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How Congress Can Restore The Freedom of Senior Citizens to Make Private Agreements with Their Doctors

Robert E. Moffit

Most Americans would agree that the relationship between a doctor and a patient is nobody's business—especially the government's. Nonetheless, Congress and the Clinton Administration have made a confusing mess of the Medicare law that governs this very relationship.

Buried deep in the Balanced Budget Act of 1997 is a provision (Section 4507) that deliberately curtails a senior citizen's right to spend his or her own money on a medical service covered by Medicare and provided by a doctor of his or her choice. According to this law, to contract privately to treat a senior citizen a doctor must:

- Sign an affidavit to that effect and submit it to the Secretary of Health and Human Services within ten days.
- Agree to remove himself from the Medicare program and refrain from submitting any claims to Medicare for reimbursement for two full years.

Because very few physicians can afford to drop out of Medicare for two years, the vast majority refuse to treat senior citizens privately.

No other government health program has a similar statutory restriction for any other class of Americans. Indeed, senior citizens and their physicians in the United States have less personal freedom to engage in private contractual relationships than their counterparts enrolled in the British National Health Service, one of the world's best-known systems of socialized medicine.

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The premises of the new Medicare restrictions are even worse than most Americans might imagine, because the Clinton Administration recently convinced a federal court that a Medicare beneficiary's right to privacy in a contractual relationship with a doctor—*even though no tax dollars are involved*—is not protected by the U.S. Constitution. This result of this odd combination of congressional, executive, and judicial actions has been twofold: a profoundly damaging precedent that curtails the personal freedom of doctors and patients, and a unique and confusing situation for doctors and patients in the Medicare program.

RESTORING THE RIGHTS OF SENIORS

There is a proposal before Congress, however, to restore the rights of seniors and their physicians. The Medicare Beneficiary Freedom to Contract Act (S.1194/H.R. 2497), introduced by Senator Jon Kyl (R–AZ) and Representative Bill Archer (R–TX), would:

- Restore the right of doctors and patients to enter into private agreements on mutually agreed upon terms by repealing the legal requirement that doctors give up their Medicare reimbursement for two years if they enter into a private contract.
- Repeal the statutory requirement that doctors submit an affidavit to the Secretary of HHS agreeing not to submit any Medicare claims for two years.
- Clarify that nothing in Medicare law prevents Medicare patients from entering into private agreements with their doctors on a case-by-case basis for any length of time.
- Take steps to ensure that private contracting does not lead to Medicare fraud.

CONCLUSION

The emerging debate over private contracting has exposed both the essentially authoritarian assumptions underlying the current Medicare system and the arbitrary operations of an arrogant bureaucracy unchecked by serious congressional oversight. It is time for Congress to begin to exercise serious oversight over the Health Care Financing Administration, the federal agency that oversees Medicare and has contributed significantly to confusing the issue of private contracting for senior citizens and their doctors.

Congress should curtail the excesses of the Medicare bureaucracy and fix what is clearly broken. Lawmakers should make sure that doctors and patients in Medicare enjoy at least the same professional flexibility and personal freedom that their fellow citizens enjoy.

In addition, members of the National Bipartisan Commission on the Future of Medicare, assembled to present recommendations to reform the financially troubled program, can make sure that America's senior citizens are never again burdened with similar bureaucratic restrictions.

By doing so, they can reaffirm the principle that all Americans retain the fundamental freedom to spend their own money on the physicians and medical treatments of their choice. Freely chosen contractual relationships between doctors and patients are the business of doctors and patients, not of Congress or the federal bureaucracy.

—Robert E. Moffit is Director of Domestic Policy Studies at The Heritage Foundation.

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Other than one's relationship with a member of the clergy, no professional relationship is as sacred as the relationship between doctor and patient, the terms of which are nobody else's business. Congress and the Clinton Administration, however, have made a confusing mess of the Medicare law governing this relationship. Members of Congress soon will have an opportunity to end this confusion.

Under Section 4507 of the Balanced Budget Act of 1997, a senior citizen's right to spend his or her own money on a medical service covered by Medicare and provided by a doctor of his or her choice—without any claim on taxpayers' dollars—has been deliberately curtailed.[1] As a result, if a person enrolled in Medicare deems it advisable, for any reason, to go outside of the program and pay another physician for services covered by Medicare, that person can do so only under highly restrictive conditions enforced by the federal bureaucracy. This is a dangerous precedent.

No other government health program has a similar statutory restriction for any other category of citizens, including those enrolled in Medicaid, the federal-state program that covers the poor and the indigent, or the Federal Employees Health Benefits Program (FEHBP), the popular consumer-driven program that covers Members of Congress, congressional staff, and other federal employees and their families. Indeed, senior citizens and their physicians in the United States have less personal freedom to engage in private contractual relationships than their counterparts enrolled in Britain's National Health Service, one of the world's best-known systems of socialized medicine.[2]

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The premises of the new Medicare restrictions are even worse than most Americans might imagine, because the Clinton Administration recently convinced a federal court that a Medicare beneficiary's right to privacy in a contractual relationship with a doctor—even though no tax dollars are involved—is not protected by the U.S. Constitution.[3] The result of this

1. This new restriction does not apply to medical services that are not covered by the Medicare program.

odd combination of congressional, executive, and judicial actions has been twofold: a profoundly damaging precedent that curtails the personal freedom of doctors and patients, and a unique and confusing situation for doctors and patients in the Medicare program. Meanwhile, the Health Care Financing Administration (HCFA) has taken almost a year to propose regulations for enforcement of the new provision.[4]

The basic responsibility for the current situation, however, does not rest with the White House, or with HCFA, the federal agency that runs the Medicare program, or with the federal judiciary. It rests with the Members of Congress who drafted and enacted the complex and vague law governing the Medicare program. That law confers vast discretionary authority on HCFA, and Congress has failed to exercise the oversight needed to ensure that the agency's operations do not undermine either the personal freedom of patients or the professional integrity of their doctors.

There is a proposal before Congress, however, to restore the rights of seniors: The Medicare Beneficiary Freedom to Contract Act (S. 1194/H.R. 2497), introduced by Senator Jon Kyl (R–AZ) and Representative Bill Archer (R–TX), chairman of the House Ways and Means Committee, would undo the restrictions of Section 4507 and clarify that nothing in the Medicare law prevents doctors and Medicare patients from entering into private agreements for any medical service for any period of time. The Kyl–Archer bill also includes tough provisions to protect taxpayers and senior citizens from fraud.

The emerging debate over private contracting has exposed both the essentially authoritarian assumptions underlying the current Medicare system and the arbitrary operations of an arrogant bureaucracy unchecked by serious congressional oversight. Members of the National Bipartisan Commission on the Future of Medicare, assembled to present recommendations to reform the financially troubled program, can make sure that America's senior citizens are never again burdened with similar bureaucratic restrictions.

They also can reaffirm the principle that all Americans retain the fundamental freedom to spend their own money on the physicians and medical treatments of their choice. Freely chosen contractual relationships between doctors and patients are the business of doctors and patients, not of Congress or the federal bureaucracy.

WHAT SECTION 4507 SAYS

Under Section 4507 of the Balanced Budget Act,[5] any doctor is free to contract privately with a patient enrolled in Medicare, treat that patient on an independent basis outside of HCFA rules and regulations, and refrain from submitting any claims to Medicare for Medicare reimbursement.

However, there is a catch: A doctor who wishes to contract privately with a patient enrolled in Medicare Part B—the part that pays for physicians' services—must first sign an affidavit to that effect and submit that affidavit to the Secretary of Health and Human Services (HHS) within ten days. In the affidavit, the doctor will agree to remove himself from the Medicare program and refrain from submitting any claims for Medicare reimbursement for a period of two years. Section 4507 does not specify when a doctor must make such an election.[6]

Section 4507 also requires that the contract between doctor and patient must be written and signed. The patient must agree not to file a claim

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2. For a brief account of the British practice, see Robert E. Moffit, "Official Washington's Continuing Assault on the Doctor–Patient Relationship," Heritage Foundation *F.Y.I.* No. 161, November 10, 1997, p. 5.

3. *United Seniors Association Inc.* v. *Donna Shalala*, U.S. District Court for the District of Columbia, Civ. No. 97–3109, April 14, 1998.

4. See *Federal Register*, Vol. 63, No. 108 (June 5, 1998), Part II, Department of Health and Human Services, Health Care Financing Administration, pp. 30818 *et seq.*

5. For the full text of this provision, see the Appendix.

with Medicare and must pay 100 percent of the doctor's charge. The law thus allows the charges to be determined by a mutual transaction between doctor and patient in a free market, subject neither to Medicare's complex fee schedules for over 7,000 different medical treatments nor to its rigid price controls. Moreover, the private contract must disclose that neither Medicare nor the patient's Medigap policy—the insurance policy that most Medicare patients buy to cover the services that Medicare does not cover—will pay any part of the cost of the medical service.

Under Section 4507(3)(B)(ii), any doctor who enters into a private contract with a Medicare beneficiary must agree in the affidavit that he will not submit any claim "for any item or service" provided to "any Medicare beneficiary" during the mandatory two-year period. The House Ways and Means Committee staff and officials of the Clinton Administration have confirmed that this legislative language means that legal restrictions on private contracting in Medicare apply only to services covered by Medicare. The precise meaning of Medicare coverage, however, is still a matter of dispute.[7]

Under the terms of Section 4507(b)(5)(A), a Medicare beneficiary is any individual "who is entitled to benefits under part A or enrolled under part B." Part A of Medicare covers hospital services to the elderly and is financed by payroll taxes; Part B pays for physicians' services and is financed by a combination of general tax revenues and premiums paid by persons who enroll in the Part B program.[8]

Under Section 4507, the Secretary of HHS is to report to Congress in 2001 on the impact of private contracts on total federal expenditures, out-of-pocket expenditures by Medicare beneficiaries, and the quality of the care provided to patients under those contracts.

No matter how artfully official Washington and its allies attempt to defend the enactment of Section 4507, the result is clear: Most Americans over the age of 65 will not be able to spend their own money to secure the medical services or treatments currently provided by Medicare on terms mutually agreed upon with a personal physician of their choice outside of Medicare. The wall of personal liberty and privacy in the provision of health care has been breached by this unprecedented government intrusion.

CONGRESSIONAL CONFUSION AND FEDERAL MISINFORMATION

In proceedings before the U.S. District Court for the District of Columbia in the case of *United Seniors Association Inc.* v. *Donna Shalala*, Kent Masterson Brown, consulting attorney for the United Seniors Association and a prominent expert on Medicare law, has characterized Section 4507 as

> a clear statute. It says if a doctor wants to privately contract, that's fine, but he will have to get out of Medicare for two years.

