



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

CBO KYL AMON DMEWT
ANALYSIS

Kyl File

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.

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.

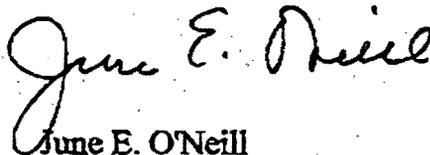
If direct contracting were extensively used, however, Medicare claims could be significantly reduced. At the same time, HCFA's efforts to screen inappropriate or fraudulent claims could be significantly compromised because it would be difficult to evaluate episodes of care with gaps where services were 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
Page 3

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

Honorable Bill Archer

Page 4

Honorable William V. Roth, Jr.

Chairman

Senate Committee on Finance

Honorable Daniel Patrick Moynihan

Ranking Minority Member

Senate Committee on Finance

Honorable Jon Kyl

U.S. Department of Labor

Assistant Secretary for
Pension and Welfare Benefits
Washington, D.C. 20210



DATE: 10/27

TO: Chris Jennings

AGENCY: _____

TELEPHONE NUMBER: _____ FAX: _____

FROM: **MEREDITH A. MILLER**
Deputy Assistant Secretary for Policy
Pension and Welfare Benefits Administration
U.S. Department of Labor
200 Constitution Avenue, NW, Room S-2524
Washington, DC 20210

COMMENTS:

NUMBER OF PAGES INCLUDING COVER SHEET 5

Should you experience any problems receiving this transmission please call
(202) 219-8233.

MEMORANDUM

*I need
beck!*

TO: Janet Corrigan, PhD., Executive Director
Members of the Subcommittee on the Quality
Improvement Environment

FROM: Betty Bednarczyk

DATE: October 20, 1997

RE: Whistleblower Protection

In response to last month's meeting where a number of questions arose regarding the need for whistleblower protections, I am writing to explain how existing federal and state laws fail to protect whistleblowers in the health care industry and why, therefore, federal legislation is needed. Although there are a number of federal and state whistleblower laws, none provide comprehensive and effective protection for whistleblowers in the health care industry. As explained below, the existing laws fall short both in terms of the extent of coverage as well as the effectiveness of the remedies provided. Without federal protection, frontline health care workers cannot be effective advocates for the people in their care. No comprehensive strategy for improving the quality of health care can work if care providers are afraid to speak out when they see patients are not receiving proper care.

Perhaps the most comprehensive whistleblower protection exists for federal employees, under the Civil Service Reform Act of 1978, which prohibits adverse personnel actions for whistleblowing disclosures, refusal to violate the law, exercise of appeal rights, or off-duty conduct that does not affect job performance. Violations of related constitutional or statutory rights also are prohibited. The whistleblower protections in the Civil Service Reform Act were significantly strengthened by the Whistleblower Protection Act of 1989 and its 1994 amendments. However, its provisions do not apply to the vast majority of health care workers who are not federal employees.

In addition to the Civil Service Reform Act and the federal Whistleblower Protection Act, the federal government has passed 28 whistleblower protection provisions. These are narrow in coverage and are tucked into various federal laws such as environmental or public health and safety statutes. They are part of the enforcement schemes for those particular laws. None apply specifically to the health care industry. About half of the federal whistleblower provisions are part of the enforcement schemes in environmental protection statutes. The federal False Claims Act also contains a whistleblower protection provision, but it applies

ANDREW L STERN
International President

BETTY BEDNARCZYK
International Secretary-Treasurer

PATRICIA ANN FORD
Executive Vice President

ELISEO MEDINA
Executive Vice President

PAUL POLICICCHIO
Executive Vice President

SERVICE EMPLOYEES
INTERNATIONAL UNION
AFL-CIO, CLC

1313 L Street, N.W.
Washington, D.C. 20005
202.898.3200

<http://www.seiu.org>

only in cases of fraud and only where fraud involves federal funds. The most commonly used statute is the Occupational Safety and Health Act (OSHA).

Federal protection for private-sector whistleblowers is largely limited to these piecemeal protections in environmental and other statutes. Although there may be a few specific situations where these statutes apply to whistleblowers in the health care industry, there is no federal law which generally applies to health care whistleblowers in either the private or public sector. Moreover, this patchwork quilt of laws is full of holes: Many employees and types of reportable violations are simply not covered by current law. Even when they are covered, whistleblowers remain vulnerable to retaliation because enforcement remedies in existing statutes are often impractical and ineffective. For example, many of the laws have an unreasonably short 30-day statute of limitations. This means that whistleblowers who wait longer than one month to file a claim after they have been retaliated against will automatically lose their case. This statute of limitations is impractical because it frequently takes employees longer than a month just to discover that there is a law that might protect them! Many other deficiencies in these laws were detailed in a report commissioned by the Administrative Conference of the United States (Administrative Conference of the United States, Recommendation 87-2, *Federal Protection of Private Sector Health and Safety Whistleblowers* (adopted June 11, 1987), 1 CFR § 305.87-2.)

Forty-two states and the District of Columbia have adopted common-law remedies under the public policy exception to the employment-at-will doctrine.¹ Traditionally, under the employment-at-will doctrine, an employee who works without an employment contract or a collective bargaining agreement can be fired for any reason or no reason. But under the public policy exception to the "employment-at-will" doctrine, a person cannot be fired for reporting violations of what a court decides is an "important public policy".

This state common law doctrine provides very weak protection for whistleblowers. What the state court defines as an issue "important" enough to the public to merit whistleblower protection varies from state to state. Some states apply the doctrine only where there has been a violation of law. Other states only provide protection when a public policy expressly declared by the state legislature has been violated. As a practical matter, the exception is rarely successfully invoked.

There are other problems with this common law doctrine. It applies only in the case of a termination and not to other cases of discrimination (such as demotions, pay cuts, etc) which also

¹ The following states and the District of Columbia have recognized the public policy exception to the termination-at-will doctrine. Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming. This list is current as of 1996.

intimidate and silence whistleblowers. Thus, for example, a worker who was demoted for reporting an illegal medical practice would have no protection. In addition, since this is a common law doctrine developed by the judicial decisions, it lacks the detailed provisions and enforcement procedures contained in most whistleblower statutes.

In addition to this limited common law doctrine, nineteen states have passed specific statutes offering varying levels of legal protection to certain private-sector whistleblowers.² The extent of coverage, the protection which is afforded and the procedures that a whistleblower must follow vary widely among the states. A greater number of states, thirty-eight, have adopted laws protecting government workers, generally state employees, who are whistleblowers.³ Like the private sector laws, they vary widely from state to state.

The imperative need for federal whistleblower protection is demonstrated by the fact that many states have attempted to fill the gap by passing their own whistleblower laws. However, state laws do not provide the comprehensive protection necessary for whistleblowers in the health care industry. For example, state statutes vary widely on the following important issues: 1) Which employees are protected? Some statutes do not cover the health care industry. Others protect only government employees; 2) What kind of retaliation is prohibited? Some statutes only protect employees from wrongful termination, not from other insidious forms of harassment and discrimination; 3) Can employers find ways around the whistleblower laws by forcing employees to sign overbroad confidentiality agreements? 4) To whom can the whistleblower report? Some statutes only protect workers who report violations to an outside agency -- workers fired for reporting fraud or patient abuse to their own supervisor remain vulnerable. Other states require mandatory disclosure to the worker's employer, which does not help anonymous whistleblowers who know that appeals to their boss would be futile, and gives the employer time to conceal evidence before an outside investigation begins. 5) What kinds of violations can whistleblowers report? Some state statutes only protect workers who report an "actual" violation of law; others require only that the employee report in good faith a "suspected" violation of law. Some state laws also require that the violation must "affect the public interest", or even more strictly, that the violations must present a "specific and substantial danger" to "the public health and safety". In the fast-paced health care context, however, where life and death decisions can be made in a few seconds, it is unreasonable to expect workers to prove that unsafe conditions were actually *illegal* or *substantially dangerous*

² California, Connecticut, Delaware, Florida, Hawaii, Louisiana, Maine, Michigan, Minnesota, Montana, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oregon, Rhode Island, Tennessee and Washington. This list is current as of 1996.

³ Alaska, Arizona, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, West Virginia, and Wisconsin. This list is current as of 1996.

to the public at large. Clearly, this piecemeal collection of state statutes leaves gaping holes in protection for health care workers and their patients.

In conclusion, new federal legislation is necessary to protect health care whistleblowers because the range of existing whistleblower laws on both the federal and state level are woefully inadequate and do not provide anything approaching comprehensive and effective protection for health care workers. A federal law is needed that will provide comprehensive and effective protection for public and private sector health care workers who expose improper, illegal or dangerous care and conditions in health care institutions which threaten the health and safety of patients. Such a law will stop health care workers from being forced to choose between protecting and properly caring for their patients and keeping their jobs. Consumers of health care will be greatly reassured when they know that health care workers are free to speak freely and forcefully on their behalf.

BB/lmwk

Kyl file

DRAFT: PROPOSED CHANGE TO MEDICARE PHYSICIAN PRIVATE CONTRACTING

Balanced Budget Act Provision

- Allows physicians to contract with Medicare beneficiaries for Part B covered services outside of the Medicare program. This contract requires that:
 - The beneficiary pays all of the costs for the physician, with no Medicare reimbursement, and
 - The physician agrees to not submit a claim to Medicare and may charge any rate without regard to Medicare payment rates or balance billing protections.
- Physicians entering into these contracts must agree to opt out of Medicare entirely for two years. They may treat Medicare beneficiaries but only through private contracts.
- To ensure consumer protection, the private contract must be in writing, cannot be signed when the beneficiary needs an emergency service, and must assure that the beneficiary is aware of the cost liability that will result from the contract.

The Proposed Amendment (Introduced by Thomas, Bliley & Kyl)

- Allows private contracting but does not require physicians to opt out of Medicare for two years. Providers may participate in Medicare for some beneficiaries and / or services even if they have one or many private contracts with Medicare beneficiaries.

Concerns about the New Proposal

- **Could create access problems:** If a physician can have a private contract with one beneficiary but not another, there is an incentive to only treat sick beneficiaries through the private contract (where they can charge whatever rate they want) and healthy beneficiaries through Medicare. In small towns or rural areas, this could make it difficult for sick beneficiaries to find a doctor.

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.
- **Fraud:** If physicians can selectively choose beneficiaries and / or services that are subject to private contracts, Medicare will have to keep track of every single contract. Otherwise, there will be no way to know whether a claim submitted by a physician participating in Medicare for a Medicare beneficiary is valid or not.
- **Beyond original proposal:** Even the first proposal, prior to any Democrats' input, only applied to "a physician or other health care professional who does not provide items or services under the program under this title" (i.e., Medicare). Both the Senate floor amendment and final law apply on an all-or-nothing basis; i.e., private contracts are permissible only for physicians who opt-out of Medicare.

Want to Pay for Something Medicare Doesn't Cover? Forget It.

The year is 2015. Hillary Rodham Clinton is over the age of 65 and wants a medical service that Medicare doesn't cover. What does she do? Thanks to her husband's pension, she can afford to do pay a physician privately for the service she needs.

But wait a minute. She can't find a doctor willing to take her money. For this, Mrs. Clinton can thank Congress and her husband's administration, which in 1997 made it unlawful for a doctor to take a private payment from a Medicare-eligible patient if during the previous two years he has billed Medicare for any service rendered to a patient over the age of 65. It is a

Rule of Law

By Kent Masterson Brown

good thing Mrs. Clinton can afford the airline ticket to London. There, a doctor would be delighted to see her, because it is perfectly lawful in England for her to pay privately for medical services.

This limitation on the rights of seniors is a little-noticed amendment to the Medicare Act that was enacted in August as part of the balanced budget deal. The reality is that few or no physicians are going to be able to make ends meet if they can't accept Medicare patients for two years. This means that few or no physicians are going to limit their practices to non-Medicare patients, which in turn means that, for all practical purposes, it is now unlawful for a senior to contract privately for medical services. In other words, unlike the rest of us, seniors have no option but to receive only the services that their insurance carrier, Medicare, will recognize and pay for.

The focal point of the current controversy is a 1992 opinion by federal district

Judge Nicholas Politan in the case of *Stewart v. Sullivan* in New Jersey. The Medicare beneficiaries in *Stewart*, whom I represented, wanted to pay personally for their physician to visit them more than once a month at their residences, some of which were nursing homes. (One visit a month was all that Medicare permitted.) Yet the federal Health Care Financing Administration, in bulletins issued through the insurance companies administering Medicare, repeatedly threatened physicians with stiff sanctions, including exclusion from the Medicare program altogether, if they entered into private arrangements with a Medicare beneficiary.

What statutory authority did HCFA then possess to make such threats? I could find nothing. In fact, the Medicare Act contemplated just such a situation in which a Medicare beneficiary might receive medical services and not file a claim. Under the Medicare Act, payment for medical services by the Medicare program—and the resulting physician obligations—were triggered only if a claim was filed. The Medicare beneficiaries in *Stewart* did not want to file claims with Medicare.

In *Stewart v. Sullivan*, HCFA argued that a claim must be filed each and every time a medical service was rendered by a physician for a Medicare beneficiary—even if the beneficiary wanted to pay for it himself and not file a claim. But HCFA could never point the court to any provision that said as much.

The result of the case was a clear victory for private contracting. Judge Politan found nothing in the Medicare Act that prohibited a Medicare beneficiary from personally paying a physician for a medical service. In addition, he found that HCFA had promulgated no "clearly articulated" policy prohibiting such activity. Consequently, he found that there was nothing for a court to decide; the plaintiffs went ahead and paid the doctor.

Since that decision HCFA has not promulgated any "clearly articulated" regulation or policy prohibiting private contracting. It knows it has absolutely no authority to do that. Yet it continues to threaten physicians with sanctions if they and their Medicare patients try to contract privately.

The Medicare Carriers Manual, a document written by HCFA, warns insurance companies that administer Medicare that some physicians and beneficiaries are trying to enter into agreements so that beneficiaries will not have to use their Medicare coverage for certain claims.

If you are over 65, you have just lost the right to pay privately for any medical service not covered by Medicare.

"Congress enacted these requirements," the manual reads, "for the protection of all Medicare Part B beneficiaries and their application cannot be negotiated between a physician and his/her patient."

Why would a federal agency administering a program so close to bankruptcy threaten physicians when their Medicare patients seek to relieve the financial burden on the program by shouldering it themselves whenever they can? Right now, the population of Americans over 65 is the wealthiest, healthiest, most well-educated elderly population the world has ever known. From what do these people need protection?

HCFA is a classic example of a federal agency out of control. It doesn't care what the law says. It seeks only to protect its control over the provision of health care. It wants to control who renders it, how it is delivered and, most important, what service is or is not delivered. And it wants to

expand that control. Private contracting is HCFA's greatest threat. Unfortunately, Congress—which is supposed to oversee the agencies it creates—doesn't seem to care. Rather, it lets HCFA tell it what its own statutes mean. And that is the problem now.

Convinced by HCFA that private contracting is not permitted, Congress eliminated private contracting as an option for any Medicare beneficiary. Instead of overseeing HCFA, Congress just succumbed to it. Mr. Clinton threatened to veto the entire budget agreement if Congress passed the act without the Medicare amendment intact.

And so, if you are over 65, you have just lost the right to pay privately for any medical service not covered by your government insurance. In this regard, age is the only difference between you and any other patient. Those under 65 with private insurance can still go to a physician who is not in their plan and pay that physician's fee for the medical service. Similarly, younger patients can obtain a service not covered by their plan simply by paying privately.

Hoping to undo what was done in August, Sen. John Kyl (R., Ariz.) and Rep. Bill Archer (R., Texas) have introduced bills entitled the Medicare-Beneficiary Freedom to Contract Act. The legislation would clearly state the right of Americans over 65 to contract privately with the physician of their choice. Seniors—all of us, for that matter—can only hope that that the legislation passes and survives an almost-certain presidential veto. Today, Americans over 65 have less freedom than do patients in Britain's notoriously inadequate National Health Service.

Mr. Brown practices law in Kentucky and Washington, D.C. He was counsel for the plaintiffs in the case that forced the White House to open the meetings and the records of Hillary Clinton's Health Care Task Force.

KyL Fly

**LEADERSHIP COUNCIL
OF
AGING ORGANIZATIONS**

James P. Firman, Chairman

AARP

ALLIANCE FOR AGING RESEARCH

ALZHEIMER'S ASSOCIATION

AMERICAN ASSOCIATION FOR INTERNATIONAL

AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING

AFL-CIO DEPARTMENT OF EMPLOYEE BENEFITS

AFSCME RETIREE PROGRAM

AMERICAN FOUNDATION FOR THE BLIND

AMERICAN GERIATRICS SOCIETY

AMERICAN SOCIETY ON AGING

ASOCIACION NACIONAL PRO PERSONAS MAYORES

ASSOCIATION FOR GERONTOLOGY IN HIGHER EDUCATION

**ASSOCIATION FOR GERONTOLOGY AND HUMAN DEVELOPMENT IN
HISTORICALLY BLACK COLLEGES AND UNIVERSITIES**

ASSOCIATION OF JEWISH AGING SERVICES

B'NAI B'RITH CENTER FOR SENIOR HOUSING AND SERVICES

ELDERCARE AMERICA, INC.

FAMILIES USA

THE GERONTOLOGICAL SOCIETY OF AMERICA

GRAY PANTHERS

GREEN THUMB, INC.

NATIONAL ASIAN PACIFIC CENTER ON AGING

NATIONAL ASSOCIATION FOR HOME CARE

NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING

NATIONAL ASSOCIATION OF FOSTER GRANDPARENT PROGRAM DIRECTORS

NATIONAL ASSOCIATION OF MEAL PROGRAMS

NATIONAL ASSOCIATION OF NUTRITION AND AGING SERVICES PROGRAMS

NATIONAL ASSOCIATION OF RETIRED AND SENIOR VOLUNTEER PROGRAM DIRECTORS, INC.

NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES

NATIONAL ASSOCIATION OF SENIOR COMPANION PROJECT DIRECTORS

NATIONAL ASSOCIATION OF STATE UNITS ON AGING

NATIONAL CAUCUS AND CENTER ON BLACK AGED, INC.

NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

NATIONAL COUNCIL OF SENIOR CITIZENS

NATIONAL COUNCIL ON THE AGING, INC.

NATIONAL HISPANIC COUNCIL ON AGING

NATIONAL INDIAN COUNCIL ON AGING, INC.

NATIONAL OSTEOPOROSIS FOUNDATION

NATIONAL SENIOR CITIZENS LAW CENTER

NATIONAL SENIOR SERVICE CORPS DIRECTORS ASSOCIATIONS

NORTH AMERICAN ASSOCIATION OF JEWISH HOMES AND HOUSING FOR THE AGING

OWL

UNITED AUTO WORKERS RETIRED MEMBERS DEPARTMENT

October, 1997

THE NATIONAL COUNCIL ON THE AGING

409 Third Street SW Washington, DC 20024 TEL 202 479-1200 TDD 202 479-6674 FAX 202 479-0735 <http://www.ncoa.org>
Contact: Mike Reinemer, 202/479-6975

LCAO Opposes Medicare Private Contracting Proposal

My name is Howard Bedlin and I am the Vice President for Public Policy and Advocacy for the National Council on the Aging, which currently chairs the Leadership Council on Aging Organizations (LCAO). The LCAO represents 43 national organizations serving over 40 million older persons.

The Leadership Council of Aging Organizations opposes efforts to overturn current provisions that protect Medicare beneficiaries from physician overbilling. Doctors are already permitted to charge 15% more than what Medicare considers to be a reasonable price, and now they want to charge even more. We oppose opening up Medicare provisions enacted under the Balanced Budget Act just two months ago on an issue that has far reaching implications, yet has never been the subject of a congressional hearing or even debated on the House or Senate floor. LCAO members will be sending a letter to members of Congress next week to express our opposition to this ill-conceived, anti-consumer proposal.

The National Council on the Aging believes that the proposals introduced by Senator Kyl and Chairman Archer are not designed to solve any problem experienced by Medicare beneficiaries. Well over 90 percent of physician's bills accept Medicare rates and there is no evidence to indicate that access problems exist because of Medicare payments to doctors. The proposals would, however, increase physicians' income and fundamentally change the nature of the doctor-patient relationship.

