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Official Washington's Continuing Assault on the Doctor-Patient Relationship

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Unless Congress takes corrective action, American doctors and patients participating in the Medicare program next year will have less personal and professional freedom than their counterparts in the British National Health Service (NHS). If physicians in Britain's government-run health care system want to treat patients on a private basis, they may do so without being forced to give up their patients in the NHS. If patients want to "go private," they may do so without jeopardizing their government health benefits.

Buried deep in the voluminous Balanced Budget Act of 1997, however, is a provision that could destroy the ability of most persons in the United States to contract privately with a personal physician once they reach age 65. Under the recently enacted legislation, a doctor who wishes to contract privately with a patient enrolled in Medicare Part B must first sign an affidavit to that effect and agree to remove himself completely from the Medicare program for a period of two years. This financial hardship effectively prohibits private contracting by all but a small number of physicians.[1] The result: Most Americans over the age of 65 will not be able to spend their own money to secure the medical services or treatments they want on terms mutually agreed upon with a physician of their choice.

This raises a fundamental question: By what right does Congress presume to limit a personal transaction between a doctor and a patient? A look at the activities of the federal Health Care Financing Administration (HCFA) may help explain the genesis of this assault on the doctor-patient relationship.

HCFA's Campaign Against Doctor-Patient Privacy. HCFA officials have been pushing the most expansive interpretation of their regulatory authority under existing Medicare law. In communications with doctors and patients, they have long argued that it was illegal for doctors to treat senior citizens and not submit claims for reimbursement to the Medicare program. HCFA's traditional position has been that,

1. According to an August 29, 1997, fact sheet by staff of the House Ways and Means Committee, the congressional restrictions on private contracting between doctors and patients in Medicare are confined to medical services covered by Medicare. They do not appear to affect the provision of medical services not covered by Medicare.

while senior citizens might have a right to contract privately with their personal physicians, they could exercise such a right only if they dropped out of the Medicare Part B entitlement program. This is a huge price to pay for most elderly Americans. Meanwhile, over the past several years, HCFA bureaucrats have threatened sanctions against doctors who attempt to treat these patients. According to Kathleen Buto, Director of HCFA's Bureau of Policy,

> A physician can choose not to treat Medicare beneficiaries. However, once a physician renders services to a Medicare beneficiary, he or she is subject to Medicare's requirements and regulations, *regardless of the physician's participation as a Medicare provider.* A physician's failure to comply with the claim filing requirement violates Medicare law and subjects him or her to possible monetary penalties [emphasis added].

Under current law, a doctor who fails to submit a Medicare claim for a service in treating a patient within the Medicare program can be fined up to $2,000 per claim. A doctor who "knowingly and willfully" violates this statute can be excluded from Medicare for up to five years, excluded from state health care programs, and assessed civil monetary penalties. The question is: Do these bureaucratic claim-filing requirements—absent clear congressional declarations or formal agency regulations—constitute a legal limitation on the ability of doctors and patients to enter into a purely private agreement? For years, Congress gave no clear and unambiguous answer to this question.

Curiously, the rules are different for doctors and patients in Medicaid, the huge health program for the poor and the indigent, financed jointly by federal and state funds. Nothing prevents a Medicaid recipient from seeing a private physician and paying that physician for services rendered outside of the Medicaid system.

Limited Case Law. Because America is a free country, citizens have the right to engage in activities that are not clearly prohibited by law. This is the essential meaning of limited, constitutional government. Do the ominous communications from Medicare carriers and letters from HCFA bureaucrats constitute a formal policy, legally binding on doctors and patients?

In 1992, five senior citizens and their physician, internist Lois Copeland, filed suit against the Secretary of Health and Human Services (HHS) for injunctive relief against a federal government "policy" that allegedly stopped doctors and patients from entering into private contracts for medical treatment on a "case-by-case" basis and from choosing not to submit these claims to Medicare for reimbursement.[2] In *Stewart* v. *Sullivan*, Judge Nicholas Politan dismissed the plaintiffs' case. Significantly, he did so because there was in fact no such policy against private contracting: "I have concluded that plaintiffs' claims are not ripe because plaintiffs have not established that the Secretary has clearly articulated a policy on private contracting."[3] Moreover, HCFA's reliance on its carriers' communications and other similar pronouncements is legally insufficient as a basis for assuming the existence of such a policy. Judge Politan continued:

> The bulletins from the carriers come closest to reflecting the policy alleged by the plaintiffs. The bulletins make the broad statement that the law cannot be bypassed by entering into private contracts in which patients disclaim coverage. Again, this statement does not "specifically prohibit Medicare patient-beneficiaries from paying for such services out of their own funds and requesting their physician not to submit a claim for Medicare Part B benefits to the Secretary on their behalf."

