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FREEDOM TO PAY OR FREEDOM TO CHOOSE? PRIVATE CONTRACTING AND MEDICARE BENEFICIARIES

Marilyn Moon[†]

LIKE MANY OTHER ISSUES BEING DEBATED about the Medicare program, private contracting evokes both adamant supporters and opponents. Essentially, private contracting is an agreement between a physician and a Medicare beneficiary where the patient agrees not to submit a claim to Medicare, but agrees to pay privately for the medical service. This allows physicians to bypass the strict rules that govern how much they can be paid for providing services to Medicare beneficiaries. Not surprisingly, this option has been strongly supported by many physician groups.

In this Article, I examine the issue from the perspective of beneficiaries and the Medicare program as a whole. Does private contracting constitute good public policy? Is there a legitimate problem facing beneficiaries or the program as a whole that this policy would address? What other goals might be used to justify abrogating physician autonomy? How would the economic incentives established by such a rule work in practice? These questions are likely to engender a different answer from a beneficiary's perspective than one might get if looking at it from the point of view of providers of services.

Before examining the specifics of private contracting, it is important to put the discussion into the context of the history of the Medicare program and of broader changes taking place in the delivery of care. The analysis that concludes the Article examines the tradeoffs in the context of economic theory.

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I. A BRIEF HISTORY TO SET THE CONTEXT

When Medicare came into being in 1966, a chief concern was that there would be an unwillingness by many physicians and other practitioners to participate in this government program. The American Medical Association (AMA) and other groups had strongly opposed a universal insurance program for persons aged sixty-five and over, fearing considerable governmental control over the practice of medicine. In fact, there had been calls in some quarters for a national boycott of Medicare.¹ To alleviate such fears, the initial legislation for Medicare sought to reassure physicians by exercising almost no control over payments. Medicare was to serve as a conduit for payment, compensating physicians for eighty percent of usual and customary charges using the same methodology of many private insurance plans. Physicians were allowed to bill patients for amounts in excess of their twenty percent co-payment requirement.² These additional amounts were referred to as "balance billing," meaning that physicians were charging patients for the balance between Medicare's 100% allowed charge and the actual bill. Physicians could choose to accept "assignment" -- that is, they would treat the 100% allowed charge as payment in full and seek no amount from beneficiaries above their twenty percent co-payment. In practice, Medicare proved to be a very good deal for physicians,³ and nearly all of them treated Medicare patients.

By the early 1980s, however, interest in cost containment grew as the costs of health care in general had grown rapidly since the late 1970s. Pressures on the Medicare program were particularly great, reflecting both an interest in limiting public spending in general as well as a concern about the costs of health care. Efforts to hold the line on payments for all types of Medicare services dominated legislation on the program in the 1980s. Physician fees were a target both because they constituted a large share of Medicare spending and because in the late 1970s and early 1980s,

¹ See generally *Medicare Caution Given Physicians: AMA Finds Antitrust Risk in a Concerted Boycott*, N.Y. TIMES, Aug. 12, 1965, at 15 (discussing the AMA's announcement that its doctors could individually refuse to accept Medicare patients, and the possible antitrust implications of such an action).

² See generally ROBERT J. MYERS, *MEDICARE 144-53* (1970) (explaining how physicians are reimbursed under supplementary medical insurance).

³ See, e.g., *id.* at 244 (discussing a study which indicated that in all but four percent of the cases, the reasonable charge equaled the charge made by the physician).

these payments were growing at rates averaging about twenty percent each year. Thus, in 1984, payments to physicians were frozen to achieve short run savings and presumably to set the stage for longer-term reform.⁴ To try to keep balance billing reasonable while fees were frozen, the 1984 legislation also included provisions to discourage balance billing.⁵ This reflected an attempt to prevent physicians from merely shifting costs onto beneficiaries.