Without notice, or in the middle of a course of treatment, doctors could tell Medicare patients that treatment will be denied unless payment is made for the full amount of whatever the doctor wants to charge. No other insurance policy, in either the public or private sectors, permits this. Access to specialists would suffer, as they could refuse to see the vast majority of Medicare beneficiaries so that a small handful of the wealthiest seniors could pay their higher rates. Instances of fraud and abuse would increase, as unscrupulous doctors would have an easy time getting away with double billing both Medicare and the patient.

Beneficiaries could be subject to bait-and-switch tactics, in which doctors begin a course of treatment under Medicare and then turn around and demand full payment of higher charges out-of-pocket for treatment to continue. What if a particular doctor doesn't like what Medicare is paying him for one particular service? What if the doctor notices that the patient has driven up in a nice new car? The kind of uncertainty this proposal would create would be extremely harmful to Medicare beneficiaries.

We strongly urge members of Congress to reject this proposal, to act in the interest of 33 million Medicare beneficiaries, and to refuse to line the pockets of a few greedy doctors.

###



OWL PRESS RELEASE

666 11TH STREET, NW • WASHINGTON, DC 20001 • 202-783-6686 • FAX 202-638-2356

For further information:
Roberta Weiner/202/783-6686

FOR IMMEDIATE RELEASE
Tuesday, October 8

NEW KYL LEGISLATION WOULD DISPROPORTIONATELY HARM OLDER WOMEN

Older Women Are Poorer, Have More, and More Complex, Illnesses;
Increased Costs Would Price Them Out Of Health Care Marketplace

OWL, an organization representing the more than 57 million American women over the age of 40, today (October 8) issued the following statement opposing S 1194/HR 2497, bills that would enable physicians, without any consumer protections, to contract privately for services with Medicare beneficiaries.

"Kyl II," which would give doctors license to charge whatever the market would bear for services that already have Medicare-imposed cost ceilings, would be particularly damaging to women who suffer from more, and often more complex conditions than men. Requiring more general physician care and more specialist care, these already vulnerable patients, who even now have trouble affording the out-of-pocket health care expenses they must pay, could be faced with a choice of private treatment or a Medicaid-funded nursing home stay.

"Kyl II" would make bad public policy worse. The so-called Medicare "reforms" that were included in the Balanced Budget Act have aptly been identified as the start down a slippery slope that will eventually lead to the total dismemberment of Medicare. OWL believes that "Kyl II" would be a large rock rapidly careening down that slope, taking with it the guarantees of access and quality that Medicare has always provided to America's older women.

21.8 million (out of 38.1 million) of all Medicare beneficiaries are women, and 83% have an annual income of less than \$25,000 per year. In fact, older women live on a median income of \$9,355 a year (compared to a man's \$14,983), and depend upon Medicare and their monthly Social Security check for maintaining their independence at home rather than entering a nursing home. This proposed legislation not only threatens to destroy the foundation of a critical social insurance program, but could seriously threaten the lives of America's older women.

#

**Extension of Remarks of Congressman Pete Stark
In the House of Representatives
September 23, 1997**

*file!
Kyl amendment*

In 1995, Medicare Paid 393 Doctors More than \$1 Million for Services; 3,152 Doctors Received between \$500,000 and \$1,000,000. Now a Greedy Few Want More

Mr. Speaker:

The Medicare agency tells me that in 1995, Medicare paid 393 doctors more than \$1 million for services; 3,152 doctors received between \$500,000 and \$1,000,000. Now a Greedy Few want more.

Despite the ability of doctors to make a fortune from Medicare by providing lots of services to beneficiaries, a few doctors are pushing an amendment by Senator Kyl to let doctors privately contract with Medicare benefits.

Strip away the rhetoric, and a private contract is a contract between a doctor who holds his life in your hands in which he demands that you give up your Medicare benefits and that you promise not to file a claim with Medicare. Instead, you agree to let him charge you anything he wants--because you are desperate for your health. We like to think of contracts between equals, negotiated fairly. There is no equality, there is no fairness in these contracts.

Want an example of a private contract? Look at today's Washington Post, page B-3, where a doctor in Manassas, Virginia is being investigated for charging a Medicare-eligible patient \$12,000 for the injection of a massive dose of aloe vera into the stomach in order to combat lung cancer. The investigation is due to the fact the man died in the doctor's office after the injection. Medicare does not cover quackery. It does not pay \$12,000 for an injection. But this man and this doctor had a private contract. There will be a lot more of this murderous nonsense if the Kyl amendment succeeds.

**Extension of Remarks of Congressman Pete Stark
In the House of Representatives
September 22, 1997**

**People have trouble seeing doctors because they don't have enough money--
not because Medicare pays doctors too little**

Mr. Speaker:

The just-enacted Balanced Budget Act includes a provision that allows doctors not to participate in Medicare for two years at a time, but instead to private contract with patients so that they can charge these patients much more than the Medicare fee schedule.

There is now a move underway to strike the two year requirement and let doctors do wallet biopsies--decide on a patient-by-patient basis whether they are going to ask patients to give up their Medicare rights and insurance and pay the extra in an individual private contract.

I can think of nothing that will encourage patients to move into HMOs faster, so that they are protected against the fear of this type of doctor extortion. The American Medical Association supports the proposal, but it is an idea that must have been deviously planted in their Association by a mole from the HMO lobby--the American Association of Health Plans!

The proposal is pure greed wrapped in the flag of freedom.

Before the Congress is drowned in the rhetoric of this issue, we should note the facts. To the extent that Medicare beneficiaries have trouble seeing doctors, it is almost totally due to the fact that the cost is too much for the beneficiaries---not that Medicare doesn't pay the doctor enough to allow the doctor to see patients.

The latest data from the independent Congressional advisory panel--the Physician Payment Assessment Commission--shows that only 4% of all Medicare beneficiaries reported having trouble getting health care in the last year. About 11% had a medical problem, but failed to see a physician, while 12% did not have a physician's office as a usual source of care. Roughly 10% of Medicare beneficiaries delayed care due to cost. Considering all four access measures, about

26% of Medicare beneficiaries cited experiencing at least one of these problems.

PhysPRC reports that from their surveys of those who failed to see a physician for their serious medical problem, 43 cited cost as the reason. About 8 percent of those who failed to see a physician could not get an appointment or find an available physician. For another 8 percent, transportation was the problem, 13% felt there was nothing a doctor could do, and 11% were afraid of finding out what was wrong.

In another words, Congress is preparing to let doctors charge patients infinitely higher fees because less than 1% of all Medicare beneficiaries had trouble finding a doctor (perhaps they lived in a rural area, etc.). Yet over 5% of Medicare's nearly 40 million beneficiaries could not get to a doctor because they didn't have enough money--and Congress is silent.

Mr. Speaker, a humane Congress, a compassionate Congress, a logical, rational Congress would put 5 times as much effort into addressing the problem of doctors costing too much as it would in addressing what may be a 1% problem of a few doctors wanting to get paid more.

Where are our priorities, Mr. Speaker? A vote to let doctors, the richest 1% income group in our nation, charge "the sky's the limit," while ignoring the needs nearly 2 million seniors who find doctors already too expensive is a shameful vote.

WANT AN EXAMPLE OF PRIVATE CONTRACTING?

Dear Colleague:

Senator Kyl wants to make it easier for doctors to force seniors to give up their Medicare rights and be charged the sky's the limit.

No matter that doctors already make a lot of money from Medicare. In 1995, Medicare paid 393 doctors more than \$1,000,000. Another 3,152 received between \$500,000 and \$1 million. The busiest 10% of doctors average \$323,409 from Medicare.

The Kyl amendment is just pure greed. Medicare pays enough for doctors to see Medicare patients. The Physician Payment Review Commission--the Congressional advisory body on doctor payments--reports that about the same number of doctors are accepting new Medicare patients as are accepting new private-pay patients. They report that the main reason Medicare patients have trouble seeing a doctor is because the patient doesn't have enough money--not because the doctor is not being paid enough.

Medicare and the government have spent hundreds of billions to educate doctors and support medical research; we spend about \$60,000 a year on each resident doctor we train; it is only fitting that doctors in turn live with the Medicare fee schedule.

You want to see an example of a private contract? Look on the back. Charging a Medicare eligible patient \$12,000 for a deadly alternative is a private contract.

Oppose amendments to make it easier for doctors to private contract--**extort**--Medicare patients.

Sincerely,

Va. Doctor's Treatment of Man Who Died Is Scrutinized

9/23/97

By Leef Smith

Washington Post Staff Writer

A Texas man who had lung cancer died in the spring in the office of a Manassas physician to whom he had gone for a costly intravenous treatment that is not officially sanctioned but that he hoped would save his life, according to Virginia State Police.

The man, Clarence Holland Lander, 83, became "violently ill" shortly after the \$12,000 treatment was administered, and he died May 17, according to records in Prince William County Circuit Court.

The physician, Donald L. MacNay, an orthopedic surgeon, is under investigation in connection with Lander's death and with the treatment allegedly employed—intravenous administration of "a concentrated form of aloe vera and other substances," police said. Aloe vera, a cactus-like member of the lily family, is known to have some healing properties.

Police said that their investigation is continuing and that MacNay has

not been charged with any offense. MacNay, who investigators said still is licensed to practice medicine, did not return phone calls to his Manassas office yesterday.

An assistant to MacNay, Ronald Ragan Sheetz, 41, of Manassas, was arrested Thursday and charged with nursing without a license. According to an affidavit that accompanied the request for the arrest warrant, MacNay ordered Sheetz to give Lander the aloe vera injection.

"This procedure was carried out by the subject believed to be Ronald Sheetz who has no medical license on file, under Dr. MacNay's direction and presence," the warrant states. State Police spokeswoman Lucy Caldwell said MacNay also is under investigation in connection with Sheetz's action.

"We're looking into questionable medical practices, drug transactions and suspicious cancer treatments of this doctor's office," Caldwell said. "At this time we're trying to determine how wide-reaching the practice

here may be. It's still too early to say."

A spokeswoman for the U.S. Food and Drug Administration said that the intravenous aloe vera treatment has not been approved by the agency and that officials with the National Cancer Institute said they are not studying aloe in connection with cancer treatment.

At the same time, the healing properties of aloe are being studied by researchers exploring alternative medicines to treat diseases, and papers and advertisements about oral aloe-based concentrates are found easily on the Internet. Experts say that as many as 50 percent of the cancer patients in the United States try some kind of therapy that is not officially sanctioned.

Such treatments include special diets, vitamins, mental imagery, wearing magnets, coffee enemas and consuming cartilage and oil from sharks.

Lander's son, James Lander, said that his father was in excellent health before the terminal cancer was diag-

nosed and that he jumped at the chance to beat the disease. He said his father learned about the aloe treatment from reading an article and found MacNay through word-of-mouth referrals.

"The treatment gave him hope," James Lander said. "He completely brightened up. You could just see it. I'm sure he thought it would cure him or he wouldn't have gone to Virginia" from his home in Waco, Tex.

In a search warrant affidavit filed Friday in Circuit Court, investigators said they were seeking "patient files and other records related to appointments and [the] treatment of other patients who have received this treatment and have both lived and died."

An affidavit was filed yesterday in Fairfax County Circuit Court to obtain a search warrant for an office in Annandale that police said MacNay opened in July.

Sheetz was released from jail on personal recognizance. If convicted of the felony charge, he could be sentenced to up to five years in prison.

**Extension of Remarks of Congressman Pete Stark
In the House of Representatives
September 23, 1997**

The Greedy

Mr. Speaker:

A move is underway to let doctors force patients to give up their Medicare benefits so that a handful of doctors can charge them anything they want--without limit.

This is a gift to the greediest doctors in the nation.

Ninety-five percent of the nation's doctors accept new Medicare patients and the Medicare fee schedule. The independent Congressional advisory panel known as the Physician Payment Review Commission reports that this is comparable to the rate of doctors who are accepting new private, non-Medicare patients. In other words, there is no noticeable difference in access--ability to see a doctor--between Medicare and non-Medicare patients.

Doctors who accept Medicare and its fee schedule understand the Hippocratic Oath and the social compact in which society has paid hundreds of billions of dollars for the education and training and research that make American doctors special and in turn, these doctors accept the Medicare payment system.

But Congress is about to cater to the few who want more, more, more from people in their hour of illness.

The Employee Benefit Research Institute in its September, 1997 Issue Brief shows what a special gift this legislation will be to a few doctors who are out of step with their colleagues:

Recent findings indicate that only between 4 percent and 6 percent of physicians accepting new patients were not accepting new Medicare patients. One survey found that between 1991 and 1992, the proportion of physicians not accepting new Medicare patients increased from 4 percent to 5.9 percent (Lee and Gillis, 1994). The same survey found that between 1992 and 1993 the percentage of physicians not accepting new Medicare patients decreased to 4.7 percent. Surveys by the Physician Payment Review Commission (PPRC) also found that in 1993 less than 5 percent of physicians were not accepting new Medicare patients (Physician Payment Review Commission, 1994). The PPRC study concluded that the implementation of the Medicare fee schedule has not caused physicians to close their practices to Medicare patients.

BILL THOMAS, CALIFORNIA, CHAIRMAN
SUBCOMMITTEE ON HEALTH

NANCY L. JOHNSON, CONNECTICUT
JIM McCREERY, LOUISIANA
JOHN ENSIGN, NEVADA
JON CHRISTENSEN, NEBRASKA
PHILIP M. CRANE, ILLINOIS
WMO HOUGHTON, NEW YORK
AM JOHNSON, TEXAS

ORTNEY PETE STARK, CALIFORNIA
JENJAMIN L. CARDIN, MARYLAND
GERALD D. KLECZKA, WISCONSIN
JOHN LEWIS, GEORGIA
XAVIER BECERRA, CALIFORNIA

Ex Office:
BILL ARCHER, TEXAS
CHARLES B. RANGEL, NEW YORK

BILL ARCHER, TEXAS, CHAIRMAN
COMMITTEE ON WAYS AND MEANS

A. L. SINGLETON, CHIEF OF STAFF
CHARLES N. KAHN II, SUBCOMMITTEE STAFF DIRECTOR

JANICE MAYS, MINORITY CHIEF COUNSEL
BILL VAUGHAN, SUBCOMMITTEE MINORITY

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

September 8, 1997

Franklin Raines, Director
Office of Management and Budget
The Old Executive Office Building
Washington, DC 20503

Dear Director Raines:

Included in the Balanced Budget Act is an amendment by Senator Kyl allowing a doctor to sign private contracts with Medicare beneficiaries requiring those beneficiaries to give up their Medicare insurance when they use that doctor. A doctor who signs such a contract must make a commitment not to bill Medicare for any of his patients for a two year period.

Advocates of private contracting support it in the name of freedom.

I had thought it was just plain greed--the desire of a doctor to bill any amount rather than have to live with the Medicare resource-based relative value fee schedule.

But perhaps it is a question of freedom, in which case the better response by the public would be to accept this proposal--but the public should have the freedom to bill the doctor, with interest, for all the public subsidies he or she has received.

The reason that American medicine is a world leader and that medicine has moved beyond the level of penicillin, amputations, and mustard plasters is the hundreds of billions of taxpayer dollars that have been poured into the National Institutes of Health, the Public Health Service, the various health professions manpower training programs, Medicare's Graduate Medical Education programs (which average about \$60,000 a year in subsidy for the training of each resident doctor), and the capital assistance to the hospitals in which these doctors trained.

The doctors who advocate private contracting tend to say that they are special and can command extra fees. The only reason that is true is that the public has substantially subsidized their education and the research on which their fame and fortune rests.

For a doctor to now want to private contract and avoid Medicare patients would be like a West Point cadet saying that he or she did not want to serve in the Regular Army after graduation. That may be freedom, but it is a subsidy we do not permit.

In the case of these doctors who became competent through the massive health subsidies we have provided, we should permit them to privately contract as long as they repay, with interest, the estimated value of the subsidies they received. I hope the Office of Management and Budget could estimate the total value of physician and clinical practice health subsidies, including tax subsidies, that have been provided over the past forty years. From this we could develop a formula so that when, for example, a 55 year old doctor decides he wants the freedom to private contract, he can also have the freedom to repay the public for its investment in making him such a wonderful doctor who can command such high fees.

Thank you for your assistance with this request.

Sincerely,

PS

Pete Stark
Member of Congress



Bringing lifetimes of experience and leadership to serve all generations.

Medicare Physician Private Contracting S.1194/H.R. 2497

Some physicians are urging Congress to repeal important program integrity and consumer protection provisions that are part of the Medicare private contracting section of the Balanced Budget Act of 1997. **AARP believes that such attempts would leave Medicare vulnerable to greater fraud and abuse and beneficiaries at risk of higher health care costs.**

Background

Section 4507 of the Balanced Budget Act of 1997 (BBA) allows physicians to contract privately with Medicare beneficiaries for services that would otherwise be covered by the program. Under a private contract arrangement, a beneficiary agrees to pay 100% of whatever amount the physician charges for services covered by the contract. Medicare does not pay any portion of the cost of these services. Prior to the BBA, covered services provided to a Medicare beneficiary enrolled in Part B were bound by Medicare's payment rules and private contracting was not allowed. (There are no restrictions on private contracting for services the program does not cover.) While there was some anecdotal evidence of "private arrangements" for covered services, these were not consistent with the Medicare statute.

The BBA provision, which originated in a floor amendment offered by Senator Jon Kyl (R-AZ) on June 25, was intended, according to Senator Kyl, to allow "for those 9 percent of the physicians who do not treat Medicare patients to continue to treat their patients as they always have."

To protect Medicare from fraud and to ensure that private contract arrangements are limited to the narrow subset of physicians who otherwise would not be available to Medicare beneficiaries, the BBA provision is limited to physicians who agree, in an affidavit, to forgo all reimbursement from Medicare for at least 2 years. To ensure that beneficiaries know the consequences of their decision to contract privately with one of these physicians, the new law also requires the doctor to disclose to the beneficiary that no Medicare payment will be made for privately contracted services, no balance billing limits will apply, no Medigap coverage will be available, and the services to be performed would be paid for by Medicare if provided by another physician. In other words, if a physician and a beneficiary want to have a private agreement, they can, but the beneficiary knows up front, at least in general terms, to what they are agreeing.

S. 1194/H.R. 2497 - Proposals to Amend the BBA Private Contracting Provision

On September 18, less than 2 months after the BBA was signed into law, Senator Kyl, with the strong backing of the American Medical Association (AMA), proposed repealing some of the program integrity and consumer protections included in the private contracting provision and expanding the scope of private contracting far beyond the original Kyl proposal.

If Section 4507 of the Balanced Budget Act of 1997 is amended by S. 1194/H.R. 2497 the resulting law would:

- Allow all physicians to charge more than the levels set by the Congress or negotiated with Medicare+Choice plans by contracting privately with beneficiaries. S. 1194 and H.R. 2497 would permit physicians in the traditional Medicare program as well as those in HMOs and the new Medicare+Choice plans to contract privately with their patients. The contract – which would have to be signed by the beneficiary and the provider prior to services being provided – would indicate that no claims would be submitted to Medicare for payment for the services identified in the contract. The beneficiary would have to agree to be responsible for 100% of the physician's charges for all privately contracted services.
- Expand the private contracting provision in the BBA to allow physicians to charge higher fees by contracting privately on a service-by-service, or “a la carte,” basis. This means that a physician could bill a beneficiary for 100% of his charge for some of the services the beneficiary received and bill Medicare for other services.
- Allow physicians to negotiate higher charges privately with low-income “dually eligible” and Qualified Medicare Beneficiary (QMB) recipients.
- Repeal the requirement in the BBA for physicians who privately contract for higher fees to file an affidavit with the Health Care Financing Administration (HCFA) and forgo reimbursement from Medicare for all Medicare patients for 2 years.
- Allow Medicare to collect only “the minimum information” necessary from physicians to assure that the program doesn't pay for services that have already been paid for by the beneficiary (See page 3).
- Maintain the provision that physicians who have been excluded from the Medicare program for fraud and/or poor quality of care disclose this fact to beneficiaries in the contract.

- Maintain the BBA requirement that the contract a beneficiary signs clearly indicate that: claims will not be submitted to Medicare by either the physician or the beneficiary; the beneficiary is responsible for the full cost of the privately contracted services; balance billing limits do not apply to contracted services; Medigap coverage will not be available for contracted services; and the services to be performed could be paid for by Medicare if provided by another physician.

