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SECTION 4507 AND THE IMPORTANCE OF PRIVATE CONTRACTS

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ONE OF THE MORE CONTROVERSIAL sections of the Balanced Budget Act of 1997¹ ostensibly enables physicians and Medicare patients to enter into private contracts for the provision of health services beyond the scope of the Medicare program.² Unfortunately, the draconian terms of Section 4507 succeed to prevent, rather than promote, private contracts between physicians and their patients. For the first time in the Medicare program, the law effectively prohibits private contracts except as dictated by Section 4507. While Section 4507 gives the appearance of enhancing a patient's ability to choose health care providers and services,³ it actually succeeds in limiting patient choice as never before.

This Article discusses some of the inherent flaws created by Section 4507. A fundamental tenet underlying this discussion is that Medicare patients and providers should be able to enter into private arrangements with their physicians for services on a case-by-case basis without governmental interference.

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¹ Pub. L. No. 105-33, § 4507, 111 Stat. 439, 439-42 (1997) (codified as amended at 42 U.S.C. § 1395a(b) (Supp. III 1998)).

² The Medicare program was established in 1965 and is now the largest public payer of health care services and supplies. Recent numbers show that Medicare covers about 38 million persons 65 years of age and older, and about five million disabled persons under 65 years of age. The Medicare program consists of two parts: A and B. Part A benefits extend to hospital, skilled nursing facility, home health, and hospice care. Physician and outpatient services are covered by Part B, which is affected by Section 4507. See Karen Visocan, *Recent Changes in Medicare Managed Care: A Step Backwards for Consumers?*, 6 ELDER L.J. 31, 32 (1998) (citations omitted).

³ Section 4507 is codified under 42 U.S.C. § 1395a which, ironically, is entitled: "Free choice by patient guaranteed."

Section 4507 weakens this basic principle. The reader will ultimately conclude that the law is inappropriate for the health needs of the Medicare population and should be modified significantly or repealed.

I. BRIEF OVERVIEW OF THE LAW

A. Medicare Options Generally

Medicare is currently the only insurance option for those sixty-five years of age or older, as no other insurance plan offers such coverage.⁴ Thus, in a classic Hobson's choice, a patient over sixty-five may go uninsured or "voluntarily" join the federal program.⁵ In order to receive reimbursement for services under the Medicare program, a physician⁶ or practitioner⁷ (hereinafter referred to jointly as "physician") has two options: accept assignment of a patient's benefits and receive Medicare rates, or bill a patient directly for up to fifteen percent above the Medicare rate. Acceptance of assignment results in direct payment to the physician from Medicare's contracted Part B carrier. Under the second option, a patient would receive reimbursement directly from Medicare, and the patient would have the fiscal responsibility to pay the physician directly for her services. Also, a patient has always and may still privately contract for services that are excluded from Medicare, such as cosmetic surgery or hearing aids.

⁴ Since the enactment of Medicare, private health insurance companies no longer provide primary coverage for those 65 years of age or older. *See* Complaint For Declaration of Rights and Injunctive Relief at 10-11, *Stewart v. Sullivan*, 816 F. Supp. 281 (D.N.J. 1992) (No. 92-417) (requesting that plaintiffs maintain their enrollment in Medicare, yet have the ability to pay for certain services privately without losing enrollment status).

⁵ The Hobson's choice element of Medicare only enhances the restrictive nature of Section 4507.

⁶ For purposes of Section 4507, "physician" means a "doctor of medicine or a doctor of osteopathy who is currently licensed as that type of doctor in each State in which he or she furnishes services to patients." 42 C.F.R. § 405.400 (1999).

