Editorials

Controversies in Family Medicine

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

No: Medicare for All Would Cause Chaos and Fail to Control Health Care Costs

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Proposals for Medicare for All relate to two goals that often clash: more comprehensive insurance coverage and lower costs. Ultimately, both goals highlight the reason why the U.S. health care system is not ready for Medicare for All. We cannot afford it.

There is no dispute that administrative costs for Medicare (about 2% of overall costs[1]) are less than those for private health insurance, for which the Affordable Care Act sets the allowable overhead at 20% of premiums.[2] However, expansion of Medicare or private insurance would not address the deeper problems in our health care system.

No matter how Medicare for All is implemented, chaos would ensue in the early days. Medicare currently pays about 88% of the estimated cost of a hospital stay, compared with 145% by private insurers.[3] Under Medicare for All, urban hospitals would close unless payments increased or regulatory burdens decreased, thereby reducing operating costs. The impact on rural hospitals would likely be mixed; those that already receive most of their income from public insurance plans and have high rates of uninsured patients could come out ahead. However, rural hospital sustainability would further depend on changes to existing alternative payment models, such as critical access definitions.

One advantage of Medicare for All is that it would likely roll back the exorbitant prices charged by large integrated health care systems, many of which are "nonprofit" but paradoxically make the most profit.[4] Instead of delivering lower costs through greater efficiencies, these large health systems have used their near-monopolistic market share and vertical integration to raise prices much faster than the general inflation rate.[5,6] These health systems would likely be essentially forced to accept Medicare rates for all services covered by Medicare, which should lower total health care costs.

However, the Centers for Medicare and Medicaid Services is not allowed to consider costs in its coverage determinations for new tests and treatments.[7] For example, Medicare is not allowed to negotiate with drug manufacturers for lower prices, but the U.S. Department of Veterans Affairs health system is, which is why it pays much less than Medicare for the same drug. In addition, the Social Security Act requires that Medicare cover all services that are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."[8]

Too often in the United States, discussions about health care coverage revolve around finance mechanisms. Funding approaches vary considerably among other Western countries, yet these countries manage to allocate a lower percentage of their economies on health care: 9% to 12% vs. 16.9% in the United States.[9] The United Kingdom and Scandinavian countries pay primary care physicians by capitation; Switzerland, Germany, France, Australia, and Canada use fee-for-service; and the Netherlands uses a blended approach.

Other countries are willing to make difficult decisions to keep health care costs low. In 2016, the United Kingdom's National Health Service (NHS) refused to pay for lumacaftor/ivacaftor (Orkambi), an expensive cystic fibrosis drug.[10] After two years of negotiations, a deal was reached allowing the manufacturer to supply the drug and its future versions. Although the price has not been disclosed, the NHS is thought to have agreed to about £10,000 to £20,000 ($12,000 to $25,000) per year per patient.[11] In contrast, the same drug costs more than $258,000 per year per patient in the United States.[12]

Differences between Medicare and other national health systems are not limited to costs. Physicians in other countries practice differently to stay within budget limits, and patients implicitly agree to those limits. In the United Kingdom, colon cancer screening occurs only once, at 60 years of age. In addition, UK physicians argued against expanding statin coverage to lower-risk populations, advocating instead

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

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to limit treatment to patients with a 20% risk of coronary artery disease over 10 years.[13] In Sweden, general practitioners generally do not promote statins for primary prevention of heart disease.[14]

Improving the status of family physicians is another reform that has not occurred under Medicare; therefore, the pessimism that this issue would continue under Medicare for All is justified. Medicare has not paid family physicians to provide a comprehensive scope of services associated with lower total health care costs.[15] In fact, the scope of services provided by family physicians has eroded in the era of Medicare-sponsored payment reforms.[16] Medicare also does not support direct primary care models or other innovative ways for family physicians to deliver and be paid for their services, instead of being tied to the specialist-dominated Current Procedural Terminology (CPT) coding system.[17]

All major health insurance companies use Medicare's documentation, coding, and billing structure and the relative value units tied to CPT codes. Therefore, many of the things that frustrate family physicians about the current system originated with Medicare: the devaluation of primary care services; the relative overpayment for specialist care; the inability to bill for helping patients with more than two or three concerns in one visit; the requirement for face-to-face services (before the coronavirus disease 2019 exceptions took effect); the refusal to pay family physicians for clinic and hospital work on the same day; and the lack of incentives for full-scope family medicine.

Solidarity is the secret ingredient that enables other countries to have better health outcomes at a lower cost than the United States. Citizens of these countries are willing to make personal sacrifices (e.g., less convenience, longer wait times, fewer diagnostic and treatment options, more minimalistic guidelines for chronic disease prevention and management) so that their health care systems are more equitable and provide universal coverage. Without public support for such sacrifices here, Medicare for All is merely another payment approach that perpetuates the dysfunctional system we already have, which Medicare had a large role in creating.

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