

Is Medicare Voluntary?

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ABSTRACT

According to judicial precedents, onerous regulations such as price controls and administrative review mechanisms can be imposed on physicians without constitutional constraints because participation in the program is “voluntary.” Americans who do not wish to be a part of the system are finding that the definition of “voluntary”—in the light of requirements for “participating,” “not participating,” “opting out,” and “enrolling”—is confusing and contradictory. The status of those who wish to decline this government “benefit” or “entitlement” may ultimately require elucidation in court.

A radically egalitarian medical system would require “everybody in, nobody out,” an expression frequently used by proponents of a “single payer” system. A search of the Physicians for a National Health Program website (www.pnhp.org) finds 86 citations of this phrase. Anyone receiving or providing a medical service outside the system, it is argued, would be siphoning off, for selfish personal gain, resources that rightfully belong to the collective.

In this paradigm, “health care” is, axiomatically, called a “right.” Like all other rights including life, liberty, and property, it is viewed as being bestowed by the system, which immediately places limits on it. One has the “right” to receive “necessary” and “appropriate” medical services without charge at the point of service, but *no right* to obtain or provide services not supervised and permitted by the system. There are corresponding duties. All must pay taxes, and those granted the privilege (license) to work as a medical professional must provide services under conditions prescribed by the system. Operationally, the system turns all “rights” into privileges. Compulsion is an essential feature of the system.

While egalitarianism forms the basis of the Canadian medicare system, it is explicitly contrary to the principles enacted by Congress in the enabling act for Medicare, without which this program would never have passed. Congress enacted into law the following guarantees, and no statutory repeal has ever been overtly proposed:

§ 1801. Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which Medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

§ 1802. Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.

§ 1803. Nothing contained in this title shall be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against the cost of any health services.

The difference between Canadian medicare and American Medicare is thus much more than a matter of age of eligibility. By law, the American system was not set up as a single payer, and is, in principle, voluntary.

Participation by Seniors

Mere passage of Medicare was not enough, in the atmosphere of the times, to assure its success. Thus, Lyndon Johnson used the power of the presidency to coerce private insurers to cancel all policies written for persons over age 65, to the great consternation of many senior citizens.¹ Medicare supplemental policies are only supplements, not replacements, covering only deductibles and copayments, for Medicare-allowed services. They have the effect of canceling any restraining effect on overutilization that is the purpose of copayments and deductibles, so they have helped fuel the explosive increase in expenditures, without providing any escape for seniors through alternate insurance.

Government destroyed the private insurance market for seniors, and the option of self insurance is penalized. A senior can disenroll from Part B, but if he decides to re-enroll pays a lifelong financial penalty of 10 percent multiplied by the number of years out of the program.² As the price for not taking benefits for Part A, a senior must forfeit all Social Security benefits and refund any he has already received. This requirement was promulgated in the Social Security Program Operations Manual System (“POMS”) in (a) *Waiver of Hospital Insurance Entitlement by Monthly Beneficiary*, POMS HI 00801.002, (b) *Withdrawal Considerations*, POMS HI 00801.034, and (c) *Withdrawal Considerations When Hospital Insurance is Involved*, POMS GN 00206.020, without even the required notice-and-comment rulemaking.³

Participation by Physicians

At first Medicare was seen as a bonanza, and most physicians, aside from a few with moral reservations against accepting money taken by force, gladly accepted the increased revenues. As long as patients could file their own claims, and Medicare checks went to the patients, physicians could generally accept the funds indirectly without qualms of conscience. Provider numbers were assigned automatically. Medicare would reimburse patients for the services of any licensed provider, if a claim was filed and the provider had not been excluded from Medicare as a punishment for some infraction.

It did not take long for the problems predicted by AAPS to materialize, and several lawsuits were filed, as previously summarized.⁴

As expenditures mounted, the government started imposing controls, as in the Professional Standards Review Organizations (PSROs), the precursor to today’s Peer Review Organizations

(PROs). AAPS challenged these in *AAPS v. Weinberger*. Government attorneys argued, in a motion to affirm the decision by U.S. District Court for the Northern District of Illinois upholding the PSROs, that the government has the right to regulate that which it pays for.

Patients whose medical care is provided by public funds *have no constitutional right* to whatever care [their physicians] using the “highest standards of medical practice” ... may “judge necessary” ... or to obtain that care “from a physician *** of their choice” [emphasis added].⁵

Moreover, they stated that “Congress need not agree to pay for whatever care appellants desire to provide” and can, §1801 notwithstanding, “influence both the standard of care and the identity of its provider by prior review no less than by *post hoc* review designed to achieve the same purpose.”⁵

By declining to hear the appeal, the U.S. Supreme court upheld the finding of the District Court that physician participation in Medicare was *voluntary*.

