general liability policies to conform with policies they wanted to sell. The Court explained that a boycott exists where, in order to coerce a target into certain terms on one transaction, parties refuse to engage in a second, unrelated or collateral, transaction with the target. "It is this expansion of the refusal to deal beyond the targeted transaction that gives great coercive force to a commercial boycott: unrelated transactions are used as leverage to achieve the terms desired." *Id.* at 802-03.

Applying this test in two cases decided since *Hartford*, the Eleventh Circuit has found no boycott. In *Uniforce Temporary Personnel, Inc. v. National Council on Compensation Ins., Inc.*, 87 F.3d 1296 (11th Cir. 1996), temporary-employment firms alleged that a conspiracy of workers compensation insurers, a rating organization, and a reinsurance pool acted to "boycott, coerce, and intimidate" them in order to

⁴³ See also, e.g., *Ballard v. Blue Shield of Southern West Virginia, Inc.*, 543 F.2d 1075, 1078 (4th Cir. 1976), *cert. denied*, 430 U.S. 922 (1977); *Monarch Life Ins. Co. v. Loyal Protective Life Ins. Co.*, 326 F.2d 841, 846 (2d Cir. 1963), *cert. denied*, 376 U.S. 952 (1964).

⁴⁴ The ordinary Sherman Act meaning of boycott is seen as "a concerted refusal to deal." See, e.g., *Barry v. St. Paul Fire & Marine Ins. Co.*, 555 F.2d 3, 7 (1st Cir. 1977) (the lower court decision that was affirmed in the Supreme Court's *Barry* decision). Today, the majority of group boycotts are subject to the rule of reason, and are not illegal *per se*. See *FTC v. Indiana Fed. of Dentists*, 476 U.S. 447, 458 (1986) (*per se* boycott classification not to be "expanded indiscriminately.").

deprive the industry of access to the voluntary market for such insurance. Citing *Hartford's* boycott definition, the *Uniforce* court found the primary transaction to be the purchase of workers' compensation insurance, and there was no allegation that the insurers refused to deal with the firms in a collateral transaction, such as the purchase of health insurance, in order to coerce the terms of its purchase of workers' compensation insurance. Similarly, in *Slagle v. ITT Hartford*, 102 F.3d 494 (11th Cir. 1996), a Florida resident argued that insurers conspired to foreclose the windstorm insurance market by boycotting and refusing to deal with customers in certain Florida counties. Relying on *Hartford's* boycott definition, the *Slagle* court concluded that the conditions of the insurers' refusal to deal related directly to the terms of the purchase of windstorm insurance, the primary transaction, and thus again, found there was no prohibited boycott.

C. The Activity Must Constitute the "Business of Insurance"⁴⁵

The final prerequisite to antitrust protection under McCarran-Ferguson is that the activity must constitute the "business of insurance"—another undefined term in the Act. Before 1969, courts construed the term to encompass "virtually all activities engaged in by insurance companies."⁴⁶ When an action was brought against an insurer, courts simply inquired, under the Act's other two prerequisites, whether the state "had entered the field" and whether the activity constituted an act of boycott, coercion, or intimidation.⁴⁷ The courts apparently assumed the challenged activities satisfied the third prerequisite, "the business of insurance."⁴⁸ After 1969, as discussed below, the courts turned their attention to this final prong.

1. The Supreme Court's Development of the "Business of Insurance" Test

In 1969, the Supreme Court narrowed the "business of insurance" provision by distinguishing the "business of insurance" from the "business of insurance companies" and clarifying that McCarran-Ferguson exempts only the former. In *SEC v. National Securities, Inc.*, 393 U.S. 453, 459-60 (1969), the Court explained:

⁴⁵ Until recently, decisions construing the Employee Retirement Income Security Act of 1974 (ERISA) and its savings clause (under which state laws regulating insurance, banking, and securities are saved from preemption by ERISA) relied, to varying degrees, on cases interpreting the "business of insurance" under the McCarran-Ferguson Act. However, in *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003), the Supreme Court made a "clean break" from the McCarran-Ferguson factors in the ERISA context, noting that the statutory language of ERISA's savings clause differed substantially from that of McCarran-Ferguson, and that the McCarran-Ferguson factors were developed in cases that characterize conduct by private actors, not state laws. Because the statutory contexts of the cases differ, the ERISA cases are not discussed further here.

⁴⁶ *Am. Family Life Assurance Co. of Columbus v. Planned Mktg. Assocs.*, 389 F. Supp. 1141, 1144-45 (E.D. Va. 1974).

⁴⁷ *Id.*

⁴⁸ See, e.g., *FTC v. Nat'l Cas. Co.*, above, 357 U.S. 560; *Transnat'l Ins. Co. v. Rosenlund*, above, 261 F. Supp. 12; *Miley v. John Hancock Mut. Life Ins. Co.*, 148 F. Supp. 299 (D. Ma.), *cert. denied*, 355 U.S. 828 (1957).

The statute did not purport to make the States supreme in regulating all the activities of insurance *companies*; its language refers not to the persons or companies who are subject to state regulation, but to laws “regulating the *business* of insurance.” 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.

(Emphasis in original.)

After the *National Securities* decision, therefore, courts began to focus on activities that were unique to the insurance industry. Over time, and relying on several of its prior decisions, the Supreme Court ultimately developed three factors to be considered in deciding whether a particular activity constitutes the “business of insurance.” As most recently articulated by the Supreme Court, these factors are:

[F]irst, whether the practice has the effect of transferring or spreading a policyholder’s risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.

Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119 at 129 (1982) (emphasis in original). These factors evolved in part from *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979) (“*Royal Drug*”), which built on principles the Supreme Court had previously set forth in two of its “first clause” decisions, *SEC v. Variable Annuity Life Ins. Co.*, 359 U.S. 65 (1959),⁴⁹ and *SEC v. National Securities, Inc.*, above. The basic parameters of the three individual business-of-insurance factors are set forth below, followed by a detailed discussion of how the courts have applied them.

Factor #1: The practice has the effect of transferring or spreading a policyholder’s risk

Variable Annuity Life was one of the earliest Supreme Court decisions to emphasize the core idea of risk-spreading in defining the “business of insurance.” In that case, the SEC sought to enjoin several insurers from offering their annuity contracts to the public without registering them under the Securities Act of 1933 and complying with the Investment Company Act of 1940. The insurers argued that because the contracts were regulated by state insurance commissioners, McCarran-Ferguson exempted them from the federal securities laws. The Court rejected this argument, reasoning that, absent some guarantee of fixed income, variable annuity contracts placed all investment risk on the annuitant and none on the issuing company. By contrast, the Court found that insurance involves some risk-taking by the insurer. The Court concluded:

⁴⁹ The *Variable Annuity Life* decision also established that the meaning of insurance under the McCarran-Ferguson Act is a federal question, that is, a matter for determination by the federal courts, not the state courts.

The companies that issue these annuities take the risk of failure. But they guarantee nothing to the annuitant except an interest in a portfolio of common stocks or other equities—an interest that has a ceiling but no floor. There is no true underwriting of risks, the one earmark of insurance as it has commonly been conceived of in popular understanding and usage.

Id. at 71-73.

In its subsequent McCarran-Ferguson decisions, the Supreme Court has continued to underscore the indispensability of risk-spreading as a core characteristic unique to insurance. See, e.g., *Union Labor Life Ins. Co. v. Pireno*, above, 458 U.S. 119 at 127, citing *Group Life & Health Ins. Co. v. Royal Drug Co.*, above, 440 U.S. 205 at 211-12. As discussed below, the lower courts have applied this factor in a number of different contexts.

Factor #2: The practice is an integral part of the policy relationship between insurer and insured

The meaning of the second business-of-insurance factor is illustrated by *SEC v. National Securities, Inc.*, above, 393 U.S. 453, which raised questions about the SEC's power to regulate activities of insurance companies and persons engaged in the insurance business. In *National Securities*, an insurer allegedly engaged in a fraudulent scheme centering on a merger of insurance companies, and the SEC sought to invalidate the merger—which shareholders and the state insurance director had approved—under the Securities and Exchange Act of 1934. The insurers argued that McCarran-Ferguson exempted their actions from the federal securities laws, because the state director of insurance found the merger was not inequitable to the stockholders and not otherwise contrary to law, in accordance with the state insurance laws. If the securities laws applied, the insurers asserted, they would improperly preempt the state insurance laws.

The question before the Supreme Court was whether the state statute was a law enacted for the purpose of regulating the “business of insurance” within the meaning of McCarran-Ferguson, and the Court ruled it was not. As the Court explained, a statute aimed at protecting the interests of insurance company stockholders did not come “within the sweep of the McCarran-Ferguson Act. Such a statute is not a state attempt to regulate ‘the business of insurance,’ as that phrase was used in the Act.” *Id.* at 457. The Court continued:

Congress was concerned with the type of state regulation that centers around the contract of insurance, the transaction which *Paul v. Virginia* held was not “commerce.” 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 exact scope of the statutory term, it is clear where the focus was—it was on the relationship between the insurance company and the policyholder. Statutes aimed

at protecting or regulating this relationship, directly or indirectly, are laws regulating the “business of insurance.”

Id. at 460.

Factor #3: The practice is limited to entities within the insurance industry

The third business-of-insurance factor was developed by the Supreme Court in its decision in *Royal Drug*. In *Royal Drug*, Group Life & Health, known as Blue Shield of Texas, offered health insurance policies that included a prescription drug benefit. Separately, Blue Shield offered to enter into pharmacy agreements with every pharmacy in Texas, and had such agreements with many of them. If the selected pharmacy had an agreement, the insured would pay a fixed price for every drug and Blue Shield would pay the remaining cost to the pharmacy. If the selected pharmacy did not have an agreement, the insured would pay the full price charged by the pharmacy and obtain reimbursement from Blue Shield for 75 percent of the difference. Independent pharmacists who declined to enter into these agreements brought an antitrust action; the question before the Supreme Court was whether the agreements were part of the “business of insurance.” The Court applied the two factors it had identified previously and created a third.

First, the Court said that its decision in *Variable Annuity Life* recognized the significance of underwriting or spreading of risk as an “indispensable characteristic of insurance.”⁵⁰ The Court distinguished between Blue Shield’s obligations under its insurance policies—which insure against the risk that policyholders will be unable to pay for prescription drugs during the coverage period—and Blue Shield’s pharmacy agreements—which serve only to minimize its costs in fulfilling its underwriting obligations. The Court found that the agreements were merely arrangements for Blue Shield to purchase goods and services, and held that, while such cost-savings arrangements may be a good business practice and may inure to the benefit of policyholders in the form of lower premiums, they were not the business of insurance.

