

Editorials

Controversies in Family Medicine

Would Medicare for All Be the Most Beneficial Health Care System for Family Physicians and Patients?

Yes: Improved Medicare for All Would Rescue an American Health Care System in Crisis

Ed Weisbart, MD, CPE, FAAFP, Physicians for a National Health Program, Olivette, Missouri

Published online August 20, 2020

The coronavirus disease 2019 (COVID-19) pandemic has exposed several shortcomings in the U.S. health care system. The illusion of reliable employer-based health insurance is crumbling; our safety nets have wide geographic variations; high-deductible insurance plans result in delayed care for people with chronic conditions; and underlying racial and geographic disparities in care are worsening.¹⁻⁵ The United States spends far more on health care than any other nation, but our life expectancy has fallen behind.⁶

We must use the lessons of this crisis to better prepare for the next one and address the shortcomings in our health care system. We would have been better positioned to manage acute and chronic health problems during the pandemic if the country had already adopted Improved Medicare for All.

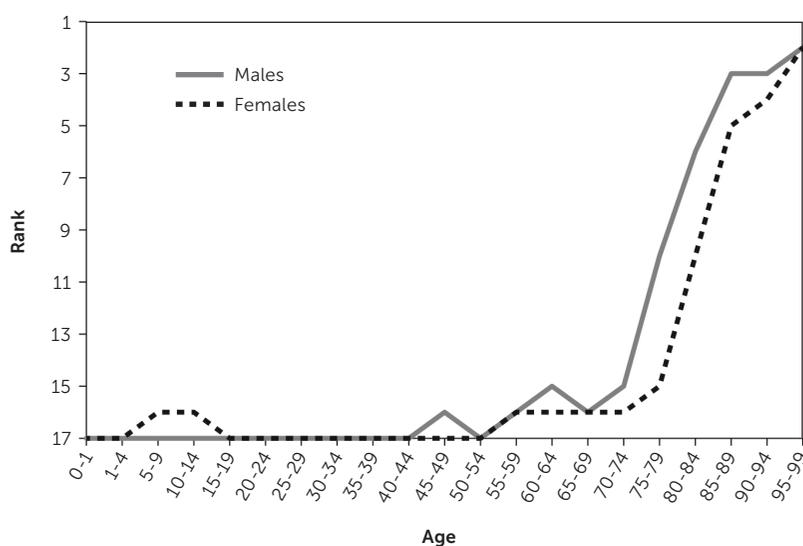
Medicare has benefits uncommon with other health insurance plans. Patients can choose from a network that includes 93% of U.S. primary care physicians.⁷ Once adults are eligible for coverage, their age-specific mortality increases from the worst among 17 peer nations to one of the best (Figure 1).⁸

The multiyear gap in life expectancy between Black and White patients who require dialysis disappears when both groups are covered by Medicare.⁹ Medicare also does a much better job of controlling costs compared with private health insurance: during the past decade, Medicare's cumulative increase in per-enrollee spending was 21.5%, far less than the 52.6% average increase among private insurers.¹⁰

However, Medicare is far from perfect. The reimbursement model for physicians is bewilderingly complex¹¹; high levels of patient cost-sharing can bankrupt older adults; and the benefit design has significant gaps (dentistry, pharmacy, optometry, and audiology, among others).

The Improved Medicare for All approach addresses each of these problems through a simple concept: fix the flaws in the current program, then provide it to all Americans.¹²

FIGURE 1



Ranking of U.S. mortality rates by age group among 17 peer countries, 2006-2008.

Reprinted from Woolf SH, Aron LY; National Academies; Institute of Medicine. U.S. Health in International Perspective: Shorter Lives, Poorer Health. National Academies Press; 2013:48.

This is one in a series of pro/con editorials discussing controversial issues in family medicine.

See related editorial on page 392.

A collection of Editorials: Controversies in Family Medicine published in AFP is available at <https://www.aafp.org/afp/pro-con>.

Improved Medicare for All would provide universal access to all medically necessary care. It would obviate the need to develop emergent funding strategies to cover screening, treatment, and prevention of a single viral infection, such as COVID-19, in uninsured and underinsured patients.

