

Restoring Freedom of Contract between Doctor and Patient in Medicare Part B

David E. Bernstein



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David E. Bernstein. "Restoring Freedom of Contract between Doctor and Patient in Medicare Part B." Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, September 2015.

ABSTRACT

Despite promises that Medicare would not interfere with patients' ability to choose their physician and to purchase additional health coverage on the open market, over the decades Medicare rules and regulations have gradually eroded senior citizens' ability to control their healthcare choices. With Medicare facing financial and regulatory pressures that threaten to drive more and more physicians out of the system, it's time for Congress to allow private contracting to play a significantly greater role in Medicare Part B. Congress should eliminate the limit on patients' ability to negotiate fees with nonparticipating physicians, expand the scope of Medigap coverage to include services not covered by Medicare, and liberalize the rules for opt-out physicians.

JEL codes: H51, I11, I13, I14, I18, I38, I39, J26, K00, K10, L84

Keywords: Medicare, Medicare Part B, freedom of contract, Centers for Medicare & Medicaid Services, participating physicians, non-participating physicians, Balanced Budget Act of 1997, preferred provider organizations, Medigap, balance billing

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Release: September 2015

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Before Medicare and Medicaid became law in 1965, health care in the United States was overwhelmingly governed by private contracts between a physician and either a patient or the patient’s private insurance company. Medicare, by providing government-funded and government-controlled health insurance to Americans aged 65 and older, represented a broad and novel extension of government into the American healthcare system.

Before its passage, critics of the proposed Medicare law, such as future president Ronald Reagan, warned that federal funding of health care for the elderly would inevitably lead to widespread government regulation of the healthcare industry in general and of doctor-patient relationships in particular. Critics argued that once the government insinuated itself so prominently into the healthcare system, it would ultimately dictate which medical providers patients could see, under what circumstances, and according to what terms.¹

President Lyndon Johnson tried to alleviate concerns that Medicare would unduly interfere with doctor-patient relationships by promising that Medicare would in no way hinder patients’ freedom to choose their healthcare providers.² Congress backed up Johnson’s promise by inserting language into Medicare asserting (a) that beneficiaries would be free to obtain healthcare services from any provider “qualified to participate” in Medicare and (b) that nothing in Medicare “shall be construed . . . to preclude” a beneficiary from “purchasing or otherwise securing protection against the cost of any health services.”³

In other words, the government would pay much of senior citizens’ healthcare costs, but seniors would be able to freely choose their doctors from

1. “Ronald Reagan Speaks Out against Socialized Medicine,” YouTube recording, 10:06, from a 1961 record sent out by the American Medical Association, posted by Restoring the American Dream, August 1, 2007, <https://www.youtube.com/watch?v=fRdLpem-AAs>.

2. “The Johnson View: Campaign Special—18,” *Christian Science Monitor*, August 15, 1964, 9.

3. 42 U.S.C. § 1395(a)–(b).

all participating physicians. Seniors would also be allowed to purchase supplemental insurance and to pay directly for healthcare services.

As this paper discusses, over the ensuing decades the freedom of doctors and Medicare-eligible patients to contract for health services has been eroded by various amendments to Medicare and by related regulations. To be sure, if they are not employed by hospitals, most physicians can avoid Medicare entirely if they so choose and limit their over-65-year-old patients to the tiny minority who decline to accept Medicare benefits. But for the vast majority of physicians who do accept Medicare patients, their relationship with their patients who are 65 and older is subject to complex and draconian regulations—regulations that in practice are nearly impossible for physicians and their patients to contract around.

This paper focuses on Medicare Part B, which covers outpatient medical services and outpatient care. This includes doctors' visits; hospital outpatient care; limited home health care; some preventive services like exams, lab tests, and screening shots; and durable medical equipment. Part I of this paper reviews the history of Medicare Part B and how the federal government has gradually eroded the freedom to contract for participants. Part II proposes reforms that would enhance freedom of contract. In particular, Medicare should be reformed to remove caps on what Medicare patients may agree to pay nonparticipating physicians.

PART I. THE GRADUAL EROSION OF FREEDOM TO CONTRACT

Under Medicare, physicians must choose annually whether to be designated as participating or nonparticipating physicians, with corresponding duties and privileges. Participating doctors are entitled to bill insurance carriers directly for payment, but are precluded from charging anything in excess of the Medicare-established fees for services. Patients pay a 20 percent copay. Nonparticipating doctors, meanwhile, decide whether to accept assignment. If a physician accepts assignment, Medicare pays the physician directly based on Medicare payment rates, and the physician collects a 20 percent copay from the patient. If a physician chooses not to assign a claim, Medicare usually reimburses the patient based on the Medicare payment rate. The physician then must collect the entire balance from the patient.

