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Challenging Medicare Part B Amount Determinations: The Transcendence of the Reasonable Charge

Stewart Reifler

CHALLENGING MEDICARE PART B AMOUNT DETERMINATIONS: THE TRANSCENDENCE OF THE REASONABLE CHARGE

I. INTRODUCTION

Before 1987, Medicare Part B beneficiaries were precluded from judicial review of all benefit amount determinations. Under the Social Security Amendments of 1965,[1] judicial review was available to persons challenging their entitlement to both Part A and Part B benefits, but enrolled beneficiaries could only challenge "the determination of the amount of benefits under [P]art A" in a federal court.[2] Therefore, a Part B beneficiary could seek relief only by administrative appeal.[3]

The administrative-appeal procedures of a Part B benefit amount determination consists of a two-tier review process.[4] First, a dissatisfied claimant has to request a de novo review conducted by the Medicare Part B carrier.[5] Second, the claimant can request a statutory "fair hearing"[6] conducted by an "officer designated by the appropriate official of the carrier."[7] The hearing officer may be an employee of the Part B carrier.[8] According to the regulations, this hearing is a forum of last resort because "[t]he hearing officer's decision . . . shall be final and binding upon all parties to the hearing."[9]

In 1982, the Supreme Court found this review procedure constitutional.[10] The Court held that this "fair hearing" did not deny due process because the presumption, without factual findings to the contrary,

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1. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286, 290.

2. *Id.* § 1869(a), 79 Stat. at 330.

3. *See generally* 42 C.F.R. §§ 405.801-.872 (1991) (establishing procedures for review and hearings of appeals under Medicare Part B).

4. *See id.*

5. *See id.* §§ 405.807-.812. A Medicare carrier is defined as "an organization which has entered into a contract with the Secretary [of Health and Human Services] pursuant to section 1842 of the [Social Security] Act and which is authorized to make determinations with respect to Part B of title XVIII of the Social Security Act." *Id.* § 405.802(a).

6. § 1842(b)(3)(C), 79 Stat. at 310-11 (current version at 42 U.S.C. § 1395u(b)(3)(C) (1988)).

7. 42 C.F.R. § 405.823.

8. *Id.* § 405.824.

9. *Id.* § 405.835.

10. *See* Schweiker v. McClure, 456 U.S. 188 (1982).

was that a hearing officer was unbiased.[11] Furthermore, in a different case decided on the same day,[12] the Court held that, based on statutory language, congressional intent, and legislative history, there was no federal subject-matter jurisdiction for review of Part B amount determinations.[13] The Court concluded that Congress foreclosed judicial review because "payments under the Part B program generally were expected to be smaller than those under the *primary* Part A program."[14]

In 1986, however, the Court, operating under a "strong presumption that Congress intend[ed] judicial review of administrative action,"[15] held that challenges to the validity of the administrative regulations, which established the methodology used to determine the amount of benefits, were not judicially foreclosed by Congress.[16] In the same year, Congress amended the Social Security Act and permitted appeal to an administrative law judge (ALJ) under Part B if the amount in controversy was not less than $500 and judicial review if the aggregate amount in controversy was not less than $1000.[17] The fair-hearing requirement was also amended to reflect this change.[18]

One year later, Congress amended the new Part B fair-hearing requirement by changing the statute's phrasing.[19] Congress also authorized the General Accounting Office to "conduct a study concerning the cost effectiveness of requiring [fair] hearings . . . before having a hearing before an administrative law judge."[20] One circuit court interpreted this as requiring a complete exhaustion of administrative remedies before any review by a federal court.[21] Thus, judicial review of Part B amount determinations, albeit not foreclosed, is certainly

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11. *See id.* at 195.

12. *See* United States v. Erika, Inc., 456 U.S. 201 (1982).

13. *See id.* at 206-11.

14. *Id.* at 208 (emphasis added).

15. Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667, 671 (1986).

16. *See id.* at 670.

17. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9341(a)(1)(C), 100 Stat. 2037, 2037.

18. *Id.* § 9341(a)(2), 100 Stat. at 2038. The fair-hearing requirement was changed from amounts in controversy of "$100 or more" to amounts of "at least $100, but not more than $500." *Id.*

19. *See* Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4085(i)(5), 101 Stat. 1330, 1330-130 (codified as amended at 42 U.S.C. § 1395u(b)(3)(C) (1988)). The new law changed the wording from "not more than $500" to "less than $500." *Id.*

20. *Id.* § 4082(d), 101 Stat. at 1330-128.

21. *See* Isaacs v. Bowen, 865 F.2d 468 (2d Cir. 1989).

forestalled.[22] The net effect—particularly because the beneficiaries are not only elderly but also, as evidenced by the filing of a claim, in need of medical service—is tantamount to foreclosure because time and the ability to maintain the review process work against senior citizens.

In 1986, while addressing the issues of judicial review of Medicare Part B amount determinations, Congress created the Physician Payment Review Commission to investigate and analyze physician charges under the Part B program.[23] Congress also authorized the Secretary of Health and Human Resources (HHS) to develop a national fee schedule for physician charges for use with the Part B program.[24] Three years later, Congress enacted the Omnibus Budget Reconciliation Act of 1989,[25] which directed the HHS Secretary to establish a national fee schedule for physician charges under Medicare Part B.[26] On November 25, 1991, the Secretary issued regulations to implement the new payment method effective January 1, 1992.[27]

Meanwhile, the states were also addressing the issue of Medicare Part B amount determinations. Under a concept called "mandatory assignment," some state legislatures imposed restrictions on a physician's ability to charge Medicare beneficiaries.[28] Some states, such as

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22. In order to exhaust all the administrative remedies, a beneficiary must file a claim, receive an initial determination, request a review, receive a review determination, request a fair hearing, take part in a fair hearing, receive a fair-hearing determination, request an ALJ hearing (for amounts more than $500), take part in an ALJ hearing, and receive an ALJ decision, before any challenge involving claims in aggregate of $1000 would be entitled to judicial review. The Second Circuit estimated the time between the initiation of a claim and completion of ALJ review to be nineteen months and stated that this was not "remarkable in the Medicare, Social Security and employment benefits systems." *Id.* at 477.

23. *See* Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9305(a), 100 Stat. 190 (current version at 42 U.S.C. § 1395w-1 (1988)).

24. *See id.* § 9305(e)(1), 100 Stat. at 192.

25. Pub. L. No. 101-239, 103 Stat. 2106.

26. *Id.* § 6102, 103 Stat. at 2169-70.

27. *See* 56 Fed. Reg. 59,502 (1991) (to be codified at 42 C.F.R. §§ 405, 413, 415).

28. *See generally* Massachusetts Medical Soc'y v. Dukakis, 637 F. Supp. 684, 701-03 (D. Mass. 1986) (discussing the effects of mandatory assignment legislation), *aff'd*, 815 F.2d 790 (1st Cir.), *cert. denied*, 484 U.S. 896 (1987); Peter J. Strauss, *Law and the Aging: Legislative Update*, N.Y.L.J., Oct. 31, 1990, at 3 (discussing mandatory assignment laws in New York, Pennsylvania, Connecticut, Massachusetts, Rhode Island, and Vermont).

Connecticut,[29] Massachusetts,[30] and Pennsylvania,[31] require physicians to accept the Medicare Part B amount determination as payment in full. Others, such as New York, impose levels that limit a physician from charging a Medicare beneficiary more than a statutory percentage of the Part B amount determination.[32] Still other states, while not imposing mandatory assignment, require physicians to notify beneficiaries that they are liable for payments in excess of the Medicare Part B determination.[33]

At issue in any challenge to a Part B amount determination is the reimbursement amount due the beneficiary. This note examines the issues presented when a Medicare Part B carrier partially reimburses a beneficiary—either directly or indirectly—for a covered medical expense. Partial reimbursement occurs because "Medicare pays no more for Part B medical and other health services than the 'reasonable charge' for such service."[34] This payment standard is not based on the actual charge incurred by the beneficiary, but on what the carrier determines to be "reasonable." The first issue, therefore, is whether the federal statutes, regulations, and carrier-made rules that create and utilize a "reasonable-charge" payment standard are valid. If so, the second issue is whether the beneficiary or the provider of service is liable for the difference between the charge actually billed and the reimbursement made by the carrier. If the providers are liable, the final issue is whether a valid constitutional challenge to the complete regulation of medical fees exists. The resolution of these issues will help determine the shape of health-care delivery systems into the twenty-first century.

Part II of this note presents a general background of the Medicare system and compares it to other national health-service programs. Part III examines the statutory authority of the reasonable charge and how the issues of Part B amount determinations have been resolved by federal courts. Part IV focuses on both federal and state actions limiting physician charges. Finally, Part V addresses the national fee schedule that went into effect on January 1, 1992. This note concludes that the reasonable charge has survived as a legal concept, but has transcended into a government-imposed fee schedule. It is this fee schedule which most likely will shape health-care reform in the 1990s.

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29. CONN. GEN. STAT. ANN. § 17a-391 (West 1992).

30. MASS. GEN. L. ch. 112, § 2 (Supp. 1991).

31. PA. STAT. ANN. tit. 35, § 449.34 (Supp. 1992).

32. N.Y. PUB. HEALTH LAW § 19 (McKinney Supp. 1992).

33. *See, e.g.*, MONT. CODE ANN. § 53-5-901 (1991); OR. REV. STAT. § 677.099 (1991); R.I. GEN. LAWS § 5-37-22 (Supp. 1991).

34. 42 C.F.R. § 405.501(a) (1991).

II. THE HISTORY AND STRUCTURE OF MEDICARE

A. *Origins*

In order to effectively analyze the legal issues concerning the reasonable charge, it is necessary to understand the formation of, and subsequent changes in, the federal program commonly called "Medicare." Medicare is this country's late entry into the world's compulsory health-insurance arena.[35] Although the demands for government involvement in a national health-insurance scheme date back to the beginning of the twentieth century, Medicare did not become a legislative reality until 1965.[36]

Although socialized medicine had been proposed after World War I, and was advocated by some during the 1920s, opposition by such groups as the American Medical Association (AMA) and the American Federation of Labor prevented the United States from following England's example of government health insurance for low-income workers.[37] But by the 1930s, the economic climate had created such national pressures that socialized medicine once again was put on the nation's agenda.[38] President Roosevelt's advisory Committee on Economic Security, created in 1934 to draft Social Security legislation, broached the subject of government health insurance as part of the overall program.[39] Roosevelt's fear, however, that this controversial issue would hurt the passage of his Social Security bill and his chances for re-election kept him from vigorously sponsoring any such program.[40]

Meanwhile, the Great Depression had created serious problems for the medical community.[41] During the 1930s, the American Hospital Association created a non-profit, tax-exempt insurance program called "Blue Cross," which offered private limited health insurance to workers.[42] The purpose of the Blue Cross program was to establish a "prepayment mechanism" to ensure a stable source of revenue for

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35. THEODORE R. MARMOR, THE POLITICS OF MEDICARE 7 (1973).

36. *See id.*

37. *See id.* at 7-8. The American Federation of Labor feared that government health insurance would serve as an excuse for government control of the work force. *Id.* at 7.

38. *See id.* at 8.

39. *See id.*

40. *See id.* at 8-9.

41. *See* Sylvia A. Law & Barry Ensminger, *Negotiating Physicians' Fees: Individual Patients or Society? (A Case Study in Federalism)*, 61 N.Y.U. L. REV. 1, 9 (1986).

42. *See id.*

hospitals, particularly when treating lower- and middle-income patients.[43] The Blue Cross plan used a service benefit feature in which hospitals agreed to accept payments based upon a fee schedule.[44] The hospitals received payment directly from Blue Cross and not from patients.[45]

The AMA, on the other hand, maintained that medical ethics would only permit health insurance that would pay patients directly. Arguably there could never be a direct relationship between the physician and the insurer.[46] Yet, by World War II, the AMA had retreated from this position, and the Blue Shield program, patterned after Blue Cross, was created and implemented by individual state medical societies.[47]

Both Blue Cross and Blue Shield were community-rated plans that allowed all people in the community to pay a similar rate.[48] This form of health insurance became available to a broad spectrum of working people, although there was no effort to help the unemployed and the poor.[49] In contrast, by 1940, no western European country was without a government health-insurance program, at least for low-income workers.[50]

Throughout the 1940s, compulsory health insurance remained a national issue.[51] It was not until President Truman was re-elected in 1948, however, that it became a lead item on the administration's agenda.[52] Truman's administration was less concerned with income security than Roosevelt's New Deal Administration had been.[53] Instead, Truman's administration focused on the access-to-care problem caused by the inequitable distribution of medical services.[54] In 1949, Truman

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43. *See id.*

44. *See id.* at 10.

45. *See id.* at 9.

46. *Id.*

47. *See id.*; *see also* MARMOR, *supra* note 35, at 9 (stating that the reason the AMA reversed its position opposing private health insurance, which paid doctors directly, was to forestall federal action on any kind of socialized medicine).

48. *See* Law & Ensminger, *supra* note 41, at 10.

49. *See id.*

50. *See* MARMOR, *supra* note 35, at 7.

51. *See id.* at 9-10.

52. *See id.*

53. *See id.*

54. *See id.* Marmor stated:

> [t]he proponents of Truman's compulsory insurance program took for granted that financial means should not determine the quality and quantity of medical services a citizen received. "Access to the means of attainment and preservation of health," the 1953 report of Truman's Commission on the Health Needs of the

mounted a vigorous campaign to secure congressional enactment of universal government health insurance.[55] The AMA vehemently fought this campaign, characterizing socialized medicine as an "impersonal medical world . . . in which patients and doctors were forced unwillingly upon each other."[56] In the end, the AMA prevailed over Truman.

Truman nevertheless persistently requested compulsory health insurance during the remaining years of his second term.[57] The 1949 failure to enact a universal health-insurance program, however, along with subsequent failures in 1950 and 1951, demonstrated that a broad program would never succeed.[58] Toward the end of his Administration, Truman revamped his compulsory health-insurance program by eliminating the access-to-care issue and concentrating solely on the medical needs of Social Security recipients.[59]

Consequently, socialized medicine in the United States is currently only for the elderly and this makes it unlike any other program in the world. No other industrialized society has compulsory health insurance only for its senior citizens.[60] In addition, no other compulsory health-insurance program ever began with such a beneficiary group. The standard had been to cover either the work force or the poor.[61]

Choosing senior citizens was a logical solution to Truman's political problem. The elderly, like widows and orphans, commanded public sympathy, and the statistical data proving them sicker and poorer than the rest of society was formidable and readily available.[62] Moreover, postwar growth in health insurance was uneven.[63] Compared to the rest of the

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> Nation flatly stated, "is a basic human right." The health insurance problem in this view was the degree to which the use of health services varied with income (and not simply illness). In contrast, for those who considered minimum accessibility of health services a standard of adequacy, the provision of charity medicine in doctors' offices and general hospitals represented a solution, and the problem was to fill in where present charity care was unavailable.

Id. at 10. (quoting [sic] PRESIDENT'S COMM. ON THE HEALTH NEEDS OF THE NATION, BUILDING AMERICA'S HEALTH, H.R. DOC. 55, 83d Cong., 1st Sess. 3 (1965)).

55. *See id.* at 11-12.

56. *Id.* at 13.

57. *See id.*

58. *See id.*

59. *See id.* at 13-14.

60. THEODORE R. MARMOR, *Coping with a Creeping Crisis: Medicare at Twenty, in* SOCIAL SECURITY: BEYOND THE RHETORIC OF CRISIS 177, 178 (Theodore R. Marmor & Jerry L. Mashaw eds., 1988) [hereinafter MARMOR, *Creeping Crisis*].

61. *See id.*

62. *See* MARMOR, *supra* note 35, at 16.