The Kyl Bill Would Hurt Beneficiaries and Medicare

- **The Kyl Bill Leaves Beneficiaries and the Medicare Program More Vulnerable to Fraud and Abuse**
 - ⇒ HCFA – which already confronts significant fraud and abuse in Medicare – could find it more difficult to prevent or detect fraud or abuse because the bill eliminates provisions from the underlying BBA that would have made more careful tracking possible. S. 1194 and H.R. 2497 provide that only “the minimum information necessary to avoid any payment under part A or B for services covered under the contract” would be given to HCFA or Medicare+Choice plans for use in determining which claims should be paid by Medicare. This choice of language may, intentionally or not, tie the hands of program administrators seeking to protect the fiscal integrity of the program. For instance, will this information specifically include the names of the doctor and the patient, as well as the specific services affected by the contract? Consider this example: a physician who contracts privately with a beneficiary for payment of two of five services might fraudulently file a claim with Medicare for all five services – even though only three services should be paid by the program. In this case, unless HCFA has complete information on each private contract – including the doctor, patient, and specific services involved – and can align it with claim filings, both Medicare and the beneficiary could end up paying for the same services.
 - ⇒ Allowing physicians to privately contract with low-income dually eligible and QMB beneficiaries also creates the possibility of Medicaid fraud if physicians bill both the beneficiary and state Medicaid programs – which are also struggling with the problem of fraud and abuse.
 - ⇒ Beneficiary costs could increase significantly because physicians would be free to “unbundle” services that are normally paid for as a package of services. In these cases, beneficiaries – particularly when they are very ill -- would pay significantly more out-of-pocket because they would pay for each individual service rather than for a group of services.

- **Allowing Private Contracting Arrangements in Medicare+Choice Plans Poses Unique Problems:**

- ⇒ Under BBA, the Medicare program will make per capita payments to the new Medicare+Choice plans. In return, these plans will provide beneficiaries with health care services, including physician services. Since the Kyl bill allows physicians to privately contract for services they provide to beneficiaries in Medicare+Choice plans, physicians could be paid twice for the same services. For instance, physicians in the new Provider Sponsored Organizations (PSO) could be paid once by Medicare through its per capita payment and again by the beneficiary for the same service through the private contract arrangement. Since the per capita payment is made in advance to the plans by Medicare, this double payment would be very difficult, if not impossible, for Medicare to recoup.
- ⇒ The capitated payments Medicare makes to HMOs and the new Medicare+Choice plans include funds to cover physicians' services. Yet if physicians are allowed to privately contract with beneficiaries in these plans, the plans would be able to keep the funds for services not provided by the plans, but which beneficiaries paid for under private contracts.
- ⇒ Beneficiaries are likely to join Medicare+Choice plans because they believe these plans may cost them less out-of-pocket than traditional fee-for-service coupled with supplemental insurance (Medigap). S. 1194 and H.R. 2497 would undermine efforts to encourage more beneficiaries to enroll in the new Medicare+Choice plans because beneficiaries could end up paying more, not less, for their care.
- ⇒ Physicians who contract with employer-provided plans to provide care for younger workers typically abide by the plan's reimbursement rates and the limits on enrollee out-of-pocket costs. However, under the new Kyl proposal, doctors who contract with Medicare HMOs and the new Medicare+Choice plans would not have to adhere to the plan's reimbursement or to beneficiary out-of-pocket limits as they have to in comparable private sector arrangements. They would be able to privately contract with beneficiaries enrolled in these plans. This practice essentially would deny Medicare beneficiaries a protection enjoyed by millions of workers and their families.

- **Physicians Won't Have to Disclose the Cost of Services Being Privately Contracted:** As with the underlying BBA, the new Kyl bill does not require physicians who contract privately to disclose their fees to beneficiaries before the services are provided. There would be no fee schedule, no limits on what physicians may charge under a private contract and no protection from out-of-pocket costs under Medigap policies. Therefore, beneficiaries would not know what their out-of-pocket liability for private contract charges would be and would have difficulty budgeting for the costs of their care. While this may be manageable for some wealthy individuals, it may not be manageable for the average beneficiary.
- **The Kyl Bill Leaves Low-Income Beneficiaries Vulnerable:** The Kyl bill would allow physicians to contract privately with beneficiaries who are dually eligible for Medicare and Medicaid as well as those low-income beneficiaries who are eligible for the Qualified Medicare Beneficiary (QMB) program. By definition, these are beneficiaries with very modest incomes -- below 100% of poverty. It is unclear whether or to what extent this would leave state Medicaid programs vulnerable to higher costs.

AARP believes that the new Kyl bill would weaken critical protections in BBA for beneficiaries and the fiscal integrity of the Medicare program. For many beneficiaries, the "choice" available under the Kyl bill could mean an immediate and dramatic increase in out-of-pocket costs for physicians' services. Equally as important, for the Medicare program, the Kyl bill would add to the already critical problems of fraud and abuse.

AARP Federal Affairs
10/3/97



PRESS RELEASE

Congressman
Ben Cardin

Third Congressional District, Maryland

FOR IMMEDIATE RELEASE
Oct. 8, 1997

CONTACT: Susan Sullam
Phone: 202-225-4016

**REP. CARDIN CONDEMNS BILL THAT WOULD ALLOW DOCTORS TO BYPASS
MEDICARE AND CONTRACT PRIVATELY WITH SENIORS FOR HEALTH CARE**

WASHINGTON -- Rep. Benjamin L. Cardin today joined advocates for senior citizens to criticize a proposal that would allow doctors to bypass Medicare and contract privately with seniors for health care expenses.

Sponsored by Sen. Jon Kyl, the Medicare Physician Private Contracting Act (S. 1194/H.R. 2497) would provide physicians with the option of deciding not to accept Medicare reimbursement for a service and instead charge senior patients what they want.

Until passage of the Balanced Budget Act, Medicare prohibited doctors from privately contracting with patients outside of Medicare because of the high risk for fraud and abuse. Unfortunately, the recently enacted Balanced Budget Act does allow doctors to privately contract with seniors for health care services. However, it includes a strong consumer protection by prohibiting doctors who choose to privately contract with seniors from receiving Medicare reimbursements for a two-year period.

Medicare also has strong balance billing protections that limit the amount that doctors can charge above Medicare's reimbursement. These protections were enacted in 1989 with broad bipartisan support in response to evidence that seniors were being grossly overcharged for Medicare-covered services. Private contracts would have no such protections against overcharging.

Rep. Cardin disagreed with the provision allowing for any private contracting, but it would not have the same kind of impact as the Kyl bill because "there are few doctors who could afford to run a practice solely through private contracting with seniors without accepting any Medicare patients."

Rep. Cardin, a member of the Ways & Means' Health Subcommittee, said the Kyl bill "will devastate Medicare and result in two-tier coverage for seniors -- one for the rich and one for the rest of seniors. We must not forget that in the days before Medicare it was almost impossible for seniors to purchase health care at a reasonable price."

The Congressman said seniors are right to be frightened by this new proposal because its clear that "costs are likely to increase significantly if doctors are allowed to negotiate privately with individual patients."

Baltimore Office: 540 E. Belvedere Ave., Suite 201, Baltimore, MD 21212 (301) 433-8886

Citizens for a Sound Economy



<http://www.cse.org>

(202) 783-3870

RELEASE: Friday, October 8, 1997

CONTACT: Peter Cleary (202) 942-7608

Consumer Group:

Give Medicare Patients the Same Freedom Enjoyed by British

(WASHINGTON) Citizens for a Sound Economy President Paul Beckner today called on President Clinton and Congress to fix the law that soon will prohibit Medicare patients from obtaining out-of-pocket health care from doctors.

"As Congress continues to cut Medicare payments, Medicare patients will find it more and more difficult to receive quality care," said Beckner. "Not only do seniors have a right to contract privately with any doctor they wish, this right will ensure more seniors have access to the highest quality care available." Citizens for a Sound Economy is a 250,000-member consumer advocacy group.

Doctors who contract privately with Medicare Part B enrollees as of Jan. 1, 1998 may not participate in the Medicare program for two years. Enacted into law under the Balanced Budget Act of 1997, this exclusion effectively prohibits Medicare beneficiaries from contracting with their own doctor outside the program.

"The two-year exclusion makes it nearly impossible for most seniors to contract privately," Beckner said. "Currently, only 4 percent of doctors do not participate in Medicare and few doctors can afford to give up their Medicare practice for the sake of those patients who wish to contract privately."

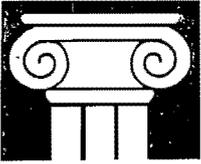
Beckner noted this leads to perverse incentives that will deny less-affluent Medicare patients the services of leading specialists. "Specialists with a few wealthy clients can opt out of Medicare entirely. Under the new law, such doctors will be forbidden from treating middle and lower income seniors who cannot afford to see them without Medicare," Beckner said.

Beckner claimed the new law eliminates a practice that could relieve financial pressure on the Medicare program. "When seniors pay their medical bills themselves, they save the federal government money. Why would anyone oppose a practice that gives seniors more treatment choices and lessens the financial pressures on Medicare?" Beckner asked.

Beckner noted that all patients and doctors in the United Kingdom's socialist National Health Service have the right to contract privately for health care, without penalty. "Most Medicare patients would be horrified to learn that subjects of the British Crown have

more medical freedom than they do. President Clinton and the Congress would be wise to fix that before American seniors find out the hard way."

Beckner expressed support for legislation introduced by Arizona Sen. Jon Kyl (S. 1194) and Rep. Bill Archer of Texas (H.R. 2497) that would enshrine seniors' right to pay for care into law. "Congress should enact these bills," Beckner said, "before seniors have to travel to England to get the care they need."



**Medicare Patients Put At Risk
Under So-Called "Freedom to Contract Act"**

**By Max Richtman
Executive Vice-President
The National Committee to Preserve
Social Security and Medicare**

October 8, 1997

Not much more than a month ago, Congress adopted a carefully crafted compromise for letting physicians and Medicare-eligible patients arrange "private contracts" for treatment outside and apart from the Medicare system.

That compromise was straight-forward: Providers who see Medicare beneficiaries and accept Medicare reimbursement are required, as always, to adhere to Medicare's consumer-protection billing procedures. Providers who want to charge more and practice free of Medicare's patient protections are required to do exactly that -- to practice outside the Medicare system, for at least two years.

Now, however, just a few weeks after that compromise became law, there is new legislation, the so-called Freedom to Contract Act, being promoted to undo the agreement.

With this legislation, providers get to have it both ways. They are cleared for the first time ever to pick and choose which treatments and techniques and procedures they will bill for under Medicare and which other medical services they will arbitrarily set the fee for outside of Medicare under a "private contract" and without the Medicare ceilings on billing that traditionally have protected retirees from overbilling.

This bill is, in fact, a form of rationing of medical care. Medicare beneficiaries will have fewer choices, not more, under this bill as providers begin to limit what services they will perform under Medicare so they can charge more through a private contract.

The provider will set the fee as high as the market will bear; the beneficiary will have no choice other than to dig deep into their own pocket to pay it or try to find a provider who will do it under Medicare. Older beneficiaries with no expertise in legal contracts or medical billing will find themselves negotiating with no leverage for affordable treatment from providers and their clinics who will have all the edge and clout to set fees and charges as they please.

The National Committee to Preserve Social Security and Medicare urges Congress to reject this bill.

NEWS

**FROM Rep. Pete Stark (D-CA), Ranking Democrat
Health Subcommittee, Committee on Ways and Means**

**FOR IMMEDIATE RELEASE
October 8, 1997**

**CONTACT: Ellen Dadisman
202-225-4021**

KYL PROVISION WOULD DESTROY MEDICARE

WASHINGTON — Senator Kyl's proposal to allow doctors to demand that seniors give up their right to bill services to Medicare and instead pay out-of-pocket for health care would destroy the Medicare program, Democratic Representatives and senior groups said today.

The Kyl provision allows doctors to demand that Medicare beneficiaries forego Medicare's billing rates in order to receive the services of that particular doctor. Instead, the doctor can charge seniors any fee, which seniors then would have to pay out-of-pocket, as if they were not insured at all.

"The Kyl provision offers a solution where there is not a problem," said Rep. Pete Stark (D-CA), ranking Democrat on the Health Subcommittee of the Committee on Ways and Means. "Medicare already subsidizes the education of many doctors and provides a ready pool of insured, paying patients. This provision just plays to selfishness and greed."

Stark said the facts show that the vast majority of doctors participate in Medicare, and profit from it.

- 96 percent of doctors' bills accept the Medicare fee schedule.
- Doctors already make plenty of money from Medicare. In 1995, 393 doctors received more than \$1 million each from Medicare; 3,152 received between \$500,000 and \$1 million.
- The annual net median income (from all sources) of all doctors is estimated at \$160,000; the mean income is about \$195,500.
- The Physician Payment Assessment Commission reports no problems of access because Medicare underpays doctors. In fact, the biggest access problem is seniors' reluctance to see a doctor because the 20 percent copay costs too much.
- Medicare subsidizes today's average medical resident \$70,000 a year.

- MORE -

Contrary to some recent news reports, doctors always have been allowed to charge seniors out-of-pocket costs for services that Medicare does not cover (such as most cosmetic plastic surgery, acupuncture, etc.). A Kyl amendment ("Kyl I") that was included in the recently-passed Balanced Budget Act of 1997 allows doctors to bill patients for services Medicare *does* cover, as long as the doctors opt out of Medicare billing altogether for a two-year period.

The provision Kyl now is promoting ("Kyl II") would allow doctors to forego the two-year opt-out period and simply select which patients they deemed wealthy enough to privately bill.

Stark charged that "Kyl II' would eliminate the almost-universal acceptance of Medicare and dramatically increase out-of-pocket costs for seniors." The AARP, in a statement released last Friday, said that Kyl II would "add to the already critical problems of fraud and abuse."

Before Medicare, over 30 percent of seniors were poor. Many didn't have health insurance, and doctors couldn't count on being paid by seniors. With the advent of all seniors having insurance, doctors suddenly had a huge volume of newly-paying customers — with one caveat: there would be limits on what the doctors could charge the Medicare program.

"If the doctors don't want the volume of seniors they get with Medicare, they don't have to participate in the program," said Stark. "But you can't have it both ways."

###



Bringing lifetimes of experience and leadership to serve all generations.

Medicare Physician Private Contracting S.1194/H.R. 2497

Some physicians are urging Congress to repeal important program integrity and consumer protection provisions that are part of the Medicare private contracting section of the Balanced Budget Act of 1997. **AARP believes that such attempts would leave Medicare vulnerable to greater fraud and abuse and beneficiaries at risk of higher health care costs.**

Background

Section 4507 of the Balanced Budget Act of 1997 (BBA) allows physicians to contract privately with Medicare beneficiaries for services that would otherwise be covered by the program. Under a private contract arrangement, a beneficiary agrees to pay 100% of whatever amount the physician charges for services covered by the contract. Medicare does not pay any portion of the cost of these services. Prior to the BBA, covered services provided to a Medicare beneficiary enrolled in Part B were bound by Medicare's payment rules and private contracting was not allowed. (There are no restrictions on private contracting for services the program does not cover.) While there was some anecdotal evidence of "private arrangements" for covered services, these were not consistent with the Medicare statute.

The BBA provision, which originated in a floor amendment offered by Senator Jon Kyl (R-AZ) on June 25, was intended, according to Senator Kyl, to allow "for those 9 percent of the physicians who do not treat Medicare patients to continue to treat their patients as they always have."

To protect Medicare from fraud and to ensure that private contract arrangements are limited to the narrow subset of physicians who otherwise would not be available to Medicare beneficiaries, the BBA provision is limited to physicians who agree, in an affidavit, to forgo all reimbursement from Medicare for at least 2 years. To ensure that beneficiaries know the consequences of their decision to contract privately with one of these physicians, the new law also requires the doctor to disclose to the beneficiary that no Medicare payment will be made for privately contracted services, no balance billing limits will apply, no Medigap coverage will be available, and the services to be performed would be paid for by Medicare if provided by another physician. In other words, if a physician and a beneficiary want to have a private agreement, they can, but the beneficiary knows up front, at least in general terms, to what they are agreeing.



S. 1194/H.R. 2497 - Proposals to Amend the BBA Private Contracting Provision

On September 18, less than 2 months after the BBA was signed into law, Senator Kyl, with the strong backing of the American Medical Association (AMA), proposed repealing some of the program integrity and consumer protections included in the private contracting provision and expanding the scope of private contracting far beyond the original Kyl proposal.

If Section 4507 of the Balanced Budget Act of 1997 is amended by S. 1194/H.R. 2497 the resulting law would:

- Allow all physicians to charge more than the levels set by the Congress or negotiated with Medicare + Choice plans by contracting privately with beneficiaries. S. 1194 and H.R. 2497 would permit physicians in the traditional Medicare program as well as those in HMOs and the new Medicare + Choice plans to contract privately with their patients. The contract – which would have to be signed by the beneficiary and the provider prior to services being provided – would indicate that no claims would be submitted to Medicare for payment for the services identified in the contract. The beneficiary would have to agree to be responsible for 100% of the physician's charges for all privately contracted services.
- Expand the private contracting provision in the BBA to allow physicians to charge higher fees by contracting privately on a service-by-service, or “a la carte,” basis. This means that a physician could bill a beneficiary for 100% of his charge for some of the services the beneficiary received and bill Medicare for other services.
- Allow physicians to negotiate higher charges privately with low-income “dually eligible” and Qualified Medicare Beneficiary (QMB) recipients.
- Repeal the requirement in the BBA for physicians who privately contract for higher fees to file an affidavit with the Health Care Financing Administration (HCFA) and forgo reimbursement from Medicare for all Medicare patients for 2 years.
- Allow Medicare to collect only “the minimum information” necessary from physicians to assure that the program doesn't pay for services that have already been paid for by the beneficiary (See page 3).
- Maintain the provision that physicians who have been excluded from the Medicare program for fraud and/or poor quality of care disclose this fact to beneficiaries in the contract.

- Maintain the BBA requirement that the contract a beneficiary signs clearly indicate that: claims will not be submitted to Medicare by either the physician or the beneficiary; the beneficiary is responsible for the full cost of the privately contracted services; balance billing limits do not apply to contracted services; Medigap coverage will not be available for contracted services; and the services to be performed could be paid for by Medicare if provided by another physician.

The Kyl Bill Would Hurt Beneficiaries and Medicare

- **The Kyl Bill Leaves Beneficiaries and the Medicare Program More Vulnerable to Fraud and Abuse**
 - ⇒ HCFA – which already confronts significant fraud and abuse in Medicare – could find it more difficult to prevent or detect fraud or abuse because the bill eliminates provisions from the underlying BBA that would have made more careful tracking possible. S. 1194 and H.R. 2497 provide that only “the minimum information necessary to avoid any payment under part A or B for services covered under the contract” would be given to HCFA or Medicare+Choice plans for use in determining which claims should be paid by Medicare. This choice of language may, intentionally or not, tie the hands of program administrators seeking to protect the fiscal integrity of the program. For instance, will this information specifically include the names of the doctor and the patient, as well as the specific services affected by the contract? Consider this example: a physician who contracts privately with a beneficiary for payment of two of five services might fraudulently file a claim with Medicare for all five services – even though only three services should be paid by the program. In this case, unless HCFA has complete information on each private contract – including the doctor, patient, and specific services involved – and can align it with claim filings, both Medicare and the beneficiary could end up paying for the same services.
 - ⇒ Allowing physicians to privately contract with low-income dually eligible and QMB beneficiaries also creates the possibility of Medicaid fraud if physicians bill both the beneficiary and state Medicaid programs – which are also struggling with the problem of fraud and abuse.
 - ⇒ Beneficiary costs could increase significantly because physicians would be free to “unbundle” services that are normally paid for as a package of services. In these cases, beneficiaries – particularly when they are very ill -- would pay significantly more out-of-pocket because they would pay for each individual service rather than for a group of services.

