

Medicare Private Contracting

American College of Physicians
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Executive Summary

MEDICARE PRIVATE CONTRACTING A Position Paper of the American College of Physicians

Medicare private contracting refers to a payment practice in which physician and patient agree that the patient will pay for covered services completely out-of-pocket without contributions from Medicare or supplemental insurance. The fee is set by the physician, not Medicare. The Health Care Financing Administration has interpreted Medicare law to prohibit private contracting. Two court cases in 1989 and 1992 left the issue unsettled judicially, so that HCFA's interpretation remained in force. The Balanced Budget Act of 1997 (BBA) allows very limited private contracting that is unlikely to have much effect on the overall Medicare program. The BBA requires physicians who engage in private contracting to leave Medicare for two years. To expand the BBA provision, Sen. Jon Kyl (R-AZ) and Rep. Bill Archer (R-TX) have introduced the Medicare Beneficiary Freedom to Contract Act.

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, which is supported by data. Medicare patients have more choice – of both physicians and, with the BBA, soon of health plans – than most private sector patients.

While there is nothing inherently wrong with the *concept* of private contracts as provided for in the Kyl bill, *implementation* within the Medicare program creates potential problems for the program's integrity. The American College of Physicians is concerned that private contracting as provided for in the Kyl bill will work against the successes of Medicare by 1) creating access problems where none existed, 2) increasing administrative complexity for physicians, who will be struggling with billing errors and *ad hoc* income testing of their patients, and 3) producing conflict in the physician-patient relationship.

Because of these concerns, the College suggests more targeted solutions to the issues of physician compensation, access, and choice raised by the Kyl bill. If access becomes a problem due to Medicare payment schedules, reimbursement should be addressed directly. One approach is to allow limited additional balance billing of higher-income seniors. Additionally, the Health Care Financing Administration should better inform physicians and patients of existing alternatives for Medicare payment and delivery arrangements.

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HCFA's Interpretation

Except for the limited provisions in the BBA, the Health Care Financing Administration has generally interpreted Medicare law to prohibit private contracting.^{**} However, Medicare-eligible patients can choose not to enroll in Part B, and physicians can choose not to take Medicare enrollees as patients. (Seven percent of the Medicare-eligible population is not enrolled in Part B, and about 4 percent of physicians do not have any Medicare patients, whether by choice or because of specialty.^{5 6}) Thus, the possibility exists under HCFA's existing interpretation of Medicare law for physicians and elderly patients to see each other outside of Medicare and set up whatever payment arrangements they wish, without invoking the private contracting provision of the BBA.

Moreover, HCFA allows physicians to bill patients directly for uncovered services and even for covered services which may be considered by the carrier to be medically unnecessary.^{7 8 9} Again, these existing direct billing practices do not invoke the private contracting provision of the BBA; nor would these practices change with passage of the Kyl bill. In the case of medically unnecessary services, the physician files a claim along with an "Advance Beneficiary Notice (ABN)." This notice advises the patient that Medicare may determine the service medically

* In this paper, the term "private contracting" refers to the Kyl-Archer legislation unless otherwise noted.

** As explained in this section, certain provisions of Medicare law allow private payment in specific situations, but this is not considered to be private contracting.

unnecessary and deny payment and that payment would then be the patient's responsibility. ABNs are to be produced by the physician's office and kept in the patient's chart. They are not submitted to Medicare.

Elective cosmetic surgery is an example of an uncovered service for which physicians can bill patients directly. Periodic testing of liver function in patients on cholesterol-lowering drugs is an example of a covered service which a carrier may consider medically unnecessary for a particular patient. Some services may be difficult to assign to either category, and physicians may want to file the ABN as a precaution.

Much of the public discourse on direct billing of patients has been confused and inaccurate. It cannot be stressed enough that these direct billing provisions in Medicare are not at issue in the private contracting debate.

In addition to voluntary exclusion from Part B and direct billing for services that are uncovered or deemed unnecessary by the carrier, two other situations allow for private payment arrangements.¹⁰ First, Medicare requires physicians to submit all "authorized" claims. Thus, if a patient does not authorize a claim, the physician does not submit it and bills the patient directly. However, Medicare's balance billing limits apply. This may occur when a patient is concerned about privacy, such as with psychiatric treatment. Second, Medicare HMO patients may see a physician outside their plan, even for a service the plan covers, and pay the entire bill out-of-pocket. In this case, the service is considered by HCFA to be an "uncovered" service. The patient and non-plan physician make whatever payment arrangement they wish, without regard to balance billing limits.