⁷ For purposes of Section 4507, "practitioner" means a "physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical psychologist, or clinical social worker, who is currently legally authorized to practice in that capacity by each State in which he or she furnishes services to patients or clients." *Id.*

1. Advanced Beneficiary Notices

For non-covered services, a physician may provide a patient with an Advanced Beneficiary Notice (ABN) warning a patient that potential services may not be paid by Medicare, and that the patient may be responsible for the entire cost of services. However, ABNs are far from a panacea to Section 4507. In general, Medicare's determination for reimbursement of services depends on the standard of "reasonable and necessary,"⁸ a standard with little guidance that often eludes even the most perceptive physicians. The Health Care Financing Administration (HCFA) has never published a final rule describing how it determines whether a health care service is or is not "necessary," thereby leaving a physician unable to predict if services will be reimbursed.⁹ Often times it is unclear whether a service will be covered by the program until *after* a claim has been filed. As discussed below, this uncertainty surrounding reimbursement creates a tangible risk for physicians utilizing ABNs.¹⁰

Misuse of ABNs can expose physicians to fraud and abuse sanctions; HCFA is likely to undertake severe sanctions against a physician for providing unnecessary services.¹¹ Even when

⁸ The Social Security Act prohibits payment for Medicare Services "which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." 42 U.S.C. § 1395y(a)(1)(A) (1994).

⁹ According to a 1989 proposed rule, the criteria considered by HCFA when determining the reasonableness and necessity are whether the health care service is (i) safe and effective; (ii) not experimental or investigational; (iii) cost effective; and (iv) appropriate. See Medicare Program; Criteria and Procedures for Making Medical Services Coverage Decisions That Relate to Health Care Technology, 54 Fed. Reg. 4302, 4307-09 (1989). HCFA has never defined any of the terms used in these factors. In fact, HCFA states that "[n]ot all of the criteria are necessarily pertinent to every coverage issue and each criterion is not necessarily given equal consideration in reaching a final decision. Because of the complexity and variety of issues involved in making coverage decisions, [HCFA does] not think it is possible, or advisable, to try to get quantitative standards or develop a formula in the application of these criteria." *Id.* at 4307.

¹⁰ When a physician provides services to a Medicare beneficiary that may not be covered and cause the physician to provide an ABN to the patient, the physician nevertheless bills the patient and the Medicare program for the services. If denied by Medicare as non-covered, the physician may seek payment from the beneficiary, having provided the ABN warning to the patient prior to providing the services.

¹¹ See *Private Contracting in Medicare: Hearing Before the Senate Finance Committee*, 105th Cong. (1998) [hereinafter *Hearing*] (statement of Kent Masterson Brown, Counsel, United Seniors Association) available in 1998 WL 8992722.

physicians make use of ABNs, they may remain vulnerable to violating Federal law:

Any person . . . that . . . knowingly presents or causes to be presented to an officer, employee or agent of the United States, or of any department . . . thereof, or of any State agency . . . a claim . . . that the [HCFA] determines . . . is for a pattern of medical or other items or services that a person knows or should know are not medically necessary . . . shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than \$10,000 for each item or service In addition, such a person shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim In addition the [HCFA] Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs . . . and to direct the appropriate State agency to exclude the person from participation in any State health care program.¹²

In a statement before the Senate Finance Committee regarding private contracting, attorney Kent Masterson Brown stated that:

All that is needed for HCFA to begin the sanction process against a physician is a "pattern" of what it claims are "unnecessary" services Because ABNs cannot be used routinely without being subject to sanctions, physicians will severely limit and not provide health care services which they believe HCFA may find to be "unnecessary."¹³

Because federal law discourages a physician's utilization of ABNs, this notice should in no way be presented as a viable alternative to private contracting on a case-by-case basis.

¹² 42 U.S.C.A. § 1320a-7a(a) (West Supp. 1999).

¹³ *Hearing, supra* note 11.

