Medicon Medical Sciences
Volume 2 Issue 1 January 2022
Mini-Review

Medicare for All Takes Center Stage

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Received: December 15, 2021; **Published:** December 30, 2021

Abstract

Rising interest in a single-payer healthcare system known as Medicare for All (MFA) has reached the support of nearly 55% of physicians and two-thirds of Americans polled [1]. This comes at a time when nearly 29 million Americans remain uninsured in the setting of a 4.6% increase in healthcare spending in 2019 totaling $3.8 trillion in expenditures, despite the implementation of the multitude of insurance options within the Affordable Care Act (ACA) of 2010 [2]. Presently, there are two bills in the legislature being considered to address this matter with the Medicare for All Act of 2019. Lobbyists are considering a government-funded healthcare system that would serve to reduce burdensome administrative and health-related costs and simplify an already multiplex insurance-laden system.

Keywords: Medicare programs; Fee-for-service; Private insurance; Selection bias; Drug costs; Medicare reimbursement

Discussion

According to the MFA Act of 2019, this system shall provide every U.S. resident with healthcare coverage, while also promoting no cost-sharing (with exceptions) [1, 3]. This coverage may prevent insurance companies from their usual practice of selection bias [4]. People will also benefit from a decrease in exorbitant monopolized drug prices by drug companies. Finally, administrative costs would be lowered in this system through the eradication of profits made by insurers and merging administrative tasks [5, 6]. As for the disadvantages of MFA, the main objection by critics is that it reduces patient choice when it comes to their providers [4, 6] as well as the lower pay that clinicians would receive, which may translate into decreased productivity due to lower incentivization [5, 6]. As it stands, Medicare roughly reimburses providers 45-50% compared to private insurance (45-80%) and Medicaid reimbursement rates (15-20%), or the comparative Medicaid-to-Medicare fee index range of 0.38-1.26 nationally [7, 8]. The proposed MFA plan states that it will use the same reimbursement rates as Medicare's fee-for-service program [6]. The concern is this may compel physicians to gravitate to private insurance models of care while Physician Assistants (PAs) may assume MFA clinical duties. The Medicare Payment Advisory Commission (MedPAC) recommends eliminating "incident to" in MFA for increased efficiency, better utilization of PAs, reduction of fraud, and stream-lined reimbursement strategies [9]. Moreover, ancillary medical services such as Optometry, Dentistry, and Audiology would likely see increased access to care along with primary care services, however, the fiscal burden from increased utilization shows only estimated costs related to traditional medicine [5].

Under current MFA proposals in the U.S., private insurance companies would be eliminated. However, in countries such as Canada, Australia, and England, there are options to have secondary private insurance that serves as supplemental and/or substitutive insurance, or as benefit enhancements [1, 6]. The proposed MFA would likely consolidate the various ACA insurance companies under its

umbrella, leaving the larger and more profitable companies to serve as supplemental insurance carriers, similar to the Japanese health system. Other public programs such as Tricare, Veterans Health Administration, Medicaid, and Indian Health Service may or may not exist alongside the MFA system [6]. As such, the current Medicare program is ideally not one that applies to "all" because there are still certain entities that provide healthcare services to the aforementioned populations with unique patient and funding needs.

In summary, MFA shows great promise in helping America solve its healthcare crisis provided that they construct a system that instrumentally addresses issues of administrative and cost-sharing, ancillary medical service funding, and distilling a multifarious insurance structure into a single-payer system alongside supplemental private insurance.

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