63. *See id.*

population, a lower proportion of the aged were covered, and the coverage that existed was limited.[64] This created a strong health-insurance need for senior citizens. Additionally, the lack of insurance protection made the elderly dependent on their children for financial assistance. Therefore, this new program could seek broad political support by appealing to the families of the aged.[65]

Truman's new program, now called Medicare, came much too late in his Administration for any chance of success. When the Republicans recaptured the White House in 1952, after a twenty-year hiatus, they shelved Medicare because the program had no political sponsorship in either the House or the Senate.[66] Moreover, President Eisenhower himself had campaigned against socialized medicine.[67] It was not until the election of John F. Kennedy, who included a hospital-insurance program for the aged as part of his "New Frontier," that the program was revitalized.[68]

In his first year in office, President Kennedy attempted to enact his version of the Medicare program into law, but a combination of AMA lobbying and solid opposition by the Southern Democrats defeated the bill in the Ways and Means Committee.[69] This defeat, however, did not weaken the proposal but instead strengthened its viability. Support for Medicare grew over the next several years.[70] With the 1964 landslide election creating a mandate, pursuant to President Johnson's "Great Society," Medicare was signed into law on July 30, 1965.[71]

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64. *See id.* at 16-17.

65. *See id.* at 17.

66. *See id.* at 29.

67. *See id.*

68. *See id.* at 39.

69. *Id.* at 40-54.

> To forestall action in Congress, the A.M.A. and AMPAC [the American Medical Political Action Committee] stepped up their campaigns. The women's auxiliary was the first to attack. In a program called Operation Coffee Cup, thousands of doctors' wives held afternoon parties for friends and neighbors, at which they ate cookies, drank coffee, and listened to a recording of a talk by Ronald Reagan. "One of the traditional methods of imposing statism or Socialism on a people has been by way of medicine," Reagan assured his listeners, and he urged the ladies to write letters, and get their friends to write letters, to members of Congress. "If you don't do this," he said, "one of these days you and I are going to spend our sunset years telling our children and our children's children what it once was like in America when men were free."

RICHARD HARRIS, A SACRED TRUST 139 (1966) (quoting Ronald Reagan).

70. *See* MARMOR, *supra* note 35, at 54-57.

71. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286. President

B. *Structure*

Medicare is divided into two distinct programs: the Hospital Insurance Benefits for the Aged (HI)[72] and the Supplementary Medical Insurance Benefits for the Aged (SMI).[73] Together, these two programs form Title XVIII of the Social Security Act, known as the "Health Insurance for the Aged."[74] Title XVIII is divided into three parts: (1) "Part A" pertains to HI; (2) "Part B" pertains to SMI; and (3) "Part C" concerns the miscellaneous provisions applicable to both programs.[75]

The fundamental structure of Medicare has not changed since its enactment in 1965.[76] All amendments to the overall program have maintained the individual integrity of Parts A and B.[77] Although once under the authority of the Social Security Administration (SSA) and the former Department of Health, Education, and Welfare, Medicare is now administered by HHS through the Health Care Financing Administration (HCFA).[78]

Although Part B is the focus of this note, it is important to understand several aspects of the Part A program that are organically different from Part B. Part A is a mandatory program financed by the Federal Hospital Insurance Trust Fund through the appropriation of Social Security taxes.[79] Primarily, it covers hospital, skilled-nursing facility, home-

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Johnson, along with 200 of the nation's leaders, held the signing ceremony in Independence, Mo., in the presence of Harry Truman, in order to honor the former president. RASHI FEIN, MEDICAL CARE, MEDICAL COSTS 68 (1986). At the ceremony, Johnson declared that "no longer will illness crush and destroy the [life] savings [of older Americans]." John D. Morris, *President Signs Medicare Bills; Praises Truman*, N.Y. TIMES, July 31, 1965, at A1.

72. Social Security Amendments of 1965, Pub. L. No. 89-97, § 1801, 79 Stat. 286, 291-301 (current version at 42 U.S.C. §§ 1395c to 1395i-4 (1988)).

73. *Id.* § 1801, 79 Stat. at 301-13 (current version at 42 U.S.C. §§ 1395k to 1395w-4 (1988)).

74. § 1801, 79 Stat. at 291.

75. *Id.* This note follows the common usage of referring to HI as "Part A" and SMI as "Part B."

76. *See generally* 42 U.S.C. §§ 1395-1395ccc (1988) (setting forth regulations for health insurance for the aged and disabled).

77. *See generally id.*

78. *See* MARMOR, *Creeping Crisis*, *supra* note 60, at 188. "[I]n 1977 . . . [HCFA] was created . . . to administer both Medicare and Medicaid, thereby releasing Medicare from the SSA's managerial ethos and bureaucratic style." *Id.*

79. *See* 42 U.S.C. § 1395i (creating the Federal Hospital Insurance Trust Fund and describing the administration and management of the fund).

health, and hospice-care expenses.[80] The provider of service—usually a hospital—must be Medicare certified.[81] It is the provider, not the beneficiary, who interacts with an intermediary, such as Blue Cross or an insurance company, to secure payment. The only requirement for beneficiaries to receive Medicare benefits is for them to use a Medicare-certified facility.[82] Any benefit paid to the provider is subject to a deductible and coinsurance, which becomes the beneficiary's liability.[83]

In 1983, the claim process for Part A changed from a retrospective-payment or reimbursement system to a prospective-payment system (PPS).[84] All beneficiaries are assigned to a diagnosis-related group (DRG) when admitted to a hospital. Medicare payments are then paid by HCFA through the intermediaries based upon the DRG assigned, not the services performed.[85] Thus, a person admitted to a hospital for a specific condition is classified by a specific DRG. Under this classification, the provider is entitled to a fixed amount, regardless of the services provided and the number of days the patient is confined to a hospital.[86]

Part B is a voluntary, federally subsidized health-insurance program, financed by the Federal Supplementary Insurance Trust Fund.[87] Part B is available to any individual entitled to Part A benefits.[88] Beneficiaries pay a monthly premium that is deducted from their Social Security benefit.[89] Basically, Part B covers physician services, diagnostic tests, outpatient hospital services, inpatient or outpatient radiology and pathology services, x-rays, drugs and biologicals that cannot be self-administered, transfusions, medical supplies, physical and occupational therapy, speech-pathology services, ambulance services, and limited chiropractic, podiatric, psychiatric, dental, and optometric services.[90] The program

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80. *See id.* § 1395d.

81. *See id.* § 1395cc.

82. *See generally id.* §§ 1395f-1395h (describing the conditions and limitations of various types of payment methods for services rendered).

83. *Id.* § 1395e. The statute provides a formula to compute the yearly deductibles and coinsurance. *See id.*; *see also* Patrick B. Nemore & Jeanne Finberg, *MCAA Updates: Qualified Medicare Beneficiaries and Restrictive Medicaid Rules*, 26 CLEARINGHOUSE REV. 601, 601 n.8 (1991) (stating that in 1992 beneficiaries shall pay a "$652 deductible per benefit period; [and] $163 in coinsurance, for each day after the 60th day of hospitalization").

84. *See* 42 U.S.C. § 1395ww(d).

85. *See id.*

86. *See id.*

87. *See* 42 U.S.C. §§ 1395j, 1395t (1988).

88. *See id.* § 1395o.

89. *Id.* § 1395s(a).

90. HEALTH CARE FIN. ADMIN., U.S. DEP'T OF HEALTH AND HUMAN SERVS., Pub.

only covers services that are medically reasonable and necessary. It excludes routine, preventative, and non-skilled custodial care.[91] Because Part B payments, unlike Part A, are based on service charges, not service locations, no requirement exists that service providers be "Medicare certified."[92] Medicare Part B beneficiaries are free to choose their own doctors.[93] Whether the beneficiary is reimbursed, and for what amount, depends on the service performed.

The Part B claim-processing procedure is also different than Part A. Like Part A, the HHS Secretary contracts with private organizations, called carriers instead of intermediaries, for the administration of Part B benefits.[94] The major carriers are Blue Cross and Blue Shield, although there are some commercial insurers such as Aetna, Travelers, and Nationwide that have Part B contracts.[95]

Unlike Part A, Part B claims are paid retrospectively, and the reimbursement is based on the "approved" or "reasonable charges" for the service.[96] The beneficiary must absorb an annual deductible before any benefits are paid.[97] After the deductible is met, reimbursement is paid subject to a coinsurance which is generally eighty percent.[98]

Medicare Part B was never structured to reimburse a beneficiary on a dollar-for-dollar basis but instead was designed to generally pay only eighty cents on the dollar. More importantly, no cap currently exists on this coinsurance amount.[99] Thus, even if a beneficiary is liable for only twenty percent of Part B services, an extended or expensive illness could still "crush and destroy" a beneficiary's savings.[100] Moreover, this structure increases a beneficiary's personal liability by the difference between the actual charge billed and the reasonable charge approved.[101]

No. 10050, THE MEDICARE HANDBOOK 13-19 (1989) [hereinafter HANDBOOK]; *see also* 42 U.S.C. §§ 1395j-1395n (Supp. 1988 and 1990) (codifying Medicare provisions).

91. HANDBOOK, *supra* note 90, at 4-15, 22.

92. *See id.* at 1-2, 4.

93. 42 U.S.C. § 1395a (1988).

94. *See id.* § 1395u(a).

95. *See* HANDBOOK, *supra* note 90, at 33-37.

96. *Id.* at 20.

97. *Id.* at 14.

98. *Id.* Certain services, such as diagnostic tests and second opinions, have a coinsurance of 100%, meaning full reimbursement. *See* 42 U.S.C. § 1395l(a)(1)(D) (1988).

99. The Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 201, 102 Stat. 683, 700, which would have capped out-of-pocket expenses at $1370.00 (subject to increases) was repealed by the Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L. No. 101-234, 103 Stat. 1979, 1981.

100. *Beyond Medicare*, CONSUMER REPORTS, June 1989, at 375.

101. For example, a beneficiary incurs a $100 medical expense. If $100 is the

C. *Statistics*

National health expenditures were $666.2 billion in 1990, $602.8 billion in 1989, $546 billion in 1988, and $494.1 billion in 1987.[102] This represents an increase of 10.5% in 1990, 10.4% in 1989, and 10.5% in 1988. This also represents a 266% increase since 1980 and an 895% increase since 1970.[103] Of greater importance, national health expenditures represented 12.2% of the gross national product in 1990,[104] compared to 9.2% in 1980 and 7.3% in 1970.[105]

Of this $666.2 billion, $585.3 billion was spent on personal health care.[106] Personal health care is defined as "all spending for health services received by individuals and health products purchased in retail outlets."[107] For personal health care, Medicare paid out $108.9 billion on approximately 26.6 million of the approximately 34.2 million enrollees.[108] The $108.9 billion can be broken down to Part A payments for hospital services of $68.3 billion, representing almost 63% of total personal health-care expenditures,[109] and to Part B payments for physician services of $30 billion or 27.5%.[110] Although Part B

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approved charge, and the deductible has been met, then the beneficiary is reimbursed $80 if the coinsurance rate is 80%. But if the approved charge is only $60, then the reimbursement is only $48 ($60 × 80% = $48). The beneficiary's personal liability increases from $20 to $52 ($100 − $48 = $52), when the ceiling is $60.

If a beneficiary has a Medicare supplemental policy (Medigap) from a private insurer, the personal liability may still be substantial because these policies usually only pay 20% of the approved charge. *Id.* at 382-85. Thus, in the above example, a beneficiary with a Medigap policy would receive a 100% reimbursement if $100 were approved. A $60 approved charge, however, would still leave the beneficiary with a $40 out-of-pocket expense, because only $48 ($60 × 80%) would be paid by Medicare and only $12 ($60 × 20%) would be paid by the Medigap insurer. Without a ceiling on this out-of-pocket expense, the beneficiary's potential liability could be in the tens of thousands of dollars.

102. Katharine R. Levit et al., *National health expenditures, 1990*, HEALTH CARE FIN. REV., Fall 1991, at 29, 29.

103. *See id.* at 47-48.

104. *Id.* at 29.

105. *Id.* at 46. The Commerce Department recently estimated 1992 health-care expenditures at $838.5 billion and projected 1993 expenditures at $939.9 billion. Robert Peer, *Health-Care Costs Up Sharply Again, Posing New Threat*, N.Y. TIMES, Jan. 5, 1993, at A1, A10. Of greater significance is that the Commerce Department estimates that 1992 expenditures represented over 14 percent of the 1992 Gross National Product. *Id.*

106. Levit et al., *supra* note 102, at 53.

107. *Id.* at 30.

108. *Id.* at 41.

109. *Id.* at 39.

110. *Id.*

expenditures are considerably less than Part A expenditures, $30 billion is still a substantial sum to a debt-ridden nation.[111]

In 1986, Medicare Part B was the nation's fourth-largest entitlement program after Social Security, Medicare Part A, and Medicaid.[112] Moreover, it was the fastest growing major domestic spending program.[113] This trend is likely to continue because the Medicare population of the United States is increasing at a rate of about two percent per year, compared to the general population, which is increasing at about one percent per year.[114] The shifts in health-care delivery systems from inpatient to outpatient further strengthen this trend.[115]

Although 1990 Medicare expenditures were $30 billion for physician services,[116] this figure does not include the Part B deductible and the 20% coinsurance that Part B does not pay.[117] Medicare Part B beneficiaries were responsible for $2.66 billion in total deductibles and $7.5 billion in coinsurance payments.[118] This does not include the liabilities of Medicare Part B beneficiaries for physician charges above the reasonable charge. About 25% of all Part B claims involve some excess charges, and this figure continues to mount.[119]

D. *Health Insurance Versus Health Service*

Medicare did not create a national health service, but rather a limited national health-insurance program.[120] The program was not designed to fulfill most Americans' notions of socialized medicine where a nationwide administrative structure dispenses medical care that all citizens, regardless

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111. "Medicare spending for physician services increased 9.5 percent from 1989, reaching $30.0 billion in 1990. Medicare's share of total spending for physician services grew from 11.8 percent in 1970 to 19.0 percent in 1980 and 23.9 percent in 1990." *Id.* at 40.

112. Law & Ensminger, *supra* note 41, at 2 (quoting OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, PAYMENT FOR PHYSICIAN SERVICES 3 (1986)).

113. *See id.*

114. Levit et al., *supra* note 102, at 41, 46.

115. *Id.* at 42.

116. *Id.* at 53.

117. *Id.* at 33.

118. *Id.* at 39 (26.6 million users × $100 deductible = $2.66 billion; $30 billion ÷ 80% = $37.5 billion; $37.5 billion − $30 billion = $7.5 billion).

119. *Beyond Medicare*, *supra* note 100, at 377.

120. *See* William A. Glaser, *"Socialized Medicine" in Practice*, *in* NATIONAL HEALTH CARE 41 (Ray H. Elling ed., 1971).

of their status as workers or taxpayers, have a right to use.[121] Medicare, both Parts A and B, is an insurance program. It does not provide payment for all medical expenses because the "insurance" philosophy of medical-care financing is to pay sufficient and substantial portions of health-care costs, as compared to a "prepayment" philosophy that seeks to separate financing from medical considerations.[122]

The Medicare program's structure is similar to health-insurance programs of the 1950s and early 1960s.[123] These programs were provided by employers to their employees under employee-benefit plans.[124] These plans, usually contracted with the local Blue Cross organization, primarily consisted of a basic hospital-service plan because health-care delivery was—at that time—hospital based.[125] This was the model that Part A used. Some employee-benefit plans had a Blue Shield component that provided additional service benefits for physician services performed in the hospital.[126] Part B, however, was not modeled after those Blue Shield plans.[127] Instead, the program was modeled after the supplemental health plans, offered by commercial insurers to employers, that "wrapped around" the basic hospital program.[128] These plans featured an indemnity benefit, paid directly to the insured.[129] The reimbursements were for excesses not paid by the basic hospital plan.[130] Thus, Part B historically has been regarded as a secondary program of minor importance—and still is by many.[131] But based on the factors stated above, Part B Medicare has been increasing in economic, political, and legal importance over the last ten years.