By the end of the 1980s, physician payment reform was finally adopted after a considerable amount of controversy. Even though the reforms enacted were meant to be budget neutral and not change overall spending on physician services, the goal of the new fee schedule goal was to alter *relative* prices substantially -- raising payments for primary care physicians relative to specialists and altering longstanding geographic differences in payment levels. As a consequence, there was concern that without further controls on balance billing, physicians would simply use that mechanism to offset these changes and undo the adjustments in payment levels that were the goal of the legislation. Although the earlier restrictions on balance billing were still in place, they were widely regarded as obscure and difficult to enforce. The new system ultimately established a firm upper boundary on how much physicians could be paid for specific services, even when they chose not to accept assignment. As a result, balance billing is now limited to fifteen percent above Medicare's allowable rates.⁶

What did all these legislative changes mean to Medicare beneficiaries? Initially about sixty percent of all bills subject to the twenty percent coinsurance amount were assigned.⁷ During the early 1980s, that share fell to a little over fifty percent.⁸ When the 1984 legislation was put in place, assignment rates began to increase, reaching seventy-seven percent in 1988 and ninety-seven

⁴ See generally PHYSICIAN PAYMENT REV. COMM'N, ANNUAL REPORT TO CONG. 23-24, 134 (1988) (discussing trends in health care expenditures in the Medicare program as a context for considering changes in physician payment policy).

⁵ See *id.* at 134-36 (describing changes in Medicare's policy on assignment and balance billing).

⁶ See PHYSICIAN PAYMENT REV. COMM'N, ANNUAL REPORT TO CONG. 15-17 (1992) (discussing reform efforts in the payment of physicians).

⁷ See SOC. SEC. ADMIN., ANN. STAT. SUPP. TO SOC. SEC. BULL. 334 (1995).

⁸ See OFFICE OF STRATEGIC PLANNING, U.S. DEP'T OF HEALTH & HUMAN SERV., HEALTH CARE FINANCING REV. 110 (Stat. Supp. 1998) (discussing Medicare physician and supplier assignment rates by state).

percent in 1996.⁹ Most physicians now find it in their interest to simply take Medicare's fee schedule as payment in full.

The most important impact has thus been to reduce substantially the amount of cost sharing that beneficiaries must do to receive physician and other related services. In 1977, balance billing constituted 17.9% of cost sharing liability under Part B of the program.¹⁰ That proportion rose to 23.2% in 1981.¹¹ After 1986, the share of liability from balance billing declined steadily to 2.2% of Part B cost sharing in 1996.¹² Thus, most beneficiaries now face little or no balance billing, resulting in cost sharing liabilities that are much less than they might have been without the controls.

These reductions in balance billing liabilities came at a time when other cost sharing liabilities were growing rapidly in Medicare. Use of all services has risen as has the level of payments, which generally affects the coinsurance amounts required for each service. For example, between 1977 and 1996, total cost sharing liabilities for beneficiaries rose 356% as compared to a decline of eighty-eight percent in balance billing liabilities.¹³ If balance billing had remained at a thirty percent share of Part B cost sharing through 1996, beneficiary liabilities would have risen by 512% instead.

Because the combination of relatively low increases in payments to physicians over the past two decades and the limitations on balance billing, policy makers have periodically expressed concerns about whether beneficiaries are or soon will face problems in finding physicians and other service providers willing to serve them at the prices that Medicare will agree to pay. Consequently, the Physician Payment Review Commission (PPRC) and other groups have periodically attempted to poll beneficiaries regarding access to physicians. Surveys by the PPRC have found that physicians overwhelmingly participate in the Medicare program.¹⁴ Well

⁹ See *id.* at 310.

¹⁰ See *id.* at 199.

¹¹ See *id.*

¹² See *id.*

¹³ *Id.* at 198.

¹⁴ See MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONG.: CONTEXT FOR A CHANGING MEDICARE PROGRAM 136 (1998) (citing Carol-Ann Emmons, *Survey of Physicians About the Medicare Program and Fee Schedule: A Study Conducted for the Physician Payment Review Commission by the National Opinion Research Center* (1994)). See also Jennifer O'Sullivan & Cecilia O. Echeverría, *Medicare: Private Contracts*, in CONG. RESEARCH SERV. REP. FOR CONG. 2 (last modified Oct. 21, 1997) <<http://www.senate.gov/gov/~dpc/crs/reports/pdf/97-944.pdf>> (citing

over ninety percent of all physicians (excluding areas such as pediatrics where few beneficiaries would be treated in any case) take Medicare patients, and many of them continue to accept new Medicare patients as well.¹⁵ The problems of access that the PPRC survey found relate more to shortages of physicians within a geographic area than to Medicare policy per se. As yet, there is little evidence that the tight limits on how much physicians can be paid for services performed on Medicare beneficiaries has led to any decline in access to such services.¹⁶ Thus, from the perspective of most beneficiaries, the policy of limiting balance billing has been highly successful because it has reduced what their out-of-pocket (or insurance premium) costs otherwise would have been without restricting their choices of providers.