Underlying the constitutionality of the challenged legislation is the basic premise that each individual physician and practitioner *has the ability to choose whether or not to participate in the program*. It is true that there will exist economic incentive or inducement to participate in the program. However, such inducement is not tantamount to coercion or duress [emphasis added].⁶

In their opinion, Judges William F. Pell, Thomas R. McMillen, and William J. Lynch noted that the statute “does not bar physicians from practicing their profession but only ‘provides standards for the dispensation of federal funds.’”

This decision left open the questions of whether the government has the right to regulate that which it does *not* fund; the definition of coercion or duress; and the constitutionality of a law that employs coercion or duress to get either beneficiaries or providers to participate.

In the early 1980s, Medicare began imposing limits on physicians’ fees. A number of AAPS physicians filed suit (*Whitney v. Heckler*). The court upheld the fee freeze on the basis that participation in Medicare is *voluntary*: “Governmental regulation that affects a group’s property interests does not constitute a taking of property where the regulated group is not required to participate in the regulated industry.... In the instant case, appellants are not required to treat Medicare patients....”⁷ It is noteworthy that the physicians who brought the suit were not filing claims; they were “non-participating.” The decision does not address the issue of a service for which no claim is filed by either physician or patient.

This issue was taken to court by AAPS Past President Lois Copeland, M.D., and some of her patients in *Stewart v. Sullivan*. They wanted to continue to use Medicare benefits for some services, but to have additional services, which were not available because of Medicare restrictions, through private contracts without filing a claim. They were afraid to engage in such contracts because of communications from Medicare carriers, which are private companies under Medicare contract to administer claims, asserting that private contracts were illegal. The federal district court in New Jersey dismissed the case because it could find no law or properly promulgated policy to prevent plaintiffs from private contracting.⁸ This decision did nothing to relieve plaintiffs’ concerns of ruinous consequences from acting on it. Then something worse happened.

Opting Out

Although a provision in the Balanced Budget Act (BBA) of 1997 was intended to clarify the right to contract privately, it established what might be considered a “safe harbor” for such contracts if and

only if they were an all-or-none affair that prevented any of a physician’s patients from collecting Medicare benefits for any of his services, with narrow exceptions, for two years.

Note that the BBA does not itself forbid private contracting under circumstances outside its provisions. Attorney John Hoff writes:

Specifically, section 4507 provides that, if its conditions are met, “nothing” in the Medicare law “shall prohibit a physician or practitioner from entering into a private contract with a Medicare beneficiary for any item or service.” If no other provision in the Medicare law outlaws private contracting, therefore, it does not matter whether the conditions of section 4507 are met. Private contracting would be permissible, and section 4507 would be irrelevant.⁹

Then-Secretary of Health and Human Services Donna Shalala did not respond to an AAPS letter requesting clarification of HHS’s view on case-by-case private contracting.¹⁰

Section 4507 of the BBA is, technically speaking, “an exception to nothing.”⁹ This does not stop the Medicare administration from acting as though the existence of a “benefit” or entitlement gives it plenary authority over all services a beneficiary receives that might arguably be “covered.”¹¹ Its Mandatory Claims Submission Unit claims the authority to fine a physician \$10,000 for not filing a claim, even one it is likely to deny or reject.

“The claims filing requirement applies to all *physicians and suppliers* who provide services to Medicare beneficiaries” [emphasis added], writes WPS Medicare, with the note that “[i]f you enter into a private contract, this article does not apply to you.”¹² “As a rule,” a claim need not be filed for “non-covered services”—unless the beneficiary thinks they might be covered or possibly wants to submit to a supplemental insurer. Instead of the word “physicians,” NHIC, Corp., the Medicare administrative contractor for Massachusetts, New Hampshire, Rhode Island, and Vermont, writes that the claims filing requirement “applies to all *providers and suppliers* who provide services to Medicare beneficiaries” [emphasis added].¹³ As noted below, a physician at this time is not necessarily a provider.

Most likely, Medicare would learn of non-filing through a complaint by a patient or family member who is motivated either by the prospect of receiving money or by resentment of the physician. The bigger the volume that a physician has, the bigger the nightmare if Medicare demands that he reimburse all fees paid by Medicare-eligible patients.

Is Medicare still voluntary—now that a Medicare patient is not just one who is receiving a Medicare-covered service for which a claim is to be filed, but any Medicare-eligible person, even one who intends to decline government money?

The Medicare administration apparently sees Medicare not just as a benefit that may be claimed through a deliberate action by an entitled person—but also as a restriction on that person’s liberty to obtain any medical service without governmental oversight and approval.