2. Contrast Media - An Example of the Inadequacies of ABNs

ABNs are not appropriate for every health care service, and, unfortunately, are "not allowed with regard to certain procedures."¹⁴ A perfect example of an ABN's limitation is found in the use of non-ionic contrast media for imaging procedures. There are presently two options for imaging studies -- non-ionic contrast media (also known as low osmolar contrast media or LOCM) or ionic intravenous contrast media. Hundreds of studies in animals and humans have shown that LOCM causes less "discomfort and nausea and fewer other minor generalized reactions,"¹⁵ and helps prevent complications, particularly for patients with congestive heart failure, severe aortic stenosis, cardiogenic shock, and left main coronary artery disease.¹⁶ However, LOCM is more expensive than ionic material,¹⁷ and will be reimbursed by Medicare only under very narrow criteria.¹⁸

¹⁴ *Group Argues Legislation Improperly Bars Seniors From "Wanted Medical Treatment,"* MEALEY'S MANAGED CARE LIAB. REP., July 22, 1998, at 14, 14 (presenting the opinion of the Citizens Against Government Waste).

¹⁵ John W. Hirshfeld, Jr., *Low-Osmolality Contrast Agents -- Who Needs Them?*, 326 NEW ENG. J. MED. 482, 482 (1992) (discussing the costs and benefits of conventional and low-osmolar contrast media agents in imaging procedures).

¹⁶ A large independent study evaluating non-ionic and ionic contrast agents in approximately 400,000 patients has confirmed that if one uses severe reactions as an indication of safety, non-ionics are approximately six times safer. See Hitoshi Katayama et al., *Adverse Reactions to Ionic and Nonionic Contrast Media: A Report from the Japanese Committee on the Safety of Contrast Media*, 175 RADIOLOGY 621 (1990).

¹⁷ See Douglas P. Utter, *Survey of Contrast Media Use in Southeastern U.S. Hospitals*, 68 RADIOLOGY TECH. 386, 386 (1997) (investigating current contrast usage in hospital radiology departments in the Southeast, and identifying current trends related to contrast media).

¹⁸ If the beneficiary does not meet any of the following criteria, the payment for contrast media is considered to be bundled into the technical component of the procedure, and the beneficiary may not be billed for LOCM:

- (1) A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting;
- (2) A history of asthma or allergy;
- (3) Significant cardiac dysfunction, including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension;
- (4) Generalized severe debilitation; or
- (5) Sickle cell disease.

1 CCH, INC., *Medicare and Medicaid Guide*, ¶ 3453 at 1254-55 (1999) (citing Special Rules for Payment of Low Osmolar Contrast Media, 56 Fed. Reg. 59, 627 (1991)).

Besides these barriers, the use of LOCM is further complicated by state requirements for informed consent that encourage patient choice. A number of state courts have adopted the modified informed consent disclosure of risks and alternatives of medical procedures known as the "prudent patient" standard. In these states, the standard is not based on a "prudent physician," or what a reasonable physician would have done in the situation (e.g., choose to disclose the risk of a procedure), but rather on whether the physician disclosed those risks which a reasonable man would have considered material to his decision whether or not to undergo the procedure.¹⁹ Although radiological studies requiring injection of contrast media carry relatively minimal risk overall, there is a statistical probability that one in 100,000 patients can die from an adverse reaction to the contrast.²⁰ In states following the "prudent patient" standard, physicians generally seek consent prior to performing exams requiring contrast media.

According to recent statistics, the cost differential between non-ionic and ionic media has dropped significantly.²¹ Nevertheless, HCFA's payment policy has remained unchanged. Thus, even though LOCM is ideal for some patients, and some patients, having been informed of the potential risk of death from the procedure, may request the arguably safer but more expensive non-ionic contrast material, they are prohibited by Section 4507 from paying out-of-pocket for the procedure if they do not fit Medicare's restrictive categorization. That is, physicians cannot request an ABN for a procedure that is a covered service, albeit at an inadequate payment level for those outside the criteria but desirous of using LOCM. Patient choice is hampered because this is a payment policy, not a coverage issue.

¹⁹ See *Hoffman v. Mogil*, 665 A.2d 478, 483 (Pa. Super. 1995) (quoting *Festa v. Greenberg*, 511 A.2d 1371, 1375 (Pa. Super. 1986)).

²⁰ See *Pauscher v. Iowa Methodist Medical Center*, 408 N.W.2d 355, 357 (Iowa 1987) (holding that a physician was not liable for the death of a patient by failing to inform the patient of a one in 100,000 procedural risk).