The Balanced Budget Act of 1997

The Balanced Budget Act of 1997 (BBA) gives statutory approval to limited private contracting. Under the BBA, physicians choose either to contract privately or abide by Medicare payment rules -- one or the other, but not both -- for a period of two years. Physicians who choose private contracting must file an affidavit with HCFA stating they will not submit claims during the two-year period beginning on the date the affidavit is signed.

The two-year opt-out requirement was included in the BBA for these reasons:¹¹

- It limits the number of physicians likely to engage in private contracting by making it an all-or-nothing proposition (for two years), keeping costs down for beneficiaries.
- It maintains predictability of patient medical costs. That is, patients have the certainty of knowing, in advance of a service, the payment amount and the type of payment arrangement (Medicare v. private contracting). Patients know the physician will not ask for a private contract for any services, unless, of course, the physician intends to forego all Medicare participation.

- The opt-out makes it possible for HCFA to prevent billing errors (billing both a patient and Medicare for a private contract service). Since HCFA can identify the private contracting physicians through their affidavits, any claims submitted by these physicians for Medicare payment can be rejected. Without the opt-out, HCFA cannot know if a patient has been billed for a service for which a claim also has been submitted.

Supporters of unrestricted private contracting as provided for in the Kyl bill say that the basic right to enter into a private contract at any time supersedes the above reasons for a two-year opt-out. Kyl bill supporters say that private contract patients will be alerted of double payment by receipt of an explanation of benefits statement, and that the possibility that patients will alert HCFA of double billing is sufficient monitoring.

The BBA's private contracting provision also contains these beneficiary protections:

- The contract must be entered into before services are provided.
- A contract cannot be entered into in an emergency or urgent care situation.
- The contract must clearly indicate to the beneficiary that the beneficiary: agrees not to submit a Medicare claim for the covered services; agrees to be responsible for payment whether or not additional insurance is available; understands that Medicare will not reimburse any portion of the bill; understands that Medigap will not cover the services and that other supplemental plans may elect not to; understands that Medicare balance billing limits do not apply; and understands that the beneficiary has the right to have services provided by other physicians with normal Medicare reimbursement.

Medicare Beneficiary Freedom to Contract Act

The "Medicare Beneficiary Freedom to Contract Act," introduced on Sept. 18, 1997, by Sen. Kyl and Rep. Archer, would eliminate the BBA's two-year restriction and requirement to file an affidavit with HCFA. Thus, the bill would allow all physicians to contract privately with Part-B enrolled beneficiaries and also to submit Medicare claims. The private contracting decision would be made on a service-by-service basis; that is, a physician could accept private payment for some services provided to a given patient and bill Medicare for other services provided to the same patient.

The Kyl/Archer bill contains these other provisions:

1) Contracts must:

- be signed prior to services being provided;
- state that no claims are to be submitted to Medicare, that the beneficiary is responsible for all of the physician's charges, that there are no balance billing limits, and that Medigap coverage is not available; and
- disclose if a physician has been excluded from Medicare for fraud or poor quality of care.

2) Medicare may collect “the minimum information” necessary to ensure that managed care plans or the Medicare program do not pay for services privately contracted.

3) Physicians may charge privately for emergency services if the contract was signed prior to the emergency.

The bill does not require that physicians disclose their fees or publish a fee schedule prior to delivery of services.

The Arguments For And Against Private Contracting

A recent Congressional Research Service analysis of private contracting provides an impartial description of the arguments on each side of the issue.¹² A summary follows:

Supporters of private contracting object to Medicare payment levels and balance billing limits, pointing to the fact that Medicare payment levels are only 71% of those of private-pay insurance plans. Further, they object to Medicare's administrative requirements. They argue that private contracting is a basic freedom. Since Medicare is not paying the bill, physicians who choose private contracting should not be subject to Medicare's rules. They draw a comparison to Britain's nationalized health system, which allows private contracting at the discretion of the physician and patient. Restrictions on private contracting in Medicare are viewed as a violation of privacy.

The supporting material issued by proponents of private contracting frames the issue as one of freedom of choice, as in the bill's title.^{13 14 15 16} These materials warn of physicians unable to afford to treat Medicare patients, whose access to the physician of their choice is therefore curtailed. The materials describe patients in rural areas as unable to get treatment from specialists even when willing to pay out of their own pockets.

