

reductions. Thus, NASD Regulation believes that, under most circumstances, below-breakpoint sales made pursuant to a bona fide asset allocation program do not constitute a breakpoint violation. Moreover, NASD Regulation does not want to discourage its members from suggesting asset allocation investment options to those customers who would benefit from such strategies.

To aid in distinguishing between bona fide and improper below-breakpoint sales, NASD Regulation proposes amendment of IM-2830-1 to more precisely identify the facts and circumstances the staff will consider when reviewing a particular below-breakpoint sale. Specifically, IM-2830-1 will be amended to provide that NASD Regulation examination staff, in reviewing a below-breakpoint sale, will consider, among other things, (1) whether a member has retained records demonstrating that the transaction was executed in accordance with a bona fide asset allocation program and (2) whether the particular customer involved was informed that volume sales reductions would not be available for the particular sale due to the allocation of the total purchase among a variety of funds.

## II. Discussion

The Commission has determined to approve the Association's proposal to amend IM 2830-1. The standard by which the Commission must evaluate a proposed rule change is set forth in Section 19(b) of the Act. The Commission must approve a proposed NASD rule change if it finds that the proposal is consistent with the requirements of Section 15A of the Act<sup>4</sup> and the rules and regulations thereunder that govern the NASD.<sup>5</sup> In evaluating a given proposal, the Commission examines the record before it. In addition, Section 15A of the Act establishes specific standards for NASD rules against which the Commission must measure the proposal.<sup>6</sup>

The Commission believes that the proposal to amend IM-2830-1 to clarify the application of the mutual fund breakpoint sales rule to modern portfolio investment strategies such as a bona fide asset allocation plan is consistent with Section 15A(b)(6) of the Act in that it is designed, among other things, to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of

trade, and, in general, to protect investors and the public interest.<sup>7</sup>

The Commission agrees with NASD Regulation that the proposal promotes just and equitable principles of trade by providing enhanced guidance to both NASD members and the NASD Regulation examination staff regarding the application of the Association's breakpoint sales rule. The Commission further believes that the proposal, by drawing attention to the importance of (a) maintaining records describing the reasons for a particular asset allocation plan, and (b) disclosing breakpoint sales practices and discounts to customers, the rule should help to deter fraudulent and manipulative acts and practices by NASD members.

## III. Conclusion

The Commission believes that the proposed rule change is consistent with the Act, and, particularly, with Section 15A thereof.<sup>8</sup> In approving the proposal, the Commission has considered its impact on efficiency, competition, and capital formation.<sup>9</sup>

*It is therefore ordered*, pursuant to Section 19(b)(2) of the Act,<sup>10</sup> that the proposed rule change (SR-NASD-98-69) is approved.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.<sup>11</sup>

Margaret H. McFarland,  
Deputy Secretary.

[FR Doc. 98-30825 Filed 11-17-98; 8:45 am]

BILLING CODE 8010-01-M

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## SOCIAL SECURITY ADMINISTRATION

### Demonstration to Improve Enrollment in State Buy-in to Medicare for Low-Income Medicare Beneficiaries

**AGENCY:** Social Security Administration.

**ACTION:** Notice, request for comments and solicitation for demonstration participation by States.

**SUMMARY:** Title IV of Division A, Social Security Administration, of the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999, Public Law 105-277, directs the Commissioner of Social Security to expend \$6,000,000 for Federal-State partnerships which will evaluate means to promote the Medicare buy-in programs targeted to elderly and disabled individuals under titles XVIII

and XIX of the Social Security Act (the Act). Administration of the Medicare buy-in programs described in titles XVIII and XIX of the Act is the responsibility of the Administrator of the Health Care Financing Administration (HCFA) in the Department of Health and Human Services. The Commissioner of Social Security is responsible for the Social Security and Supplemental Security Income (SSI) programs described in titles II and XVI of the Act.

The Medicare and Medicaid programs are statutorily linked to the programs administered by the Social Security Administration (SSA). Because of this linkage, SSA provides certain Medicare- and Medicaid-related services to HCFA, the States and to SSA's beneficiaries. Among these services are public service information activities about the Medicare and Medicaid programs, categorically needy Medicaid eligibility determinations in most States and referral activities for certain Medicaid benefits in all States. The scope of SSA's involvement in the Medicare and Medicaid programs is defined in the Act and in agreements between SSA and HCFA and between SSA and the States.

The demonstration project specified in Public Law 105-277 will assist SSA's low-income disabled beneficiaries and beneficiaries age 65 and over who are or could be eligible for Medicaid benefits to help pay their Medicare costs. SSA intends to work with HCFA to identify and investigate barriers and to foster enrollment of those beneficiaries in the Medicare buy-in programs. SSA is requesting public comment about these plans and soliciting States to express their interest in participating in this demonstration.

**DATES:** Interested persons are invited to submit comments on or before December 18, 1998. States interested in participating in this demonstration should submit expressions of interest on or before December 18, 1998 to the address below.

**ADDRESSES:** Written comments and expressions of State interest in participation should be addressed to Craig A. Streett, Office of Program Benefits, Social Security Administration, 6401 Security Boulevard, Room 3-M-1 Operations Building, Baltimore, MD 21235, or should be electronically mailed to the internet address [Craig.Streett@ssa.gov](mailto:Craig.Streett@ssa.gov), or should be faxed to 410-966-0980. All comments and expressions of State interest in participation received at the internet address will be acknowledged by electronic mail to confirm receipt.

<sup>4</sup> 15 U.S.C. 780-3.

<sup>5</sup> 15 U.S.C. 78s(b).

<sup>6</sup> 15 U.S.C. 780-3.

<sup>7</sup> 15 U.S.C. 780-3(b)(6).

<sup>8</sup> 15 U.S.C. 780-3.

<sup>9</sup> 15 U.S.C. 78(c)j.

<sup>10</sup> 15 U.S.C. 78s(b)(2).

<sup>11</sup> 17 CFR 200.30-3(a)(12).

**FOR FURTHER INFORMATION CONTACT:**

Craig A. Streett, (410) 965-9793. Individuals who use a telecommunications device for the deaf (TDD) may call 1-410-966-5609 between 7:00 AM and 7:00 PM, Eastern Time, Monday through Friday.

**SUPPLEMENTARY INFORMATION:** Section 226 of the Act [42 U.S.C. 426] describes the rules for entitlement to Medicare Hospital Insurance (HI) benefits, also known as Medicare Part A. Generally, Social Security beneficiaries who have attained age 65 are entitled to Medicare Part A benefits without filing an application or other request for those benefits, as are disabled beneficiaries who have received 24 consecutive months of Social Security benefits. Under section 226A of the Act [42 U.S.C. 426-1], certain individuals who suffer from end stage renal disease can also become entitled to Medicare HI benefits. Some individuals may also be entitled to Medicare HI benefits through purchase under the rules in sections 1818 and 1818A of the Act [42 U.S.C. 1395i-2 and 1395i-2a].

Section 1840 of the Act [42 U.S.C. 1395s] describes the rules for purchase of Medicare Supplementary Medical Insurance (SMI) benefits, also known as Medicare Part B. Generally, Medicare Part B benefits will begin when Medicare Part A benefits begin unless the beneficiary declines the Part B benefits. Usually the beneficiary is responsible for the payment of a monthly premium for Medicare Part B benefits. Section 1843 of the Act [42 U.S.C. 1395v] describes the agreements States may enter into to purchase SMI benefits for some individuals. The purchase of SMI benefits by a State for an individual is referred to as "Medicare Part B buy-in."

Section 1902(a)(10)(E) of the Act [42 U.S.C. 1396a(a)(10)(E)] requires each State's plan for medical assistance to provide for Medicare cost-sharing (including Medicare Part B buy-in) for certain groups of low-income individuals. Some of the groups of low-income individuals are:

1. *Qualified Medicare beneficiaries (QMBs).* QMBs are individuals who are eligible for Medicaid payment of their Medicare premiums, deductibles and coinsurance. QMBs must be entitled to Medicare HI benefits (through their own entitlement or by purchase). QMBs must also have income that does not exceed the Federal poverty level (FPL) after application of the SSI income exclusions, and have resources with values that do not exceed twice the SSI standards after application of the SSI resources exclusions.

2. *Specified low-income Medicare beneficiaries (SLMBs).* SLMBs are Medicare beneficiaries who would be QMBs but for income which exceeds the FPL but is less than 120 percent of the FPL after application of the SSI income exclusions. SLMBs are eligible for Medicare Part B buy-in.

3. *Qualified individuals—1 (QI-1s).* Subject to the availability of funding, QI-1s are Medicare beneficiaries who would be QMBs or SLMBs but for income which exceeds the allowable limit but is less than 135 percent of the FPL after application of the SSI income exclusions. QI-1s are eligible for Medicare Part B buy-in.

For most Medicare beneficiaries, Medicare entitlement is an automatic result of Social Security entitlement when other statutory factors of Medicare eligibility are met. Thus, most Medicare beneficiaries also are beneficiaries of the Social Security program administered by SSA. Because of the linkage between Medicare entitlement and Social Security entitlement in title II of the Act and the duties of the Commissioner of SSA in title VII of the Act, both SSA and HCFA have Medicare entitlement responsibilities. In addition, SSA performs additional enrollment and other Medicare-related activities under the auspices of agreements between HCFA and SSA.

Many States have entered into agreements with SSA for SSA to make categorically needy Medicaid eligibility determinations for the State's SSI beneficiaries under the authority in section 1634 of the Act [42 U.S.C. 1383c]. Acting on behalf of States with such agreements, SSA processes Medicare Part B buy-in for SSI beneficiaries who are eligible for this assistance under the rules in section 1843 of the Act.

Although Medicare entitlement usually is a product of the Social Security entitlement process, Medicare Part B buy-in eligibility determinations are a Medicaid process. Under title XIX of the Act, Medicaid is State-administered under the terms of State plans approved by HCFA. SSA plays only a limited role in qualifying individuals for Medicare Part B buy-in. SSA does make some buy-in decisions in certain States, but only for SSI beneficiaries. SSA also publicizes the availability of the Medicare Part B buy-in programs in its field offices and through the SSA toll-free number, 1-800-SSA-1213.

A lack of awareness about the Medicare Part B buy-in programs appears to be one of the major obstacles to enrollments. Other obstacles to enrollments have also been suggested,

including the confusion of potential eligibles as to how to apply for these programs and a preference for dealing with SSA field offices rather than with local welfare offices.

Because of the low enrollments in the Medicare Part B buy-in programs, SSA will conduct a Medicare Part B buy-in demonstration to assist our beneficiaries. The two-part demonstration will be designed to identify and overcome the obstacles to Medicare Part B buy-in enrollments for QMBs, SLMBs and QI-1s. Conferring with HCFA, SSA intends to implement both internal and external components of the demonstration, and SSA invites States to form Federal-State partnerships with SSA to participate in this demonstration.

As currently envisioned, the internal component of the demonstration would involve increased Medicare Part B buy-in referral activities by SSA employees when contacted by Medicare-entitled beneficiaries. An example of this type of increased referral activities may be eligibility screening and subsequent direct notification of Medicaid State agencies when a Social Security beneficiary appears to be potentially eligible for Medicare Part B buy-in. Currently, SSA suggests that beneficiaries get in touch with the Medicaid State agency to discuss eligibility for Medicare Part B buy-in without identifying those beneficiaries to the State.

Medicare-entitled Social Security beneficiaries routinely contact SSA for a number of reasons, such as reports of the death of a spouse. When informed of a spouse's death, SSA recomputes the widow(er)'s benefit to determine if the widow(er) might be entitled to a larger monthly benefit. In all States, SSA could use these contacts to screen carefully for potential Part B buy-in eligibility and both refer the caller to the Medicaid State agency and provide identifying information about potential Medicare Part B buy-in eligibility to the Medicaid State agency for State-initiated followup.

The external component of the demonstration would involve Federal-State partnerships. State partners that wish to participate in the demonstration would provide ZIP code information that relates to areas within each State with a high proportion of low-income aged and disabled Medicare beneficiaries who could be eligible but are not participating in the Medicare Part B buy-in programs. State participants would join with SSA in publicizing this demonstration in the targeted communities. Some State partners also would be involved in

educating SSA employees about the State welfare Medicare buy-in application process, and/or providing welfare workers who would be assigned to take applications in SSA field offices at certain mutually agreeable, fixed times during the demonstration.

SSA expects to implement the external part of this demonstration in no more than 15 communities. That is, SSA and its State partners would identify three sets of up to five comparable communities in several States. Each set of five comparable communities would be selected to participate in each of the following three models:

1. *Screening*—Publicity would direct Medicare beneficiaries who may be potentially eligible for Medicare Part B buy-in to contact a toll-free telephone number staffed by SSA employees. SSA staff would perform an in-depth Medicare Part B buy-in eligibility screening if at all possible while the caller is on the telephone. Potential eligibles would then be referred to the local welfare office to file applications for benefits, and SSA would track the progress of those applications with the State partner.

2. *Co-location*—In addition to the publicity and screening efforts cited in the preceding model, potential Medicare Part B buy-in eligibles also would be invited to file an application for benefits with a State welfare worker stationed (for at least some fixed part of the week) at the local SSA office.