²¹ The cost differential has dropped from 15-20:1 to 5-7:1. See Paul M. Silverman, *Re: Ionic Versus Nonionic Contrast Media*, 168 AM. J. ROENTGENOLOGY 1620, 1620-21 (1997).

B. Section 4507

Erroneously construed as a new option, private contracting under Section 4507 allows a physician to opt-out of Medicare and bypass the program's rules entirely. In such cases, all payments for services become a patient's responsibility. To effectively opt-out, a physician, whether participating in the Medicare program or not, must submit an affidavit stating that he or she will not submit any claim under Medicare for any item or service provided to a patient during a two-year period beginning on the date the affidavit is signed.²² Thus, even if a physician desires to contract privately with just a single patient, a physician's decision to opt-out would affect his or her entire patient base.²³ In addition to this affidavit, a physician must enter into a separate agreement with each of his or her patients that includes certain language requested by law.²⁴ These requirements make Section 4507 an unattractive choice for physicians.

II. SECTION 4507 DOES NOT SANCTION A PREVIOUSLY FORBIDDEN PRACTICE

Prior to Section 4507, the Medicare program did not bar private contracting, and any suggestion to the contrary is incorrect. The Medicare regulations clearly state that one of the conditions for Medicare payment is that a "provider, supplier, or beneficiary, as appropriate, must file a claim that includes or makes reference to a request for payment."²⁵ Thus, if no claim was filed for Medicare reimbursement, a patient and a physician could determine their own arrangement. The lack of a bar against private contracting was affirmed in *Stewart v. Sullivan*,²⁶ a 1992 case decided by the New Jersey U.S. District

²² See 42 U.S.C. § 1395a(b)(3)(B) (Supp. III 1998).

²³ One of the requirements of the opt-out affidavit is an acknowledgment by a physician that "the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by the physician or practitioner during the opt-out period . . . without regard to any payment arrangements the physician or practitioner may make." 42 C.F.R. § 405.420(h) (1999).

²⁴ See 42 U.S.C. § 1395a(b)(2) (Supp. III 1998) (requiring that, among other things, the contract include agreements by the beneficiary that he will not submit claims to Medicare, and that he will be responsible for payment for services rendered).

²⁵ 42 C.F.R. 424.5(a)(5) (1999).

²⁶ 816 F. Supp. 281 (D.N.J. 1992) (examining the issue of private contracts between physicians and Medicare patients with respect to the alleged policy of the De-

Court. The plaintiffs in *Stewart* were Lois J. Copeland, M.D., a New Jersey physician, and five patients who desired to contract privately with Dr. Copeland.²⁷

The plaintiffs attempted to affirm their rights and the rights of other Medicare patients to contract and pay for medical services privately on a case-by-case basis without having to disassociate themselves completely from Medicare Part B.²⁸ The Court stated that “[n]either the [Medicare] statutes nor the regulations expressly address the issue of whether disenrollment on a partial or service-by-service basis is acceptable under the Medicare program.”²⁹ Most importantly, Judge Nicholas Politan found that he could not “possibly conclude that the Secretary [of the Department of Health and Human Services] has clearly articulated a policy on the issue of private contracting.”³⁰ Because the Medicare program did not expressly forbid private contracts, basic principles of statutory construction dictate that patients could enter into private contracts with their physicians. This, of course, changed with the enactment of Section 4507.

III. PRIVATE CONTRACTING IS NOT A REALITY DUE TO THE LAW

“[O]ver . . . [ninety-six percent] of . . . [U.S.] physicians provide services to Medicare beneficiaries.”³¹ The vast majority of physicians are unable to meet the obviously stringent parameters of Section 4507. It is unlikely that all of a physician’s Medicare patients would want to contract privately, and few physicians could withstand a two-year opt-out from the program. Not surprisingly, as of October 1, 1998, a scant 647 of the more than 600,000 physicians who annually bill Medicare had opted-out,³² and the restrictive nature of the law makes it unlikely that this number will increase significantly. Also, the law appears to limit private contracting for Medicare services to the

partment of Health and Human Services of examining these contracts on a case-by-case basis).

