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The Truth on Wait Times in Universal Coverage Systems

By Thomas Waldrop October 17, 2019

In a fact sheet accompanying his recent executive order on Medicare, President Donald Trump falsely asserted that expanding coverage under Medicare for All would "force patients to face massive wait times for treatments and destroy access to quality care," claiming that it would "increase your wait times, ration quality care, and stifle innovation."[1] President Trump is not the only person to make such claims. Health care industry actors and conservative groups have begun ramping up opposition to coverage expansion proposals. One such anti-Medicare for All ad, by conservative advocacy group One Nation, similarly argues that expanding coverage would dramatically increase wait times.[2]

However, the data—both from other nations with universal coverage and from historic expansions of coverage within the United States—show that this is not the case. Patients in peer nations generally have similar or shorter wait times than patients in the United States for a variety of services, refuting the argument that universal coverage would necessarily result in longer wait times in the future.

This issue brief provides an overview of the factors that affect wait times, outlines evidence that suggests universal coverage need not increase wait times in the long run, and discusses policy solutions to mitigate any impact on wait times in the short run.

Background

Discussions of wait times often ignore the fundamental reality that, for many patients, wait times are already long. Where a patient lives has a significant effect on their wait time, largely due to provider concentration in more urban areas compared with more rural ones. For example, a 2017 analysis of hospital wait times found that mid-size metropolitan areas—cities such as Hartford, Connecticut—had 32.8 percent longer wait times than large metropolitan areas such as Washington, D.C.[3] A recent article in the *Journal of the American Medical Association* further supports this idea.[4] The study found that wait times at private-sector hospitals ranged from 16.5 days in New York City to 57.33 days in Boston, Massachusetts. The same study compared wait times between a

similar set of private and U.S. Department of Veterans Affairs (VA) hospitals and found that VA hospitals had "significantly shorter" wait times than private hospitals, in part because wait times at VA hospitals have improved in recent years—now averaging 20 days—while wait times at private hospitals have stagnated at around 41 days.[5]

Insurance status also affects wait times. Generally, privately insured patients have shorter wait times than publicly insured patients, though the magnitude of this difference varies. A 2018 study by the Leonard Davis Institute of Health Economics in Philadelphia found that Medicaid beneficiaries' wait times for new primary care physician (PCP) appointments were, on average, only two days longer than those for privately insured patients.[6] Meanwhile, an examination of the impact of Medicaid expansion in Michigan found that wait times for PCP appointments were approximately one day longer on average, both before and after expansion.[7] A similar study of 10 states found that privately insured patients were almost universally more likely than publicly insured patients to have wait times of less than one week for a new PCP appointment and were less likely to have a wait time of more than 30 days—which represented the 50th and 90th percentiles, respectively.[8] This difference in wait times is largely attributable to differences in payment rates between payers, not any inherent advantage to private insurers. Many coverage expansion proposals address this issue of differing payment rates: Both the House and Senate versions of Medicare for All establish the federal government as the only payer, and the Center for American Progress' Medicare Extra proposal indirectly lowers the rates that private insurers pay by limiting out-of-network providers to receiving no more than what the federal government pays.[9]

All of these studies, however, focus on insured patients. Newly released data from the U.S. Census Bureau estimate that the uninsured rate is approximately 8.5 percent, which amounts to more than 27 million people.[10] Since discussions of wait times fail to consider these individuals, they paint a far rosier picture than the reality. Uninsured people are much more likely to postpone seeking care or skip needed care due to cost.[11] And while specific data on wait times for uninsured patients are missing from the discussion, what is known is that being uninsured is associated with worse access to care and that, for some uninsured patients, their wait times are essentially infinite.

Wait times in universal coverage systems

Data from other nations show that universal coverage does not necessarily result in substantially longer wait times. In fact, there are a variety of circumstances in which the United States' peer nations have shorter wait times. While the White House's fact sheet largely focused on the United Kingdom's health care system, no candidate currently running for president is proposing nationalizing health care providers like the U.K.'s National Health Service.[12] The most comprehensive source of international comparative data on health care is the Commonwealth Fund's "Mirror, Mirror" series, which, in 2017, examined a variety of metrics across 10 European countries and the United States. Four of these metrics were particularly useful for studying wait times.[13]

- Patients reported that they saw a doctor or nurse on the same or next day the last time they sought medical care.
- Doctors reported that patients often experience difficulty getting specialized tests—for example, CT and MRI scans.
- Patients reported that they waited two months or longer for a specialist appointment.
- Patients reported that they waited four months or longer for elective or nonemergency surgery.

On each of these metrics, the United States performed worse than several nations with universal coverage, though no individual nation outperforms the United States on every metric. For example, only 51 percent of U.S. patients reported being able to see a provider within a day, compared with 53 percent, 56 percent, and 67 percent of patients in Germany, France, and Australia, respectively.[14] Similarly, nearly 30 percent of U.S. doctors reported that their patients have difficulty getting a specialized test, compared with only 11 percent and 15 percent of doctors in Australia and Sweden, respectively.[15] U.S. outcomes on the other two metrics were better across the board but still show that the United States performs worse than other nations with more equitable health care coverage systems. For instance, in the United States, 4 percent of patients reported waiting four months or longer for nonemergency surgery, compared with only 2 percent of French patients and 0 percent of German patients.[16] For specialist appointments, the situation is even worse: 6 percent of U.S. patients reported waiting two months or longer for an appointment, compared with only 4 percent of French patients and 3 percent of German patients.[17]