3. *Application*—In addition to the publicity and screening efforts cited in the preceding two models, potential Medicare Part B buy-in eligibles would be invited to file an application for those benefits, completing the appropriate forms with an SSA employee at the local SSA office.

SSA does not envision all three of these models starting at exactly the same time. Federal information collection clearance procedures, training, logistical details and mutual convenience for both the Federal and State partners will dictate starting dates. SSA expects these models to end within nine months after implementation.

SSA intends to employ an independent contractor to consult on the design of the demonstration and to conduct an evaluation of the net outcomes (e.g., increased applications to and enrollments in the buy-in programs) of the demonstrations. The role of the contractor in the design phase of the demonstration will be to advise SSA on how to implement the three models described above. SSA will be responsible for collecting data, and SSA will develop a management information system. The contractor will assist SSA

and the States in specifying key data elements to enhance data comparability across sites. This system may include existing SSA administrative data as well as data collected through the demonstration. Designs that the contractor will consider include both experimental and nonexperimental approaches. An experimental design might involve a random assignment of cases to treatment and control groups, while a nonexperimental design could include the collection of analogous data from comparison sites. Each has important implications for the implementation of the three models and for the development of the management information system. State partners will be expected to cooperate with the contractor at key points of the design and evaluation activities. The contractor will be expected to consult with HCFA on its activities. Both the internal and external components of this demonstration will be designed to avoid duplicating any other Federal efforts.

The evaluation component will include analyses of the relative effectiveness of the three models in terms of increasing Medicare Part B buy-in applications from the eligible population and increasing enrollments in the buy-in programs. The evaluation also will include a comparison of buy-in program applications and enrollments under the SSA interventions versus HCFA publicity efforts. An appropriate design is critical to proper measurement of increases in Medicare Part B buy-in enrollments.

SSA invites the public to comment on its proposed demonstration design. SSA also invites States to express interest in participating in this demonstration. State partners in the demonstration may be asked to implement any or all of the models described above; however, if a State that wishes to participate would prefer participation in less than all three models, those preferences will be honored to the extent possible.

**Authority:** Division A, Title IV of Public Law 105-277.

Dated: November 13, 1998.

**Kenneth S. Apfel,**

*Commissioner of Social Security.*

[FR Doc. 98-30873 Filed 11-17-98; 8:45 am]

BILLING CODE 4190-29-P

## DEPARTMENT OF STATE

### Office of the Secretary

[Public Notice No. 2932]

### Nigeria; Determination Under Presidential Proclamation

I hereby make the determination provided for in section 6 of Presidential Proclamation No. 6636, of December 10, 1993, that the suspension of entry into the United States as immigrants and nonimmigrants of persons who formulate, implement or benefit from policies that impede Nigeria's transition to democracy is no longer necessary. Restrictions imposed in said proclamation, pursuant to Section 212(f) of the Immigration and Nationality Act of 1952 as amended (8 U.S.C. 1182(f)), shall therefore lapse, and said proclamation shall terminate effective immediately.

This determination will be reported to Congress and published in the **Federal Register**.

Dated: October 26, 1998.

**Madeleine K. Albright,**  
*Secretary of State.*

[FR Doc. 98-30760 Filed 11-17-98; 8:45 am]

BILLING CODE 4710-10-M

## DEPARTMENT OF STATE

### Office of the Secretary

[Public Notice: 2924]

### Extension of the Restriction on the Use of United States Passports for Travel to, in, or Through Libya

On December 11, 1981, pursuant to the authority of 22 U.S.C. 211a and Executive Order 11295 (31 FR 10603), and in accordance with 22 CFR 51.73(a)(3), all United States passports were declared invalid for travel to, in, or through Libya unless specifically validated for such travel. This restriction has been renewed yearly because of the unsettled relations between the United States and the Government of Libya and the possibility of hostile acts against Americans in Libya.

The Government of Libya still maintains a decidedly anti-American stance and continues to emphasize its willingness to direct hostile acts against the United States and its nationals. The American Embassy in Tripoli remains closed, thus preventing the United States from providing routine diplomatic protection or consular assistance to Americans who may travel to Libya.

*From funds provided under the first paragraph, not less than \$200,000,000 shall be available for conducting continuing disability reviews.*

*From funds provided under the first paragraph, the Commissioner of Social Security shall direct \$6,000,000 for Federal-State partnerships which will evaluate means to promote Medicare buy-in programs targeted to elderly and disabled individuals under titles XVIII and XIX of the Social Security Act.*

*In addition to funding already available under this heading, and subject to the same terms and conditions, \$355,000,000, to remain available until September 30, 2000, for continuing disability reviews as authorized by section 103 of Public Law 104-121 and section 10203 of Public Law 105-33. The term "continuing disability reviews" means reviews and redeterminations as defined under section 201(g)(1)(A) of the Social Security Act as amended.*

*In addition, \$75,000,000 to be derived from administration fees in excess of \$5.00 per supplementary payment collected pursuant to section 1616(d) of the Social Security Act or section 212(b)(3) of Public Law 93-66, which shall remain available until expended. To the extent that the amounts collected pursuant to such section 1616(d) or 212(b)(3) in fiscal year 1999 exceed \$75,000,000, the*

## CORPORATION FOR PUBLIC BROADCASTING

The conference agreement includes language proposed by the Senate providing an additional \$15,000,000 for digitalization, if specifically authorized by subsequent legislation by September 30, 1999. The Federal Communications Commission (FCC) has mandated that all public television stations be converted from analog to digital transmissions by May 2003. Public broadcasting stations face substantial financial obstacles in meeting this schedule. Digital conversion will cause extreme hardship on small rural stations and the conference agreement encourages that funds provided be targeted to those stations with the most financial need.

## FEDERAL MEDIATION AND CONCILIATION SERVICE

The conference agreement includes language proposed by the Senate regarding the authority of the Director to accept and use gifts.

## INSTITUTE OF MUSEUM AND LIBRARY SERVICES

The conference agreement provides \$166,175,000 for the Institute of Museum and Library Services instead of \$146,340,000 as proposed by the House and \$156,340,000 as proposed by the Senate. Within this amount, the conference agreement sets aside \$25,000,000 for national leadership projects, including \$4,000,000 for a broad-based competition on improving the quality of library and museum services. This competition shall be administered in a manner consistent with the requirements applicable in authorizing statutes and the Institute's General Administrative Manual. In administering this competition, the Director shall give full and fair consideration to applications submitted by the institutions identified in the Senate Report (105-300) and in this statement of the managers. The Metropolitan Museum of Art has undertaken an innovative project to record and library digital photographs of a substantial portion of its collection, which is the largest collection in the Western Hemisphere. In order to assist the Museum make its collection available to students and library patrons throughout the Nation, the Director is encouraged to provide \$500,000 for this project. In addition, the Director is encouraged to continue a National Leadership grant award to an historic medical library.

The conference agreement includes \$10,000,000 for the National Constitution Center for exhibition design, program planning, and operation of the Center to engage all citizens in understanding the Constitution and its history. The conference agreement includes \$750,000 for the Digital Geospatial and Numerical Data Library at the University of Idaho. The conference agreement includes \$1,250,000 for the Franklin Institute in Philadelphia, PA to maintain and enhance the oldest scientific journal in the United States, to manage an extensive international program and to provide an innovative science education program in the library setting.

The conference agreement also includes \$2,000,000 for the New York Public Library to enhance digitization efforts to improve online access to library collections. The conference agreement includes \$35,000 for the Children's Museum in Manhattan. The conference agreement includes \$300,000 for competing transcription, indexing, cataloging, and microfilming of approximately 1,200 oral history interviews relating to Iowa labor and unions and to process and catalog approximately 800 shelf feet of labor history archival material in order to make the entire collection accessible to researchers and to the public. The conference agreement includes \$1,100,000 for the Museum of Science and Industry in Chicago, Illinois for a nautical exhibition.

## NATIONAL LABOR RELATIONS BOARD

The conference agreement provides \$184,451,000 for the National Labor Relations Board as proposed by the Senate instead of \$174,661,000 as proposed by the House.

## RAILROAD RETIREMENT BOARD

## DUAL BENEFITS PAYMENTS ACCOUNT

The conference agreement provides \$189,000,000 for dual benefits payments as proposed by the Senate instead of \$191,000,000 as proposed by the House.

## LIMITATION ON ADMINISTRATION

The conference agreement includes a limitation on transfers from the railroad trust funds of \$90,000,000 for administrative expenses as proposed by the Senate instead of \$86,000,000 as proposed by the House.

## LIMITATION ON THE OFFICE OF INSPECTOR GENERAL

The conference agreement includes a limitation on transfers from the railroad trust funds of \$5,600,000 for the Office of Inspector General as proposed by the Senate instead of \$5,400,000 as proposed by the House. The conference agreement includes a provision by the House prohibiting the use of funds for any audit, investigation or review of the Medicare program. The conference agreement makes this prohibition a permanent change in law.

## SOCIAL SECURITY ADMINISTRATION

## SUPPLEMENTAL SECURITY INCOME PROGRAM

The conference agreement includes \$21,552,000,000 for the Supplemental Security Income Program instead of \$21,495,000,000 as proposed by the House and \$21,538,000,000 as proposed by the Senate. The conference agreement includes language authorizing the Commissioner of Social Security to use \$6,000,000 for Federal-State partnerships to evaluate ways to promote Medicare buy-in programs targeted to elderly and disabled individuals. The conference agreement includes \$1,000,000 to be used to conduct policy research to support the goals of the Presidential Task Force on Employment of Adults with Disabilities. In designing and implementing research on the barriers to employment for persons with disabilities, the Social Security Administration shall consult fully with the Presidential Task Force.

## LIMITATION ON ADMINISTRATIVE EXPENSES

The conference agreement includes a limitation of \$5,996,000,000 on transfers from the Social Security and Medicare trust funds and Supplemental Security Income program for administrative activities instead of \$5,949,000,000 as proposed by the House and \$5,982,000,000 as proposed by the Senate.

The Social Security Administration operates a unique cooperative training program with the Association of Administrative Law Judges, Inc., which is recognized by State bar associations for continuing legal education credits. It is believed that this unique program will improve SSA's ability to meet its performance goals and SSA is encouraged to continue and expand its support of this program, including reimbursement of conference registration fees for the Association of Administrative Law Judges, Inc. annual training conference, to increase ALJ participation.

## OFFICE OF INSPECTOR GENERAL

The conference agreement provides \$56,000,000 for the Office of Inspector General through a combination of general revenues and limitations on trust fund transfers as proposed by the House instead of \$50,212,000 as proposed by the Senate.

## UNITED STATES INSTITUTE OF PEACE

The conference agreement provides \$12,160,000 for the United States Institute of

Peace instead of \$11,160,000 as proposed by the House and \$11,495,000 as proposed by the Senate. Funding provided above the President's request level shall be used for the Bosnia initiative described in the Congressional budget justification accompanying the fiscal year 1999 budget request.

## TITLE V—GENERAL PROVISIONS

## DISTRIBUTION OF STERILE NEEDLES

Both the House and Senate bills contain prohibitions on the use of Federal funds for the distribution of sterile needles for the injection of any illegal drug (section 505). The Senate language allows the Secretary to waive the prohibition to allow a needle exchange program if she determines that such program is effective in preventing the spread of HIV and does not encourage the use of illegal drugs and that the program is operated in accordance with criteria established by the Secretary to ensure those conditions are met. The House bill includes a strict prohibition with no waiver authority. The conference agreement is the same as the House language.

## ABORTION RESTRICTION

Both the House and Senate bills contain the Hyde amendment that was revised in the fiscal year 1998 appropriations Act. However, the House bill includes additional clarifying language to ensure that the Hyde amendment applies to all trust fund programs funded in the bill. The conference agreement is the same as the House language.

## FUND TRANSFER PROHIBITION

Both the House and Senate bills contain a provision that prohibits transfers of funds from an appropriation account in the Departments of Labor, health and Human Services and Education except as authorized in this or any subsequent appropriations Act or in the Act establishing the program for which funds are contained in this Act. The conference agreement makes this provision permanent.

## TEAMSTERS ELECTION

The conference agreement includes a general provision proposed by the House that prohibits the use of funds in this Act for the election of officers of the International Brotherhood of Teamsters. The Senate bill had no similar provision.

## UNOBLIGATED SALARIES AND EXPENSES

The conference agreement includes a general provision proposed by the House that would allow salaries and expenses funds in the bill that are unobligated at the end of fiscal year 1999 to remain available for three additional months, provided that the Appropriations Committees are notified before the funds are obligated. The Senate bill had no similar provision.

## NATIONAL LABOR RELATIONS ACT

The conference agreement does not include a general provision proposed by the House that would have amended the National Labor Relations Act to require the National Labor Relations Board to adjust its jurisdictional threshold amounts for the inflation that has occurred since the adoption of the current thresholds an August 1, 1959. The Senate bill had no similar provision.

## HEALTH IDENTIFIER

The conference agreement includes a general provision proposed by the Senate modified to provide that none of the funds in this Act may be used to adopt a final standard providing for a unique health identifier for an individual until legislation is enacted specifically approving the standard. The House bill had no similar provision.

