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HEALTH LAW—FEDERAL PREEMPTION OF STATE MEDICARE BALANCE BILLING REGULATIONS

Pennsylvania Medical Society v. Marconis (1991)

I. INTRODUCTION

The United States is facing a growing health care crisis. This crisis presents two interrelated challenges. The first challenge is to provide universal access to adequate health care; the second is to place a reasonable limit on the cost of that care.1 In the public sector, the Federal Medicare program, which provides health insurance to persons over sixty-five, is in the center of the maelstrom.2 In the last decade, Congress has struggled to maximize access to high quality health care while minimizing the cost for those with Medicare insurance.3 Congress has sought to achieve this balance by encouraging, but not requiring, physicians to accept a standardized fee for patients with Medicare insurance, and by limiting the amount that physicians who do not accept the standardized fee can charge in excess of that fee.4 Unsatisfied with the balance struck by Congress, several states have enacted statutes that restrict the billing options physicians can choose when treating Medicare patients.5


2. In 1986, the United States spent $458 billion (10.9% of the Gross National Product) on health care. Payments; Currents, HOSPITALS, Aug. 5, 1987, at 22. Medicare accounted for 19% of those expenditures. Id.; see also Ginsburg, supra note 1, at 448.

3. For a discussion of recent amendments to the Medicare Act, see infra notes 24-32 and accompanying text.

4. See Pennsylvania Medical Soc’y, 942 F.2d at 843-45 (discussing the recent evolution of fee caps in the Medicare Act); see also, Ginsburg, supra note 1. For a discussion of Medicare billing practices, see infra notes 15-32 and accompanying text.


In addition, between 1987 and 1989, 18 states, including Arkansas, California, Florida, Indiana, Illinois, Iowa, Maine, Maryland, Mississippi, Montana, New Hampshire, Pennsylvania, Oregon, Ohio, New York, Rhode Island, South Carolina and Wyoming, considered but did not pass laws restricting balance billing.
In an effort to limit the cost of health care for the elderly, the Pennsylvania legislature enacted the Pennsylvania Health Care Practitioners Medicare Fee Control Act (FCA). The FCA prohibits physicians who treat Medicare patients from billing those patients in excess of the recognized payment established by the Medicare program. In the


For a definition of the term “balance billing,” see infra note 7 and accompanying text. For a discussion of the term “balance billing,” see infra notes 20-23 and accompanying text. For a discussion of the term “assignment,” see infra notes 17-19 and accompanying text.


Legislative Finding—The General Assembly finds that there exists in this Commonwealth a major crisis because of the continuing escalation of costs for health care services. Because of the continuing escalation of costs, an increasingly large number of Pennsylvania citizens have severely limited access to appropriate and timely health care. Senior citizens and the disabled are disadvantaged by the continuing escalation of costs for health care services. Increasing costs are also undermining the quality of health care services currently being provided. Further, the continuing escalation is negatively affecting the economy of this Commonwealth and is restricting new economic growth and impeding the creation of new job opportunities in this Commonwealth.

Id. § 449.32(a).

7. Id. Section 449.34 of the FCA provides: “It shall be unlawful for any health care practitioner, or any primary health center, corporation, facility, institution or other entity that employs a health care practitioner, to balance bill.” Id. § 449.34.

The term “balance billing” is defined in § 449.33 of the FCA as: “To charge or collect from a beneficiary of . . . the Medicare Program, an amount in excess of the reasonable charge for the service provided, as determined by the United States Secretary of Health and Human Services.” Id. § 449.33.

Although both the Third Circuit and the FCA use the phrase “reasonable charge,” recent changes in the Medicare Act make the phrase obsolete. For a discussion of those changes, see infra notes 15 & 24. In its place the phrase “recognized payment amount” will be used. As defined in the Medicare Act, this phrase is equivalent to both the phrase “reasonable charge” and the current equivalent of this phrase. See 42 U.S.C. § 1395w-4(g)(2)(D) (1988).

Penalties for violation of § 449.34 of the FCA are provided in § 449.35 of the FCA. Section 449.35 establishes the following penalties:

(a) General penalties.—If a person violates section 4, the licensing board . . . shall do the following:

(1) Publicly reprimand the violator.

(2) Order the violator to repay the victim the amount of excess payments made and received, plus interest on that amount at the maximum legal rate from the date payment was made until the date repayment is made.

(b) Additional violations.—If a person violates section 4 more than once, the penalties set forth in subsection (a) shall again be ordered. In addition, the following penalties shall be imposed:

(1) For a second violation, a fine of $2,000.

(2) For a third violation, a fine of $5,000.
jargon of the Medicare program, the FCA bans “balance billing.” In Pennsylvania Medical Society v. Marconis, the United States Court of Appeals for the Third Circuit upheld the FCA against a challenge based on the Supremacy Clause of the United States Constitution.

At the time of its decision in Pennsylvania Medical Society, the Third Circuit was only the second federal appellate court to consider the issue of whether state restrictions on Medicare balance billing are preempted by the Medicare Act. With its decision, the Third Circuit joined the First Circuit in upholding such legislation. Subsequently, the United States District Court for the Southern District of New York decided a similar issue in accord with the First and Third Circuits.

