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PRIVATE CONTRACTING IN MEDICARE

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

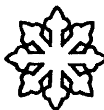
ONE HUNDRED FIFTH CONGRESS

SECOND SESSION

ON

S. 1194

FEBRUARY 26, 1998



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PRIVATE CONTRACTING IN MEDICARE

THURSDAY, FEBRUARY 26, 1998

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:00 a.m., in room SD-215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Grassley, Mack, Rockefeller, Graham, Bryan, and Kerrey.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will please be in order.

Today we will hear testimony on the issue of private contracts in Medicare. Private contracts simply refer to agreements under which a physician or other health care practitioner agrees to treat a Medicare patient and the patient chooses to pay the bill out of pocket rather than use Medicare.

Prior to the Balanced Budget Act, Medicare law required doctors and other practitioners to always follow two rules. First, to submit a bill for each service provided to a Medicare patient; second, to limit charges to a Medicare patient to the maximum allowed for each medical service.

BBA provided a new, if limited, opportunity for private contracts. A doctor or other practitioner is not subject to these rules if he or she agrees to forego Medicare reimbursement for 2 years.

The purpose of today's hearing is to understand Medicare policy regarding private contracts as it exists today, how it evolved, and to hear about legislation offered by Senator John Kyl that would expand Medicare private contracts.

So we will proceed at this stage. We are very pleased to have with us our distinguished colleagues, Senator Kyl, Senator Durbin, and Congressman Cardin. Welcome. It is a pleasure to have you with us.

So at this time I would call upon Senator Kyl.

STATEMENT OF HON. JON KYL, A U.S. SENATOR FROM ARIZONA

Senator KYL. Thank you very much, Mr. Chairman. Thank you for holding this hearing. I appreciate it very much.

Specifically, I am here to testify in support of Senate bill 1194, the Kyl-Archer Medicare Beneficiaries Freedom to Contract Act. S. 1194, I might say, now has 48 co-sponsors. The House companion bill, H.R. 2497, introduced by House Ways and Means Chairman Bill Archer, I believe, has at least 185 co-sponsors.

Mr. Chairman, I want to thank you also for your leadership on this issue during debate on the Balanced Budget Act of 1997. Although I believe more needs to be done, this Act allows seniors to enter into private contracts with practitioners outside of Medicare, an important principle, and I think this change represents a modest, but significant, improvement over the Health Care Financing Administration's prior interpretation of the Medicare statute.

I also want to thank HCFA Administrator Nancy-Ann Min DeParle and the American Association of Retired Persons for working with me on this issue.

Mr. Chairman, this legislation would protect the right of Medicare beneficiaries to be treated for Medicare covered services by physicians and practitioners of their own choice, outside of Medicare, on a case-by-case basis and a patient-by-patient basis.

Basically, this legislation would repeal the 2-year exclusionary provision contained in the private contracting amendment enacted as part of the Balanced Budget Act of 1997.

The right of seniors to pay out of their own pocket for the health care of their choice is essential to our Nation's concept of liberty. In fact, I think there is no more fundamental principle at stake in any legislative issue before us.

In his State of the Union address, President Clinton asserted that, "All Americans should have the right to choose the doctor you want for the care you need." That is what he said. I could not agree more. But this is a right that most seniors do not have after the Balanced Budget Act became law on January 1.

Imagine if on the day you turned 65 you went for a check-up to your doctor of 30 years and he tells you he can no longer treat you. Amazed, you ask why. He replies that, due to the paperwork, the regulatory burdens, and the Medicare low reimbursement rates, he just cannot afford to take on any Medicare patients.

You say, well, just bill me directly. I will pay you directly. We will save Medicare money. He said, no, I cannot do that. If I take your money, I would be fined, excluded from Medicare, even criminally prosecuted for health care fraud. That is the status of the law.

Once you turn 65, in effect, it is Medicare or no care. How can this be true? How can it be illegal in America for seniors to choose to pay for their own health care?

Well, it is true, as you know. This actually happened to a friend of mine, Maryann Howard, in Prescott, Arizona. Through this flawed interpretation of the Medicare law, the government has prohibited Medicare beneficiaries from using their own money to go to the doctor of their choice for covered services.

Recent reports of the Physicians Payment Review Commission suggests one of the possible causes for this problem, which I alluded to earlier. Medicare rates of reimbursements to physicians, which average roughly 71 percent of typical private reimbursement rates.

In certain hot spot areas, this disparity may render physicians unable to accept additional Medicare patients and still cover their overhead and medical insurance. This limits the ability of many seniors to continue with the doctor or provider of their choice and to receive the quality of care that they want in order to prevent or treat serious illness.

There may also be limitations for those who want to maintain strict confidentiality of all of their medical records by not filing claims with HCFA.

To remove these restrictions, I introduced S. 1289 in the 104th Congress. This legislation sought to clarify that all Medicare Part B beneficiaries and providers could enter into private agreements for covered services on a patient by patient and case by case basis.

To facilitate passage on the Senate floor, the bill was modified to apply only to those providers who had never participated in Medicare or those who, for an undetermined period, agreed not to participate in the system. As you know, the Senate passed this provision as an amendment to the Balanced Budget Act.

This was the version that survived a budget point of order. The vote, by the way, was 64 to 35 on June 25, 1997. It was then adopted by voice vote and sent to the Conference Committee as part of the Balanced Budget Act.

But the administration threatened to veto the entire budget over this provision and forced the Senate/House conferees to reluctantly accept a poison pill. In order to enter into such a voluntary private agreement under the so-called compromise, a physician or other provider would have to sign out of Medicare for 2 years in advance.

So the two year exclusion presents your doctor with a very difficult choice. He can either treat you, his patient of, say, 30 years, on a private contract basis and dump all of his other Medicare patients, or refuse to treat you in favor of his current Medicare patients.

I would just say that it seems like a rather perverse incentive, if we are trying to get physicians to treat as many Medicare patients as possible, to put this kind of a dilemma in front of them. You have to dump all of your patients if you want to treat somebody on a private contract basis.

Over 96 percent of doctors accept some Medicare patients, and I do not think that they would likely be willing to impose such a hardship on their current patients. So I think, as a practical matter, the 2-year option reduces the choice to an almost meaningless choice.

To remove this limitation on patient choice, Chairman Archer and I introduced the Medicare Beneficiaries Freedom to Contract Act. This bill removes the 2-year exclusion and ensures that any Medicare beneficiary can enter into an agreement with the provider of his or her choice for any health care services.

Opponents of the bill make three basic arguments: the bill would increase fraud, would put seniors at the mercy of doctors and other providers, and would hurt Medicare.

With respect to fraud, the bill contains extensive anti-fraud measures, including the requirement of a written contract with clear terms, such as the fact that the service could not be paid for

by Medicare. Further, the agreement cannot be entered into when the beneficiary is experiencing a medical emergency.

Now, about the matter of unethical doctors who would take advantage of vulnerable seniors. I think that common experience with medical professionals who save lives even without reimbursement, especially in emergency situations, and seniors who read and question virtually every line on their Medicare bill, clearly refutes this claim. Further, a senior can, for any reason, terminate the contract prospectively and return to Medicare for the covered benefit.

Now, the third point, some believe private contracting will destroy Medicare. But private contracting will result in fewer claims being paid out of the near-bankrupt Medicare trust fund, while also creating greater health care choices for seniors.

Further, the right to enter into these agreements has technically existed since the inception of Medicare in 1965, with no damage to the system.

I do not think that we want to be the Congress that denies seniors the right to spend the money they have saved for years in order to get the kind of health care they want for themselves or a loved one.

Just imagine, for example, a law that made it illegal for seniors to supplement their Social Security check with private funds. Such a law would be met with derision and disbelief.

Sandra Butler, president of the United Seniors Association, strongly supports this bill. She believes the government's view of private contracting violates a basic—in fact, the basic—principle of American life: freedom. Even Great Britain's notoriously inadequate system of socialized medicine gives its beneficiaries this freedom. Senators and their staffs have this freedom. Surely American should do no less for its seniors.

Finally, Mr. Chairman, I want to comment on a fact that has nothing to do with my sponsorship of this legislation. One of the organizations that supports this legislation has been sending fund-raising letters to people around the country as a means of generating funds, making claims about this legislation, most of which I believe are true.

It should not detract from the requirement, the necessity, of getting this legislation passed, that an organization may make claims which some people dispute in order to raise funds as a result of their support for the legislation. So I urge that we not be taken off track by an attack on one of the organizations that supports this legislation.

That has nothing to do with the underlying merit of this legislation which, as I said, gets back to a very basic, fundamental principle: should Americans in this country have the right to save money and to contract for health care outside of the government health care system after they turn 65?

I think we have to answer that question in the affirmative and that it has to be a practically exercisable choice so that you do not have a situation where we put a limit, like a 2-year opt out for physicians, that, as a practical matter, renders the right meaningless.

Thank you very much for the opportunity to testify, Mr. Chairman.

The CHAIRMAN. Well, thank you very much, Senator Kyl. I certainly agree that the legislation we are considering at this hearing should be determined on its merits. I think it was most unfortunate, to be candid, that that particular organization to which you made reference made statements that I think were misleading, but that should in no way impact upon the consideration of this bill and I congratulate you for your very excellent statement.

[The prepared statement of Senator Kyl appears in the appendix.]

The CHAIRMAN. It is a pleasure to have Senator Durbin here today. Will you proceed, please?

STATEMENT OF HON. RICHARD J. DURBIN, A U.S. SENATOR FROM ILLINOIS

Senator DURBIN. Mr. Chairman, it is an honor to be in the presence of a man who has an IRA named after him. [Laughter.]

The CHAIRMAN. Do you have one? [Laughter.]

Senator DURBIN. I am looking at it.

Senator ROCKEFELLER. On every television station in America, every day.

Senator DURBIN. I used to think the G.B. Sonny Montgomery Bill of Rights was the most well-known member of Congress, but I think you are surpassing him. Thank you, Mr. Chairman.

Let me say at the outset that, though I may disagree with my colleague Senator Kyl on his legislation, I do have the highest respect for him and I understand that his intentions are very good in trying to make certain that seniors do have every available option for quality health care. We may disagree on the approach here, but my respect for him is not diminished in any way.

When it comes to an organization which I am about to talk about, I recall a statement made by a former colleague of Senator Kyl and mine in the House when he said, "You can't blame an idea for the people it attracts." In this situation, one of the groups that this idea attracted is the United Seniors Association.

My interest in this subject was heightened, Mr. Chairman, when Mr. and Mrs. Richard Durbin of Springfield, Illinois received a mailing from the United Seniors Association, and there in bold print on the front of his mailing it said, "Mr. and Mrs. Richard Durbin, as of January 1998, our government, for the first time ever, will stop everyone over age 64 from getting life-saving medical treatment." Imagine my surprise!

As I read this letter, I learned that the reason that they purport to use for this is the Balanced Budget Act of 1997. I am sure it comes as a great shock to every member of this committee that that legislation resulted in this claim, at least, from the United Seniors Association, because every member of this Finance Committee, with the exception of Senator Gramm, voted for that legislation.

This is a blatant distortion of the truth. The fact is, Medicare was established in 1965 to provide all seniors with guaranteed access to health care regardless of their age, health status, or, most importantly, their income.

Contrary to the United Seniors Association assertion, the Balanced Budget Act actually increased beneficiaries' options for care.

We added Medicare choice, private fee-for-service, and provider sponsored organization plans for seniors to choose from. For the record, I want to point out a few facts about the group that is behind these scare mailings.

I am glad, Senator Roth, that the Finance Committee is having this hearing so that seniors across the United States, and many others—I guess I am not in that category; I am AARP eligible—who are receiving this publication will think twice about the claims that are made.

The United Seniors Association was founded by Richard Vigory and Dan Alexander. Richard Vigory, as many of you know, is a direct mail specialist and a well-known political activist. Mr. Alexander's checkered past, which I will not get into, hardly suggests any expertise in health care or senior issues.

Though neither remain on the United Seniors Association board today, Mr. Vigory's direct mail company, ATA, has frequently been hired by this association to send out their fundraising scare mailings on Medicare and Social Security.

These mailings follow a predictable pattern. They make an outrageous and scary claim, followed by an appeal for money. The recent mailing I received made similar outlandish and frightening claims and again advised seniors to, first, send them a "generous check."

As a 501(c)(4) organization, the United Seniors Association pays no taxes whatsoever. They have use of a nonprofit mailing permit. Thus, these fundraising scare mailings are being subsidized by us and every taxpayer in America.

Senator David Pryor, now retired, from Arkansas, pointed out in 1995 that the United Seniors Association had a contract at that time that paid Mr. Vigory up to 50 percent of all the money that was sent in.

If such a scheme is still in operation—and I hope you will ask representatives of the United Seniors Association who will be testifying what their contractual arrangement is with Mr. Vigory—then half of the money raised from this scare mail goes to Mr. Vigory.

Seniors all across my State have received these mailings, and many have anxiously called my office. That is one of the main reasons I am here today, to put the record straight.

Another interesting point about the head of the United Seniors Association, Ms. Sandra Butler, is she is also chairman of the United Seniors PAC. This pack was the conservative Republican Committee PAC until 1994, when it changed its name. FEC reporting shows that they received $153,223 in 1997 in contributions, and made donations to a long list of Republican candidates.

I have here a chart that outlines some of the inaccuracies in the United Seniors' Operation, so-called, Alarm mailings. They characterize themselves in this particular iteration as "Americans lobbying against rationing of medical care."

One claim that they make, "You cannot use personal funds to pay for your health care if you are eligible for Medicare." This alarms a lot of seniors and is a ridiculous claim. The average senior spends more than $2,600 a year on health care out of their own pocket for prescription drugs, deductibles, co-pays, and services that Medicare does not cover. If Congress did not limit what doc-

tors can charge Medicare patients for Medicare-covered services, they would spend a lot more.

Later in the mailing, Operation Alarm claims that, "If Medicare won't pay for your health and medical needs, you may have to go without treatment, unless you are wealthy and can fly overseas for treatment by a foreign doctor."

This statement is categorically false. Medicare beneficiaries have always been able to freely purchase non-Medicare-covered services with their own money or through the purchase of Medigap insurance.

Another less than credible claim is, "Seniors will fall through the cracks as Medicare continues to cut the amount it reimburses doctors and hospitals for treating Medicare patients, which results in rationing of health care for seniors."

The Physicians Payment Review Commission, PPRC, in 1997 reported that the number of physicians taking the Medicare fee schedule charge as payment in full had increased to 78 percent in 1996, up from 52 percent in 1992.

Ninety-six percent of all claims are paid on assignment. These are hardly the numbers expected if physicians were truly dissatisfied with the Medicare program and its reimbursement. In fact, 96 percent of the Nation's doctors do treat Medicare patients under the current system. Medicare is the most widely accepted health insurance plan in America.

The main incentive that encourages doctors to participate in Medicare is that all Medicare patients are treated equally. If a doctor wants to see anyone over the age of 65, the doctor is paid according to the Medicare fee schedule.

Since there are over 38 million Americans relying on Medicare and many of them are in increasing need of health services either because they are disabled or becoming older, this represent a significant portion of a doctor's potential patients.

In exchange for participating in Medicare, we ask doctors to accept the Medicare fee schedule. This is exactly the same as other health insurance plans ask of doctors who participate.

Can you imagine a Kaiser-Permanente doctor being able to tell a person enrolled in that plan that they wanted the patient to pay out of pocket and to pay more than the insurance plan fee schedule?

That is why the Clinton Administration insisted on restricting doctors from billing Medicare for 2 years after they decide to privately contract. They were saying that you are either in the Medicare program or you were not, but you cannot have it both ways.

If the rules for private contracting were loosened as some advocate, we can have doctors in Medicare managed care plans that are paid a per capita fee for seeing a patient also charging that patient even more on a private basis.

Finally, this so-called Operation Alarm claims, "Our government is, by law, rationing health care for people who can afford to pay for it." Nothing could be further from the truth. The current rules prevent doctors from engaging in price discrimination.

Do we really imagine that it would be comforting to seniors if a doctor were able to differentiate between them and other bene-

ficiaries and were able to charge them according to what they thought the beneficiary could pay?

Do we really want doctors to start asking questions about a person's income in the waiting room, or do we want them only to see people who can afford to pay more?

Private contracting allows doctors to cherry pick, or treat those that they believe can pay more. If you are a senior living in a small rural town—and I have a lot of them in Illinois—where there is only one doctor, what guarantee does private contracting give you that you will actually be able to see a doctor if you cannot afford to pay more?

In my State of Illinois we have the fourth highest number of under-served areas. Private contracting will likely drain those areas even further of doctors in the more lucrative private payment system. We are in danger of creating a two-tiered health care system where those living on modest incomes have less and less access to quality health care and a quality health professional.

Rather than being in danger of government rationing care, we are in far more danger of health care being rationed for those on modest incomes by the existence of private contracting systems. In short, United Seniors' Operation Alarm is a false alarm.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Durbin. As I said to Senator Kyl, we are holding these hearings to enable the advocates and opponents to offer the reasons why they think this is good or bad legislation, as the case may be. We do not intend to let it be based upon misinformation.

[The prepared statement of Senator Durbin appears in the appendix.]

The CHAIRMAN. At this time it is a great pleasure to welcome our friend from across the Capitol, Congressman Cardin.

STATEMENT OF HON. BENJAMIN L. CARDIN, A U.S. REPRESENTATIVE FROM MARYLAND

Congressman CARDIN. Senator Roth, thank you very much for this opportunity to testify before this committee. It is a real pleasure to be with my former colleagues from the House that have now been elevated to the Senate. I had a chance to work with both Senator Kyl and Senator Durbin in the House, and I know we all share the same goal of affordable quality health care for our seniors.

Mr. Chairman, I also very much appreciate this hearing because there has been a lot of misunderstanding concerning private contracting. This hearing gives all of us an opportunity to explain to our seniors and to the public exactly what the law was before the passage of the Balanced Budget Act, what the current status is, and what Senator Kyl's recommended changes would mean to our Medicare system.

Let me just stress that, prior to the Balanced Budget Act, there were no private contracts. For non-covered services, it was permissible for a Medicare beneficiary to pay privately for those services. But, in regard to covered services, there was no opportunity for the physician to bill privately.

So Senator Kyl's example of that person turning 65 who wants to enter into a private arrangement with that physician was not

permitted before the passage of the Balanced Budget Act. Nothing has changed in regard to those circumstances.

The Balanced Budget Act did give a very limited exception for a physician to be able to enter into a private contract for covered services. The 2-year prohibition was put there intentionally because of the example that was given to us that there are some physicians—not many—out there that want nothing to do with the Medicare system.

They should have an opportunity to decide to stay out of the Medicare system if they want, and base their entire practice based upon seniors who are willing to pay privately. That is what we did last year.

There has been, as Senator Durbin pointed out, a lot of misrepresentation about what we did last year. And I must tell you, there are people in my community who now believe that what we did last year requires a physician to have a private contract for non-covered services. That is just not true.

If the services are not covered, if a senior wants to have plastic surgery that is not covered under Medicare or the senior wants to have certain types of testing done that are not covered under Medicare, or wants to have a physical exam that Medicare believes is unnecessary, that senior can enter into an arrangement to pay the physician privately without the need of a private contract.

HCFA has made that very clear to our physicians in the 1998 Medicare Participating Physicians and Suppliers Agreement when it states, "With respect to non-covered services, a private contract is unnecessary and Section 4507 does not apply."

In other words, beneficiaries continue to be able to pay for any services that Medicare does not cover out of their own pockets under the payment arrangements they make with their physicians, without having to enter into a private contract subject to the provisions of Section 4507. I hope we have put that to rest.

Now, Senator Kyl's bill would remove the 2-year restriction. It would allow physicians to have choice. I take issue with the statement that we are giving our beneficiaries choice. We are giving physicians choice, that is true. They can pick and choose who they want to bill Medicare for and who they want to bill privately, but as for our beneficiaries, they will have less choice, not more. We will be effectively eliminating the balance billing protections that have been in Medicare since 1985.

A beneficiary, a senior going to a doctor's office, will have no certainty as to whether that doctor will accept Medicare payments under the Medicare system when that person sees the doctor. They will always wonder whether the doctor is going to ask for that person to pay privately. It will restrict the options of our seniors, not add to them.

As Senator Durbin indicated, it is contrary to what private insurance company arrangements are with physicians. We would be putting Medicare in a different category than private health care insurance or reimbursement in their relationships with their physicians.

My major concern is that I think Senator Kyl's change would have a rather extreme effect on Medicare, and let me explain why. Care to a large number of seniors would now be based upon ability

to pay. If you can afford to pay privately, you will have a different list of physicians that you can see than if you cannot afford to pay privately.

The Congressional Budget Office has said that there is a serious potential of over-billing if we were to allow physicians to choose when they wish to enter into a private contract with their patients or when they do not.

Prior to the balance billing protections of 1985, 34.5 percent of the physicians in this country charged more than the normal and customary fees. That was a rather high number. That was prior to 1985, Senator.

Senator ROCKEFELLER. What percentage?

Congressman CARDIN. 34.5 percent of physicians charged more than customary fees.

Today, that number is down to 4 percent; 96 percent accept the Medicare amount as full payment for the services. Physicians today are generally satisfied with what Medicare is paying for certain charges. If we now allow physicians to go back and to enter into private arrangements for payment, if we go back to the days before balance billing, it is likely that that number of less than 3 percent will grow again to about 35 percent.

This is an extreme number and I do not think it would hit this amount, but if we ended up with that number of physicians doing private contracts our seniors would now be paying privately about $15 billion a year in extra health care cost as a result of private contracts.

I do not think any of us want to shift that type of cost over to our seniors. You and I know that the Medicare system will not see the savings. It will be an extra cost to the system.

I have introduced H.R. 3259, the Medicare Private Contracting Clarification Act. If any bill is necessary—and quite frankly, I am not sure any legislation is necessary—I urge you to consider H.R. 3259. It makes clear what we did last year, that no private contract is needed for non-covered services, so that we can at least put to rest the issue of whether a person can use their own funds to pay for those services that are not covered under Medicare. That has been the law. That currently is the law. What the Kyl bill would do, is make an extreme change in the Medicare laws.

I would urge you to, if you need to consider legislation in this area, take a look at H.R. 3259. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Representative Cardin.

[The prepared statement of Representative Cardin appears in the appendix.]

Senator KYL. Mr. Chairman, in view of the fact that two opponents here have testified and some of the members have come in late, might I be offered the opportunity to speak for about two minutes in response?

The CHAIRMAN. Well, we are running out of time. We have votes at 11:00. So keep it to a minute.

Senator KYL. Well, in that case, I will not say that I agree with Mr. Cardin on the issue of uncovered services, except to say it.

I think that, first of all, this is not like private insurance. With private insurance, you and I have the option to buy whatever kind of insurance we want to. But if we are going to say in this country

that when you turn 65 years of age you have no options, you have only the government program, no matter how much money you have you cannot go outside that government program to buy your own insurance, then we have established, I think, a very pernicious principle in this country.

What age should we establish as the age at which you no longer have any option except to go through the government program? That is the principle that we would be establishing if we allow this law to continue.

I think, regardless of some of the technical issues here which have been brought up and which I am happy to work with my colleagues on addressing, we cannot get to the point where we say to people in this country, the only health care that you can receive is a government program and you can never go outside of that program regardless of your needs or regardless of your ability to pay. That is the basic principle involved in this legislation.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, gentlemen, thank you very much for being here today. We appreciate your testimony. Thank you very much.

It is now my pleasure to welcome Ms. Nancy-Ann Min DeParle, who is Administrator of HCFA. This is her first appearance before the committee since Senate confirmation as the Administrator of HCFA, and we look forward to working with her. Ms. DeParle will discuss Medicare policy on private contracting and the administration's views on this issue.

Ms. DeParle, it is a pleasure to welcome you. Please proceed.

STATEMENT OF NANCY-ANN MIN DePARLE, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Ms. DEPARLE. Thank you, Mr. Chairman and other members of the committee. I appreciate the opportunity to be here today to discuss the issue of private contracts between Medicare beneficiaries and their doctors.

As you know, Mr. Chairman, Medicare beneficiaries have always been free to pay physicians whatever they want for any service that Medicare does not cover. That was the law before the Balanced Budget Act and it is the law today.

Unfortunately, some opponents of the provision in the Balanced Budget Act have been spreading a great deal of misinformation, and I was glad to hear this morning that your colleagues in the Congress agree that this misinformation is bad and that it is frightening many beneficiaries.

Just last night I was looking at some of the letters that we have received, and one of them really stuck in my mind because it said, "Please tell us old people the truth. We're worried." I am glad, Mr. Chairman, that you have given us the opportunity to talk about the facts today.

What the Balanced Budget Act does is create a new option for physicians, while maintaining protections for Medicare beneficiaries. Beneficiaries can still buy services not covered by Medicare as they have always been able to do.

Doctors can still provide and charge whatever they want to Medicare beneficiaries for services that are not covered and doctors are

free to offer private contracts to any and all patients. But if they wish to contract privately with a Medicare beneficiary for Medicare services, they must agree not to bill Medicare for two years.

This provision ensures that all Medicare beneficiaries are treated equitably. It ensures that they will know in advance whether their doctor accepts Medicare or whether he or she will expect them to pay the entire bill, and it prevents private contracts from opening a new avenue to abuse by unscrupulous providers who could attempt to double bill both Medicare and the patient.

I will take just a few minutes to summarize my written testimony and ask that my full statement be submitted for the record.

The CHAIRMAN. Without objection.

[The prepared statement of Ms. DeParle appears in the appendix.]

Ms. DEPARLE. When Congress enacted limits on Medicare physician payments in 1984, it included limits on how much physicians could bill beneficiaries. Senator Dole, who was then chairman of this committee, championed these limits on physician charges and he explained that, "There has been a great deal of concern about how physicians can be prevented from shifting the burden of such a freeze to beneficiaries. Simply freezing what we pay for physician services provides little protection to program beneficiaries."

He went on to point out that, "If a physician does not elect to take assignment, beneficiaries can be held responsible for the full difference between what the program pays and what the physician charges."

For that reason and with that sort of debate, Congress enacted what are called balance billing limits, which limit the amount that doctors can charge a beneficiary above the fee schedule.

The Balanced Budget Act, which we are here discussing today, gave doctors another option. Now they can privately contract with Medicare beneficiaries as long as certain requirements are met.

A private contract exempts a physician from two statutory billing requirements. First, the claim submission requirement, and second, balance billing limits that I have just discussed.

There has been substantial misunderstanding about what the new law does and what it does not do, so I want to clarify several points. First, Medicare rules apply only to individuals enrolled in Medicare. Therefore, a private contract is not necessary for a doctor to provide services to someone who is eligible but who is not enrolled in Medicare. The Balanced Budget Act did not change this.

Second, Medicare rules apply only to services covered by Medicare. Beneficiaries can, and in fact they must, pay out of their own funds or have other sources of insurance for uncovered services, like routine physicals or eyeglasses. That was the law a year ago, and it is the law today.

Third, the Balanced Budget Act did not change advance beneficiary notices which allow a beneficiary to make an informed consumer decision by knowing in advance that he or she may have to pay out of pocket.

There has been some confusion about these notices and their relationship to private contracts. Advance beneficiary notices have been in the law since 1972. They are not private contracts. They are used when a physician believes that, in a given situation, Medi-

care likely will not cover a service. In contrast, private contracts are used under the Balanced Budget Act for services that would be covered under Medicare if the physician were in Medicare and submitted a claim.

Finally, a beneficiary may choose on a service-by-service basis to see any physician, whether the physician remains or opts out of Medicare. The Balanced Budget Act did not change this aspect of Medicare. It was the law a year ago, and it is the law today.

When Senator Kyl and Representative Archer proposed their legislation to change the Balanced Budget Act, I spoke with both of them and I agreed to consider it fairly and carefully.

I know that they are both sincere in trying to deal with what they consider to be a serious problem, and therefore we evaluated the new proposal by the following four principles: does it minimize the potential for fraud and abuse; does it promote the ability of beneficiaries to make informed choices; does it provide stable and predictable financial protection for beneficiaries; and does it promote access to high-quality care regardless of ability to pay.

Mr. Chairman, in my written testimony I go into some detail about our analysis of each of these four principles. As you will see, unfortunately, we conclude that the proposed legislation does not measure up in comparison with these principles.

I think, Mr. Chairman, that we share the same goal, which is to ensure fair and equitable payments to physicians within a framework that guarantees affordable and accessible health care to beneficiaries. I know this is a difficult issue and it requires a careful balance between the need to protect Medicare beneficiaries and the desire to give physicians flexibility to charge higher fees.

The administration opposed the original private contract provision in the Senate bill, but we agreed to the Balanced Budget Act provision because we thought it struck that careful balance.

We have carefully studied Senator Kyl's bill and evaluated it against the principles that are outlined in my testimony. And, as I said, I have also discussed these issues with several members of Congress, with doctors, and with many beneficiaries.

While I know that the sponsors of this bill are sincere in wanting to improve on the Balanced Budget Act, I do not believe that it achieves that goal and, therefore, cannot support it.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Ms. DeParle.We are going to limit questions to 5 minutes. As I mentioned, we have two votes at 11:00 and we have to complete our hearing by noon.

Ms. DeParle, as you may know, the issue of private contracts arose when a constituent complained to Senator Kyl. That constituent, Bill Howard, was the husband of an Arizona Medicare patient. His wife wanted to see a doctor who was no longer accepting new Medicare patients into his practice, and offered to pay cash. The doctor refused, of course, because of Medicare law.

Ms. DeParle, why should a Medicare patient not be able to pay a doctor with her own money without that doctor having to be locked out of Medicare for 2 years?

Ms. DEPARLE. Well, Mr. Chairman, the important thing is that we do everything we can to protect the Medicare program and its beneficiaries from further abuse.

The concern I have about that particular situation is whether or not allowing those kinds of payments to be made could subject the program to double billing by providers and them also billing beneficiaries. Frankly, there is not any way to prevent against that without us being able to track the providers and what they are doing and whether or not they are entering into private contracts.

That is why we felt that the Balanced Budget Act included those protections because it required the doctors to be out of Medicare for a finite period so that our carriers who pay the bills would know whether or not that doctor was in or out and whether or not they were collecting from the beneficiary or whether they were also eligible to collect from Medicare.

I do want to say, though, I have read and I have talked to Senator Kyl about the situation of the woman and her husband in, I think it was, Prescott, Arizona.

If the problem is that there are doctors who are participating in Medicare but will not take additional patients, or if there are particular diagnoses where, for whatever reason, they do not believe that our reimbursement is fair and it causes a problem for beneficiaries, then that is what we ought to be looking at.

My concern would be if we go down a road that opens up this program both to potential fraud and abuse, which I know this committee not only does not want, but you want us to do a better job at preventing that, I think that would be the wrong road to go down, and that is my concern.

The CHAIRMAN. Let me ask you this question. In your written testimony you noted that 96 percent of physicians accept some Medicare reimbursement. But that does not tell the whole story. Can you tell me how many physicians limit the number of Medicare patients in their practices, and in what areas of the country to Medicare patients have problems in gaining access to doctors?

Ms. DEPARLE. Sir, I would like to look at that and provide you with some more information for the record. I have discussed that issue, in particular, with Senator Murkowski of this committee, and I know he is concerned about that problem in Alaska.

I do not believe the data that we have right now tells us. It tells us how many doctors accept some Medicare patients. What it does not tell us, is whether some of those doctors are beginning to limit their practices. I think that is what the Chairman is concerned about. I am not sure we have that information right now, but I would like to check and see if we can get you some better information because I think that may be the issue here.

The CHAIRMAN. I would appreciate your submitting that in writing, and everybody will be free to submit written questions until the end of the day.

[The information appears in the appendix.]

The CHAIRMAN. Let me ask you this. Are you aware of any other health insurance program, public or private, that tells people they cannot use their own money to purchase health care? Do any of the other Federal health care plans, Medicaid, FEHBP, or Defense Health, have similar restrictions?

Ms. DEPARLE. Well, sir, it is my understanding in the Federal Employees Health Benefits Program that the physicians who operate in that program, if they are in the program, are supposed to

accept, for covered services, the amounts, whatever the FEHBP plan gives them. So in that sense, I think it is similar to Medicare. I do not believe that they allow physicians to enter into private contracts in that way.

The CHAIRMAN. It is my understanding that that depends upon the individual plan. It is not by Federal regulation or requirement. There may be plans where the doctor is required, but that could differ from plan to plan.

Ms. DEPARLE. Yes. The plan that I am familiar with is the FEHBP program, which is the Blue Cross/Blue Shield standard. I believe if you are a participating physician, I do not believe that Blue Cross/Blue Shield allows a doctor to accept other than the payment that is for the covered service.

Now, for non-covered services, it is just like Medicare, with all of these programs, I think. If the service is not covered, then the physician can charge whatever they want to for it. But I am not familiar with plans that allow something different, although I would be happy to speak with the OPM and look into that.

The CHAIRMAN. Finally, Medicare patients who belong to HMOs can go out of plan and pay for health services from their own pockets. Why should fee-for-service Medicare patients not have the same right?

Ms. DEPARLE. Well, in the Medicare HMOs, or the risk plans, if a beneficiary goes out of the plan it is considered to be not a covered service. In that case, yes, sir, they can pay whatever they want to for it.

The CHAIRMAN. My time is up.

Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

First of all, Senator Baucus asked me to apologize. He has written a letter to Senator Moynihan. He is very concerned about the Kyl bill, particularly in rural areas, potential harmful impact of private contracting on access in rural areas. He is doing IST authorization today, or legislation.

He is particularly unhappy because Dr. William Reynolds, who is president of the American College of Physicians, is from Masula, Montana.

Mr. Chairman, I would ask that my prepared statement be made part of the record.

The CHAIRMAN. Without objection.

[The prepared statement of Senator Rockefeller appears in the appendix.]

Senator ROCKEFELLER. Secretary DeParle, why was balance billing instituted?

Ms. DEPARLE. Well, as I understand it, Senator, it was because of concerns in Congress that beneficiaries might be forced to pay the full freight, or much above, what Medicare was supposed to be paying if there were not balance billing limits.

In my testimony, I have looked at the legislative history of this, and Senator Dole, in particular, talked about the concern that members had about beneficiaries being forced to pay above the Medicare payment rate. I believe there was evidence that beneficiaries were having to pay much more out of pocket than Congress intended.

Senator ROCKEFELLER. Is it not true that since the 1989 implementation of that, that beneficiaries have saved about $2 billion a year in out-of-pocket costs?

Ms. DEPARLE. Yes, sir. That would be our estimate, yes.

Senator ROCKEFELLER. One of the problems that I think bothers some people is they say, well, under the present law if you want to take on a special relationship or private relationship with a beneficiary and you are taking assignment, you cannot bill Medicare for two years. On the surface, that sounds kind of rugged.

I think one of the keys, is what you brought up in your legislation but which I have never heard discussed before, and that is the very simple act of advance notice.

I would like you to explain that again in very good lay terms, because that has everything to do with not having a physician feel, if I go ahead with this test which is not covered and I do it on a private contract basis, I can do it for this patient, but then I am toast for the next 2 years. Physicians can get out of that very easily by?

Ms. DEPARLE. By using an advance beneficiary notice, which is a protection which was put in the law, as I understand it, in 1972. What it is, is that if a physician has a patient, who is a Medicare beneficiary and it is a service that they think may not be covered by Medicare, let us say it is a test that they think might not be covered for whatever reason, he can ask the beneficiary to look at an advance beneficiary notice and sign it. And all it says is——

Senator ROCKEFELLER. So it is not back and forth to Washington, DC, it is right there with the patient.

Ms. DEPARLE. No, it is not. In fact, we do not even see them. The physician puts it in the file. But it is supposed to say that the beneficiary has full notice as a consumer that the service may not be covered and that, in that instance, they have to pay the physician. We do not ever have to know about it, frankly.

I was not aware of any problems with this until all of this debate about private contracting came up. I do think that some physicians now are confused about the use of the advance beneficiary notice.

Senator ROCKEFELLER. As well as a lot of Senators. I think that is actually one of the key reasons why a number of Senators are co-sponsors of this legislation and would not otherwise be so. In fact, one of the reasons that we are having this hearing, and I am very happy that Chairman Roth is having this hearing, is because there are 47 co-sponsors and there really ought to be about 20. I think that is one of the reasons that people feel that doctors will be shut out of the process if they do this.

Ms. DEPARLE. Yes. I have even heard that some doctors think that if they sign an advance beneficiary notice now or if they give one to a patient, that that is an automatic opt-out for 2 years, which is not the case.

Senator ROCKEFELLER. And that is not the case.

Ms. DEPARLE. I think we would like to work with you and your colleagues to get some more information out to doctors and educate them on that because if there is confusion, that is not good for the program.

Senator ROCKEFELLER. The patient in the clinician's office, let us say, how would that work? Let us take an uncovered service. The

doctor would say, oh, this is not covered by Medicare. I think you need to have this.

Ms. DEPARLE. Well, they make their own forms. There is no prescription for this. But it just says, "I understand that this service may not be covered by Medicare, and if it is not, I, the beneficiary, agree to pay the physician for it." The physician, therefore, is not subject to any of the rules and can charge the beneficiary as though it were a non-covered service.

Senator ROCKEFELLER. And go ahead and see beneficiary patients from that day forward.

Ms. DEPARLE. Certainly. It is not a private contract and they do not opt out of Medicare.

Senator ROCKEFELLER. Thank you. That is very helpful.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Rockefeller.

Senator Mack?

Senator MACK. Thank you, Mr. Chairman. Being one of the 47 and probably being one of the 20——[Laughter].

Senator MACK [continuing.] I would just try to ask a few questions here. Unfortunately, I got in after Senator Kyl had made his statement and so I only had the opportunity to listen to the other two individuals.

It seemed like their discussion, as has been most of the discussion this morning, was to say that you all are confused about this; you should not worry about it because there is a difference between covered services and uncovered, or non-covered, services. The implication, I think, that was made, was that covered services are very small.

So I guess my first question to you would be, what percentage of a retiree's medical expenses are in the covered category?

Ms. DEPARLE. I do not know precisely, Senator, but I think Medicare is a good benefit and I hope it covers a good percentage of what a retiree needs. I think that is what we all hope. I can look at that and try to get you a more precise answer.

Senator MACK. As a matter of fact, I think in the material that I have seen Medicare covers about half of the elderly's health care costs, a substantial portion, I would say. Therefore, the comments about, do not worry about it, this is a debate about what is covered and what is not covered, in fact, is not the issue. The issue is here that half of the expenses of a retiree are affected by the debate that we are having here this morning, so I think it is significant.

The second point that I would make, is that this debate seems to be circulating around the issue of the physician. I do not think that is the issue. I think the issue, frankly, is about the patient. I would say, is it Mr. and Mrs. Howard?

The CHAIRMAN. Yes.

Senator MACK. Did Mr. and Mrs. Howard do something wrong? I mean, I gather they went to a physician and the physician said, I cannot treat you. Does that not bother you that there are some things, that Medicare beneficiaries would like to see other physicians but they cannot under the restrictions that are in the Medicare program?

Ms. DEPARLE. Well, Senator, as I said, it does bother me. But I thought the issue with the Howards, and I have not met them but

I have read a lot about them, as I understood it, they wanted to go to a doctor who does treat Medicare patients, and I believe they would have been happy to use their Medicare coverage. But he said, I have as many Medicare patients as I would like; I do not want any more. So for me, what I question is, is the issue really sort of an absolute issue of choice, which I think to Senator Kyl, in my discussions with him, that is the principle to him. We might disagree on that.

But is that the issue or is it also an issue of certain doctors, for whatever reason, believing that what we pay them, our reimbursement rates for particular things, perhaps—I think Mrs. Howard's husband was a diabetic. I think that is what they needed special services for. If we are not reimbursing adequately, then I think that is an issue that we need to look at. If that is the root issue here, then I think we ought to look at that issue. My concern is going down a road that would open up this program to——

Senator MACK. That is where you all want to focus. What I think Senator Kyl is trying to say, it is an issue about choice, that in essence, 50 percent of the elderly's health expenses are covered by the debate we are having here this morning.

There are people who I would suggest that there are lots of different reasons, not just the reasons that the Howards may have had, reasons of their own that really do not have anything to do with the level of reimbursement, that we are saying that we know better than them as to how they should get their health care.

The next point that I would make, and this will actually give you an opportunity to expand your reasons why the Howards should not have this option, because the answer that I thought you gave anyway indicated that you would be opposed to doing this because this will open the opportunity for more fraud.

Ms. DEPARLE. Among other things.

Senator MACK. There is a legitimate reason to be concerned about fraud. There is probably not a Federal Government program that there could not be ways to reduce that fraud. But to give as an excuse for not pursuing that because you are worried about fraud—again, I will give you an opportunity if you want to take it to tell me the other reasons about why we should not do this.

But I find it very troubling that we are restricting seniors, given the debate that has already taken place, the difference between covered and non-covered. We are talking about covered services here and we are denying people a choice.

Ms. DEPARLE. Senator, one point I do need to make, though, is that there is choice right now whether to participate in Medicare. In a situation like the Howard's——

Senator MACK. Again, I do not think that is a fair response, to tell you the truth, that you can either be in or out. Again, I think we are setting up an unfair situation. There is much more to this issue than just either you can be in or you can be out, and I am sorry.

The CHAIRMAN. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman. Also, I join in expressing appreciation for your holding this hearing in what is an important and complex issue.

I also want to thank Ms. DeParle. Early in her status as the head of the Federal Health Care Financing agency, she took a full day to come to South Florida and personally immerse herself in a number of the issues of health care fraud, which unfortunately are heavily impacting on that community.

In the course of the day that we spent together, I think we saw that one of the potential areas of vulnerability to fraud is where people such as medical clinic directors were able to establish those clinics, and there are some thousand or more in South Florida, without any regulatory or other demonstrated competence to either provide medical supervision or financial supervision and management of those clinics.

If, in fact, there were to be a licensure requirement for operators of medical clinics, I assume the effect of that would be to restrict choice in that some of the people who are operating those thousand or more clinics would not be able to meet the standards for precisely the reason that we are concerned about the abuses that they are currently inflicting upon the system. Would that be correct?

Ms. DEPARLE. Yes, sir. As you saw, we saw instances where doctors said they did not even know that their provider numbers were being used in that way. That kind of thing could happen in this situation as well.

