

Barriers to Physician Care for Medicare Beneficiaries

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INTRODUCTION

The 1989 Omnibus Budget Reconciliation Act (OBRA 89) included physician payment reform, part of which was a limit on balanced billing. The provision limiting charges was implemented in 1991. Under this reform, physicians who did not accept Medicare assignment were prohibited from billing Medicare beneficiaries more than 140 percent of the prevailing charge for evaluation and management services, and 125 percent of the prevailing charge for all other services. With the implementation of the physician fee schedule in 1992, the limits on balanced billing became more stringent. Physicians who did not participate in Medicare were allowed 95 percent of the physician fee schedule amount for covered services from Medicare and could charge beneficiaries up to 120 percent of the fee schedule amount in 1992 and 115 percent of the fee schedule amount in 1993. In 1993, then, the actual amount that physicians could charge Medicare beneficiaries for covered services equaled 115 percent of the 95 percent allowed fee schedule amount—or 9.25 percent over the fee schedule rate. This limit has been in effect since 1993.

Before the OBRA 89 reforms, limits on the amount physicians could charge beneficiaries for Medicare covered services were much higher. At the time these limits were implemented there was speculation from special interest groups that many

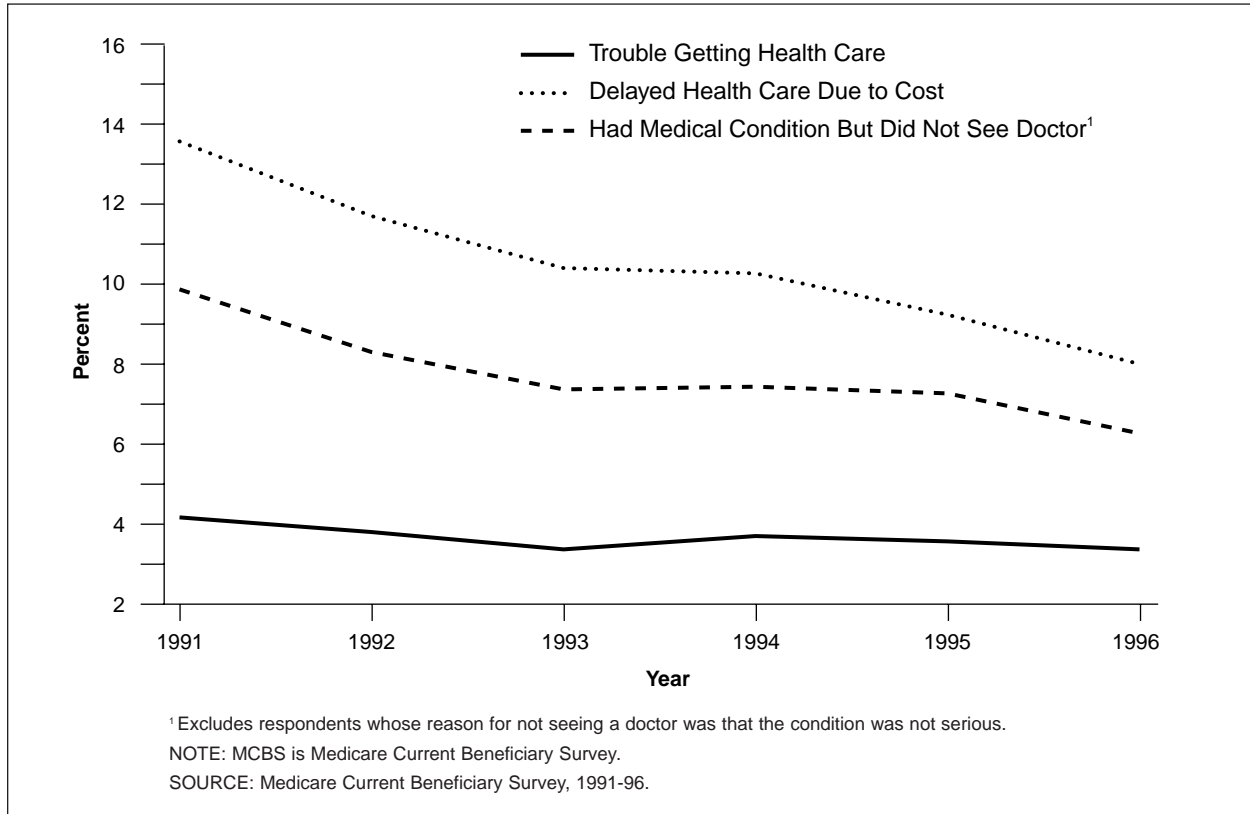
physicians would stop treating Medicare patients, causing beneficiaries to have difficulty receiving medical care, even though at the time roughly 80 percent of physicians accepted assignment. Proposed legislation in the Senate (S 1194) and the House of Representatives (HR 2497) would allow physicians to enter into private contracts with Medicare beneficiaries for covered services that effectively circumvent the balanced billing limits. The proposed legislation would allow physicians to accept Medicare payment for covered services from some patients while entering into private contracts for the same services with other patients. The physician, then, would determine the amount charged to the beneficiary for services provided under private contracts and Medicare would pay for no portion of those services. The legislation is designed to allow better access to care for Medicare beneficiaries in response to anecdotal reports from beneficiaries that their physicians are unwilling to take them as Medicare patients.