III. ANALYSIS OF THE REASONABLE CHARGE

A. *Statutory Analysis of the Reasonable Charge*

After the 1964 election, with Medicare a legislative certainty, one of the core issues in formulating the Part B program was the method of

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121. *See id.*

122. *See* MARMOR, *supra* note 35, at 78.

123. *See id.*

124. *See* Law & Ensminger, *supra* note 41, at 10.

125. *See* MARMOR, *supra* note 35, at 80.

126. *Id.*

127. *Id.* at 11.

128. *Id.*

129. *Id.* at 10-11.

130. *Id.* at 80.

131. *See* United States v. Erika, Inc., 456 U.S. 201, 208 (1982).

physician payment.[132] To satisfy the AMA and to enlist the support of the medical profession, a Blue Cross-type fee schedule was avoided.[133] Congress feared that physicians would act on their repeated threats of non-cooperation in implementing Part B.[134] Instead, the program allowed physicians to be paid their "usual and customary" fee, but with a condition that the fee be "reasonable."[135] Moreover, the program had no proscription against charging a Medicare beneficiary a fee higher than this "reasonable" fee and did not require physicians to interact with carriers because benefits—in the form of reimbursements—were to be paid directly to the beneficiary.[136] Thus, the program enabled physicians to charge their patients more than what Medicare may have deemed reasonable.[137] Congressional sympathy for physicians' distaste of government control, coupled with the fear that restrictive fee schedules would discourage physicians from treating Medicare patients, made the reasonable-charge concept appear to be a sensible standard of payment.[138]

This payment standard caused serious and persistent problems because the legislation did not define the reasonable charge.[139] The statute only offered a reasonable-charge standard, stating:

> (B) [the carrier] will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, (i) such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier . . . .
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> . . . .
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> . . . In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services.[140]

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132. *See* MARMOR, *supra* note 35, at 80.

133. *See id.*

134. *See id.*

135. *Id.*

136. *See id.*

137. *See id.*

138. *Id.* at 80-81.

139. *See id.* at 85.

140. Social Security Amendments of 1965, Pub. L. No. 89-97, § 1842(b)(3), 79 Stat. 286, 310-11 (current version at 42 U.S.C. § 1395u(b)(3) (1988)).

This reasonable-charge standard proved completely unworkable in the beginning because "[n]o one knew what doctors were customarily charging."[141] Physicians and government officials could not agree on what constituted the upper limit of a prevailing charge.[142] And although Blue Shield and other commercial insurers had some retrievable data pertaining to physician fees, the insurance industry could not agree on what constituted "comparable services" under "comparable circumstances."[143]

Today, the "reasonable charge" is still a term of art that Congress continues to include in the statutes, albeit without definition.[144] The reasonable-charge "standard" or "basis" has not been altered since 1965.[145] To date, no statutory definition exists for the customary charge.[146] The "prevailing charge" has been given, if not a statutory definition, a statutory framework that must be used in determining the reasonable charge.[147] Yet the reasonable charge is now, indirectly, a factor of the new Medicare fee schedule.[148] Thus, an understanding of the development of reasonable-charge criteria is necessary to understand the impact upon the current program.

From the beginning, Congress left the task of defining the reasonable charge to the administrators of the Medicare program.[149] The statute authorizes HHS to establish "standards and criteria for the efficient and effective performance of [carrier] contract obligations" that must be

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141. MARMOR, *supra* note 35, at 85.

142. *See id.* at 85-86.

143. *Id.* at 86. This uncertainty as to what the reasonable charge was "gave physicians every incentive to raise their fees." *Id.*

144. *See, e.g.*, 42 U.S.C. §§ 1395*l*, 1395u, 1395x (1988).

145. *See id.* § 1395u(a)(1)(A), (b)(3)(B).

146. *See generally id.* § 1395x (defining terms relevant to this subchapter).

147. *See* 42 U.S.C. § 1395u(b)(3)(L). This section states:

> [n]o charge may be determined to be reasonable . . . if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable to the [HHS] Secretary for similar services in the same locality . . . on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the 12-month period ending on the June 30 last preceding the start of the calendar year in which the service is rendered.

Id.

148. *See generally id.* § 1395w-4 (Supp. 1990); 56 Fed. Reg. 59,502 (1991) (to be codified at 42 C.F.R. §§ 405, 413, 415).

149. Social Security Amendments of 1965, Pub. L. No. 89-97, § 1869(a), 79 Stat. 290, 330.

published in the Federal Register.[150] In interpreting the statute, the HHS Secretary established criteria recognizing that "[t]he law allows for flexibility in the determination of reasonable charges to accommodate reimbursement to the various ways in which health services are furnished and charged for."[151] The criteria for the customary charge,[152] the prevailing charge,[153] and the exceptional charge[154] command the most attention.

The customary charge is defined by the HHS Secretary as "the uniform amount which the individual physician or other person charges in the majority of cases for a specific medical procedure or service."[155] The reasonable charge may never be higher than the customary charge, except under special and extraordinary circumstances.[156] Thus, if a carrier has determined a physician's customary charge to be $50 for a specific service, and the physician increases the charge to $75 for the particular service, then the customary charge is still $50 and will remain $50 until a new customary charge is determined and established by the carrier.

The prevailing charge is not specifically defined by the regulations.[157] Instead, the statutory instruction is that the prevailing charge is based on seventy-five percent of the customary charges made for

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150. 42 U.S.C. § 1395u(b)(2)(A).

151. 42 C.F.R. § 405.502(a) (1991).

152. *See id.* § 405.502(a)(1).

153. *See id.* § 405.502(a)(2).

154. *See id.*

155. *Id.* § 405.503(a).

156. *Id.*

157. *See id.* § 405.504(a)(2). The regulation states:

> [n]o charge for Part B medical or other health services may be considered to be reasonable if it exceeds the higher of: (i) The prevailing charge for similar services in the same locality in effect on December 31, 1970, provided such prevailing charge had been found acceptable by HCFA; or (ii) the prevailing charge that, on the basis of statistical data and methodology acceptable to HCFA, would cover: (A) 75 percent of the customary charges made for similar services in the same locality during the 12-month period of July 1 through June 30 preceding the fee screen year (January 1 through December 31) in which the service was furnished; or (B) In the case of services furnished more than 12 months before the beginning of the fee screen year (January 1 through December 31) in which the claim or request for payment is submitted, 75 percent of the customary charges made for similar services in the same locality during the 12 month period of July 1 through June 30 preceding the fee screen year that ends immediately preceding the fee screen year in which the claim or request for payment is submitted.

Id.

similar services in the same locality during a twelve-month period.[158] A locality is usually a political or economic subdivision of a state defining a specific geographic area.[159] If a locality has four physicians, and each performs a similar service only once in the specified twelve-month period, and the four charges are $50, $60, $70 and $80, then the prevailing charge is $70 because it covers seventy-five percent of the locality's customary charge. The carrier can establish either a specific prevailing charge for a service or a range of prevailing charges, based upon the carrier's accumulated data.[160]

The exceptional-charge criteria are explicitly defined by both the statute and the regulations.[161] The criteria allow factors that are found necessary and appropriate with respect to a specific service to be used in judging the "inherent reasonable[ness]" of the charge.[162] If the standard rules for calculating reasonable charges result in "grossly deficient or excessive charges,"[163] then HCFA or the carrier may establish special reasonable-charge limits that may fix either upper or lower limits.[164] Some of the factors taken into account include: (1) whether the marketplace is competitive or uncompetitive; (2) whether Medicare is the primary or sole source of payment; (3) whether the technology is new or changing; (4) whether prevailing charges are inequitable; and (5) whether increases can be explained by inflation or technology.[165] Essentially, these criteria allow the carrier a broad response to any actual charge.

The reasonable charge—also called the "approved" or "allowable charge"—is usually the lower of the customary, prevailing, or actual charge.[166] If, for example, the range of prevailing charges in a given locality is between $80 and $100, then: (1) a physician who customarily charges $80 but who actually charged $75 has a reasonable charge of $75 because the reasonable charge cannot be higher than an actual charge; (2) a physician who customarily charges $85 and who actually charged $85 has a reasonable charge of $85 because it is the physician's customary charge and it falls within the prevailing charge range; (3) a physician who customarily charges $125 and who actually charged $125 has a reasonable charge of $100 because that is the ceiling of the prevailing charge fee

158. *See id.*

159. *Id.* § 405.505.

160. *See id.* § 405.504(b), (c).

161. *See* 42 U.S.C. § 1395u(b)(8) (1988).

162. 42 C.F.R. § 405.502(a)(7) (1991).

163. *Id.*

164. *Id.*

165. *See id.* § 405.502(g)(1).

166. *See* HANDBOOK, *supra* note 90, at 20.

screen; and (4) a physician who customarily charges $80 and who actually charged $100 has a reasonable charge of $80 because the customary charge is lower than either the prevailing or actual charge.[167]

The reasonable charge is still, by congressional action or inaction, loosely defined and therefore ambiguous.[168] This ambiguity, however, allowed HCFA and the carriers a wide latitude in developing and applying a reasonable-charge methodology. Moreover, it was the carriers information system, programmed to accommodate this methodology, that in effect established the reasonable charge for any particular service in any particular community.[169] In most instances, by using these computation formulas, particularly the seventy-five percent derivation rule, the prevailing charge usually determined the reasonable charge, because the prevailing charge was the last to be affected by any increase in fees.[170] Indeed, many amendments to Medicare purposely utilized the prevailing charge for cost containment.[171]

The customary charge no longer reflects true customary levels. The Deficit Reduction Act of 1984[172] (DEFRA) froze the customary- and prevailing-charge levels for a fifteen-month period, beginning July 1, 1984, at levels no higher than those set beginning July 1, 1983.[173] Congress later extended this freeze to March 14, 1986.[174] DEFRA also divided physicians into two groups: those who would contractually agree to accept the reasonable charge as the full and only charge (participating physicians), and those who would not (non-participating physicians).[175] Non-participating physicians would not be allowed to charge Medicare patients in excess of the physicians' actual charge for the same services during the calendar quarter beginning April 1, 1984. Those who violated this cap would be prohibited from any participation in the Medicare program for up to five years and would be subject to civil penalties of up

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167. *See* 42 C.F.R. § 405.507 (1991).

168. *See* MARMOR, *supra* note 35, at 85.

169. "Figuring the doctor's customary charge and the prevailing charge is a mind-boggling, if not a computer-boggling, exercise. . . . Blue Cross [of New York] processes about 25 million pieces of information in its computers to determine the [reasonable] charge . . . ." *Beyond Medicare*, *supra* note 100, at 376.

170. Law & Ensminger, *supra* note 41, at 12.

171. *See* 42 U.S.C. § 1395u(b)(3) (1988). Of particular interest is 42 U.S.C. § 1395u(b)(7)(B)(ii)(III) in which the customary charge may be set at no higher than 85% of the prevailing charge of a similar service.

172. Pub. L. No. 98-369, § 2306, 98 Stat. 494, 1070-72.

173. *Id.*

174. *See* Emergency Extension Act of 1985, Pub. L. No. 99-107, § 5(b), 99 Stat. 479, *amended by* Pub. L. No. 99-201, § 2, 99 Stat. 1665.

175. *See* § 2306, 98 Stat. at 1071-72.

to $2000 for each violation.[176] Moreover, DEFRA specified that in determining the customary charges of non-participating physicians for the twelve-month periods beginning October 1, 1985 and October 1, 1986, the HHS Secretary would not recognize increases in actual charges when the freeze was lifted.[177] Participating physicians' increases, on the other hand, would be factored into the computation of new post-freeze, customary-charge levels.[178]

This meant that a physician's customary charge was subject to manipulation based on participation status. Although Medicare carriers had been accumulating customary charges for twenty-five years, it could be argued that the current levels, reflecting this manipulation, are not what physicians would customarily charge in a free marketplace. Instead, the customary charge is but a historical base that the government, through the carriers, has used to control fees.[179] Moreover, because the customary charge determined the prevailing charge, and the prevailing charge was usually the lowest charge, the reasonable charge no longer represented an objective community standard as originally conceived. Rather, it became a statistic-driven derivative that was prima-facie evidence of itself.

The statutory reasonable charge of the 1960s has been fundamentally transformed for the 1990s. The Omnibus Budget Reconciliation Act of 1989,[180] amended by the Omnibus Reconciliation Act of 1990,[181] authorized the HHS Secretary to create a national fee schedule for physician services to be used by carriers when paying Part B claims.[182] In essence, this fee schedule will replace the reasonable charge. The final rules implementing the fee schedule were released on November 25, 1991.[183]

Since January 1, 1992, Part B claims for physician services are paid based on the lesser of the actual charge for the service or the fee schedule amount.[184] The statute allows a transition period which generally blends

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176. *See id.* § 2306(j), 98 Stat. at 1072.

177. *See id.* § 2306(a)(4)(D), 98 Stat. at 1070.

178. *Id.*

179. It would seem that the only logical response to a reasonable-charge payment standard based on customary- and prevailing-charge criteria would be government control of physicians' fees. "Since the payment a doctor receives is determined by the stated charges at some time in the recent past, doctors have strong economic incentives to keep stated charges high." Law & Ensminger, *supra* note 41, at 12.

180. Pub. L. No. 101-239, 103 Stat. 2106.

181. Pub. L. No. 101-508, 104 Stat. 1388.

182. 103 Stat. 2106, 2169-70.

183. *See* 56 Fed. Reg. 59,502 (1991) (to be codified at 42 C.F.R. §§ 405, 413, 415).

184. *See* 42 U.S.C. § 1395w-4(a)(1) (Supp. 1990).

the fee-schedule amount with the reasonable charge—now called the "adjusted historical payment basis"—at the following ratios: 1:7 in 1992; 1:4 in 1993; 1:3 in 1994; and 1:1 in 1995.[185] In 1996, the reasonable-charge payment method will be eliminated for all physician services, and any physician—both participating and non-participating—treating a Medicare beneficiary will be required to adhere to this fee schedule for all billing purposes.[186] Although the reasonable-charge standard is still applicable to most non-physician services, these services account for a fraction of total Part B claims.[187] Accordingly, although the reasonable charge still maintains a statutory posture in the Medicare Act, it seems to have been relegated to a level of statutory insignificance.

B. *Case-Law Analysis of the Reasonable Charge*

The validity of the reasonable charge has been examined by the courts on three related levels. The first is whether a carrier's determination of a reasonable charge conforms with Medicare regulations and statutes.[188] The second is whether the regulations promulgated by HHS are valid.[189] The third is whether Congress has the authority to create a reasonable-charge payment standard for Part B reimbursements.[190] Although case law is still developing in this area, a validity test has been discerned and applied by the Supreme Court.[191]

1. The Jurisdictional Obstacle

Case-law development in this area has been consistently hampered by the "thorny question"[192] of jurisdiction. Although the 1986 amendments to the Social Security Act made this issue moot for disputes after January

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185. *See* § 1395w-4(a)(2)(a), (b) (Supp. 1990).

186. *See* § 1395w-4(g).

187. *See* Levit et al., *supra* note 102, at 39.

188. *See* Michigan Academy of Family Physicians v. Blue Cross and Blue Shield, 728 F.2d 326 (6th Cir.) [*Michigan Academy I*], *cert. granted and vacated sub nom.* Heckler v. Michigan Academy of Family Physicians, 469 U.S. 807 [*Michigan Academy II*], *remanded sub nom.* Michigan Academy of Family Physicians v. Blue Cross and Blue Shield of Michigan, 751 F.2d 809 (6th Cir. 1984) [*Michigan Academy III*], *order rescinded*, 757 F.2d 91 (6th Cir. 1985) [*Michigan Academy IV*], *aff'd sub nom.* Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667 (1986) [*Michigan Academy V*].

