PLEASE NOTE: THIS RESOLUTION WILL BE DEBATED AT THE 2020 COUNCIL MEETING. RESOLUTIONS ARE NOT OFFICIAL UNTIL ADOPTED BY THE COUNCIL AND THE BOARD OF DIRECTORS (AS APPLICABLE).

RESOLUTION: 32(20)

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SUBJECT: Loss of Health Insurance Due to COVID-19

PURPOSE: Support adoption of Medicare-for-All as an alternative to employment-based insurance (with conditions) and explore opportunities to partner with other like-minded organizations favoring a Medicare-for-All approach.

FISCAL IMPACT: Budgeted staff and committee time and resources.

WHEREAS, The COVID-19 pandemic has caused almost 27 million Americans to lose health care coverage as a result of becoming involuntarily unemployed[1]; and

WHEREAS, Tying insurance to employment creates an undue burden on both employees and businesses alike; and

WHEREAS, The 2010 Affordable Care Act (ACA) created a complex and inefficient bureaucracy that works through private insurers with high administrative overhead, and even prior to COVID-19 left 28 million Americans uninsured and another 44 million underinsured, causing them to receive care at an advanced stage of disease or to forego care altogether[2]; and

WHEREAS, Medicare-for-All is an alternative to employment-based insurance, with financing streamlined through a single-payer system; adds simplicity to billing and medical care administration resulting in lower overhead; and has the potential to help American businesses compete globally by reducing their financial obligations for their employees' health care; and

WHEREAS, Recent polls demonstrate majority support for Medicare-for-All or single-payer by the general public[3,45] and among clinicians[6]; and

WHEREAS, There is no truth to the memes that Medicare-for-All is "socialized medicine"; that it is "government-controlled health care"; that it represents a massive pay cut for physicians; or that it will block health care competition, diminish quality, forestall medical innovation, or inhibit patient choice of provider; and

WHEREAS, In 1999, the ACEP Council adopted Resolution 15(99) Promotion of Health Care Insurance stipulating that ACEP formulate and implement a strategic plan to promote expansion of health insurance coverage for the uninsured and underinsured, a stipulation that has yet to be consummated; and

WHEREAS, ACEP's Health Care Financing Task Force, created in 2017 to study alternative financing models that foster competition and preserve patient choice, did not provide any actionable conclusions; and

WHEREAS, ACEP's Acute Unscheduled Care Model (AUCM), created by the Alternative Payment Model

Task Force, focused on physician ***reimbursement*** rather than overall health care ***financing***; therefore, be it

RESOLVED, That ACEP support adoption of Medicare-for-All as an alternative to employment-based insurance – but only if such a program provides universal access, fosters competition, preserves patient choice of provider and physician autonomy, and recognizes the essential value of emergency medicine; and be it further

RESOLVED. That ACEP explore opportunities to partner with other like-minded organizations that favor the Medicare-for-All approach to providing universal health care to all Americans.

[1] Garfield R, Claxton G, Damico A, Levitt L. Eligibility for ACA health coverage following job loss – data note. Kaiser Family Foundation. Published May 13, 2020, at: www.kff.org/8b2d153/
[2] Collins SR, Bhupal HK, Doty MM. Health insurance coverage eight years after the ACA: fewer uninsured Americans and shorter coverage gaps, but more underinsured (Commonwealth Fund, February 2019), at: https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca.
[3] KFF Health Tracking Poll. Public opinion on single-payer, national health plans, and expanding access to Medicare coverage (slide file; published May 27, 2020), at: http://files.kff.org/attachment/SP_5.21.20
[4] Poll: 69 percent of voters support Medicare for All. *The Hill.* Published April 24, 2020, at: https://thehill.com/hilltv/what-americas-thinking/494602-poll-69-percent-of-voters-support-medicare-for-all
[5] Murad Y. As coronavirus surges, 'Medicare for All' support hits 9-month high. *Morning Consult/Politico* poll (February 21-23, 2020 and March 27-29, 2020; published April 1, 2020), at: https://morningconsult.com/2020/04/01/medicare-for-all-coronavirus-pandemic/
[6] Serafini M. Why clinicians support single-payer – and who will win and lose. *NEJM Catalyst.* Published on January 17, 2018, at: https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0278

Background

The resolution calls for ACEP to support the adoption of Medicare-for-all as an alternative to employment-based insurance, but only if such a program provides universal access, fosters competition, preserves patient choice of provider and physician autonomy, and recognizes the essential value of emergency medicine. Additionally, it calls for ACEP to explore opportunities to partner with other like-minded organizations that favor the Medicare-for-all approach to providing universal health care to all Americans.

