SUPREME COURT OF THE UNITED STATES

No. 99–116

JEFFREY ALLAN FISCHER, PETITIONER *v.* UNITED STATES

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

[May 15, 2000]

JUSTICE THOMAS, with whom JUSTICE SCALIA joins, dissenting.

In my view, the only persons who receive "benefits" under Medicare are the individual elderly and disabled Medicare patients, not the medical providers who serve them. Payments made by the Federal Government to a Medicare health care provider to reimburse the provider for the costs of services rendered, rather than to provide financial aid to the hospital, are not "benefits." I respectfully dissent.

I

The jurisdictional provision of 18 U. S. C. §666(b) requires that an "organization, government, or agency receiv[e], in any one year period, benefits in excess of $10,000 under a Federal program involving a grant, contract, subsidy, loan, guarantee, insurance, or other form of Federal assistance." As the Court notes, an organization is not a beneficiary of a federal program merely because the organization receives federal funds. *Ante*, at 9, 13. Rather, as the Court admits, a "benefit" is something that "guards, aids, or promotes well-being"; "useful aid"; or a "payment, gift [as] financial help in time of sickness, old age, or unemployment." Webster's Third New International Dictionary 204 (1971). Therefore, the Court ac-

knowledges, an organization "receives . . . benefits" within the meaning of §666(b) only if the federal funds are designed to guard, aid, or promote the well-being of the organization, to provide useful aid to the organization, or to give the organization financial help in time of trouble. In my view, payments made by the Federal Government to a Medicare health care provider as part of a market transaction are not "benefits."[1]

The statutory and regulatory scheme governing Medicare reimbursements leaves no doubt that hospitals do not receive "benefits" from the Federal Government within this meaning of the term, but merely receive payments for costs pursuant to a market transaction. Although the Medicare reimbursement scheme is quite complex, it suffices to point out a few critical components.[2]

Under the "reasonable cost" reimbursement provisions relied on by the Court, *ante*, at 5–7, the Federal Government reimburses providers for "the cost actually incurred, excluding therefrom any part of incurred cost found to be

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[1] Even if I thought that, under a reading of §666(b) standing alone, a market exchange of payment for services might amount to "benefits," §666(c) would eliminate that doubt. Section 666(c) makes clear that "bona fide . . . expenses paid or reimbursed, in the usual course of business," are not covered by the statute. As discussed below, Medicare payments to health care providers are precisely this type of payment.

[2] In 1993, the year relevant to the instant case, Medicare consisted of two separate programs, Parts A and B. Part A provides insurance for certain elderly or disabled persons to cover the costs of inpatient hospital care, nursing facility care, home health services, and hospice care. See generally 42 U. S. C. §§1395c– 1395i–4. Part B is a voluntary program that provides supplemental benefits to elderly or disabled Medicare participants to cover the costs of, among other things, physician services, laboratory and diagnostic tests, ambulance services, and prescription drugs. See generally §§1395j– 1395w–4. The Government did not present evidence at petitioner's trial regarding which provisions of Medicare accounted for the payments made to the West Volusia Hospital Authority in 1993.

unnecessary in the efficient delivery of needed health services." 42 U. S. C. §1395x(v)(1)(A). The Social Security Act that created Medicare instructed the Secretary of Health and Human Services to promulgate regulations establishing the methods of determining "reasonable costs" and specifically directed the Secretary to consider, among other things, reimbursement methods used by private insurers. *Ibid*. See also *Shalala* v. *Guernsey Memorial Hospital,* 514 U. S. 87, 91–92 (1995).

Under these regulations, the Federal Government reimburses medical providers based upon the lower of the provider's reasonable cost of furnishing these services to beneficiaries or the provider's customary charges for the services. 42 CFR §413.1(b) (1999). The regulations are designed to provide reimbursement for the actual cost of providing care to elderly and disabled Medicare beneficiaries. See §413.5(a) ("Thus, the application of this approach, with appropriate accounting support, will result in meeting actual costs of services to beneficiaries"). The regulations make clear that the Federal Government will reimburse hospitals only for the costs of providing medical care to Medicare patients, as opposed to nonbeneficiary patients. §413.80(d) ("Under Medicare . . . costs of services provided for other than beneficiaries are not to be borne by the Medicare program"); §413.9(a) ("All payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries"); §413.9(c)(3) ("The determination of reasonable cost of services must be based on cost related to the care of Medicare beneficiaries").

Although these reimbursement provisions permit hospitals to recover capital costs, such as the cost of maintaining building facilities, §413.9(c), the allowable reimbursement for these expenditures is only the amount reasonably attributable to Medicare patients as opposed to general maintenance of the facilities. See §413.9(b) ("The objective

is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program").