- **Allowing Private Contracting Arrangements in Medicare+Choice Plans Poses Unique Problems:**

- ⇒ Under BBA, the Medicare program will make per capita payments to the new Medicare+Choice plans. In return, these plans will provide beneficiaries with health care services, including physician services. Since the Kyl bill allows physicians to privately contract for services they provide to beneficiaries in Medicare+Choice plans, physicians could be paid twice for the same services. For instance, physicians in the new Provider Sponsored Organizations (PSO) could be paid once by Medicare through its per capita payment and again by the beneficiary for the same service through the private contract arrangement. Since the per capita payment is made in advance to the plans by Medicare, this double payment would be very difficult, if not impossible, for Medicare to recoup.
- ⇒ The capitated payments Medicare makes to HMOs and the new Medicare+Choice plans include funds to cover physicians' services. Yet if physicians are allowed to privately contract with beneficiaries in these plans, the plans would be able to keep the funds for services not provided by the plans, but which beneficiaries paid for under private contracts.
- ⇒ Beneficiaries are likely to join Medicare+Choice plans because they believe these plans may cost them less out-of-pocket than traditional fee-for-service coupled with supplemental insurance (Medigap). S. 1194 and H.R. 2497 would undermine efforts to encourage more beneficiaries to enroll in the new Medicare+Choice plans because beneficiaries could end up paying more, not less, for their care.
- ⇒ Physicians who contract with employer-provided plans to provide care for younger workers typically abide by the plan's reimbursement rates and the limits on enrollee out-of-pocket costs. However, under the new Kyl proposal, doctors who contract with Medicare HMOs and the new Medicare+Choice plans would not have to adhere to the plan's reimbursement or to beneficiary out-of-pocket limits as they have to in comparable private sector arrangements. They would be able to privately contract with beneficiaries enrolled in these plans. This practice essentially would deny Medicare beneficiaries a protection enjoyed by millions of workers and their families.

- **Physicians Won't Have to Disclose the Cost of Services Being Privately Contracted:** As with the underlying BBA, the new Kyl bill does not require physicians who contract privately to disclose their fees to beneficiaries before the services are provided. There would be no fee schedule, no limits on what physicians may charge under a private contract and no protection from out-of-pocket costs under Medigap policies. Therefore, beneficiaries would not know what their out-of-pocket liability for private contract charges would be and would have difficulty budgeting for the costs of their care. While this may be manageable for some wealthy individuals, it may not be manageable for the average beneficiary.
- **The Kyl Bill Leaves Low-Income Beneficiaries Vulnerable:** The Kyl bill would allow physicians to contract privately with beneficiaries who are dually eligible for Medicare and Medicaid as well as those low-income beneficiaries who are eligible for the Qualified Medicare Beneficiary (QMB) program. By definition, these are beneficiaries with very modest incomes -- below 100% of poverty. It is unclear whether or to what extent this would leave state Medicaid programs vulnerable to higher costs.

AARP believes that the new Kyl bill would weaken critical protections in BBA for beneficiaries and the fiscal integrity of the Medicare program. For many beneficiaries, the "choice" available under the Kyl bill could mean an immediate and dramatic increase in out-of-pocket costs for physicians' services. Equally as important, for the Medicare program, the Kyl bill would add to the already critical problems of fraud and abuse.

**Following are the text of the original Kyl Amendment adopted in Senate
June 25;**

the text of the amendment as enacted in the BBA;

and the text of HR 2497

AMENDMENT NO. 468

(Purpose: To allow medicare beneficiaries to enter into private contracts for services)

On page 685, after line 25, add the following:

SEC. . FACILITATING THE USE OF PRIVATE CONTRACTS UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1804 of such Act (42 U.S.C. 1395b-2) the following:

"CLARIFICATION OF PRIVATE CONTRACTS FOR HEALTH SERVICES

"SEC. 1805. (a) IN GENERAL.—Nothing in this title shall prohibit a physician or another health care professional who does not provide items or services under the program under this title from entering into a private contract with a medicare beneficiary for health services for which no claim for payment is to be submitted under this title.

"(b) LIMITATION ON ACTUAL CHARGE NOT APPLICABLE.—Section 1848(g) shall not apply with respect to a health service provided to a medicare beneficiary under a contract described in subsection (a).

"(c) DEFINITION OF MEDICARE BENEFICIARY.—In this section, the term 'medicare beneficiary' means an individual who is entitled to benefits under part A or enrolled under part B.

"(d) REPORT.—Not later than October 1, 2001, the Administrator of the Health Care Financing Administration shall submit a report to Congress on the effect on the program under this title of private contracts entered into under this section. Such report shall include—

"(1) analyses regarding—

"(A) the fiscal impact of such contracts on total Federal expenditures under this title and on out-of-pocket expenditures by medicare beneficiaries for health services under this title; and

"(B) the quality of the health services provided under such contracts; and

"(2) recommendations as to whether medicare beneficiaries should continue to be able

to enter private contracts under this section and if so, what legislative changes, if any should be made to improve such contracts."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to contracts entered into on and after October 1, 1997.

SEC. 4507. USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES.

(a) ITEMS OR SERVICES PROVIDED THROUGH PRIVATE CONTRACTS.—

(1) IN GENERAL.—Section 1802 (42 U.S.C. 1395a) is amended by adding at the end the following new subsection:

(b) USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES.—

(1) IN GENERAL.—Subject to the provisions of this subsection, nothing in this title shall prohibit a physician or practitioner

from entering into a private contract with a medicare beneficiary for any item or service—

(A) for which no claim for payment is to be submitted under this title, and

(B) for which the physician or practitioner receives—

(i) no reimbursement under this title directly or on a capitated basis, and

(ii) receives no amount for such item or service from an organization which receives reimbursement for such item or service under this title directly or on a capitated basis.

(2) BENEFICIARY PROTECTIONS.—

(A) IN GENERAL.—Paragraph (1) shall not apply to any contract unless—

(i) the contract is in writing and is signed by the medicare beneficiary before any item or service is provided pursuant to the contract;

(ii) the contract contains the items described in subparagraph (B); and

(iii) the contract is not entered into at a time when the medicare beneficiary is facing an emergency or urgent health care situation.

(B) ITEMS REQUIRED TO BE INCLUDED IN CONTRACT.—

Any contract to provide items and services to which paragraph (1) applies shall clearly indicate to the medicare beneficiary that by signing such contract the beneficiary—

(i) agrees not to submit a claim (or to request that the physician or practitioner submit a claim) under this title for such items or services even if such item or services are otherwise covered by this title;

(ii) agrees to be responsible, whether through insurance or otherwise, for payment of such items or services and understands that no reimbursement will be provided under this title for such items or services;

(iii) acknowledges that no limits under this title (including the limits under section 1848(g)) apply to amounts that may be charged for such items or services;

(iv) acknowledges that Medigap plans under section 1882 do not, and other supplemental insurance plans may elect not to, make payments for such items and services because payment is not made under this title; and

(v) acknowledges that the medicare beneficiary has the right to have such items or services provided by other physicians or practitioners for whom payment would be made under this title.

Such contract shall also clearly indicate whether the physician or practitioner is excluded from participation under the Medicare Program under section 1128.

(3) PHYSICIAN OR PRACTITIONER REQUIREMENTS.—

(A) IN GENERAL.—Paragraph (1) shall not apply to any contract entered into by a physician or practitioner unless an affidavit described in subparagraph (B) is in effect.

FROM BBA

during the period any item or service is to be provided pursuant to the contract.

"(B) AFFIDAVIT.—An affidavit is described in this subparagraph if—

"(i) the affidavit identifies the physician or practitioner and is in writing and is signed by the physician or practitioner;

"(ii) the affidavit provides that the physician or practitioner will not submit any claim under this title for any item or service provided to any Medicare beneficiary (and will not receive any reimbursement or amount described in paragraph (1)(B) for any such item or service) during the 2-year period beginning on the date the affidavit is signed; and

"(iii) a copy of the affidavit is filed with the Secretary no later than 10 days after the first contract to which such affidavit applies is entered into.

"(C) ENFORCEMENT.—If a physician or practitioner signing an affidavit under subparagraph (B) knowingly and willfully submits a claim under this title for any item or service provided during the 2-year period described in subparagraph (B)(ii) (or receives any reimbursement or amount described in paragraph (1)(B) for any such item or service) with respect to such affidavit—

"(i) this subsection shall not apply with respect to any items and services provided by the physician or practitioner pursuant to any contract on and after the date of such submission and before the end of such period; and

"(ii) no payment shall be made under this title for any item or service furnished by the physician or practitioner during the period described in clause (i) (and no reimbursement or payment of any amount described in paragraph (1)(B) shall be made for any such item or service).

"(4) LIMITATION ON ACTUAL CHARGE AND CLAIM SUBMISSION REQUIREMENT NOT APPLICABLE.—Section 1849(g) shall not apply with respect to any item or service provided to a Medicare beneficiary under a contract described in paragraph (1).

"(5) DEFINITIONS.—In this subsection:

"(A) MEDICARE BENEFICIARY.—The term 'medicare beneficiary' means an individual who is entitled to benefits under part A or enrolled under part B.

"(B) PHYSICIAN.—The term 'physician' has the meaning given such term by section 1861(r)(1).

"(C) PRACTITIONER.—The term 'practitioner' has the meaning given such term by section 1842(b)(18)(C)."

(2) CONFORMING AMENDMENTS.—

(A) Section 1802 (42 U.S.C. 1395a) is amended by striking "Any" and inserting "(a) BASIC FREEDOM OF CHOICE.—Any".

(B) Section 1862(a) (42 U.S.C. 1395y(a)), as amended by sections 4319(b) and 4432, is amended by striking "or" at the end of paragraph (17), by striking the period at the

end of paragraph (18) and inserting "; or", and by adding after paragraph (18) the following new paragraph:

"(19) which are for items or services which are furnished pursuant to a private contract described in section 1802(b)."

(b) REPORT.—Not later than October 1, 2001, the Secretary of Health and Human Services shall submit a report to Congress on the effect on the program under this title of private contracts entered into under the amendment made by subsection (a). Such report shall include—

(1) analyses regarding—

(A) the fiscal impact of such contracts on total Federal expenditures under title XVIII of the Social Security Act and on out-of-pocket expenditures by Medicare beneficiaries for health services under such title; and

(B) the quality of the health services provided under such contracts; and

(2) recommendations as to whether Medicare beneficiaries should continue to be able to enter private contracts under section 1802(b) of such Act (as added by subsection (a)) and if so, what legislative changes, if any should be made to improve such contracts.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to contracts entered into on and after January 1, 1998.

FILE h2497.ih

HR 2497 IH
105th CONGRESS
1st Session

To amend title XVIII of the Social Security Act to clarify the right of Medicare beneficiaries to enter into private contracts with physicians and other health care professionals for the provision of health services for which no payment is sought under the Medicare program.

IN THE HOUSE OF REPRESENTATIVES

September 18, 1997

Mr. ARCHER (for himself, Mr. THOMAS, Mr. GINGRICH, Mr. ARMEY, Mr. DELAY, Mr. BOEHNER, Mr. LIVINGSTON, Mr. HYDE, Mr. STUMP, Mr. COMBEST, Mr. TALENT, Mr. CRANE, Mr. NORWOOD, Mr. GANSKE, Mr. LINDER, Mr. PAUL, Mr. COOKSEY, Mr. COBURN, Mr. SHAW, Mr. MCCRERY, Mr. RAMSTAD, Mrs. JOHNSON of Connecticut, Mr. COLLINS, Mr. CAMP, Mr. SAM JOHNSON of Texas, Mr. ENSIGN, Mr. HAYWORTH, Mr. WELLER, Mr. ISTOOK, Mr. ROHRBACHER, Mr. DAN SCHAEFER of Colorado, Mr. BARTON of Texas, Mr. BONILLA, Mr. BOB SCHAEFFER of Colorado, Mr. DOOLITTLE, Mr. MILLER of Florida, Mr. SMITH of Michigan, Mr. HASTINGS of Washington, Mr. MANZULLO, Mrs. CUBIN, Mr. HOEKSTRA, Mr. UPTON, Mr. HOSTETTLER, Mr. KNOLLENBERG, Mr. STEARNS, Mr. DICKEY, Mr. THORBERRY, Mr. SESSIONS, Mr. CANNON, Ms. GRANGER, Mr. BRADY, Mr. HILL, and Mr. SALMON) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XVIII of the Social Security Act to clarify the right of Medicare beneficiaries to enter into private contracts with physicians and other health care professionals for the provision of health services for which no payment is sought under the Medicare program.

[Italic->] Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, [*-Italic*]

SECTION 1. SHORT TITLE.

This Act may be cited as the 'Medicare Beneficiary Freedom To Contract Act of 1997'.

SEC. 2. USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES FOR PROFESSIONAL SERVICES.

(a) IN GENERAL- Section 1802 of the Social Security Act (42 U.S.C. 1395a) is amended by striking subsection (b), as added by section 4507(a) of the Balanced Budget Act of 1997 (Public Law 105-33), and inserting the following:

(b) CLARIFICATION OF USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES FOR PROFESSIONAL SERVICES-

(1) IN GENERAL- Nothing in this title shall prohibit a medicare beneficiary from entering into a private contract with a physician or health care practitioner for the provision of medicare covered professional services (as defined in paragraph

(5)(C)) if--

(A) the services are covered under a private contract that is between the beneficiary and the physician or practitioner and meets the requirements of paragraph (2);

(B) under the private contract no claim for payment for services covered under the contract is to be submitted (and no payment made) under part A or B, under a contract under section 1876, or under a Medicare+Choice plan (other than an MSA plan); and

(C)(i) the Secretary has been provided with the minimum information necessary to avoid any payment under part A or B for services covered under the contract, or

(ii) in the case of an individual enrolled under a

(ii) in the case of an individual enrolled under a contract under section 1876 or a Medicare+Choice plan (other than an MSA plan) under part C, the eligible organization under the contract or the Medicare+Choice organization offering the plan has been provided the minimum information necessary to avoid any payment under such contract or plan for services covered under the contract.

(2) REQUIREMENTS FOR PRIVATE CONTRACTS- The requirements in this paragraph for a private contract between a medicare beneficiary and a physician or health care practitioner are as follows:

(A) GENERAL FORM OF CONTRACT- The contract is in writing and is signed by the medicare beneficiary.

(B) NO CLAIMS TO BE SUBMITTED FOR COVERED SERVICES- The contract provides that no party to the contract (and no entity on behalf of any party to the contract) shall submit any claim for (or request) payment for services covered under the contract under part A or B, under a contract under section 1876, or under a Medicare+Choice plan (other than an MSA plan).

(C) SCOPE OF SERVICES- The contract identifies the medicare covered professional services and the period (if any) to be covered under the contract, but does not cover any services furnished--

(i) before the contract is entered into; or

(ii) for the treatment of an emergency medical condition (as defined in section 1867(e)(1)(A)), unless the contract was entered into before the onset of the emergency medical condition.

(D) CLEAR DISCLOSURE OF TERMS- The contract clearly indicates that by signing the contract the medicare beneficiary--

(i) agrees not to submit a claim (or to request that anyone submit a claim) under part A or B (or under section 1876 or under a Medicare+Choice plan, other than an MSA plan) for services covered under the contract;

(ii) agrees to be responsible, whether through insurance or otherwise, for payment for such services and understands that no reimbursement will be provided under such part, contract, or plan for such services;

(iii) acknowledges that no limits under this title (including limits under paragraph (1) and (3) of section 1848(g)) will apply to amounts that may be charged for such services;

(iv) acknowledges that medicare supplemental policies under section 1882 do not, and other supplemental health plans and policies may elect not to, make payments for such services because payment is not made under this title; and

(v) acknowledges that the beneficiary has the right to have such services provided by (or under the supervision of) other physicians or health care practitioners for whom payment would be made under such part, contract, or plan.

Such contract shall also clearly indicate whether the physician or practitioner involved is excluded from participation under this title.

(3) MODIFICATIONS- The parties to a private contract may mutually agree at any time to modify or terminate the contract on a prospective basis, consistent with the provisions of paragraphs (1) and (2).

(4) NO REQUIREMENTS FOR SERVICES FURNISHED TO MSA PLAN ENROLLEES- The requirements of paragraphs (1) and (2) do not apply to any contract or arrangement for the provision of

apply to any contract or arrangement for the provision of services to a medicare beneficiary enrolled in an MSA plan under part C.

(5) DEFINITIONS- In this subsection:

(A) HEALTH CARE PRACTITIONER- The term 'health care practitioner' means a practitioner described in section 1842(b)(18)(C).

(B) MEDICARE BENEFICIARY- The term 'medicare beneficiary' means an individual who is enrolled under part B.

(C) MEDICARE COVERED PROFESSIONAL SERVICES- The term 'medicare covered professional services' means--

(i) physicians' services (as defined in section 1861(g), and including services described in section 1861(s)(2)(A)), and

(ii) professional services of health care practitioners, including services described in section 1842(b)(18)(D),

for which payment may be made under part A or B, under a contract under section 1876, or under a Medicare+Choice plan but for the provisions of a private contract that meets the requirements of paragraph (2).

(D) MEDICARE+CHOICE PLAN; MSA PLAN- The terms 'Medicare+Choice plan' and 'MSA plan' have the meanings given such terms in section 1859.

(E) PHYSICIAN- The term 'physician' has the meaning given such term in section 1861(r).'

(b) CONFORMING AMENDMENTS CLARIFYING EXEMPTION FROM LIMITING CHARGE AND FROM REQUIREMENT FOR SUBMISSION OF CLAIMS- Section 1848(g) of the Social Security Act (42 U.S.C. 1395w-4(g)) is amended--

(1) in paragraph (1)(A), by striking 'In' and inserting 'Subject to paragraph (8), in';

(2) in paragraph (3)(A), by striking 'Payment' and inserting 'Subject to paragraph (8), payment';

(3) in paragraph (4)(A), by striking 'For' and inserting 'Subject to paragraph (8), for'; and

(4) by adding at the end the following new paragraph:

(8) EXEMPTION FROM REQUIREMENTS FOR SERVICES FURNISHED UNDER PRIVATE CONTRACTS-

(A) IN GENERAL- Pursuant to section 1802(b)(1), paragraphs (1), (3), and (4) do not apply with respect to physicians' services (and services described in section 1861(s)(2)(A)) furnished to an individual by (or under the supervision of) a physician if the conditions described in section 1802(b)(1) are met with respect to the services.

(B) NO RESTRICTIONS FOR ENROLLEES IN MSA PLANS- Such paragraphs do not apply with respect to services furnished to individuals enrolled with MSA plans under part C, without regard to whether the conditions described in subparagraphs (A) through (C) of section 1802(b)(1) are met.

(C) APPLICATION TO ENROLLEES IN OTHER PLANS- Subject to subparagraph (B) and section 1852(k)(2), the provisions of subparagraph (A) shall apply in the case of an individual enrolled under a contract under section 1876 or under a Medicare+Choice plan (other than an MSA plan) under part C, in the same manner as they apply to individuals not enrolled under such a contract or plan.'

(c) CONFORMING AMENDMENTS-

(1) Section 1842(b)(18) of the Social Security Act (42 U.S.C. 1395u(b)(18)) is amended by adding at the end the following:

(E) The provisions of section 1848(g)(8) shall apply with respect to exemption from limitations on charges and from billing requirements for services of health care practitioners described in this paragraph in the same manner as such provisions apply to

exemption from the requirements referred to in section 1848(g)(8)(A) for physicians' services.'

(2) Section 1866(a)(1)(O) of such Act (42 U.S.C. 1395cc(a)(1)(O)), as amended by section 4002(e) of the Balanced Budget Act of 1997, is amended by inserting '(other than under an MSA plan)' after 'Medicare+Choice organization under part C'.

(3) Section 4507(b) of the Balanced Budget Act of 1997 (Public Law 105-33; 111 Stat. 441) is amended--

(A) in the matter before paragraph (1), by striking 'on the program under this title of private contracts entered into under the amendment made by subsection (a)' and inserting 'on title XVIII of the Social Security Act of private contracts permitted under section 1802(b) of such Act'; and

(B) in paragraph (2), by striking 'section 1802(b) of such Act (as added by subsection (a))' and inserting 'such section'.

(d) EFFECTIVE DATE- The amendments made by this section shall be effective as if included in the enactment of section 4507 of the Balanced Budget Act of 1997.

**Extension of Remarks of Congressman Pete Stark
In the House of Representatives
September 23, 1997**

In 1995, Medicare Paid 393 Doctors More than \$1 Million for Services; 3,152 Doctors Received between \$500,000 and \$1,000,000. Now a Greedy Few Want More

Mr. Speaker:

The Medicare agency tells me that in 1995, Medicare paid 393 doctors more than \$1 million for services; 3,152 doctors received between \$500,000 and \$1,000,000. Now a Greedy Few want more.