II. CASE ANALYSIS

A. Background

Medicare, a federally funded program administered by the Department of Health and Human Services, provides health insurance for all persons who are sixty-five and older. Part B of the Medicare program provides for the payment of physicians for their services. Medicare, however, does not cover the full cost of these services. Instead, the Department of Health and Human Services has established a “recognized payment amount” for each potential service. For any given procedure

(3) For a fourth or subsequent violation, a fine of $1000 or more than the last fine imposed.

(e) EXCEPTIONS.—No penalty imposed under this section shall be considered cause to withhold, suspend or revoke the license of a health care practitioner by a licensing board.

10. Id. at 857; see also U.S. Const. art. VI, cl. 2.
11. See Massachusetts Medical Soc’y v. Dukakis, 815 F.2d 790, 796-97 (1st Cir. 1987). In Massachusetts Medical Society, the United States Court of Appeals for the First Circuit upheld a Massachusetts statute prohibiting balance billing of patients with Medicare insurance. Id. The court held that the statute was not preempted by federal legislation and that the statute did not violate the Due Process Clause of the Fourteenth Amendment. Id.
12. See Medical Soc’y of N.Y. v. Cuomo, 777 F. Supp. 1157 (S.D.N.Y. 1991). In Medical Society of New York, the United States District Court for the Southern District of New York upheld a New York statute that limited the amount physicians could balance bill to less than the amount permitted under the federal Medicare Act. Id. at 1158. The court held that the state statute is not preempted by the Medicare Act and that the state statute does not violate the Due Process Clause of the Fourteenth Amendment. Id.
15. Id. at 843 n.2. As the Third Circuit noted, the “reasonable charge is
or service, Medicare pays eighty percent of the recognized payment amount, and the patient is expected to pay the remaining twenty percent.16

Pursuant to this basic structure, Medicare reimburses physicians in one of two ways. A physician can either choose to accept assignment or charge on the basis of an itemized bill.17 If a physician chooses to accept assignment, he or she agrees to accept the recognized payment amount as full payment.18 Accordingly, a physician who accepts assignment bills Medicare directly for eighty percent of the recognized payment amount and bills the patient for the remaining twenty percent.19

Alternatively, a physician can choose to charge on the basis of an itemized bill.20 In this case, the physician must bill the patient directly for 100% of the “actual charge,” and then Medicare will reimburse the patient for eighty percent of the recognized payment amount.21 Physicians who choose this option can bill a patient in excess of the recognized payment amount.22 This practice, called “balance billing,” is prohibited by the FCA.23

This basic outline of how physicians are reimbursed for their services under Medicare is complicated by a number of amendments to the Medicare Act affected by recent federal budget agreements.24 In an ef-

determined from a complicated set of formulae found in the Medicare Act.” Id. (citing 42 U.S.C.A. §§ 1395u(b)(3), 1395x(v) (West 1983 & Supp. 1991); 42 C.F.R. §§ 404.502-.504 (1990). Commencing in 1992, the “reasonable charge” system was replaced with a national fee schedule. 42 U.S.C. § 1395w-4(g)(2) (Supp. I 1989). While the national fee schedule radically altered the way in which the recognized payment amount is determined, the change has no impact on the application of the FCA. Id.

16. 42 U.S.C. § 1395l(a)(1). The portion paid by the patient is commonly referred to as a co-payment. See Pennsylvania Medical Soc’y, 942 F.2d at 844.
18. Id. § 1395u(b)(3)(B)(i).
19. Pennsylvania Medical Soc’y, 942 F.2d at 844 (discussing the basic mechanics of Medicare billing practices). Billing Medicare directly is the most obvious advantage of accepting assignment because the physician is guaranteed prompt payment of at least 80% of the recognized payment amount. Id.
21. Pennsylvania Medical Soc’y, 942 F.2d at 844. One of the obvious disadvantages to directly billing the patient for 100% of the actual charge is that the physician takes the risk that the patient will be delinquent in paying the bill. Id.
24. See Pennsylvania Medical Soc’y, 942 F.2d at 843-45. Of particular importance are the Deficit Reduction Act of 1984 (DEFRA), the Omnibus Budget Reconciliation Act of 1986 (OBRA ’86) and the Omnibus Budget Reconciliation Act of 1989 (OBRA ’89). Id.

DEFRA is responsible for creating the Participating Physicians Program (PPP) and a number of incentives to encourage participation in the program. Id. at 844; see also 42 U.S.C. § 1395u(h)(1) (1988). The PPP allows physicians to
fort to reduce health care costs for persons over sixty-five, Congress has sought to encourage physicians to accept assignment and to forego balance billing.\textsuperscript{25} As part of this effort, Congress created the Participating Physicians Program (PPP).\textsuperscript{26} Physicians who choose to join the PPP agree on an annual basis to accept assignment for all services provided to their Medicare patients.\textsuperscript{27}

In addition to the significant incentives for participation in the PPP, Congress has placed significant limits on the billing practices of physicians who choose not to participate.\textsuperscript{28} First, Congress has banned balance billing for patients covered by both Medicare and Medicaid—those who are both elderly and poor.\textsuperscript{29} Second, for all other Medicare patients, Congress has limited the amount physicians can bill in excess of the recognized payment amount.\textsuperscript{30}

Despite the restrictions and disincentives placed upon balance billing, Congress has not banned the practice altogether.\textsuperscript{31} On the other hand, Congress has not acted to protect balance billing by expressly preempting known state restrictions.\textsuperscript{32}

B. Procedural History

The Pennsylvania Medical Society (PMS), the American Medical Association (AMA), the Crawford County Medical Society (CCMS) and an individual physician who provided services to Medicare beneficiaries, choose to accept assignment for all Medicare patients on an annual basis. \textit{Id.} Incentives for participation in the PPP include listing in a national directory made available to Medicare beneficiaries and permission to charge five percent more for any given service than a non-participating physician. \textit{Id.} § 1395u(h)(4)-(6).

