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Medicare: Private Contracts

Jennifer O'Sullivan
Specialist in Social Legislation
Cecilia O. Echeverría
Analyst in Social Legislation
Education and Public Welfare Division

Summary

Private contracting is the term used to describe situations where a physician and a patient agree not to submit a claim for a service which would otherwise be covered and paid for by Medicare. Under private contracting, physicians could bill patients at their discretion without being subject to upper limits specified by Medicare. The Health Care Financing Administration (HCFA, the agency that administers Medicare) had interpreted the law to preclude such private contracts. Some physicians recommended that the law be modified specifically to allow such arrangements.

The Balanced Budget Act of 1997 (BBA 97) included language permitting a limited opportunity for private contracting, effective January 1, 1998. However, if and when a physician decides to enter a private contract with a Medicare patient, that physician must agree to forego any reimbursement by Medicare for 2 years. The patient is not subject to the 2-year limit; the patient would continue to be able to see other physicians who were not private contracting physicians and have Medicare pay for the services.

The BBA 97 provision has been the subject of considerable controversy. Proponents of private contracting are seeking to expand the provision arguing that any limitations are unwarranted. Opponents of private contracting support the 2-year exclusion as a disincentive for physicians to enter into these arrangements. The Medicare Beneficiary Freedom to Contract Act (H.R. 2497; S. 1194), introduced by Representative Archer and Senator Kyl, would remove the 2-year exclusion.

Background

Medicare Payments to Physicians. Currently, physicians are required to submit bills to Medicare for services provided to Medicare patients and they are limited on the amounts they can charge. Medicare pays 80% of the fee schedule amount (the Medicare-

approved amount) for physicians services after beneficiaries have paid a $100 deductible. Beneficiaries are responsible for the remaining 20% (coinsurance).

Physicians may choose whether or not to accept Medicare **assignment** on a claim. Accepting assignment means that the physician agrees to accept the payment amount set by Medicare under the fee schedule. The physician can then only charge the patient the 20% coinsurance plus any unmet deductible. Physicians who agree to accept assignment on all Medicare claims for the forthcoming year are considered **participating physicians**. Physicians who do not accept assignment on all Medicare claims are known as **non-participating physicians**.[1] The Medicare-approved amount for non-participating physicians is 95% of the recognized amount for participating physicians.

Non-participating physicians may charge beneficiaries more than the fee schedule. This is known as **balance billing**. However, there is a limit on how much can be charged. Currently, a limit of 115% of the fee schedule can be charged by non-participating physicians. This results in an amount only 9.25% higher than the amount recognized for participating physicians (i.e., 115% x 95% = 109.25%). Doctors who charge more than these limits may be sanctioned with civil penalties and/or exclusions from Medicare.

The higher fees recognized for participating physicians, coupled with the limits on balance billing and the requirement that physicians file a claim for all services, have encouraged many physicians to become participating physicians. In 1997, 80% of physicians and practitioners who serve Medicare beneficiaries are participating versus 28% participating in 1986. Claims paid on assignment represented 96% of allowed charges in 1996, compared to 70% in 1986.[2]

History of Medicare and Private Contracting. Private contracting is the term used to describe the situation 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 HCFA has long interpreted the law as prohibiting physicians from entering into such private contracts with Medicare beneficiaries. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89, P.L. 101-239) established the physician fee schedule. It also required physicians to submit claims for *all* services beginning September 1, 1990. (Previously, physicians were only required to submit assigned claims.) Specifically, it required that providers "complete and submit a claim for . . . service on a standard claim form specified by the Secretary to the carrier on behalf of a beneficiary." OBRA 89 also outlined penalties for not submitting a claim to Medicare for any covered service provided to a Medicare beneficiary.

A 1992 court case, *Stewart vs. Sullivan*[3], brought attention to the issue when a U.S. District Court Judge concluded that there was no law or Department of Health and Human

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[1] A physician who is a "non-participating physician" may still see Medicare patients.

[2] Physician Payment Review Commission. Monitoring the Financial Liability of Medicare Beneficiaries. Report No. 97-2, 1997. p. 15. The actual percentage of physicians (such as pediatricians) who do not see Medicare patients is not known. A 1996 survey by the American Medical Association (AMA) found that 96% of physicians saw at least one Medicare patient during the year.

[3] U.S. District Court. District of New Jersey. *Stewart, et al. vs. Sullivan, et al.*, No. 92-417, October 26, 1992. 816 FSupp 281.

Services (HHS) policy which restricted private contracting; the suit was dismissed because HCFA had not issued a specific policy regarding private contracting. While the internist who had originally filed suit and some physician groups concluded that the case allowed physicians to enter into private contracts, HCFA remained firm that private contracting was not an acceptable practice.

Subsequently, HCFA issued Medicare Carriers Manual instructions.[4] The Medicare Carriers Manual §3044 states that "agreements with Medicare beneficiaries purportedly waiving Federal requirements have no legal force or effect." Additionally, the section states 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."