Second, citing its decision in *SEC v. National Securities*, the Court noted that another “commonly understood aspect of the business of insurance relates to the contract between the insurer and the insured.”⁵¹ The Court found that the pharmacy agreements were not between insurer and insured, but were separate contractual arrangements between Blue Shield and pharmacies that sold and distributed goods and services other than insurance. At most, the Court declared, the agreements resulted in cost savings to Blue Shield that might be reflected in lower premiums if they were passed on to policyholders. Referring to *National Securities*’ statement that activities closely related to an insurer’s status as a reliable insurer might be placed in the same class, the Court explained, “in that sense, every business decision

⁵⁰ *Royal Drug*, 440 U.S. at 212. Among other things, the Court found that references to the meaning of the “business of insurance” in the legislative history of McCarran-Ferguson “strongly” suggested that Congress understood the business of insurance to be the underwriting and spreading of risk. *Id.* at 220-21.

⁵¹ *Id.* at 215.

made by an insurance company has some impact on its reliability, its ratemaking, and its status as a reliable insurer.”⁵² To take such a broad interpretation would, the Court concluded, bring almost every business decision of an insurer into the scope of the “business of insurance,” a result plainly contrary to the statutory language of the McCarran-Ferguson Act.

Finally, the *Royal Drug* Court introduced a third factor to the analysis. After a lengthy review of McCarran-Ferguson’s legislative history, the Court stated that one of Congress’s chief concerns was that insurance companies be allowed to continue to engage in “intra-industry” cooperative or concerted activities which would otherwise be subject to the antitrust laws, such as those carried out for statistical and ratemaking purposes.⁵³ The Court found, however, that there was not the “slightest suggestion” Congress contemplated that arrangements involving the mass purchase of goods and services from entities outside the insurance industry, as was the case in *Royal Drug*, were the business of insurance.⁵⁴ As the Court concluded:

If agreements between an insurer and retail pharmacists are the “business of insurance” because they reduce the insurer’s costs, then so are all other agreements insurers may make to keep their costs under control Such agreements would be exempt from the antitrust laws if Congress had extended the coverage of the McCarran-Ferguson Act to the “business of insurance companies.” But that is precisely what Congress did not do.

Id. at 232-33.

In sum, in cases decided prior to *Royal Drug*, “an expansive perception of the ‘business of insurance’ requirement prevailed in a majority of the circuit courts of appeals.”⁵⁵ Although the influence of *Royal Drug* can be seen most clearly in cases involving relationships between insurers and non-insurance entities, as discussed below, its impact is evident in almost all subsequent cases where courts have considered whether an activity is the “business of insurance.”

The *Royal Drug* criteria were reinforced and refined three years later in *Union Labor Life Ins. Co. v. Pireno*, above. In *Pireno*, some of an insurer’s health insurance policies limited the company’s liability for chiropractic treatments to reasonable

⁵² *Id.* at 216-17.

⁵³ “Because of 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.” *Id.* at 212-22.

⁵⁴ *Id.* at 224.

⁵⁵ *United States v. Title Ins. Rating Bureau of Arizona, Inc.*, 700 F.2d 1247, 1251 (9th Cir. 1983), *cert. denied*, 467 U.S. 1240 (1984), citing *Portland Retail Druggists Ass’n v. Kaiser Found. Health Plan*, 662 F.2d 641, 647 (9th Cir. 1981). See also *Proctor v. State Farm Mut. Auto. Ins. Co.*, 675 F.2d 308, 318 (D.C. Cir.), *cert. denied*, 459 U.S. 839 (1982) (“Courts and commentators have generally agreed that the articulation and application of these criteria in *Royal Drug* significantly narrowed the scope of the term ‘business of insurance.’”).

charges for necessary medical care and services. To determine what charges were reasonable and what care was necessary, the insurer consulted with the state chiropractic association's peer review committee. Because the committee occasionally found treatments unnecessary or charges unreasonable, one chiropractor argued that the consultation arrangement enabled the insurer to fix the prices that chiropractors could charge. Citing *Royal Drug*, the Supreme Court found that this activity did not constitute the business of insurance:

In sum, *Royal Drug* identified three criteria relevant in determining whether a particular practice is part of the "business of insurance" exempted from the antitrust laws by § 2(b): *first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry. None of these criteria is necessarily determinative in itself

Pireno, 458 U.S. at 129 (emphasis in original).

The *Pireno* Court elaborated on *Royal Drug's* third criterion (which in fact had not been made explicit in that decision). The *Pireno* Court stated that challenged practices were not necessarily disqualified from the McCarran-Ferguson exemption solely because they involved parties outside the insurance industry. The involvement of such parties, however, even if not dispositive, was part of the inquiry mandated by *Royal Drug*. "As the Court noted [in *Royal Drug*], § 2(b) was intended primarily to protect 'intra-industry cooperation' in the underwriting of risks." *Pireno*, 458 U.S. at 133 (emphasis in original). The *Pireno* Court continued:

Arrangements between insurance companies and parties outside the insurance industry can hardly be said to lie at the center of that legislative concern. More importantly, such arrangements may prove contrary to the spirit as well as the letter of § 2(b), because they have the potential to restrain competition in noninsurance markets. Indeed, the peer review practices challenged in the present cases assertedly realize precisely this potential: Respondent's claim is that the practices restrain competition in a provider market—the market for chiropractic services—rather than in an insurance market.

Id.

In *Hartford Fire Ins. Co. v. California*, above, 509 U.S. 764, the Supreme Court expanded on *Pireno*; the issue according to *Hartford* was whether "a particular practice" is part of the business of insurance exempted from the antitrust laws. As the *Hartford* Court explained:

While "business" may mean "[a] commercial or industrial establishment or enterprise," . . . the definite article before "business" in § 2(b) shows that the word is not used in that sense, the phrase "the business of insurance" obviously not being meant to refer to a single entity. Rather,

“business” as used in § 2(b) is most naturally read to refer to “[m]ercantile transactions; buying and selling; [and] traffic.” . . .

The cases confirm that “the business of insurance” should be read to single out one activity from others, not to distinguish one entity from another.

Id. at 781.

2. Application of the “Business of Insurance” Test As It Evolved Over Time

The remainder of this opinion discusses the courts’ application of the McCarran-Ferguson Act’s test, as it evolved over time, for deciding when an activity constitutes the “business of insurance” exempt from federal antitrust liability (provided the activity is also “regulated by State law” and does not constitute an act of boycott, coercion, or intimidation). For ease of reference, the cases are discussed according to the relationships at issue: (a) relationships among insurers; (b) relationships between insurers and agents; (c) relationships between insurers and insureds; and (d) relationships between insurers and other third parties. The results of these cases are all highly fact-specific, and thus generalities about them are necessarily imprecise and must be applied with caution.⁵⁶ Further, because the legal tests under the Act have evolved over time, it is unlikely that all of the earlier rulings would survive today and that a court would rule on the same facts in the same way. Greater reliance therefore should be placed on the most recent cases. With these caveats, the following general conclusions can be drawn:

- Courts tend to find that activities among insurers involving cooperative ratemaking and related functions constitute the business of insurance. Insurers may enter into agreements or arrangements that do not involve such matters, but the more these activities extend to functions that are not unique to the insurance business, or whose primary impact is not on the insurance market, the less likely courts are to apply the exemption.
- Courts tend to find that activities between insurers and agents involving the terms of their contracts or the termination of their relationships constitute the business of insurance, provided the activities are closely linked to the insurer/insured relationship and involve the agent’s insurance dealings.
- Courts tend to find that activities involving the relationship between the insurer and insured, such as disputes over the tying of products and the terms and conditions of the policy, constitute the business of insurance. If the activity does

⁵⁶ “Courts have carefully defined the ‘business of insurance’ requirement to effect the limited congressional purposes behind the act, and for the same reasons consistently use a fact-based conduct analysis to determine whether that requirement is met in a particular case.” *Centennial Sch. Dist. v. Independence Blue Cross*, 1994-1 Trade Cas. (CCH) ¶ 70,526 (E.D. Pa.). *See also* FTC Staff Advisory Opinion of Aug. 19, 2003, in response to inquiry by Stonebridge Life Insurance Company (stating that whether an activity is exempt under McCarran-Ferguson—an “activity-based” exemption—requires a factual analysis of the activities in question).

not involve risk-spreading, however, or if its primary impact on competition is not on the insurance industry, courts are less likely to apply the exemption.

- Courts have not found activities involving arrangements between insurers and third-party providers of non-insurance goods and services, such as medical practitioners and hospitals, to constitute the business of insurance at least since the late 1970s, when the current “business of insurance” test was formulated.

a. Relationships Among Insurers

As noted above, in *Royal Drug*, the Supreme Court concluded that, “[b]ecause . . . 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.” *Royal Drug*, 440 U.S. at 221; *see also SEC v. Nat’l Securities*, 393 U.S. at 460 (“[c]ertainly the fixing of rates is part of this business [of insurance].”). The concern for informed ratemaking was most acute for smaller enterprises and insurers. Accordingly, as detailed below, courts tend to find that activities among insurers involving cooperative ratemaking and related functions constitute the business of insurance.

(i) Ratemaking and Related Functions

One early case concluded that insurers acting in concert to agree on the rate of agent commissions was the business of insurance; “[i]t is common knowledge that the rate of commission paid to agents is a vital factor in the ratemaking structure.” *California League of Indep. Ins. Prods. v. Aetna Cas. & Sur. Co.*, 175 F. Supp. 857, 860 (N.D. Cal. 1959).⁵⁷ Courts have also found that the business of insurance encompasses concerted actions among insurers to set market prices for life insurance, *Steingart v. Equitable Life Assurance Soc’y of the United States*, 366 F. Supp. 790 (S.D.N.Y. 1973); concerted actions among auto insurers to reclassify their insureds’ risks, *Meicler v. Aetna Cas. and Sur. Co.*, 372 F. Supp. 509 (S.D. Tex. 1974), *aff’d*, 506 F.2d 732 (5th Cir. 1975); and the increase of auto insurance rates by a state insurance rating board and its members without state approval or regulation, *Ohio AFL-CIO v. Ins. Rating Bd.*, 451 F.2d 1178 (6th Cir. 1971), *cert. denied*, 409 U.S. 917 (1972).