## SALARIES AND EXPENSES REDUCTION

The conference agreement deletes section 515 of the Senate bill that would have reduced salaries and expenses appropriations



**SOCIAL SECURITY ADMINISTRATION**

**Brian D. Coyne  
Chief of Staff**

Cover Plus 1 Pages

DATE: 8/13/98

FROM:  **Office of the Commissioner  
DC Office: (202) 358-6013  
Fax #: (202) 358-6076**

TO: Chris Jennings

Location/Organization: DPC

Telephone Number: \_\_\_\_\_

FROM:  **Office of the Commissioner  
Baltimore: (410) 965-3120  
Fax #: (410) 966-1463**

Fax Number: 456-5557

**MESSAGE:**

*Attached is 1-page description of SSA's  
Proposed demonstration pilot on QMB/SLMB. Let  
me know your thoughts.*

*Brian Coyne*

File SSA

**Social Security Administration  
Qualified Medicare Beneficiary Outreach Proposal**

This paper proposes an SSA outreach demonstration for \$5 million in fiscal year (FY) 1999 to promote Medicare buy-in programs targeted to elderly and disabled individuals who are eligible for these programs, but have not enrolled.

*\$5 million  
for FY 1999*

A buy-in outreach demonstration would measure the impact of increasing the amount of public information about the existence of buy-in programs and reducing public resistance to filing because of obstacles identified in the most recent study published by Families USA.

SSA is proposing three model demonstrations each of which would be conducted in five communities, for a total of 15 communities in participating States' targeted areas. Federal Register notices would invite public comment and invite states to participate. The models are:

*5 comm.*

**1. Publicity** - Measuring the increase in welfare office buy-in participation because of a marked increase in public information including local public service radio and print announcements targeted to this population and a targeted mailing, using data available through SSA databases, to elderly and disabled residents in these areas on SSA letterhead paper. The mailing would include local or toll-free telephone information number.

*public service radio, print announce*

**2. Referrals** - Measuring increases in buy-in participation resulting from mailings that invite the beneficiary to call a toll-free number or make an appointment with the local SSA office to assess potential eligibility, or to file an application with the local welfare office. SSA will facilitate application appointments with the local welfare office and follow up on referrals with the welfare office.

*mailings*

**3. Co-location** - Measuring increases in buy-in participation in response to mailings and SSA referrals of applicants to a welfare worker outstationed in SSA offices to take applications for buy-in.

An independent contractor will consult on the design and evaluate the demonstration. Application referrals set up by SSA that do not result in buy-in applications will be evaluated to determine the reason that these outreach efforts did not result in an application.

This project will need to be financed with an additional \$5 million added to SSA's research and demonstration funding request for FY 1999. Congress would need to appropriate the requisite funding for this account and include appropriations language specifically authorizing the Commissioner to take an active role under section 1110a of the Social Security Act when performing a demonstration relating to Titles XVIII and XIX.

## SSA BUY-IN OUTREACH DEMONSTRATION

SSA would undertake a demonstration to measure the obstacles to buy-in enrollments for Medicare beneficiaries who have no current connection with the welfare or SSA office. The demonstration would take place in the 15 poorest communities in States participating due to response to Federal Register notices.

All 15 communities will receive heightened publicity (posters, radio and print public service announcements, leaflets) and outreach mailings on SSA letterhead paper to beneficiaries who could be eligible for buy-in based on available SSA information. Mailings would include a self-selection device and emphasize what income and resources are not counted (e.g., the beneficiary's home).

One-third of the communities will receive the publicity and mailings suggesting potential candidates file for buy-in benefits with the appropriate welfare office.

Two-thirds of the communities will receive publicity and mailings suggesting potential candidates file with the welfare office or call a free phone number staffed by SSA employees. SSA employees will screen callers for potential buy-in eligibility:

- In half of these communities, SSA will make appointments for potential eligibles to file applications with the local welfare office and follow up with that office.
- In the other half of these communities, SSA will make appointments for potential eligibles with a welfare worker outstationed in the SSA office.

An independent evaluator will be contracted to help with demonstration design and to determine the increase in buy-in traffic resulting from:

- Increased, targeted publicity,
- SSA serving as an intermediary in the buy-in eligibility process, and
- Redirecting the buy-in application process out of the welfare office.

The projected cost of this demonstration is \$5 M in fiscal year 1999 research and demonstration funds and will require enabling legislative language that directs use of these funds for this demonstration by SSA. This demonstration could not be funded by a Continuing Resolution without specific appropriations language. Enabling legislation should also include a specific start date or otherwise permit SSA expedited forms clearances under the Paperwork Reduction Act of 1995 for timely implementation.

*From August*

## SSA BUY-IN OUTREACH DEMONSTRATION

SSA would undertake a demonstration to measure the obstacles to buy-in enrollments for Medicare beneficiaries who have no current connection with the welfare or SSA office. The demonstration would take place in the 15 poorest communities in States participating due to response to Federal Register notices.

All 15 communities will receive heightened publicity (posters, radio and print public service announcements, leaflets) and outreach mailings on SSA letterhead paper to beneficiaries who could be eligible for buy-in based on available SSA information. Mailings would include a self-selection device and emphasize what income and resources are not counted (e.g., the beneficiary's home).

One-third of the communities will receive the publicity and mailings suggesting potential candidates file for buy-in benefits with the appropriate welfare office.

Two-thirds of the communities will receive publicity and mailings suggesting potential candidates file with the welfare office or call a free phone number staffed by SSA employees. SSA employees will screen callers for potential buy-in eligibility:

- In half of these communities, SSA will make appointments for potential eligibles to file applications with the local welfare office and follow up with that office.
- In the other half of these communities, SSA will make appointments for potential eligibles with a welfare worker outstationed in the SSA office.

An independent evaluator will be contracted to help with demonstration design and to determine the increase in buy-in traffic resulting from:

- Increased, targeted publicity,
- SSA serving as an intermediary in the buy-in eligibility process, and
- Redirecting the buy-in application process out of the welfare office.

The projected cost of this demonstration is \$5 M in fiscal year 1999 research and demonstration funds and will require enabling legislative language that directs use of these funds for this demonstration by SSA. This demonstration could not be funded by a Continuing Resolution without specific appropriations language. Enabling legislation should also include a specific start date or otherwise permit SSA expedited forms clearances under the Paperwork Reduction Act of 1995 for timely implementation.

# Federal - State Partnership Models

## ✓ Common factors

- Publicity
- Toll free phone number staffed by SSA employees
- In-depth screening
- SSA tracks progress of applications

## ✓ Screening Model

- Referrals to State welfare office for applications

## ✓ Co-Location Model

- State welfare worker in SSA office takes application

## ✓ Application Model

- SSA completes application form

# Buy-In Demonstration Program Time Line

Summer 1998

- Program design

Fall 1998

- Federal Register announcement

Winter 1998

- Identification of State participants

- Obtain design/evaluation contractor

- Development of screening device

- Training of SSA staff

Spring 1999

- Demonstration begins

# **Medicare Buy-In**

**Demonstration  
Program**

# Goal

- ✓ To find ways to use SSA processes to efficiently and effectively increase Medicare Part B buy-in participation by title II beneficiaries, including widow(er)s.

# Buy-In Demonstration

✓ 9 month demonstrations

✓ Total of 15 communities in 3-5 States

✓ Evaluation contractor

# Target

✓ Low-income disabled and aged beneficiaries, including potential:

- Qualified Medicare beneficiaries;
- Specified low-income Medicare beneficiaries;
- and
- QI - 1s

# Buy-In Demonstration Components

## ✓ Internal:

- Increased Medicare Part B buy-in screening and referral activities
- Nationwide

## ✓ External

- Federal-State partnerships
- 15 Communities
- 3 Models

## Social Security Administration Buy-In Outreach Demonstration

SSA's demonstration will promote the Medicare buy-in programs targeted to the elderly and disabled who may be eligible but have not enrolled. The demonstration will:

- measure the impact of reducing obstacles to buy-in enrollments identified in the most recent study published by Families USA, and
- intensify efforts to identify potential eligibles from the Medicare population who contact SSA, such as persons who become widow(er)s.

SSA will issue internal instructions on referring potential eligibles identified during SSA processes (such as death reports taken from new widow(er)s) to Medicaid State agencies and run a three model demonstration. Each model would be conducted in 3-5 communities, for a total of up to 15 communities, in participating States' targeted areas. A Federal Register notice will solicit public comment and invite States to participate in the demonstration. The models are:

1. **Screening** - Measuring the increase in buy-in participation resulting from SSA serving as an intermediary and facilitator for buy-in applications appointments at the welfare office.
2. **Co-location** - Measuring buy-in participation increases resulting from SSA referrals to a welfare worker outstationed in SSA offices to take buy-in applications.
3. **Application** - Measuring participation increases resulting from SSA helping applicants complete the State's buy-in application forms at the SSA office.

Each community would have a demonstration-specific, free telephone number to call staffed by SSA personnel who would screen for potential buy-in program eligibility and set up appointments for applications. In two-thirds of the communities, the application would be taken at an SSA office. In one-third of the communities, the application would be completed at the welfare office. SSA also would follow up on outstanding buy-in decisions with the welfare office.

An independent contractor will consult on the design and evaluate the demonstration to determine the increases in buy-in traffic resulting from SSA serving as an intermediary in the buy-in eligibility process, and from redirecting the buy-in application process out of the welfare office. The demonstration would not duplicate any other Federal efforts to analyze the obstacles to buy-in enrollments.

## Other SSA Buy-In Initiatives

SSA has other initiatives in place to promote Medicare buy-in. While SSA plans for the multi-State buy-in outreach demonstration and prepares new referral procedures for potential eligibles identified during SSA processing, other activities are in place to serve the needs of vulnerable aged and disabled Medicare beneficiaries:

- Program Information - 35,000,000 cost-of-living adjustment notices sent to Social Security beneficiaries this month reflect more prominent, revised and expanded Medicare buy-in program information.
- Publicity - SSA is working with the Health Care Financing Administration (HCFA) to increase publicity about the Medicare buy-in programs in SSA's field offices, publications and information campaigns.
- Targeting Eligibles - SSA has made its records available to HCFA to select beneficiaries who may be eligible for buy-in.

### In Addition

- Since the Summer, SSA issued two sets of detailed reminders to each of its 45,000 intake workers about the importance of following existing instructions to discuss the Medicare buy-in programs routinely in contacts with the public and to inform potential eligibles how to file for those programs.

QMB File

Nov. 13th

**PRESIDENT LAUNCHES NEW CAMPAIGN TO ENSURE THAT  
LOW-INCOME MEDICARE BENEFICIARIES RECEIVE PREMIUM ASSISTANCE**

**July 7, 1998**

Today, the President announced a new outreach campaign to help millions of low-income seniors and people with disabilities get assistance in paying Medicare premiums. A study by Families USA reports that over 3 million low-income Medicare beneficiaries are not enrolled in the Qualified Medicare Beneficiary (QMB) and related programs that pay for Medicare premiums and (for some) copayments and deductibles. This assistance was expanded last year in the Balanced Budget Act. However, as this new report underscores, many eligible beneficiaries are not aware of these cost-sharing protections and others have difficulty accessing this critically needed assistance.

To address this problem, the President has requested that the Department of Health and Human Services (HHS) and the Social Security Administration (SSA) launch a multi-faceted effort to enroll eligible Medicare beneficiaries in QMB and related programs. These new initiatives, that build on existing efforts to help identify and enroll eligible beneficiaries and parallel the President's efforts on children's health outreach, include:

- **Launching major new initiatives to educate Medicare beneficiaries about premium assistance programs.** HHS and SSA will make unprecedented efforts to ensuring that beneficiaries know about these programs by distributing clear, plainly written information about these programs by:
  - **Sending information to all 38 million Medicare beneficiaries** about this program in either the Medicare handbook and/or new pamphlets that will be sent to all beneficiaries this fall. ✓
  - **Informing every one of the 1.8 million new Medicare beneficiaries** about this program in the Medicare initial enrollment package that is sent to these beneficiaries. ✓
  - **Including information describing this program and an eligibility screening worksheet on the new Medicare Internet site, "www.medicare.gov,"** which is used by millions of older Americans and their families, as well as others who work with the elderly and people with the disabilities. ✓
  - **Sending program information to more than 36 million individuals receiving Social Security benefits** in the annual cost-of-living adjustment (COLA) notices this fall. ✓
  - **Distributing 450,000 pamphlets as well as placing posters in SSA's 1,300 field offices** where millions of beneficiaries go to enroll and ask questions about these programs. ✓
- **Encouraging the use of a simplified application process.** In July, the Health Care Financing Administration (HCFA) will send a letter to State Medicaid agencies that includes a model, simplified application as well as examples of successful outreach and enrollment programs. HCFA will encourage states to adopt simple, user-friendly procedures such as a mail-in application. ✓

Nov 12th

Training  
Consumer

FACA Rule

Trish Nemo, Albert Fouts, Paula USA, NSCC

Barbara  
AASP

Sunny

July

- **Creating a Federal-State-consumer advocate task force to develop new strategies to enroll eligible beneficiaries.** Beginning this month, HHS, SSA, the National Governors' Association, and advocates of the elderly and people with disabilities will collaborate to identify and implement strategies to educate beneficiaries about this program and to make it easier to enroll.
- **Targeting eligible beneficiaries through direct mailings.** This fall, HCFA will send a letter to a targeted group of beneficiaries who are likely to be eligible for these protections. The targeting population list will come from a list of beneficiaries supplied by SSA that the agency believes may be eligible. The letter will explain the program and encourage beneficiaries to apply.
- **Directing SSA field office employees to strengthen efforts to advise beneficiaries about QMB and related programs.** SSA will immediately send a reminder to all its workers about this program and encourage them to reach out to the millions of beneficiaries they see every day to ensure they are informed about these programs.
- **Providing the State Insurance Counseling and Assistance Programs (ICAs) with materials to assist beneficiaries in enrolling in the premium assistance programs.** ICAs provide assistance on insurance and benefits to millions of older and disabled Americans.

