

Considerations for Universal Health Care Systems in the United States

An Information Paper

by the Health Care Finance Task Force

September 2018

Purpose and Directive

In October 2016, the ACEP Council adopted a resolution to create a Health Care Financing Task Force (HCFTF), to study alternative health care financing models that foster competition and preserve patient choice. A task force was appointed in June 2017 and the first meeting was held during ACEP17 at which time it was determined that a major focus would be to evaluate single payer (SP) health care, since other ACEP task forces had addressed other aspects of health care financing. The following report is in response to this objective. Members of the task force studied the merits, as well as the weaknesses, of health care systems predominantly funded by a single payer. A majority of the research and discussion has been done through a lens focused on SP. Although the national conversation has shifted in support of a health care system that provides universal coverage, “Medicare for All”, 2018 is still an opportune time to openly discuss how to remedy the persistent shortcomings of the current health care system despite changes brought forth by the ACA.

This task force is building upon the ACEP policy supporting universal health insurance coverage (the policy was originally approved in December 1999, revised and approved August 2009, and reaffirmed June 2015):

1. All Americans must have health care coverage;
2. Health care coverage will contain a benefits package that provides quality care;
3. Medical necessity determinations made under the benefit package should reflect generally accepted standards of medical practice supported by outcome-based evidence, where available.

Shortly after the Patient Protection and Affordable Care Act (ACA) was passed by Congress, ACEP released “Health Care Reform Positions” in 2010. ACEP advocates for universal health coverage but also distinguished it from a single payer system.

“There has been some confusion among ACEP members that “universal coverage” equates to a single payer system. That is not the case. ACEP’s support of universal coverage is support of the concept that everyone in America should have insurance coverage of some sort (government or private) and that emergency physicians should be paid for the medical care they provide.”

ACEP’s Board elaborated on these principles, including certain mechanisms for achieving them, in connection with ACEP’s “Myths and Realities” advocacy campaign in the fall of 2009:

“Every person in America must have meaningful and affordable health insurance coverage provided through a combination of employer and individually mandated insurance. ACEP believes insurance requirements should be means-tested allowing those in need to receive coverage or financial support to buy insurance. A combination of private sector and governmental solutions may be needed to achieve universal coverage.”

ACEP also continues to stand by its “Principles for Reform of the U.S. Health Care System” with the adoption of 11 “Principles for Reform of the U.S. Health Care System” along with the AMA, AOA and other leading medical organizations. (See Appendix A).

The principles and recommendations of the HCFTF are consistent with and repeat many of those principles espoused by ACEP. This report provides recommendations to the ACEP Board of Directors about the merits and weaknesses of different health care financing models. This will inform the College’s deliberations on this topic for years to come as it develops its legislative and advocacy agenda:

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. Evaluation and comparison of health care financing models should incorporate the following nine principles when determining whether ACEP could support such a model:

1. *Access*
2. *Budget*
3. *Choice*
4. *Reduce Disparities*
5. *Promote Competition*
6. *Physician Input and Support*
7. *Lower Administrative Costs*
8. *Maintain Quality*
9. *Training*

Introduction

Understanding how to reconfigure US health care financing requires some knowledge of what has happened over the past 70 years. The beginnings of the current health care system began with Medicare in 1965, Medicaid expansion, and the development of HMO's and PPO's in the 1970's creating the current financing mechanisms to providing care. Emergency medicine (EM) as a specialty was particularly enhanced by the EMS Act of 1973 and again by Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986 This was further bolstered by the Prudent Layperson Standard (PLS) and provided in the Patient Protection and Affordable Care Act (ACA) enacted in 2010. These statutory changes put EM at the forefront of providing care, regardless of an individual's ability to pay for services. The ACA has further created profound changes in health care financing, however universal access to coverage supporting the nine principles outlined has not yet been achieved.

The task force provides recommendations on how the U.S. health care system can achieve universal access to care while conforming to the nine "Fundamental Principles". This could be achieved in several different types of systems based on what currently exists in the United States and abroad. At first glance, the current mix of employer-based insurance with federal and state-funded systems may be modifiable to achieve universal access. However, other countries have transitioned to a system of government and privately administered or one with an insurance mandate. Finally, there is a growing popularity in a single payer system and the proposal to expand Medicare to the general population (Medicare for All¹).

