

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

Should Physicians Be Able to Refuse to Care for Patients Insured by Medicare?

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Abstract

This commentary on a case considers whether and to what extent refusal to care for Medicare patients is a form of “turking.” Medicare is a federal program to provide insurance for people over age 65, those who have certain disabilities, and those with end-stage renal disease; eligibility criteria include contributions from wages and salaries during a patient’s working career. Although all clinicians in the United States can care for Medicare patients, some opt out, resulting in harms to eligible patients and in oversubscription of remaining clinical practices. Opting out should be reconsidered, given that resident training is supported by Medicare funding. Although patients who receive services upon engaging with a health care practice might believe that they are under the care of a clinician, any harms of administrative nonadherence to practice guidelines accrue to the clinician.

Case

JT is a 65-year-old male with a history of hypertension (HTN) who is newly enrolled in Medicare. He is generally in good health, and his HTN is well controlled on hydrochlorothiazide, which he has been on for the past 10 years. He takes no other medications. He is a retired high school history teacher and recently moved with his wife to a new neighborhood. Since A1 Primary Care Clinic is within walking distance from their home, he decides to visit in person to make an appointment with Dr N to establish care with a new primary care physician. “I’ve been fasting, so I’m ready to have blood drawn this morning.”

The office staff member responds, “Dr N does not normally take Medicare patients. Let me check with him in back.” The staff member does so and then says, “We can schedule you, and he always orders the same blood work for new patients, so we can draw your blood now.”

JT agrees, and a phlebotomist draws JT’s blood. Dr N’s office, however, never schedules JT’s clinic visit and JT’s blood sample is never sent to the lab.

Commentary

The first question to consider is whether JT and Dr N have a patient-clinician relationship. In her article, “When Is a Patient-Physician Relationship Established?,” Valerie Blake argues that a “patient-physician relationship is generally formed when a physician affirmatively acts in a patient’s case by examining, diagnosing, treating, or agreeing to do so.”¹ At the initial visit to Dr N’s office, JT was not examined, diagnosed, or treated, but he was told that he needed to get blood work done as part of Dr N’s practice. This act fulfills one of the criteria of Dr N agreeing to take JT on as a patient. Thus, JT and Dr N have a patient-physician relationship.

Another question is whether it is permissible for Dr N, as JT’s physician, not to have an agreed-upon test sent to the lab. The American Medical Association (AMA) *Code of Medical Ethics* states: “The process of informed consent occurs when communication between a patient and physician results in the patient’s authorization or agreement to undergo a specific medical intervention.”² The intervention in JT’s case is pre-visit blood work. Although Dr N does not speak with JT, the clinical clerk provides a description of the testing (eg, pre-visit blood work) and a stated benefit (eg, patients need to do this before seeing Dr N, and seeing Dr N is one of JT’s goals). JT is not informed that the blood he might have drawn could be discarded rather than being tested. This omission thus constitutes a violation of the informed consent process. In addition, this omission meets the Agency for Healthcare Research and Quality (AHRQ) definition of an incident, which is “a patient safety event that reaches the patient, regardless of whether the patient was harmed” and would further be categorized as a preventable incident, as it is an error related to “monitoring ... or assessing patients.”³

Rights and Obligations

Medicare, which was signed into law in 1965,⁴ is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with end-stage renal disease.⁵ Part A covers inpatient care in hospitals and other facilities, while Part B covers physician services and outpatient care.⁵ Medicare is funded primarily by a tax on wages and salaries; citizens or permanent residents of the United States who have been employed by organizations that withhold payment of payroll taxes for at least 10 years are eligible for coverage at the age of 65.⁶ Since JT has Medicare coverage, it can be assumed that he had his wages or salary taxed in the stipulated way, and as the purpose of Medicare is to pay for health care for those aged 65 years or older, JT has a right to receive care through this funding mechanism.