For the first two decades or so of Medicare, the government placed no restrictions on the fees charged by nonparticipating physicians who refused assignment. In 1984, faced with double-digit annual increases in Medicare

costs, Congress froze the fees it paid physicians.⁴ The freeze lasted until the end of 1986.⁵ Meanwhile, a host of new regulations were enacted between 1986 and 1988 to dictate the terms of any Medicare-covered services.⁶ The fee freeze, combined with costly new regulations, significantly reduced the real (postinflation) value of Medicare fees paid to physicians.

Medicare experts became concerned that physicians would be tempted to designate themselves as nonparticipating so they could try to collect market rates for their services. This would have resulted in a higher percentage of medical costs being paid by patients, contrary to Medicare's intent (and the obvious political incentives) to relieve the elderly of most of the financial burden of their medical care. Congress responded to these concerns in 1989 by significantly reducing the financial incentive for physicians to designate themselves as nonparticipating.

The new legislation prohibited nonparticipating physicians from charging Medicare Part B enrollees anything in excess of a "limiting charge" (also known as an "excess charge") established by the Department of Health and Human Services (HHS).⁷ Current rules provide that a physician may only charge a patient up to 15 percent over the amount that participating providers are paid. Medicare allows states to enact rules further limiting how much nonparticipating physicians in their state may charge, and some states do so. Because of the small potential financial gains from being a nonparticipating physician, and the extra difficulties attendant to having to collect money from patients, as of 2010 less than 5 percent of doctors who accepted Medicare patients designated themselves as nonparticipating.⁸

Meanwhile, in a further attempt to reduce out-of-pocket costs for seniors, the government put additional restrictions on private contracts between senior citizens and their physicians via the Health Care Financing Administration (HCFA). The HCFA was established in 1977 to administer

4. J. B. Mitchell, G. Wedig, and J. Cromwell, "The Medicare Physician Fee Freeze: What Really Happened?," *Health Affairs* 8, no. 1 (February 1989): 22–33.

5. *Ibid.* See also *Whitney et al. v. Heckler*, 603 F. Supp. 821 (N.D. Ga. 1985), affirmed, 780 F.2d 963 (11th Cir. 1986), rejecting petitioner's price freeze challenge.

6. See Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-272; Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203; and Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360.

7. Kent Masterson Brown, "The Freedom to Spend Your Own Money on Medical Care: A Common Casualty of Universal Coverage" (Policy Analysis No. 601, Cato Institute, Washington, DC, October 2007), 5, citing 42 U.S.C. § 1395w-4(g)(1) and (2).

8. Kaiser Family Foundation, *Medicare Chartbook*, 4th ed., 2010, 28, accessed February 1, 2015, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8103.pdf>.

“Many opt-out physicians avoid seeing Medicare-eligible patients for fear of running afoul of vague and ambiguous federal regulations that attempt to differentiate between urgent and non-urgent care.”

Medicare and Medicaid.⁹ It was renamed the Centers for Medicare & Medicaid Services (CMS) in 2001, and is part of the federal HHS.

The HCFA at times tried to impose regulations without clear legal authority for doing so. For example, Medicare will in some circumstances reimburse participating physicians for no more than one patient visit per month. Lois Copeland, a nonparticipating doctor who practiced internal medicine in New Jersey, had some Medicare patients who wanted to see her more frequently than this policy allowed.¹⁰ Copeland informed her patients that because Medicare only paid for monthly visits, they would need to pay out of pocket for all additional visits.¹¹

No formal federal regulations prohibited such an arrangement. Nevertheless, after some of her patients agreed to these terms, Copeland began receiving bulletins from the HCFA warning her against private contracting.¹² One such bulletin read, “A provider must abide by all Medicare rules and regulations [as long as covered services are provided]. The law cannot be bypassed by having patients sign a disclaimer stating that services provided to them should not be billed to Medicare.”¹³

Copeland later received a letter from the HCFA stating that a doctor must not initiate a private contract with Medicare patients. And if a patient initiated a private contract with his or her doctor, the HCFA would still set prices for these contracts.¹⁴ For visits in excess of one per month, that would mean a price of zero, which means that no such contract would ever be agreed upon, effectively preventing the patient from seeing the physician more than once a

9. Medicare and Medicaid Services website, accessed March 1, 2013, <http://www.cms.gov/About-CMS/Agency-Information/History/index.html>.

10. *Stewart v. Sullivan*, 816 F. Supp. 281, 285 (D.N.J. 1992).