DATA enrolled vs eligible

AA

These new initiatives build on an ongoing commitment by HCFA and SSA to target and enroll these vulnerable, low income Americans. For example, HCFA has provided training materials on identifying and assisting potential beneficiaries to providers, advocates and States. SSA has included information on programs in SSA pamphlets and handouts that could reach potential candidates and conducted training for staff who interact with beneficiaries.

**Background on the QMB and related programs.** The following table shows eligibility for premium and cost sharing assistance programs, which are offered in all States.

Category	Income (Poverty)	Annual Income (1998)		Medicaid Pays For:
		Individual	Couple	
QMBs: Qualified Medicare Beneficiaries	0 to 100%	Up to \$8,290	Up to \$11,090	Medicare Part A & B premiums, deductibles, copayments
SLMBs: Specified Low-Income Medicare Beneficiaries	100-120%	\$8,291 to 9,900	\$11,091 to 13,260	Medicare Part B premium
QI-1s: Qualified Individuals 1	120-135%	\$9,901 to 11,108	\$13,261 to 14,888	Medicare Part B premium
QI-2s: Qualified Individuals 2	135-175%	\$11,109 to 14,328	\$14,889 to 19,228	Part of Medicare Part B premium

Notes: Income guidelines include a \$240 unearned income disregard; poverty thresholds are different in AK and HI. There is also an assets limit of \$4,000 for individual and \$6,000 for couples for all groups. QI programs are subject to the availability of capped funding allotments.

And to low income seniors

Medicaid Private Contracts

April 14, 1998

Note to: Bill Walters/Bill Vaughn  
Howard Cohen/Bridgett Taylor  
Alec Vachon/Katie Horton

Subject: Revised (April 1998) Program Memorandum on Private Contracts

Attached is a copy of a revised Program Memorandum on private contracts that we just issued to carriers. This April 1998 document revises the January 1998 Program Memorandum on private contracts. The questions and answers remain unchanged and were only reprinted. The revisions are in the instructions to carriers and deal with inadvertent vs. knowing and willful submission of claims by opt-out physicians. The changes are flagged. Please let us know if you have any questions.

Debbie Chang  
Director, Office of Legislation

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**PROGRAM MEMORANDUM  
CARRIERS**

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Department of Health  
and Human ServicesHealth Care Financing  
Administration

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**Transmittal No. B-98-12**

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**Date APRIL 1998**

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**CHANGE REQUEST #468****SUBJECT: Private Contracts Between Beneficiaries and Physicians/Practitioners**

The purpose of this Program Memorandum (PM) is to furnish you with material needed for the implementation of §1802 of the Social Security Act, as amended by §4507 of the Balanced Budget Act (BBA) of 1997 which permits a physician or practitioner to "opt out" of Medicare and enter into private contracts with Medicare beneficiaries if specific requirements are met.

The amendment made by §4507 of the BBA of 1997 to §1802 of the Social Security Act shall apply with respect to contracts entered into on and after January 1, 1998.

The questions and answers (Q's and A's) included in this PM differ from those previously sent to you because of recent policy decisions. The Q's and A's shown in this PM supersede any Q's and A's you have received prior to this PM.

**This is a BBA Provision.**

**These instructions should be implemented within your current operating budget.**

**This Program Memorandum may be discarded December 31, 1998.**

**The policy contact person for this Program Memorandum is Anita Heygster at (410) 786-4486.**

**The carrier operations contact person for this Program Memorandum is Rhem Gray at (410) 786-6986.**

**DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in a Program Memorandum and is only being reprinted.**

**Private Contracts Between Beneficiaries and Physicians/Practitioners.**--Section 1802 of the Social Security Act, as amended by §4507 of the BBA of 1997, permits a physician or practitioner to "opt out" of Medicare and enter into private contracts with Medicare beneficiaries if specific requirements are met.

For purposes of this provision, the term "physician" is limited to doctors of medicine and doctors of osteopathy who are legally authorized to practice medicine and surgery by the State in which such function or action is performed; no other physicians may opt out. Also, for purposes of this provision, the term "practitioner" means any of the following to the extent that they are legally authorized to practice by the State and otherwise meet Medicare requirements: physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical psychologist, or clinical social worker.

When a physician or practitioner opts out of Medicare, no services provided by that individual are covered by Medicare and no Medicare payment can be made to that physician or practitioner directly or on a capitated basis. Additionally, no Medicare payment may be made to a beneficiary for items or services provided directly by a physician/practitioner who has "opted out" of the program. Under the statute, the physician or practitioner cannot choose to opt out of Medicare for some Medicare beneficiaries but not others; or for some services but not others.

Medicare will make payment for covered, medically necessary services that are ordered by a physician or practitioner who has opted out of Medicare if the ordering physician or practitioner has acquired a unique provider identification number (UPIN) from Medicare and provided that the services are not furnished by another physician or practitioner who has also opted out. For example, if an "opt out" physician admits a beneficiary to a hospital, Medicare will reimburse the hospital for medically necessary care.

In an emergency or urgent care situation, a physician or practitioner who opts out may treat a Medicare beneficiary with whom he or she does not have a private contract. In such a situation, the physician or practitioner may not charge the beneficiary more than what a non-participating physician would be permitted to charge and must submit a claim to Medicare on the beneficiary's behalf. Payment will be made for Medicare covered items or services furnished in emergency or urgent situations when the beneficiary has not signed a private contract with that physician/practitioner.

**Effective Date of the "Opt Out" Provision.**--A physician or practitioner may enter into a private contract with a beneficiary for services furnished no earlier than January 1, 1998. The physician or practitioner must submit the affidavit to all pertinent Medicare carriers within 10 days of the date the first private contract is signed by a Medicare beneficiary.

**Contents of the Private Contract With the Beneficiary.**--Under §4507 of the BBA, a valid private contract must:

- o Be in writing and be signed by the Medicare beneficiary or the beneficiary's legal representative in advance of the first service furnished under the agreement;
- o Clearly indicate if the physician or practitioner is excluded from participation in the Medicare program under §1128 of the Social Security Act;
- o Indicate clearly that by signing the contract the beneficiary or the beneficiary's legal representative:
  - Agrees not to submit a claim or to request the physician or practitioner to submit a claim for payment under Medicare, even if such items and services would otherwise be covered by Medicare;
  - Acknowledges that Medigap plans do not, and that other supplemental insurance plans may choose not to, make payment for items and services furnished by the physician or practitioner under the contract;

- Agrees to be responsible for payment of such items or services;
- Acknowledges that no reimbursement will be provided by Medicare for such items and services;
- Acknowledges that the physician or practitioner is not limited in the amount that he or she may charge the beneficiary for the items and services furnished; and
- Acknowledges that the beneficiary has the right to have such items and services provided by other physicians/practitioners who have not "opted out" of the program.

To be valid, the agreement cannot be signed by the beneficiary or the beneficiary's legal representative when the Medicare beneficiary is facing an emergency or urgent health care situation.

**Contents of the Affidavit.**—The physician or practitioner must file an affidavit with the Medicare carrier servicing their area no later than 10 days after the first private contract is entered into. The carrier will ensure that the affidavit is valid and will keep it on file. Under §4507 of the BBA, a valid affidavit must:

- o Provide that the physician or practitioner will not submit any claim to Medicare for any item or service provided to any Medicare beneficiary during the 2 year period beginning on the later of the date the affidavit is signed or its effective date;
- o Provide that the physician or practitioner will not receive any Medicare payment for any services provided to Medicare beneficiaries either directly or on a capitated basis;
- o Identify the physician or practitioner (so that the carrier can take appropriate action to ensure no payments are made to that physician or practitioner during the opt out period);
- o As with participation agreements, affidavits must be filed with all carriers who have jurisdiction over claims the physician or practitioner would otherwise file with Medicare; and
- o Be in writing and be signed by the physician or practitioner.

**The Relationship Between This Provision and Medicare Participation Agreements.**—Participating physicians and practitioners may opt out by filing an affidavit that meets the above-described criteria and which is received by the carrier at least 30 days before the first day of the next calendar quarter showing an effective date of the first day in that quarter (i.e., 1/1, 4/1, 7/1, 10/1). Their participation agreement will terminate at that time. They may not provide services under private contracts with beneficiaries earlier than the effective date of the affidavit. Non-participating physicians and practitioners may opt out at any time.

You need to make the systems changes that will enable you to put necessary edits in place without altering the payment amounts in effect for that part of the fee schedule year before which the participating physician or practitioner opts out.

**Relationship to Non-Covered Services.**—Since Medicare rules and regulations do not apply to items or services not covered by Medicare, a private contract is not needed to furnish such items or services to Medicare beneficiaries. A private contract is needed only for items or services that would be covered by Medicare and where Medicare might make payment if a claim were submitted. Examples of services not covered by Medicare include cosmetic surgery and routine physical exams.

Similarly, where a beneficiary, who is enrolled in a Medicare risk-based managed care plan, goes out of plan to acquire a service and the plan does not cover it, the enrollee is liable for the full charge for the service and the physician or practitioner does not need to sign a private contract to collect payment for the noncovered service.

**Maintaining Information on "Opt Out" Physicians.**—Maintain information on the "opt out" physicians/practitioners. At a minimum, capture the name and UPIN of the physician/practitioner, the effective date of the "opt out" affidavit, and the end date of the opt out period. You may also include other provider-specific information you may need. If cost effective, you may house this information on your provider file.

**Informing Managed Care Plans Who the "Opt Out" Physicians Are.**—Develop data exchange mechanisms for furnishing Medicare managed care plans in your service area with timely information on physicians and practitioners who have opted out of Medicare. For example, you may wish to establish an internet website "Home Page" which houses all the "opt out" physicians/practitioners information. You will need to negotiate appropriate "opt out" information exchange mechanisms with each managed care plan in your service area.

**System Identification.**—Ensure that your system can automatically identify claims that include services furnished by providers or practitioners who have opted out of Medicare. Do not make payment to any "opt out" physician/practitioner for items or services furnished on or after the effective date of their "opt out" affidavit unless there are emergency and urgent care situations involved. In an emergency and urgent care situation, payment can be made for services furnished to a Medicare beneficiary if the beneficiary has no contract with the "opt out" physician/practitioner. Refer to the following section title, "Emergency and Urgent Care Situations".

**Emergency and Urgent Care Situations.**—Payment may be made for services furnished by an "opt out" physician/practitioner who has not signed a private contract with a Medicare beneficiary for emergency and urgent care items and services furnished to, or ordered or prescribed for such beneficiary on or after the date the physician "opted out".

In this circumstance the physician or practitioner must submit a completed Medicare claim on behalf of the beneficiary and document on an attachment that the services furnished to the Medicare beneficiary were emergency or urgent and the beneficiary does not have a private agreement with him or her. If the physician or practitioner did not submit the appropriate documentation, then deny the claim so that the beneficiary can appeal. Inform your provider community via your next Medicare Carrier Bulletin that documentation is needed in this situation.

Deny payment for emergency or urgent care items and services to both an "opt out" physician/practitioner and the beneficiary if these parties have entered into a private contract.

**Denial of Payment to Employers of "Opt Out" Physicians and Practitioners.**—If an "opt out" physician or practitioner is employed in a hospital setting and submits bills for which payment is prohibited, the Part B carrier surveillance process usually detects and investigates the situation. However, in some instances an "opt out" physician/practitioner may have a salary arrangement with a hospital or clinic or work in group practice and may not directly submit bills for payment. If you detect this situation, contact the hospital/clinic/group practice and inform them that you are reducing the amount of their payment by the amount of Federal money involved in paying the "opt out" physician/practitioner.

**Denial of Payment to Beneficiaries and Others.**—If a beneficiary submits a claim that includes items or services furnished by an "opt out" physician or practitioner on dates on or after the effective date of opt out by such physician or practitioner, deny such items or services.

**Payment for Medically Necessary Services Ordered or Prescribed By An Opt Out Physician or Practitioner.**—If claims are submitted for any items or services ordered or prescribed by an "opt out" physician or practitioner under §4507 of the BBA of 1997, you may pay for medically necessary services of the furnishing entity, provided the furnishing entity is not also a physician or practitioner that has opted out of the Medicare program.

**Mandatory Claims Submission.**—Social Security Act §1848(g)(4), Physician Submission of Claims, regarding mandatory claims submission, does not apply once a physician or practitioner signs and submits an affidavit to the Medicare carrier opting out of the Medicare program, for the duration of his/her “opt out” period, unless he/she knowingly and willfully violates a term of the affidavit.

