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Health, Education, and
Human Services Division
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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.

[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.

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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.

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[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. What was the law concerning private contracting before the Balanced Budget Act of 1997 was enacted?

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. 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.

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

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[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.

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

ENCLOSURE 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."

ENCLOSURE ENCLOSURE

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.

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