FINDINGS

A look at the Medicare Current Beneficiary Survey (MCBS) data from 1991 to 1996 (Figure 1) shows that access to medical care has actually improved since the implementation of balanced billing limits in 1991 and the physician fee schedule in 1992. The percent of respondents reporting delaying medical care due to worries about cost or not seeking necessary care from a doctor or other health care professional for a medical

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Figure 1
MCBS Respondents Reporting Trouble Getting Health Care, Delaying Health Care, or Not Seeing a Doctor for a Medical Condition: 1991-96



condition have both dropped since 1991. The percent of respondents indicating that they have had trouble getting wanted or needed health care during the year also declined slightly, from 4.1 percent in 1991 to 3.4 percent in 1996. It should be noted, however, that the MCBS data are representative at the national level but are not currently designed to study conditions at the local level. Difficulty getting health care could be a problem in local areas but not be apparent at the national level.

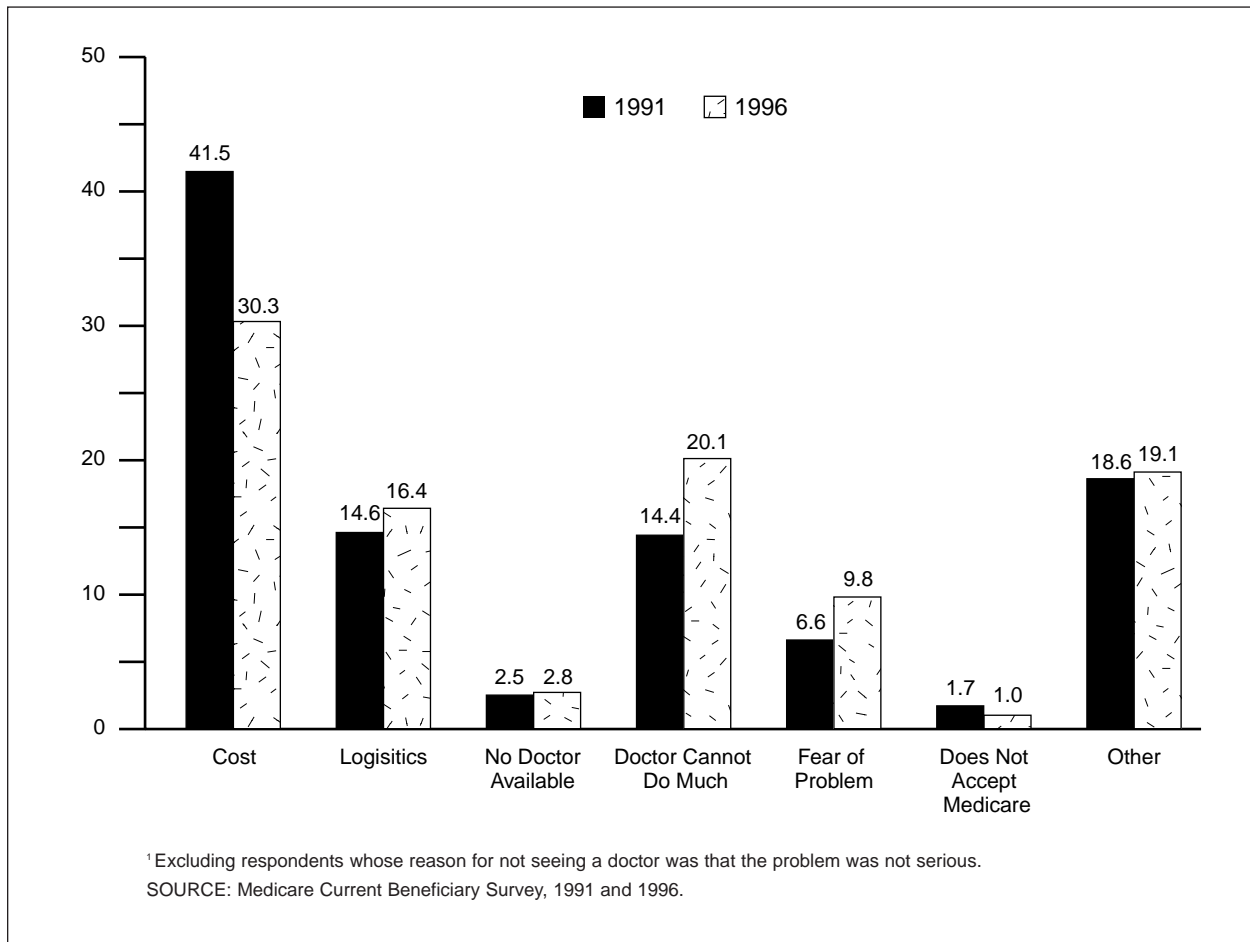
The small number of respondents reporting trouble getting health care usually cited cost as the reason, while relatively few respondents indicated that they had a problem with a doctor not accepting Medicare (Figure 2). Of the 3.4 percent of beneficiaries reporting trouble getting care, 35 percent (1.1 percent of the total