Despite the ability of doctors to make a fortune from Medicare by providing lots of services to beneficiaries, a few doctors are pushing an amendment by Senator Kyl to let doctors privately contract with Medicare benefits.

Strip away the rhetoric, and a private contract is a contract between a doctor who holds his life in your hands in which he demands that you give up your Medicare benefits and that you promise not to file a claim with Medicare. Instead, you agree to let him charge you anything he wants--because you are desperate for your health. We like to think of contracts between equals, negotiated fairly. There is no equality, there is no fairness in these contracts.

Want an example of a private contract? Look at today's Washington Post, page B-3, where a doctor in Manassas, Virginia is being investigated for charging a Medicare-eligible patient \$12,000 for the injection of a massive dose of aloe vera into the stomach in order to combat lung cancer. The investigation is due to the fact the man died in the doctor's office after the injection. Medicare does not cover quackery. It does not pay \$12,000 for an injection. But this man and this doctor had a private contract. There will be a lot more of this murderous nonsense if the Kyl amendment succeeds.

**Extension of Remarks of Congressman Pete Stark
In the House of Representatives
September 22, 1997**

**People have trouble seeing doctors because they don't have enough money--
not because Medicare pays doctors too little**

Mr. Speaker:

The just-enacted Balanced Budget Act includes a provision that allows doctors not to participate in Medicare for two years at a time, but instead to private contract with patients so that they can charge these patients much more than the Medicare fee schedule.

There is now a move underway to strike the two year requirement and let doctors do wallet biopsies--decide on a patient-by-patient basis whether they are going to ask patients to give up their Medicare rights and insurance and pay the extra in an individual private contract.

I can think of nothing that will encourage patients to move into HMOs faster, so that they are protected against the fear of this type of doctor extortion. The American Medical Association supports the proposal, but it is an idea that must have been deviously planted in their Association by a mole from the HMO lobby--the American Association of Health Plans!

The proposal is pure greed wrapped in the flag of freedom.

Before the Congress is drowned in the rhetoric of this issue, we should note the facts. To the extent that Medicare beneficiaries have trouble seeing doctors, it is almost totally due to the fact that the cost is too much for the beneficiaries---not that Medicare doesn't pay the doctor enough to allow the doctor to see patients.

The latest data from the independent Congressional advisory panel--the Physician Payment Assessment Commission--shows that only 4% of all Medicare beneficiaries reported having trouble getting health care in the last year. About 11% had a medical problem, but failed to see a physician, while 12% did not have a physician's office as a usual source of care. Roughly 10% of Medicare beneficiaries delayed care due to cost. Considering all four access measures, about

26% of Medicare beneficiaries cited experiencing at least one of these problems.

PhysPRC reports that from their surveys of those who failed to see a physician for their serious medical problem, 43 cited cost as the reason. About 8 percent of those who failed to see a physician could not get an appointment or find an available physician. For another 8 percent, transportation was the problem, 13% felt there was nothing a doctor could do, and 11% were afraid of finding out what was wrong.

In another words, Congress is preparing to let doctors charge patients infinitely higher fees because less than 1% of all Medicare beneficiaries had trouble finding a doctor (perhaps they lived in a rural area, etc.). Yet over 5% of Medicare's nearly 40 million beneficiaries could not get to a doctor because they didn't have enough money--and Congress is silent.

Mr. Speaker, a humane Congress, a compassionate Congress, a logical, rational Congress would put 5 times as much effort into addressing the problem of doctors costing too much as it would in addressing what may be a 1% problem of a few doctors wanting to get paid more.

Where are our priorities, Mr. Speaker? A vote to let doctors, the richest 1% income group in our nation, charge "the sky's the limit," while ignoring the needs nearly 2 million seniors who find doctors already too expensive is a shameful vote.

WANT AN EXAMPLE OF PRIVATE CONTRACTING?

Dear Colleague:

Senator Kyl wants to make it easier for doctors to force seniors to give up their Medicare rights and be charged the sky's the limit.

No matter that doctors already make a lot of money from Medicare. In 1995, Medicare paid 393 doctors more than \$1,000,000. Another 3,152 received between \$500,000 and \$1 million. The busiest 10% of doctors average \$323,409 from Medicare.

The Kyl amendment is just pure greed. Medicare pays enough for doctors to see Medicare patients. The Physician Payment Review Commission--the Congressional advisory body on doctor payments--reports that about the same number of doctors are accepting new Medicare patients as are accepting new private-pay patients. They report that the main reason Medicare patients have trouble seeing a doctor is because the patient doesn't have enough money--not because the doctor is not being paid enough.

Medicare and the government have spent hundreds of billions to educate doctors and support medical research; we spend about \$60,000 a year on each resident doctor we train; it is only fitting that doctors in turn live with the Medicare fee schedule.

You want to see an example of a private contract? Look on the back. Charging a Medicare eligible patient \$12,000 for a deadly alternative is a private contract.

Oppose amendments to make it easier for doctors to private contract--**extort**--Medicare patients.

Sincerely,

Va. Doctor's Treatment of Man Who Died Is Scrutinized

9/23/97

By Leef Smith
Washington Post Staff Writer

A Texas man who had lung cancer died in the spring in the office of a Manassas physician to whom he had gone for a costly intravenous treatment that is not officially sanctioned but that he hoped would save his life, according to Virginia State Police.

The man, Clarence Holland Lander, 83, became "violently ill" shortly after the \$12,000 treatment was administered, and he died May 17, according to records in Prince William County Circuit Court.

The physician, Donald L. MacNay, an orthopedic surgeon, is under investigation in connection with Lander's death and with the treatment allegedly employed—intravenous administration of "a concentrated form of aloe vera and other substances," police said. Aloe vera, a cactus-like member of the lily family, is known to have some healing properties.

Police said that their investigation is continuing and that MacNay has

not been charged with any offense. MacNay, who investigators said still is licensed to practice medicine, did not return phone calls to his Manassas office yesterday.

An assistant to MacNay, Ronald Ragan Sheetz, 41, of Manassas, was arrested Thursday and charged with nursing without a license. According to an affidavit that accompanied the request for the arrest warrant, MacNay ordered Sheetz to give Lander the aloe vera injection.

"This procedure was carried out by the subject believed to be Ronald Sheetz who has no medical license on file, under Dr. MacNay's direction and presence," the warrant states. State Police spokeswoman Lucy Caldwell said MacNay also is under investigation in connection with Sheetz's action.

"We're looking into questionable medical practices, drug transactions and suspicious cancer treatments of this doctor's office," Caldwell said. "At this time we're trying to determine how wide-reaching the practice

here may be. It's still too early to say."

A spokeswoman for the U.S. Food and Drug Administration said that the intravenous aloe vera treatment has not been approved by the agency and that officials with the National Cancer Institute said they are not studying aloe in connection with cancer treatment.

At the same time, the healing properties of aloe are being studied by researchers exploring alternative medicines to treat diseases, and papers and advertisements about oral aloe-based concentrates are found easily on the Internet. Experts say that as many as 50 percent of the cancer patients in the United States try some kind of therapy that is not officially sanctioned.

Such treatments include special diets, vitamins, mental imagery, wearing magnets, coffee enemas and consuming cartilage and oil from sharks.

Lander's son, James Lander, said that his father was in excellent health before the terminal cancer was diag-

nosed and that he jumped at the chance to beat the disease. He said his father learned about the aloe treatment from reading an article and found MacNay through word-of-mouth referrals.

"The treatment gave him hope," James Lander said. "He completely brightened up. You could just see it. I'm sure he thought it would cure him or he wouldn't have gone to Virginia" from his home in Waco, Tex.

In a search warrant affidavit filed Friday in Circuit Court, investigators said they were seeking "patient files and other records related to appointments and [the] treatment of other patients who have received this treatment and have both lived and died."

An affidavit was filed yesterday in Fairfax County Circuit Court to obtain a search warrant for an office in Annandale that police said MacNay opened in July.

Sheetz was released from jail on personal recognizance. If convicted of the felony charge, he could be sentenced to up to five years in prison.

**Extension of Remarks of Congressman Pete Stark
In the House of Representatives
September 23, 1997**

The Greedy

Mr. Speaker:

A move is underway to let doctors force patients to give up their Medicare benefits so that a handful of doctors can charge them anything they want--without limit.

This is a gift to the greediest doctors in the nation.

Ninety-five percent of the nation's doctors accept new Medicare patients and the Medicare fee schedule. The independent Congressional advisory panel known as the Physician Payment Review Commission reports that this is comparable to the rate of doctors who are accepting new private, non-Medicare patients. In other words, there is no noticeable difference in access--ability to see a doctor--between Medicare and non-Medicare patients.

Doctors who accept Medicare and its fee schedule understand the Hippocratic Oath and the social compact in which society has paid hundreds of billions of dollars for the education and training and research that make American doctors special and in turn, these doctors accept the Medicare payment system.

But Congress is about to cater to the few who want more, more, more from people in their hour of illness.

The Employee Benefit Research Institute in its September, 1997 Issue Brief shows what a special gift this legislation will be to a few doctors who are out of step with their colleagues:

Recent findings indicate that only between 4 percent and 6 percent of physicians accepting new patients were not accepting new Medicare patients. One survey found that between 1991 and 1992, the proportion of physicians not accepting new Medicare patients increased from 4 percent to 5.9 percent (Lee and Gillis, 1994). The same survey found that between 1992 and 1993 the percentage of physicians not accepting new Medicare patients decreased to 4.7 percent. Surveys by the Physician Payment Review Commission (PPRC) also found that in 1993 less than 5 percent of physicians were not accepting new Medicare patients (Physician Payment Review Commission, 1994). The PPRC study concluded that the implementation of the Medicare fee schedule has not caused physicians to close their practices to Medicare patients.

BILL THOMAS, CALIFORNIA, CHAIRMAN
SUBCOMMITTEE ON HEALTH

NANCY L. JOHNSON, CONNECTICUT
JIM McCRERY, LOUISIANA
JOHN ENSIGN, NEVADA
JON CHRISTENSEN, NEBRASKA
PHILIP M. CRANE, ILLINOIS
WMO HOUGHTON, NEW YORK
AM JOHNSON, TEXAS

ORTNEY PETE STARK, CALIFORNIA
JENJAMIN L. CARDIN, MARYLAND
GERALD D. KLECZKA, WISCONSIN
JOHN LEWIS, GEORGIA
XAVIER BECERRA, CALIFORNIA

Ex OFFICIO:
BILL ARCHER, TEXAS
CHARLES B. RANGEL, NEW YORK

BILL ARCHER, TEXAS, CHAIRMAN
COMMITTEE ON WAYS AND MEANS

A. L. SINGLETON, CHIEF OF STAFF
CHARLES N. KAHN III, SUBCOMMITTEE STAFF DIRECTOR

JANICE MAYS, MINORITY CHIEF COUNSEL
BILL VAUGHAN, SUBCOMMITTEE MINORITY

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

September 8, 1997

Franklin Raines, Director
Office of Management and Budget
The Old Executive Office Building
Washington, DC 20503

Dear Director Raines:

Included in the Balanced Budget Act is an amendment by Senator Kyl allowing a doctor to sign private contracts with Medicare beneficiaries requiring those beneficiaries to give up their Medicare insurance when they use that doctor. A doctor who signs such a contract must make a commitment not to bill Medicare for any of his patients for a two year period.

Advocates of private contracting support it in the name of freedom.

I had thought it was just plain greed--the desire of a doctor to bill any amount rather than have to live with the Medicare resource-based relative value fee schedule.

But perhaps it is a question of freedom, in which case the better response by the public would be to accept this proposal--but the public should have the freedom to bill the doctor, with interest, for all the public subsidies he or she has received.

The reason that American medicine is a world leader and that medicine has moved beyond the level of penicillin, amputations, and mustard plasters is the hundreds of billions of taxpayer dollars that have been poured into the National Institutes of Health, the Public Health Service, the various health professions manpower training programs, Medicare's Graduate Medical Education programs (which average about \$60,000 a year in subsidy for the training of each resident doctor), and the capital assistance to the hospitals in which these doctors trained.

The doctors who advocate private contracting tend to say that they are special and can command extra fees. The only reason that is true is that the public has substantially subsidized their education and the research on which their fame and fortune rests.

For a doctor to now want to private contract and avoid Medicare patients would be like a West Point cadet saying that he or she did not want to serve in the Regular Army after graduation. That may be freedom, but it is a subsidy we do not permit.

In the case of these doctors who became competent through the massive health subsidies we have provided, we should permit them to privately contract as long as they repay, with interest, the estimated value of the subsidies they received. I hope the Office of Management and Budget could estimate the total value of physician and clinical practice health subsidies, including tax subsidies, that have been provided over the past forty years. From this we could develop a formula so that when, for example, a 55 year old doctor decides he wants the freedom to private contract, he can also have the freedom to repay the public for its investment in making him such a wonderful doctor who can command such high fees.

Thank you for your assistance with this request.

Sincerely,



Pete Stark
Member of Congress

Citizens for a Sound Economy



<http://www.cse.org>

(202) 783-3870

RELEASE: Thursday, October 3, 1997

CONTACT: Jay Hopkins (202) 942-7684

Consumer Group:

Give Medicare Patients the Same Freedom Enjoyed by British

(WASHINGTON, DC) Citizens for a Sound Economy President Paul Beckner today called on President Clinton and Congress to fix the law that soon will prohibit Medicare patients from obtaining out-of-pocket health care from doctors.

"As Congress continues to cut Medicare payments, Medicare patients will find it more and more difficult to receive quality care," said Beckner. "Not only do seniors have a right to contract privately with any doctor they wish, this right will ensure more seniors have access to the highest quality care available." Citizens for a Sound Economy is a 250,000-member consumer advocacy group.

Doctors who contract privately with Medicare Part B enrollees as of Jan. 1, 1998 may not participate in the Medicare program for two years. Enacted into law under the Balanced Budget Act of 1997, this exclusion effectively prohibits Medicare beneficiaries from contracting with their own doctor outside the program.

"The two-year exclusion makes it nearly impossible for most seniors to contract privately," Beckner said. "Currently, only 9 percent of doctors do not participate in Medicare and few doctors can afford to give up their Medicare practice for the sake of those patients who wish to contract privately."

Beckner noted this leads to perverse incentives that will deny less-affluent Medicare patients the services of leading specialists. "Specialists with a few wealthy clients can opt out of Medicare entirely. Under the new law, such doctors will be forbidden from treating middle and lower income seniors who cannot afford to see them without Medicare," Beckner said.

Beckner claimed the new law eliminates a practice that could relieve financial pressure on the Medicare program. "When seniors pay their medical bills themselves, they save the federal government money. Why would anyone oppose a practice that gives seniors more treatment choices and lessens the financial pressures on Medicare?" Beckner asked.

Beckner noted that all patients and doctors in the United Kingdom's socialist National Health Service have the right to contract privately for health care, without penalty. "Most Medicare patients would be horrified to learn that subjects of the British Crown have

more medical freedom than they do. President Clinton and the Congress would be wise to fix that before American seniors find out the hard way.”

Beckner expressed support for legislation introduced by Arizona Sen. Jon Kyl (S. 1194) and Rep. Bill Archer of Texas (H.R. 2497) that would enshrine seniors' right to pay for care into law. “Congress should enact these bills,” Beckner said, “before seniors have to travel to England to get the care they need.”

PPRC

Annual Report to Congress

1997

Physician
Payment
Review
Commission

2120 L Street, NW, Suite 200, Washington, DC 20037

(202) 653-7220 fax (202) 653-7238

www.pprc.gov

Access and Beneficiary Financial Liability under the Medicare Fee Schedule

Important changes in Medicare physician payment policy were enacted as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA89). The law included provisions to establish the Medicare Fee Schedule which, when implemented in 1992, restructured payments across services, specialties, and geographic areas. OBRA89 also put in place a Volume Performance Standard (VPS) system to constrain growth in expenditures for physicians' services, and limits on physicians' charges to strengthen beneficiary financial protection. Such policy changes have the potential to influence beneficiary access to care and financial liability. For this reason, the Congress called for the Secretary of Health and Human Services and the Physician Payment Review Commission to monitor implementation of the program and recommend measures to address any problems with beneficiary access or financial protection that are identified.

In fulfilling this congressional mandate, the Commission has adopted a strategy that captures many of the dimensions of access that shape beneficiaries' experiences in obtaining care. Access monitoring must encompass the perspectives of both beneficiaries and physicians. To do so requires use of data from multiple sources, since no single data set can fully address all aspects of access to care. Medicare claims data can show changes in beneficiary use of services. Clinically based indicators of access allow the Commission to examine beneficiary use of specific services considered necessary for the care of different acute and chronic conditions. Data from the

This chapter includes:

- *Analyses of beneficiary service use*
- *Analyses of access as reported by beneficiaries*
- *Analyses of access problems of vulnerable beneficiaries*
- *New information on beneficiary financial liability*

Medicare Current Beneficiary Survey (MCBS) reveal whether beneficiaries report problems obtaining care or have become less satisfied with the care received. Gathering data on beneficiary complaints about access to physicians can complement the MCBS data. Both physician surveys and claims data can be used to assess physician willingness to serve Medicare beneficiaries. Over the years, the Commission has analyzed data from these varied sources to provide the Congress with an assessment of how Medicare beneficiaries are faring under the policies adopted in OBRA89 and modified since that time.

A key element in the Commission's monitoring strategy has been to focus on access for vulnerable groups of beneficiaries. These groups, such as African Americans and those living in poverty areas and in Health Professional Shortage Areas (HPSAs), are believed to be more likely to experience access problems related to payment policy changes. Historically, much of the research on access for vulnerable groups, including that of the Commission, has been descriptive in nature, focusing on differences in access between these groups and others. The Commission's recent work has addressed the underlying reasons for those problems, such as differences in income, supplemental insurance coverage, and health status.

* Since it began its monitoring efforts, the Commission has found consistently that access has remained good for most beneficiaries. Any decreases seen in use of selected services since the fee schedule was introduced appear related not to changes in payment rates but, rather, to changes in treatment modalities and other factors unrelated to access. Beneficiaries report no increases in problems obtaining care and their satisfaction with care continues to be high.

Despite these generally positive findings on access, the Commission is concerned that some vulnerable groups, including African Americans, continue to experience access problems that existed prior to 1992. These groups use fewer primary care services than others and visit emergency rooms more often than others. In surveys, they report more problems obtaining care and lower satisfaction with care.

* With respect to beneficiary financial liability, OBRA89's charge limit is constraining the additional amounts physicians bill beneficiaries. Charges above the limit have declined since 1992. Commission analyses have shown that most charges exceeding the limit do so by relatively small amounts.

The full implementation of the Medicare Fee Schedule does not diminish the need for monitoring. Further developments in both Medicare and the broader health care market will continue to affect beneficiaries. For example, flaws in the current VPS system could result in substantial reductions in payments to physicians (see Chapter 12). Proposed changes in the VPS policy to correct these flaws could have differential effects on physicians depending on the mix of services they provide. Other policy changes, such as implementation of resource-based practice expense relative values, scheduled for 1998, will reduce payments for some services while increasing payments for others (see Chapter 13). Finally, changes in the market for health services, such as the growth of managed care, could affect the cost and availability of care under Medicare fee for service as well.

The Commission's mandated reports on access and financial liability will be submitted to the Congress in May. This chapter previews analyses to be presented in those reports. The first section updates the Commission's earlier work on beneficiary access using Medicare claims data and data from the Medicare Current Beneficiary Survey. It also presents an analysis of factors contributing to the access problems of vulnerable groups of beneficiaries. The chapter then turns to issues of beneficiary financial liability for physicians' services, updating information on assignment rates and the percentage of physicians participating in Medicare. In addition, this year the Commission has broadened its examination of beneficiary financial liability to include information on beneficiary out-of-pocket spending for other services in addition to physicians' services. Plans for additional work to be included in the Commission's mandated reports are discussed in both sections of the chapter.

ACCESS TO CARE

Analyses of Medicare claims data and responses to the Medicare Current Beneficiary Survey allow the Commission to assess service use and beneficiaries' experiences in obtaining care. These Medicare program data are updated each year.