More recently, the fixing of rates for workers’ compensation insurance was found to be the business of insurance. In *In re Workers’ Compensation Ins. Antitrust Litigation*, 867 F.2d 1552 (8th Cir.), *cert. denied*, 492 U.S. 920 (1989), employers complained that underwriters and a rating association agreed not to charge less than the maximum rate set by the insurance commissioner. The Eighth Circuit found such rate-fixing to be integral to the price charged to policyholders and to their contractual relationship; “[a]lthough a price fixing agreement may maximize profit, it is axiomatic that the fixing of rates is central to transferring and spreading the insurance risk.” *Id.*

⁵⁷ *But see Royal Drug*, 440 U.S. 205 at 224-25 n. 32 (“It is clear from the legislative history that the fixing of rates is the ‘business of insurance.’ The same conclusion does not so clearly emerge with respect to the fixing of agents’ commissions.”).

at 1556.⁵⁸ Similarly, in the context of medical malpractice insurance, the Third Circuit found that joint rate-setting and risk classification through a rating association were the business of insurance. *See Owens v. Aetna Life & Cas. Co.*, 654 F.2d 218 (3d Cir.), *cert. denied*, 454 U.S. 1092 (1981).⁵⁹

A variation on the ratemaking-as-business of insurance cases is *Proctor v. State Farm Mutual Automobile Ins. Co.*, 675 F.2d 308 (D.C. Cir.), *cert. denied*, 459 U.S. 839 (1982), a case influenced by *Royal Drug*. In *Proctor*, auto repair shops alleged that insurers improperly agreed to pay damage claims on the basis of an agreed-upon hourly labor rate. The D.C. Circuit rejected this argument, relying on *Royal Drug's* references to the intra-industry concerns that formed a basis for the McCarran-Ferguson Act. The court thought that Congress intended the exemption to cover data sharing on the rate of past losses, as well as information on the probability that particular losses would occur. Insurers also had to factor into their premiums the magnitude of their payment if the loss occurred, the court reasoned, and the magnitude of the loss included the cost of repairing the car. Because the court did not believe that Congress intended to allow concerted action to determine the rate of past losses and probability of future losses, but not allow similar combined efforts to calculate the expected magnitude of loss—the current cost of repair—it held the latter to be covered as well. The court recognized that not everything affecting premium levels constitutes the business of insurance, but stressed that the cost of repairs was directly related to the calculation of premiums and virtually a part of the ratemaking process.⁶⁰

In the most recent reported case on this issue, *Gilchrist v. State Farm Mutual Automobile Ins. Co.*, 390 F.3d 1327 (11th Cir. 2004), policyholders alleged that their insurers conspired to limit coverage for certain auto body repairs to the cost of less expensive and possibly lower quality parts. Although the policyholders characterized their challenge as an attack on insurers' cost-cutting arrangements with third parties, the court found that the allegations actually attacked the insurers' premium-setting practices and the performance of their contractual obligations to policyholders—

⁵⁸ *See also Uniforce Temporary Personnel, Inc. v. Nat'l Council on Comp. Ins.*, 87 F.3d 1296 (11th Cir. 1996) (alleged conspiracy among insurers and rating organization to make temporary employee firms pay higher workers' compensation insurance rates was business of insurance). In *Calico Trailer Mfg. Co. v. Ins. Co. of North America*, 1995-1 Trade Cas. (CCH) ¶ 71,022 (E.D. Ark. 1994), an insured alleged that an insurer, a loss control services firm, and a rating organization conspired to coerce it to pay excessive workers' compensation insurance premiums. The firm argued this was not the business of insurance because the loss control services firm was not in the insurance industry. The court found the fixing of rates to be the business of insurance, and loss control services to be essential to fixing rates. Because loss control services were "intimately related" to insurers, and regulated by state insurance authorities, the court found the firm was part of the insurance industry.

⁵⁹ An insurer's alleged fixing of windstorm insurance rates through a state-created joint underwriting association is also the business of insurance. *Slagle v. ITT Hartford*, 102 F.3d 494 (11th Cir. 1996).

⁶⁰ *See also Quality Auto Body, Inc. v. Allstate Ins. Co.*, 660 F.2d 1195, 1201 n. 4 (7th Cir. 1981), *cert. denied*, 455 U.S. 1020 (1982); *Workman v. State Farm Mut. Auto. Ins. Co.*, 520 F. Supp. 610, 615-16 n. 7 (N.D. Cal. 1981). The *Proctor* court recognized the agreement it was reviewing might not, strictly speaking, involve the spreading or underwriting of risk, but noted that *Royal Drug* did not make clear whether this was an exclusive or dispositive test. *Proctor v. State Farm Mut. Auto. Ins. Co.*, 675 F.2d at 324.

matters involving the “heart of the relationship” between insurer and insured. The court found, therefore, the activities to be exempted.

A unique set of facts was presented in *Grant v. Erie Ins. Exchange*, 542 F. Supp. 457 (M.D. Pa. 1982), *aff’d*, 716 F. 2d 890 (3d Cir.), *cert. denied*, 464 U.S. 938 (1983). An issue of statutory interpretation arose as to whether a deceased victim could receive work loss benefits under a state no-fault motor vehicle insurance act; the insurers had allegedly refused to pay such benefits and consulted with each other in making their coverage determinations. The representatives of deceased victims challenged these activities under the antitrust laws, but the court ruled they were exempt under McCarran-Ferguson. The court found no distinction between, on the one hand, cooperating to collect statistical data and set rates and, on the other hand, joint undertakings to interpret the existence and extent of coverage. The court also found the insurers’ meetings to discuss common litigation strategy and other combined efforts to avoid paying benefits to deceased victims to be the business of insurance. “Since these activities are necessary to carry out any agreement concerning the extent of insurance coverage and type of policy, they fall within the language of the statute. . . .” 542 F. Supp. at 463.

Another court has found that collective action among insurers and reinsurers to reduce their exposure under commercial general liability policies by changing standard policy language, and avoiding the underwriting or reinsuring of risks written on disfavored policy terms, to be the business of insurance. *See In re Insurance Antitrust Litigation*, 723 F. Supp. 464 (N.D. Cal. 1989), *rev’d in part and remanded*, 938 F. 2d 919 (9th Cir. 1991). The court concluded that both reinsurance and retrocessional insurance (insurance for reinsurers) were the business of insurance.⁶¹

The area of title insurance has spawned a number of “business of insurance” cases whose holdings have shifted since *Royal Drug* and *Pireno*. In *Commander Leasing Co. v. Transamerica Title Ins. Co.*, 477 F.2d 77 (10th Cir. 1973), decided before these cases, purchasers of title insurance alleged that the title insurers had conspired to obtain a monopoly. Although part of the title insurance fee was a service charge for procuring and examining evidence of title, not for the premium, the Tenth Circuit held that title insurance was insurance for purposes of McCarran-Ferguson. Relying on *National Securities*, the court then found that examination of evidence of title preparatory to issuance of a title insurance policy was an activity related so closely to the insurers’ status as reliable insurers that it constituted the business of insurance. *Id.* at 83; *see also Schwartz v. Commonwealth Land Title Ins. Co.*, 374 F. Supp. 564 (E.D. Pa. 1974) (conspiracy among insurers and rating association to impose uniform seller charges for title insurance is the business of insurance).⁶²

⁶¹ *See also UNR Indus., Inc. v. Continental Ins. Co.*, 607 F. Supp. 855 (N.D. Ill. 1984) (alleged conspiracy by insurers to change types of policies offered was business of insurance). In a case involving a different kind of risk avoidance associated with an insurer’s unilateral action, a former agent alleged that the insurer engaged in “redlining,” the arbitrary refusal to underwrite the risks of persons residing in predominantly black neighborhoods. *Mackey v. Nationwide Ins. Cos.*, 724 F.2d 419 (4th Cir. 1984). The court found that the activity fell within the antitrust exemption, but that McCarran-Ferguson did not foreclose a claim under the Fair Housing Act or Civil Rights Acts.

⁶² *See also Mitgang v. Western Title Ins. Co.*, 1974-2 Trade Cas. (CCH) ¶ 75,322 (N.D. Cal. 1974) (conspiracy among title insurers to fix rates is business of insurance); *First American Title Co. of*

The result was different, however, in *United States v. Title Ins. Rating Bureau of Arizona, Inc.*, 700 F.2d 1247 (9th Cir. 1983), *cert. denied*, 467 U.S. 1240 (1984), decided after *Royal Drug* and *Pireno*. In *Arizona*, title insurers relied on the *Commander* and *Schwartz* decisions to argue that their provision of escrow services was the business of insurance. The Ninth Circuit found neither case persuasive because both predated *Royal Drug*. Applying the *Royal Drug/Pireno* criteria, the *Arizona* court found the services were not the business of insurance because the escrow process did not spread or underwrite risk. The court noted also that non-insurers performed escrow services, so “immunizing price-setting by insurance companies who perform escrow services would distort competition by those who are not insurance companies.” *Id.* at 1252.⁶³

(ii) Other Activities Among Insurers

Courts are less inclined to find that insurer practices not involving cooperative ratemaking and related activities constitute the business of insurance. The merger of two insurers was held not to be the business of insurance in *American General Ins. Co. v. FTC*, 359 F. Supp. 887 (S.D. Tex. 1973), *aff'd*, 496 F.2d 197 (5th Cir. 1974), for example. The court explained that the relationships there were between individual companies and between companies seeking to merge and the industry as a whole, and that the competitive aspects of the mergers were “far removed” from the relationship between insurer and insured contemplated by *National Securities*.⁶⁴

Other types of concerted insurer activity held not to be the business of insurance involve actions designed to harm another insurer’s business. *DeVoto v. Pacific Fidelity Life Ins. Co.*, 354 F. Supp. 874 (N.D. Cal. 1973), *rev’d on other grounds*, 516 F.2d 1 (9th Cir. 1975), for example, involved two insurers vying for the customer list of a mortgage lender for the sale of mortgage protection insurance. The unsuccessful insurer alleged that its successful competitor and the lender had violated the Sherman Act, and the competitor and lender responded that their activities were protected under McCarran-Ferguson. The court found that the activity was peripheral to the insurance business and thus immunity did not attach. In a post-*Royal Drug* decision, *Escrow Disbursement Ins. Agency, Inc. v. American Title and Ins. Co.*, 550 F. Supp. 1192 (S.D. Fl. 1982), an insurance agency marketed a policy to cover the gap in title insurance coverage between the time of title search and

South Dakota v. South Dakota Land Title Ass’n, 541 F. Supp. 1147 (D.S.D. 1982), *aff’d*, 714 F.2d 1439 (8th Cir.), *cert. denied*, 464 U.S. 1042 (1984) (attempts by insurers to enforce state law requiring policies to be signed by abstractor was business of insurance; agreements by insurers, abstractors, and board of examiners to fix fees for abstractor countersignatures on policies was not business of insurance).

⁶³ Moreover, in *Ticor Title Ins. Co. v. FTC*, 998 F.2d 1129 (3d Cir. 1993), *cert. denied*, 510 U.S. 1190 (1994), the FTC claimed title insurers were unfairly agreeing to set uniform rates for title search and examination services. The court held the activities did not constitute protected “business of insurance” because the services were analogous to the peer review process in *Pireno* and the insurer-pharmacy reimbursement process in *Royal Drug*, and thus had nothing to do with the actual performance of the title insurance contract.

⁶⁴ *Am. Gen. Ins. Co.*, 359 F. Supp. at 897. Another court has found overlapping directorates between banks and insurers and between bank holding companies and insurers not to be the business of insurance. *United States v. Crocker Nat’l Corp.*, 422 F. Supp. 686 (N.D. Cal. 1976).

recording of the mortgage or deed of conveyance. The agency alleged that title insurers conspired to cut off this business by sending letters to customers that spread false information about the firm and its policy. Applying the *Pireno* criteria, the court ruled that sending such letters might not constitute the business of insurance. It reasoned that the letters did not spread risk; that it was unclear whether the letters related to the contractual relationship between insurer and insured; and that it was unclear whether the practice of issuing these letters was limited to the title insurance industry.