The "prospective payment system" adopted by Congress in 1983 to increase efficiency and reduce costs operates somewhat differently than the "reasonable cost" provisions but is also designed to reimburse hospitals for the cost of providing care to Medicare beneficiaries. 42 U. S. C. §1395ww; 42 CFR pt. 412 (1999). Under this system, the Medicare program pays hospitals a fixed price for each case based on the patient's diagnosis related grouping (DRG), which is assigned based on the patient's diagnosis, age, and sex, among other things. 42 U. S. C. 1395ww(e); 24 CFR §412.60 (1999). The DRG figure represents the average cost of treating patients within the DRG. 42 U. S. C. §1395ww(d)(2); 49 Fed. Reg. 251 (1984). Significantly, because hospitals are paid fixed amounts based on the DRG, the hospital, like any other private contractor, bears the risk of higher costs. See Kinney, Making Hard Choices under the Medicare Prospective Payment System: One Administrative Model for Allocating Medical Resources under a Government Health Insurance Program, 19 Ind. L. Rev. 1151, 1151–1152 (1986).

Thus, the statute and regulations make clear that medical providers are entitled only to reimbursement for the actual or estimated cost of services rendered to Medicare patients and that individual elderly and disabled patients– not hospitals– are the beneficiaries of the Medicare program. Indeed, the Social Security Act explicitly says so. See 42 U. S. C. §1395a(b)(5) (1994 ed., Supp. III) ("The term 'medicare beneficiary' means an *individual* who is entitled to benefits" (emphasis added)). The Act repeatedly refers to Medicare "benefits" as assistance provided to individual participants, rather than to medical

providers. See, *e.g.*, §1395a ("Any individual entitled to insurance benefits under this subchapter"); §1395b–2 ("Such notice shall be mailed annually to individuals entitled to benefits under part A or part B of this subchapter and when an individual applies for benefits under part A of this subchapter or enrolls under part B of this subchapter"); §1395b–4(a) ("health insurance coverage to individuals who are eligible to receive benefits under this subchapter"); §1395b–4(b)(2)(A)(i) ("information that may assist individuals in obtaining benefits"). In contrast, the Act commonly refers to "payments" to providers of medical services. See, *e.g.*, §1395g(a) ("no such payments shall be made to any provider unless it has furnished such information as the Secretary may request"); §1395f(a) ("payment for services furnished an individual may be made only to providers of services"); §1395n(a) (1994 ed. and Supp. III) ("payment for services . . . furnished an individual may be made only to providers of services which are eligible"). This terminology, and the Medicare regulations defining allowable costs, reflect the fact that Medicare is a program for providing "financial help" to individual elderly and disabled patients rather than to the health care providers who treat them. Medicare's provisions for reimbursing providers' costs do nothing more than establish a market exchange of payment for services, and so cannot be said to provide "benefits" within the meaning of 18 U. S. C. §666(b).

II

Although the statutory provisions and regulations cited above demonstrate that Medicare operates as a reimbursement scheme with respect to health care providers, and not as a means of providing them "useful aid" or "financial help," the Court finds in the statute and regulations evidence that health care providers are, along with the individual elderly and disabled patients, also target

beneficiaries of the program. I think that the Court's reasoning is both unpersuasive and boundless; any funds flowing from a federal assistance program could be deemed "benefits" under the Court's rationale, notwithstanding the Court's concluding disclaimer of such a result. Thus, although the Court purports to reject the Government's argument that "benefits" means "funds that originate in a federal assistance program," the Court, in practice, adopts it.

A

First, the Court describes Medicare's elaborate funding structure and notes that Medicare's reasonable cost recovery system allows recovery of certain capital costs and the costs of education and training. *Ante*, at 5. These provisions of Medicare do not establish that hospitals receive "benefits." To the contrary, the capital costs recoverable under those provisions of Medicare are the costs tied to the treatment of Medicare patients. See *supra*, at 3. In this sense, the cost provisions of Medicare expressly defeat any suggestion that they are meant to provide a "benefit" to the hospital. These provisions are not designed to provide financial assistance to the hospital; they are designed to ensure that Medicare beneficiaries receive quality medical care. And again, the Medicare program picks up only the portion of the costs attributable to the care of Medicare beneficiaries. 42 CFR §§413.50, 413.85 (1999). In fact, the Court does not grapple with the evidence that Medicare systematically *under*-compensates health care providers, evidence that would further undermine the notion that hospitals are receiving some form of financial assistance from the program. See Utz, Federalism in Health Care: Costs and Benefits, 28 Conn. L. Rev. 127, 138–139 (1995).