The impact of coverage expansions on wait times

Expansions of coverage in the United States, while not resulting in universal coverage, show that passing any of the universal coverage proposals currently being discussed in Congress would not significantly increase wait times. For example, in 2006, Massachusetts passed significant health reform legislation—similar to the Affordable Care Act—that expanded Medicaid eligibility and encouraged health insurance enrollment through an individual mandate.[18] The law was extremely effective at its goals: Massachusetts continues to have the lowest uninsured rate in the country, currently estimated at 2.8 percent.[19] While wait times did increase in the short term following the implementation of the Massachusetts law, researchers have found no evidence that this increase had any negative impact on preventable hospitalizations.[20]

Other, more recent research has examined primary care appointment wait times in 2012 and 2016, finding that while most states saw decreases in wait times of less than a week and increases in those of more than 30 days, Massachusetts saw the opposite.[21] For both privately insured patients and Medicaid beneficiaries in the state, wait times improved during this period.[22] This suggests that the impact of

health coverage expansions diminishes over time as provider supply rises to meet the new demand. Policymakers can therefore be reassured that patients will not have worse health outcomes as a result of expanded coverage and that policies can be included in any expansion to help mitigate the effect in the short term and accelerate provider supply increases.

Transition can mitigate any impact on wait times

The idea of increasing wait times for insured patients is unappealing; however, it is not a necessary component of any proposal to expand coverage. There are a variety of policy tools that can be used to help ensure that provider supply meets, as quickly as possible, the new demand for health care associated with coverage expansions. Two of the best ways to achieve this are by expanding the scopes of practices for nonphysician providers and by adjusting payment rates to better incentivize primary care providers.

Expanding scopes of practice

Expanding the scopes of practice for nonphysician providers can help to reduce the impact of physician shortages, including minor shortages such as those temporarily created by coverage expansions. One of the provider types that can best fill this gap is advanced practice registered nurses (APRNs). APRNs are nurses who have master's degrees, in addition to the educational requirements for all registered nurses.[23] They are typically authorized to order, conduct, supervise, and interpret diagnostic and laboratory tests; prescribe pharmacological agents and nonpharmacologic therapies, and teach and counsel patients.[24] However, the scopes of practice for these providers currently vary significantly by state. Two of APRNs' most significant barriers to practicing are the lack of practice independence and prescriptive authority. Only 22 states and the District of Columbia allow APRNs to practice independently, and while most states allow them to prescribe medications, the types of drugs they can prescribe vary significantly, as does the level of oversight required from physicians.[25]

What is a scope of practice?

A scope of practice defines the services that a qualified health professional is deemed competent to perform and permitted to undertake.[26] Scopes of practice typically scale with the amount of education and experience a provider has; for example, physicians, who have the most education and experience, have the most expansive scopes of practices, while nurses' scopes of practice vary more significantly depending on their professional licensure and experience levels.

The evidence shows that these two aspects of practice—scope and independence—greatly influence where an APRN chooses to practice and if they continue practicing at all. A 2013 study found that restrictive scope of practice regulations reduce APRN numbers by around 10 per 100,000 people and reduce the growth rate of those who enter the profession by approximately 25 percent.[27] Another study, conducted in 2016, found that states that allow independent practice have 5.4 more APRNs per 100,000 people than states with blanket restrictions on APRN practice—and that states with collaborative practice requirements have 4.1 more APRNs per 100,000 people.[28]

Evidence also suggests that prescriptive authority is an important aspect of APRN practice. For example, a study of the factors that affect nurse practitioners (NPs) moving to states found that prescriptive authority was associated with nearly half of NPs' movement in a given year.[29] Both by expanding the scopes of practice for APRNs to allow for more independent practice and by standardizing prescriptive authority, policymakers can make sure that the negative, short-term impacts of coverage expansions are reduced, ensuring that the transition to universal coverage is a smooth one.

Adjusting payment rates

In addition to expanding APRNs' scopes of practice, policymakers can adjust payment rates to incentivize primary care over specialty care in order to avoid potential short-term increases in wait times. PCP visits have been declining in recent years,[30] yet primary care is some of the most cost-effective treatment available. Multiple studies affirm primary care as less expensive and of higher quality than specialty care for most patients.[31] Many coverage expansion proposals acknowledge this. For example, CAP's Medicare Extra proposal explicitly does so, as it recommends raising Medicare payment rates for primary care services and reducing them for specialty care. In addition, both the Senate and House versions of Medicare for All establish an Office of Primary Health Care to ensure that primary care services are properly valued.[32]

The importance of primary care was also acknowledged in the Affordable Care Act, as it raised Medicaid primary care rates to the same level as Medicare rates for two years.[33] This temporary "fee bump" was not associated with significant increases in Medicaid participation, which researchers attribute to the temporary nature of the increase.[34] Other research has found that while Medicaid participation did not increase, the fee bump allowed for increased availability of primary care appointments among physicians already participating, without increasing wait times.[35] Making this rate adjustment permanent, rather than temporary, would help to promote primary care participation both during and after the transition to universal coverage.

Conclusion

The concerns of opponents of health care coverage expansions and current industry players are unfounded at best. The current U.S. health care system already involves long wait times for many patients and does not ensure that all patients have health insurance coverage. Expanding coverage is a necessary tool to promote health equity, and the evidence—both domestic and international—clearly shows that universal coverage does not require long wait times.

Policymakers, especially those at the state level, can work to expand access to care by increasing APRNs' autonomy and authority in order to help address existing provider shortages. In addition, adjusting primary care payment rates would help mitigate the short-term impact of health coverage expansions.

Wait time concerns amount to little more than fearmongering by those who oppose expansion of coverage. Policymakers should not rely on inaccurate spin from the health care industry to lead their decision-making. The United States can and should expand public programs to ensure universal coverage, and this can be done without sacrificing access to care for those currently insured.

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Endnotes

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