Antitrust immunity under McCarran-Ferguson was also denied in the context of agreements between two prepaid healthcare insurers, in *Hahn v. Oregon Physicians Service*, 689 F.2d 840 (9th Cir. 1982), *cert. denied*, 462 U.S. 1133 (1983). In *Hahn*, podiatrists alleged that the insurers violated the antitrust laws by agreeing to require insureds to obtain certain podiatric services only from medical doctors; refusing to reimburse insureds for treatment by a podiatrist unless referred by a medical doctor; and refusing to permit podiatrists to become members of their healthcare associations. Noting that *Royal Drug* limited the scope of the McCarran exemption, the *Hahn* court found no evidence of *bona fide* risk-related reasons for an insurer to distinguish between the services of medical doctors and podiatrists, “much less that such a distinction is at the core of what is commonly understood to be the ‘business of insurance.’” *Id.* at 843. The court analogized the facts to those in *Pireno* and concluded that arrangements whose primary impact was on competition in markets other than that for insurance, as was the case both in *Pireno* and here, do not fall within the exemption.

Finally, courts have denied antitrust immunity in cases involving agreements between insurers to allocate markets. In *Garot Anderson Marketing, Inc. v. Blue Cross and Blue Shield United of Wisconsin*, 772 F. Supp. 1054 (N.D.Ill 1990), insurance agents alleged that, in terminating a health insurance plan, the insurers conspired to monopolize group health insurance in a certain geographic area. The court found the insurers’ conduct did not constitute the business of insurance, because, while it involved two insurers, there was no shifting of risk between insurer and insured (only between two insurers), and the termination of the plan was not an integral part of the policy relationship between the subscribers and either insurer. Likewise, in *State of Maryland v. Blue Cross and Blue Shield Ass’n*, 620 F. Supp. 907 (D.Md. 1985), Maryland alleged that insurers had violated the antitrust laws by agreeing to allocate the insurance market in the state. In finding that there were material factual issues on the question whether the market allocation was “the business of insurance,” and thus that summary judgment was inappropriate, the court declared that, to meet the first *Pireno* requirement, the insurers had to show that exclusive geographic territories directly facilitated risk-spreading.⁶⁵

⁶⁵ The *Blue Cross* court also found the insurers’ decision not to market at all in a particular geographic area was one step removed from the aspects of the insured/insurer relationship that lie at the core of the business of insurance. The court referenced the dissent in *Owens v. Aetna Life and Cas. Co.*, above, 654 F.2d 218, in which the dissenting judge found that market allocation agreements among insurers were generally not the business of insurance; pooling agreements between insurers contribute to risk spreading, while agreements to divide markets would appear to have the opposite result.

b. Relationships Between Insurers and Agents

Courts tend to exempt activities that involve relationships between insurers and agents involving the terms of their contracts and the termination of their relationships, provided the activity is closely linked to the insurer/insured relationship and involves the agent's insurance dealings as such. As the Tenth Circuit explained in *Commander Leasing Co. v. Trans-America Title Ins. Co.*, above, 477 F.2d at 86, “[i]n applying the McCarran Act, we see no reason to distinguish between a principal insurer and its agent. It would appear to us that an insurance agent, as well as an insurance company, is engaged in the ‘business of insurance.’” Nevertheless, the Supreme Court has left unresolved whether “transactions between an insurer and its agents, including independent agents, are ‘the business of insurance.’” See *Royal Drug*, 440 U.S. at 224 n. 32.

(i) Terms of Agency Contracts and Termination of Relationships

Insurer-agent contracts that require exclusive representation of the named insurers have been found to be the business of insurance. In *Black v. Nationwide Mutual Ins. Co.*, 429 F. Supp. 458, 463 (W.D. Pa. 1977), *aff'd*, 571 F.2d 571 (3rd Cir. 1978), the court found the agent's relationship with the insurers “so closely connected to the ‘core of the insurance business’, the ‘relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation and enforcement’ as to come within the scope of the ‘business of insurance’” as defined in *National Securities*.⁶⁶ In *Thompson v. New York Life Ins. Co.*, 644 F.2d 439 (5th Cir. 1981), a separate and optional agency contract provision that had additional benefits, but precluded an agent from engaging in another business for remuneration or profit without the insurer's consent, was found to constitute the business of insurance. While the court noted that “not all provisions that could be placed in an agency contract, nor all dealings between insurance companies and their agents are exempted by the McCarran-Ferguson Act,” *id.* at 444, the court concluded that the restrictions did not force the agent to engage in activities unrelated to insurance—they were incentives to encourage him to focus his skills on selling insurance—and found this distinction “significant and dispositive.” *Id.*⁶⁷

⁶⁶ See also *Steinberg v. Guardian Life Ins. Co.*, 486 F. Supp. 122 (E.D. Pa. 1980) (contract that ties general agency to requirement of full-line sales is the business of insurance). But see *Ray v. United Family Life Ins.*, 430 F. Supp. 1353 (W.D.N.C. 1977) (funeral home operator who sold burial insurance alleged one insurer coerced him into ending his agreements with competitors; the court analyzed the facts as involving the relationship of agency and company, not policyholder and company, and found no indication in McCarran that Congress wanted insurance agents to be treated differently from other kinds of agents in relation to their companies).

⁶⁷ Similarly, in *Gribbin v. Southern Farm Bur. Life Ins. Co.*, 1984-1 Trade Cas. (CCH) ¶ 65,798 (W.D. La. 1984), the court found three restrictions in agency contracts to be the business of insurance. First, the requirement to return rate books and files upon termination was the business of insurance because insurers were ensuring that existing contracts would remain in force. Second, insurers' instructions not to sell policies to certain racial or ethnic groups or to attorneys were directly related to their relationship with prospective policyholders. Third, prohibiting agents from brokering business with other insurers until their obligations were fulfilled in their territory was the business of insurance; the provision was designed to motivate agents to focus their efforts on selling insurance under the terms of their contracts.

The termination of an agency relationship was at issue in *Hopping v. Standard Life Ins. Co. v. Blue Cross*, 1984-1 Trade Cas. (CCH) ¶ 65,814 (N.D. Miss. 1983). A life insurer teamed with a healthcare insurer to sell their policies as a package or independently. The life insurer informed one of its pre-existing agents that he could work for the firm on a contract basis if he agreed not to replace the healthcare policy part of the packages with competing policies. The agent would not accept the limitation and was terminated. The court found this transaction to be between an insurer and its agent, resulting from the relationship between this insurer and the second insurer. The court ruled that the proper focus in determining whether such transactions were the business of insurance was on the impact of the challenged activity or restriction on the insurer/insured relationship. The appropriate test to be applied was whether the agent's participation in the scheme concerned his insurance dealings as such. The *Hopping* court stated that because transactions between an insurer and its agents related to the insurer's methods of inducing people to become policyholders, they pertained to the policyholder relationship and were an integral part of the business of insurance.

The outcome was the opposite in *Zelson v. Phoenix Mutual Life Ins. Co.*, 549 F.2d 62 (8th Cir. 1977). In *Zelson*, an agent sold and serviced both insurance policies and securities, and the insurer terminated its agency contract after the agent refused to sell securities through the firm's securities affiliate. The court focused on the fact that the agent acted as both an insurance agent and a securities broker, and that the activities involved the supervisory control of an insurance agent by its principal, but noted that the activity "impinges upon the competition within the securities industry, not upon the competitive forces within the insurance industry." *Id.* at 66. The court concluded that, in such cases, whether the agent's participation in the activity concerned his insurance dealings was a strong indication whether the activity had a bearing on the core relationship between insurer and insured. Because the court found that the substance of the activity in *Zelson* was a restraint on trading in securities, not a restraint on insurance trade, it held the activities were not the business of insurance.

(ii) Other Activities

Several cases have found that activities interfering with the ability to conduct insurance business are not the business of insurance. *American Family Life Assurance Co. v. Planned Marketing Assocs., Inc.*, 389 F. Supp. 1141 (E.D. Va. 1974), for example, involved two cancer insurers. One insurer alleged that the second induced its agents to stop selling its insurance in favor of the second insurer's policies, to use its trade secrets and customer lists, and to switch its policyholders to policies issued by the second insurer. The court concluded that these facts did not involve the business of insurance. The activities did not bear on the unique relationship between an insurer and the insured; "the activities complained of could easily be employed by one stock brokerage firm against another as by one insurance company against another."⁶⁸

⁶⁸ *Id.* at 1147. In *Am. Standard Life & Accident Ins. Co. v. U.R.L., Inc.*, 701 F. Supp. 527 (M.D. Pa. 1988), an insurer alleged that, after it purchased blocks of insurance business from a second insurer, former agents of the second insurer used information gained from their prior relationship to induce the second insurer's policyholders to replace their policies with those from competing insurers. The court

In a similar case, *Allied Financial Services, Inc. v. Foremost Ins. Co.*, 418 F. Supp. 157 (D. Neb. 1976), an insurer's general agent employed sub-agents to sell mobile home physical damage insurance. The insurer was alleged to have breached the agency contract by "pirating" the sub-agents and circumventing the general agency. The court declined to extend the McCarran exemption to "a dispute which should have little or no effect on the interests of policyholders and which primarily involves an agency agreement, not the 'contract of insurance.'" *Id.* at 161. The court found that the alleged interference with contract relations and other anticompetitive behavior involve insurance only peripherally.⁶⁹

An allegation that insurers were conspiring to exclude an agent from the marketplace was not shielded from antitrust scrutiny in *King v. G.D. Van Wagenen Co.*, 1987-1 Trade Cas. (CCH) ¶ 67,534 (D. Minn. 1987). The court found the underlying activity—the marketing of a collateral protection program and a "payment shaver" program—had insurance features as ancillary elements, but application of the *Royal Drug/Pireno* factors showed they were not the business of insurance. The court rejected the argument that the determining factor should be the existence of a relationship between agent and insurer, finding that agent-insurer disputes were not *per se* within the exemption.

Finally, in a more recent case involving an insurer's limitations on agents, *Bogan v. Northwestern Mutual Life Ins. Co.*, 953 F. Supp. 532 (S.D.N.Y. 1997), Bogan, the agent, contested his termination as a district agent for an insurer that marketed its products through a tiered agency system. General agents were assigned territories and contracted with district agents and special agents, who in turn contracted with sales agents. Bogan claimed this system prevented district agents terminated for cause from working for another general agent. Applying *Pireno*, the court found the restrictions were not the business of insurance, because the system did not further McCarran-Ferguson's purpose of allowing insurers to coordinate their policy structures to facilitate risk-spreading.

c. Relationships Between Insurers and Insureds

As noted above, the "core" of the business of insurance is "[t]he relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement." *SEC v. National Securities, Inc.*, above, 393 U.S. at 461. Courts therefore generally exempt from antitrust liability activities that involve the insurer-insured relationship, including the tying of products and the terms and conditions of the policy. If the activity does not involve risk-spreading, however, or if its primary impact on competition is not in the insurance industry, courts are less likely to apply the exemption.

held this was not the business of insurance. *But see Lawyer's Realty Corp. v. Peninsular Title Ins. Co.*, 428 F. Supp. 1288 (E.D. La. 1977) (alleged conspiracy between two title insurers and an agent to exclude another agent from the title insurance business is the business of insurance).