The ACA expanded coverage to nearly 30 million Americans by requiring purchase of private insurance policies with partial subsidizing of those policies by government payments to private insurers, and by expanding Medicaid eligibility to those with higher incomes. Despite the progress of the ACA, 30 million people will still be uninsured in 2023, and tens of millions will remain underinsured.² If current trends in health care financing continue, the system will continue to operate with limited policy options, narrow provider networks that limit and deny care, and increased co-pays, deductibles and other out-of-pocket costs. Without a penalty for the mandate to buy health insurance, the ACA may see fewer individuals enroll in health insurance plans.¹

The ACA has preserved a fragmented financing system. The law continues the unfair financing of health care, whereby costs are disproportionately borne by middle- and lower-income Americans and those families facing acute or chronic illness. However, how to finance true coverage for all Americans has yet to be determined, especially the costs due to use of the ED by those lacking coverage.

One proposed solution is to have the US health care system progress to a single payer system. There are a significant number of physicians and health care experts in the USA who are proponents of SP. One survey found that 59% of US physicians support a single payer system.³

The Expanded and Improved Medicare for All Act, H.R. 676, introduced in the 115th Congress would establish an American single-payer health insurance system, publicly financed and privately delivered, that builds on the existing Medicare program. With its introduction came increased attention to adoption of single payer health care in the U.S.

¹ [Effects of Health Care Payment Models on Physician Practice in the United States, M. Friedberg et. al, RAND Corporation, 2015](#)

Polls over the past two decades have shown increasing support for this approach.² However there are still many physicians and politicians that believe the current system can be fixed without the need for drastic changes to health care delivery and financing.

The debate will continue in the U.S. about whether health care is a privilege or a right. Many agree that EMTALA and the nature of Emergency Medicine provides a “safety net” to provide the most basic care without being subject to costs. However, this “right” at present is an unfunded mandate and thus a system of universal access and reimbursement for services should be explored further.

Universal Access to Health Care

Achieving universal health care has largely been accomplished in three different ways; by mandating the purchase of private insurance while the government provides catastrophic coverage, by providing both private insurance options and coverage for certain health care services under a government-run health plan, and through a single-payer system in which the government or a contracted private entity provides coverage. There are several considerations for which type of system could be adopted for use in the U.S. including the ability to cover the entire population, who pays for services, what is paid for, and how to work within the confines of perception of a system that works while keeping with financial reality.

In many ways the U.S. already has a two-tier health care system but lacks universal coverage for all citizens. The two tiers are made up of private insurance combined with comprehensive government-sponsored programs such as Medicaid and Medicare at the state and federal levels, and local/ county hospitals and individual health care systems (such as the Kaiser model discussed later) provide coverage or a guarantee of certain limited health services on a smaller scale. The current debate on establishing universal access is whether to expand the current two-tier system in the U.S. or to convert to a single payer system or to adopt a hybrid system that combines elements of both.

One of the impediments to universal access to care is the political issue of whether healthcare is a basic human right. While popular opinion in the U.S. is everyone deserves at least basic catastrophic coverage, irrespective of their origin, background, or financial status, the political will has not yet been strong enough to lead dramatic changes in the current system. While other industrialized countries have enacted one of the three systems and guaranteed universal access to health care, the U.S. has yet to choose a different financing and delivery method, although alternative constructs of a possible SP system are currently being debated at the national and state level of government. In order to look beyond the current political arguments for an SP system and universal access to health care coverage, the HCFTF looked at what makes both possible and how each could adhere to the 10 principles for reform of the U.S. health care system endorsed by ACEP along with the AMA, AOA, and other leading medical organizations.³

Defining Universal Health Care and Coverage

Universal health care, which is also known as *universal care*, *universal coverage*, and *universal health coverage*, addresses a system that provides health care and financial assurance that a minimum level of coverage will be afforded to every citizen. The aim of providing financial risk protection, improved health outcomes, and improved access to health services is to promote sufficient health care services of a quality that ensures no undue hardship for anyone. Universal health care does not provide coverage for everything, but rather it can be determined by three critical dimensions, which include:

1. Who is covered
2. What services are covered
3. How much of the cost is covered

According to the World Health Organization (WHO), universal health care first started in Germany in 1883 and has since been adopted by much of the industrialized world.⁴ The objectives of a universal healthcare system include:

² [Doctors Warm to Single-Payer Health Care, R. Bluth, Kaiser Health News, 2017.](#)

³ ACEP Principles for Reform of the U.S. Health Care System, 2006

⁴ [Arguing for Universal Health Coverage, WHO, 2013](#)

1. A strong, efficient, well-run health system;
2. A system for financing health services;
3. Access to essential medicines and technologies;
4. A sufficient capacity of well-trained, motivated health workers.

