National Center for Policy Analysis

BRIEF ANALYSIS
No. 268
For immediate release:
Thursday, June 4, 1998

Answering the Critics of Medicare Private Contracting

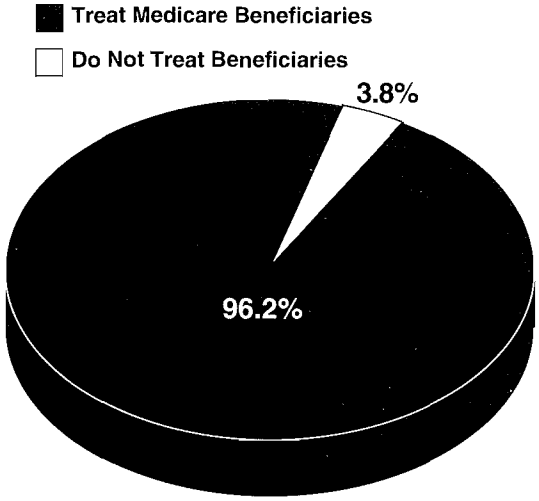
A National Public Radio story on William Delashmit, 72, recently highlighted the problem of Medicare private contracting. Delashmit suffers from Cogan's dystrophy, an abnormality of the cornea that has caused him to lose sight in his right eye. There is a 95 percent chance laser surgery could restore his sight.

Unfortunately, Dr. William Stark of Johns Hopkins University, Delashmit's physician, may not be able to help him. According to Stark, "Medicare reimburses $400 for the procedure. The problem is, we use a laser that costs a half-million dollars, and the people who own the laser charge us $800 to use the laser."

The best solution would be to take the $400 Medicare reimbursement and let Delashmit pay the $400 difference. But that is against the law.

The next best solution would be to let the patient contract privately with the physician by paying out of pocket for the entire cost of the procedure. But under the Balanced Budget Agreement of 1997, that is also illegal unless the physician is willing to refuse any Medicare reimbursements for two years. Since about 96 percent of all doctors receive at least part of their income from Medicare, few doctors are willing to contract privately. [See the figure.] Thus the law effectively denies seniors the freedom to spend their own money on health care.

Physicians and Medicare*



* Excludes pediatricians.

Source: American Medical Association: Medicare Involvement Among Physicians, 1994-96 (Sept. 30, 1997).

What is the issue behind private contracting? Under current law, seniors on Medicare may pay out of pocket for items and services such as prescription drugs, screenings and other specifically designated procedures. However, there are many services that Medicare normally covers, but may refuse to if Health Care Financing Administration (HCFA) officials deem them unnecessary. In addition, some seniors may want to bypass the Medicare process completely for personal reasons such as privacy concerns.

A new law introduced by Sen. Jon Kyl (R-Ariz.) and House Ways and Means Chairman Bill Archer (R-Texas) would eliminate the two-year exclusion period and permit seniors to contract privately with physicians. But opponents of private contracting have raised a number of objections, many of which they did not raise in earlier phases of the debate and have only recently come to embrace.

Objection #1: Doctors would take advantage of patients. To slow the growth of Medicare spending, Congress has occasionally cut the amount of money — actually, reduced the rate of growth — that Medicare reimburses physicians, hospitals and other health care providers. Currently, Medicare pays, on average, only about 70 percent of what physicians would normally charge for a service and, in cases such as Delashmit's, much less.

Opponents of Medicare private contracting contend that doctors — especially those practicing in rural areas where the supply of physicians is limited — would try to persuade their elderly patients to pay the full price of a procedure out of pocket. And they would try to make this agreement at a time when senior patients were most vulnerable. This concern led private contracting opponent Rep. Pete Stark (D-Calif.) to introduce his "No Private Contracts to Be Negotiated When the Patient Is Buck Naked Act of 1997" (H.R.2784).

What this criticism overlooks is that physicians can already charge 15 percent more than Medicare if they "refuse assignment" (i.e., they do not accept Medicare's reimbursement rate). Yet only about 20 percent of physicians choose to do so.