⁶⁹ See also *Center Ins. Agency v. Byers*, 1976-1 Trade Cas. (CCH) ¶ 60,940 (N.D. Ill. 1976) (alleged conspiracy to pirate trade secrets and confidential information pertaining to policy and marketing is not the business of insurance).

(i) Tying of Products

Royal Drug's most obvious influence is seen in a series of cases involving the tying of insurance to a loan product. The pre-*Royal Drug* case of *Addrisi v. Equitable Life Assurance Society of the United States*, 503 F.2d 725 (9th Cir. 1974), *cert. denied*, 420 U.S. 929 (1975), for example, involved an insurer who made loans for the purpose of financing residential real property sites. The insurer's agent also acted as the loan agent and, as a "tie-in," the prospective borrower was required to purchase a cash value life insurance policy. In finding the tie-in practice to be the business of insurance, the Ninth Circuit concluded that the activity concerned the "relationship between [the insurer] and its insureds and the issuance of life policies." *Id.* at 728. Similarly, in *McIlhenny v. American Title Ins. Co.*, 418 F. Supp. 364 (E.D. Pa. 1976), title insurers required purchasers of newly constructed homes to buy mechanic's lien insurance as part of their services. The court stated that "[m]atters of rate, extent of coverage, and policy provisions go to the very heart of the relationship between the insurance company and the policyholder and therefore clearly fall within the *National Securities* definition of the business of insurance." *Id.* at 369.⁷⁰

After *Royal Drug*, the courts addressed similar facts differently. In *FTC v. Dixie Finance Co.*, 695 F.2d 926 (5th Cir.), *cert. denied*, 461 U.S. 928 (1983), the FTC launched an investigation into whether finance companies and auto dealerships were misrepresenting to consumers that they could only obtain credit if they purchased credit insurance. The firms argued that their activity was protected from antitrust review because they sold insurance as an incident of their lending activities. The Fifth Circuit found that under *Royal Drug*, the focus must be on the particular activity under attack—here, not the sale of the insurance policies but the possible misrepresentation that the purchase of credit insurance is a prerequisite to the extension of credit. Because the lending activities were separate from any insurance activities the firm might engage in, the court concluded that the relationship was not one between insurer and insured and thus was not protected. The court added, "the business of insurance intrudes upon the business of financing only at the point at which the borrower or his lender deal with the insurer regarding the particulars of the policy being purchased." *Id.* at 930.⁷¹

Another tying case preceding *Royal Drug* is *Mathis v. Automobile Club Inter-Ins. Exchange*, 410 F. Supp. 1037 (W.D. Mo. 1976). *Mathis* involved an auto insurer that required its policyholders to join a certain automobile club, on the theory that club members were better drivers than the general public. Relying on *National Securities*,

⁷⁰ See also *Dexter v. Equitable Life Assurance Soc'y*, 527 F. 2d 233, 235 (2nd Cir. 1975) ("Forcing people to buy insurance may well be an undesirable practice—and we do not suggest that we approve of it—but it is part of the 'business of insurance.' . . . An insurance company's methods of inducing people to become policyholders pertain to the company-policyholder relationship, and thus constitute an integral part of 'the business of insurance.'").

⁷¹ See also *FTC v. Mfg. Hanover Consumer Servs., Inc.*, 567 F. Supp. 992 (E.D. Pa. 1983). The *Dixie Finance* court found the decisions in *Addrisi* and *Dexter* had "lost their viability and were distinguishable in light" of *Royal Drug*, where the emphasis was placed on the particular activity being questioned. *Dixie Finance*, 695 F.2d at 931. Moreover, the court in *Zelson v. Phoenix Mut. Life Ins. Co.*, above, 549 F.2d at 67, noted that these cases "do not support a conclusion that using insurance as a coercive lever or tying device in order to compel certain dealings in a non-insurance product is the business of insurance."

the court found this arrangement to constitute the business of insurance. Likewise, in *Anglin v. Blue Shield of Virginia*, 693 F.2d 315 (4th Cir. 1982), the insurer refused to offer a prospective policyholder a policy that did not include his wife. The court found the practice concerned the firm's relations with policyholders, involved the "very essence" of the relationship between insurer and policyholder, and was protected as the business of insurance.

A variation on this theme, with an emphasis on risk spreading, is *Feinstein v. Nettleship Co. of Los Angeles*, 714 F.2d 928 (9th Cir. 1983), *cert. denied*, 466 U.S. 972 (1984). In *Feinstein*, a county medical association entered into an agreement with medical malpractice insurers under which the insurers offered malpractice insurance only to association members, even those in high-risk practices. Association members could purchase malpractice insurance elsewhere, but only association members could purchase malpractice insurance through these insurers. After the insurers increased their market share and substantially increased their rates, non-member physicians challenged the agreement. Applying *Pireno*, the Ninth Circuit found the practice was related to the allocation and spreading of risk, because it defined a pool of insureds over which risk was spread, and thus was protected under *McCarran-Ferguson*. The court rejected the argument that the association was neither the insured nor the insurers, concluding that the only role of the non-insurer association was in negotiating the terms of the policy relationship between insurer and insured.

Still other aspects of an insurer's requirements imposed upon an insured have been determined to be exempted under *McCarran*. *Klamath-Lake Pharmaceutical Ass'n v. Klamath Medical Service Bureau*, 701 F. 2d 1276 (9th Cir.), *cert. denied*, 464 U.S. 822 (1983), involved a healthcare insurer that distributed drugs only through a designated pharmacy. The insurer ultimately established its own pharmacy and generally required policyholders to use this pharmacy in order to take advantage of their prescription drug benefit. Other pharmacies alleged that the insurer improperly tied a health care contract and a prescription drug benefit. Applying *Royal Drug* and *Pireno*, the Ninth Circuit found the arrangement came within the exemption. As the court explained, "[t]he insurer-insured agreement embodied in both the basic health care contract and the supplemental pharmacy benefit settles the distribution of risk that insureds will need medical goods and services, including prescription drugs. It defines the relationship between insurer and insured. And it is limited to these two traditional actors in the insurance industry." *Id.* at 1286.

(ii) Terms and Conditions of Insurance Policies

Cases involving the terms of insurance policies are likely to be encompassed within the business of insurance. In *Mulhearn v. Rose-Neath Funeral Home, Inc.*, 512 F. Supp. 747 (W.D. La. 1981), insurers issued funeral service policies that stated a face value for the service and designated a funeral director to provide the service. Each policy provided that if an insured's family did not want to use the services of the designated funeral director, the family would receive a smaller cash payment. The court found this practice exempt because it concerned the issuance of policies and their provisions.⁷² Likewise, an insurer's decision to reduce an insured's monthly

⁷² See also *Chatelain v. Mothe Funeral Home, Inc.*, 1998 WESTLAW 166212 (E.D. La. 1998) (funeral policy that tied purchase of casket to agreement to provide funeral services is business of insurance).

benefits pursuant to a group term policy issued to her employer was the business of insurance in *Freier v. New York Life Ins. Co.*, 679 F.2d 780, 782 (9th Cir. 1982).⁷³

A health insurer's introduction of a health maintenance organization (HMO) option, and its institution of an "adverse selection" policy of pricing for its traditional insurance, were also deemed to be the business of insurance in *Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of Rhode Island*, 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990). In *Ocean State*, Blue Cross purchased health services from physicians and other healthcare providers on behalf of its subscribers. Ocean State was a for-profit HMO that contracted with physicians to provide medical care to its subscribers and paid them on a fee-for-service basis. Physicians could contract with either or both. To compete with Ocean State, Blue Cross launched its own HMO and instituted an "adverse selection" policy of pricing its traditional insurance based on characteristics of the insured group.⁷⁴ The court found both practices to be the business of insurance under *Royal Drug/Pireno*: both involved risk-spreading; both directly involved the relationship between insurer and insured; and the policies were limited to entities in the insurance industry as broadly construed.

Two different results were reached in cases where the insurer acted to exclude or otherwise limit the services offered to subscribers by certain medical practitioners. In *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981), psychologists challenged two insurers' policies of refusing to pay for their services unless billed through a physician. In finding that this practice was not the business of insurance, the Fourth Circuit explained that the insurers had been paying claims for the underlying disorders for years, so the decision was not whether to underwrite the risk but merely who would be paid. However, the Eighth Circuit in *Health Care Equalization Comm. of the Iowa Chiropractic Society v. Iowa Medical Society*, 851 F.2d 1020 (8th Cir. 1988), found that insurers' exclusion of chiropractic services from its subscriber contracts was the business of insurance. The court found that the activity involved the contractual relationship between insurers and insureds, and concluded that the contracts, and the extent to which the insurers may have attained a dominant position in the market, were an integral part of the business of insurance.⁷⁵

But see Battle v. Liberty Nat'l Life Ins. Co., 493 F.2d 39 (5th Cir. 1974) (burial insurer that contracted with funeral home to furnish merchandise and services required by the policies as an intermediary with authorized funeral directors might go beyond business of insurance).

⁷³ At least one court has found that auto insurers' practices of limiting the reimbursement of policyholders to the reasonable or competitive cost of repairs is the business of insurance. *Custom Auto Body, Inc. v. Aetna Cas. and Sur. Co.*, 1983-2 Trade Cas. (CCH) ¶ 65,629 (D.R.I. 1983).

⁷⁴ Blue Cross also instituted a policy of not paying a physician more for any service than that physician was accepting from any other healthcare provider, which caused many Ocean State physicians to resign to avoid reducing their fees. The court found that this activity, which involved Blue Cross's relationships with its provider physicians, not its subscribers, was not the business of insurance.

⁷⁵ *But see Rozema v. Marshfield Clinic*, 1997-1 Trade Cas. (CCH) ¶ 71,796 (W.D. Wis. 1997) (insured's allegation that insurer improperly eliminated competition by deciding not to include a certain chiropractor in its panel of providers is not the business of insurers; the termination of the chiropractor may have had an indirect effect on the contract between insurer and insured, but the allegations related primarily to the relationship between the insurers and the chiropractor).