Finally, in the Social Security Amendments of 1994 (P.L. 103-432) a technical amendment made specific changes to the Medicare law. It changed the language relating to balance billing and specifically applied the charge limits to all persons enrolled in part B — not just those submitting a bill. This amendment has been viewed by many as strengthening HCFA's position against private contacting.

Private Contracting Issues

Proponents of private contacting generally object to Medicare's payment levels as well as balance billing limits and point to the fact that Medicare payments are only 71% of what would be paid under private insurance plans.[5] Further, they object to the program's administrative requirements and paper work. They contend that private contracting is a basic freedom associated with private consumption decisions. They state that since Medicare is not paying the bill, physicians who choose to private contract should not be governed by Medicare rules. Additionally, the nationalized system of health care in Britain is pointed to as a system which still allows private contracting at the discretion of the physician and the patient. Finally, the inability to enter into private contracts is pointed to as a violation of the privacy and confidentiality of the health care provider and patient relationship.

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 all other Medicare eligibles. This two-tiered system would allow mostly wealthier Medicare beneficiaries to seek health care outside of the Medicare system and would conceivably create a situation where only wealthier beneficiaries have access to the Nations's, or an area's, leading specialists for a medical condition. At the same time, the potential decrease in the number of physicians serving Medicare patients is a major concern. This would be particularly problematic in areas where a significant proportion of the specialists or sub-specialists choose only private contracts (foregoing Medicare payment). In geographic areas served by few specialists and limited numbers of general practitioners this situation has the potential to create serious access problems

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[4] HCFA implements the Medicare program through program regulations as well as instructions to carriers (entities which process Medicare claims). These instructions take the form of modifications to the Medicare Carriers Manual.

[5] Physician Payment Review Commission. Annual Report 1996. p. 218.

for the Medicare beneficiaries who choose or are financially unable to enter into private contracts. Finally, there is concern about the ability of physicians to charge *any* price for services rendered and the Medicare beneficiary being responsible for *100%* of the bill. This becomes especially problematic for the beneficiary living in an area where the only specialist decides to use only private contracts.

Section 4507 of the Balanced Budget Act of 1997

The private contracting provision was originally introduced as a floor amendment to the BBA 97 by Senator Kyl. As originally included in the Senate-passed bill, the provision would have specified that nothing in Medicare law could prohibit a physician, or another health care professional, who does not provide items and services under Medicare, from entering into a private contract with a Medicare beneficiary for services for which no claim is to be submitted. Medicare's limiting charges would not have applied to these services. The provision was intended to apply only to physicians who were outside of Medicare entirely. The provision was opposed by the White House during conference. The conferees agreed to modify the provision to incorporate a number of beneficiary protections (discussed below). The provision was enacted into law on August 5, 1997.

The enacted version of the BBA 97 provision permits private contracting, under specified conditions. A contract must provide specified beneficiary protections. It must be written and signed by the beneficiary before services are provided pursuant to the contract. It can not be entered into at a time when the beneficiary is facing an emergency or urgent health care situation. The contract must also clearly indicate to the beneficiary that by signing the contract the beneficiary agrees not to submit a Medicare claim; agrees to be responsible, whether through insurance or otherwise, for payments for services; understands that no Medicare reimbursement will be provided; acknowledges that no Medicare charge limits apply; understands that Medigap plans do not, and other supplemental insurance plans may elect not to, make payments for such items and services; and understands that the beneficiary has the right to have services provided by other physicians for whom Medicare payment would be made.[6]

BBA 97 specified that an affidavit must be in effect at the time services are provided pursuant to the contract. It must be in writing and signed by the physician or practitioner and filed with HHS. This would enable HHS to know which physicians have entered into private contracts and prevent double payment. The affidavit must state that the physician or practitioner will not submit *any* Medicare claim for any item or service provided to a Medicare beneficiary (and will not receive any reimbursement for any such item or service) for a 2-year period beginning on the date the affidavit is signed. In other words, a physician entering a private contract is out of the Medicare program for 2 years. (The Senate-passed provision applied to a physician "who does not provide items or services" under Medicare. The period of time that a physician or other practitioner would have to

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[6] This applies only to Medicare beneficiaries who have chosen to enroll in the optional Medicare Part B program. Part B coverage requires the payment of a monthly premium. Medicare beneficiaries who opt out of Part B are not affected by the provisions in BBA 97. They are allowed to private contract with physicians in order to obtain services otherwise covered by Part B enrollment.

be out of Medicare was not specified. BBA 97 specifies 2 years.) The BBA 97 also includes enforcement provisions. If a physician or practitioner signing an affidavit knowingly and willfully submits a Medicare claim (or receives Medicare reimbursement for) an item or service during such 2-year period, the ability to provide services under the private contract provision would not apply for the remainder of the period. Further, the physician or practitioner could not receive Medicare payments during such period.

