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The Tortuous History of the Kyl Amendment

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COMMONLY CALLED THE KYL AMENDMENT, Section 4507 of the Balanced Budget Act of 1997 (BBA) amended Title XVIII of the Social Security Act to permit private contracting between physicians and Medicare beneficiaries. Under Section 4507, the circumstances under which private contracting is permitted are expressly limited, so much so, in fact, that proponents of private contracting deem the provision practically ineffectual and have sought to have it amended by Congress, rulemaking, and the federal courts. As codified, the provision requires that physicians opt out of Medicare entirely for a period of two years in order to contract privately with one or more Medicare beneficiaries.

I. STATUTORY AND REGULATORY HISTORY OF PRIVATE CONTRACTING

The question of whether physicians could enter into private contracts with beneficiaries first arose with the enactment of Medicare provisions designed to contain the costs of medical services and to prevent physicians from shifting uncontained costs to Medicare Part B beneficiaries. In a Medicare system re-designed to protect beneficiaries, private contracting, though it increased beneficiaries’ freedom of choice, circumvented financial safeguards. Provisions creating financial safeguards appeared to be at odds with older provisions proclaiming the interests of beneficiaries in freedom from interference from the government and freedom to select their providers.
Beginning in 1984, Congress enacted a number of new Medicare provisions restricting reimbursement practices. Some of the most relevant restrictions include the creation of participation plans, the imposition of charge limits, and the mandatory submission of all claims. Physicians were given incentives to become participating physicians and to agree to accept assignment of each beneficiary's payment.\(^5\) Participating physicians had to accept a reasonable charge as full payment, and were prohibited from balance billing their patients.\(^6\) Non-participating physicians were limited in the amount they could charge beneficiaries and could not bill beneficiaries for unassigned fees for services that were not medically necessary.\(^7\) Finally, physicians were required to submit all claims for beneficiaries, whether or not they had accepted assignment.\(^8\)

Under these restrictions, it was neither clear whether physicians should submit claims for services that Medicare may not cover, nor whether a physician could contract privately with a patient willing to forego coverage and waive the claims submission requirement.

The Health Care Financing Administration (HCFA) took the position, not surprisingly, that physicians could not circumvent the intended effects of these laws by contracting privately with patients. Its position, however, was not clearly articulated in any law, regulation, or rule issued by the agency. The position developed, as one commentator described it, as a kind of subterranean policy, articulated through letters to carriers and in bulletins passed on to

\(^{5}\) See 42 U.S.C.A. § 1395u(h) (West Supp. 1999) (providing requirements and benefits of participating physicians).


\(^{8}\) See 42 U.S.C.A. § 1395w-4(g)(4) (West Supp. 1999) (discussing submission of claims by physicians and other practitioners).
physicians. HCFA’s position may have been implied from existing laws and regulations because private contracting could potentially erode the financial protections afforded beneficiaries. But the lack of any clear directive made private contracting a risky venture for physicians who feared being sanctioned.

In Stewart v. Sullivan, a physician in New Jersey wanted to contract privately with several of her Medicare patients. She had received a number of bulletins from Medicare carriers, including one that stated that Medicare laws “cannot be bypassed by having patients sign a disclaimer stating that services provided to them should not be billed to Medicare.” The physician also received a letter from the administrator of HCFA that stated, in relevant part:

[A private agreement] initiated by a physician would be invalid. In the rare event, however, that a patient, for his or her own reasons, and entirely independently, chooses not to use Part B coverage, the law does not require the submission of a claim by the physician. Where patients have Part B enrollment, a patient can choose not to use Part B coverage for certain physician services. However, by law the physician is still required to follow certain Medicare requirements other than the claims submission requirement. This would include the limiting charge provision applicable to a nonparticipating physician when assignment is not accepted, or advance written notice to the patient when the physician furnishes services which are not considered reasonable and necessary under Medicare guidelines.