Senator GRAHAM. So the essence of requiring some type of standards for people to participate is a key part of hardening the system against fraud and abuse. Is that correct?

Ms. DEPARLE. I believe so. I believe we have to have fair, but tough, standards before we let someone into the Medicare program.

Senator GRAHAM. So the unfortunate corollary of providing services which are professional, ethical, and to the maximum extent possible avoiding fraud and abuse, is to exclude some people and some practices from the system because they do not meet those standards.

Ms. DEPARLE. Unfortunately, I think it is.

Senator GRAHAM. Applying that principle to the issue that we are now discussing, could you elaborate, for instance, on the potential abuse of double billing that you see might be the incident of allowing a physician who is receiving some of his or her patients on the Medicare reimbursement schedule, but other patients are being denied the use of that Medicare reimbursement schedule and are being required to privately contract with that same physician. What do you see as the potential of double billing or other fraudulent practices that would emanate from that dual relationship?

Ms. DEPARLE. Senator, I think I can answer that best by contrasting what is in the Balanced Budget Act with the new proposal. In the Balanced Budget Act, the physicians are required to be out of Medicare for a finite period, which means that their carriers who pay these bills would know who they are, so if a bill came in from Dr. Graham and we knew he had opted out of Medicare, we could know that we were not supposed to pay that bill.

The problem with the way this current proposal is structured, is that the doctor can decide on a case-by-case basis who he will accept assignment on and who he will ask for a private contract and ask them to pay.

So if you came in and Senator Rockefeller came in, they could decide right at that moment, well, we are going to charge Senator Rockefeller more, but we are going to take Senator Graham's Medicare reimbursement.

For all I know, they could send in a bill to our carrier down in Florida and the carrier would not know for sure whether the doctor was in or out, whether they had charged Senator Rockefeller and were also charging Medicare.

As you saw, we have problems right now that we need to fix. I am afraid this kind of thing would exacerbate it. Whereas, what you did in the Balanced Budget Act, because it requires this finite period of time, enables us to know where a given physician is and whether or not we should pay the bill.

Senator GRAHAM. Thank you.

The CHAIRMAN. Let me ask you on this point, is it not true that the risk is reduced because Medicare does send an explanation of benefits to the patient so the patient would know if there was double billing?

Ms. DEPARLE. That would help, Senator. We do send an explanation of Medicare benefits to every beneficiary. The beneficiaries, though, could also be confused by this.

The CHAIRMAN. All right.

Senator Bryan?

Senator BRYAN. Thank you very much. We are pleased to have you with us this morning.

Let me pursue a line of questioning Senator Graham embarked upon, and that is the element of fraud. As I understand Senator Kyl's provision, a physician would be allowed to bill not only with respect to a particular patient, but also with respect to a particular service provided for that patient. For example, if a patient who is Medicare covered comes in and needs perhaps two or three different procedures, all of which are compensated under the Medicare Payment Schedule, a physician would be able to say, in effect, with respect to two of those procedures, I am willing to accept the Medicare reimbursement rate. With respect to a third, I am not, and I will charge you X number of dollars for that service. Am I correct?

Ms. DEPARLE. That is correct, and I am glad you asked that because it follows up on the Chairman's question. That is what I meant, Mr. Chairman, when I said it might be confusing. The way this bill is structured, if you came in they could say, two of the things we have done today are covered by Medicare, but on this other one we want to charge you extra.

When the beneficiary gets their explanation of Medicare benefits, if they bill Medicare for all three, he may or may not know for sure what happened a month ago and whether or not he was supposed to be paying or whether or not the Medicare program was supposed to pay. So it seems like we would need to do something to make that clear in order to make this work.

Senator BRYAN. So it is your testimony then that that would enhance the potential of fraud. Not to accuse every physician of fraud.

Ms. DEPARLE. No.

Senator BRYAN. That certainly is not the purpose of my line of questioning, and I take it that is not your position either. But, by and large, in effect a physician could pick and choose, with respect to a patient on a given day, the range of services which would be reimbursed at the Medicare schedule and those that should be privately charged.

Ms. DEPARLE. Yes, sir, that is right. In my testimony, or at least in my statement today, I used the word abuse, because we saw situations down in Florida where it was not even the doctor who was doing the billing, it was the office, and they were not straight, or in some cases I think they knew what they were doing, but they were billing for things that had not been provided or were improper. There is just a lot of potential for confusion here, I think.

Senator BRYAN. Let me pursue the confusions from the patients' point of view. Those of us who are not yet Medicare eligible, let us say, we are in the pre-Medicare years of our life, going to a physician is a fairly traumatic and frightening experience for most of us, even those of us who are privileged to enjoy good health.

I presume that there would be an enormous potential for confusion on the part of the Medicare patient as he or she comes in, not knowing exactly what the physician is going to diagnose, or what is required for the particular condition that brings the patient to the office. So the patient would never know going into the physician's office whether or not the particular medical treatment he or she needs is going to be Medicare covered and the physician would be satisfied with Medicare payment, or whether or not the patient may find himself or herself in a situation in which the physician would say, again, the example we just used, two of these things I am happy to be compensated on the Medicare schedule, but the third I am going to be insisting upon some kind of private contractual arrangement because I do not think the rate of reimbursement is fair.

Ms. DEPARLE. I think that is right. I think that, with the beneficiaries not knowing until they go to the office, or indeed, until they get the diagnosis, that could lead not only to confusion, but it changes the physician/patient relationship in ways that I am not sure are good. I have struggled with this issue, as I have talked to Senator Kyl, who believes very strongly that this choice should just be there. But I guess my concern, Senator Mack, is whether this is a real choice. If you go in and the doctor says, all right, I have diagnosed breast cancer.

Medicare will cover the diagnosis, but for your treatment we have to go out of pocket. I want a private contract from you. Maybe that is the worst case scenario, but it is a scenario that scares me. I do not think it is the right road to go down.

Senator BRYAN. Medicare may not be perfect, but for 38 million Americans there is at least the certainty that, there is a payment schedule of benefits that are covered. We all know that Medicare beneficiaries want to see those benefits expanded to cover such services as prescription medicines, and we all understand that.

But people do understand that, by and large, unless it is ancillary to hospitalization, your prescription medications are not covered by Medicare. But there is a certainty of what the Medicare payment schedule is, what benefits are provided, and that would

be lost, it seems to me, if this particular provision were enacted into law.

Ms. DEPARLE. That is my concern as well.

Senator BRYAN. Finally, and you probably addressed this, with respect to some of the false assertions that are made, any non-covered Medicare service, whether it is for cosmetic surgery or whether it is for an additional diagnostic examination that is not covered, under the current law and prior to the Balanced Budget Agreement, a patient could always pay privately for those non-covered services.

Ms. DEPARLE. That is correct.

Senator BRYAN. If you wanted a second, third, or fourth opinion and, for whatever reason, it was not covered under Medicare, both prior to the Balanced Budget Agreement and after the Balanced Budget Agreement, every Medicare patient in America has the right to make that judgment and to pay privately for that non-covered service.

Ms. DEPARLE. That is correct.

Senator BRYAN. Thank you.

The CHAIRMAN. Thank you, Senator Bryan.

I think that completes the oral questioning.

Senator GRAHAM. Mr. Chairman, could I ask Ms. DeParle one last question? I think this will take 30 seconds.

The CHAIRMAN. Please proceed.

Senator GRAHAM. Part B of Medicare is voluntary, is that correct?

Ms. DEPARLE. Yes, sir.

Senator GRAHAM. So if a person did not want to take advantage of Medicare reimbursement, they could elect not to participate in Part B.

Ms. DEPARLE. Yes. Then they would not be paying the $43 a month. Yes.

Senator GRAHAM. And at that point they would be a non-Medicare beneficiary and the doctor who accepted Medicare payments for those who were Medicare beneficiaries could treat that person. Is that correct?

Ms. DEPARLE. Yes, sir. And could charge them whatever they worked out.

Senator ROCKEFELLER. Mr. Chairman, if the Senator from Florida would yield.

The CHAIRMAN. Thirty seconds.

Senator ROCKEFELLER. It will not take that much.

I have to agree with my colleague from Florida, that Senator Graham is absolutely correct. But that is something a Medicare beneficiary makes that choice very early not to be. We are talking about an episode of potential confusion.

I think it is better to address the fact that Medicare beneficiaries can do private contracting. There are other ways, in fact, even than you had mentioned, but not simply to say that in Part B you could just say, well, I choose not to participate. That is not really a good argument, I think, with all due respect.

Senator GRAHAM. It was not an argument, it was just an option that is available to the individual.

The CHAIRMAN. The Chair would like to proceed. We do have a vote on the floor, motion to invoke cloture on the McCain substitute amendment. Then there will be a second vote.

So we thank you for being here today, Ms. DeParle, and we look forward to working with you on this and other matters.

Ms. DEPARLE. Thank you. I look forward to working with the committee.

The CHAIRMAN. So at this time I will call forward the next panel. Taking our witnesses in alphabetical order, we have with us Dr. Beatrice Braun, who appears on behalf of AARP; Mr. Kent Masterson Brown, for the United Seniors Association; Dr. J. Edward Hill, for the American Medical Association; and Dr. William A. Reynolds, for the American College of Physicians.

I do know, as was indicated, Dr. Reynolds, that Senator Baucus was anxious to be here this morning to introduce you. But, since he cannot, let me say as a summer neighbor of yours, we are, indeed, delighted to have you here on behalf of the American College of Physicians.

We will recess temporarily. We have two votes. I will go down and vote and come back as quickly as possible. I apologize for this delay. The committee is in recess.

[Whereupon, at 11:10 a.m., the hearing was recessed.]

The CHAIRMAN. The committee will please be in order.

We will ask that each witness limit his or her testimony to 5 minutes. Dr. Braun, we will call on you, first.

STATEMENT OF BEATRICE BRAUN, M.D., MEMBER OF THE BOARD OF TRUSTEES, AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, DC

Dr. BRAUN. Thank you, Mr. Chairman. I am delighted to be here to testify today.

I am Dr. Bea Braun. I am a mostly retired physician from Springhill, Florida and I am a member of AARP's board of directors.

Since the Balanced Budget Act was enacted, Medicare beneficiaries have been deluged, as you have heard this morning, with misinformation about the physician private contracting provision.

I have spent a lot of time, since I live in Florida and I am out in the field a lot, answering questions from people who have been frightened into thinking that, since the BBA, Congress has restricted their choice and jeopardized their health care.

After I explain the facts, they look at me and say, if I can pay privately for anything that Medicare does not pay for, why would I want to pay for what Medicare does pay for?

AARP has found out that in order for our members to understand the BBA private contracting provision, it is important to know how private contracting was handled before the BBA was enacted, how the new law actually expands private contracting, and what the proposed changes would mean for beneficiaries in the Medicare program. We appreciate the committee giving us a public forum today to examine the facts.

As we have heard today, beneficiaries have always paid privately for services that Medicare does not cover. But many beneficiaries

were not aware that, prior to BBA, private contracting for Medicare-covered services was not permitted.

The BBA lifts restrictions on private contracting so long as program fiscal integrity and consumer protections are met. These requirements are essential to protect Medicare from fraud, to prevent doctors from cherry picking more profitable beneficiaries or services, and to ensure that beneficiaries know up front what they are agreeing to.

Unfortunately, bills recently introduced in Congress would eliminate some of these important protections by significantly broadening private contracting to allow physicians to decide on a service-by-service, case-by-case basis whether they will accept Medicare's payment or not.

In most health plans, including Congress' FEHBP, it is common practice for doctors to agree to abide by the plan's payment rules. Under S. 1194, however, this rule would no longer pertain to Medicare.

For AARP, a major concern with eliminating program integrity and consumer protections from the BBA is Medicare and beneficiaries would be left vulnerable to more fraud and abuse, as we have heard this morning.

That concern has been echoed by the Congressional Budget Office. CBO has found that, without fiscal integrity provisions and adequate funds to track privately contracted services, Medicare's efforts to combat fraud and abuse would probably be hampered.

At a time when Americans are demanding better policing of health care fraud, it makes little sense to enact changes that make Medicare fraud easier. Just as serious is the potential for significant increases in out-of-pocket costs.

As people understand what private contracting really is, as I said before, they often ask, why would I want to pay out of pocket for health care services that my insurance, my Medicare, already covers? Most people I talk to are looking for relief from high health costs, not for ways to spend more money out of pocket.

Mr. Chairman, the BBA gives beneficiaries more control over how they pay for health care. It broadens options for beneficiaries and doctors to contract privately for Medicare-covered services, while it also protects the program against further fraud.

If protections are eliminated, beneficiaries will be vulnerable to fraud and increased costs and the integrity of the Medicare program will be weakened.

The Medicare program will need to undertake many changes, we all know that, over the coming years. But on private contracting, current law as enacted in the BBA, should not be reopened.

Thank you for the opportunity to testify.

The CHAIRMAN. Thank you.

[The prepared statement of Dr. Braun appears in the appendix.]

The CHAIRMAN. We will take the witnesses in alphabetical order. Mr. Brown, you will be next, Dr. Hill, then we will finish with you, Dr. Reynolds.

Mr. Brown?

STATEMENT OF KENT MASTERSON BROWN, ESQ. ON BEHALF OF THE UNITED SENIORS ASSOCIATION, WASHINGTON, DC

Mr. BROWN. Thank you, Mr. Chairman. Thank you for the invitation to speak here and address you today. I also want to thank you for holding this forum on what I regard as a very important issue facing the American people.

I just heard, with all respect to Dr. Braun, a comment that she made, I think, twice in her statement. She said, "If I can pay privately for what Medicare does not pay for, why would I want to pay for something Medicare does pay for," quoting a beneficiary in Florida.

Let me state at the outset that it is precisely the second phrase of that question that was asked that is at issue. That is, that there is ample evidence out there that many people, even though it is a service that arguably Medicare would pay for, are not able to get them and are being denied them.

Now, I know United Seniors has taken some heat here this morning, but I want to emphasize to this committee, and to you, Mr. Chairman, that there are serious denials in Medicare, and I want to explain where and how they are, very briefly.

First of all, there is one other, I think, misconception that has been somewhat rampant. That is, that somehow private contracting was prohibited prior to Section 4507 being enacted. I want to state to this committee that that is not true. Medicare never prohibited private contracting prior to the passage of the Balanced Budget Act of 1997.

There is nothing in any subsection of Medicare that states that. In fact, all those provisions of claims filing are predicated on if the beneficiary wants Medicare to pay the claim. If the beneficiary does not, then the rules do not apply. It is if a claim is filed, if payment is requested, then certain things happen.

To underscore that, a letter which I have in my formal written statement, Mr. Chairman, from Gail R. Wilensky in October of 1991, commenting, upon a direct question from Cyler Garner, the president of the Medical Association of Georgia, that private contracting was perfectly lawful so long as it was initiated by a beneficiary. There is no duty on the path of a physician to file the claim.

Now, there has been some commentary that, since the OBRA of 1993, that this has somehow changed and that Medicare, as of June of 1993, has inserted into the Medicare Carriers Manual that there is now a prohibition against private contracting, pursuant to the Medicare Carriers Manual, which, of course, is not law.

But let me state, we also have a letter included in my formal testimony from Thomas A. Alt, the director of the Bureau of Policy Development of HCFA, in response to a direct question from James C. Pyles, an attorney in this city, stating that private contracting was perfectly lawful.

So if you have got letters from two of the chief executives of HCFA in 1991 and 1995 stating that it is perfectly lawful and there is nothing in the statute prohibiting it, then where are we? I think it is perfectly lawful and that Section 4507 actually set us back. It has now prohibited it for the first time and, in fact, has made claims filing mandatory for the first time.

To move on, let me talk for a second about the denial. We have heard a great deal here today about the use of advance beneficiary notices. What Administrator DeParle said was absolutely true. A doctor can use an advance beneficiary notice if he believes that Medicare may find the service he is about to render to a patient to be medically unnecessary.

What is unnecessary? Senators, folks, we have no idea what is unnecessary. HCFA has never published a final rule defining the term. In fact, a lawsuit had to be filed in 1989 to force HCFA to publish a proposed rule, which has never been made final. So we really do not know what necessary is. HCFA has never defined it, and it is fundamentally arbitrary in many ways.

Nevertheless, with mandatory claims filing after Section 4507, and now we really do not know what necessity is, sure, a physician, if he feels a service might not be recognized as necessary, could get an advance beneficiary notice. But what will happen? He will get a letter back from HCFA, so will the patient, telling him that the service was unnecessary and for him to refund the money. Now, he might be absolved from actually refunding the money, but he is probably going to lose the patient.

Beyond that, for services that are rendered that are unnecessary, physicians face potential sanctions, up to $10,000 per instance, after Kennedy-Kassebaum, or Kassebaum-Kennedy, exclusion from Medicare, and possible fraud.

Now, who is going to render the service? Nothing is more clearly illustrative of this problem than with clinical diagnostic laboratory services after the March 3, 1997 Office of the Inspector General model compliance plan, which has now made laboratory services that are asymptomatic virtually impossible to get.

Thank you. I will be happy to answer questions.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Brown appears in the appendix.]

The CHAIRMAN. Dr. Hill?

STATEMENT OF J. EDWARD HILL, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, WASHINGTON, DC

Dr. HILL. Good morning. My name is Edward Hill and I am a family doctor from Tupelo, Mississippi and a member of the AMA's board of trustees. I hope my comments will help clear the air about what is at stake in this Medicare freedom to contract debate.

First, private contracting is about physicians and patients mutually agreeing not to submit a claim for a Medicare-covered service. Now, why is that a problem? Because HCFA has consistently interpreted Medicare law as requiring physicians to submit claims for all Medicare services provided to patients.

In so doing, HCFA has historically taken this position, that our Medicare patients were prohibited from entering into private contracts with physicians, unlike participants in every other Federal health program, including the Federal Employees Health Benefit Plan.

HCFA officials have recently claimed that physicians have never been required to submit a Medicare claim when the patient simply refused to authorize a claim, for example, when a patient does not

want information divulged about their HIV status or their mental status.

However, there was no official Medicare instruction stating this policy until a carrier instruction issued late January of 1998, last month, the 24th of January, and even those instructions are far from clear.

Physicians cannot afford to take risks as to what is and what is not HCFA policy. In fact, Medicare instructions have provided, since 1991, that physicians who failed to submit claims are subject to sanctions that you just heard, up to $2,000 per violation and exclusion from the Medicare program.

Now, the Balanced Budget Act of 1997 tried to remedy this confusion with language that permits private contracting if certain conditions are met. But under the new law, even if one Medicare patient privately contracts with a physician, then that physician cannot see any other Medicare patients for two long years.

The AMA believes that is unfair to patients, we think it is discriminatory towards seniors, and ought to be changed. We believe that the Medicare Beneficiary Freedom to Contract Act is the answer. The patient choice legislation introduced by Senator Kyl and Representative Archer would repeal this 2-year lock-out.

But opponents of the bill are using scare tactics and making misleading statements about the legislation. It has been alleged that private contracting will create a two-tiered system as physicians and more affluent elderly opt out of Medicare, leaving regular Medicare a welfare program for the elderly.

The truth is, the Medicare system is already multi-tiered. For example, due to Medicare's hodgepodge payment rates, some patients have much different access to a different set of benefits than others do. For the poor elderly, access to service differs from State to State depending upon the variations in the Medicaid payment rates.

Now, Congress, in the Balanced Budget Act, partially addressed the first of these problems. But the Balanced Budget Act actually worsened the second problem by gutting the requirement that State Medicaid programs pay the Medicare co-payments for these dual-eligible patients.

It is ironic, because the same group that now professed concern about a two-tiered system declined to join the AMA in its battle against this misguided dual-eligible provision.

Now, experience with Medicare's risk management contract program has shown that seniors are remarkably good health care bargain hunters. The popularity of point of service plans shows that many people are willing to pay more in order to receive care from the physician of their choice.

In the same way, some patients just entering Medicare might want to continue treatment with a physician who has chosen not to participate in the Medicare program.

Others face threatening medical conditions and may wish to seek care from a recognized expert who does not accept any new Medicare patients. But under the current law, these choices would be impossible.

Here is some more fiction. Private contracting will result in confusion, double billing, and outright fraud. I have heard repeatedly

this morning the implication of rampant greed and rampant fraud out there, the guilty until proven innocent theory. All of these assumptions of guilt just amaze me.

It reminds me of an anecdote, Mr. Chairman. When I was in the seventh grade I was sent to the principal's office. I will not say whether it was an infraction or not. The principal utilized corporal punishment, which was allowed in those days, then called my father to come to the school, so I assumed I would have another punishment, probably much worse.

There was the teacher, the principal, me, and my father. My father asked the teacher, what did he do? Well, he did not do anything, but he was getting ready to. The assumption of guilt, this greed people talk about out there.

After 30 years in practice in a rural community, with 70 percent of my patients are Medicare or Medicaid patients, I did not see any of this greed or this alleged fraud. So it has disturbed me a great deal this morning.

But the truth about the Kyl-Archer legislation includes important patient protections which would ensure that seniors understand the obligations they are going into when they sign this contract. Any private contract would clearly identify the professional services to be covered and must be written and signed by both parties.

In closing, Mr. Chairman, in this country, whose founding principle is individual liberty, the AMA believes the answer to this Medicare problem is the Kyl-Archer legislation.

Thank you, sir.

The CHAIRMAN. Thank you, Dr. Hill.

[The prepared statement of Dr. Hill appears in the appendix.]

The CHAIRMAN. Now, if I could call on Dr. Reynolds.

STATEMENT OF WILLIAM A. REYNOLDS, M.D., PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS, WASHINGTON, DC

Dr. REYNOLDS. Thank you, Mr. Chairman. I am Dr. Bill Reynolds from Masula, Montana, and I am sorry that Senator Baucus was not able to be here. I also want you to know that Senator Roth grew up in Helena, Montana and went for a time to the University of Montana, and we are very proud of both Senators. We also want you to know that Montana should be known for more than the home of the Unibomber. [Laughter.]

Dr. REYNOLDS. I am president of the American College of Physicians. This is the organization for doctors of internal medicine who are physicians for adults. We, as a specialty, take care of more Medicare patients than any other specialty and we really do have the concern of our patients at heart. That is the point of why we are here today.

We have heard that choice, affordability, and access are working quite well in Medicare and we have documented that in our printed testimony. The data does say that there really is not a significant access problem.

We also recognize that there is a small segment of Medicare patients that may prefer services outside of Medicare and wish to remain enrolled in Part B. As you know, anybody can opt out of Part

B anytime they wish, and opt back in. Once a year you can opt back in, for a very small penalty. So people do have that freedom.

Senator Kyl's legislation would allow the choice of opting out while remaining in Part B and privately contracting. We appreciate his efforts to increase freedom of choice and flexibility, and I do not think anybody can be opposed to that concept. But the devil is in the details and the bill raises a number of very significant problems, some of which have already been raised, but I would like to review those that we are most concerned about.

They are these. We are concerned that private contracting could create access problems. I will tell you expressly how that can happen. Concern about administrative complexity for the physician who will be struggling with billing errors and ad hoc income testing of patients right in the office, and concern about potential conflicts in the physician/patient relationship.

Now, concerning decreased access. There could be, for a majority of patients in a given area, and it would occur if most or all of the physicians in that area elected to take private contracting only for Medicare patients, or even probably more realistically, they say, well, we are not going to take any new Medicare patients without privately contracting.

That is what could have happened in Arizona. That physician could have taken a new Medicare patient, private contract. Why would all the other doctors not say, well, that is not bad, I will keep taking care of my Medicare patients as always, but the new ones will be privately contracted. That does create an access problem, and the bill would allow that.

Most Medicare patients are in moderate to low income status. As we know, 71 percent have a total income that is spendable of about $25,000 or less. Clearly, most patients cannot afford to pay more out-of-pocket costs and we do not want to do anything that will allow that to happen.

Now, the administrative complexity. The potential for billing errors is really there. I do not think physicians are going to commit fraud doing this, although if they make some kind of a billing error they are scared to death about being charged with fraud.

I would say that is the biggest concern on the minds of physicians in America today, and I have talked to a lot of them. The fraud and abuse problem has really got them scared to death.

This bill would create more options for making a billing error. You could easily double bill for services. You have got to decide which are going to go to the patient, which to Medicare. If it is done service by service, you can imagine the tremendous problems that would create.

If you are in a point of service plan, you could get double paid and not even realize it. If you are in a capitated managed care plan you can get double paid without probably realizing it.

The information has got to be updated as the contract changes, so this creates an awful lot of problems in offices that already have too many problems. So, physicians are really overburdened with struggling to comply with the burdensome Medicare documentation requirements that are already on the books.

Now, the college is also concerned about the potential negative effects on the physician/patient relationship. There is confusion

over what services would be covered by the private contract and what would be excluded.

So I am going to sit in my office. There is a patient who comes to me to have an endocrine consultation and I am going over that patient, and we have got a contract, and I find a thyroid nodule that we did not know was there and that needs to be aspirated.

So I do that technique, send the biopsy off to the pathologist, some more charges, an extra charge for the aspiration. We get done. The patient has some chest pain and needs to have a treadmill. That was not considered.

Now, when we get all done, how are we going to divide up the bills? If I send them all, say, in this private contract, the patient said I did not contract for that, you can imagine the kind of problems that are going to occur with this scenario. You will be hearing about some of those. When they come to my office and are not satisfied, then they go to Medicare, and ultimately you may get to arbitrate some of those.

So we think that is not a very good way to go. It is an awkward, uncomfortable, and time-consuming thing for the patient and the doctor to do that.

We have a number of very good options, we think, that are in my written testimony and I would be happy, as you ask questions, to go over some of those. But there are five separate things that we think would be better options than the Kyl amendment, as written.

Thank you.

The CHAIRMAN. Thank you, Dr. Reynolds.

[The prepared statement of Dr. Reynolds appears in the appendix.]

The CHAIRMAN. Now, I would like to direct this question to Dr. Reynolds, and you, Dr. Hill, because clearly your two groups have taken a different position on private contracts. I would like to go back to this question of access.

I understand about 96 percent of physicians accept Medicare reimbursement. Can either one of you tell me how many physicians limit the number of Medicare patients in their practices and whether there are, to your knowledge, areas of the country where Medicare patients have problems in granting access to doctors? Do you think private contracts will affect access in such cases?

Dr. REYNOLDS. I do not think we know the number that limit their practices. It may actually be less than it used to be. As managed care has come along and payments are less, Medicare looks more attractive.

I know many physicians now think that is maybe the best part of their practice, where it used to be difficult to say they did not cover overhead. But I think access is not a big problem in Medicare today.

The CHAIRMAN. Dr. Hill?

Dr. HILL. Well, first, I think both of our organizations are actually after the same thing, and I want to clear up any misconception some people in here might have had this morning about this being a physician interest issue as opposed to a patient interest issue. Both of our organizations absolutely know that this is a patient interest issue.

As far as access is concerned, we think that private contracting could very likely improve access, and I can tell you a couple of ways. For instance, what if there were a physician who was a particular expert in some area and did not want to take any more Medicare patients and privately contracted for his very expensive and very special expert procedure, or whatever he did.

He would be willing, and I think almost all physicians would be willing to do this that are in expert positions like this, and we have testimony from some that are, to shift costs if he could privately contract for patients who could afford his services.

By cost shifting, he would be able to take care of a lot more of those middle income and lower income patients with his expertise that he could not otherwise take care of. So we think it would actually increase the access.

The implication was also made that in a rural, small-town area where you had a limited number of practitioners, if, say, you had a town of 3,000 with one doctor and they had several thousand Medicare patients and he elected to privately contract, that would decrease access.

Well, I come from one of those small towns and I have never known a colleague in my life that would ever consider doing that and cutting out his other Medicare patients from care. That is just absurd. I cannot even imagine that happening. So, I think the access issue is overblown significantly. It is not very realistic at all.

Dr. REYNOLDS. Senator, could I add to that?

The CHAIRMAN. Yes.

Dr. REYNOLDS. If access and payment issues are a problem for access, I think we ought to address that more directly. We could raise the balance billing for those who qualify by a means test, and I think that is essential, that those affluent patients who wish to pay more and the balance bill limit could be raised and that would be an easy thing to administer and may resolve that. So that would be our suggestion, if that is going to be a problem as far as access.

Dr. BRAUN. Senator.

The CHAIRMAN. Yes, Mr. Brown.

Mr. BROWN. Where I see access improved with private contracting is where physicians are fearful to use ABNs in services that a physician believes Medicare may find not to be necessary, even though in his considered medical judgment he believes it is necessary. These are two different standards.

What Medicare's standard is is entirely different than what a doctor might believe his own standards of care to be. If he was able to render service without that fear, the service could be delivered, service could be ordered, the labs could be taken, and it could be done under a private arrangement.

Senator, most of these kinds of services are very inexpensive. I mean, a lipid panel is $15, a PSA test is $57. We are not talking about services that are a great deal of money. They are services every citizen would want. But I am afraid, given this current regulatory climate, many citizens, many Medicare beneficiaries, are not going to get them unless there is a private contract.

The CHAIRMAN. Yes, Dr. Braun.

Dr. BRAUN. Mr. Chairman, can your emeritus physician on this panel speak?

The CHAIRMAN. Sure.

Dr. BRAUN. I would just like to bring up the fact that I saw patients and had to refer patients to other doctors in the days before balance billing limitations were there. There were access problems in those days, much, much more so than later on because it was difficult to find a physician who was willing to take a patient on assignment when, usually, he charged a great deal more. It was very difficult for patients to go to any doctor that they wanted. I have a great concern to see that possibly coming back again through legislation like this.

The CHAIRMAN. Let me go to a proposal of yours, Dr. Reynolds. You suggested in your written testimony that expansion of Medicare private contracts should be examined by the Medicare Commission. I would like to have the viewpoint of the other members of the panel on this proposal.

Dr. Braun?

Dr. BRAUN. I do think that the Medicare Commission is going to have to look at the whole picture and that it is not the time now to be making the kind of changes that are happening here. I certainly would agree with Dr. Reynolds that the payment schedule in Medicare certainly may be the basic problem much more so than some of the other issues that would be caused by this.

The CHAIRMAN. Mr. Brown?

Mr. BROWN. Mr. Chairman, I personally am concerned about time. I think it is probably something that the commission is ultimately going to look at anyway. But I am concerned about time because I do see, and we have documented examples of, serious denials out there.

I do believe that only with a private contract are we going to be able to see this freed up. I am concerned about whether seniors are going to get the diagnostic care necessary to prevent serious problems in the future unless we free this up.

The CHAIRMAN. Dr. Hill?

Dr. HILL. I would hope and pray that the Medicare Commission has got a much bigger, broader, and more important agenda than private contracting. Private contracting is minuscule as far as what the commission needs to do. It needs to save a program that is very good and we believe is going to go down the tubes. So I would hope that this would not be an issue.

The other fact is, this is a freedom of choice and a freedom-to-do-with-your-money-what-you-wish issue, and not an issue that the commission should probably even deal with. Thank you.

The CHAIRMAN. Dr. Reynolds, we ought to give you a chance to comment on your proposal.

Dr. REYNOLDS. I think there are going to be a lot of changes that need to be looked at as we save Medicare, and this would be one of them. I think working around the edges at this point is probably not the most productive way to go. I do not think it is such a critical issue that we have to settle that this year. I think the other way would be the preferable one.

The CHAIRMAN. Senator Bryan?

Senator BRYAN. Thank you very much.

Mr. Brown, let me ask you a couple of questions, if I may.

Mr. BROWN. Yes, sir.

Senator BRYAN. This is the letter your group, United Seniors Association, has sent out called the "A.L.A.R.M. letter," is it not? This is what you all have sent out.

Mr. BROWN. I think it is. Yes, sir.

Senator BRYAN. In that letter you put in the third paragraph, "In other words," and then you identify the individual you are writing, "if Medicare says they will not pay for medical needs you have, you may not be able to have it, even if you want to pay for it personally and even if you need it to save your life."

Mr. BROWN. That is correct. That is correct.

Senator BRYAN. You stand by that statement?

Mr. BROWN. Absolutely, I stand by that statement.

Senator BRYAN. Now, you know the General Accounting Office has reviewed this letter, has specifically referenced that language, and indicated that that is false.

Mr. BROWN. Senator, I do not know what the General Accounting Office may or may not have done. I know it is true, Senator.

Senator BRYAN. Let me try to find out if we are talking about the same thing. Both before the Balanced Budget Agreement of 1997 and after the Balanced Budget Agreement, the current state of the law is if Medicare does not provide for a service, for example, cosmetic surgery, an individual Medicare patient can enter into an agreement with a private physician to pay for that service. Do you not agree with that?

Mr. BROWN. We are talking in that statement about an otherwise covered service that Medicare adjudicates it will not cover.

Senator BRYAN. Well, that is not, I think, anybody's fair reading of that language. But let me just try to get to the facts here.

Would you agree that if a Medicare patient seeks cosmetic surgery which is not covered by Medicare, that the Medicare patient has the full ability to enter into any kind of contractual arrangement he or she wants with the physician?

Mr. BROWN. Senator, up until the passage of Section 4507——

Senator BRYAN. I do not know why we cannot get an answer.

Mr. BROWN. Well, let me give you——

Senator BRYAN. Why do you not give me an answer, then give me your explanation. Is that yes or no?

Mr. BROWN. The answer is, as of now, yes. As of now, yes. A categorically excluded service, under 1395(y) can be paid for by the beneficiary. They are small in number, but they can be paid for by the beneficiary.

Senator BRYAN. And 4507 did not change any of that.

Mr. BROWN. It technically did change that.

Senator BRYAN. In what way?

Mr. BROWN. In this sense, Senator. Up until we got a clarification from HCFA, Section 4507.2(b)(2)(v) required the beneficiary to enter into an agreement whereby the beneficiary acknowledged that that service could be provided by another physician and paid for by Medicare. The patient would have to acknowledge that up front before the service was rendered.

Senator BRYAN. But we are talking about a service which, under my question, which I think your statement in this letter is highly misleading, is clearly not covered by Medicare.

Mr. BROWN. It is not, Senator. If that is the only circumstance under which a private agreement could be entered into that is set forth in Medicare, then, indeed, the Secretary would have the power to interfere with other services that are rendered under private arrangement. If that is the only service that is recognized, that the patient has to acknowledge that he could get this service from another physician and Medicare would pay for it, frankly, I do not even know of a service like that.

Senator BRYAN. Mr. Brown, I do not think we are on the same wavelength. I do not know what you are telling me. We are talking about a service that is clearly not covered by Medicare.

Mr. BROWN. Exactly. Exactly.

Senator BRYAN. Let us talk about plastic surgery.

Mr. BROWN. Exactly. Plastic surgery.

Senator BRYAN. Now, with any non-covered service, like plastic surgery, a patient is free to enter into whatever arrangement he or she wants with a physician. Is that not true?

Mr. BROWN. As of right now, they are, yes. The answer is yes.

Senator BRYAN. And that has been true historically, has it not?

Mr. BROWN. It has been true historically.

Senator BRYAN. Historically, so if it is a non-covered service, whether it is plastic surgery, whether it is an additional diagnostic test that Medicare does not pay for. Let us suppose that I am a Medicare patient and one diagnostic examination is covered and provided. I am not comfortable with that; I want a second or third. If that is not covered, I can currently pay a private physician whatever he or she charges.

Mr. BROWN. As of now, yes.

Senator BRYAN. When you say as of now——

Mr. BROWN. Ms. DeParle has clarified that with the physicians' letter that was sent out on January 1 of this year.

Senator BRYAN. But, sir, that has been true since 1965.

Mr. BROWN. It has been. But with the passage of Section 4507, it put it in doubt. Section 4507 put that in doubt.

Senator BRYAN. Would you cite the particular provision that placed that in doubt?

Mr. BROWN. It is subpart small letter (v) under subsection 2(b), which requires the beneficiary to acknowledge in writing on the contract that he could get the service from another physician and it would be paid for by Medicare.

Now, the statement I am making here is that if that is the only area where contracting is lawful in Medicare, does it give the authority to the Secretary to interfere with others? The answer is, possibly, yes.

Senator BRYAN. Mr. Brown, I must say, that is very disingenuous. The provisions that have historically existed, that currently exist, that exist after the legislation we passed last year, referred to non-covered services and they do not relate to the private contracting procedures under Senator Kyl's amendment. Do you not agree with that? There is no requirement for a physician and a patient to enter into the protocol for private contracting services for those Medicare non-covered services.

Mr. BROWN. It does not say that in Section 4507, Senator. That is one of the problems with it. It does not talk about categorically excluded services.

Senator BRYAN. Well, I know of no one in America that has been confused by that.

Mr. BROWN. All I am saying is, we have raised the issue. It is not my main issue with this statute. We have raised the issue. It was clarified by Nancy-Ann Min DeParle and HCFA in the January 1 letter.

Senator BRYAN. But here is what you say in your letter. "In other words, if Medicare says they won't pay for a medical need you have," again, non-covered service——

Mr. BROWN. Yes. Yes.

Senator BRYAN [continuing.] "You can't have it."

Mr. BROWN. Yes. And that is true with——

Senator BRYAN. "Even if you want to pay for it personally and even if you need to have it to save your life." In my opinion, that is blatantly false. Do you not agree?

Mr. BROWN. It is not false. That is absolutely true. That is absolutely true. An otherwise covered service that Medicare adjudicates it will not pay also has attendant to it threats to the physician. The physician, if he is going to be threatened, will not provide the service.

Senator BRYAN. I have dealt with the medical community, I have a son who is a physician, and I have never heard anybody that has any problem.

Now, Dr. Hill, would you not agree that for non-covered Medicare service, that physicians have historically, and can continually, work out whatever arrangements they want?

Dr. HILL. That is correct.

Senator BRYAN. And you do not have to go through the protocol that is required in that limited provision under the Kyl amendment as to private contracting for a covered Medicare service.

Dr. HILL. That is correct.

Senator BRYAN. Would you agree with that, Dr. Reynolds?

Dr. REYNOLDS. I do.

Senator BRYAN. Now, one last question, if I may. You, Dr. Reynolds, had indicated some additional options that you think we ought to take a look at. Could you just encapsulate those provisions for us?

Dr. REYNOLDS. Well, first, address the payment issue with increased balance billing, but for those who qualify. We do not want that for all Medicare patients, but for those who wish to pay more and have the money to do it, they should have a right to do so. I think that was included in the Senate bill passed last year. That could easily be done.

I think the patients should be informed, and we should make an effort to inform patients about the new private fee-for-service option that was in BBA that gives many of these choices that I think most people do not know about. I do not guess they are quite available yet, but soon will be.

Then the medical savings account, which have not fulfilled their quota. That gives other options. HCFA should let people know that if they do not like what is going on, they can get out of Part B tem-

porarily, and once a year they can get back in for a small increased fee. I think that is not recognized. That is total freedom.

We need educational seminars to educate patients and doctors about many of these things. There is so much misinformation and lack of information. That creates a lot of the problem that we are having.

Senator BRYAN. May I ask one last question, Mr. Chairman?

The CHAIRMAN. Please.

Senator BRYAN. I promise to be very brief.

Dr. Reynolds or Dr. Hill, my understanding of the law, both prior to the Balanced Budget Agreement and after the Balanced Budget Agreement, is that if I am a Medicare patient, for a Medicare-covered service, but I choose for whatever reason, privacy concerns or otherwise, not to authorize the physician to submit to Medicare for that payment, may I not, as a private patient, pay that physician for that service?

Dr. REYNOLDS. I think there has been some question about it, but I believe that is what the law says.

Senator BRYAN. Dr. Hill, do you understand my question?

Dr. HILL. I am not sure I do.

Senator BRYAN. Well, let me try. I may not have phrased it artfully, and I apologize to you, sir.

Dr. HILL. No. I had it toward the end.

Senator BRYAN. Let me try again. We are talking about a covered service. I am a Medicare patient. I say, doctor, I do not want you to submit that bill to Medicare.

Dr. REYNOLDS. An HIV test, for example.

Senator BRYAN. Yes, an HIV test. Suppose it is a privacy concern. I am concerned about access to my medical records on something that I believe is highly sensitive. Under those circumstances, Doctor, it is my understanding that the patient may pay the physician privately.

Dr. BRAUN. That is correct.

Senator BRYAN. I believe that is correct.

Dr. REYNOLDS. I think that is correct.

Senator BRYAN. And, Doctor, that is the state of the law, subject, however, to this restriction. I think this is important, Mr. Chairman, and I will conclude on that note. The private compensation is limited to the Medicare Schedule for Reimbursement.

Dr. HILL. That is correct.

Senator BRYAN. Both of you agree.

Dr. REYNOLDS. Yes.

Senator BRYAN. So that would be decidedly different from what is authorized under the private contracting provisions in the Balanced Budget Agreement. Dr. Hill, you are saying yes.

Dr. HILL. Correct.

Senator BRYAN. Dr. Reynolds?

Dr. REYNOLDS. Yes.

Senator BRYAN. Mr. Chairman, I thank you for your indulgence.

The CHAIRMAN. Thank you, Senator Bryan.

Mr. Brown, I do not want to continue this discussion of that particular mailing of your organization, but I do want to make it very clear that it is not satisfactory to many of us on both sides of the aisle.

We are not here to try to scare senior citizens with respect to their health care. I think it was a serious mistake to use the kind of statements that are contained in this letter, which was a fund-raising letter, which can only result in scaring senior citizens. That is not the purpose of the program, that is not the purpose of the hearings, and I would hope that in the future your organization would look more carefully at what it states.

Mr. BROWN. May I say something in response, Mr. Chairman?

The CHAIRMAN. Very briefly.

Mr. BROWN. I stand by the statements that were made in those letters. They are true. Health care is denied, sir.

The CHAIRMAN. You have made that statement several times. We know your position, Mr. Brown.

Mr. BROWN. I want to make it clear.

The CHAIRMAN. Well, I think you have made it clear. I just want to make it clear that those kinds of statements are not satisfactory to the Chairman.

The committee is in recess.

[Applause].

[Whereupon, at 12:15 p.m., the hearing was concluded.]

APPENDIX

Additional Material Submitted for the Record

Prepared Statement of Hon. Max Baucus

Thank you, Mr. Chairman, for calling this hearing today.

At the end of last year, senior citizens in my state received a mailing from a group that supposedly represents senior citizens. The mailing implies that if Medicare decides not to cover a particular service, the government prohibits a person from paying for it themselves. To quote the mailing:

"Starting in a few months, January of 1998, if Medicare won't pay for your health/medical needs, you have to go without treatment."