Finally, applying *Pireno* and other decisions, the court in *Nurse Midwifery Assocs. v. Hibbett*, 549 F. Supp. 1185 (M.D.Tn. 1982), found that a conspiracy between insured physicians and a medical malpractice insurer to cancel the malpractice insurance of a competitor physician was not the business of insurance. In *Hibbett*, certified nurse midwives who joined with an obstetrician to form a maternity practice alleged that other physicians combined to prevent the midwives from competing with them by having the first physician's malpractice insurance canceled. Relying on *Pireno's* language that the involvement of third parties outside the insurance industry had the potential to restrain competition in non-insurance markets, the court found the targeted marketplace was that of maternity services, not medical malpractice insurance, and thus the McCarran exemption did not apply.

d. Relationships Between Insurers and Other Third Parties

Since the Supreme Court's decisions in *Royal Drug* and *Pireno*, activities that involve relationships between insurers and third-party providers of non-insurance goods and services have not been exempted as the business of insurance. The following discussion provides examples of both pre- and post-*Royal Drug* decisions as illustrations of how the courts have narrowed the McCarran exemption.

(i) Agreements Between Automobile Insurers and Providers of Repair Services

The influence of *Royal Drug* can be seen clearly in cases concerning agreements between auto liability insurers and auto glass dealers and installers. Before *Royal Drug*, the court in *General Glass v. Globe Glass and Trim Co.*, 1978-1 Trade Cas. (CCH) ¶ 61,998 (N.D.Ill. 1978), ruled that an insurer's agreements with certain auto glass replacement firms, relating to prices and billing procedures for glass replacements for insureds, might be the business of insurance. Rejecting the lower court's decision in *Royal Drug* (prior to the Supreme Court's *Royal Drug* decision), the court found that the mere fact that a non-insurance service company was involved in the claims settlement process did not preclude a conclusion that the business of insurance embraced these types of arrangements.

The result was different a year later, after the Supreme Court had decided *Royal Drug*. In *Liberty Glass Co., Inc. v. Allstate Ins. Co.*, 607 F.2d 135 (5th Cir. 1979), auto glass companies alleged that insurers had agreed with certain other auto glass companies to fix the prices to be paid for glass replacement in cars covered by the insurers, in order to effect a territorial allocation of the market, discriminate in price, and eliminate competition. The district court concluded the activity fell within the McCarran exemption as the business of insurance, but the Fifth Circuit reversed on the basis of the intervening *Royal Drug* decision. The Fifth Circuit noted *Royal Drug's* holding that the business of insurance did not encompass agreements between insurers and third-party providers of goods and services where, as in *Liberty Glass*, they were merely arrangements for the purchase of goods and services by the insurer resulting in cost savings.⁷⁶

⁷⁶ In a variation, *Proctor v. State Farm Mut. Auto. Ins. Co.*, above, 675 F.2d 308, concerned allegations by auto repair shops that insurers conspired to fix prices by entering into agreements with certain

(ii) Agreements Between Insurers and Hospitals

Several mid-1970s cases involving agreements between insurers and hospitals arrived at similar conclusions—that the agreements constituted the business of insurance. In *Travelers Ins. Co. v. Blue Cross of Western Pennsylvania*, 481 F.2d 80 (3d Cir. 1973), *cert. denied*, 414 U.S. 1093 (1973), a private insurer objected to a Blue Cross contract with area hospitals specifying the amount and terms under which it would pay for services rendered its subscribers. Relying on decisions holding that ratemaking constituted the business of insurance, the Third Circuit found “the interrelationship of hospital payments and subscribers’ rates was such that Blue Cross’ arrangement with hospitals should be considered part of the ‘business of insurance.’” *Id.* at 83.⁷⁷ In *Nankin Hospital v. Michigan Hospital Service*, 361 F. Supp. 1199 (E.D. Mich. 1973), a hospital complained that a hospital service corporation terminated its contract as a participating hospital in connection with a state statute defining hospitals with which the corporation could contract. The court held that Blue Cross’s basic function of providing pre-paid hospital care was the business of insurance; the negotiation of contracts with nonprofits as regulated by state law constituted “acts in the conduct” of such business; and enforcement of the qualification standards under state law was an “act in the conduct” of Blue Cross’s insurance business. *Id.* at 1210.

However, in *Reazin v. Blue Cross and Blue Shield of Kansas*, 663 F. Supp. 1360 (D. Kan. 1987), the court analyzed *Royal Drug* in connection with a hospital’s complaint that Blue Cross improperly terminated its contractor provider agreement, and declined to apply the McCarran exemption to restraints involving an agreement with firms outside the insurance industry that did not involve risk-spreading. The court rejected the argument that an insurer’s practices involving third parties acquires the exemption when its practices restrain trade in the insurance market alone; “[t]he three criteria for determining whether the ‘business of insurance’ requirement is met are stated by the Court [in *Pireno*] in the conjunctive (‘and’), not the disjunctive. All three must be satisfied to bring a particular practice or activity within the [McCarran] § 2(b) exemption.” *Id.* at 1408.

(iii) Agreements Between Insurers and Medical Practitioners

Most post-*Royal Drug* cases concerning the relationships insurers have with medical practitioners have concluded that they do not involve the business of insurance. In a pre-*Royal Drug* decision, *Manasen v. California Dental Services*, 424 F. Supp. 657 (N.D. Cal. 1976), *rev’d on other grounds*, 683 F.2d 1152 (9th Cir. 1979), dentists charged that the activities of a prepaid dental care insurer in establishing benefits as between participating and non-participating dentists excluded non-participating dentists from the market. The court found that dentists’ fees were a major factor in

repair shops to perform work at rates agreed upon in advance. The court found such arrangements were similar to those in *Royal Drug* and were not the business of insurance, because the agreements were for the purchase of goods and services outside the insurance industry. *See also Quality Auto Body v. Allstate Ins.*, 660 F.2d 1195 (7th Cir. 1981), *cert. denied*, 455 U.S. 1020 (1982); *Workman v. State Farm Mut. Auto. Ins.*, 520 F. Supp. 610 (N.D. Cal. 1981).

⁷⁷ *See also Frankford Hosp. v. Blue Cross of Greater Philadelphia*, 417 F. Supp. 1104, 1109 (E.D. Pa. 1976), *aff’d*, 554 F.2d 1253 (3rd Cir.), *cert. denied*, 434 U.S. 860 (1977).

determining premiums; the payment arrangements to service providers were critical elements in the insurer's contractual agreements with its subscribers; these arrangements were intimately related to the interpretation and implementation of the insurer's policies and its reliability as an insurer; and thus the McCarran exemption applied.

The results were different after *Royal Drug*. In *Hoffman v. Delta Dental Plan of Minnesota*, 517 F. Supp. 564 (D. Mn. 1981), a nonprofit dental service plan corporation entered into subscriber agreements that provided for a payment differential between participating and non-participating dentists. The court found the case indistinguishable from *Royal Drug* in that the provider agreements incorporated the terms of the subscriber contracts that described the payment differential. As in *Royal Drug*, the court held that the agreements were not the business of insurance, reasoning that if mere inclusion of this type of provision in a subscriber contract resulted in an exemption, form would improperly be exalted over substance. Moreover, the *Delta Dental* court concluded that the payment differential did not spread risk; at most, the insurer was minimizing its costs in fulfilling its underwriting obligations.⁷⁸

In another variation on third-party agreement cases, *Trident Neuro-Imaging Laboratory v. Blue Cross and Blue Shield of South Carolina*, 568 F. Supp. 1474 (D.S.C. 1983), involved physician-directed private clinics and patients who alleged that insurers conspired with health planning agencies to restrain trade by not reimbursing policyholders for CAT scans performed outside of hospitals. Applying the *Royal Drug/Pireno* factors, the court concluded the arrangement was not the business of insurance. It reasoned that the insurer's decision not to reimburse for physician-owned scanners was a cost reduction decision, not an underwriting one; the practice did not affect the benefit conferred on the policyholder; and the practice inevitably involved third parties wholly outside the insurance industry—neurologists.

(iv) Agreements Between Insurers and the Pharmaceutical Industry

In a case involving arrangements between insurers and the pharmaceutical industry, *Portland Retail Druggists Ass'n v. Kaiser Foundation Health Plan*, 662 F.2d 641 (9th Cir. 1981), pharmacists challenged the contractual arrangements by which an HMO acquired drugs from manufacturers, wholesalers, and distributors. The court found the situation conceptually identical to that in *Royal Drug* and characterized the allegation of improper tying as a challenge to conditions the insurer may or may not place on its relationships with members. The court remanded the case for further factual developments to determine “[w]hether those conditions sufficiently partake of

⁷⁸ Similarly, in *Kartell v. Blue Shield of Massachusetts*, 542 F. Supp. 782 (D. Mass. 1982), physicians alleged that insurer's agreements with participating physicians that prohibited balance billing (recovering from subscribers any amount in excess of what the insurer has agreed to pay) was price fixing. The court found that the agreements were the same as those in *Royal Drug* except that participating physicians agreed to be compensated for their services on a *pro rata* basis if Blue Shield could not fully compensate them because of a depletion of its funds. The court agreed with the insurer that this placed some risk on a participating physician, but this level of risk was not enough to satisfy the first test of *Royal Drug*—absent the physicians' agreement to carry this risk, Blue Shield would carry this risk. Thus the *Kartell* court found the agreements were not the business of insurance.

the ‘indispensable characteristic of insurance’ ‘spreading of risk,’ recognized in *Royal Drug* as essential” for the exemption. *Id.* at 647.

(v) Agreements Between Insurers and Peer Review Organizations

Finally, in a case decided after *Royal Drug* and *Pireno* addressing the practice of using peer review committees, *Ratino v. Medical Service of the District of Columbia*, 718 F. 2d 1260 (4th Cir. 1983), a nonparticipating physician alleged that the insurer’s “usual, customary, and reasonable” insurance plan, which involved provider agreements and peer review committees, constituted an illegal price fixing arrangement. Applying *Pireno* and *Royal Drug*, the Fourth Circuit found the activities could not be characterized as the business of insurance. The court reasoned that the peer review activities were indistinguishable from those in *Pireno* and, thus, that the practice was not exempt under McCarran-Ferguson.

CONCLUSION

The McCarran-Ferguson Act’s antitrust exemption for insurance activities is limited by its own terms and has been further narrowed by the courts in the 60 years since the Act’s passage. Pursuant to the Supreme Court’s three-factor test as articulated in *Royal Drug* and *Pireno*, courts closely scrutinize the nature of an insurance activity in determining whether it constitutes the “business of insurance.” Under this test, only those limited activities at the core of and unique to the insurance industry are potentially eligible for the antitrust exemption. Exempt activities also must be “regulated by State law” and not run afoul of the Sherman Act’s boycott, coercion, and intimidation prohibitions.

March 4, 2005

Attachment

SUMMARY OF CASES ON THE “BUSINESS OF INSURANCE”

This is a summary of court decisions addressing whether a particular activity constitutes the “business of insurance.” Under the McCarran-Ferguson Act, activities deemed to be the business of insurance are exempt from the federal antitrust laws if they also are “regulated by State law” and do not constitute “an agreement to boycott, coerce, or intimidate, or [an] act of boycott, coercion, or intimidation.” 15 U.S.C. §§ 1012(b), 1013(b).