OBRA '86 included a new system of price control for non-participating physicians by placing an across-the-board limit on charges called "maximum allowable actual charges" or MAAC's. \textit{Pennsylvania Medical Soc'y}, 942 F.2d at 844. In addition, OBRA '86 created the Physicians Payment Review Commission (PPRC) "as an advisory body to Congress to submit annual recommendations for rates and methods of payment for services under Medicare Part B." \textit{Id.} (citing 42 U.S.C. §§ 1395w-1(a), 1395(b)(1) (1988)).

OBRA '89 banned balance billing for people eligible for both Medicare and Medicaid and established a new system for limiting balance billing by non-participating physicians based on "limited charges." \textit{Id.} at 85. The limiting charges were set to gradually reduce the amount a non-participating physician could charge in excess of the "required payment amount" over the course of several years. \textit{Id.}; 42 U.S.C. § 1395w-4(g) (1988).

27. 42 U.S.C. § 1395u(h)(1).
28. For a discussion of incentives for participation in the PPP, see supra note 24 and text accompanying notes 25-30.
29. 42 U.S.C. § 1395w-4(g)(3).
30. 42 U.S.C. § 1395w-4(g).
32. \textit{Id.} at 849.
brought suit in the United States District Court for the Western District of Pennsylvania against the members of the Pennsylvania State Board of Medicine. As plaintiffs, and later as appellants, they sought to prove that the FCA violates the Supremacy Clause of the United States Constitution. They argued that the Medicare statute and its legislative history show congressional intent to preempt regulation of balance billing by the states. At trial, the district court held that the FCA was valid and granted the defendants’ motion for summary judgment. The PMS, the AMA, the CCMS and the individual physician appealed the district court’s decision.

C. Analysis

On appeal, the Third Circuit addressed the preemption arguments made by the appellants in two parts. First, the court determined that the FCA was entitled to a presumption of validity. Second, the court considered and rejected the appellants’ substantive preemption arguments. In upholding the FCA, the Third Circuit determined that the appellants did not provide “clear and manifest” evidence that Congress intended to occupy the field of Medicare billing practices to the exclusion of the states. The Third Circuit also concluded that the FCA’s ban on balance billing does not pose an obstacle to the accomplishment of the goals of the Medicare program.

1. The Initial Presumption

The decisive issue in Pennsylvania Medical Society was whether the FCA is entitled to a presumption of validity. In general, a state statute is entitled to a presumption of validity if it regulates a field historically within state police power. This presumption places “a heavy burden [on the party arguing for preemption] of proving that preemption was

33. Id. at 845 (discussing the procedural history of this case); Pennsylvania Medical Soc’y v. Marconis, 755 F. Supp. 1305, 1305 (W.D. Pa.), aff’d, 942 F.2d 842 (3d Cir. 1991).
35. Id. at 1308-13.
36. Id. at 1314.
37. See Pennsylvania Medical Soc’y, 942 F.2d at 842.
38. For a discussion of the Third Circuit’s analysis of the presumption of validity, see infra notes 42-51 and accompanying text.
39. For a discussion of the Third Circuit’s analysis of appellants’ substantive preemptive arguments, see infra notes 52-90 and accompanying text.
40. For a discussion of the Third Circuit’s analysis of appellants’ “occupation of the field” arguments, see infra notes 55-75 and accompanying text.
41. For a discussion of the Third Circuit’s analysis of appellants’ arguments regarding the goals of the Medicare program, see infra notes 76-90 and accompanying text.
42. Pennsylvania Medical Soc’y, 942 F.2d at 846 (citing Pacific Gas & Elec. v. State Energy Resources Comm’n, 461 U.S. 190, 206 (1983) (discussing state authority to regulate utilities)).
the 'clear and manifest purpose of Congress.'” Relying on the Supreme Court’s decision in Schneidewind v. ANR Pipeline Company, the appellants argued that this presumption of validity only applies to neutral state laws of general application. They further argued that the presumption does not apply to state laws, such as the FCA, which only function to regulate federal legislation (i.e., non-neutral state laws).

The Third Circuit rejected the appellants’ interpretation of Schneidewind. The Third Circuit explained that in Schneidewind, congressional intent to occupy the field at issue was clear. The Third Circuit stated that when such intent is clear, state statutes are not presumed valid.

In the present case, the FCA regulates matters within the traditional state police powers, namely, health care. Further, appellants failed to show clear congressional intent to preempt state restrictions on balance billing, as was demonstrated by the plaintiffs in Schneidewind. Thus, the Third Circuit concluded that the FCA is entitled to a presumption of

43. Id.
44. 485 U.S. 293 (1988). In Schneidewind, natural gas companies challenged the validity of a Michigan statute that required them to obtain state agency approval before issuing long-term securities. Id. at 295-98. The natural gas companies successfully argued that the state statute was implicitly preempted by federal regulation pursuant to the National Gas Act. Id. at 300-11.
45. Pennsylvania Medical Soc’y, 942 F.2d at 846-47.
46. Id.
47. Id. at 847. The Third Circuit stated:
   The appellants’ reliance on Schneidewind is misplaced because Congress intended to preempt state regulation of rates and facilities of natural gas companies and it was clear that the Natural Gas Act was intended by Congress to occupy this field. Accordingly, the issue [in Schneidewind] was not whether Congress intended to preempt state regulation in the occupied area. Rather, it was whether the state statute amounted to such regulation.
48. Id. The Third Circuit then pointed out that the issue in the case at bar concerned congressional intent. Id.
49. Id. The court specifically stated that “the non-neutral statute at issue in Schneidewind was not entitled to a presumption of validity . . . because congressional intent otherwise was clear.” Id.

