COVID-19, Medicare for All, and the Uncertain Future of Emergency Medicine

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In this issue of *Annals*, Smulowitz et al[1] report on the possible effect of a single-payer Medicare for All program on payments to emergency physicians and out-of-pocket costs for treat-and-release emergency department (ED) visits. The goal of Medicare for All is to address the under- and uninsured problem by moving everyone who is uninsured, publicly insured outside of Medicare, or with private insurance to Medicare insurance. Addressing insurance gaps is highly relevant to EDs that have high fixed costs and are required to deliver care for all regardless of their ability to pay. Using national data sets from 2013 to 2016, Smulowitz et al estimated that Medicare for All would increase total payments to emergency physicians from $85.5 billion to $89.0 billion and out-of-pocket costs for patients would decrease from $116 to $45 per visit. Maintaining Medicaid as opposed to moving everyone to Medicare would decrease total payments to $79.4 billion and out-of-pocket costs to $36 per visit.

This analysis presents one possible outcome that would be good for both patients and emergency physicians. However, any enthusiasm should be tempered by 3 issues: First, Medicare for All is unlikely without broader change in how the US political system works. Second, the coronavirus disease 2019 (COVID-19) pandemic has caused major shifts in acute care and economics in general, which have broad implications for EDs. Third, if surprise billing legislation passes, it would substantially reduce payments to EDs for the privately insured.

The late Princeton economist Uwe Reinhardt[2] described many barriers to implementing Medicare for All. Because US political campaigns receive support from special interests. As a result, lobbyists have great power over lawmakers and health care policy. Powerful insurance industry lobbyists do not favor Medicare for All and will vehemently promote continuing private health insurance. Altering lobbyist influence requires campaign finance reform, which is also strongly opposed by lobbyists benefitting from this status quo. Although public health or care delivery crises foment desire to change payment policy, a Medicare for All system is unfeasible, given the power the insurance industry wields over lawmakers. Other less drastic expansions of government-based insurance programs—for example, a public option to compete with private insurance companies or expanded eligibility for existing Medicare and Medicaid programs—may be more realistic. The effect of such programs on ED economics would benefit from further analyses similar to those of the study by Smulowitz et al.

The COVID-19 pandemic markedly changed ED care its first few months. At the April trough, there was a 40% to 50% decrease in year-over-year ED visits. Since then, recovery has been slow and incomplete. Visits decreased because the public heard messages predicting overload and saw war zone–like images of EDs. Some wanted to "help" by avoiding care; others feared risking ED-based contagion. Social distancing also decreased ED visits by decreasing other daily life risks such as the risk of injuries and other communicable diseases. Limitations on elective procedures also diminished acute post-procedural complications, further decreasing ED demand.

Telehealth has also expanded significantly since COVID-19 began because it provides a socially distanced way to get care. Furthermore, restrictions on the ability to bill insurance have relaxed. This has made telehealth broadly reimbursable, a policy that will likely outlast the pandemic. Although telehealth cannot provide definitive care for many acute conditions, it improves accessibility, aptly resolves some needs, and can offer advice about whether in-person care is necessary. Since COVID-19 began, telehealth increases have correlated with decreasing ED and outpatient clinic visits, suggesting telehealth substituted for in-person visits.[3] Retail clinics and urgent care clinics have historically not substantially affected ED volume.[4,5]

A concern with the telehealth shift is the selective siphoning of low-acuity, privately insured, high-margin ED

patients. These patients give EDs a financial cushion to serve the critically ill, uninsured, and government insured, which pay lower rates and in general have thin or negative margins.[6] Before COVID-19, the telehealth industry targeted these profitable patients with varied success. Yet since the arrival of COVID-19, this strategy has flourished. In the end, it is possible that ED visits may not return to pre–COVID-19 levels. The ones remaining may be lower-margin, publicly insured, higher-acuity visits. Another unusual facet of COVID-19 is that patients with severe illness have delayed or avoided care, with sites noting fewer ED patients for stroke and other life-threatening conditions. This is both a public health concern and an economic concern for EDs and hospitals.

An added threat of COVID-19 is the havoc it's caused on the economy, with unemployment summiting 15% in May 2020.[7] Greater unemployment will increase the uninsured and Medicaid enrollment, 2 groups whose only option is commonly the ED. States may also limit Medicaid coverage (including ED visits) to control costs with increasing enrollment and decreasing tax revenue to fund the program. Superimposed on this is another challenge: efforts to limit "surprise billing" (ie, out-of-network clinicians who seek compensation directly from patients when there is a gap in coverage), which gained momentum before COVID-19 and added support as the pandemic grew. All versions of surprise billing legislation create downward pressure on ED payments for the privately insured, further threatening ED economics.

Taken together, these trends paint a gloomy picture of the potential future economics of EDs: lower volumes and lower average payment per visit.[8] This may mean fewer ED jobs, lower compensation, and even closures of EDs that care for vulnerable populations, such as inner-city and rural facilities. The ability to garner institutional support to maintain emergency services will be harder as hospitals face similar economic challenges. The confluence of COVID-19, a shift to telehealth, a broader economic downturn, and surprise billing legislation may together be the tipping point that finally disrupts the fragile economics of hospital-based ED care.

Several unknowns could alter this trajectory. The first is whether telehealth reimbursement continues beyond COVID-19. Second is when the public will feel truly safe coming back again, which will require visible protective equipment, protocols for "clean" and "dirty" areas, and rapid COVID-19 testing. Third is the virus's trajectory: the height and width of additional spikes and the speed of return to normal with a vaccine or "new normal" with people ideally using face masks. A durable pandemic with periodic openings and closings could suppress ED visits longer term. Another unknown is the potential reliance on EDs to deliver COVID-19 care. If an effective treatment emerges, demand will markedly increase, particularly among the mildly and moderately ill. The financial feasibility of alternatives to ED care (eg, primary care) is also uncertain. With other, in-person options fading, EDs may be the only option in some communities. The final unknown is that all the futurists may be wrong. Perhaps the world will just go back to normal, particularly if the virus loses potency or if Americans stop fearing it.

More than any time in recent history, the future of emergency medicine is uncertain. The COVID-19 pandemic has created short-term, seismic change and may change our long-term practice, payments, and employment options. But there are reasons to be hopeful. Emergency physicians have the skills and ability to adapt to a complex digital world. With great change will come great opportunity. Ultimately, emergency physicians are in an optimal position to innovate in an evolving COVID-19 and post–COVID-19 world.

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