11. *Id.*

12. *Id.*

13. Brown, “Freedom to Spend Your Own Money,” 6, citing Exhibit A, Complaint, *Stewart*, 816 F. Supp. 281 (No. 92-417).

14. *Stewart*, 816 F. Supp. at 285.

month. The only way for a patient to evade this rule would be to drop out of Medicare Part B entirely.¹⁵

Copeland sued, but her lawsuit was dismissed as unripe. In other words, the court found that the case was not yet ready to be litigated. Ironically, the court held that because the HCFA policies enumerated to Copeland were not implemented as formal regulations through the procedure of notice and comment required of federal agencies under the Administrative Procedure Act (APA)¹⁶ but were instead announced informally in letters and bulletins, there were no concrete rules for the court to review.¹⁷

The good news is that the court's ruling implicitly meant that the HCFA had not complied with the APA and therefore had no legal authority to punish physicians who privately contracted with their Medicare patients for services beyond those permitted by Medicare. The bad news was that there was nothing stopping the HCFA from continuing to articulate policies prohibiting private contracting and then forcing physicians to hire attorneys to defend them from any sanctions the HCFA tried to impose. In 1993, just a year after Copeland's lawsuit was dismissed, the HCFA amended its carrier manual to limit private contracting between doctors and Medicare recipients.¹⁸ Once again, the HCFA did so without any congressional oversight or public notice and comment.¹⁹

The HHS's authority over private contracting was clarified by the Balanced Budget Act of 1997 (BBA)²⁰ and by subsequent litigation. Under section 4507 of the BBA, doctors who contract privately with any Medicare recipient for services covered by the program,²¹ even for just one covered service, are said to have opted out of Medicare, and are ineligible for Medicare reimbursement for two years after their decision to opt out. The only exception to the rule

15. *Id.* at 286. If patients drop out of Medicare Part A, which provides hospital coverage, they not only lose future Social Security benefits, but they also must repay all the benefits they received before dropping out of Part A. This rule does not apply to Part B.

16. Brown, "Freedom to Spend Your Own Money," 7; Robert E. Moffit, "How Congress Can Restore the Freedom of Senior Citizens to Make Private Agreements with their Doctor," Backgrounder #1209 on Health Care, Heritage Foundation, August 3, 1998, <http://www.heritage.org/research/reports/1998/08/how-congress-can-restore>. See also 5 U.S.C. § 553, requiring all federal agencies to publish all proposed rules in the *Federal Register* and give the public a chance to comment on said rules.

17. See *Stewart*, 816 F. Supp. at 285, 288–91.

18. Brown, "Freedom to Spend Your Own Money," 8. The HCFA manual stated that doctors could contract privately, but they could not charge Medicare patients in excess of the limiting charge, and patients could not pay out of pocket for clinical diagnostic tests.

19. *Ibid.*

20. Pub. L. No. 105-33, § 4507.

21. The bill primarily restricts private contracts between doctors and Medicare B recipients. See *United Seniors Ass'n. v. Shalala*, 182 F.3d 965, 967 (D.C. Cir. 1999).

barring Medicare reimbursements for two years is that physicians could still get reimbursement for providing qualified emergency or urgent care.

However, the HHS will only reimburse opt-out doctors for urgent care provided to Medicare recipients with whom they have *not* previously entered into a private contract.²² So let's say a Medicare patient contracted privately with a cardiologist in 1996. In 1997, following passage of the BBA, the cardiologist decided to opt out of Medicare. Several months later, the former patient suffered chest pain and wanted to see the old doctor. Unless the patient could afford to pay the full cost of a physician visit and treatment out of pocket, the patient would not be able to see this physician, even in an emergency.²³

Even if a patient could afford to see an opt-out physician for urgent care, many opt-out physicians avoid seeing Medicare-eligible patients for fear of running afoul of vague and ambiguous federal regulations that attempt to differentiate between urgent and non-urgent care. The HHS itself has acknowledged the difficulty of discerning the difference between urgent care and non-urgent care.²⁴

Meanwhile, 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. First, the HHS requires opt-out doctors to submit an affidavit to the Medicare officials within 10 days of privately contracting with a Medicare recipient.²⁵ The affidavit must state, among other things, that the doctor agrees not to receive Medicare reimbursement for any patient during the next two years, with the qualified exception of urgent care for patients with whom the doctor has not previously privately contracted.²⁶ Second, the HHS imposes 15 requirements that opt-out doctors must follow for each private contract into which they enter.²⁷ Among other requirements, opt-out doctors must make all private contracts with patients who have not opted out of Medicare available to the government upon demand.²⁸

The draconian consequences of opting out discourage physicians from seeing Medicare-eligible patients (that is, patients aged 65 and over) outside of the Medicare system. Indeed, opting out also creates the risk that the physician

22. 42 C.F.R. § 424.440.

23. See Thomas W. Greeson and Heather L. Gunas, "Section 4507 and the Importance of Private Contracts," *Health Matrix* 10, no. 1 (Winter 2000): 35–50.

24. *Ibid.*, 47.

25. 42 C.F.R. § 424.410.

26. *Id.* § 424.420.

27. *Id.* § 424.415.

