The Heritage Foundation
Backgrounder
Executive Summary

No. 1347 February 18, 2000

CONGRESS SHOULD END THE CONFUSION OVER MEDICARE PRIVATE CONTRACTING

ROBERT E. MOFFIT, PH.D.

As a result of a provision in the Balanced Budget Act (BBA) of 1997, Medicare patients are legally restricted in their ability to spend their own money as they wish on medical services that they desire. This untenable development in a system that is supposed to ensure that seniors and the disabled have access to good health care is the direct result of a combination of federal law, federal regulation, and federal court rulings. It means that—thanks to Congress, the Clinton Administration, and the courts—Medicare patients may not seek a medical service from a doctor of their choice and pay for it on their own if it is already "covered" or "paid for" by the Medicare program. There is simply no exception to this rule for any medical service that the Medicare bureaucracy deems "covered."

The U.S. Court of Appeals for the District of Columbia Circuit ruled in 1999 that under certain conditions, Medicare patients could enter into the *equivalent* of a private agreement with a doctor. However, this arrangement would be controlled by a bureaucratic paperwork process established by the Health Care Financing Administration (HCFA), the powerful agency that runs the huge Medicare program. Under this exception, a Medicare patient could pay a doctor privately for a medical service that HCFA considers medically "unnecessary" if HCFA does not also think that the service is "unwarranted." Unfortunately, the Court of Appeals did not define what is or is not a "warranted" medical service. It shifted that crucial responsibility to HCFA, which has not yet even finalized its definition of "medical necessity."

While the 1999 Court of Appeals decision did grant narrow relief to patients who seek to contract privately with their physicians under judicially prescribed conditions, it did not settle the fundamental policy questions or outstanding constitutional issues raised by this unprecedented statutory restriction on the doctor–patient relationship.

Most Americans would think that patients have a natural right to seek and pay for a medical treat-

Produced by
The Domestic Policy Studies Department

Published by
The Heritage Foundation
214 Massachusetts Ave., N.E.
Washington, D.C.
20002–4999
(202) 546-4400
http://www.heritage.org

This paper, in its entirety, can be found at: *www.heritage.org/library/backgrounder/bg1347es.html*

ment of their choice. But the law on private contracting, embodied in Section 4507 of the Balanced Budget Act (BBA) of 1997, holds that a Medicare patient may contract privately with a doctor only if that doctor signs an affidavit to that effect, submits the affidavit to the Secretary of Health and Human Services (HHS) within 10 days, and then drops out of Medicare for two full years. This has generated concern because:

- **This statutory restriction on private agreements between doctors and their patients is unprecedented.** There had never been a statutory restriction on Medicare private contracting before enactment of the BBA.
- **No similar statutory restriction has ever been imposed in any other government health insurance program,** including Medicaid, the Federal Employees Health Benefits Program (FEHBP), the Department of Defense health program, the Veterans Administration program, or the Indian Health Service.
- **In two separate rulings, the federal courts upheld this bizarre law.** The restrictions of Section 4507 elicited immediate and intense opposition across the ideological spectrum. The United Seniors Association was joined by the Washington Chapter of the American Civil Liberties Union (ACLU) and a number of patient and medical groups in a suit seeking to strike down Section 4507 as a violation of basic constitutional rights of liberty and privacy. The U.S. District Court for the District of Columbia declared in 1998 that, on the basis of judicial precedent, Medicare patients had no constitutional right to privacy in their relationships with their physicians, and it refrained from striking down Section 4507. In subsequent litigation, the U.S. Court of Appeals for the District of Columbia dodged the constitutional issues and ruled in 1999 that there was an administrative avenue within the narrow confines of HCFA's regulatory system.
- **Medicare patients have limited legal access to a private agreement with a physician only if the Medicare bureaucracy considers that particular service uncovered or "unnecessary" or potentially "unnecessary."** It does not matter whether the Medicare patient wants to obtain a service of a higher quality or is willing to pay more out of pocket for the special skills of a particular physician. As long as that service is "covered" by Medicare, the service may not be obtained outside of the system.
- **The only other officially stated exception to the restrictions in Section 4507 is a weak privacy exception.** The Clinton Administration declared that privacy is an exception to the statutory requirement that doctors must submit the claims of their patients, which sometimes contain sensitive information, to the Medicare bureaucracy. Meanwhile, the U.S. General Accounting Office reported that Medicare's privacy safeguards are weak and that unauthorized individuals could gain access to confidential patient information.

Medicare patients are uniquely disadvantaged by the restrictions in Section 4507 of the Balanced Budget Act. Such restrictions on personal liberty and privacy reflect the troubling transformation of Medicare into an engine of bureaucratic control over virtually every aspect of the financing and delivery of medical services to the nation's retirees. Congress needs to create a new Medicare program that will serve the next generation of retirees, especially the first wave of the 77 million baby boomers who will begin to retire in 2011.

In the meantime, Congress should clarify the right of Medicare patients to spend their own money on the services of physicians of their choice, regardless of how HCFA or its contractors or the courts choose to classify them. Representative Patrick Toomey (R–PA) has introduced the Seniors' Health Care Freedom Act (H.R. 2867) to guarantee the right of seniors to contract privately regardless of HCFA's views. No one, least of all the government, should decide how or when or under what circumstances American citizens may spend their own money on lawful medical services. Congress, under pressure from the Administration, created this mess. And only Congress can fix it.

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ROBERT E. MOFFIT, PH.D.

Medicare patients are restricted by federal law in their ability to go *outside* of the Medicare system to spend their own money on a medical service of their choosing, even if no taxpayer money is involved. This untenable development is the direct result of a provision in the Balanced Budget Act (BBA) of 1997. If a service is already "covered" or "paid for" by Medicare, a Medicare patient is not allowed to purchase that service privately under any circumstance, even if it is a life-saving procedure, of a better quality than Medicare provides, or performed by an outstanding physician or surgeon of choice. There is simply no exception to this rule for "covered" Medicare medical services.

This provision has generated intense reactions, including litigation brought in federal court by a prominent seniors group in an attempt to have the law ruled unconstitutional. Indeed, in 1999, the U.S. Court of Appeals for the District of Columbia Circuit ruled that under certain conditions, a Medicare patient may enter into the equivalent of a private agreement with a doctor for a medical service. However, the Health Care Financing Administration (HCFA), the powerful agency that runs Medicare, must consider that service to be not "covered" or medically "unnecessary." Moreover, it must determine that the service is not "unwarranted."