Fearing sanctions for privately contracting with her patients, the physician filed suit in United States District Court of New Jersey for a declaration of rights and injunctive relief. In October 1992, the suit was dismissed for lack of ripeness; the plaintiff had failed to establish that HCFA had a clearly articulated policy on private contracting. Even though the communications sent to the physi-

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10 816 F. Supp. 281 (D.N.J. 1992) (dismissing a challenge of a Department of Health and Human Services policy which prohibited physicians from entering into private contracts for treatment on a case-by-case basis).
11 Id. at 285.
12 Id.
13 See id at 289-90.
ician appeared to prohibit private contracting and threatened sanctions, the judge found that there was confusion regarding their origin and that HCFA had not promulgated rules or regulations formally espousing the policy.14

In June 1993, following the Stewart decision, HCFA released Section 3044 of the Medicare Carriers Program Manual entitled "Effect of Beneficiary Agreements Not to Use Medicare Coverage."15 The section instructed carriers that “[a]greements with Medicare beneficiaries purportedly waiving Federal requirements have no legal force or effect. Physicians who treat Medicare Part B beneficiaries must comply with the law or be subject to Federal penalties.”16 This instruction, like the bulletins in the Stewart case, did not have the force of law, but it clearly indicated that HCFA would not recognize private contracting.

In response to HCFA’s unofficial prohibition of private contracting, legislators attempted to clarify the right to contract.

II. SENATOR KYL’S FIRST BILL

In September 1995, Senator Jon Kyl (R-AZ) introduced a bill entitled “Senior Citizens Health Care Freedom to Contract Act of 1995” that would permit private contracting between patients and physicians on a case-by-case basis.17 The bill stated, in relevant part: “Nothing in this title shall prohibit a physician or other provider 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.”18 The bill also specified that actual charge limitations did not apply to services provided under private contract. The bill was referred to the Committee on Finance, but lawmakers did not take any further action.

14 See id.
15 See Electronic Media Claims, B3 3044: Effect of Beneficiary Agreements Not to Use Medicare Coverage, HCFA PROGRAM MANUALS: MEDICARE CARRIERS PART 3 (June 1993) (on file with Health Matrix).
16 Id.
18 Id.
III. MODIFIED VERSION OF FIRST BILL INTRODUCED

In June 1997, Senator Kyl moved to have Amendment No. 468, a modified version of the Senior Citizens Health Care Freedom to Contract Act, included in the Senate version of the Balanced Budget Act of 1997 (BBA). In his remarks upon introducing the bill, Senator Kyl commented that the bill was a necessary response to HCFA's interpretations of the 1994 technical amendments to the Medicare statutes. Specifically, he stated:

The Health Care Financing Administration [HCFA] interprets this change as expanding existing restrictions on private payments in Medicare cases in which claims are filed, to all cases involving Medicare enrolled individuals, regardless of whether a claim is filed.

If HCFA imposes this interpretation through regulations reportedly now being drafted, HCFA would have the authority to completely prohibit Medicare enrollees who do not submit reimbursement claims to HCFA, and who do not have claims submitted on their behalf, and who are willing to pay their own bills in full – from paying non-Medicare physicians out of pocket for needed Medicare-covered services.

Senator Kyl also noted that a recent poll revealed that sixty percent of Americans felt they should be able to supplement government payments with their own funds to get "unrationed health services." Furthermore, HCFA's interpretations would "end the practice of cost shifting, whereby doctors have an incentive to treat more Medicare patients who can't afford to supplement Medicare's low reimbursement rate with funds from those who choose to pay out of pocket."
In order to ensure that the bill would survive a budget point-of-order challenge, the 1995 language was modified to include a short phrase that limited the ability to enter private contracts to those providers who did not provide items or services under Medicare.\footnote{See 143 CONG. REC. S6259 (daily ed. June 29, 1997) (Kyl Amend. No. 468) (clarifying the use of private contracts for health services); Letter from co-sponsoring Senators Jon Kyl and Don Nickles and Congressmen Bill Archer and Bill Thomas to Colleagues in Congress (Sept. 18, 1997) (on file with Health Matrix).} Under this language, the bill permitted providers who had never participated, or who agreed not to participate in Medicare, to enter into private contracts.\footnote{See Letter from co-sponsoring Senators Jon Kyl and Don Nickles and Congressmen Bill Archer and Bill Thomas to Colleagues in Congress, supra note 24 (advocating that physicians should be able to enter into private agreements on a patient-by-patient or case-by-case basis).} The bill did not specify the length of any time period for which a provider would be required to opt-out. With these vaguely worded modifications, the bill survived the budget point-of-order challenge and was sent to the Conference Committee as part of the Senate’s Balanced Budget Act.\footnote{See id. (stating that the bill survived the challenge by a vote of 64-35 on June 25, 1997).}