6. In its initial instructions to Medicare carriers, HCFA declared that doctors must terminate their Medicare practice by February 2, 1998, before entering into any private contract. As the American Psychiatric Association noted, "This 'drop dead' date was completely unsupported by the statute, an assertion borne out by the second set of instructions (issued in January 1998) that would allow physicians to drop their participation agreements for one day each quarter, provided that the requisite affidavit was received not later than 30 days prior to the first day of each new quarter." American Psychiatric Association, Testimony on Medicare Private Contracts, Committee on Finance, U.S. Senate, 105th Cong., 2nd Sess., February 26, 1998, p. 6; cited hereafter as American Psychiatric Association Testimony.

7. Services that are categorically excluded by statute from Medicare coverage, such as cosmetic surgery, eyeglasses, hearing aids, or routine physical exams, do not present a problem. The problem occurs when the Medicare bureaucracy decides that medical services otherwise covered under Medicare are unnecessary and doctors are threatened with penalties for performing them. For an excellent discussion of this issue, See Kenneth Smith, "Keeping Seniors from Their Doctors," *Readers Digest*, Vol. 152 (June 1998), pp.165–169.

8. Part A is mandatory, but Part B is not. Almost 2 million people have chosen not to enroll in Part B.

> No matter what they say would be the legislative history. And I must say this was one of those items where I think everyone here agrees, it was inserted at the last minute. There were no hearings on this thing. What we have from the floor of the House and Senate are just totally conflicting things.[9]

Other experts are less charitable. The American Psychiatric Association describes the provision as "regrettably ill crafted," and the two-year opt-out as "ludicrous public policy on its face."[10] John Hoff, an attorney and author of a new monograph on Section 4507,[11] argues that "Although the real world effect of Section 4507 is clear, the provision is genuinely confusing, both in concept and in detail; and it provides little meaningful guidance to doctors, patients, or even officials at HCFA."[12]

Even Members of Congress seem to be confused over its meaning.[13] The debate on the Balanced Budget Act of 1997 includes no coherent explanation of why Congress adopted Section 4507. Various Members and congressional staff employees have released contradictory and erroneous information not only regarding the previous status of the law and the right of doctors and patients to engage in private contracts, but also over the current status of the Medicare law and how it is to be enforced and applied. And far too many Members, including those who want to reverse the current policy, persist in telling their constituents—erroneously—that Medicare law previously prohibited private contracts between doctors and Medicare patients.[14]

Nor is this confusion limited to Members of Congress and their staffs. As noted by the American Psychiatric Association, "statements by senior HCFA staff and successive Administrators have been rife with contradictions, with the unacceptable result that physicians—even when seeking to respond to the directives of their own patients—are left completely vulnerable to the whims of individual Medicare carriers."[15]

Some recent official communications on Section 4507 are nothing short of bizarre. For example, according to HCFA's January 1998 *Program Memorandum* on Medicare private contracts:

> If an "opt out" physician/practitioner violates his or her agreement to not file claims to Medicare (except for emergency claims or urgent care services furnished to a beneficiary with whom the physician/practitioner has not entered into a private contract) he/she must thereafter submit claims for all services to Medicare beneficiaries (for which no Medicare payment may be made) and must abide by limiting charge rules and regulations (which the

9. Transcript of Preliminary Injunction Hearing Before The Honorable Thomas F. Hogan, U.S. District Court Judge, in *United Seniors Association Inc.* v. *Donna Shalala*, CA–97–3109, U.S. District Court for the District of Columbia, March 6, 1998, p. 7; cited hereafter as Oral Argument.

10. American Psychiatric Association Testimony, p. 4.

11. John Hoff, *Medicare Private Contracting: Paternalism or Autonomy* (Washington, D.C.: AEI Press, 1998).

12. Author's communication with John Hoff, June 17, 1998.

13. According to Senator Arlen Specter (R–PA), for example, "current law does not prohibit Medicare beneficiaries from accessing necessary care. If a Medicare beneficiary desires to pay cash for a medical service instead of billing Medicare, even if Medicare would have covered the service, the beneficiary has the right to do so without penalty to the provider." Letter from Senator Arlen Specter to Thomas A. Schatz, Citizens Against Government Waste, May 13, 1998.

14. A review of congressional correspondence on the subject submitted by citizens to The Heritage Foundation reveals a pattern. Many congressional letters will have a paragraph telling constituents that Section 4507 was a "liberalization" of private contracting, invariably described as a previously "illegal" practice. This usually is followed by a paragraph spelling out the Member's opposition to the provision and closing with a promise to support corrective legislation.

15. American Psychiatric Association Testimony, p. 2.

carrier must enforce) for the duration of the "opt out" period.[16]

In other words, the scofflaw physician henceforth would be required to file Medicare claims the admitted purpose of which is to secure absolutely *no* Medicare payment, and Medicare's price controls are to be applied and enforced on a price that does not even exist.

Since passage of the Balanced Budget Act of 1997, disputes have arisen over a variety of questions, including the limitations on payments to physicians who treat emergency cases, even if they have withdrawn from Medicare; the status of Medicare patient privacy and its reach and applicability beyond certain politically sensitive conditions explicitly noted by HCFA, such as AIDS or mental illness; the use of "advanced beneficiary notices" for services that may not be covered by Medicare; the impact of Section 4507 on the status of Medicare-eligible persons who have withdrawn voluntarily from Medicare Part B; and the legal status of private contracts for "otherwise covered" Medicare services distinct from categorically "noncovered services," such as eyeglasses or custodial care.

The need to resolve these ambiguities has led to congressional action. In the fall of 1997, Senator Kyl put a "hold" on the nomination of Nancy-Ann Min DeParle as HCFA Administrator and sought specific assurances from the Clinton Administration that the statutory language would be interpreted and applied by HCFA in ways less damaging to the interests of doctors and patients.[17] Representative Benjamin Cardin (D–MD), responding to claims that the new restriction exceeded covered services in Medicare, introduced the Medicare Private Contracting Clarification Act of 1998 (H.R. 3259) to make it clear that no private contract, as specified in Section 4507, would be required for services Medicare does not cover.

In response to inquiries raised by Senator Daniel Patrick Moynihan (D–NY), the U.S. General Accounting Office (GAO) issued a report on the contentious issues raised by both proponents and opponents of the enactment of Section 4507.[18] Curiously, however, on certain crucial policy issues the GAO simply repeats the official views of HCFA—precisely the views that are at issue in the current controversy.

Harming Patients

While Section 4507 has generated more questions than answers among taxpayers and senior citizens, certain things are clear.

1. **Patients lose the services of certain doctors.** If a doctor chooses to contract privately with a Medicare patient and opts out of the system, he will, in effect, be required to abandon Medicare reimbursement from all of his other Medicare patients for at least two years. Thus,

16. Department of Health and Human Services, Health Care Financing Administration, *Program Memorandum Carriers*, Transmittal No. B–97–17, January 1998, p. 6. The memo says, in effect, that all a physician has to do to violate the affidavit with the beneficiary is simply submit a claim to Medicare; on the other hand, if the beneficiary submits a claim to Medicare, that submission does not constitute a violation of the affidavit. The memo further notes that "The Questions and Answers (Q and A's) included in this program memorandum (PM) differ from those previously sent to you because of *recent policy decisions*." Emphasis added.

17. After these assurances, Senator Kyl lifted the hold and allowed the DeParle nomination to go to the Senate floor for a successful vote. The November 1997 assurances included an agreement that the law would be confined clearly to covered services, that it would not affect the provision of "partially covered" medical services, that restrictions on a doctor who opts out of Medicare would not affect fellow members of a group medical practice, and that DeParle would cooperate with Congress to find ways to "maximize" patients' freedom to choose their own physicians. HHS Secretary Donna Shalala called Senator Kyl to confirm these interpretations. "While Secretary Shalala made no firm commitments, she did pledge to follow Congressional intent in the area of private contracting and to continue working to increase patient options." Senator Jon Kyl, press statement, November 7, 1997.

18. U.S. General Accounting Office, *Medicare: Clarification of Provisions Regarding Private Contracts Between Physicians and Beneficiaries*, GAO/HEHS–98–98R, February 23, 1998.

Section 4507 not only restrains doctors who wish to contract privately, but also harms Medicare patients who are denied that doctor's services.

2. **Doctors are placed in an invidious position.** Under the restrictive terms of Section 4507, the decision over whether to engage in a private contract with a Medicare patient is not, and cannot be, the patient's. The entire burden of the decision, and thus the onus of refusing to enter into such an agreement if the patient should wish it, is imposed on the doctor. Thus, Members of Congress and officials of the Clinton Administration have cleverly shifted responsibility from themselves to the medical profession for the execution of this restrictive policy.

3. **The legislation has virtually ended private contracting.** Contrary to the widely publicized claims of leading Members of Congress, Section 4507 is not designed to "liberalize" private contracting between doctors and Medicare patients. HCFA reports that during the first quarter of 1998, of 691,000 physicians and other practitioners enrolled in the Medicare program, only 300 physicians signed affidavits to pursue private contracting with Medicare patients and to withdraw from the Medicare program for two years.[19] The provision thus effectively nullifies the ability of most persons enrolled in Medicare to enter a private contractual relationship with their personal physicians for whatever reason seems good to them. Because many doctors reside in communities where it is financially impossible for them to give up their Medicare practice for two full years, the provision guarantees that private contracting will be virtually impossible for all but a tiny minority of physicians.

WHAT THE FEDERAL JUDICIARY SAYS SECTION 4507 MEANS

If the Constitution includes, as the U.S. Supreme Court says it does,[20] a basic right to privacy, ordinary Americans would doubtless find it hard to imagine a more serious invasion of that privacy than Section 4507's limitation on private agreements between doctors and patients who make transactions outside of Medicare.

In 1997, Medicare patients and members of the United Seniors Association filed suit asking the U.S. District Court for the District of Columbia to strike down the provision as a violation of basic rights to liberty and privacy under the Constitution. In his decision in *United Seniors Association Inc.* v. *Donna Shalala* (1998), U.S. District Court Judge Thomas F. Hogan stated:

> The Court does not pass judgment on Congress's wisdom in passing Section 4507. The Court's role here is solely to determine whether the United States Constitution confers a fundamental right on individuals to contract privately with their physicians. *The Court finds that it does not.*[21]

In defense of Section 4507, lawyers for the Clinton Administration insisted that senior citizens did not have a fundamental right to "autonomous decision-making" (the term of legal art used by lawyers concerning matters of personal liberty and privacy) in choosing a private contractual relationship with their doctors. The U.S. District Court for the District of Columbia thus agreed with the Clin-

19. "HCFA Says 300 Physicians Opted Out of Medicare to Contract Privately," Bureau of National Affairs *Health Care Policy Report*, Vol. 6, No. 18 (May 4, 1998), p. 1.

20. In *Griswold* v. *Connecticut* (1962), a health care-related case in which plaintiffs challenged the constitutionality of a state law forbidding the use of contraceptives, Justice William O. Douglas wrote: "The right of privacy which presses for recognition here is a legitimate one. The present case, then, concerns a relationship lying within the zone of privacy created by several constitutional guarantees.... We deal with a right of privacy older than the Bill of Rights."