Well, January has come and gone and, miraculously, senior citizens in my state can still pay for services that Medicare does not cover. Mr. Chairman, to say this mailing is misinformed is an understatement.

Anybody who has run for public office knows that there are groups out there who send letters like this. When a mailing criticizes me, or the President, or other members on this committee, we can take it. Being in politics, we've developed a thick skin.

But this mailing targeted seniors. There were many folks who called my office very worried that their access to health care would be in jeopardy.

Even worse, the mailing hit up those seniors for a contribution.

To quote once again:

"Write out a check for $10, $15, $25, $50, or $100 or whatever you can afford to help organize and lead a national grassroots campaign."

Mr. Chairman, in Montana most seniors live on a fixed income. Their average income is less than $23,000 a year. To ask our older citizens to take a portion of their hard earned money to fight a problem that doesn't exist is unscrupulous.

But the mailing I described is not the focus of our work here today. And while this false alarm is simply wrong, I do not mean to detract from the importance of the issue before us, and that is Medicare private contracting.

I strongly believe that repealing the current law prohibition on private contracting will benefit doctors, not patients. And perhaps doctors have a good point. As Congress continues to reform Medicare, we have been racheting down payments to providers. Many doctors believe that Medicare payments are inadequate.

And they are right. That is why we appointed a Medicare commission to look at these long-term issues. Reforming Medicare and maintaining the program for our grandchildren cannot be accomplished simply by cutting payments to providers.

But the proposal offered by my friend from Arizona, Senator Kyl, is not the right answer. We cannot expose our senior citizens living on fixed incomes to significantly higher out-of-pocket costs. This is the wrong way to increase provider payments.

And the witnesses at today's hearing, including the administrator of HCFA, will be able to walk us through the many dangers that private contracting poses on Medicare beneficiaries. Perhaps this hearing will yield alternative methods to increase provider payments without hurting seniors in Montana and across the country.

Mr. Chairman, once again I commend you for calling this hearing, and I look forward to today's discussion.

Prepared Statement of Beatrice Braun, M.D.

Mr. Chairman and members of the Committee, I am Dr. Beatrice Braun from Spring Hill, Florida. I am a retired physician and a member of the Board of Direc-

tors for the American Association of Retired Persons (AARP). I appreciate the opportunity to testify today on the issue of physician private contracting in Medicare.

Since the Balanced Budget Act of 1997 (BBA) was enacted into law, Medicare beneficiaries and their families have been deluged with misinformation about the provision that allows private contracting. Unfortunately, much of the misinformation was intended to frighten and mislead beneficiaries into thinking that the Congress restricted their choice or put their health care coverage in jeopardy.

In my home state of Florida, I have spent considerable time answering questions from Medicare beneficiaries who have been frightened by the inaccurate claims made in some of the mailings they have received. Most recently, there was a mailing that claimed "As of January 1998 our government for the first time ever will stop everyone over the age of 64 from getting life-saving medical treatment." The inaccuracies in these mailings and some press reports have led to serious confusion about the new private contracting provision. For instance, many beneficiaries do not know that if they agree to a private contract, they will have to pay the total cost of the services provided through the contract. AARP believes it is critical that Medicare beneficiaries and Members of Congress have clear and accurate information about the new provision. We appreciate the Committee's efforts to provide a public forum to examine the facts.

No Private Contracting Before the Balanced Budget Act

To fully understand how the Balanced Budget Act changes the practice of private contracting, it is important to be clear on what the law did and did not allow before passage of the budget bill.

Prior to the BBA, physicians and beneficiaries were not permitted to contract privately outside of Medicare for services covered by the program. Many beneficiaries were not aware of this restriction. The bi-partisan physician payment reform law of 1989 established the requirement that all doctors treating Medicare patients file the claim with Medicare. That law also established limits—known as "balance billing" limits—on the amount a physician could charge a beneficiary over and above Medicare's approved payment level. These limits were the result of a bi-partisan compromise worked out in this committee and involving physicians and beneficiaries.

The Balanced Budget Act

The Balanced Budget Act actually expanded previous Medicare law by allowing physicians to contract privately with beneficiaries for services that would otherwise be covered by the program. Interestingly, the provision in law is much broader in scope than the amendment originally offered by Senator Kyl. That amendment would have limited private contracting to "a physician or another health care professional who does not provide items or services" under Medicare.

The BBA provision broadened the Kyl amendment to allow any doctor to privately contract as long as important anti-fraud and abuse protections are met. First, a doctor who contracts privately with a Medicare beneficiary must provide the beneficiary with a written contract to sign before the services are provided. The contract must clearly state that:

- no claims will be filed with Medicare by either the physician or the beneficiary;
- the beneficiary will be fully responsible for the costs of the medical services;
- no balance billing limits will apply to the doctor's charges;
- no Medigap coverage will be available; and
- the services to be performed would be paid for by Medicare if provided by another physician.

The law also states that the contract may not be initiated in an emergency or urgent health care situation, and it must clearly state if the physician is excluded from Medicare for fraud, abuse or other illegal activity. It's worth noting that the provision does not exclude those physicians who have been expelled from the program.

These disclosure requirements are key. Medicare beneficiaries are careful health care consumers. But in order to make informed choices, they must have all of the facts. Most of us would not make a large purchase without understanding what our financial obligation would be. If a beneficiary decides to step outside of the Medicare program and pay completely out-of-pocket for a service, he/she deserves to be fully informed about what this means. A written contract ensures that there will be no surprises for beneficiaries and that they know in advance what their financial responsibility will be if they decide to privately contract with a health care practitioner.

The second anti-fraud and abuse protection is the requirement that private contracting be limited to a physician who agrees, in an affidavit, not to file any Medi-

care claims for a two-year period. This requirement is intended to prevent physicians from billing both beneficiaries and the Medicare program for the same service. An exclusionary period makes it easier for HCFA to track fraud because it can identify claims from those physicians who would not be billing Medicare for an extended period of time. It is also to prevent physicians from "cherry-picking" or asking some beneficiaries to privately contract while accepting Medicare payment for others in order to make more money.

There has been considerable controversy about whether this requirement unfairly penalizes doctors. The exclusionary period protects beneficiaries and the Medicare program from double-billing. This provision is similar to the type of rule which is common practice in most private insurance plans' contracts with providers, including the Federal Employee Health Benefits Program (FEHBP). In such contracts, a doctor agrees to participate in the health plan, and abide by the plan's payment rules for the length of the contract. Thus, when non-Medicare individuals go to doctors in their health plans, they know that their physicians must provide them services based on the plan's rules. This principle is the same in Medicare. With the advent of private contracting, the exclusionary period ensures that beneficiaries won't be asked by Medicare providers to pay more than Medicare deems appropriate.

Uncovered and Extra Medicare Services

There are several other areas of confusion about the BBA provision. For instance, early press reports led beneficiaries to believe that the BBA prevented them from purchasing services that Medicare does not cover. Medicare beneficiaries have always been able to privately purchase services or goods not covered by Medicare, such as annual physical exams, prescription drugs or eyeglasses. In fact, the Balanced Budget Act of 1997 does not change this practice. When a beneficiary purchases an uncovered item or a service, no Medicare claim is filed and the beneficiary pays the provider directly. This is not considered "private contracting" because the services are not covered by Medicare.

Medicare beneficiaries have been able to—and still can purchase "extra" services beyond what Medicare will cover. For instance, Medicare will pay for one screening mammogram a year for an older woman who is not at high risk. If she chooses to have a second mammogram that is not determined to be medically necessary, she is free to pay for that service.

Since the "category" of service—in this example a mammogram—is covered by Medicare, the physician will file a claim. (One of the reasons this is done is that, in some cases, Medicare will determine that an extra service is warranted and will pay for it.) If Medicare denies the claim, the beneficiary pays for the service. When a physician believes that a service is beyond what Medicare will normally cover and is likely to be denied, the physician can ask the beneficiary to sign an Advance Beneficiary Notice (ABN), sometimes known as a waiver of liability form. This allows the physician to collect payment directly from the beneficiary if the program denies payment. These payments are not subject to the balance billing limits.

S. 1194—Senator Kyl's Legislation

Legislation has now been introduced to repeal some of the program integrity and consumer protections included in the private contracting provision and expand the scope of private contracting far beyond the original proposal. AARP has carefully reviewed S. 1194 and we have very serious concerns about what this legislation would mean for Medicare beneficiaries and the program.

Potential for Greater Fraud in Medicare

AARP firmly believes that if S. 1194 were adopted, beneficiaries and the Medicare program would be more vulnerable to fraud and abuse. This belief was echoed by the Congressional Budget Office which found that without consumer protections, and adequate funds to track privately contracted services, Medicare's efforts to combat fraud and abuse would probably be hampered.

Specifically, S. 1194 provides that "the minimum information necessary to avoid any payment under Part A or B for services covered under the contract" would be given to the Health Care Financing Administration (HCFA) or Medicare+Choice plans for use in determining which claims should be paid by Medicare. One could argue that this provision will give HCFA the information they need to detect fraud and abuse. As a practical matter, however, the language in the legislation may, intentionally or not, tie the hands of program administrators seeking to protect the fiscal integrity of the program.

The use of the term "minimum" indicates a reticence to provide specific and detailed information, such as the name of the doctor and patient, the specific service provided and the date of the service, for each incidence of private contracting. HCFA already confronts significant fraud and abuse in Medicare and has the daunting

task of implementing the complex and extensive provisions of BBA. We seriously question whether it has the means to compare services paid privately with the claims filed for Medicare reimbursement. A physician who contracts privately with a beneficiary for payment of two of five services might fraudulently or inadvertently file a claim with Medicare for all five services—even though only three services should be paid for by the program.

Unique Problems in Medicare+Choice Plans

By allowing private contracting in the new Medicare+Choice plans, S. 1194 creates a unique set of problems. For instance, under BBA, the Medicare program will make per capita payments to the new Medicare+Choice plans. In return, these plans will provide beneficiaries with health care services, including physician services. Since the Kyl bill allows physicians to privately contract for services they provide to beneficiaries in Medicare+Choice plans, physicians could be paid twice for the same services. Under this scenario, there is even less likelihood that HCFA would detect double billing. For example, physicians in the new Provider Sponsored Organizations (PSO) could be paid once by Medicare through its per capita payment and again by the beneficiary for the same service through the private contract arrangement. Since the per capita payment is made in advance to the plans by Medicare, this double payment would be very difficult, if not impossible, for Medicare to recoup.

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.

One of the strongest incentives for beneficiaries to join Medicare+Choice plans will be because they believe these plans may cost them less out-of-pocket than traditional fee-for-service coupled with supplemental insurance (Medigap). S. 1194 would undermine efforts to encourage more beneficiaries to enroll in the new Medicare+Choice plans because beneficiaries could end up paying more, not less, for their care.

It is important to note that physicians who contract with employer-provided plans to provide care for workers typically abide by the plan's reimbursement rules. However, under the new Kyl proposal, doctors who contract with Medicare HMOs and the new Medicare+Choice plans would not have to adhere to the plans' reimbursement rules as they must in comparable private sector arrangements. They would be able to privately contract with beneficiaries enrolled in these plans. This practice essentially would deny Medicare beneficiaries a protection enjoyed by millions of workers and their families.

Potential for Higher Out-of-Pocket Costs

By allowing physicians to charge unlimited amounts for health care services, S. 1194 essentially circumvents the balance billing protection that was a key element of the 1989 physician payment reform legislation. Before Congress established limits on balance billing, beneficiaries were spending about $2 billion a year on physician charges that exceeded Medicare's approved payment. Without this out-of-pocket protection, beneficiary costs would likely increase significantly.

Potential for Greater Beneficiary Uncertainty

By expanding private contracting on a service-by-service basis and in Medicare+Choice plans, S. 1194 would leave Medicare beneficiaries with greater uncertainty about how their health care services would be covered. Physicians would decide whether beneficiaries would be treated as Medicare patients whose claims would be filed with the program; or whether they would be asked to sign a contract to pay privately for all of their services; or whether the physician would file a claim with Medicare for some of the services but ask the beneficiary to privately contract for the others. Those beneficiaries who do not agree to enter into a private contract for Medicare services, would have to find other physicians to deliver some or all of their care. The end result would be a fragmented system of health care.

Potential for Greater Fraud in Medicaid

S. 1194 would allow physicians to contract privately with beneficiaries who are dually eligible for Medicare and Medicaid as well as those low-income beneficiaries who are eligible for the Qualified Medicare Beneficiary (QMB) program. By definition, these dually eligible and QMB beneficiaries are people with very modest incomes—below 100 percent of poverty. Further, it is unclear whether or to what extent this would leave state Medicaid programs vulnerable to higher costs.

Allowing physicians to privately contract with these low-income beneficiaries not only raises questions about how these individuals could possibly pay privately for these services, but also increases the likelihood of Medicaid fraud. Physicians could—fraudulently or inadvertently—bill both the beneficiary and state Medicaid programs.

Conclusion

One of the questions I get most often from people who fully understand private contracting is, why would I want to pay out-of-pocket for health care services that Medicare already covers? AARP believes that this is the central question in the current debate. Older Americans already spend about one-fifth of their income out-of-pocket on health care. Most of the beneficiaries I talk to are looking for relief from high health care costs, not for ways to spend more money out-of-pocket.

The Balanced Budget Act gives beneficiaries more control over how they pay for health care. The private contracting provision expands—not restricts—a beneficiary's options. At the same time, it provides important protections for both beneficiaries and the Medicare program.

AARP firmly believes that beneficiaries and the Medicare program must be protected from fraud and abuse. If private contracting for Medicare services is to remain an option, then there must be strong consumer protections. We urge the Committee to oppose any attempts to weaken the Medicare program by eliminating such protections from the Balanced Budget Act.

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STATEMENT OF KENT MASTERSON BROWN,
COUNSEL FOR UNITED SENIORS ASSOCIATION, INC.
BEFORE THE SENATE FINANCE COMMITTEE ON
PRIVATE CONTRACTING IN MEDICARE
FEBRUARY 26, 1998 *

On behalf of the **UNITED SENIORS ASSOCIATION, INC.**, and its 600,000 members I want to thank the Senate Finance Committee, and you, Mr. Chairman, for the kind invitation to me to address the Committee today. I want to take this opportunity to inform the Committee of: (1) the effect of Section 4507 of the Balanced Budget Act of 1997, and (2) the reasons why the enactment of S. 1194, "The Medicare Beneficiary Freedom to Contract Act," is essential.

EXECUTIVE SUMMARY

1. Nothing in the Medicare Act prohibited private contracting prior to the enactment of §4507. Claims-filing was mandatory only if the beneficiary actually wanted Medicare to pay for a health care service. HCFA, however, **has tried** (without **authority**) **to threaten physicians who contract privately with beneficiaries with sanctions.**

2. **With the enactment of §4507, claims-filing is now mandatory unless the physician agrees to cease to participate in Medicare (over 96% of the nation's physicians cannot). Thus, HCFA will now adjudicate the "necessity" of <u>all</u> "otherwise covered" health services provided to Medicare beneficiaries.**

3. For services a physician believes Medicare **may** not cover, he/she can have the beneficiary sign an Advance Beneficiary Notice ("ABN") **before** the service is rendered whereby the beneficiary agrees to pay privately.

   a. **But ABNs cannot be used routinely because HCFA has the statutory power to order the physician to refund any monies collected from the beneficiary for services for which HCFA has determined it will not pay and sanction the physician for providing such services.**

   b. In many cases, no one knows whether a service will be "covered" until **after** a claim is filed, usually 30 to 90 days. Even with an ABN, letters are sent by HCFA's carriers to

* Editor's note. The exhibits referred to in this statement are not included in this print.

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the physician and the beneficiary when a claim is denied, stating the service was "unnecessary" and ordering the physician to refund the money collected in 30 days or face sanctions.

c. **Critically, the physician may not have to refund money to the beneficiary because the beneficiary executed the ABN, but the physician, nevertheless, may be subject to severe sanctions for providing what HCFA deems to be "unnecessary" services.**

The types of sanctions which HCFA may impose are:

i. Civil penalties -- now up to **$10,000** (after Kassebaum-Kennedy) **per instance** and/or exclusion from Medicare;

ii. Exclusion from Medicare; and/or

iii. Criminal fraud

All that is needed for HCFA to begin the sanction process against a physician is a "pattern" of what it claims are "unnecessary" services.

d. **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."** Consequently, diagnostic -- even preoperative -- chest x-rays, nursing home and home visits (more than once a month), diagnostic laboratory tests, among countless other services, are often not provided to Medicare beneficiaries by physicians out of fear of denial letters and sanctions.

4. **Physicians are not now -- and have never been -- on notice as to what standard HCFA uses to determine services to be "unnecessary."**

a. **HCFA has never published a final rule defining the term "necessary."** Only a "proposed" rule was **ordered** published by a federal court in 1989. 54 *Fed. Reg.* 4302 (January 30, 1989). **It has never been made final by HCFA.** Physicians often do not know when a service **might** be deemed "unnecessary" by HCFA.

b. HCFA's definition of "necessity" is vastly different from the standards of care of the medical profession.

c. **Thus, even when a physician believes a service to be "necessary" under the medical standards of care, he/she will likely not provide it to a Medicare beneficiary if HCFA may threaten him/her with a denial letter and sanctions.**

5. **Nowhere does the problem of denial of care present itself more acutely with Medicare beneficiaries than in the use of clinical diagnostic laboratory services.**

   a. Laboratory services must be billed on an "assignment" basis. Physicians do not bill beneficiaries for laboratory services. The laboratories perform the services and bill HCFA.

   b. The Inspector General of HCFA issued a "Model Compliance Plan for Laboratories" on March 3, 1997 -- 62 *Fed. Reg.* 9435 - 9441 -- **stating that Medicare may regard screening tests** (asymptomatic tests for prostate cancer, diabetes, hyperthyroidism, hypothyroidism, anemia, etc.) as **"unnecessary," and may impose sanctions against physicians who order them.**

   c. These laboratory screens (which would detect diseases before symptomatology appears in order to cure or effectively treat them), consequently, are being denied Medicare beneficiaries even though physicians could order them using an ABN. Physicians are afraid to do so. The threat of harm is very high. Diabetes, for example, detected early, can be treated with diet and other simple regimens. Diabetes, with symptoms, however, is treated with great expense to the system and can lead to death.

6. **Only the right to contract privately, as contemplated in S.1194, will allow Medicare beneficiaries the "escape valve" to obtain many medically necessary health care services which they are now being denied.**

I. Introduction

Throughout my 23-year career as a litigator of constitutional

iss es, principally those arising in the health care arena, I have wit essed the growth of Medicare with a sense of alarm. From what was designed by Congress to be a "voluntary" health insurance benefits program for the elderly, Medicare has mutated into a bureaucratic leviathan which controls who provides health care ser ices, as well as how those health care services are delivered in spite of absolutely explicit, statutory guarantees to the contrary.[1] As a result, we have a federal agency, the Health Care Financing Administration ("HCFA"), which has virtually obliterated those guarantees in its relentless effort not to pay for, and to ration and deny, necessary health care services to the elderly, and, to thereby control the delivery of health care. That control now manifests itself in the denial of basic health care services to the elderly, as well as access by the elderly to the most innovative and cost-effective health care technologies which HCFA's bureaucratic claims process and payment system has been found to be

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[1] "Explicit guarantees" are found in 42 U.S.C. §§ 1395, 1395a and 1395b

42 U.S.C. §1395 provides:

> Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency or person.

42 U.S.C. §1395a provides:

> Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency or person qualified to participate under this title if such institution, agency or person undertakes to provide him such services.

42 U.S.C. §1395b provides:

> Nothing contained in this title shall be construed to preclude any state from providing, or any individual from purchasing or otherwise securing, protection against the cost of any health services.

too cumbersome to acco modate. Much of what HCFA has done to exercise control ove the delivery of health care is extra-statutory; in oth r words, it has been accomplished by HCFA without authority or even notice-and-comment. Congress, unfortunately, has been unwilling to use its oversight authority to control HCFA, giving it thereby, a "free hand."

In the past 10 to 15 years HCFA has exercised its power to control the delivery of health care by steadily racheting-down payment for health care services, and, at the same time, stepping up its threats against providers who deliver health care services which HCFA, for what it claims to be fiscal reasons, deems "unnecessary," even though those services might be health- or life-saving, and even though the federal government does not pay for them. Health care is thus "rationed" to Seniors.

Providers of health care services practice in an absolute state of fear, and Medicare beneficiaries, as a consequence, are denied access to some of the most basic health- and life-saving services. And all of this occurs because the federal government wants to control the delivery of health care, not because any money is really saved or any better health care is delivered by its actions. In fact, the policies of HCFA have largely led to the increase in medical costs generally (mostly "compliance costs") and, in part, to the near-bankruptcy of the Medicare program. Every American citizen should hold those in charge of Medicare accountable for what, in any private-sector business, would be total malfeasance.

Let me provide an example of the malfeasance. Nowhere in the Medicare Act, up until the enactment of Section 4507 of the Balanced Budget Act of 1997, was a beneficiary required to file a claim for payment for health care services each and every time he or she visited a physician. Yet, HCFA and its carriers, without any statutory authority and without any notice-and-comment rulemaking, have consistently threatened physicians with severe sanctions -- even criminal prosecution -- if they did not! **Congress never enacted any statute mandating the filing of claims.** Why has HCFA made such a demand? If a private insurance company made such a demand on its policyholders, it would bankrupt. But such is how HCFA has been administering Medicare; making extra-statutory demands which only limit and deny care and add to costs.

II. *Stewart v. Sullivan*

In 1992, in response to those threats, I filed a lawsuit in federal court in Newark, New Jersey in order to allow five (5) Medicare patients to contract privately with their personal

physician. That case is known as *Stewart v. Sullivan*.[2] All those Medicare patients in *Stewart v. Sullivan* desired was the opportunity to see their personal physician in the nursing home or at home more than once a month and to protect the privacy of their medical records, nothing more. One of those Medicare patients was even being seen by the physician free of charge! HCFA, through its carriers, however, threatened the physician with sanctions if she complied with the patients' wishes and did not file claims. HCFA entered the courtroom declaring that the physician could not contract privately with her Medicare patients because she was required to file a claim with Medicare each and every time she provided any service for her Medicare patients. If those patients wanted to pay privately, HCFA declared, they could write a check to the federal government. That revelation came on the heels of the *New York Times* reporting that Medicare was near financial ruin.

The federal court did not agree with HCFA in *Stewart v. Sullivan*. Instead, it found that there were no statutory prohibitions against private contracting for Medicare beneficiaries, and that HCFA had developed no "clearly articulated" policies against it. The threats were made by HCFA and its carriers against physicians without any statutory or regulatory authority.[3] Since 1992, neither Congress nor HCFA has done anything to bar private contracting -- at least, until August, 1997.

III. Enactment of Section 4507 of the Balanced Budget Act of 1997

Last summer, all this sparring took a drastic change of course. Congress, under pressure from the Clinton administration, enacted Section 4507 of the Balanced Budget Act of 1997. This provision makes it unlawful for a physician to contract privately with Medicare-eligible patients unless the physician agrees, in writing, not to file claims with Medicare for any services delivered to any Medicare patients for two (2) years! We know that over ninety-six percent (96%) of the nation's physicians provide services to Medicare beneficiaries. We know that at least that same percentage of physicians will not be willing to abandon all their current Medicare patients in return for entering into private contracts with a few. Ethically, such would be unthinkable. Of the less than four percent (4%) of the physicians left, none are hospital-based physicians (such as surgeons, anesthesiologists, and radiologists), who are required by the hospitals to provide service to all patients, and many of those remaining physicians are ones who, for one reason or another, have already been excluded from the

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[2] *Stewart v. Sullivan*, 816 F.Supp. 281 (D.N.J., 1992). A copy of the Court's opinion in *Stewart v. Sullivan* is attached hereto and marked Exhibit "A".

[3] *Id.*, at 289-91.

Medicare program.[4] Thus, no Senior Citizen will be able to contract privately for any meaningful health care services even if he or she could find a physician who was willing to do so.

IV. Medicare and Claims Denial

A. Medicare is not "voluntary."

It is undisputed that a citizen 65 years of age is enrolled **automatically** in Part B of Medicare unless he or she declines to do so in writing; in other words, it is not a "voluntary" program as is advertised. There exists no other primary health care coverage for individuals 65 years of age or older other than Medicare. If the Medicare program is denying Seniors essential care -- which it is -- they have no other coverage available to them if they have to disenroll from Medicare in order to contract privately.[5]

B. HCFA has refused to discuss its claims adjudication process.

HCFA, in all of its correspondence on this issue, repeatedly asserts that Seniors are not denied any needed care, and that the contentions of denial by **UNITED SENIORS** and others to the contrary are false. In all its correspondence, **HCFA fails to discuss its own mandate that claims be filed for all services; the actual practice of filing claims; how its own carriers adjudicate Medicare claims;** and **how the process of claims-denial causes health care services for America's Seniors to be rationed, curtailed, and even denied.** All HCFA does is argue that the bare provisions of the Medicare Act do not amount to a denial of care.

C. HCFA insists claims must be filed for every service so that it will be able to adjudicate the "necessity" of every service.

HCFA asserts that, in the past, it has insisted (without statutory authority until the passage of Section 4507) upon claims

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[4] Most of the physicians who are able to contract privately are those who have been excluded from Medicare for fraud or other reasons, as the nearly 3,700 excluded physicians in the United States are able, under Section 4507, to contract privately with Medicare beneficiaries. *United Seniors Ass'n, et al. v. Shalala*, No. 97-3109 (D.D.C., 1998) (*Affidavit of Merrill Matthews, Ph.D.*, at 5, citing Socioeconomic Monitoring System (SMS), American Medical Association, September 30, 1997).

[5] *Stewart v. Sullivan, supra; United Seniors Ass'n, et al. v. Shalala*, No. 97-3109 (D.D.C. 1998) (*Affidavit of J. Patrick Rooney*, at 1).

being filed each and every time a physician renders a health care service for a Medicare beneficiary, and it enforces that requirement by civil penalties and/or exclusion from Medicare if physicians do not comply.[6] Parenthetically, Section 4507, for all

[6] See Medicare Carriers Manual, Section 3044 (June, 1993).

The Medicare Carriers Manual is routinely amended without any notice-and-comment rulemaking under 5 U.S.C. §553.

Although HCFA cites Section 3044 as grounds for asserting that private contracting is not lawful, it has never cited any **statutory** or **regulatory** authority for its requirement. There is none. **In fact, HCFA, before the passage of Section 4507, has actually asserted that private contracting was lawful and that claims filing was not mandatory.** HCFA Administrator, Gail R. Wilensky, Ph.D., on October 15, 1991, wrote to Cyler D. Garner, M.D., President of the Medical Association of Georgia, stating in pertinent part:

> 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.**

A copy of the October 15, 1991 letter from Gail R. Wilensky, Ph.D., to Cyler D. Garner, M.D., is attached hereto and marked Exhibit "B".

Again, in response to a direct question about private contracting from Washington, D.C. lawyer, James C. Pyles, HCFA Director of the Bureau of Policy Development, Thomas A. Ault, wrote on August 4, 1995, in part:

> **In line with insurance practice,** Medicare regulations (42 C.F.R. 424.36 - 424.40) generally require a signed claims authorization by the beneficiary (or his representative) on the claims form (or on a separate statement included on the claims form by reference) as a condition for Medicare payment for the services.... **Therefore, if the beneficiary chooses to withhold a claims authorization for his own reasons, entirely free of any pressure from the physician, the Medicare**

practical purposes, now makes claims-filing mandatory unless the physician is able to surrender his or her participation in Medicare. Consequently, with the exception of those health care services which are "categorically excluded" from coverage (including physical examinations without laboratory tests and/or x-rays, hearing aids, orthopedic shoes, eyeglasses, cosmetic surgery, etc.),[7] **all other health care services are "otherwise covered," meaning Medicare reserves the right to adjudicate whether it will pay for the service and the amount it will pay after a claim is filed.**[8]

D. HCFA has never published any final rule setting forth how it determines whether a health care service is or is not "necessary," or, defining the term "necessary."

Every "otherwise covered" service is assigned a procedure code from coding systems known as the HCFA Common Procedure Coding System ("HCPCS") or Current Procedure Terminology ("CPT"). There are more than 7,000 such procedure codes, each of which must be accompanied on any claim by one or more of the thousands of the International Classification of Diseases, 9th Revision ("ICD-9"), codes in order for any claim to be **considered** for payment under the Medicare program.[9] The code combination submitted on the claim by the physician's office, however, will be reviewed by HCFA's carrier using an **unknown factor** to determine whether the service was

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> **program recognizes that the physician has no right or duty to submit a claim on the beneficiary's behalf.**

The foregoing letter was written **after** Section 3044 was added to the Medicare Carriers Manual in June, 1993.

A copy of the August 4, 1995 letter from Thomas A. Ault to James C. Pyles is attached hereto and marked Exhibit "C".

No provision of the Medicare Act mandates claims-filing. All claims-filing is **predicated** on the Medicare beneficiary actually wanting Medicare to pay for the health care services rendered. 42 U.S.C. §§ 1395k, 1395n, 1395u, 1395w-4. See also 42 C.F.R. §§ 424.1, *et seq.*, "Conditions for Medicare Payment."

[7] 42 U.S.C. §1395y and 42 C.F.R. §411.15(a) - (j).

[8] 42 U.S.C. §1395y(a)(1)(A)

[9] 42 U.S.C. §1395u(p).

"reasonable and necessary," a so-called "standard" set forth in a "Notice of Proposed Rulemaking" by HCFA **which has never been promulgated as a final rule.**[10] Among the factors HCFA uses to determine "reasonableness and necessity," according to its 1989 "proposed rule," are: (1) the service is safe and effective; (2) the service is not experimental or investigational; (3) **the service is cost effective;** and (4) the service is appropriate.[11] **It actually took litigation to force the proposed rule's disclosure.**[12] In fact, HCFA has not only never published the rule as final, it has never defined any of its terms, and it has never disclosed how it or its carriers apply its so-called "standard" to any of the health care services found in the codes so that physicians may provide services and file claims **knowing** the services will be "covered." Simply, HCFA keeps its claims processing guidelines secret.[13] Wrote one health lawyer: "[this reflects] HCFA's tenacious effort to maintain to the greatest extent possible what is one of the most expansive bodies of secret law ever developed for application against a broad segment of the American population."[14] HCFA's claims adjudication process, consequently, has been, and is now, absolutely arbitrary. With ever-changing budgetary considerations and internal rules, no-one knows whether or not HCFA will actually "cover" a particular service or declare it "not necessary."

What is not secret are the professional standards of care practiced by physicians. Those standards of care are entirely different from HCFA's so-called cost-oriented standard of "reasonableness and necessity." The professional standards of care -- those enforced by courts in medical malpractice actions -- place extremely high duties on the physicians to provide necessary services.

If and when the code combination or a claim passes HCFA's unknown "reasonable and necessary" test -- anywhere from thirty (30) to ninety (90) days or more **after** the physician renders the service -- **purportedly**, payment will be made. Thus, "coverage" for

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[10] 54 *Fed. Reg.* 4302 (January 30, 1989).

[11] *Id.*

[12] *Jameson v. Bowen*, C.A.No. CV-F-83-547-REC (E.D.Cal., 1989).

[13] Blanchard, T.P., "'Medical Necessity' Denials as a Medicare Part B Cost-Containment Strategy: Two Wrongs Don't Make it Right or Rational," 34 *St. Louis Univ. L.J.* 939 - 1040 (1990) (hereinafter "*Blanchard*"), at 1029 - 1030.

[14] *Blanchard*, at 981 - 982.

any health care service is a determination made by HCFA and its carriers long after the service was rendered and after a claim has been filed.

With the enactment of Section 4507, when a Medicare patient obtains a health care service from a physician, the physician must file a claim with the Medicare carrier. The carrier will then adjudicate the claim by paying it in whole or in part or denying it. In either event, the carrier will send an Explanation of Medical Benefits ("EOMB") to the Medicare patient, explaining its decision.[15]

E. HCFA assigns "liability" for denied claims.

Although the foregoing sounds much like the system used by private insurers, once a claim is denied, any resemblance between private insurance and Medicare coverage ends. Unlike private insurers, Medicare carriers are given authority to "assign liability" for **all denied** claims.[16] If the carrier denies a claim on the ground that the service was "not necessary," it will forward letters to the physician **and** to the Medicare beneficiary notifying them of that fact.[17] If the physician is a "non-participating" physician (one who directly bills his Medicare patients), the carrier will inform the physician and the Medicare beneficiary that the physician must refund to the patient any money collected for the service within thirty (30) days or face sanctions, unless (a) the physician did not know or could not have known that Medicare would deem such service to be "not necessary;" or (b) the physician informed the patient before the service was rendered that Medicare might deem the service to be "not necessary" and deny payment, and that the patient agreed, in writing, to pay for the service himself or herself.[18] The aforesaid written agreement between the physician and the Medicare beneficiary is known as an "advance beneficiary notice" ("ABN").[19] If the physician is a "participant" (one who

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15 *Blanchard*, at 959.

16 42 U.S.C. §1395u(l)(1); 42 C.F.R. §§ 411.402, 411.406 and 411.408(d).

17 42 U.S.C. §1395u(l)(2). Copies of letters assigning liability for denied claims are attached hereto and marked Exhibit "D".

18 42 U.S.C. §§ 1395u(b)(3)(B)(ii) and 1395u(i)(2); 42 U.S.C. §1395u(l)(1); 42 C.F.R. §411.408(d), (e) and (f).

19 42 U.S.C. §1395u(l) and 42 C.F.R. §411.408(d). A copy of an "ABN" is attached hereto and marked Exhibit "E".

directly bills Medicare), he or she may use an ABN and, if the service is deemed "not necessary," Medicare will not pay the physician, and it will order the Medicare beneficiary not to pay the physician.[20]

HCFA would have us believe that a physician may have his or her Medicare patients sign ABNs any time he or she believes HCFA and the carrier may not pay for a service. Thus, HCFA implies, the presence of Section 4507 does not deny health care services to Medicare beneficiaries. Such is absolutely false.

F. "Advanced Beneficiary Notices" cannot be used routinely without the threat of sanctions.

One expert has referred to the ABN not as the "waiver of liability," but the "liability of waiver."[21] **While an ABN may technically absolve the physician of monetary liability to the patient, it does not absolve the physician from sanctions by the Medicare program.** HCFA and its Office of the Inspector General ("OIG") have the authority to impose civil monetary penalties and/or exclusion from participation in the Medicare program for those physicians who provide services for Medicare beneficiaries which **HCFA determines** to be "not reasonable and necessary." All HCFA and its OIG need to impose penalties is a "pattern of medical items or services" provided that the physician "knows are not medically necessary."[22] "Necessity," of course, is based upon

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[20] 42 U.S.C. §1395u(b)(3)(B)(i) and 42 U.S.C. §1395u(i)(2).

[21] *Blanchard*, at 1012.

[22] See 42 U.S.C. §§ 1320a-7, 1320a-7a, and 1320a-7b and 42 C.F.R. Part 1000, *et seq.*

42 U.S.C. §1320a-7:
The Secretary **shall** **exclude** the following individuals and entities from participation in [Medicare] and shall direct that the following individuals and entities be excluded from participating in [Medicaid]:
(6) Any individual or entity that the Secretary determines--
(B) **has furnished or caused to be furnished items or services to patients... substantially in excess of the needs of such patients....**

42 U.S.C. §1320a-7a:
Any person... that--

HCFA's unknown and unpublished "standard" of what is "necessary." A "pattern" may be two (2), three (3), four (4) or any number of services, items or instances where services and/or items have been provided. Frequent use of ABNs may also trigger a fraud investigation.[23] **Physicians cannot use ABNs routinely. ABNs, accordingly, must be used sparingly or the physician will face potentially ruinous legal action by the Secretary.** To one expert, this process is nothing more than HCFA's "resort to *ad hoc* secret law to reduce benefit payments by **trick, trap or terrorism.**"[24]

G. Because ABNs cannot be used routinely, health care services are denied.

Consequently, if ABNs cannot be used routinely, a physician will severely limit or not provide services to Medicare patients which he or she believes the carrier will find to be "not reasonable and necessary," even when the physician's medical judgment would be to provide the service. On the one hand, the physician cannot afford to bear the liability for the cost of the service himself or herself by not entering into an ABN, and, on the

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> (1) Knowingly presents or causes to be presented to an officer, employee or agent of the United States, or any department thereof, or of any state agency..., a claim... **that the Secretary determines--**
>
> **(E) is for a pattern of medical items or services that a person knows or should know are not medically necessary...**
>
> **shall be subject,** in addition to any other penalties that may be prescribed by law, **to a civil monetary penalty of not more than $10,000 for each item or service.... In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs** [Medicare] and to direct the appropriate State agency to exclude the person from participating in any state health care program.

[23] 42 U.S.C. §1320a-7(b)(a); see *Blanchard*, at 1018 - 1020, n.381 (noting that "precise knowledge is frequently imputed to physicians under the Medicare program, and intent is readily inferred. *United States v. Greber*, 760 F.2d 68 (3rd Cir. 1985); *United States v. Kats*, 871 F.2d 105 (9th Cir. 1989)").

[24] *Blanchard*, at 1032.

other hand, the physician cannot afford to provide too many services he or she believes the carrier may find to be "not necessary" under an ABN for fear of being sanctioned. As noted by health care expert Timothy Blanchard:

> [A]ll physicians have a strong incentive to assess the relative risks imposed by these carrier [HCFA] tactics. **Unfortunately, in the current environment, the practice option presenting the lowest risk [to the physician] is to refrain from recommending potentially beneficial and covered services to Medicare beneficiaries whenever it appears likely that the carrier might deny the claim.**[25]

Necessary health care services, consequently, are severely limited and denied every day to all Medicare beneficiaries.

H. Health Care Services Denied Seniors.

i. Generally

Among those essential health care services which **UNITED SENIORS** has documented are now being severely limited or denied to Medicare beneficiaries are house calls and nursing home visits (more than once a month), x-rays, including pre-operative chest x-rays and diagnostic chest x-rays, pre-operative cardiology examinations, innovative and technologically-advanced surgical services for which HCFA's coding and fee schedule amendment process has not timely accommodated so as to make same reasonably available (such as arthroscopic surgery), as well as a host of prosthetics and orthotics from physicians upon conclusion of surgical procedures so as to prevent injury, to name only a few. **Health care services that Medicare patients need and desire now, and on an ongoing basis, are actually being severely limited to them and denied them because of the aforesaid claims adjudication system.**[26]

ii. Clinical Diagnostic Laboratory Services

Among those denied services which Seniors want and need are screening/laboratory tests, among countless others. Laboratory screening tests (asymptomatic tests performed for the early detection of disease or to rule out disease) are considered "otherwise covered" services by HCFA. **Physicians, however, are not**

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[25] *Blanchard,* at 1021.

[26] See *United Seniors Ass'n, et al. v. Shalala,* No. 97-3109 (D.D.C. 1998) (*Affidavit of David V. Young, M.D. and Martha S. Young ("Young Aff.")*, at 6 - 7; *Affidavit of Robert P. Nirschl, M.D. ("Nirschl Aff.")*, at 5 - 6, 9 - 11; *Affidavit of Lois J. Copeland, M.D. ("Copeland Aff.")*, at 8 - 10).

allowed to bill Medicare patients directly for any clinical diagnostic laboratory service for which any claim is be filed.[27] Rather, clinical diagnostic laboratory services must be performed on an "**assignment**" **basis**, meaning Medicare must be billed directly. **Only clinical laboratory facilities that are certified by HCFA can perform laboratory tests ordered by physicians, and because the burden for complying with the Clinical Laboratory Improvement Act is so great, most such laboratories are now corporate-owned and operated.**[28]

On March 3, 1997, the OIG and HCFA published the "OIG Model Compliance Plan for Clinical Laboratories," which states:

> **We believe that physicians must be made aware the Medicare program will only pay for tests that meet the Medicare definition of 'medical necessity' and that Medicare may deny payment for a test that the physician believes is appropriate, such as a screening test, but which does not meet the Medicare definition of medical necessity.**[29]

The Medicare Act requires the submission of an "approved" diagnosis code ("ICD-9") along with any claim for reimbursement from Medicare, and, Section 4317 of the Balanced Budget Act of 1997, effective January 1, 1998, requires, further, that physicians must now provide to the laboratory the "approved" ICD-9 for all laboratory tests ordered for Medicare patients.[30] But the OIG and HCFA have actually warned laboratories that they cannot disseminate lists of ICD-9s that have triggered reimbursement for laboratory tests in the past.[31] **So, physicians generally do not know what tests will actually be paid by Medicare.** The OIG has warned physicians that it **may** not regard screening tests as "medically necessary."[32]

Inexpensive screening tests for prostate cancer, diabetes, hypothyroidism, hyperthyroidism, anemia, high cholesterol (heart

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27 42 U.S.C. §1395l(h)(5)(D).

28 42 U.S.C. § 263a.

29 62 *Fed. Reg.* 9435 - 9441, 9436 (Mar. 3, 1997). A copy of the aforesaid "OIG Model Compliance Plan for Laboratories" is attached hereto and marked Exhibit "F".

30 42 U.S.C. §1395u(p).

31 62 *Fed. Reg.* at 9437.

32 *Id.*

disease), and kidney and liver function could be health and life-saving. The aforementioned diseases often have very long asymptomatic periods. Because Medicare patients may have pre-symptomatic diseases which could only be detected by the performance of laboratory screens, it is critical to be able to perform such tests in order to detect the diseases early. All of the aforementioned diseases can be **cured** or effectively and inexpensively **treated** if detected early.[33]

The OIG Model Compliance Plan for Clinical Laboratories, however, asserts that laboratories must inform physicians "... to **only order tests that are medically necessary for each patient... and... the OIG takes the position that a physician who orders medically unnecessary tests for which Medicare reimbursement is claimed may be subject to civil penalties.**"[34]

Because all laboratory tests are performed on an "assignment" basis, and HCFA demands all such claims be filed (and the laboratories thus file all such claims), physicians who order **any** screening laboratory tests **will suffer** civil penalties even though the physicians firmly believe, under their own professional standards of care, that their Medicare patients should have the tests. The pressure on the physicians **not** to order screening tests is thus overwhelming. **Consequently, they are not ordered for Medicare patients. UNITED SENIORS has documented that screens for prostate cancer, diabetes, anemia, hyperthyroidism, hypothyroidism, kidney and liver dysfunction and heart disease, among many others, are all being denied America's Seniors.**[35]

V. Conclusion

Without the escape-valve to contract privately, Seniors are now being -- and will continue to be -- denied health care services

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[33] See *United Seniors Ass'n, et al. v. Shalala*, No. 97-3109 (D.D.C. 1998) (*Young Aff.*, at 10 - 12; *Copeland Aff.*, at 7 - 9; *Affidavit of Norman Kingsbury Brown, M.D.* ("*Brown Aff.*"), at 2 - 3).