Note: The results of these cases are highly fact-specific, and thus generalities about them are necessarily imprecise and must be applied with caution. Further, because the legal tests under the Act have evolved over time, it is unlikely that all of the earlier rulings would survive today and that a court would rule on the same facts in the same way. Greater reliance therefore should be placed on the most recent cases.

Relationships Among Insurers

Courts have determined that the following activities or practices are the “business of insurance”:

- Concerted action by insurers to agree on the rate of commission paid to automobile insurance agents—*California League of Indep. Ins. Prods. v. Aetna Cas. & Sur. Co.*, 175 F. Supp. 857 (N.D. Cal. 1959). *But see Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 224 n. 32 (1979) (“It is clear from the legislative history that the fixing of rates is the ‘business of insurance.’ The same conclusion does not so clearly emerge with respect to the fixing of agents’ commissions.”).
- Concerted action by insurers to set prices for life insurance—*Steingart v. Equitable Life Assurance Soc’y of the United States*, 366 F. Supp. 790 (S.D.N.Y. 1973)
- Concerted action by insurers to reclassify risks for automobile insurance—*Meicler v. Aetna Cas. and Sur. Co.*, 372 F. Supp. 509 (S.D. Tex. 1974), *aff’d*, 506 F.2d 732, 734 (5th Cir. 1975)
- Agreement by insurance rating board and its members to fix prices of automobile insurance premiums—*Ohio AFL-CIO v. Ins. Rating Bd.*, 451 F.2d 1178 (6th Cir. 1971), *cert. denied*, 409 U.S. 917 (1972)
- Cooperative agreements between insurers and a rating association to set workers’ compensation insurance rates—*In re Workers’ Comp. Ins. Antitrust Litigation*, 867 F.2d 1552 (8th Cir.), *cert. denied*, 492 U.S. 920 (1989)
- Arrangements among insurers, a rating organization, and a workers’ compensation reinsurance pool to compute premiums by combining loss

- experiences—*Uniforce Temporary Personnel, Inc. v. Nat'l Council on Comp. Ins., Inc.*, 87 F.3d 1296 (11th Cir. 1996)
- Arrangements among an insurer, a loss control services firm, and a rating organization for issuance of workers' compensation insurance to establish rates—*Calico Trailer Mfg. Co. v. Ins. Co. of North America*, 1995-1 Trade Cas. (CCH) ¶ 71,022 (E.D. Ark. 1994)
 - Insurer's refusal to deal in windstorm insurance on open market and fixing of higher rate through state-created joint underwriting association—*Slagle v. ITT Hartford*, 102 F.3d 494 (11th Cir. 1996)
 - Jointly setting rates and classifying risks through a rating association—*Owens v. Aetna Life & Cas. Co.*, 654 F. 2d 218 (3rd Cir.), *cert. denied*, 454 U.S. 1092 (1981)
 - Horizontal price fixing among automobile insurers through joint use of a reimbursement formula for insurance claims—*Proctor v. State Farm Mut. Auto. Ins. Co.*, 675 F.2d 308, 318-25 (D.C. Cir.), *cert. denied*, 459 U.S. 839 (1982); *see also Quality Auto Body, Inc. v. Allstate Ins. Co.*, 660 F.2d 1195, 1201 n. 4 (7th Cir. 1981), *cert. denied*, 455 U.S. 1020 (1982); *Workman v. State Farm Mut. Auto. Ins. Co.*, 520 F. Supp. 610, 615-16 n. 7 (N.D. Cal. 1981)
 - Agreement among insurers to limit insurance coverage for certain external auto body repairs to the cost of less expensive parts—*Gilchrist v. State Farm Mut. Auto. Ins. Co.*, 390 F.2d 1327 (11th Cir. 2004)
 - Alleged agreements among insurers to refuse to offer insurance coverage with respect to work loss benefits of deceased victims of motor vehicle accidents, and to provide a joint and uniform defense to claims for such benefits—*Grant v. Erie Ins. Exchange*, 542 F. Supp. 457 (M.D. Pa. 1982), *aff'd*, 716 F.2d 890 (3d Cir.), *cert. denied*, 464 U.S. 938 (1983)
 - Collective action among insurers and reinsurers to reduce their exposure under commercial general liability policies by changing standard policy language and avoiding underwriting or reinsuring risks written on disfavored policy terms; reinsurance and retrocessional insurance are insurance for McCarran-Ferguson Act purposes—*In re Ins. Antitrust Litigation*, 723 F. Supp. 464 (N.D. Cal. 1989), *rev'd in part and remanded*, 938 F.2d 919 (9th Cir. 1991)
 - Alleged conspiracy by insurers to change the types of policies offered—*UNR Indus., Inc. v. Continental Ins. Co.*, 607 F. Supp. 855 (N.D. Ill. 1984)
 - Engaging in racial "redlining"—*Mackey v. Nationwide Ins. Cos.*, 724 F.2d 419 (4th Cir. 1984) (but the court found that McCarran-Ferguson did not foreclose claim under the Fair Housing Act or Civil Rights Acts)
 - Agreements by title insurance companies to fix prices for title examination and insurance—*Commander Leasing Co. v. Transamerica Title Ins. Co.*, 477 F.2d 77 (10th Cir. 1973); *see also Schwartz v. Commonwealth Land Title Ins. Co.*, 374 F.

Supp. 564 (E.D. Pa. 1974); *Mitgang v. Western Title Ins. Co.*, 1974-2 Trade Cas. (CCH) ¶ 75,322 (N.D. Cal. 1974). *But see United States v. Title Ins. Rating Bur. of Arizona, Inc.*, 700 F.2d 1247 (9th Cir. 1983) (provision of escrow services by title insurance companies is not the business of insurance) and *Ticor Title Ins. Co. v. FTC*, 998 F.2d 1129 (3d Cir. 1993), *cert. denied*, 510 U.S. 1190 (1994) (title search and examination services are not the business of insurance).

- Alleged attempts by title insurance companies to enforce state law requiring title insurance policies to be signed by an abstractor—*First Am. Title Co. of South Dakota v. South Dakota Land Title Ass'n*, 541 F. Supp. 1147 (D.S.D. 1982); *aff'd*, 714 F.2d 1439 (8th Cir.), *cert. denied*, 464 U.S. 1042 (1984)

Courts have determined that the following activities or practices are not, or may not be, the “business of insurance”:

- Alleged agreements by title insurers, abstracters, and the abstractor’s board of examiners to fix fees for countersignatures to be provided by abstracters on title insurance policies—*First Am. Title Co. of South Dakota v. South Dakota Land Title Ass'n*, 541 F. Supp. 1147 (D.S.D. 1982), *aff'd*, 714 F.2d 1439 (8th Cir.), *cert. denied*, 464 U.S. 1042 (1984)
- Provision of escrow services by title insurance companies—*United States v. Title Ins. Rating Bureau of Arizona, Inc.*, 700 F.2d 1247 (9th Cir. 1983), *cert. denied*, 467 U.S. 1240 (1984)
- Collective setting of uniform rates for title search and examination services by title insurers—*Ticor Title Ins. Co. v. FTC*, 998 F.2d 1129 (3rd Cir. 1993), *cert. denied*, 510 U.S. 1190 (1994)
- The merger of two insurance companies—*Am. Gen. Ins. Co. v. FTC*, 359 F. Supp. 887 (S.D. Tex. 1973), *aff'd*, 496 F.2d 197 (5th Cir. 1974)
- Challenged overlapping directorates between banks and insurance companies and between bank holding companies and insurance companies—*United States v. Crocker Nat'l Corp.*, 422 F. Supp. 686 (N.D. Cal. 1976), *rev'd on other grounds*, 656 F.2d 428 (9th Cir. 1981)
- Attempt by first insurer to induce lender to breach agreement with second insurer in the context of a competition for the lender’s customer list—*DeVoto v. Pacific Fid. Ins. Co.*, 354 F. Supp. 874 (N.D. Ca. 1973), *rev'd on other grounds*, 516 F.2d 1 (9th Cir. 1975)
- Title insurers’ issuance of “gap letters” to customers concerning the underwriter’s responsibility for the acts of the independent title agent or approved attorney might not be the business of insurance—*Escrow Disbursement Ins. Agency, Inc. v. Am. Title and Ins. Co.*, 550 F. Supp. 1192 (S.D. Fl. 1982)
- Alleged activities on the part of providers of prepaid health insurance in requiring insureds to obtain certain podiatric services only from medical doctors, refusing

- to reimburse insureds for treatment by a podiatrist unless they are referred by a medical doctor, and not allowing podiatrists to be members of healthcare associations—*Hahn v. Oregon Physicians Service*, 689 F.2d 840 (9th Cir. 1982), *cert. denied*, 462 U.S. 1133 (1983)
- Alleged market allocation by insurers accomplished by termination of health plan—*Garot Anderson Mktg., Inc. v. Blue Cross and Blue Shield United of Wisconsin*, 772 F. Supp. 1054 (N.D.Ill 1990)
 - Insurers’ exclusive marketing areas policy may not be the business of insurance—*State of Maryland v. Blue Cross and Blue Shield Ass’n*, 620 F. Supp. 907 (D.Md. 1985)

Relationships Between Insurers and Agents

Courts have determined that the following activities or practices are the “business of insurance”:

- An insurance agent, as well as an insurance company, is engaged in the business of insurance—*Commander Leasing Co. v. Trans-America Title Ins. Co.*, 477 F.2d 77 (10th Cir. 1973). *But see Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. at 224 n. 32 (suggesting that transactions between an insurer and its agents may not be the business of insurance).
- The authorizing of agents to solicit individual or group policies—*Owens v. Aetna Life & Cas. Co.*, 654 F.2d 218 (3rd Cir.), *cert. denied*, 454 U.S. 1092 (1981)
- An agency contract that requires exclusive representation of the named insurers—*Black v. Nationwide Mut. Ins. Co.*, 429 F. Supp. 458 (W.D. Pa. 1977), *aff’d*, 571 F.2d 571 (3rd Cir. 1978). *But see Ray v. United Family Life Ins. Co., Inc.*, 430 F. Supp. 1353 (W.D. N.C. 1977) (an insurer’s coercion of an agent to cease selling for competitors is not the business of insurance).
- An agency contract that ties the general agency to the requirement of full-line sales—*Steinberg v. Guardian Life Ins. Co.*, 486 F. Supp. 122 (E.D. Pa. 1980)
- An agency contract provision that precludes an agent from engaging in any other business or occupation for remuneration or profit without the consent of the insurer—*Thompson v. New York Life Ins. Co.*, 644 F.2d 439 (5th Cir. 1981)
- Agency contract provisions that require agents to return records to insurer upon termination, limit categories of persons to whom policies may be sold, and prohibit agents from brokering business with other insurers until their contractual obligations are fulfilled within their territory—*Gribbin v. Southern Farm Bur. Life Ins. Co.*, 1984-1 Trade Cas. (CCH) ¶ 65,798 (W.D. La. 1984)
- Termination of agent who would not accept a limitation on the policies he could offer—*Hopping v. Standard Life Ins. Co. v. Blue Cross*, 1984-1 Trade Cas. (CCH) ¶ 65,814 (N.D. Miss. 1983)