### IV. SECTION 4507

The Conference Committee made significant alterations qualifying the right to contract privately before incorporating the bill into Section 4507 of the BBA. The most controversial of these was a provision requiring physicians to opt out of Medicare for two years. Apparently, the Conference Committee inserted the two-year restriction in the late stages of the budget talks, under threat of veto of the entire budget by the Clinton administration.\footnote{See 143 CONG. REC. S12080 (daily ed. Nov. 8, 1997) (statement of Senator Kyl) (discussing the Medicare Beneficiary Freedom to Contract Act). See also Medicare: Kyl Pushing Bill Favored by AMA to Change Private Contract Provision, Daily Rep. for Executives (BNA) No. 181, at A-32 (Sept. 18, 1997) (reporting Kyl’s wishes to restore the original language and intent of the bill by eliminating the two-year restriction). The official legislative history of Section 4507 is silent on the circumstances surrounding the modification and simply summarizes the additional provisions regarding beneficiary protections, contract requirements, including the two-year restriction, and affidavit requirements. See H.R. CONF. REP. NO. 105-217, at 777 (1997), reprinted in 1997 U.S.C.C.A.N. 398-99.}

According to Chris Jennings, the deputy assistant to the President for health policy development, the Administration had called for the two-year restriction to ensure that seniors could make in-
formed decisions when deciding who should treat them.28 The Administration believed patients would not be able to know in advance whether a physician would seek private payment absent the two-year restriction.

Senator Kyl has remarked that the modification occurred without his knowledge, late at night, when a member of the House and a member of the Senate "compromised with the Administration . . . and inserted a poison pill."29 However, Senator Kyl has also characterized Section 4507 as an improvement over both HCFA's prior interpretations of the law and the Senate-endorsed version of the provision.30

Section 4507, as enacted, imposes the following requirements: First, a private contract between the patient and physician must be in writing.31 It must be entered into before any service is provided, and it may not be entered into when the beneficiary is "facing an emergency or urgent health care situation."32 Second, the contract must contain particular items alerting the beneficiary of his obligations.33 The beneficiary must (i) agree not to submit a claim even if the services are covered by Medicare, (ii) accept responsibility for payment and acknowledge that Medicare will not reimburse for the services, (iii) acknowledge that actual charge limits do not apply to the services, and (iv) acknowledge that Medigap plans will not cover the services.34 In addition, the contract must indicate whether the physician is excluded from participation in

28 See Administration Opposes Senator's Attempt to Change Contracting Rule, BNA DAILY REP. FOR EXECUTIVES 1997 DER 182, at D-6 (Sept. 19, 1997) available in LEXIS [hereinafter Administration] (adding also that the Administration considers it too soon to debate the hospital transfer provision).
29 Senator Jon Kyl et al., Private Doctor-Patient Agreements: How the Medicare Law Forbids Free Choice, Address at the Heritage Foundation Lecture (June 30, 1998), in 620 HERITAGE LECTURES <http://www.heritage.org/heritage/library/lecture/hl620.html> (presenting Senator Kyl's views regarding HCFA's ability to impose rules and regulations on patients within and outside the scope of Medicare).
30 See Letter from co-sponsoring Senators Jon Kyl and Don Nickles and Congressmen Bill Archer and Bill Thomas to Colleagues in Congress, supra note 24 (qualifying that this improvement would still constrain the ability of Medicare beneficiaries to contract privately with physicians).
32 Id.
33 See id.
34 See id.
Medicare under section 1320a-7 (which excludes physicians for numerous reasons, including fraud and abuse).\textsuperscript{35}

In addition to the written contract requirements, Section 4507 requires physicians to file an affidavit with the secretary of HHS averring that they will not submit claims for covered services for an opt-out period of two years.