[34] 62 *Fed. Reg.* at 9437. Such threat of civil penalties is codified at 42 U.S.C. §1320a-7a(1)(E). See sample of instructions to physicians from Dynacare Laboratories, Seattle, Washington, pursuant to "OIG Model Compliance Plan for Laboratories," January 1, 1998, attached hereto and marked Exhibit "G".

[35] See *United Seniors Ass'n, et al. v. Shalala*, No. 97-3109 (D.D.C. 1998) (*Brown Aff.*, at 3, Exh. A; *Young Aff.*, at 8 - 12; *Nirschl Aff.*, at 8 - 12; and *Copeland Aff.*, at 7 - 11).

essential to their health and lives. The escape-valve is denied by Section 4507. Our Seniors thus are left with a "take it or leave it" system which denies and rations health care. All our Senior Citizens will get is only what the federal government allows! Nothing more will be provided -- even if they wish to pay for it themselves.

This is Medicare's "brave new world." It is a world that offers the minimum at best. It allows for no decision-making on the part of the Medicare beneficiary! In a country which has the healthiest, wealthiest, most well-educated population of individuals over age 65 the world has ever seen, the government prefers to believe these people to be incapable of making such decisions. Medicare is a totally paternalistic program. The Medicare beneficiary takes what the federal government offers or "lumps it."

It is incredible that in this country -- supposedly the freest on earth -- the government prohibits a senior citizen from paying for his or her own health care. Even in the British National Health Service a citizen can privately contract! But not here.

I am mindful that this same prohibition against contracting privately was found in the Clinton Health Security Act, -the enormous bill put together by Hillary Clinton's secret health care task force and rejected wholesale by the American people.[36] Now Congress and the Clinton administration have implemented it for our Seniors.

I do not believe that the citizens of this nation will accept such a system. This is still the United States of America. This country is still governed by a written Constitution to which we have all pledged our allegiance over-and-over-again. And if that Constitution protects a pregnant teenager when she seeks an abortion, even one so young the law considers her as lacking the capacity to vote, it must protect our Seniors who seek only to receive the health care they want for themselves and for which they will personally pay. If that Constitution protects the medical records of those with death-dealing diseases about which we know very little, it surely protects the medical records of our Seniors who seek privacy. If that Constitution protects citizens against discrimination, it surely protects our Seniors from being singled out and denied the opportunity to make decisions regarding their personal health just because they are 65 years of age or older. And if the courts are now questioning the extent of the power of Congress in that Constitution, they must surely question the power of Congress to deny a Senior the right to seek the health care he

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[36] Clinton Health Security Act, §1406(d)(2), submitted to Congress on October 27, 1993.

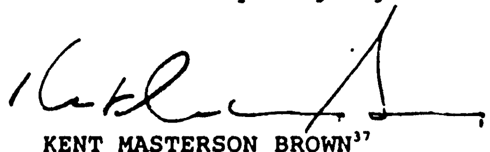
or she wants and for which he or she will personally pay.

For all these reasons -- but, particularly, to enable America's Seniors to receive health care services they desire free from restraint -- Section 4507 of the Balanced Budget Act of 1997 must be repealed and the Kyl Amendment, S. 1194, "The Medicare Beneficiary Freedom to Contract Act," must be enacted.

In the meantime, **UNITED SENIORS ASSOCIATION, INC.**, and its 600,000 members and members of **UNITED SENIORS, TONI PARSONS, PEGGY SANBORN, RAY PERRY** and **MARGARET PERRY** filed a lawsuit in federal court on December 30, 1997 asking that Section 4507 of the Balanced Budget Act of 1997 be declared unconstitutional as violative of Article I, Section 8, of the Constitution and the First, Fourth, Fifth, Ninth, Tenth, and Fourteenth Amendments to the Constitution. With their complaint, **UNITED SENIORS** and its members filed a motion for a preliminary injunction to stop the Clinton administration from enforcing Section 4507 and to enjoin any attempts by HCFA to interfere with private contracting by America's Seniors. Argument on the pending motion for a preliminary injunction is set for March 6, 1998 in United States District Court in Washington, D.C.

Rest assured, **UNITED SENIORS** will do everything possible to stop what it firmly believes is an abuse of power. **UNITED SENIORS** will prosecute the case as far as the processes of the courts allow, and it will notify every Senior Citizen of each and every step, mobilizing them by informing them, until this unconstitutional law is voided, and freedom and liberty reign again in our Seniors' health care system.

Thank you very much.



KENT MASTERSON BROWN[37]

February 26, 1998

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[37] Mr. Brown's *curriculum vitae* is attached hereto and marked Exhibit "H".

55-718 00-3

Prepared Statement of Hon. Benjamin L. Cardin

Chairman Roth and members of the Committee, thank you for allowing me to be with you today to discuss private contracting for Medicare beneficiaries. The issue before you holds wide-ranging implications for the future of the Medicare program itself. In recent months, Medicare private contracting has been the subject of contentious debate, replete with numerous misconceptions and scare tactics. Therefore, it is essential that an open and honest discussion of private contracting's purposes and effects take place. I believe we all share the same goal for our seniors—that they have access to affordable quality health care. I am pleased that this Committee is encouraging such a discussion, and I thank you for asking me to appear before you this morning.

I believe it is important to provide some background on this issue. Congress created Medicare in 1965 because millions of seniors were unable to obtain affordable health insurance through the private marketplace. Medicare has proven a very successful program, virtually eliminating the problem of the uninsured elderly and reimbursing doctors fairly for their services, often at a higher rate than many managed care plans do. In fact, 97.2% of physicians accept Medicare's payment rate for services.

Prior to passage of the Balanced Budget Act, federal law did not address the issue of private contracting between physicians and beneficiaries. The Kyl Amendment to the BBA explicitly states that doctors can now reject Medicare and privately contract for medical services with individual Medicare beneficiaries. This means that seniors who agree to privately contract would not be able to use their Medicare or their Medigap coverage for medical care. Instead they would have to pay 100% of their medical care out-of-pocket. However, it is important to note that the Balanced Budget Act does retain some very important protections for seniors.

Under BBA, doctors who choose to privately contract with Medicare beneficiaries are barred from accepting Medicare patients for two years. This is a vital protection. It means that doctors will not be able to bill Medicare for some services and then ask their patients to pay them separately for other services. It means that seniors visiting a doctor's office will know in advance whether their Part B insurance is valid for that doctor's care. It means that seniors will know that a doctor with whom they privately contract will not be able to collect payment from them and also bill Medicare for those services. In sum, it reinforces seniors' belief that their Medicare coverage will be there for them when they need it.

In addition, Medicare rules include balance billing limits. In 1989, Congress passed a law prohibiting doctors from charging Medicare patients more than 15% above the Medicare reimbursement rate. This protection is vital: it means that seniors know in advance of a visit to their doctor that they are shielded by these financial protections. Seniors who enter private contracts give up this financial protection.

The bill before you today, S. 1194, would jeopardize these vital protections by removing the two-year exclusion period and by permitting physicians to elect on a service-by-service basis whether to accept Medicare. It would allow a doctor to decide at each encounter with a patient whether he believes Medicare's payment is sufficient and to disregard the patient's Part B coverage. The potential for disruption to patient care is tremendous.

Let me give you an example. If this bill is enacted, a rural doctor who may be the only cardiologist for miles around would be able to decide at the moment a senior enters his office whether he will accept Medicare Part B for that day's services. If he chooses not to, despite a long-standing relationship with that doctor, the patient would be forced at that time to sign a private contract to receive the service at whatever rate the doctor wants to charge, regardless of the financial burden to the senior. The senior may have no real choice.

I ask you to remember that all health care markets are not the same. In Washington, New York City, Dallas, Miami and other major urban areas, there may be enough physicians to stimulate some competitive pricing and keep charges affordable for seniors. But in rural Iowa, Utah, Alaska, Mississippi—areas where physicians are scarce—seniors will be forced to pay the lone area physician's desired rates, however high.

In addition, the potential for increased fraud and abuse in Medicare is overwhelming. Many doctor's offices have established electronic billing systems to file Medicare claims. Without the protections in current law, doctors could easily bill both Medicare and their patients. The Congressional Budget Office has stated that private contracting holds a "serious potential for overbilling."

I would be remiss if I did not address the false claims that are being made about the BBA private contracting provisions that now exist. Proponents of S. 1194 claim

that the current law forces seniors to sign private contracts with doctors for all services, even those not covered by Medicare. This is simply not true. The Balanced Budget Act only applies to Medicare-covered services. Nothing in the BBA affects the ability of seniors to pay doctors for services that Medicare does not cover.

The Health Care Financing Administration has stated this clearly in its "1998 Medicare Participating Physician or Supplier Agreement," which includes a fact sheet on changes to the Medicare program. That fact sheet states,

> *"With respect to non-covered services, a private contract is unnecessary and Section 4507 does not apply. In other words, beneficiaries continue to be able to pay for any services that Medicare does not cover out of their own pockets, under the payment arrangements they make with their physician, without having to enter into a private contract subject to the provisions of Sec. 4507."*

Finally, proponents of the Kyl Bill claim their bill gives seniors "choice." In fact, nothing could be further from the truth. First, seniors can choose now whether to receive care from a doctor who accepts Medicare. Second, seniors can choose now not to have their physician bill Medicare for any given service by simply refusing to sign the Medicare claim form. If the beneficiary's signature is not provided, the physician cannot submit that claim to Medicare for payment, and the senior is personally responsible for what Medicare would have paid. Third, seniors can choose now whether or not to enroll in Medicare Part B, which is an entirely voluntary program. Those seniors who wish to visit any doctor who will see them and pay out-of-pocket a fee that may exceed 115% of the Medicare fee schedule may do so by disenrolling from Medicare Part B. Medicare rules for physician services are not applicable to seniors who are eligible for Medicare, but who choose not to enroll in Part B. Those seniors who are paying Part B premiums deserve to have the insurance policy they bought from the government honored by the doctors who contract with the program.

The truth is that this bill only gives physicians "choice." The choice to opt out of the Medicare program during each encounter with a Medicare beneficiary. The choice to charge a patient whatever he or she wishes, with no regard for the agreement they have signed with the Medicare program. It is a choice they would never be allowed by any private insurance company. I repeat: no private health plan would allow its member physicians to charge patients above the plan's contracted payment rates. Our seniors deserve no less than the protections offered by the private market. Despite these facts, some groups continue to wage misinformation campaigns, and, unfortunately, our seniors, who are often society's most vulnerable to these kinds of tactics, have been confounded and confused by their claims.

For this reason, I have introduced H.R. 3259, The Medicare Private Contracting Clarification Act of 1998. Its purpose is just that: to eliminate the confusion surrounding this much-debated issue, to assure seniors that their contract with Medicare, a public contract, will continue to be honored. My bill clarifies that no private contract is required for services that Medicare does not cover. It is designed to put an end to the false rhetoric and scare tactics that are making seniors fearful for their future. I would hope that all of us would agree that if any legislation is needed (and I am not sure that any is), H.R. 3259 should be that legislation. If we then want a debate on the merits of balance billing protection for seniors, let us limit the discussion to that issue.

Let's keep the Medicare program intact. Let's not provide another avenue for rampant fraud and abuse of the Medicare program. Let's not return to the days before 1965 when only America's wealthiest seniors could afford health care.

If it is necessary to pass legislation, I urge you to support my bill, which clarifies this issue, and to reject the Kyl bill, which weakens the important protections we have promised our senior citizens under Medicare. Thank you.

Prepared Statement of Hon. John H. Chafee

I want to thank the Chair for holding this hearing today. Over the last several months I have heard from many Rhode Islanders concerned about the impact private contracting could have on the Medicare program and their relationships with their physicians. There have been numerous op-ed pieces written in newspapers across the country, and my office almost daily receives mail from those on both sides of the issue. The merits of this proposal must be discussed carefully, and I welcome the opportunity we have this morning to take a closer look at what is clearly a controversial subject.

Prior to the Balanced Budget Act (BBA), private contracts between physicians and Medicare beneficiaries for services covered by Medicare had no validity. During debate on the BBA, Senator Kyl offered an amendment to allow patients enrolled in

Medicare to contract privately for Medicare-covered services with physicians "opting out" of the Medicare program for a period of 2 years. I supported his amendment, and was happy to see it included in the BBA. I believe that provision struck an appropriate balance between our desire to expand options for Medicare beneficiaries and physicians, and the need to maintain the integrity of both the Medicare program and the physician-patient relationship.

I do have some concerns about expanding private contracting beyond the provision included in the BBA. The Medicare Beneficiary Freedom to Contract Act would expand the scope of private contracting by removing the two year opt-out requirement for physicians. It would allow private contracts between providers and beneficiaries on a patient-by-patient and service-by-service basis.

Also as part of the BBA, we established a new bipartisan commission on Medicare. I believe that Commission is scheduled to meet for the first time next week. It seems unwise to make such a fundamental change to the Medicare program as to allow service-by-service private contracting before the Commission has a chance to begin—much less conclude—their study of the program.

It is my hope that we will allow the Commission to move forward with its analysis of how best to preserve and protect the Medicare program for the long term before making any new, significant changes to the program.

PREPARED STATEMENT OF NANCY-ANN MIN DEPARLE

INTRODUCTION

Mr. Chairman, Mr. Moynihan, and other Members of this Committee, I appreciate the opportunity to be here today to discuss the issue of private contracts between Medicare beneficiaries and their doctors. As you know, the bipartisan Balanced Budget Act of 1997 included a provision that allows physicians to contract privately with Medicare beneficiaries. There are a number of misconceptions surrounding this issue, and I hope my testimony will help clear up some of the confusion.

Today, I will summarize the law related to private contracts; address several misconceptions about private contracts and Medicare; and discuss principles by which I believe alternatives to the Balanced Budget Act private contract provision should be evaluated. Our goal is to assure fair and equitable payments to physicians within a framework that guarantees affordable and accessible health care to beneficiaries.

BACKGROUND

Under section 4507 of the Balanced Budget Act, a private contract is an agreement between a Medicare beneficiary and a physician in which the beneficiary agrees to pay fully out-of-pocket for a Medicare-covered service. The beneficiary and physician agree not to submit a claim to Medicare, even though the service would be covered if a claim were submitted. The beneficiary pays the physician's charge entirely out of personal funds and Medicare does not pay any part of the charge. Medicare protections, such as limitations on the physician's ability to charge the beneficiary more than Medicare's fee schedule, do not apply.

A private contract exempts a physician from two statutory billing requirements: (1) the claims submission provision, which requires physicians to complete and submit claims to Medicare, and (2) balance billing limits, which limit the amount a physician can charge a beneficiary above the Medicare fee schedule. The significance of these two billing requirements merits discussion in greater detail.

Claims Submission: Since September 1, 1990, the Medicare law has required that, for items or services covered under Part B of Medicare, a physician, supplier or other person must complete a claim form and submit it to Medicare on behalf of a beneficiary. Congress enacted the claims submission requirement as part of the physician payment reform legislation in 1989 for two key reasons: (1) to facilitate assessment of physician performance under the Physician Volume Performance Standard System, and (2) as a service to beneficiaries who would sometimes "shoebox" claims and inadvertently forget to send them to Medicare. The private contracting provision exempts physicians from this requirement. Under a private contract, both the beneficiary and physician agree not to submit a claim to Medicare.

Balance Billing Limits: When Congress enacted limits on Medicare payments in 1984, it included limits on how much physicians could bill beneficiaries. Since that time, beneficiary financial protections have been part of every legislated change in Medicare physician payments. These protections were designed to prevent physicians from passing on legislated payment reductions to beneficiaries through excess charges. When limits on physician charges to beneficiaries were initiated, Senator Dole, then Chairman of this Committee, explained: "Needless to say, there has been

a great deal of concern about how physicians can be prevented from shifting the burden of such a freeze to beneficiaries. Simply freezing what we pay for physician services provides little protection to program beneficiaries." Senator Dole expressed concern that "If a physician does not elect to take assignment, beneficiaries can be held responsible for the full difference between what the program pays and what the physician charges." For that reason, Congress enacted limits on how much a physician can charge a beneficiary: these limits are called "balance billing limits."

The Balanced Budget Act of 1997

The Balanced Budget Act included a provision that allows physicians and beneficiaries to privately contract for Medicare-covered services. Under the new law, physicians can privately contract with Medicare beneficiaries only when specific requirements are met. The bipartisan Balanced Budget Act requires that private contracts be written, not oral, and must be signed by the beneficiary before any item or service is furnished under the contract. It cannot be signed by the beneficiary when an emergency or urgent service is needed and must contain specific elements to assure that beneficiaries understand and consent to the private contract. Physicians and beneficiaries must also agree not to submit a claim to Medicare and acknowledge that Medicare will not make any payment. This provision helps ensure that the beneficiary willingly and knowingly enters into a private contract.

Physicians who choose to provide covered services to Medicare beneficiaries under private contracts must "opt out" of the Medicare program for two years. During this two-year period, Medicare does not pay the physician either directly or on a capitated basis for any covered services provided to Medicare beneficiaries. A physician must treat all Medicare beneficiaries in the same way; the physician cannot choose to privately contract with some Medicare beneficiaries but not others, and for some services and not others.

Requiring a physician who chooses private contracting to opt out for a finite period has two key policy implications. First, it diminishes the opportunities for fraud and abuse. Because physicians would have to notify Medicare that they are opting out for a finite period of time, the Medicare carrier would know who those physicians were, and could then ensure that no Medicare payments were made to them. Second, having a physician opt out for a specific period of time allows a beneficiary to make an informed choice of physician. In this way, the beneficiary could choose a physician, before seeking care, based on knowledge of whether the physician would accept Medicare payment or would require private contracts for all services. If a physician were allowed to opt out for some services or beneficiaries but not all, a beneficiary would not know from one visit to the next whether he or she will have to pay out-of-pocket, or whether Medicare would pay.

Misconceptions About Private Contracts

There has been substantial misunderstanding about what section 4507 of the Balanced Budget Act does, so I would like to clarify several major points. The confusion rests predominantly on four issues: who is affected by Medicare rules; when Medicare beneficiaries can pay out-of-pocket for services not covered by Medicare; what advance beneficiary notices (ABNs) are; and other beneficiary choice issues. I will also address the situation with respect to Medicare managed care.

Who Is Affected by Medicare Rules?

Medicare rules apply only to individuals enrolled in Medicare. Part B of Medicare, which covers physician services, is a voluntary program and beneficiaries choose to enroll and they can disenroll at any point. Medicare Part B rules do not apply to individuals or disabled persons who are eligible for Medicare, but not enrolled in Part B. Medicare rules do not apply to physicians' or practitioners' treatment of patients who are not enrolled in Medicare. Therefore, a private contract is not necessary for a physician to provide services to an individual who is Medicare-eligible, but who is not enrolled in Part B of the program.

Beneficiary Payment for Services Not Reimbursed by Medicare

There has been substantial confusion over the issue of what services beneficiaries can, and cannot, pay for with their own funds. Let me clarify the situation.

Medicare rules apply only to services covered by Medicare. Medicare beneficiaries can, and in fact must, pay out of their own funds or have other sources of insurance for services that Medicare does not cover. Medicare covers about half of the elderly's health expenses, and Congress determines what services are covered. Examples of services that Medicare does not cover include cosmetic surgery, hearing aids, routine physical exams, outpatient prescription drugs and long term nursing home care. If Medicare doesn't cover a service, no private contract is needed, and physicians are not limited in what they can charge. The Balanced Budget Act provision on private

contracts did not change this aspect of Medicare. A physician does not have to opt out of Medicare for two years in order to provide a non-covered service to a Medicare beneficiary. That was the law a year ago; it's still the law today.

The law requires that Medicare pay only for medically necessary services, which requires judgments about the type and quantity of services that are medically necessary. For example, Medicare may determine that one physician visit per month to a nursing home resident would be medically necessary (absent other medical complications) and would pay for one such visit. However, a Medicare beneficiary who wanted more frequent visits (absent medical complications) could pay for them out of his or her own funds, even though the carrier determined the additional visits not to be reasonable and necessary.

A private contract is not necessary to provide these more frequent visits; a physician who remains in Medicare can still provide these services to beneficiaries. In such a case, the physician files a claim with Medicare and provides the beneficiary with an "Advance Beneficiary Notice" (ABN) stating that the service may not be covered by Medicare and the beneficiary agrees to pay for the service if Medicare doesn't pay. Again, the Balanced Budget Act did not change this aspect of Medicare.

There has also been extensive misinformation about whether a beneficiary can pay for certain types of preventive services. Let me explain the situation using prostate specific antigen tests (PSAs) as an example. These are laboratory tests for which a physician generally draws the blood specimen and sends it to an independent laboratory to perform the test.

Today, Medicare coverage of the PSA test depends on whether it is a diagnostic or a screening service. A diagnostic test is performed to evaluate a sign or symptom that a physician finds in a particular patient, whereas a screening test is performed for patients across the board without regard to a symptom experienced by a particular patient. Medicare currently covers diagnostic PSA tests only. The Balanced Budget Act legislated coverage of screening PSA tests beginning in 2000. Until then, screening PSAs are not covered services and beneficiaries can pay for them out of their own funds as with any other non-covered service. Therefore, a private contract is not needed when a beneficiary wants a PSA test for screening purposes because it is not now a covered service.

If a physician believes a diagnostic PSA test is medically necessary, then Medicare will pay for it. If the beneficiary wants a screening PSA, he may pay for it out of his own funds. He does not need a private contract. If the physician believes that Medicare is likely to deny payment for a certain diagnostic PSA (for example, when the patient wants to have the test more frequently than Medicare would likely pay for), then the physician should use an ABN. The Balanced Budget Act does not preclude a beneficiary from obtaining, or a physician from providing, a diagnostic or screening PSA test.

The Advance Beneficiary Notice

An Advance Beneficiary Notice (ABN) allows a beneficiary to make an informed consumer decision by knowing in advance that they may have to pay out-of-pocket for a service. An ABN is used by a physician who believes that a service, which Medicare covers under some circumstances, may not be paid for by Medicare in a particular case. The physician provides the beneficiary a written notice, before the service is rendered, indicating this fact and explaining why denial is expected. A beneficiary agrees to pay for the service if Medicare does not pay for it. If a physician does not use this mechanism, the statute generally does not allow the physician to collect payment from the beneficiary. The physician sends the claim to Medicare to determine whether payment will be made. If Medicare does not make payment, then the beneficiary is responsible for paying.

There has been some confusion about Advance Beneficiary Notices and their relationship to private contracts. An ABN is not a private contract. An ABN is used when the physician believes that Medicare likely will not make payment, while private contracts are used for services that are covered by Medicare and where payment would be made if the physician were in Medicare and a claim were submitted. Therefore, a physician using an ABN remains in Medicare, while a physician using a private contract for services covered by Medicare would voluntarily opt out.

I understand that some physicians have expressed concern that widespread use of ABNs is not an acceptable practice. We are concerned that ABNs may be misunderstood by beneficiaries and the medical profession. We will be working with these groups to improve ABNs to make them easier to use, and to assure that there is a better understanding of what they are and how they are to be used.

Beneficiary Choices

A beneficiary may choose, on a "service-by-service" basis, to see any physician whether the physician remains in, or opts out, of Medicare. In the former case, Medicare would pay for the services while the beneficiary would pay out of their own pocket for the services in the latter case.

A beneficiary may, in some situations, refuse to authorize the release of medical information needed to submit a claim. In 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 a claim if the beneficiary refuses to authorize release of the medical information needed 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.

Managed Care Plans

There has been confusion about whether the private contracting provision applies to a beneficiary who is enrolled in a Medicare risk-based managed plan and goes out of plan to acquire a service. In general, Medicare's relationship with a beneficiary enrolled in a managed care plan is significantly different from Medicare's relationship with a beneficiary in Medicare fee-for-service. My previous discussion of private contracting pertained to Medicare fee-for-service. Beneficiaries enrolling in managed care plans agree to obtain all of their services through the plan, which is the only entity authorized to receive Medicare payment for services provided to these enrollees. Thus, these beneficiaries receive services only from physicians affiliated with that plan. In contrast, in Medicare fee-for-service, beneficiaries can receive covered services from any qualified provider who meets minimum program requirements and renders such services.

If a beneficiary who is enrolled in a managed care plan receives a service from a physician who does not have a contract with the plan, and the service is not authorized by the plan, then the service is not a "covered service." In that case, neither the managed care plan nor Medicare pays the physician or reimburses the beneficiary. The service can be provided at the fee agreed upon between the physician and the beneficiary and a private contract is not necessary in order to provide the service. The physician does not have to opt-out of Medicare for two years under the private contract provision in order to provide this service.

PROPOSED PRIVATE CONTRACTING LEGISLATION

Senator Kyl and Representative Archer have proposed legislation, the Medicare Beneficiary Freedom to Contract Act (S. 1194/H. 2497, hereafter S. 1194), to expand opportunities for physicians and practitioners to privately contract with Medicare beneficiaries. The bill would eliminate the requirement that physicians opt out of Medicare for two years in order to privately contract and would allow them to contract privately with beneficiaries on a patient-by-patient and service-by-service basis. For example, a physician could accept Medicare payment to diagnose a problem, then require the beneficiary to enter into a private contract and pay out-of-pocket to treat the same problem.

Principles to Evaluate Alternative Approaches

Any private contracting provision must strike a balance between expanding physicians' ability to charge higher fees and protecting the Medicare program and beneficiaries. We believe that section 4507 struck the proper balance. Any proposal to expand private contracting and relax the beneficiary protections in current law should be judged by the following four principles:

- Does the proposal minimize the potential for fraud and abuse?
- Does it promote the ability of beneficiaries to make informed choices?
- Does it provide stable and predictable financial protection for beneficiaries?
- Does it promote access to high quality care, regardless of ability to pay?

I will evaluate S. 1194 according to these principles.

Reducing the Potential for Fraud and Abuse

Reducing fraud, waste and abuse in Medicare must be one of our highest priorities. This includes being watchful that we do not provide any new opportunities for fraud and abuse. Therefore, a key principle to evaluate any new Medicare proposal is whether it would encourage, or discourage, fraud and abuse.

Under current law, physicians are required to notify Medicare of their decision to opt out. Since the opt out is for a finite period, Medicare carriers can identify those physicians and therefore prevent double billing (i.e., billing both the beneficiary and

Medicare). The problem is that under S. 1194, Medicare would not know which claims were the subject of a private contract and thus would not be able to deny payment for such claims with certainty. This is not to say that we expect all physicians to submit claims for services where private contracts are used, but even if their offices do so inadvertently, Medicare carriers would not be able to deny payment. An inability to enforce rules creates an environment where fraud, abuse, and double billing could become more pervasive. As the Congressional Budget Office pointed out in analyzing S. 1194: "HCFA's efforts to screen inappropriate or fraudulent claims could be significantly compromised."

It has been suggested that HCFA could use the authority of "the minimal information necessary" in S. 1194 to require physicians to submit a "no-pay claim," which is a claim that contains much the same information as a normal claim for reimbursement and indicates that a private contract was used. Even with a "no-pay claims" approach, our experience is that these claims are generally underreported. And if claims are submitted without private contract identification, it would not be possible for Medicare to deny payment. As such, we are concerned that the new proposal would encourage fraud and abuse and undermine our efforts to improve program integrity.

Furthermore, Medicare's capitated payments to managed care organizations include payment for physicians' services. S. 1194 would allow a physician who is a member of a managed care network to privately contract with a beneficiary who is a member of that managed care plan. This feature would result in overpayments to managed care plans since they would not have to compensate the physician for the privately contracted services. In addition, it could encourage fraud and abuse to the extent that managed care plans encourage physicians in their network to use private contracts.

Promoting the Ability of Beneficiaries to Make Informed Choices

Medicare should also enhance the ability of beneficiaries to make informed choices. This was one of the objectives of the new Medicare + Choice program reforms in the Balanced Budget Act.

Requiring a physician who chooses to enter into private contracts to opt out of Medicare for a finite period of time facilitates this goal. Knowing a physician's decision about opting-out of Medicare is important information that allows a beneficiary to make an informed decision about his financial liability when seeking a physician's services. For example, if a physician opted out, a beneficiary would have an opportunity to know this in advance and would be aware that he would be responsible for the entire cost of the physician's services for at least two years. Under the Balanced Budget Act, the beneficiary can know the potential liability by simply inquiring whether the physician accepts Medicare or has opted out of Medicare.

Under the new bill, physicians would be allowed to pick and choose which beneficiaries and which services to bill under private contracts, and which to bill under Medicare. Therefore, the new bill makes it more difficult for a beneficiary to choose a physician. The new bill creates uncertainty about whether a physician will accept Medicare or will require private contracts for each Medicare-covered service. In cases where a physician privately contracts for some services, but not others, a substantial potential exists for beneficiaries to misunderstand the extent of their liability, with many beneficiaries finding out, after the fact, that they are liable for a large portion of their medical bills.

And, private contracting, on a claim-by-claim basis, changes the nature of the physician-patient relationship. The new bill makes it easier for a private contract to be the result of coercion rather than beneficiary freedom of choice. Consider, for example, the situation faced by a Medicare beneficiary who has a longstanding relationship with her doctor and then develops breast cancer. The doctor may say he will treat her under a private contract, and she may feel she has no choice but to accept that arrangement and forego Medicare reimbursement. While some argue that the beneficiary has the freedom of choice to switch physicians, that choice can be hollow indeed, under these circumstances.

Providing Stable and Predictable Financial Protection for Beneficiaries

Medicare was designed to provide financial protection to beneficiaries against the high cost of illness. To expand private contracts potentially erodes the financial protection that Medicare provides to beneficiaries precisely when they need it most, that is, when they are sick and in need of the services Medicare provides. Beneficiaries who encounter numerous physicians requiring private contracts and out-of-pocket payments for Medicare-covered services would find the Medicare premium a wasted payment. Private contracts would make Medicare effectively meaningless for those beneficiaries.

Promoting Access to Care, Regardless of Ability to Pay

Medicare was also designed to help beneficiaries obtain access to care. We and the Physician Payment Review Commission (PPRC) have studied Medicare beneficiary access to care, and particularly monitored it after the Medicare physician fee schedule was implemented. While there may be long-standing differences in use among groups or areas, and while there may be problems with access in particular areas or specialties, we and PPRC have found no overall problems with access to care. In 1996, 96 percent of physicians reported having some Medicare patients. And in 1996, of physicians who treated Medicare patients, assignment was accepted for 96 percent of the dollar value of services, meaning physicians were willing to accept Medicare payment rates as payment-in-full. If the concern is that Medicare does not compensate physicians fairly, then we should work together to address that problem. We should not place beneficiaries in situations where they have to renounce the Medicare coverage for which they have paid in order to obtain a service.

Like Social Security, Medicare has been enormously successful. It has literally changed what it means to be old or disabled in America, moving millions of older people out of poverty and alleviating their fears that a medical crisis would lead to financial devastation. And one of the reasons it has been so successful is because it treats everyone the same—all Medicare beneficiaries can get the medical care they need and have earned, regardless of ability to pay.

The new proposal would allow certain physicians to provide preferential treatment to higher income and middle-income Medicare beneficiaries because they could pay out of their own pockets for services. This would undermine Medicare as a social insurance program and turn it into a program with two classes of care. In some areas or some specialties, it might become difficult for low income beneficiaries to receive access to care.

CONCLUSION

The private contracting issue requires a balance between allowing physicians increased flexibility to charge higher fees and protecting Medicare beneficiaries. The Administration opposed the original private contract provision in the Senate bill, but agreed to the Balanced Budget Act provision because it appeared to strike an acceptable balance between the two objectives. We have carefully studied S. 1194 and evaluated it against the principles outlined earlier in my testimony. I have also discussed these issues with Members of Congress, physicians, and with beneficiaries. While I know that the sponsors of S. 1194 are sincere in wanting to improve upon the Balanced Budget Act, I do not believe that S. 1194 achieves that goal and therefore cannot support a change in the law.

Questions asked by Senator Roth:

Q: Can you tell me how many physicians limit the number of Medicare patients in their practices, and in what areas of the country Medicare patients have problems in gaining access to doctors?

Answer: The Physician Payment Review Commission (PPRC) financed a survey of physicians, conducted during late 1993 and early 1994, which included questions about acceptance of new patients. The survey found that 95% of physicians accepting new patients accept new Medicare patients. We plan to collect more recent data on physician acceptance of Medicare patients.

PPRC also attempted to identify areas of the country where Medicare beneficiaries might have problems in gaining access to doctors. In their 1996 report on Monitoring Access of Medicare Beneficiaries, PPRC reported a number of reasons why it is difficult to identify hotspots of access problems, including the large number of beneficiaries from whom data need to be collected to detect even minimal access problems, since beneficiaries generally have good access to care, and the need to determine whether any access problems are unique to Medicare or are also experienced by persons covered by other payors. PPRC did conduct a pilot study in 16 areas which raised methodological issues that would need to be addressed in further work in this area. PPRC found that none of the areas with reported problems were statistically significantly different from a control group.

Q: Medicare patients who belong to HMOs can go out and pay for health services from their own pockets. Why should fee-for-service Medicare patients not have the same right?

Answer: We contacted staff at the Office of Personnel Management (OPM) and confirmed that the other indemnity plans in FEHB have similar requirements to Blue Cross Blue Shield Standard, i.e., that physicians who participate in the plan's program accept the plan's payment rates and beneficiary cost sharing provisions. Thus participating physicians may not enter into private contracts with plan enrollees. We also confirmed that that just like in Medicare, for non-covered services, physicians can charge whatever they want to for the services.

Question asked by Senator Mack:

Q: What percentage of a retiree's medical expenses are in the covered category?

Answer: Medicare pays about half of the total cost of beneficiaries' health care expenses (not including Medicare Part B premiums or private insurance/HMO premiums). Examples of services/items that Medicare does not cover include cosmetic surgery, hearing aids, routine physical examinations, outpatient prescription drugs, and long term nursing home care.

Questions for the Record from Senator Frank H. Murkowski
on
The "Private Contracting Hearing"
Before the
Senate Finance Committee
February 26, 1998

Q1: My interpretation of section #4507 of the 1997 Balanced Budget Act is that it will effectively prohibit seniors from going outside of the Medicare system for upgrading procedures that are covered by Medicare. For example, if a senior fell and broke his hip, Medicare only reimburses for the lowest-cost hip prosthesis. Since seniors cannot pay extra to upgrade, they must settle for lower quality. (Private contracting would enable them to opt for quality.)

Is this true, and, why is the federal government making that decision for seniors? If a 75-year-old woman in Fairbanks, Alaska, fell and hurt/broke her hip, do you think that your staff is competent enough to decide what hip prosthesis is best for her to gain the best mobility for the rough weather conditions of Fairbanks?

A1 Since Medicare rules do not apply to services that Medicare does not cover at all, a section 4507 private contract is not needed to bill for them, and neither the Medicare claims submission nor the Medicare limiting charges rules apply to these services. A private contract is needed only for Medicare-covered services and then only if the physician has opted-out.

A physician may furnish a covered service for which Medicare pays under some or many circumstances but for which payment would likely be denied, as not reasonable and necessary, by Medicare in a particular case. In that particular case, the physician should give the beneficiary an advance beneficiary notice (ABN) that states the service likely will not be paid for by Medicare and that the beneficiary will be liable to pay for the service if it is denied. If the claim is denied by Medicare, a private contract is not necessary to permit the physician to bill the beneficiary for that service. A hip prosthesis would be covered as a hospital service since it is implanted during an inpatient hospital stay and thus the hospital would choose the prosthesis.

Q2: Alaska has health care costs that are on average 70 percent higher than the rest of the country, we have physician shortages in two-thirds of the state and have no HMOs. All these factors combine to create a system where doctors

can't afford to treat Medicare patients--which means that patient choice for Alaskan seniors is extremely limited. I've received letters from Alaskans who have been turned down by three or four physicians--because the doctors cannot afford new Medicare patients.

Ms. DeParle, do you appreciate the fact that Section 4507 of the Budget virtually eliminates all seniors options in health care in Alaska?

A2. It seems that Section 4507 actually gives seniors more options. Prior to BBA, a physician had to bill Medicare for covered services provided to beneficiaries. Since BBA, a physician can opt-out of Medicare and provide all covered Medicare services to beneficiaries under private contracts without any limitation on what they can charge.

A beneficiary may choose, on a service-by-service basis, to see any physician whether the physician remains in, or opts out, of Medicare. In the former case, Medicare would pay for the services while the beneficiary would pay out of their own pocket for the services in the latter case.

Q3: **Let me further extrapolate this point on the difficulty of access to physicians in Alaska by quoting two letters from Alaskans. The first letter is from a Medicare recipient from Anchorage, Alaska:**

> **"...[A]s a senior in the Medicare system and a recovering heart patient I need the services of my Cardiologist to keep me alive and he does not take Medicare assignments and so I either have to find one that does--or do without medical attention specific to my problem. They (physicians) are not easy to find at this time and am not sure how many would even consider my case...It (Section 4705) is a bad piece of legislation."**

The second letter I quote is from a physician in a women's health clinic in Anchorage, Alaska to a current Medicare patient:

> **"This letter is written to regretfully inform you that as of February 1, 1998, I can no longer see you in my practice. For years Medicare has been under funded by the Federal Government and reimbursement has been roughly one-third of the reimbursement for private patients. This has been below my overhead of 50%; i.e., not only do I not get paid for seeing you, but I cannot meet the full expense of paying my nurses and office supplies by seeing Medicare patients...I enjoy taking care of**

mature women and have been willing to pay for the privilege, but recent changes have made this untenable. Medicare has just issued a 50-page booklet with new rules and regulations about what I, as a physician, need to document in history and the physical examination in order to be reimbursed. While I already do most of what they require, I find the burden of these new government regulations and interference with patient care unacceptable in a situation where I am essentially paying for the privilege of providing healthcare for mature women. Federal law precludes me from accepting you as a private patient if you have Medicare, or are Medicare eligible, so it is unfortunate there is no way I can see you in the future. This deeply saddens me, and believe me, your attendance in the office will be missed by both me and my staff. I only wish there were some way around this."

Ms. Min DeParle, do you understand that physician access *is* a problem for Medicare beneficiaries in Alaska?

A3: It is critical that Medicare beneficiaries in Alaska as well as in all other states maintain good access to care. The studies on Medicare beneficiary access to care that we and the Physician Payment Review Commission have conducted have generally found that beneficiaries have good access to care. In response to concerns that you and your colleagues have expressed, and to explore further whether earlier studies may have missed something, however, HCFA has embarked on a new project to study access to physicians' services. As part of this project, we expect to: expand the extent of the questions regarding access in our ongoing survey of Medicare beneficiaries, develop surveys of physicians to explore their willingness to serve Medicare beneficiaries, and extend our analyses of geographic variations in access to physicians' services.

One problem with private contracts as a solution to any access problems that might exist is that a private contract could actually exacerbate an access problem for the vast majority of beneficiaries who cannot afford to pay for services out of their own pocket. It appears that the beneficiary in the first letter that you quoted expresses a desire to find a cardiologist who accepts assignment. If that is the case, it is not clear that a private contract would be of assistance to that beneficiary because rather than having their financial liability limited to Medicare cost-sharing (as would happen if the physician accepts assignment) the beneficiary would have to pay for the entire service out of their own pocket under a private contract.

Q4: Don't you agree that the original intent of the 1965 Medicare statute is to

allow patient choice and patient freedom? Let me quote you Section 1801 of Title 18 of the Social Security Act (the Medicare section):

> **"Nothing in this title shall be construed to authorize any federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure or compensation of any officer or employee of any institution, agency or person providing health care..."**

A4: I believe that the private contract provision of Medicare is consistent with Section 1801 of the Social Security Act. A beneficiary has freedom to choose to see any physician regardless of whether the physician remains in, or opts out, of Medicare. The beneficiary can make this choice on a service-by-service basis.

Q5: Under what, if any, circumstances may a Medicare beneficiary refuse to authorize the release of medical information needed to submit a claim? Isn't private contracting needed to protect strict confidentiality for services Medicare covers?

A5: A beneficiary, for reasons of their own, may decline to authorize a physician to submit a claims or to furnish confidential medical information that is needed to submit a proper claim to Medicare. For example, a beneficiary may not want information about their mental illness or HIV/AIDS status to be disclosed to anyone. If the beneficiary does not sign the claim or otherwise authorize the claim submission, the physician would not submit the claim. I do not believe that private contracting is needed to protect confidentiality for services that Medicare covers.

PREPARED STATEMENT OF HON. RICHARD J. DURBIN

I would like to thank the Chairman of the Finance Committee, Senator Roth, for allowing me to testify today on this topic which I believe goes to the heart of what the Medicare Program really is and should be for all Americans.

Medicare program was set up in 1965 to provide all our seniors with the same access to quality medical services regardless of age, health status, or, most importantly, income. Over the years, Congress has added additional services and increased beneficiary protections against excessive or unexpected costs for Medicare-covered services. Since 1987 we have had caps on the amount that non-Medicare participating physicians can charge Medicare beneficiaries. OBRA-89 put further limits on the amounts physicians could bill beneficiaries. These consumer protections seek to shield beneficiaries from excessive out-of-pocket charges and provide a level of consistency as to what the charges will be. Any Medicare beneficiary may go to any doctor, and the costs that they incur for any given service will not vary greatly. This allows all beneficiaries to have the widest possible access to all the nation's doctors. Under this system, there are no monetary incentives for a doctor to treat one Medicare patient over another. The Medicare fee schedule is universally applied. Prior to the advent of "Private Contracting," rich and poor Medicare beneficiaries were treated the same and no one was shut out from seeing a doctor based on their inability to pay more than the Medicare fee schedule copay.