For a discussion of the dissent’s conflicting view on this issue, see supra notes 91-96 and accompanying text.
2. **Substantive Arguments**

Because the Medicare Act does not provide for express preemption, appellants were required to demonstrate that congressional intent to preempt state regulation of Medicare balance billing is implied in the Medicare Act.\(^{52}\) Appellants were required to show either that Congress

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51. *Id.* at 848. This summary of the court's reasoning does not do justice to its apparent circularity. The court's own language is as follows:

The licensing and regulation of physicians is a state function. Appellants have failed to prove otherwise. Thus, the state regulation is presumed valid. To rebut this presumption, appellants must show that Congress intended to displace the state's police power function. Appellants seek to avoid this burden of proof by imposing a condition on the presumption. Appellants would have the police powers presumption be proven legitimate before they are required to rebut it. This begs the question and incorrectly shifts the burden of proof. *It is up to the appellants to prove the presumption invalid, either by showing the area regulated is not in an area of traditional state regulation or by showing that Congress intended to displace this function.* Until they do so, the presumption remains.

*Id.* at 847 (citation omitted) (emphasis added).

The Third Circuit reasoned that the presumption of validity applies unless Congress' intent to preempt is clear. *Id.* The problem with this reasoning is that where Congress' intent to preempt is clear, the presumption is already rebutted. The court appears to be saying that the presumption does not apply if it is rebutted. If that is the case, it is the Third Circuit rather than appellants who beg the question.

The United States District Court for the Southern District of New York took a much different approach than did the Third Circuit to distinguish *Schneidewind.* See Medical Soc'y of N.Y. v. Cuomo, 777 F. Supp. 1157 (S.D.N.Y. 1991). The court in *Medical Society of New York* held that *Schneidewind* involved state regulation of a field not within traditional state power. *Id.* at 1161 n.3. The court stated that "[t]he regulation of natural gas [at issue in *Schneidewind*] has a much firmer basis of Congressional power—under the Constitution's Commerce Clause—than does the regulation of public health and welfare. The latter lies historically within the state sphere." *Id.*

In *Pennsylvania Medical Society,* the Third Circuit rejected appellants' reliance on a series of Supreme Court cases, in addition to *Schneidewind,* which involved non-neutral state statutes. *Pennsylvania Medical Soc'y,* 942 F.2d at 848. The Third Circuit stated that these Supreme Court cases "stand for the unexceptional point that in the face of a demonstration of a congressional intent to preempt, a state law will be invalidated." *Id.* (rejecting appellants' reliance on Felder v. Casey, 487 U.S. 131 (1988), Mackey v. Lanier Collections Agency & Serv. Inc., 486 U.S. 825 (1988) and Jersey Cent. Power & Light Co. v. Lacey Twp., 772 F.2d 1103, 1102-13 (3d Cir. 1985), cert. denied, 475 U.S. 1013 (1986)).

52. *Pennsylvania Medical Soc'y,* 942 F.2d at 848 (citing California Fed. Savings & Loan Ass'n v. Guerra, 479 U.S. 272, 280 (1987) for the general proposition that preemption is a question of congressional intent).

There are two ways to show implicit preemption. *Id.* at 848. First, Congress "may indicate an intent to occupy a given field to the exclusion of state law where the pervasiveness of the federal regulation precludes supplementation by the states." *Id.* Second, state law is implicitly preempted where it conflicts with federal law such that "it is impossible to comply with both state and federal law,
intended to occupy the field of balance billing practices to the exclusion of the states or that the FCA presents an obstacle to accomplishing the goals of the Medicare program. In addition, because the FCA is presumed valid, appellants had the burden of proving "that preemption was the 'clear and manifest purpose of Congress.'"  

a. Occupying the Field of Medicare Billing Practices

The Third Circuit first considered the issue of whether Congress’ intent to preempt states from regulating balance billing could be inferred from Congress’ intent to occupy the field of regulating balance billing practices. First, the appellants argued that the size of the Medicare program is indicative of congressional intent to preempt state regulation. In particular, they argued that the fact that the program is entirely funded and administered by the federal government shows Congress’ intent to occupy the field of regulating Medicare billing practices. Second, the appellants argued that the complexity and pervasiveness of federal regulations concerning balance billing show Congress’ intent to occupy the field. They further argued that congressional action in regulating Medicare billing practices should be given more weight than Congress’ failure to provide an express preemption provision.

In rejecting the appellants’ first argument, the Third Circuit reasoned that the appropriation of large sums of federal money does not necessarily indicate congressional intent to occupy the field. The court analogized the federal funding of the Medicare program to the federal funding of highway construction, which leaves traffic regulation to the states. The Third Circuit also rejected the appellants’ argument that the complexity and pervasiveness of the federal Medicare balance

or if the state law is an obstacle to the accomplishment of the full purposes and objectives of Congress in enacting the federal legislation.” Id.