28. *Id.*

may negligently fail to comply with the relevant regulations, which could have devastating financial consequences. If the CMS determines that an opt-out physician has failed to properly comply with the opt-out rules and fails to show to the CMS's satisfaction within 45 days of receiving notice of noncompliance that the physician made a good-faith effort to comply, all the contracts signed with patients eligible for Medicare are voided. The physician therefore may not collect any money for services not covered by Medicare, and may only submit Medicare-covered items for Medicare reimbursement at the nonparticipating physician rate and bill the patient for any Medicare-dictated copay.²⁹

Beyond that, the physician may not opt out again until the two-year period expires. During this time the physician cannot privately contract with or assign claims to Medicare for Medicare-eligible patients.³⁰ In other words, the physician may not get reimbursement from any source for seeing patients aged 65 and over until the opt-out period ends (with, once again, the qualified exception of Medicare reimbursement for urgent care provided to recipients with whom the doctors have never privately contracted).³¹

In *United Seniors Association, Inc. v. Shalala*, a group of Medicare recipients sued Secretary of Health and Human Services Donna Shalala to enjoin the operation of section 4507 of the BBA.³² The plaintiffs argued that section 4507 infringed on their liberty interest in contracting privately for healthcare services by effectively making it impossible for them to contract for medical services outside the Medicare system—particularly for services Medicare will not cover, either because they are categorically excluded or because Medicare deems them unreasonable or unnecessary in a particular case.

The case turned on the breadth of section 4507. As the plaintiffs read the section, it governs almost any agreement between a doctor and patient to provide medical services outside Medicare, regardless of whether the service is covered by Medicare. The plaintiffs argued that it would be virtually impossible to find a doctor willing to enter into a private agreement to fund non-Medicare-covered services, given the importance of Medicare to doctors' practices and the two-year bar the statute imposes for entering into even a single private contract.³³ If interpreted in this manner, Medicare, combined with section 4507, would have made it effectively impossible for most patients

29. Id. § 424.435.

30. Id. § 424.430–35.

31. See id.

32. *United Seniors Ass'n*, 2 F. Supp.2d 39, 41 (D.D.C. 1998), affirmed on other grounds 182 F.3d 965 (D.C. Cir. 1999).

33. Id.

over age 65 to receive services that Medicare did not cover. As the government ultimately acknowledged, Medicare had crowded out other options, and no close substitute for Part B existed in the private insurance market.

The district court did not dispute the plaintiffs' reading of the law but instead rejected the claim on the constitutional merits.³⁴ The court held that it could only rule in favor of the plaintiffs if the Constitution "confers a fundamental right on individuals to privately contract with their physicians." The court held that under Supreme Court precedent, there is no such fundamental right, and the court therefore rejected the plaintiffs' argument.

The plaintiffs appealed to the D.C. Circuit Court of Appeals.³⁵ That court did not discuss the merits of the plaintiffs' freedom of contract argument. The court instead ruled that the plaintiffs had misinterpreted the scope of section 4507. After acknowledging that section 4507 was far from clear on its face and that explanatory regulations were not published until long after the lawsuit had been filed, the court accepted the government's argument that the section only applies to services that Medicare covers.

Contrary to the plaintiffs' understanding of the law, the court held that physicians may provide services not covered by Medicare to their patients on a contractual basis without opting out of the program. The court justified its ruling based on both deference to the HHS's interpretation of the law and, perhaps more importantly, the fact that the HHS had recently issued formal, legally binding regulations stating that "the private contracting rules do not apply to . . . services that Medicare does not cover." So at least with regard to services clearly not covered by Medicare, physicians and their Medicare-eligible patients retain freedom of contract.

Even in the context of permissible contracting for services not covered by Medicare, however, Medicare rules limit flexibility by penalizing doctors who too often operate outside Medicare. In *United Seniors Association*, the plaintiffs argued that the HHS was effectively barring patients' access to services that they or their doctors regard as necessary but Medicare does not by penalizing doctors for issuing Advance Beneficiary Notices (ABNs).

When a physician provides a service that Medicare might not cover, Medicare rules provide that the doctor may give the patient an ABN, which advises that the patient will need to pay for the service if Medicare does not. If the patient agrees to this contingency and Medicare subsequently denies payment, the doctor may bill the patient directly. ABNs can only be used for

34. *United Seniors Ass'n*, 2 F. Supp.2d at 41-42.

35. *United Seniors Ass'n*, 182 F.3d 965 (D.C. Cir. 1999).

services that Medicare might not cover; they cannot be used for treatments that Medicare definitely does not cover.

The plaintiffs argued that the HCFA had a policy of sanctioning doctors who repeatedly use ABNs for services that they believe are warranted but Medicare regards as unnecessary and will not reimburse. The court, however, found that the formal rules issued by the HHS only allowed the sanctioning of physicians who were billing patients for unnecessary procedures, and found insufficient evidence to support the claim that the HCFA was applying the law in an illegitimate way. The court, however, left open the possibility that the plaintiffs (or other plaintiffs) could file a separate lawsuit focusing on this issue.