Unfortunately, the Court of Appeals did not define what is or is not a "warranted" medical service; it shifted that crucial responsibility to HCFA, which has not even finalized its definition of "medical necessity."

Although this 1999 appellate ruling did grant narrow relief to patients seeking to make private arrangements with their own physicians, under judicially prescribed conditions, it did not settle fundamental policy questions or the constitutional issues raised by this unprecedented statutory restriction on private agreements between doctors and their patients.

Congress created this bizarre Medicare mess under pressure from the Administration in 1997, and it is up to Congress to fix it. Members of Congress should create a new Medicare program for

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the next generation of America's retirees, one based explicitly on patient choice in a private market, to prepare for the first wave of the 77 million baby boomers who will begin to retire in 2011. In the meantime, Congress should clarify the right of Medicare patients to spend their own money on the services and physicians of their choice, regardless of whether they are officially declared "necessary" or how they are classified by HCFA, its contractors, or the courts.

THE CONFUSING RESTRICTIONS ON TREATMENT

Most Americans would think that a patient has a natural and legal right to pay out of pocket for medical treatments when and as they want to, if that is what they wish to do. But the statutory restrictions on private contracting with physicians embodied in Section 4507 of the Balanced Budget Act of 1997 maintain that a senior citizen may contract privately with a doctor only if that doctor signs an affidavit to that effect, submits the affidavit to the Secretary of Health and Human Services (HHS) within 10 days, and then drops out of the Medicare system for two full years.[1]

Medicare patients should dismiss the excuses that have been offered since 1997 by Members of Congress or the Clinton Administration for this bizarre law and recognize certain salient facts about this provision that demonstrate its confusing complexity:

- **This statutory restriction on private agreements between doctors and patients is unprecedented.** A statutory restriction on Medicare private contracting did not exist before enactment of the Balanced Budget Act of 1997. In fact, as prominent Washington attorney John Hoff, a specialist in health law, observes, "Private contracting in effect took place from the earliest days of Medicare but was not considered a problem."[2]

- **No similar statutory restriction has ever been imposed in any other government health insurance program.** Medicaid, the Federal Employees Health Benefits Program (FEHBP), the Department of Defense health program, the Veterans Administration program, and the Indian Health Service do not have any such restriction.

- **In two separate rulings, the federal courts have upheld Section 4507.** The United Seniors Association, a conservative group, was joined by the Washington Chapter of the American Civil Liberties Union (ACLU) and a number of patient and medical groups in litigation asking the court to strike down Section 4507 as unconstitutional. In 1998, the U.S. District Court for the District of Columbia declared that, on the basis of judicial precedent, Medicare patients have no constitutional right to privacy in relationships with their physicians. The Court refrained from striking down Section 4507 as a violation of the basic rights of liberty and privacy under the U.S. Constitution.[3] The U.S. Court of Appeals for the District of Columbia dodged the constitutional issues of personal liberty and privacy and ruled in 1999 that doctors and patients could participate in the equivalent of a private contract under certain regulated conditions.[4]

- **Medicare patients may have limited legal access to a private agreement with a physician only if the Medicare bureaucracy considers the**

1. For a discussion of Section 4507, see John S. Hoff, *Medicare Private Contracting: Paternalism or Autonomy* (Washington, D.C.: AEI Press, 1998); see also Robert E. Moffit, "How Congress Can Restore the Freedom of Senior Citizens to Make Private Agreements with Their Doctors," Heritage Foundation *Backgrounder* No. 1209, August 3, 1998.
2. Hoff, *Medicare Private Contracting,* p. 4.
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. *United Seniors Association Inc. et al.* v. *Donna Shalala,* U.S. Court of Appeals for the District of Columbia Circuit, No. 98–5142, July 16, 1999; cited hereafter as *Appellate Court Decision.*

particular service desired to be uncovered or "unnecessary" or potentially "unnecessary." If a medical service is "covered" by Medicare and is deemed "necessary" by the Medicare bureaucracy, then a Medicare patient may not contract privately with a doctor for it, even if that service is vital to improving health or quality of life or would be life-saving. If a Medicare patient wants to purchase a service of a higher quality than Medicare provides or to pay more for the special skills of a certain physician, he or she does not have a legal right to contract privately with the doctor for it if the service is covered by Medicare. As long as Medicare provides a medical service, Medicare patients must not obtain that service outside the system, even if they want to pay for it with their own money and not with the taxpayer's.

- **The only other officially stated exception to the restrictions of Section 4507 is a weak privacy exception.** As the Washington Chapter of the ACLU, the American Psychiatric Association, and others have noted, Section 4507 makes no exception for patient privacy in restricting private contracting. But the Clinton Administration has said that privacy is an exception to the statutory requirement on doctors to submit the claims of their Medicare patients, which sometimes contain sensitive information, to the Medicare bureaucracy. Meanwhile, the U.S. General Accounting Office recently reported that Medicare's privacy safeguards are weak and that unauthorized individuals could gain access to confidential patient information.[5]

Medicare is enormously popular, especially among current retirees. But its confusing regulatory complexity, including restrictions on the personal liberty and privacy of Medicare patients, reflects the system's quiet transformation into an engine of bureaucratic government control over virtually every aspect of the financing and delivery of medical services to the nation's retirees.

HOW DID THIS HAPPEN?

As the above analysis demonstrates, Medicare patients are uniquely restrained by the federal government from benefiting from the availability of health care choices in today's market. The judicially determined exception to the restriction preventing them from spending their own money to have a doctor perform a lawful medical service that they want—if that service is covered under Medicare—can be obtained only through an arcane administrative process governed by HCFA. This stranglehold on the doctor–patient relationship is the result of a combination of legislative, regulatory, and judicial decisions.

During the summer of 1997, under the threat of a veto, the House–Senate conference committee on the Balanced Budget Act of 1997 added Section 4507 as an alternative to an amendment offered by Senator Jon Kyl (R–AZ). Senator Kyl offered his amendment to clarify the rights of seniors enrolled in Medicare to contract privately with their physicians.