53. Id.
55. Id. at 849.
56. Id. at 850.
57. Id. ("[A]ppellants claim that the size of the Medicare Program, particularly the vast sums spent on it each year and the fact that the program is administered exclusively by the Department of Health and Human Services and selected insurance carriers, reveals congressional intent to occupy the field.").
58. Id. ("[A]ppellants argue that by enacting a pervasive and complex scheme for regulating balance billing, Congress ‘left no room’ for state legislation in this area.").
59. Id. ("[A]ppellants urge that the district court erred by giving greater weight to congressional inaction regarding a preemption provision than to the detailed and comprehensive Medicare provisions [Congress] did enact.").
60. Id.
61. Id. ("Congress appropriates large sums of money to many programs, yet does not necessarily intend to preempt state action in the areas involved.").
billing regulation implied a congressional intent to preempt. The court determined that, given the legislative history of the Medicare Act, the complexity and pervasiveness is indicative of just the opposite inference.

The Third Circuit emphasized that it was bound by the Supreme Court's decision in California Federal Savings & Loan Ass'n v. Guerra in which the Court held that "when Congress remains silent regarding the preemptive effect of its legislation on state laws it knows to be in existence at the time of such legislation's passing, Congress has failed to evince the requisite clear and manifest purpose to supersede those state laws." In applying the Guerra rule, the Third Circuit pointed out that Congress chose not to expressly preempt state restrictions on Medicare balance billing, even though it had been informed that many states had enacted or considered such restrictions. The Third Circuit reasoned that application of the rule in Guerra was particularly appropriate in this case for two reasons. First, Congress has exercised extraordinary oversight of the Medicare program. Second, Congress was aware of the unsuccessful Supremacy Clause challenge to a Massachusetts statute banning balance billing.

To further support its conclusion that Congress did not intend to preempt state regulation of Medicare billing practices, the Third Circuit cited a House Budget Committee Report associated with the 1989 amendments to the Medicare Act as evidence of congressional intent.

62. Id.

63. Id. ("[A]lthough the complexity of the Medicare Program might in some circumstances support the inference that Congress intended its regulation of Medicare Physician billing practices to be exclusive, we are dealing with an unusual situation.").

64. 479 U.S. 272 (1987).

65. Pennsylvania Medical Soc'y, 942 F.2d at 850 (citing Guerra, 479 U.S. at 287-88. In Guerra, the Supreme Court held that a California statute requiring employers to provide leave and reinstatement to pregnant women was not preempted by Title VII as amended by the Pregnancy Discrimination Act. Guerra, 479 U.S. at 292. The Court was influenced in part by the fact that Congress was aware of state laws, such as the California statute, when it enacted the Pregnancy Discrimination Act but "failed to evince the requisite 'clear and manifest purpose' to supersede them." Id. at 288 (citing Pacific Gas & Elec. Co. v. State Energy Resources Conservation and Dev. Comm'n, 461 U.S. 190 (1983)).

66. Pennsylvania Medical Soc'y, 942 F.2d at 851. Before the 1989 amendments, the PPRC gave a report to Congress which included an appendix listing the four states that had statutes restricting balance billing and the 18 states that had considered such statutes. Id. For a list of states restricting Medicare balance billing, see supra note 5. For a discussion of the PPRC, see supra note 24.

67. Pennsylvania Medical Soc'y, 942 F.2d at 850-51.

68. Id. at 850. "[I]n this case silence is particularly indicative of congressional intent given the extraordinary oversight of the Medicare program as evidenced by the very existence of the [PPRC] with its annual reports to Congress and by the frequent amendment of the Medicare Act." Id.

69. Id. at 851. For a discussion of this unsuccessful challenge, see infra notes 85-90 and accompanying text.
regarding state regulation of Medicare balance billing practices. The report contained the following statement: "The Committee intends that nothing in this section would prejudice the right of any State to require assignment on Medicare claims as a condition of licensure in the State." The Third Circuit stated that "this is the only legislative statement of which we are aware clearly indicating Congressional intent regarding preemption and it strongly indicates that preemption was not intended."

Finally, the Third Circuit cited its decision in Ford Motor Co. v. Insurance Commissioner for the proposition that "the comprehensive nature of a federal regulatory scheme, by itself, is not sufficient to preempt all state regulation." In fact, the court noted that in Ford Motor, it had stated that the absence of an express preemption provision in such a detailed regulatory scheme indicates that Congress did not intend preemption.

In light of the relevant legislative history, precedent and the interpretation of the Medicare Act itself, the Third Circuit concluded that the appellants in the present case were unable to provide the clear and manifest evidence of congressional intent to occupy the field of Medicare billing practices necessary to meet their burden of proof.

b. Obstacle to the Goals of Medicare

The Third Circuit then considered and rejected the appellants' arguments that the FCA's ban on balance billing interfered with several key objectives of the Medicare program. The appellants argued that