²⁷ *See id.*

²⁸ *See id.*

²⁹ *Id.* at 283.

³⁰ *Id.* at 289.

³¹ *Hearing, supra* note 11.

³² *See* Kay K. Hanley, *Private Contracting by Medicare Patients*, REP. OF THE A.M.A. COUNCIL ON MED. SER., 6-A-99, at 2 (1999) (describing the private contracting provision of the Balanced Budget Act of 1997 and physician reaction to opt-out opportunities) (on file with *Health Matrix*).

auspices of Section 4507, thus creating for the first time the inference that any other private contracts are barred and ineffective.

Unfortunately, in light of its importance, Section 4507 has several flaws, and its very existence stands in the way of the constitutionally protected right of patients to contract privately for medical services. Since the "all or none" approach makes it unlikely that many physicians will take advantage of Section 4507, the law has the unintended consequence of prohibiting private contracting altogether. Ultimately, then, the law serves to prohibit, rather than promote private contracts between patients and physicians.

IV. INHERENT FLAWS CREATED BY SECTION 4507

A. Section 4507 Has A Paternalistic and Suspicious Nature

The strict confines of the law are based on the assumption that patients and physicians are unable to decide independently the level and type of care necessary for the well-being of a patient. This assumption is clearly erroneous. Today's patients are able to access more health information than ever before, and can become extremely educated consumers. "[A]n abundance of new - and expensive - pharmaceuticals [are] being directly marketed to consumers on TV, radio and in print . . ." ³³ and patients are able to learn about a wide variety of treatments. Additionally, Medicare patients had relationships with other physicians prior to their "voluntary" enrollment in the program. Before age sixty-five, patients were able to determine who would provide their services and the level and type of these services. Even if an insurance payer to some extent restricted a patient's access to services, they were *always* free to pay-out-of-pocket for any uncovered services. As it stands now, the government

³³ Vida Forbister, *Risky Business: Patient Demand for Specific Drugs Has Squeezed Medical Groups with Financial Responsibility for Managing Plans' Drug Costs*, AM. MED. NEWS, July 5, 1999, at 16, 16. In fact, pharmaceuticals may be reimbursed by Medicare in the near future. Currently, patients are able to educate themselves about pharmaceuticals and often have wide latitude in choosing a particular drug treatment. It is probable that patient choice in this area could be seriously infringed under Medicare if they are unable to contract privately on a case-by-case basis.

assumes that patients are unable to continue making such key decisions into the latter part of their lives.

The practical prohibition of the law on private contracting on a case-by-case basis appears to stem also from a suspicion that physicians want to contract privately in order to receive more compensation for services, or even gouge patients by charging considerably higher-than-Medicare rates. Price gouging is not an inevitable result of private contracting.³⁴ This is particularly true considering that private contracting would allow the market to control costs. As with any other good or service, patients would be able to “shop” for the best price for certain services. It is likely that market forces would prevent a great deal of potential patient gouging. Moreover, it is outrageous for Congress to imply that most physicians are not guided by ethical concerns and the best interests of their patients. Most importantly, the many benefits of private contracting on a case-by-case basis override even a moderate risk of excessive costs.

It is in the best interest of a patient to be able to contract privately on a case-by-case basis. As discussed previously, there are certain services that fall outside even an ABN.³⁵ To illustrate this point, in a report to the American Medical Association’s House of Delegates, the AMA’s Council on Medical Service discussed some of the advantages to private contracting:

Those just entering the Medicare program might want to continue treatment with their long-standing physician, who may not participate in the program. Others faced with a life-threatening condition may want to seek care from a recognized expert who is not accepting any new Medicare patients. In addition, a patient may reside in an area where the physician does not normally take Medicare patients. Private contracting enables these relationships to be effected.³⁶

And, according to the American Psychiatric Association, “private contracting is the only means of guaranteeing Medicare

³⁴ According to one commentator, “[m]ost physicians will not take advantage of their patients. To base the policy [of Section 4507] on fear that many will do so is offensive; to impose the policy on all doctors even though only a few will do so is wrong.” JOHN S. HOFF, *MEDICARE PRIVATE CONTRACTING: PATERNALISM OR AUTONOMY* 45 (1998).