Clinton Administration officials and their supporters in Congress attempted to portray Section 4507 as an exception to a HCFA "policy" against private contracting, which HCFA had invoked even though a federal district court said, in the case of *Stewart* v. *Sullivan* (1992), that it could find no such "policy."[6] As John Hoff and others have noted, however, Section 4507 was promoted as an exception to what was in fact a nonexistent "policy."[7] During litigation on the provision, the Administration's lawyers conceded that Section 4507 was not a real "liberalization" of private contracting, but rather a statutory construction that made such private doctor–patient agreements virtually impossible.[8]

5. U.S. General Accounting Office, *Medicare: Improvements Needed to Enhance Protection of Confidential Health Information*, GAO/HEHS–99–140, July 20, 1999.
6. See *Stewart* v. *Sullivan*, 816 Supp. 218 DNJ, 1992.
7. Hoff, *Medicare Private Contracting*, pp. 14–15.

After the BBA was enacted, the conservative United Seniors Association filed suit in the U.S. District Court for the District of Columbia[9] to strike down Section 4507 as an unconstitutional violation of fundamental liberty and privacy rights. In April 1998, the court, while expressing grave concerns about HCFA's regulatory power to limit Medicare patient choices, nonetheless upheld the constitutionality of the statute. Judge Thomas Hogan declared in his ruling that

> 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.*[10]

Surprised by this decision, several medical societies and patient groups, as well as the Washington Chapter of the ACLU, joined the United Seniors Association in appealing the case (*United Seniors Association Inc. et al.* v. *Donna Shalala*) to the U.S. Court of Appeals for the District of Columbia Circuit. The plaintiffs and their *amici curiae* argued that Section 4507 was a profound violation of the right of Americans to obtain "wanted medical treatment." The ACLU and the other *amici* observed in their legal brief that this "right is so fundamental that it has not been previously questioned, nor has it required articulation."[11]

Oral argument in the appellate case was heard on October 23, 1998. The Court of Appeals decision clarifying the conditions under which doctors and patients may make private agreements was rendered July 16, 1999.

Practical Consequences of the Judicial Intervention. The Court of Appeals, while not addressing the broader question of the constitutional right of citizens to make such private agreements with doctors, did specify in 1999 a set of conditions under which such arrangements could be made. After months of controversy and confusion, generated primarily by the clumsily drafted statute and HCFA's tortuous policy agenda, the Court of Appeals ruling provided some relief to doctors and patients who wish to enter into private agreements.

The Court clarified that legal restrictions apply only to covered services, that doctors and patients could use a regulatory process to secure private agreements where Medicare might not pay for a service, and that doctors using it would be free of fraud and abuse sanctions. Says attorney John Hoff,

> The Court's decision thus permits Medicare beneficiaries and their doctors to privately contract where Medicare will not pay, but under a cumbersome process that still holds some risks. HCFA's last minute weaving and dodging has again avoided a knockout of its policy, but it has suffered more of a body blow than previously.[12]

A Cautionary Word. Doctors and patients, and taxpayers in general, should not read into this

8. See transcript of the oral arguments, *United Seniors Association Inc. et al.* v. *Donna Shalala* (Case 98–5142), U.S. Court of Appeals for the District of Columbia Circuit, October 23, 1998, p. 22; cited hereafter as *Transcript of Oral Argument*. Mr. Hoff was counsel for the *amici* ("friends" of the plaintiff).
9. *United Seniors Association Inc.* v. *Donna Shalala*.
10. *Ibid.* (emphasis added). Judge Hogan noted that the U.S. Supreme Court had not established a precedent for a privacy right governing the relationship between senior citizens and their physicians. Ironically, under current constitutional law, a privacy right does exist when physicians are performing abortions or delivering contraceptive services, but not other sensitive medical services.
11. Brief for *Amici Curiae, United Seniors Association Inc.* v. *Donna Shalala*, Secretary of the United States Department of Health and Human Services, before the United States Court of Appeals for the District of Columbia Circuit, Case No. 98–5142, July 7, 1998, p. 16.
12. John Hoff, Esq., "What the Court Did," August 5, 1999, p. 3, unpublished.

Court of Appeals decision more than is there. As a matter of law and as a matter of fact, American senior citizens still do not enjoy the right to make private agreements with their physicians freely the way all other Americans do. Worse, they have less personal freedom in Medicare than their British counterparts have in the British National Health Service (NHS). Although they manage and finance an explicit system of socialized medicine established in 1948, British officials at least recognize the legitimacy of private contracts outside of that system as a normal, noncontroversial exercise of fundamental personal liberty. In the unique case of the Medicare system, American officials do not.

The Administration's Arguments

During oral arguments in the case before the federal Court of Appeals on October 23, 1998, Thomas Bondy, the Clinton Administration's lawyer, was subjected to intense and even hostile questioning by the three-judge panel. Remarkably, in spite of the fact that the plaintiffs had challenged the constitutionality of Section 4507, the Administration did not attempt to meet the constitutional objections. In his presentation, Bondy simply ignored—as the Court of Appeals pointedly noted in its questioning—the fundamental challenge posed by the senior citizens.[13] Indeed, under the Court's interrogation, Bondy was at a loss to cite *any* constitutional basis, either in the Commerce Clause or in the spending power, for a congressional intervention such as this one, which prevents Medicare enrollees from spending their own funds on medical services outside of Medicare.

In defense of Section 4507, counselor Bondy, like the Administration's lawyers in the federal District Court case, advanced ideologically driven and logically contradictory arguments on two fronts.

The Case for a Closed System. The Clinton Administration's first argument in the appeals case was that the Medicare law was designed by Congress in 1965 to prevent a "two tiered" system of medical care for senior citizens. In effect, the Administration argued, Congress had intended all along to set up a single-tiered system of medical care for the elderly in which all would get the same treatment, presumably the same medical care, regardless of their willingness to go outside of the system and pay privately for medical services.

This argument is, however, incorrect. With the historic exception of Section 4507 of the Balanced Budget Act of 1997, there is no statutory obstacle to private contracting between doctors and Medicare enrollees and nothing explicit in the Medicare law that supports Medicare's construction as a closed, single-tiered system. The opposite is true. In 1965, among politicians and policy analysts on the left, Medicare was envisioned as the first installment of a "single-tiered," national system of government-run health insurance; but the law, with its limitations and modifications, fell far short of that objective.

As Jane Orient, M.D., executive director of the American Association of Physicians and Surgeons, has argued, Medicare would never have been enacted if Americans thought for one moment that its enactment would mean not simply help for the elderly, but a system of "compulsory dependency" on a government health care program in which retired Americans would be legally forbidden from spending their own money on "medically necessary" services.[14] In fact, the original Medicare law explicitly forbids the federal government to exercise "supervision" or "control" over the practice of medicine, and Medicare patients are explicitly protected in their right to purchase medical services and the insurance to cover those services.[15] As far as private contracting is concerned, notes Hoff, "Private contracting in effect took place from the earliest days of Medicare but was not considered a problem."[16]

13. See *Transcript of Oral Argument*, pp. 22–25.

14. Jane M. Orient, M.D., "Private Contracting—No Final Word," *Medical Sentinel*, Vol. 4, No. 6 (November/December 1999), p. 220.

