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Federal Medicare Law Does Not Preempt State Regulation of HMOs

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Federal Trade Commission ("FTC") decisions interpreting "trade or commerce" in the context of professional practices.

The court noted that federal and state court opinions drew a clear distinction between the business aspects of professional practice, as opposed to the actual or non-business aspects. The United States Supreme Court declared that setting a county-wide minimum fee schedule for title examinations constituted a business aspect of law and was therefore subject to federal antitrust regulations. Conversely, an Illinois state court held that the issue of attorney malpractice was a non-business aspect of the legal profession and was thus not subject to regulation under the Act. The Illinois court exempted the actual practice of law from the Act's coverage because, unlike other commercial service industries, the practice of law was already subject to regulation by governmental bodies and by its own professional organizations.

Using this same line of reasoning, the court deduced that the "actual practice of medicine" must likewise include those aspects of the medical practice which receive comprehensive training or which the professions regulate themselves. However, unlike legal and medical malpractice, the court noted there were no professional or governmental regulations for service contracts between hospitals and clinics. Therefore, the court determined that only the actual practice of medicine, not the business aspects of the profession, such as a service contract between a hospital and a clinic, escaped the Act's jurisdiction.

The court found further support for its conclusion regarding the meaning of "trade or commerce" in the FTC decisions. The court noted that according to the Act, when questions of interpretation arise, courts must consider the FTC's interpretations of the appropriate antitrust provision. The court found that the FTC decisions clearly showed an intent to regulate both the actual and the business practice of medicine, thereby supporting a more expansive coverage of professional organizations than that under the Act.

In response, SMH and Newman further asserted that Congress actually intended to treat contracts for medical services differently than ordinary commercial contracts. The court, however, refused to recognize such a distinction since the issue concerned the commercial effect of the contract and its impact on consumers in the community.

Patients Deceived by Undisclosed Kickback Scheme

In their second argument, SMH and Newman stated that even if the arrangement constituted an unfair trade practice, Gadson failed to show that the agreement deceived consumers, the second requirement of the Act. The court disagreed, finding that the alleged "kickback scheme," where Newman's Clinic received a fee for each patient admitted to the SMH program, amounted to deceptive trade practices.

The court found Newman's practices deceptive for two reasons. First, relying on Illinois case law, the court stated that SMH and Newman had an obligation to affirmatively disclose the kickback arrangement to their patients. The court refused to accept their argument that the $90 fee was not a kickback, but was instead compensation for medical services rendered by Newman's doctors. Regardless of whether the $90 amounted to compensation, absent any evidence from SMH or Newman that they provided the patients with information about the arrangement, the court held that the kickback arrangement deceived health care consumers.

Secondly, the court held that the arrangement increased costs to health care consumers as a result of the deceptive practices it encouraged. The court focused on studies showing that financial incentives, such as kickback arrangements, prompted doctors to artificially exploit the demand for health care in order to increase revenue. The court reasoned that exploitation of consumers under the SMH/Newman arrangement could occur through unwarranted extended hospitalization and other unnecessary inpatient treatment.

The court concluded that Gadson's allegations of deceptive trade practices, which injured medical consumers and other competing health care providers in the area, were within the jurisdiction of the Act. Accordingly, the court denied SMH and Newman's motion to dismiss and ruled that Gadson could file suit and attempt to claim relief against SMH and Newman's Clinic under the Act. ❖

— *Laura M. Zubor*

Federal Medicare Law Does Not Preempt State Regulation of HMOs

In *Solorzano v. Family Health Plan Inc.*, 13 Cal. Rptr. 2d 161 (Cal.App. 1992), the California Court of Appeals held that the federal statute and regulations governing the marketing practices of Medicare-qualified health maintenance organizations did not preempt state unfair business practice and consumer protection statutes.

What a Deal

Ada Solorzano, America Rodriguez, and Dolores Morales ("Patients") agreed to assign their federal Medicare and state Medi-Cal benefits to Family Health Plan ("FHP"), a health maintenance organization ("HMO") that conducted a coordinated care plan for Medicare beneficiaries. FHP agents assured the individuals that they could continue to see their own doctors, who did not participate in the plan, for a "nominal" fee. In fact, however, FHP allowed use of non-participating doctors only in emergencies. Except in these instances, the doctors either turned away the patient or billed them in full for the services.