189. *See Michigan Academy I*, 728 F.2d at 331-32.

190. *See* Erika, Inc. v. United States, 634 F.2d 580, 591 (Ct. Cl. 1980), *modified*, 647 F.2d 129 (Ct. Cl. 1981), *rev'd on other grounds*, 456 U.S. 201 (1982).

191. *See Michigan Academy V*, 476 U.S. at 669.

192. *Michigan Academy I*, 728 F.2d at 329.

1, 1987,[193] it was the threshold issue in most earlier cases. Moreover, it still is an issue for any pre-1987 claims on appeal.[194]

The significance of the jurisdictional obstacle is that the question of the validity of the reasonable charge is not addressed. The courts, lacking jurisdiction, did not reach the merits of the cases.[195] Dicta from these cases in which the courts held that jurisdiction was lacking, however, along with the holdings of the lower courts in which jurisdiction had been found, provide an ample basis for this analysis.[196]

Prior to 1982, federal courts invoked jurisdiction under the Tucker Act,[197] the Mandamus and Venue Act of 1962,[198] or under federal question jurisdiction.[199] In *United States v. Erika, Inc.*, the Supreme Court unanimously reversed a decision by the United States Court of Claims that had invoked jurisdiction under the Tucker Act.[200] The lower court relied on the language of the Act, which "permits the Court of Claims to hear 'any claim against the United States founded either upon the Constitution, or any Act of Congress, or any regulation of an executive department.'"[201] The Supreme Court "granted certiorari to determine whether the Court of Claims has jurisdiction over suits of this kind."[202] The Court, examining the language and the legislative history of § 1395ff(a),[203] stated that "[i]n the context of the statute's precisely drawn provisions, this omission [of Part B claim review] provides

193. *See* Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9341(b), 100 Stat. 2037, 2038.

194. *See, e.g.*, Anderson v. Bowen, 881 F.2d 1 (2d Cir. 1989) (holding that the district court had no jurisdiction to review a hearing officer's ruling on an amount determination).

195. *See, e.g., Michigan Academy I*, 728 F.2d at 332 n.5.

196. *See infra* notes 197-227 and accompanying text.

197. 28 U.S.C. § 1491 (1988); *see, e.g.*, Erika, Inc. v. United States, 634 F.2d 580, 586 (Ct. Cl. 1980), *modified*, 647 F.2d 129 (Ct. Cl. 1981), *rev'd on other grounds*, 456 U.S. 201 (1982).

198. Mandamus and Venue Act of 1962, Pub. L. No. 87-748, § 1361, 76 Stat. 744 (codified as amended at 28 U.S.C. § 1361 (1988)); *see, e.g.*, Alexander v. Schweicker, 516 F. Supp. 182, 186 (D. Conn. 1981).

199. Pub. L. No. 87-748, § 1361, 76 Stat. 744 (codified as amended at 28 U.S.C. § 1331 (1988)); *see, e.g.*, Ringer v. Schweiker, 697 F.2d 1291, 1294 (9th Cir. 1982), *rev'd sub nom.* Heckler v. Ringer, 466 U.S. 602 (1984).

200. 456 U.S. 201, 205 (1982).

201. *Id.* at 205 (quoting 28 U.S.C. § 1491 (1988)).

202. *Id.* at 206.

203. *See supra* notes 1, 12-13 and accompanying text.

persuasive evidence that Congress deliberately intended to foreclose further review of such claims."[204]

Two years later, the Supreme Court decided *Heckler v. Ringer*,[205] in which the plaintiffs challenged both Part A and Part B amount determinations. The lower court found jurisdiction under both the federal question and mandamus statutes.[206] Regarding the Part A challenge, the Supreme Court held that a challenge to an entitlement of a Part A benefit for a surgical procedure, which the HHS Secretary had declared was no longer covered, had to exhaust administrative remedies before any federal court could accept jurisdiction.[207] The only exceptions were if the HHS Secretary had waived the exhaustion requirements, having deemed such requirements futile or if the claim was "wholly collateral" to the claim for benefits.[208] The Court, however, did not even consider the Part B challenges because judicial review was precluded under *Erika*.[209] The Court found that Part B claims that challenged procedures were "inextricably intertwined" with claims for benefits and were not judicially reviewable even when the procedural elements of the claim were separated from the substantive elements.[210] Thus, *Ringer* further insulated the reasonable charge from any judicial scrutiny.

As in *Erika*, the Supreme Court, in *Bowen v. Michigan Academy of Family Physicians*,[211] addressed only the jurisdictional issue and not the validity of the reasonable charge.[212] This was because the HHS Secretary, as the petitioner, did not seek a "review of the decision on the merits."[213] Instead, the Secretary renewed an assertion, rejected by both lower courts,[214] that "Congress [had] forbidden judicial review of all

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204. *Erika*, 456 U.S. at 208.

205. 466 U.S. 602 (1984).

206. *See* Ringer v. Schweiker, 697 F.2d 1291, 1294 (9th Cir. 1982), *rev'd sub nom.* Heckler v. Ringer, 466 U.S. 602 (1984).

207. *See Ringer*, 466 U.S. at 617-19.

208. *Id.* at 618 (quoting Mathews v. Eldridge, 424 U.S. 319, 330 (1976)).

209. *See id.* at 608-09 n.4.

210. *Id.* at 614.

211. 476 U.S. 667 (1986).

212. *See id.* at 669.

213. *Id.*

214. *See* Michigan Academy of Family Physicians v. Blue Cross and Blue Shield, 502 F. Supp. 751, 752 (E.D. Mich. 1980), *remanded*, 728 F.2d 326 (6th Cir.), *cert. granted and vacated sub nom.* Heckler v. Michigan Academy of Family Physicians, 469 U.S. 807, *remanded sub nom.* Michigan Academy of Family Physicians v. Blue Cross and Blue Shield of Michigan, 751 F.2d 809 (6th Cir. 1984), *order rescinded*, 757 F.2d 91 (6th Cir. 1985), *aff'd sub nom.* Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667 (1986).

questions affecting the amount of benefits payable under Part B of the Medicare program."[215] One year earlier, the Court had denied certiorari in *Starnes v. Schweiker*,[216] in which the plaintiff had challenged a rule capping reimbursements for computerized tomography scans.[217] In deciding *Starnes*, the Fourth Circuit concluded that the district court had jurisdiction under either federal question or the mandamus statute.[218] The court, however, held that "*Ringer* decides that Starnes [sic] contention that there were procedural irregularities in the promulgation of the caps are so inextricably intertwined with a claim for benefits that any judicial review is barred by 42 U.S.C. § 1395ff."[219] Thus, it could be reasoned that the Secretary fully expected the Court, relying on *Erika*, *Ringer*, and *Starnes*, to reverse the Sixth Circuit's decision in *Michigan Academy*. The Supreme Court had granted certiorari in *Michigan Academy* specifically because the circuit courts were divided.[220]

The Court, in *Michigan Academy*, held that regulations creating a payment methodology are not insulated from judicial review.[221] Relying on the language of *Marbury v. Madison*[222] that "the very essence of civil liberty certainly consists in the right of every individual to claim the protection of the laws,"[223] the *Michigan Academy* Court effectively overruled *Ringer*. The Court distinguished between a claim-challenging procedure and a claim for benefits.[224] More importantly, by creating two distinct challenges to a reasonable-charge determination, *Michigan Academy* was distinguished from *Erika*.[225]

Arguably, *Michigan Academy* made no substantial ruling regarding the issue of the reasonable charge because only the jurisdictional question, and not the merit of the case, was at issue. By affirming the lower court's decision, however, the Supreme Court distinguished between "challenges mounted against the *method* by which such amounts are to be determined

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215. 476 U.S. at 669.

216. 748 F.2d 217 (4th Cir. 1984), *cert. denied*, 471 U.S. 1017 (1985).

217. *See id.* at 217-18. A tomography scan is an X-ray of a selected plane in the body. THE AMERICAN HERITAGE DICTIONARY 1276 (2d ed. 1982).

218. *See* 748 F.2d at 218.

219. *Id.*

220. *Michigan Academy V*, 476 U.S. at 669.

221. *See id.* at 678-81.

222. 5 U.S. (1 Cranch) 137 (1803).

223. *Michigan Academy V*, 476 U.S. at 670 (quoting *Marbury*, 5 U.S. (1 Cranch) 137, 163 (1803)).

224. *See id.* at 677-82.

225. *See id.* at 675-78 (describing challenges to the Secretary's regulations, as well as the method by which awards are computed).

. . . [and] the *determinations* themselves."[226] The Court further clarified the distinction as "the method by which Part B awards are computed as opposed to the computation."[227] Therefore, *Michigan Academy* established a dichotomy that all future Part B challenges would be tested against to resolve these jurisdictional questions. Concomitantly, this dichotomy would also test reasonable-charge validity.

2. The Method/Amount Dichotomy

The distinction between a method challenge and an amount-determination challenge can be gleaned from the facts of both *Erika* and *Michigan Academy.* Moreover, the analyses presented by the lower courts evince the difference.[228] At the same time, however, these differences may be only semantic because the dichotomy is in flux.[229]

Erika, Inc. was a major distributor of kidney-dialysis equipment and supplies, selling to both individuals and institutions.[230] Some of its customers were Medicare beneficiaries who assigned the payment of benefits directly to Erika, as provided for by statute.[231] This gave the company standing to challenge any reasonable-charge determinations.[232] Prudential Insurance Company, the Medicare carrier, used Erika's charges to determine both the customary and the prevailing charges of Erika's products because Erika's sales represented almost all the sales of the relevant materials in the locality.[233] Prudential's source for these charges was a price list located in Erika's annual catalog, effective July 1 of each year.[234] Prudential determined the reasonable charge at the beginning of its fiscal year, which was also July 1. Instead of basing the reasonable charge on Erika's current calendar year's billing, Prudential used the price

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226. *Id.* at 675 (emphasis added).

227. *Id.* at 676.

228. *See, e.g.*, American Ambulance Serv. v. Sullivan, 911 F.2d 901, 904-05 (3d Cir. 1990) (holding that an ambulance service's challenges to the method by which Part B reimbursement decisions were made were within the jurisdiction of the court); Texas Medical Ass'n v. Sullivan, 875 F.2d 1160, 1165 (5th Cir. 1989) (holding that the court had no jurisdiction to review claims of physicians and beneficiaries that carriers misapplied the computation method).

229. *See infra* notes 230-290 and accompanying text.

230. Erika, Inc. v. United States, 634 F.2d 580, 583 (Ct. Cl. 1980), *modified*, 647 F.2d 129 (Ct. Cl. 1981), *rev'd on other grounds*, 456 U.S. 201 (1982).

231. *See* 42 U.S.C. § 1395u(b)(3)(B)(ii) (1988).

232. *See Erika*, 634 F.2d at 586-87.

233. *Id.* at 583-84.

234. *Id.* at 584.

list in Erika's previous year's catalog.[235] As a result, the reasonable charge reflected pricing some twelve- to twenty-four-months old.[236]

Exacerbating the issue was the shortage of a meat product needed to make the anti-clotting drug, heparin, used in kidney dialysis.[237] Erika raised its price on the drug several times, reflecting the substantial cost increases associated with the shortage.[238] Although a supplemental price list was sent to Prudential, the carrier did not change the reasonable-charge determination immediately.[239] When Prudential finally changed the determination, it did not apply the new reasonable charge retroactively.[240] After a fair-hearing review, in which the reasonable-charge determinations were upheld, Erika brought an action in federal court.[241]

The United States Court of Claims held that Prudential violated both the statute and the regulations because the prevailing charge determinations were based not on the "preceding calendar year" but on a single day—July 1.[242] The court held that "[t]he selection of the appropriate method of calculation [was] for Prudential to determine . . . . [T]he carrier has considerable discretion to adopt whatever method of calculation it concludes would most accurately measure and reflect Erika's customary charges during the preceding calendar year."[243] But this did not include disregarding "changes in Erika's prices during the preceding calendar year."[244] By ignoring both the statutory and regulatory directives, the carrier's determination was held invalid.[245]

Although the Supreme Court reversed the lower court's decision solely on jurisdictional grounds, without discussing the reasonable-charge issue,[246] the Court's recitation of the facts of the case appears to disagree with the lower court's analysis. The Court stated that "Prudential interpreted the relevant statute and regulations to define the 'reasonable charges' for respondent's product to be their [sic] catalog price as of July

235. *Id.* at 584, 588-89.

236. *See id.*

237. *See id.* at 584.

238. *See id.*

239. *See id.*

240. *See id.* at 584, 589.

241. *Id.* at 584.

242. *Id.* at 588.

243. *Id.* at 589.

244. *Id.*

245. *See id.*

246. *See* United States v. Erika, Inc., 456 U.S. 201, 206 (1982).

1 of the *preceding* calendar year."[247] The footnote to this statement emphasizes the word "preceding" two more times, possibly inferring that the prevailing charge was to be based on the price list of the *preceding* July 1 and not the current July 1.[248] This repeated emphasis could be interpreted to mean that the carrier had applied the regulation correctly and that the Court may have reversed on the merits as well.

The dispute in *Michigan Academy* focused on a regulation promulgated by the HHS Secretary that "permit[ted] carriers to establish separate prevailing charges for 'specialists' and 'nonspecialists' and specifically provide[d] that carriers can develop more than one set of prevailing charges based on fee patterns in a local area."[249] The Medicare carrier, Blue Cross and Blue Shield of Michigan, in interpreting this regulation, created three distinct groups of physicians: (1) hospital personnel and other interns; (2) board-certified or board-eligible specialists; and (3) general practitioners, family physicians, and other non-physicians such as chiropractors and podiatrists.[250] Thus, "patients receiving one type of service from a specialist [were] entitled to incur a higher reasonable charge, and therefore to receive a larger reimbursement than if they received the identical service from a non-specialist."[251]

Michigan Academy, a nonprofit corporation representing family physicians, challenged the regulation on the grounds that it violated the Medicare statute, had an "impermissible impact" on a patient's choice of physician, "unduly infringed the free practice of medicine," and violated

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247. *Id.* at 204 (emphasis added) (quoting 42 U.S.C. § 1395u(b)(3) (1976 ed. & Supp. IV)).

248. *See id.* at 204 n.2. The complete footnote reads:

> Claimants' reimbursable "reasonable charge" cannot exceed the "prevailing charge" calculated for "the locality." 42 U.S.C. § 1395u(b)(3) (1976 ed. and Supp. IV). In an effort to control the extent to which the Medicare program contributes to the inflation of medical costs, the "prevailing charge" formula is based on typical local rates for the *preceding* year. See 42 CFR § 405.504(a)(2)(i) (1980) (defining "prevailing charge" as the fee that "would cover 75 percent of the customary charges made for similar services in the same locality during the calendar year *preceding* the start of the 12-month period (beginning July 1 of each year) in which the claim is submitted or the request for payment is made") (emphasis added). Prudential defined respondent's own catalog price as the relevant "prevailing charge" because respondent was virtually the only provider of dialysis supplies within Prudential's locality.

Id.

249. *Michigan Academy I*, 728 F.2d 326, 327 (6th Cir.) (quoting 42 C.F.R. § 405.504 (1967)).

250. *Id.* at 328.