No court since *United Seniors Association* has addressed the constitutionality of the government's enforcement of section 4507 of the BBA, and though it is still operational,³⁶ this provision has received scant public attention in recent years. Since 1998, various representatives and senators have proposed amendments that would have relaxed restrictions on private contracts for Medicare recipients. In 2013, for example, Senator Lisa Murkowski (R-AK) and Representative Tom Price (R-GA) proposed an amendment, the Medicare Patient Empowerment Act, to increase Medicare recipients' ability to contract privately with doctors.³⁷ The bill attracted the support of several Republican cosponsors and of the American Medical Association, but it has not advanced.³⁸

PART II. WHAT CONGRESS SHOULD DO NOW

As a centralized, top-down program, Medicare Part B sets prices for medical services by bureaucratic fiat. The complexity of Medicare pricing is astonishing. Medicare has 16 different payment systems for various types of providers and health plans. The physician payment system sets prices for more than seven thousand services in each of 89 payment localities.³⁹

Given this complexity, Medicare is bound to make errors and either overprice or underprice certain services. The latter scenario results in some specialists in certain locations avoiding Medicare patients because their compensation

36. See 42 U.S.C. § 1395a and 42 C.F.R. §§ 424.400–445 (2013). See also *Association of American Physicians and Surgeons v. Sebelius*, 2012 WL 5353562 at *12 (D.D.C. 2012), noting that the opt-out requirement and other restrictions on private contracting with Medicare patients were still good law.

37. Medicare Patient Empowerment Act, S. 236, 113th Congress (proposed February 7, 2013).

38. "Medicare Patient Empowerment Act," American Medical Association website, <http://www.ama-assn.org/ama/pub/advocacy/topics/medicare-patient-empowerment.page?>

39. Michael F. Cannon, "Pay-for-Performance: Is Medicare a Good Candidate?," *Yale Journal of Health Policy, Law, and Ethics* 7, no. 1 (Winter 2006).

is too low. The former situation may tempt physicians to overuse certain well-compensated procedures, to the detriment of patients' health.⁴⁰

Compounding the complexity issue is the constant budgetary pressure on Medicare payments because of its vast expense. Medicare currently pays physicians on average less than 80 percent of what private insurers pay them, even though insurers themselves sometimes use Medicare rates as a baseline.⁴¹ Medicare's low reimbursement rates are accompanied by onerous regulations, including a regulation effective as of 2015 that penalizes physicians who do not demonstrate sufficient use of electronic health records.⁴² Physicians also have to deal with an opaque Medicare bureaucracy that at times denies claims by particular providers for no coherent reason.⁴³ These burdens fall particularly heavily on physicians in small private practices and on small hospitals not affiliated with a large hospital chain because they have fewer resources to invest in technology and in legal advice to navigate the Medicare bureaucracy.

Meanwhile, the Affordable Care Act establishes the Independent Payment Advisory Board (IPAB). The IPAB is charged with limiting the per capita growth rate for Medicare to predetermined figures. If projected spending as determined by the chief actuary of the CMS exceeds the target, the IPAB must develop a plan to reduce Medicare spending, which is to be implemented by the HHS. If the IPAB fails to submit a proposal that meets the terms of the law, the secretary of HHS is required to implement his or her own plan to achieve the same amount of savings. While the exact effect of the IPAB remains to be seen, it too is likely to put additional pressure on Medicare reimbursement rates.

More and more physicians are already trying to avoid Medicare patients entirely. The government has reported that, despite onerous opt-out rules, 9,539 physicians who had previously accepted Medicare opted out of the program in 2012—up from 3,700 in 2009 (these appear to be the most recent years for which statistics are available).⁴⁴ That's approximately one out of every seventy doctors dropping out of Medicare in just one year. Moreover, it reflects a worrisome trend, especially since the numbers are to a great extent

40. See, for example, Julie Creswell and Reid Abelson, "Medicare Payments Surge for Stents to Unblock Blood Vessels in Limbs," *New York Times*, January 29, 2015.

41. Richard Wolf, "Doctors Limit New Medicare patients," *USA Today*, June 21, 2010.

42. Molly Gamble, "Number of Physicians Opting Out of Medicare Triples," *Becker's Hospital Review*, July 29, 2013.

43. See *DeWall Enterprises, Inc. v. Thompson*, 206 F. Supp.2d 992, 1001 (D. Neb. 2002), holding that Medicare had abused a medical service provider by unjustifiably denying claims for the same reason so many times that the medical service provider was being driven out of business.

44. "Number of Physicians Opting out of Medicare Nearly Tripled," *California Healthline*, July 29, 2013.

cumulative—doctors who opt out of Medicare tend to stay opted out until they retire and are joined by new opt outs. In addition, many physicians who have not opted out of Medicare are declining to take new Medicare patients. Approximately one out of five physicians, including one out of three primary-care physicians, do not accept new Medicare patients.⁴⁵

With Medicare fees significantly below the fees paid by private insurance, a growing regulatory burden,⁴⁶ the Affordable Care Act set to shift substantial funding from Medicare to other health programs, and leading Democratic and Republican experts agreeing that something must be done to slow the growth of healthcare spending, Medicare is on the precipice of a potential crisis like the one already facing Medicaid.