**Violation of Agreement Not to File Claims.**—When a physician or practitioner who has “opted out” of the Medicare program and knowingly and willfully submits a bill to Medicare, the penalty is that “this subsection shall not apply with respect to any items and services provided by the physician or practitioner pursuant to any contract.....” per §1802(b)(3)(C)(i) of the Social Security Act. Thus, he or she is no longer exempt from the mandatory claims and limiting charge rules and must submit claims (which HCFA will deny per §1802(b)(3)(C)(ii) of the Social Security Act) and is bound by the limiting charge in what he/she can charge the beneficiary.

If you receive a claim from an “opt out” physician or practitioner without the required documentation of an emergency or urgently needed care situation, send him/her a letter advising him/her that you have received a claim and believe that it may have been filed in error. Ask the physician or practitioner to provide you with a response within 45 days (per Medicare Carriers Manual §3319) as to whether the received claim was: a) an emergency or urgent situation, with missing documentation; or b) filed in error.

In your development letter request that he/she submit the following information with their response:

- 1) Emergency/urgent care documentation if the claim was for a service furnished in an emergency or urgent situation but included no documentation to that effect; and/or
- 2) If the claim is was filed in error, ask the physician or practitioner to explain whether the filing was an isolated incident or a systematic problem affecting a number of claims.

In either case, explain in your request to the physician or practitioner that you would like to resolve this matter as soon as possible in order to avoid the initiation of administrative proceeding against him/her. Instruct them that they must provide the information you requested within 45 days of the date of your development letter. Provide the physician or practitioner with the name and telephone number of a contact person in case they have any questions.

If claim submission was due to a systems problem, ask the physician or practitioner to include with their response an explanation of the actions being taken to correct the problem and when he/she expects the systems error to be fixed. If the claim submission problem persists beyond the time period indicated in his/her response, re-contact him/her to ascertain why the problem still exists and when they expect to have it corrected. Repeat this process until the system problem is corrected.

Also, in your development request, advise the physician or practitioner that if no response is received by the due date you will assume the claim was submitted intentionally and that this could result in a determination that they are once again subject to Medicare rules.

Hold the claim and any others you receive from the physician or practitioner in suspense until you hear from the physician or practitioner or the response date lapses.

If the physician or practitioner responds that the claim was filed in error, continue processing the claim, deny the claim and send the physician or practitioner the appropriate Remittance Advice and send the beneficiary an EOMB with the appropriate language explaining that the claim was submitted erroneously and they are responsible for this charge. In other words, the limiting charge provision does not apply and the beneficiary is responsible for all charges. This process will apply to all claims until the physician or practitioner is able to get his/her problem fixed.

If you do not receive a response from the physician or practitioner by the development letter due date or if it is determined that the “opt out” physician/practitioner knowingly and willfully violated his or her agreement not to file claims to Medicare (except for claims for emergency or urgent care services furnished to a beneficiary with whom the physician or practitioner has not entered into a private

contract) he/she must thereafter submit claims for all services to Medicare beneficiaries (for which no Medicare payment may be made) and must abide by the limiting charge rules and regulations (which the carrier must again enforce) for the duration of the "opt out" period. In other words, the physician/practitioner's knowing and willful act of submitting a claim to the program, other than a claim for emergency/urgent care as discussed above, is in violation of the physician's or practitioner's agreement (per the affidavit) not to file such claims and makes the contract with the Medicare beneficiary null and void. **Formally notify the physician/practitioner of this determination and of the rules that again apply (e.g., mandatory submission of claims, limiting charge, etc.).**

The act of claims submission by the beneficiary for an item or service provided by a physician/practitioner who has "opted out" is not a violation by the physician/practitioner and does not nullify the contract with the beneficiary. However, if there are what you consider to be a substantial number of claims submissions by beneficiaries for items or services by an "opt out" physician or practitioner, investigate to ensure that contracts between the physician/practitioner and the beneficiaries exist and that the terms of the contracts meet Medicare statutory requirements outlined in this instruction. If non-compliance with the "opt out" affidavit is determined, develop claims submission or limiting charge violation cases, as appropriate, based on your findings.

**Notice to "Opt Out" Physicians or Practitioners.**—To ensure that the notice denying payment to the "opt out" physician or practitioner indicates the proper reason for denial of payment, include language in the notice appropriate to particular circumstances as follows:

- o Use the following message when the claim is submitted inadvertently by the "opt out" physician or practitioner. Use claim adjustment reason code 28 (coverage not in effect at the time service was provided) at the claim level with group code PR (patient responsibility) and the new claim level remark code MA47:

- "Our records show that you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As a result, we cannot pay this claim. The patient is responsible for payment."

- o Use the following message when the claim is submitted knowingly and willfully by the "opt out" physician or practitioner. Use claim adjustment reason code 28 (coverage not in effect at the time service was provided) at the claim level with group code PR (patient responsibility) and the new claim level remark code MA56:

- "Our records show that you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As a result, we cannot pay this claim. The patient is responsible for payment. Under Federal law you cannot charge more than the limiting charge amount."

**Notice to Beneficiaries.**—To ensure that the notice to the beneficiary indicates the proper reason for denial of payment, include language in the notice appropriate to particular circumstances as follows:

- o Use the following message when the claim is submitted inadvertently by the "opt out" physician or practitioner (use which ever message is appropriate for your system):

- EOMB # 21.30 — "The provider decided to drop out of Medicare. No payment can be made for this service. You are responsible for this charge."

- MSN # 21.20 — "The provider decided to drop out of Medicare. No payment can be made for this service. You are responsible for this charge."

- o Use the following message when the claim is submitted knowingly and willfully by the "opt out" physician or practitioner (use which ever message is appropriate for your system):

- EOMB # 21.29 -- "The provider decided to drop out of Medicare. No payment can be made for this service. You are responsible for this charge. Under Federal law your doctor can not charge you more than the limiting charge amount."

- MSN # 21.19 -- "The provider decided to drop out of Medicare. No payment can be made for this service. You are responsible for this charge. Under Federal law your doctor can not charge you more than the limiting charge amount."

o Use the following message when the claim is submitted by the beneficiary for a service furnished by an "opt out" physician or practitioner (use whichever message is appropriate for your system):

- EOMB # 21.30 -- "The provider decided to drop out of Medicare. No payment can be made for this service. You are responsible for this charge."

- MSN # 21.20 -- "The provider decided to drop out of Medicare. No payment can be made for this service. You are responsible for this charge."

**Reporting.**—Compile data for HCFA on the number of physicians and practitioners who sign up to privately contract with Medicare beneficiaries. Prepare a quarterly "Private Contracting" report and submit it to HCFA CO and copy your RO. Send quarterly reports to: HCFA, Center for Health Plans and Providers, Provider Purchasing and Administration Group, Division of Practitioner Claims Processing, 7500 Security Boulevard, Baltimore MD, 21244. Reports may be faxed to (410) 786-4047, Attn: CHPPs, PPAG, DPCP, in lieu of mailing a hardcopy report. Prepare a separate report for each contract jurisdiction.

Use the following report format:

Name of Report: Private Contracting Data

1. Carrier name:
2. Carrier number:
3. Quarter: (beginning and end date)
4. Number of "private contracting" affidavits received during report period:
5. Detail information: (use the following format)

<u>Specialty</u>	<u>Name/Address</u>	<u>PIN</u>	<u>UPIN</u>	<u>Par Status</u>	<u>Affidavit Receipt Date</u>	<u>Effective Date</u>
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Sort the report data by physician/practitioner specialty.

The report is due 30 days after the end of each quarter (e.g., a report for the 4/1/98-6/30/98 quarter is due July 30, 1998).

HCFA will notify you if and when this report is either discontinued or put on the CROWD system.

**Questions and Answers on Private Contracts.**—Following are the most frequently asked questions and answers. Include this information in your next regularly scheduled bulletin.

1. What is a "private contract" and what does it mean to a Medicare beneficiary who signs it?

As provided in §4507 of the Balanced Budget Act of 1997, a "private contract" is a contract between a Medicare beneficiary and a physician or other practitioner who has "opted out" of Medicare for 2 years for all covered items and services he/she furnishes to Medicare beneficiaries. In a private contract, the Medicare beneficiary agrees to give up Medicare payment for services furnished by the physician or practitioner and to pay the physician or practitioner without regard to any limits that would otherwise apply to what the physician or practitioner could charge.

## 2. What has to be in a private contract and when must it be signed?

The private contract must be signed by both parties before services can be furnished under its terms and must state plainly and unambiguously that by signing the private contract, the beneficiary or the beneficiary's legal representative:

- Gives up all Medicare coverage of, and payment for, services furnished by the "opt out" physician or practitioner;

- Agrees not to bill Medicare or ask the physician or practitioner to bill Medicare for items or services furnished by that physician or practitioner;

- Is liable for all charges of the physician or practitioner, without any limits that would otherwise be imposed by Medicare;

- Acknowledges that Medigap will not pay towards the services and that other supplemental insurers may not pay either; and

- Acknowledges that he/she has the right to receive items or services from physicians and practitioners for whom Medicare coverage and payment would be available.

The contract must also indicate whether the physician or practitioner has been excluded from Medicare.

A contract is not valid if it is entered into by a beneficiary or by the beneficiary's legal representative when the Medicare beneficiary is facing an emergency or urgent health situation.

## 3. Who can "opt out" of Medicare under this provision?

Certain physicians and practitioners can "opt out" of Medicare. For purposes of this provision, physicians include doctors of medicine and of osteopathy. Practitioners permitted to opt out are physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, and clinical psychologists.

The "opt out" law does not define "physician" to include optometrists, chiropractors, podiatrists, dentists, and doctors of oral surgery; therefore, they may not opt out of Medicare and provide services under private contract. Physical therapists in independent practice and occupational therapists in independent practice cannot opt out because they are not within the "opt out" law's definition of either a "physician" or "practitioner".

## 4. Can physicians or practitioners who are suppliers of durable medical equipment (DMEPOS), independent diagnostic testing facilities, clinical laboratories, etc., opt out of Medicare for only these services?

No. If a physician or practitioner chooses to opt out of Medicare, it means that he or she opts out for all covered items and services he or she furnishes. Physicians and practitioners cannot have private contracts that apply to some covered services they furnish but not to others. For example, if a physician or practitioner provides laboratory tests or durable medical equipment incident to his or her professional services and chooses to opt out of Medicare, then he or she has opted out of Medicare for payment of lab services and DMEPOS as well as for professional services. If a physician who has opted out refers a beneficiary for medically necessary services, such as laboratory, DMEPOS or inpatient hospitalization, those services would be covered. (See #18.) In addition, because suppliers of DMEPOS, independent diagnostic testing facilities, clinical laboratories, etc., cannot opt out, the physician or practitioner owner of such suppliers cannot opt out as such a supplier.

5. How can participating physicians and practitioners opt out of Medicare?

Participating physicians and practitioners may opt out if they file an affidavit that meets the criteria and which is received by the carrier at least 30 days before the first day of the next calendar quarter showing an effective date of the first day in that quarter (i.e., 1/1, 4/1, 7/1, 10/1). They may not provide services under private contracts with beneficiaries earlier than the effective date of the affidavit.

Non-participating physicians and practitioners may opt out at any time by filing an affidavit.

6. What happens if a physician or practitioner who opts out is a member of a group practice or otherwise reassigns his or her Medicare benefits to an organization?

Where a physician or practitioner opts out and is a member of a group practice or otherwise reassigns his or her rights to Medicare payment to an organization, the organization may no longer bill Medicare or be paid by Medicare for the services that physician or practitioner furnishes to Medicare beneficiaries. However, if the physician or practitioner continues to grant the organization with the right to bill and be paid for the services he or she furnishes to patients, the organization may bill and be paid by the beneficiary for the services that are provided under the private contract.

The decision of a physician or practitioner to opt out of Medicare does not affect the ability of the group practice or organization to bill Medicare for the services of physicians and practitioners who have not opted out of Medicare.

7. Can organizations that furnish physician or practitioner services opt out?

No. Corporations, partnerships, or other organizations that bill and are paid by Medicare for the services of physicians or practitioners who are employees, partners, or have other arrangements that meet the Medicare reassignment-of-payment rules cannot opt out since they are neither physicians nor practitioners. Of course, if every physician and practitioner within a corporation, partnership, or other organization opted out, then such corporation, partnership, or other organization would have in effect, opted out.

8. Can a physician or practitioner have "private contracts" with some beneficiaries but not others?

No. The physician or practitioner who chooses to opt out of Medicare may provide covered care to Medicare beneficiaries only through private agreements.

To have a "private contract" with a beneficiary, the physician or practitioner has to opt out of Medicare and file an affidavit with all Medicare carriers to which he or she would submit claims, advising that he or she has opted out of Medicare. The affidavit must be filed within 10 days of entering into the first "private contract" with a Medicare beneficiary. Once the physician or practitioner has opted out, such physician or practitioner must enter into a private contract with each Medicare beneficiary to whom he or she furnishes covered services (even where Medicare payment would be on a capitated basis or where Medicare would pay an organization for the physician's or practitioner's services to the Medicare beneficiary), with the exception of a Medicare beneficiary needing emergency or urgent care.

Physicians who provide services to Medicare beneficiaries enrolled in the new Medical Savings Account (MSA) demonstration created by the BBA of 1997 are not required to enter into a private contract with those beneficiaries and to opt out of Medicare under §4507 of the BBA.