251. *Id.*

the Fifth Amendment by denying due process and equal protection.[252] The Sixth Circuit found that the "similar services" clause of 42 U.S.C. § 1395u(b)(3) had been violated.[253] Recognizing that deferential consideration must be granted to regulations promulgated by the HHS Secretary and emphasizing that caution must be exercised when overturning such regulations, the Sixth Circuit held that the regulation was invalid and ruled in favor of the plaintiff.[254]

Having found the regulation "statutorily unsound,"[255] the Sixth Circuit did not address the constitutional issues. Based on public-policy considerations, however, the court also held that the regulation was "irrational."[256] The Sixth Circuit agreed with the "district court's findings concerning the pernicious impact of this system on the cost of medical care."[257] The system induced physicians to become specialists and forced patients to seek specialists, even for routine health care.[258] The court concluded that this regulation infringed upon a patient's free choice of physicians.[259]

Erika and *Michigan Academy* presented two distinct fact patterns. In *Michigan Academy*, the "similar services" clause of the statute was violated,[260] while the violation in *Erika* concerned a carrier's interpretation and application of a regulation.[261] Arguably, in order to invalidate a reasonable-charge determination, the statute, not the regulation, must be violated.[262]

Michigan Academy, by creating the method/amount dichotomy, opened the doors to the federal courts that *Erika* and *Ringer* had previously closed. Subsequently, based on the *Michigan Academy* holding, some circuit courts reversed district court dismissals.[263] One case of

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252. *Id.*

253. *See id.* at 331-32 (citing 42 U.S.C. § 1395u(b)(3) (1988)).

254. *See id.* at 332.

255. *Id.* at 332 n.5.

256. *Id.* at 332.

257. *Id.*

258. *See id.*

259. *See id.* at 333.

260. *Id.* at 331-32.

261. *See* United States v. Erika, Inc., 456 U.S. 201, 204-06 (1982).

262. *See Michigan Academy I*, 728 F.2d at 330-31.

263. *See, e.g.*, Karnak Educ. Trust v. Bowen, 821 F.2d 1517 (11th Cir. 1987) (reversing the district court's dismissal based on lack of subject-matter jurisdiction, but affirming the court's dismissal for failure to state a cause of action); Medical Fund-Phila. Geriatric Ctr. v. Heckler, 804 F.2d 33 (3d Cir. 1986) (reversing the district court's dismissal based on lack of subject-matter jurisdiction and allowing plaintiffs to amend the

particular concern is *Linoz v. Heckler*.[264] In *Linoz*, the Ninth Circuit held that a rule created by the HHS Secretary denying Part B coverage for certain ambulance services was invalid because the rule was not authorized by statute and did not conform with the notice and comment procedures of the Administrative Procedure Act (APA).[265] Although this was a total denial of a benefit and not an amount determination, this case is notable because the Court of Appeals found jurisdiction by applying *Michigan Academy*, thus foreclosing the defendant's assertion that the "inextricably intertwined" rule of *Ringer* barred review.[266] Moreover, the court found the rule invalid because the rule was characterized as substantive and not interpretive.[267]

By applying the holding of *Linoz* to a reasonable-charge dispute, a substantive rule by the HHS Secretary would fall under the *Michigan Academy* side of the dichotomy.[268] Therefore, it would be a "method of computation" dispute. Thus, a reasonable charge determined by the application of such a rule, not promulgated pursuant to the Medicare statutes nor conforming to the APA requirements, would most likely be found invalid.[269]

Other cases appeared on the federal dockets asserting challenges to methodology. These cases, however, were held to be amount-determination disputes dressed up as method disputes to take advantage of the *Michigan Academy* rule.[270] Two of these cases, because of their

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complaint to allege federal-question jurisdiction); Linoz v. Heckler, 800 F.2d 871 (9th Cir. 1986) (reversing the district court's grant of summary judgment based on lack of subject-matter jurisdiction).

264. 800 F.2d 871 (9th Cir. 1986).

265. Pub. L. No. 89-554, 80 Stat. 378 (1966) (codified as amended at 5 U.S.C. § 553 (1988)); *see Linoz*, 800 F.2d at 877-78. The rule, promulgated by the HHS Secretary, was included in a manual for carriers and was not published in the Federal Register, thus violating the APA. *See id.* at 878 n.11.

266. *Linoz*, 800 F.2d at 875-76.

267. *See id.* at 877-78 n.10.

268. *See id.*

269. *See id.* at 878.

270. *See* Kuritzky v. Blue Shield, 850 F.2d 126, 128 (2d Cir. 1988) (holding that a plaintiff's assertion of "method" does not mean carrier's method of applying the regulation but method set forth in the Secretary's regulatory scheme), *cert. denied*, 488 U.S. 1006 (1989); American Ambulance Serv. v. Sullivan, 716 F. Supp. 861 (E.D. Pa. 1989) (finding no subject-matter jurisdiction because plaintiff's challenge did not specifically challenge any statutory provision or any rule, regulation, or policy promulgated by the Secretary), *rev'd*, 911 F.2d 901 (3d Cir. 1990); United States v. Ruegsegger, 702 F. Supp. 438, 447 (S.D.N.Y. 1988) (holding that a "disgruntled Medicare claimant cannot avoid the proscription of *Erika* by simply recasting a challenge to an [amount] determination as an

fact patterns and the dollar amounts in dispute, merit further examination.

In 1988, the Sixth Circuit once again was presented with a challenge to a reasonable-charge determination in *Association of Seat Lift Manufacturers v. Bowen*.[271] The court affirmed the lower court's dismissal of this pre-1987 claim dispute by applying the *Erika* ruling.[272] It applied *Erika* instead of *Michigan Academy* because here, "as in *Erika*, only [the] implementation of a method [and] not the method itself, was at issue."[273]

At issue were the reasonable-charge determinations of seat-lift chairs, used by persons who cannot rise or have difficulty rising from a sitting position.[274] Finding the prevailing charge for this item excessive, the carrier exercised its discretionary responsibility by using other data to establish a reasonable charge based on the "inherent reasonableness" provision of the exceptional-charge criteria.[275] The carrier, "[h]aving considered the entire formidable compendium of statistical and comparative information collected during its comprehensive survey,"[276] agreed with an HCFA letter citing a Sears seat-lift chair as an "'example' of available sources . . . ."[277]

Accordingly, the carrier determined the reasonable charge based on the cost of the Sears model listed in the 1985-1986 Sears Home Health Care "Specialog."[278] The plaintiff, representing medical-equipment suppliers, asserted that HCFA instructed the carrier to determine the reasonable charge based on the Sears model. The plaintiff characterized

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attack on methodology"); *see also* Texas Medical Ass'n v. Sullivan, 875 F.2d 1160, 1165 (5th Cir.) (holding that the semantics of the amount/methodology distinction must be transcended to review Part B claim disputes), *cert. denied*, 493 U.S. 1011 (1989); Association of Seat Lift Mfrs. v. Bowen, 858 F.2d 308, 317 (6th Cir. 1988) (holding that the plaintiff's characterization of the carrier's application of method is an amount determination and not a methodology dispute), *cert. denied*, 489 U.S. 1078 (1989); *cf.* Anderson v. Bowen, 881 F.2d 1, 3 (2d Cir. 1989) (holding that the plaintiff's characterization of the complaint "artfully tracks the mandate of [*Michigan Academy*]").

271. 858 F.2d 308, 308 (6th Cir. 1988), *cert. denied*, 489 U.S. 1078 (1989) [hereinafter *Seat Lift*].

272. *See id.* at 316-17.

273. *Id.*

274. *See id.* at 309-10.

275. *Id.* at 310-11.

276. *Id.* at 313-14.

277. *Id.* at 313.

278. *See id.* at 314.

this as a methodology subject to review under *Michigan Academy*.[279] The Sixth Circuit, however, ruled:

> challenges to statutes, regulations, and instructions prescribing Part B payment criteria, rather than challenges to the application of such criteria . . . were the only type of challenge that could not be adjudicated in a Carrier fair hearing. Because the instant plaintiffs essentially disputed only [the carrier's] application of the "inherent reasonableness" criterion in determining the reasonable charge . . . rather than the validity of the criterion itself, their so-called "method" challenge is actually a challenge to an amount determination . . . .[280]

This court narrowed, or at least refined, the *Michigan Academy* holding by requiring a direct and clear challenge to the validity of the statutes, the regulations, or the instructions.[281] Because the plaintiffs in *Seat Lift* did not specifically challenge the validity of the exceptional-charge criterion, their complaint was characterized as an amount dispute, which could only be reviewed in a fair hearing and not in federal court.[282]

A 1989 decision of the Fifth Circuit may further affect the distinctions of this dichotomy. In *Texas Medical Ass'n v. Sullivan*,[283] the carrier, while converting customary- and prevailing-charge data to a new information system, was unable to retrieve the reasonable-charge data for eighteen medical procedures.[284] In response to physician complaints about underpayment for these eighteen procedures, the carrier set the reasonable charge at the highest prevailing rate.[285] HCFA became aware of this situation, corrected the data, and found that the program overpayment totaled $13.3 million, paid to 5125 physicians and nearly 15,000 beneficiaries.[286] HCFA then directed the carrier to institute recoupment efforts.[287]

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279. *See id.* at 315.

280. *Id.* at 316.

281. *See id.*

282. *See id.* at 317.

283. 875 F.2d 1160 (5th Cir. 1989).

284. *See id.* at 1161-62.

285. *See id.* at 1162.

286. *See id.* at 1162-63.

287. *See id.* at 1163.

The plaintiffs sued to enjoin the carrier from implementing the recovery plan, and the district court granted the injunction.[288] The Fifth Circuit reversed, holding that there was no subject-matter jurisdiction because these were pre-1987 claims and the dispute involved a misapplication of the method of computation.[289] The Fifth Circuit was critical of the district court's finding of an improper payment methodology, stating:

> [the district court] failed to transcend the semantics of the amount/methodology distinction. It is crucial to go beyond semantics because all challenges to Part B benefit determinations can be recast as reviewable challenges to methodology since all awards of Part B benefits or payments are based on a method of calculation. To separate the grist from the chaff and method from amount, we must determine whether the challenge is to the validity of a rule, regulation, or instruction of the Secretary or merely a claim that [the carrier] "misapplied or misinterpreted valid rules and regulations." The amount/methodology distinction really boils down to a "distinction between the rules, regulations and statutes setting forth the proper computation method and the carrier's applications of those provisions in determining the benefits owed."[290]

As in *Seat Lift*, this court attempted to create a standard to test reasonable-charge challenges. In doing so, however, the "inextricably intertwined" concept of substance and procedure may have been resurrected. Although any amount determinations may be recast as method disputes, any legitimate method dispute that involves a benefit claim may fail the *Texas Medical* test because it can also be characterized as an amount dispute. Unless the challenge is so clearly removed from the benefit claim, all reasonable-charge disputes may be characterized as only carrier misapplication of the regulations and statutes.

3. Government Authority

Congress has the authority to create and perpetuate a payment standard based upon a reasonable-charge concept. The "legislation conferring monetary benefits is granted a 'strong presumption of

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288. *See* Texas Medical Ass'n v. Bowen, 678 F. Supp. 643, 644 (W.D. Tex. 1988), *rev'd sub nom.* Texas Medical Ass'n v. Sullivan, 875 F.2d 1160 (5th Cir. 1989).

289. *See* 875 F.2d at 1164-65.

290. *Id.* at 1165-66 (quoting Kuritzky v. Blue Shield, Inc., 850 F.2d 126, 128 (2d Cir. 1988), *cert. denied*, 488 U.S. 1006 (1989)).

constitutionality,' . . . because 'Congress should have discretion in deciding how to expend necessarily limited resources.'"[291] Furthermore, no case directly challenges this authority. Such silence may be regarded as a concession.[292]

Moreover, because of *Whitney v. Heckler*, it is unlikely that any direct challenge asserted today would survive.[293] In *Whitney*, plaintiffs challenged Congress's authority to freeze the customary and prevailing charge and to regulate the reasonable charge.[294] It is important to note that the plaintiffs "concede[d] that Congress has the power to regulate medical services and charges . . . but nevertheless insist[ed] that in doing so, Congress must provide an administrative mechanism to ensure that all doctors are guaranteed a 'reasonable' profit."[295] The Eleventh Circuit held that DEFRA did not deny physicians due process, and that freezing the customary and prevailing charge was neither a taking under the Fifth Amendment nor could be construed as a bill of attainder.[296] The court stated that the fee ceiling imposed by the legislation, which was "to reduce the federal deficit without placing the burden of such reduction solely on Medicare beneficiaries,"[297] was permissible because it was not arbitrary.[298] Moreover, the penalties imposed by DEFRA were constitutional because they were intended to further non-punitive goals.[299] With the Supreme Court denying certiorari,[300] Congress's authority to limit increases in the customary and prevailing charge, even on a temporary basis, in turn, strengthened Congress's authority to control physician fees.

In *Metrolina Family Practice Group, P.A. v. Sullivan*,[301] a district court held that the Tenth Amendment to the Constitution does not prevent

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291. Alexander v. Schweicker, 516 F. Supp. 182, 189 (D. Conn. 1981) (quoting Schweiker v. Wilson, 450 U.S. 221, 238 (1981) and Mathews v. De Castro, 429 U.S. 181, 185 (1976)). (Inconsistent spelling of litigant's name reflects lower court's mistake. The correct spelling is Schweiker.).

292. *See* Whitney v. Heckler, 780 F.2d 963, 968-69 (11th Cir.), *cert. denied sub nom.* Whitney v. Bowen, 479 U.S. 813 (1986).

293. *Id.*

294. *See id.* at 967.

295. *Id.* at 968-69.

296. *See id.* at 971-73.

297. *Id.* at 970.

298. *See id.*

299. *See id.* at 974.

300. *See* 479 U.S. 813 (1986).

301. 767 F. Supp. 1314 (W.D.N.C. 1989).

the government from controlling physician fees.[302] The court reasoned that because Medicare regulations "directly controlling a small area of medical practice"[303] constituted a valid exercise of Congress's power under the Spending Clause of the Constitution,[304] "the Tenth Amendment will not act as a bar to legislation that is 'plainly national in area and dimensions.'"[305] In addition, the court rejected plaintiff's arguments that the regulations created an unconstitutional taking under the Fifth Amendment[306] because "[i]t is well established that government price regulation does not constitute a taking of property where the regulated group is not required to participate in the regulated industry."[307]

Primarily, the courts have examined the validity of the reasonable charge at the regulatory level. In *Alexander v. Schweicker*,[308] plaintiffs directly challenged the method adopted by the Secretary for computing the annual Part B deductible.[309] They specifically "object[ed] to the . . . policy and practice of applying the officially-approved 'reasonable charge' for physicians' services" instead of the actual charge.[310] Having found mandamus jurisdiction under the Mandamus and Venue Act of 1962,[311] the district court held that the "construction of the statutory language [relating to the reasonable charge] is consistent with the Congressional intent reflected in the Medicare Act"[312] of imposing uniform reimbursements in order to discourage physicians from overcharging.[313] Therefore, a challenge to the reasonable charge will succeed only if the

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302. *Id.* at 1320.

303. *Id.* at 1321.

304. U. S. CONST. art. I, § 8 ("Congress shall have Power To . . . provide for the . . . general Welfare.").

305. 767 F. Supp. at 1321 (quoting Helvering v. Davis, 301 U.S. 619, 644 (1936)).

306. U.S. CONST. amend. V ("No person shall be . . . deprived of life, liberty, or property, without due process of law.").

307. 767 F. Supp. at 1322 (quoting Whitney v. Heckler, 780 F.2d 963, 972 (11th Cir.), *cert. denied sub nom.* Whitney v. Bowen, 479 U.S. 813 (1986)).

308. 516 F. Supp. 182 (D. Conn. 1981).

309. *Id.* at 183.

310. *Id.*

311. Pub. L. No. 87-748 § 1361, 76 Stat. 744.

312. *Alexander*, 516 F. Supp. at 187.

313. *Id.* at 188. The court stated: "[i]f physicians knew that their patients were more likely to receive Medicare Part B benefits if they were to charge those patients at *high* rates, the physicians would not be under the same pressure to conform their charges to prevailing rates as the existing Medicare Part B system requires." *Id.*

methodology of calculating the reasonable charge is found inconsistent with the program's purpose.