21. See *United Seniors Association Inc.* v. *Donna Shalala*, U.S. District Court for the District of Columbia, Civ. No. 97–3109, April 14, 1998; emphasis added.

ton Administration's interpretation of the law, leaving senior citizens with no constitutional right to enter into private agreements with their doctors outside of the Medicare system.[22]

At the same time, Judge Hogan noted that, contrary to the misleading claims of Section 4507's congressional supporters, the application of Medicare law by HCFA will further restrain patient choice of doctors: "The Court is concerned, however, that the regulations and interpretations of HCFA further limit patients' access to physicians of their own choosing."[23]

Judge Hogan also noted that, under existing circumstances, current congressional and Administration policy ensures that senior citizens have no practical alternative to the Medicare system: "Medicare is, in effect, the only primary health insurance available to people over age 65. No private health insurance companies offer 'first dollar' insurance to this group; they offer only supplemental insurance."[24] In other words, as Senator Kyl has argued, for today's senior citizens, "it's either Medicare or no care."[25]

The United Seniors Association, a conservative senior citizens group, joined by the American Civil Liberties Union of the National Capital Area and a number of medical and patient groups, has appealed the case to the U.S. District Court of Appeals for the District of Columbia Circuit.[26] In their *amicus* brief, the appellants state:

> The right of personal autonomy involved in this case—the right of a competent individual, in consultation with a licensed physician, to obtain desired medical services at his or her own expense—is fundamental. It has been recognized historically and without dissent, as Appellants' brief amply demonstrates. And it is recognized in all current law (with the sole exception of the statute at issue) and contemporary morals.[27]

Shortly before the U.S. District Court decision, the Senate adopted a resolution that in principle supports the right of doctors and Medicare patients to make private agreements. Offered by Senator Kyl during consideration of the 1999 budget resolution, this legally non-binding resolution specifies that "It is the sense of the Congress that seniors have the right to see the physician of their choice, and not be limited in such a right by the imposition of unreasonable conditions on providers who are willing to treat seniors on a private basis."[28]

After a heated floor debate on March 31, 1998, the Kyl resolution passed the Senate by a vote of

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22. The District Court ruling has dramatic implications for seniors enrolled in Medicare. As noted by Richard Epstein, professor at the University of Chicago Law School, "Judge Hogan's decision comes as no surprise given the current tenor of constitutional law, with its regrettable effort to distinguish between fundamental personal liberties and mere contract rights. But in truth any viable system of individual liberty must be seamless, for individuals can protect their choices on how to be treated only if they can choose who shall treat them. Right now Medicare is an omnivorous state monopoly. Judge Hogan's decision helps it drive all potential competitors away from offering their services to seniors." Quoted in "Federal Judge Rules: No Constitutional Right," *Health Freedom Watch*, Institute for Health Freedom, Vol. 1, Issue 3 (May/June 1998), p. 3.

23. *United Seniors Association Inc.* v. *Shalala*, *op. cit.*

24. *Ibid.*

25. The Hon. Jon Kyl (R–AZ); Kent Masterson Brown; J. Edward Hill, M.D.; and Robert E. Moffit, Ph.D., "Private Doctor–Patient Agreements: How the Medicare Law Forbids Free Choice," *Heritage Lecture* No. 620, June 30, 1998 (symposium held May 11, 1998), p. 3.

26. Brief for *Amici Curiae*, *United Seniors Association Inc.*, v. *Donna Shalala*, Secretary of the United States Department of Health and Human Services, before the U.S. District Court of Appeals for the District of Columbia Circuit, Case Number 98–5142, July 7, 1998; cited hereafter as Brief for *Amici Curiae*.

27. *Ibid.*, p. 15.

28. See Senate debate on Amendment 2169 to S. Con. Res. 86, *Congressional Record*, March 31, 1998, esp. pp. 2818–2823.

51 to 47. So far, the House of Representatives has not adopted a similar resolution.

PROPOSITIONS WASHINGTON WANTS RETIREES TO ACCEPT

The rationales for the new Medicare restrictions advanced by official Washington since the enactment of Section 4507 involve a number of questionable, and at times seemingly contradictory, propositions. For example:

PROPOSITION #1: Americans 65 and over who are enrolled in Medicare have no constitutional right to privacy in their relations with their physicians unless they are getting an abortion or securing birth control services.

Lawyers for the Clinton Administration argue that seniors represented by the United Seniors Association are wrong, both in asserting that private agreements with doctors constitute a liberty protected by the Constitution and in asserting a privacy right in such agreements that is protected by the Constitution.

The Administration's lawyers argue that the privacy right concerns two kinds of personal interests: avoidance of the "disclosure of personal matters" and "independence in making certain kinds of important decisions";[29] but "Neither interest is implicated here…. The right to autonomous decision-making applies only in certain limited contexts involving marriage, contraception and abortion, family relationships, child rearing and education."[30] The U.S. District Court agreed.

The upshot, then, is that constitutionally protected transactions between doctors and patients for health care services are restricted to politically correct conditions like abortion and contraception, but not cancer screenings or urological consultations.

PROPOSITION #2: Medicare patients are now told that they have always had the right to withhold authorization for the submission of Medicare claims, invoking confidentiality or privacy as a reason for doing so, but the Medicare bureaucracy has no obligation to notify them of this right.

As noted by the American College of Physicians, "There is no official, systematic method for educating physicians and patients on Medicare payment and other rules."[31] Worse, the record shows that the Medicare bureaucracy and its allies say different things at different times and, in some crucial circumstances, say nothing at all.

In 1997 briefs filed with the U.S. District Court in Washington, Clinton Administration lawyers denied that seniors had a constitutional right to liberty or privacy in their relationships with their physicians and repeated the view that physicians treating Medicare patients must submit a claim to Medicare for every service rendered to a patient, without exception.[32] Then, toward the close of 1997,

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29. Defendant's Memorandum of Points and Authorities in Opposition to Plaintiff's Motion for a Preliminary Injunction and in Support of Defendant's Motion to Dismiss, or In the Alternative, for Summary Judgment, *United Seniors Association, Inc.* v. *Donna Shalala*, U.S. District Court for the District of Columbia, Civ. No. 97–3109, p. 26; cited hereafter as Defendant's Memorandum.

30. *Ibid.*

31. American College of Physicians, Statement on Medicare Private Contracting, Committee on Finance, U.S. Senate, 105th Cong., 2nd Sess., February 26, 1998, p. 5; cited hereafter as American College of Physicians Statement.

32. On pages 8, 16, and 19 of the Defendant's Memorandum, where the question is addressed, Clinton Administration lawyers insist on the mandatory submission of Medicare claims for each and every service *without any exceptions*, including confidentiality. As noted, only in their last filing before the oral argument in the U.S. District Court for the District of Columbia on March 6, 1998, did such an "exception" surface. See Defendant's Reply to Plaintiff's Response to Defendant's Motion to Dismiss or, in the Alternative, for Summary Judgment in *United Seniors Association Inc.* v. *Donna Shalala*, February 27, 1998, p. 20.

the Administration's policy team started to carve out a "privacy exception" for certain stated conditions, notably AIDS and mental illness.

This privacy exception had not been mentioned in previous Administration legal presentations. It first surfaced in a December 1997 circular to Medicare carriers, listing 22 questions on the meaning of Section 4507. In response to Question 21, HCFA says that there are "some circumstances" when a physician who remains in Medicare may refrain from sending a bill to the Medicare program if the patient does not want his illness or medical condition exposed. [33] More formally, HCFA Administrator Nancy-Ann DeParle stated in February 1998 Senate testimony that

> A beneficiary may, in some situations, refuse to authorize the release of medical information needed to submit a claim. On this case, a physician who remains in Medicare does not have to submit a claim for a covered service provided to a Medicare beneficiary. Examples would be when the beneficiary does not want information about mental illness or HIV/AIDS to be disclosed to anyone. I want to clarify that a physician will not be subject to penalties for failing to submit the claim. The Balanced Budget Act did not change this aspect of Medicare. It was the law a year ago and it is still the law today.[34]

Needless to say, nothing in Section 4507—the law controlling Medicare private contracting—provides any exception for patient privacy or confidentiality for AIDS, mental illness, or any other medical condition. Moreover, if a privacy or confidentiality exception did exist somewhere in the Medicare law before the enactment of Section 4507, HCFA has been conspicuously silent about it.[35]

The GAO, for its part, simply repeats HCFA's position on this question[36] without even noting that HCFA has changed its position that a doctor is legally required to submit a Medicare claim for every instance involving treatment of a Medicare patient. The GAO, moreover, does not cite any statutory basis for such an exception.

The newly discovered privacy exception must have been a surprise even to the most vocal political supporters of the new Medicare restrictions. In fact, the record of many years, including previous litigation on the subject, shows that different ranks of HCFA officials affirmed repeatedly that doctors, without exception, were required to submit claims to the Medicare bureaucracy every time they treated a Medicare patient.

33. Circular to Medicare carriers, "Q's and A's on Private Contracts," Health Care Financing Administration, December 1997, p. 6; cited hereafter as HCFA Q and A.

34. Nancy-Ann DeParle, "Private Contracting in Medicare," Statement before the Committee on Finance, United States Senate, 105th Cong., 2nd Sess., February 26, 1998, p. 7.

35. In response to an inquiry from Heritage Foundation Research Assistant Sarah Youssef concerning the legal basis for the "privacy exception," HCFA staff cited the Code of Federal Regulations 424.32 as the regulatory grounds for DeParle's statement to the Senate Finance Committee. But CFR 424.32 does not establish any regulatory basis for a privacy exception. It merely lays out the technical requirements for filing Medicare claims, including the requirement that the claim be filed with the proper intermediary, filed on time, use the right code, and include the beneficiary's signature, among other things. When pressed, Judy Hunt, the HCFA official handling the congressional hearings, conceded that if CFR 424.32 is the basis for DeParle's statement, the information "would seem incorrect." Personal communication from Judy Hunt to Sarah Youssef, March 30, 1998.

36. See GAO, *Medicare: Clarification of Provisions*, p. 6. The GAO simply repeats HCFA's examples of AIDS and mental illness as grounds for a privacy exception.

The list is impressive.[37] For example, on January 7, 1992, John Delaney, Chief of the Policy and Technical Assistance Branch of Medicare, insisted:

> There is no federal requirement that a physician must treat Medicare patients. However, if a physician *does* treat a Medicare patient, all Medicare rules, regulations and laws are applicable. For example, the Omnibus Reconciliation Act of 1989 requires physicians to file Medicare claims on all services provided to Medicare beneficiaries. This requirement applies to physicians who do not accept assignment as well as to those who do accept assignment.[38]

If a privacy exception to claims submission for Medicare beneficiaries always existed in Medicare law, then HCFA officials might have been expected to publicize such an important exception before the controversy erupted on Section 4507. But they did no such thing. There was no regulation; there was no guideline. Nor is there any evidence that HCFA ever notified Medicare patients of their long-standing right to pay a doctor with their own money and refrain from submitting a claim because of privacy or confidentiality concerns. Over the years, in federal courts and in communications with carriers, HCFA insisted on the usual submission of claims.

