IS MEDICARE-FOR-ALL READY FOR PRIMETIME?

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Midwest Winter Symposium

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DISCLOSURES

- ACEP Board of Directors
- Clinician and Health Services Researcher with Allegheny Health Network (Owned by Highmark BlueCross [!]) and US Acute Care Solutions
- Views are my own, not of these entities
- Thank you to Rebecca Parker, MD, Todd Taylor, MD, and Marilyn Heine, MD for their contributions to this talk.

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OUTLINE

- A Brief History of How We Got Here
- Acknowledging Reality
- Medicare-for-All Myth Busters
- Where Do We Go From Here?

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HISTORY OF HEALTHCARE IN THE U.S.

"Those who forget the past are condemned to repeat it."

– George Santayana

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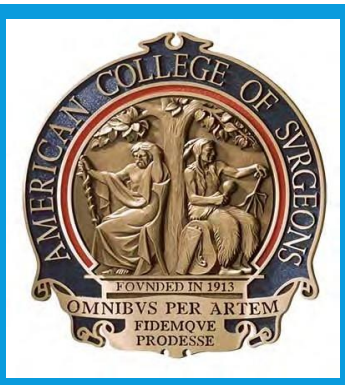
PRE-1920…WE'VE BEEN IN THIS DEBATE BEFORE

- **Sickness Insurance versus Health Insurance**
  - Medical expenditures low
  - Chief cost? Lost wages.
  - Insurance companies unwilling to offer health insurance; too risky
- **Hospitals**
  - Mostly religious and charitable organizations
    - Income Tax created and hospitals allowed non-profit status with property tax waivers
  - ACS started and created quality programs and accreditation



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WHY DOES THE U.S. HAVE EMPLOYER-BASED INSURANCE?

- **1920s-1930s**
- **Medical care shifts**
  - Increasing demand and technology advances
  - Rising costs
- **Birth of Blue Cross Blue Shield (BCBS)**
  - Blue Cross = Pre-paid Hospital Insurance
    - 1929 Dallas schoolteachers and Baylor University Hospital
  - Blue Shield Followed = Pre-paid Physician Services
    - Blue Cross popular
    - 1934 AMA adopted principles for voluntary health insurance to be physician (not hospital)-led
  - Both state-level legislation for non-profit, tax exempt status, free from usual insurance regulation

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WHY DOES THE U.S. HAVE EMPLOYER-BASED INSURANCE?

- **1940s-1960s**
- **Government Policies Encouraged Employer Health Insurance**
  - World War II government wage and price controls limited wage increases
    - 1942 Stabilization Act: employer can add employee insurance plans to secure workers
    - 1945 and 1949 employers cannot modify/cancel group plans during contract period, NLRB won that wages include pension and insurance benefits (SCOTUS upheld)
  - ***Most influential: 1943 and then finally 1954 Internal Revenue Code gave tax exempt status for health insurance cost for employers and employees.***

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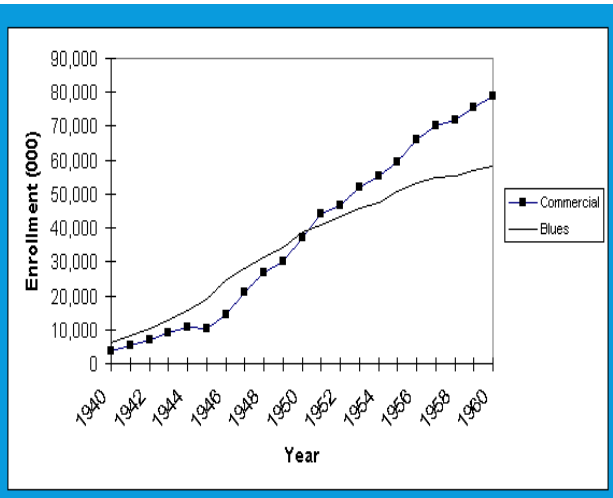
WHY DOES THE U.S. HAVE EMPLOYER-BASED INSURANCE?