While Medicare's payment levels have tended to be below those paid by the private sector,¹⁷ the gap does not seem to have widened over time, largely because private insurers, particularly managed care organizations, have become more restrictive in their payments as well. In fact, Medicare's rates as a share of private rates increased from sixty-six percent in 1994 to seventy-one percent in 1996.¹⁸ This likely helps to explain why access has not been a concern.

But if Medicare has not worsened relative to other private plan payments, why has the concern about private contracting been raised? While the rules under which Medicare now operates are also generally consistent with private insurance plans that also seek discounts from participating providers, there is one important exception. Medicare limits what beneficiaries who "go out of network" for care can be charged by their physicians. In many private plans, the amount that the plan will pay is also limited and less generous than for "in network" providers, but the ultimate amount that the patient pays the doctor is not under the control of the pri-

a report of the Physician Payment Review Commission claiming that in 1997, eighty percent of physicians serving Medicare beneficiaries were "participating" physicians).

¹⁵ See MEDICARE PAYMENT ADVISORY COMM'N, *supra* note 14.

¹⁶ See *generally id.* at 127-37 (discussing the PPRC's analysis of the Medicare Current Beneficiary survey, a longitudinal survey of Medicare beneficiaries administered by HCFA in 1996).

¹⁷ See Diana K. Verrilli & Stephen Zuckerman *Preferred Provider Organizations and Physician Fees*, HEALTH CARE FIN. REV., Spring 1996, at 161, 162 (referring to findings by the Physician Payment Review Commission suggesting that Medicare fees were thirty to forty percent below private fees during the 1990s).

¹⁸ See MEDICARE PAYMENT ADVISORY COMM'N, *supra* note 14, at 126.

vate plan. In this way, Medicare uniquely sets an upper boundary on what any physician may charge a Medicare beneficiary for a covered service. This is essentially the source of much of the criticism concerning payment policy.

At least in theory, before 1997 the only way that physicians could be totally free of such controls was not to treat Medicare patients. The only way that the Health Care Financing Administration (HCFA) that runs the Medicare program would know if patients are now making private arrangements to pay physicians more would be if a patient complained. There is some anecdotal evidence of physicians requiring waivers of patients to pay more than Medicare would allow before they would provide treatment. This may be the Medicare version of a "don't ask, don't tell" policy. But in response to *Stewart v. Sullivan*,¹⁹ a court case that left considerable confusion on what the rules were on private contracting, 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.²⁰ These efforts were intended to prevent physicians from asking patients to sign waivers concerning payment limits.

II. VERSIONS OF PRIVATE CONTRACTING LEGISLATION

The legislation proposed and enacted on private contracting has stirred up a considerable amount of controversy, and both proponents and opponents have sought further clarifications on how physicians may deal with Medicare patients. Much of the recent legislative activity began as a floor amendment by Senator Jon Kyl to the 1997 Balanced Budget Act (BBA) legislation. The amendment specified that nothing in Medicare law could prohibit a physician, or another health care professional from entering into a private contract with a Medicare beneficiary for services for which no claim would be submitted. Furthermore, "[t]he provision was in-

¹⁹ 816 F. Supp. 281 (D.N.J. 1992) (holding that plaintiffs' claims were not ripe because plaintiffs had not established that the Department of Health and Human Services had articulated a policy on private contracting).

²⁰ See O'Sullivan & Echeverria, *supra* note 14, at 2-3 (discussing the history of Medicare and private contracting).

tended to apply only to physicians who were outside of Medicare entirely."²¹

The conference committee changed this amendment. The version of private contracting enacted in the Balanced Budget Act of 1997 contained a number of restrictions on private contracting -- attempting to limit such activities. Physicians wishing to engage in private contracting would have to agree not to bill Medicare for any services for any of their patients for a two-year period.²² That is, they would have to explicitly opt out of Medicare for a period of time. Not only did this piece of the BBA not satisfy those who pushed for the Kyl version of private contracting, but it brought on scathing criticism accusing the BBA of making the situation worse. Thus, there was not even agreement on whether the BBA loosened the restrictions that HCFA believed were in place or whether it made explicit a prohibition that some physicians argued should not apply.