One question is whether JT has a right to receive care specifically from Dr N through Medicare coverage. Medicare regulations permit clinicians to opt out of the **Medicare program**; this decision must apply to the physician’s entire practice and cannot be made on a case-by-case basis.⁷ As of 2022, fewer than 1% of physicians in the United States had elected to opt out, so these few physicians do not unduly burden the remaining physicians who do accept Medicare patients.⁸ Of note, in the case under discussion, the clinic staff member explains to JT that the physician “does not normally take Medicare patients,” which implies that Dr N is utilizing the opt-out mechanism on a case-by-case basis rather than as a rule that applies to the entire practice—in violation of Medicare regulations. Although the AMA *Code* stipulates that, unless there is a medical emergency, “physicians are not ethically required to accept all prospective patients,”⁹ it lists “limited circumstances” under which physicians may decline to accept patients, including when “meeting the medical needs of the prospective patient could seriously compromise the physician’s ability to provide the care needed by his or her other

patients.”⁹ This is the reason some physicians use to defend opting out of caring for Medicare patients. If the Medicare reimbursement rate is relatively lower than the rates of private insurers and would have the effect of limiting the ability of the practice to sustain itself, this financial shortfall could then limit the ability of the clinician to provide care to others in the patient pool. In 2012, Howrigan stated: “in some situations, Medicare pays more than 30% less for a service than the commercial insurance companies.”¹⁰ More recently, a Kaiser Family Foundation literature review based on data from 2010 to 2017 found that, on average, private insurers pay 199% of Medicare rates for hospital services and 143% of Medicare rates for physician services,¹¹ suggesting that there is a short-term and a longer-term financial cost of including Medicare patients in one’s practice. Moreover, as mentioned, the Medicare program regulations permit individual clinicians to opt out of participation, so it is permissible, on a regulatory basis, for Dr N to withhold care from the entire category of patients who want to use Medicare.

However, there is one additional aspect of Medicare obligation that should be considered. Medicare provides substantial **funding for residency programs** accredited by the Accreditation Council for Graduate Medical Education; the funding is used to cover resident stipends as well as other direct and indirect costs associated with running a residency program.¹² If the Medicare program funds the training of new physicians and if Medicare services exist to allow older patients to receive health care, a reasonable assumption is that Medicare supports physician training in the hopes that those physicians will, upon graduation, be available to care for patients covered under Medicare. This physician obligation is not explicit, but, much as medical students receive student loans to fund their undergraduate medical education and are expected to repay those loans upon graduation, graduate trainees such as residents arguably ought to be required to take Medicare patients as compensation for the funding of their further training. This obligation wouldn’t be a permanent one but could reasonably be interpreted to require that physicians accept a certain number of Medicare patients or provide care for a specific number of years for Medicare patients postgraduation. Physicians, however, might argue that hospitals that accept Medicare funding to support their residency programs are able to generate additional revenue based upon the larger workforce that now includes residents; they might argue that by allowing for this additional revenue to be generated, residents have already repaid any obligation related to Medicare funding.

Referral Duties

The AMA Code specifies that physicians must “facilitate transfer of care when appropriate” when terminating the patient-physician relationship.¹³ As stated previously, by ordering blood work for JT, Dr N initiated a patient-physician relationship, so not offering an office visit would be congruent with a termination of the relationship. Thus, Dr N should provide JT with a list of other physicians. Moreover, Dr N’s choosing to exclude patients with Medicare expresses an unwillingness to provide treatment for those patients, and, as such, Dr N has an obligation to refer JT to physicians who do accept Medicare.

Conclusion

In summary, Dr N has the right to exclude patients with Medicare insurance from their practice. However, this decision must be applied to all prospective patients equally and not deployed on a case-by-case basis. By informing JT that blood work would be ordered and by directing him to have the testing, the office assistant has established a patient-

clinician relationship between JT and Dr N. By not sending the blood specimen to the laboratory for testing, Dr N violated JT's right to informed consent; this act would also be considered a preventable safety incident by AHRQ criteria. Having chosen not to set up an appointment for JT but having already established a patient-clinician relationship, Dr N is obligated to "facilitate transfer of care" to another clinician.¹³ If Dr N and JT had not established a patient-clinician relationship, Dr N should have provided JT—as Dr N should provide all prospective patients who will not be accepted into their practice because of Medicare insurance—a list of local clinicians who do accept Medicare.

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Editor's Note

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Conflict of Interest Disclosure

Author disclosed no conflicts of interest.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

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