Section 4507, as noted, contains no privacy exception. From that standpoint, therefore, it makes the situation worse. In fact, given the breadth of the reporting requirement imposed on the Secretary of Health and Human Services under Section 4507, the American Psychiatric Association observes that "the specifics of the reporting requirement are so sweeping that we believe the requirement would require extensive violations of patient confidentiality."[39]

Moreover, even if one assumed that Congress at some point had enacted a privacy exception to Medicare claims submission, one would have to wonder why it has shown such indifference to HCFA's failure to publicize and enforce so crucial a patient protection. This indifference is all the more curious when one considers the official threats of sanctions made against doctors who wanted to contract privately with patients, especially since the *Stewart* v. *Sullivan* case in 1992.[40]

HCFA's newly discovered privacy exception to the submission of Medicare claims is good public policy, but it would be even better if Congress were to ground it solidly in statute rather than leave it as a desperate assertion by an embattled bureaucracy responding to angry senior citizens. Even so, however, the right of private contracting is a fundamental liberty, and its justification should not be limited narrowly to privacy concerns.

PROPOSITION #3: Section 4507 of the Balanced Budget Act of 1997 is a "liberalization," not a restriction, of private contracting in Medicare.

When Section 4507 was passed, various Members of Congress defended their handiwork as a "liberalization" of personal choice and professional freedom in Medicare. For example, the House Republican Conference, in a set of talking points on Section 4507, declared that "The Balanced Budget Act *loosens* federal red tape on private contracts. The Bal-

37. It includes, for example, Kathleen Buto, Director of the Bureau of Policy Development, December 22, 1992; Bruce Vladek, HCFA Administrator, 1994; and Thomas Ault, Director of the Bureau of Policy Development, February 27, 1996. Cited in American Psychiatric Association Testimony, *op cit.*

38. Letter from John Delaney, Chief, Section 2, Policy and Technical Assistance Branch, Division of Medicare, to Ms. Kim Small, Professional Emergency Service Association Corporation of Irving, Texas, January 7, 1992.

39. American Psychiatric Association Testimony, p. 4.

40. *Stewart* v. *Sullivan*, 816 Supp. 218 DNJ 1992.

anced Budget Act gives seniors more choices and physicians more freedom. Our bill allows physicians to opt out of the Medicare system and set their own fees and rates if they choose to do that."[41]

Similarly, in oral argument before the U.S. District Court for the District of Columbia, lawyers for the Clinton Administration initially described Section 4507 as a "liberalization" of Medicare law.[42] John Rother, legislative Director of the American Association of Retired Persons (AARP), argues that Section 4507, rather than weakening Medicare beneficiaries' right to contract privately with their physicians, actually expands that right.[43]

In fact, however, the notion that Section 4507 liberalizes the right of private contracting in Medicare is nonsense. Judge Thomas Hogan's decision in *United Seniors Association Inc.* v. *Shalala* certainly did not portray Section 4507 as an expansion of the right of contract. Moreover, during oral argument in the case, when Judge Hogan noted that the provision was so narrowly drawn as to be "meaningless," the Clinton Administration's trial attorney, Anthony J. Coppolino, responded, "I concede that the provision was gutted in conference to make it probably not very useful...."[44] As Judge Hogan remarked in his ruling, "Both parties also substantially agree that the two year restriction on physicians who enter such contracts represents a substantial barrier to the receipt of contracted services."[45]

HCFA's preliminary 1998 report on the infinitesimal number of doctors willing to contract privately under Section 4507 confirms the true intent of Section 4507: to make private contracting between doctors and patients in Medicare all but impossible.

PROPOSITION #4: Private contracts between doctors and Medicare patients were always illegal even if they were not against the law.

Americans think that they live in a free society under a system of limited, constitutional government. In practice, this should mean that Americans, being a free people, enjoy the liberty to engage in private activity and otherwise pursue happiness for themselves and their children unless there is a law prohibiting such activity.

But official Washington and its allies have a different standard when it comes to private agreements between doctors and Medicare patients. "As an initial matter," argue lawyers for the Clinton Administration, "the fact that the Medicare Act did not expressly 'prohibit' private contracts *is of no significance*. Congress need not add a provision to every statute it passes stating that its requirements may not be circumvented by private agreement."[46]

In the sphere of Medicare policy, the tacit assumption is that one may engage in private transactions outside of the program only if federal officials permit one to do so. According to the staff of the House Ways and Means Committee, "Prior to the Balanced Budget Act of 1997, private physician contracting was not

41. "The Truth About Medicare's Private Contracting Provisions," *Reality Check*, House Republican Conference, September 5, 1997, p. 1.

42. Oral Argument, p. 26. Later in the same oral argument, Anthony J. Coppolino, the same government trial lawyer, conceded that the "liberalizing" provision has rendered private contracting in Medicare practically "meaningless."

43. Elliot Carlson and Don McLeod, "AARP Answers Scare Campaign on Medicare Private Contracting," *Newsbreak*, February 1998, p.3.

44. Oral Argument, p. 29.

45. *United Seniors Association Inc. et al* v. *Donna Shalala*, U.S. District Court for the District of Columbia, Civ. No. 97-3109, April 14, 1998, p. 2.

46. Defendant's Memorandum, p. 19.

allowed."[47] Likewise, John Rother and the AARP have emphasized in communications to AARP members that until the passage of Section 4507, senior citizens had never been permitted to contract privately for services covered by Medicare.[48]

The truth, however, is that before the enactment of Section 4507, there was nothing to forbid private contracting between doctors and Medicare beneficiaries: "Before the enactment of the BBA," observes the GAO, "Medicare law did not expressly prohibit private contracting between physicians and beneficiaries."[49] HCFA simply took the position that they were illegal.[50]

HCFA's attempt to outlaw private agreements in Medicare was a creative effort to twist the technical statute governing Medicare claims submission requirements into a far-reaching federal policy forbidding private transactions between doctors and patients outside of Medicare.[51] But, as Senator Kyl argued in the summer of 1997, Congress never intended that senior citizens be prevented from spending their own money on medical services provided by physicians of their choice.

This, in substance, was also the view of the federal judiciary. In *Stewart* v. *Sullivan*, the first major federal court proceeding on the subject, Judge Nicholas Politan dismissed the case brought by Dr. Lois Copeland and five of her elderly patients, not because their concerns or interests were trivial, but because the alleged policy forbidding them to contract privately did not exist either in law or in regulation.[52]

Had HCFA truly believed that there was an existing privacy or confidentiality exception to the submission of claims, it could simply have notified the plaintiffs and saved the taxpayers the expense of unnecessary litigation. Instead, it continued to threaten doctors with sanctions and tried to seize upon any legislative reed, no matter how thin, to make a case against private contracting.[53] However, it always stopped short of issuing formal regulations, subject to formal notice and comment under the Administrative Procedures Act as well as a renewed legal challenge by the plaintiffs in the original *Stewart* v. *Sullivan* case. Then, with the enact-

47. "Private Contracting," talking points for legislative assistants, U.S. House of Representatives, accompanying an informational memorandum from Anne Marie Lynch, Subcommittee on Health, House Ways and Means Committee, August 29, 1997; cited hereafter as Staff Memorandum.

48. Carlson and McLeod, "AARP Answers Scare Campaign," *op. cit.*

49. GAO, *Medicare: Clarification of Provisions*, p. 8. Once again, the GAO interpretation of the legal situation suffers from an attempt to mirror the HCFA position. On page 8 of its report, the GAO notes that there was no law against private contracting; two pages earlier, it describes Section 4507 as a provision of law that gives Medicare beneficiaries a "new option" to contract privately. If private contracting was not previously illegal, it is hard to see how it could be a new legal option. The operating principle seems to be that something can be true and not true at the same time.

50. "HCFA, however, took the position that private contracts for Medicare-covered services had no legal force or effect, because of the statutory requirements that physicians abide by Medicare's charge limits and submit all authorized claims. That is also HCFA's position today." *Ibid.*

51. On the subject of mandatory claims submission, Anthony J. Coppolino, lead lawyer for the Clinton Administration, on March 6, 1998, told the U.S. District Court for the District of Columbia that " Congress doesn't have to expressly state in a statute we really mean this, and you can't avoid this by contract." Oral Argument, p. 42.

52. When *Stewart* v. *Sullivan* is cited, supporters of the new Medicare restrictions invariably note that the case was "dismissed" on grounds of "ripeness." But they often fail to add the real reason it was dismissed: the absence of a law or policy against private contracting.

53. During the debate on his original amendment to the Balanced Budget Act of 1997, Senator Kyl noted that HCFA officials seized on the Medicare Technical Corrections Act, signed into law in 1995, which contained language subtle enough for HCFA to exploit for purposes of restricting private contracting, regardless of any congressional intent to do so.

ment of Section 4507, HCFA's previously non-existent "policy" became law.

PROPOSITION #5: The freedom to spend one's own money on medical services outside of Medicare depends not on federal law or regulation associated with that law, but on what HCFA bureaucrats say in Carrier Manuals.

"In 1993," according to the staff of the House Ways and Means Health Subcommittee, "HCFA issued Carrier Manual instructions prohibiting private contracting."[54] Similarly, both the House Republican Conference and the Clinton Administration's lawyers have cited Section 3044 of the 1993 Carrier Manual to demonstrate HCFA's intent to prevent private agreements in Medicare.[55] (The widely cited section, incidentally, contains no exceptions for Medicare claims submission for reasons of privacy or confidentiality in treatment of AIDS or mental illness or any other condition.)

In *Stewart* v. *Sullivan*, Judge Politan stated that the alleged federal policy forbidding private contracts between doctors and Medicare patients existed neither in law nor in regulation. In the wake of that decision, HCFA did not recommend any legislation to restrict private contracting and did not promulgate any regulations to enforce such a restriction. Instead—in a process that avoids the public notice and comments on regulatory initiatives required by the Administrative Procedures Act—it amended its carrier manual (instructions to Medicare carriers) to communicate its institutional opposition to private contracting.

Carrier Manual instructions, however, are not legally binding. In other words, before 1992, there was no policy forbidding private doctor-patient arrangements.[56] Then, after 1992, doctors and patients in the Medicare program were subject to HCFA "policies" that were of no legal force or effect.

On October 15, 1991, two years before the issuance of Carrier Manual Section 3044 and one year before *Stewart* v. *Sullivan*, HCFA Administrator Gail Wilensky stated: "In the rare event, however, that a patient, for his or her own reasons, and entirely independently, chooses not to use Part B coverage, the law does not require the submission of a claim by the physician."[57] Wilensky's reading of the law was compatible with Judge Politan's finding that there was no existing federal policy against private contracting between doctors and Medicare patients.

Again, on August 4, 1995, two years after the issuance of Carrier Manual Section 3044, Thomas A. Ault, Director of HCFA's Bureau of Policy Development, stated that "if the beneficiary chooses to withhold a claims authorization for his own reasons, entirely free of any pressure from the physician, the Medicare program recognizes that the physician has no right or duty to submit the claim on the beneficiary's behalf."[58]

Despite repeated requests to HCFA by Heritage research staff for any official notices to beneficiaries or physicians describing such options, however, no such documents have been forthcoming.