Universal health care is the link between utilization and the economic consequences of utilization. Defined benefits that every member of society is bound to receive, subsidized by the government, equals the total financial cost to deliver quality health care. Since many arguments against universal health care in the U.S. have included the possibility of lower quality care and reimbursement for providers, the task force decided to list 9 essential principles necessary for a health care system that supports adequate emergency care.

In the context of universal health care, the task force examined two-tier, insurance mandate, and single payer systems, amongst others. Although close attention was paid to providing adequate coverage that protects individuals and families from financial ruin, the larger focus is on reform of the financing for appropriate health services, and how emergency physicians would best fit into each system.

What is a Single Payer Health Care System?

Single payer financing models, in which one government entity is the sole third-party payer of healthcare costs, can achieve universal access to healthcare without barriers based on ability to pay.⁵ A single public agency or contracted entity will take on the fiduciary responsibility of financing health care for a population. The U.S. already partially finances health care for part of the population for the poor, disabled, and those who are age 65 and older via Medicaid and Medicare. However, in a single payer system, the delivery of care remains largely in private hands, as it currently is via Managed Medicaid or Medicare.⁶ Through single payer health care access to necessary services, such as prescription medication, doctors, long-term care, hospitals, vision care, and dental are included in a “core” plan and in some cases private insurance may be available as a supplemental. In most single payer systems around the world, individuals can choose the place they receive care. Most importantly, multiple payers would be streamlined into a single entity, with taxes replacing premiums, co-pays, and deductibles.

Although single payer health care systems offer substantial reforms to delivery of care in the current U.S. system, there are potential tradeoffs that must be considered in the context of how health care is financed compared to other countries and systems. Critical points include; restricted availability and lengthy wait times for certain elective procedures, as well as the potential for capitation that could limit reimbursement for providers.⁷ Because much of the single payer debate is rooted in finance and the possible erosion of high-quality care options and physician reimbursement, the task force examined the 9 principles for the future of health care in the U.S. for three single payer models – Canada, United Kingdom, and the Medicare For All proposal currently introduced in Congress. Proponents of the “Medicare For All” proposal claim that the system would be different from other single payer models found in other countries. Although the task force has considered the merits of Medicare expansion, an examination of what changes would need to be made if other single payer models were adopted was also debated. A Medicare expansion proposal must first consider the shortcomings of the current system, especially for physician payments which do not currently keep pace with inflation.

The task force had a robust discussion on the anticipated advantages and disadvantages to adopting universal health care:

Arguments in Support of Adopting Universal Health Care in the U.S.

Equal Access to Primary Care and Comprehensive Basic Benefits

- Every health plan offered will include basic preventative, and catastrophic coverage, regardless of employment status and income. Premiums, cost-sharing, and services excluded from deductibles are transparent.

⁵ [Achieving a High-Performance Health Care System with Universal Access: What the United States Can Learn from Other Countries, Annals of Internal Medicine, 2008](#)

⁶ [FAQ Single Payer in the U.S., Physicians for a National Health Program, 2018](#)

⁷ [Factors Contributing to Higher Health Care Spending in the United States Compared with Other High-Income Countries, JAMA, 2018](#)

Improves Public Health with a Stronger Social Safety Net

- The entire population spreads the cost of health care, a key difference from the current U.S. system where risk is limited to a web of individual markets. Because coverage is available without the need for employment or disability, preventative care is more accessible.

Less Enrollment Burden and Complexity

- Lower costs to enroll, including auto-enrollment and a nationwide wage tax plus enrollee premiums, along with a robust risk adjustment mechanism. Supplemental insurance options will help ease waiting lists and strains on facilities and staff and may lessen the current administrative burden for both physicians and health plan providers.

Stops Medical Bankruptcies

- Universal access to health services will significantly reduce the number of medical bankruptcies as well as out-of-pocket costs by patients. In 2007, 62% of all bankruptcies in the U.S. were related to medical expenses, even for those with health insurance.⁴ With universal health care, catastrophic care coverage can prevent costly emergency care from becoming an undue burden. However, proponents recognize that not all care would be covered for all patients.

Encourages Entrepreneurship and Benefits the Economy

- Universal health care will encourage entrepreneurship, according to the projections made by *Kauffman-RAND Institute for Entrepreneurship Public Policy*. Most individuals avoid starting their own business due to fear of losing the health insurance that they receive from their current employer. With universal health care in place, self-employment in the U.S. could increase 2-3.5%.⁸
- Approximately 60% of Americans receive health insurance through their employer in the private sector.⁴ The high cost that is associated with employers paying for health insurance has put private U.S. businesses at a competitive disadvantage in the international marketplace.⁶ Hence, with universal healthcare, private businesses could reduce employer labor costs by more than 12%.

