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BILL SEEKING TO REPEAL THE MCCARRAN FERGUSON ACT'S ANTITRUST EXEMPTION INTRODUCED IN CONGRESS

by James M. Burns

On September 18, Congressman Phil Roe (R-Tennessee) introduced legislation (H.R.3121) that would, among other things, amend Section 3 of the McCarran-Ferguson Act (15 U.S.C. 1013) to repeal the Act's antitrust exemption for health insurers. Congressman Roe's McCarran-Ferguson repeal provisions (Subtitle B of the legislation) are part of a larger piece of legislation – almost 200 pages in all – that would also repeal the Affordable Care Act. In adding a McCarran repeal component to his bill, Congressman Roe's bill joins several other bills currently pending in Congress that would repeal McCarran's antitrust exemption for health insurers, including H.R. 99 (introduced by Congressman John Conyers, D-Michigan), H.R. 344 (introduced by Congressman Steven Lynch, D-Massachusetts, H.R. 743 (introduced by Congressman Peter DeFazio, D-Oregon) and H.R. 911 (introduced by Congressman Paul Gosar, R-Arizona).

The McCarran-Ferguson Act provides an exemption from the federal antitrust laws for the "business of insurance," provided that such conduct is subject to state regulation and does not constitute an act of "boycott, coercion or intimidation." Enacted in 1945, over the last few years, McCarran's antitrust exemption has been under considerable attack, particularly with respect to its application to health insurance. Under Congressman Roe's bill, "the business of health insurance (including the business of dental insurance)" would be carved out of the "business of insurance," placing it within the scope of the federal antitrust laws. H.R. 3121 also makes clear that the "business of health insurance" does not extend to life insurance, annuities or property & casualty insurance, thus continuing the exemption as to those activities. Finally, H.R. 3121 would also subject health insurers, whether for-profit or non-profit, to Section 5 of the FTC Act, which prohibits unfair competition.

The McCarran repeal provisions of H.R. 3121 are quite similar to those of the previously introduced bills. Specifically, each proposed bill would extend the federal antitrust laws only as to the business of health insurance, except for Congressman Conyers's bill (H.R. 99), which would also repeal the exemption as to medical malpractice insurance. All of the proposed bills would also extend the scope of Section 5 to for-profit and non-profit health insurers.

H.R. 3121 has been sent to the House Judiciary Subcommittee on Regulatory Reform, Commercial and Antitrust Law for further action, which is where all of the previously introduced bills currently reside. Notably, when Congressman DeFazio introduced H.R. 743 earlier this year, he noted that over 400 House members voted in favor of similar legislation last Congress and urged legislators to act swiftly, and favorably, on the legislation this Congress. Nevertheless, to date, none of these McCarran repeal bills has been taken up by the subcommittee, and with Congress now undoubtedly set to focus on budget issues in early 2014, the prospects for any of these McCarran repeal bills is quite uncertain. Stay tuned.

SECOND CIRCUIT AFFIRMS DISMISSAL OF ANTITRUST CASE AGAINST INSURANCE SERVICES OFFICE

by James M. Burns

On October 18, the Second Circuit Court of Appeals issued an affirmance in *Vedder Software Group v. Insurance Services Office*, ruling that District Court Judge Glenn Suddaby (N.D. N.Y.) had properly dismissed plaintiff's antitrust claims against Insurance Services Office ("ISO") and Liberty Mutual Insurance for failure to state a claim.

Vedder's claim centered upon the contention that ISO had engaged in anticompetitive conduct designed to enhance the success of ISO's loss estimating software, called Xactware, and the failure of Vedder's competing product, the Estimating Wizard. Specifically, Vedder claimed that ISO had conspired with several p&c insurers, including but not limited to Liberty Mutual (which was the only other named defendant), to require that the insurers' vendors utilize Xactware, and to refrain from using the Estimating Wizard.

In assessing Vedder's antitrust claim, the Second Circuit noted that the plaintiff had not alleged an express agreement among the insurers to utilize Xactware, and instead relied on the insurers' parallel conduct (*i.e.*, the use of Xactware) in support of its conspiracy claim. Thus, to state a claim, Vedder was required to allege "plus factors" that would "tend to exclude the possibility of independent action," or fail to meet their pleading obligations under the Supreme Court's *Twombly* decision. The Court noted, however, that the only plus factors alleged by Vedder were that (1) the insurers held an ownership interest in Xactware's parent company, and (2) that the insurers had allegedly insisted on the use of Xactware by their vendors.

In affirming the lower court's dismissal of Vedder's complaint, the Court held that the ownership interest in Xactware's parent company held by several insurers, standing alone, was insufficient, to state a conspiracy claim. In addition, Vedder's allegation that the insurers had insisted that their vendors use Xactware was also insufficient to meet its pleading obligations, because the insurers may have demanded their vendors use Xactware to ensure consistency in estimates, and not to cause competitive harm to Vedder. Thus, Vedder's allegations did not "tend to exclude the possibility of independent action," and suggested only "the mere possibility of misconduct." Accordingly, the complaint was properly dismissed.