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70. Pennsylvania Medical Soc'y, 942 F.2d at 851.
72. Id. While the Third Circuit found this statement of legislative intent persuasive, other courts have refused to attach any significance to it. Cf. Medical Soc'y of N.Y. v. Cuomo, 777 F. Supp. 1157, 1163 (S.D.N.Y. 1991) (rejecting defendants' reliance on committee report); Pennsylvania Medical Soc'y v. Marconis, 755 F. Supp. 1305, 1310 n.7 (W.D. Pa.) (rejecting defendants' reliance on committee report), aff'd, 942 F.2d 842 (3d Cir. 1991). Other courts rejected reliance on this committee report because Congress did not adopt the statement in the amendments and because the Committee Report was superseded by a Conference Report which did not include the same language. See Medical Soc'y of N.Y., 777 F. Supp. at 1163; Pennsylvania Medical Soc'y, 755 F. Supp. at 1310 n.7.
73. Pennsylvania Medical Soc'y, 942 F.2d at 851 (citing Ford Motor Co. v. Insurance Comm'r, 874 F.2d 926, 939 (3d Cir. 1989)). In Ford Motor, the Third Circuit held that a Pennsylvania statute prohibiting affiliations between insurance companies and savings and loans institutions was not entirely preempted. Ford Motor Co., 874 F.2d at 940.
74. Pennsylvania Medical Soc'y, 942 F.2d at 851 (citing Ford Motor Co., 874 F.2d at 939).
75. Id.
76. Id. at 851-52. One argument which the court noted, but which was apparently not raised on appeal, was that a ban on balance billing would interfere
the FCA's ban would reduce access to health care and increase overall Medicare costs. The Third Circuit conceded that if the appellants could support these hypotheses, they would have a strong interference argument. The court, however, concluded that the record contained no evidence to support the appellants' assertions, and that such theories were "sheer speculation" and "pure conjecture." In addition, the court reasoned that if such problems actually arose, Congress is free to amend the Medicare Act to address them.

The appellants also attempted to analogize their case to Pokorny v. Ford Motor Co. In Pokorny, the Third Circuit held that the National Traffic and Motor Vehicle Safety Act, which gave manufacturers certain options for vehicle design, preempted a Pennsylvania common law action against the Ford Motor Company for negligent design, because the allegedly negligent design was one of the permitted options. The Pennsylvania Medical Society court noted that in Pokorny, it was clear that Congress intended to give manufacturers the right to choose among several options. The court found that in Pennsylvania Medical Society, however, it was far from clear that Congress intended to guarantee physicians the option to balance bill, especially considering the fact that Congress has not expressly preempted state restrictions on balance billing.

with the Medicare program requirement that physicians voluntarily accept assignment. Id. at 852. The Third Circuit noted the district court's response to this argument that "'voluntary' referred to voluntariness from the federal perspective." Id. In other words, the voluntary provision meant only that no federal Medicare provision could coerce a physician to accept assignment. Id.

77. Id. at 852-53. Appellants argued that fewer physicians would be willing to treat Medicare patients if they were limited to charging the recognized payment amount. Id. at 852. Appellants also argued that reducing the out-of-pocket cost of particular services would cause patients to seek more of those services, thereby increasing overall costs to the federal government. Id. at 853.

78. Id. at 855. The Third Circuit acknowledged that a state law that frustrated the objectives of federal legislation would be preempted even though compliance with one would not require violation of the other. Id.

79. Id. Before moving for summary judgment in the district court, the parties agreed to stipulated facts, which apparently did not include any evidence to support appellants' assertions. Id. at 845.

80. Id. at 855.

81. 902 F.2d 1116 (3d Cir. 1990).

82. Id. at 1126.

83. Pennsylvania Medical Soc'y, 942 F.2d at 854-55 ("In Pokorny, we recognized that Congress made its intention to give manufacturers safety options, including using manual seat belts, 'repeatedly . . . clear in the regulatory history of this particular safety standard.'").

84. Id. at 855. The Third Circuit noted that appellants' argument could be characterized in terms of "balance billing being an 'integral part' of the Medicare program," or in terms of balance billing as a congressionally created entitlement. Id. at 855 n.9. Either way, the issue for the court was "whether Congress intended to protect the federal legislation from any state regulation." Id.
The Third Circuit concluded its analysis of the appellants' obstacle arguments by analogizing the present case to the First Circuit's decision in *Massachusetts Medical Society v. Dukakis*. In *Massachusetts Medical Society*, the First Circuit upheld a Massachusetts statute which required, as a condition of licensure, that physicians who accept Medicare patients accept assignment for those patients. The First Circuit concluded that the appellants failed to show clear and manifest evidence that Congress intended to guarantee physicians the right to balance bill. Despite the fact that there had been significant amendments to the Medicare statute relating to balance billing since 1987, the Third Circuit found the reasoning in *Massachusetts Medical Society* to be both persuasive and pertinent to the instant case because the parties arguing preemption in both cases relied on much of the same legislative history and many of the same cases. The Third Circuit concluded that the changes in the Medicare statute since *Massachusetts Medical Society* support the validity and continuing relevance of the decision because Congress did not take advantage of the opportunity to reverse the decision. The court reasoned that at most, the recent legislative history shows that Congress was not ready to disturb the status quo.

