

October 30, 1997

Honorable Bill Archer
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

At your request, the Congressional Budget Office (CBO) has reviewed H.R. 2497, the Medicare Beneficiary Freedom to Contract Act of 1997, as introduced on September 18, 1997. (S. 1194, an identical bill, was introduced in the Senate on the same day.)

Direct contracting allows beneficiaries to make financial arrangements with health providers outside of the established Medicare payment rules. The direct contracting provision in current Medicare law, enacted in the Balanced Budget Act of 1997 (P.L. 105-33), requires providers contracting directly with patients to forgo any Medicare reimbursement for two years. Under that condition, CBO expects that direct contracting will almost never be used.

H.R. 2497 would eliminate the two-year exclusion period, allowing health providers to contract directly with their Medicare patients on a claim-by-claim basis. For example, a physician could bill Medicare for an office visit while directly contracting with the patient for an associated test or procedure.

Enactment of H.R. 2497 would affect Medicare outlays. Because of uncertainties about the number of claims that would be separately contracted and about the effectiveness of the regulatory oversight of those contracts by the Health Care Financing Administration (HCFA), however, CBO cannot estimate either the magnitude or the direction of the change in Medicare outlays that would ensue.

With Medicare's restrictions on balance billing—which limit the amount beneficiaries must pay for services covered by Medicare—providers may in some cases receive lower payments than what their patients would have been willing to pay out of pocket. The bill would allow physicians and other health care providers to increase their incomes by negotiating direct contracts that included prices in excess of Medicare's fees, effectively bypassing the limits on balance billing. For some services, CBO believes that such contracting would not be very widespread because few beneficiaries would be willing to pay the entire fee (not just the difference between the provider's charge and what Medicare would have paid). For other services—such as those where the need for timely medical treatment might increase patients' willingness to pay—direct contracting could become much more common.

If direct contracting continued to be rarely used, there would be no changes in benefit payments, no additional difficulties in combating fraud and abuse, and no major new administrative burdens placed on HCFA.

If direct contracting were extensively used, however, Medicare claims could be significantly reduced. At the same time, HCFA's efforts to screen inappropriate or fraudulent claims could be significantly compromised because it would be difficult to evaluate episodes of care with gaps where services were directly contracted. Furthermore, HCFA would be unlikely to devote significant administrative resources to the regulation of direct contracting. HCFA's efforts to administer other areas of Medicare law, including many of the new payment systems envisioned in the Balanced Budget Act, will continue to strain the agency's resources. Without adequate regulatory oversight, unethical providers could bill Medicare while also collecting from directly-contracted patients.

Although the impact of H.R. 2497 on the federal budget is uncertain, the bill would almost certainly raise national health spending. Even if direct contracts were rarely used, payments made under those contracts would probably be higher than what Medicare would have paid, and Medicare's efforts to combat fraud and abuse would probably be hampered to some extent.

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If you have any questions about this analysis, we will be pleased to answer them. The CBO staff contact is Jeff Lemieux.

Sincerely,

June E. O'Neill
Director

cc: Honorable Charles B. Rangel
Ranking Minority Member

Honorable John R. Kasich
Chairman
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