Courts have determined that the following activities or practices are not, or may not be, the “business of insurance”:

- Requiring agents to provide securities services in a particular manner in order to continue selling and servicing its insurance policies may not be the business of insurance—*Zelson v. Phoenix Mut. Life Ins. Co.*, 549 F.2d 62 (8th Cir. 1977)
- Conspiracy between first insurer and second insurer’s agents to induce second insurer’s agents to switch principals—*Am. Family Life Assurance Co. v. Planned Mktg. Assocs., Inc.*, 389 F. Supp. 1141 (E.D. Va. 1974); *see also Am. Standard Life & Accident Ins. Co. v. U.R.L., Inc.*, 701 F. Supp. 527 (M.D.Pa. 1988). *But see Lawyer’s Realty Corp. v. Peninsular Title Ins. Co.*, 428 F. Supp. 1288 (E.D. La. 1977) (alleged conspiracy between two title insurers and an agent to exclude another agent from the title insurance business is the business of insurance).
- Alleged pirating of agent’s sub-agents by insurer—*Allied Financial Servs., Inc. v. Foremost Ins. Co.*, 418 F. Supp. 157 (D. Neb. 1976)
- Insurer’s conspiracy to pirate agency’s trade secrets and confidential information—*Center Ins. Agency v. Byers*, 1976-1 Trade Cas. (CCH) ¶ 60,940 (N.D. Ill. E.D. 1976)
- Conspiracy among insurers to restrict the sale of collateral protection programs in a state to one agent was not the business of insurance; the programs at issue were not the business of insurance and agent-carrier disputes are not *per se* within the exemption—*King v. G.D. Van Wagenen Co.*, 1987-1 Trade Cas. (CCH) ¶ 67,534 (D. Minn. 1987)
- Insurer’s restrictions on the transfer of subordinate agents—*Bogan v. Northwestern Mut. Life Ins. Co.*, 953 F. Supp. 532 (S.D.N.Y. 1997)

Relationships Between the Insurer and the Insured

Courts have determined that the following activities or practices are the “business of insurance”:

- Mortgage and residential real property loans that are conditioned on the purchase of life insurance—*Addrisi v. Equitable Life Assurance Soc’y of the United States*, 503 F.2d 725 (9th Cir. 1974), *cert. denied*, 420 U.S. 929 (1975); *Dexter v. Equitable Life Assurance Soc’y*, 527 F.2d 233 (2nd Cir. 1975)
- Requirements by title insurance companies that purchasers of newly constructed homes buy mechanic’s lien insurance as part of their services—*McIlhenny v. Am. Title Ins. Co.*, 418 F. Supp. 364 (E.D. Pa 1976)

- Requirement by issuer of automobile insurance that purchasers also join an automobile club as a condition to being insured—*Mathis v. Auto. Club Inter-Ins. Exchange*, 410 F. Supp. 1037 (W.D. Mo. 1976)
- Insurer's refusal to offer individual a policy that did not include his spouse—*Anglin v. Blue Shield of Virginia*, 693 F.2d 315 (4th Cir. 1982)
- Agreement between a county medical association and medical malpractice insurers under which insurers offer malpractice insurance only to association members—*Feinstein v. Nettleship Co. of Los Angeles*, 714 F.2d 928 (9th Cir. 1983), *cert. denied*, 466 U.S. 972 (1984)
- Funeral service policy that designates an authorized funeral director and provides for an lower benefits if his services are not used—*Mulhearn v. Rose-Neath Funeral Home, Inc.*, 512 F. Supp. 747 (W.D. La. 1981). *But see Battle v. Liberty Nat'l Life Ins. Co.*, 493 F.2d 39 (5th Cir. 1974) (insurer issuing burial coverage who contracted with funeral homes company to furnish merchandise and services required by policies as intermediary with authorized funeral directors might have exceeded the business of insurance and encroached on the business of providing funeral services).
- Funeral insurance policy that ties purchase of a casket to the provision of the funeral services—*Chatelain v. Mothe Funeral Homes, Inc.*, 1998 WESTLAW 166212 (E.D. La. 1998)
- Insurer's decision to reduce insured's monthly benefits pursuant to group term policy issued to employer—*Freier v. New York Life Ins. Co.*, 679 F.2d 780, 782 (9th Cir. 1982)
- Automobile insurers' policies that limited the reimbursement of policyholders to the reasonable or competitive cost of repairs—*Custom Auto Body, Inc. v. Aetna Cas. and Sur. Co.*, 1983-2 Trade Cas. (CCH) ¶ 65,629 (D.R.I. 1983)
- Health care provider's requirement that insureds fill their prescriptions through its pharmacy, and its denial of reimbursement under the insurance contract for certain prescriptions filled at other pharmacies—*Klamath-Lake Pharm. Ass'n v. Klamath Medical Serv. Bur.*, 701 F.2d 1276 (9th Cir.), *cert. denied*, 464 U.S. 822 (1983)
- Health insurer's introduction of health maintenance organization option, and its institution of an "adverse selection" policy of pricing for its traditional insurance based upon characteristics of the insured group—*Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of Rhode Island*, 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990)
- Non-profit health care service corporations' exclusion of chiropractic services from subscriber contracts—*Health Care Equalization Comm. of the Iowa Chiropractic Soc'y v. Iowa Medical Soc'y*, 851 F.2d 1020 (8th Cir. 1988)

Courts have determined that the following activities or practices are not, or may not be, the “business of insurance”:

- Misrepresenting that the purchase of credit insurance is a prerequisite to the extension of credit—*FTC v. Dixie Finance Co., Inc.*, 695 F.2d 926 (5th Cir.), *cert. denied*, 461 U.S. 928 (1983); *FTC v. Mfrs. Hanover Consumer Servs., Inc.*, 567 F. Supp. 992 (E.D. Pa. 1983)
- Insurers’ policy of refusing to pay for services of clinical psychologists unless they were billed through a physician—*Virginia Acad. of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980)
- Insurers’ decision not to include certain chiropractor in its panel of providers—*Rozema v. Marshfield Clinic, 1997-1 Trade Cas.* (CCH) ¶ 71,796 (W.D. Wis. 1997)
- Conspiracy between insured physicians and medical malpractice insurer to cancel medical malpractice insurance of a competitor physician—*Nurse Midwifery Assocs. v. Hibbett*, 549 F. Supp. 1185 (M.D. Tn. 1982)

Relationships Between Insurers and Non-Insurance Entities

Courts have determined that the following activities or practices are the “business of insurance”:

- Automobile insurer’s practice of entering into agreements with certain auto glass replacement firms relating to prices and billing procedures for glass replacement for insureds—*Gen. Glass v. Globe Glass and Trim Co.*, 1978-1 Trade Cas. (CCH) ¶ 61,998 (N.D.Ill. 1978)
- Nonprofit hospitalization insurer’s contract with hospitals which prescribes the amounts and terms under which it would pay for services rendered its subscribers—*Travelers Ins. Co. v. Blue Cross of Western Pennsylvania*, 481 F.2d 80 (3d Cir. 1973), *cert. denied*, 414 U.S. 1093 (1973); *Frankford Hosp. v. Blue Cross of Greater Philadelphia*, 417 F. Supp. 1104 (E.D. Pa. 1976), *aff’d*, 554 F.2d 1253 (3d Cir.), *cert. denied*, 434 U.S. 860 (1977)
- Hospital service corporation’s negotiation of contracts with nonprofit hospitals, and enforcement of qualification standards—*Nankin Hosp. v. Michigan Hosp. Serv.*, 361 F. Supp. 1199 (E.D. Mich. 1973)
- Establishment of fee schedules and reimbursement policies to dentists by nonprofit corporation engaged in the administration and operation of prepaid dental care plans—*Manasen v. California Dental Servs.*, 424 F. Supp. 657 (N.D. Cal. 1976), *rev’d on other grounds*, 683 F.2d 1152 (9th Cir. 1979)

Courts have determined that the following activities are not, or may not be, the “business of insurance”:

- Automobile liability insurer’s securing for particular glass dealers the sales and installation jobs required by insurer’s claimants—*Hill v. Nat’l Auto Glass Co.*, 293 F. Supp. 295 (N.D. Cal. 1968)
- Mere arrangements for the purchase of goods and services by the insurer, enabling the insurer to minimize costs and maximize profits, but where the agreements did not involve underwriting or spreading of risk—*Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979)
- Agreement between insurers and glass installers to fix prices to be paid for automobile glass replacement in automobiles covered by insurers—*Liberty Glass Co. v. Allstate Ins. Co.*, 607 F.2d 135 (5th Cir. 1979)
- Agreements entered into by auto insurance companies with certain preferred repair shops that agreed in advance to do repair work at fixed prices, generally in exchange for assurances of referrals—*Proctor v. State Farm Mut. Auto. Ins. Co.*, 675 F.2d 308 (D.C. Cir.), *cert. denied*, 459 U.S. 839 (1982); *Quality Auto Body, Inc. v. Allstate Ins. Co.*, 660 F.2d 1195 (7th Cir. 1981), *cert. denied*, 455 U.S. 1020 (1982); *Workman v. State Farm Mut. Auto. Ins. Co.*, 520 F. Supp. 610 (N.D. Cal. 1981)
- Functioning as a third-party administrator for self-insured plans, and activities in private health care financing that affect entities beyond the business of insurance—*Reazin v. Blue Cross and Blue Shield of Kansas, Inc.*, 663 F. Supp. 1360 (D. Kan. 1987), *aff’d*, 899 F.2d 951 (10th Cir. 1990)
- Dental insurer’s contracts with its subscribers and participating dentists that provide for a payment differential between participating and non-participating dentists—*Hoffman v. Delta Dental Plan of Minnesota*, 517 F. Supp. 564 (D. Mn. 1981)
- Insurer’s practice of banning “balanced billing”—*Kartell v. Blue Shield of Massachusetts*, 542 F. Supp. 782 (D. Mass. 1982)
- Insurer’s decision not to reimburse policyholders for physician-owned CAT scanners—*Trident Neuro-Imaging Lab. v. Blue Cross and Blue Shield of South Carolina*, 568 F. Supp. 1474 (D.S.C. 1983)
- Arrangements between insurers and the pharmaceutical industry concerning the cost of pharmaceuticals may not be the business of insurance—*Portland Retail Druggists Ass’n v. Kaiser Found. Health Plan*, 662 F.2d 641 (9th Cir. 1981)
- Health insurer’s use of the professional association’s peer review committee to examine chiropractor’s statements and charges and render an opinion on necessity for treatments and reasonableness of charges—*Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982)

- Design and implementation of “usual, customary, and reasonable” insurance plan offered by insurer, with provision for peer review of medical charges—*Ratino v. Medical Serv. of the District of Columbia*, 718 F. 2d 1260 (4th Cir. 1983)