85. 815 F.2d 790 (1st Cir. 1987).
86. Id. at 791; see also Mass. Gen. Laws Ann. ch. 112, § 2 (West 1985).
87. *Massachusetts Medical Soc'y*, 815 F.2d at 791-796. The Massachusetts Medical Society argued that the Medicare Act itself and its legislative history showed that Congress intended to protect the option to balance bill. Id. at 792-93. First, the Massachusetts Medical Society argued that the structure of the billing options, under which a physician who does not accept assignment must bill the patient directly for the full fee rather than be guaranteed 80% payment directly from Medicare, supported the inference that Congress intended to protect balance billing as an option. Id. Presumably, its point was that the disincentive for balance billing is built into the Medicare Act. Second, the Massachusetts Medical Society argued that statements by several members of Congress supported the inference that Congress intended to protect the option to balance bill. Id. Third, the Massachusetts Medical Society argued that Congress expressly rejected proposals to end balance billing. Id. After considering these arguments, the First Circuit held that this evidence was insufficient to rebut the presumption that Congress did not intend to preempt state law. Id. at 793-94. The First Circuit also rejected the Massachusetts Medical Society's argument that a ban on balance billing would reduce access to medical care. Id. at 795.
88. *Pennsylvania Medical Soc'y*, 942 F.2d at 856. In particular, appellants in both cases relied heavily on Congress' refusal to ban balance billing. Id. For a discussion of recent amendments to the Medicare statute, see supra notes 24-32 and accompanying text.
89. *Pennsylvania Medical Soc'y*, 942 F.2d at 857 ("[T]he amendments demonstrate that the right to balance bill is not sacrosanct and rather than protecting balance billing [the amendments] limited it.").
90. Id. Another reasonable interpretation of this phenomenon is that Congress was not able to ban balance billing itself, but was willing to let the states do so.
D. Dissent

Chief Justice Sloviter disagreed with virtually every step in the majority’s analysis. After concluding that the FCA was not entitled to a presumption of validity, she challenged each element of the majority’s reasoning in rejecting appellants’ substantive arguments.

Chief Justice Sloviter agreed with the majority that state regulations in areas traditionally within the states’ police power are entitled to a presumption of validity. She also agreed that regulation of public health is within these traditional state powers. Chief Justice Sloviter argued, however, that a ban on balance billing which “regulates doctors’ fees, and in particular only certain doctors’ fees charged to certain patients, is [not] a matter of traditional state concern.” Chief Justice Sloviter distinguished regulation of the “substantive practice of medicine,” from regulation of fees. The former, which includes qualifications for licensing and quality of care, is clearly within traditional state powers; the latter is not. In fact, Chief Justice Sloviter apparently agreed with the appellants’ interpretation of Schneidewind, and argued that the FCA should be subject to the general rule that non-neutral state laws which target federal programs be viewed with suspicion.

Chief Justice Sloviter found that the majority’s interpretation of congressional intent was based on four elements: “a statement of legislative history, the awareness of Congress of several state laws precluding balance billing, [the Massachusetts Medical Society decision], and ‘the very complexity of the Medicare legislation.’”

Chief Justice Sloviter argued that there are two problems with relying on the legislative history contained in the House Budget Committee Report. First, “there is no way to ascertain whether this statement was approved by the committee.” Second, and more importantly, the bill underwent significant changes after the report was filed. The Confer-

91. Id. at 858 (Sloviter, C.J., dissenting).
92. Id. (Sloviter, C.J., dissenting).
93. Id. (Sloviter, C.J., dissenting). Chief Justice Sloviter pointed out that while such regulation might be permissible, “there has been no showing of a history of state oversight over medical fees.” Id. (Sloviter, C.J., dissenting).
94. Id. (Sloviter, C.J., dissenting).
95. Id. (Sloviter, C.J., dissenting) (“[I]t is taking too great a leap to conclude that a state statute that regulates doctors’ fees, and in particular only certain doctors’ fees charged to certain patients, is a matter of traditional state concern.”).
96. Id. at 859 (Sloviter, C.J., dissenting). She argued that “[e]ven if we would not hold that a state statute targeting participants in a federal program for state regulation is presumptively invalid, it certainly should not be presumed to be valid.” Id. (Sloviter, C.J., dissenting) (emphasis added).
97. Pennsylvania Medical Soc’y, 942 F.2d at 859 (Sloviter, C.J., dissenting).
98. Id. (Sloviter, C.J., dissenting).
99. Id. at 861 (Sloviter, C.J., dissenting).
ence Report that accompanied the final bill contained "no language whatsoever concerning state mandatory assignment laws." As to the congressional silence in the face of state laws banning balance billing, Chief Justice Sloviter argued that allowing congressional silence to defeat preemption arguments would defeat the whole idea of implicit preemption.\footnote{101}

Chief Justice Sloviter was equally quick to reject the majority's reliance on Massachusetts Medical Society. She argued that Massachusetts Medical Society was probably wrong because the First Circuit based its decision on the presumption that the Massachusetts statute was valid.\footnote{102} Moreover, she argued that the changes in the Medicare legislation since 1987 rendered the opinion obsolete.\footnote{103}

Finally, Chief Justice Sloviter argued that the complexity of the Medicare statute more readily gives rise to the inference of an intent to preempt than the contrary inference.\footnote{104} The complexity of the statute shows that Congress intended to regulate the entire field.\footnote{105} Moreover, Chief Justice Sloviter argued that the fact that Congress did not ban balance billing when it had the opportunity, combined with the possibility that such a ban would lead to reduced access to health care, is evidence that Congress intended to leave balance billing intact.\footnote{106} Chief Justice Sloviter closed her argument with the following analogy. A state law


101. \textit{Pennsylvania Medical Soc'y}, 942 F.2d at 859-60 (Sloviter, C.J., dissenting). For a discussion of the majority's interpretation of congressional silence, see \textit{supra} notes 66-68 and accompanying text.