How can we afford this plan? Administrative savings. Medicare operates with less than 2% overhead, whereas private health insurers often operate with more than 12%.^{13,14} The complexity of billing multiple payers adds tens of thousands of dollars to medical office overhead, and it diverts time from patient care to administrative tasks. Hundreds of economists declared that the United States would come out ahead economically under Improved Medicare for All.^{15,16}

Compared with our peers in nine other countries, U.S. primary care physicians are far less satisfied with medical practice.¹⁷ A key driver of dissatisfaction is the moral indignity of knowing how to help a patient but facing insurmountable economic barriers.¹⁸ It breaks our hearts when a patient tells us, “I’ll pray and wait until I turn 65 and have Medicare.” Medical bankruptcy would be scandalous in any comparable nation.¹⁹

Improved Medicare for All could help resolve the issue of excessive documentation. Electronic health records are one example of the unique administrative burdens of medical practice in the United States. A study of more than 10 million ambulatory progress notes in one record system determined that those written by clinicians in Canada, the United Kingdom, Australia, Netherlands, Singapore, and the United Arab Emirates averaged 1,000 characters; the average number of characters in notes written by U.S. clinicians was four times higher.²⁰ Adopting a single-payer system would not automatically shorten these to global norms. However, it would mitigate two drivers of excessive documentation: complex requirements for maximal reimbursement and legal risk protection. If reimbursement requirements were more akin to global norms, physicians could document based on clinical—not economic—needs. If coverage of future medical care were guaranteed by law, patients would have fewer reasons to sue physicians.

Simplifying administrative burdens would allow more time for patient care. A 2016 study found that in some U.S. medical practices, physicians spend as little as 26% of their time with patients.²¹ In contrast, family physicians in

Canada spend 79% of their time on patient care,²² which could be one reason that more of them report being satisfied with their practices.¹⁷

In 2018, John Cullen, MD, then-president of the American Academy of Family Physicians, described U.S. medical practice as “an incredible bureaucratic mess to get anything done for patients.”²³ At the same time, Trina Larsen Soles, MD, then-president of Doctors of British Columbia, said of the Canadian system, “It’s not a big hassle. I can focus on patient issues, not administrative issues.”²³

Although the political obstacles are formidable, family physicians owe it to our patients and our profession to join the fight for Improved Medicare for All.

Address correspondence to Ed Weisbart, MD, CPE, FAAFP, at edweisbart@gmail.com. Reprints are not available from the author.

Author disclosure: Dr. Weisbart chairs the Missouri chapter of Physicians for a National Health Program. He receives no financial compensation for this role.

References

1. Kiertzner J. GM stops paying for health care coverage for striking UAW members. Updated September 18, 2019. Accessed May 28, 2020. <https://bit.ly/38ouGDX>
2. Kaiser Family Foundation. Status of state Medicaid expansion decisions: interactive map. April 27, 2020. Accessed May 28, 2020. <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map>
3. Thorpe KE, Calder K, Hyde A, et al. The challenges of high-deductible plans for chronically ill people. *Health Affairs Blog*. April 22, 2019. Accessed April 14, 2020. <https://www.healthaffairs.org/doi/10.1377/hblog20190416.47741/full>
4. Kaiser Family Foundation. Uninsured rates for the nonelderly by race/ethnicity. Timeframe: 2017. Accessed April 14, 2020. <https://bit.ly/2ZdJouK>
5. Ray R. Why are Blacks dying at higher rates from COVID-19? The Brookings Institution. April 9, 2020. Accessed April 14, 2020. <https://www.brookings.edu/blog/fixgov/2020/04/09/why-are-blacks-dying-at-higher-rates-from-covid-19>
6. Sarasohn-Kahn J. Let’s increase life expectancy in America in 2018: a new year for opioids, social determinants, and financial health. *Medium*. December 30, 2017. Accessed April 14, 2020. <https://bit.ly/38nThJ7>
7. Boccuti C, Fields C, Casillas G, et al. Primary care physicians accepting Medicare: a snapshot. Kaiser Family Foundation. October 30, 2015. Accessed August 11, 2019. <https://www.kff.org/medicare/issue-brief/primary-care-physicians-accepting-medicare-a-snapshot>
8. Woolf SH, Aron LY; National Academies; Institute of Medicine. *U.S. Health in International Perspective: Shorter Lives, Poorer Health*. National Academies Press; 2013.
9. Norris K, Mehrotra R, Nissenson AR. Racial differences in mortality and ESRD [editorial]. *Am J Kidney Dis*. 2008; 52(2):205-208.
10. Altman D. Private insurance’s costs are skyrocketing. *Axios*. December 16, 2019. Accessed April 26, 2020. <https://bit.ly/3gne81P>