As a consequence, Senator Kyl introduced legislation to modify the BBA, establishing a substantially more flexible set of rules for private contracting even as compared to his initial amendment.²³ This legislation would have allowed individuals to enter into private contracts with their physicians under certain conditions. The contract would relate only to Medicare-covered services, would have to be drawn up in advance of receiving services, and would have to indicate what specific services would be subject to the contract. Presumably this could be done on a service-by-service basis so that a physician could, for example, identify a specific procedure that he or she would perform only on a private contract basis. Thus far, this legislation has not been enacted, but it is likely to be an issue again in the future.

The level of discourse on this issue has been highly charged and both sides have made exaggerated claims although they often have at least some basis in reality. Opponents of the BBA approach went so far as to argue that it would prevent beneficiaries from receiving services not covered by Medicare because doctors

²¹ *Id.* at 4.

²² CCH EDITORIAL STAFF PUBLICATION, 1997 MEDICARE AND MEDICAID LEGISLATION: LAW AND EXPLANATION ¶ 719-21, at 156-57 (1997).

²³ See S. 1194, 105th Cong. § 1 (1997) (proposing an amendment to the Social Security Act which would clarify the right of Medicare beneficiaries to enter into contracts with physicians and other health care professionals for health care services for which no payment was sought from Medicare).

would be subject to the new rules for all health care services.²⁴ These claims continued despite specific assurances by the head of the Health Care Financing Administration that runs the Medicare program that Medicare requirements do not apply to such additional services.²⁵ For those services covered by Medicare, the 1997 BBA statute effectively allows physicians who have decided not to participate in Medicare to enter into private contracts -- the original problem that Kyl sought to address. It does, however, restrict behavior of physicians who wish to set their own prices either by service or for specific patients while still participating in Medicare.

Opponents of any form of private contracting, including that in the BBA, argued that loosening restrictions on physicians contracting with patients for higher payments was just the first step toward allowing doctors to balance bill at will for all Medicare-covered services. Although relaxation of balance billing was not part of the proposed Kyl legislation, opponents feared that it would be followed by a second round later in which physician groups would be able to attract beneficiary support for having Medicare pay their share regardless of contracting arrangements. If so, private contracting would expand substantially once beneficiaries no longer would have to pay the full costs of care. But perhaps the most important claim that needs to be sorted out relates to the title of Senator Kyl's 1997 bill: "Medicare Beneficiary Freedom to Contract Act of 1997." Prohibitions on private contracting do limit physician flexibility, but do they help or harm beneficiaries?

III. WHAT ARE THE RELEVANT POLICY ISSUES?

The key question concerning this legislation is whether it enhances the choice and freedom of beneficiaries, the rights of physicians to charge for services, or both. The arguments cast the issue of private contracting in a very different light depending upon what we assume is the nature of the protection and who is being protected.

²⁴ See Letter from Sandra Butler, President, United Seniors Ass'n, to Senior American[s] (Fall 1997) (on file with *Health Matrix*).

²⁵ See *Private Contracting in Medicare: Hearing Before the Senate Finance Committee, 105th Cong.* (1998) (statement of Nancy-Ann Min Deparle, Administrator, Health Care Financing Administration) available in LEXIS, CIS Congressional Universe Library, Federal Document Clearing House Congressional Testimony File (clarifying that Medicare patients can use their own funds to pay for services that Medicare does not cover).

A. Physicians' Concerns

The most straightforward argument is that private contracting would aid physicians, allowing them to determine what to charge which patients. Private contracting, particularly on a service-by-service basis, would allow physicians to key in on specific payments that they believe are too low and establish higher charges for those services. While many physicians could not afford to drop out of Medicare entirely, they might be willing to risk losing some patients on a more selective basis. For example, in cases where a patient receives most of his care from a particular physician, would he go elsewhere to obtain one particular service for which the physician requires a private payment? Physicians would retain considerable leverage if they used private contracting selectively.

Another argument often used by physicians is that they should be able to charge more from patients with high incomes. Why, the argument goes, should wealthy patients get these discounts? Many physicians have argued that, as a consequence, they would have more resources in that case to devote to treating patients who do not have substantial resources. The problem is that when balance billing was largely uncontrolled, there was only mixed evidence that doctors attempted to distinguish between who could afford services and who could not.²⁶ Physicians may have a tendency to treat all patients alike. Further, doctors in midtown Manhattan with well-heeled patients are not likely to also treat low-income patients from elsewhere in New York City.

The best argument for private contracting is assuring the freedom of physicians to charge for services. Even proponents of balance billing limits often acknowledge that the current Medicare structure does not allow for highly skilled, outstanding physicians to obtain the higher fees that they would be able to command in a free market. Medicare's fee schedule and balancing billing limits do put substantial barriers in the way of such freedoms for physicians.