³⁵ See discussion, *supra* Part I.A.2.

³⁶ Hanley, *supra* note 32, at 4.

beneficiaries of confidentiality when seeking psychiatric treatment if they desire."³⁷ The paternalistic and suspicious nature of Section 4507 prevents private contracting on a case-by-case basis despite a number of legitimate reasons to grant patients the maximum ability to choose physicians and services.

B. Law Grants Medicare Managed Care Participants Most Choice

As noted above, Section 4507 pertains to Medicare Part B, or the fee-for-service portion of the program. However, some patients participate in a Medicare managed care program for Part B services.³⁸ These managed care programs seek to control access to services and physicians; compared with the fee-for-service patients, participants have fewer physician options and possibly other restrictions. Because of these restrictions, if a Medicare managed care patient seeks services from a non-network physician, he or she is responsible for paying the non-network physician. This is in line with the policy that any service not covered by Medicare is considered outside of the program and is, therefore, payable entirely by the patient.³⁹ A managed care patient is able to pay privately for any type or level of service, as long as the service is outside the network. Ironically, with the enactment of Section 4507, Medicare managed care participants now have much more latitude and choice than Medicare fee-for-service patients! This is an absurd result considering that the premise of managed care is centered around providing greater management and regulatory controls than the fee-for-service environment. This difference in patient choice is particularly pronounced in those areas where over thirty percent of the Medicare population is in managed care plans.⁴⁰

³⁷ *Testimony of the American Psychiatric Association on Medicare Private Contracts, Presented to the Senate Committee on Finance*, Feb. 26, 1998 (on file with *Health Matrix*).

³⁸ About fifteen percent of Medicare patients receive care through managed care or capitated plans. See HOFF, *supra* note 34, at 53.

³⁹ To recap, such extra-Medicare services may be obtained through private contracting. See discussion, *supra* Part I.A.

⁴⁰ See Visocan, *supra* note 2, at 33 (citation omitted).

C. Restriction on Emergency and Urgent Care Has Potential Harmful Effects

A private contract entered into by a patient and a physician shall “[n]ot be entered into by the beneficiary or by the beneficiary’s legal representative during a time when the beneficiary requires emergency care services or urgent care services.”⁴¹ However, the regulations state that a physician’s decision to opt-out will not be affected if a physician “furnishes emergency care services or urgent care services to a Medicare beneficiary with whom the physician or practitioner has not previously entered into a private contract, provided the physician or practitioner complies with [certain] billing requirements . . . [under Section 405.440(b)].”⁴² Along the same vein, a physician may *not* submit claims for emergency or urgent care for those patients with whom the physician has a private contract. Because emergency and urgent care can be extremely expensive and beyond the budget of most patients, the result of this restriction is to impose a financial barrier to discourage the opted-out physician from treating his or her patients with emergency or urgent care.

The restriction has the serious potential of jeopardizing a patient’s health. Presumably, a patient and a physician would enter into a private contract because the patient seeks services from that particular physician. It is not an improbable scenario that the patient and the physician could find themselves faced with an emergency or urgent situation. The physician is obviously in the best position to address this kind of situation.⁴³ As the patient’s physician, he or she is probably the most knowledgeable about the patient’s condition and, therefore, would be best equipped to render treatment. Also, the physician may be exposed to considerable liability by delegating the patient’s care to others in such scenarios.

In a program memorandum regarding the implementation of Section 4507, HCFA requires Medicare Part B carriers to “[d]eny payment for emergency or urgent care items and services to both an ‘opt out’ physician or practitioner and the bene-

⁴¹ 42 C.F.R. § 405.415(k) (1999).

⁴² 42 C.F.R. § 405.440(a) (1999).