- **1940s-1960s**
- Growth of Health Insurance
  - BCBS Proved Success
    - Employer Sponsored, So Younger, Less Sick
    - State Level Advantages
- BCBS Competitors – 20 New Ones in Quick Succession
  - BCBS non-profit status required to charge same for sick as non-sick
  - Others could offer lower rates to healthy saving $$$



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1965 - THE CREATION OF MEDICARE AND MEDICAID

- **President Johnson - Great Society**
  - Signed in 1965
  - Amendment to FDR's 1935 Social Security Act
  - Created Medicare:
    - Age 65 and above
    - Medicare Part A = Hospitals
    - Medicare B = Outpatient and Physicians
  - Created Medicaid for indigent, federal matching program with states

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POST 1965 KEY CHANGES - PUBLIC

- **Medicare/Medicaid**
  - 1969 Hospital non-profit tax breaks now require Medicare/Medicaid Participation
  - 1997 CHIP program
  - 2003 Medicare Advantage "Part C" & 2006 Part D (Prescription Drugs)
  - 2015 MACRA for physicians; CMS base payment, and MIPS and APM bonus programs
- **1986 EMTALA**
  - Hospital law who participate with Medicare
  - ***Hospitals*** receive disproportionate funds (DSH)
- **1997 Prudent Layperson Standard**
  - Expanded to all with ACA in 2010

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POST 1965 KEY CHANGES - PRIVATE

1974 Employee Retirement Income Securities Act (ERISA)

- Allows employer to be insurer, self insure
- Federal law, rules and regulations
- Employers are funding and designing these employee plans

60%+ of employer sponsored insurance now ERISA

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POST 1965 KEY CHANGES – PUBLIC AND PRIVATE

2010 Patient Protection and Affordable Care Act (ACA or Obamacare)

- **Individual mandate (key provision); *eliminated in 2017 Tax Cuts and Jobs Act***
- Medicaid Expansion (non-mandated) & Exchanges
- Resulted in an extremely commercial insurance friendly act:
  - Consolidation of markets, increased power and profits of private insurers
  - Promulgated poor plan design: high deductible plans, narrow networks

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OTHER CHARITY CARE SYSTEMS?

Clinics

- Federally Qualified Health Clinics
- Free and Charitable Clinics
- Public Health Clinics
- County Clinics

NAFC
The National Association of Free & Charitable Clinics

Hospitals

- County Hospitals
- Critical Access/Rural Hospitals
- Underserved Hospitals

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ACKNOWLEDGING REALITY

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WHERE WE AGREE

- Everyone should have access to care and health insurance.
- The current system is accidental in its genesis. No one would create what we have from scratch.
- We as emergency physicians have a ringside seat to what is wrong with the healthcare system.
- COVID-19 revealed the multiple gaps in the current health care system.

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WHERE WE DISAGREE

- That Medicare-for-All is the best way to attain universal insurance and access to care.
- That quality, safety, innovation, and outcomes will be substantively better or at least not worse under a Medicare-for-All system.
- That Medicare-for-All will result in similar reimbursement for emergency physician services as the current system.
- That Medicare-for-All will result in more physician autonomy than the current system.

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MEDICARE-FOR-ALL

MYTHBUSTERS

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MYTH BUST #1: UNDER MEDICARE-FOR-ALL, QUALITY WILL IMPROVE

Original Investigation

September 8, 2020

Association Between Patient Social Risk and Physician Performance Scores in the First Year of the Merit-based Incentive Payment System

Dhruv Khullar, MD, MPP[1,2,3]; William L. Schpero, PhD[1]; Amelia M. Bond, PhD[1]; et al

» Author Affiliations | Article Information

JAMA. 2020;324(10):975-983. doi:10.1001/jama.2020.13129

JAMA®

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MYTH BUST #1: UNDER MEDICARE-FOR-ALL, QUALITY WILL IMPROVE

CONCLUSIONS AND RELEVANCE In this cross-sectional analysis of physicians who participated in the first year of the Medicare MIPS program, **physicians with the highest proportion of patients dually eligible for Medicare and Medicaid had significantly lower MIPS scores compared with other physicians**. Further research is needed to understand the reasons underlying the differences in physician MIPS scores by levels of patient social risk.