9. What has to be in the "opt out" affidavit?

To be valid, the affidavit must:

- Provide that the physician or practitioner will not submit any claim to Medicare for

any item or service provided to any Medicare beneficiary during the 2 year period beginning on the date the affidavit is signed;

- Provide that the physician or practitioner will not receive any Medicare payment for any items or services provided to Medicare beneficiaries;

- Identify the physician or practitioner sufficiently that the carrier can ensure that no payment is made to the physician or practitioner during the opt out period. If the physician has already enrolled in Medicare, this would include the physician or practitioner's Medicare uniform provider identification number (UPIN), if one has been assigned. If the physician has not enrolled in Medicare, this would include the information necessary to be assigned a UPIN;

- Be filed with all carriers who have jurisdiction over claims the physician or practitioner would otherwise file with Medicare and be filed no later than 10 days after the first private contract to which the affidavit applies is entered into; and

- Be in writing and be signed by the physician or practitioner.

10. Where and when must the "opt out" affidavit be filed?

An "opt out" affidavit must be filed with each carrier that has jurisdiction over the claims that the physician or practitioner would otherwise file with Medicare and must be filed within 10 days after the first private contract to which the affidavit applies is entered into.

11. How often can a physician or practitioner "opt out" or return to Medicare?

Pursuant to the statute, once a physician or practitioner files an affidavit notifying the Medicare carrier that he or she has opted out of Medicare, he or she is out of Medicare for 2 years from the date the affidavit is signed. After those 2 years are over, a physician or practitioner could elect to return to Medicare or to "opt out" again.

12. Can a physician or practitioner "opt out" for some carrier jurisdictions but not others?

No. The opt out applies to all items or services the physician or practitioner furnishes to Medicare beneficiaries, regardless of the location where such items or services are furnished.

13. What is the effective date of the "opt out" provision?

A physician or practitioner may enter into a private contract with a beneficiary for services furnished on or after January 1, 1998.

14. Does the statute preclude physicians from treating Medicare beneficiaries if they treat private pay patients?

No. Medicare does not preclude physicians from treating Medicare beneficiaries if they treat private pay patients, when such private pay patients are persons not eligible for Medicare under age 65 or are individuals who are entitled to Medicare benefits but have chosen not to enroll in Part B.

15. Do Medicare rules apply for services not covered by Medicare?

If a service is one of a type that Medicare categorically excludes from coverage, Medicare rules, including opt-out rules, do not apply to the furnishing of the noncovered service. For example Medicare does not cover hearing aids; therefore, there are no limits on charges for hearing aids, and beneficiaries pay completely out of their own pocket if they want hearing aids.

If a service is one that is not covered because, under Medicare rules, the service is never found to be medically necessary to treat illness or injury, no claim need be submitted, but the physician or practitioner who has not opted out may charge the beneficiary for the noncovered service only if he

or she gives the beneficiary an advance beneficiary notice of noncoverage.

If a service is one which Medicare has determined is medically necessary where certain clinical criteria are met, but is not medically necessary where these criteria are not met, a claim must be submitted since it is possible that the carrier may determine that the service is covered in the individual beneficiary's case, even where the physician or practitioner who has not opted out believes that it will not be covered and has given an advance beneficiary notice to that effect. In this case, if Medicare denies the claim on the basis that the service was not medically necessary, the physician or practitioner who has given the advance beneficiary notice may bill the beneficiary.

Where a physician or practitioner has opted out of Medicare and agreed to provide covered services only through private contracts with beneficiaries that meet the criteria specified in the law, the physician or practitioner who has opted out is prohibited from submitting claims for covered services.

16. Is a private contract needed for services not covered by Medicare?

No. Since Medicare rules do not apply for services not covered by Medicare, a private contract is not needed. A private contract is needed only for services that are covered by Medicare and where Medicare might make payment if a claim were submitted.

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 that particular case (e.g., multiple nursing home visits, some concurrent care services, two mammograms within a 12 month period, etc.). If the physician or practitioner gives the beneficiary 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 permit the physician or practitioner to bill the beneficiary if the claim is denied.

17. What rules apply to urgent or emergency treatment?

The law precludes a physician or practitioner from having a beneficiary enter into a private contract when the beneficiary is facing an urgent or emergency health care situation.

Where a physician or a practitioner who has opted out of Medicare treats a beneficiary with whom he does not have a private contract in an emergency or urgent situation, the physician or practitioner may not charge the beneficiary more than the Medicare limiting charge for the service and must submit the claim to Medicare on behalf of the beneficiary for the emergency or urgent care. Medicare payment may be made to the beneficiary for the Medicare covered services furnished to the beneficiary.

18. Will Medicare make payment for services that are ordered by a physician or practitioner who has opted out of Medicare?

Yes, provided the "opt out" physician or practitioner ordering the service has acquired a uniform provider identification number (UPIN) and the services are not furnished by a physician or practitioner who has also opted out.

19. Clinical psychologists and clinical social workers are currently not recognized by and enrolled by Medicare unless they meet certain criteria specified by HCFA, some of which are voluntary. Are the requirements for opting out of Medicare different for these practitioners?

No. A clinical psychologist or clinical social worker must meet the affidavit and private contracting rules to opt out of Medicare.

20. What is the relationship between an Advanced Beneficiary Notice and a private contract?

There is no relationship between these instruments. 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" under Medicare program standards in the particular case. 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, and payment for the service is denied as a "medical necessity denial," a private contract is not necessary to bill the beneficiary if the claim is denied.

21. Are there any situations where a physician or practitioner who has not opted out of Medicare does not have to submit a claim for a covered service provided to a Medicare beneficiary?

Yes. A physician who has not opted out of Medicare must submit a claim to Medicare for services that may be covered by Medicare unless the beneficiary, for reasons of his or her own, declines to authorize the physician or practitioner to submit a claim or to furnish confidential medical information to Medicare that is needed to submit a proper claim. Examples would be where the beneficiary does not want information about mental illness or HIV/AIDS to be disclosed to anyone. Moreover, if the beneficiary or their legal representative later decides to authorize the submission of a claim for the service and asks the physician or practitioner to submit the claim, the physician or practitioner must do so.

The Health Care Financing Administration does not seek to limit or interfere in the right of a beneficiary to obtain medical care from the physician or practitioner of his or her choice. However, once a physician or practitioner who has not opted out of Medicare has furnished a covered item or service to a beneficiary who is enrolled in Part B of Medicare, the law requires that the physician or practitioner submit a claim to Medicare for the covered services.

22. How do the private contracting rules work when Medicare is the secondary payer?

When Medicare is the secondary payer, and the physician has opted out of Medicare, the physician has agreed to treat Medicare beneficiaries only through private contract. The physician or practitioner must, therefore, have a private contract with the Medicare beneficiary, notwithstanding that Medicare is the secondary payer. Under this circumstance, no Medicare secondary payments will be made for items and services furnished by the physician or practitioner under the private contract.

Kyl File

# AMERICAN ACADEMY OF FAMILY PHYSICIANS OF FAMILY PHYSICIANS

2021 MASSACHUSETTS AVENUE, N.W. WASHINGTON, D.C. 20036

ROSEMARIE SWEENEY  
VICE PRESIDENT  
SOCIOECONOMIC AFFAIRS AND POLICY ANALYSIS

202-232-9033 FAX 202-232-9044

## Memorandum

To: Barbara Woolley  
From: Rosi Sweeney *RS*  
Subj: **AAFP Position on Kyl Amendment**  
Date: February 4, 1998

Full Text of  
AAFP Position on Kyl Amendment  
February 4, 1998

The following is the position of the American Academy of Family Physicians on Private Contracting/Kyl Amendment.

The American Academy of Family Physicians could support the Kyl amendment with the following provisions for protection of patients' rights:

1. Contract Terms are fairly stated.
2. Full disclosure of fees to patients before contracts signed.
3. Ensure access to physicians, such as possibly excluding sole community providers from private contracting.
4. Prohibition on private contracting for dual eligibles (Medicare/Medicaid).

In its present form, the American Academy of Family Physicians cannot support the bill.



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# Backward Move On Medicare

By Philip R. Lee

Wednesday, November 5, 1997; Page A21  
The Washington Post

As a member of the American Medical Association for almost 50 years, I am outraged by the AMA's support for a change in Medicare (proposed by Sen. John Kyl, R-Ariz.) that would allow physicians to charge Medicare beneficiaries more than the amount that Medicare allows. Proponents, including James Glassman [op-ed, Sept. 23], Steve Forbes and Rush Limbaugh, claim that this proposal would enhance beneficiaries' ability to choose their physicians. But its real impact would be to enhance physicians' ability to choose how much to charge -- undermining valuable protections for beneficiaries the AMA explicitly endorsed not even a decade ago.

What are the Medicare rules the AMA and Kyl would change? Since 1992 Medicare has used a "fee schedule" to determine what the program pays physicians and has prohibited physicians from charging beneficiaries more than 15 percent above program rates. The goal behind that policy was to enable Medicare to limit program payments without shifting costs to beneficiaries, many of whom were recognized as paying too much. Achieving that goal required a deal: The AMA agreed to limits on physicians' ability to charge extra in return for certain rules in determining how much Medicare would pay. As chair of the congressional Physician Payment Review Commission, I helped get that agreement in 1989. And I believe it continues to represent an effective way to control Medicare physician spending reasonably (even generously) rewarding physicians while protecting beneficiaries.

At the time Medicare adopted this policy, there was concern that limiting physicians' ability to charge would lead them to refuse service to Medicare beneficiaries. Numerous studies have shown that this hasn't happened. In 1994 the Physician Payment Review Commission found physicians just as likely (96 percent) to be taking new Medicare patients as to be taking new private fee-for-service patients (97 percent). In practice, Medicare's limits substantially reduced extra charges by physicians without limiting beneficiaries' access to care.

Now the AMA is trying to turn back the clock. The effort began in the Balanced Budget Act, in which Sen. Kyl successfully sought an explicit provision allowing physicians who do not participate in Medicare in any way (in his estimate, about 9,000 of the nation's 700,000 physicians) to treat beneficiaries outside the program and to charge beneficiaries whatever they wish. Not satisfied, the senator and the AMA are now seeking to extend that "opportunity" to every physician for every service.

What's really at stake in the Kyl amendment is whether Medicare is going to return to a policy of letting physicians choose what beneficiaries will have to pay or whether the program will continue to guarantee its beneficiaries access to care at predictable costs. If the AMA thinks that the program doesn't pay physicians adequately, it should argue that case directly to Congress and the public. Personally, I think that's a tough case to make. But to try would be more honest than to seek extra payments by the back door at beneficiaries' expense.

What would happen if the Kyl amendment were enacted? Proponents of the policy argue that physicians reluctant to see Medicare patients would become more willing to serve them. But since we don't see an access problem to begin with, it is far more likely that physicians who have been perfectly willing to serve Medicare patients would charge them more. Further, higher charges would not be limited to beneficiaries with higher incomes. Studies of physicians' charges in the 1980s showed that physicians did not limit extra charges to people with higher incomes; for specialty services, physicians charged more, regardless of people's ability to pay. The result, then, would be higher costs or reduced access to care for middle- and low-income Medicare beneficiaries who already face very high health care cost burdens.

Proponents of the Kyl amendment argue that their proposal doesn't force beneficiaries to pay more; it gives them a choice. They can go outside the Medicare program and pay more if they want to. As a physician with 49 years of experience, I find this argument disingenuous, at best. Patients who are sick and in need of care are hardly in a negotiating position. I've never met a Medicare beneficiary itching to pay physicians higher prices, and none of the elderly who testified before the Physician Payment Review Commission while I was chairman (1986-1993) sought a policy change to make that possible.

Support for the Kyl amendment is not the first case in which the AMA has put physicians' economic interests above professional obligations to patients. If Congress enacts the Kyl amendment, it will be doing precisely the same thing.

The writer is professor emeritus and senior adviser to the



## American College of Physicians

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William A. Reynolds, MD, FACP  
President

November 5, 1997

The Honorable Jay Rockefeller  
Senate Finance Committee  
United States Senate  
531 Hart Senate Office Building  
Washington, DC 20510-4802

ACIP  
ANTI-KYL  
letter

Dear Senator Rockefeller:

I am writing to express the concerns of the American College of Physicians with Medicare private contracting legislation (S. 1194), sponsored by Sen. Jon Kyl. The American College of Physicians, as you know, is the nation's largest medical specialty society, with 100,000 members in the field of internal medicine. Internists treat more Medicare patients than any other specialty.

The ACP commends your committee for introducing significant innovations and flexibility into the Medicare program in the recently enacted Balanced Budget Act (BBA). However, we urge you not to legislate further on the issue of private contracting. Because this issue is central to the integrity of the Medicare program, it would be unwise to make such a fundamental change without consideration by the new bipartisan commission on Medicare.

The American College of Physicians has the following concerns with the Kyl bill, which permits private contracting on a service-by-service basis:

### **The bill could undermine physician-patient relationships.**

Most people are not comfortable discussing fees and finances with physicians, but the Kyl bill forces patients to take the initiative of asking. Furthermore, private contracting on a service-by-service basis could create ambiguity that can easily lead to conflict. Since the scope of services needed can never be fully predicted, what happens when, for example, a physician believes a private contract patient needs a sonogram? Does the physician tell the patient what it costs before doing the sonogram? Do the physician and patient then negotiate whether the sonogram is part of the contract, right in the exam room? Should the decision to have the sonogram hinge on what the doctor will charge or whether the doctor will take Medicare's fee? As physicians, we must insist these decisions be based on patients' medical needs. As physicians, we are concerned that the Kyl bill will be seen by our patients as an effort to increase our incomes at patient expense, overshadowing our commitment to high-quality patient care.