⁴³ An example might be an emergency situation that occurs during a patient’s visit to the physician’s office.

ficiary if these parties have entered into a private contract.”⁴⁴ Moreover, HCFA admits that the distinction between emergency/urgent care and non-emergency/urgent care is not easily discernable and is based on the carrier’s judgement: “[t]his is not going to be an easy line to draw and is probably going to require individual judgmental medical decision making by [the carrier]. . . .”⁴⁵ Certainly this distinction will be difficult for physicians as well. At the least, Section 4507 should be modified to allow all emergency and urgent care to be reimbursed even if such care is rendered to a Medicare patient by a physician who has opted out.

V. RATIONALE FOR PRIVATE CONTRACTING ON A CASE-BY-CASE BASIS WITH NO GOVERNMENTAL INTERFERENCE

A. Private Contracting on a Case-By-Case Basis Increases Physician Choice

Medicare rates for services are lower than rates in the private market for similar services.⁴⁶ These lower rates prompt or even require physicians to limit the number of Medicare patients in their practice. In fact, a 1994 survey of 1,000 physicians indicated that only seventy-three percent were accepting any new Medicare patients.⁴⁷ Many Medicare patients would be willing to buy a level of service that is not reimbursable by Medicare, and many are able to pay more than Medicare rates. As discussed below, the Medicare population will increase dramatically in the near future. Because many physicians already limit their number of Medicare patients, patient choice will become increasingly restricted. Case-by-case private contracting allows patients to be cared for by physicians who already have a maximum number of Medicare patients. Also, private contracting facilitates “the ability of physicians to serve more Medicare

⁴⁴ CCH, INC., *Private Contracts Between Beneficiaries and Physicians*, MEDICARE AND MEDICAID GUIDE ¶ 150,028 [1998-2 Transfer Binder] at 400,081.

⁴⁵ *Id.* at 400,081-82.

⁴⁶ “Medicare [currently] pays only 71% of . . . rates paid by the commercial [insurance] market.” HOFF, *supra* note 34, at 35 (citing PHYSICIAN PAYMENT REVIEW COMMISSION, 1996 ANNUAL REPORT TO CONGRESS 216 (1996)).

⁴⁷ *See id.* (citing National Opinion Research Center, *Survey of Physicians About the Medicare Program and Fee Schedule*, May 11, 1994, at 43).

beneficiaries by using the higher private contracting rates to offset the lower Medicare paid amounts."⁴⁸

B. Upcoming Demand on Medicare Program Makes Selective Private Contracting Fiscally Sound

We are facing a major increase in the Medicare audience. Today, one in eight Americans is over the age of sixty-five;⁴⁹ by 2050 the number will have increased to about one in five, with the fastest period of growth occurring between the years 2010 and 2030.⁵⁰ The "oldest old," or those eighty-five or older, will have the greatest growth during this time even though they comprise only ten percent of the current population -- it is anticipated that by 2050 they will represent up to twenty-five percent of the population.⁵¹ Technology, as well as demographics, may aid Medicare's growth. As technology improves, it is likely that more services will be covered by the program. Consequently, Medicare can only expect to see increases in the number of participants and utilization rates.

With this upcoming burden, it is imperative that policy makers develop cost-saving measures. It is only logical and cost-effective to permit Medicare participants who have the financial resources to pay their physicians privately. Such a policy would help preserve the program for other patients who must or want to continue their Medicare fee-for-service coverage. There has been much debate and discussion recently to means test Medicare coverage according to a patient's ability to pay. Private contracting helps to means test Medicare coverage informally without having the government mandate such restrictions.

C. Government Has Presented No Constitutional or Legal Justification For Intervening In The Patient-Physician Relationship

It seems reasonable that a Medicare patient should be able to spend his or her own money to purchase medical care pri-

⁴⁸ Alexandra E. Trinkoff, *Private Contracting with Medicare Patients*, 5 N.Y. HEALTH L. UPDATE 3 (1998).