15. See, in particular, Sections 1801, 1802, and 1803 of Title 18 of the Social Security Act.

Not surprisingly, the Court of Appeals greeted the Clinton Administration's single-tiered system argument with palpable derision. Citing the common example of Americans, including senior citizens, who obtain better seating from airlines by paying more for those services, the court told the Administration's lawyer that it did not want to hear this ideological argument for a single-tiered Medicare system again, and the Administration backed off.[17]

The Paperwork Process. The second legal argument advanced by the Clinton Administration was that doctors and patients could resort to an Advanced Beneficiary Notice (ABN), a form given by the doctor to the patient notifying him that Medicare is not likely to pay for the medical service, and by which the patient agrees to pay the doctor privately if Medicare does not. This use of an ABN would enable doctors and patients to circumvent the restrictions imposed by Section 4507, restrictions that otherwise would force a doctor to drop out of Medicare for two full years.

Curiously, the Administration's argument for the viability of an ABN as a means to secure a doctor–patient agreement on private terms was a logical contradiction of its collectivist plea that the Medicare system was, and was intended to be, a single-tiered health care system in which the undeserving "rich" would be forbidden to buy medical services on their own.

Attorneys for the United Seniors Association and their *amici*, including the Washington Chapter of the ACLU, argued that resorting to an ABN was no protection for a private doctor–patient agreement because routinely resorting to ABNs for medical services that Medicare deems "unnecessary" had been grounds for Medicare to charge doctors with fraud and abuse for dispensing "medically unnecessary" services. Thus, the plaintiff's attorneys noted, if a doctor were to resort routinely to using an ABN, he would risk prosecution for fraud and ruination of his professional career.

The Administration's Regulatory Retreat. During the October 23, 1998, interrogation by the Court of Appeals, the Clinton legal team put even more reliance on the ABN approach to ward off the plaintiff's arguments that the restrictions would deny seniors "wanted" care. On November 2, 1998, 10 days *after* the oral arguments in *United Seniors Association et al.* v. *Shalala*, the Secretary of HHS promulgated new regulations to clarify the use of the advanced beneficiary notice.

The November 1998 HCFA regulations accomplished two policy objectives. First, they confirmed *ex post facto* the second major argument advanced by the Administration's legal team in the federal Court of Appeals: that physicians henceforth could rely on an ABN process to secure private payment for medical services under certain specified conditions. Second, they led the court to say that physicians previously threatened by prosecution for fraud and abuse for the routine use of ABNs should no longer worry; the Clinton Administration could not recommend that doctors use ABNs and then use this against them in fraud and abuse investigations.

In the preamble to their November 2, 1998, regulations, HCFA officials state that the physician may use an ABN wherever the doctor "*believes* that the service will not be covered by Medicare."[18] This was a serious clarification; it formalized a subjective standard of the doctor's belief as the legitimate basis for using the ABN. The regulations also clarified another key point: The use of an ABN will neither require a doctor to drop out of Medicare for two years nor invite punitive action against the doctor for fraud:

16. Hoff, *Medicare Private Contracting,* p. 4.

17. *Transcript of Oral Argument,* pp. 55–57. It is worth noting, for the record, that when the Administration's lawyers advanced a similar argument in the federal District Court case, Judge Thomas Hogan, even though he ruled in their favor, noted the profoundly authoritarian character of the Administration's argument for a "single tiered" system and characterized it as undemocratic.

18. *Federal Register,* November 2, 1998, p. 58,901.

> Physicians and practitioners should not hesitate to furnish services to Medicare beneficiaries when the physician or practitioner believes that those services are in accordance with accepted standards of medical care, even when those services do not meet Medicare's particular and often unique coverage requirements.[19]

This was a remarkable development. As Kent Masterson Brown, attorney for the plaintiff United Seniors Association, remarks, "This is the first admission ever by the Secretary that the Medicare program's bureaucratic dictates do not necessarily represent accepted standards of medical care for the provision of health care services to the elderly."[20]

THE APPELLATE COURT'S DECISION

The Good News

In the Appellate Court litigation, opponents of Section 4507 sought, but did not get, general relief from that law through judicial review. But United Seniors Association members Toni Parsons, Peggy Sanborn, and Ray and Margaret Perry did seek and receive specific relief from the limitations of Section 4507. They argued that they were, in effect, being denied medical services because HCFA would threaten doctors with sanctions for providing certain medical services, such as screening and laboratory tests, that HCFA or its contractors deemed "medically unnecessary."

Moreover, they argued, physicians who provided "medically unnecessary" services to Medicare patients would be subject to government sanctions, such as prosecution for fraud and abuse and the penalties associated with that prosecution. As attorney Brown noted,

> Screening laboratory tests—those performed without symptoms—were held by the Secretary's Inspector General to be always "not reasonable and necessary." Doctors were warned not to order them even though many of the killer diseases afflicting the elderly, such as diabetes, hyperthyroidism, hypothyroidism, prostate cancer and the like, often have very long asymptomatic periods. If Medicare beneficiaries could not contract privately with their doctors for such services, they would be denied them altogether.[21]

Thus, by virtue of their draconian restrictions on doctors' ability to contract privately with their patients, HCFA's policy and Section 4507 together constituted an obstacle to these seniors getting the care they wanted.

Confronted with the seniors' argument, the lawyers for the Administration backtracked, promised to clarify the legitimacy of an administrative avenue for these seniors to get medical services privately, and thus secured their right to pay doctors privately for screening laboratory services and certain other medical services. In this process, noted counselor Brown, the HHS Secretary "surrendered" on her previous policy of threatening to sanction doctors who provided such services routinely through this administrative process. This was a significant policy change. In its July 16, 1999, decision, the Appellate Court in effect clarified the view that routine use of ABNs will no longer form the basis of fraud and abuse investigations.

While the issue of Medicare private contracting will continue to be debated in Congress and elsewhere, seniors should understand the key findings of the Court of Appeals:

19. *Ibid.*

20. Kent Masterson Brown, Special Counsel, United Seniors Association, statement on the occasion of the decision of the Federal Court of Appeals, District of Columbia, July 16, 1999, in the case of *United Seniors Association et al.* v. *Donna E. Shalala*, p. 7.