It relinquishes that oversight with reluctance for opted-out physicians, making the requirements for a “valid” opt-out increasingly onerous, with major consequences for inadvertent failure to “maintain opt out”—for example, timely renewal and production on demand of contracts that satisfy the Medicare carrier. Physicians might face demands to refund patients’ payments if their contract was found to be defective.

Medicare is also imposing more constraints on a patient’s ability to be reimbursed for testing or procedures requested by a Medicare opted-out physician but performed by a Medicare provider. Unless the deadline is extended again, after Jan 3, 2011, Medicare will not

pay for services ordered or referred for by providers who are not enrolled in its Provider Enrollment and Chain Ownership System (PECOS).¹⁴ According to CMS officials on a “Special Open Door Forum: Medicare Provider and Supplier Enrollment” on May 7, 2010, the “compliance date” is even sooner, July 6, 2010.

Signing up for PECOS requires, among other things, enabling electronic funds transfers (ETFs) from the physician’s bank account, even if he never accepts assignment. This allows for “adjustments,” which means taking money directly out of the account, for example in the event of alleged “overpayment.”¹⁵

It appears from carriers’ communications with AAPS members that Medicare would like not only to prevent reimbursement but even performance of services ordered by an opted-out or nonenrolled physician, potentially making it impossible for him to care for patients. When asked about this at a meeting of the Pima County Medical Society Board of Directors, the medical director for Noridian stated his opinion that this would indeed be a likely and intended consequence of Medicare’s efforts to “get rid of the deadwood out there” (W. Mangold, oral communication, 2010). This belief is also validated in testimony by CMS Deputy Administrator Herb Kuhn, who told Congress in July 2008 that “we anticipate implementing changes in 2009 that will limit ordering and referring to individual practitioners enrolled in the Medicare program.”¹⁶

Disenrollment and Nonenrollment

Physicians are increasingly asking whether opting out is necessary. Not only has it become more complicated, but other changes have occurred. A physician is no longer assumed to be a Medicare provider, subject to Medicare’s jurisdiction, simply because he has provided a potentially covered service to a Medicare beneficiary. All must now deliberately enroll, by filling out CMS form 855I, and also “revalidate” enrollment periodically. A provider’s number is deactivated if there is no claims activity for 12 months.¹⁷

The revalidation requires, among other things, that physicians promise to abide by all Medicare regulations, both past and future, and to provide access to their bank account by electronic funds transfer. Failure to revalidate successfully will result in a revocation of one’s Medicare billing “privileges.” It also may mean that one’s patients cannot receive reimbursement, as some previously did by filing CMS form 1490S, Patient’s Request for Medical Treatment. Items or services provided at a time when a supplier is ineligible will be “rejected... , not denied.”¹⁸

Apparently unlike non-revalidated physicians, “[o]pt out physicians are technically enrolled in Medicare, even though their enrollment is inactive, so they can order services,” writes Michele Kelly, associate director, CMA Center for Economic Services in Orange, Calif. (email communication, 2009). She states that: “In order to protect your rights under Medicare, you must enroll in the program, then submit an affidavit to opt out. Physicians have no other legal protections from the Medicare law, which requires them to submit claims if they see a Medicare patient and to be bound by Medicare rules.” Why, then, the need to sign a contract on revalidation?

A disenrolled or nonenrolled physician cannot submit a Medicare claim because he lacks billing “privileges.” Thus, how can he be penalized for not doing so? And how can he be penalized for violating Medicare rules when apparently a contractual agreement to the rules is required, and the physician has no contract? Of course, in the past he has signed such an agreement with each and every claim he submitted, but these did not apply to future actions.

CMS notes that a provider must enroll in Medicare to submit a claim, and acknowledges that some physicians will not do so. It also

advises beneficiaries, in that event, to complain to the contractor and submit Form CMS 1490S. The contractor is supposed to pay the beneficiary if the service “would be payable by Medicare were it not for the provider’s or supplier’s refusal to submit the claim and/or enroll in Medicare.”¹⁹ Note that payment would *not* be made if the physician is opted out. This statement apparently contradicts the earlier entry in the Federal Register.¹⁸ As far as I can determine, no relevant rule-making occurred between July and September 2008. Medicare apparently stopped paying claims submitted by patients whose claims it had previously paid, after their formerly non-participating but enrolled provider missed his revalidation deadline.

Note also that the mandatory claims filing requirement applies to “covered” services. According to §1848 [42 U.S.C. 13952-4], the term “covered professional services” means services “for which payment is made under...this section” and “which are furnished by an eligible professional.”²⁰ How can payment be made if no claim is filed? How can a nonenrolled physician be eligible?

Medicare-entitled patients may decline to see opted-out physicians because they do not want to pay out of pocket, especially if they have timely access to participating physicians. But what if they decide they do want to see an opted-out or nonenrolled physician?