54. Staff Memorandum.

55. Oral Argument, p. 23.

56. *Stewart v. Sullivan*, *op. cit.* The key point in the 1992 case was that if a Medicare beneficiary did not want to file a claim, he did not have to do so. In commenting on the case, Judge Thomas Hogan of the U.S. District Court for the District of Columbia told Kent Masterson Brown, attorney for the seniors and their doctor, "I like your reading of *Stewart v. Sullivan*; it sounds like you won the case when the government got it dismissed." Oral Argument, p. 6.

57. Letter from the Hon. Gail Wilensky, Administrator, Health Care Financing Administration, to Cyler D. Garner, President of the Medical Association of Georgia, October 15, 1991.

58. Letter from the Hon. Thomas Ault, Director, Bureau of Policy Development, Health Care Financing Administration, to James Pyles, August 4, 1995.

Proposition #6: HCFA has authority to impose rules and regulations not only on transactions between doctors and patients within Medicare, but also on transactions that take place outside of Medicare.

Americans might disagree with specific Medicare policies, but they would not challenge the right of Congress and the federal bureaucracy to make rules and regulations governing the financing and delivery of medical services within the Medicare system, including the statutory denial of outpatient prescription drug coverage and catastrophic coverage, the limitation of medical services, or the outright denial of a growing number of medical claims that bureaucrats think are "unnecessary or inappropriate."

Most people take for granted the fundamental distinction between what is public and what is private, but this commonsense distinction does not apply to Medicare. As noted, HCFA's traditional view is that all claims must be submitted for all medical services in all instances. Even if one were to accept in good faith the agency's privacy exception for someone who does not wish to submit a claim and wants to pay the doctor outside of Medicare, official Washington says the system's price control regime would still apply. It would apply even if the doctor wanted to charge the patient less than the Medicare charge, or even if the doctor wanted to charge the patient nothing at all as an act of charity or personal friendship. As the GAO reports:

> Without the patient's authorization, the physician cannot submit the claim. Medicare's limiting charge amounts still apply, however, and cap the amount the physician may charge. Because Medicare pays no part of the charges, the beneficiary is fully responsible for paying for the treatment up to the limiting charge.[59]

Private transactions in health care, in other words, are legally permitted only for Americans below age 65 who are not disabled. Thus, Congress has created a unique program, run by an arbitrary bureaucracy, that regulates not only transactions that take place within it, but also transactions that take place outside of it.

Nevertheless, the fact remains that the Medicare law contains no explicit requirement that Medicare's price controls be applied to transactions between doctors and patients outside of the Medicare system. This is merely one more creative HCFA interpretation designed to expand the agency's power.[60]

PROPOSITION #7: The rules governing doctors in Medicare should be just as restrictive as the rules governing doctors in employer-based HMOs or managed care networks.

Americans might think that the professional independence and integrity of the medical profession, just like patient choice of doctors, health plans, or medical treatments, is a positive good that federal policymakers would wish to preserve and promote.

Not so. Some of the very Members of Congress who condemn existing restrictions on employer-based health insurance, undercutting the professional freedom of doctors and the choice of patients, will go so far as to cite the practices of employer-based insurance as a justification—or even a model—for restrictions on doctors and patients in Medicare. During the March 31, 1998, Senate debate on the Kyl resolution, Senator Paul Wellstone (D–MN) drew exactly such an analogy:

59. GAO, *Medicare: Clarification of Provisions*, pp. 6–7.

60. In the regulation governing the filing of Medicare claims, Section 424.30 (42 CFR Ch. IV), there also is no such stipulation. The claims filing process is governed by HCFA's payment rules. This means that if a doctor wants to get paid under Medicare, he must file a claim. Only if a doctor files a claim is he under the rules and regulations of Medicare.

> Take the Kaiser Plan. It is a well known, managed care plan. You join the Kaiser Plan and you are going to pay a given fee, the enrollees pay a given fee. Can you imagine what it would be like if all of a sudden doctors in the Kaiser plan could decide on their own, based upon what particular symptom they were seeing, that they would charge more for service? You join the plan just like people join Medicare.[61]

Officials of the American College of Physicians claim that private contracting between doctors and patients is incompatible with what they see as a desirable policy of promoting managed care in Medicare:

> The ACP is also concerned that private contracting runs counter to the incentives of the Balanced Budget Act to encourage use of managed care and to use health resources economically. Under the Kyl bill, any managed care enrollee could pay an outside physician separately for a service under a private contract, a service which already has been actuarially factored into the managed care capitated payment.[62]

Spokesmen for the AARP worry that if Medicare patients have the right to engage in private contracts, they will be able to get out of the new HMO plans for specific medical services and undermine HCFA's existing payment system for HMOs:

> The capitated payments Medicare makes to HMOs and the new Medicare Choice plans include funds to cover physicians services. Yet if physicians are allowed to privately contract with beneficiaries in these plans, the plans would be able to keep the funds for services not provided by the plans, but which beneficiaries paid for under private contracts.[63]

Moreover, notes the AARP, a senior citizen allowed to go outside of HMOs most likely will pay a doctor a different amount for a medical service than the amount dictated by the HMO plan or the government: "This practice essentially would deny Medicare beneficiaries a protection enjoyed by millions of workers and their families."[64]

Of course, as the national media report, a great many Americans would be quite happy to be free of HMO "protections," now so widespread in restrictive employer-based health insurance. But if senior citizens feel it necessary to get out of HMOs to purchase the services they want, and if HMO use declines, there is no reason why Congress cannot simply adjust HMO payments accordingly, recoup any "windfalls," and save the taxpayers even more money. In any case, good HMOs in Medicare should not have to worry about serious inroads from patient choice through private contracting.

PROPOSITION #8: The Balanced Budget Act's private "Medicare Choice Plans," including medical savings accounts (MSAs), are private in name only.

Among the most intriguing issues to arise during the debate on Section 4507 is the provision's likely impact on the status of medical savings accounts, the new tax-free accounts available to a limited number (390,000) of

61. See Senate debate on Amendment 2169, *Congressional Record, op. cit.*

62. American College of Physicians Statement, p. 2.

63. "Medicare Private Contracting, S. 1194/H.R. 2497," *Talking Points*, American Association of Retired Persons, Washington, D.C., October 3, 1997, p. 4.

64. *Ibid.*

Medicare enrollees. According to the House Republican Conference, for example,

> The legislation makes quite clear that the private contracting and Medical Savings Accounts options are separate and distinct. MSAs expand patient choice for seniors, and allow doctors and patients to privately negotiate whatever reimbursement rate they wish for any medical service.[65]

In other words, the MSA is a vehicle for a private contract: a free-market transaction. Its very purpose is to maximize freedom of choice for doctors and patients.

But Section 4507 does not allow that maximum freedom. If a Medicare patient wants the special services of a physician who has signed an affidavit to contract privately and drop out of Medicare for a period of two years, that doctor may not treat that Medicare patient and be paid, even if that patient is enrolled in an MSA plan. "Physicians will be able to opt out of Medicare, set their own rates, and operate independent from HCFA," according to the staff of the House Ways and Means Health Subcommittee. "However, when a physician makes this choice, he is required to remain out of the Medicare program for two years. That includes Medicare fee for service, HMOs, PSOs, and MSAs."[66] HCFA is responsible for finalizing regulations in this area.[67]

Americans can be excused for finding the logic of the congressional argument hard to follow: For a doctor to contract privately with a Medicare patient is acceptable only if the doctor willingly gives up his right to contract privately with the Medicare patient enrolled in an MSA plan. Thus, what appears to be an opportunity for private contracting becomes a way to *restrict* private contracting. Regardless of congressional rhetoric, the so-called private options in the Medicare Choice system appear to be private in name only. They really are new vehicles for congressional expansion of HCFA's already enormous regulatory authority into the new territory of private health insurance.

PROPOSITION #9: The plain language of the law is to be applied and obeyed except when it comes to Section 4507.

Before the enactment of Section 4507, HCFA said that a Medicare patient could contract privately with a doctor if that patient were to get out of Medicare Part B and give up all coverage under Medicare Part B. Since there is no viable private insurance market for senior citizens outside of Medicare, however, the effect of this penalty is draconian. As Judge Politan noted in *Stewart* v. *Sullivan*, this "either/or" requirement constitutes a real harm to Medicare patients, and thus gives them standing to sue the federal government.[68]

Once again, it should be noted that there is not now, and there was not then, any specific requirement in the Medicare law that forced a person to drop Medicare coverage; HCFA simply used this notion as a weapon in its campaign against private contracting. Needless to say, there is no evidence that HCFA ever notified Medicare beneficiaries that giving up Medicare Part B was the price they had to pay for engaging the services of a doctor outside of the Medicare system.[69]

Section 4507 is remarkably restrictive, but HCFA is trying to interpret it in a way that makes it more acceptable to retirees, taxpayers, and Members of Congress. For purposes of the restrictions on private contracting, for exam-

65. "The Truth About Medicare's Private Contracting Provisions," p. 2.

66. Staff Memorandum.

67. As John Hoff notes, there is no statutory basis for exempting the new MSA plans from the policy on private contracting. Hoff, *Medicare Private Contracting*, p. 40.

68. See *Stewart* v. *Sullivan*, 816 Supp. 218 DNJ 1992.

ple, a Medicare beneficiary is defined as any person who is enrolled in Medicare under Part A, which covers hospitalization, *or* Part B, which covers payments to doctors. The language of the statute makes it plain that the restrictions on private contracting apply even to patients who are not enrolled in Part B.

Thus, anyone who dropped out of Part B would still be a Medicare beneficiary and therefore could not be treated privately by any doctor who signed the government's affidavit and dropped out of Medicare for two years. Moreover, no physician treating such a patient could submit a bill to Medicare on behalf of a patient who is not enrolled in Part B and thus is no longer eligible for Part B coverage; if a doctor did submit the bill to Medicare, he could be in violation of the False Claims Act or the ominous fraud statutes.[70]

Yet HCFA says that the restrictions on private contracting will only apply to Medicare patients enrolled in Part B.[71] It is hardly surprising that even Members of Congress—the very people responsible for passing the law in the first place—have been saying different things to different affected constituents.[72]

THE HIDDEN ASSUMPTIONS

The real debate over Section 4507 is not about protecting vulnerable senior citizens from predatory physicians; it is about power and control. The strongest congressional supporters of the new Medicare restrictions invariably are the most prominent advocates of a single-payer, government-run health care system. Under such a system, the government would control not only the financing, but also the medical benefits available to American citizens. What patients personally want and what doctors professionally can give would be subordinated to the rules of the system.

