A Brief Review of Private Contracting

Andrew L. Schlafly, Esq.

Medical licenses are, of course, issued by states rather than by the federal government. There is no federal board of medicine, and it is doubtful that one could be constitutionally created.

The unique system of federalism in the United States, whereby state and federal governments are co-equal sovereigns, remains a bulwark against overreaching by the national sovereign. Nowhere does this protection matter more than in the field of medicine.

But the federal government has an immense financial advantage. He who has the gold, rules. The federal government has increasingly influenced and controlled medical practice by placing conditions on the Medicare program.

Even before passage of the Patient Protection and Affordable Care Act (PPACA), more commonly known as "ObamaCare," the federal share of dollars spent on medical care has been sharply increasing. For example, federal health care expenditures jumped from 24% to 27% of the total in merely one year, between 2008 and 2009. Meanwhile, the state and local shares of total medical spending actually declined from 17% to 16% during that same period.[1]

Conditions can typically be imposed on spending by the entity that controls the money. But what about the other 73% of medical dollars not included in the federal share? It is doubtful that the federal government can control all of that spending in addition to its own.

Stewart v. Sullivan

Two decades ago, Lois Copeland, M.D., who later served as AAPS president, filed a lawsuit along with five of her patients to protect the practice of private medicine. Dr. Copeland was a nonparticipating physician in Medicare Part B, and her patients were enrolled under Parts A and B of the Medicare program.[2] They challenged limitations placed by the Medicare program on private contracts between physicians and Medicare patients.

This lawsuit objected to several aspects of federal interference, but the limitation most familiar to physicians is the prohibition against charging Medicare Part B patients in excess of a limiting charge:[3] "If a nonparticipating physician knowingly and willfully bills on a repeated basis for physicians' services…an actual charge in excess of the limiting charge…the Secretary may apply sanctions against" the physician.[4]

The Court noted that as of 1992, these discretionary sanctions included possible exclusion from Medicare for up to five years, and civil monetary penalties as high as $2,000 per offense and double the amount charged for a service or item provided.[5] These penalties, however, require proof of exceeding the limiting charged on a "repeated basis," and in a knowing and willful manner.

By its own terms, this prohibition applies to nonparticipating physicians. The statute defines "nonparticipating" broadly to include any physician who does not "participate" in Medicare, which could arguably include physicians who are disenrolled. The more common, narrow meaning of those who do not take assignment but do submit forms to Medicare would make more sense, as the Medicare program would be regulating only those who are enrolled in Medicare. The broader definition to include all physicians would have obvious difficulties with the U.S. Constitution, federalism, and the traditional state jurisdiction over the regulation of the ordinary practice of private and local medicine.

The Court in *Stewart v. Sullivan* held that if claim forms have not been submitted, then it is not clear whether the government would even take the position that the physician has "engaged in knowing and [willful] violations of the Medicare statute."[6] As a result, the Court did not find any infringement on private contracting, and dismissed the lawsuit for lack of ripeness.

The Government Response to the Ruling

The federal government was not happy about the holding in *Stewart v. Sullivan*. In response, "the Health Care Financing Administration attempted to strengthen its prohibition against private contracting first through instructions in its Carriers' Manual and then through a technical amendment in 1994 indicating that balance billing limits applied to all persons enrolled in Part B and not just those submitting bills."[7] But we are not aware of any enforcement of this broad view with respect to physicians who do not seek reimbursement by Medicare. Such enforcement would make the legal claims in *Stewart v. Sullivan* ripe for litigation, and courts could then revisit the important issues raised in that case.

Opting Out

In 1997 Congress passed a safe harbor for physicians to "opt out" of Medicare. This bill, enacted as part of the Balanced Budget

Act of 1997, requires an affidavit every two years from the physician as well as agreements signed by patients every two years containing specific disclosures. Compliance with these requirements enables physicians to be confident in their right to enter into private contracts with patients, including Medicare beneficiaries.

Opting out is not the same as disenrolling, and some carriers even require physicians to enroll in order to opt out. An opted out physician may bill Medicare for emergency services, while a disenrolled physician presumably cannot. An opted physician is also listed for the purposes of Medicare reimbursement of laboratories or imaging facilities for tests the physician may order, while a disenrolled physician could encounter difficulties with such reimbursement.

The Zelman Memorandum

In the heyday of the Clinton Administration—during Hillary Clinton 's notorious Health Care Task Force in 1993—a legal analysis by Douglas Letter, appellate litigation counsel, Civil Division, Department of Justice, was prepared for the White House Health Care Task Force, and addressed to Walter Zelman, who was one of the leaders of the Task Force. This Department of Justice memorandum candidly admits:

> However, where a restriction on the availability of treatment at any price goes beyond protecting the integrity of a government reimbursement system—and the restriction imposed is for economic reasons (rather than health and safety, as in the case of FDA regulations)—there could be a constitutional problem.
>
> This is an uncharted area of the law. The right to medical treatment has been given constitutional protection in the area of abortion, but that is for reasons that are not generally applicable to other types of treatment. Where the treatment sought is medically necessary—and particularly where a life-threatening condition is involved—it is entirely possible that the courts would impose some constitutional limits on the government's ability to impose, for economic reasons, restrictions on a patient 's ability to obtain treatment for which he or she is willing to pay.[8]

In other words, even if the federal government attempted to assert control over payments by patients to disenrolled physicians, courts may well hold that it is unconstitutional for government to interfere with payments made by Medicare-enrolled patients for services rendered by physicians who have disenrolled.

Disenrollment is a potentially powerful approach to private contracting that bypasses the safe harbor of formally opting out every two years. As implied by the Zelman Memorandum nearly two decades ago, disenrollment is a voyage into uncharted waters, but is possibly more satisfactory than the tyranny left behind.

Whether Medicare officials will pursue those who leave or never enroll in the first place remains unclear at this time. It seems unlikely that Medicare officials would risk losing in court over this issue about the extent of their power. And what would be the penalty if courts did allow the Centers for Medicare and Medicaid Services (CMS) to discipline physicians in these circumstances? Perhaps nothing more than exclusion by Medicare, a program the physician had already left.

Conclusion

Formally opting out of Medicare has grown in popularity. But a tantalizing alternative approach is emerging: disenrolling from Medicare altogether.

We are unaware of a court case establishing or forbidding this option. Government may prefer not to test its authority over disenrolled physicians rather than risk a new precedent against its power.

A consequence of the ObamaCare litigation may be to resolve this issue too. If ObamaCare is invalidated for going beyond the constitutional authority of the federal government, then that precedent may also limit federal authority over private contracts with disenrolled physicians.

Andrew L. Schlafly, Esq., is general counsel for AAPS, and co-author of the recent amicus brief filed on behalf of the AAPS in the case now before the U.S. Supreme Court involving the unconstitutionality of ObamaCare. Contact: aschlafly@aol.com.

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3 "Omnibus Budget Reconciliation Act of 1989," Pub.L. 101-239 (Dec. 19, 1989).

4 42 U.S.C. § 1395w-4(g).

5 42 U.S.C. § 1395u(j)(2)(A), 42 U.S.C. § 1395u(j)(2)(B); 42 U.S.C. § 1320a-7a(a).

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