

Perspectives on Medicare for All

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In my roles as President and CEO of UMass Memorial Health Care and as an emergency medicine physician, I have had the privilege and opportunity to observe the U.S. health system from three unique perspectives. First, as CEO of one of the state's largest private employers and the single largest employer in Central Massachusetts, I understand how difficult it is for an employer to balance the competing priorities of great health coverage for employees on the one hand and controlling costs on the other. Second, as the leader of a safety net health system serving a disproportionate share of vulnerable patients, I have seen firsthand the unfortunate and inequitable gap between hospitals that predominantly serve the neediest patients and those that serve patients with fewer socioeconomic challenges. And, third, as a physician who still practices in one of the Commonwealth's busiest emergency departments, all too often I see how the lack of health insurance coverage affects patients in their greatest time of need.

From each of these perspectives, I believe Medicare for All holds potential to improve the U.S. health system. In fact, in our present national debate about the future of health care, it is the only proposal that appears capable of addressing the following four challenges:

1. Ensures *everyone* has comprehensive health insurance, regardless of their financial circumstances;
2. Reduces the overall cost of health care;
3. Levels the playing field between disproportionate share hospitals and wealthier institutions with more financially favorable payer mixes; and
4. Alleviates physician burnout by reducing administrative burdens associated with insurance coverage approvals and disputes.

Though the latter two challenges are not often the subject of public discussion, they are the focus of this summary.

Regarding number three, most members of the public categorize hospitals by using the most obvious factors, such as big versus small or rural versus urban. While these distinctions have some relevance, they are not the most important in assessing health insurance reform proposals. Instead, the more appropriate distinction is between disproportionate share hospitals and their more affluent peers. Whether small and rural or large and urban, disproportionate share hospitals struggle with similar financial and operational challenges. And these challenges affect their ability to serve the most vulnerable patients, thereby contributing to inequities across our national health system.

Disproportionate share hospitals are at the frontline of the nation's most impactful health challenges yet are under-resourced compared to other systems. From rural towns to our largest cities, these organizations treat patients with some of the most complex needs, while grappling with fiscal challenges that result directly from living up to their missions – such as Medicaid funding shortfalls and bad debt from treating uninsured patients. These systems

must try to counterbalance these losses through other funding sources such as commercial insurance and fundraising but are hamstrung on both fronts compared to wealthier peers. Due to their smaller commercial payer mix, they do not have the negotiating power of wealthier hospitals and, therefore, are typically paid lower rates by insurance companies. And, due to the financial circumstances of their patients (and, oftentimes, of their home communities), their philanthropic pool is both narrower and more shallow. Consider UMass Memorial as just one example: Of the six academic medical centers in Massachusetts, our revenue rate is the lowest, amounting to only 74% and 83% of its two most well-endowed peers.¹ In fact, if UMass Memorial were reimbursed in 2017 at the same rate for inpatient services as its most well-funded in-state academic medical center peer, we would have been paid \$180 million more than we actually were!

In my view, Medicare for All will help address this inequity in multiple ways. Although wealthier hospitals also struggle with administrative burdens of negotiating with commercial insurers, these organizations generally oppose Medicare for All because they oppose the prospect of reducing commercial rates down to Medicare rates. By contrast, safety net hospitals should consider Medicare for All as an opportunity to be more fairly reimbursed for treating those patients who are central to their missions – i.e., those who are either uninsured or covered by Medicaid, which has rates that are well below Medicare. In addition, by simplifying and streamlining insurance processes, Medicare for All may lessen one of the most significant contributors to cost growth – administrative burden -- even for disproportionate share hospitals. For example, UMass Memorial currently has contracts for well over 100 commercial insurance products (including Medicare Advantage and Medicaid MCO products), plus traditional Medicare and Medicaid. Each of these products has unique, and oftentimes burdensome, processes for preauthorization, claims approval/denial, appeals and contracting. Dealing with all these processes takes an inordinate amount of staff time and resources, while all too often also impeding the relationship between patient and caregiver. Having one consistent system could dramatically reduce administrative burden and help flatten the cost growth curve. As such, Medicare rates that currently do not entirely cover costs, could become much closer to the actual cost of care.

In terms of the fourth challenge referenced above, caregiver burnout is among the most difficult issues facing hospitals today. Burnout of doctors, nurses and other caregivers is inextricably tied to the profit strategies of enormous, market-dominant for-profit insurance companies. It is no secret that processes such as pre-approvals, denials and appeals ultimately contribute to the profit margin of insurers – particularly large, national, for-profit companies – while disadvantaging patients both financially and medically. While these processes benefit the bottom line of large corporations, they impede the patient-physician relationship by preventing doctors from providing patients with the care they *know* they need, when they need it. These processes redirect excessive time and resources away from patient care while physicians and other caregivers fight with distant companies on behalf of their

¹ *Acute Hospitals Profile Report* Center for Health Information and Analysis, Comparison of Inpatient Net Patient Service Revenue per Case Mix Adjusted Discharge, December 2018 (using 2017 data).

<http://www.chiamass.gov/assets/docs/r/hospital-profiles/2017/FY17-Massachusetts-Hospital-Profiles-Compendium.pdf>

patients. In so doing, they contribute to frustration and burnout among caregivers whose core objective is simply to improve the health of their patients. These committed professionals dedicated years and years of education and training toward the noble, mission-oriented goal of healing and comforting people in their most difficult times. Yet, when they undertake their careers they are confronted with the jarring reality that, each and every day, they and their support staff must surrender valuable energy, time and resources away from treating patients to fighting with insurance companies in an attempt to clear hurdles that bear no obvious relation to appropriate medical care. It is no wonder that studies estimate some 35 to 54 percent of American doctors and nurses have substantial symptoms of burnout.²

By its nature, caring for patients will always be a busy and sometimes stressful endeavor. But the negative impact of unnecessary fights with insurance companies upon the administrative burden, schedules, workload, energy and morale of caregivers is truly incalculable. In my opinion, it is among the largest contributors to burnout. It does *not* have to be this way, and I believe that, if planned and administered correctly, a Medicare for All system could alleviate this contributor to burnout.

As with any major reform, Medicare for All must be constructed and implemented to carefully address each of the four objectives above, while avoiding unintended consequences. We don't want to displace one set of administrative burdens with another. One suggestion I think worthy of consideration is a tiered approach toward both Medicare expansion and revenue that would, year-by-year, decrease the minimum eligibility age for Medicare while expanding revenue sources to pay for the expansion. Implemented over time – perhaps one decade – this would enable hospitals and health systems to adjust to this new model in a manageable, well-planned and constructive way. Essentially, this tiered approach would both provide “proof of concept” and allow for adjustments and improvements informed by experience prior to full implementation.

In closing, hospital leaders should welcome this debate about the future of the U.S. health care system. It provides us with a unique and valuable opportunity to have our voices heard and to shape the system in a manner that best fosters our core mission of improving the health of our patients and communities.

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² *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being*, National Academy of Sciences, October 2019. <https://nam.edu/wp-content/uploads/2019/10/CR-report-highlights-brief-final.pdf>