Thus, if one examines the arguments for the new Medicare restrictions, they are logically indistinguishable from arguments against any free-market transactions in the health care system. For example:

- **Without these new Medicare restrictions, doctors as a class, unlike other classes of professionals, cannot be trusted to deal honestly with elderly patients.** The tacit premise is that doctors, as a class of professionals, will take advantage of the elderly, who somehow are uniquely vulnerable to the machinations of greedy doctors. For example, Representative Fortney "Pete" Stark (D–CA) says that the campaign to restore private contracting in Medicare "is pure greed wrapped in the flag of freedom."[73] Similar accusations are leveled by supporters of the new restrictions outside of Congress. Taxpayers should note that advocates of these restrictions do not advance any similar argument against senior citizens dealing directly with any other class of professionals—especially lawyers.

  In 1997, federal investigators estimated that about $23 billion (about 14 percent of all Medicare expenditures) is lost annually to waste, fraud, and abuse. Every penny is lost within the confines of Medicare's inefficient,

69. In explaining HCFA's previous position that a Medicare beneficiary would have to disenroll from Medicare Part B to contract privately with a physician, HCFA public affairs officer Paul Cotton stated that private contracting limitations affect only the doctor, not the patient. Therefore, HCFA did not need to send notification of this condition to Medicare beneficiaries. Personal communication from Paul Cotton to Sarah Youssef, May 13, 1998.
70. The False Claims Act prohibits the making of a false record or statement so that Medicare or any other government agency will pay the fraudulent claim. Penalties are stiff: Violators must repay three times the damages suffered by the federal government, plus a mandatory civil penalty of between $5,000 and $10,000 per claim.
71. Hoff, *Medicare Private Contracting*, p. 26. As Hoff notes, based on the statutory language, today's HCFA policy could change tomorrow.
72. Letter from Anne E. Shipps to Robert E. Moffit, January 19, 1998.
73. Representative Pete Stark (D–CA), *Congressional Record*, September 22, 1997.

outdated, third-party contract payment system, which now processes over 800 million claims per year. The way this system is organized virtually invites serious problems, although it is not always clear whether unjustified payments are due to genuine errors or outright fraud.

Recently, the inspector general (IG) of the Department of Health and Human Services conducted an audit of 8,048 Medicare claims filed in 1997 and found that 1,907 of these claims did not comply with Medicare rules and regulations. On closer examination, the IG found that over half of these problems were due to "inadequate documentation" or "coding errors." Linda Ruiz, a top HCFA official, has conceded that the federal government does not know how many of the 1,907 claims were fraudulent.[74] In sharp contrast to this wasteful Medicare structure, a radically different system based on the direct and open exchange of value for money between doctors and patients in a free market is the least susceptible to fraud of any financing arrangement.

The belief that private contracting will promote widespread "double billing" of Medicare is based on the probability of this scenario: A physician will run the extraordinary risk of filing a separate claim for a service with Medicare while he is also being privately reimbursed by the patient for that same service.[75]

Every time Medicare pays a claim, it sends the patient an explanation of Medicare benefits (EOMB) form detailing what has been reimbursed. Any doctor who double bills Medicare for a service after a patient has contracted privately for the same service and paid the full charge out his own pocket will be faced with two things: a very angry patient with access to the Medicare anti-fraud telephone hot line, and the strong likelihood of an aggressive prosecution for fraudulent billing.

The premise of the argument is that physicians who contract privately with a minority of Medicare patients are going to risk, at the very least, a $10,000 fine, exclusion from Medicare, possible imprisonment for Medicare fraud, a loss of reputation, and a loss of professional standing just to double bill at the expense of the taxpayer. Such illegal behavior, while obviously possible, is akin to that of the CEO of a major corporation with an impressive array of internal financial controls who decides to jeopardize his substantial salary, benefits, and stock options and face possible arrest, fines, imprisonment, and loss of standing in the community just to dip into petty cash for personal expenses.[76]

- **Without these new Medicare restrictions, doctors will exploit the elderly and erode Medicare coverage.** The notion that doctors can or will coerce senior citizens into private contracts reflects a profound misunderstanding of the functioning of a free market. This is true for several reasons.

First, private economic arrangements governing the delivery of services, like private contracts, are not driven exclusively by supply.

74. At a National Orthopedic Leadership Conference, Ms. Ruiz told the assembled doctors, understandably upset at public perception of fraud among physicians, to "stop whining and let's start working together." "IG Audit Found Errors Not Fraud in Medicare Claims," *American Academy of Orthopedic Surgeons Bulletin*, June 1998, p. 13.

75. This possibility of double billing also exists under HCFA's recently discovered "privacy exception," whereby the doctor does not have to submit any claims to Medicare for treating a Medicare patient. As Merrill Matthews of the National Center for Policy Analysis observes, "Indeed, Kyl–Archer has a provision—one that some of the supporters of the bill want removed and that probably could be dropped considering HCFA's new position—requiring physicians to report to Medicare that a service was performed. Thus, if the concern is double billing, Kyl–Archer may be safer than current law." Merrill Matthews, "Answering the Critics of Medicare Private Contracting," National Center for Policy Analysis *Brief Analysis* No. 268, June 4, 1998, p. 3.

76. The author is indebted to Mike Korbey, Legislative Director of the United Seniors Association, for the business analogy.

Supply is key only when the government has control of it and consumer demand or consumer choice is irrelevant. Therefore, a doctor contemplating a practice based solely on private contract would have to overcome powerful countervailing incentives on the demand side of the economic equation.

To enter into a permanent contractual relationship with such a doctor, patients would have to give up their Medicare coverage and the huge taxpayer subsidies that go with it (approximately 80 percent of the cost of the program and growing) and forgo the return on all of their previous financial contributions to Medicare in taxes and premiums. Although some patients with special wants or needs might find it advantageous to forgo the entire range of Medicare subsidies, the demand for such arrangements generally would be small, if not infinitesimal. The most likely result of true liberalization of private contracting on a case-by-case basis would be to reproduce dynamics similar to those which prevail in the British National Health Service. And few in Britain believe that their National Health Service is threatened with extinction because of private contracting.

Second, powerful incentives on the supply side of the economic equation would dissuade the overwhelming majority of physicians from permanent withdrawal from Medicare. Today, physicians overwhelmingly accept "assignment" (the official Medicare payment for a service) for almost all Medicare covered services. Under current law, "non-participating" physicians (those who do not accept assignment) can charge 15 percent above the Medicare-approved price for a service. Only 20 percent of them, however, choose to do so.[77] Some physicians, given the chance to escape Medicare's legendary hassle factors, would even prefer to charge Medicare patients less.

Medicare payment, even though substantially below what private markets currently reimburse in most cases, is still a guaranteed payment.[78] A huge portion of physician income is based on Medicare payment. And with the projected growth of the Medicare population over the next 30 years, the demand for Medicare services is going to increase. Thus, even under the pressures of the Medicare bureaucracy, doctors are not likely to give up Medicare practice.

- **Without these new restrictions, Medicare itself would be damaged.** Advocates of the new Medicare restrictions argue that without them, Medicare costs will increase and the program will suffer economic damage. In fact, the economic consequences of private contracting are uniformly positive for the program.

Consider a similar practice in employer-based health insurance. If a patient decided to go outside of his employer's plan, seek the services of a physician independently, and refrain from billing the employer's plan, not only would the plan managers be delighted, but so would the employer. From the standpoint of the fiscal health of the private plan, the fewer claims submitted, the better. Given Medicare's financially troubled state, one would think that Members of Congress, who have fiduciary responsibility for the program, would applaud private contracting, particularly among wealthy seniors, instead of discouraging it.

The rising demand for physician services has been the major source of double-digit increases in Part B, especially since the 1980s. That is why Congress in 1989 established controls on the volume of medical services in Medicare, proportionately reducing physician reimbursement if volume were to exceed officially accepted levels in a given year.[79] Thus, any increase in the number persons who contract privately for Part B services, reducing the claims on Medicare Part B trust fund, would

77. Matthews, "Answering the Critics," *op. cit.*

78. Currently, Medicare physician payment is about 70 percent of private-sector payment.

reduce the level of taxation required to fund Part B. This has the added social benefit of leaving more Medicare funds available to care for low-income elderly people.

Any expansion of private contracting would enable doctors, especially top-ranked specialists, to shift costs and help additional numbers of low-income Medicare enrollees. Dr. Walter Stark of Johns Hopkins University Medical Systems, one of the top ophthalmologic centers in the country, notes that advanced laser surgery treatment costs about $800, but Medicare will pay only $440 for the procedure. Thus, every time Hopkins treats a Medicare patient under current arrangements, it loses money.

A real liberalization of private contracting in Medicare would help defray these costs, permitting doctors to charge upper-income beneficiaries more and thereby increase the number of treatments for lower-income persons. As Dr. Stark told *The Washington Post*, "I cannot understand why the government would object to having wealthier patients help support access to specialized care for those less well off."[80]

Direct cash transactions, by avoiding the paperwork costs of complying with Medicare's guidelines for claims filing and submission, also would result in direct savings in time and effort. This alone would give the doctor a direct incentive to waive deductibles for low-income patients and offer a medical service at a cash discount. Under current law, doctors cannot charge patients either more or less than the approved Medicare price. Section 4507, with its required two year opt-out, magnifies the absurdity of Medicare rules.

Consider the recent case of a Palo Alto, California, psychiatrist who was thinking of private contracting. According to the American Psychiatric Association:

> In this instance, the psychiatrist was providing a wide range of services through his clinic, including resident supervision and direct patient care, all for a flat per capita fee which was less than the fee the physician received for Medicare patient care in his private practice, yet he could not opt out in private practice without concurrently dropping out of patient care and resident supervision in the clinic.[81]

In another instance, as a prelude to the case of *Stewart* v. *Sullivan*, Dr. Lois Copeland, one of the plaintiffs, provided a service to a poor Medicare patient at no cost, refusing to charge the Medicare deductible. But the Medicare bureaucracy's "policy" was that the deductible had to be paid and claims had to be submitted anyway or Dr. Copeland would be fined $2,000 for each non-submitted claim.[82]

WHY A REVERSAL IN POLICY IS NEEDED

The same Congress that, under heavy pressure from President Clinton, enacted Section 4507 can reverse course, clear up the reigning confusion, and uphold the rights of doctors and patients in Medicare. The problem is far too serious to be left to HCFA or to carriers whose operations are governed by confusing and often contradictory agency notices, letters, guidelines, or manuals. There are at least seven reasons for Congress to act.

79. Coincidentally, this regulatory arrangement creates incentives among individual physicians to do exactly the opposite of what Congress clearly intends, and encourages physicians to crank up the volume of medical services in anticipation of future reductions.

80. Walter Stark, M.D., letter to the editor, *The Washington Post*, October 24, 1997, p. A26.

81. American Psychiatric Association Testimony, p. 6.

82. For an excellent firsthand account of the circumstances surrounding the case of *Stewart* v. *Sullivan*, see Lois J. Copeland, M.D., "Please Do No Harm: A Doctor's Battle With Medicare Price Controllers," *Policy Review*, No. 65 (Summer 1995), p. 8.