The actual impact of private contracting on physicians depends upon whether they are able to engage in "price discrimination." In economic theory, this term refers to the ability of suppliers to set different prices for different customers, charging each what they are willing to pay. Economic theory indicates that sup-

²⁶ See PHYSICIAN PAYMENT REV. COMM'N, *supra* note 4, at 146 (discussing factors that may be involved in physician decisions to accept or reject assignments).

pliers who are able to price discriminate effectively among their customers can achieve higher profits. That is, in the present context, physicians would charge consumers who are willing to pay more a higher price, and charge those who will only purchase that good or service at a lower price that lower amount. This allows sellers to reap the advantages of high volume, while still charging higher prices to some. Without price discrimination, the only way to sell the higher volume is to lower the price for everyone. In a purely competitive market, price discrimination is not possible as buyers would seek other suppliers willing to offer services at the market price. Thus, it is usually only when the sellers have an advantage in the market (such as a reputation for high quality care or as the sole provider of such services) that they can price discriminate.

B. The Beneficiary's Perspective

Next consider the more complicated question of what private contracting means for beneficiaries. Supporters make the claim that such legislation will open up new horizons for Medicare beneficiaries, giving them access to doctors who now refuse to participate in the Medicare program. Senator Kyl has argued that:

Under current law, seniors do not enjoy the same rights as the rest of us. If Congress fails to correct this inequity, I fear we will have established a pernicious principle: that when it comes to health care, senior citizens have only one option -- a government program -- no matter what their desire or their ability to pay for care outside of Medicare.²⁷

Private contracting is thus characterized as a choice issue, and the argument is that Medicare beneficiaries cannot go to doctors of their choice even if they are willing to pay.

Such a prohibition on private contracting does restrict the ability of beneficiaries to compensate physicians at a higher level, but does it really restrict choice? First, consider the two types of physicians affected by private contracting. The BBA already addresses the issue of allowing beneficiaries to contract with those physicians who do not participate at all in Medicare. The changes that Senator Kyl proposes would allow more flexible contracting

²⁷ Jon Kyl, Give Seniors Same Health Care Choice as Other Americans, Kyl Tells Panel, Feb. 26, 1998, Press Release (announcing Senator Kyl's testimony before the Senate Finance Committee).

whereby physicians could do this for only part of their practice. If that causes some physicians who now take no Medicare patients to accept such patients for at least some services, then beneficiaries might have access to a few additional doctors. Since very few doctors now decline to treat Medicare patients, however, this is likely to be only a limited advantage.

But physicians now in Medicare who dislike the level of some of their fees or who decide to set fees higher for some patients (if the Kyl legislation passed) would effectively restrict beneficiary access for those who lack the ability to pay the higher charges. For example, if a physician decides to raise his fees for a particular procedure beyond the level that Medicare allows, some patients may be unable to afford that rate and have to change doctors when they need a particular procedure. It is difficult to characterize such an effect as an expanded choice. It is also questionable whether those who would sign contracts would do so voluntarily or would feel coerced into doing so.

The current system of placing an upper boundary on the amount that beneficiaries must pay for particular services through the fee schedule and balance billing limits makes the cost of care more affordable for beneficiaries. From that perspective, it also protects their ability to exercise choice in the selection of physicians.

Whether choice expands or contracts for beneficiaries in actual practice depends upon the relative size of the two competing effects. How many physicians who now decline to treat any Medicare patients will accept them under private contracting as compared to the numbers of physicians who will use private contracting to accept only patients with greater financial resources who can pay privately? As described above, most doctors already participate in the Medicare program. On the other hand, there are a large number of studies that indicate that affordability is a barrier to individuals getting care. To the extent that private contracting would reduce the affordability of physician services, that could have a major impact on which physicians patients could afford to see and even how often they might be able to afford to go. The stringent limits on private contracting in the 1997 BBA were specifically designed to discourage physicians from opting for these arrangements. If private contracting were expanded to allow service-by-service contracts, more beneficiaries would likely be disadvantaged by this policy. And if the policy did ultimately lead to a relaxation of balance billing limits, then we might see a return to a

large portion of physician services being billed at higher-than-Medicare rates. Despite gains in incomes since the Medicare program began, there are still a large number of beneficiaries with incomes of less than 200% of poverty.²⁸ The number of persons adversely affected by the inability to afford services if private contracting were expanded would likely be greater than the number of persons able to access doctors who now are not available to them.