To enforce the affidavit requirement, Section 4507 provides that if a physician knowingly and willfully submits a claim during the opt-out period, "this subsection shall not apply . . . 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 that "no payment shall be made" for those same services.\textsuperscript{36}

One commentator noted that the language of the enforcement provision is opaque and probably the result of last-minute drafting.\textsuperscript{37} The commentator hypothesized that Section 4507 at one point imposed a two-year opt-out period as a sanction for fraudulent double-billing under case-by-case private contracting, but that once the two-year preclusion became a prerequisite for private contracting, the enforcement provision no longer made sense.\textsuperscript{38} HCFA only recently addressed how it will interpret the enforcement provision.\textsuperscript{39} A physician who violates the agreement not to file claims during the opt-out period will still be required to submit claims under the mandatory claims rule, although HCFA will deny the claim pursuant to the enforcement provision, and the physician will be bound by limiting charges.\textsuperscript{40}

**V. REACTION TO SECTION 4507**

Proponents of private contracting reacted negatively to the two-year opt-out provision. Members of the American Medical Association (AMA) expressed their belief that the two-year re-

\textsuperscript{35} See id.
\textsuperscript{38} See id. at 6.
\textsuperscript{40} See id.
striction effectively “emasculated” the provision and created a “non-functioning” program.\textsuperscript{41} Senator Kyl criticized the provision in remarks on the floor, claiming that the provision “makes it virtually impossible for patients to actually have the benefit of . . . freedom of choice.”\textsuperscript{42} Indeed, HCFA reported that in the first quarter following the provision’s enactment, only 300 physicians and practitioners submitted affidavits to opt out of Medicare.\textsuperscript{43} Of the 300, almost half were psychiatrists.\textsuperscript{44} Statistics from the Department of Health and Human Services indicated that in 1997, approximately 691,000 physicians and practitioners were enrolled in the participating physician program.\textsuperscript{45}

\section*{VI. Senator Kyl’s New Bill}

On September 18, 1997, Senator Kyl introduced S. 1194, a bill entitled “Medicare Beneficiary Freedom to Contract Act of 1997,” amending Section 4507 to eliminate the two-year preclusion.\textsuperscript{46} Congressman Bill Archer (R-TX) introduced an identical bill, H.R. 2497,\textsuperscript{47} in the House. Kyl’s bill makes explicit the right to contract privately and does not require that the physician opt-out of Medicare for any period of time. It provides that the Secretary of HHS or an organization offering a Medicare+Choice plan will receive the minimum information necessary to avoid payment for any services provided under the contract. The bill also retains the requirement of a written contract. A written contract must contain terms acknowledging that (1) no claims may be submitted for services; (2) that the beneficiary is liable in full for the services provided; (3) that limiting charges do not apply to such services; (4) that supplemental policies do not apply to such services; and (5) that the beneficiary has the right to seek services from another physician for whom payment would be made under Medicare. Finally, the bill excludes contracts with beneficiaries enrolled in

\textsuperscript{41} See Administration, supra note 28, at D-6 (quoting AMA members during a question and answer period following Jennings’ address to the AMA).

\textsuperscript{42} 143 CONG. REC. S12080, supra note 27, at S12080.

\textsuperscript{43} See HCFA Says 300 Physicians Opted Out of Medicare to Contract Privately, 6 HEALTH CARE POL’Y REP. (BNA), May 4, 1998, available in LEXIS (adding that seven specialties accounted for eighty percent of the physicians showing affidavits).

\textsuperscript{44} See id.

\textsuperscript{45} See id. (noting that the array of services provided by those physicians accounted for more than ninety-two percent of Medicare-allowed charges).

\textsuperscript{46} S. 1194, 105th Cong. (1997).

\textsuperscript{47} H.R. 2497, 105th Cong. (1997).
Medical Savings Account (MSA) plans under Part C from the written contract requirements.

While S. 1194 was being considered, Senator Kyl, fearing that HCFA would adopt an unduly restrictive interpretation of Section 4507, placed a hold on the Clinton administration's nominee for administrator of HCFA, Nancy-Ann Min DeParle.\(^4\) Once Senator Kyl gained assurances from HCFA and the Administration that the agency's interpretations of Section 4507 would not affect the provision of non-covered and conditionally covered services, and that the agency would seek to maximize beneficiaries' choice of physicians, he withdrew his objection to the nomination.\(^4\)

**VII. THE SENATE HEARINGS**

In February 1997, the Senate Finance Committee held hearings to evaluate the provisions of S.1194. Witnesses testifying in opposition to the measure included representatives from HCFA, the American Association of Retired Persons (AARP), and the American College of Physicians. Witnesses testifying to support the measure included the United Seniors Association, and the AMA.