The truth of this statement is attested to by the American Medical Association's own estimates that 96% of doctors (excluding pediatricians and obstetricians or gynecologists) see Medicare patients. In fact the Physician Payment Review Commission (PPRC) in 1997 reported that the number of physicians willing to take Medicare claims on assignment—that is to take the Medicare fee schedule amount as payment in full—has increased to 78% in 1996 from 52% in 1992. 96% of all claims in 1996 were paid on assignment up from 70% in 1986.

The whole incentive structure that encourages doctors to participate in the Medicare program is based on all Medicare beneficiaries being treated equally. If a doctor wants to see anyone over the age of 65, the doctor will be paid according to the Medicare fee schedule for Medicare covered services. Since there are over 38 million Americans reliant on the Medicare program and many of them are increasingly in need of health care services either because they are disabled or are becoming older, this represents a significant portion of the population that might use a doctor's services.

"Private contracting" on the other hand, allows doctors to cherry pick for treatment those they believe they can charge more. What happens to those who cannot afford to pay more? Their access to care is restricted due to private contracting. If you are a senior living in a small rural town where there is only one doctor, what guarantees does "private contracting" give you that you will actually be able to see a doctor if you cannot afford to pay more ? In my state of Illinois, we produce the third greatest number of doctors through our many medical schools, yet we have the fourth highest number of underserved areas. Private contracting is likely to drain those areas even further of doctors who will shift to the more lucrative private contracting system if there are no limits on what a doctor can charge a senior. We are in danger of creating a two-tier system of care, where those living on modest incomes have less and less access to quality health care and quality health professionals.

Some have suggested that the Medicare Fee Schedule has constrained wealthy seniors from getting better care. However, there is very little data to suggest this is true. In fact quite the opposite would appear true from analysis by PPRC. PPRC is charged with monitoring beneficiaries access and financial liability under the Fee-for-Service Program. Part of PPRC's mandate includes assessing whether the Medicare Fee Schedule causes a barrier to accessing care. The reason for this mandated analysis arises from Medicare's major goal of improving all beneficiaries access to care and providing them with financial protection against excessive expenses. The Medicare Current Beneficiary Survey (MCBS) assesses whether beneficiaries report problems obtaining care or have become less satisfied with the care they received. Since the commission began monitoring access, it has consistently found that access has remained good for most beneficiaries. Any problems have been found to be unrelated to the fee schedule. That is not to say that all beneficiaries have equal access to care. African-Americans and those living in urban poverty areas continue to experience problems with access similar to the problems that they had prior to enactment of the fee schedule. The two reasons cited most for beneficiaries' inability to access care was their inability to make the copayments or lack of a family doctor. Those who were functionally disabled also had more difficulty accessing care. Finally those who could not afford supplemental insurance were more likely to go

without care. None of these groups would benefit from "private contracting." In fact, many of them already cannot afford the charges they incur which is why they are not getting necessary care. Elderly Americans spend nearly four times more out of pocket for health care than those under 65. Noninstitutionalized Medicare beneficiaries, on average, spent over $2600 for health care in 1996. On average, this represents 21% of all elderly's income. Those living at incomes near the poverty level spend on average, 31 % of their income on medical expenses. "Private contracting" asks seniors to pay more. There are no restrictions on it that would ensure it would only be applied to wealthy seniors. It merely encourages doctors to treat those who can afford to pay more.

The net result of "private contracting" is that it promotes health care rationing. Its proponents falsely charge that the current system produces rationing by government. Many of my constituents have been receiving a lot of false information in the mail that has scared them. These mailings have claimed that the government is preventing them from accessing necessary health care services. News articles have appeared that wrongly suggest that seniors are not allowed to purchase non-Medicare covered services with their own funds. They suggest that if Medicare believes a service is not medically necessary then a beneficiary will be prevented by the government from receiving that service. I think that we need to examine some of these claims and put the record straight through the hearing process. In truth, rather than the government rationing care, private contracting promotes rationing by doctors because those living on limited fixed incomes will not be able to afford to pay more. There will be strong monetary incentives for doctors to see private paying patients before or instead of those that cannot afford to pay as much. Yes that will be rationing, but it will be rationing by a private contracting system.

PREPARED STATEMENT OF J. EDWARD HILL, M.D.

Good morning. My name is J. Edward Hill, MD. I am a family physician from Tupelo, Mississippi, and a member of the American Medical Association's (AMA) Board of Trustees. On behalf of our 300,000 physician and medical student members, I would like to thank you for inviting the AMA to testify on private contracting in the Medicare program. There has been a great deal of confusion and controversy over this issue in recent months and the AMA appreciates this opportunity to set the record straight.

I. BACKGROUND

Private contracting is the term used to describe situations under which a physician and a patient agree not to submit a claim for a service which would otherwise be covered and paid for by Medicare. The Health Care Financing Administration (HCFA) has consistently interpreted governing Medicare law as requiring physicians to submit claims for all services on behalf of beneficiaries. Consequently, HCFA has taken the position that beneficiaries and physicians are prohibited from entering into such private contracts.

A 1992 court case, *Stewart v. Sullivan,* brought attention to the issue when a U.S. District Court Judge concluded that there was no law or Department of Health and Human Services (HHS) policy which restricted private contracting. The suit was dismissed because HCFA had not issued a specific policy regarding private contracting. While many concluded that the case allowed beneficiaries and physicians to enter into private contracts, HCFA remained firm that private contracting was not an acceptable practice.

Subsequently, HCFA issued Medicare Carriers Manual instructions (Sec. 3044) stating that "agreements with Medicare beneficiaries purportedly waiving Federal requirements have no legal force or effect." In addition, the instruction reads that "penalties may also be assessed for failing to submit a claim to the Medicare carrier on the beneficiary's behalf within 1 year of providing a service for which the beneficiary is entitled to receive payments from Medicare."

While HCFA officials have recently stated that physicians are not required to submit a claim to Medicare if the beneficiary refuses to authorize the claim (e.g. for mental illness or HIV/AIDS claims), there had not been any official written guidance on this issue until a question and answer document was issued just last month, and even that document is not clear on this issue. This is not an area in which physicians wish to take undue risks on HCFA policy since Medicare Carriers Manual instructions (§3314) state that physicians who fail to submit a claim "are subject to sanctions, including civil monetary penalties of up to $2,000 per violation and exclusion from the Medicare program."

The Balanced Budget Act of 1997 (BBA) attempted to remedy this confusion with a provision (Section 4507) that permits beneficiaries and physicians to enter into private contracts, if certain conditions are met. The private contracting provision was originally introduced as a floor amendment to the BBA offered by Senator Jon Kyl (R-AZ). However, due to opposition from the Administration, the conferees agreed to modify the provision to allow physicians to privately contract with beneficiaries only if the physician is willing to be locked out of the Medicare program for all Medicare beneficiaries for a two-year period. Because most physicians want to continue to take care of their Medicare patients—despite Medicare's low reimbursement rate—few physicians are likely to enter into private contracts under the BBA provision.

II. MEDICARE BENEFICIARY FREEDOM TO CONTRACT ACT

The Medicare Beneficiary Freedom to Contract Act (S. 1194 and H.R.2407), introduced by Senator Jon Kyl and Representatives Bill Archer (R-TX) and Bill Thomas (R-CA), would repeal the two-year opt out provision and allow seniors greater flexibility and freedom to see the physician of their choice. Opponents of the proposal have made a number of misleading allegations about the new legislation, and the AMA would like to take this opportunity to set the record straight.

Fiction: Private contracting will create a two-tiered system as physicians and more affluent elderly opt out of Medicare, leaving regular Medicare a welfare program for the elderly.

Facts: The Medicare system is already multi-tiered. For example, due to Medicare's hodgepodge payment rates to risk-based plans, some beneficiaries have access to much richer plans than others. In addition, for the poor elderly, access to services differs from state to state due primarily to variations in Medicaid payment rates. Congress, in the Balanced Budget Act, partially addressed the first of these problems with changes in the way risk-based payments are calculated. But the BBA actually worsened the second problem by gutting a provision requiring state Medicaid programs to pay the Medicare copayments for these dually-eligible beneficiaries. Ironically, the same groups now professing concern about two-tiered medicine declined to join the AMA in its unsuccessful battle against this misguided dual-eligibles provision.

Neither physicians nor patients are likely to make wide-scale use of private contracting, but the option will be important in certain circumstances. Experience with Medicare's risk-contracting program has shown that seniors are good health care bargain hunters. In today's competitive medical marketplace, those bargains will continue to exist and it is uncertain whether patients or physicians would use private contracting to any large degree. However, the popularity of point-of-service managed care plans has also shown that most people are willing to pay more for certain services in order to receive care from the physician of their choice. Some patients just entering Medicare might want to continue treatment with a physician who has chosen not to participate in the program, for example. Others, faced with a threatening medical condition may on a case-by-case basis wish to seek care from a recognized expert unwilling to accept any new Medicare patients.

A restructured private contracting option could actually encourage physicians to see more Medicare patients of all income levels. Medicare payment rates, which on average are about 30% lower than private plans, are expected to fall well below current rates over the next few years. As a result, physicians increasingly are being forced to either restrict the number of Medicare beneficiaries they take or to scale back services to these patients. The Budget Act's all-or-nothing approach does nothing to reverse the trend and could even worsen most beneficiaries' access to the highly-sought-after physicians most likely to engage in private contracting. However, a true private contracting option structured along the lines of the Kyl-Archer-Thomas legislation could improve access for all beneficiaries by enabling doctors to offset losses on some Medicare patients by charging others rates that more closely reflect their costs.

Fiction: Private contracting will result in confusion, double billing and outright fraud.

Facts: The Medicare Beneficiary Freedom to Contract Act includes important patient protections that would ensure that seniors understand the obligations they are entering into. Any private contract must clearly identify the professional services to be covered, and must be in writing and signed by the parties. The contract must indicate that the beneficiary agrees to be responsible for payment for the services, that neither party may submit a bill to Medicare, and that no balance billing limits will apply. The contract cannot cover services provided prior to the time it was en-

tered into. Nor can it cover treatment of an emergency medical condition unless the contract was entered into before the onset of the emergency condition.

Potentially fraudulent billing practices could be detected and punished through a combination of specific provisions in the bill, existing fraud and abuse laws and standard auditing procedures in Medicare and private plans. For example, the bill requires physicians to provide HCFA and risk-based Medicare plans with information to ensure that Medicare will make no payments for services provided under a private contract. Private plans could take action based on contracts which typically prohibit physicians in their networks from billing patients separately for services already covered by the plan's capitated rate. Moreover, even if the program did pay for services covered by the private contract, the patient would receive an explanation of Medicare benefits (EOMB) and thus alerted could notify Medicare's fraud hotline.

Fiction: If the Freedom to Contract Legislation is enacted, physicians will coerce many patients who cannot afford it to pay out-of-pocket for their care.

Fact: Both experience and logic suggest that physicians would not use private contracting to raise fees for patients who can't afford to contribute to the cost of their care. Moreover, any physicians engaging in coercive practices would run the risk of losing their medical license for ethical violations. Today, some Medicare carriers frequently deny the initial claim for some types of services on grounds that the service isn't covered by Medicare. Once Medicare has denied payment for these services, physicians can charge the patient. However, most resubmit the claim, going to considerable effort and expense to ensure that patients aren't forced to pay out-of-pocket for services that the program actually should have covered. There is no incentive for a physician to run up overhead costs by generating bills that cannot be collected. In fact, poor patients may gain greater access to care under the new legislation because selective use of private contracting may enable physicians to take on more undercompensated or uncompensated care.

III. CONCLUSION

The AMA strongly believes that every Medicare beneficiary should have the unrestricted right to spend his or her own money to purchase health care services outside of the Medicare program—just as every Member of Congress and federal employee has the option to contract privately for health care services outside of the Federal Employees Health Benefits Program. Seniors may choose to privately contract with a physician for a variety of reasons: to ensure privacy with respect to medical treatment; to continue seeing a physician outside of an HMO's closed panel; or to simply avoid government intrusion into their medical care.

The bottom line is this: Should patients, in consultation with their physicians, be allowed to make their own health care decisions? Or must bureaucrats protect patients from themselves and their doctors? In a country whose founding principle is individual liberty, the AMA believes the answer is clear. We urge the Committee to join the 47 Senate cosponsors in support of Senator Kyl's legislation, and to work for the enactment of this important patient choice legislation at the earliest possible opportunity.

PREPARED STATEMENT OF HON. JON KYL

Mr. Chairman Roth, thank you.

Mr. Chairman, and members of the Committee, thank you for the opportunity to testify in support of S. 1194, the Kyl-Archer Medicare Beneficiaries Freedom to Contract Act. S. 1194 now has 47 Senate cosponsors. The House companion bill—H.R. 2497, introduced by House Ways and Means Chairman Bill Archer—has 185 cosponsors.

Mr. Chairman, I also want to thank you for your leadership on this issue during debate on the Balanced Budget Act of 1997. Although more needs to be done, the act allows seniors to enter into private agreements with practitioners outside of Medicare. This change represents a modest but significant improvement over the Health Care Financing Administration's prior interpretation of the Medicare statute.

I thank, too, United Seniors Association, The Seniors Coalition, 60 Plus, and the American Medical Association, the American Association of Physicians and Surgeons, and the National Right to Life Committee, for their strong support of this legislation.

I also want to thank HCFA Administrator Nancy Ann Min De Parle and the American Association of Retired Persons for working in good faith with me to address many issues arising from this legislation.

Mr. Chairman, this legislation would protect the right of Medicare beneficiaries to be treated for Medicare -covered services by the physicians and practitioners of their choice outside Medicare, on a "case-by-case" and a "patient-by-patient" basis.

Essentially, this legislation would repeal the two-year exclusionary provision contained in the private contracting provision enacted as part of the Balanced Budget Act of 1997.

Mr. Chairman, the right of seniors to pay out of their own pocket for the health care of their choice is essential to our nation's concept of liberty. In fact, there is no more fundamental principle at stake in any legislative issue before us.

In his State of the Union address, President Clinton asserted that all Americans "should have the right to choose the doctor you want for the care you need." I could not agree more. But this is a right that most seniors do not have after the Balanced Budget Act became law.

Imagine if, on the day you turned 65, you went for a check-up to your doctor of 30 years. He tells you that she can no longer treat you. Amazed, you ask why, and he replies that, due to Medicare's paper work and regulatory burdens, as well as the system's low reimbursement rates, he can't afford to take any more Medicare patients.

You ask, "Can I just pay you out of my own pocket?" No, your doctor replies, "if I take your money, I could be fined, excluded from Medicare, or even criminally prosecuted for health-care fraud."

So you call HCFA and find out that your doctor is right: Once you turn 65, it's in effect Medicare or no care.

You wonder, how can this be true? How can it be illegal in America for seniors to choose to pay for their own health care?

Well, it is true. This actually happened to a friend of mine, Mary Ann Howard, in Prescott, Arizona. Through a flawed interpretation of the Medicare law, the government has prohibited Medicare beneficiaries from using their own money to go to the doctor of their choice for covered services.

Recent reports of the Physician Payment Review Commission may suggest a possible cause of the problem: Medicare's rates of reimbursement of physicians, which average roughly 71 percent of typical private reimbursement rates. In certain "hotspot" areas, this disparity may render physicians unable to accept additional Medicare patients and still cover their overhead and medical insurance. This limits the ability of many seniors to continue with the doctor or provider of their choice and to receive the quality of care they want to prevent and treat serious illness.

This also presents a serious limitation to those who may want to maintain strict confidentiality of all of their medical records by not filing claims with HCFA.

To remove this restriction, I introduced S. 1289 in the 104th Congress. This legislation sought to clarify that all Medicare Part B beneficiaries and providers could enter into private agreements for covered services on a "patient-by-patient" and a "case-by-case" basis.

To facilitate passage on the Senate floor, S. 1289 was modified to apply only to those providers who had never participated in Medicare, or those who, for an undetermined period, agreed not to participate in the system.

The Senate passed this provision as an amendment to the Balanced Budget Act of 1997. This was the version that survived a budget point of order challenge 64-35 on June 25, 1997, was then adopted by voice vote, and sent to the Conference Committee as part of the Balanced Budget Act.

But the administration threatened to veto the entire budget over this provision, and forced the Senate-House conferees to reluctantly accept a poison pill: In order to enter into a such voluntary private agreements under the so-called "compromise," a physician or other provider would have to sign out of Medicare for two years.

So, the two-year exclusion presents your doctor with a difficult choice: He can either treat you, his patient of 30 years, on a private contract basis, and drop his other Medicare patients for two years, or refuse to treat you in favor of his current Medicare patients.

Over 96 percent of doctors accept some Medicare patients and would not likely be willing to impose such a hardship on their current patients. So your options will likely be reduced.

To remove this limitation on patient choice, Chairman Archer and I introduced the Medicare Beneficiaries Freedom to Contract Act. The bill removes the two-year exclusion and ensures that any Medicare beneficiary can enter into an agreement with the provider of his or her own choice for any health-care service.

Opponents of the bill make three basic arguments: the bill will increase fraud, will put seniors at the mercy of doctors and other providers, and will hurt Medicare.

With respect to fraud, the bill contains extensive anti-fraud measures, including the requirement of a written contract with clear terms, such as the that fact that the service could be paid for by Medicare. Further, the agreement cannot be entered into when the beneficiary is experiencing a medical emergency.

Others believe that unethical doctors would take advantage of vulnerable seniors. Common experience with medical professionals who save lives without reimbursement in emergency situations, and seniors who read and question virtually every line in their Medicare bill, clearly refute this claim. Further, a senior can for any reason terminate the contract prospectively and return to Medicare for the covered benefit.

Some believe private contracting will destroy Medicare. However, private contracting will result in fewer claims being paid out of the near-bankrupt Medicare trust fund, while also creating greater health care choices for seniors. Further, the right to enter into these agreements has technically existed since the inception of Medicare in 1965—with no damage to the system.

We must not be the Congress that denies seniors the right to spend money they may have saved for years so that they could get a nationally- renowned surgeon for a procedure they or a loved one needs.

Also, imagine a law that made it illegal for seniors to supplement their Social Security check with private funds! Such a law would be met with derision and disbelief.

Sandra Butler, president of United Seniors Association, strongly supports this bill. Butler believes the government's view of private contracting "violates a basic—no, the basic -principle of American life: freedom."

Even Great Britain's notoriously inadequate system of socialized medicine gives its beneficiaries this freedom. Senators and their staffs have this freedom. Surely, America should do no less for its seniors.

Thank you, Mr. Chairman.

Prepared Statement of Hon. Daniel Patrick Moynihan

Mr. Chairman:

The issue of private contracting between Medicare beneficiaries and their doctors has generated much controversy, in part because it has not been clear under what circumstances private contracts are permitted. It is not well understood that there are no restrictions—and no need for a private contract—when a patient seeks a service not covered by Medicare, or when a patient wants to receive a service more frequently than is covered by Medicare. For example, Medicare will pay for an annual mammogram, but if a Medicare beneficiary would like the mammogram more often, she is free to pay for it outside of Medicare. This has always been the law and remains so today.

As we prepared for this hearing, it appeared to me that this subject was generating much disinformation. I therefore asked the General Accounting Office to review the accuracy of some of the information being circulated and "to clarify issues regarding beneficiaries' access to physicians and options for private contracts."

In its reply of February 23rd, the GAO wrote:

> . . . [M]uch of the information that we reviewed on this topic contained inaccurate statements or omitted important details. For example, several documents falsely claimed that the private contracting provisions of the Balanced Budget Act limit, rather than expand, beneficiaries' options for seeking care from physicians.

Mr. Chairman, I ask that the GAO letter be included in the record of today's hearing, and I hope our witnesses will shed additional light on this important subject, which is of genuine concern to many Americans.

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-279031

February 23, 1998

The Honorable Daniel Patrick Moynihan
Ranking Minority Member
Committee on Finance
United States Senate

Subject: Medicare: Clarification of Provisions Regarding Private Contracts Between Physicians and Beneficiaries

Dear Senator Moynihan:

The Balanced Budget Act of 1997[1] (BBA) provides for a dramatic expansion of health plan choices available to the 38 million Americans who depend on Medicare for health care coverage. Under the act's new Medicare+Choice program, beneficiaries will have new health plan options, including preferred provider organizations, provider-sponsored organizations, and private fee-for-service plans. Beneficiaries who remain in traditional fee-for-service Medicare also have a new option for obtaining services from physicians and some practitioners (in this correspondence, we refer to this group collectively as "physicians").[2] Section 4507 of the BBA permits beneficiaries to privately contract with physicians for services normally covered by Medicare. This could potentially enable beneficiaries to receive normally covered services from physicians who do not accept Medicare patients. Physicians set their own fees for services delivered under private contracts, and no claim is submitted to Medicare. Although any Medicare beneficiary can enter into a private contract under the provisions of section 4507, only physicians who agree not to submit any claims to Medicare for a 2-year period may do so.

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[1]P.L. 105-33.

[2]Physicians who may enter into private contracts under section 4507 are limited to doctors of medicine and doctors of osteopathy who are legally authorized to practice medicine by the state in which they practice. Practitioners who may enter into private contracts include physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical psychologists, and clinical social workers who are legally authorized to practice in the state and otherwise meet Medicare requirements.

Many are concerned, however, that the private contracting provisions included in section 4507 of the BBA are not well understood by beneficiaries. Because of the importance of the private contracting issue to Medicare beneficiaries and your concern about the possible spread of misinformation about it, you asked us to review information given to you about section 4507[3] and to clarify issues regarding beneficiaries' access to physicians and their options for private contracting. This correspondence responds to your request.

To address questions about access to physicians, we reviewed available reports from the Physician Payment Review Commission[4] (PPRC) and data from the American Medical Association (AMA). We discussed Medicare law and policies regarding private contracting with officials from the Health Care Financing Administration (HCFA)–the agency charged with administering the Medicare program. We also reviewed section 4507 of the BBA and relevant legal filings. We did our work from February 6 through February 20, 1998, in accordance with generally accepted government auditing standards.

In summary, the information available to us indicates that Medicare beneficiaries have ready access to physicians. Overall, about 96 percent of physicians accept and treat Medicare patients. While 4 percent of beneficiaries report difficulty obtaining physician care, the amount that Medicare reimburses physicians does not appear to be the cause of this difficulty. Medicare beneficiaries continue to be able to pay out of pocket whenever they do not want a claim submitted on their behalf or when they want to obtain services Medicare does not cover. In addition, section 4507 of the BBA offers beneficiaries a new option for obtaining services from physicians willing to enter into private contracts. However, much of the information that we reviewed on this topic contained inaccurate statements or omitted important details. For example, several documents falsely claimed that the private contracting provisions of the BBA limit, rather than expand, beneficiaries' options for seeking care from physicians.[5] Following are detailed answers to your specific questions.

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[3]The enclosure contains a list of documents we reviewed for accuracy.

[4]The Physician Payment Review Commission has merged with the Prospective Payment Assessment Commission into a new congressional advisory body known as the Medicare Payment Advisory Commission.

[5]Statements from United Seniors Association, Inc., documents and a Jan. 5, 1998, Wall Street Journal editorial.

1. What proportion of physicians serve Medicare beneficiaries? (Excluding categories of physicians such as obstetricians and pediatricians, who do not normally serve Medicare beneficiaries, what proportion of remaining physicians serve Medicare beneficiaries?)

Nearly all physicians treat Medicare patients and accept new patients covered by Medicare. Recent data from the AMA indicate that 96.2 percent of all nonfederal physicians (excluding residents and pediatricians, who do not normally serve Medicare patients) treated Medicare beneficiaries in 1996. Moreover, the percentage of physicians treating Medicare patients has increased–from 95.2 percent in 1995 and 94.2 percent in 1994–over the last 2 years. The AMA data do not indicate whether these physicians are accepting new Medicare patients. However, a 1994 survey of patient care physicians[6] commissioned by PPRC found that 95 percent of physicians accepted new fee-for-service Medicare patients.[7]

2. What proportion of Medicare beneficiaries report difficulty obtaining covered services from physicians?

According to recent reports from PPRC, "access for most [fee-for-service] beneficiaries remains excellent and . . . measures of access are essentially unchanged from previous years."[8] Approximately 10 to 12 percent of beneficiaries said they either had a medical problem but did not see a physician, had delayed care because of the cost, or were without a physician's care. However, only 4 percent of beneficiaries reported problems obtaining care when desired. An extremely small fraction (two-tenths of 1 percent) said they had problems getting care because they could not find a physician who would accept Medicare patients.

[6]The survey included primary care physicians and most specialists; it excluded anesthesiologists, pathologists, radiologists, nephrologists, and pediatricians.

[7]A National Opinion Research Center survey conducted for PPRC. The Center surveyed 1,000 patient care physicians about their experiences with Medicare and its fee schedule.

[8]The most recent PPRC report (1997) used data from the 1995 Medicare Current Beneficiary Survey (MCBS) to update PPRC's analyses of beneficiary access to physician services (Monitoring Access of Medicare Beneficiaries, No. 97-3 (Washington, D.C.: PPRC)).

Some groups of beneficiaries, however, experience more problems obtaining physician care than others. Beneficiaries who lack supplemental insurance are more likely to report access problems than other beneficiaries. African American and Hispanic beneficiaries and beneficiaries who are functionally disabled also report higher than average access problems.

Ease of access to physician services may also vary by geographic location. A 1995 PPRC report[9] identified seven locations where Medicare beneficiaries reported difficulty finding a physician at some point during the preceding year. Problems obtaining physician services in these areas were not necessarily unique to the Medicare population, however. In four of the seven areas, non-Medicare individuals also reported above average difficulty obtaining physician services. The report also notes that access problems are often temporary.

Although 7 percent of both the Medicare and the non-Medicare respondents said they had a problem with physician access at some point during the preceding year, only 1 percent reported having a problem at the time of the PPRC survey.[10] This result is consistent with an earlier PPRC conclusion that physician access problems are often due to temporary dislocations, such as those that occur when a beneficiary moves or his or her physician retires or dies.

3. Does the evidence indicate that low Medicare physician reimbursement rates are primarily responsible for beneficiaries' reported access problems? Please compare Medicare physician reimbursement rates with managed care reimbursement rates.

For the relatively few beneficiaries who reported access problems, Medicare reimbursement rates were not the primary reason. The 1996 PPRC report on Medicare access found "no systematic link between Medicare payment rates and access to care."[11] PPRC's analysis of 1994 beneficiary survey responses found that cost and transportation were the most commonly cited causes of

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[9] Identifying Hotspots of Poor Access to Care (Washington, D.C.: PPRC, Oct. 1995).

[10] The difference in the percentage of beneficiaries reporting access problems in the 1995 PPRC report and in later reports may be the result of differences in how the questions about access were asked.

[11] Monitoring Access of Medicare Beneficiaries, No. 96-1 (Washington, D.C.: PPRC, 1996).

physician access problems. Moreover, PPRC's analysis of 1992 through 1996 Medicare claims data revealed no changes in physician access that were clearly related to changes in Medicare's physician payment rates.

The 1996 PPRC report also suggests that "Medicare rates, while low by private standards, currently provide adequate financial compensation for physicians to serve Medicare patients." Although physicians are permitted to charge beneficiaries 15 percent more than Medicare's approved amount, nearly all physicians accept the Medicare approved amount as payment in full. In 1997, 98.5 percent of Medicare payments to physicians for covered services were for claims for which the physician accepted the Medicare-approved amount as payment in full.

PPRC found that the gap between Medicare rates and those of the average private payers narrowed between 1992 and 1996, the last year studied, and estimated the overall Medicare fee-for-service physician payment rate to be 71 percent of the private payment rate for 1996. The report cites higher Medicare payment rates combined with "rapidly falling inflation in private rates" as helping to close the gap. A number of factors were believed to have contributed to the decline in private rates, including competition among health plans, a surplus of physicians, and private payer adoption of payment policies similar to Medicare's. The report also noted that the gap between Medicare and private rates is much smaller for office visits and other primary care services than it is for tests and other procedures. Furthermore, the gap varies significantly among market areas and payers.

Data are not available to compare Medicare fee-for-service and managed care reimbursement rates for physicians. Health maintenance organization (HMO) payment rates are not directly comparable to Medicare payment rates or to those of other indemnity plans because managed care reimbursements to physicians may be based on other factors--such as physician performance and patient satisfaction--and may include additional payments such as bonuses. However, a 1995 report commissioned by PPRC found that a substantially higher proportion of physicians were willing to accept new Medicare fee-for-service patients (95 percent) than were willing to accept any new HMO patients (77 percent). Whether physicians' preference for fee-for-service patients is the result of relatively higher reimbursement rates or some other factors is unknown.

4. Under the private contracting provision in the Balanced Budget Act of 1997, can a physician serve a Medicare beneficiary but not bill the Medicare program? If so, under what conditions?

The BBA extended a new option to Medicare beneficiaries by permitting them to enter into private contracts with physicians for services normally covered by Medicare. Under section 4507 of the BBA, physicians who wish to enter into such contracts must first agree to "opt out" of the Medicare program for a 2-year period. During that period, physicians may not bill or receive payment from Medicare.[12] Physicians who opt out must do so completely. That is, they may not bill Medicare for some patients and enter into private contracts with others. In contrast, beneficiaries who sign private contracts do not leave the program. They may enter into private contracts with physicians who have opted out of the program and, at the same time, may receive Medicare coverage for services provided by physicians who remain in the program.

Beneficiaries who sign private contracts for physicians' services agree not to submit claims to Medicare for those services or to have them submitted on their behalf. Under the BBA's private contracting provisions, physicians set their own fees and are not bound by Medicare's limiting charge amounts. Beneficiaries are responsible for 100 percent of these physician fees. Also, because claims for these services are not submitted to Medicare, supplemental "Medigap" insurance covers no portion of the amount.

In addition to the private contracting option, there are a number of other situations in which physicians who remain in the program may legally serve Medicare beneficiaries without submitting a claim to Medicare. These situations–which also existed before the BBA's enactment–fall into one of two categories: (1) the beneficiary does not authorize the physician to submit the claim or (2) the services provided are not covered by Medicare. In either case, physicians need not opt out of the program and may continue to submit claims for other services and patients.

A beneficiary may choose not to authorize his or her physician to submit a claim to Medicare for payment for a covered service. 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

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[12]However, physicians who have opted out can submit Medicare claims for emergency care provided to beneficiaries with whom they have not contracted. In these cases, physicians may not charge beneficiaries more than the Medicare limiting amount and must submit the claims to Medicare on behalf of the beneficiaries. Medicare payment may be made to the beneficiaries for the covered services they received.

responsible for paying for the treatment up to the limiting charge. Although HCFA anticipates that this situation is most likely to arise when a beneficiary does not want to disclose sensitive information such as mental illness or human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) treatment, the beneficiary does not have to state a reason for withholding submission authorization. In such a case, the beneficiary can be enrolled in Medicare part B and the physician can receive Medicare payments for other services provided to that patient or other patients. If the beneficiary later changes his or her mind and asks the physician to submit the claim, the physician must comply.[13] The key differences between this arrangement and private contracting are that the action (refusing to authorize the claim's submission) must be initiated by the beneficiary, Medicare's limiting charge amounts still apply, and the beneficiary can later decide to submit the claim to Medicare.

Physicians need not opt out of the Medicare program to provide noncovered services to Medicare patients and bill patients for those services. Cosmetic surgery and routine physical exams are two examples of noncovered Medicare services. Physicians set their own fees for these services, and beneficiaries are fully-responsible for the charges.

Services may also be "noncovered" for particular individuals either because they choose not to enroll in Medicare part B or because they are enrolled in a capitated Medicare+Choice plan.[14] Although most eligible individuals choose to enroll in Medicare part B–a program that provides coverage for many physician services[15]–such enrollment is voluntary. An individual who does not want his or her physician services claims submitted to Medicare may decline or drop part B coverage. Another example of noncoverage is illustrated by beneficiaries who enroll in Medicare+Choice capitated plans. Because Medicare pays capitated plans a predetermined monthly amount for each enrollee,[16] such plans are required to provide all covered services. Enrollees

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[13]Claims must be submitted before the claims filing time limit expires–approximately 2 years from the date of the service.

[14]Currently, Medicare+Choice plans consist primarily of HMOs with Medicare risk contracts.

[15]Part B enrollees pay a monthly premium and are subject to coinsurance and deductibles.

[16]Enrollees may pay a monthly premium, copayments, and deductibles.

who seek care outside of their capitated plan without authorization from that plan are not eligible for Medicare reimbursement.[17] Physicians who treat such patients would be providing a "noncovered" service, could not submit a claim to Medicare, and do not have to opt out of the program.

Medicare beneficiaries always have the right to obtain treatment for services that Medicare deems not medically necessary. If the service is one that Medicare covers in some cases, the physician must submit the claim to Medicare. For example, Medicare covers mammograms, but does not pay for more than one mammogram in a 12-month period unless there are specific medical indications. However, any beneficiary who is willing to pay the cost may obtain mammograms more frequently. The physician is required to provide an Advance Beneficiary Notice (ABN) to the patient informing her that Medicare may deny the claims as medically unnecessary. Patients who sign the ABN are responsible for the charges for the tests if Medicare denies the claims.

5. <u>What was the law concerning private contracting before the Balanced Budget Act of 1997 was enacted?</u>

Before the enactment of the BBA, Medicare law did not expressly prohibit private contracting between physicians and beneficiaries. HCFA, however, took the position that private contracts for Medicare-covered services had no legal force or effect, because of statutory requirements that physicians abide by Medicare's charge limits and submit all authorized claims. That is also HCFA's position today. Unless private contracts are between a beneficiary and a physician who has formally opted out of Medicare for a 2-year period as required by the BBA, they are unenforceable. The exceptions to the bar on private contracting, which arise when the beneficiary declines to authorize the physician to submit the claim or when the claim is for a noncovered service, were also applicable before the enactment of the BBA.

6. <u>Please review the attached briefing materials, which have been provided to Members of Congress and their staffs. Please comment on inaccuracies contained in the material, if any.</u>

All of the documents you asked us to review contain inaccurate statements, omit important details, or both. (The enclosure lists the documents.) Many of

[17]Some health plans have "point of service" options that reimburse enrollees for some care obtained from nonplan providers. However, the reimbursement is from the health plan and not the Medicare program.

the documents falsely state that section 4507 prohibits Medicare beneficiaries from paying out of pocket for services that Medicare either does not cover or deems medically unnecessary. None of the documents mention that beneficiaries can refuse to authorize the submission of claims for covered services or discuss the impact private contracting has on other Medicare beneficiaries. Given the time constraints we had in responding, we did not analyze each statistic and sentence for accuracy. However, the following are examples of the most egregious cases of misinformation.

None of the documents mention that beneficiaries may decline to authorize physicians to submit claims to Medicare. Beneficiaries may withhold authorization for any reason, although they become fully responsible for the charges for the treatment. Such action does not constitute a private contract as defined under the BBA, and physician fees for these services are restricted by Medicare's limiting charge amounts. Also, none of the documents discuss the impact that a private contract between a physician and one Medicare beneficiary would have on that physician's other Medicare beneficiaries. Physicians who enter into any private contracts for Medicare-covered services agree not to submit any Medicare claims for a 2-year period. Other Medicare patients who wish to see that physician for covered services would need to enter into a private contract with that physician and may no longer have those services reimbursed by Medicare. Those patients may, of course, be reimbursed for services from physicians who have not opted out of the Medicare program.

Several documents inaccurately state that Medicare beneficiaries are prohibited from paying out of pocket for services Medicare does not cover. For example, a letter to beneficiaries from Americans Lobbying Against Rationing of Medical Care states "if Medicare says they won't pay for a medical need you have, you can't have it–even if you want to pay for it personally and even if you need it to save your life."[18] A Wall Street Journal editorial echoes the same misinformation: "If you feel you need a test–a CAT brain scan, for example–you will not be able to have it at your own expense."[19]

One document, the November 1997 United Seniors paper, "Health Care Freedom for Seniors: Medicare Private Contracting Examined," claims that Medicare beneficiaries are having increasing difficulty finding physicians willing

[18]Americans Lobbying Against Rationing of Medical Care (A.L.A.R.M.), which is affiliated with United Seniors Association, Inc.

[19]"Welcome to Section 4507" (Jan. 5, 1998), p. A-22.

to treat them. However, the accuracy of this statement is questionable because PPRC studies have found that access to physicians remains consistently high and AMA data indicate that a growing proportion of physicians treat Medicare patients.

Several statements in these documents that characterize the 1992 Stewart v. Sullivan case involving Medicare private contracting issues are misleading. United Seniors asserts that the court decided the legal issues in that case. In fact, however, the court dismissed the case as premature and never addressed its merits. HCFA's position was that these contracts had no legal force or effect. Although there was no express statutory prohibition against private contracts, HCFA cited statutory requirements for claims submission and charge limits as the basis for its position. With the exception of contracts expressly permitted by section 4507, HCFA's position regarding private contracts remains unchanged today.

AGENCY COMMENTS

In commenting on a draft of this correspondence, HCFA officials generally agreed with our findings and said that we had accurately represented the issues related to Medicare beneficiaries' access to physicians and provisions regarding private contracts between physicians and beneficiaries. They also made technical suggestions, which we incorporated where appropriate.

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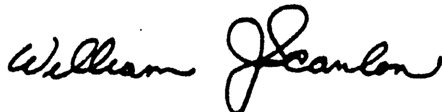
As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this correspondence until 6 days after the date of this letter. At that time, we will make copies available to others on request.

If you have questions about this correspondence, please contact me at (202) 512-7114 or James Cosgrove, Assistant Director, at (202) 512-7029. Other contributors include Keith Steck and Stefanie Weldon.

Sincerely yours,



William J. Scanlon
Director, Health Financing and
Systems Issues

Enclosure

DOCUMENTS AVAILABLE TO BENEFICIARIES ABOUT SECTION 4507

You gave us the following documents to review. These documents are grouped by source.

UNITED SENIORS ASSOCIATION, INC.

- Letter from Americans Lobbying Against Rationing of Medical Care (A.L.A.R.M.) and petition and contribution form, undated.
- "Talking Points on Private Contracting in Medicare," undated.
- Mission statement, adopted December 9, 1997.
- "Statement of Sandra L. Butler on Filing of United Seniors Association's Medicare Private Contracting Law Suit," December 30, 1997.
- Paper by Terree P. Wasley entitled "Health Care Freedom for Seniors: Medicare Private Contracting Examined," November 1997.
- "Answers to Frequently Asked Questions About Private Contracting in Medicare," November 1997.
- Packet entitled "Articles and Information on Medicare Private Contracting," undated.

KENT MASTERSON BROWN, ATTORNEY FOR UNITED SENIORS

- Undated statement announcing the filing of United Seniors' lawsuit challenging the constitutionality of section 4507 of the Balanced Budget Act of 1997, United Seniors Association, Inc., Toni Parsons, Peggy Sanborn, Ray Perry, and Margaret Perry v. Donna Shalala, Secretary of the U.S. Department of Health and Human Services.

AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP)

- "The Most Frequently Asked Questions About Physician Private Contracting in Medicare."
- "Medicare Physician Private Contracting, S.1194/H.R. 2497."

OTHER DOCUMENTS

- Wall Street Journal editorial entitled "Welcome to Section 4507," Jan. 5, 1998, p. A-22.

- Defendants' Memorandum of Points and Authorities in Opposition to Plaintiffs' Motion for a Preliminary Injunction and in Support of Defendants' Motion to Dismiss or, in the Alternative, for Summary Judgment," in response to United Seniors' lawsuit, United Seniors Association, Inc., Toni Parsons, Peggy Sanborn, Ray Perry, and Margaret Perry v. Donna Shalala, Secretary of the U.S. Department of Health and Human Services, undated.

(101711)

PREPARED STATEMENT OF HON. FRANK H. MURKOWSKI

Mr. Chairman, this past New Year rang in a harsh reality for senior citizens of America: As of January 1, 1998, senior citizens, for all practical purposes, have been stripped of a health care right afforded to any other insured American—the right to pay out-of-pocket for the doctor of their choice.

I am outraged over this provision—a provision that was added into the Balanced Budget Act of 1997 in the twelfth hour of negotiations between the White House and Congress.

The provision prohibits doctors who privately contract from treating Medicare patients for a period of two years. Therefore, it is now unlawful for a doctor to take a private payment from a Medicare patient if during the previous two years he has billed Medicare for any service rendered to a patient over the age of 65.

What is the reality of the provision?

- The reality is that it will be almost impossible for a senior citizen to contract privately for medical services because few or no physicians are going to be able to make ends meet if they can't accept Medicare patients for two years.
- The reality is that, unlike every other insured American, senior citizens have now lost a significant right—a right of choice in who provides their health care.

I am pleased that the Finance Committee is examining Senator's Kyl's legislation—I believe it is an important fix. The Medicare Beneficiary Freedom to Contract Act of 1997 will protect the right of the elderly to be treated by the physician of their choice. in brief, the bill will ensure that Medicare patients who choose to pay out of pocket will have an unrestricted right to health care—whether deemed necessary by Medicare or not.

The ability for a senior citizen to privately contract is magnified in Alaska. Alaska has no HMOs, physician shortages exist in two-thirds of the state and health care costs that are on average 70 percent higher than the rest of the country.

All these factors combine to create a system where doctors can't afford to treat Medicare patients—which means that patient choice for Alaskan seniors is extremely limited.

Mr. President, even in the socialized medical system of Great Britain, choice is offered to the elderly. In Great Britain, a senior citizen has the choice to pay privately for his or her medical services. Don't the elderly of America deserve that same choice?

PREPARED STATEMENT OF WILLIAM A. REYNOLDS, M.D.

My name is Dr. William A. Reynolds, and I practice internal medicine in Missoula, Montana. I currently serve as President of the American College of Physicians, which I am pleased to represent today. Our membership is comprised of nearly 100,000 doctors of internal medicine—internists—who are doctors for adults. I and my colleagues in internal medicine care for more Medicare patients than any other specialists; therefore, we have special concerns about Medicare and the patients and doctors who participate in the program.