JAMA

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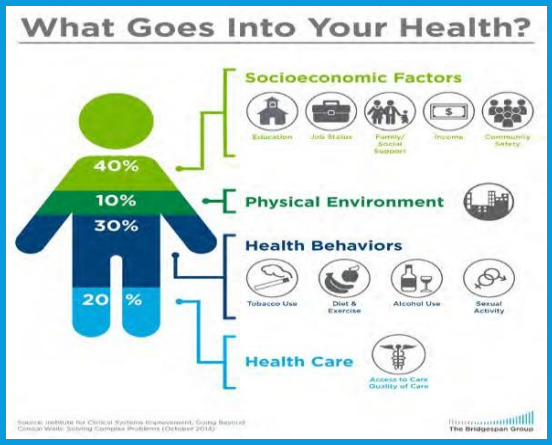
REALITY CHECK #1. QUALITY WILL NOT AUTOMATICALLY IMPROVE

Medicare and Medicaid Quality programs have significant flaws and have not fixed standardization of quality.

Social Determinants of Health need serious study, attention, and addressing to improve health quality.



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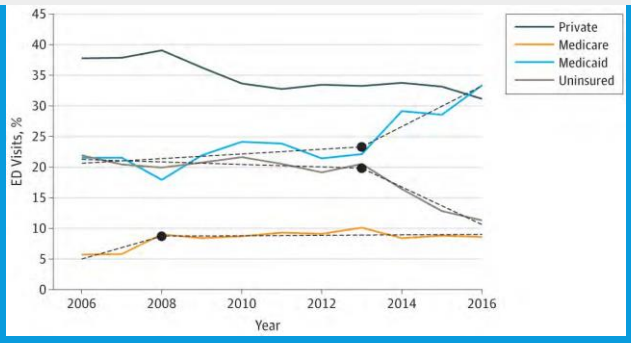
MYTH BUST #2: UNDER MEDICARE-FOR-ALL WE WILL MAKE THE SAME MONEY

From: **US Emergency Department Visits and Hospital Discharges Among Uninsured Patients Before and After Implementation of the Affordable Care Act**

JAMA Netw Open. 2019;2(4):e192662. doi:10.1001/jamanetworkopen.2019.2662



EDs: The Worst Payer Mix

Figure legend: Percentages of US Emergency Department (ED) Visits by Insurance Type for Patients Aged 18 to 64 Years,

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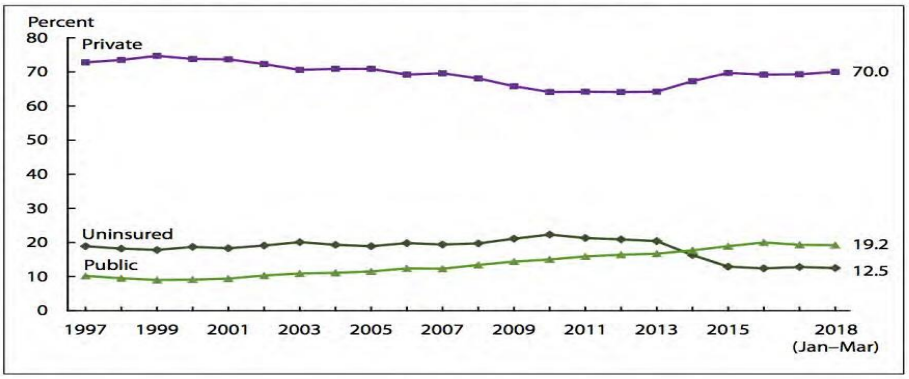
MYTH BUST #2: UNDER MEDICARE-FOR-ALL WE WILL MAKE THE SAME MONEY

Figure 1. Percentage of adults aged 18–64 who were uninsured or had private or public coverage at the time of interview: United States, 1997–March 2018



NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 1997–2018, Family Core component.

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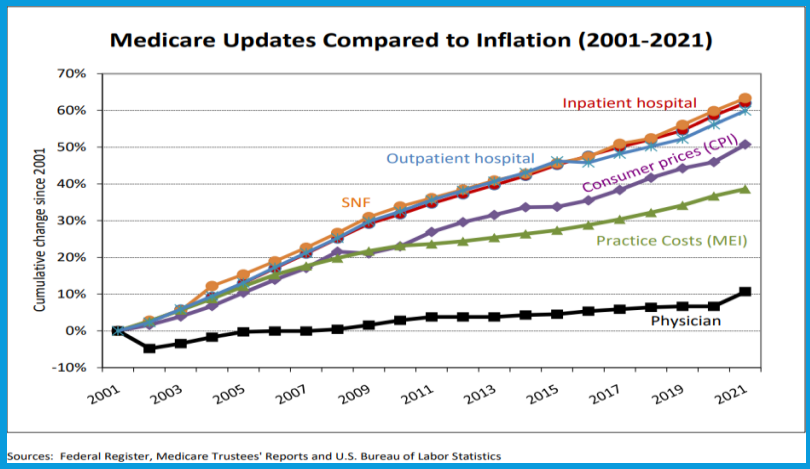
MYTH BUST #2: UNDER MEDICARE-FOR-ALL WE WILL MAKE THE SAME MONEY