Competition and Private Insurance Still Exist

- Creating an on-ramp plan with basic, comprehensive coverage, while allowing a private marketplace to offer supplemental insurance options will foster competition and offer incentives for patients to be accountable for their own health care.⁹ Depending on the type of health care financing system, participation is mandatory, but patients still decide on what primary care, specialists, and hospitals they want to utilize, encouraging competition amongst providers.

Arguments Against Adopting Universal Health Care in the U.S.

Restraints on Budgets, Capitation, and Global Budgeting

- The U.S. spends more on health care as a percentage of GDP compared to other countries, however the stronger social safety net afforded by their universal health care systems comes at a significant cost.¹⁰ International comparisons conflate health care with numerous other influences, such as personal and environmental factors that determine health, outside of the clinical system.
- Capitation limits resources, and global budgeting, can further perpetuate a system of winners and losers.¹¹ Restraints on budgets makes it difficult to solve a vast public problem with the modest levers available to the government. Stop-gaps to avoid insolvency and automatic benefits cuts to cover budget shortfalls must be considered.

Risk Adjustment, Risk Pools, and Public Financing Shared with Full Population

- Sharing risk in a universal health care system removes typical limits currently found in the U.S., such as risk pools being limited to individual markets instead of the entire population. Risk adjustment is usually funded by a wage and/or general income tax that allows the risk to be shared across the entire population, creating the possibility for a destabilization of the health care system in times of economic crisis, with a recent example

⁸ [Is Employer-Based Health Insurance a Barrier to Entrepreneurship? Kauffman-RAND Institute for Entrepreneurship Public Policy, 2010.](#)

⁹ [Comparing the U.S. Health Insurance System to Those of Other Countries, The Commonwealth Fund, 2017.](#)

¹⁰ [Where the US Health Care System Stands Compared to Other Industrialized Countries, The Commonwealth Fund, 2017.](#)

¹¹ [Why Medicare-For-All Is Not The Answer, D. Goldman and A. Leive, Health Affairs Blog, 2017.](#)

being Greece where the government was forced to shift the financial burden to patients by limiting primary care options creating a catastrophe for the emergency medicine community nationwide.¹²

- Public financing, where the government controls the distribution of health care, amounts to 18% of the U.S. economy.⁴ Free market forces determine much of the availability and cost of health care services, not the federal government. The introduction of universal health care would lead to a great distortion in the economy as enrollee premiums and tax credits would be replaced by wage and income tax revenues that would effectively be viewed as an increase in taxes.

Rationing of Health Care Based on Demonstrated Need

- Common criticisms of the Canadian, United Kingdom, Sweden, and other universal health care systems is the lack of urgency in receiving certain types of care, including specialist care, and long wait times for emergency services.^{13,14} Studies have shown that when a two-tier system, or any system which allows private insurance products to be sold, public health care options frequently lack capacity to serve increasing volumes of patients.

Competition and Innovation in a Free Market Economy

- Universal access to health care eliminates some of the free market for health care, where prices may be lower.¹⁴ There is also less incentive for investment in pharmaceutical and other technological advancements if global budgets and capitation dictate the way forward for the financing of future projects.⁴ Competition could be stifled by lack of a truly open marketplace to try and sell new ideas, resulting in the U.S. losing its core advantage over other nations with universal health care systems in place.
- Employment growth of health care professionals in the U.S. could slow significantly if the current way in which providers and facilities are reimbursed for the services they provide changes.¹⁵ If reimbursement falls further behind inflation, the result could be a reduction in salaries and benefits for health care workers. This could create a shortage of physicians and other caregivers over time. Over a ten-year period, the health care sector adds 1 in every 3 new jobs in the U.S.¹⁵ The correlation between controlling costs in a universal health care system and maintaining adequate growth of health care workers could lead to a catastrophic shortage as seen in Canada, the United Kingdom and Germany.^{16,17}

Ability to Accomplish Incremental Changes Over Time

- Disruptive changes brought on by a switch to a universal health care system could create enormous financial winners and losers among households and businesses.¹⁸ Country-specific systems that have been studied showed that the ACA was dramatically less disruptive, and that changes would need to happen all at once and not over a longer period in a universal health care switch over. At-risk populations may end up dropping coverage if plans cost more than their current insurance plan, or many may forgo registration for benefits, causing a bottleneck and erosion of public confidence.