21. *Ibid.*, p. 5.

- **Section 4507 restrictions on private contracting in Medicare apply only to services paid by Medicare.** The language of Section 4507 says that its restrictions apply to "any item" or medical service and suggests, at least on its face, a broader regulatory reach.[22] The court took note of the plain language of Section 4507 and observed that the vagueness and ambiguity of that language justified the skepticism of the plaintiffs in the case and the critics of Section 4507. Said the court:

  > Plaintiff's skepticism is not unjustified. The meaning of Section 4507 is hardly plain on its face. Moreover, because HCFA did not promulgate formal regulations on the Section until ten days after oral argument in this case, its own interpretation could only be gleaned from memoranda issued to Medicare carriers and testimony delivered to Congress, of which Medicare beneficiaries may well have been unaware.[23]

  The court went on to argue that, on the basis of U.S. Supreme Court precedent, it is the custom to defer to an enforcing executive agency's "reasonable interpretation" whenever a statute is ambiguous. In this case, the court affirmed that the Secretary's interpretation—in the face of the vagueness of the statutory language—was a "reasonable" one, and thus deferred to it. In this case, the terms of Section 4507, affirmed by the Court of Appeals, applied only to services paid for under the Medicare program.

- **If a doctor believes that Medicare will not pay, whether or not the service is categorically excluded, or for some other reason, he can enter into a private arrangement with a Medicare patient and not file any Medicare claim at all.** This avenue for private contracting would hold even if the service was one for which Medicare requires the doctor to file a claim with the Medicare bureaucracy.[24]

- **Under certain circumstances, physicians can avoid Section 4507's requirement to drop out of Medicare for two years and treat a patient privately through the use of advanced beneficiary notices without—on the basis of the court's construction—fear of bureaucratic retaliation.** The court, while conceding that "HHS's past pronouncements have not been perfectly clear," accords deference to the Clinton Administration's view, articulated in the oral argument, on the use of the advanced beneficiary notices. In other words, if a medical service is a "covered service" but payment might be denied because Medicare does not consider that service to be "medically necessary or appropriate," then a doctor and a patient may use an ABN. In using the ABN, by giving the patient notice in this way, the doctor does not have to enter into the restrictive private contract specified by Congress in Section 4507 and drop out of Medicare for two years if the Medicare claim is denied.

- **In using an ABN under these defined circumstances, doctors are not only free of the two-year opt out rule, but also free of the Medicare bureaucracy's bizarre price controls.** Again, a doctor must believe that a service will not be covered by Medicare because it is not officially medically necessary. The court, deferring to the Administration's promised set of regulations issued 10 days *after* the oral arguments in the case, declared:

  > At oral argument, counsel for the Secretary advised that HCFA was planning to issue formal regulations incorporating the above stated views. Those regulations were published on November 2, 1998. See 63 Fed. Reg. at

22. On this point, see Hoff, *Medicare Private Contracting*, p. 24.

23. *Appellate Court Decision*, p. 9.

24. Personal communication with Kent Masterson Brown, Special Counsel, United Seniors Association, October 29, 1999.

> 58, 901. Consistent with the position recounted above, the explanatory preamble states that "the private contracting rules do not apply to…services that Medicare does not cover."' Id. At 58,850. It further states that when a physician "'furnishes a service that does not meet Medicare's criteria for being reasonable and necessary, and the physician has furnished the beneficiary with an ABN…*there are no limits on what the physician may charge the beneficiary*…and the act of providing an ABN does not then require that the physician opt out of Medicare…." Id at 58,851…. On the basis of our examination of HCFA's announced views, we conclude that the agency has consistently interpreted section 4507 and its opt out rules as applying only to contracts for services that Medicare itself would reimburse.[25]

In this respect, the Court's ruling is indeed novel.

On the private payment issue, it is worth noting that HCFA officials previously have stated that even if a Medicare beneficiary gets medical services *outside* of the Medicare program, the doctor would still somehow be subject to Medicare's price controls.[26] No statute explicitly says any such thing.[27] In any case, however, this federal judicial decision and the regulations promulgated in November 1998 upon which the decision is based amount to a reversal, or at least a clarification, of HCFA's old "policy" on the question.

The Bad News

Although the federal Court of Appeals decision gives doctors and patients a way around Section 4507, it does not by any means settle the broader policy questions raised by the provision. Very bad policy is still in place. For example:

- **The federal Appeals Court dodged the fundamental constitutional issue of Medicare patients' liberty and privacy.** In its opinion, the court observed that

> The district court found the statute constitutional and granted summary judgment for the Secretary of Health and Human Services. We affirm the grant of summary judgment without reaching the constitutional questions because the Secretary's recently-clarified interpretation of Section 4507, to which we must defer, eliminates the injury that is the basis of the plaintiff's constitutional attack.[28]

Senior citizens who are enrolled in Medicare still have no constitutional right of privacy in their relationship with their physicians. Thus, they and their doctors are left with a legal and moral paradox.

The personal decision to spend one's own money and refrain from making a claim on the tax dollars of one's fellow citizens through an entitlement program is a serious one. Under the terms of the court's decision, a Medicare

25. *Appellate Court Decision*, p. 14 (emphasis added).

26. See Moffit, "How Congress Can Restore the Freedom of Senior Citizens," p. 14.

27. On this point, HCFA officials have simply cited themselves as their own authority, pointing to their own regulations. But HCFA's regulations have not been much help to a reasonable person. In the regulation governing the filing of Medicare claims, Section 424.30 (42 CFR Ch. IV), there is no such stipulation. The claim filing process is governed, of course, by HCFA's payment rules. This means that if a doctor wants to get paid under Medicare, he must first file a claim; then, and only then, is he under the rules and regulations of Medicare. HCFA's position has been that a doctor is governed by payment rules controlling the filing of claims for payment even when claims are not filed for payment. This is a logical absurdity.

28. *Appellate Court Decision*, p. 3.

patient may contract privately with a physician for a service that is "categorically excluded" by law from coverage under Medicare. A Medicare patient may also contract privately with a physician for a service that is never deemed to be "medically necessary" by the Medicare bureaucracy or its contractors. A Medicare patient may also contract privately for medical services that are "covered" by Medicare but not deemed "medically necessary" in a particular case and through a prescribed administrative process. But a Medicare patient is not allowed to contract privately for any medical services that are covered by Medicare but deemed medically "necessary." Thus, every Medicare benefit expansion also becomes, in and of itself, a loss of patient control over the delivery of medical treatment.