The resolution notes the economic impact of the COVID-19 pandemic that resulted in dramatic job losses in the U.S., especially during the first several months of the response. While some of these losses were temporary and the economy has recovered a large portion of the initial drop, as of mid-August, weekly unemployment claims numbered nearly one million. Since President Trump declared a state of emergency on March 14, 2020, more than 56 million Americans have applied for unemployment benefits in a 21-week period. The resolution further notes that because of the predominance of the employer-sponsored model of health insurance in the U.S., unemployment is directly linked to a loss of insurance, which in turn affects individual and public health in addition to its financial impacts on the health care system.

The resolution references the Health Care Financing Task Force (HCFTF) established in response to Amended Resolution 19(16) to study alternative health care financing models, including single payer. The task force submitted its report to the Board of Directors in fall 2018 and the report served as the foundation for the 2018 Council Town Hall Meeting. The report notes:

> Although the HCFTF cannot recommend a financing system at this time, a majority of the HCFTF agree that there are elements of [single payer] systems that strongly adhere to the '9 Principles' outlined. Therefore, if ACEP were to advocate for significant health care financing reform in the future, HCFTF members would want some elements of varied single-payer models to be considered and included in an ACEP-endorsed model.

The task force determined that ACEP should continue to advocate for and propose meaningful ideas for health care financing reform, but at the current time, no one system – single payer, two-tier, or the current health care system –

could be espoused over another. The HCFTF concluded "ACEP shall focus on securing access to coverage for our patients and their families for, acute unscheduled care services in any health care financing model, including single payer."

It is important to recognize that single-payer is not equivalent to universal health care. Universal health care refers to a system in which all citizens have access to health care services, although payment for these services could derive from either a single source or multiple sources. Single-payer, on the other hand, is a health care financing system where all reimbursements derive from one entity.

Further, while the resolution states "Single-payer health insurance, often known as 'Medicare-for-All'…", it should be noted that "single-payer" and "Medicare-for-All" are also considered distinct proposals, even by many proponents. For example, a 2016 poll conducted by Kaiser Family Foundation (KFF) found significant variation in support among Democratic voters for various proposals, including Medicare-for-All (53% very positive), guaranteed universal health coverage (44% very positive), single-payer health insurance (21% very positive), and socialized medicine (22% very positive). However, those variations appear to have diminished within the past few years – according to a 2019 Morning Consult poll, a majority of voters support either Medicare-for-all (53%) or single-payer (51%). Regardless, as the Morning Consult notes, while the terms are often used interchangeably, "there are differences between the two: Single-payer is a sweeping term for a system in which the costs of essential care for all residents are covered by one public system, while a "Medicare for all" program could be single-payer but does not necessarily have to be."

Recently, there appears to be growing public support for Medicare-for-All proposals, driven by the COVID-19 pandemic. The resolution cites an April 2020 Morning Consult/Politico survey of registered voters showing an approximately 40 percent increase in support for both the Affordable Care Act and for universal health care proposals. It is unclear if this trend has continued in the ensuing weeks. It also found that support for Medicare-for-All was supported by 55 percent of registered voters, a one percent increase since June 2019.

The United States currently operates under a multi-payer system. Individuals and businesses pay taxes to the government, in the form of payroll taxes and income taxes, as well as paying premiums to private insurers. The government then reimburses health care providers who deliver care through one of the public programs, such as Medicare, Medicaid, CHIP or military health care (TRICARE or VA/CHAMPVA). For those who are privately insured, health care providers seek reimbursement from the respective insurance company. Presently, there are dozens of private health insurance companies and thousands of private health insurance plans offered through state and federal insurance exchanges, public programs and in the private marketplace. Government programs insured 95 million Americans while private insurance covered 196 million of those who had health insurance in 2010,.

In the case of single-payer financing, individuals and businesses would pay taxes to the government. The government would then reimburse health service providers directly for care delivered through a national health insurance program. Although the collection of funds and the process of reimbursement are conducted by one entity, the delivery of care would be through both public and private sources. For example, under the terms of the single-payer system proposed by Physicians for a National Health Program (published in the Journal of the American Medical Association in 2003), all residents of the U.S. would be enrolled and all medically necessary care would be covered. Obviously, the question of what is considered medically necessary could be contentious, especially given the recent developments in the State of Washington.