Federal and State Revenues are a Major Source of Financing for all Coverage Types

- Existing programs, such as Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), are already a significant part of the overall federal budget. Adding the costs of universal health plans, such as Medicare For All, could add on average \$2.5 trillion per year creating over a \$1 trillion per year financing shortfall.¹⁶ Since most universal health plans are funded by increases in taxes on income and capital gains, including payroll, estate, and elimination of tax deductions, many could end up paying more under a universal health plan than they do for their private health insurance plan.
- Enacting reforms for current government programs, such as Medicaid and Medicare, have consistently failed in the past few decades, while the solvency of the trust funds supporting each of the programs has come dangerously close to running out.¹⁶ Political forces could also put pressure on public health services, causing disruption in services and/or payment to providers when disputes arise.

¹² [The Public Health Crisis in Greece, N. Papalambros, Northwestern University, 2017.](#)

¹³ [Pros and Cons of Universal Health Care in the United Kingdom, Formosa Post, 2017.](#)

¹⁴ [Is Canada the Right Model for a Better U.S. Health Care System? University of Pennsylvania, 2017.](#)

¹⁵ [Health Care Employment Growth and the Future of US Cost Containment, J. Skinner and A. Chandra, Journal of the American Medical Association, 2018.](#)

¹⁶ [A Comparison of Hospital Administrative Costs in Eight Nations: US Costs Exceed All Others By Far, D. Himmelstein et al. Health Affairs, 2014](#)

¹⁷ [Pros and Cons of Universal Health Care in Canada, Formosa Post, 2016.](#)

¹⁸ [An Analysis of Senator Sanders Single Payer Plan, K. Thorpe, Emory University, 2016.](#)

Options for Implementing a Universal Health Care System in the U.S.

With the passage of the ACA in 2010, many without insurance had an opportunity to obtain their own coverage through a federal or state marketplace. However, around 30 million U.S. citizens are unable to afford health insurance.¹⁹ By expanding the ACA to include universal coverage for all, fewer individuals would be left uninsured, however there are limiting factors that must be overcome to achieve such progress. For example, mechanisms to keep premiums lower and more stable with the ACA are not yet currently in effect. Implementing universal health care in the U.S. will be challenging and complex because of the political environment and other impediments to reform. The task force studied more than 30 universal health care systems and all-payer models domestic and international. As was demonstrated by Taiwan in 1994, the transition to a national single payer health care system greatest challenge is maintaining quality of services while also providing enough subsidies and options to meet the needs of all populations.²⁰

A move to a national universal health program would first need to overcome the financial, political, and payer structure realities that exist today. Compared to countries like Taiwan, the U.S. delivery system is fragmented. Although the U.S. spends 50% more than the next highest country on health care costs, overutilization, rationing, and higher costs than anticipated from transitioning the current system to a universal health care system would outweigh prospective gains.²¹

Implementation of most universal health care systems throughout the world took place before 1980, making a road map to adoption in the U.S. difficult for the task force to consider. However, the task force did look at each of the three-universal health care system models to hypothesize how implementation would work in the U.S.

Germany was considered as one of the examples of a possible insurance mandate universal health system that could be adopted in the U.S. Germany offers private insurance plans, with many offerings like what is found in both private, commercial, and public plans in the U.S., through ‘sickness funds’ that are managed at the state level and regulated at the national level (See Appendix D). Germans are required to annually purchase from a selection of relatively small and independent health plans. Individual health insurance premiums are calculated based on income, and not age or number of dependents.²² With providers paid directly by sickness funds for their services, patients are only responsible for their plan premiums, many of which are not subject to taxation. Like the U.S., the German system faces growing demands from an aging population, and many of the individual sickness funds have been forced to raise premiums and payroll taxes on all enrollees to pay for burden of providing care to older populations.²³

Canada, a single payer system, covers the entire population with a well-defined medical benefits package (See Appendix C).²⁰ Income taxes finance much of the system with only a small fraction of the population responsible for paying co-pays and premiums. Physician choice is unlimited, however primary and specialist care have lengthy waiting times at public facilities. The Canadian system does not require patients to participate in the reimbursement process. Considering the current U.S. system largely involves the patient, the Canadian system does not allow physicians to collect from patients in most cases. Instead, global budgets by province are set on an annual basis with volume of patients and procedures pre-determined.²⁰ The Canadian single payer model presents many challenges for implementation in the U.S. due to the shifting focus to quality metrics over the volume of procedures now under MACRA and MIPS.

Although both Canada and Germany represent examples of systems that could be adopted in the U.S., the task force graded an additional 28 systems based on the 9 principles. The task force does not recommend any one country-specific universal health care model, however there is much to learn about access, quality of care, equity, efficiency, and overall public health as to how the U.S. could implement a universal health care system in the future.