The customary-, prevailing-, and exceptional-charge criteria would most likely be found consistent with congressional intent. The permissibility of the regulatory criteria may be evidenced by the dictum in *Seat Lift*.[314] The court appears to affirm the validity of the exceptional-charge criterion because the carrier "is given wide discretionary judgment to consider inherent reasonableness criteria under those circumstances where use of customary and prevailing charge data alone would result in unreasonable costs."[315] The court's holding is based, however, on a challenge to the application of the method,[316] and the criteria may still be subject to examination. On the other hand, the court's dictum, if taken to its logical conclusion, might permit a carrier, deciding that customary- and prevailing-charge data yield an unacceptable result, to use an alternate method of broad scope.[317]

4. The Fair-Hearing Requirement

In *Michigan Academy*,[318] the Supreme Court stated:

> [a]s the Secretary has made clear, "the legality, constitutional or otherwise, of any provision of the Act or regulations relevant to the Medicare Program" is not considered in a fair hearing held by a carrier to resolve a grievance related to a determination of the amount of a Part B award.[319]

Nevertheless, two years later, in *Seat Lift*, the Sixth Circuit stated that "it is important to note that a Carrier fair hearing was available to adjudicate the validity of appellant's claims"[320] and then recited the particulars of the procedure approvingly.[321] The court then stated that "the existence of a hearing in the instant case significantly undercuts any argument for federal court jurisdiction."[322] Although never stated, it can be inferred

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314. *Seat Lift*, 858 F.2d 308, 310 (6th Cir. 1988), *cert. denied*, 489 U.S. 1078 (1989).

315. *Id.*

316. *Id.*

317. *See generally id.* at 310-16.

318. Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667 (1986).

319. *Id.* at 675-76 (quoting Medicare Carrier's Manual § 12016 (1985)).

320. *Seat Lift*, 858 F.2d at 316.

321. *See id.* at 317.

322. *Id.*

that the disputed amounts were in the millions of dollars.[323] Thus, even multi-million-dollar disputes must fulfill the fair-hearing requirement. Moreover, the application of the court's logic might mean that the existence of the fair-hearing procedure justifies the requirement, even in post-1987 cases.

The *Texas Medical* court likewise concluded that the fair hearing was the only review available, even when the amount in dispute was more than $13 million.[324] Furthermore, the court stated that because these challenges are matters for a fair hearing, the plaintiffs have "failed on the additional and now superfluous ground of failure to exhaust the administrative remedies before seeking relief from a federal district court."[325] This court may have imposed a fair-hearing requirement even if jurisdiction had been granted. While dismissing the case, the court emphasized the "bald faith we are placing . . . in the Secretary, HCFA and [the carrier] to prescribe a workable system that will . . . not impede the fundamental fairness due to all physicians and beneficiaries entitled to such review."[326] *Texas Medical* may have created a fair-hearing requirement for all reasonable-charge disputes, subject to a test of fundamental fairness.[327]

Isaacs v. Bowen,[328] however, may become the leading post-1987 case. Paradoxically, it returns almost full circle to *Erika* because it forestalls—though not forecloses—judicial review of amount determinations.[329] The plaintiffs, dissatisfied Part B claimants who disputed charges in excess of $500, were denied direct access to an ALJ because they had not first had a fair hearing.[330] The district court initially found for the plaintiffs, based on the Omnibus Budget Reconciliation Act of 1986.[331] But on a motion for reargument, the court reversed, holding that, based on the Omnibus Reconciliation Act of

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323. The court noted that more than 11,500 seat-lift chairs were sold to Medicare beneficiaries between April 1984 and March 1985. *See id.* at 313 n.5. The range of prevailing charges for this item was from $1150 to $2262. *Id.* at 311. The carrier determined a reasonable-charge of $869.51. *Id.* at 314. Even a $300 dispute would total almost $3.5 million for that year.

324. Texas Medical Ass'n v. Sullivan, 875 F.2d 1160, 1170 (5th Cir. 1989).

325. *Id.*

326. *Id.* at 1170-71.

327. *See id.* at 1160.

328. 865 F.2d 468 (2d Cir. 1989).

329. *See id.* at 478.

330. *See* Isaacs v. Bowen, 683 F. Supp. 930, 933 (S.D.N.Y. 1988), *aff'd*, 865 F.2d 468 (2d Cir. 1989).

331. Pub. L. No. 99-509 § 9341, 100 Stat. 2037-38; *see Isaacs*, 683 F. Supp. at 934.

1987,[332] it was Congress's intent to make appeals to an ALJ contingent on a preliminary fair hearing for amounts in dispute more than $100.[333]

The Second Circuit affirmed the decision.[334] Addressing a due-process challenge, the court cited *Schweiker v. McClure*[335] as upholding the constitutionality of the mandatory fair hearing.[336] The court found that even though there would be a nineteen-month delay between claim initiation and ALJ review,[337] "[r]egrettably, delay is a natural concomitant of our administrative bureaucracy."[338] Moreover, the court stated several times that Medicare benefits are not based on financial need, so the risk of government-created poverty is minimal.[339] Also, the court noted that most Part B claim disputes are brought not by the beneficiaries, but by the physicians.[340] Finally, echoing *Erika*, the court stated that "Part B covers supplementary medical services, not those primary services covered by Part A."[341]

Unanswered by this case is whether a method challenge likewise requires a fair hearing. Arguably, such a requirement exists simply because of the difficulty in distinguishing the dichotomy. The courts, having recognized that any amount determination may be recast as a method challenge,[342] could invoke the corollary that all method disputes may appear as amount disputes because a claim is usually involved. Because method disputes may be recast as amount disputes and amount disputes recharacterized as method disputes, it would be logical to assume that the courts would require a fair hearing for all disputes. In doing so, the *Texas Medical* semantics may not need to be transcended. Furthermore, by using the fair hearing and ALJ review as a filtering process, the courts might be able to alleviate docket congestion.

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332. Pub. L. No. 100-203 § 4082, 101 Stat. 1330-128; *see Isaacs*, 683 F. Supp. at 934-35.

333. *See Isaacs*, 683 F. Supp. at 932-35.

334. *See* Isaacs v. Bowen, 865 F.2d 468, 475 (2d Cir. 1989).

335. 456 U.S. 188 (1982).

336. 865 F.2d at 475 (citing Schweiker v. McClure, 456 U.S. 188 (1982)).

337. *See id.*

338. *Id.* at 477.

339. *See id.* at 476.

340. *See id.* The court offered no support. Doctors, however, are more likely to bring a lawsuit than an elderly ill person.

341. *Id.*

342. Texas Medical Ass'n v. Sullivan, 875 F.2d 1160, 1165 (5th Cir. 1989).

5. Afterview

Although the cases never presented a direct challenge to the validity of Congress's authority to create the reasonable charge,[343] there is no doubt that Congress has this right. All cases involving Medicare issues begin with a recitation of the Medicare program[344] and cite the statutes applicable to Part B amount disputes.[345] It cannot be disputed that Medicare is a lawful creation of Congress. Accordingly, Congress has the power to authorize the HHS Secretary to promulgate a methodology to be used to determine the reasonable charge.[346] A reasonable charge may be challenged if the Secretary's regulations do not comport with the Medicare statutes or if they violate a provision of the Administrative Procedure Act.[347] Similarly, a carrier's application of the method may, since 1987, be challenged in a federal court.[348] The carrier, however, has been given wide discretion by Congress, the Secretary, and the courts.[349] Furthermore, the imposition of a fair hearing in all claim disputes, though still uncertain, would appear to place the burden of proving a charge's unreasonableness on the claimant if the carrier is presumed to be correct.[350]

The fair-hearing requirement, along with all other challenges to a Medicare Part B amount determination, will most likely be rendered moot as the system shifts from the reasonable-charge payment method to the fee-schedule payment method. This is because Congress has expressly precluded both judicial and administrative review of: (1) any determination of the adjusted historical payment basis (i.e., the reasonable charge); (2)

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343. *See, e.g.*, Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667, 669 (1986) (recognizing that "[b]ecause it ruled in favor of respondents on statutory grounds, the District Court did not reach their constitutional claims," thereby avoiding any direct challenge to Congress's authority); United States v. Erika, Inc., 456 U.S. 201, 206 n.5 (1982) (noting that respondent declined to raise any constitutional claim).

344. *See, e.g.*, Isaacs v. Bowen, 865 F.2d 468, 469-70 (2d Cir. 1989); Whitney v. Heckler, 780 F.2d 963, 965-67 (11th Cir. 1986).

345. *See, e.g.*, *Whitney*, 780 F.2d at 965-66.

346. 42 U.S.C. § 1395u(b)(2)(A), (b)(3)(B) (1988).

347. 5 U.S.C. § 553 (1988); *see* Linoz v. Heckler, 800 F.2d 871, 878 (9th Cir. 1986); Buschmann v. Schweiker, 676 F.2d 352, 355-56 (9th Cir. 1982).

348. *See* 42 U.S.C. § 1395ff(c) (1988).

349. *See, e.g.*, Erika, Inc. v. United States, 634 F.2d 580, 589 (Ct. Cl. 1980) (noting that "[t]he carrier has considerable discretion to adopt whatever method of calculation it concludes would most accurately measure and reflect Erika's customary charges during the preceding calendar year.") *clarified in response to defendant's motion for reh'g*, 647 F.2d 129 (Ct. Cl. 1981), *rev'd on other grounds*, 456 U.S. 201 (1982).

350. *See supra* notes 2-12 and accompanying text.

any determination of the components of a fee-schedule amount; and (3) the establishment of the system for coding physician services.[351] Thus, an amount challenge to a future Part B claim brought in either an administrative or a judicial forum should be denied. If, however, the challenge is framed as a method dispute rather than an amount dispute, *Marbury v. Madison*[352] and *Bowen v. Michigan Academy*[353] might open the forum's door. Of course, whether the challenge would prevail on the merits of the case is a question that can only be answered based on the particular facts and circumstances of the case.

IV. LIMITING PHYSICIAN CHARGES

A. *Federal Action*

An important issue relating to the development of the Medicare program was not only what the physician-payment method would be, but also who would pay the physician fees.[354] The existing Blue Shield plans paid the physicians directly, while the commercial insurers usually reimbursed the patient.[355] The early Blue Shield plans required the physician to accept the Blue Shield payments as full compensation for services rendered, but competitive pressures from the commercial insurers required Blue Shield to keep their premiums low.[356] Thus, to maintain physician participation in the program, most Blue Shield plans found it necessary to permit physicians to charge patients amounts in excess of the Blue Shield payment rather than limiting their fees.[357] This practice of charging the patient more than what the insurer pays is called "balance billing."[358]

Balance billing represented the best of both worlds to the provider of service. It allowed a physician treating a Blue Shield patient to have the security of knowing that Blue Shield would pay at least the fee-schedule

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351. 42 U.S.C. §§ 1395 w-4(i)(1)(A), (i)(1)(B), (i)(1)(E) (1988).

352. 5 U.S. (1 Cranch) 137 (1803).

353. 476 U.S. 669 (1986).

354. MARMOR, *supra* note 35, at 85.

355. Law & Ensminger, *supra* note 41, at 15-16.

356. *Id.* at 16.

357. *Id.*

358. Massachusetts Medical Soc'y v. Dukakis, 815 F.2d 790, 790 (1st Cir. 1987). The common usage of the term "balance billing" refers to when a patient is liable for the difference between the bill and the benefit determination of the insurer. *See id.* For example, if a Blue Shield patient incurs a bill of $2000 for physician services in a hospital, and based upon a fee schedule, Blue Shield pays the doctor $1800, then the doctor would bill the patient $200, representing the balance remaining on the original bill. *See id.* at 793.

amount, while permitting the physician to bill the balance to the patient.[359] If the physician had not contracted with Blue Shield or if the patient was not a Blue Shield subscriber, the physician would bill the patient the entire fee, which the patient would pay directly to the physician.[360] The patient who had a commercial health-insurance policy could then submit a claim for reimbursement to the insurer.[361]

In 1965, the issue during the creation of the Medicare program was whether the program should pay physicians directly or reimburse the beneficiary.[362] To minimize the risk of patient nonpayment while extending their patient base, physicians naturally wanted both options.[363] A compromise was achieved whereby physicians could choose, at the time of service, whether to have Medicare or the patient designated as the payor. This was never a feature of any Blue Shield program. But similar to the early Blue Shield plans, if a physician opted for Medicare to be the payor, the reasonable charge, like the fee-schedule amount, had to be accepted as payment in full. Thus, although Medicare Part B was patterned after supplemental health insurance, the Medicare program included this modified Blue Shield component to satisfy the opposing views of those who wanted to impose fee schedules.[364]

Under Medicare parlance, a physician who accepts Medicare as the payor (and the reasonable charge as the fee) is said to "accept assignment."[365] A physician may accept assignment on a patient-by-patient, case-by-case, procedure-by-procedure, or even a charge-by-charge basis.[366] Unlike a Blue Shield contract, a physician was not required or obligated to accept the reasonable charge when treating a Medicare patient.[367]

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359. *See id.* at 793.

360. *See* Law & Ensminger, *supra* note 41, at 8.

361. *See id.* at 16.

362. MARMOR, *supra* note 35, at 80; *See also* American Medical Ass'n v. Bowen, 857 F.2d 267, 268 (5th Cir. 1988) (allowing physicians either to accept or to deny assignment on a case-by-case basis).

363. *See* MARMOR, *supra* note 35, at 80.

364. The Social Security Amendments of 1965, Pub. L. No. 89-97, § 1842(b)(3)(B), 79 Stat. 286, 309-10, states that the carrier

> will take such action as may be necessary to assure that . . . where payment . . . for a service is on a charge basis . . . such payment will be made on the basis of a receipted bill, or on the basis of an assignment under the terms of which the reasonable-charge is the full charge for the service.

Id.

365. Law & Ensminger, *supra* note 41, at 16.

366. *Id.*

367. *Id.*

In 1984, DEFRA created the status of the "Medicare participating physician."[368] Physicians were asked to sign twelve-month, irrevocable agreements in which they would agree to always accept assignment. As an inducement, the participating physicians would be listed in a special directory that would be mailed to enrollees without charge or made available by a toll-free telephone number.[369] Also, an electronic claims-receipt system would be developed that would expedite claim payment for participating physicians.[370] Notably, by contrast, those physicians who did not participate were prohibited from raising their fees to Medicare patients above the actual charge for the calendar quarter beginning April 1, 1984; those physicians who knowingly and willfully violated this prohibition were subject to both fines and exclusion from the Medicare program.[371]

Because only about thirty percent of physicians became participating physicians, Congress made further efforts to curtail the cost to Medicare beneficiaries who use non-participating physicians.[372] Congress enacted the Omnibus Budget Reconciliation Act of 1986 (OBRA 1986),[373] which required all non-participating physicians to charge no more than a maximum allowable actual charge (MAAC) for any service or procedure performed on any Medicare patient during 1987 and thereafter. Thus, a physician's ability to balance bill a Medicare patient, even though the patient was the payor, was restricted because the actual charges were now capped and monitored by HCFA.[374] The MAAC was calculated by determining either a weighted average or a median of the physician's previous actual charges.[375] Future MAAC determinations were indexed to the existing prevailing charge, thereby limiting a physician's ability to increase his fees.[376] This, in effect, meant that the gap between the reasonable charge and the MAAC would become less each year that the MAAC was computed.

Because of this computation method, the MAAC and the reasonable charge began to converge and would have eventually equaled each other.

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368. Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2306, 98 Stat. 494, 1070-73.

369. *See id.* at 1071.

370. *Id.*

371. *See id.*

372. Alfred J. Chiplin, *The MAAC: Medicare Cost Containment Efforts in OBRA 1986*, 21 CLEARINGHOUSE REV. 351, 351-52 (1987).

373. Pub. L. No. 99-509, § 9331(b), 100 Stat. 2018, 2019-20.

374. *See* Chiplin, *supra* note 372, at 351.