In response to the looming Medicare crisis, the first thing the government should do is to do no further harm. It should not heed calls to force physicians to accept Medicare, and it should adhere to the current interpretation of section 4507 that allows participating medical providers to contract freely with their patients for services not covered by Medicare. Despite the district court’s suggestion to the contrary in *United Seniors Association*, forbidding individuals to contract for services not covered by Medicare would run into serious constitutional difficulties.

The Supreme Court is unlikely to revive the old “liberty of contract” doctrine or to suddenly reinvigorate the Constitution’s Contracts Clause. Nevertheless, the court is also unlikely to permit the government to ban individuals from contracting for medical services that the government itself refuses to pay for.⁴⁷ Indeed, even in Canada, where the

“In response to the looming Medicare crisis, the first thing the government should do is to do no further harm.”

45. Melinda Beck, “More Doctors Steer Clear of Medicare,” *Wall Street Journal*, August 29, 2013.

46. See, for example, Andrew T. Maxham, “CMS Rule Creates Burdensome Version of False Claims Act for Medicare Providers and Suppliers,” *Public Contract Law Journal* 43, no. 2 (Winter 2014): 315.

47. For various constitutional theories on which the Supreme Court may rely to find a right to pursue medical remedies, see Eugene Volokh, “Medical Self-Defense, Prohibited Experimental Therapies, and Payment for Organs,” *Harvard Law Review* 120 (2007): 1813.

public is very attached to its single-payer healthcare system, and “social rights” are sometimes thought to counterbalance private constitutional rights,⁴⁸ the Canadian Supreme Court has held that patients have a right to pay privately for services that are not being adequately provided by the government-run system.⁴⁹

The government can relieve some of the stress on Medicare’s finances while also preserving physician availability and enhancing freedom of contract by increasing the ability of Medicare-eligible patients to contract privately with their doctors and with private insurance companies. Perhaps the simplest step would be to abolish the excess charge or limiting charge rules, and allow non-participating physicians to charge market rates for their services, as they were allowed to do during Medicare’s first two decades.⁵⁰

Jeffrey Singer enumerates some of the benefits that the American medical system enjoyed before the government imposed the excess charge rules: “Medicare more closely resembled traditional health insurance. Doctors had more incentive to stay in the Medicare system. Seniors took on a greater degree of responsibility for the cost of their health care. As a result, they also demanded more accountability and were more cost-effective in their utilization of health care dollars.”⁵¹

The obvious objection to eliminating the excess or limiting charge rules is that this action could simply lead to inflation of physician fees, as doctors who now accept Medicare as full payment would instead pocket Medicare fees and then charge a premium on top of that.⁵² If so, there is a simple solution that private insurers have already discovered. In a typical preferred provider organization (PPO) plan, participating physicians are paid at the plan rate, with patients responsible only for the deductible, just as with physicians who participate in Medicare. When a patient sees a physician who does not participate with the plan, the patient typically pays out of pocket, and the physician then submits an insurance claim on behalf of the patient. The plan then reimburses the patient for the fee it would have paid a participating doctor, *minus* some set percentage, such as 25 percent.

48. See Martha Jackman and Bruce Porter, “Justiciability of Social Rights in Canada,” <http://www.cwp-csp.ca/wp-content/uploads/2011/07/2008-Justiciability-of-Economic-and-Social-Rights-in-Canada-Porter-and-Jackman.pdf>.

49. *Chaoulli v. Quebec*, 1 S.C.R. 791 (2005), 2005 SCC 35.

50. See Patrick K. Price, “A Medicare ‘Fix’ That Really Works: Eliminate the Limiting Charge,” *Mo Med* (September–October 2010), <http://www.omagdigital.com/article/Perspective/552106/52688/article.html>; Jeffrey A. Singer, “A Simple Way to Improve Medicare,” *Reason.com*, November 25, 2010, <https://reason.com/archives/2010/11/25/a-simple-way-to-improve-medica>.

51. Singer, “Simple Way to Improve Medicare.”

52. See Greeson and Gunas, “Section 4507 and the Importance of Private Contracts.”

The result is that patients can limit their copay by seeing only participating physicians, just as the Medicare system currently provides. But if patients wanted to see nonparticipating physicians, the physicians could charge a market rate for their services. The patients would be responsible for the balance, but a substantial percentage of their costs would still be reimbursed. Adopting this system for Medicare would enhance freedom of contract, ensure the availability of physicians when Medicare's reimbursement rates are too low, provide price signals to Medicare to help determine whether its rates are in fact too low (or too high), and encourage the best practitioners to stay in the system, as they would be able to collect a premium for their services.