Based on an eleven-country average, the U.S. system ranks in the lower tier of public health system performance, while the U.K. and Germany ranked in the upper third.¹⁹ Part of the reason is lack of access to care combined with the quality of care made available.²⁴ Despite expansion of Medicaid under the ACA, access is still limited. Medicaid

¹⁹ [Factors Contributing to Higher Health Care Spending in the United States Compared With Other High-Income Countries, S. Parente, Journal of the American Medical Association, 2018.](#)

²⁰ [Taiwan’s Health Care System: The Next 20 Years, T. Cheng, Brookings Institution, 2015.](#)

²¹ [Where the US Health Care System Stands Compared to Other Industrialized Countries, R. Osborn, The Commonwealth Fund, 2017.](#)

²² [Comparisons of Health Care Systems in the United State, Germany, and Canada, G. Ridic, et. Al, Sarajevo International University, 2012.](#)

²³ [Issues in the German and U.S. Health Care Systems, AIGCS, 2012.](#)

²⁴ [How Medicare Pales Against Health Care Abroad, R. Eisenberg, Forbes Next Avenue, 2017.](#)

expenditures have risen as a percentage of total state spending, growing from 20 percent in 2008 to 29 percent in 2017.²⁵ Insufficient reimbursement to cover the cost of service delivered to Medicaid patients has been reported as a disincentive for physicians in the community to provide care for this population. Lack of access for patients with the greatest need may be addressed by a universal health care system based on the 9 principles the task force has identified.

Reimbursement in a Universal Health Care System

How physicians and facilities will be reimbursed for their services is a crucial part of a transition plan to a universal health care system. For example, many have suggested tying payment to Medicaid or Medicare as a basis for mandatory catastrophic health insurance, creating a major disruption in how reimbursement works in the U.S. While this scenario is unlikely in the current political climate, the task force considered how reimbursement for physician and facilities could work in a universal health care system.

The current U.S. health care financing system involves patients in the process. Their ability and willingness to pay for health care is an important part of the current financing model. Most health care decisions—such as orders for tests, treatments, hospital admissions, and consultations—are made by physicians.²⁶ The costs for health care products and services are largely not paid by the people receiving the care, but collectively by society through insurance and taxes in a universal health care system. This presents a problem for reimbursement for physician services as most universal health care systems pay for volume over value, whereas the U.S. health system has begun to move away from this financing model. Removing patients from financial responsibility for their health care costs could put physicians and facilities at a disadvantage in negotiating their reimbursement rates with the government and other payers.

The difference between spending on health care versus social care is also a major impediment to reimbursement in a potential U.S. universal health care system. One issue with the adoption of the ACA is the fair distribution of patients in regional risk pools, creating situations where a few high utilizers of care drive up the costs of care for an entire population.²² The same issue occurs with Medicaid paying for complex and expensive long-term services. Universal health care systems spend, on average, twelve percent more on social care, while at the same time spending four percent less on health care.¹⁹ The social safety net spreads the risk over the entire population, including long term care options and catastrophic care plans. The U.S. would need to determine an appropriate percentage of GDP to spend on social care versus health care.

Reimbursement would also depend less on premiums and copays collected from patients and more on wage and income taxes collected.¹³ Continued increases in health care funding by the government could create a situation where many pay more for their government-sponsored insurance than they do now for private insurance. Higher health care costs for families through higher insurance premiums presents a major impediment to receiving care now, however a higher effective tax rate or less applicable deductions could create an economic crisis. The task force found that to provide universal coverage, the immense costs would need to be managed in a capitated system with global budgets, found in most universal health care systems. More importantly, the task force suggests it would be more prudent to decide what a universal health insurance plan will provide as essential health benefits for all, and what benefits will need to be available as an add on comprehensive plan option. A better option may be to look at what health care reforms in the U.S. on both a local and state level have been able to accomplish, and to build off one or multiple models.

Maryland All-Payer Model

One example the task force considered as a potential transition model is the Maryland All-Payer Model approved by CMS as a waiver that sets rates for hospital services on a per capita basis.²⁷ Maryland agreed to shift away from payment to hospitals based per inpatient admission in exchange for per capita total hospital cost growth.²⁴ This model could be looked upon as a transitional approach to a “Medicare for All” or single payer system based on the results of the five-year performance period evaluation. Under this type of system, the reimbursement a provider receives for a given service is the same regardless of who pays. Although the all-payer rate setting has mainly been used for hospital inpatient and outpatient services, the possibility for increasing the quality of health care, lower costs, and meeting the nine principles outlined below is possible. It should be noted however that the federal government provided

²⁵ [State Expenditure Report: Fiscal Overview 2015-2017, National Association of State Budget Officers, 2017.](#)

²⁶ [A Comparison of Hospital Administrative Costs in Eight Nations: US Costs Exceed All Others By Far, D. Himmelstein, Health Affairs, 204.](#)

²⁷ [Maryland All-Payer Model, Centers for Medicare & Medicaid Services, 2018.](#)

substantial funding to ensure the feasibility of the Maryland program, unlikely to be financially feasible on a national level.