It should be noted that *the 2-year limitation applies to physicians*. Under BBA 97, a beneficiary who enters into a private contract with one physician would continue to be able to see other physicians who were not private contracting physicians and have Medicare pay for these services. The 2-year exemption does not directly apply to beneficiaries. However, the limit does indirectly affect beneficiaries since Medicare will not pay for any services provided by private contracting physicians during the 2-year period. If the beneficiary wishes to see a private contracting physician, the beneficiary will be liable for 100% of all charges, with no limits on these charges. When the provision was enacted many speculated about its limited use since patients would have to pay 100% out-of-pocket for services. These patients had already made partial payment for Medicare coverage of physician services through payment of the Part B premium.

Response to Balanced Budget Act of 1997

The private contracting provision has received substantial media attention. The provision creates a limited opportunity for private contracting. However, proponents of private contracting do not believe the BBA 97 provision goes far enough. They suggest that with the 2-year exclusion, private contracting would remain more restrictive than that of the nationalized health system of Britain. Proponents also suggest that persons who want to keep some physician contracts strictly confidential (such as visits to psychiatrists) should be allowed to do so. Furthermore, proponents argue that wealthy Medicare beneficiaries unfairly use scarce public program resources for services which they are able to pay for out-of-pocket if they choose to do so. Therefore, having more wealthy Medicare eligibles elect private contracts preserves scarce public dollars for those who truly require assistance in financing their medical expenses — allowing some savings for Medicare. For these reasons organizations like the AMA have supported private contracting without a requirement that a physician exit Medicare for a period of time.

Other observers point to beneficiary protections as a reason to maintain the 2-year exemption. They argue that the 2-year exemption is the only disincentive for physicians to move into private contracting. Therefore, this disincentive to private contract protects beneficiaries from losing local physicians to a private contracting system. Opponents of private contracting suggest that despite the beneficiary protections incorporated in BBA 97, beneficiaries may not become fully aware of the implications of private contracting until they are faced with a large bill which they have to pay 100% out-of-pocket.

Organizations such as the American Association of Retired Persons (AARP) have publicly opposed private contracting altogether for these and other reasons. The AARP and others want protections to ensure that private contracting does not create opportunity for fraud and abuse. They suggest that under a case-by-case private contracting system Medicare, or a Medicare managed care plan, would have difficulty in identifying private contracting cases. As a result, physicians could fraudulently double bill and collect from both the patient and the program.

Medicare Beneficiary Freedom to Contract Act (H.R. 2497. S. 1194)

Since passage of the BBA 97 provision, a number of parties recommended passage of legislation which more closely parallels the original private contracting provision sponsored by Senator Kyl. The Medicare Beneficiary Freedom to Contract Act (H.R. 2497) was introduced in the House by Representative Archer on September 18, 1997. The companion measure (S. 1194) was introduced in the Senate on the same date by Senator Kyl. As of October 9, 1997, the House bill had 109 cosponsors and the Senate measure had 42 cosponsors. Arguments for and against these proposals are similar to those discussed above.

H.R. 2497/S. 1194 makes a number of changes to the BBA 97 provisions. The bills would *eliminate the BBA provisions* which: (1) require physicians entering private contracts to file an affidavit with the Secretary of HHS; (2) prohibit physicians with private contracts from billing Medicare for any services for a 2-year period; and (3) specify enforcement provisions for physicians with private contracts who bill Medicare (or receive Medicare payments) during the 2-year period.

The proposed legislation would also clarify the private contracting provisions under BBA 1997. The revised legislation would specify that beneficiaries are free to enter into private contracts provided certain conditions are met. It would specify that private contracting provisions relate only to *Medicare covered* services. (As under current law, beneficiaries could enter into private contracts for non-covered services, for example, cosmetic surgery.) The private contract would specify the scope of services covered under the contract and the period, *if any*, to be covered under the contract. The contract could not cover any services provided before the contract was entered into. It could also not cover the treatment of an emergency medical condition, unless the contract was entered into before the onset of the emergency medical condition. While not specifically stated, the language appears to allow private contracting on a service-by-service basis.

The proposed legislation would continue the prohibition on making any claims for Medicare payments for services provided under a private contract. It would specify that a contract could be entered into if, in addition to meeting other requirements, the Secretary was provided with the minimum information necessary to avoid making any payment under the Medicare fee-for-service program for services covered under the contract. Similarly, for individuals enrolled under a Medicare managed care arrangement, the organization would have to be provided with the minimum information necessary to avoid any payment under such arrangement for services covered by the private contract. The legislation does not specify how this minimum information would be provided.

The proposed legislation would generally retain the contract disclosure requirements contained in BBA 97. It would specify that the parties to a private contract could mutually agree at any time to modify or terminate the contract.

The legislation would clarify that persons who have elected medical savings accounts (MSAs) under the demonstration program authorized under BBA 97 would not be subject to the private contracting provisions. (See *Medical Savings Accounts: Legislation in the 105th Congress,* CRS Report 97-643, by Bob Lyke.) It would also clarify that these individuals are not subject to Medicare's balance billing restrictions.