The Patients consequently withdrew from the FHP plan and sued. They claimed that the HMO's practices violated both California civil code provisions against deceptive practices in consumer transactions and the state business and professional code. The three individuals sought to enjoin the FHP's allegedly deceptive trade practices. They further requested general and punitive damages for fraud and intentional infliction of emotional distress. In response, FHP argued that the court should dismiss the claims because federal Medicare statute and regulations controlled, and therefore the case belonged in federal, not state court. The trial court granted FHP's motion to dismiss, and the Patients appealed.

The Medicare Regime

Medicare, a federal health insurance program primarily for the aged, pays most benefits through a traditional fee-for-service arrangement. In this arrangement, doctors and hospitals send bills for services rendered directly to Medicare. Additionally, HMOs and other coordinated care plans provide all services covered by Medicare, and sometimes more, at little or no added cost. However, in these programs, beneficiaries forfeit the right to seek care from outside doctors and hospitals.

The Health Insurance for the Aged Act, 42 U.S.C. 1395 *et seq.* (the "Medicare Act") governs Medicare. The section governing the relationship between Medicare and health plans, such as HMOs, authorizes the Health Care Financing Administration (the "Administration") to set rules and procedures for enrolling Medicare beneficiaries. The Administration must also review and approve all promotional materials used by health plans. Plans that misrepresent or falsify information provided to any individual are subject to civil fines.

The federal regulations covering Medicare and coordinated health plans require such plans to provide basic explanations of benefits, eligibility requirements, non-covered services, and other information beneficiaries need to make informed choices. The section of the regulations that covers marketing activities specifically prohibits: (1) unethical practices; (2) activities that might mislead, confuse, or defraud potential beneficiaries; (3) use of payments as an inducement to enroll; and (4) making of promises that materially alter the marketing material information submitted to the Administration.

Plea for Preemption

FHP presented two arguments for the dismissal of the suit. First, it argued that the Medicare Act and regulations effectively preempted the California Health Care Service Plan Act. Alternatively, FHP argued that state court injunctions against certain HMO marketing practices created potential conflicts with federal regulations.

Addressing the preemption argument, the court noted that Congress historically preempted state regulatory authority in two ways. Congress either explicitly stated its intent to preempt or created statutes and regulations so comprehensive and pervasive that it effectively precluded state supplement. Nowhere in the Medicare Act, the court stated, did Congress expressly state an intent to preclude state regulation. Furthermore, the court concluded that Congress did not intend to implicitly preempt state authority over health plan marketing. Rather, the court found that the regulations and Act are "neither particularly extensive nor particularly detailed," leaving states ample room to supplement them. The court also noted that in areas other than health plan marketing, courts have consistently rejected the argument that the federal Medicare regulations are pervasive enough to preempt state authority.

Even viewing the federal health plan marketing rules as comprehensive, the court found that they would not preempt state authority. The court gave two reasons for this conclusion—one statutory, the other historical. In the Medicare Act, the court stated, Congress expressed its intent to minimize federal intrusion into Medicare administration. The court also noted that public health regulation historically has been a state police power.

Next, the court considered the contention that California's regulation of health plan marketing was invalid because it could potentially conflict with federal regulation. The court rejected this argument on two grounds. First, the court asserted that states may set tougher penalties or standards of proof than required by federal law without precluding federal regulation. Second, federal law will preempt state law only if compliance with both state and federal rules is a "physical impossibility" or when the state law creates an obstacle to the goals of Congress. The court concluded that neither condition existed in this case. Instead, the state and federal regulatory schemes were found to be "strikingly similar" systems working together to prevent misrepresentations and other unfair practices by Medicare-qualified health plans. In fact, the court pointed out that the Administration directed Medicare-qualified HMOs to follow state and local marketing rules.

The court offered one final argument against preemption. It noted that Congress amended the Medicare statute as recently as 1990. At that time, Congress was presumably aware that some states, such as California, regulated HMO marketing practices. However, the 1990 amendments contained no specific preemption terms. The court found that because Congress was silent about preemption of state laws it knew existed, it did not intend to displace them.

Thus, the Court of Appeals reversed the California trial court, holding that states could regulate Medicare-qualified health plans to protect consumers without violating either the Medicare Act or its implementing regulations. ❖

— Timothy Stanton