Kaiser Permanente Model

A second example of a possible model that could be adopted in the U.S. is the Kaiser Permanente model in which a pre-paid integrated health system of a health plan, medical groups of physicians, and hospitals all share the risks of providing high-quality affordable care and manage population health.²⁸ This model has consistently been viewed as an exemplary model of integrated care, reducing costs, and has provided excellent population health. Utilizing a capitated payment system, patients are managed by Kaiser-employed physician groups and share risk with hospitals. The ability to maintain affordability in the system for patients has greatly reduced the risk of costly catastrophic care and management of chronic conditions before patients need to visit an emergency department.

ACEP Principles that Must be Addressed in Universal Health Care Financing Models

Based on all the models reviewed, the task force created a framework of nine principles to compare universal health care with the current U.S. system. A grid has been created to attempt to objectively rank different health care systems and financing models against each other. This should help inform and guide discussions on how ACEP will advocate for health care system reform. These principles will also be used to comment on, support, and critique positions for future efforts on health care system reform.

- 1. Patient access.** All U.S. citizens are entitled to health care and will have immediate access to care without undue financial burden. The care available to patients in emergency departments will be equitable regardless of age, race, ethnicity, gender, geography and socio-economic factors.

Unfortunately, the current U.S. health system under the ACA falls short in terms of both universality and comprehensiveness. Fewer than half of U.S. uninsured residents have gained coverage, and underinsurance remains ubiquitous.²⁹ Many of the estimated 11 million Americans who have purchased plans on the ACA's exchanges face high copayments and deductibles. Such underinsurance often compromises access to care and financial wellbeing.

Universal health care coverage, in contrast, could provide comprehensive coverage with limited copayments or deductibles, replacing the complex and inefficient patchwork of coverage. All medically necessary services and catastrophic care would be covered, including inpatient, outpatient, and dental care, as well as prescription drugs.

The task force believes there are two major hurdles to overcome to create a path to universal health care. First, what the government will cover as essential benefits will need to be decided within the confines of a capitated system/global budgeting. Second, a decision must be made for services that would be purchased through supplemental plans.

- 2. Financing / Budget:** Health care spending currently in the U.S. comprises 18 percent of GDP and continues to increase. If the U.S. moves towards a capitated/global budgeting system, adequate levels of reimbursement must be maintained for providers and facilities. The task force strongly believes that universal health care reform must be fiscally responsible and realistic and should look to other countries and models already used in the U.S. for guidance.

If a universal health system is adopted, there will be a need to preserve private health insurance for those that want the choice of supplemental coverage. Second, there must be limits to social and health care benefits since no health care financing system could cover all services available. Some services will need to be paid out of pocket or by supplemental private insurance.

A true single payer system could be adopted, with institutional providers paid for their operating expenses through global ("lump-sum") budgets, akin to Maryland's current all-payer model, pending substantial investment unlikely to be replicated nationwide. By eliminating per-patient billing, administrative savings from such a change could be very significant.²⁴ A federally-run single payer system could fund modernization and expansion projects through separate, explicit capital grants targeted to community needs, rather than profitability.

²⁸Kaiser Permanente – California: A Model for Integrated Care for the Ill and Injured, J. Pines et. al, The Brookings Institution, 2015.

²⁹ An Emerging Approach to Payment Reform: All-Payer Global Budgets for Large Safety-Net Hospital Systems, J. Sharfstein et. al, The Commonwealth Fund, 2017.

- 3. Patient choice:** Patients would have access to different types of coverage programs and benefits, allowing them to purchase insurance products that meet their needs. However, due to the insurance tenet that coverage programs must spread risk among a large population of insureds, there will need to be an understanding that premiums will have to be adequate to cover the benefits provided. The task force believes that a clear delineation of what essential benefits must be included in any health care financing plan, such as the PLS, should be considered. Likewise, there will be non-essential benefits that would have to be paid for through patient purchased supplemental plans, an HSA, etc.

