**Resolution in Support of Universal Healthcare**

**WHEREAS,** despite important gains made since the implementation of the Affordable Care Act, millions of Americans remain without health insurance while millions more remain underinsured and skip necessary medical care because they are unable to afford the cost; and

**WHEREAS,** the burden of caring for the uninsured and underinsured falls heavily on states and local municipalities such as (CITY/TOWN/COUNTY); and

**WHEREAS,** the rising costs of health care continually outstrip both the aid our local communities receive and our limited budgetary resources, placing reckless demands on our citizens and businesses; and

**WHEREAS,** the COVID-19 pandemic has highlighted the problems with our current healthcare system including the hazards of tying health insurance to employment, resulting in massive increases in uninsured among those who lose their jobs or are otherwise unable to maintain employer-sponsored health insurance, and recent polls show that a majority of Americans support universal healthcare; and

**WHEREAS,** establishment of universal healthcare coverage will eliminate the burden of caring for uninsured and underinsured individuals in [CITY/TOWN/COUNTY], reduce the cost of health care for our current and retired local government employees and eliminate concerns about rising health care costs, which will no longer be held hostage to market forces out of our control, allowing us to budget appropriately for our community needs;

**NOW THEREFORE, BE IT RESOLVED,** that the (CITY/COUNTY/TOWN BOARD) supports the following proposals toward the goal of establishing universal healthcare in the United States and calls on our federal legislators to work toward enactment of legislation to effect these proposals, in consultation with local governments to ensure appropriate and efficient health care for all residents of the United States**, to wit:**

1. **Encourage expansion of Medicaid.** The current formula for calculating the federal share of each state's Medicaid costs (formally known as the Federal Medical Assistance Percentage, or FMAP) should be changed. Instead of basing federal cost sharing solely on a state's average per capita income, the FMAP should also consider the percentage of those below the national average per capita income who receive Medicaid services to better serve the purpose of varying the FMAP, i.e., to ease the burden of care for low-income households more fairly for those states that are required to provide more services to them. Additionally, changes should be made to federal waivers that limit eligibility, especially those that are known to be counterproductive, such as work requirements.

Equally important would be the gradual merging of Medicaid into the Medicare program, eliminating entirely the state and local components so that eligibility requirements, services provided, and reimbursements are eventually equalized across the country. There are several advantages to this. First, administrative costs would decrease by at least 7%, a savings of billions of dollars a year. Second, barriers to care would be removed due to elimination of waivers that vary according to state. Third, additional barriers would be relieved due to elimination of state-by-state restriction of services due to budget restraints (often in the form of reduced reimbursement rates, decreasing the availability of providers). Fourth, access to care across state borders would be enabled, currently a problem for many complex medical problems requiring specialized consultations and for routine problems for patients living in areas near state borders. These changes would establish greater equity among all residents of the nation, regardless of their place of residence, employment status, or income level.

Several options could be considered for carrying out a gradual transition of Medicaid into Medicare. Each year a proportion of states could be offered the option to transfer all Medicaid patients into Medicare, relieving them entirely of the cost of their care. The choice of states could be determined by lottery or, in order to implement the goal of expanding Medicaid more rapidly, the order of states could be determined first by the order in which they opted to expand Medicaid, and then by their FMAP (the lower the FMAP the sooner the offer of transfer to Medicare). Alternatively, each year a percentage of each state's Medicaid patients could be transferred into Medicare.

2. **Strengthen the Affordable Care Act (Obamacare) by making it more affordable and understandable.** An easy improvement to make in Obamacare would be to eliminate the bronze tier and the catastrophic coverage option. It is hard enough for consumers to make the best choices when shopping, but healthcare is too complicated to expect individuals to choose what is best for them when unreasonable choices are placed before them. The multiple tiers of coverage in the ACA marketplace are confusing enough, but the bronze tier and catastrophic coverage options offer too little coverage to be of value to anyone but the wealthiest individuals. Yet these are the people who are either unlikely to choose them or who have little need of the cost savings they offer. Low-income individuals are only too likely to take the risk of choosing coverage with low annual premiums in the hope that they will not get sick, ignoring the possibility that they will likely be unable to afford the care they need if they do get sick because their insurance will not cover it. The bronze tier and catastrophic options offer confusion and disappointment without significant benefit to anyone.

   Similarly, short-term policies, available in some states, should be eliminated. These policies have a number of limitations, including failure to cover pre-existing conditions, inability to apply for standard Obamacare coverage if you lose coverage during the year until the next open enrollment, limits on covered benefits, limited provider networks, and limits on what is considered cost sharing toward out-of-pocket limits. These limitations are not always well understood by individuals who

purchase these plans because of their low cost, and they are often unable to afford the cost of care if they get sick.

Lower out-of-pocket costs are essential to make Obamacare more affordable. Out-of-pocket costs are a major cause of treatment delay and missed care. In 2016, 16% of those under 65 were in households that had problems paying medical bills. Deductibles in particular have a negative effect on access to care and particular attention should be paid to elimination or dramatic reduction of these. Copayments should be eliminated or kept to a level that minimizes the likelihood that they will cause individuals to avoid care and reasonable limits should be placed on total annual out-of-pocket costs.

It is also important to provide higher subsidies for premiums and cost sharing. Instead of subsidizing only those individuals with income below a certain level, the suggestion that premium subsidies be provided for anyone for whom the premium exceeds a certain percentage of household income (e.g., 8%) is more reasonable. This has the advantage of achieving the goal of affordability without setting an arbitrary level of income for eligibility. It also allows for changing needs as premiums vary according to the marketplace. A similar method could be used for cost sharing, comparing the annual limits on cost sharing to the household income. To reduce the burden of cost sharing, these subsidies should be based on the gold tier instead of the silver tier, as is currently done.