"ANY WILLING INSURER" LEGISLATION INTRODUCED IN PENNSYLVANIA

by James M. Burns

A significant number of states have "Any Willing Provider" statutes that require a health insurer to admit all requesting providers into the health insurer's preferred provider network. While some of these statutes are limited in scope (covering only pharmaceutical providers), others require insurers to admit any "willing" hospital or physician that meets the insurer's credentialing standards into its network as well. However, in an unusual twist on these concepts, legislation was recently introduced in Pennsylvania that would require all hospitals in the state that are part of an integrated health system to contract with "any willing insurer." If enacted into law, the legislation, H.B. 1621, would be the first of its kind in the country.

H.B. 1621 was introduced by Representatives Jim Christiana and Dan Frankel in the Pennsylvania Assembly in early October, and appears to be a legislative response to a public dispute between University of Pittsburgh Medical Center (the largest health system in Western Pennsylvania) and Highmark Blue Cross Blue Shield (the region's largest commercial insurer). Specifically, UPMC has announced its intention not to remain in Highmark's network beginning in 2014, a development that the bill's sponsors contend would have adverse consequences for Pennsylvania citizens in terms of patient choice and healthcare access. Seeking to address this potential concern, H.B. 1621 would require that all hospitals operating as part of an integrated delivery network (which would include, but not be limited to, UPMC) contract with "any willing insurer" that desires to contract with it. In addition, the bill would prohibit such hospitals from requiring that the insurer agree to any contractual provisions that would restrict access to hospital facilities (*i.e.*, steering provisions, anti-tiering provisions, etc.). Finally, the bill would also require the hospital to submit any dispute with the insurer over reimbursement rates to binding arbitration if the parties are unable to reach an agreement, with a default reimbursement rate being established in accordance with the rate paid by insurers under the Affordable Care Act to non-participating providers when providing emergency services (which, at least in most cases, would likely be less than that sought by the hospital).

While the introduction of H.B. 1621 may have been precipitated by the UPMC/Highmark dispute, if enacted, it would constitute a major shift in the contracting landscape for hospitals and insurers throughout Pennsylvania. Recognizing the significance of the bill, UPMC noted that "No state has ever enacted legislation that would require a hospital to give an in-network contract to whatever insurer wants one and on whatever terms the government or some outside party specifies," and characterized the proposal as "regressive" and "anti-competitive." While H.B. 1621's prospects for passage are uncertain at this time, if "any willing insurer" legislation were to "catch fire" in the same way that "any willing provider" legislation has over the last ten years, provider/insurer contracting could be significantly impacted all across the country. Stay tuned.

FILED RATE DOCTRINE DERAILS ANTITRUST CLAIM AGAINST HEALTH INSURER

by James M. Burns

On September 27, Chief Judge Joy Flowers Conti (W.D. Pa.) dismissed antitrust claims against University of Pittsburgh Medical Center (UPMC) and Highmark Blue Cross Blue Shield (Highmark), finding that the claims asserted by plaintiff, Royal Mile Company, and the class it sought to represent, were barred by the Filed Rate Doctrine.

Plaintiff's claims centered on the contention that UPMC, the largest health system in Western Pennsylvania, and Highmark, its largest insurer, had conspired to restrain competition in the markets for both healthcare services and health insurance in the region. Specifically, plaintiff, on behalf of an alleged class of adversely impacted insureds, claimed that the defendants had agreed to permit UPMC to dominate the hospital market, passing on inflated charges to Highmark that were then passed on to insureds in the form of higher insurance premiums.

Seeking to have the claim dismissed on a preliminary motion, the defendants argued that because the plaintiff was ultimately challenging the insurance rates they had paid, and Highmark's rates had been approved by the Pennsylvania Insurance Department, the Filed Rate Doctrine barred plaintiff's claim. In addressing defendants' motion, Judge Conti observed that the Filed Rate Doctrine, which is rooted in the Supreme Court's *Keogh* decision in 1922, "bars antitrust suits based on rates that have been filed and approved by federal and state agencies." Plaintiff, anticipating this argument, maintained that the group rates it paid were not expressly approved by the Insurance Department; instead, with respect to group insurance rates, the Pennsylvania Insurance Department only approves rates within a 15% range, leaving a degree of discretion to the insurer with respect to the actual rates to be charged. Thus, plaintiff argued, the Filed Rate Doctrine should not bar the claim.

Judge Conti, after a thorough review of the applicable Filed Rate Doctrine precedent, rejected plaintiff's argument, holding that plaintiff ultimately was seeking to have the Court determine what the rates *would or should have been* absent the alleged conspiracy, and thus the claim was barred by the Filed Rate Doctrine. Judge Conti did, however, grant plaintiff leave to file an amend complaint, which plaintiff did in late October.

Assuming that plaintiff's amended complaint does not lead to a materially different ruling on the Filed Rate Doctrine issue, Judge Conti's decision is likely to embraced by health insurers all across the country when defending similar rate-related claims. And, given that the rationale for the Filed Rate Doctrine has been repeatedly questioned over the last several years (including by the Antitrust Modernization Commission in 2007), the *Royal Mile* decision is likely to reignite the debate about whether the Filed Rate Doctrine should be modified or eliminated. Stay tuned.