Financing the proposal would be achieved using existing sources of government funding (for public programs) and supplemented with new taxes. According to PNHP, businesses and individuals would pay more taxes, but those taxes would be offset because there would no longer be health insurance premiums. Hospitals would receive a global budget for operating expenses every month. Medications and supplies would be purchased by the federal government according to a national formulary and using its bulk purchasing power to negotiate the lowest prices for medications and supplies. Physicians would have three reimbursement options: (1) fee-for-service (with a simplified, binding fee schedule); (2) salaried positions in facilities that receive global budget payments (i.e. hospitals); or (3) salaried positions within group practices or HMOs receiving capitation payments.

Two of the more common economic arguments in favor of single-payer are administrative simplification and the ability to control costs. According to a 2003 New England Journal of Medicine study, the U.S. spends more than $294

billion annually on administrative costs, which represents 31% of health expenditures in this country. However, not all administrative costs are harmful or inappropriate, thus diminishing the amount of savings generated by administrative simplification. Furthermore, these savings would only be generated one time.

Regarding cost control, the U.S. has a fragmented, non-centrally coordinated system where different payers operate by different rules. Some argue that these variances have curtailed efforts to implement effective, systemic cost control measures, such as global budgeting (lump-sum monthly payments for all care provided); price controls; supply controls; reimbursement caps; and overall expenditure targets. Centrally administered plans, such as single-payer, provide policy makers who wish to institute cost controls with a substantial tool for obtaining that objective. Although, implementing that option would be largely dependent on public opinion. Additionally, if cost containment measures are too aggressive, it can lead to an underfunded system with significant wait times for elective procedures, insufficient resources and diminished research and development.

Some argue that the biggest disadvantage to a single-payer system is the threat of underfunding by the government (due to fiscal or policy determinations). A single-payer system is particularly reliant upon a government that is committed to high funding levels to ensure quality of care is not diminished. As the Medicare and Medicaid Trust Funds rapidly approach projected insolvency, questions arise about the federal government's ability to sufficiently provide benefits even under our current system. Another acknowledged disadvantage is that the transition from the current U.S. system to single-payer would be very difficult and disruptive. The ACEP HCFTF also notes several potential tradeoffs with regard to implementing a single-payer system. These include: "restricted availability and lengthy wait times for certain elective procedures, as well as the potential for capitation that could limit reimbursement for providers." Finally, it has been suggested that Americans would have to be willing to accept other certain sacrifices under a single-payer system, such as accepting less choice in their coverage options and a willingness to accept more government control, oversight, and regulations through a single-payer system.

ACEP Strategic Plan Reference

Goal 1 – Improve the Delivery System for Acute Care

Objective B – Develop and promote delivery models that provide effective and efficient emergency medical care in different environments across the acute care continuum, including rural areas.

Objective E – Pursue strategies for fair payment and practice sustainability to ensure patient access to care.

Fiscal Impact

Budgeted staff time and resources. Potential additional costs associated with working with like-minded partners or coalitions.

Prior Council Action

Resolution 37(19) Single-Payer Health Insurance not adopted.

October 2018, the Health Care Financing Task Force report served as the foundation for the 2018 Council Town Hall Meeting.

Amended Resolution 19(16) Health Care Financing Task Force adopted. Directed ACEP to establish a Health Care Financing Task Force to study alternative health care financing models, including single-payer, and provide a report to the 2017 Council.

Substitute Resolution 31(14) Financing Health Insurance adopted. Directed ACEP to create a Health Care Financing Task Force to study alternative financing models that foster competition and preserve choice for patients and that the task force report to the 2015 ACEP Council regarding its investigation.

Resolution 20(12) Single Payer Universal Health Insurance not adopted. The resolution supported the adoption of single payer health insurance and explore opportunities to partner with other organizations that favor the single payer approach.

Resolution 26(11) Single-Payer Universal Health Insurance not adopted. The resolution supported the adoption of single-payer health insurance and explore opportunities to partner with other organizations that favor the single payer approach.

Substitute Resolution 21(10) Medicare-for-All Health Insurance referred to the Board. The original resolution Supported the adoption of Medicare for everyone and work with organizations that favor this approach to providing health insurance for all Americans. The substitute resolution directed the Board to appoint a taskforce to investigate alternative models of healthcare financing.

Resolution 18(09) Single-Payer Health Insurance not adopted. Directed ACEP to support the adoption of single payer health insurance and work with organizations that favor the single-payer approach.