Changes in Beneficiary Use of Services

Growth in beneficiary use of services was relatively modest in 1996. The volume and intensity of all services per beneficiary rose at a rate of 1.0 percent between 1995 and 1996 (Table 14-1).¹

The low volume growth in 1996 may be part of a trend that emerged in the early 1990s. Before 1992, volume growth was volatile. During the 10 years ending in 1991, the annual rate of volume growth ranged from 3.7 percent to 10.0 percent. Volume growth was low for two consecutive years only once during that period, in 1984 and 1985 (PPRC 1996). By contrast, volume growth has been low—5 percent or less—every year since 1992.

Claims data do not reveal changes in beneficiary access to care that are clearly related to changes in Medicare's physician payment rates (Table 14-1). Between 1995 and 1996, some services with payment rate decreases also experienced a fall-off in volume (e.g., outpatient visits and electrocardiograms), while for others the volume increased (e.g., cataract lens replacements and echocardiograms). Evidence of a possible relationship between lower Medicare payment rates and a decline in beneficiary use of services would prompt further analysis by the Commission.²

¹ Two limitations of the claims data should be considered when interpreting these results. First, the claims files are incomplete since they include only those claims processed by September of each year, or three months beyond the half-years under study. Second, analysis of a 5 percent sample of claims means the payment rate and service use measures presented are subject to sampling error. Further details on the Commission's analyses of Medicare claims data are provided in *Monitoring Access of Medicare Beneficiaries* (PPRC 1995).

² Further analysis of the relationship between payment rates and use of services would require consideration of factors other than payment rates which may influence use of services. Those factors include health system characteristics, such as physician supply and improvements in medical technology, as well as beneficiary characteristics, such as health status and supplemental insurance coverage.

Table 14-1. Change in Payment and Use per Beneficiary for Selected Services, 1992-1996 (percentage)

Type of Service	Annual Percentage Change						Percentage of 1996 Physician Services Outlays
	1992-1995			1995-1996			
	Payment per Service	Volume ^a	Count of Services ^b	Payment per Service	Volume ^a	Count of Services ^b	
All Services	2.8	4.1	3.8	-2.2	1.0	-2.0	100.0
Primary Care Services	6.9	4.1	3.3	0.7	1.7	0.7	22.8
Office and other outpatient visits	6.2	3.0	2.7	-1.2	-0.7	-1.9	16.3
Emergency department visits	9.0	9.3	7.5	0.4	2.4	1.9	2.6
Nursing facility/rest home visits	10.8	7.6	6.0	1.4	6.5	5.4	2.1
Home visits	10.7	4.5	3.9	3.1	4.8	3.8	0.2
Other Evaluation and Management Services	5.4	5.0	2.5	1.9	0.5	-1.8	18.2
Surgical Services	2.8	2.3	5.7	-5.0	2.5	3.6	21.6
Cataract lens replacement	-1.1	-1.3	-1.3	-15.5	0.9	0.9	2.9
Joint prosthesis	2.2	5.0	4.5	-4.8	2.4	2.5	1.4
Coronary artery bypass graft	2.6	5.4	6.3	-3.1	4.5	5.7	1.4
Transurethral prostate surgery	5.6	-12.1	-11.8	0.5	-9.3	-8.4	0.3
Arthroscopy	1.6	7.5	7.3	-7.2	0.3	-0.1	0.2
Open prostate surgery	5.0	-15.5	-14.9	0.5	7.3	5.5	0.1
Other Nonsurgical Services	-0.2	4.8	4.0	-4.1	0.0	-3.4	37.4
Diagnostic radiology, other	0.2	0.4	0.8	-3.1	-0.8	-2.4	3.1
Electrocardiograms	— ^c	— ^c	— ^c	-2.7	-2.7	-5.7	2.0
Echocardiograms	-5.1	13.3	13.7	-15.2	13.2	25.3	1.8
CAT scans	-0.1	3.0	4.1	-3.8	6.2	6.0	1.6
Colorectal endoscopy	-0.8	2.3	-2.3	-5.0	2.0	-0.5	1.4
Magnetic resonance imaging	1.6	10.9	11.3	-1.2	11.3	10.7	1.1
Upper GI endoscopy	-4.2	3.8	2.5	-10.3	1.5	0.7	0.9
Angioplasty	-6.5	10.5	10.4	-10.4	8.5	5.2	0.6
Mammography	1.1	-1.7	0.8	-0.5	-3.2	-1.5	0.4

SOURCE: Physician Payment Review Commission analysis of 1992-1996 Medicare claims, 5 percent sample of beneficiaries.

^a Measures change in outlays if prices were frozen (number and intensity of services).

^b Measures change in the number of services only.

^c Not applicable due to payment change.

NOTE: Data are for the first six months of each year.

The use of some services decreased between 1995 and 1996 (Table 14-1). The volume of transurethral prostate surgery dropped by 9.3 percent, and the volume of mammography fell by 3.2 percent. Other services with volume decreases are office and other outpatient visits (-0.7 percent), routine diagnostic radiology (-0.8 percent), and electrocardiograms (-2.7 percent).

Reductions in the use of transurethral prostate surgery do not appear to be related to access to care. Such reductions have occurred in previous years and appear to be part of changes in treatment modalities for prostate disease (PPRC 1996).

In the case of mammography, the Commission has found that less than 40 percent of female Medicare beneficiaries receive a mammogram every two years (PPRC 1995). Claims data show that mammography volume growth was 20 percent from 1990 to 1991, the first year that Medicare coverage was extended to include screening mammography.³ Since then, mammography volume growth has been low, suggesting that awareness of the screening benefit may not have increased after its initial announcement.

Other declines in service use—office visits, routine diagnostic radiology, and electrocardiograms—are more difficult to explain. In an environment where practice patterns are changing, because of managed care and other influences, some decreases in volume may not be surprising. The decreases could be the result of improved efficiency in the delivery of services, or they could involve reductions in the use of needed services.

Because of the uncertainty about the cause of some volume decreases, the Commission will examine the affected services further in its upcoming access report. Some of this work will assess whether use of needed services has decreased. The Commission will use clinically based indicators of access, developed by RAND, for this analysis (PPRC 1995). These indicators will not provide a comprehensive assessment of why the volume of selected services decreased. They can show, however, whether certain services that experienced an overall decline in use also declined in relation to specific conditions for which they are considered necessary. Other work will consider decreases in use of services by geographic area to explore the relationship between health care market characteristics and changes in the volume of services.

Access As Reported by Beneficiaries

The Commission's analyses of beneficiary reports about their access to care have been updated with data from the 1995 MCBS. The MCBS provides information on specific aspects of beneficiary access to care, such as difficulty in finding a physician, delays in seeking care, availability of a usual source of care, and satisfaction with care.

Access for All Beneficiaries. Responses to MCBS questions were used to construct eight measures of access to care. Four of these measures address the process of care: whether a beneficiary (1) had trouble getting care, (2) had a problem but did not see a physician, (3) delayed care due to cost, or

³ Previously, Medicare covered only diagnostic mammography.

(4) did not have a physician or physicians' office as a usual source of care.⁴ Four other measures address nonclinical outcomes of care: (1) strong agreement with the statement "physician checks everything," (2) strong agreement with the statement "great confidence in physician," (3) very satisfied with availability of medical care at night and on weekends, and (4) very satisfied with overall quality of care. All these measures are believed to be sensitive to changes in access but can be influenced by other factors, such as the quality of care received.

Data from the 1995 MCBS show that access for most beneficiaries remains excellent and that measures of access are essentially unchanged from previous years. Among all beneficiaries, about 4 percent had trouble getting care, and 10 percent to 12 percent either had a problem but did not see a physician, delayed care due to cost, or were without a physician or physician's office as a usual source of care (Table 14-2). Measures of nonclinical outcomes (e.g., very satisfied with the availability of care) from the 1995 MCBS also show little change from previous years. Of the respondents, 26 percent strongly agreed with the statement that their physician checks everything; 27 percent reported great confidence in their physician (Table 14-3). About 21 percent said they are very satisfied with the availability of medical care, and 33 percent are very satisfied with the overall quality of care (Table 14-3).⁵

Access for Vulnerable Groups. Data from the 1995 MCBS show essentially no change in the access problems reported by some vulnerable groups in earlier rounds of the MCBS. Nonwhite and Hispanic beneficiaries, and those with no supplemental insurance, reported more trouble getting care (Table 14-2).⁶ The functionally disabled, who require help with activities of daily living, were also more likely to have trouble getting care. Each of these groups was also more likely to have delayed care because of cost. Nonwhite and Hispanic beneficiaries, and those without supplemental insurance, were also less likely to have a physician or physician's office as a usual source of care.

Distinctions among groups were also found in their responses to questions on nonclinical outcomes, such as satisfaction with the availability of care (Table 14-3). Compared with their counterparts, four groups—nonwhite beneficiaries, those needing help with activities of daily living, those over the age of

⁴ Over the successive annual rounds of the MCBS, similar percentages of beneficiaries have indicated they have "had a problem but did not see a physician." This measure is influenced both by the extent to which beneficiaries have health problems and by the extent to which they do or do not see a physician. For access monitoring, the extent to which beneficiaries see a physician is more important, but the structure of the MCBS does not permit separation of the two influences. Because of the measure's stability, this limitation of the MCBS does not seem important. If the measure does change, the Commission will attempt to determine whether the change is due to the extent to which beneficiaries are seeing a physician when they have a health problem.

⁵ Analyses of nonclinical outcomes distinguish those respondents who are "very satisfied" or "strongly agree" from all others. This approach conforms with concerns noted by Ware (1995) about collapsing categories in ordered scales, such as "very satisfied" and "satisfied." Collapsing categorical responses to survey questions masks important differences among perceptions of health care outcomes.

⁶ Within Hispanic populations, access to care may vary depending on a person's ethnic origin (Schur et al. 1987). Since MCBS respondents designating themselves as Hispanic are not asked about ethnic origin, the analysis does not address these subgroups.

Table 14-2. Medicare Beneficiaries Reporting Problems with Access, 1995 (percentage)

Population Group	Had Trouble Getting Care	Had Problem, But Did Not See a Physician	Delayed Care Due to Cost	No Usual Source of Care ^a
All Beneficiaries	4	11	10	12
Race				
African American	5	14	12	19
White	3	10	9	11
Other	7	14	12	25
Ethnicity				
Hispanic	b	b	14	27
Other	b	b	9	11
Functional Disability				
Help needed	8	17	15	9
No help needed	3	10	9	13
Age				
85 years and over	b	7	5	7
Under 85	b	11	10	12
Supplemental Insurance ^c				
No	9	19	24	27
Yes	3	10	8	10

SOURCE: Physician Payment Review Commission analysis of 1995 Medicare Current Beneficiary Survey.

^a Defined as not identifying a physician's office or a particular physician as a usual source of care.

^b No statistically significant difference between population groups at the 5 percent level.

^c Supplemental insurance includes private and public coverage.

NOTE: This analysis excludes institutionalized beneficiaries and beneficiaries enrolled in managed-care plans.

85, and those without supplemental insurance coverage—were less satisfied with the quality of their care. African Americans and Hispanics were also less apt to agree with statements that they had great confidence in their physician or that their physician checks everything. African Americans and those without supplemental insurance were less likely to be very satisfied with the availability of medical care.

Factors Related to the Access Problems of Vulnerable Groups

The Commission's analyses of Medicare claims and enrollment data have also shown that some groups of beneficiaries, such as African Americans and those living in urban poverty areas and urban Health Professional Shortage Areas, use fewer primary care services and make more visits to emergency rooms and hospital outpatient departments than others. Health outcomes, measured by mortality rates and other indicators, are often poorer for these groups (PPRC 1993; PPRC 1995; PPRC 1996).

Table 14-3. Medicare Beneficiaries' Attitudes Toward the Care They Receive, 1995
(percentage)

Population Group	Strongly Agree with "Physician Checks Everything"	Strongly Agree with "Great Confidence in Physician"	Very Satisfied with Availability of Medical Care	Very Satisfied with Overall Quality of Care
All Beneficiaries	26	27	21	33
Race				
African American	19	20	10	20
White	27	28	22	35
Other	28	27	21	24
Ethnicity				
Hispanic	33	a	a	a
Other	26	a	a	a
Functional Disability				
Help needed	23	a	18	29
No help needed	27	a	21	34
Age				
85 years and over	23	24	21	28
Under 85	27	27	18	34
Supplemental Insurance ^b				
No	22	22	16	25
Yes	27	28	21	34

SOURCE: Physician Payment Review Commission analysis of 1995 Medicare Current Beneficiary Survey.

^a No statistically significant difference between population groups at the 5 percent level.

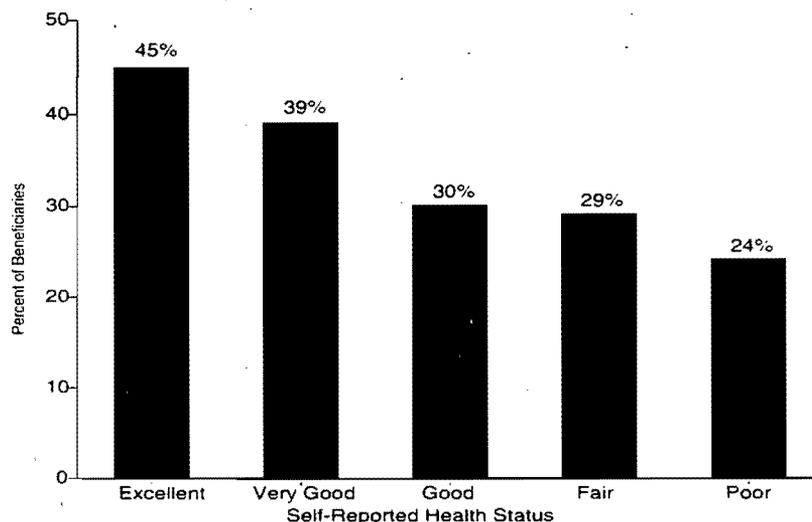
^b Supplemental insurance includes private and public coverage.

NOTE: This analysis excludes institutionalized beneficiaries and beneficiaries enrolled in managed-care plans.

This year, the Commission sought to move beyond describing the access problems of vulnerable groups to identifying factors contributing to those problems. Such analyses are meant to show whether there are factors that could be influenced by Medicare payment policy. Previous research has shown that access is related, in part, to personal characteristics, such as age, income, and education, of those needing care (Aday and Andersen 1981; Weissman and Epstein 1994). Characteristics of the health care system, such as the availability and organization of services, have also been shown to be associated with access (Aday and Andersen 1981; Weissman and Epstein 1994). It is in this second area where payment policy may play a role.

Methods. To analyze factors related to the access problems of vulnerable groups of Medicare beneficiaries, regression analyses were conducted using data from the 1994 MCBS. The analyses allowed the estimation of independent statistical relationships between explanatory variables, measuring beneficiary and health system characteristics, and various measures of access to care. Some

Figure 14-1. Beneficiaries Who Are Very Satisfied with Overall Quality of Care, by Health Status (percentage)



SOURCE: Physician Payment Review Commission analysis of 1994 Medicare Current Beneficiary Survey.

NOTE: Percentages adjusted for differences in beneficiary and health system characteristics. See discussion in text.

explanatory variables described characteristics of beneficiaries, such as age, sex, race, and self-reported health status. Residence in a HPSA described the health system available to beneficiaries.⁷ Other variables captured a combination of personal and health system characteristics, such as secondary insurance coverage. Dependent variables in the analysis (measures of access to care) included the eight process and nonclinical outcomes measures used in the MCBS analysis described above.⁸

This analysis is limited by the set of variables available from the MCBS. Some important factors—such as health behaviors and attitudes, better measures of health status, and some aspects of the availability of services—are not addressed by the MCBS. Other measures, including clinically oriented outcomes of care and the use of high-tech services, could not be included in the analysis because the sample size was too small. Nonetheless, the MCBS does allow analysis of a number of important factors believed to influence access to care.

Results. Several factors help explain variation in measures of beneficiary access to care. Self-reported health status appears to have an important influence on access, controlling for other beneficiary and health system characteristics (Figure 14-1). Those reporting poorer health status also cite more access

⁷ Alternative regression models were estimated using a physician-to-population ratio, based on county-level data from the Area Resource File, as a measure of the availability of services. The ZIP code-specific HPSA variable was found to have a stronger statistical relationship with the access measures than the county-level physician-to-population ratio.

⁸ Since the dependent variables had a value of either zero or one, logistic regression models were estimated. The models were estimated with SUDAAN software, which corrected the standard errors of the estimates for the nonrandom design of the MCBS.

problems than others and lower satisfaction with the care received. For example, 45 percent of those reporting excellent health also report being very satisfied with the overall quality of care. Only 24 percent of those reporting poor health are very satisfied with the overall quality of care. Those saying they are in excellent health are more likely than those in poor health to be without a physician or physicians' office as a usual source of care. About 20 percent of those reporting excellent health report no physician or physicians' office as a usual source of care, whereas only 11 percent of those citing poor health report the same problem (Figure 14-2). Those reporting poor health may be more likely to have a physician or physician's office as a usual source of care owing to their greater need for care.

A marker of vulnerability, the lack of supplemental insurance coverage, is another factor associated with variation in beneficiary access to care, controlling for other beneficiary and health system characteristics. Findings with respect to two of the eight access measures—no physician or physician's office as a usual source of care and satisfaction with the overall quality of care—are illustrative. Among those without supplemental insurance, 24 percent report not having a physician or physician's office as a usual source of care compared with 11 percent of those with private supplemental coverage (Figure 14-3). Supplemental insurance coverage was not significantly related to satisfaction with the overall quality of care in this analysis.

Race also helps explain variation in beneficiary access. Compared with whites, more African-American beneficiaries are without a physician or physician's office as a usual source of care. The difference between the two groups is small, however (Figure 14-4). Fewer African-American beneficiaries are very satisfied with the overall quality of care (30 percent) compared with white beneficiaries (34 percent) (Figure 14-5). These differences are smaller than those presented earlier in this chapter (Tables 14-2 and 14-3). The results presented earlier were not adjusted for beneficiary and health system characteristics.

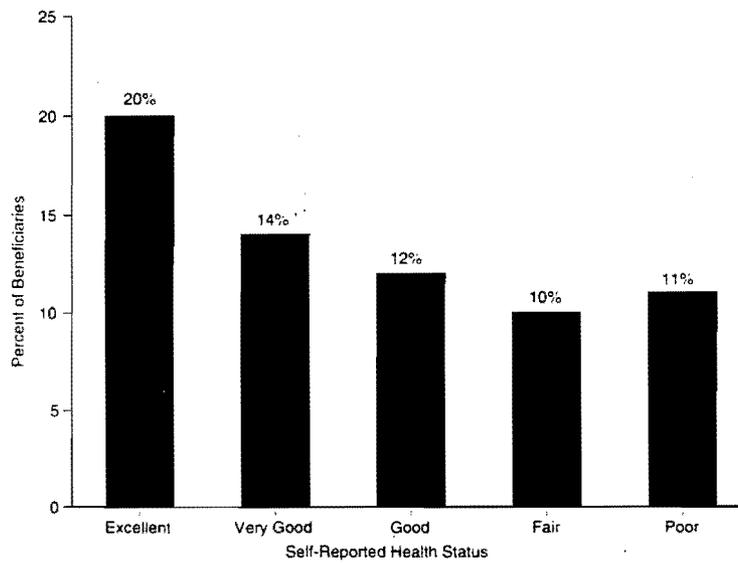
Conclusions. Some tentative conclusions are possible. Several factors help explain variation in measures of beneficiary access to care. Chief among these appears to be health status. Those reporting poorer health status also report more access problems than others and lower satisfaction with the care received.⁹ Supplemental insurance coverage is another factor that appears to be related to process-oriented measures of access, such as not having a physician or physician's office as a usual source of care, but supplemental insurance does not seem to be related to satisfaction.

After adjusting for certain personal and health system characteristics, some differences in access between African-American and white beneficiaries remain unexplained.¹⁰ There are a number of

⁹ These fee-for-service enrollee findings are consistent with the findings of a Commission-sponsored survey of Medicare managed-care enrollees (Nelson et al. 1996).

¹⁰ Other differences in access between African-American and white beneficiaries, not addressed in this analysis, could be important and deserve further research. For example, African American beneficiaries are less likely to have supplemental insurance coverage than white beneficiaries (Chulis et al. 1993). Some of the association between supplemental insurance coverage and access, found in this analysis, could be a combination of the effect of race on supplemental coverage and the effect of supplemental coverage on access.