Patients can see an opted-out physician only under properly executed, current (<2 years old), CMS-approved contract. They will likely have to receive any urgent or emergent care from a Medicare provider, as contracts cannot be executed under these circumstances, and opted-out physicians willing to provide treatment gratis, or willing to file a claim, may be unavailable.

The situation with nonenrolled physicians is not clearly addressed by Medicare. The Medicare Benefit Policy Manual, last updated Dec 18, 2009, acknowledges the existence of the “physician/provider who has never enrolled in Medicare” (§40.13, Rev. 92, effective Sep 29, 2008). It states that if such a physician wishes to opt out, he must provide the carrier with a National Provider Identifier (NPI). Apparently, a CMS form 855 is not needed unless reimbursement for an urgent service is desired. The possibility that such a physician may simply want to ignore the existence of Medicare is not addressed in this manual. This question could be even more urgent for practitioners who do not have the ability to opt out, such as chiropractors, physical therapists, and occupational therapists.

A clinical psychologist, John N. Tripper, who assumed that since he had never opted in he must be opted out was told by a Medicare representative that he could not charge Medicare beneficiaries for services if he was not a Medicare provider. He was told that he had to return all his clients’ money and that he would be turned over to the Medicare fraud unit. The American Psychological Association Insurance Trust stated that “it is very difficult to get definitive information about Medicare rules, particularly from those who are the appointed phone representatives of the medical intermediaries.”²¹ APAIT consultants state that Google is the best research source, and cite no specific reference for their assertion that any arrangement, aside from one by participating or nonparticipating providers that complies with all the rules, is a form of balance billing and is considered Medicare fraud.²¹ If this is correct, then *not* filing a claim can be a *false* claim, and a government program can be defrauded when \$0 has been requested from the program, and \$0 has been paid by it—and in fact nothing could be paid because the provider is not duly enrolled. According to such logic, one must sign an agreement not to violate billing rules, yet one can be in violation though one has neither signed the agreement nor billed Medicare! If all physicians are to be “deemed” providers as in the past, as if Medicare were a

managed-care rental network with which physicians may be “deemed” to have contracted without their knowledge or consent, why the onerous and time-consuming applications—which have even been denied for want of an original Social Security card or lack of a complete list of practicing locations since beginning practice?”²²

Medicare’s Non-answer

As one physician who called AAPS wrote to me: “It seems to me the flaw lies in the assumption that you have to do it. No one asks why.” He recounted a conversation with the representative of a Medicare fiscal intermediary:

Rep.: “Medicare. How can I help you?”

M.D.: “I was calling to find out how to opt out. How do I do this?”

Rep.: “What’s your provider number?”

M.D.: “I don’t have one.”

Rep.: “How are you gonna opt out if you don’t have a number? You can’t opt out of something you never opted into.”

M.D.: “I feel the same way. Can you send that to me in writing?”

Rep.: “Please hold.”

The physician reports that he was on hold for an hour before he hung up.

What Is Voluntary?

It is possible that Medicare price controls, as well as the increasingly costly and onerous compliance requirements, might be held unconstitutional if participation in Medicare were not voluntary. But what does “voluntary” mean? Does it mean that a physician has accepted government payment? Or does one “volunteer” by simply rendering a service to anyone who might be eligible for a benefit? Or by practicing medicine, or even by earning a medical degree?

From the patient’s standpoint, “voluntary” participation in Medicare Part A is already taken to mean “accepting Social Security benefits.” (As detailed above, one can decline Medicare Part A only by forfeiting all Social Security benefits also.) Could it also mean “electing to receive a medical service?” Or will “voluntary” submission to the requirements of the new Patient Protection and Affordable Care Act (PPACA) mean “electing not to die”?

A common-sense definition would be that voluntary participation in Medicare means giving informed consent to an agreement, not made under duress, and accepting consideration. Should physicians not be entitled to disclosure at least as complete as demanded for patients in contracts with opted-out physicians? And should they not have the right to treat anyone who seeks their services privately, even patients who on other occasions wish to claim their entitlement?

Conclusion

The initial promises that enabled the passage of Medicare—that it would be a voluntary program that guaranteed freedom of choice—have been violated. Increasingly heavy-handed controls have escaped being struck down on constitutional grounds, on the pretext that participation is voluntary. If physicians assert their right to turn down government dollars and thereby free themselves from Medicare’s jurisdiction, would CMS attempt to impose its rule on private patient-physician relations? If it did, a fundamental constitutional challenge to Medicare should clearly be ripe.

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Disclaimer: Nothing in this article is intended to constitute legal advice. Medicare and its intermediaries have a history of seeking to impose extremely costly requirements even without the clear statutory or regulatory authority to do so. Physicians are advised to seek legal counsel for their individual situation.

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