This is ludicrous. Imagine the application of Medicare's new "patient choice" principles to education policy. Imagine a teacher who teaches in a public school and also wants to help children after school through private tutorials. A mother, for example, with a child in a public school would be legally forbidden to spend her own money to send her child to that tutor to learn math and English if the local public school already "covered" math and English, even if she was morally certain that the trusted tutor with an excellent reputation could privately provide her child with superior teaching and better coursework. Moreover, the legality of the mother's spending her own money on a tutor in a private setting would be totally dependent on the public school bureaucracy's determination that the tutor's private coursework was "unnecessary" or might be unnecessary or was never covered in the public school curriculum.

In general, such a tutor would be allowed to provide only "unnecessary" instruction. In any case of doubt, the tutor would be required to give the parent a form, an "advanced pupil notice," to the effect that the privately provided coursework is something that might not be provided or paid for in the public school setting. In the meantime, the tutor would have to make sure that any private coursework given to the child was not going to be judged "unwarranted" by the public school bureaucracy. A constant occupational hazard for the tutor under such a bizarre system would be running afoul of the public school bureaucracy's confusingly complex determinations of "necessary" and "unnecessary" studies or "warranted" and "unwarranted" coursework.

Applied to medicine, this odd policy will invite more controversy. For example, Dr. Jane Orient, executive director of the Association of American Physicians and Surgeons, observes that, under this appellate ruling, a patient is forbidden to spend her own money for medically necessary and even "life-saving" medical services, and Medicare patients must accept them on "any terms" the Medicare bureaucracy sets for their delivery. This includes Medicare's complex and cumbersome price controls or "oppressive regulation," even if those terms include "lengthy waits" for medical treatment, the use of "outdated procedures," or being subjected to the skills of "second rate surgeons."[29]

Medicare patients, now and in the future, will legally be stuck with only the "quality" of care in the provision of medical services that the federal bureaucracy gives them, simply because Medicare "covers" those services. In that respect, Medicare patients and their doctors are in a far worse legal position than their private-sector counterparts who are subject to the contractual restrictions and abuses of substandard HMOs. The reason: Private patients in HMOs can contract privately outside of the HMO without legal hindrance.

Therefore, unless they are granted congressional relief, Medicare patients may not privately seek and pay for higher quality medical services if those services are already "covered"

29. Jane Orient, M.D., "An Entitlement Is Not a Right," *AAPS News*, Vol. 55, No. 9 (September 1999), p. 1.

by Medicare. They can do so only if the doctor providing those services were to sign an affidavit and drop out of Medicare for two full years under the literal terms of Section 4507, which is highly unlikely. Seniors should realize that such relief is not likely to come through the federal courts. For any federal court to remedy such a problem, future plaintiffs would have to show that any denials of a right to seek higher quality medical services would have to rise to the level of a denial of constitutional dimensions; and that would be most difficult to prove.[30]

- **The federal Court of Appeals decided to rely not on congressional intent or on the plain language of the statute, but on the promises of a federal agency to issue future regulations to reinterpret the meaning of the law.** In trying to discern the limits of private contracting, at least as understood by the Clinton Administration, the appellate court decided to rely on "assurances" made by HCFA in a number of formal and informal ways, including communications and transmittals, testimony before Congress, and future promises of regulatory clarification.

  This raises an intriguing problem. HCFA is engaged in an all-out campaign to stop fraud and abuse in Medicare, and it is targeting physicians and other practitioners who provide services that they deem "medically unnecessary." In the reliance on the ABN process, notes John Hoff, the Court of Appeals is telling the medical community "not to worry" because HCFA officials are telling doctors to use the process and they cannot, apparently, also be readying sanctions against doctors who do so:

  > The Court has used one policy of HCFA to blunt another. HCFA may not agree with this formulation of its policy. However, the Court has provided at least a defense against HCFA sanctions for fraud and abuse. Even then, however, would the defense be of much use against a Department of Justice prosecution?[31]

  Until Congress eliminates these conundrums, members of the medical profession labor under a cloud of uncertainty.

TROUBLING ISSUES REMAIN

Since August 1997, in the debate on Medicare private contracting, the public has been treated to a series of bizarre and confusing propositions advanced by HCFA and its allies.[32] Much of the confusion can be attributed to desperate attempts to justify a confusing policy forged behind closed doors in the midst of a major budget battle, which backfired in the media. As the Court of Appeals noted during oral arguments in *United Seniors Association et al.* v. *Donna Shalala*, the Administration misrepresented the case of the opponents of Section 4507[33] while conceding that the Medicare patients had no real options outside of the program for their primary coverage.[34]

In allowing HCFA to interpret Section 4507, the Court of Appeals deferred to an agency that for years, as the American Psychiatric Association has shown, has been a veritable font of misinformation and logical contradictions on the subject of private contracting.[35] Moreover, in a remarkable turn of events, the court, apparently to avoid striking down an act of Congress as unconstitutional, sought to rely on HCFA's own interpretation of the law even before that cleverly evolving interpreta-

30. Personal communication with Kent Masterson Brown, October 29, 1999.

31. Hoff, "What the Court Did," p. 2.

32. For an analysis of the sometimes genuinely strange arguments of congressional supporters of Section 4507, see Moffit, "How Congress Can Restore the Freedom of Senior Citizens," pp. 8–16.

33. *Transcript of Oral Argument,* pp. 32–33.

34. *Ibid.*, pp. 17–19.

tion was formalized in regulations—which was not until 10 days *after* the oral arguments in the appellate case, almost 11 months after the law went into effect, and over 16 months after enactment of the Balanced Budget Act of 1997. Even then, the court relied on the preamble to the regulations, not on HCFA's regulations themselves.

Doctors, patients, and taxpayers in general should be deeply troubled by the legal status afforded to doctors and patients in the Medicare program *as a matter of policy.* For example:

- **The limited liberalization of the right of private contracting is largely the result of the Administration's regulatory retreat to avoid a court ruling on the constitutionality of Section 4507.** In initial arguments, the Administration's legal team and its allies in Congress insisted on the need to prevent the emergence of a "two tiered" system of medical care for American retirees. In its zeal to impose a single-tiered health care system on seniors and to protect Section 4507 from a direct constitutional challenge, the Clinton Administration resorted to an administrative remedy that simultaneously undercut its own argument against a two-tiered health care system. As noted, in the area where a medical service may or may not be covered—what is often referred to as "an otherwise covered service"— private contracting through the ABN process outside of the restrictions of Section 4507 becomes a real option. As a result of the Court of Appeals decision clarifying this limited private contracting option, Medicare is in effect a judicially ratified "two-tiered" system, both in law and in fact.