Substitute Resolution 24(08) Single-Payer Health Insurance adopted. Directed ACEP to support the adoption of single-payer health insurance and work with organizations that favor the single-payer approach. A substitute resolution was adopted, although the title of the resolution was not changed. The substitute resolution directed the Board of Directors to derive a list of essential components to be included in any new healthcare system and create a white paper.

Resolution 21(07) Single-Payer Health insurance referred to the Board of Directors.

Resolution 34(05) Single-Payer Health Insurance referred to the Board of Directors.

Resolution 11(00) Funding the Mandate referred to the Board.

Amended Resolution 15(99) Promotion of Health Care Insurance adopted. Directed the College to develop a strategic plan to promote expansion of health insurance coverage for the uninsured and underinsured; make a long-term commitment to work with federal, state, and private agencies to resolve the problem; and provide a progress report at the 2000 Council meeting. This resolution was linked to Resolution 12(99). A health policy report, “Emergency Medicine and the Debate Over the Uninsured: A Report from the Task Force on Health Care and the Uninsured” was developed and included in the published proceedings of ACEP’s educational conference “National Congress for Preserving America’s Healthcare Safety Net.” The report included several principles developed by the task force, including the urgent need to expand health insurance coverage.

Substitute Resolution 12(99) Education Program Addressing Underinsured and Uninsured adopted. It called for ACEP to continue working with the AMA and other leaders on developing and implementing an educational program, on the issue of the medically uninsured and underinsured.

Substitute Resolution 17(98) Responsibilities of On-call Physicians adopted. It called for a study on the ramifications of on-call physicians and EMTALA including reimbursement issues.

Resolution 46(96) Medicaid and the Welfare Reform Act of 1996 adopted. The resolution asked for swift action to identify any adverse effects on public health, safety, and access to emergency services resulting from the Act that could result in making many persons covered by Medicaid ineligible, thus increasing the number of uninsured, and to seek immediate government action if any of these are jeopardized.

Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted. The resolution called for the increase of federal taxes on handguns and ammunition to support increased coverage for the uninsured.

Amended Resolution 38(94) Single-Payer System adopted. The resolution asked the board to endorse the concept of a single-payer system for the United States, saying it would reduce administrative costs, thereby offsetting the costs of providing expanded coverage to the poor and uninsured.

Substitute Resolution 44(92) Universal Access to Health Insurance adopted.

Resolution 18(92) Effect of Transfer Legislation on Emergency Medical Care referred to the Board of Directors.

Prior Board Action

September 2018, accepted the final report from the Health Care Financing Task Force. The report was distributed to the Council.

Amended Resolution 19(16) Health Care Financing Task Force adopted.

June 2015, reaffirmed the policy statement, "Universal Health Care Coverage;" reaffirmed August 2009; originally approved December 1999.

Substitute Resolution 31(14) Single Payer Health Insurance adopted.

April 2014, approved the revised policy statement "Health Care Cost Assignments by Taxes," replacing the policy statement "Health Promotion Revenues ("Sin Taxes"); reaffirmed October 2006; revised and approved July 2000; originally approved in 1993.

Substitute Resolution 24(08) Single-Payer Health Insurance adopted.

January 2008, discussed whether ACEP should have a more defined position on health care reform, including universal health care coverage. There was consensus that system reform and health care coverage were ACEP's primary goals in the health care debate.

August 2007, agreed with the assessment of the Federal Government Affairs Committee that support of reform principles and involvement in discussions regarding health care reform constitute sound approach to health care reform and thus took no action on Resolution 34(05).

January 2006, endorsed the "Principles of Reform of the U.S. Health Care System" developed by eleven physicians' organizations, including ACEP.

June 2005 discussed whether ACEP should take the lead in advocating for fundamental changes in public financing of health care to provide universal coverage of basic benefits.

Resolution 11(00) Funding the Mandate was assigned to the EMS Committee, Reimbursement Committee, Federal Government Affairs Committee, and the State Legislative/Regulatory Committee. ACEP addressed the resolution through ongoing legislative and regulatory activities, both nationally and at the state level.

Amended Resolution 15(99) Promotion of Health Care Insurance adopted.

Substitute Resolution 12(99) Education Program Addressing Underinsured and Uninsured adopted.

Substitute Resolution 17(98) Responsibilities of On Call Physicians adopted.

Resolution 46(96) Medicaid and the Welfare Reform Act of 1996 adopted.

Amended Resolution 48(94) Increased Taxes on Handguns and Ammunition adopted.

Amended Resolution 38(94) Single-Payer System adopted.

Substitute Resolution 44(92) Universal Access to Health Insurance adopted.

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