⁴⁹ See INSTITUTE OF MEDICINE, BEST AT HOME: ASSURING QUALITY LONG-TERM CARE IN HOME AND COMMUNITY-BASED SETTINGS 22 (Jill C. Feasley ed., 1996) (providing that this growth stems from the aging of the baby boom generation).

⁵⁰ See *id.*

⁵¹ See *id.*

vately from a specific physician. The AMA's Council on Medical Service notes that:

Supporters of private contracting . . . argue that Congress has not articulated any Constitutional or legal justification for intervening in the patient-physician relationship Under Article I, Section 10 of the [U.S.] Constitution, no state can pass any law impairing the obligation of contracts. It is unclear how Congress, under the authority granted to it by Article I, Section 8, could control or limit the right of two persons to engage in such a contract. If a person is not taking taxpayers' money and goes outside of Medicare to seek or give independent medical treatment, that behavior is logically exclusive of Medicare and not fit for congressional or governmental supervision. That supervision, funding, and control should cease at the boundaries of Medicare itself.⁵²

The fundamental right of personal autonomy has long been recognized by the Supreme Court and this right should extend to a person's ability to make decisions concerning his or her medical care. The Supreme Court found a fundamental liberty interest in the right of individuals to make decisions regarding contraception,⁵³ and in decisions regarding the refusal of unwanted medical treatments to sustain life.⁵⁴ It follows that Medicare beneficiaries should have the right to exercise their personal autonomy to purchase desired medical services at their own expense, and that this right is fundamental. As an example, under the analysis of contrast media, a Medicare beneficiary who fails to meet the Medicare reimbursement criteria for low osmolar contrast media is deprived of the right to choose and pay out-of-pocket expenses for such media in order to minimize the potential for an adverse reaction during a radiological pro-

⁵² Hanley, *supra* note 32, at 4-5.

⁵³ *See generally* Griswold v. Connecticut, 381 U.S. 479 (1965) (holding that a Connecticut statute forbidding contraceptive use violated the right of marital privacy, which is within the penumbra of specific guarantees of the Bill of Rights).

⁵⁴ *See generally* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261 (1990) (holding that a state can require evidence of an incompetent patient's wishes regarding the withdrawal of life-sustaining treatment to meet a clear-and-convincing standard).

cedure.⁵⁵ This denial of choice deprives the patient of a fundamental liberty interest. Furthermore, using the same example, depriving an individual who happens to be a Medicare beneficiary of the right to purchase the more expensive non-ionic contrast media deprives that individual of the fundamental right to equal protection. Since the right to personal autonomy should be treated as a fundamental right, the government should be required to show a compelling interest in order to justify such discrimination against Medicare beneficiaries.⁵⁶

VI. CONCLUSION

Rather than preserve the right for Medicare beneficiaries to contract privately, Section 4507 of the Balanced Budget Act establishes a barrier that had not previously existed. As discussed above, the problems surrounding Section 4507 are obvious. Ideally, Section 4507 should be repealed entirely in order to maximize patient choice and reinforce the ability of patients to make decisions concerning their medical care. However, amending the law could prove helpful. New legislation could repeal the two-year opt-out period and empower a Medicare patient and her physician to enter into a private contract on a case-by-case basis for any period of time. This simple amendment would correct many of the concerns discussed in this Article. In fact, these amendments were in the "Medicare Beneficiary Freedom to Contract Act" which was introduced in the 105th Congress.⁵⁷ Ultimately, the benefits of private contracting on a case-by-case basis for any length of time clearly outweigh any risks to the integrity of the Medicare program.

⁵⁵ Studies have shown that low-osmolality agents reduce the risk of major adverse reactions during radiographic examinations. See Hirshfeld, *supra* note 15, at 482.

⁵⁶ See *Cruzan*, 497 U.S. at 278-84.

⁵⁷ See H.R. 2497, 105th Cong. (1997) (attempting to "amend Title XVIII of the Social Security Act to clarify the right of Medicare beneficiaries to enter into private contracts with physicians . . . for the provision of health services for which no payment is sought under the Medicare program").