But these carrier bulletins did not meet the test of establishing a formal policy against private contracting by the Secretary of HHS. Said Judge Politan: "This is not a case where the Secretary has clearly stated his position on a posed issue. The Secretary has not promulgated any rules or regulations either formally or

2. For an account of the circumstances surrounding this case by one of the principals, see Lois J. Copeland, M.D., "Please Do No Harm," *Policy Review*, No. 65 (Summer 1993), pp. 4–11.
3. *Stewart* v. *Sullivan*, 816 F. Supp. 281 DNJ 1992.

informally espousing the policy alleged by the plaintiffs." If the physician plaintiff in the case had violated Medicare law, the Secretary would be empowered to impose a sanction against the doctor. But, said Judge Politan, "As concluded above, plaintiffs have not established a determination by the Secretary that doctors who engage in private contracting whereby claim forms are not submitted and the fee limitation provision is not followed have engaged in knowing and willful violations of the Medicare statute."

Since *Stewart* v. *Sullivan*, HCFA officials have continued to threaten physicians who want to contract privately. In 1993, HCFA issued "Carrier Manual Instructions" which it says justify its authoritative opposition to private contracting—virtually the same sort of communication that Judge Politan stated does *not* constitute a formal government policy. Nonetheless, these kinds of communications can be intimidating to doctors and patients. These manuals, it should be noted, are not formal regulations subject to the public notice and comment requirements of the Administrative Procedures Act. HCFA officials therefore are attempting to make policy—or what they want to call government policy—without going through the public process of publishing formal regulations.

Congressional defenders of HCFA's authority to limit private contracting also cite the Social Security Act Amendments of 1994. If this legislation contained a specific congressional prohibition against persons privately contracting with a physician, however, it was not clear. As Kent Masterson Brown, attorney for the plaintiffs in *Stewart* v. *Sullivan*, observes, the 1994 law simply says that a physician must file a claim for a service within Medicare's complex price control system *if* the beneficiary desires reimbursement or payment from Medicare.[4]

The Senate's Aborted Rescue. During Senate floor debate on the Balanced Budget Act, Senator Jon Kyl (R–AZ) argued that bureaucrats at HCFA had taken advantage of unclear legislative language to expand their regulatory authority over doctors and patients in the Medicare program, whether or not these doctors and patients filed claims with Medicare. Regardless of HCFA's lavish interpretations of its own authority, observed Kyl, Congress never intended to prevent Americans enrolled in Medicare from spending their own money for medical services.

Senator Kyl offered an amendment designed to end the confusion. Introducing the amendment, he declared that Congress never intended to prohibit private contracting between doctors and patients in Medicare any more than the enactment of Social Security would prohibit a private contract between a retiree and a stockbroker: "Surely, a law that made it illegal to supplement with private funds the amount received from Social Security would be met with disbelief and derision."

Kyl's amendment easily overcame a procedural hurdle and then passed by voice vote. It seemed to settle the issue. Most Capitol Hill observers would have thought that a Senate measure promoting private contracting between a doctor and a patient, an independent agreement between consenting adults that would have no impact on the taxpayer, would be warmly received and staunchly supported in a House of Representatives led by conservative Republicans. They would have been wrong.

The House Compromise: How Not to Make Matters Better. The House had no provisions in the Balanced Budget Act governing private contracting in Medicare. Senior congressional staff relate that on this vital issue, as on a couple of other key Medicare issues,[5] House Ways and Means Committee members for all practical purposes aligned themselves with the Clinton Administration and its minions at HCFA. According to an August 29 House Ways and Means fact sheet on the subject, "The private contracting provision was first included in a Republican-sponsored amendment on the Senate floor.... The House conferees accepted the original Senate provision. The Administration, however, was strongly opposed to

4. Personal communication from Kent Masterson Brown, Esq., of Danville, Kentucky, and Washington, D.C., September 3, 1997. The Medicare law is complex and is a fruitful field for HCFA bureaucratic ingenuity.
5. Two items are worth noting. The first is the House–Senate conference's destruction of the Breaux–Mack demonstration project for a system of consumer choice like the Federal Employees Health Benefits Program (FEHBP) as a model for Medicare reform. This demonstration project was strongly opposed by HCFA. The House also pushed for an expansion of the Clinton Administration's remarkable proposal—originally confined to hospitals in New York—to have taxpayers subsidize hospitals for *not* training physicians.

private contracting. Revisions to the policy...were made through negotiations with the White House." In other words, the House caved.