1. **Members of Congress allied with the Clinton Administration have profoundly restricted personal liberty and privacy.** No one disputes the right of Congress and the Medicare bureaucracy to regulate transactions—such things as setting prices, adding or denying coverage, and deciding what medical treatments or procedures elderly or disabled Americans enrolled in the program will or will not have—that take place within the confines of the Medicare system. Congress and the Administration can do these things even if, as a matter of policy, they are unwise. But for Congress or HCFA to intrude into personal transactions between doctors and patients outside of Medicare represents a dangerous expansion of government power.

2. **Some lawmakers and officials now seem to assume that Medicare's bureaucratic power is more important than the patients the system is designed to serve.** Historically, private agreements between doctors and Medicare patients have been rare. Very few of America's more than 38 million senior or disabled citizens choose to engage the services of a physician privately and pay directly for services already subsidized by the taxpayers through Medicare. Nevertheless, this large and growing component of the population does include some who, under certain circumstances, may wish to do so.

   Confidentiality is only one of many possible reasons for this. A person might need the superior skills of a special physician, find direct payment to the doctor convenient, prefer not to abide by Medicare's restrictions or conditions concerning the doctor's delivery of a medical service, or want to continue treatment with a well-established physician who does not participate in Medicare. Bill and Mary Ann Howard of Prescott, Arizona, found themselves in just such a situation:

> Mary Ann is a diabetic. The medicine she was on was not working, and she wanted to change doctors to one who specializes in diabetics. It is very difficult to get in to a new doctor in Prescott. Many of them do not take new patients. We found a diabetic specialist, and were able to get him to make an exception and take Mary Ann as a new patient." The nurse said, "Who is your insurance carrier? There are two insurance plans which we do not accept." I told her Mary Ann was on Medicare. The nurse said, "Unfortunately, we do not accept Medicare patients." My comment was, "No problem: we will pay our own bill and forget Medicare, because it is a lot more important to us that she be treated by a specialist versus a general practitioner. The office person I was talking to said, "You can't do that." I said, "You've got to be kidding. Ask the doctor. Tell the doctor we will ignore Medicare, and we will pay our own bill. We want him to accept Mary Ann as a patient." Two hours later, the nurse called me back and said she had discussed it with the doctor, who said, "If I were to accept Mary Ann as a patient and ignore Medicare, I would be accused of Medicare fraud. I am not willing to take that risk. I will not accept Mary Ann as a patient."[83]

Supporters of the new Medicare restrictions, both in Congress and elsewhere, obviously are prepared to accept such a situation. But taxpayers should realize that both liberals and conservatives traditionally have regarded transactions between doctors and patients as normally beyond the bounds of government intervention. The right of doctors and patients to interact on mutual terms—including the terms of a contract—is and should remain a fundamental right of American citizens regardless of age, class, or condition.

83. Letter from Bill Howard, Prescott Arizona, to Senator Jon Kyl, undated, 1997.

3. **Congress has encroached on matters traditionally reserved to the states.** In the American legal tradition, private contracts are presumed to be sacrosanct. Normally, they are governed by state law, not federal law. Moreover, under Article I, Section 10 of the Constitution, no state may pass any law impairing the obligation of contracts. Thus, Congress cannot presume to set the terms of any private contract without potentially invading the constitutional authority of the states or weakening the sanctity of contracts.

   This issue seems not to have surfaced during the congressional deliberations on the Balanced Budget Act of 1997. Moreover, under Article I, Section 8 of the Constitution, it is hard to imagine how Members of Congress could justify acting to control or limit a person's right to such a private contract, and being treated by a neighborhood doctor certainly does not fit easily within congressional jurisdiction under the Interstate Commerce Clause.

4. **Some lawmakers and officials argue that they have a right to control the personal behavior of elderly citizens by virtue of their enrollment in Medicare.** During the debate on the Kyl resolution, Senator Dale Bumpers (D–AR) declared that "[If] there is a problem with Medicare, if we are not paying enough to entice a majority of the doctors in this country to provide services under Medicare, let's raise the rates. But for Pete's sake, let's not allow people to enter these private contracts...."[84]

   Opponents appear to assume that the federal government has some sort of "property right" in the elderly once they enroll in Medicare which allows it to control their personal behavior indirectly even when taxpayers' money is not involved. John Delaney, Chief of Medicare's Policy and Technical Assistance Branch, is explicit: "A person who is entitled to Medicare can not abdicate this entitlement."[85]

   But what if this logic were applied with equal force to other federal entitlement programs? Americans who are eligible for farm subsidies would not be able to get loans from a private source except under tightly prescribed statutory conditions. Analogously, anyone entitled to welfare would be duty bound to accept a welfare check, legally required to submit the paperwork to get it, and forbidden to take advantage of private charity.

5. **The new Medicare limitations on private contracting do not apply to any other class of citizens or physicians enrolled in any other government program.** The rules embodied in Section 4507 are different for doctors and patients in Medicaid, the health program for the poor and indigent financed jointly by federal and state funds. Nothing prevents a Medicaid recipient from seeing a private physician and paying that physician, or having family and friends pay for medical services that otherwise would be rendered by Medicaid. Nothing in the Medicaid law says that a doctor who wishes to treat a Medicaid enrollee privately—perhaps even free of charge—must give up all other Medicaid patients for some specified period of time.

   The same is true for every other government health care program. Nothing like Section 4507 is found in any of the statutes governing the veterans system, the military health system, the Indian Health Service, or the consumer-driven Federal Employees Health Benefits Program.

   Certain groups that support the new Medicare restrictions imply that similar restrictions exist in the FEHBP, but this is both incorrect and misleading. A Member of Congress, congressional staff employee, or federal worker who goes outside of any of the many private health plans competing for federal employees to seek independent medical treatment may have to pay more for the service or meet other

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84. Senate debate on Amendment 2169, *Congressional Record*, *op. cit.*

85. Delaney letter, *op. cit.*

contractual conditions, but neither doctor nor patient will be breaking any law or running afoul of any statutory obstacle by doing so. There is nothing in Chapter 89 of Title V, the law governing the FEHBP, even vaguely resembling Section 4507.

6. **Medicare's policy toward participating doctors and specialists is unique. No similar restrictions apply to any other class of professionals contracting with the government.** Lawyers providing services under federal legal services are not required to drop out of such programs for two years if they independently prepare a suit for low-income clients. If Section 4507 embodies a sound principle of public policy because it advances some public good, it is not clear why the principle should not be applied to other professions.

7. **Members of Congress should realize that private medical contracts are not inherently incompatible with public provision of medical services.** The British National Health Service, like Medicare, is a government health system. Doctors and specialists can work for the NHS, a system of socialized medicine, either full-time or part-time.

   It is estimated that a majority of British medical specialists maintain a private practice in addition to working in the NHS. They suffer no legal penalty for doing so. Likewise, British patients have the right to "go private," without penalty, whenever they want to seek private treatment from doctors who also practice within the NHS. Britain's system of private medical contracting is not governed by any law resembling Section 4507; it also is not plagued either by widespread fraud and abuse.

THE LONG-TERM CONSEQUENCES OF SECTION 4507

Like so many other regulatory intrusions into complex sectors of the economy, the new congressional restrictions on private doctor-patient agreements in Medicare can be expected to have profound and unintended consequences. Among these are:

- **A Rigid Medical Class System.** Some Members of Congress allied with the Clinton Administration say that they are opposed to any "two tiered" system of health care: All Medicare beneficiaries should be treated alike and should have access to the same level and kind of care, regardless of personal interests or ability to pay. In *United Seniors Association Inc.* v. *Shalala*, the government's attorney, Anthony J. Coppolino, characterized the plaintiffs in dismissive terms:

  > They don't want to get out of Medicare; they want everything Medicare will give them. But in selective cases they want to get out when it suits their interests and they can afford it. And what you will have is a system whereby the rich can buy what they want and those many beneficiaries who are on fixed incomes will not be able to afford those services.[86]

  This led Judge Thomas Hogan to remark, "I think that is probably Congressional policy, but I think it is wrong—your statement—that someone who can afford something cannot have it because someone else doesn't have the money. So, they are not allowed to spend their money. I don't think that is democracy."[87]

  The new Medicare restrictions will guarantee the very two-tiered system that liberals in Congress say they wish to avoid. Forced to choose between staying in or withdrawing from Medi-

86. Oral Argument, p. 38. A similar point is made by the ACLU and others in their Brief for *Amici Curiae* in the appeal of *United Seniors Association* v. *Shalala*.

87. *Ibid.*

care, some physicians, including very highly regarded specialists, will get out. Doctors who reside in upscale communities comprised of wealthy retirees who do not have to depend on Medicare will have a strong incentive to leave the system. They can afford to forgo all of the bureaucratic, paperwork, and administrative hassle that automatically comes with doing business with HCFA. The result: Private contracting for medical services could become the exclusive practice of a minuscule number of doctors and the privileged preserve of the very wealthy.

Moreover, Members of Congress will have created a strange set of economic incentives for physicians otherwise financially independent of Medicare (such as pediatricians) to broaden their practice to include geriatric care. Likewise, the language of Section 4507, in addition to creating incentives for highly specialized doctors in wealthy communities to withdraw from Medicare, also invites the very worst doctors—those who were legally excluded from the program—to engage in private contracting.[88] The worst way to counteract these perverse incentives would be to authorize yet another layer of HCFA rules and regulations.

- **Diminished Choice.** Section 4507 specifically forbids doctors and patients from entering into any private agreement in an emergency, or what is called an "urgent" situation. The word "urgent," as distinct from an emergency, is to be defined in regulation.

The object of this restriction ostensibly is to protect patients from making such agreements under duress. Its effect, however, is to prevent a person from entering into an agreement with a special doctor precisely when the patient may want or need that doctor's specialized services the most. Once again, the congressional interest in restricting private contracting in Medicare is clearly more important than the right of a desperate patient to see the doctor of his or her choice.

Additionally, it is unclear whether a doctor who has opted out of Medicare may treat a Medicare patient in an emergency room and still be paid. The plain language of the statute makes no such exception. HCFA simply says that the doctor may treat Medicare patients and submit a claim anyway (even though the language of the statute clearly forbids it); and the doctor (who is, after all, out of Medicare for two years) can get paid as long as he abides by Medicare's payment rules.[89]

- **More Difficulties for Doctors.** Under current Medicare law it is unclear how doctors could know whether they can safely engage in a private relationship with a Medicare patient for a specific medical service. To do so, they would have to know beforehand whether the service is or is not covered by Medicare.

This obviously is not a problem for "categorical" exclusions like hearing aids, routine physicals, or custodial care. It is a problem, however, in the case of medical services deemed "otherwise covered" under Medicare. A medical service is covered if HCFA says it is "reasonable and necessary." But it is not always clear to doctors and their patients whether Medicare will accept a service as medically necessary. This may be the most powerful weapon in HCFA's formidable regulatory arsenal, for the determination of what is or is not medically necessary is not defined either in law or finalized regulation.[90]

What is "reasonable and necessary" to HCFA may not be what is reasonable and necessary to doctors treating individual patients. For doctors, this means that making medical decisions for patients enrolled in Medicare is an increas-

88. The language of Section 4507 says only that such doctors must tell the beneficiary that they have been excluded from the program.