The American College of Physicians values and supports Medicare's role as an affordable, widely accessible public insurance program. Choice, affordability, and access are generally working well in Medicare. Medicare patients have more choice—of both physicians and, with the BBA, soon of health plans—than most private sector patients. The data do not indicate an access problem in Medicare. The 1997 Annual Report to Congress of the Physician Payment Advisory Commission states: "Data from the 1995 MCBS (Medicare Current Beneficiary Survey) show that access for most beneficiaries remains excellent and that measures of access are essentially unchanged from previous years."[1] A 1994 Physician Payment Review Commission report found that physicians were accepting new Medicare patients at the same rate as under-65 patients. In the study, 96 percent of physicians were taking new Medicare patients compared with 97 percent taking new non-Medicare fee-for-service patients.[2]

We recognize that a small segment of the Medicare population may prefer to seek medical services outside of Medicare while remaining enrolled in Medicare Part B. Legislation proposed by Senator Kyl would allow that choice, but it raises a number of problems that must be addressed. The ACP is concerned that private contracting as proposed can: 1) create access problems where none existed, 2) increase administrative complexity for physicians, who will be struggling with billing errors and ad hoc income testing of their patients, and 3) produce conflict in the physician-patient relationship. We suggest several alternatives that would address the issues raised by the Kyl bill.

POTENTIAL FOR DECREASED ACCESS

Private contracting has the potential to decrease access for the majority of Medicare patients who cannot afford higher out-of-pocket costs. This could occur if many physicians in a community or geographic area accept Medicare patients only on a private contract basis. Data show that most Medicare beneficiaries are moderate to low-income individuals. They have little disposable income to pay higher medical bills. Seventy-one percent of Medicare beneficiaries live on an annual income (from all sources) of less than $25,000, and nearly one third (29%) of beneficiaries live on less than $10,000.[3] On average, the elderly spend 21% of their income on out-of-pocket medical expenses. For those living on incomes below 125% of the federal poverty guidelines, out-of-pocket medical costs take up nearly one third of their incomes.[4]

ADMINISTRATIVE COMPLEXITY

In addition to access, the ACP is very concerned about the administrative complexity and increased potential for billing errors created by the Kyl approach. For each private contract patient, physician offices would need to determine which services are billed to Medicare and which services are billed to the patient, and the information would have to be updated as the private contract changes. Physicians are already struggling to comply with overly burdensome Medicare documentation requirements. While acknowledging the need for proper documentation for billing, physicians are beginning to feel as if a simple coding mistake will result in severe penalties. Private contracting on a service-by-service basis can only increase the potential for billing mistakes, which has repercussions on the entire profession, not just those physicians who choose to take on the administrative burden of private contracting.

The bill as written requires provision of only minimal information necessary to prevent double payment for a service delivered under a private contract. The bill does not require that the names of providers, patients, and services be given to HCFA or a private contract patient's health plan. Inadvertently, Medicare or a point-of-service plan could be billed for a service already charged to the patient. Even if the specific information were provided, HCFA would have to match the information with claim filings—a burdensome and costly process. For these reasons, the Congressional Budget Office, in its review of the bill, underscored the difficulty HCFA would have in monitoring implementation.

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. In essence, plans can be paid for services they do not provide. In provider sponsored organizations, physicians could be paid twice under private contracting—once by the patient and once as part of the actuarially calculated capitated payment to the plan.

PHYSICIAN-PATIENT RELATIONSHIP

The American College of Physicians is also concerned about potential negative effects on the physician-patient relationship resulting from the Kyl bill. Confusion and conflict could easily develop over what services are considered covered in a private contract and what services are excluded because the scope of services needed can never be fully predicted. What happens, for example, when a physician believes a private contract patient having a physical exam needs some additional immediate service? Do the physician and patient then negotiate whether the additional service is part of the contract, right in the exam room? Should the decision to undergo the recommended intervention hinge on what the doctor will charge or whether the doctor will take Medicare's fee? This is an uncomfortable and time-consuming situation for both physicians and patients, and all the more difficult for elderly patients. The focus of the physician-patient encounter should be on healing. Moreover, patients who are charged for services they thought were covered by Medicare will take their complaints back to their physicians' offices, creating additional administrative burdens. And it won't stop there. Eventually, these complaints will find their way to your offices.

As defined in the Kyl bill, private contracting may interfere in the physician-patient relationship in other ways. Physicians will need to perform ad hoc income testing of their patients to determine who can afford private contracts. Government, not physicians, should bear the responsibility of income testing. Informal means testing conducted by physicians is inherently inaccurate. It is a burden on physicians. It

puts finances into the middle of the physician-patient relationship, invades patient privacy and may prevent some patients from voicing their financial concerns or even seeking treatment.

RECOMMENDATIONS

Because of the concerns outlined above, the ACP suggests other alternatives to addressing any remaining access problems in Medicare caused by inadequate physician payment rates.

First, if Medicare access problems develop, address the payment issue directly. One approach is to permit balance billing of those Medicare patients who can afford to pay a higher rate for physician services.

Currently, balance billing is limited by law to 15 percent of the Medicare allowable charge, which works out to only 9 percent above the Medicare fee schedule. Most physicians (78%) are participating providers; that is, they accept the Medicare fee schedule as payment in full and do no balance billing of patients. (The claims submitted by these physicians account for an even larger proportion of Medicare charges—92%. Additionally, non-participating providers submit some claims on assignment, so that 96% of all Medicare claims involve no balance billing.)[5]

Allowing limited additional balance billing of the wealthiest Medicare patients through uniform income-testing would protect access for moderate and low-income beneficiaries. It provides an incentive that will help meet the goal of the Kyl bill: to encourage more physicians to care for Medicare patients.

Selective balance billing would be relatively easy to administer in a system of income-tested premiums. The Senate's version of the Balanced Budget Act of 1997 included higher Part B premiums for wealthier beneficiaries. While the measure did not pass the House, it is likely to be considered by the National Bipartisan Commission on the Future of Medicare and serves as a starting point for evaluating patient ability to pay more of the physician's fee.

Any income threshold that triggers additional balance billing should be set high to ensure continued access to care. Caution is especially important in deciding costs at the point-of-service, since these costs impact directly on a patient's decision to get care. This means that the income threshold permitting balance billing may be higher than any threshold agreed on by the Commission or Congress to determine additional premium liability.

For physicians who choose to do so, balance billing limits would be raised for services provided to higher income beneficiaries. Balance billing information could be coded on Medicare cards, which would be used at the physician's office. Privacy would be protected since no conversation is necessary. Only the billing clerk would need to handle the information. Annual income testing for premiums or balance billing would require the annual issuance of new Medicare cards for those patients experiencing income changes. While this presents an additional burden on Medicare, it appears to be an unavoidable direction; the advent of open enrollment periods for the new Medicare managed care choices authorized by the BBA will also mean yearly changes for many beneficiaries.

Second, the Health Care Financing Administration should inform patients who wish to establish private arrangements with physicians of the new private fee-for-service option established by the BBA as well as the medical savings account demonstration project.

A new Medicare option created by the BBA—private fee-for-service—might achieve some of the goals of the Kyl bill, especially freedom of choice, with fewer problems for traditional Medicare. Under this option, patients can join a private indemnity plan. Medicare will contribute the average annual per capita payment amount to these private indemnity plans, which can set their own coverage rules. The plans may charge patients any premium they are willing to pay, and the plans may reimburse physicians at any rate. Medicare balance billing rules apply, but they are based on the plan's actual reimbursement rate, not Medicare's allowable charge. If the market makes these plans viable, physicians will be able to see plan subscribers without having to 'opt out' of Medicare and engage only in private contracting.

Third, HCFA should better inform patients of their right to opt out of Part B and arrange their own private payment options.

Medicare-eligible patients do not have to enroll in Part B, and a small number do not enroll (about 7 percent). Patients who have strong feelings about government involvement in health care or are dissatisfied with Medicare for any other reason can opt out of Part B and make whatever private arrangements they wish. Patients

who do so can re-enroll with a premium surcharge. HCFA could to a better job of communicating this option.

Fourth, Medicare should require carriers to sponsor educational seminars, in conjunction with other organizations if desired, in which Medicare payment options and other carrier rules would be explained in plain language.

Many physicians (and patients) lack knowledge of existing payment rules and options under Medicare. For example, many physicians are unaware of the procedure for billing patients for services which may be considered medically unnecessary by the carrier; these physicians express the concern that if they disagree, provide the service, and then bill the patient, they are breaking Medicare rules.

With clearer information, confusion on these issues might have been avoided. Many have misunderstood the effects of the BBA. The limited private contracting provision in the Balanced Budget Act of 1997 allows physicians to continue billing patients directly for uncovered services and for services considered medically unnecessary by the carrier. In the latter case, the physician also submits an advance beneficiary notice signed by the patient and acknowledging the patient's liability for payment. Physicians who bill patients directly for these uncovered services remain in the Medicare program as usual, and no private contract is needed..

There is no official, systematic method for educating physicians and patients on Medicare payment and other rules. Periodic half-day seminars, with accompanying materials written in plain language, would go a long way toward clarifying confusion. Charging carriers with this responsibility is appropriate, since carriers apply Medicare rules. A public seminar format will lend consistency and accountability to carrier implementation of Medicare rules. A small, at-cost fee for such seminars, set by HCFA, would be appropriate.

Fifth, the National Bipartisan Commission on the Future of Medicare should examine the issue of private contracting and other Medicare structural issues.

Structural changes to Medicare should be considered in the context of full Medicare reform. Questions about the future of Medicare fee-for-service and managed care, the special needs of the Medicare population, how best to meet them, and how best to pay for them are all part of the larger issue of reform. With the creation of the bipartisan commission, Congress has a tremendous resource at its disposal. With so many unanswered questions about how private contracting would affect choice, affordability, access, and administrative and billing capacity, it makes sense to tread lightly as we make changes to Medicare.

CONCLUSION

As Medicare managed care grows along with concerns about quality, it is important that traditional fee-for-service remain a viable option for Medicare beneficiaries. Traditional Medicare serves as a both a refuge for beneficiaries and a competitive impetus for managed care plan performance. By increasing the cost and complexity of the traditional program, the Kyl bill's approach to private contracting may push more patients into managed care.

The administrative complexity of Medicare has increased substantially, and its effects on physician participation should be a concern to Congress. Our members are fearful that minor and inadvertent billing mistakes will lead to threatening Inspector General audits. Soon, physicians will have to comply with a new set of billing documentation requirements that are onerous and time-consuming. The billing complexities of private contracting would only add to an already overwhelming administrative burden.

Mr. Chairman, Congress has enacted important changes in the Medicare program. The new options allowed by the Balanced Budget Act provide opportunities for patients to seek care under a variety of financing arrangements and settings for the delivery of medical care. Alternatives such as medical savings accounts and private fee-for-service plans allow patients choice of physician and financial arrangements. It will be important to evaluate the effects of these changes over the next several years. We believe that the additional recommendations submitted by the American College of Physicians, along with new options allowed under Medicare, accomplish the goal which we all share: to provide choice and full access to medical care for the nation's senior citizens. We appreciate the opportunity to testify and look forward to working with this Committee to improve the Medicare program.

ENDNOTES

[1]: Physician Payment Review Commission, Annual Report to Congress, 1997, p. 304.

[2]: Physician Payment Review Commission, Annual Report to Congress, 1994, p. 334.
[3]: PPRC, 1997, p. 4.
[4]: PPRC, 1997, p. 5.
[5]: PPRC, 1997, p. 313.

PREPARED STATEMENT OF HON. JOHN D. ROCKEFELLER IV

Mr. Chairman and fellow members of the Senate Finance Committee, I know I do not need to impress on you the importance of our hearing today. We are addressing a bill that has major implications to the future direction of the Medicare program. It is our job to decide if the merits of the bill warrant the risks it portends.

A 15 year journey has led us here today.

In 1984 Medicare costs spiraled upward. Under the leadership of Senator Dole, Congress and President Reagan recognized the need to maintain the integrity of Medicare by keeping physician costs down.

In 1989, Senator Durenberger and I helped develop the Medicare fee schedule that remains in place today. That schedule has limited excess charges and reduced out-of-pocket costs to seniors by $2 billion a year, while actually increasing physician participation in the program.

Last year in the Balanced Budget Act we made a major revision to Medicare law to allow—for the first time—private contracting between a Medicare beneficiary and physician for services usually covered by Medicare. The Balanced Budget Act gave seniors a new choice but with protections built in to maintain affordability and access to care. Now we are asked to review a new proposal broadening the intent of that historic change.

Proponents of this new legislation argue that the bill is about increasing choice for seniors but it is really about eroding the choice that seniors already have. Medicare beneficiaries already have a vast choice of physicians—96% of all doctors participate in the Medicare program. I'm concerned the bill will result in fewer physicians willing to participate in Medicare. As a result, medical access may be reduced, Medicare beneficiaries may be forced to pay more for their health care, and society's health care costs will increase.

As found by the Physician Payment Review Commission, the main reason Medicare beneficiaries have trouble seeing a physician is the lack of funds for out-of-pocket expenses—not the lack of physicians willing to see them. We are now asked to look at a bill that potentially increases out-of-pocket expenses and jeopardizes the excellent physician access we have achieved to date.

For the first time in over 3 decades access to health care for seniors may again be predicated on their ability or inability to pay, not on their medical needs.

As enacted the Balanced Budget Act did what Senator Kyl asked us to do—it opened access for Medicare beneficiaries to care by the "9% of physicians" who in no way participated in Medicare. Importantly, we preserved without change, the ability for seniors to privately purchase, without the need of a contract, care not covered by Medicare.

Most physicians are honorable, honest, and caring professionals who give much of themselves to their patients. But I'm concerned S. 1194 would give physicians an unregulated liberty to ask beneficiaries to pay more than they can afford for the same basic service. In a rural setting like West Virginia, it takes just one or two physicians who see seniors only on a private contract basis to drastically reduce access to health care.

Mr. Chairman, I am glad we are here today addressing this very important issue. Right now, Medicare continues to offer seniors excellent access to physicians and at an affordable price. We cannot risk reducing access and increasing costs by hastily expanding private contracting without considering all the ramifications.

COMMUNICATIONS

STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

INTRODUCTION

The 85,000 member American Academy of Family Physicians is submitting this statement for the record of the Senate Finance Committee's February 26 hearing on S. 1194, the "Medicare Beneficiary Freedom to Contract Act of 1997," introduced by Senator Jon Kyl (R-AZ). This legislation addresses the issue of private contracting in the Medicare program, an issue of growing importance and confusion among patients and physicians alike. The Academy is eager to work with Senator Kyl and the committee staff to develop a private contracting policy that is fair and workable for patients and physicians. Towards this end, we appreciate the opportunity to provide the observations and recommendations in this statement.

A bitter debate has erupted over private contracting in the Medicare program. Supporters view this option as necessary to preserve access by the elderly and disabled to certain physicians, who do not take Medicare patients because of declining payment rates. According to data collected by the American Medical Association, Medicare fees on average are 30 percent lower than private fees, a fact lending some credence to the concerns of private contracting proponents. Supporters also believe that Medicare beneficiaries who prefer to opt out of the program completely from time to time ought to be free to do so. By contrast, the opponents of private contracting believe it will promote price gouging and cherry picking, leading to a two-tiered health care system. Somewhere between these diametrically opposed viewpoints there should be an acceptable and workable standard on private contracting.

BACKGROUND

The term "private contracting" itself refers to a situation in which a beneficiary pays for Medicare-covered health care services or items with his or her own resources instead of the physician submitting a claim for payment to the Medicare program. However, ever since enactment of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) that established the present Medicare physician fee schedule, physicians who provide covered services to beneficiaries must file a claim with the program and accept the program's limiting charge for the service (known as the balance billing limit).

Prior to enactment of the Balanced Budget Act of 1997 (P.L. 105-33), private contracting was of questionable legality. That is, the Health Care Financing Administration's interpretation of the Medicare statute was that when a physician provided a Medicare-covered service to a Medicare beneficiary, the physician must submit a claim to the program and be subject to all the applicable rules, including the limiting charge.

This interpretation was the subject of a lawsuit, *Stewart et al. v. Sullivan,* that went before the federal courts in 1991. In this case, a New Jersey physician and five of her Medicare patients challenged Medicare policy on this issue of private contracting. The U.S. District Court judge in the case dismissed it because HCFA had not given its policy on private contracting the force of regulation. In the Stewart opinion, the judge wrote "the Secretary [of Health and Human Services] has not promulgated any rules or regulations either formally or informally espousing the policy alleged by plaintiffs." The result was that both sides claimed victory. Advocates of private contracting argued that the court's decision upheld their right to enter into such contracts, since the court found nothing to expressly forbid them. HCFA, in turn, argued that because the case was dismissed, the question of the legality of private contracting was never settled, and as a result HCFA policy remained in effect.

In the ongoing debate over private contracting, some situations have become confused with private contracting. For example, the beneficiary who pays out of pocket

for services and items not covered by Medicare is not involved in private contracting and, in fact, would have no need to engage in private contracting. Family physicians are quite familiar with this particular situation because beneficiaries must use their own resources to pay for preventive health visits (CPT codes 99381-99387 for new patients and CPT codes 99391-99397 for established patients). Unfortunately, most preventive health care services are not covered by Medicare. Paying out of pocket is also allowed for services and items provided to patients who choose not to enroll in the Medicare Part B program that covers physicians' services. These two situations remain unchanged by the balanced budget law.

It is worth noting, however, that under current regulations a physician can obtain payment for a service when the question of whether Medicare will cover it is uncertain. In such cases, the physician can provide an enrollee with an "advanced beneficiary notice" stating that the service may not be covered by Medicare and that the enrollee will have to pay for it in full if Medicare does not pay the bill. Such a situation arises when, for example, an asymptomatic female beneficiary asks for a mammogram although she has already received the annual mammogram covered by Medicare. The physician must submit a claim despite the likelihood the claim will be denied on the grounds that the beneficiary already received the annual mammogram benefit and another one in the same year is medically unnecessary. The advanced beneficiary notice ensures that the physician will be paid for the service.

Further, there remain today certain situations in which patients do not have freedom of choice. The ability to enter into private contracts would be beneficial to them. For example, nearly 17 percent of family physicians do not participate in Medicare or accept Medicare patients in their practice. The long-time patient of such a physician must make a difficult decision upon turning age 65. The patient can either (1) choose not to enroll in Part B and personally pay for all of her physician services in order to continue seeing her family physician, or (2) enroll in Part B and begin seeing a new, participating physician so that Medicare pays substantially all of her doctor bills. The latter choice leads to a disruption in the continuum of care for the beneficiary. In addition, both of these choices have practical limitations rendering them inadequate to the beneficiary's needs. This is because some physicians cannot accept new Medicare patients, yet only four percent of the approximately 39 million beneficiaries forego Part B coverage in order to continue seeing a non-participating physician.

These problems illustrate some of the problems confronting beneficiaries when private contracting is not an option. Yet, we believe that people should be allowed to pay out of their own pockets for Medicare-covered health care services even if they are enrolled in Medicare. As a consequence, we believe the Medicare statute should be rewritten to permit private contracts between beneficiaries and physicians and, in this way, promote genuine freedom of choice in the Medicare program.

PRIVATE CONTRACTING AND THE BALANCED BUDGET ACT OF 1997

To firmly address the legal status of private contracting and to make the option widely available to patients and workable for physicians, the balanced budget law adopted last year includes a section on private contracts. In Section 4507 of the law, physicians are allowed to enter into these agreements with beneficiaries. Accordingly, physicians have been able since January 1 to contract with enrollees and set their own fees for services covered by Medicare.

The contracts must include certain provisions to be deemed valid. For instance, the contracts must clearly state that a patient has to pay the entire fee charged by a physician for services rendered, and that a physician may not submit a claim for these services to Medicare. The contracts must stipulate that Medicare's balance billing limits do not apply to services rendered. The contracts also must notify the beneficiary that he or she can still obtain health care services (even those covered in the private contract) from other health care professionals participating in Medicare. Further, contracts can not be signed in emergencies when beneficiaries may be unable to give full consideration to the terms. These requirements seem to respond fairly to the warning "caveat emptor" by offering protections for the beneficiary who may want to enter into a private contract.

However, an extremely controversial element of the new policy requires a physician to forfeit participation in the Medicare program for two years after entering a private contract even if the physician arranges a private contract with only one beneficiary. This two-year exclusion from Medicare participation is unreasonable. The consequence of the exclusion policy is that physicians must choose between providing services to Medicare Part B enrollees exclusively or else to those who choose private contracting, but the physician cannot provide health care services to both groups. This situation amounts to a limitation on health care services available to

the elderly and disabled. The practical implications of this provision render the private contracting section of the law so unreasonable that virtually no family physicians are expected to enter private contracts with beneficiaries. Although HCFA is unable to provide an accurate count of physicians entering private contracts until it issues quarterly reports, we expect that very few physicians will engage in private contracting because of the onerous two-year exclusion requirement.

We do not believe that limiting the ability to participate in private contracting in this manner was the original intent of Senator Kyl who, in fact, sought to include a much broader Medicare private contracting provision in the balanced budget law. Like the Senator, the Academy believes that Section 4507 does not offer adequate opportunities for physicians and beneficiaries to pursue private contracts, and that the law must be rewritten.

THE MEDICARE BENEFICIARY FREEDOM TO CONTRACT ACT OF 1997

Soon after the balanced budget law was enacted last year, Senator Kyl introduced S. 1194, the "Medicare Beneficiary Freedom to Contract Act of 1997." Representative Bill Archer (R-TX) introduced a companion measure, H.R. 2497, in the House.

The Kyl-Archer legislation would remedy the present law by removing the two-year exclusionary period and clarifying that any Medicare beneficiary can enter into an agreement with a physician of their choice for any health care service and for any length of time when they choose to pay for these services out of their own pocket. This legislation also stipulates contract provisions similar to those mandated in the budget law.

THE AAFP POSITION ON THE KYL-ARCHER BILL

The Academy believes that S. 1194 and H.R. 2497 represent a step in the right direction toward making the private contracting option a practical one for beneficiaries and physicians. However, the Academy cannot support the Kyl-Archer bill until five additional requirements are added, as listed below.

The contract must be written in "plain English" so that its terms and conditions are fairly stated and easily understood by beneficiaries. HCFA has a great deal of experience with developing standardized guidelines and even forms for a variety of Medicare program functions, including Medigap policies. This experience should be drawn upon in developing standards for private contracts, templates for the contracts, or actual contract forms. These standards and forms should, of course, be culturally sensitive and appropriate for use by all Medicare-eligible populations.

Physician fees must be disclosed to beneficiaries before they sign a private contract. It is especially important that beneficiaries have this information so that they can compare a physician's private fee to the Medicare payment for a service. In this way, patients would be informed about payment mechanisms and incentives in order to make an informed decision about their medical benefits. We believe that the disclosure of fees would justify a discontinuation of the balanced billing limit, which the Academy strongly opposes. Limiting charges unfairly constrain the reimbursement of primary care physicians and are unnecessary. If the payment rates posted by a physician are excessive or otherwise unreasonable, the market place will force the physician to make adjustments more effectively than an arbitrary billing limit set by Congress and HCFA.

For patients and physicians entering into private contracts, there must be an annual enrollment period. The purpose of the enrollment period is to ensure that physicians and patients enter into private contracts during a defined time period, rather than at the time a patient requires a particular service and may be particularly vulnerable. Any services not specified as covered by the private contract will be subject to Medicare payment and coverage policies during the following year.

There must be a ban against private contracting in situations where a physician is the only provider in a community of the services that would be covered by the contract. This safeguard is needed to ensure that beneficiaries are not forced to enter private contracts in order to readily obtain health care services, for example, in a health professions shortage area (HPSA). A December 31, 1997 report issued by the Bureau of Primary Health Care's Division of Shortage Designation shows there is a total of 2,737 primary medical HPSA areas, 981 dental HPSA areas and 583 mental health HPSA areas. Most of these shortage areas include rural communities. Nearly 5,400 additional primary care physicians are needed in the medical HPSA areas just to remove this particular shortage designation and 12,176 would be needed to achieve a target population-to-physician ratio of 2,000:1 for primary care physicians. Given that the elderly make up a larger proportion of the rural and underserved population and that Medicare assumes a greater role as the sole source of health care funding in these areas, an enrollee's ability to choose a physician in un-

derserved communities may be seriously hampered if the physician only delivered services through private contracts.

The Academy believes that family physicians should be aware of the availability and accessibility of health care services to the people of an area in which they practice and should participate in efforts to correct or prevent a decline in the availability and accessibility of services. Prohibiting private contracting by physicians who are the only providers of a particular service(s) is consistent with this policy of the Academy.

Physicians must not enter into private contracts with individuals who are dually eligible for Medicare and Medicaid coverage. This group includes Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs). These individuals are Medicare beneficiaries who are qualified to receive benefits through their state Medicaid programs because they qualify as categorically or medically needed. The Medicare program essentially is their primary insurer, and Medicaid is their secondary insurer. According to the 1997 Annual Report of the Physician Payment Review Commission, roughly 5.4 million people were enrolled in both Medicare and Medicaid in 1995. This translates into 15 percent of each program's enrollment being dually eligible. The Medicare Current Beneficiary Survey for 1995 shows that most dually eligible persons are female, nonwhite, disabled, functionally impaired, among the extremely old (85 years of age or older), and institutionalized. Their care is fragmented and costly. The potential for private contracting to disrupt the delivery of health care services for this vulnerable population is sufficient in this case for the Academy to oppose private contracting for this group.

These recommendations are consistent with the family physician's role as an advocate for a patient's interests in the health care system. It is our hope, therefore, to work closely with the sponsors of the Kyl-Archer legislation and committee staff to rewrite Medicare private contracting policy so that it includes the four recommendations noted above.

IMPLEMENTATION CONCERNS

Lawmakers should address HCFA's treatment of physicians who inadvertently submit a Medicare claim after opting out of the program. Carriers apparently have been told that when a physician who has opted out of Medicare submits a claim, this action automatically nullifies all private contracts for this physician and forces him or her to accept balance-billing limits for the remainder of the two-year opt out period. Human errors such as inadvertently submitting a claim for a service rendered under a private contract should not be punished in such a rigid and unreasonable fashion. Unless it can be proven that a physician "knowingly and willfully" submitted claims for services covered by a private contract, he or she should not be forced to accept balance billing limits and other program regulations for the remainder of the two-year opt out period. The Academy joins the American Medical Association on this issue in urging HCFA Administrator Nancy-Ann Min DeParle to immediately contact the carrier community and instruct them not to limit physician's charges for patients because of inadvertently submitted claims.

We have also learned from HCFA staff that some physicians are confused by the law's requirements for the filing of private contracting affidavits. Physicians are supposed to file these documents with their regional carrier but a number of the affidavits are instead arriving at HCFA headquarters and regional offices. HCFA should be asked to report to Congress on whether delays stemming from this confusion will place physicians in jeopardy because they may believe they are legitimately engaged in private contracting when, in fact, they may not yet be correctly recorded as doing so with their regional carrier.

CONCLUSION

The Academy believes that these recommendations for amending the Kyl-Archer legislation are reasonable and promote a Medicare private contracting policy that fairly balances the interests of patients and physicians alike. As long-standing supporters of universal coverage, we view the private contracting option as one that ultimately promotes genuine freedom of choice for beneficiaries and broader practice opportunities for family physicians. It is worth noting that even the British health care system permits its enrollees to privately contract for health care services. Therefore, it is possible for universal eligibility programs such as Medicare to include private contracting based on the Academy's recommendations. We are, consequently, very eager to work with Senator Kyl and the committee staff to draft a

private contracting bill and move it through the legislative process during this session.

STATEMENT OF THE AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS (AANS) AND THE CONGRESS OF NEUROLOGICAL SURGEONS (CNS)

The American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS), representing over 4,000 practicing neurosurgeons in the United States, thank the committee for this opportunity to share our views on the issue of Medicare Private Contracting. The AANS and CNS strongly endorse the "Medicare Beneficiary Freedom to Contract Act of 1997" (S. 1194) as introduced by Senator John Kyl. This legislation is a necessary technical correction to the private contracting provision passed in the Balanced Budget Act (BBA) of 1997, and the AANS and CNS commend the committee for convening a hearing on this important matter.

BACKGROUND

Under current law, balance billing limits prohibit physicians from billing Medicare more than 15% above the Medicare Fee Schedule. Physicians and beneficiaries have traditionally believed they were free to negotiate rates for certain services, rather than being locked into Medicare's fee limits. The AANS and CNS have long argued that such "private contacts" are permissible, as long as physicians do not submit a bill to Medicare for the services rendered.

In recent years, however, the Health Care Financing Administration (HCFA) has considered private fee arrangements for Medicare covered services illegal. HCFA has promulgated regulatory interpretations of Medicare law that provide for severe penalties if physicians do not submit all claims for "Medicare-eligible" patients. The requirement for submission of all claims effectively prohibits private contracting for Medicare patients. Although there was never a statutory prohibition on private contracting, Medicare carrier instructions indicated that private contracts had no legal force and pronounced penalties for physicians not submitting claims. These penalties include civil monetary fines of up to $2000 per violation, and potential exclusion from the Medicare program.

BALANCED BUDGET ACT OF 1997

Senator John Kyl offered a floor amendment to the Senate version of the Balanced Budget Act (BBA) of 1997 to clarify that patients have the right to privately contract with their physicians for Medicare covered services. That provision allowed Medicare beneficiaries to receive and pay for services outside of the Medicare payment system by negotiating private contracts with their physicians. Because the Administration opposed the provision, however, the conferees added language excluding physicians from the Medicare program for two years if they avail themselves of the private contracting option.

The AANS and CNS ardently believe that Medicare beneficiaries have the right to enter private contracts with their physicians for medical treatment. The two-year moratorium hinders use of the private contracting option for most physicians, and thus most Medicare patients. We strongly oppose the two year exclusion from Medicare for those physicians electing to privately contract with their Medicare patients. The two-year exclusion limits patient choice, while the original intent of the private contracting measure was to increase choice for Medicare beneficiaries. We believe that patients and physicians have the right to decide not to submit claims to Medicare for Medicare covered services if they decide the particular situation warrants such action.

BENEFICIARY FREEDOM TO CONTRACT ACT OF 1997

In September 1997, Senator Kyl introduced the Medicare Beneficiary Freedom To Contract Act of 1997 (S. 1194). This legislation would restore the original intent of the private contracting measure by repealing the two-year exclusion from Medicare. The bill allows private contracting on a patient-by-patient/service-by-service basis. Companion legislation (H.R. 2497) was introduced in the House of Representatives by Congressman Bill Archer. The AANS and CNS endorse both of these bills.

BENEFICIARY CHOICE IS FUNDAMENTAL

The government should not interfere when a patient seeks to receive medical services at their own expense. On rare occasions, a Medicare patient may wish to

privately contract with a physician to spend their own money rather than being restricted by the Medicare fee schedule. The intent of the original Kyl measure was to clarify an issue about which there had been considerable confusion. The result of the modified provision, however, has made matters worse. It is imperative that Medicare patients have the right to choose their physician, and to decide what care they need and how they will pay for it.

The private contracting provision is also inconsistent with the spirit of the Balanced Budget Act (BBA) as it relates to expanding choice for seniors. Congress recognized the importance of choice in the Medicare program by creating Medicare+Choice (Part C). Medicare Part C will allow beneficiaries to choose from many new options including managed care plans, provider sponsored organizations (PSOs), private fee for service plans and medical savings accounts (MSAs). We believe that the current private contracting provision is inconsistent with the intent of that legislation. The two-year exclusion from Medicare for physicians has the unfortunate result of restricting choice at a time when Congress sought to increase choices for Medicare beneficiaries.

WHY PRIVATE CONTRACTING?

There are several scenarios where private contracting is an important option.

1. *Physicians who have a limited Medicare patient load.* Some physician practices must limit their Medicare case mix to maintain the viability and quality of their practice. This is becoming more common as Medicare continues to lower reimbursement for physician services. Medicare rates are currently as much as 30% lower than private plans and will continue to fall dramatically over the next five years, particularly for neurosurgical and other surgical procedures, as other changes to the Medicare physician fee schedule are implemented.

2. *Physicians with special skills.* There are certain difficult procedures or services utilizing new technologies where particular physicians are specially trained and/or have developed specific skills related to particular diseases or ailments. Beneficiaries may wish to privately contract for the services of such physicians.

3. *Beneficiary access to current physician.* Because some physicians limit their Medicare patient load, those beneficiaries just entering the Medicare system may find that their personal physician may not be able to continue treating that patient. That patient may wish to privately contract with their personal physician to retain access to his/her services. Also, the movement to Medicare managed care may mean that many specialists will no longer be available, and beneficiaries may therefore want to privately contract for the services of those specialists.

ACCESS TO CARE

The Administration sought the two-year exclusion to keep physicians in the Medicare system. The current private contracting provision may actually limit access to those physicians who have "opted out" of the Medicare program because many beneficiaries may not be able to pay for those services. For example, a physician who has developed special skills for performing a difficult procedure or new technology will not likely have difficulty maintaining a practice without Medicare patients. These "high demand" physicians may opt out of Medicare leaving seniors with less access to such special procedures. Given a choice, these physicians would rather remain in the Medicare program. Based on the restrictions of the current law, however, they will likely choose the private patients. Private contracting on a case-by-case basis could actually increase access to care, because physicians would not be required to make this "all or nothing" choice.

THREAT OF A TWO-TIERED MEDICARE SYSTEM

Many organizations and individuals have expressed fear that private contracting will leave Medicare with a sicker patient load, driving up costs and premiums. However, senior citizens do not have to opt out of Medicare—they will likely do so just for certain services, remaining in Medicare for most of their care. Those beneficiaries entering into private contracts for these services will still pay the standard premium. This may actually save Medicare money as the program will not be responsible for the costs of these services, but will nevertheless be collecting the full premium from those beneficiaries.

BENEFICIARY PROTECTIONS

Some organizations and individuals have expressed concerns that seniors will be unaware of the increased costs they face under private contracting arrangements. The detailed requirements of the law, however, should allay these concerns. The

AANS and CNS believe there are adequate patient protections in Senator Kyl's legislation to ensure that seniors' freedom of choice will not leave them open to abusive and coercive practices. We strongly believe that the majority of physicians have the best interest of the patient in mind when deciding what services are needed and that such fears are unfounded.

S. 1194 includes patient protections that ensure seniors clearly understand the private contracting arrangement and require these agreements to be in writing, signed by both the physician and the patient. The bill includes specific requirements for the terms of such contracts and the conditions under which they can be signed. Private contracts may not be entered into for emergency services or for services provided prior to the date of the contract. The contracts must clearly provide a description of the services and the payment arrangement for those services. Finally, the contract must state that neither party will submit a claim to Medicare, and that balance billing limits do not apply.

FRAUD AND ABUSE

The Health and Human Services Inspector General (IG) is concerned that private contracting will open the door to fraud by giving physicians the opportunity to engage in double-billing, that is, billing the patient and the program. The AANS and CNS believe that the patient protections in the bill, Medicare's current auditing practices, and the current fraud and abuse laws are adequate safeguards against double-billing.

CONCLUSION

Medicare beneficiaries have a fundamental right to spend their health care dollars as they choose, without the federal government's interference. The "Medicare Beneficiary Freedom To Contract Act of 1997" is meant to ensure this right. The AANS and CNS urge the Congress to enact this bill so that all Medicare beneficiaries can have continued prompt access to high quality medical care, without unnecessary restriction.

Thank you for considering our views.

STATEMENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Introduction:

Mr. Chairman, this testimony is presented on behalf of the American Psychiatric Association (APA), the medical specialty society representing more than 42,000 psychiatric physicians nation-wide.

First, we wish to commend Senator Kyl for his determined advocacy to ensure that Medicare beneficiaries enjoy the same rights as other Americans, namely to freely choose their own physician (or other health professional) and—for whatever their personal reasons—to voluntarily and at their own initiative elect to go entirely outside the Medicare program for their health care services. We also commend Representative Archer for his foresight in introducing Medicare private contracting legislation in the House of Representatives. Let us begin by recalling the United States Supreme Court decision in *Jaffee v. Redmond:* "Effective psychotherapy depends upon an atmosphere of confidence and trust, and therefore the mere possibility of disclosure of confidential communications may impede development of the relationship necessary for successful treatment. . ."

We believe that the Kyl and Archer bills (S. 1194; H.R. 2497) deserve the strong support of both houses of Congress. The administrative complexities—and threats to a patient's medical records confidentiality—resulting from the unfortunate and regrettably ill-crafted "compromise" on Medicare private contracting enacted as part of the Balanced Budget of 1997 lead APA to urge that your Committee take prompt action to approve S. 1194.

APA's support for an explicit private contracting provision in the Medicare statute is long-standing. Our support stems from two main concerns:

- First, we believe that a private contract is the only means of assuring Medicare beneficiaries of absolute confidentiality in the provision of psychiatric (or other healthcare) treatment if they request such privacy.
- Second, we believe that the Federal Government should not deny any Medicare beneficiary the right—at his or her own election—to go outside the Medicare program via private contract for any personal reason.

Unfortunately, neither condition is met by the current Medicare statute (section 1802 of the Social Security Act as amended by section 4507 of the Balanced Budget Act of 1997, Public Law 105-33) or current Medicare administrative policy. The de-

bate over private contracting is not helped by the often-contradictory claims and counterclaims currently being made. In some instances, advocates of private contracting assert that the current private contract law have eliminated their rights under the status quo ante to enter into unfettered private contracts, while opponents have argued that "Section 4507) has gone too far in establishing a new right to private contracts. While we believe neither assertion is entirely correct, what is clear is that the confusing and contradictory patchwork of legislation, regulation, litigation, and public policy pronouncements relative to Medicare private contracting requires a definitive legislative response by the Congress to ensure a patient's right to protection of the confidentiality of his or her medical treatment.

Background:

We believe the Committee would be served by having a detailed exposition about contracting. The genesis of the debate over private contracts predates even the often-cited Stewart v. Sullivan case (1992), and is inextricably interwoven with underlying statutory requirements that physicians file claims on behalf of beneficiaries, as well as statutory provisions dealing with balance billing and charge limits. As you know, the judge in the *Stewart* case essentially held that the Department of Health and Human Services had not established clear policy on private contracts and that the plaintiffs' case was not ripe for judicial review at the time.

While it may be true in a technical sense that the Medicare statute's silence on private contracts could be read as "neutral" (i.e., neither expressly permitting nor expressly denying the legality of private contracts), the administrative policy set out by the U.S. Health Care Financing Administration (HCFA) for years has been that private contracts between physicians and beneficiaries for Medicare-covered services are either invalid or irrelevant or both. Unfortunately, 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.

As noted, the interest of the American Psychiatric Association in establishing clear and reasonable guidelines for the use of Medicare private contracts based on confidentiality concerns predates even the *Stewart* case. APA raised the issue in communications with HCFA in January, 1991. In a June 24, 1991, response to APA's inquiry, Max Buffington, Acting Director, Division of Carrier Procedures, stated that Medicare law "does not require that a physician submit a Medicare claim when the beneficiary, because of concern about confidentiality (or other concerns not arising from any pressure from the physician), does not wish a Medicare claim to be submitted. If a Medicare beneficiary does not wish to claim Medicare payment and agrees to assume liability for payment out-of-pocket, we do not believe a claim submission violation exists."

This is well and good, but the letter also stipulates that "if the beneficiary subsequently decides he/she wants to pursue Medicare payment for services received, the obligation of the physician or supplier to file a Part B claim would be reinstated at such a time. A violation occurs . . . when the service provider . . . fails to submit a Part B claim on (a patient's) behalf . . . within one year of providing a service." This scenario is at best administratively cumbersome and at worst raises the likelihood that a physician could be subject to sanctions because a patient (or the patient's family or legal representative) changes their mind about claims submission ex post facto.

Less than 6 months later, in a letter to the Medical Association of Georgia dated October 15, 1991, HCFA Administrator Gail R. Wilensky, Ph.D., states that "We are not aware of any instances where a patient has initiated agreements with a physician to the effect that Medicare will not be billed for the physicians' services. Further, such an agreement initiated by a physician would be invalid." Similarly, in a written response, dated December 22, 1992, to an article on the *Stewart* case in American Medical Association News, Kathleen A. Buto, Director of the Bureau of Policy Development, stated that, "Penalties (against physicians) may also be assessed for failing to submit a claim the Medicare carrier on the beneficiary's behalf within one year of providing a service for which the beneficiary is entitled to receive reimbursement from Medicare . . . application (of Medicare requirements) cannot be negotiated between a physician and his or her patient. Agreements with Medicare beneficiaries purportedly waiving Federal requirements have no legal force or effect; physicians who treat Medicare beneficiaries must comply with the law or be subject to Federal penalties."

Ms. Buto also noted in a memorandum to HCFA Regional Administrators dated July 28, 1993 (FQA-831), that with respect to physicians who require patients "to waive their rights to have their doctors submit their claims to Medicare and (obli-

gate) patients to pay privately for Medicare covered services . . . such waivers are invalid and will not protect physicians against civil sanctions if knowing, willful, and repeated violations by the physician for the claims submission or other Medicare requirements come to (HCFA's) attention."

A 1994 statement by HCFA Administrator Bruce Vladeck also stated "When physicians require Medicare Part B beneficiaries to enter into 'private contracts'—that is, individual agreements not to use their Medicare coverage—they are attempting to circumvent provisions of Medicare law designed to protect beneficiaries. That law requires that physicians submit claims on behalf of beneficiaries and that they limit their charges to beneficiaries. Violations of these requirements are subject to sanctions . . . Medicare does not recognize these private agreements as having any legal validity."

Most recently, in a 1996 memorandum to Medicare Associate Regional Administrators (FKA-53, February 27, 1996), Tom Ault, HCFA Director of the Bureau of Policy Development, stipulated that "nothing in the law exempts physicians from these requirements, or Medicare services from coverage, because physicians enter into private agreements with beneficiaries. Violations of these requirements may result in sanctions and/or exclusion from Medicare."

The memorandum goes on to state that "we will not pursue sanctions against the physician for not submitting the claim to Medicare . . . in the rare case in which the beneficiary . . . refuses to authorize submission of a claim . . ." but that, ". . . if the Part B beneficiary or his/her legal representative (in the case of death or incapacity) later requests that the physician submit a claim to Medicare, the physician must do so or be subject to the sanctions available under the law." This is hardly helpful policy, since it leaves the physician permanently open to the changing desires not just of the patient, but also of the patient's family and successors, and the patient's legal representative. This is simply not a viable policy.