Medicare population) attributed it to either the cost being too high, the beneficiary not having money, or the services not being covered, only 3.4 percent of those reporting trouble (.01 percent of the total Medicare population) cited doctors not accepting Medicare as a problem. While cost is obviously the largest factor in access to medical care for beneficiaries, this problem seems to be improving since the implementation of limits on balanced billing. In 1991, 14 percent of respondents indicated that they had delayed seeking medical care in the past year because they were worried about the cost; in 1996, only 8 percent reported they had.

In 1991, 14.4 percent of MCBS respondents reported having a health problem or condition for which they thought they should see a doctor or other medical pro-

Figure 2

Main Reason Beneficiary Did Not See a Doctor for a Medical Condition: 1991 and 1996¹



fessional but did not. By 1996 that figure had declined to 9.5 percent. When the respondents who indicated that they did not see a doctor because the medical condition was not serious are excluded, the percentages are even lower, 9.9 percent in 1991 and 6.2 percent in 1996.

Again, most of these respondents cite cost as the reason they did not see a doctor or medical professional about the condition. In 1996 more than 33 percent of respondents (excluding those who did not see a doctor because the problem was not serious) indicated that the one reason for failing to see a doctor was that it cost too much. While this figure is substantial, it is lower than in 1991 when 49 percent of respondents cited cost as a reason for not

seeing a doctor. Only 1 percent of the respondents that did not see a doctor in 1996 indicated that it was because the doctor did not accept Medicare.

CONCLUSION

The MCBS data seem to indicate that Medicare beneficiaries had better access to care in 1996 than in 1991 when balanced billing limits were higher. Fewer beneficiaries report trouble getting health care, delaying health care because of the cost, or not seeing a doctor for a medical condition that requires attention. Respondents who have had problems getting medical care or do not see a doctor for a medical condition overwhelmingly indicate that the reason is

the cost rather than availability of physicians who accept Medicare patients. Since balanced billing and the fee schedule have been in effect, the proportion of beneficiaries reporting access problems due to cost has dropped, perhaps due to the limits that doctors can charge patients. The MCBS

clearly shows that the cost of medical services is a much larger barrier to medical care for beneficiaries than the availability of doctors.

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