Can Medicare for All Control Health Care Costs?

Frederick M. Chen, MD, MPH; Joshua M. Liao, MD, MSc

(Fam Med. 2020;52(1):75-6.)
doi: 10.22454/FamMed.2020.620564

Debates about the role of universal coverage in American health care have made this a remarkable time in health policy. Overall, we are encouraged by the ongoing discourse about challenges that face our current health insurance marketplace, and coverage solutions such as Medicare for all.

To date, much of the discussion has centered on issues related to definitions ("What is Medicare for all?"),[1] implementation ("How could Medicare for all be operationalized?"), and financing ("How would we pay for a Medicare-for-all system?"). Unfortunately, these issues obscure the most important question: How much would Medicare for all pay clinicians and hospitals?

Some proposals suggest that payment continue at the current rates,[2] while others would peg reimbursement at a given percentage of current Medicare rates,[3] and yet others seek to give the Secretary of Health and Human Services broad authority to set payment amounts[4] via strategies such as global budgets and fee schedules.[5] We believe this is a key distinction that carries implications for how a Medicare for all system would fundamentally impact providers and patients nationwide.

Consider a Medicare-for-all policy that maintains current payment rates. This approach could achieve the goals of universal coverage and streamline the current health insurance system while also mostly preserving the status quo, without major disruptions to other segments of the health care industry. Clinicians and health systems could continue delivering care largely as they have been. This approach would mirror what we saw with the Affordable Care Act (ACA)—expanded coverage, more insured individuals, less uncompensated care, and a bigger pie of payment.

However, this approach would fail to restrain health care spending—perhaps the single-most important driver of reform in health care over the last decade. Without major payment rate changes, provider organizations may not be compelled to implement major delivery system changes to improve health care. This reality—increased health care coverage at the expense of greater costs—is in fact one of the legacies of the ACA, and Romney Care in Massachusetts before it.

The alternative would be a Medicare-for-all system in which the proverbial payment pie doesn't get bigger, and universal coverage was implemented alongside counterbalancing rate cuts to reign in health care spending. The potential financial benefits of this approach are straightforward: providers would have to stamp out administrative and clinical inefficiencies, address labor costs, and explore other solutions such as price negotiation, supply chain changes, waste reduction, and care standardization.[6]

However, the potential negative consequences of implementing universal coverage with rate reductions could be far-reaching. This is particularly true for provider organizations, many of whom have expressed concern about the adverse impact on financial viability and ability to care for patients as they currently do.[7]

From the Department of Family Medicine (Dr Chen), and Department of Internal Medicine (Dr Liao), University of Washington School of Medicine, Seattle, WA.

One particular concern related to payment reductions is the unintentional consequence of worsened selection—a phenomenon in which providers seek out ("cherry pick") low-risk or low-cost individuals and avoid ("lemon drop") high-risk or costly ones. Currently, selection already occurs at the health plan level, with providers seeking to avoid insurance plans with too many high-cost individuals.

Universal coverage and lower payments could stoke selection at the individual patient level. Without different payers to select, providers could only cherry pick by patient or geographic community—a concerning possibility given the widespread health care disparities that already exist. Such selection could manifest through providers choosing not to serve communities perceived to be high risk (eg, not building clinics or hospitals in certain areas), or operating in those areas but avoiding high-cost individuals.

Ultimately, health care spending will not decrease on its own, and policies that increase coverage only heighten attention on efforts and strategies for curbing costs. It is up to decision makers to determine if cost control should be incorporated into universal coverage policies or addressed separately. If the former, other nations' health insurance systems caution that while a single payer can be a powerful tool, it must be empowered properly in order to achieve coverage without undoing progress to control health care spending. If the latter, both political will and practical solutions will be needed outside of Medicare for all to meaningfully address national health care spending. Medicare for all would give our patients universal access and coverage, but it's the provider payment that will dictate the future of family medicine and US health care.

CORRESPONDENCE: Address correspondence to Dr Frederick Chen, Department of Family Medicine, University of Washington School of Medicine, 325 9th Ave, Seattle, WA 98104. fchen@u.washington.edu.

References

1. Anderson D, Liu J, Friedberg M. Medicare for all: sounds good, but what does it mean? Health Affairs Blog. November 19, 2018. https://www.healthaffairs.org/do/10.1377/hblog20181116.137123/full/. Accessed December 13, 2019.
2. Wynne B, Llamas A. Medicare for all can begin in 2021: here's how. Health Affairs Blog. February 28, 2019. https://www.healthaffairs.org/do/10.1377/hblog20190228.968246/full/ Accessed December 13, 2019.
3. Kocher R, Berwick DM. While considering Medicare for all: policies for making health care in The United States Better. Health Affairs Blog. June 6, 2019. https://www.healthaffairs.org/do/10.1377/hblog20190530.216896/full/ Accessed December 13, 2019.
4. Foley J. Taking Medicare for all seriously. Health Affairs Blog. June 11, 2019. https://www.healthaffairs.org/do/10.1377/hblog20190606.959973/full/. Accessed December 13, 2019.
5. Keith K. Unpacking the House Medicare-For-All Bill. Health Affairs Blog. March 3, 2019. https://www.healthaffairs.org/do/10.1377/hblog20190302.150578/full/ Accessed December 13, 2019.
6. Grumbach K, Bodenheimer T. Painful vs painless cost control. JAMA. 1994;272(18):1458–1464.
7. Rizzo S. Would medicare for all mean hospitals for none? The Washington Post. July 3, 2019. https://www.washingtonpost.com/politics/2019/07/03/would-medicare-for-all-mean-hospitals-none/. Accessed December 13, 2019.