The administrator of HCFA, Nancy-Ann Min DeParle, testified that a two-year opt-out provision was essential to diminish the opportunities for fraud and abuse in selective private contracting and to ensure that beneficiaries could make an informed choice of physicians.\(^5\) Fraud and abuse will be kept at a minimum under the opt-out period because Medicare carriers will be able to identify non-participating physicians and therefore prevent double billing. Beneficiaries will be able to make informed choices in selecting their physicians because they will know the extent of their finan-

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\(^4\) See Washington Health Briefs: While HCFA Designee's Stalls Again, 23 HEALTH LEGIS. & REG. 43 (Oct. 29, 1997). See also Physician Contracting: Kyl Amendment Stirs Controversy, HEALTH LINE (Nov. 5, 1997).


cial liabilities prior to treatment. In addition, the opt-out period will protect the patient-doctor relationship by reducing possible coercion to contract privately. Selective private contracting, on the other hand, would erode the system of financial protections Medicare otherwise affords beneficiaries. Furthermore, selective private contracting would endanger access to care by facilitating preferential treatment for beneficiaries willing to contract privately, creating a two-tier system with different standards of care for low and middle-to-high income beneficiaries. Finally, the administrator supported the two-year opt-out provision as enacted because it struck the appropriate balance between protecting beneficiaries and permitting physicians the flexibility to charge higher fees.51

Beatrice Braun, a board member of the AARP, testified that the two-year opt-out provision is necessary to preserve the Medicare program's integrity and consumer protections.52 Selective private contracting would enhance the potential for fraud and abuse because it would frustrate monitoring of privately contracted services. The AARP believes that private contracting would pose particular problems for monitoring billing for services offered under Medicare+Choice plans, where physicians could privately contract for services already covered by capitated payments. Unlimited private contracting also threatens to increase beneficiary costs because private contracts are not subject to balance billing limitations. Finally, the AARP believes that the existing two-year opt-out provision expands a beneficiary's options without sacrificing important beneficiary protections.53

Kent Masterson Brown, counsel for the United Seniors Association, testified that the two-year opt-out provision poses a great barrier to private contracting, which is the only "escape valve" from HCFA's highly rationed coverage for medical services.54

51 See id.
52 See Private Contracting in Medicare: Hearing on S. 1194 Before the Senate Committee on Finance, 105th Cong. (1998), available in LEXIS, Committee Hearing Transcripts Library, Federal News Service file (statement of Beatrice Braun, M.D., Board Member of the American Association of Retired Persons) (discussing the possible disadvantages to Senator Kyl's proposed legislation to limit the Medicare private contracting provision in the Balanced Budget Act of 1997).
53 See id.
54 See Private Contracting in Medicare: Hearing on S. 1194 Before the Senate Committee on Finance, 105th Cong. (1998), available in LEXIS, Committee Hearing Transcripts Library, Federal News Service file (statement of Kent Masterson Brown, Counsel, United Seniors Assoc., Inc.) (arguing that private contracting is necessary to ensure that Medicare beneficiaries can make choices regarding their health care and to maintain the quality of Medicare programs).
Brown was very critical of HCFA for: (1) prohibiting private contracting without a clear statutory basis; (2) failing to articulate clear policies; (3) creating disincentives for physicians to provide care that comports with the standards of the medical profession; and (4) denying coverage for a number of essential health services. According to Brown, private contracting offers the only viable alternative to what the United Seniors Association believes is a paternalistic program that denies seniors the choice to make personal payments for their health care.55

Dr. William A. Reynolds testified that the American College of Physicians is in favor of increasing freedom of choice and flexibility, but opposes the repeal of the two-year opt-out provision because of concerns that repeal would limit patient access to physicians accepting Medicare, that it would complicate billing procedures for physicians and expose them to fraud and abuse sanctions, and that discussions of liability for services would introduce conflict in the physician/patient relationship.56

In the months following the hearings, Senator Kyl was unable to rally sufficient support for the bill. One of his efforts to mobilize support served to gauge where the Senate stood on the measure. On April 1, 1998, during the floor debate on the budget plan, the Senate approved by fifty-one to forty-seven a non-binding "Sense of Congress" amendment to the FY 1999 budget resolution, declaring that seniors should have the freedom to contract privately.57

But by late April 1998, although the bill had forty-nine co-sponsors in the Senate and 193 co-sponsors in the House, it lacked the support of Republican Senators John Chafee (R-RI) and Jim Jeffords (R-VT) on the Senate Finance Committee. Without these