What about the quality of the doctors who choose not to participate in Medicare? Is it the best doctors who find they can do without Medicare patients? Here there is little evidence although proponents of private contracting argue strongly that this is an issue. If these doctors now totally drop out of the Medicare program, the current BBA version of private contracting is probably sufficient to meet their needs since they are unlikely to want to selectively contract with beneficiaries. In a more flexible, partial private contracting environment, doctors most likely to be able to price discriminate -- that is, charge at least some of the patients substantially higher fees -- are those who have a competitive advantage, either because of their reputations or the lack of other physicians with similar specialties in a given location. Ironically, quality might become more of an issue from the relaxation of private contracting because of this market power. Thus, instead of helping to give patients access to high quality care, this policy could contribute to the creation of a two-tiered Medicare program, differentiated by the ability to pay.

A second way in which access to care might be affected is the time that a physician spends with patients. If payment levels are too low, would physicians respond by cutting the time spent with each patient? Would higher payment levels lead to better care? Again, there is little evidence that this is a problem in fee-for-service Medicare. Complaints in this area are more likely to be associated with those who participate in some form of managed care, both Medicare beneficiaries and others.

C. The Federal Government's Role

Another key player in this discussion is the federal government, both as a payer of bills and as an overseer of the public in-

²⁸ See NAT'L ACADEMY ON AN AGING SOCIETY, *DEMOGRAPHY IS NOT DESTINY* 32 (1999) (discussing the distribution of the elderly by income relative to the poverty level for 1975 and 1997).

terest. As a payer, the federal government has an interest in limiting its own obligations. Allowing more flexibility in what physicians can charge may indirectly allow the government to pay less. Physicians who believe they can shift any unpaid balance onto beneficiaries are less likely to hold the federal government accountable for higher fee schedules. But as the responsible party for assuring enrollees that they receive all the benefits to which they are entitled, the federal government might be concerned about the prospects of turning Medicare into a two-tiered system in which only wealthier beneficiaries can afford the best, or at least the highest priced, physicians.

IV. BALANCING BENEFICIARY PROTECTIONS AGAINST PHYSICIANS' FREEDOM

While supporters of private contracting have implied that both physicians and beneficiaries stand to gain from the Kyl legislation, it is more likely that, in practice, these two groups are pitted against each other. On balance, beneficiaries are likely to face less choice and higher costs from more flexible private contracting, while physicians would likely gain. So how should the interests of these two competing groups be reconciled?

Allowing more flexibility might result in higher quality physicians getting higher fees. They would presumably be able to demand and receive such higher payments. But this assumes that beneficiaries are well-informed about the quality of physicians and have the ability to make those distinctions. Private contracting may not be the best way to achieve the goal of rewarding quality. Other remedies addressing this issue might be more appropriate. For example, Medicare could establish higher payment levels for outstanding physicians based on a set of objective criteria. The Administration's summer 1999 proposal for Medicare reforms includes plans to reward centers of excellence and to establish a preferred provider arrangement. These principles, in theory, could be extended to physician fee schedules as well, recognizing quality differences.²⁹

The potential advantages of allowing price discrimination by physicians need to be weighed against the disadvantages this creates for beneficiaries. When price discrimination occurs for goods and services that have alternatives or are considered less essential

²⁹ DOMESTIC POL'Y COUNCIL & NAT'L ECON. COUNCIL, *THE PRESIDENT'S PLAN TO MODERNIZE AND STRENGTHEN MEDICARE FOR THE 21ST CENTURY* 1-7 (1999).

than health care, few objections are usually raised. Unlike the case of a standardized good or service, however, the ability to price discriminate for physicians' services may allow physicians to deny care to some individuals, and/or to effectively offer different products to different patients, for example, time spent with the patient. The sensitive nature of health care and the argument that it deserves a special set of protections are claims often made to justify seeking equal treatment for all Medicare beneficiaries. The substantial variation in the ability of beneficiaries to pay for services suggests that changing these rules will result in a decline in equal treatment. Governmental intervention is justified when markets fail to serve the public good. Historically, the justification for the Medicare program was the need to assure consistently high quality care to elderly and disabled persons. Thus, the essential tradeoff is between the freedom of physicians to charge what the market will bear and a Medicare program that treats beneficiaries consistently regardless of ability to pay.