375. *Id.* at 352.

376. *See id.*

At that point, all non-participating physicians would have been, in effect, accepting assignment involuntarily because the reasonable charge would be the maximum charge that could be billed. This would mean that accepting assignment was federally mandated. Mandatory assignment, however, was rejected by Congress in 1984, based on a fear that physicians would not treat Medicare patients.[377] Therefore, the MAAC provisions of OBRA 1986, although designed to narrow the gap between participating and non-participating physicians, did not intentionally seek to force non-participating physicians to always accept assignment, but only to cap their bills.[378]

In 1989, as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989),[379] the MAAC was replaced by the limiting charge (LC). The LC is defined as a fixed percentage above the recognized payment amount, which would be the reasonable charge before January 1, 1992, and the fee-schedule amount for services furnished after January 1, 1992.[380] Congress set the LC at twenty-five percent for 1991,[381] twenty percent for 1992,[382] and fifteen percent for 1993 and thereafter.[383] A physician who knowingly and willfully bills above the LC on a repeated basis is subject to sanctions of both exclusion from the Medicare program for up to five years and a fine of up to $2000.[384]

B. *State Action*

While the MAAC and the LC were Congress's *sub rosa* attempts at legislating mandatory assignment, some states actively pursued such legislation. Currently, Connecticut, Massachusetts, and Pennsylvania have legislation prohibiting physicians from balance billing.[385] New York has a statute similar to the federal LC, which caps the maximum amount a physician may charge as a percentage over the reasonable charge.[386] Other states, such as Rhode Island, Montana, and Oregon, have notice statutes that require physicians to notify the Medicare beneficiary, before

377. *See* Law & Ensminger, *supra* note 41, at 41-46.

378. *See* Chiplin, *supra* note 372, at 352.

379. Pub. L. No. 101-239, § 6102, 103 Stat. 2106, 2181 (1989).

380. *See* 42 U.S.C. § 1395w-4(g)(2) (Supp. 1990).

381. *See id.* § 1395w-4(g)(2)(A).

382. *See id.* § 1395w-4(g)(2)(B).

383. *See id.* § 1395w-4(g)(2)(C).

384. *See id.* § 1395w-4(g)(1).

385. *See supra* text accompanying notes 29-31.

386. *See* N.Y. PUB. HEALTH LAW § 19 (McKinney Supp. 1992).

treatment, as to whether the physician accepts Medicare assignment as payment in full.[387]

1. Massachusetts

Massachusetts is the only state where Blue Shield limits payments to participating physicians by requiring them to accept program fees as full payment.[388] In 1978, the Massachusetts Medical Society (MMS) challenged this policy in an antitrust suit against Blue Shield of Massachusetts.[389] After six years of procedural disputes—including several motions for recusal and a certification of a state-law question to the state's Supreme Judicial Court—the district court found Blue Shield guilty of violating the Sherman Act by restraining trade.[390] Eight months later, the First Circuit reversed and held that Blue Shield's ban against balance billing was not an unreasonable restraint of trade because Blue Shield acted as a buyer of medical services for its subscribers.[391] The Supreme Court later denied certiorari.[392]

In 1985, Massachusetts enacted the first mandatory assignment legislation in the nation.[393] The statute mandated that the Board of Registration in Medicine

> shall require as a condition of granting or renewing a physician's certificate of registration, that the physician, who if he agrees to treat a beneficiary of health insurance under Title XVIII of the Social Security Act, shall also agree not to charge to or collect from such beneficiary any amount in excess of the reasonable charge for that service as determined by the United States Secretary of Health and Human Services.[394]

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387. *See* MONT. CODE ANN. § 53-5-901 (1991); OR. REV. STAT. § 677.099 (1991); R.I. GEN. LAWS § 5-37-22 (Supp. 1991).

388. Law & Ensminger, *supra* note 41, at 16.

389. *See* Kartell v. Blue Shield of Mass., Inc., No. 78-594-S, 1978 WL 1469 (D. Mass. 1978) (dismissing complaint on grounds that balance-billing policy was authorized by state law), *vacated and remanded*, 592 F.2d 1191 (1st Cir. 1979) (certifying the state-law question to the Massachusetts Supreme Judicial Court), *tried*, 582 F. Supp. 734 (D. Mass.) (finding that policy imposed unreasonable restraint on competition), *rev'd*, 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985).

390. *See Kartell*, 582 F. Supp. at 755.

391. *See Kartell*, 749 F.2d at 934.

392. *See Kartell*, 471 U.S. 1029, 1029.

393. MASS. GEN. LAWS ANN. ch. 112, § 2 (West Supp. 1992).

394. *Id.*

MMS brought suit against the Commonwealth of Massachusetts, alleging that the Medicare Act specifically created a right to balance bill.[395] In support of such right, MMS proffered the statute itself, which permitted physicians either to present an itemized bill or to accept assignment.[396] The argument was supported by the legislative history, which showed a compromise by Congress in 1965 to create this right to balance bill by legislating the dual-payment system.[397] The plaintiffs also relied on the failure of the mandatory assignment bill in Congress and the enactment of the participating physician program in 1984 as further evidence of this right.[398] Thus, it was argued that under the Supremacy Clause of the Constitution, Massachusetts had impermissibly enacted a law in opposition to the Medicare Act and that such law was void.[399]

The district court ruled against MMS. Judge Robert E. Keeton decided that the Supremacy Clause is applicable only when "a state law . . . stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress."[400] Although the Medicare Act permits balance billing, this was characterized as merely a method of payment and not a right created by Congress.[401] The Act evidenced no affirmative right and created no reasonable expectations of the right to be free from state regulation.[402] Therefore, the Massachusetts mandatory-assignment statute was constitutional.

On appeal, the First Circuit found that the evidence was "not sufficient to show that Congress intended to create a *right* to balance bill."[403] The presumption was that Congress did not intend to displace state law.[404] The court stated that "[i]f one rereads the language and history of the Medicare Act . . . one finds them (at most) ambiguous as to whether Congress meant merely to leave the practice of balance billing undisturbed or meant as well to create a balance billing right that the states could not alter."[405] The Supremacy Clause cannot preempt a state statute with such ambiguity. The court found that physicians' organizations may

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395. Massachusetts Medical Soc'y v. Dukakis, 637 F. Supp. 684, 700 (D. Mass. 1986), *aff'd*, 815 F.2d 790 (1st Cir.), *cert. denied*, 484 U.S. 896 (1987).

396. *See id.*

397. *See id.*

398. *Id.* at 701-02.

399. *Id.* at 687.

400. *Id.* at 687 (citing Hines v. Davidowitz, 312 U.S. 52, 67 (1941)).

401. *See id.* at 700.

402. *Id.*

403. *Massachusetts Medical Soc'y*, 815 F.2d at 793 (emphasis added).

404. *See id.*

405. *Id.* at 794.

have won a legislative victory in 1965 by stopping a federal ban on balance billing, but the victory did not include a federal prohibition against state regulation of physician fees.[406]

Regarding the argument that DEFRA and the failed mandatory assignment legislation of 1984 manifested a congressional intent to create a right to balance bill, the court was reluctant to apply failed legislation to evince Congress's earlier intent.[407] But even beyond that, the failed legislation "still does not unmistakably show a congressional intent to create the kind of indefeasible right with respect to which the Massachusetts law might seem to be an 'obstacle.'"[408]

The plaintiffs had asserted that physicians would stop treating Medicare patients and, thereby, frustrate the purpose of the Act.[409] The First Circuit disposed of this argument based on the fact that ninety-nine percent of all physicians in Massachusetts participate in Blue Shield, which had a similar ban.[410] Also, prior to mandatory assignment, Massachusetts physicians accepted assignment on ninety percent of all Medicare claims, accounting for ninety-four percent of all Medicare charges.[411] Furthermore, seventy-one percent of all Medicare patients were protected by the ban against balance billing under other insurance plans.[412] The court concluded that these facts made it difficult to believe that physicians were so sensitive to their fee levels that they would stop treating the elderly or leave the state.[413]

2. Pennsylvania

In 1991, Pennsylvania's mandatory assignment law was challenged by the Pennsylvania Medical Society.[414] Like the Massachusetts physicians, the plaintiffs argued that the sprawling Medicare legislation evidences a federal occupation of this field that preempts any and all state

406. *See id.*

407. *See id.*

408. *Id.*

409. *Id.*

410. *See id.* at 795.

411. *See id.*

412. *See id.*

413. *See id.*

414. *See* Pennsylvania Medical Soc'y v. Marconis, 755 F. Supp. 1305 (W.D. Pa.), *aff'd*, 942 F.2d 842 (3d Cir. 1991).

regulation.[415] Summary judgment was granted to the defendants,[416] and the medical society appealed.[417]

Seven months after the district court's memorandum opinion, the Third Circuit affirmed, framing the issue as purely a question of congressional intent.[418] Following the decision of the First Circuit, the Third Circuit held that without clear evidence of congressional intent to preempt any state regulation of billing practices, the state statute is valid. The court held that "clear proof is a requirement for a finding of preemption because courts are not eager to find that a state is precluded from acting pursuant to its police powers."[419] Chief Judge Dolores K. Sloviter dissented:

> [t]he issue before us is not whether balance billing of Medicare patients is good or bad, reasonable or unreasonable, social or antisocial. It is simply whether beneficiaries and participants in a carefully titrated federal program which has, since its inception, sought to accommodate the views and needs of patients and providers alike, should be compelled to rely for their protection from what may be deemed to be excess charges on the statute and administrative scheme Congress enacted and supervises or whether the various states may superimpose their own, and potentially different, schemes.[420]

The dissent argued that any state scheme that permitted balance billing either above or below the LC levels set by Congress, or one that completely eliminated balance billing, conflicts with congressional intent.[421]

3. New York

Three months after the Third Circuit handed down its decision, the District Court for the Southern District of New York addressed the same issue in *Medical Society of New York v. Cuomo*.[422] There, plaintiffs

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415. *See id.* at 1308.

416. *See id.* at 1313.

417. *See Pennsylvania Medical Soc'y*, 942 F.2d at 842.

418. *See id.* at 847.

419. *Id.* at 857.

420. *Id.* at 861-62 (Sloviter, C.J., dissenting).

421. *See id.* at 861.

422. 777 F. Supp. 1157 (S.D.N.Y. 1991), *aff'd*, No. 91-9364, slip op. 7043 (2d Cir. Sept. 24, 1992).

challenged a New York law[423] capping the amount by which physicians could balance bill their patients.[424] These caps were lower than the balance-billing caps set by Congress in 1989.[425] The plaintiffs contended that the New York law not only was preempted by the Medicare Act but also violated the Due Process Clause of the Fourteenth Amendment of the federal constitution.[426] The district court, however, granted New York's motion for summary judgment on both issues.[427]

The district court observed that the regulation of public health was an area of traditional state power,[428] and that "the party arguing preemption [in such a case] carries the heavy burden of showing that preemption was the 'clear and manifest purpose of Congress.'"[429] In short, the district court held that the plaintiffs failed to meet this burden.[430] Moreover, the court rejected the argument that Congress's regulation of physician balance billings created an unadjustable "safety valve."[431] The court stated that there was no evidence "that Congress' safety valve was meant to bind each and every state."[432]

On appeal, the Medical Society of New York challenged the district court's finding that no preemption existed.[433] The Second Circuit affirmed the lower court's finding that Congress had not preempted state regulation of a Medicare provider's balance billing, either expressly[434] or impliedly.[435] Moreover, the court relied on Congress's silence following the enactment by several states of regulations proscribing or limiting balance billing as tacit approval of the practice.[436] While acknowledging that "congressional silence provides a squishy reed upon which to base . . . intent,"[437] the court noted that the Third Circuit had

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423. N.Y. PUB. HEALTH LAW § 19 (McKinney Supp. 1992).

424. 777 F. Supp. at 1159.

425. *Id.*

426. *Id.* at 1158.

427. *Id.*

428. *Id.* at 1160-61.

429. *Id.* at 1160 (quoting Pacific Gas & Electric v. State Energy Resources Comm'n, 461 U.S. 190, 206 (1989)).

430. *Id.* at 1163, 1164.

431. *Id.* at 1164.

432. *Id.*

433. *See* No. 91-9364, slip op. at 7045 & n.1.

434. *See id.* at 7051.

435. *See id.* at 7054, 7059, 7060-61, 7062.

436. *See id.* at 7054-55.

437. *See id.* at 7056.

also relied on Congressional silence in response to state regulation of physician balance billing.[438]

4. Summary

From the affirmance of *Medical Society of New York*[439] and the denial of certiorari in *Massachusetts Medical Society*,[440] it would appear that, on a state level, mandatory assignment passes constitutional muster. The significant effect of mandatory assignment is that it removes the beneficiaries as plaintiffs in any reasonable-charge litigation.[441] Because balance billing is eliminated, most beneficiaries are only liable for the twenty percent of coinsurance that Medicare does not pay. Many Medicare beneficiaries have Medicare supplemental—or Medigap—insurance that is specifically designed to pay this twenty percent.[442] Thus, because the patient is reimbursed for 100 percent of the charges, it is highly unlikely that a beneficiary would challenge a reasonable-charge determination.

Mandatory assignment, while removing the beneficiaries as possible litigants, increases the likelihood of litigation brought by physicians. Without the freedom to decide when, and from whom, to accept assignment, physicians have more incentive to challenge the wide array of reasonable-charge determinations. Moreover, physicians are highly organized and have the resources to mount sustained challenges.[443] The potential economic benefits of a redetermination could be substantial.[444] The sheer economic motivation might cause the AMA to accumulate and assemble its own reasonable charges, based on the method of computation proposed by the regulations and statutes, and to challenge the carrier's application directly. Thus, the notable effect of Section 9305 of Title IX of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA

438. *Id.* at 7056-57 (citing Pennsylvania Medical Soc'y v. Marconis, 942 F.2d 842, 850 (1991)).

439. No. 91-9364, slip op. 7043 (2d Cir. Sept. 24, 1992).

440. Massachusetts Medical Soc'y v. Dukakis, 484 U.S. 896 (1987).

441. *See generally* Law & Ensminger, *supra* note 41, at 21 & n.105 (noting that "the Massachusetts Medical Society has devoted enormous resources to demonstrating that mandatory assignment is harmful and illegal").

442. *See generally id.* at 15 (noting that "if fees are too low doctors may refuse to participate" in mandatory-assignment programs).

443. *See id.* at 53.

444. *See, e.g.*, Texas Medical Ass'n v. Sullivan, 875 F.2d 1160 (5th Cir. 1989); Association of Seat Lift Mfrs. v. Bowen, 858 F.2d 308 (6th Cir. 1988), *cert. denied*, 489 U.S. 1078 (1989).

1985),[445] which was enacted in order to help the beneficiaries,[446] may instead benefit the physicians by allowing judicial review of large-dollar disputes. The ability to challenge amount determinations, however, is subject to whether physician-payment reform effectively has insulated the new fee schedule from any administrative and judicial review.[447]

V. PHYSICIAN PAYMENT REFORM

In 1986, as part of COBRA 1985,[448] Congress created the "Physician Payment Review Commission" (Commission). The Commission's purpose was to "mak[e] recommendations to the Congress, not later than March 31 of each year . . . regarding adjustments to the reasonable charge levels for physicians' services . . . and changes in the methodology for determining the rates of payment, and for making payment, for physicians' services."[449] In addition, COBRA 1985 authorized the HHS Secretary to "develop a relative value scale that establishes a numerical relationship among the various physicians' services for which payment may be made under [Part B]."[450]

The Commission's recommendations, along with the development of a resource-based relative-value scale (RBRVS), were introduced in both houses of Congress under legislation known as the "Physician Payment Reform Act of 1989."[451] The supporters of RBRVS stated that the new system would make payments to physicians "more fair and more workable" because payments would be made according to the cost of providing care.[452] In doing so, unfairness in the Medicare system would be eliminated so that physicians would not be discouraged "from seeing patients in rural America or in innercities."[453] Also, RBRVS proponents said that the system would eliminate the current "distorted financial incentives to over-provide expensive procedures."[454] Under this view,

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445. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9305(a), 100 Stat. 82, 190 (current version at 42 U.S.C. § 1395w-1 (1988)).