55 See id.
56 See Private Contracting in Medicare: Hearing on S. 1194 Before the Senate Committee on Finance, 105th Cong. (1998), available in LEXIS, Committee Hearing Transcripts Library, Federal News Service file (highlighting the statement of Dr. Reynolds, president of the American College of Physicians on problems of private contracting in S. 1194).
57 See S. Con. Res. 86, 105th Cong. (1998). The resolution states, in relevant part:

It is the sense of Congress that seniors have the right to see the physician or health care provider of their choice and not be limited in such right by the imposition of such unreasonable conditions on providers who are willing to treat seniors on a private basis, and that the assumptions underlying the functional totals in this resolution assume that legislation will be enacted to assure this right.

Id.
senators behind the bill, Senator Kyl saw little chance that it would be able to leave the Committee.\textsuperscript{58} Moreover, the recent "Sense of Congress" resolution indicated that the bill was nine votes short of sixty votes it needed in the Senate to go to cloture.\textsuperscript{59} Senate bill 1194 did not progress any further in the 105\textsuperscript{th} Congress.\textsuperscript{60}

\section*{VIII. THE IMPLEMENTING REGULATIONS}

On November 2, 1998, as the 105\textsuperscript{th} Congress wound down to adjournment, HCFA published its final rule with comments on Section 4507.\textsuperscript{61} The rule included ancillary policies that HCFA stated it believed were necessary to clarify what it means when a physician or practitioner opts out of Medicare.

As a first matter, HCFA stated in the opening comments that the private contracting rules did not apply to individuals who only have Medicare Part A, to individuals over age sixty-five who do not have Medicare, or to services Medicare does not cover. In regard to the last category – services Medicare does not cover – HCFA stated that when a physician or practitioner furnishes a service that is not reasonable and necessary under Medicare's criteria, there are no limits on what the physician or practitioner may charge the beneficiary. In these situations an advance beneficiary notice (ABN) must be furnished to the patient indicating the likelihood that Medicare will deny the claim. However, HCFA indicated an ABN is not the equivalent of a private contract and does not result in an opt-out of Medicare. HCFA also stated that for services Medicare categorically does not cover (such as cosmetic surgery and routine physical examinations), a private contract under Section 4507 is not necessary and thus, the two-year opt-out is not required.

Moreover, when a Medicare beneficiary enrolls in a Medicare+Choice managed care plan and does not adhere to the plan's rules (such as seeking care from a non-network physician if coverage is limited to network physicians), the physician may charge the beneficiary without regard to the limiting charge and without needing a private contract or an opt-out of Medicare. Medi-

\begin{footnotes}
\textsuperscript{58} See Kyl et al., supra note 29.
\textsuperscript{59} See id.
\textsuperscript{60} See generally Jonathan Gardner, Fitting the Bills: AMA: Private Contracting is Out, Patient Protection and Tobacco Control Are In, MOD. HEALTHCARE, June 8, 1998, at 27 (noting that Senator Kyl conceded defeat of S. 1194 for that year).
\end{footnotes}
care+Choice organizations were prohibited under the final rule from contracting with or paying physicians or practitioners who opt-out (except for beneficiaries seeking care for emergency conditions) and were required to check with the Medicare carriers to acquire the names of the opting out physicians and practitioners.

However, HCFA drew a distinction between the forgoing situations and one where services are furnished and no claim for benefits is submitted by either the physician or the beneficiary. Commenters had argued that private contracting was valid in these circumstances and did not require adherence to Section 4507 and the two-year opt-out requirement. HCFA disagreed, maintaining that no private contracting is valid except as specified in Section 4507. The mandatory submission rules of Section 1848(g)(4), effective September 1, 1990, precluded any simple circumstances where no claim for benefits is made. This section required the completion of a claim form by participating physicians and suppliers. Additionally, Section 1848(g)(1)(A)(i) flatly prohibited participating physicians and suppliers from charging more than the limiting charge. For these reasons, HCFA concluded, private contracting outside of Section 4507 is precluded.

HCFA also clarified that a physician or practitioner need not opt-out of Medicare to furnish charitable care, that is, services for which they do not charge or services for which they waive the copayment or deductible because of the beneficiary’s indigence.