  Faced with a direct attack on its broader health care policy agenda and the constitutionality of Section 4507, the Administration beat a tactical regulatory retreat to protect its strategically restrictive Medicare policy. What can be done by regulation—even if such regulation is ratified by a federal court—can be undone by regulation. Regrettably, seniors also should realize that the Court of Appeals legitimized a new regulatory weapon for HCFA to use against doctors and patients who wish to contract privately: a determination of whether a medical service is "warranted." Thus, Medicare patients are still at the mercy of HCFA and do not yet enjoy statutory protection in the exercise of their rights.

- **The Medicare process for determining "medical necessity"—the source of so much trouble between HCFA and doctors—remains unchanged.** The doctor who uses the ABN process to make a private contract does so on the grounds that Medicare is not likely to pay for the medical service because HCFA or its contractors think the medical service is not medically necessary. Of course, HCFA has never finalized regulations defining "medical necessity" in the Medicare program, and doctors and patients are subjected to an arbitrary process whereby such decisions are being made by HCFA's contractors all over the country. In the meantime, the doctor obviously cannot bill the patient until Medicare has turned down the claim. As John Hoff notes, the doctor "must wait for months and then bill the patient, who by that time may have forgotten the commitment to pay and may also be less inclined to pay when he receives Medicare's statement that the service was not reasonable and necessary."[36]

  Although taxpayers are rightly concerned that private-sector insurance executives have been making determinations about what is or is not medically necessary and appropriate for patients in managed care plans, they should also be aware that the Medicare bureaucracy and its contractors routinely tell Medicare patients that the services their doctors have provided are not "medically necessary" or appropriate. Based on 1997 statistics, 19 per-

35. See, in particular, American Psychiatric Association, Testimony on Medicare Private Contracts, Committee on Finance, U.S. Senate, 105th Cong., 2nd Sess., February 26, 1998.

36. Hoff, "What the Court Did," p. 3.

cent of all Medicare Part B claims have been denied for reasons of "medical necessity," and if one excludes claims denials grounded in statutory exclusion, that figure rises to 45 percent.[37] If one is a doctor treating Medicare patients, a substantial part of the price of taking Medicare patients is to have one's professionalism questioned and thus be periodically insulted by HCFA or its contractors.

Curiously, congressional concern over the inappropriate use of the "medical necessity" restrictions on doctors is confined to private managed care plans. The U.S. House of Representatives, for example, recently enacted the Bipartisan Consensus Managed Care Improvement Act (H.R. 2723), popularly known as the Dingell–Norwood bill. The effect of this law is to shift the bulk of the authority for defining what is or is not a "medical necessity" to members of the medical profession rather than insurance executives in the private sector. Remarkably, Members of Congress generally have demonstrated no interest in making the same changes, which would reinforce the professional authority of physicians in the Medicare program.[38] Thus far, there is a notable congressional double standard in the treatment of private and public insurance programs, reinforcing the perception that Medicare patients have "second class citizenship."

- **The court has affirmed yet another undefined standard governing medical practice in Medicare; services may be warranted or "unwarranted," as well as "medically necessary" or "medically unnecessary."** According to the Court of Appeals, a doctor may resort to the ABN process for the private provision of medical services to Medicare patients that the Medicare bureaucracy says are unnecessary or may be unnecessary; but the Court also holds, following HCFA's November 2, 1998, issuance of regulations, that a doctor may not legally use that process for medical procedures that are "unwarranted." In other words, under the court's ruling, a doctor legitimately could perform "unnecessary" procedures that are fully "warranted." Likewise, a doctor conceivably could provide medically "necessary" procedures for a Medicare patient, but these would be illegally delivered and thus logically "unwarranted" services simply because they were provided under the terms of a private agreement. Says the Court of Appeals: "Needless to say, billing patients for unwarranted procedures may well be subject to sanction…."[39] At this point, what constitutes an "unwarranted" medical service is anybody's guess.

The new standards for medical practice suggested in HCFA's November 1998 regulations and reaffirmed by the Court of Appeals will doubtless invite further litigation, and lawyers and judges, rather than medical professionals, will doubtless make the key determinations about which services are "warranted" and "unwarranted" under the terms of exception provided by the ABN. According to Kent Masterson Brown, although the difference between "unwarranted" and "unnecessary" as a standard of medical practice in Medicare is unclear, the court unquestionably has raised the bar for the imposition of government sanctions so that doctors should be free to provide medical services to Medicare patients without fear of bureaucratic retaliation.[40] As John Hoff notes,

37. Sandra Mahkorn, M.D., M.P.H., "Why an Unreformed Medicare Is Hazardous to Your Health," Heritage Foundation *Backgrounder* No. 1295, June 18, 1999, p. 5.

38. Before the October 1999 debate on H.R. 2723 in the House of Representatives, Representative John Peterson (R–PA) submitted an amendment to the Rules Committee that would have applied the provisions of H.R. 2723 to government-run health plans, including Medicare. The Peterson amendment (No. 29), along with many others, was rejected by the Rules Committee for floor consideration. See Summary of Amendments Submitted to H.R. 2723, the Bipartisan Consensus Managed Care Improvement Act, Committee on Rules, U.S. House of Representatives, 106th Cong., 1st Sess., October 5, 1999.

39. *Appellate Court Decision*, p. 16.

> Although the Court did not consider it further, this formulation implies that there is a difference between services that are not "reasonable and necessary" and those that are "unwarranted." Thus, it further implies that HCFA does not pay for some services that are warranted. No one knows what the difference between "warranted" and "reasonable and necessary" is.[41]

- **The federal government has made the complicated Medicare billing process even more cumbersome and confusing.** Based on the appellate court decision, doctors are to use the ABN process if they contract privately with a Medicare patient. At the same time, HCFA says that a doctor does not have to submit a claim to Medicare on behalf of a patient if Medicare "never" pays for a particular medical service. But the doctor must still give the patient an ABN. "Thus the doctor," Hoff observes, "will be put in the strange position of telling the patient that Medicare may not pay a claim that he is not going to submit. And when does the doctor bill the patient in that circumstance?"[42]
- **The status of a senior citizen's right to contract privately with a physician for reasons of privacy is unclear.** Thrown on the defensive early in the debate on Section 4507, congressional supporters of the new Medicare restrictions, taking their cue from HCFA, said that senior citizens could always refrain from authorizing a doctor to submit a claim to Medicare for reasons of confidentiality, citing such cases as treatment for AIDS or psychiatric disorders. No such exception is contained in Section 4507, and no confidentiality exception has been cited by HCFA or its congressional allies in current Medicare law.