446. *See* 131 CONG. REC. S10,808 (daily ed. Aug. 1, 1985) (introduction of the legislation by Sen. Durenberger).

447. *See supra* notes 359-361 and accompanying text.

448. Pub. L. No. 99-272, § 9305(a), 100 Stat. 82, 190.

449. *Id.* § 9305.

450. *Id.* § 9305(b), 100 Stat. at 192 (codified at 42 U.S.C. § 1395w-1(e) (1988)).

451. S. 1809, 101st Cong., 1st Sess. (1989); H. 2629, 101st Cong., 1st Sess. (1989). *See also* 135 CONG. REC. E2142 (daily ed. June 14, 1989) (House bill); 135 CONG REC. S14,423 (daily ed. Oct. 31, 1989) (Senate submission of amendments by Sens. Durenberger and Rockefeller).

452. 135 CONG REC. S14,423 (daily ed. Oct. 31, 1989) (statement of Sen. Rockefeller).

453. *Id.*

454. *Id.*

RBRVS would "protect beneficiaries . . . help stabilize program costs . . . and promote better medicine and a better distribution of medical resources."[455]

This legislation was incorporated in OBRA 1989, which was passed on December 19, 1989.[456] It provided that, effective January 1, 1992, payments for all physician services for which payment is otherwise made on the basis of a reasonable charge will instead be based on the lesser of (i) the actual charge for the service, and (ii) the amount determined under the fee schedule established by the Secretary of HHS within the parameters of the statute.[457] Specifically, the fee-schedule amount for all physician services furnished in all fee-schedule areas (i.e., a Medicare "locality")[458] will be equal to the product of: (1) the relative value for the service; (2) the geographic adjustment factor for the service for the fee schedule area; and (3) the conversion factor for the year.[459]

The relative value for any service under the statute is determined through a methodology developed by the Secretary that combines a "work component," a "practice expense component," and a "malpractice component."[460] A work component is defined as the portion of the resources used in furnishing the service that reflects the physician's time and intensity in furnishing the service, which includes activities before and after direct patient contact.[461] The practice expense component is defined as the portion of the resources used in furnishing the service that reflects the general categories of expenses (such as office rent and personnel wages but excluding malpractice expenses) comprising practice expenses.[462] The malpractice component is defined as the portion of the resources used in furnishing the service that reflects malpractice expenses in furnishing the service.[463]

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455. *Id.*

456. *See* 42 U.S.C. § 1395w-4 (1988).

457. *Id.* §§ 1395w-4(a)(1)(A), (B).

458. *See supra* note 159 and accompanying text.

459. 42 U.S.C. § 1395w-4(b)(1). The general formula to determine a fee schedule payment is the product of the following:

Payment = RVUts × GAFtA × CF

where

RVUts = total Relative Value Units for service
GAFtA = total Geographic Adjustment Factor for fee schedule Area
CF = uniform national Conversion Factor.

Id.

460. *See id.* § 1395w-4(c)(2)(A).

461. *See id.* § 1395w-4(c)(1)(A).

462. *See id.* § 1395w-4(c)(1)(B).

463. *See id.* § 1395w-4(c)(1)(C).

Under this statutory scheme, the Secretary is authorized to use extrapolation and other techniques to determine the number of relative value units (RVUs) for physician services for which specific data are not available, taking into account Commission recommendations and the results of consultations with organizations representing physicians who provide such service.[464] Moreover, in determining the practice expense and malpractice RVUs, the Secretary must factor in the "base allowed charges" for the service, defined as the national average of allowed charges for services furnished during 1991 as estimated by the Secretary using the most recent available data.[465] Thus, reasonable-charge data, albeit not directly incorporated into the new fee-schedule methodology, may indirectly be factored into fee-schedule amounts through the above application.[466]

The RVU for any service is then adjusted by a geographic adjustment factor.[467] This factor is equal to the sum of the following three factors determined by indices established by the Secretary:[468] (1) a geographic cost-of-practice index, which reflects the relative costs of the mix of goods and services comprising practice expenses (other than malpractice expenses) in the different fee-schedule areas compared to the national average of such costs; (2) a geographic malpractice adjustment factor, which reflects the relative costs of malpractice expenses in the different fee-schedule areas compared to the national average of such costs; and (3) a geographic physician work adjustment factor, which reflects one-fourth of the difference between the relative value of the physician's work effort in each of the fee-schedule areas and the national average of such work effort.[469] Each of these three factors is a product of the proportion of the total relative value for the service that reflects the RVUs for the applicable practice expenses, malpractice, and work component, multiplied by the appropriate index value.[470] In other words, this factor is equal to a weighted average of the individual adjustment factors for each of the three

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464. *See id.* § 1395w-4(c)(2)(A)(ii).

465. *See id.* § 1395w-4(c)(2)(C), (D).

466. *See* 56 Fed. Reg. 59,502 (1991) (to be codified at 42 C.F.R. § 415). The regulation states:

> [u]nder the formula specified at section 1848(c)(2)(C), the practice expense and malpractice RVUs are based on historical data for practice expense as a fraction of total physician revenue, weighted by specialty, applied to estimate 1991 average allowed charges under the customary, prevailing, and reasonable charge methodology.

Id.

467. *See* 42 U.S.C. § 1395w-4(e) (1988).

468. *See id.* § 1395w-4(e)(1), (2).

469. *See id.* § 1395w-4(e)(1)(A).

470. *See id.* § 1395w-4(e)(3), (4), (5).

RVU components.[471] The law does not specify the methodology to be used in developing these geographic practice-cost indices (GPCIs); instead, it leaves the methodology to the Secretary's discretion.

In order to convert the geographically adjusted RVU into a dollar amount, a conversion factor is used.[472] The statute requires that the conversion factor be budget-neutral relative to the 1991 predicted expenditure levels so that the total payments under the fee schedule would be the same as total payments expected in 1991 under the reasonable-charge payment methodology.[473] The statute requires the Secretary to recommend to Congress by April 15 of each year an update to the fee-schedule conversion factor for the following calendar year, taking into account: (1) the percentage change in the Medicare Economic Index (MEI)[474] for that year; (2) the percentage generally by which expenditures for all physician services for the fiscal year ending in the year preceding the year in which such update is made were greater or less than actual expenditures for such services in the fiscal year ending in the second preceding year; (3) the relationship between the percentage in (2) for a fiscal year and the performance-standard rate of increase[475] for that

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471. *See* 56 Fed. Reg. 59,502 (1991) (to be codified at 42 C.F.R. § 415). Separate GPCIs have been developed for the three components of the fee schedule. Under section 1848(e) of the Act, the GAF is equal to a weighted average of these three GPCIs. To compute the adjustment factor:

Payment = RVUtS × [(GPCIwA × w%S) + (GPCIpeA × pe%S) + (GPCImA × m%S)] × CF

where

GPCI = Geographic Practice Cost Index
RVUts = total Relative Value Units for service
GPCIwA = GPCI value reflecting ¼ of the geographic variation in physician work applicable in the fee schedule Area
w%S = Work percentage for Service S
GPCIpeA = GPCI value for practice expense applicable in the fee schedule Area
pe%S = practice expense percentage for Service S
GPCImA = GPCI value for malpractice expense applicable in the fee schedule Area
m%S = malpractice percentage of Service S
CF = uniform national Conversion Factor

Id.

472. *See* 42 U.S.C. § 1395w-4(b)(1)(B).

473. *See id.* § 1395w-4(d)(2)(E)(i).

474. The Medicare Economic Index is an inflation index. *See* § 1395u(b)(3).

475. The Medicare volume performance standard rate of increase is another factor which Congress and the Secretary quantify each year. As with the conversion factor update, the Secretary is to recommend to Congress an annual performance standard rate of increase for all physicians' services, taking into consideration (1) inflation; (2) changes in number of enrollees; (3) changes in the age composition of enrollees; (4) changes in technology;

fiscal year; (4) changes in either volume or intensity of services; (5) access to services; and (6) other factors contributing to changes in the volume or intensity of services or access to services.[476] Additional factors that the Secretary may consider are: (1) unexpected changes by physicians in response to the implementation of the fee schedule; (2) unexpected changes in outlay projections; (3) changes in the quality or appropriateness of care; and (4) any other relevant factors not measured in resource-based payment methodology.[477] Congress may choose to enact the Secretary's recommendation, to enact some other update amount, or not to act at all.[478] If Congress does not act, the annual update is set according to a "default" mechanism in the law.[479] This update will differ from the Secretary's MEI-based estimate by the same percentage by which actual expenditures in the second previous fiscal year were less or greater than the performance-standard rate of increase for that fiscal year.[480] The Medicare volume performance-standard rate of increase is another component in the conversion factor. In 1990, it was equal to the sum of the Secretary's estimate of the weighted average percentage increase in the reasonable charge for physicians' services.[481] HCFA expects to publish in the Federal Register by October 31 of each year a separate notice providing the annual updates and the performance-standard rates of increase.[482]

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(5) evidence of inappropriate utilization of services; (6) evidence of lack of access to necessary physicians' services; and (7) any other factor which the Secretary considers appropriate. § 1395w-4(f).

476. *See* § 1395w-4(d)(2)(A).

477. *See id.* § 1395w-4(d)(2)(B).

478. *See* 56 Fed. Reg. 59,502 (1991) (to be codified at 42 C.F.R. § 415).

479. *See* 42 U.S.C. § 1395w-4(d)(3)(A).

480. *See id.* § 1395w-4(d)(3)(B)(i).

481. *See* 56 Fed. Reg. 59,502 (1991) (to be codified at 42 C.F.R. § 415).

482. The regulations present this capsulation of the methodology used in determining the fee-schedule amount:

> The work, practice expense, and malpractice percentages are the fraction of the total RVUs for a service represented by the work, practice expense, and malpractice RVUs, respectively; they sum to 100 percent. In effect, this statutory formula accomplishes separate adjustment of each of the three components of the total RVUs for each service by the value for the fee schedule area of a GPCI specific to that component. (The statute specifies, however, that only one-fourth of the geographic variation in physician work resource costs is to be taken into account in the formula.) The three GPCI-adjusted RVU values are summed to produce a total RVU value, which is converted into a dollar payment amount specific to that service and that fee schedule area by application of a uniform, national CF. Thus, for ease of computation and understanding, we have transformed the original formula stated above into an algebraic equivalent as follows:

It would appear that the Medicare reasonable-charge payment methodology has been transcended by Congress into a Medicare reasonable-fee-schedule payment methodology. Although a pure theoretical methodology might develop RVUs independent of the reasonable charge, the fact is that HCFA's primary source of national-level claims data used for developing the fee schedule was the Part B Medicare annual data (BMAD) files (Procedure, Provider, and Beneficiary files). In order to use the most complete data available, HCFA primarily used "aged" 1989 BMAD files for calculating the national CF and for calculating the practice expense and malpractice RVUs.[483] Thus, the reasonable charge has been incorporated into the new fee schedule. Moreover, the transition period, which phases in the fee schedule, uses the reasonable charge but calls it the "adjusted historical payment basis."[484]

Although "comparable service . . . under comparable circumstances" and "customary charges for similar services" may no longer be a part of the new methodology, their legal import has not been repealed by Congress.[485] Therefore, the reasonable charge, relegated to methodological history, will maintain its posture as a term of art and thus as a legal concept.

VI. CONCLUSION

Contrary to the original statutory language, the reasonable charge is no longer a method that limits a physician's fee to what is usually charged. Congress, the HHS Secretary, HCFA, and the Medicare Part B carriers have transformed the reasonable charge into a statistic-driven control device that regulates the fees that physicians can charge. Essentially, the reasonable charge has been transformed into a national reasonable fee schedule. As a legal concept, however, the reasonable charge will remain viable until Congress strikes it from the Medicare statutes.

The significance of both the mandatory-assignment statutes and the national fee-schedule legislation is that they remove the beneficiary from

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Payments = [(RVUwS × GPCIwA) + (RVUpeS × GPCIpeA) + (RVUmS × GPCImA)] × CF,

where

RVUwS = Physician work Relative Value Units for the service;
RVUpeS = Practice expense Relative Value Units for the service;
RVUmS = Malpractice Relative Value Units for the service.

56 Fed. Reg. 59,502 (1991) (to be codified at 42 C.F.R. § 415) (emphasis added).

483. *See* 56 Fed. Reg. 59,502 (1991) (to be codified at 42 C.F.R. § 415).

484. *See* 42 U.S.C. § 1395w-4(a)(2)(A)(i).

485. *See* § 1842(b)(3), 79 Stat. at 310.

the payment process. Thus, beneficiaries will no longer have to contend with the Medicare appeals process regarding amount determinations. Of course, entitlement to coverage disputes will still involve these beneficiaries with the system, and there will be cases in which treatment is not performed because it is not covered by Part B. Beneficiaries, however, will no longer be subject to the practice of balance billing, and their major concern will be their deductible and coinsurance portions, unpaid by Medicare.

The implementation of mandatory assignment or the transfer from a reasonable-charge standard to a fee-schedule standard, however, does not eliminate amount-determination disputes. The difference is that physicians, along with other providers of service, will become the principal parties in amount-dispute litigation. Physicians have the resources, the political influence, and the motivation to challenge these fee-schedule amount determinations. Moreover, they have the ability, through their organizations, to compile and assemble their own determinations of what a proper fee schedule should be. Thus, physicians are best able to meet these burdens of production.

Whether the courts will want to try these amount disputes is another issue. The case law indicates that these disputes will be divided into two groups: (1) those challenging the method of computation of the fee amount, along with the various adjustment factors; and (2) those challenging the computation or application of the method. Based on the holding of the Second Circuit,[486] as well as the dicta of the Fifth[487] and Sixth[488] Circuits, the latter computation challenges would have to exhaust all administrative remedies, particularly the carrier fair hearing, before a federal court would accept jurisdiction. These same cases, however, may impose the fair-hearing requirement even for method disputes, given the interchangeability of these issues. Therefore, it is likely that fair hearings would be required for all amount-determination challenges, whether they are reasonable-charge or reasonable-fee-schedule challenges. But the courts may strictly construe the administrative- and judicial-review preclusion of the Physician Payment Reform Act, thus preventing relief for both the beneficiary and the provider of service.

Finally, it must be noted that the above analysis may fundamentally impact health-care reform implementation in the 1990s. It is uncertain to

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486. *See* Isaacs v. Bowen, 865 F.2d 468, 475-77 (2d Cir. 1989).

487. *See* Texas Medical Ass'n v. Sullivan, 875 F.2d 1160, 1164-70 (5th Cir. 1989).

488. *See* Michigan Academy of Family Physicians v. Blue Cross and Blue Shield, 728 F.2d 326, 329-30 (6th Cir.) (holding that the district court did not have proper jurisdiction to review plaintiffs' claims when administrative remedies were available), *cert. granted and vacated sub nom.* Heckler v. Michigan Academy of Family Physicians, 469 U.S. 807, *remanded sub nom.* Michigan Academy of Family Physicians v. Blue Cross and Blue Shield of Michigan, 751 F.2d 809 (6th Cir. 1984), *order rescinded*, 757 F.2d 91 (6th Cir. 1985), *aff'd sub nom.* Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667 (1986).

what extent Medicare Part B amount-determination disputes will be relevant. However, the difference between the federal government creating a health-insurance program for the elderly and federal occupation of the entire national health-care industry through price control is great. Thus, Medicare statutory and case law history may come to play an important role in shaping America's health-care destiny.

Stewart Reifler