### **The Kyl bill could undermine the integrity and incentives of Medicare payment.**

To encourage cost-effective use of resources, Medicare encourages managed care. Yet, 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 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.

Also, private contracting tends to unbundle payment for services. For the beneficiary, this means greater out-of-pocket costs. The largely low-income population served by Medicare can scarcely afford the out-of-pocket costs that will be generated by widespread availability of private contracting.

### **The Kyl bill could confound efforts to reduce fraud and abuse.**

Even though the vast majority of physicians bill as accurately as they can, private contracting on a service-by-service basis creates the potential for fraud and abuse. On a service-by-service basis, it creates administrative difficulties and would require HCFA to spend resources on monitoring. The Kyl bill 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. This makes it possible to bill Medicare or a point-of-service plan 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.

### **Services under private contracting escape quality and utilization monitoring.**

Fair and effective collaborative monitoring by physicians and others can improve quality and decrease costs. Private contracting is a regression from efforts to get more for our health care dollars. Additionally, private contracting works against efforts to collect data with which to measure and improve quality and cost efficiency.

Because private contract services escape programmatic assessment of medical necessity, private contracting would not necessarily reduce Medicare claims. Aside from problems of potential double-billing and fraud and abuse, any savings to Medicare could be offset by new services generated by private contract visits. For example, Medicare may bear the cost of follow-up services to false positive results of medically unnecessary tests performed under private contracts.

### **The Kyl bill could threaten the viability of Medicare as an insurance program that offers accessible, affordable high-quality care.**

Physicians already have the freedom to opt out of Medicare. Most choose not to do so because like private health plans, Medicare delivers significant numbers of patients to participating

providers. By allowing the decision to be made on a service-by-service basis, the Kyl bill threatens Medicare's viability as a health plan. An analogy can be found in the private sector. Neither employers nor the FEHBP, upon which the Medicare+Choice options are based, allow physicians to contract privately for a higher fee outside the payment rules of the plan chosen by the employee. This practice would undermine the economic dynamics that enable health plans to meet market demand for high-quality care at a reasonable cost. In both Medicare and the private sectors, physicians can opt into or out of a plan, but they cannot join a plan and then decide to write their own rules for participation.

By allowing private contracting on a service-by-service basis, the Kyl bill sets up a perverse financial incentive for physicians to avoid Medicare patients. A Medicare program governed by legislative incentives that encourage the upper middle class, the wealthy, and physicians to shun the program cannot maintain financial and political support. Such incentives are created when Congress allows exceptions to Medicare payment and quality rules, as with the separate set of fee-for-service options in the BBA - MSAs, private fee-for-service and private contracting. Because these options are more attractive to wealthier patients and those with better health risks, the pool of remaining Medicare enrollees, including managed care enrollees, could become sicker, poorer and costlier to care for. The Kyl bill may be an additional drain on Medicare's resources.

Senator Rockefeller, in conclusion, private contracting as expanded by the Kyl bill will have many unknown effects that should be studied in the broader context of Medicare reform by the bipartisan commission. The issue is not, as some have claimed, freedom to choose one's doctor. Medicare patients have that freedom - in contrast to many enrollees in Medicaid and employer-sponsored plans. The issue, at its core, is balance billing. The Medicare billing dilemmas which the Kyl bill tries to address might be solved by less drastic means - such as raising or eliminating balance billing limits on wealthy seniors, allowing patients to opt-out of Medicare totally, and allowing physicians to waive co-payments for low-income patients, for example. The commission can give proper consideration to these and other reasonable solutions.

Thank you for the opportunity to address our concerns. The ACP looks forward to further dialogue with you on this issue. Should your staff have any questions regarding our policy development in this area, please contact Kathleen Haddad, MS, in our Washington office, 202-393-1650.

Sincerely,

*William A. Reynolds*  
William A. Reynolds, MD, FACP

**OFFICE OF MANAGEMENT AND BUDGET**

*Legislative Reference Division  
Labor-Welfare-Personnel Branch*

Telecopier Transmittal Sheet

Kyl File



FROM: Bob Pellicci -- 395-4871

DATE:

11/4

TIME:

5:50 P.M.

Pages sent (including transmittal sheet):

14

COMMENTS:

*Per our conversation --  
testimony on private contracts/  
Medicare*

TO:

*Chris / Sarah*

PLEASE CALL THE PERSON(S) NAMED ABOVE FOR IMMEDIATE PICK-UP.

**TESTIMONY****PRIVATE CONTRACTS BETWEEN MEDICARE PATIENTS & PHYSICIANS****SENATE FINANCE COMMITTEE****NOVEMBER 6, 1997****Introduction**

I appreciate the opportunity to be here today to discuss the question of private contracts between Medicare beneficiaries and their doctors. This is an important issue and one that merits careful consideration. Today, I will provide a description of current law, briefly discuss the history of Medicare payment changes and limits on physician charges and its relation to private contracts, and describe the changes brought about in the Balanced Budget Act of 1997 and those proposed in the "Medicare Beneficiary Freedom to Contract Act of 1997", including our concerns about this issue. In considering this issue, our goal is to assure fair and equitable payments to physicians within a framework that guarantees affordable and accessible health care to beneficiaries and at the same time, provides them with a full range of health care options.

**Background**

I want to begin by emphasizing that participation in Part B of Medicare is voluntary. Under the law, the provisions of Part B at issue here apply only to Medicare beneficiaries who "elect to enroll" in the program. And under Part B, physicians are either "participating" or "non-participating". Participating physicians voluntarily agree to accept an assignment of each beneficiary's claims. Accepting assignment means that the physician accepts the Medicare fee schedule as full payment for services rendered. Medicare then pays the physician 80 of the payment and the patient is liable for the 20 percent balance. Non-participating physicians may choose on a claim-by-claim basis either to bill the patient directly for the service, requiring the

patient to seek Medicare reimbursement, or to accept an assignment of the patient's claim in the same manner as a participating physician. If a physician does not accept assignment on the claim, then the statute specifies that the physician can charge the beneficiary up to 15 percent more than the fee schedule amount.

Since September 1, 1990, the Medicare law has required that a physician complete a claim form and submit it to Medicare on behalf of a beneficiary when assignment is not accepted. In this case, while the physician submits the claim, the Medicare payment is made to the beneficiary, who is responsible for paying the physician's bill. The claims submission requirement only applies to unassigned claims since by definition an assigned claim means that a physician submits the claim to Medicare and the physician receives Medicare's payment.

The Social Security Amendments of 1994 clarified the enforcement provisions for balance billing limits. The thrust of the law is to tell physicians what the rules are and seek their voluntary compliance. When potential violations are found, the goal is to educate a physician about the rules and encourage voluntary compliance. The law requires that the carrier compare actual charges with the balance billing limit when the claim is processed. If the actual charge exceeds the balance billing limit, the law requires the carrier to send a notice to the physician indicating a potential violation and the need to make a timely refund to the beneficiary. The law gives the Secretary authority to apply sanctions for physicians who knowingly, willfully and on a repeated basis violate balance billing limits or the claims submission requirement. At this point, while the Department has pursued several cases of flagrant violations, no sanctions have been applied.

I want to clarify that beneficiaries can and often do receive services that Medicare does not cover, and in those cases, they pay for the services out of their own pocket at whatever rate they work out with the physician of their choice. Examples of services Medicare does not cover are cosmetic surgery, hearing aids, routine physical exams or certain screening preventive benefits more frequently than a specified number during a period of time (e.g., a screening mammogram more once per year).

Current Medicare law also allows Medicare beneficiaries to receive and pay for services more frequently than Medicare determines is medically necessary. For example, Medicare does not pay for routine daily physician visits to nursing home patients because they are not medically necessary (though payment may be made in a particular situation if the physician furnished appropriate medical documentation). By signing an Advanced Beneficiary Notice, a beneficiary acknowledges that the service may be denied by Medicare as not medically necessary and agrees to pay for the service in this case.

#### Brief History of Medicare Payment Changes and Limits on Physician Charges

Over the past 15 years, beneficiary protections have been part of every legislated change in physician payments. These accompanying beneficiary protections have been established to prevent physicians from passing on excess charges to beneficiaries.

In 1984, legislation froze Medicare physician payments (i.e., no update) and froze physician actual charges to Medicare beneficiaries. Congress recognized that just holding down Medicare outlays

would be of little benefit to Medicare beneficiaries if physicians could decline to take assignment and still bill the patient at the same or higher rates. As Senator Dole, then Chairman of the Senate Finance 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. If a physician does not elect to take an assignment, beneficiaries can be held responsible for the full difference between what the program pays and what the physician charges."

At the end of the fee freeze, Congress established a complicated set of rules limiting how much physicians could charge (called the Maximum Allowable Actual Charges or "MAACs"). As in the 1984 legislation, Congress reiterated that merely reducing Federal outlays would be of only limited public good if physicians were able to balance bill their patients at whatever rates they chose after the fee freeze was lifted.

The limits on actual charges were simplified and became what are today called "balance billing" limits. Balance billing limits, an integral part of the physician payment reform legislation, protected beneficiaries financially as the fee schedule redistributed Medicare physician payments among procedures.

In the early 1990s, some physicians questioned whether they could free themselves from the balance billing limits and claims submission provision by requiring beneficiaries to enter into

private contracts whereby beneficiaries would not use their Medicare coverage. In 1991 former HCFA Administrator Gail Wilensky responded to an inquiry from the Medical Association of Georgia indicating that "such an agreement initiated by a physician would be invalid."

As the members of this Committee are aware, in 1992, a physician and a group of her patients filed suit in Federal District Court in New Jersey challenging Dr. Wilensky's determination. The lawsuit was dismissed because the Court found that the issue was not ripe for review. The plaintiffs did not appeal. The Clinton Administration position on this issue is consistent with that advanced by the Bush Administration. In 1993 the Clinton Administration continued the Bush Administration's position, stating "There is nothing in the law that exempts physicians from these requirements or Medicare services from coverage because the physicians obtain from beneficiaries (private) agreements". In addition, the Clinton Administration indicated: "Congress enacted these requirements for the protection of all Medicare Part B beneficiaries, and their application cannot be negotiated between a physician and his/her patient. Agreements with Medicare beneficiaries purportedly waiving Federal requirements have no legal force or effect." The Social Security Amendments of 1994 strengthened enforcement provisions for balance billing limits and the claims submission provisions and broadened application of balance billing limits.

*which contract?*

In both the Bush Administration and the Clinton Administration, we took the position that it is permissible not to submit a claim in very limited circumstances. Former HCFA Administrator Gail Wilensky's 1991 response to the Medical Association of Georgia in 1991 indicated: "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. The physician must, however, submit claims promptly if the patient changes his or her mind, in order to avoid penalties." Thus, for example, beneficiaries who want to keep some physician contacts strictly confidential (such as visits to psychiatrists) can do so by refusing to authorize the physician to submit the claim.

#### **Private Contracting Provision in the Balanced Budget Act of 1997**

The Balanced Budget Act of 1997 allows private contracting on a limited basis. The BBA allows physicians who opt out of the Medicare program for a two year period to provide services to Medicare beneficiaries under private contracts. Physicians who choose to provide services through the Medicare program may not privately contract with Medicare beneficiaries. Under the BBA provision, a physician must treat all beneficiaries in the same way. If the physician opts to privately contract, the physician must privately contract with all Medicare beneficiaries. Similarly, if a physician chooses to bill Medicare for services, the physician must serve all beneficiaries under the Medicare rules.

Under a private contract, a beneficiary agrees not to submit a claim to Medicare, even though the service would be covered if a claim were submitted. The beneficiary agrees to pay for the service entirely out of their own pocket. A private contract is different from a service on a non-assigned basis because Medicare would pay the beneficiary Medicare's 80 percent in the latter case while Medicare pays the beneficiary nothing in the former case.

The BBA includes specific requirements related to the private contract that are intended to protect beneficiaries. The private contract must be written and contain specific elements to assure beneficiary knowledge and consent. In the contract, the beneficiary must acknowledge that they will not submit a claim and that Medicare will not make payment for the service. In order to protect the beneficiary from having to sign a contract to receive care in an emergency, the BBA does not allow a contract to be signed by a beneficiary when that beneficiary needs an emergency service. Physicians who choose to private contract must file an affidavit with the Health Care Financing Administration (HCFA).

The BBA provision does not affect a physician's treatment of people with private pay, Medicaid, or other non Medicare Part B coverage. The BBA provision relates only to Medicare Part B beneficiaries. For example, if a physician chooses to opt out of Medicare and privately contract with beneficiaries, that physician may continue to bill private insurers and Medicaid for services.

The BBA does not establish new civil or criminal penalties for physicians who choose to opt-out of Medicare. If a physician chooses not to participate in Medicare for two years but then, after a year, bills Medicare for a service, that physician will not be subject to civil or criminal penalties.