Second, the Court relies on the numerous obligations imposed on health care providers participating in Medi-

care. *Ante*, at 4–7. The Court notes that health care providers must satisfy licensing standards, provide a laundry list of particular health care services, and ensure an effective quality-assurance program. I assume, however, that the same could be said of most Government contractors. The defense contractor who agrees to build the military's equipment is, no doubt, subject to an extensive list of statutory and regulatory requirements, not because the Government intends to provide "benefits" to the contractor, but because the Federal Government intends to place controls on the expenditure of federal dollars. See *United States* v. *Copeland*, 143 F. 3d 1439, 1442 (CA11 1998) (discussing regulatory burdens on defense contractors). Similarly, private insurers no doubt impose various requirements on those who receive reimbursements from them. In requiring hospitals to meet certain standards, the Federal Government is no different from these private insurers, except that the Federal Government exercises vastly greater market power. In other words, the imposition on health care providers of an intricate regulatory scheme is irrelevant to the question whether funds paid pursuant to that scheme are benefits.

Third, the Court contends that some health care providers receive "special treatment" in the form of lump sum payments designed to ensure the providers' ability to satisfy financial obligations. *Ante*, at 6. This feature of Medicare is also insufficient to show that any "benefits" were received by West Volusia Hospital Authority. These payments, which are part of the prospective payment system, see *supra*, at 3–4, are based on estimated costs of providing services to Medicare beneficiaries. See, *e.g.*, 42 CFR §412.108 (1999). Like the standard reimbursement schemes outlined above, this payment system does not subsidize the hospital, it pays the hospital prospectively for performing a service.

Finally, the Court concludes, based on its observations

of Medicare, that "Medicare operates with a purpose and design above and beyond point-of-sale patient care," namely, "ensuring the availability of quality health care for the broader community." *Ante*, at 10, 12. According to the Court, Medicare guarantees that "providers possess the capacity to render, on an on-going basis, medical care to the program's qualifying patients." *Ante*, at 13. In other words, Medicare exists to guarantee patients' access to quality medical care. Quality medical care is available only if medical providers remain financially viable. Medicare payments create demand for medical services and, therefore, provide "benefits" to health care providers. This syllogism, however, amounts to nothing more than the self-evident point that Medicare aims to ensure that the beneficiaries of the program— patients— are able to receive the program's intended benefits. It does not establish that Medicare exists to put hospitals on the dole.

In short, none of the components of Medicare cited by the Court establishes that benefits flow to hospitals. It is significant that, although the Court repeatedly invokes, mantra-like, its conclusion that Medicare exists for a purpose above and beyond reimbursing hospitals for treating Medicare patients, see, *e.g.*, *ante*, at 10, 11, 12, 13, when the Court comes around to actually identifying this purpose, it can only state: "The structure and operation of the Medicare program reveal a comprehensive federal assistance enterprise aimed at ensuring the availability of quality health care for the broader community." *Ante*, at 12. The Court cannot bring itself to say, as it must, that Medicare exists for the *hospital*.[3]

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[3]And even if I were to accept that some provisions of Medicare— the special treatment provisions, for example— provide a benefit to health care providers, there is no evidence in the record that West Volusia Hospital Authority received any such payments. Without such evidence, the Court's reliance on special provisions to uphold petitioner's

B

Although the Court disclaims the Government's argument that "benefits" means only funds provided under a federal assistance program, the Court, in practice, adopts it. The Court's expansive rationale could be applied to any federal assistance program that provides funds to any organization. This result is inconsistent with the plain meaning of the statute. If Congress had meant to apply §666 to any organization that receives "funds" totaling more than $10,000 per annum, it would have said so. Cf. 18 U. S. C. §665 ("Whoever, being . . . connected in any capacity with any agency or organization receiving finan-

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conviction is improper. Title 18 U. S. C. §666(b) is, after all, a jurisdictional provision that allows federal prosecution only if the specific organization at issue received more than $10,000 in "benefits." The Court treats the provision as window dressing. It is not necessary, under the Court's view, to show that *this* organization received benefits. It is sufficient to show that some hospitals receive them.

This approach is particularly inappropriate because §666(b), or some similar jurisdictional provision, is constitutionally required. Section 666 was adopted pursuant to Congress' spending power, Art. I, §8, cl. 1. We have held that the spending power requires, at least, that the exercise of federal power be related "to the federal interest in particular national projects or programs." *South Dakota* v. *Dole*, 483 U. S. 203, 207 (1987) (internal quotation marks omitted). See *id.*, at 213 (O'CONNOR, J., dissenting). Arguably, if Congress attempted to criminalize acts of theft or bribery based solely on the fact that– in circumstances unrelated to the theft or bribery– the victim organization received federal funds as payment for a market transaction, this constitutional requirement would not be satisfied. Without a jurisdictional provision that would ensure that in *each* case the exercise of federal power is related to the federal interest in a federal program, §666 would criminalize routine acts of fraud or bribery, which, as the Court admits, would "upse[t] the proper federal balance." *Ante*, at 13. Cf. *United States* v. *Lopez*, 514 U. S. 549, 561 (1995) ("[Section] 922(q) contains no jurisdictional element which would ensure, through case-by-case inquiry, that the firearm possession in question affects interstate commerce").