EDITORIALS

- Centers for Medicare and Medicaid Services. Shared savings program. Accessed April 15, 2020. <https://www.cms.gov/medicare/medicare-fee-for-service-payment/sharedsavingsprogram>
- Medicare for All Act of 2019, HR 1384, 116th Cong (2019). Accessed April 2, 2020. <https://www.congress.gov/bill/116th-congress/house-bill/1384>
- 2019 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. April 22, 2019. Accessed May 2, 2020. <https://go.cms.gov/38n7mX4>
- Livingston S. Insurers' bottom lines unscathed by COVID-19 in first quarter. *Modern Healthcare*. May 4, 2020:10.
- 253 economists endorse Medicare for All ahead of House budget hearing. News release. National Economic and Social Rights Initiative. Updated November 2019. Accessed April 7, 2020. <https://dignityandrights.org/2019/05/253-economists-sign-letter-backing-medicare-for-all>
- Kahn JG, Sachs J, Fremstad A, et al. Economists conclude that Medicare for All (M4A) could be considerably less expensive than the current healthcare finance system. The Hopbrook Institute. February 28, 2020. Accessed February 29, 2020. <https://bit.ly/2BCFfXX>
- Schoen C, Squires D, Osborn R, et al. A survey of primary care doctors in ten countries shows progress in use of health information technology, less in other areas. The Commonwealth Fund. November 15, 2012. Accessed May 28, 2020. <https://bit.ly/2D0sdUw>
- Dean W, Talbot S, Dean A. Reframing clinician distress: moral injury not burnout [published correction appears in *Fed Pract*. 2019;36(10):447]. *Fed Pract*. 2019;36(9):400-402.
- Sick around the world. *Frontline*. PBS television. April 15, 2008. Accessed April 15, 2020. <https://www.pbs.org/wgbh/frontline/film/sickaroundtheworld>
- Downing NL, Bates DW, Longhurst CA. Physician burnout in the electronic health record era: are we ignoring the real cause? [editorial]. *Ann Intern Med*. 2018;169(1):50-51.
- Sinsky C, Colligan L, Li L, et al. Allocation of physician time in ambulatory practice: a time and motion study in 4 specialties. *Ann Intern Med*. 2016;165(11):753-760.
- Canadian Medical Association. Average hours worked per week by physicians, 1997-2017. Accessed May 28, 2020. <https://www.cma.ca/sites/default/files/pdf/Physician%20Data/34-TrendData-e.pdf>
- Meyer H. Why does the U.S. spend so much more on healthcare? It's the prices. *Modern Healthcare*. April 7, 2018. Accessed May 26, 2020. <https://bit.ly/3e3jluo> ■

E/M Coding Changes are Coming Are You Ready?

Office visit evaluation and management coding guidelines change January 1, 2021. Ensure you receive accurate payment with the AAFP's new E/M reference card. Use this reference card to:

- Understand the new guidelines
- Select the appropriate code based on total time or MDM
- Reduce documentation time

Preorder your card today!

Orders will begin shipping by January 15, 2021.



aafp.org/emcoding

2021 Office Visit Evaluation and Management Coding and Documentation Reference Card

Evaluation and management (E/M) office visit codes (99202-99205 and 99212-99215) will change January 1, 2021. Understanding how to appropriately document office visits will help you optimize payment, decrease administrative burden, and reduce the stress associated with coding.

This guidance is not all-inclusive. It is meant as a quick reference for daily use in the clinic setting. For more information, refer to the *Evaluation and Management Services Guide* published by the Centers for Medicare and Medicaid Services and the Current Procedural Terminology (CPT) code set published by the American Medical Association.

CODE SELECTION METHODS

The level of service for CPT codes 99202-99205 and 99212-99215 is selected by using either total time or medical decision making.

The 2021 E/M documentation guidelines do not include history and exam as elements of code selection. The care professional (QHP) should determine the nature and extent of the history and/or exam performed. These requirements, so the physician or other QHP should use clinical judgment to determine appropriate documentation.

CODE SELECTION USING TOTAL TIME

When total time is used to select the level of E/M service, it is defined by the 2021 CPT code descriptor noted in the guidelines below. **Please note:** midpoint calculations are no longer necessary for the times associated with 99212-99215, and there is no longer a need to be concerned with how much of the time is spent in counseling and/or coordination of care.

Table 1. Office Visit E/M Total Time				
	Level 1	Level 2	Level 3	Level 4
New Patient		99202 (15-29 min.)	99203 (20-44 min.)	99204 (45-59 min.)
Established Patient	99211 (see specific guidance on back page)	99212 (10-19 min.)	99213 (20-29 min.)	99214 (30-39 min.)

2021 GUIDELINES FOR CALCULATING TOTAL TIME

Code selection using total time should be based on the total time spent in care of the patient on the date of the encounter, including non-face-to-face time personally spent by the physician and/or other QHPs on the date of the encounter, as determined by clinical staff.

Total time includes the following:

- Time spent in counseling and/or coordination of care, which may include review of previous test results
- Time spent in reviewing a separately obtained history and/or physical examination and/or evaluation and/or management of the patient or family/caregiver