Finally, with respect to confidentiality—the overarching concern of APA and our patients—we call to the Committee's attention a statement in an August 4, 1995 letter from Director Ault, which states in part that "It is conceivable that the medical records in connection with psychotherapy services for which no claim is filed may be needed in order for the carrier to determine whether and in what amount Medicare payment may be made for other psychotherapy services for which a claim is filed." We focus the Committee's attention to this confidentiality oxymoron as this statement completely undercuts any interest—however cursory—HCFA may have had in accommodating those who wished to preserve strict confidentiality of patient medical records in light of the mandatory claims filing requirement.

Section 4507 and Subsequent Carrier Instructions:

Thanks to the persistence and determination of Senator Kyl, the Congress approved a private contracting provision at section 4507 of the Balanced Budget Act of 1997. While we note that section 4507 is the first explicit statutory provision establishing the right of Medicare beneficiaries to enter into private contracts, the "compromise" embodied in the section—through no fault whatsoever of Senator Kyl's—is simply not a coherent, reasonable, or even viable provision.

As you know, as enacted, section 4507 would permit physicians and other health professionals to enter into private contracts for health care services with Medicare beneficiaries, provided that the physician or other health professional entering into such a private contract with a single Medicare beneficiary stipulates that he or she agrees not to submit to Medicare any claim for any item or service provided to any Medicare beneficiary for a period of two years from the effective date of the initial private contract.

The law also directs the Secretary to report to Congress by October 1, 1991 on the impact of private contracting; the specifics of the reporting requirement are so sweeping that we believe the requirement would require extensive violations of patient confidentiality.

HCFA has not yet issued any regulations to implement the private contracting law. Instead, HCFA has issued two instructions to Medicare carriers on how to implement the law. We acknowledge that HCFA has been left to its own devices on how to implement a severely flawed statute, but the instructions issued to date have raised as many questions as they have answered.

Mr. Chairman, this "compromise" on Medicare private contracting is the worst of all possible worlds. On the one hand, the mandatory two year "opt out" is ludicrous public policy on its face. For the sake of accommodating a request by a single Medicare beneficiary to enter into a private contract, a physician would be required to compel all his or her Medicare patients to enter into private contracts, or to seek treatment elsewhere. On the other, the extensive HHS reporting requirements

would completely undercut APA's primary objective of protecting absolute confidentiality of patient medical records.

Problems with Current Law, Regulation, and Carrier Instructions:

Both the law and the instructions on section 4507 and the still-standing HCFA policy on claims filing are fraught with problems. These include the following:

- Interference with continuity of treatment and patient care: By requiring an "all in or all out" decision by a physician, section 4507 undercuts a basic foundation of the therapeutic relationship between psychiatrist and patient, namely continuity of care. A psychiatrist would have to decide whether to give precedence to the request of a single Medicare patient to guarantee absolute preservation of confidentiality via private contract, or to other Medicare patients who wish to have claims filed on their behalf. If the former, patients could feel compelled to break treatment and seek it elsewhere, thus vitiating a long-standing therapeutic relationship to the potential detriment of patient health. If the latter, the express wishes of a patient relative to preservation of confidentiality would have to be disregarded.
- No guarantee of confidentiality under current HCFA claims filing policy: The August 4, 1995 letter from Director Ault stating that "medical records in connection with psychotherapy services for which no claim is filed may be needed in order for the carrier to determine whether and in what amount Medicare payment may be made for other psychotherapy services for which a claim is filed" renders any HCFA statement about confidentiality moot. HCFA's policy is clear: even where a patient requests that no claim be filed, HCFA reserves the right to go on a fishing expedition through these records for unrelated claims.
- No guarantee of confidentiality under section 4507: As noted above, section 4507 requires the Secretary of HHS to undertake reporting on "the fiscal impact of such (private) contracts on total Federal expenditures under title XVIII . . . and on out-of-pocket expenditures by Medicare beneficiaries . . . and . . . the quality of the health care services provided under such contracts . . ." It is impossible to envision how the Secretary would be able to fulfill these reporting requirements without major breaches of patient medical records confidentiality. How, for example, would the Secretary be able to report on the quality of health care services provided under private contracts without engaging in extensive contacts with patients receiving such care? Imagine, if you will, the reaction of Medicare beneficiaries who specifically directed their treating physicians to enter into private contracts precisely to ensure confidentiality when the HHS Inspector General or other Federal health official sends them a letter asking for specific comments on the care they have received under their supposedly confidential private contract.
- Adverse impact on beneficiaries: Section 4507's requirement that "if one, then all" services are provided under private contract and the rigid requirements of the two-year opt out are needlessly draconian and, as noted, force physicians to choose between the one and the many, and patients to choose between maintaining a long-standing relationship with a physician who has entered into a private contract and finding a compatible specialist who—thus far—has not. Worse, the "in or out" requirement raises the possibility that patients may find themselves repeatedly uprooted as one physician after another sequentially enters into private contracts. Perversely, the two-year opt out requirement seems guaranteed to result in the two-tiered medicine that opponents of private contracting decry.
- Extra-statutory provisions of the section 4507 manual instructions: The first set of HCFA instructions to carriers on section 4507—issued to coincide with the mailing by carriers of the annual "Dear Doctor" letter on Medicare participation—required participating physicians to terminate their participate agreements by February 2, 1998 before they could enter into any private contract. Failure to terminate a participation agreement by February 2 would bar the physician from entering into any private contract for calendar 1998. 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. While we welcome this change, we believe that any such limitation cannot be supported by the statute.
- No guarantee of protection even where physicians comply with instructions: APA has repeatedly sought to obtain from HCFA officially approved templates for the affidavit and private contracts required by the law and by the two sets

of carrier instructions issued to-date. No such templates have been forthcoming; we are advised that if they are produced, it will not be until Spring. While the instructions replicate the requirements for content of the affidavit and contract included in the statute, we believe there is considerable risk to physicians in the absence of any officially approved templates. What happens to physicians who make all reasonable efforts to comply with the instructions if subsequent instructions (or templates, if any) are issued?

- Confusing and contradictory information: We have been contacted by psychiatrists "in the field" who have received contradictory and in some cases flatly incorrect advice from their Medicare carriers. In one case, a psychiatrist in private practice in the Palo Alto area asked his carrier representative whether it was permissible for him to "opt out" in his private practice without affecting the services he provided at a community mental health center run by Stanford University. The clinic's billing officer and the supervisory medical officer at Stanford also made inquiries on our member's behalf. All were told by the carrier that the psychiatrist could opt out for his private practice without affecting the clinic "because of the group practice exemption" in the carrier instructions received from HCFA. This advice was, in fact, absolutely incorrect, since the group practice provision had no applicability in this case and the instructions elsewhere note that "in some instances an 'opt out' physician/practitioner may have a salary arrangement with a hospital or clinic . . . and may not directly submit bills for payment."
- Negative patient care and resident supervision impact: While our Palo Alto psychiatrist decided not to opt out in his private practice, this example highlights the pointless contradictions which flow from the policy. In this instance, the psychiatrist was providing a wide range of services through the 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. How are the needs of patients and medical residents met by this absurd policy?

Mr. Chairman, these are just some of the many problems we have identified with current law, current regulation, and current carrier guidelines.

APA Recommendations:

As noted at the outset, our primary concern is the protection of our patients confidential medical records. Nowhere is the need for privacy more clearly seen than in the psychiatrist-patient relationship, where the assurance of privacy is the foundation on which the therapeutic relationship is based. Let us recall again that the Supreme Court's 1996 *Jaffee v. Redmond* decision stated that "Effective psychotherapy depends upon an atmosphere of confidence and trust, and therefore the mere possibility of disclosure of confidential communications may impede development of the relationship necessary for successful treatment. . ."

While the lower court ruled that confidentiality could be breached if in the interests of justice the evidentiary needs for disclosure outweighed the patient's privacy interests, the Supreme Court overruled and said that "The balancing component implemented by the Court of Appeals is rejected, for it would eviscerate the effectiveness of the (patient-therapist) privilege by making it impossible for participants to predict whether their confidential conversations will be protected." That is the dilemma which an we believe and urge an effective private contracting law to resolve, namely that those Medicare beneficiaries for whom absolute confidentiality is the sine qua non of the therapeutic relationship should be able to know that entering into a private contract will clearly, and irrevocably meet their needs.

Sadly, the current morass surrounding this issue fails to address these concerns. Moreover, for those who remain skeptical in the wake of the thorough review of confidentiality-confounding statements presented in this testimony, we note that Medicare carriers are elsewhere taking actions which directly breach confidentiality in unprecedented ways.

In Massachusetts, for example, we are advised that the Medicare carrier has demanded the original case notes from a psychiatrist who filed claims using CPT Evaluation and Management codes. The chilling rationale for the request was that the carrier was conducting random surveys to see if selected physicians were complying with the new AMA/ HCFA documentation guidelines, even though enforcement of the guidelines has been delayed until July 1, 1998. Thus, a psychiatrist is being pressured to (improperly, we believe) disclose the most sensitive patient information in order to determine whether guidelines which are not now required to be used are being met.

With respect to the general policy, we fail to see any convincing rationale for denying Medicare beneficiaries their basic rights to go outside their health insurer to seek treatment, at their own expense, when they freely elect to do so. As a general matter, we do not take so paternalistic and patronizing a view that seniors are incapable of being sound health care consumers; to the contrary, we find Medicare beneficiaries to be acutely aware of health care pricing. Thus we believe there is little evidence to support a contention that widespread price gouging will occur in the wake of a viable private contracting law.

Mr. Chairman, the APA urges your support for implementation of a sensible, rational Medicare private contracting law. As we have outlined in our testimony, the confusing and needlessly complex instructions flowing from section 4507, coupled with the adversarial and contradictory statements by various HCFA officials, lead APA to conclude that prompt legislative action is clearly needed and warranted.

As a matter of policy, APA supports a private contracting law which allows Medicare beneficiaries to enter into private contracts with any physician for the provision of any or all health services required by the beneficiary at any time without triggering any mandatory opt out requirement. This would allow those patients who—freely and of their own volition—wish to seek such private contracts to do so, while enabling those who do not to continue to have Medicare pay their bills directly. Further, those entering into private contracts should be assured that the confidentiality of such arrangements will not be breached.

Mr. Chairman, we commend you for calling these hearings, and again, we urge you to support enactment of a viable, rational Medicare private contracting law as embodied in the legislation sponsored by Senator Kyl and Representative Archer. Thank you for this opportunity to testify.

STATEMENT OF THE ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS (AAPS)

The Association of American Physicians and Surgeons, representing thousands of physicians in all practices and specialties, was established in 1943 to preserve the practice of private medicine. AAPS is dedicated to the Oath of Hippocrates and to protecting the sanctity of the patient-physician relationship.

I. INTRODUCTION

The right of senior citizens to use their own resources to obtain the medical treatment of their choice is one of the self-evident, unalienable rights recognized in the United States Declaration of Independence. If a citizen may not exercise the liberty to use his own property to protect his own life, then the government has violated his basic human rights.

Title XIII (Medicare) of the Social Security Act was passed as an entitlement to help senior citizens pay their medical bills, not as a barrier to private medical care. In order to administer the Medicare program and to protect the public Treasury against the burgeoning costs of this entitlement, Congress has passed certain laws, and the Health Care Financing Administration (HCFA) has implemented certain regulations. It is proper that these laws and regulations are triggered by the filing of a claim on the public Treasury. It should be self-evident that Medicare regulations do not apply to private medical care, that is, medical care that is not paid for by the federal government.

The stated purpose of S. 1194 could probably be achieved in a single line—*that the regulatory authority of the HCFA is restricted to medical services for which a HCFA form 1500 is filed and Medicare reimbursement is claimed.* We believe that its authority is already restricted by the U.S. Constitution, but such a statute would clarify the ambiguity resulting from Medicare carriers' publications and certain recent statutes.

We are opposed to S. 1194 in its current form because of a provision that would require patients and physicians to inform the federal government of all private medical transactions involving a person who, by reason of age or disability, has become eligible for Medicare Part A or Part B. The effect of S. 1194 would be the opposite of its stated purpose. Moreover, this provision is, in our view, unconstitutional.

Although the reporting provision has been referred to as the "Anti-Fraud Provision," it actually turns the entire law into the "Medicare Beneficiary's Restricted Freedom to Contract" Act. It is apparently introduced to appease those who believe that physicians are greedy and Medicare beneficiaries feeble and gullible.

An analogous law would be a Citizen's Right to Freedom of Speech Law providing that publishers may print and citizens may purchase written materials as long as they inform the government of each transaction, filing a form equivalent to the HCFA 1500 (which has name, address, Social Security number, diagnosis, and pro-

cedure codes) with officials believed to favor the Alien and Sedition Act passed during the administration of President John Adams. The reporting provision might be just as reasonably called an "Anti-Fraud Provision," based on the assumption that publishers are greedy and readers stupid and gullible.

2. BASIS FOR PRIVATE CONTRACTING IN THE LAW

Social Security Act of 1965

In addition to the U.S. Constitution, the foundation for the right to private contract is found in the statute that established Medicare:

- 1801. Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which Medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.
- 1802. Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.
- 1803. Nothing contained in this title shall be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against the cost of any health services.

These provisions were a promise to the American people. Without them, Medicare could never have been enacted. If they are effectively abrogated, then how can the American people place any faith in any promise made to them by the federal government?

Stewart v. Sullivan

In 1992, The Association of American Physicians and Surgeons initiated a lawsuit to establish the right to private contract. The case, *Stewart v. Sullivan* (816 F.Supp. 281 D.N.J. 1992), brought by five Medicare beneficiaries and their private physician, Dr. Lois Copeland, former president of AAPS, was vigorously contested by the Department of Health and Human Services.

Yet it was apparent that HHS did not want a Court to decide the constitutionality of a de facto ban on private contracting—U.S. attorneys made the remarkable statement in open court that they did not know the source of the statements by Medicare carriers that were chilling the exercise of this right. The Judge ruled that plaintiffs had not proved the existence of the alleged HHS policy and that the case was therefore not ripe.

Since the decision in this case, HHS has never, to our knowledge, made an unambiguous statement that senior citizens enrolled in Part B are forbidden to spend their own money to obtain a medical service that might be covered under Medicare, without filing a claim.

Numerous letters have queried the Department about this issue. Replies have been carefully worded, to the effect that the official "can't say that private contracting is legal." Generally, letters refer to a statutory obligation for physicians to file claims. Very often, physicians fear to serve Medicare beneficiaries as private patients because of such statements, even in the absence of a clear statement that private contracts are actually illegal.

3. HOW PRIVATE CONTRACTING PROTECTS PATIENTS

Private contracting improves access to medical care.

If senior citizens are forbidden to purchase medical services privately, then they are forced to depend solely on the federal government for needed medical care. If certain treatments are unavailable because of federal rationing (a consequence of price controls even if rationing is not explicit), then the citizen may lose his life or suffer avoidable pain and disability. Although it is claimed that most physicians are still serving Medicare beneficiaries, this is cold comfort to senior citizens if their doctor has retired early, closed his practice to Medicare recipients, has a three-month wait for an appointment, or can only afford to spend five minutes with them.

It is very difficult to measure such covert rationing. However, repeated AAPS surveys have shown that the majority of respondents restrict their Medicare practice in some way. Results of these surveys detail for the first time the impact of Medicare enforcement and regulations on patients' access to care. Some findings:

- Almost one-half (46%) report restricting services to Medicare patients;
- About 12% accept no new Medicare patients;
- 18% accept new Medicare patients only under special circumstances;

- Medicare pays only 50% of the doctors' actual fees;
- More than 56% report they lose money on Medicare patients because allowed fees do not cover overhead;
- More than one-third (37%) have had trouble finding referral physicians for their Medicare patients;
- More than 70% say they are considering early retirement.

Perhaps the most disturbing finding is that almost three-fourths (74%) of physicians who restrict services to Medicare patients do so because of "hassles and/or threats from Medicare" or fear of fines and prosecution by federal or state law enforcement agencies.

Physicians have traditionally been willing to care for patients who are unable to pay or are unable to pay the full fee. However, they do resent demands to work at their own expense for patients who are more affluent than they are. Moreover, if they are forbidden to collect a market price from those willing and able to pay it, they are less able to be generous with the poor.

Increasing numbers of physicians prefer to receive no payment at all rather than deal with the HCFA. And a majority of them (66%) would provide pro-bono care to Medicare patients if they could receive a tax deduction worth an average of 75% of the Medicare fee—in preference to filing a claim with the HCFA for the full amount allowed, at least for bills less than a few hundred dollars. In other words, the majority consider even the IRS to be less onerous than the HCFA.

Even patients who do NOT choose to exercise their private option receive the benefits of having it available. Those who do opt for private care relieve the burden on the federal Treasury; in fact, the tax revenues that fund Part B would increase. This will become increasingly important as the date of Medicare bankruptcy looms nearer. All senior citizens need the security of knowing that a private alternative is available if a financially constrained agency denies payment for a service they believe is worth paying for.

Private contracting protects patient privacy.

Some patients wish to contract privately simply because they do not want federal bureaucrats to have access to their medical records. Additionally, they may fear that the information may leak from the bureaucracy to other areas. Some have a realistic fear that knowledge of their condition may affect their employability or reputation. But all Americans have the right to consult a physician in confidence.

4. HOW THE REPORTING PROVISION IMPERILS PRIVATE CONTRACTING AND VIOLATES PATIENTS' RIGHTS

The bill as written requires that physicians who engage in private contracting provide HCFA with "the minimum information necessary to avoid any payment under part A or B for services covered under the contract." It has been suggested that this take the form of a "dummy claim" identical to the HCFA form 1500.

The requirement to file a HCFA form 1500 is likely to diminish the availability of services to senior citizens. In effect, a true private contract will no longer be available. The entire expensive and onerous burden of claims filing will be imposed although no benefit whatsoever is forthcoming. And of course the benefit of patient confidentiality will no longer exist.

The imposition of the reporting requirement discriminates against patients simply because of Medicare eligibility (age or disability) and American citizenship. (Aliens may see an American physician without the intrusion and oversight of the federal government.) Less obviously, it may discriminate against patients who have a medical need (as opposed to those who are receiving a noncovered service such as cosmetic surgery) or who have chosen not to enroll in a Medicare HMO (services outside the HMO are not covered).

The reporting requirement violates the rights of physicians by treating them as suspected criminals. The lawful act of providing a medical service to a patient without burdening the taxpayer subjects him to suspicion of trying to defraud Medicare. He must report an activity to which HCFA has repeatedly demonstrated its hostility, in effect inviting an audit, which is inevitably costly and vexatious.

The reporting requirement burdens both patients and physicians by imposing on them an additional cost.

Government requirements are generally defended by referring to a "balance" between public needs and private burdens. In this instance, the rationale is to deter fraudulent double billing. However, this rationale has no merit. The fraud against the taxpayers would lie in the filing of the claim for Medicare reimbursement, not in collecting the private payment. Yet the private payment is the one that invites the governmental scrutiny. And other mechanisms are more than adequate for detecting fraud. If the patient receives an Explanation of Medicare Benefits form, he

knows that a Medicare claim was filed. Patients who are intelligent and attentive—we believe the majority of Medicare beneficiaries—would react with outrage. The prospect of having even one such patient in his private practice should deter the most unscrupulous physician from "double-dipping."

The perils of this reporting requirement extend far beyond the Medicare program. It would establish a dangerous precedent for forcing citizens to report on a wide variety of lawful activities. If the government has the right or the need to know about a senior citizen consulting a doctor for arthritis, is there any personal action that should be immune from surveillance?

Indeed, one personal activity that should logically be next is the purchase of food and sundries by persons eligible for food stamps. The analogous provision would force grocery store owners to file a form with the federal government reporting all cash purchases by persons eligible to receive food stamps, whether they use them or not.

5. REMEDIES FOR FRAUD

The Medicare system promotes fraud in many ways: by encouraging "assignment of benefits" (paying the provider instead of the beneficiary); by encouraging electronic claims submission; by not requiring copayments for certain services (e.g., laboratory and home health services, which are not coincidentally the most commonly involved in large-scale fraud); and by not requiring an "Explanation of Medicare Benefits" (EOMB) form for all services.

Studies should be undertaken to identify the most common areas of fraud, specifically addressing the area of assigned vs. unassigned claims. Private companies have found that when fraud is suspected, a simple notice that the provider will no longer be paid on an assignment basis leads to an immediate end to suspect claims, saving millions of dollars. If providers fear that patients may pocket the insurance reimbursement without meeting their financial responsibilities, a dual-payee check could be used.

In summary, a serious effort to combat fraud, which would not violate the civil rights of patients or physicians, would involve the following:

1. Outlawing the assignment of benefits.
2. Requiring copayments on all types of services.
3. Requiring the carriers to send an EOMB for every claim.
4. Revising the EOMB so that a person of normal intelligence could understand it easily.
5. Reducing the huge volume of claims filed for trivial sums of money (thus reducing administrative costs as well as making it easier to detect fraud). Congress could repeal the requirement to file claims before the deductible is met and encourage the use of Medical Savings Accounts.

Suggested Alternative to the Reporting Provision

Instead of reporting all private contracts or filing "dummy claims," we suggest that the EOMB would be a much more effective mechanism for deterring and detecting fraud without violating patient privacy or increasing administrative costs to both physicians and the government.

The EOMB should include a plain-English explanation of services provided, and by whom, instead of just incomprehensible codes. Patients would be advised that if they have paid privately for any services which have been reimbursed by Medicare, that they should report it as potential fraud. The form could also include an 800 number for patients to call if they had a question or suspected fraud.

Simply, if a doctor tries to "double-dip" Medicare, the patient will have clear proof to provide to Medicare. An army of millions of seniors will be able to monitor potential fraud.

6. CONCLUSIONS

It is the basic right of senior citizens to receive and physicians to offer medical services without filing a Medicare claim whenever no Medicare reimbursement is to be claimed. Congress should repeal all laws that restrict that right, and HCFA should be restrained from actions that impede or deter the exercise of that right.

The right should not be further impaired by the unconstitutional burden of filing a "dummy claim" under the specious rationalization that this will deter fraud.

S. 1194 should be amended so that it accomplishes rather than destroys its stated purpose, and it should be passed in amended form.

Congress should seriously address the problem of fraud, which can be solved only by removing the incentives, not by impairing the civil rights of patients and physi-

cians or subjecting them to increasingly intrusive government surveillance of their private lives.

The Association of American Physicians and Surgeons is ready to work with Congress to achieve these goals.

STATEMENT OF THE CONSUMERS UNION

[SUBMITTED BY ADRIENNE MITCHEM, LEGISLATIVE COUNSEL]

Consumers Union (CU)[1], publisher of *Consumer Reports,* appreciates the opportunity to submit our testimony for the legislative record of the February 26, 1998 hearing on Medicare private contracts , specifically S. 1194, introduced by Senator Jon Kyl.

Consumers Union strongly opposes S. 1194. S. 1194 threatens to replace Medicare beneficiaries' freedom of choice of doctor and protection against excess charges with a system that reduces access to quality care, exposes seniors to surprise unrestricted medical bills, and introduces a new source of fraudulent practices into the Medicare program.

THE BACKGROUND

Before, Medicare, millions of our nation's elderly had no health insurance at all. Today, a full 99 percent of those who are 65 years or older have health insurance. That's a success.

Medicare already allows patients and providers to contract privately for services Medicare already covers, in the name of patient choice under the Balanced Budget Act of 1997. Any physician who enters a private contract with a Medicare patient must forego any reimbursement by Medicare for two years. This controversial provision resulted in new legislation proposed this year by Senator Jon Kyl and Representative Bill Archer (S. 1194 and H.R. 2497, respectively).

WHAT IS THE PROBLEM WITH THE PRIVATE CONTRACTING BILLS?

The private contracting bills (S. 1194 and H.R. 2497) threaten seniors with unpredictable increases in out-of-pocket costs by encouraging doctors to negotiate the price and terms (i.e., private or through Medicare) for individual services, escaping Medicare's limitations on fees for privately provided services. Currently, Medicare beneficiaries have the freedom to choose their own doctor; they are effectively protected against unlimited physician bills; and they are free to contract privately for services not offered under Medicare (e.g., prescription drugs, cosmetic surgery). S. 1194 and H.R. 2497 circumvent safeguards that were instituted to limit seniors' exposure to large out-of-pocket health care costs.

These financial protections are critical when weighed against the fact that two-thirds of this nations' seniors are living at or near the poverty line according to the Social Security Administration. A recent Consumers Union report, *Hidden From View—The Growing Burden of Health Care Costs,* showed that seniors already face a disproportionate health care burden. According to the report, 57 percent of households 65 years and older spend at least 10 percent of their income on out-of-pocket costs and premiums. Simply put, exposing the nation's seniors to more unmanageable health care expenses is not sound public policy.

WHY IS IT IMPORTANT TO PRESERVE THE CURRENT PAYMENT SYSTEM?

Curbing physician charges above Medicare-approved levels has been a remarkable success story. S. 1194 and H.R. 2497 would unravel this achievement. Only 70 percent of claims were paid on assignment (i.e., at Medicare-approved fee levels) in 1986, but in 1996, a full 96 percent of claims were paid on assignment according to the Physician Payment Review Commission. The non-partisan Congressional Budget Office (CBO) predicts, if approved, this legislation would "almost certainly" send national health care spending spiraling upwards.

In addition, the Congressional Budget Office predicts that this new proposal would lead to an explosion of new fraud when unethical doctors move to scam the system and double bill, collecting payments from both Medicare and the direct patient contract. And the new fraud could be coupled by a problem of other doctors fleeing the system altogether. If America embraces private contracting on a service-by-service basis, as proponents urge, the viability of the Medicare program is threatened because this fundamental shift sets up a "perverse incentive for physicians to avoid Medicare patients," according to the American College of Physicians.

CONCLUSION

Today, Medicare beneficiaries have the freedom to choose their own doctor; they are effectively protected against unlimited physician bills; and they are free to contract privately for services not offered under Medicare (e.g., prescription drugs, cosmetic surgery). The private contracting bills (S. 1194 and H.R. 2497) would harm the Medicare program by encouraging doctors to negotiate the price and terms (i.e., private or through Medicare) for individual services, escaping from Medicare's limitations on fees. The legislation would increase fraudulent double-billing (where doctors charge through Medicare AND for private payment). The bills would make it harder for Medicare enrollees to obtain the services of specialists (who prefer private patients) and it could limit access in geographic areas that have a limited numbers of providers. The private contracting proposal threatens to create a two-tier system that offers expensive care (not reimbursable under Medicare) for the rich, and less accessible care for the poor. In addition, it threatens Medicare beneficiaries with unexpected, not reimbursable medical expenses, possibly imposed on them in the middle of a course of treatment. It would unravel the success story of curbed physician fees under which 96 percent of Medicare claims are now paid on assignment (i.e., at Medicare-approved fee levels). Consequently, Consumers Union urges you and your colleagues to vote against S. 1194.

ADDITIONAL RESOURCES

"Hidden from View—The Growing Burden of Health Care Costs," Consumers Union, January 22, 1998.
"The Most Frequently asked Questions about Physician Private Contracting in Medicare," AARP, December 8, 1997.
"Medicare Physician Private Contracting S. 1194/H.R. 2497," AARP, Oct. 3, 1997.
"Revising Medicare," Washington Post, January 5, 1998.
"Backward Move on Medicare," Philip R. Lee, Washington Post, Nov. 5, 1997.
Letter from June E. O'Neill, Director, Congressional Budget Office to Honorable Bill Archer, Chairman, Committee on Ways and Means, U.S. House of Representatives, October 30, 1997.
Jennifer O'Sullivan, "Medicare: Private Contracts," CRS Report for Congress, October 21, 1997.
F.A.L.S.E. ALARM (Fooling Americans into Losing Senior Entitlements), Fact Sheet, Medicare Rights Center, January 21, 1998.
"The Truth About the New Medicare Private Contract Provisions," National Senior Citizens Law Center.
Letter from William A. Reynolds, M.D., President, American College of Physicians to the Honorable William v. Roth, Jr., Chairman, Senate Finance Committee, United States Senate, November 5, 1997.
"Monitoring the Financial Liability of Medicare Beneficiaries," Physician Payment Review Commission, No. 97-2, 1997.

ENDNOTES

[1]: Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance; and to initiate and cooperate with individual and group efforts to maintain and enhance the quality of life for consumers. Consumers Unions income is solely derived from the sale of Consumer Reports, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports with approximately 4.5 million paid circulation, regularly carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

STATEMENT OF THE COUNCIL FOR CITIZENS AGAINST GOVERNMENT WASTE

The Council for Citizens Against Government Waste is pleased to provide testimony on the need to repeal Section 4507 of the 1997 Balanced Budget Act.

Many believe that Section 4507 is somehow better than what existed before passage of the Balanced Budget Act and that prior to the BBA, seniors citizens were not allowed to privately contract with their doctors. We respectfully disagree. Kent Masterson Brown and the doctor and patients he represented in the 1992 case *Stewart v Sullivan* proved that there was nothing in the Medicare law that prevented

a beneficiary from entering into a private contract with their doctor for a medical service. In other words, the law was mute on the subject. With the passage of the Balanced Budget Act, Section 4507 now codifies for the first time that a Medicare beneficiary has the right to enter into a private contract BUT ONLY IF THE DOCTOR AGREES NOT TO ACCEPT PAYMENT FROM MEDICARE FOR TWO YEARS. So, while the Balanced Budget Act guarantees private contracting, it takes it away at the same time because very few doctors will choose not to participate in Medicare for two years.

At the end of last year, the Health Care Financing Administration sent out a fact sheet assuring providers that the new law only applies to Medicare covered services. What does this mean for a Medicare beneficiary? Here are some examples:

- Suppose a Medicare beneficiary is embarrassed or wants confidentiality about a medical condition and wants to personally pay for a service because he does not want any insurance accountants or government bureaucrats looking at his medical record or bill? Since about 95 percent of all physicians in the United States have Medicare patients, it will be difficult for the beneficiary to find a physician who either does not take Medicare patients at all or would be willing to give up all his Medicare patients to treat the patient's singular health problem. The patient is essentially out of luck.
- Suppose a Medicare beneficiary wants to go see a specialist about a health problem but that specialist is no longer taking any more Medicare patients. Even if the patient is willing to personally pay for the service out of her own pocket, she is out of luck. It is highly unlikely the specialist will treat her if it means losing the rest of his Medicare patients.
- Suppose a Medicare beneficiary is in an HMO and wants to see a physician outside of the network. The patient is willing to personally pay for the service since he is going out of the network. If the doctor takes his money, the doctor must refuse all Medicare payments for two years. The patient is essentially out of luck because it is highly unlikely the doctor will treat him.

If this is not bad enough, HCFA tries to assure providers that they don't have to worry about providing an "extra" service because the law does not apply in that scenario—as long as they follow the rules. The fact sheet states "a physician or practitioner may furnish a service that Medicare covers under some circumstances but which the physician anticipates would not be deemed 'reasonable and necessary' by Medicare in the particular case (e.g. multiple nursing home visits, some concurrent care services, two mammograms in a twelve month period, etc.) If the beneficiary receives an 'Advance Beneficiary Notice' that the service may not be covered by Medicare and that the beneficiary will have to pay for the service if it is denied by Medicare, a private contract is not necessary to bill the beneficiary if the claim is denied."

So now the doctor is in a guessing game with HCFA bureaucrats. With penalties of up to $10,000 hanging over their head, the doctor and patient relationship has been destroyed even further. The law says "any item or service." The fact sheet sent out by HCFA is based simply on guidelines. They are not regulations, they are not law and they can be changed tomorrow. The law creates a chilling effect and the real concern is what doctors and patients will do in the real world.

The Council for Citizens Against Government Waste finds it ironic that no similar restriction exists in any other government-run healthcare plan—not Medicaid, not the Indian Health Service, not the VA, not even the Federal Employees Health Benefit Plan (FEHBP) that covers Members of Congress and federal employees. We have a simple question for the Members of Congress, particularly those that are testifying here today in support of leaving Section 4507 as it is:

Suppose you want complete privacy when it comes to obtaining a health service, or for any other reason, want to go outside of your healthcare plan and personally pay for that medical service. Will your doctor be banned from providing service to other participants in the Federal Employees Health Benefit Plan if he provides that special service to you?

We ask HCFA Administrator Nancy Ann Min Deparle, who is also testifying today, can you go outside of the FEHBP and personally pay for a service if you choose? Will your doctor be banned from the plan if he provides the service?

CCAGW also asks the representative of AARP testifying here today. Can you go outside of your plan to get medical service for whatever reason you choose? Will your doctor be forbidden from providing service to other AARP employees if he helps you?

The answer in each case is no, yet this Congress has denied senior citizens this same right. Since the Contract With America is suppose to guarantee that any law passed by Congress should apply to Congress as well, we are wondering which mem-

ber of Congress will be brave enough to introduce a bill that puts the same restrictions on their healthcare plan as Section 4507?

We have notified our members, many of whom are 65 or older, about this issue and frankly, they are furious. They are enraged that this Congress passed a law that effectively denies them the ability to personally pay for a medical service. They are tired of the patronizing attitude that seems to be pervasive in Washington, DC—seniors are incapable of making wise decisions and doctors can't be trusted. They are horrified that Section 4507 takes away a basic Constitutional right. They are livid that as of January 1, 1998, citizens in Great Britain, even with their notorious socialized medicine, have more rights when it comes to healthcare choices then our seniors do. Britons can choose to "go private" for their medical care any time they choose. Not our senior citizens—they need to be baby-sat by Congress and HCFA bureaucrats.

Tens of thousands of CCAGW members have joined as citizen co-sponsors of the Medicare Beneficiary Freedom to Contract Act. This bill will once again return a basic right to our senior citizens.

Some say this issue is about selfish, money-grabbing doctors and has the potential for increased fraud. CCAGW, an organization that has taken the lead in fighting Medicare fraud, disagrees. The Kyl-Archer Bill provides more than adequate protection for patients and enforcement tools for the Health Care Financing Administration. Current law already exacts harsh penalties for Medicare fraud, including a $10,000 fine per incident and even expulsion from the Medicare program.

This battle is really about fighting government intrusion into private lives and restoring fundamental Constitutional rights of liberty and privacy to a certain group of Americans—the elderly—and allowing them to spend their own money anyway they choose. There are few things more sacred and private than the relationship that exists between a patient and their doctor. Section 4507 essentially destroys that relationship.

Some say repealing Section 4507 will disrupt the fiscal integrity of the Medicare program. CCAGW is at a loss on how senior citizens choosing to personally pay for a medical service out of their own pocket is going to disrupt a government-run program and hurt taxpayers. In fact, it will reduce the financial strain on Medicare.

Medicare is going broke and is in dire need of significant reforms before the baby boomers begin to use the program. Section 4507 is only one of the many things that needs to be fixed. Instead of putting more restrictions on our senior citizens, we suggest that Congress incorporate marketplace concepts to change Medicare and make it look more like their healthcare plan. After all, if it is good enough for them, why not our senior citizens?

STATEMENT OF HON. JERRY KLECZKA

Since the President signed the Balanced Budget Act into law this past summer, there has been a tremendous amount of misinformation circulating about so-called Medicare "private contracts." As of January 1, 1998, Medicare physicians and providers are allowed for the first time to contract privately with Medicare beneficiaries for Medicare-covered services and charge rates higher than the Medicare program allows. This provision was originally inserted in the budget bill by Sen. Jon Kyl, who indicated during Senate debate that he wanted to include this provision to ensure that the small percentage of physicians who do not participate in Medicare are able to serve Medicare-eligible patients privately outside of the program. No such provision was included in the House-passed version of this bill.

During negotiations on the final compromise budget package, a change was made to the original provision requiring physicians who enter into private contracts to forgo participation in the Medicare program for two years. In other words, the doctor must choose to either participate in Medicare and be subject to the program's charge limits, or initiate private contracts with patients and charge beneficiaries more than the fee schedule allows. Doctors cannot do both. This restriction was included to protect the program against fraud, guard against a massive exit of physicians from the program, and ensure that doctors would not create a two-tiered Medicare system—one waiting room for private pay patients who are served first, and one for non-private Medicare beneficiaries who are served last.

Now, legislation is pending in the House and the Senate to repeal the two-year limitation and allow every physician, not just those who do not participate in Medicare, to decide patient-by-patient and even procedure-by-procedure what will be paid by Medicare at its set rates and what will be paid privately at rates the doctor sets. Proponents of this legislation contend that private contracts do not force seniors to pay more for their care, they simply give seniors greater choice. The only "choice"

issue under private contracting is the choice of the doctor to refuse to accept senior citizens' Medicare insurance coverage as payment and force them to pay out of their own pocket at whatever rate the doctor sets.

Over 95% of providers accept Medicare patients today. Seniors can go to virtually any doctor in the country and get treatment under Medicare. Typically, Medicare beneficiaries have even more choices of doctors than many individuals do in the private insurance market. The suggestion by proponents of private contracting that Medicare beneficiaries are somehow being denied the care they need is just plain wrong. In fact, less than one percent of Medicare beneficiaries report trouble in finding a doctor to treat them. The truth is the Medicare system works. It provides all seniors access to the health care services they need and it fairly pays doctors for the services they provide.

Private contracting, by contrast, has the potential to create serious access problems for seniors who are financially unable to pay for services privately. Few seniors are financially able to give up their Medicare insurance coverage that they have paid for and instead pay 100 percent of all health care costs out of their own pocket year after year. I believe prohibiting private contracts outright is the only way to prevent Medicare from becoming a two-tiered system, where the elderly of modest means are forced to receive second rate medical care or bankrupt themselves and pay high prices under private contracts. It is not difficult to imagine a world where private contracts are widespread: patients with the private contract will get the best care first, and those who chose to remain in Medicare will be treated last, if at all.

That is why I have introduced legislation to repeal the so-called Kyl amendment contained in the Balanced Budget Act of 1997 and place an outright prohibition on any private contract for services currently covered by Medicare. This bill, H.R. 3126, the Medicare Preservation and Restoration Act will stop America's seniors from being forced to give up their Medicare coverage by doctors who refuse to treat Medicare-eligible patients. It will restore Medicare's balance billing limits and keeps doctors from charging whatever the market will bear for senior health care.

We must ask ourselves if we are going to continue to guarantee all seniors access to medical care at reasonable rates by preserving Medicare, or are we instead going to allow physicians to decide which seniors will have to pay for medical care when they need it the most at whatever rate the doctor sets.

SENATE FINANCE COMMITTEE
February 26, 1998

Testimony of William J. Rand, MD
Director, The Rand Eye Institute

On The Destruction of Medical Excellence In The United States

Every year, for the past 13 years, Medicare has reduced what it pays to physicians, effectively devaluing the insurance coverage that Medicare provides. Considering what government can afford to pay, the Medicare system will never be able to fund itself adequately to provide the best level of health care for every senior citizen. The problem is that current law prohibits any Medicare patient from voluntarily electing to contribute more towards his or her health care in order to find a better doctor or to obtain an additional level of care.

Because there is a severe limitation on the capital entering the system, there is no market for excellence in the profession. This will inevitably lead to the eradication of the professionally elite class of physicians and surgical specialists. These doctors were always dependent on revenue from patients who would seek them out, voluntarily paying more for their services. The additional level of reimbursement they received was generally accepted as being merited by the extraordinary level of care and the continuous stream of innovations that these elite doctors provided.

Unfortunately, we are now on the road to a devalued health care system that will be devoid of excellence and absent the accomplishments of these extraordinary individuals. America's seniors citizens are presently tied to the sinking ship of Medicare. If they would only be allowed to pay more when they believe it is in their best interest to so, then there can still be a market for excellence.

SENATE FINANCE COMMITTEE
February 26, 1998

Testimony of William J. Rand, MD

I have devoted the past 23 years of my life to the science and art of restoring lost vision. I am qualified to make this candid analysis because of my unique expertise. I am one of America's most experienced eye surgeons. I am an innovator in my field, an educator and the founder of one of the largest and finest eye centers in the country, the Rand Eye Institute. I have personally instructed thousands of eye surgeons with lectures and Academy presentations. Tens of thousands of eye surgeons from all over the world have studied my techniques through videotape presentations.

Cataract surgery is my specialty and the sight restoring surgical service, that I and my colleagues provide for senior citizens, is a vital public service that we provide at the Rand Eye Institute. We are one of the largest surgical centers in the country for cataract surgery. Our surgical division, The Rand Surgical Pavilion is a Joint Commission Accredited facility, certified with Commendation. This is equivalent to a five star rating in the Hotel industry. We provide the highest level of quality care that a patient could possibly hope to receive.

I know ophthalmology and cataract surgery as well as anyone. Because the Ophthalmology profession services primarily the senior citizen population, my observations may be relevant and to the point regarding how our current Medicare situation is leading towards the eventual destruction of the excellence in our medical system.

Modern cataract surgery is one of the great medical gifts of our time. Only a generation ago, in the early 1970's, millions of America's senior citizens experienced a life of cataract induced vision impairment. Even those who received the cataract surgery of the time, were left with impaired and distorted vision.

At that time, vision impairment from cataract imposed a major socioeconomic burden on our country, with millions of seniors afflicted with forced inactivity, lost productivity, premature senility and even institutional confinement, all because of cataracts.

That is the ophthalmology environment I found when I entered the profession of Ophthalmology in 1974. So much has changed in medicine since then.

In one of the most outstanding examples of medical progress, the science of cataract surgery was brought to a level of sophistication, unimaginable 20 years ago. Today's senior American thinks that cataract blindness is something out of the ancient past. Almost unaware of the difference between then and now, today's cataract patient expects that his or her vision will be restorable to near childhood levels. As a result of modern cataract surgery, in the 1990's, America's senior citizens remain engaged in active and productive lifestyles.

Cataract surgery, like all surgery, is performed when the quality of life is impaired enough to make it worth taking the risk of the surgery. Because the risk of cataract surgery is less and because the results are better, it is natural that an earlier decision for surgery is made. In 1970, we waited until the good eye was blind. Now we properly have cataract surgery when our lifestyle is impaired.

In most other parts of the world, cataract is still the leading cause of blindness. Here, in the United States, nearly 2,000,000 seniors enthusiastically elect to undergo sight restoring cataract surgery every year.

The return to an active lifestyle of so many senior citizens, and the boost to the whole economy occasioned by having so many millions of people able to pursue active and productive lives, represents a paradigm shift in the quality of life for the elderly American.