Under Section 4507 of the Balanced Budget Act as drafted by House and Senate negotiators, doctors and patients may enter into private contracts and not bill Medicare for the services. The conditions are, of course, that no claim can be submitted to, or reimbursement received from, the Medicare program; the contract must be in writing and signed by the beneficiary; and the contract cannot be entered into in a medical emergency. The Medicare beneficiary likewise agrees not to submit a claim to Medicare; acknowledges that payment will not be subject to Medicare's price controls; and agrees to be responsible for payment. But Congress then adds a draconian condition on any physician trying to exercise such an option—a written affidavit: "The affidavit provides that the physician practitioner will not submit any claim under this title for any item or service provided to any Medicare beneficiary (and will not receive any reimbursement or amount described in paragraph (1)(b) for any such item or service) during the 2-year period beginning on the date the affidavit is signed...." So, if a doctor enters into *any* such private contract, he must refrain from accepting *any* Medicare patients for a period of two years. According to the August 29 Ways and Means Committee fact sheet, the exclusion applies not only to the traditional Medicare program, but also to Medicare's "private" HMOs, PSOs, and MSAs. (This is curious. After all, the whole point of the MSA is to facilitate a direct relationship and a direct payment between doctors and patients. The rationale underlying the Act's policy is mysterious.) For the administrative convenience of HCFA bureaucrats monitoring these agreements, the doctor must submit the affidavit to the Secretary of HHS within ten days.

This entire process has a surrealistic quality. While the financially troubled Medicare program is imposing ever larger financial pressures on taxpayers, Congress is now requiring doctors to jump through a series of burdensome hoops, including the signing and submission of a formal affidavit, *not* to spend taxpayers' money.

The New Congressional Intent: An Improvement? Senior congressional staff assure constituent inquirers that the new private contracting provision is an improvement over current law. Even if one grants the ambiguities in the previous law and agrees that the Budget Act's language introduces a refreshing clarity, the specificity of this crabbed authorization of private contracting is nonetheless onerous enough to discourage it. Indeed, it only points out how profoundly the federal government has come to restrict personal freedom.

Beyond that, the Budget Act's micromanagement reenacts the law of unintended consequences. Patient access to a private contract with a physician depends ultimately on whether a physician is financially dependent on Medicare. And this, in turn, depends on the vagaries of demography and geography. Some physicians are completely independent of Medicare. Medicare beneficiaries who want to contract with those few physicians will have to hunt for them, however.

While the language against private contracting in an emergency or "urgent" situation obviously is intended to protect a patient from making a decision under duress, the same language effectively prevents a patient from contracting with a favored physician precisely at the time and under circumstances when the patient might be in the most need of that doctor's specialized services. The legislation's report language does not define "urgent." Perhaps doctors and patients should keep their eyes peeled for the crisply written *Federal Register* notice instructing them on the topic of medical urgency in Medicare.

Similarly, if an elderly American wants treatment for a condition that is sensitive, unusual, or likely to cause some personal embarrassment, where the patient does not want claims going to the bureaucracy, this also will be almost impossible. Then, of course, there is the creation of a two-tiered health care system. While the Budget Act's provisions are designed to make private contracting in Medicare all but impossible, private contracting will appeal to the small number of physicians—sick of the hassle, the unbearable stupidity, and the mountainous Medicare paperwork—who reside in very wealthy communities where upper-income elderly citizens are less dependent on Medicare Part B. This will, in effect, create the very two-tiered system in Medicare that congressional liberals are so desperate to prevent.

Even if one accepted HCFA's previous interpretations of the law and its authority as correct—that private contracting would be permissible for the elderly who gave up their Medicare Part B benefits—this at least gave 38 million Americans, at great personal cost, the option to enter such agreements. Under the language of the Budget Act, the option is now confined to an unknown number of the nation's 700,000 doctors who would have to jettison their Medicare practice for two full years. It is hard to see how this makes the situation better for private contracting.