The CRS report describes the arguments against private contracting:

Opponents of private contracting contend that the ability to enter into private contracts benefits the pocketbooks of physicians and creates a two-tiered system -- one for the wealthy and one for others. This two-tiered system would conceivably create a situation in which only wealthier beneficiaries have access to leading specialists. At the same time, the number of physicians treating Medicare patients could decline as a result of private contracting, inhibiting access for those unable to pay out-of-pocket. The access problem could be especially serious in geographic areas served only by specialists who privately contract or with few primary care physicians.

Additionally, opponents of private contracting have raised the issue of fraud and abuse.¹⁷ The Kyl bill does not require sufficient information be submitted to HCFA to prevent double billing, they say. Monitoring would create administrative burdens on an agency already under Congressional fire for not controlling fraud and abuse in Medicare.

ACP Analysis

While there is nothing inherently wrong with the *concept* of private contracts as provided for in the Kyl bill, *implementation* within the Medicare program creates potential problems for the program's integrity.

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."¹⁸ 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.¹⁹

For 30 years, Medicare has maintained the health of the elderly population and kept seniors out of poverty. The American College of Physicians is concerned that private contracting as provided for in the Kyl bill will work against these successes of Medicare by 1) creating access problems where none existed, 2) increasing administrative complexity for physicians, who will be struggling with billing errors and *ad hoc* income testing of their patients, and 3) producing conflict in the physician-patient relationship.

Because of these concerns, the College suggests more targeted solutions to the issues of physician compensation, access, and choice raised by the Kyl bill, solutions which would protect Medicare's role as a public insurance program.

Potential for Decreased Access

Finding a balance between appropriate physician compensation, access to care, and choice of physician is complicated by their interdependence. Greater compensation increases the supply of physicians in Medicare and presumably access and choice. However, if widespread private contracting increases the number of physicians who accept Medicare *patients*, but these physicians do not accept Medicare *payment*, then patients' access to care and choice of physician would decline because they could not afford it. This would occur if many physicians in a

community or geographic area accepted current or new Medicare patients only on a private contract basis. This is a major concern – that private contracting would *not* increase access and choice for the majority of Medicare patients but could actually *decrease* it.

Data show that most Medicare beneficiaries are moderate to low-income with 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 29 percent of beneficiaries live on less than \$10,000.²⁰ On average, the elderly spend 21 percent of their income on out-of-pocket medical expenses. For those living on incomes below 125 percent of the federal poverty level, out-of-pocket medical costs take up about 31 percent of their incomes.²¹

Administrative Complexity

In addition to access, the College is concerned about the administrative complexity and increased potential for billing errors created by the Kyl bill. 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 a criminal charge. 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.

Widespread private contracting would also be extremely burdensome for the Health Care Financing Administration and require extensive resources for monitoring. A recent review of the Kyl bill by the Congressional Budget Office underscored the difficulty HCFA would have in monitoring.²² 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.

Physician-Patient Relationship

The College 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.

Private contracting interferes 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.

ACP Recommendations

Because of the concerns outlined above, the ACP suggests alternatives to addressing any remaining access problems in Medicare caused by inadequate physician payment rates.

Recommendation 1:

If Medicare access problems develop, address the payment issue directly. One approach is to allow 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 percent) 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 percent. Additionally, non-participating providers submit some claims on assignment, so that 96 percent of all Medicare claims involve no balance billing.)²³ Allowing some limited additional balance billing of the wealthiest Medicare patients through uniform income-testing would protect access for moderate and low-income beneficiaries while providing incentives for physicians to stay in the Medicare program.

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.

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.

Recommendation 2:

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 less harm to traditional Medicare.²⁴ Under this option, patients can join a private indemnity plan, and 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 fee schedule. If the market makes these plans viable, physicians may realize higher rates of reimbursement and have the ability to see plan subscribers without having to "opt out" of Medicare and engage only in private contracting. Likewise, Medicare's medical savings account demonstration program provides an opportunity for beneficiaries to make private payment arrangements with physicians. Both of these options should be monitored and evaluated for their effects on cost and access within the overall Medicare program.

Recommendation 3:

HCFA should better inform patients of their right to opt out of Part B and arrange their own private payment options.

As stated above, 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 do a better job of communicating this option.

Recommendation 4:

HCFA 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 likely to 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. Such erroneous information may be motivating some physicians to support private contracting.