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REALITY CHECK #2. WE WILL NOT MAKE THE SAME SALARY

Medicare and Medicaid rates have not, and will not, keep up with inflation for physicians. Congress will not fix it.

Emergency medicine, and medicine overall, relies heavily on commercial payers. Once they are gone, finances falter significantly.

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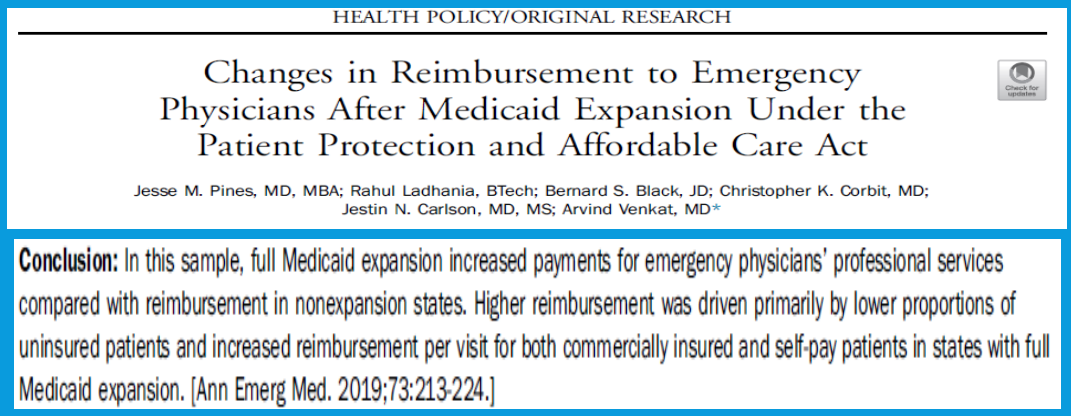
REALITY CHECK #2. ACA HAS BEEN GOOD FINANCIALLY FOR EMERGENCY PHYSICIANS



HEALTH POLICY/ORIGINAL RESEARCH

Changes in Reimbursement to Emergency Physicians After Medicaid Expansion Under the Patient Protection and Affordable Care Act

Jesse M. Pines, MD, MBA; Rahul Ladhania, BTech; Bernard S. Black, JD; Christopher K. Corbit, MD; Jestin N. Carlson, MD, MS; Arvind Venkat, MD*

Conclusion: In this sample, full Medicaid expansion increased payments for emergency physicians' professional services compared with reimbursement in nonexpansion states. Higher reimbursement was driven primarily by lower proportions of uninsured patients and increased reimbursement per visit for both commercially insured and self-pay patients in states with full Medicaid expansion. [Ann Emerg Med. 2019;73:213-224.]

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MYTH BUST #3: UNDER MEDICARE-FOR-ALL GOVERNMENT FUNDED DOES NOT MEAN GOVERNMENT CONTROLLED

Monopsony

Coding and Billing will not go away

- CPT, ICD-10, RVUs coordinated between AMA and CMS

Push to pay for Quality, not Volume, will not go away

- MIPS measures, APMs, are here to stay (CMS)
- Bundled payments have had moderate success (CMS BPCI programs)
- Physician input very difficult

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REALITY CHECK #3. GOVERNMENT FUNDING MEANS MORE GOVERNMENT INVOLVEMENT

CMS is intertwined now in the coding and billing infrastructure. This will not change.

CMS carries a big stick. Fraud. And they use it.

CMS for decades has tried to create and implement a pay for quality program. Sometimes with physician input.

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MYTH BUST #4: UNDER MEDICARE-FOR-ALL EVERYONE IS HAPPY, AND THERE WILL NOT BE LONG WAITS


Forbes

257,231 views | Apr 1, 2019, 05:00am EDT

Britain's Version Of 'Medicare For All' Is Struggling With Long Waits For Care

Sally Pipes Contributor

Policy

I cover health policy as President of the Pacific Research Institute

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REALITY CHECK #4. THERE WILL BE UNHAPPY PEOPLE WAITING FOR HEALTH CARE

The Medicare and Medicaid system currently has long waits. Adding more will not change this.