The Budget Act's language effectively sets the elderly apart from every other class of Americans. As noted, there is no obstacle to Medicaid beneficiaries, using financial help from families or relatives, in securing the private services of a physician outside of the Medicaid program. For consistency, perhaps Members of Congress will impose similar restraints on doctors in Medicaid, making it all but impossible for physicians to treat low-income patients outside of the officially approved benefits structure of Medicaid. If Congress and the Clinton Administration think this is such a good principle, why should it not be applied to other professionals? Applying official Washington's logic to education, for example, a public school teacher could not privately tutor a child having academic difficulties unless that teacher dropped out of the public school system for two years.

Perhaps Congress could take lessons from abroad. Medicare, like the British National Health Service, is based on the key principles of central planning and price regulation. Medical specialists can work for the NHS either full-time or part-time. It is estimated that a majority of medical specialists or "consultants" have a private practice. British general practitioners (GPs) normally have a full-time commitment to their NHS practice, but they, too, can obtain additional income from private sources. This is spelled out clearly in the *General Practitioners Handbook* of the British Medical Association. British patients may switch back and forth between NHS and private practice, though they pay for the NHS through their taxes whether they use it or not. So even British citizens enrolled in an explicit system of socialized medicine have the right to "go private" with doctors who also operate within the NHS. Elderly Americans enrolled in Medicare, with few exceptions, have no such right unless they are able to find a physician who is capable of giving up his or her entire Medicare practice for two full years. The result: Americans enrolled in Medicare have less personal freedom than British citizens enrolled in the British National Health Service.

Endangering the Future of Medicare Reform. One does not achieve structural reform of Medicare by enlarging "private options" and then regulating them into mind-numbing uniformity or making them private in name only. The object of structural reform of Medicare should be to expand consumer choice and competition, to expand personal freedom of patients and the professional independence of physicians, not to expand the power of the Health Care Financing Administration into new and previously uncharted private-sector territories.

To their credit, Clinton Administration officials have been consistent: There is not a nook or cranny of the American health care system that they would refrain from micromanaging. On the question of the doctor-patient relationship, the Clinton Administration outlined its vision in its 1,342-page 1993 Health Security Act, which would have extended federal regulation and restrictions into every area of the health care system. The Clinton version of Medicare reform is a logical extension of the Administration's vision for the broader health insurance market: the imposition of a bureaucratic uniformity on private plans, replete with government-standardized benefits and government cost controls and a pervasive bureaucratic supervision over the most intricate transactions in the system. The very real danger is that Congress, seemingly lacking any clear vision of the kind of health care system it wants for the American people, will enact a Clinton-style regulatory apparatus on the installment plan—as it seems to be doing with this latest private contracting policy. If Congress previously had never intended to throw obstacles in the way of an older person's private contractual relationship with a physician, as Senator Kyl has forcefully argued, that cannot be said today.

In response to growing public outrage over enactment of this restrictive provision, Senator Kyle and Representative Bill Archer (R–TX), chairman of the House Ways and Means Committee, have introduced corrective legislation, the Medicare Beneficiary Freedom to Contract Act of 1997 (S. 1194 and H.R. 2497, respectively). The legislation would clarify that nothing in the Medicare law prevents doctors and

Medicare patients from entering into private agreements for any medical treatment. Moreover, it adds provisions to the Medicare law to protect taxpayers from fraud, as well as strong consumer protections for Medicare beneficiaries who enter into private agreements with doctors. S. 1194 has 46 cosponsors, and H.R. 2497 has 157.

A Better Policy. Medicare is drowning in paperwork and red tape, and will remain that way until it is fundamentally reformed. Real reform means real consumer choice and real competition, not highly restrictive government "choices" and even more government regulation. Under the Balanced Budget Act, congressional leaders will appoint members of a Medicare reform commission. It is vitally important that this commission be composed of persons dedicated to real reform, not those content to tinker around the edges of the *status quo*.

In the meantime, Members of Congress should curtail the excesses of the Medicare bureaucracy and fix what is clearly broken. Specifically, they should make sure that doctors and patients in Medicare enjoy, at the very least, the same professional flexibility and personal freedom that their British counterparts enjoy in an explicit system of socialized medicine.