WHAT'S AT STAKE

# Medicare Private Contracting

Over time, policy ideas gain and lose popularity, including several that threaten the effectiveness of major health care programs like Medicare, Medicaid, and the Affordable Care Act (ACA). In this series—What's at Stake—we explore some of these reform ideas and how they could affect coverage, care, and outcomes for older adults and people with disabilities.

Some policymakers endorse proposals to give Medicare providers the right to charge beneficiaries more for care than is currently allowed, either through balance billing or private contracting. Under these reforms, providers could require their Medicare patients to negotiate a contract for the cost of their care, or simply charge more for Medicare-covered services, leaving those beneficiaries with additional costs on top of their premiums, copayments, and coinsurance.[1]

## Current Protections

Health care providers have flexibility to decide how to participate in Medicare and what cost sharing to accept, including whether they can use balance billing. Each option has different standards:[2]

- **Participating providers** receive the bulk of their reimbursement from Medicare and charge patients the standard Medicare coinsurance—generally 20%. They cannot balance bill by setting prices above Medicare-approved rates and then recouping the excess from beneficiaries.

[1] See, e.g., "Medicare Patient Empowerment Act of 2015" (H.R.1650 and S.1849), https://www.congress.gov/bill/114th-congress/house-bill/1650.
[2] Medicare Interactive, "Participating, non-participating, and opt-out providers" (last visited January 23, 2024), https://www.medicareinteractive.org/get-answers/medicare-covered-services/outpatient-provider-services/participating-non-participating-and-opt-out-providers.

- **Non-participating providers** accept Medicare insurance, but they do not accept Medicare's approved amount for health care services as full payment. They can balance bill by charging beneficiaries up to 15% above Medicare's standard amount, though some states further limit these charges.
- **Opt-out providers** do not accept Medicare at all and have signed an agreement to be excluded from the Medicare program. This means they can charge whatever they want for services but must follow certain rules to do so.

These categories came about due to beneficiary access issues. In the 1980's, many people with Medicare were confused about provider costs and were being charged high, and escalating, fees for seeing the doctor.[3] In response, Congress established new rules, including limitations on balance billing. This prohibited providers who accept Medicare from charging beneficiaries more than the Medicare-allowed rates.[4] According to one study, out-of-pocket spending declined by 9% among Medicare households because of these protections and patient access to doctor's visits and specialty care was unaffected.[5]

In the 90's, Congress went further and established rules around private contracting, requiring providers to opt-out of Medicare entirely if they want to charge fees that are unrelated to Medicare-approved rates.[6] Opt-out providers must enter into contracts with their prospective patients, explaining patient financial liability and the lack of Medicare coverage for care from that provider. Such contracts are not permitted in the case of emergency.[7]

## Access to Providers

Those favoring alternative arrangements argue that there is a provider shortage in Medicare and balance billing or private contracting is the solution. However, there is little evidence to support this position as only 1.1% of non-pediatric physicians have opted out of Medicare. Rates are higher among some specialties. Psychiatrists, for example, opt out at a rate of 7.7%, but they are also less likely than other physician specialties to accept new patients any type of

[3] Cristina Boccuti, "Paying a Visit to the Doctor: Current Financial Protections for Medicare Patients When Receiving Physician Services" (November 30, 2016), https://www.kff.org/medicare/issue-brief/paying-a-visit-to-the-doctor-current-financial-protections-for-medicare-patients-when-receiving-physician-services/.
[4] Cristina Boccuti, "Paying a Visit to the Doctor: Current Financial Protections for Medicare Patients When Receiving Physician Services" (November 30, 2016), https://www.kff.org/medicare/issue-brief/paying-a-visit-to-the-doctor-current-financial-protections-for-medicare-patients-when-receiving-physician-services/.
[5] Robin McKnight, "Medicare Balance Billing Restrictions: Impacts on Physicians and Beneficiaries," Journal of Health Economics (March 1, 2007), https://www.sciencedirect.com/science/article/abs/pii/S016762960600097X.
[6] Pub. L. No. 105-33 § 4507.
[7] Cristina Boccuti & Tricia Neuman, "Private Contracts Between Doctors and Medicare Patients: Key Questions and Implications of Proposed Policy Changes" (January 23, 2017), https://www.kff.org/medicare/issue-brief/private-contracts-between-doctors-and-medicare-patients-key-questions-and-implications-of-proposed-policy-changes/.

coverage, suggesting they generally prefer to be paid directly and avoid insurance-related burdens and cost constraints.[8]

In 2019, 89% of office-based physicians accepted new Medicare patients, similar to the 91% who accepted new privately insured patients.[9] These numbers hold steady across rural and urban settings, and a robust 96% of people with Medicare report having regular access to providers.[10]

## The Risk

Without the protections of current law, people with Medicare could be subjected to virtually any cost for any service. Providers could freely choose what to charge people with Medicare—eradicating cost predictability, coverage affordability, and care access, and undermining the doctor-patient relationship.

Allowing Medicare private contracting beyond the current opt-out system could price people out of health care and create a two-tier program. One tier would be for people who could afford to pay what doctors would demand. Such beneficiaries would face higher costs but might not lose access to the care they need. The other tier would be patients unable to afford doctors' new prices, untethered from Medicare's limitations. This group would face declining access to care, health, and economic well-being. The effects would likely be the most severe in rural and other areas where provider options are already limited, but all beneficiaries would be at risk for care delays and higher costs.

[8] Nancy Ochieng & Gabrielle Clerveau, "How Many Physicians Have Opted Out of the Medicare Program?" (September 11, 2023), https://www.kff.org/medicare/issue-brief/how-many-physicians-have-opted-out-of-the-medicare-program/.
[9] Nancy Ochieng, et al., "Most Office-Based Physicians Accept New Patients, Including Patients With Medicare and Private Insurance" (May 12, 2022), https://www.kff.org/medicare/issue-brief/most-office-based-physicians-accept-new-patients-including-patients-with-medicare-and-private-insurance/.
[10] Cristina Boccuti, et al., "Medicare Patients' Access to Physicians: A Synthesis of the Evidence" (December 10, 2013), https://www.kff.org/medicare/issue-brief/medicare-patients-access-to-physicians-a-synthesis-of-the-evidence/.