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RESEARCH SUMMARY

RESTORING FREEDOM OF CONTRACT BETWEEN DOCTOR AND PATIENT IN MEDICARE PART B

In the five decades since the enactment of Medicare, the federal government has increasingly restricted the freedom of doctors and Medicare-eligible patients to contract privately for supplemental or alternative health services. Today physicians face sharply below-market payments from Medicare, stringent price controls, increased regulations, and at times incompetent and arbitrary administration by the program's bureaucracy. As this trend continues, it could drive more doctors away from Medicare, potentially leading to a crisis like that in Medicaid—the health program for low-income people—in which many patients have great difficulty finding doctors willing to treat them.

While some will respond by calling for more rules and limits on nonparticipating physicians, a better solution lies in the opposite approach: providing more flexibility for Medicare patients and their doctors to contract for services free of undue federal regulation.

A new study published by the Mercatus Center at George Mason University describes how such an approach in Medicare Part B—which covers outpatient services such as office visits and preventive care—could enhance doctors' participation in the program, expand choices for beneficiaries, boost innovation, and make prices more responsive to market forces. Below is a brief summary of this analysis. Please see "Restoring Freedom of Contract between Doctor and Patient in Medicare Part B" to read the entire study and to learn more about its author, David E. Bernstein, the George Mason University Foundation Professor at George Mason University School of Law.

THE GRADUAL EROSION OF FREEDOM TO CONTRACT

Doctors who participate in Medicare Part B can bill the program directly but may not charge anything higher than Medicare-established fees; the patient pays a 20 percent copay. Nonparticipating physicians may collect basic fees from Medicare or from the patient (who is then reimbursed by Medicare), plus a 20 percent patient copay. For roughly the first two decades of the program,

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Medicare placed no restrictions on any additional charges and services nonparticipating doctors and their patients agreed to.

Starting in 1984, faced with double-digit increases in Medicare costs, Congress froze physician payments for two years and later imposed new regulations. The combination reduced the inflation-adjusted value of Medicare reimbursements, tempting physicians to become “nonparticipating” so they could try to collect market rates. This led Congress to discourage nonparticipation:

- New legislation prohibited nonparticipating physicians from charging patients more than a “limiting charge” (or “excess charge”) of 15 percent above Medicare fees.
- The Balanced Budget Act of 1997 dictates that any doctor who contracts privately with a Medicare enrollee—even if only for one service—has opted out of Medicare and may not receive program reimbursements for two years.
- Physicians who opt out of Medicare are not free to contract with Medicare-eligible patients without substantial government interference—interference that does not apply to non-Medicare-eligible patients who similarly wish to contract with their doctors. This includes meeting 15 requirements for each contract. Among these requirements, opt-out doctors must make available to the government all private contracts with patients who have not totally opted out of Medicare.

Opt-out physicians who fail to comply with the government’s regulations are penalized by having all their contracts with Medicare-eligible patients voided so they can submit only Medicare-covered items for reimbursement and may not collect any of the fees they contracted for.

WHAT CONGRESS SHOULD DO NOW

As a centralized, top-down program, Medicare Part B determines prices for medical services not on the basis of supply and demand, as the market does, but through bureaucratic fiat. The program has 16 different payment systems for various types of providers and health plans and sets prices for more than 7,000 services in each of 89 payment localities. As a result, Medicare is bound to make errors, overpricing or underpricing certain services, and leading some specialists to avoid taking Medicare patients at all. Compounding these problems are constant budgetary and regulatory pressures in the program.

- Medicare currently pays physicians on average 20 percent less than what private insurers pay, and these fees are subject to additional cuts owing to budgetary pressures.
- These low reimbursement rates are accompanied by onerous regulations, including a new one, effective this year, that penalizes physicians who fail to make sufficient use of electronic health records.
- The Affordable Care Act created the Independent Payment Advisory Board, charged with developing plans to reduce Medicare spending if it exceeds a predetermined per capita

growth rate. This poses a further threat to future Medicare payments to healthcare providers.

These conditions have led a growing number of doctors to leave the program. In 2012, a total of 9,539 physicians had opted out of Medicare, significantly more than the 3,700 who did so in 2009. Although this is not a large share of the 685,000 doctors who participate, it represents a worrisome trend, especially because the figures are largely cumulative: doctors who opt out tend to stay out, and are joined by others.

Some warn that Medicare could face a crisis similar to that in Medicaid, in which a large percentage of physicians refuse to accept patients because of inadequate reimbursements, and some are tempted to provide additional services of questionable value to make up the difference.

The answer to these problems lies not in adding regulations or forcing doctors to participate in the program. Instead, the government should allow greater freedom to contract. This could help relieve some of the stress on Medicare's finances and encourage physicians to continue serving Medicare patients.

A simple first step would be to eliminate "excess" or "limiting" charge rules, so that nonparticipating physicians could charge market rates for their services, coupled with the following measures:

- Medicare could adopt a system employed by preferred provider organization health plans, which limit reimbursements to patients who obtain services outside the plan. Patients are responsible for the balance. Among other benefits, this system would provide price signals to help determine whether Medicare rates are in fact too low (or too high).
- In addition, some Medigap plans—which some Medicare enrollees purchase to supplement their coverage—already cover excess charges, and could play a larger role if nonparticipating physicians were allowed to charge market prices.
- Congress also should liberalize Medigap regulations so that such policies can cover additional contingencies and noncovered services, such as office visits exceeding the frequency Medicare deems appropriate.

Lawmakers also should relax opt-out rules so that they are not all or nothing. For example, physicians should be allowed to participate in Medicare for some percentage of their patients receiving standard, customary services, and still contract privately with other patients seeking services that Medicare does not cover. This approach could lead to greater innovation in health services, which also could help lower costs.