Such a system may raise concerns that physicians would “rip off” their elderly patients. But the system works for non-elderly members of PPOs, and it would be unfair and discriminatory to base public policy on the assumption that elderly people, as a class, are incompetent or incapable of making the same economic decisions that younger people routinely make. That said, the lack of transparency in medical pricing when patients are operating outside their insurance plan's agreement can be a significant problem. This problem, however, could be addressed by requiring a nonparticipating physician who wants to charge a Medicare patient more than the Medicare rate to disclose prices up front.⁵³ Once that is accomplished, one could reform Medicare Part B to mimic a PPO model.

One concern that has been raised is that any significant increase in the percentage of nonparticipating physicians would create a two-tier system in which some Medicare-eligible individuals are able to buy better care than others. The government has argued in court that allowing increased contractual freedom in Medicare would result in a system whereby the rich can buy what they want and those many beneficiaries who are on fixed incomes will not be able to afford those services.⁵⁴ This criticism is misguided for several reasons.

First, while this paper has focused on Medicare Part B, PPO plans are already an option for participants in privately run Medicare Advantage plans,⁵⁵

53. “Require price transparency of Medicare-reimbursed services. Price is the mechanism by which buyers and sellers communicate in the marketplace. Vigorous competition to provide the best quality at the best price drives superior performance.” Richard Dolinar and S. Luke Leininger, “Pay-for-Performance or Compliance? A Second Opinion on Medicare Reimbursement,” *Indiana Health Law Review* 3, no. 2 (2006): 397, 418.

54. Transcript of Oral Argument at 41, *United Seniors Ass'n*, 2 F. Supp.2d 39 (No. 97-3109).

55. Ironically, because they can contract easily with doctors outside their managed care plans, “Medicare managed care participants now have much more latitude and choice than Medicare fee-for-service patients! This is an absurd result considering that the premise of managed care is centered around providing greater management and regulatory controls than the fee-for-service environment.” Greeson and Gunas, “Section 4507 and the Importance of Private Contracts,” 45.

“Just because physicians *may* charge seniors the market rate for their services doesn’t mean they *must*.”

sometimes referred to as Medicare Part C. About 25 percent of Medicare recipients use these plans as an alternative to the traditional Medicare Part B. As Medicare’s own website acknowledges, “each [Medicare Advantage] plan gives you flexibility to go to doctors, specialists, or hospitals that aren’t on the plan’s list, but it will usually cost more.”⁵⁶ Medicare Advantage is under serious threat from new Affordable Care Act rules that require a significant decrease in government funding, potentially eliminating the PPO option for many seniors. However, the fact that PPO plans require additional patient payments to nonparticipating physicians has raised few eyebrows, perhaps because this is a common feature of health insurance plans for Americans under age 65.

Second, when balance billing was common before the Medicare amendments in 1989, physicians often wrote off the balances for their poorer patients while collecting them from wealthier patients.⁵⁷ Just because physicians *may* charge seniors the market rate for their services doesn’t mean they *must*.

Also, seniors concerned about potential liability for balances due from nonparticipating physicians would be able to purchase Medigap insurance. Medigap is the name applied to a wide variety of private, nonsubsidized insurance plans that Medicare recipients purchase to supplement Medicare’s coverage.⁵⁸ Most Medicare recipients who are not poor (and therefore not eligible for Medicaid) pay for Medigap coverage.⁵⁹ These plans vary in their scope and premium cost, but two plans, Medigap F and Medigap G, include coverage for Medicare Part B excess charges.⁶⁰

56. See “Preferred Provider Organization (PPO) Plans,” Medicare.gov, <http://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/preferred-provider-organization-plans.html>.

57. Singer, “Simple Way to Improve Medicare.”

58. Centers for Medicare & Medicaid Services, *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* (2015), 9.

59. Richard Kaplan, “Top Ten Myths of Medicare,” *Elder Law Journal* 20 (2012): 10.

60. “Medicare Part B Excess,” Medicare Pathways website, accessed February 28, 2013, <http://www.medicarepathways.com/2012/10/medicare-part-b-excess/>.

These Medigap policies would play a larger role if nonparticipating physicians were permitted to charge market rates for their services.

Beyond those considerations, medical care provided to seniors already varies by income. Among other examples, employed seniors with excellent healthcare plans can and do decline to participate in Medicare Part B until they retire. The very wealthy can go to opt-out physicians, or even go abroad, for specialized treatments. Individuals either living in or with the means to travel to urban areas with large university medical centers can access a higher quality of care than those whose options are more limited. Veterans receive special services from the Department of Veterans Affairs.