89. HCFA Q and A, Question 17.

90. HCFA published a proposed rule on the subject only in January 1989.

ingly tricky business. As Dr. Philip R. Alpert, a California internist specializing in geriatrics, has asked:

> If a doctor orders a stool specimen to test for occult blood—which might indicate an early colon cancer—is he engaging in good medical practice or criminal behavior? Answer: it depends. If the patient doesn't have symptoms and the bill is sent to Medicare, it's a criminal offense because these preventive services are not covered benefits. Thus, billing them to Medicare is considered fraud. The absence of intent to cheat Medicare doesn't matter. Fines up to $10,000 per incident of fraud may be levied on the physician who simply orders the test from a lab at no personal profit.[91]

HCFA and its allies in Congress also claim that the likelihood that a service will not be covered by Medicare poses no problem.[92] The reason: If Medicare is not going to cover something, a physician can have the Medicare patient sign an Advanced Beneficiary Notice (ABN), a form indicating that Medicare probably will not pay for the service and that the patient will have to pay for it privately.

Once again, a doctor can follow official Washington's advice at his peril. Under current "policy," if a doctor uses ABNs routinely, he is in effect routinely performing medical services that HCFA considers "unnecessary," and HCFA retains both the right to order the doctor to pay back the Medicare beneficiary for these "unnecessary" services and the right to sanction the doctor for providing them. Medicare sanctions range from the imposition of civil penalties to exclusion from Medicare to penalties under the comprehensive new anti-fraud statutes. As United Seniors Association counsel Kent Masterson Brown argues, "Because ABNs cannot be used routinely without being subject to sanctions, physicians will severely limit and not provide health care services which they believe HCFA may find to be unnecessary."[93]

Thus, observes Washington-based health care attorney John Hoff, "The ABN process does not work because of the other Medicare rules, which HCFA does not mention even as it counsels reliance on ABNs."[94] Remarkably, HCFA characterizes the ABN controversy as a "communications problem" which it will work to correct. Says HCFA Administrator Nancy-Ann DeParle, "We are concerned that ABNs may be misunderstood by beneficiaries and the medical profession."[95]

HOW THE KYL–ARCHER BILL WOULD RESTORE THE FREEDOM TO CONTRACT

The Medicare Beneficiary Freedom to Contract Act (S. 1194/H.R. 2497) would restore the right of doctors and patients to enter into private agreements on mutually agreed upon terms. Specifically, it would repeal the legal requirement that doctors give up their Medicare reimbursement for two years if they enter into private contracts, as well as the statutory requirement that doctors submit an affidavit to the Secretary of HHS agreeing not to submit any Medicare claims for two years, and would clarify that nothing in Medicare law prevents Medicare patients from entering into pri-

91. Philip Alpert, M.D., "Free Doctors from Medicare's Shackles," *The Wall Street Journal*, November 5, 1997, p. 22.

92. Letter to Sandra L. Butler, President, United Seniors Association, from Representatives Benjamin Cardin (D–MD) and Fortney "Pete" Stark (D–CA), January 26, 1998.

93. Kent Masterson Brown, Statement on Medicare Private Contracting before the Committee on Finance, U.S. Senate, 105th Cong., 2nd Sess., February 26, 1988, p. 2.

94. Hoff, *Medicare Private Contracting*, p. 22.

95. DeParle, "Private Contracting in Medicare," p. 6.

vate agreements with their doctors on a case-by-case basis for any length of time.

The bill also specifies legal conditions for such contracts, requiring that they be in writing, identify the covered service, and include the signature of the Medicare patient. Like Section 4507, the bill specifies that such contracts may not be entered into under emergency conditions and may be entered into only on a prospective basis: In other words, they do not apply to any medical services rendered before the signing of the contract. The language of the bill also includes disclosure requirements detailing what Medicare patients are and are not responsible for in payment to physicians.

Protecting Confidentiality? Finally, the bill includes "consumer protection" language to prevent double billing by requiring doctors to submit "only such information as may be necessary" to avoid additional payment under Part A or Part B for services covered under a private contract.

On this point, the Kyl-Archer language is problematic. It should be noted that this notification requirement is more restrictive than the practice that HCFA now says it approves when a Medicare patient, for personal reasons or reasons of confidentiality, wants to refrain from authorizing submission of a claim to Medicare. Obviously, under such an arrangement, *no* information would be transmitted to Medicare.

On this basis, there is no reason why Congress could not apply the same policy to the submission of "necessary" information in the provision of private contracts. If a Medicare patient, for personal reasons, does not want any information transmitted, those personal reasons should be respected by Congress. If the Clinton Administration is sincere in its commitment to privacy exceptions for the submission of claims, it is hard to see how it could object to such an exception.

CONCLUSION

Americans cherish personal freedom, which is something of greater value than the administrative preferences of the Health Care Financing Administration. Medicare is not well served either by the erection of legal obstacles that lock people into such a bureaucratic system with no practical chance of escape or by the imposition of draconian penalties—the loss of basic coverage or exclusion from Medicare—on doctors or patients who wish to engage in private contractual relationships for the treatment of particular medical conditions.

It is time for Congress to reverse course and begin to exercise serious oversight over HCFA in the interest of protecting the personal freedom of patients and the professional integrity and independence of doctors. Congress also should curtail the excesses of the Medicare bureaucracy and fix what is clearly broken. Specifically, lawmakers should make sure that doctors and patients in Medicare enjoy at least the same professional flexibility and personal freedom that their fellow citizens enjoy, and even the level of freedom that Britons enjoy in their explicitly socialized system of medicine.

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APPENDIX

SEC. 4507. USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES.

(a) ITEMS OR SERVICES PROVIDED THROUGH PRIVATE CONTRACTS.—

(1) IN GENERAL.—Section 1802 (42 U.S.C. 1395a) is amended by adding at the end the following new subsection:

"(b) USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES.—

"(1) IN GENERAL.—Subject to the provisions of this subsection, nothing in this title shall prohibit a physician or practitioner from entering into a private contract with a [M]edicare beneficiary for any item or service—

"(A) for which no claim for payment is to be submitted under this title, and

"(B) for which the physician or practitioner receives—

"(i) no reimbursement under this title directly or on a capitated basis, and

"(ii) receives no amount for such item or service from an organization which receives reimbursement for such item or service under this title directly or on a capitated basis.

"(2) BENEFICIARY PROTECTIONS.—

"(A) IN GENERAL.—Paragraph (1) shall not apply to any contract unless—

"(i) the contract is in writing and is signed by the [M]edicare beneficiary before any item or service is provided pursuant to the contract;

"(ii) the contract contains the items described in subparagraph (B); and

"(iii) the contract is not entered into at a time when the [M]edicare beneficiary is facing an emergency or urgent health care situation.

"(B) ITEMS REQUIRED TO BE INCLUDED IN CONTRACT.—Any contract to provide items and services to which paragraph (1) applies shall clearly indicate to the [M]edicare beneficiary that by signing such contract the beneficiary—

"(i) agrees not to submit a claim (or to request that the physician or practitioner submit a claim) under this title for such items or services even if such items or services are otherwise covered by this title;

"(ii) agrees to be responsible, whether through insurance or otherwise, for payment of such items or services and understands that no reimbursement will be provided under this title for such items or services;

"(iii) acknowledges that no limits under this title (including the limits under section 1848(g)) apply to amounts that may be charged for such items or services;

"(iv) acknowledges that Medigap plans under section 1882 do not, and other supplemental insurance plans may elect not to, make payments for such items and services because payment is not made under this title; and

"(v) acknowledges that the [M]edicare beneficiary has the right to have such items or ser

vices provided by other physicians or practitioners for whom payment would be made under this title.

Such contract shall also clearly indicate whether the physician or practitioner is excluded from participation under the Medicare Program under section 1128.

"(3) PHYSICIAN OR PRACTITIONER REQUIREMENTS.—

"(A) IN GENERAL.—Paragraph (1) shall not apply to any contract entered into by a physician or practitioner unless an affidavit described in subparagraph (B) is in effect during the period any item or service is to be provided pursuant to the contract.

"(B) AFFIDAVIT.—An affidavit is described in this subparagraph if—

"(i) the affidavit identifies the physician or practitioner and is in writing and is signed by the physician or practitioner;

"(ii) the affidavit provides that the physician or 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; and

"(iii) a copy of the affidavit is filed with the Secretary no later than 10 days after the first contract to which such affidavit applies is entered into.

"(C) ENFORCEMENT.—If a physician or practitioner signing an affidavit under subparagraph (B) knowingly and willfully submits a claim under this title for any item or service provided during the 2-year period described in subparagraph (B)(ii) (or receives any reimbursement or amount described in paragraph (1)(B) for any such item or service) with respect to such affidavit—

"(i) this subsection shall not apply with respect to any items and services provided by the physician or practitioner pursuant to any contract on and after the date of such submission and before the end of such period; and

"(ii) no payment shall be made under this title for any item or service furnished by the physician or practitioner during the period described in clause (i) (and no reimbursement or payment of any amount described in paragraph (1)(B) shall be made for any such item or service).

"(4) LIMITATION ON ACTUAL CHARGE AND CLAIM SUBMISSION REQUIREMENT NOT APPLICABLE.—Section 1848(g) shall not apply with respect to any item or service provided to a Medicare beneficiary under a contract described in paragraph (1).

"(5) DEFINITIONS.—In this subsection:

"(A) MEDICARE BENEFICIARY.—The term '[M]edicare beneficiary' means an individual who is entitled to benefits under part A or enrolled under part B.

"(B) PHYSICIAN.—The term 'physician' has the meaning given such term by section 1861(r)(1).

"(C) PRACTITIONER.—The term 'practitioner' has the meaning given such term by section 1842(b)(18)(C)."

(2) CONFORMING AMENDMENTS.—

(A) Section 1802 (42 U.S.C. 1395a) is amended by striking "Any" and inserting "(a) BASIC FREEDOM OF CHOICE.—Any".

(B) Section 1862(a) (42 U.S.C. 1395y(a)), as amended by sections 4319(b) and 4432, is amended by striking "or" at the end of paragraph (17), by striking the period at the end of paragraph (18) and inserting "; or", and by adding after paragraph (18) the following new paragraph:

"(19) which are for items or services which are furnished pursuant to a private contract described in section 1802(b)."

(b) REPORT.—Not later than October 1, 2001, the Secretary of Health and Human Services shall submit a report to Congress on the effect on the program under this title of private contracts entered into under the amendment made by subsection (a). Such report shall include—

(1) analyses regarding—

(A) the fiscal impact of such contracts on total federal expenditures under title XVIII of the Social Security Act and on out-of-pocket expenditures by Medicare beneficiaries for health services under such title; and

(B) the quality of the health services provided under such contracts; and

(2) recommendations as to whether Medicare beneficiaries should continue to be able to enter private contracts under section 1802(b) of such Act (as added by subsection (a)) and if so, what legislative changes, if any should be made to improve such contracts.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to contracts entered into on and after January 1, 1998.