cial assistance or any funds under [a certain federal program] knowingly enrolls an ineligible participant, embezzles, willfully misapplies, steals, or obtains by fraud any of the moneys, funds, assets, or property which are the subject of a financial assistance agreement or contract pursuant to such Act shall be [punished]"). Congress, for that matter, could have omitted the word "benefits" from the statute and provided simply that any organization that "receives, in any one year period, in excess of $10,000 under a Federal program involving a . . . form of federal assistance" is covered by the statute. That Congress did not do so suggests that the word "benefits" has a meaning separate and apart from the words "under a Federal program involving a . . . form of federal assistance." I am doubtful that the Court's interpretation gives any meaning at all to the word "benefits" in §666(b) because, under the Court's rationale, any organization that receives $10,000 under a Federal program involving Federal assistance receives "benefits" in such an amount.

This expansive construction of §666(b) is, at the very least, inconsistent with the rule of lenity– which the Court does not discuss. This principle requires that, to the extent that there is any ambiguity in the term "benefits," we should resolve that ambiguity in favor of the defendant. See *United States* v. *Bass*, 404 U. S. 336, 347 (1971) ("In various ways over the years, we have stated that when choice has to be made between two readings of what conduct Congress has made a crime, it is appropriate, before we choose the harsher alternative, to require that Congress should have spoken in language that is clear and definite" (internal quotation marks omitted)).

C

I doubt that there is any federal assistance program that does not provide "benefits" to organizations under the Court's expansive rationale, but will illustrate my point

with just one example employed by two lower courts. See *United States* v. *Wyncoop*, 11 F. 3d 119, 123 (CA9 1993); *United States* v. *LaHue*, 998 F. Supp. 1182, 1187 (Kan. 1998), aff'd, 170 F. 3d 1026 (CA10 1999). Many grocery stores accept more than $10,000 per annum in food stamps distributed to individual beneficiaries as part of the Federal Food Stamp and Food Distribution Program. Like Medicare providers, stores participating in the Food Stamp Program are required to satisfy a comprehensive series of statutory and regulatory requirements. See 7 CFR pt. 278 (1999). For example, stores are qualified to participate only if they sell an adequate percentage of staple foods such as meat, cereal, and dairy products. §278.1(b)(1). Stores must document an ability to attract food stamp business and demonstrate the business integrity and reputation of the store owners and managers. §§278.1(b)(2)–(3). Like Medicare, the Food Stamp Program monitors the providers' compliance with the program's requirements. See §278.1(n). Like Medicare, the Food Stamp Program sanctions noncompliance with dismissal from the program. §278.1(l). And, the Food Stamp Program is like Medicare in that it can be described as having "a purpose and design above and beyond point-of-sale" of food. *Ante*, at 10. Undoubtedly, the Food Stamp program helps to address the "grocery gap," that is, the lack of availability of reasonably priced nutritional foods in some low-income and rural areas. See Note, Food Stamp Trafficking: Why Small Groceries Need Judicial Protection from the Department of Agriculture (And from Their Own Employees), 96 Mich. L. Rev. 2156, 2176–2177 (1998); Department of Agriculture, Office of Analysis & Evaluation, Food Retailers in the Food Stamp Program: Characteristics and Service to Program Participants 15 (Feb. 1997) (Table 6). There is ample evidence on the face of the statute and regulations that Congress and the agency had in mind the need to ensure that low-income

communities have access to grocery stores. See 7 U. S. C. §2021(a) (1994 ed., Supp. IV) (requiring the Secretary to consider hardship to the community in making disqualification determinations); 7 CFR §278.1(b)(1)(ii)(C) (1999) (listing availability of food stores in the community as a factor relevant to a firm's application to participate in the program). It could be said, therefore, that the grocery store's "own operations are one of the reasons for maintaining the program." *Ante*, at 13.

To my mind, the reason that a corner grocery does not receive "benefits" is simply that it merely receives payment from the Government in a market transaction. I fail to see, however, how the Court could reach the same conclusion that I would. Although the Court assures us that its holding today is narrow and factbound, depending on the "structure, operation, and purpose" of Medicare, *ibid.*, the consequences of the Court's reasoning are far reaching. In fact, the Court candidly acknowledges that its interpretation is expansive when it reads 18 U. S. C. §666(b) to suggest that "Congress viewed *many* federal assistance programs as providing benefits to participating organizations." *Ante*, at 10 (emphasis added). In contrast, I think that the plain language of §666(b) reflects a congressional intent to reach only those organizations that are *themselves* the beneficiaries of "useful aid" or "financial help in time of sickness, old age, or unemployment," rather than organizations that merely receive funds as part of a market transaction for goods or services.

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For the foregoing reasons, I respectfully dissent.