Can we ever calculate the value of the cataract procedure? What is the value to society of this miracle of modern medical science? Should we try to calculate a value based on how much time the doctor spends and how much he pays his receptionist? Can we put a value on the contribution made by a generation of ophthalmologists, who completely reinvented the cataract operation and then reeducated themselves to perform these better, but more complex and difficult operations? What is the value of the service that the modern eye surgeon provides? What is the value of the services of the cataract surgeon who can do the surgery better than almost everyone else in the profession?

Not everyone can be an eye surgeon. This is truly a specialized field requiring the utmost dexterity, talent, training and judgment. One false slip of an instrument or an inappropriate maneuver during surgery can mean blindness or impaired vision for life. What is the value of your life without your eyesight? What would you pay to have your eyesight restored? Ask a blind person!

Not every ophthalmologist can do cataract surgery well. Not every ophthalmologist can do cataract surgery at the highest level. The most advanced cataract procedures utilize small incisions without injections around the eye, allowing an instantaneous vision restoration with almost no pain or suffering associated. To achieve this requires extraordinary skill that can not be valued by time. Not every ophthalmologist can perform surgery at this level of expertise. Many eye surgeons are still injecting potentially dangerous anesthetic injection blocks around the eye where it can take hours or days for the eye to open. Many still use wide open incisions with stitches that delay healing and create vision distortion that lasts for months, even forever.

There is a wide span of quality differentials in the medical marketplace of ophthalmology. This is not surprising because every aspect of American life exhibits a variation in levels of quality. We traditionally value better quality things and better quality services at a higher level of reimbursement. This has always been the American way.

There are those who do not understand or who would misrepresent the complexity and skill that goes into the cataract operation. Today's most advanced cataract surgery is so good that may seem to be easy and even simplistic. The patients have no pain and they go right home after surgery, with good vision, hardly looking the image of someone who has undergone a major eye operation. Some non physician "experts" have indeed missed the whole point of medical progress and interested only in cost cutting, they have alleged that more is really less. For the first time in history, great operations are being trivialized because of the extraordinary excellence of it's most proficient surgeon practitioners. I wonder how they would value the game saving catches that Willie Mays made to appear to be so effortless.

Modern cataract surgery is an incredibly intricate and demanding operation, involving more delicate surgical manipulations and maneuvers than at any time in history. Most doctors take an hour or longer to perform cataract surgery, but some elite surgeons can do the operation in less than ten minutes. This shows clearly, that the value of the procedure to the patient and to society, has no relation to the time spent performing the operation. Should we pay the better surgeon less?

There does exist a class of elite surgeons who are the star athletes of the ophthalmology profession. Just as one would not want to trivialize the sport of basketball because of the ease and grace of Michael Jordan or Magic Johnson, one must avoid making inappropriate conclusions about the complexity of a surgical procedure because of the finely honed skills of the extraordinary surgeon. It is exactly this kind of misrepresentation of value that Medicare and it's statistical researchers have used against the ophthalmology profession in justifying and then setting arbitrary and absurdly low values for surgical services.

Can you imagine that it is illegal for a senior citizen to voluntarily pay more to get a better doctor to save his or her life or to save his or her eye? Do you think that all doctors are equal? Do you think that all doctors practice medicine with the same dedication to ongoing learning, and to the ongoing perfection of the art of healing? Do all doctors have the same inherent abilities?

How many times have I personally been responsible for saving or restoring the eyesight of someone who had already been to other licensed and competent doctors, whose expertise just was not sufficient to make the patient see? So many of my patients had been previously told that nothing could be done for them anywhere. Yet they sought me out because of my reputation. And I succeeded. Not once, not twice, but hundreds of times.

I have met with and discussed the health care issues of the times with many Senators, Congressmen and their staff aids. I know what has happened in Washington and what went on behind the scenes. I know how legislation is passed and how it is compromise amended, for better or worse.

Beginning with legislation in 1984, the medical profession has been targeted for cost reduction in a series of legislative actions. Dedicated physicians, people who have put their hearts and souls into the well being of the American public; people who have put in endless hours of learning and accomplishment, have been subjected to false and sometimes intentionally misleading statistical

analysis of fluky data, just to justify why their services are overpriced, so that arbitrary reimbursements reductions seem to be justified.

In every profession there is a top level, a middle level and a bottom level. What the government has done to health care is to take the bottom level and use it as it's tool for justification all that it has done. It has glorified the most mediocre elements of the medical profession by equalizing by law, the financial parameters in which all doctors must function.

The greatest and most catastrophic flaw is that they have completely forgotten about the cultivation of quality medicine and most particularly, the most elite groups. They have price fixed to the bottom and have left no market for excellence.

Within a very short period time, we will have permanently removed the ability for that excellence to be here in the future. Excellence requires the best equipment, the best facility, the most skilled supportive staff, all of which requires large capital expenditures and salaries which can not be fixed. Labor is one of the most expensive costs for a medical organization such as The Rand Eye Institute. And as one tries to keep it's best, that cost rises. All the while, our reimbursements are lowered. If one understands mathematics, it is a matter of time before the reimbursements will not cover the costs. We have reached this time now. Slowly but surely, the best are leaving the profession. There is a limit to how long the others can hold on.

Medicare is planning to again cut our surgical fees for all Medicare patients (those over 65 years of age). These fees are already arbitrarily cut down to 30% of our normal surgical fees. And now they want to save even more. Because most eye surgical patients are elderly, a good percentage of our patients are Medicare patients. Our surgical fees for Medicare patients are absolutely price controlled by law, and doctors are not allowed to charge the patient any part of past or future fee reductions, no matter how arbitrary they may be.

What is even more absurd is that I am prohibited by law from charging a penny more for my cataract surgery than even the most inexperienced beginner eye surgeon. I have a staff of 75 employees, but a doctor who rents a one room office from the local Lens Crafters optical shop in the shopping mall by law, receives exactly the same amount for his professional and surgical services.

Because of my unique surgical skills and international reputation, I have been sought out by many physicians, world leaders, and military, business, labor and religious leaders for sight restoring eye surgery. But according to the laws of this country, I must now provide cataract surgery to any Medicare patient, rich or poor, for $ 835 and this amount is scheduled to drop each year until the year 2001 when cataract surgery can cost no more than $565. This absurd amount includes all postoperative care and office visits for three months after surgery. I just went to the dentist and it cost more for a crown than for the cataract operation!

The government says that it is illegal for the doctor to accept more from a Medicare patient even if the patient wants to pay more. This absolutely limits the total amount of capital in the Medicare medical system with no possible avenue for additional funding. The fees are absurdly

low. The price is absolutely controlled. There is no additional avenue of revenue allowed. How can an additional level of care ever be provided? The answer is that it can not be. Therefore, there will be no place for people like me in the system and my patients will eventually be deprived of my care.

Who will build the next generation of beautiful new buildings and medical enterprises such as the Rand Eye Institute. Hundreds of future centers of professional excellence will never be built. Can you put a value on their lost contribution to society?

By what right does the government make it illegal to be reimbursed for the additional level of care that I provide, even if the patient wants it so? In a discussion with Senator Ron Wyden, years ago, he stated that it is logical that an additional level of care merits an additional level of reimbursement. The legal system allows it. Lawyers charge commensurate with skill and experience. People are glad to pay more for something they value more.

My son is diabetic. I am thankful that I can go to the best doctor, who I have sought out from among them all. And I am glad that he charges more than the average, because he deserves it. I am concerned that a system is developing where government thinks we can keep on getting the best care for less than it is worth.

On what basis does government deprive the system of adequate funding when there are willing patients, eager to obtain a better level of care? I am not saying that government should pay any part of the extra cost for a Medicare beneficiary receiving an additional level of care. But in the United States of America, the people have always had a choice to pursue something better, at their own expense. And government is denying them their right to seek out the best.

If we similarly price fixed ice cream so that all brands and qualities would have to sell for $1 a quart, how long do you think that premium brands would be in business? Ben and Jerry's and Haagen Daz would soon have to cut all their quality ingredients and reduce themselves to the lowest common denominator or go out of business. Is this to be the future for medicine? This is the road to quality oblivion and we have already set our course firmly in this direction. We must change our priorities now.

A return to historically normal balance billing practices and the removal of arbitrary and unnecessary price controls is the only hope for the salvation of our system of medical excellence. It is not something radical and unproven and it needs no defense or justification. It is the way Medicare functioned for 20 years, until it was amended in 1984. It simply involves the restoration of the American way of doing business and this way has always stood this country in good stead. Price controls failed dismally for Presidents Nixon and Carter. And they are now killing the medical system. Even the Russians have learned this lesson. Why do we persist in this folly?

Medicare can reimburse at any rate they choose. They do not need fluky schemes or ploys or trumped up studies to justify what they will pay. They can and should pay only what they can afford. But the system must be free to fund itself by voluntary patient contributions. Not

everyone would pay more, only the ones who want benefits and care that are beyond what the government can afford to pay for,

Government's reason for price controls, is ostensibly to keep Medicare solvent while simultaneously protecting the Medicare patient from increased costs as the government causes the Medicare entitlement to be devalued.

There is a true need for government to live within it's means and to contain it's expenditures. Perhaps we bit off more than we could chew, if we thought we could provide full health care coverage for all of the nation's senior citizens. It was certainly clear to everyone, in the early 1980's, that something had to be done. Medicare could not afford to continue to reimburse tors and other health care providers the same dollar amounts that at that time even Medicare sidered to be fair, reasonable and customary.

ne goal of the COBRA legislation of 1984 was to balance the Medicare budget. The proper and reasonable and legal course of action would have been for the people in charge of Medicare, to inform the public, "telling it like it is." They should have clearly stated that it was necessary to cut the value of the Medicare patient's medical insurance coverage. They should have instituted calculated percentage reductions as necessary, to reduce Medicare expenditures to balance the budget. This would have balanced the Medicare budget in one simple, direct and logical act.

The debate at that time, was that if government cut the value of the Medicare insurance benefit, and if the doctors were allowed to continue to charge the same professional fees, the senior citizens would have to pay more. Wouldn't this represent an unacceptable burden on seniors, because they would have to pay for the government's devaluation of their insurance coverage? And wouldn't the seniors be likely to vent their considerable voting wrath on congress for cutting their entitlement?

The truth is that most doctors would have continued to do business as usual. There is no shortage of doctors in this country. Most doctors would have continued to accept assignment, absorbing the reduction in fees. Some doctors would have maintained their same fees, and their patient's would have had to choose whether they were willing to pick up the difference. The patient could have decided to change to another doctor who would be accepting of the lower reimbursement if the patient did not want to pay more. Any patient could have found another doctor still willing to accept assignment or he or she could have chosen to enroll in an HMO plan and then pay nothing at all.

Whether or not Medicare HMO's are a good or bad idea, the HMO's were available options for those who would not or could accept the burden of additional health care costs. There were, therefore, no Medicare patients at risk for unavoidable financial hardship as a result of the Medicare coverage devaluation process. The Medicare budget could have been balanced and all patients could have found a doctor or HMO plan of their choice. Each patient would have ended up paying as little or as much as he or she wanted to, depending only upon their own perception of value, just as every other economic decision is made in this country.

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The seniors were not protected from increases from their attorneys or from their car repairmen or from their plumbers. But the Medicare insurance devaluation could be considered to be a direct assault on the senior's Medicare entitlement benefits by congressional action. And it was politically expedient to insulate the seniors from what had been done to their insurance program entitlement.

So as to not make the seniors angry, legislation to price fix the doctors to the Medicare allowable rates was legislated. No matter how much the Medicare benefit s would be devalued, in 1984 or in the years to come, the Medicare beneficiary would never know it.

In the OBRA legislation of 1989, in addition to mandating more reductions in Medicare payments, doctors were limited to only a 15% maximum surcharge over the Medicare allowable. Any doctor who refused to sign a "participation" agreement, which obligated the doctor to accept Medicare assignment all of the time, was subject to punitive treatment. Every one of his patients' reimbursement would be penalized an additional 5% off the Medicare allowable as penalty for the doctor's not being a participating physician. This 5% penalty, applied even if the doctor accepted assignment on that particular case.

Simple mathematics show that the difference between the option to participate and the option to not participate was 10%. In effect, doctors had had no choice but to accept a participation agreement at that time. It cost more than the 10% difference just to collect a non assigned claim.

There were numerous bizarre and pseudoscientific studies and Medicare adopted a Harvard generated professional fee formula for payment called the RVRVS. The RVRVS system purported to replace the evil free market system with a seemingly rational formula for paying doctors based on the relative value of their time spent and practice expenses incurred. This removed any relation to perceived value from the Medicare system.

I was one of the doctors who was surveyed by the Harvard researchers. I spent hours on the phone with a seemingly very ignorant person, who could not explain any details about the ridiculous and convoluted questions he was asking me. I was asked how my efforts in time and expenses in performing a "lamellar keratoplasty" related, in percentage differences, to everything from removing a foreign body to cataract surgery and to corneal transplantation. I had not done a lamellar keratoplasty in 15 years, and neither had many of my colleagues, because it was an obsolete procedure. I tried to tell this fellow ten times, that the data I was giving him was meaningless. I should have hung up on him, but I was too professional to do this. And then the RVRVS became the law of the land. Charles Osgood just the other day, said on the radio, "an American tradition is screwing up a good thing!"

With absolute price controls in effect for the profession, the doctors fees went down with every arbitrary cut in the Medicare payment schedule. Between 1984 and 1998, reimbursement cut followed reimbursement cut. All this occurred without the patients having any idea how badly their insurance had been devalued. The seniors remained 100% shielded from every penny of the impact of the Medicare entitlement devaluation. And the doctors paid for it dollar for dollar.

There was no political fallout because the seniors even today, do not know what happened to them. They might wonder why many doctors do not seem to treat them the same. Doctors were forced to labor under progressively lower reimbursements, increased labor costs and practice expenses, the effects of inflation and the dwindling of their medical practices as HMO's penetrated the medical marketplace.

Can you imagine if government would have tried this with the Teamsters or the Construction unions.

Without discussing the issues of HMO profiteering and managed care abuses, the Medicare insurance system has clearly been devalued to the category of an indigent care system where it's patients are often viewed by doctors as charity patients or worse. Is there any wonder as to why it is getting harder for a Medicare patient to get quality time and answers to their questions from their doctors?

The question in reality is what is the true value of a medical service? Can government really know what that value is? Does government have the right to decide what that value is and to impose that determination on patients and doctors alike?

When government decides that it can no longer afford to pay for the Medicare comprehensive entitlement insurance it once provided, does government have the right to reduce payment and if so, does government have the right to force doctors to personally absorb every dollar of that reduction as a personal tax on the doctors, with none of that burden placed on the patients? For most doctors, they just adapt to seeing more patients and they spend less time with their patients. But this just does not work for the doctors in the elite class of excellent providers. Organizations that were founded to provide an additional level of care can not just cheapen the ingredients without abandoning the essence of what made them what they are.

Does government have the right to do this especially when there was never a social or economic need to bind doctors and patients in this way. At no time was there ever a need to protect the Medicare entitlement beneficiaries from the increased costs of the government imposed devaluation of their insurance coverage. Each Medicare beneficiary always had the freedom to change to another doctor or to voluntarily convert to a virtually cost free Medicare HMO.

In 1984, a dental crown cost $300. It now costs $800 or more. Everything else costs more than twice as much. as it did then. At the Rand Eye Institute, in 1984 a cataract operation cost $ 2750 and government is going to cut this to $ 565. This is not the American way. Are cataract services a public utility?

In the United Kingdom, after 50 years of socialized medicine, their government is now eager to encourage a private sector. Many private English eye clinics charge $3000 for lesser forms of cataract surgery and they receive this reimbursement willingly from patients who shun the free socialized system, seeking the best for themselves. In Argentina, the fees are as high as $ 5000 for the surgery. Even indigent poor people deserve the right to put themselves into debt if they want to seek out the best doctor. Without health, everything else is futile and meaningless.

Only in America is it illegal for a senior citizen to pay more to find better health care. This is absurd. Medicare was designed to help senior citizens pay for their medical care, not to become a barrier to the Medicare patient's obtaining the best care money can buy.

Health care pundits are now proclaiming that there are too many specialists and that this is bad for the country. Are they crazy? When can a country have too many experts available to save someone from blindness or to fix your mother's hip, or to find a cure for your father's Alzheimer's disease? The problem is really, that we have too many health care experts. Education does not make an expert. Senators, you must learn that expertise comes only from life experience and can not be gained by a quick study?

The doctors are not the problem. They are not the disease. America's doctors always were and always will be an essential part of the cure.

When there is no more excellence in the American health care system, it will be each one of us who will suffer from it. The lifesaving treatment from a elite surgeon of the future may not be possible because that individual may have become an MBA, a stock broker or a corporate executive. Our best people have traditionally followed the American path of financial incentive in choosing their professional careers. It is only a matter of time before this arbitrary suppression of those who accomplish and achieve within the medical profession will become common knowledge.

Something is wrong in this country when Demi Moore is paid $20 million dollars to perform a striptease in a movie and Mike Tyson gets $ 30 million to bight off someone's ear. But what about the specialist who lives a life of ongoing learning, and who in your darkest hour, will be the person you will most want to call upon to save your life or the life of your child. That person, who you or your children will depend upon is right now being regulated into absolute mediocrity.

At that time, when we are possibly near the end of our life, and when clearly, money is no object, we will find out, unfortunately, that it was. Because we made excellence in medicine unsustainable. We will find out at that time, that we have allowed ourselves to become the architects of our own suffering and demise.

STATEMENT OF THE RETIRED PUBLIC EMPLOYEES ASSOCIATION

[SUBMITTED BY STANLEY WINTER, EXECUTIVE DIRECTOR]

I am writing as Executive Director of the Retired Public Employees Association, which represents more than 70,000 of New York's state and local government retirees and their spouses. We urge the repeal of Section 4507 of the Balanced Budget Act of 1997 and the rejection of the proposed Kyl-Archer Amendments(H.R.2497, S.1194) both of which legalize private contracts between health care providers and Medicare beneficiaries. We believe that private contracts are a form of medical coercion, that they will create conditions conducive to Medicare fraud and that they will impede the efficient administration of Medicare reform.

Medical Coercion—Under all private contracting arrangements, (especially the Kyl Archer Amendments which legalize private contracts on a procedure by procedure basis), the possibility exists that less affluent Medicare beneficiaries will be forced to choose between a private contract which they can ill afford or an interruption in the continuity of their care. Consider the fact that for patients covered only by Medicare, the costs from private contracts will be added to the full cost-sharing liability already borne by these persons. Even for those with some type of "Medigap" insurance, costs will increase because the right to contract does not require "other supplemental health plans or policies . . . to make payments for such services." At an age in life when peoples' incomes are decreasing, they will be faced with substantial, unavoidable and unexpected increases in out-of-pocket medical costs. Who will be able to withstand the pressure to enter into one of these contracts? Who will forgo treatment that might restore one's own health or that of some family member?

Medicare Fraud—Private contracts will increase the difficulty of monitoring the way Medicare funds are expended. Consider the October 1997 letter from June O'Neill, Director of the Congressional Budget Office to the House Committee on Ways and Means which stated that under Kyl-Archer, "HCFA's efforts to screen inappropriate or fraudulent claims could be significantly compromised because it would be difficult to evaluate episodes of care with gaps where services were directly contracted." Inadequacies in the Health Care Financing Administration's procedures to detect and combat fraud will be definitely exploited by the unscrupulous.

Medicare Reform—Since many of our members are Medicare beneficiaries who often become confused and fearful when there are major changes in programs, it is important for HCFA to implement the Medicare reforms, especially the Medicare+Choices, in a timely and unconfused manner Repealing private contracts would free administrative resources that would otherwise be used on tracking affidavits, and developing data-bases relating specifically to direct contracts.

Senior Beacon IN FOCUS FOR PEOPLE OVER 50

February 23, 1998

Mr. Bruce Anderson
Editorial Department
Senate Finance Committee
219 Dirksen Senate Office Bldg.
Washington, DC 20510

Dear Mr. Anderson:

A mission of the *Senior Beacon* newspaper, with a readership of 150,000 older adults throughout the Greater Washington area, is to bring the views of concerned readers on important issues to the attention of responsible decision makers.

We published a "Pro & Con" in a recent issue on the subject of Private Contracting in Medicare, and received more mail in response than on any single subject we have covered in the past 8 years.

I am enclosing a copy of that "Pro & Con" as well as copies of the letters we have received on this issue. To date, sentiment is running 6 to 1 against the Kyl Amendment.

I would like to request that these views be reflected in reports to be issued by the Senate Finance Committee on the Private Contracting in Medicare hearings taking place on February 26, 1998.

Thank you for your consideration.

Very truly yours,

Stuart P. Rosenthal
Publisher

Enclosures

P.O. Box 2227, Silver Spring, MD 20915-2227 • (301) 608-0700 • Fax: (301) 608-2145
www.seniorbeacon.com • E-mail: info@seniorbeacon.com

PRO & CON

FREEDOM OF CHOICE

By Robert E. Moffit

What if the federal government made it practically impossible for you to spend your money on a medical treatment provided by your own family doctor?

Unfortunately, as of this month, anyone 65 or older and enrolled in Medicare now faces just such a restriction.

No other Americans are subject to such limits on their medical choices.

So how did this happen? The Clinton administration, behind closed doors and wielding the threat of a veto, insisted that the Balanced Budget Act of 1997 include special language (outlined in Section 4507) governing doctor-patient relationships for people enrolled in Medicare.

Here's how Section 4507 works: If you want to go outside Medicare and pay your doctor directly, with your own money, for a medical treatment or procedure covered by Medicare, you can do so. But there's a catch: Your doctor must sign an affidavit agreeing not to submit a payment claim to Medicare for any other Medicare patient for a full two years.

In other words, your right to contract privately with a doctor outside of Medicare depends entirely on your doctor's ability or willingness to give up all other Medicare patients for two years. Obviously, very few doctors can or will make such a sacrifice, leaving seniors with no one to turn to but Medicare.

This new law is likely to have some unintended consequences. By forcing doctors to choose between taking or refusing patients with Medicare, some of the best doctors will likely leave, restricting their practice to wealthy seniors who don't need Medicare in the first place.

The result: Medical freedom for seniors will become the exclusive right of the very wealthy. As a result, this will create the very kind of "two-tiered" healthcare system liberals say they oppose.

If you are a Medicare patient, Section 4507 places your concerns beneath what the Clinton administration and Congress think is best for you.

You may like a particular doctor and want to take advantage of his or her special skills. You may want to receive specific medical care, such as psychiatric help, and keep your treatment confidential from Medicare bureaucrats. Or you may simply value the convenience of dealing directly with a doctor outside of Medicare's maze of rules and regulations. Too bad.

Curiously, nothing like Section 4507 is found in the laws regulating any other government health insurance program, including Medicaid, the Veterans Administration healthcare system, the Indian Health Service, the military healthcare system or the Federal Employees Health Benefits Program (the plan that covers members of Congress, their staffs, and millions of federal workers and retirees).

All these people will still be free to go outside of their insurance programs if, for any reason, they think they can get better care from a doctor privately.

But not seniors. Section 4507 turns Medicare into a second-class healthcare system for them. If politicians are smart, they will broaden, not narrow, the medical choices available to America's seniors.

Robert E. Moffit is deputy director of domestic policy studies at The Heritage Foundation, a Washington-based public policy research institute.

Subject: Kyl-Archer Medicare ammendment
Sent: 01/27/1998 06:02PM
Received: 01/28/1998 09:05AM
From: WaterQual@aol.com
To: Senior Beacon, seniorb@erols.com
CC: WaterQual@aol.com

Freedom of choice is a wonderful slogan. And it seems that all politicians are pro-choice; at least when it comes to Medicare. It is comforting to know that the Heritage Foundation's Robert Moffit and the American Medical Association want me to have the freedom to pay my doctor as much as he wants and have all the money come out of my pocket, with my medical insurance paying nothing. This gives me the freedom to go bankrupt.

What I don't understand is why I would want to have the freedom to choose to pay a doctor the full price out of my pocket, rather than having my Medicare insurance pay its share. I could understand it if the doctor refused to treat me if I insisted on using Medicare. But there are already doctors who refuse to treat Medicare patients. And they would lose nothing by being barred from taking Medicare patients for two years.

Alternatively, I suspect that if I exercised my freedom of choice and refused to contract with the doctor for his fee, he would agree to treat me under Medicare. But the Medicare treatment would represent a less than full treatment. And if fee-for-service Medicare becomes a two-tiered, less-than-complete treatment Medicare, then I believe all Medicare beneficiaries will be forced to choose HMOs or some form of managed care in order to receive adequate treatment.

If this happens, the freedom to pay any amount out of the patient's own pocket will help achieve the real purpose of the Medicare+Choice act of 1997, which was to reduce the cost of Medicare to the government by 20 billion dollars.

I can understand why the American Medical Assosociation is interested in protecting and enhancing the wages and benefits of its members. Every industrial labor union does that. What I can't understand is why the conservative Heritage Foundation and Senator Kyl and Congressman Archer are suddenly pro-union as well as pro-choice.

Robert Schoen
2716 Calkins Road
Herndon, VA 20171
(703) 860-3888
Water Qual@aol.com

14207 Myer Terrace
Rockville, MD 20853
January 19, 1998

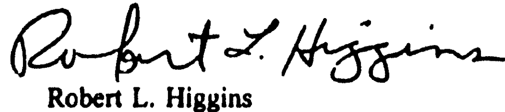
The Editor
Senior Beacon
P. O. Box 2227
Silver Spring, MD 20915

Dear Editor:

I oppose the Kyl amendment.

The acceptance of Medicare fees by 85 percent of all physicians in the U.S. shows that the Medicare system works and that the fee schedules are fair and reasonable. I believe that allowing doctors to charge higher fees and still continue to accept Medicare payments would destroy Medicare. The prohibition on private contracting has worked well for many years and should be retained.

Sincerely yours,



Robert L. Higgins

3203 White Street
Falls Church, VA 22xxx
January 6, 1998

Why are senior citizens treated as 2nd Class citizens? We have worked hard all our lives - put money into social security and now we are facing the fact that as we get older, Doctors we rely on for our care may not be able to treat us.

It is a fact of life that as everyone ages there are things that fail in our bodies. People pay dearly for their cars, boats and other luxury items - Having a good medical care system is not a luxury.

The majority of people on medicare do not seek medical care on a constant basis. We go when there is a problem or to prevent a problem -

It would be wise to look into those Companies and people who are defrauding the medicare system. If that could be eliminated there shouldn't be a problem keeping medicare on a sound basis. We ask you as concerned senior citizens to defeat the Kyle amendment -

In response to Mr Moffitt's article on Freedom of Choice - he stated that nothing like Section 4507 is found in laws regulating any other Government health Insurance program - mentioning the Military health care system as one example - That part I know is false - Those of us on medicare can be seen at military clinics and hospitals on a space - available only system - except

in certain areas of the country where they are trying to circumvent medicare -

My husband served as an officer in the Navy for 33 years - and unless it is a direemery-ency there is a long wait to see a Doctor. I myself have cardiac problems and was seen every 6 months - It has now been 1 year since I have been able to see a Dr in Cardiology. I was very fortunate recently when I ran into the Cardiologist I had been seeing 2 years ago - He told the woman who makes the appointments, that he would accept me again as a patient. It is a very scary practice.

We all know too that Congressmen and others in high places in Government

are treated at Military Health Facilities, and are given priority over those who were in the service or are still active.
Not a very Good situation to be in -

Louis R Appel[?]

January 19, 1998

Sir:

I refer to your article in the January issue by Robert E. Moffit.

I am a retired Federal Government employee, age 69, with Medicare as my principal insurer (A & B) and healthcare insurance under the Federal Employees Health Benefits Program as my secondary insurer.

I strongly oppose Section 4507 and strongly support Senator Kyl's amendments.

Sincerely, Margaret J. Barnhart

4000 Tunlaw Road, N.W. #707
Washington, D.C. 20007-4847

1/20/98

Dear Sir,

The article attributed to Mr Protulis reads like a White House press release. It misstates the basics of the Kyl amendment, uses bureaucratic rhetoric to try to polarize the issue eg rich vs poor, needy vs greedy etc. and never addresses the impact of the bill upon the average senior.

In the not to distant past, when the White House and other so-called "senior organizations", used language similar to that of Mr Protulis in an attempt to support the "Catastrophic tax" of a health bill - the seniors used their common sense to dissect the issue and fought for its eventual demise. In a poll by the AARP, the majority of members were opposed to the provisions but the top echelon of AARP voiced their support to Congress against the wishes of the rank-and-file members.

The Protulis article emulates that of the AARP, e.g. a member cannot read the measure and make a sensible and informed decision. Rather, they should just pay their dues and let the top echelon of the organization lead them down any path the politics of the situation dictates. I disagree, and believe the members are capable of viewing all the facts and making an informed and intelligent decision.

Subsequent to the AARP action regarding the catastrophic tax myself and many others opted out of the AARP, and based on the viewpoints expressed by Mr Protulis I would not become a member of, or support, the National Council of Senior Citizens.

The measure as it stands, without the Kyl amendment is a reintroduction of the Clinton's health plan which was rejected by seniors in the past. It is an attempt to be the first stage of a planned effort ~~that~~ would result in socialized medicine.

Regardless of the rhetoric and the politics — the measure as it stands would abrogate my freedom of choice guaranteed by the Constitution and Bill of rights. I should like the freedom to chose and pay any Doctor I please for my medical services. I do not want some faceless bureaucrat making decisions regarding my health.

Perhaps Mr. Protuker has dealt with Doctors that would take advantage of their patients, but the Doctors that have looked after my health over the past 70+ years do not fall into that category. They have been without exception honorable, dedicated professionals, doing what is best and right for their patients.

I want to retain my freedom of choice regarding my health care and medical services and support the Kyl amendment, since it will affirm that freedom.

Allen J. Pate

Herbert L. Tanenbaum, M.D., F.A.C.P., F.A.C.C.
9812 Belhaven Road
Bethesda, Maryland, 20817-1732

Phone: (301) 530-4433 Fax: (301) 530-4434

January 15, 1998

The Editor, Senior Beacon
P.O. Box 2227, Silver Spring, Md. 20915

Dear Editor,

I would like to express my strong opposition to Senator Kyl's bill, S-1194. In my opinion this bill, if passed, would lead to a two- tier system for medicare patients.

Doctors with a "high profile" or popularity rating (so called 5th. Avenue physicians) as well as those affiliated with a medical school or institution, would be prime physicians to negotiate their fees. Often, these fees are inflated without control when dealing with financially well off patients or frightened extremely ill individuals. In short time, the majority of these physician's patients will be from this category and result in fewer routine medicare patients being seen or left with prolonged waiting times to be seen or to get appointments.

As a result, a greater burden of medicare patients would be thrown back to other practicing physicians. In time, this could overburden their practice and encourage them to opt out of the medicare program.

Currently, a physician can choose not to accept the standard medicare fee and charge a small amount (10-15%) above the approved fee. Most patients, in addition, have medigap policies. This combination of payment is often more than adequate. Certain procedures such as plastic surgery for personal cosmetic reasons or non accepted experimental techniques, should not be covered, but could be negotiated if the patient is willing to assume the financial burden and risks involved.

Finally, the quality of medical care is not improved one bit by this Bill and the potential for serious harm to the Medicare Program is great.

Thank you for the opportunity to express my opinion.

Very truly yours,

Herbert L. Tanenbaum, M.D.

1500 Massachusetts Av., NW
Washington, DC 20005
January 12, 1998

The Editor, Senior Beacon
P.O. Box 2227
Silver Spring, Md. 20915

Your article concerning proposed legislation to allow Medicare recipients to pay physicians out of pocket at fees set by the physician was most interesting to me because it brings into stark relief the dichotomy between what the electorate wants and what is rammed down their throat by special interests.

It has been said that what is wrong with American medical care today is that, unlike most services sought by consumers, $ 20,000-a-year patients are seeking medical care from $ 200,000 a-year doctors and $80-a-day workers are going to $800-a-day hospitals. Probably in no other area are the supply-demand relationships so out of balance as they are in health care. Can you imagine someone taking a television set in for repair and coming back to pick it up and pay a bill of $10,000 or more?

Although affluent retirees may be more likely to seek second opinions or change doctors if they don't like or trust the one they have, very few people will pay more than necessary for medical care. Other than cosmetic surgery or some avant-garde medical procedure that is not covered by medicare, very few Medicare recipients have any desire to pay their physicians any more than they can avoid. Most of us think we pay too much as it is.

The Kyl bill simply won't fly. It is a phony issue, having no public support and is a perfect example of the kind of legislation that passes or fails because of corruption in our system of funding elections through political contributions made by narrow special interests. Eventually, the whole house of cards will come tumbling down and physicians will be forced to freeze their charges or be placed on a government-stipulated salary, much like any other monopoly regulated by State Public Utilities Commissions. The Kyl bill, should it pass, will hasten such an eventuality.

Randolph W. Burgess

16 Shagbark Ct.
Rockville, MD20852
January 12, 1998

Mr. Stuart Rosenthal, Editor
Senior Beacon
P.O. Box 2227
Silver Spring, MD 20915

Dear Mr. Rosenthal:

This letter concerns the Kyl legislation.

Some people are never satisfied. I am not one of them. I have been pleased with Medicare since the 1989 legislation, which restricted non-participatory doctors to 15% over the Medicare approved cost.

In November of 1997, I went to an otolaryngologist three times for a sinus infection. At each visit a diagnostic laryngoscopy and x-ray of the sinuses were done. The doctor requested $400 for each visit. Medicare approved $160.64. The doctor received the full $160.64 from medicare plus medigap. This amount seems quite adequate for the 15 to 20 minutes of service.

Each month I pay $43.80 for medicare and $90.50 for AARP medigap plan F for a total of $134.30. Under the Kyl law, I would have to pay $1200 for the three visits. My monthly cost of $134.30 would count for nothing.

My view is that the Kyl bill should be known as the "Doctors' Pot-Of-Gold Bill". I am very much against the concept. Furthermore, I believe that any doctor who opts for this choice should never be allowed to accept any medicare patients.

Sincerely yours,

Norma Eisinger

Norma Eisinger

Mrs. Malcolm R. Luebkert
4000 Cathedral Ave. NW #324 B
Washington, DC 20016

Jan. 14, 1998.

Senator Jon Kyl (R. Ariz.)
c/o The Editor
P.O. Box 2227
Silver Spring, Md 20915

Dear Senator Kyl,

I am a Senior Citizen aged 83, and have been paying into BC/BS Federal program since 1941. Up until the last few years have used claims infrequently (Very minor).

In the last nine years I have had cancer & up to date have been very satisfied with the insurance Coverage (Medicare + BC/BS). I do not see why your proposed change to the Medicare Insurance will benefit anyone but the Doctors. Already they receive payment for services rendered.

Please leave well enough alone.

Sincerely yours
Chantal B. Luebkert

4321 Homer Ave #A
Suitland, md
Washington 20746

I agree with Steve Protulis. Congress needs to ~~rato~~ realize all people are important not just the ones with money. People work all their lives. They need fair treatment not to be used for some to make some unholy people rich.

Emma Baylor

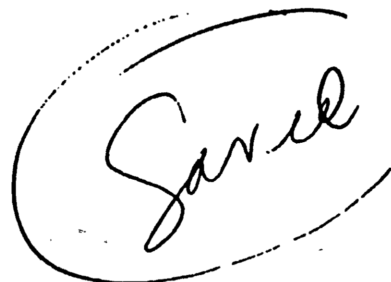
2-10-98

Mr S.P. Rosenthal

I am strongley agaist the medicare bill proposed by Rep Kahl.

Regards

P D Elmore
14401 Woodmere Ct
Centreville Va 20201



Subject: Dear Editor
Date: Sun, 15 Feb 1998 15:40:36 -0500 (EST)
From: WaterQual@aol.com
To: seniorb@erols.com
CC: WaterQual@aol.com

While most of the letters in your February issue on the Kyle-Archer Medicare amendment are clearly against the amendment, the single letter in support struck a responsive chord, even though I do not agree with it. The problem is that the current law requires that any doctor who enters into a private contract with a Medicare-eligible individual, must give up the right to treat any other individual under the Medicare program for a period of 2 years. The current Medicare laws apply to anyone who is Medicare-eligble. Clearly what we need is to allow seniors to decide for themselves whether they want to remain eligible for Medicare. Surely seniors who are old enough to qualify for Medicare are old enough to know their own minds.

All seniors should have the freedom to choose to opt out of Medicare A and B irrevocably and permanently. Then they will have the freedom to contract with any physician to pay the physician's full charges. They will not be encumbered by having the federal government pay any portion of their fees nor will the doctor be prevented from treating other Medicare patients for 2-years.

If at some future time they discover that they can no longer pay for their medical care, they can always fall back on the taxpayer-supported Medicaid program.

Surely this simple remedy, which would be exercised by only those few who want to be assured that "some faceless bureaucrat" doesn't make their health care decisions, is preferable to forcing millions of perfectly happy Medicare beneficiaries to have to seek out new doctors who don't demand a private contract, accepting second-rate care under Medicare fee-for-service, or being forced to join an HMO.

Re: Pro: Seniors deserve medical freedom (1/98)

In response to the article Pro: Seniors deserve medical freedom (1/98)
Written by: hsplrs
hsplrs@pilot.infi.net

This law eliminates the pressure valve that even England's socialized medical system contains, i.e. the ability to go out of the system with private funds, if you are dissatisfied or prefer a different approach or want to eliminate a waiting period. The law is also very unclear. For example, how does it apply to someone between age 65 and 70, who is still working and not receiving Social Security pension benefits. My husband will soon be in that category. His employer will continue to pay for his group medical insurance, and, therefore, he will not apply for Medicare Part B, only Part A. Since he will be eligible to receive Part B, will he have to pay for it? Will his doctors be willing to have him pay only with his private insurance? Does this law cover this circumstance? None of the physicians I have spoken with seem to know.

Thanks for any clarification you can give.

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Subject: Regarding Senator Kyl's Medicare Amendment
Sent: 01/23/1998 04:10PM
Received: 01/24/1998 02:00PM
From: Jimlcathy, Jimlcathy@aol.com
To: Senior Beacon, seniorb@erols.com

Dear Senior Beacon -
We strongly object to Senator Kyl's new amendment which would allow doctors to enter into private contracts with Medicare patients for Medicare-covered services without having to opt out of Medicare for two years.

If enacted this bill would allow doctors to 'cherry-pick' their patients, charging some under Medicare and others (perhaps the seemingly more affluent) private, higher rates which would have no restrictions. The choice of whom to bill either way most times would be left to the the physician. Undoubtedly this would lead to significantly higher medical costs for a great many Medicare patients. This is hardly a beneficial expansion of 'choice' for the elderly.

The new Kyl bill would also allow doctors to 'unbundle' Medicare services by charging separately for services that are normally paid for as a package.They could then charge a patient privately (at higher and unlimited prices)) for some of these and Medicare for others. The potential for fraud and abuse seems obvious here. Unscrupulous doctors could bill both the patient and Medicare for the same services, and even honest ones may have confused billing departments send out bills to Medicare which have already been paid by the patient. The amendment states that physicians need only provide 'the minimum information' to avoid double payment.

In conclusion, the original intent for enacting Medicare was to provide decent and affordable medical care to the elderly. This Kyl amendment threatens the integrity of this program by eliminating its important consumer protections and opening it up to probably greater fraud and abuse.

Yours truly,
James and Catherine Pfiester
Falls Church, VA

January 23, 1998

Written Statement
Submitted to the Senate Finance Committee
by Patricia A. Ford, Executive Vice President of the Service Employees International Union,
in Opposition to Medicare Private Contracting Legislation
(S. 1194; H.R. 2497)

Hearing Date: February 26, 1998

The Service Employees International Union strongly opposes S. 1194, the Medicare private contracting legislation. We are deeply concerned about the consequences that this legislation would have for access to affordable, quality care for Medicare beneficiaries. In our view, this legislation is an underhanded effort to destabilize the entire Medicare system and make it unaffordable for poor and working class senior citizens.

Our union represents over 1.2 million workers and retirees. More than 600,000 of these are front line health care workers, including nurses, hospital workers, nursing home workers and home health workers, who provide Medicare funded services to senior citizens every day. We also represent our retired members - former public sector, building service and health care workers. These retired janitors, secretaries, and clerks live on fixed incomes and rely on Medicare to cover the bulk of their health care needs.

Some have touted that this amendment is about offering patients more choice, but this is very misleading. Medicare beneficiaries have always been free to privately purchase services that Medicare does not cover. Last year's Balanced Budget Act broadened choice even further by allowing beneficiaries to privately contract for services that are already covered under Medicare. Medicare Beneficiaries already have choice.

The Medicare private contracting legislation is really about offering physicians, not consumers, more choice. This legislation would remove the two-year exclusion provision and other consumer protections that govern these private contracts, giving doctors more leeway to rush people into contracts they do not understand, to charge higher rates, and to select to serve people who will make them the most money.

Currently, even with Medicare coverage, more than one out of every five retiree dollars goes to covering health care costs. And when the median income for those over 65 is a little over $11,000 that leaves precious little for food and much less for clothing and shelter. This means that the vast majority of senior citizens in this country will not have the means to enter into private contracts.

One of our major concerns - that lies at the heart of this bill - is that it would destabilize the entire Medicare system and make it unaffordable for many beneficiaries. This legislation would have the effect of transforming Medicare from a social insurance program that everyone pays into and everyone benefits from to a privatized program with incentives for doctors to serve only the most profitable patients.

The 1.2 million members of our Union, along with all working families in this country, count on care being available when they need it - that is why health insurance was developed in the first place. By allowing physicians to charge for services at will this basic premise is lost. The Medicare private contracting legislation would destroy the stability of paying into a system that insures available, affordable coverage for those who need it. Getting medical treatment - although vital - is a service and as such should not fluctuate in price depending on the income of the person who seeks it.

We object to the premise of this legislation and question why the Federal Government would want to replace a system in which 95% of all physicians provide care to 100% of qualified enrollees with a two-tiered system in which access to quality care is determined by income rather than illness. The potential effect of this legislation on overall health spending is also very alarming. The non-partisan Congressional Budget Office (CBO) predicts that if this legislation is approved it would "almost certainly" send national health care spending spiraling upwards.

Again, on behalf of our more than 1.2 million members and our thousands of low-income retired members, I urge you strongly to oppose Medicare private contracting legislation, S. 1194. Thank you.

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