There has been much discussion about the requirement for physicians to opt-out of Medicare for two years. Let me explain why the two year requirement was adopted. The Senate floor amendment applied to "a physician or other health professional who does not provide items or services under the program under this title" (i.e., the Medicare program). The language could be

interpreted to mean physicians who do not provide any services to Medicare beneficiaries at any time in the future (i.e., physicians who permanently opt-out of Medicare). During the Conference on the Balanced Budget, it was explained that the Senate provision applied only to physicians who were outside of Medicare entirely (about 4 percent of physicians have no Medicare patients) and exempted those physicians from Medicare rules when they did treat a Medicare beneficiary. Rather than requiring physicians to permanently opt-out of Medicare, the Conferees specified a finite period of time for the opt-out decision.

A finite period also has two important policy underpinnings. First, it reduces the opportunities for fraud. Since a physician would declare that they are opting-out for a finite period of time, the carrier would know who those physicians are. The carrier could then deny any claims submitted from opt-out physicians. Second, a finite period of time allows a beneficiary to make a rational choice of which physician to seek care from. The beneficiary would know before seeking care whether the physician would accept Medicare payment or would require private contracts for all services. The Conferees agreed to a two-year opt-out period.

#### **Medicare Beneficiary Freedom to Contract Act (S1194/HR2497)**

The Medicare Beneficiary Freedom to Contract Act expands physicians' opportunities to privately contract with Medicare beneficiaries without having to opt out of Medicare. The new proposal eliminates the requirement that physicians choose to opt in or out of Medicare, expands private contracting to apply to Medicare+Choice and dual eligible (Medicare/Medicaid) beneficiaries, and limits the information that HCFA may collect from physicians who choose to privately contract.

The new proposal eliminates the requirement that physicians opt in or out of Medicare and allows physicians to privately contract with beneficiaries on a patient by patient and case by case basis. The new proposal allows physicians to contract selectively; the physician may provide services under private contracts for some beneficiaries and under Medicare for other beneficiaries. Similarly, the physician may provide some services under private contracts and other services under Medicare payment rules. For example, a physician may provide an office visit under a private contract but accept Medicare payment for a follow-up lab test for the same patient.

The new proposal expands private contracting to apply to beneficiaries in Medicare+Choice organizations and low-income dually eligible (Medicare/Medicaid) beneficiaries. The BBA did not allow private contracting for these two groups. For beneficiaries who choose a Medicare+Choice option, such as an HMO, under the new proposal, a physician in that HMO may privately contract with the beneficiary for an HMO covered service.

The new proposal limits the information that HCFA may collect from physicians who choose to privately contract. The proposal repeals the requirement that physicians choosing to privately contract file an affidavit with us. HCFA is allowed to collect only the "minimum information" necessary to avoid Medicare payment for services provided under private contracts. The new proposal goes beyond the original Senate provision, considered during the debate on the BBA, in that it allows physicians to pick and choose which beneficiaries and which services to provide under private contracts.

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**Concerns About the New Proposal**

While the BBA provision allowing private contracting among physicians and Medicare beneficiaries under certain circumstances struck a balance between the objective of expanding physicians' ability to choose this option and charge higher fees, and protecting the program and its beneficiaries, we are concerned that the new proposal greatly undermines this balanced approach. The Clinton Administration has a number of concerns about this new proposal.

***Potential for Fraud***

First, we have a serious concern about whether the new proposal would encourage fraud. Under the new proposal, the Medicare carrier would not know which services from which beneficiaries were the subject of a private contract, so it would not be possible to deny payment for such claims. Since BBA requires the physician to opt out for two years, the carrier would know who those physicians are and could deny claims for services from that physician. In order to administer the new proposal without increasing the potential for fraud and abuse, every Medicare carrier would need to have a copy of every private contract between every physician and every beneficiary on a timely basis. Requiring provision of a copy of every private contract for every service for every beneficiary would be a burden to physicians, beneficiaries, and HCFA. Furthermore, such information would be viewed to be inconsistent with the concept of only requiring "the minimal information necessary."

Even if such information were furnished, carriers would need to have the capacity to make continual real-time systems changes to deny payment for any private contract claims received.

Such a system does not exist and would be very expensive to develop and operate. Without having the capacity to deny claims submitted, the new proposal would encourage fraud because the physicians and beneficiaries would know that no one was reviewing these claims to see if there were any duplications.

***Reduces Ability for Beneficiary to Make Informed Choice***

In contrast to BBA which requires the physician to opt-out for two years, the new proposal would allow physicians to pick and choose which beneficiaries to treat and which services to provide under private contracts. Knowing a physician's decision about opting-out of Medicare is important information that allows a beneficiary to make an informed decision about which physician to seek care from and what their financial liability would be. While some argue that the beneficiary has freedom of choice to switch physicians, it may be unrealistic for a beneficiary to switch physicians in the middle of treatment.

***Increases Beneficiary Out-of-Pocket Costs***

The new proposal could significantly increase the use of private contracts because it allows physicians to contract privately on a service-by-service basis and a beneficiary-by-beneficiary basis. The new proposal effectively would allow individual physicians to waive balance billing limit protections if they did not like Medicare payment rates for a particular service. We are concerned that this would increase beneficiary out-of-pocket costs significantly, and that beneficiaries may not feel that they have the leverage to refuse to enter into these agreements. For example, if a Medicare beneficiary has a longstanding relationship with her doctor and then

develops breast cancer, which the doctor says he will treat only subject to her agreeing to a private contract, we are concerned that she may feel she has no choice but to accept that arrangement and forego Medicare reimbursement. We do not think that is what Congress intended.

### ***Could Create Access Problems***

The new provision could create access problems for low income beneficiaries, particularly in small towns and rural areas. The new provision would allow physicians first to treat higher income and middle income Medicare patients who can pay the bill entirely out-of-pocket, and then treat lower income patients to the extent that their practice has space.

The same holds true for services. Physicians who believe that Medicare underpays for a particular type of service could choose to only provide it to Medicare beneficiaries through private contracts. This could limit access and increase beneficiaries' payments.

### **Conclusion**

The BBA was the result of extensive hard work by many people and included compromises on many issues. We are reluctant to open up BBA for any one issue, because others could legitimately argue that other issues should also be revisited.

During the last 15 years, Congress and the Reagan, Bush and Clinton Administrations have been concerned that changes in Medicare payment rates for physicians' services not result in increased

beneficiary out-of-pocket payments. Legislative changes related to physician payment have always included beneficiary financial protections. The private contracting issue requires a delicate balance between allowing physicians increased flexibility to charge higher fees and protecting Medicare beneficiaries. I believe that the BBA struck the right balance between these two competing goals. We should implement the provision and evaluate its impacts before making any changes.

BILL THOMAS, CALIFORNIA, CHAIRMAN  
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COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES  
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

To: Tricia Smith/Marty Cory/Howard Bedlin/Diane Jones

From: Bill Vaughan

Re: Kyl

I think there is serious movement afoot for hearings on this legislation as early as next week in various Committees.

Just got the following CBO analysis.

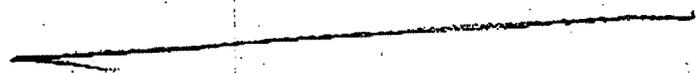
Good ammo for us.

Attached is a DRAFT press release I am trying to get clearance on.

225-4318/226-4969fax

*File  
Kyl  
Amendment*

*TO CHRIS JENNINGS*



For Release  
October 31, 1997

Contact: Ellen Dadisman

## CONGRESSIONAL BUDGET OFFICE RELEASE ANALYSIS OF KYL-ARCHER 'PRIVATE CONTRACTING' AMENDMENT.

### "Scary Halloween News for Seniors and Disabled"

The Congressional Budget Office today made public its analysis of the budget impact of the Kyl-Archer amendment which will make it much easier for doctors to charge Medicare beneficiaries anything they want, anytime they want.

"The Kyl-Archer amendment effectively ends Medicare insurance," said Rep. \_\_\_\_\_. "There is no insurance if you never know whether the doctor is going to reject your Medicare card and ask you to pay the whole bill out of your pocket."

CBO's analysis says, in part

"The bill would allow physicians and other health care providers to increase their incomes by negotiating direct contracts that included prices in excess of Medicare's fees, effectively bypassing the limits on balanced billing....For [some] services--such as those where the need for timely medical treatment might increase patients' willingness to pay--direct contracting could become much more common.

"If direct contracting were extensively used, however, Medicare claims could be significantly reduced. At the same time, 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....Without adequate regulatory oversight, unethical providers could bill Medicare while also collecting from directly-contracted patients.

"Although the impact of [Kyl-Archer] on the federal budget is

uncertain, the bill would almost certainly raise national health spending. Even if direct contracts were rarely used, payments made under those contracts would probably be higher than what Medicare would have paid, and Medicare's efforts to combat fraud and abuse would probably be hampered to some extent."

"CBO describes a scary Halloween trick for the nation's seniors and disabled," said Rep. \_\_\_\_\_ . "Doctors will be able to hold sick patients hostage for higher payments, fraud will increase, total national health care spending--already by far the highest in the world--will increase. It will be a 'treat' for doctors, but the end of insurance peace of mind for seniors."

The Leadership Council of Aging Organizations also released today a two page letter to all Members of Congress urging opposition to Kyl-Archer. Copies are available by calling 225-4318.

~~\_\_\_\_\_~~



CONGRESSIONAL BUDGET OFFICE  
U.S. CONGRESS  
WASHINGTON, D.C. 20515

June E. O'Neill  
Director

October 30, 1997

Honorable Bill Archer  
Chairman  
Committee on Ways and Means  
U.S. House of Representatives  
Washington, DC 20515

Dear Mr. Chairman:

At your request, the Congressional Budget Office (CBO) has reviewed H.R. 2497, the Medicare Beneficiary Freedom to Contract Act of 1997, as introduced on September 18, 1997. (S. 1194, an identical bill, was introduced in the Senate on the same day.)

Direct contracting allows beneficiaries to make financial arrangements with health providers outside of the established Medicare payment rules. The direct contracting provision in current Medicare law, enacted in the Balanced Budget Act of 1997 (P.L. 105-33), requires providers contracting directly with patients to forgo any Medicare reimbursement for two years. Under that condition, CBO expects that direct contracting will almost never be used.

H.R. 2497 would eliminate the two-year exclusion period, allowing health providers to contract directly with their Medicare patients on a claim-by-claim basis. For example, a physician could bill Medicare for an office visit while directly contracting with the patient for an associated test or procedure.

Enactment of H.R. 2497 would affect Medicare outlays. Because of uncertainties about the number of claims that would be separately contracted and about the effectiveness of the regulatory oversight of those contracts by the Health Care Financing Administration (HCFA), however, CBO cannot estimate either the magnitude or the direction of the change in Medicare outlays that would ensue.

Honorable Bill Archer

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With Medicare's restrictions on balance billing—which limit the amount beneficiaries must pay for services covered by Medicare—providers may in some cases receive lower payments than what their patients would have been willing to pay out of pocket. The bill would allow physicians and other health care providers to increase their incomes by negotiating direct contracts that included prices in excess of Medicare's fees, effectively bypassing the limits on balance billing. For some services, CBO believes that such contracting would not be very widespread because few beneficiaries would be willing to pay the entire fee (not just the difference between the provider's charge and what Medicare would have paid). For other services—such as those where the need for timely medical treatment might increase patients' willingness to pay—direct contracting could become much more common.

If direct contracting continued to be rarely used, there would be no changes in benefit payments, no additional difficulties in combating fraud and abuse, and no major new administrative burdens placed on HCFA.

If direct contracting were extensively used, however, Medicare claims could be significantly reduced. At the same time, 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. Furthermore, HCFA would be unlikely to devote significant administrative resources to the regulation of direct contracting. HCFA's efforts to administer other areas of Medicare law, including many of the new payment systems envisioned in the Balanced Budget Act, will continue to strain the agency's resources. Without adequate regulatory oversight, unethical providers could bill Medicare while also collecting from directly-contracted patients.

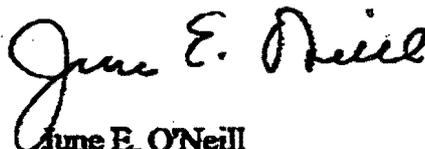
Although the impact of H.R. 2497 on the federal budget is uncertain, the bill would almost certainly raise national health spending. Even if direct contracts were rarely used, payments made under those contracts would probably be higher than what Medicare would have paid, and Medicare's efforts to combat fraud and abuse would probably be hampered to some extent.

Honorable Bill Archer

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If you have any questions about this analysis, we will be pleased to answer them. The CBO staff contact is Jeff Lemieux, who can be reached at 226-9010.

Sincerely,



June E. O'Neill  
Director

cc: Honorable Charles B. Rangel  
Ranking Minority Member

Honorable John R. Kasich  
Chairman  
House Committee on the Budget

Honorable John M. Spratt  
Ranking Minority Member  
House Committee on the Budget

Honorable Tom Bliley  
Chairman  
House Committee on Commerce

Honorable John D. Dingell  
Ranking Minority Member  
House Committee on Commerce

Honorable Pete V. Domenici  
Chairman  
Senate Committee on the Budget

Honorable Frank R. Lautenberg  
Ranking Minority Member  
Senate Committee on the Budget