Worse, on the broader issue of patient privacy, the federal court declared that there was no constitutional right of privacy in the relationship between a Medicare patient and his doctor. Through various communications, HCFA simply gave "assurances" to Congress, the U.S. General Accounting Office, and others that this was the case. Indeed, in one relatively recent formulation of the privacy exception, HCFA stated that a Medicare patient could simply refuse to authorize a doctor to submit a claim to Medicare "for reasons of his or her own."[43]

Members of Congress should realize that in declaring the legitimacy of a limited form of private contracting in the case of *United Seniors* v. *Donna Shalala*, the Court of Appeals never mentioned the patient privacy issue. Of HCFA's assurances that there is a privacy exception to the rules against Medicare private contracting, Hoff observes that

> This in theory provided a privacy exception that would permit a patient to privately contract where he did not want Medicare to know of the treatment. It is unclear how much weight should be given to this administrative assurance in light of the fact that the Court did not adopt it as it did other assurances.[44]

WHAT CONGRESS CAN DO

The controversy over Section 4507 and the subsequent litigation over the meaning of its provisions hold numerous lessons for Members of Congress. As a practical matter, it is unlikely that many senior citizens today would go outside of the Medicare system and forgo Medicare reimburse-

40. Personal communication with Kent Masterson Brown, October 29, 1999, p. 12.

41. Hoff, "What the Court Did," p. 3.

42. *Ibid.*

43. Health Care Financing Administration, "Carriers Program Memorandum," Question and Answer No. 21, January 1998, p. 10.

44. Hoff, "What the Court Did," p. 2.

ment to pay a physician privately for a medical service that Medicare already covers.

But there are times when Medicare patients wish to make such arrangements. With the rapid aging of the American population and the pending retirement of the huge baby boom generation, Members of Congress are mistaken if they imagine that Medicare—the most rigorously managed care system in America—will not run up against the problems that bedevil private-sector managed care executives who try to cut back on services and restrain patient choice in efforts to control rising health care costs.

The best option for Congress is to make serious changes now. For example:

1. **Defend personal freedom and abolish restrictions on private agreements between Medicare patients and their doctors.** Congress should eliminate restrictions on senior citizens who spend their own funds for medical services, regardless of their coverage under Medicare. This policy is embodied in legislation introduced by Representative Patrick Toomey (R–PA), the Seniors Health Care Freedom Act (H.R. 2867). In a free society, there should be no restriction on the ability of individuals to spend their own money for medical services of their choice for any reason that they choose to do so. Moreover, in a free society, there should be no restriction on the ability of two adults to enter into a mutual agreement on terms and conditions that seem fair to them.

2. **Defend personal privacy and clarify Clinton Administration concessions in law.** The Administration has conceded that Medicare patients may refrain from authorizing the submission of a Medicare claim if, for any reason, they wish to protect their privacy. At the very least, Members of Congress should clarify this privacy exception in law rather than leave clarification of it to HCFA, a federal agency that has demonstrated notorious insensitivity to the confidentiality of the personal information of Medicare patients enrolled in home health care programs.[45] In this respect, Senator Jon Kyl (R–AZ) is preparing a legislative proposal that would legally guarantee the right of a senior citizen, for his or her own reasons, to refrain from authorizing the submission of a claim to the Medicare bureaucracy.

3. **Start serious Medicare reform based on patient choice and private competition.** Congress should build on the work of the National Bipartisan Commission on the Future of Medicare, chaired by Senator John Breaux (D–LA) and Representative William Thomas (R–CA), and create a new Medicare system that is characterized by consumer choice and competition. It should be modeled after the successful Federal Employees Health Benefits Program (FEHBP). Under such a system, the regulatory authority of HCFA would either sharply contract or disappear, and the next generation of American retirees would enjoy a health care delivery system that maximizes patient choice and protects personal liberty and privacy. Any Medicare reform must clearly and unambiguously guarantee the personal liberty of senior citizens who, for whatever reason, want to spend their own money for medical services with a physician of their choice.

4. **Step up its oversight of, and restrain the excesses of, the Health Care Financing Administration.** Congress should do this with a view to protecting Medicare patients in the exercise of their personal liberty and privacy. HCFA's record on both counts, especially its 1999 efforts to collect and transmit detailed sensitive personal information on Medicare beneficiaries enrolled in home health care programs, is profoundly disturbing.[46] Whatever the timing of comprehensive Medicare reform, this oversight task is paramount.

45. For more on this controversy, see Paul Appelbaum, M.D., *et al.*, "How the Medicare Bureaucracy Threatens Patient Privacy," *Heritage Lecture* No. 646, October 15, 1999.

46. *Ibid*.

CONCLUSION

Section 4507, though less offensive after courageous litigation, remains law. It is among the worst policies in a growing body of complex Medicare law that has spawned a mind-numbing volume of rules, regulations, and paperwork.

The United States Court of Appeals for the District of Columbia, in *United Seniors Association Inc. et al.* v. *Donna Shalala*, has addressed the specific concerns of senior citizens who sought relief from federal restrictions on private contracting, and has clarified a way for seniors to engage in private arrangements with physicians under the regulatory authority of HCFA in certain tightly prescribed circumstances. However, the court dodged the fundamental constitutional issue of whether senior citizens have a basic right to contract privately with physicians and has compounded the complexities of current Medicare law by confirming new regulatory weapons by which HCFA can restrict such arrangements.

Only Congress can clear away this often absurd and complex body of law and regulation by establishing the right of senior citizens to spend their own money on medical services from doctors of their choice free from bureaucratic interference. No senior citizen should be deprived of fundamental liberty or privacy merely because he or she has enrolled in Medicare. A comprehensive reform of the overly bureaucratic Medicare system that promotes personal choice with a variety of options would spare the next generation of American retirees this anxiety.

Section 4507 is unique in that it represents both an aggressive violation of seniors' individual rights and an unprecedented federal intrusion into the doctor–patient relationship. That it remains a statute of the American Republic is a sad indication of the cavalier disregard for personal freedom that too often characterizes official Washington's deliberations on health policy.

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