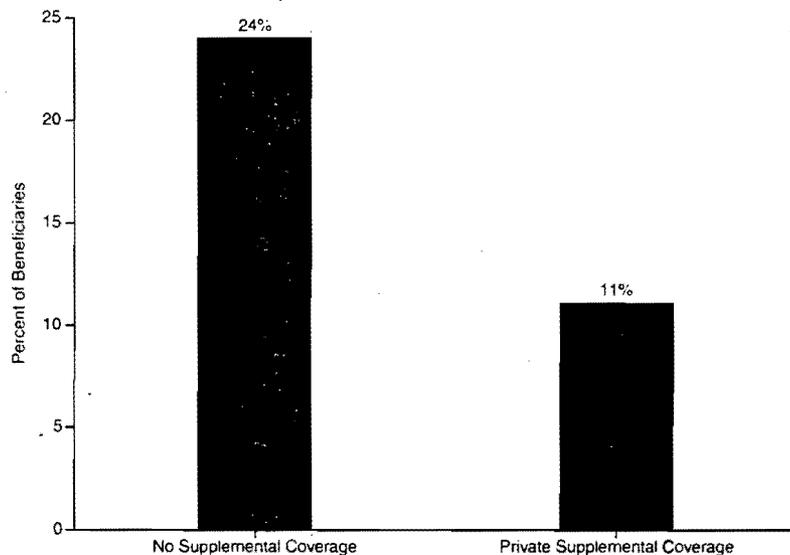
Figure 14-2. Beneficiaries with No Usual Source of Care, by Health Status (percentage)



SOURCE: Physician Payment Review Commission analysis of 1994 Medicare Current Beneficiary Survey.

NOTE: Percentages adjusted for differences in beneficiary and health system characteristics. See discussion in text.

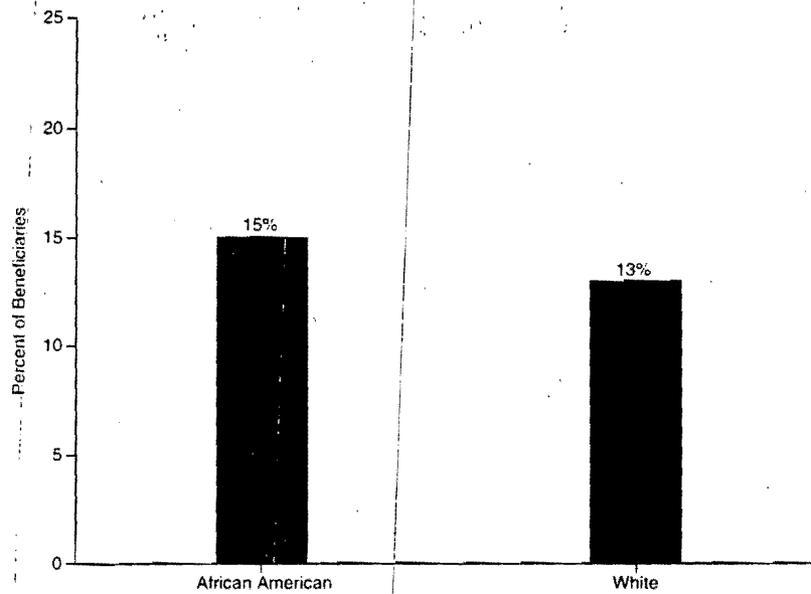
Figure 14-3. Beneficiaries with No Usual Source of Care, by Supplemental Coverage (percentage)



SOURCE: Physician Payment Review Commission analysis of 1994 Medicare Current Beneficiary Survey.

NOTE: Percentages adjusted for differences in beneficiary and health system characteristics. See discussion in text.

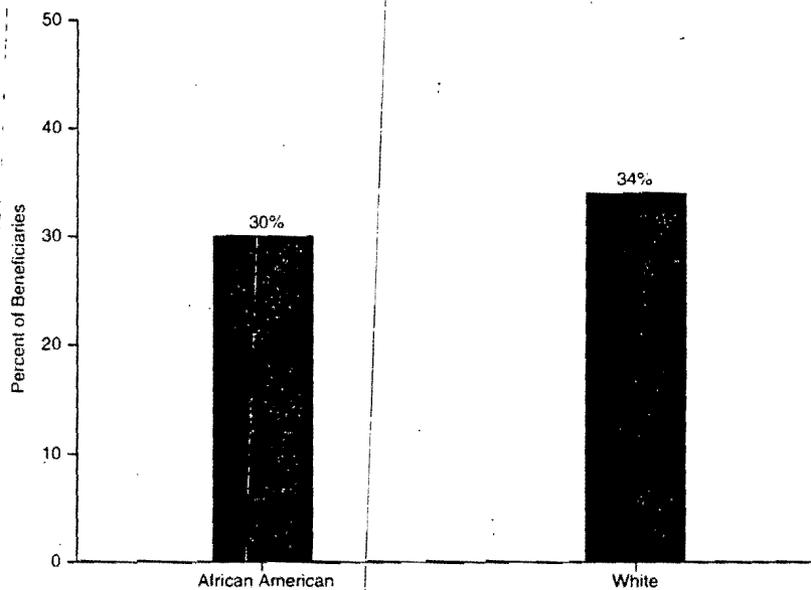
Figure 14-4. Beneficiaries with No Usual Source of Care, by Race (percentage)



SOURCE: Physician Payment Review Commission analysis of 1994 Medicare Current Beneficiary Survey.

NOTE: Percentages adjusted for differences in beneficiary and health system characteristics. See discussion in text.

Figure 14-5. Beneficiaries Very Satisfied with Overall Quality of Care, by Race (percentage)



SOURCE: Physician Payment Review Commission analysis of 1994 Medicare Current Beneficiary Survey.

NOTE: Percentages adjusted for differences in beneficiary and health system characteristics. See discussion in text.

possible explanations for these differences: that is, access may be affected by other factors, which could not be addressed in this analysis. These include other aspects of the availability and organization of services; personal preferences and behaviors of beneficiaries; unmeasured dimensions of health status, including genetic and environmental factors; and racial discrimination (Geiger 1996; Escarce et al. 1993).

This analysis was designed to aid development of options for solving the access problems of vulnerable groups. Not surprisingly, it has shown that solving those problems will be difficult. Multiple factors are important, and some of them, such as health status and supplemental insurance coverage, are only indirectly related to Medicare payment policy.

In the past, the Commission has recommended that multiple approaches should be considered to maintain and expand service delivery for underserved Medicare beneficiaries (PPRC 1995). Among those approaches are ensuring appropriate numbers and distribution of health professionals; changing payment policy; and making certain beneficiaries have access to new health care delivery systems. The analysis presented above reaffirms the importance of a broad-based strategy to improve access for vulnerable beneficiaries.

BENEFICIARY OUT-OF-POCKET SPENDING

A number of policies under Medicare fee for service are intended to protect beneficiaries from excessive out-of-pocket expenses for physicians' services. Providers are encouraged to bill on assignment, meaning that they accept the Medicare payment amount as full compensation and receive payment directly from Medicare. The Participating Physician and Supplier (PAR) program provides incentives for physicians to accept all of their claims in this manner. For example, payment under the Medicare Fee Schedule is 5 percent higher for participating physicians than for nonparticipating physicians. In addition, participating physicians are provided with toll-free lines if they submit claims electronically, and their names are included in the Medicare Participating Physician/Supplier Directory.

A form of beneficiary protection also exists for claims that are not assigned. OBRA89 specifies percentage limits on the amount that physicians can bill beneficiaries above Medicare's payment amount. The limits are 115 percent of nonparticipating physician payment rates, or 109.25 percent (115 percent of 95 percent) of Medicare Fee Schedule payment rates.

Together, these policies leave Medicare beneficiaries responsible for a \$100 deductible, coinsurance of 20 percent of the Medicare Fee Schedule payment amount, and additional charges (balance bills) of at most 15 percent of the Medicare payment for physicians' services provided on a fee-for-service basis.¹¹

¹¹ Most beneficiaries (about 87 percent) have some form of supplemental insurance policies that cover all or most of these cost-sharing expenses (see Chapter 15).

Each year, the Commission reports on beneficiary financial liability in the context of out-of-pocket spending for physicians' services. The Commission has consistently found that the physician payment reforms included in OBRA89 have successfully constrained balance billing and increasing numbers of physicians are accepting Medicare-allowed charges as payment in full.

To get a more complete picture of beneficiary financial liability, this year, the Commission has expanded its focus to examine beneficiaries' overall out-of-pocket costs related to health care. Those costs include Part B premiums (\$43.80 per month); Part A and Part B annual deductibles (\$100 and \$760, respectively); Part A and Part B copayments; and balance bills. These are in addition to expenses they may incur for supplemental health insurance premiums and services not covered by Medicare. Medicare does not place any limits on overall out-of-pocket spending.

This section includes information describing beneficiaries' out-of-pocket health care expenditures, including cost sharing for Medicare-covered services, balance billing from Part B providers, cost of noncovered services, and Medicare Part B and private health insurance premiums. It also updates information on assignment of claims, the PAR program, and balance billing.

Total Out-of-Pocket Spending

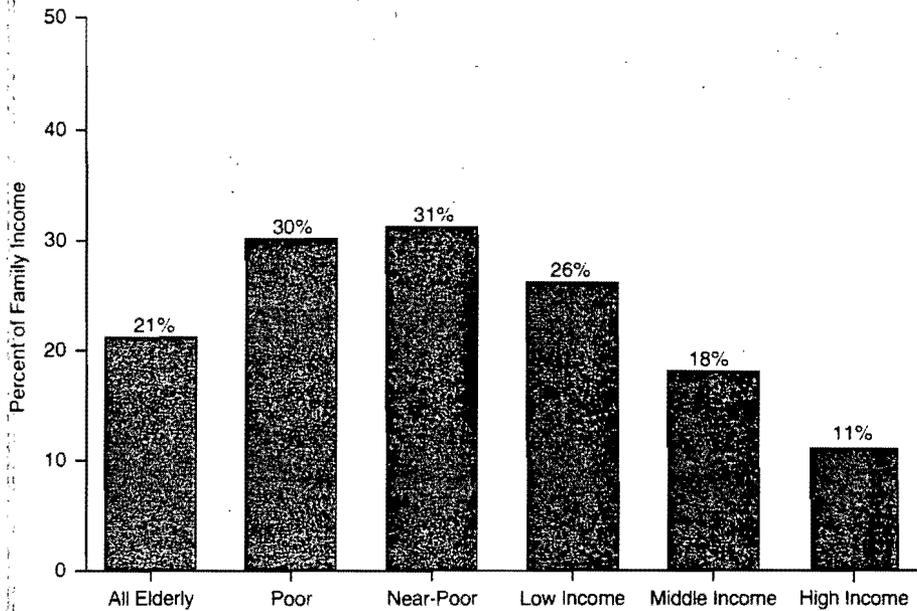
Elderly Americans spend nearly four times more out of pocket for health care than those under 65 (AARP 1995). Noninstitutionalized Medicare beneficiaries, on average, spent \$2,605 for health care in 1996 (Moon et al. 1996).¹² Currently, out-of-pocket spending represents 21 percent of household income for the elderly overall. The proportion of income the elderly devote to health care spending has risen over the years. In 1987, they spent about 15 percent of their incomes on health-related services. The elderly poor and near-poor spend an even greater percentage of their income on health care services than those in wealthier groups. For example, those with incomes below 125 percent of the poverty level spend roughly 30 percent of family income on out-of-pocket health care costs (Figure 14-6) (Moon et al. 1996).

The oldest and the sickest beneficiaries are at the greatest risk for high out-of-pocket spending. Cost-sharing burdens are highly concentrated among the most severely ill. For example, in 1996, Medicare-related out-of-pocket spending for the sickest 10 percent of the Medicare population was roughly \$5,600 per beneficiary, while the healthiest 20 percent had no cost-sharing expenses (Moon et al. 1996).

Out-of-pocket spending on health care also differs across age groups, with the proportion of family income devoted to health care costs increasing with age. While those aged 65 to 69 spend about

¹² This includes cost sharing for Medicare-covered and noncovered services and products, Medicare Part B premiums, private health insurance premiums, and balance billing. Noninstitutionalized beneficiaries represent 86 percent of the total Medicare population. Cost sharing is considerably higher for institutionalized beneficiaries (Moon et al. 1996).

Figure 14-6. Average Out-of-Pocket Health Spending by the Noninstitutionalized Elderly as a Percent of Family Income by Poverty Status, 1996



SOURCE: Moon et al. 1996.

NOTE: The poor are those with incomes at 100 percent or less of the poverty level; the near poor are those between 100 and 125 percent of poverty; low income are those between 125 and 200 percent of poverty; middle income are those between 200 and 400 percent of poverty; and high income as those with incomes over 400 percent of poverty.

18 percent of their household income on health care, the oldest beneficiaries (80 and older) spend about 25 percent (Moon et al. 1996).

Spending on health insurance premiums accounts for most of these out-of-pocket expenditures. Combined, Medicare Part B premiums, individual private insurance premiums, and employment-related insurance premiums account for about 45 percent of out-of-pocket costs of noninstitutionalized beneficiaries. Of the remaining costs, 17 percent is spent on physicians' services, 13 percent on home health services, 10 percent on prescription drugs, and 7 percent for hospital services. The remaining 8 percent is split between vision and dental services and durable medical equipment (AARP 1995).

Financial Liability for Physicians' Services

Policies designed to limit beneficiary financial liability have generally proven successful. In 1996, more than three-fourths (78 percent) of providers who served Medicare beneficiaries were enrolled in the participating physician program, compared with 52 percent of physicians with PAR agreements in 1992. Participation rates range from a high of 92 percent in North Dakota to a low of 60 percent in Idaho. These participating providers accounted for about 92 percent of Medicare charges for physicians' services last year. The proportion of Medicare claims, submitted by participating and



7 nonparticipating physicians, paid on assignment is high and continues to rise, from about 70 percent in 1986 to 96 percent in 1996.¹¹

For the remaining charges that are not assigned, beneficiaries' cost sharing has largely been contained by Medicare's limiting charges. As a percentage of Medicare payments, balance bills have been declining. On average, balance bills were 23 percent of Medicare payments in 1993, 17 percent in 1994, and 15 percent in 1995. Preliminary analysis of unassigned claims with balance bills submitted during 1996 reveals that, on average, balance bills were again 15 percent of the fee schedule payment. Although the 1996 average of 15 percent may indicate that some bills remain above the limiting charge, previous Commission analyses have found that most charges that exceed the limit do so by relatively small amounts. The increased compliance with the limiting charge is most likely related to Health Care Financing Administration (HCFA) initiatives aimed at better informing providers and beneficiaries of overcharges. Legislation enacted in 1994 clarified HCFA's authority to enforce the charge limits and require providers to refund any overcharges.

Future Work on Monitoring Out-of-Pocket Spending

Assessing out-of-pocket health care costs and understanding the financial burden these costs impose on different types of beneficiaries is critical to discussions about how to reform Medicare. Proposals to increase the Medicare Part B premium or to charge wealthier beneficiaries a higher premium have received attention recently as policymakers look for ways to contain rising program costs.

The Commission's upcoming report on beneficiary financial liability will include more detailed analyses on out-of-pocket health care spending. The most current data from the cost and use supplement to the 1992 MCBS will be used for these analyses.¹² The analyses will focus on how out-of-pocket spending varies among different segments of the Medicare population. Of particular interest are the out-of-pocket expenses of traditionally vulnerable groups of beneficiaries, including African Americans, Hispanics, those without supplemental insurance coverage, and the oldest and poorest beneficiaries.

REFERENCES

Aday, LuAnn, and Ronald Andersen, "Equity of Access to Medical Care: A Conceptual and Empirical Overview," *Medical Care* 19(12):4-27, December 1981.

American Association of Retired Persons, *Coming Up Short: Increasing Out-of-Pocket Health Spending by Older Americans* (Washington, DC: 1995).

¹¹ The estimate for 1996 is based on claims data from the first six months of that year.

¹² Once data from the 1993 and 1994 MCBS are released, the Commission will update its analyses using the 1992 data as a baseline.

The Changing Labor Market for Physicians

The Physician Payment Review Commission's interest in the changing labor market for physicians stems from two sources: its mandate to examine the supply and specialty mix of physicians, and its efforts to monitor changes in the market for health services and suggest to the Congress the implications of these changes for public policy.

Over the past 35 years, policymakers have returned periodically to issues surrounding the adequacy and competencies of the nation's health work force, focusing primarily on physicians. For many years, these debates were driven by concerns that an oversupply of physicians might undermine other efforts to bring health care costs under control, and that the nation was training relatively too many specialists and relatively too few physicians in primary care (defined as family practice, general internal medicine, and general pediatrics). (Obstetrics-gynecology is not considered a primary care field for the purposes of this chapter.) A variety of federal policies have been proposed and implemented to address these concerns.

More recently, changes in the health care marketplace have created a new context for considering these concerns. Some argue that the problems of physician oversupply and specialty imbalance are among those that will be resolved by a competitive health care market. In theory, the growth of cost-conscious integrated health systems will alter the number and mix of services used by patients and thus the number and mix of health professionals needed to provide those services. These developments will in turn result in physicians being employed at greatly reduced compensation or being unable to find jobs in medicine, thus sending a signal to students and educators to

This chapter includes:

- *Changes in the market for health services that affect the physician work force*
- *Signals of change in physician specialty mix*
- *Signs of changes in demand for physicians overall*
- *Changes in physician employment arrangements*

change. Others doubt that market forces will lead to significant change and continue to call for direct action by policymakers, educators, and payers to address concerns about supply and specialty mix. An argument can also be made that market forces cannot be expected to work, given the substantial federal subsidies for physician training.

In its 1995 and 1996 annual reports, the Commission examined whether changes in the organization and financing of health care were affecting the labor market for physicians. Two types of change in the labor market were assessed: whether there was evidence that increasing demand for primary care physicians was leading to changes in specialty mix, and whether there was any indication that the market was creating incentives to train fewer physicians overall. In last year's report, the Commission noted that the physician labor market was indeed changing, but that these changes, as captured through systematic data, were more modest than suggested by anecdotes.

In this report, the Commission once again considers the available empirical data to determine whether specialty mix and physician supply are changing. This year, the signals are ambiguous. While there are some signs that specialty mix may be changing in response to market demand for primary care physicians, there are also signs of continued strong demand for physicians in highly specialized fields. In addition, despite common beliefs to the contrary, many indicators do not reflect an oversupply of physicians. Finally, changes in the market appear to be affecting the conditions of employment for many physicians.¹

MARKETS RELEVANT TO THE PHYSICIAN WORK FORCE

In considering whether changes in the market for health services will influence shifts in physician supply and specialty distribution, it is important to recognize that there are actually two markets of interest: the market for physicians' services and the market for physician training. This distinction matters for two reasons. First, market pressures may lead to diametrically opposed responses from the two markets. Although organized systems of care may be demanding fewer physicians and relatively more primary care physicians than in the past, teaching hospitals, under significant pressure to economize, may be more dependent than ever on using residents to meet service needs. Moreover, even if graduates of U.S. medical schools begin to respond to market pressures by increasingly seeking positions in primary care fields, hospitals may continue to meet their staffing requirements by filling positions with international medical graduates (IMGs).

Second, notwithstanding substantial changes in the market for physicians' services, the length of the training pipeline and the large stock of practicing physicians will preclude any substantial short-run impact on supply and specialty mix. For example, a large increase in starting salaries for primary care physicians will not likely affect the behavior of individuals who have just begun training in surgical

¹ This chapter does not consider the impact of market changes on the geographic distribution of practicing physicians or the demographic composition of the physician work force.

specialties. As a result, one would expect that indicators measuring the production of physicians would lag behind those measuring changes in the practice environment. Furthermore, given the size of the pool of practicing physicians, even substantial changes in the behavior of recent graduates will have only a small effect on the size and composition of the physician work force.

Data are presented in this chapter that describe both of these markets. For example, data on the number and mix of residents are indicative of changes in the market for training. Data on physician incomes and practice arrangements are relevant to changes in the market for physicians' services.

CHANGES IN THE SPECIALTY MIX OF PHYSICIANS

There are several indicators of potential changes in the mix of physicians in different specialties: relative incomes, the availability of jobs, and medical students' expressed specialty preferences. These indicators, reviewed below, suggest a moderate trend toward generalism.