In countries with two-tiered systems, such as Germany and Switzerland, insurance coverage is mandated, with a catastrophic level standard offer optional health insurance offered for an additional fee. The task force advises using caution against recommending a two-tier system if it only covers preventative and catastrophic care as it may become untenable to cover other types of health care, causing many physician specialists practices to become unprofitable. Most importantly however, is the choice of providers and the preservation of physician – patient relationships that are threatened by our current system. With each enrollment cycle, patients seeking affordable premiums or changing jobs must often switch insurers and risk breaking existing relationships with providers. Proponents of a universal health care program claim that universal coverage could do away with narrow networks by replacing them with one large network.¹³ The task force is supportive of a mixture of health care financing options, including the option to purchase comprehensive coverage.

- 4. Reduction of disparities:** The current amount and quality of health care is too varied based on social determinants of health such as income, geography, job status, age, provider and hospital access, etc. Living in a rural or urban environment should afford patients the same access to physicians, other clinical providers, and facilities that is seen in suburban environments. There should also to be more accurate, risk adjusted, and appropriately attributed quality metrics of clinical effectiveness so that resources are given to those physicians and health care systems that ensure the best outcomes for patients.
- 5. Competition:** All health care financing systems should promote competition to deliver better quality of care at lower cost while improving outcomes and patient/physician experience. Lack of competition does not incentivize innovation to control costs and increase efficiency.
- 6. Physician leadership, input and buy-in:** Physician support and leadership for an affordable and high-quality system is critical for its success. Emergency physicians have a unique role in the health care system and are particularly well-suited to provide perspective on the strengths and weaknesses in the current system. Due to the nature of their work, which requires them to innovate and solve problems to assure access to care for patients, they also understand the need for universal access to care.
- 7. Lower administrative costs:** Health care administration is a top driver of the high cost of the US health care system. Health care insurance and financing reform must decrease administrative drains on available resources. There are a lot of drivers of unnecessary administrative costs the task force believes can be eliminated including, duplicative unnecessary burdens on doctors, providers, insurers, etc.
- 8. Maintenance of quality and innovation:** Continuing to demand quality outcomes, as well as efficiency of care is critical to the success of health care reform. Physicians as well as private entities should be encouraged to advance quality and drive savings in the delivery of care as well. Organization and management of the health care data also needs to be improved in ways to improve outcomes and decrease costs and redundancy. It should be recognized that costs are in part driven by the current medical liability system that prompts defensive medicine; hence medical liability reform should be promoted.
- 9. Training / Technology:** Any significant overhaul of the U.S. health care system must address training for physicians and other health care professionals. Addressing workforce development should include research on the effects of technology such as augmented intelligence. The task force believes future graduates should have more time to do research as well as incorporating GME and incurred debt into any capitated or global payment model.

Although not one of the Nine Principles, there was significant deliberation by the task force about “what” health care should be paid for and included in a health insurance plan’s essential benefits. If universal coverage were to come to fruition, then most experts predict significantly increased costs for the expanded health coverage. Others think that the

price for expanded coverage would be offset by very large savings from decreased bureaucratic and administrative expenses. Therefore, any financing mechanism would need to have limitations on what could and should be paid before. Finally, a discussion about the “what”, i.e. essential benefits, would lead to widespread conclusion and acceptance that *any health care financing model* must provide coverage for *acute unscheduled care services using a PLS* must be considered.

Other Considerations

Health care financing reform has made its way in a major way into our country’s public and political discourse. There are several options getting a lot of attention such as “Medicare for All” / Single Payer. As divisive and polarizing discussions can be about accepting or rejecting universal health care, other models will get consideration in efforts to come to consensus on health care financing reform.

Given that it is ACEP’s position that every person in America must have meaningful and affordable health insurance coverage, it is reasonable for ACEP to advocate for funding acute unscheduled acute and emergency care. This would also be an initial step in attaining universal catastrophic health care coverage for emergency services as a benefit. Employer-based insurance would continue to exist but only as a “second layer” above the catastrophic layer. The large increase in cost to the U.S. government for providing this universal coverage could be offset by a new healthcare tax.

Financing a two-tiered catastrophic system would be a combination of government funding and premiums with an adequate percentage of the premiums applied as incentives to (1) promote innovation, (2) improve quality and (3) control costs.

The task force has provided background information to support and assist future College initiatives on health care financing reform (see attached appendixes).

Conclusion

Although universal health care coverage continues to face political uncertainty in the US., the task force believes that there is widespread interest in the development of health care financing reform. Undoubtedly, ACEP should continue to propose meaningful ideas for reform. At this time the task force does not believe that any one alternate health care financing system that should be adopted in its entirety whether it be single payer, two-tier, or our current system. The task force could not espouse one system over another at this time.

The task force concluded that **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.** Evaluation and comparison of health care financing models should incorporate a core of Nine Principles presented in this paper when determining whether ACEP could support such a model.