While the final rule did not require that physicians and practitioners provide advance notice to beneficiaries that they have opted out, HCFA encouraged notification to beneficiaries at the time an appointment is made. The final rule specified fifteen requirements for the private contract to be entered into between the beneficiary and the physician or practitioner and ten requirements for the opt-out affidavit to be filed with each Medicare carrier with which the physician or practitioner would file claims in the absence of the opt-out. Nonparticipating physicians were allowed to opt-out at any time, provided that affidavit was filed within ten days of signing a private contract with a Medicare beneficiary. Participating physicians were allowed to opt-out on a quarterly basis when Medicare carriers make system changes.

**IX. THE COURT CHALLENGE**

The Secretary’s implementing regulations came just in time to avert a possible ruling from the U.S. Court of Appeals for the Dis-
strict of Columbia Circuit that Section 4507 was unconstitutional on a number of grounds. In *United Seniors Association, Inc. v. Shalala*,\(^{62}\) the federal district court was presented with a request by the plaintiffs for a preliminary injunction to prevent the enforcement of Section 4507. The plaintiffs contended that the law denied them a liberty interest to contract privately for health care services without government intrusion. The plaintiffs maintained that prior to the passage of Section 4507, Medicare beneficiaries could contract privately with physicians on a case-by-case basis and that the two-year opt-out provision in the recently enacted Section 4507 effectively precluded any physician from agreeing to contract privately. The district court did not rule on whether Medicare beneficiaries did or did not have a right to contract privately prior to enactment of Section 4507, a point disputed by the government in its defense. Instead, the district court ruled that the constitutional right to autonomous decision making was limited to child rearing and education, family relationships, procreation, marriage, contraception, and abortion. The court declined to extend the right to the right to pay for medical services outside of the Medicare Program’s rules. Additionally, the court ruled that Congress had not overstepped its authority under the Spending Clause of the Constitution,\(^{63}\) nor had it violated the Equal Protection Clause of the Fourteenth Amendment because age is not a suspect class and the government had a rational basis to limit the amount that Medicare beneficiaries pay for services. Thus, the plaintiffs’ motion for a preliminary injunction was denied and the defendant’s motion for summary judgment was granted.

The plaintiffs then took their case to the Court of Appeals, which found that it did not have to rule on the merits of the plaintiffs’ constitutional claims.\(^{64}\) In the period of time between the lower court case and the appeal, the Secretary had clarified her interpretation of Section 4507 in the briefs filed with the court and in the implementing regulations.\(^{65}\) The Secretary agreed that if a doctor and beneficiary agree that a service would not be reimbursed by Medicare either because it is categorically excluded or because it is deemed not medically necessary or reasonable by Medicare criteria, then Section 4507 does not apply, the patient may pay the physician’s charge for the service, and the physician

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63 U.S. CONST., art. I, § 8, cl.1.
64 See United Seniors Ass’n v. Shalala, 182 F. 3d 965, 969-70 (D.C. Cir. 1999).
65 See Medicare Program, supra note 61, at 58, 851.
does not have to opt-out for the two-year period. By so doing, the Secretary undercut the plaintiffs' argument that Medicare beneficiaries have a constitutional right to obtain services they cannot get from Medicare. The plaintiffs agreed at oral argument that "if Section 4507 really said what the Secretary said, then their case was at an end." The Court of Appeals found the Secretary's interpretation of the less-than-plain language of Section 4507 to be reasonable and affirmed the lower court's order.

X. CONCLUSION

The Kyl Amendment began in Congress as a crusade against government interference, a crusade for the rights of older Americans and their physicians to contract privately. However, what was reviewed as a private right by some was viewed by others as an opportunity for physicians to withhold the benefits of a vital government program from vulnerable seniors. Moreover, the massive bureaucracy of the Medicare Program does not accommodate patient-by-patient arrangements easily. As it has now evolved, the Kyl Amendment focuses not on the rights of Medicare beneficiaries, but rather on the practices of physicians. If physicians treat Medicare beneficiaries, then they must extend the benefits of the Medicare Program to them all. If they choose to withdraw from the Medicare Program, then physicians must do so for all of their Medicare patients. Their decision is not irreversible and can be changed at two-year intervals. A crusade for rights has been tempered by the realities of a complex, but beneficent government program. The debate about the balance between the two appears to be settled. The rules are clearer than they were before the Kyl Amendment. For now, that appears to be enough.

66 United Seniors Ass'n, supra note 64, at 970.