Other countries with Medicare-for-All-like systems have long waits and rationing. Most have a secondary private system.

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MYTH BUST #5: UNDER MEDICARE-FOR-ALL INNOVATION WILL NOT BE STALLED

Created in 2010 as part of ACA

CMMI purpose

- Develop and test new healthcare payment and service delivery models for Mcd, Mcr, CHIP
- Examples: ACO, BPCI, ET3

10+ Years!

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MYTH BUST #5: UNDER MEDICARE-FOR-ALL INNOVATION WILL NOT BE STALLED

Telemedicine example

- Innovation stalled for years secondary to Medicare confinements
- Explosion of use during COVID crisis, finally, because of Public Health Emergency waivers by CMS
- To keep waivers intact? Congress.

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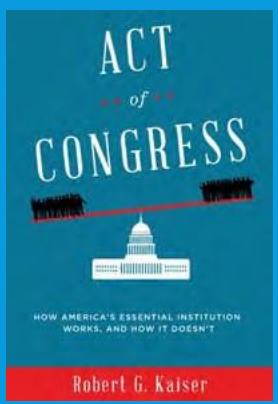
REALITY CHECK #5. INNOVATION WILL BE STALLED

The Medicare and Medicaid system support of innovation in care delivery has been mediocre at best.

It took a pandemic to modernize a crucial access point: telemedicine. May go away after the Public Health Emergency without Congressional Action.



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WHERE DO WE GO FROM HERE?

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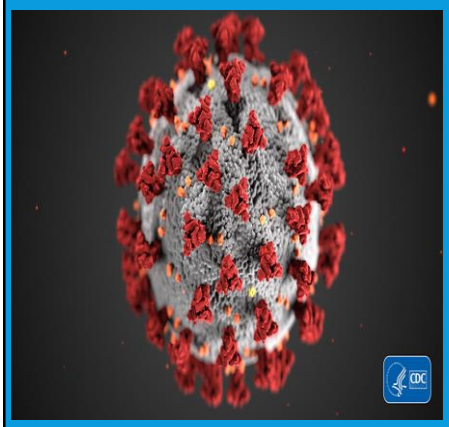
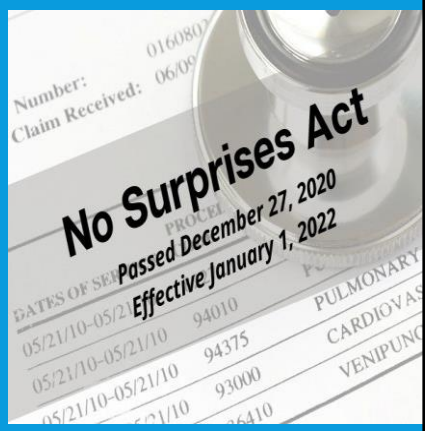
THREE CRITICAL DEVELOPMENTS





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COVID HAS REVEALED THE VULNERABILITIES IN EMERGENCY CARE

HEALTH POLICY/ORIGINAL RESEARCH

The Effect of the COVID-19 Pandemic on the Economics of United States Emergency Care

Jesse M. Pines, MD, MBA*; Mark S. Zocchi, MPH; Bernard S. Black, JD; Rebecca Kornas, MD; Pablo Celedon, MBA; Ali Moghtaderi, PhD; Arvind Venkat, MD; US Acute Care Solutions Research Group

Conclusion: The COVID-19 pandemic adversely impacted the economics of ED care, with large drops in overall and, in particular, low-acuity ED visits, necessitating reductions in clinical hours. Staffing cutbacks could not match reduced revenue at small EDs with minimum emergency physician coverage requirements. [Ann Emerg Med. 2021;■:1-13.]

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PUBLIC-PRIVATE BLENDED MODELS

HealthAffairs

How A Fire Department Funding Model Could Preserve Rural Emergency Departments And Quality Emergency Care

Jesse M. Pines, Bernard S. Black, Pablo Celedon, Ali Moghtaderi, Mark S. Zocchi, Arvind Venkat

JUNE 14, 2021 DOI: 10.1377/hblog20210610.559255

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