In previous reports, the Commission also examined data from the annual residency match to consider whether there were changes in the types of residency positions sought by graduating medical students. Because of the difficulty in interpreting these data, the Commission has not included them in this report.²

Changes in Relative Incomes

The Commission noted that in 1994 physician incomes had fallen for the first time since the American Medical Association (AMA) began collecting these data. In 1995, median physician income rebounded, rising about 3.8 percent (Table 16-1). The two-year trend, however, shows a loss of about 2.5 percent. As a result, real median incomes remain below those for 1993 (Mitka 1997). Analysis of this series through 1994 found the decline in physician earnings was directly (although weakly) associated with an increase in managed-care penetration (Simon and Born 1996).

Although most specialties experienced income increases in 1995, patterns of income changes differed somewhat across specialties. Moreover, the patterns are not consistent within specialty groups (e.g., primary care, surgery). For example, while incomes of family practitioners and pediatricians are at a new high, median incomes for internists continue to drop. Median incomes across all physician specialties continue to remain far apart, however, at \$250,000 for orthopedic surgeons and \$124,000 for those in family practice.³

² Data from the resident match can be difficult to interpret as indicators of labor market change for several reasons. First, the number of positions that happen to be offered through the match varies annually. Second, because it is geared to graduating medical students, the match does not encompass those fields that are entered in later years (for example, training in internal medicine subspecialties begins after completion of a residency in internal medicine).

³ Expectations about starting salaries are another potential barometer of income shifts between generalists and specialists. Regrettably, the annual survey on physicians' expectations about starting salaries that the Commission had included in previous reports is no longer available because the firm that conducted it, Physician Services of America, has gone out of business.

Table 16-1. Real Median Physician Income, by Selected Specialties and Years
(1995 dollars in thousands)

Specialty	1981	1985	1990	1991	1992	1993	1994	1995
Primary Care								
Family practice	\$118	\$107	\$107	\$108	\$108	\$115	\$113	\$124
Internal medicine	139	139	138	138	140	157	154	150
Pediatrics	106	106	115	116	121	126	113	129
Surgery								
General surgery	194	213	196	188	194	236	226	225
Ophthalmology	*	*	202	221	188	191	180	194
Orthopedics	*	*	311	259	269	283	279	250
Other Specialties								
Anesthesiology	194	192	230	232	237	231	205	203
Obstetrics-gynecology	181	169	212	221	204	210	187	200
Psychiatry	116	122	123	122	129	126	123	124
Radiology	191	207	230	247	258	252	226	230
All Specialties	152	155	150	154	159	164	154	160

SOURCE: American Medical Association Socioeconomic Monitoring System.

* Not available.

NOTES: Values have been adjusted for inflation using the gross domestic product deflator.

Incomes are revenues net of expenses.

Changes in Jobs Available by Specialty

Many expect the growth of managed-care organizations to result in more job opportunities for primary care physicians and fewer positions for specialists. The one longitudinal source of information on the availability of jobs in different fields is an AMA survey of residency program directors concerning the employment experience of their recent graduates, their perceptions about the difficulties graduates have in getting jobs (particularly in clinical practice), and actions they are taking at the program level to respond to those issues. This survey was conducted for the first time in 1994 and has since been repeated. In 1995, physicians in generalist fields were once again reported to have less difficulty finding positions than those in specialties (AMA 1997). For example, fewer than 1 percent of those in family practice reported difficulty finding full-time clinical positions compared with 15.8 percent of trainees in anesthesiology, 20.7 percent in gastroenterology, and 14.9 percent in ophthalmology. Overall, the percentage of residents having difficulty increased from 6.3 percent to 6.9 percent. The trend varied substantially across fields, however. Residents in a number of fields had less difficulty finding a job in 1995; these included family practice, anesthesiology, cardiology, and plastic surgery. Others had more difficulty, including residents in internal medicine, pediatrics, general surgery, obstetrics-gynecology, and ophthalmology. It is unclear whether changes in rates reflect true differences in job availability or altered perceptions about how hard it will be to find a full-time clinical position (AMA 1997).

A survey of training outcomes by the American College of Cardiology also suggests that specialists continue to be able to find jobs. Fully 98 percent of those surveyed had obtained a post-training position. While about half found the job search to be very or somewhat difficult, 42 percent found the search very or somewhat easy (American College of Cardiology 1996).⁴

Changes in Medical Students' Expressed Career Preferences

Among the indicators of changes in specialty mix, the plans of graduating allopathic medical students show a continued strong trend toward generalism (Table 16-2). Almost 32 percent of graduating allopathic medical students now indicate they are interested in primary care fields, more than double the share just five years ago. And for the first time, interest in primary care exceeds the level in 1980 when it first started to drop. Interest in primary care has traditionally been higher among osteopathic medical students; in 1995, 43 percent selected primary care as a career, the same as in 1982 (AOA/AACOM 1997).

Among allopathic students, anesthesiology and radiology continue to drop in popularity; only 1 percent of medical school seniors expressed interest in anesthesiology as a career, compared to 7 percent in 1991 (AAMC 1996a).

Table 16-2. Graduating Allopathic Medical Students' Career Preferences, by Selected Specialties and Years, 1980-1996 (percentage)

Specialty	1980	1985	1991	1992	1993	1994	1995	1996
Primary Care	31.0%	29.8%	14.9%	14.6%	19.3%	22.8%	27.6%	31.9%
Family practice	14.5	13.3	9.4	9.0	11.8	13.1	15.7	16.6
Internal medicine	10.6	10.7	2.9	3.2	4.5	6.2	7.7	9.7
Pediatrics	5.9	5.8	2.6	2.4	3.0	3.5	4.2	5.6
Surgery								
General surgery	4.8	6.2	2.1	2.1	2.1	3.0	3.4	3.8
Ophthalmology	3.5	3.6	3.4	3.4	3.2	3.4	3.0	2.7
Orthopedics	4.8	5.7	4.7	5.3	4.8	5.0	4.5	4.1
Other Specialties								
Anesthesiology	2.3	5.7	7.0	6.8	5.7	4.7	2.9	1.0
Medical subspecialties	3.7	10.6	16.0	16.4	14.2	12.2	12.0	11.0
Obstetrics-gynecology	4.2	5.4	2.5	2.7	3.1	3.8	4.0	4.5
Psychiatry	2.8	4.2	2.1	1.6	1.5	2.0	2.2	1.3
Radiology	3.8	5.7	7.7	7.2	7.3	6.6	6.7	4.2

SOURCE: 1980-1996 Association of American Medical Colleges Medical School Graduation Questionnaire.

NOTE: Percentages based only on students who had decided on a specialty. Data since 1991 based on slightly different question format.

⁴ Some 8 percent had no opinion or did not conduct a job search.

Changes in the Mix of Residency Positions and Programs

Another measure of potential changes in specialty mix is the mix of first-year residents (Table 16-3). Here there is also a trend toward generalism, although the shift is less dramatic than that for the survey of medical student career preferences. In 1995, the share of first-year residents in primary care fields rose slightly from 57 percent to 59 percent, the same level as in 1993. Specialties such as obstetrics-gynecology and orthopedics experienced slight losses.⁵ Although graduates of osteopathic medical schools have traditionally been more primary-care oriented, adding osteopathic residents in osteopathic programs to the count of trainees in allopathic programs does not substantially change the percentage in any field because of their relatively small numbers.

Table 16-3. Distribution of First-Year Residents, by Selected Specialties and Years, 1980-1995 (percentage)

Specialty	1980	1986	1990	1993	1994	1995
Primary Care	54%	57%	57%	59%	57%	59%
Family practice	13	13	11	12	13	13
Internal medicine	32	34	36	36	34	35
Pediatrics	10	11	11	11	10	11
Surgery						
General surgery	14	13	13	12	12	12
Orthopedics	1	1	1	2	2	1
Other Specialties						
Anesthesiology	3	2	2	1	1	1
Obstetrics-gynecology	7	6	5	5	6	5
Pathology	3	2	2	2	2	2
Psychiatry	6	5	5	5	5	5
Radiology	2	1	2	2	2	2

SOURCE: *Journal of the American Medical Association* Medical Education Issues.

NOTES: Percentages do not add to 100 because some specialties are not displayed.
Includes osteopathic graduates in allopathic programs.

CHANGING DEMAND FOR PHYSICIANS

In its 1996 report, the Commission noted that both the market for physicians' services and the market for training appeared to be signaling that there are too many physicians overall. This year, the evidence is less clear. Physician incomes (aggregated across all specialties) and the number of first-year and

⁵ The number of residents in some specialized fields such as anesthesiology is so small relative to the total number of residents that only massive changes would affect the specialty's share of first-year residents.

total residents continue to grow, although at lower rates than in the past. In addition, the number of residency programs is still climbing, although quite slowly in most fields except for family practice.

The number of first-year residents increased between 1980 and 1990, with particularly large growth in 1993. After returning to historical levels in 1994, these figures rose again in 1995 to 21,372 (nearly 11 percent) (Table 16-4). The number of first-year residents grew in every specialty tracked by the Commission with three exceptions: anesthesiology, obstetrics-gynecology, and orthopedic surgery. The overall increase cannot be attributed to international medical graduates. After reaching nearly 7,000, or 36 percent of first-year residents, in 1994, the number of first-year residents graduating from foreign medical schools fell to about 5,300 (25 percent) in 1995 (Table 16-5). The specialty distribution of international medical graduates has changed somewhat since 1990, with a mounting share of IMGs in anesthesiology, internal medicine, pathology, pediatrics, and psychiatry (Table 16-6).

Table 16-4. First-Year Residents, by Selected Specialties and Years, 1980-1995

Specialty	1980	1986 ^a	1990	1993	1994	1995
Primary Care						
Family practice	2,371	2,281	1,934	2,503	2,512	2,792
Internal medicine	5,948	6,234	6,518	7,843	6,524	7,502
Pediatrics	1,864	1,938	1,937	2,454	1,999	2,273
Surgery						
General surgery	2,539	2,412	2,408	2,567	2,384	2,483
Ophthalmology	^b	^b	^b	^b	^b	^b
Orthopedics	218	257	269	353	311	300
Other Specialties						
Anesthesiology	523	325	358	314	258	207
Obstetrics-gynecology	1,220	1,048	1,000	1,121	1,097	1,087
Pathology	642	415	449	538	388	513
Psychiatry	1,063	980	874	1,096	899	1,010
Radiology	409	257	376	430	420	434
All Specialties	18,702	18,183	18,322	21,616	19,293	21,372

SOURCE: *Journal of the American Medical Association* Medical Education Issues.

^a Data from 1985 are not available.

^b Residents may not enter training in ophthalmology in their first postgraduate year.

NOTE: Includes osteopathic graduates in allopathic programs.

Table 16-5. Trends in the Number and Percentage of Residents Who Are International Medical Graduates, by Selected Years, 1970-1995

Year	Total Number of Residents		Percentage Who Are International Medical Graduates	
	First-Year	All	First-Year	All
1970	11,552	39,463	29%	33%
1975	11,401	54,500	29	31
1980	18,702	61,465	21	20
1985	19,168	75,514	14	17
1990	18,322	82,902	19	18
1991	19,497	86,217	24	20
1992	19,794	89,368	25	20
1993	21,616	97,370	27	23
1994	19,293	97,832	36	24
1995	21,372	98,035	25	25

SOURCE: *Journal of the American Medical Association Medical Education Issues.*

Table 16-6. Shares of Total Residents Who Are International Medical Graduates, by Selected Specialties and Years, 1990-1995 (percentage)

	1990	1991	1992	1993	1994	1995
Primary Care						
Family practice	14.8%	16.1%	18.7%	19.7%	17.9%	16.7%
Internal medicine	28.6	34.1	36.4	39.6	41.9	42.5
Pediatrics	31.4	33.1	33.3	33.6	32.1	50.6
Surgery						
General surgery	8.5	9.0	*	10.8	11.4	11.7
Ophthalmology	3.7	4.6	4.9	6.5	6.6	6.9
Orthopedics	1.3	1.3	1.2	1.2	1.4	1.7
Other Specialties						
Anesthesiology	11.5	12.8	14.3	16.1	19.9	24.4
Obstetrics-gynecology	8.0	7.4	7.1	6.1	5.8	6.1
Pathology	28.1	28.7	29.6	30.3	30.4	33.8
Psychiatry	21.0	23.0	25.2	32.8	36.1	41.4
Radiology	3.8	3.9	4.1	4.7	4.9	5.6
All Specialties	18.0	20.0	20.0	23.3	24.0	25.5

SOURCE: *Journal of the American Medical Association Medical Education Issues.*

* Data not available.

A third indicator of the size of the graduate medical education enterprise is the total number of residents (Table 16-7) and training programs (Table 16-8). In 1995, allopathic programs grew 4 percent as the result of increases in most major specialties. The number of residents per program dropped in several specialized fields, among them anesthesiology (with 58 percent of programs becoming smaller during the 1994-1995 academic year), cardiology (30 percent) and gastroenterology

(25 percent). Fewer than 1 percent of programs in family medicine decreased the number of residents (AMA 1997).

Table 16-7. Total Residents, by Selected Specialties and Years, 1980-1995

Specialty	1980	1986*	1990	1993	1994	1995
Primary Care						
Family practice	6,344	7,238	6,680	7,976	8,587	9,261
Internal medicine	15,964	18,116	18,734	20,603	20,693	21,071
Pediatrics	5,171	5,817	6,115	7,460	7,394	7,354
Surgery						
General surgery	7,440	7,880	7,644	8,243	8,217	8,221
Ophthalmology	1,480	1,549	1,446	1,674	1,611	1,602
Orthopedics	2,418	2,822	2,630	3,029	2,903	2,872
Other Specialties						
Anesthesiology	2,490	3,864	4,889	5,696	5,490	4,861
Obstetrics-gynecology	4,221	4,525	4,315	5,074	5,046	5,007
Pathology	2,186	2,299	2,364	2,731	2,766	2,788
Psychiatry	3,911	4,892	4,673	5,044	4,979	4,919
Radiology	2,766	3,095	3,775	4,236	4,189	4,090
All Specialties	62,853	76,815	82,902	97,370	97,832	98,035

SOURCE: *Journal of the American Medical Association Medical Education Issues.*

* Data from 1985 are not available.

NOTE: Includes osteopathic graduates in allopathic programs.

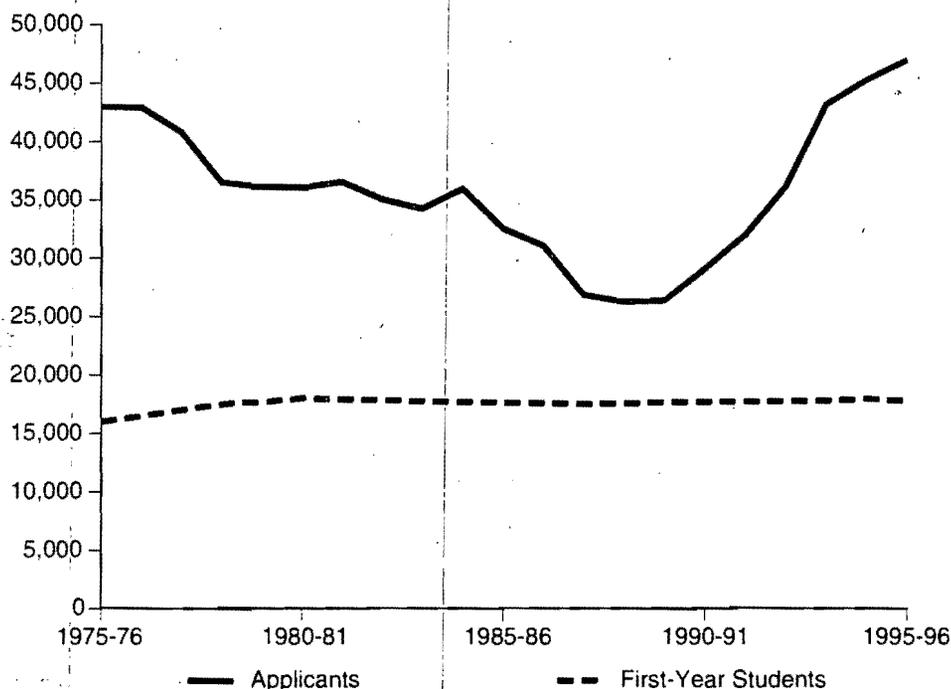
Table 16-8. Number of Allopathic Residency Programs, by Selected Specialties and Years, 1979-1995

Specialty	1979	1985	1990	1991	1992	1993	1994	1995
Primary Care								
Family practice	385	385	383	393	395	407	430	455
Internal medicine	443	442	426	427	418	416	415	416
Pediatrics	245	236	215	217	214	215	215	215
Surgery								
General surgery	331	306	281	281	270	270	271	269
Ophthalmology	155	142	136	137	135	135	137	137
Orthopedics	180	168	163	161	161	161	160	158
Other Specialties								
Anesthesiology	161	165	155	157	155	155	149	154
Obstetrics-gynecology	304	292	275	273	273	274	273	272
Pathology	358	261	217	195	192	188	186	185
Psychiatry	223	211	196	200	197	198	196	201
Radiology	221	211	210	210	206	205	206	206
All Specialties	4,742	4,799	6,938	7,189	7,065	7,277	7,347	7,657

SOURCE: *Journal of the American Medical Association Medical Education Issues.*

Changes in college students' willingness to pursue medical careers might be a lagging indicator of a tightened labor market for physicians. To date, however, there is no evidence that shifts in the organization and delivery of medical care are discouraging college students from becoming physicians. For the 1995-1996 school year, the number of allopathic medical school applications rose to an all-time high of 46,591, up about 3 percent from the prior year (Barzansky et al. 1996; AAMC 1996b). Medical school enrollment has remained relatively flat over the past 20 years (Figure 16-1). The 10,781 applicants to osteopathic schools in 1995 represented an increase of 5 percent over the prior year (AOA/AACOM 1997).

Figure 16-1. Applicants and First-Year Enrollment in U.S. Medical Schools, 1975-1995



SOURCE: Barzansky et al. 1996; AAMC 1996b.

As an indicator of change in the labor market for physicians, growth in the number of applications to medical school should be interpreted with caution, however. That is because employment prospects in other fields also influence students' willingness to apply to medical school. Uncertainty about future prospects in law, business, engineering, and other professional fields thus may contribute to students' growing interest in medical careers. A downturn in the labor market for lawyers has led to fewer law school applicants. Since 1990, the number of people taking the law school entrance exam has dropped by one-third, and about 50 of the nation's 180 accredited law schools have reduced class size in recent years (Chandrasekaran 1996).

Other changes, such as the number of physicians taking early retirement or relocating, might also be indicators of response to shrinking opportunities for physicians. While there is considerable anecdotal evidence that physicians are retiring, moving, and becoming more dissatisfied with their careers, there

continue to be no good data sources to track these factors.⁶ Similarly, changes in the roles of nonphysician practitioners who provide primary care services (for example, nurse practitioners and physician assistants) might also signal an oversupply of physicians. Such changes are more difficult to measure, however, and may be confounded by current restrictions on payment and practice, as well as by the varying roles that these practitioners play in managed-care organizations.

CHANGING TERMS OF EMPLOYMENT

Changes in the market for health services may have another effect on the labor market for physicians—namely, the terms of employment or types of practice arrangements available to new physicians. In 1995, the share of physicians who are employees increased to 39 percent, up from 36 percent in 1994. At the same time, the share of self-employed physicians dropped to 55 percent from 58 percent (Mitka 1996). Union membership has also grown dramatically among physicians, although union members still account for a small share (less than 10 percent) of the nation's practicing physicians (Worcester 1996).

A related trend is the growth in salaried positions rather than offers of income guarantees or other forms of compensation. Merritt, Hawkins and Associates, a national physician recruitment firm, reports that 63 percent of the job searches it conducted between April 1995 and April 1996 were for salaried positions, compared with just 44 percent the year before (Kostreski 1996).

CONCLUSIONS

The evolving market for health services appears to be changing the national labor market for physicians. The lack of data at the market level precludes our ability to determine whether these changes are more pronounced in the most competitive markets. National data indicate that positions in generalist fields are becoming somewhat more attractive, but that changes in relative incomes have been modest. Overall job opportunities for physicians, however, do not appear to be contracting. The changing market does appear to be affecting physicians' practice arrangements, with an increasing share of physicians becoming employees rather than being self-employed or holding equity in a group practice.

⁶ Changes in the average retirement age can be obtained from the AMA's Physician Masterfile, but these calculations are not made regularly.