Finally, funding for the federal Navigator program should be restored and increased to ensure the ACA marketplace is easy to navigate. Currently, it is not always clear to individuals whether they are eligible for Obamacare or for subsidies or how to get subsidies. Not everyone has internet access—an essential tool—or internet skills. And not everyone who needs Obamacare is fluent in English. These problems have been recognized from the outset. The ACA required that marketplaces operated by the states or the federal government must have Navigator programs that help consumers apply for coverage and financial assistance. However, since 2017, the administration has reduced Navigator funding in 32 federal marketplace states from $63 million to $10 million. This despite the fact that about 7 million people required consumer assistance in 2020.

3. **Provide a sustainable means for lower drug prices.** A sensible way to accomplish this would be to use a model that has been proven successful elsewhere. Germany, for example, has been using a system of negotiation that allows a considerable degree of freedom for drug companies, yet also constrains prices to a reasonable level. Notably, Germany has costs about one-third lower than the U.S.; duplicating spending at this level could save the U.S. about $100 billion a year.

   The details of the plan include allowing the drug company's launch price in first year without any restraint on prescription for medically necessary use. During this time an independent commission conducts and compares the new drug with

existing treatments. After the review is completed, Medicare negotiates a price based on the relative cost/benefit and the cost in other countries. If a price cannot be agreed upon, it goes to binding arbitration. Price increases are not allowed without a new assessment and a new round of negotiations.

Since generic drugs have also caused increasing problems with unwarranted price increases, they should be included in this model for negotiation. Generic price increases should not be allowed without a cost/benefit assessment and demonstration of need.

4. **Provide a better public option plan.** There is value to the concept of a public option. A better public option plan than those currently proposed should be made available that would capitalize on this potential. The most important feature of a better public option plan is that it should be administered by Medicare. This would save billions of dollars in administrative costs (on average 2-3% vs. 11.5% of total healthcare expenditures). Second, the public option plan should have no deductibles, and copayments should be gradually eliminated. These out-of-pocket costs deter needed care resulting in minimal net cost savings, when considering the increased cost of caring for patients who delay care. Third, the public option plan should phase in additional services, starting with medications, and then adding dental, hearing, home care, and nursing home services. These additional services will provide enormous benefits to all residents and can be financed from savings gained by reduced administrative costs, savings on drugs, and reduced use of more expensive services.

   These same improvements should also be added to standard Medicare. The improvements to access to care will offset the additional costs. Of note, 27% of Medicare beneficiaries do not have Part D drug coverage.

5. **Eliminate tax subsidies to encourage enrollment in public option.** In order to ensure the success of the public option plan, enrollment must be encouraged so that costs, subsidies and premiums can remain affordable. If only the sickest people enroll in the public option, costs will be too high. In order to encourage enrollment, current tax subsidies that predominantly favor the wealthy should be eliminated. These include tax deduction for premiums for health insurance when obtained through work and health savings and flexible spending accounts. Health savings accounts and flexible spending accounts are used together with high-deductible health insurance plans. They offer the greatest benefit to those with high incomes in the highest income tax brackets. Lower income individuals may choose these plans and then find they have difficulty paying their healthcare expenses. These tax-exempt plans should be eliminated. Tax exemptions for employer sponsored health insurance premiums also benefit the wealthy more than those with lower income due to their higher tax brackets. They should be gradually phased out. By eliminating these unfair tax breaks that are not available to those who are unable to get insurance from their employers, enrollment in public option plans will be more attractive.

6. **The success in achieving universal healthcare will depend on the success of Medicaid expansion and merging into Medicare, the level of benefits provided in the public option and the improved subsidies under Obamacare.** Many of the policies outlined are complex and it should not be assumed that initial plans will attain desired goals. It will likely be necessary to monitor progress and adjust designs to optimize the likelihood of achieving universal healthcare. Provider reimbursements may need to be adjusted; Medicare's administrative budget may need to be increased to improve the accuracy of claims processing; subsidies will need to be monitored to ensure that costs are not hindering enrollment; funding for outreach and consumer assistance may need to be increased. Yet it must be recognized that even with these efforts, cost control and effective achievement of universal healthcare may be limited by multiple payers.

7. **The healthcare system can be simplified by merging all public insurance into Medicare.** Instead of having a public option administered by Medicare in each state on the marketplace exchanges, anyone who wants to opt-in to the public option will be enrolling in a federally administered Medicare program. Medicare will then include anyone currently on Medicare, Medicaid or eligible for Obamacare and choosing the public option. Administrative costs would be even lower and cost-saving programs would be more efficiently managed.

   If the public option is a success and the combined Medicare program becomes the dominant form of insurance, private insurance will have a much less important role than it does today. After a transition period, a single payer system can be developed that will eliminate barriers and improve cost control. Instead of opting-in to Medicare, enrollment will be automatic and simple, eliminating confusion. Everyone will be enrolled in Medicare as their primary insurance. Anyone who wants private insurance can keep it as secondary coverage, but only the very best private insurance will be able to compete with Medicare. Individuals will be responsible for any secondary insurance billing. This would dramatically reduce the administrative burden for providers, saving billions of dollars in costs each year. Savings will be maximized. Private health insurers could continue to receive billions of dollars to process claims for Medicare, as they currently do. Savings would be maximized and disruption to the industry would be minimized.