There is no official, systematic method for educating physicians on Medicare payment options 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.

Recommendation 5:

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 substantial resource at its disposal.

Conclusion

Medicare beneficiaries have greater choice of physician than those who receive their coverage under employer sponsorship or other public sector programs. While the Kyl bill may expand choice for some physicians affordable to a few wealthy beneficiaries, the bill may also encourage other physicians to stop taking Medicare patients, thereby decreasing patient choice and access in the traditional fee-for-service program.

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 both a refuge for beneficiaries and a competitive impetus for managed care plan performance. By increasing the out-of-pocket costs and complexity of the traditional program, private contracting may push more patients into managed care. Without a fee-for-service plan to worry about, the MCOs can afford to be less responsive – to both patients and physicians. Then neither choice – traditional Medicare or managed care – may be a good one for patients.

The Kyl bill, at its core, is not about freedom of choice or access. It is about reimbursement. These issues should be confronted directly. To address them under the rubric of choice and freedom may be seen by the public as an effort to increase physician income at patient expense, overshadowing physician commitment to high-quality patient care.

Congress has enacted important changes in the Medicare program with the new options contained in the Balanced Budget Act. These options will enhance the broad choice of physicians already enjoyed by patients with new alternatives for financing and delivery of medical care. The new BBA options, combined with the ACP recommendations proposed herein, serve a goal shared by all: to provide extensive choice and full access to medical care to the nation's senior citizens.

¹ *Stewart v. Sullivan* 816 Supp. 218 DNJ 1992.

² *New York Ophthalmology Society v. Bowen*, US Supreme Court, 1989.

³ Balanced Budget Act of 1997, P.L. 105-33, Section 4507.

⁴ Medicare Beneficiary Freedom to Contract Act, S. 1194, H.R. 2497.

⁵ General Accounting Office, "Medicare: Clarification of Provisions Regarding Private Contracts Between Physicians and Beneficiaries," HEHS-98-98R, Feb. 23, 1998.

⁶ American Medical Association physician survey, 1996.

⁷ General Accounting Office, "Medicare: Clarification of Provisions Regarding Private Contracts Between Physicians and Beneficiaries," HEHS-98-98R, Feb. 23, 1998.

⁸ Medicare Carrier Manual, Section 7300.5, Payment and Post Payment Procedures.

⁹ Testimony of Nancy-Ann Min DeParle, Administrator, Health Care Financing Administration, before the Senate Finance Committee, Feb. 26, 1998.

¹⁰ Letter from Nancy-Ann Min DeParle, Administrator, Health Care Financing Administration, to Sen. Jon Kyl, Feb. 23, 1998.

¹¹ Testimony of Nancy-Ann Min DeParle, Administrator, Health Care Financing Administration, before the Senate Finance Committee, Feb. 26, 1998.

¹² O'Sullivan J and Echeverria C, "Medicare: Private Contracts," Congressional Research Service, Washington, DC, Oct. 21, 1997.

¹³ Wasley T, "Health Care Freedom For Seniors: Medicare Private Contracting Examined," United Seniors Association, Fairfax, VA., Nov. 1997.

¹⁴ Moffit R, "Answers to Frequently Asked Questions About Private Contracting in Medicare," United Seniors Association, Fairfax, VA, Nov. 1997.

¹⁵ American Medical Association, "Private Contracting: Fact and Fiction," November, 1997.

¹⁶ American Medical Association, Letter to Senate Majority Leader Trent Lott, Oct. 29, 1997.

¹⁷ American Association of Retired Persons, "Medicare Physician Private Contracting," Oct. 1997.

¹⁸ Physician Payment Review Commission, *Annual Report to Congress*, 1997, p. 304.

¹⁹ Physician Payment Review Commission, *Annual Report to Congress*, 1994, p.334.

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- ²⁰ Physician Payment Review Commission, *Annual Report to Congress*, 1997, pp. 3, 4.
- ²¹ Physician Payment Review Commission, *Annual Report to Congress*, 1997, p. 4, p. 312.
- ²² Letter from June O'Neill, director, Congressional Budget Office, to Rep. Bill Archer, Oct. 30, 1997.
- ²³ Physician Payment Review Commission, *Annual Report to Congress*, 1997, pp. 313, 314.
- ²⁴ Balanced Budget Act of 1997, P.L. 105-33, Section 4001.