Furthermore, managed care for those under age 65 often pays physicians less than Medicare. Yet physicians do not try to collect more money by talking those

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patients into paying out of pocket. Indeed, physician surveys indicate that they would be willing to *lower* their fees when patients pay out of pocket because physicians could bypass the costly and time-consuming claims process. Besides, if a patient under age 65 voluntarily chose to bypass private insurance and pay out of pocket for a procedure, no one would care — certainly not the insurance company, which would be glad not to have to pay the medical expense.

Objection #2: Private contracting would increase total health care costs. Private contracting opponents argue that besides seeking to increase their incomes by contracting privately with patients for more than Medicare pays, many physicians would commit fraud by billing both patients and Medicare for the same service. In both instances total health care spending would rise, either because patients would pay more than Medicare or because doctors would double-bill.

Critics of private contracting assume physicians will always charge seniors more than the Medicare reimbursement. However, the issue of private contracting is silent about the fee being charged. Under a private contract, a senior could pay a physician the same as the Medicare reimbursement, or less. Assuming the physician would charge more is simply wrong.

Objection #3: Seniors can already pay for Medicare services. Opponents of the Kyl-Archer bill argue that private contracting is unnecessary since Medicare beneficiaries can already pay out of pocket for services.

If a physician believes that Medicare may not cover a service or procedure — Medicare sometimes determines a service to be unnecessary — the physician can ask the patient to sign an Advanced Beneficiary Notice (ABN), which means the patient may be responsible for payment if Medicare refuses to pay. If Medicare denies payment, the physician can try to collect from the patient. But since Medicare also informs the patient that the service was unnecessary, this could raise questions in the patient's mind about the physician's judgment, thereby undermining the physician-patient relationship.

In addition, the Office of Inspector General (OIG) continually monitors such requests to ascertain whether physicians are requesting a disproportionate share of unnecessary claims. When the OIG determines this is the case, the physician is subject to fines up to $10,000 and/or expulsion from Medicare.

So a physician who contracts with a senior runs the risk of not getting reimbursed for the service if Medicare deems the service unnecessary, being investigated for fraud and being penalized if found guilty.

In addition, HCFA officials have recently discovered that seniors have the right to pay out of pocket for any Medicare-covered service and ask that the physician not file a claim with Medicare. The only restriction is that the physician must charge the Medicare-approved reimbursement rate.

However, HCFA's newfound support counters its original claim in *Stewart v. Sullivan*, the 1992 case that made private contracting a national issue. Under the suit, five nursing home patients wanted to see their physician more than the once a month for which Medicare paid. Although the patients were willing to pay out of pocket for the care, HCFA held that the physician could not see the patients without filing a claim and that if the patients wanted to pay out of pocket, they could write a check to the federal government.

But if HCFA officials are concerned that physicians will double-bill, why aren't they opposed to this provision they now support, since physicians could bill the patient *and* bill Medicare? Indeed, Kyl-Archer has a provision — one that some supporters of the bill want removed and that probably could be dropped considering HCFA's new position — requiring physicians to report to Medicare that a service was performed. Thus if the concern is double-billing, Kyl-Archer may be safer than current law.

Conclusion. The real issue behind opposition to Medicare private contracting is control — who will control seniors' health care. Opponents of private contracting have recently gone out of their way to convince people that seniors already have freedom of choice — a position HCFA officials and many members of Congress never took before the Kyl-Archer bill — and that restrictions on private contracting are an attempt to control physicians, not patients.

If that were true, William Delashmit could get the care he needs. Unfortunately, he cannot. "Why should government be able to tell me that I can't spend my own money to get medical treatment?" asks Delashmit. If private contracting were available, he could see out of his right eye again. Instead, all he sees is the Medicare bureaucracy.

This Brief Analysis was prepared by NCPA Vice President of Domestic Policy Merrill Matthews Jr.