102. \textit{Pennsylvania Medical Soc'y}, 942 F.2d at 860 (Sloviter, C.J., dissenting) ("Massachusetts Medical, however, reached its conclusion on the basis of a presumption of validity to the state law, which, as noted above, I believe is inapplicable in this situation.").

103. \textit{Id.} (Sloviter, C.J., dissenting) ("Massachusetts Medical is largely inappropriate to the present case because the regulatory landscape has changed considerably since that opinion was rendered.").

104. \textit{Id.} (Sloviter, C.J., dissenting).

105. \textit{Id.} at 860-61 (Sloviter, C.J., dissenting). Chief Justice Sloviter stated: It is hard to imagine a legislative program that more completely occupies the field of balance billing by physicians than one that expressly states which Medicare patients may not be subject to balance billing, imposes a limit on the amount of balance billing for the remainder of Medicare patients, and deals specifically and separately with certain defined services.

\textit{Id.} (Sloviter, C.J., dissenting).

106. \textit{Id.} at 861 (Sloviter, C.J., dissenting). Chief Justice Sloviter noted that when Congress increased the cap on balance billing, Congress showed that it was in fact concerned with the effect restrictions on balance billing would have on access to medical care. \textit{Id.} (Sloviter, C.J., dissenting).
that changed the cap on balance billing to 50% or 15% of the allowable charge in 1991 instead of the congressionally mandated 25% would clearly be preempts. 107 Thus, a state law that reduced that cap to 0% of the allowable charge (in essence, a ban on balance billing) should similarly be preempts. 108

III. Conclusion

The Third Circuit’s analysis of appellants’ Supremacy Clause challenge to the FCA has two basic components. First, the Third Circuit determined that the FCA is entitled to a presumption of validity because it regulates an area within the traditional realm of state police power and because there is no express preemption provision in the Medicare statute. 109 Second, the Third Circuit determined that the appellants were unable to provide the clear and manifest evidence of congressional intent to preempt required to rebut the presumption of validity. 110 More specifically, the appellants were unable to demonstrate that Congress intended to occupy the field of Medicare balance billing practices to the exclusion of the states, and that state regulation of Medicare balance billing practices would interfere with the goals of the Medicare Program. 111

The ultimate question in any presumption analysis is whether Congress intended to preempt state law. 112 There is little doubt that the Third Circuit correctly interpreted congressional intent in this case by holding that Congress did not intend to preempt state law. The fact that Congress did not act to expressly preempt existing state laws restricting balance billing is extremely persuasive, notwithstanding the normal hesitation to give congressional inaction too much weight. Perhaps the more interesting question is whether allowing states to experiment with variations of the Medicare program is a positive step towards finding a system that provides universal access to quality health care at an affordable price.

Congress itself has experimented with many possible approaches to

107. Id. (Sloviter, C.J., dissenting). In Medical Society of New York, however, the court disagreed with the premise of this analogy and upheld a statute which reduced the amount physicians can balance bill in New York. Medical Soc’y of N.Y. v. Cuomo, 777 F. Supp. 1157, 1159-60 (S.D.N.Y. 1991).

For a discussion of Medical Society of New York, see supra note 12 and accompanying text.

108. Pennsylvania Medical Soc’y, 942 F.2d at 861 (Sloviter, C.J., dissenting).

109. For a discussion of the court’s reasoning, see supra notes 42-51 and accompanying text.

110. For a discussion of appellants’ failure to provide the clear and manifest evidence of congressional intent to preempt, which is required to rebut the presumption of validity, see supra notes 52-90 and accompanying text.

111. For a discussion of appellants’ argument regarding the goals of the Medicare Program, see supra notes 76-90 and accompanying text.

112. See, e.g., Pennsylvania Medical Soc’y, 942 F.2d at 848.
this challenge.\textsuperscript{113} Congress' current approach is to place absolute caps on fees and provide incentives for physicians to accept a standard fee somewhat lower than the absolute maximum allowed fee.\textsuperscript{114} No one argues, however, that Congress has found the ideal solution to the health care crisis. Allowing states to experiment with variations of the Medicare program gives Congress a chance to observe several different systems in action before committing to any one on a national scale.

Of course, many, especially those in the health care industry, will be dubious of any state solution that reduces fees paid to health care providers.\textsuperscript{115} Their position is not without merit. It is certainly plausible that such reductions might compromise access to quality health care. But if one considers the original challenges of limiting costs and providing adequate access to care, it is clear that a balance must be found. What is not clear is where the balance should lie. State experimentation is perhaps the most efficient way of finding the best balance, and there is little danger in allowing this experimentation, especially when the scope of the experimentation is so narrow. If costs increase instead of decrease, or if access to quality care is reduced, then the states can be counted upon, at least as much as the federal government, to act in the best interests of their citizens. Perhaps through experimentation, individual states can find a more successful balance.

\textit{R. Anthony Diehl}

\textsuperscript{113} \textit{Pennsylvania Medical Soc'\textsc{y}}, 942 F.2d at 844-45 (discussing congressional experimentation through amendments to Medicare Act).

\textsuperscript{114} For a discussion of Medicare billing practices, see supra notes 15-32 and accompanying text.

\textsuperscript{115} See, \textit{e.g.}, \textit{Pennsylvania Medical Soc'\textsc{y}}, 942 F.2d at 853 (discussing appellants' argument that FCA interferes with goals of Medicare program by reducing access to health care).