A significant policy improvement should not be held hostage to a false notion that all seniors currently eligible receive precisely the same care for the same price. If Medicare moved to a PPO structure modeled on private insurance, it would ultimately save the program money and reduce pressure on physician fees, thereby benefiting all seniors in the program. After all, every time a Medicare beneficiary chose to see a physician who wasn't a "preferred provider," Medicare would be saving the difference between what it pays participating and nonparticipating physicians.⁶¹

Congress should also consider two other reforms. First, it should liberalize Medigap insurance regulations. As noted previously, Medicare-eligible patients may contract with their physicians for services that are not covered by Medicare, such as office visits in excess of what Medicare deems appropriate. However, Medigap insurance does not cover such contingencies.⁶² Congress should allow seniors to buy Medigap insurance that would pay for noncovered services.

Second, Congress should significantly relax the rules on opt-out physicians.⁶³ Opt-out should not be an all or nothing. Consider an oncologist who spends 80 percent of the time treating cancer patients with standard modalities and 20 percent of the time treating terminally ill patients with experimental

61. See Jennifer O'Sullivan and Cecilia O. Echeverria, *Medicare: Private Contracts*, Congressional Research Service report for Congress, 97-944 EPW (1997), 4. The authors note that allowing individuals to pay for services out of pocket leaves more money in the Medicare pool.

62. Patricia Barry, "If Your Doctor Opts Out of Medicare," *AARP Bulletin* (American Association of Retired Persons), December 14, 2009, http://www.aarp.org/health/medicare-insurance/info-12-2009/ask_ms_medicare_question_73.html.

63. The Medicare Beneficiary Freedom of Contract Act would have allowed Medicare patients and their physicians to enter into private contracts on a case-by-case basis without the physician being subject to the two-year opt-out limit, but it did not progress through Congress. See "H. R. 709— Medicare Beneficiary Freedom to Contract Act of 2005," OpenCongress website, <https://www.opencongress.org/bill/hr709-109/show>.

modalities that Medicare covers inadequately. Medicare may pay too little, bury the physician in paperwork, deny coverage retroactively for what seems to the physician like arbitrary reasons, or some combination of all three. The physician should be allowed to participate in Medicare for the 80 percent of “standard” patients, and contract privately with patients for the other 20 percent.

Liberalizing opt-out rules would give seniors more control over their health care, enhance freedom of contract, vindicate the right of seniors (and everyone else) to get medical care to stave off death, and, perhaps most important, spur medical innovation. A massive, lumbering government bureaucracy like the CMS is not capable of properly pricing novel, innovative treatments that in the long term will significantly enhance human health and, in many cases, reduce overall healthcare costs. Giving the private market more of a role in senior health care by relaxing the opt-out rules will allow room for innovation and also encourage the development of cost-effective solutions to medical problems because seniors, like others, are more price sensitive when they are paying the bills themselves.

One need only consider vision correction surgery over the past two decades to get an idea of what could be accomplished. Paid for almost entirely out of pocket, it has gotten both much better and much cheaper. In the beginning, such surgery was very expensive and beyond the means of many, but rapid innovation and competition has made it very affordable for most people, and outcomes have continually improved.⁶⁴

CONCLUSION

Despite promises that Medicare would not interfere with patients’ ability to choose their physician and to purchase additional health coverage on the open market, over the decades Medicare rules and regulations have gradually eroded senior citizens’ ability to control their healthcare choices. With Medicare facing financial and regulatory pressures that threaten to drive more and more physicians out of the system, it’s time for Congress to allow private contracting to play a significantly greater role in Medicare Part B. Congress should eliminate the limit on patients’ ability to negotiate fees with nonparticipating physicians, expand the scope of Medigap coverage to include services not covered by Medicare, and liberalize the rules for opt-out physicians.

64. See, for example, Lara Hoffmans, “They Unblinded Me with Science,” *Forbes*, March 23, 2012, <http://www.forbes.com/sites/larahoffmans/2012/03/23/they-unblinded-me-with-science>.

ABOUT THE AUTHOR

David E. Bernstein is a George Mason University Foundation Professor at the George Mason University School of Law in Arlington, Virginia, where he has been teaching since 1995. Bernstein is a graduate of the Yale Law School, where he was senior editor of the *Yale Law Journal* and a John M. Olin Fellow in Law, Economics, and Public Policy. He is the author of more than 60 frequently cited scholarly articles, book chapters, and think tank studies, including articles and review essays in the *Yale Law Journal*, *Michigan Law Review*, *Texas Law Review*, and *Georgetown Law Journal*. Bernstein is the author of several books, including *Rehabilitating Lochner: Defending Individual Rights against Progressive Reform* (University of Chicago Press, 2011), *You Can't Say That! The Growing Threat to Civil Liberties from Antidiscrimination Laws* (Cato Institute, 2003), and *Only One Place of Redress: African-Americans, Labor Regulations, & the Courts from Reconstruction to the New Deal* (Duke University Press, 2001). He is also coeditor of *Phantom Risk: Scientific Inference and the Law* (MIT Press, 1993). He is a former chairperson of the evidence section of the Association of American Law Schools.

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