MEMORANDUM-IN-OPPOSITION

S.3577-A (Rivera) **A.5248-A (Gottfried)**

AN ACT An act to amend the public health law and the state finance law, in relation enacting the "New York health act" and to establishing New York Health

This bill would create a Single Payer health plan called "New York Health," purportedly to provide comprehensive health and long term care coverage for all New York residents, to be financed by assessments based upon a graduated payroll tax (paid 80% by employers and 20% by employees, and 100% by self-employed) and a surcharge on other taxable income. Private insurance that duplicates benefits offered under New York Health could not be offered to New York residents.

The **New York State Association of Health Underwriters (NYSAHU),** comprised of licensed health insurance brokers, agents and employee benefits consultants, which support universal health coverage by integrating existing public plans with market-based solutions to improve the availability and affordability of health insurance plans for all, **STRONGLY OPPOSES** S.3577-A / A.5248-A.

Trying to increase health insurance coverage in New York State by addressing only the insurance aspect is only impacting the symptom of the larger underlying problem, which is the high costs of health and long term care. The rise in health and long term care insurance costs is a reflection of increases in the costs of such care.

Many of the solutions, being advocated by some lawmakers, policymakers, activists, providers, labor unions, faith-based organization, such as a single payer system, are just not realistic. Single Payer proponents, in their zeal to offer a simplistic, one-step solution, gloss over the real problems in the healthcare system. The primary driver of healthcare costs in the United States is the result of our poor lifestyle choices, not shortcomings in the healthcare delivery system, which we believe is among the best in the world.

A Single Payer healthcare plan, such as the one proposed in S.3577-A / A.5248-A, claims to be able to provide coverage to all residents by eliminating unnecessary administrative expenses in the current insurance carrier model and using that savings to provide governmental-coverage for all State residents; hence the label: "Medicare for all." The flaw in this logic is that it has never been shown that the cost savings are of the magnitude claimed by proponents.

The healthcare activists claim that Medicare operates on a bare administrative expense of only 3% v. higher administrative expenses for commercial health plans, and then they extrapolate the millions of additional people that could be covered by the supposed savings. However, Medicare's 3% only represents the amount of funds spent for claims administration by Medicare Part A and Part B contractors. It ignores the overhead functions a group health insurance carrier has, which includes: (a) claims administrative expenses; (b) general office expenses including contract and legal work, enrollment eligibility determinations, ID Cards production and issuance, communication materials such as benefit books, general accounting, payroll taxes & employee benefits, etc.; (c) risk charges; (d) premium taxes, and (e) provider oversight and utilization review. Moreover, the Centers for Medicare and Medicaid Services (CMS) operations absorb much of the "general office expenses" not directly attributed to Medicare, which are thus not included in this 3%.

Another fallacy is that a Single Payer plan will get the "bean-counters" out of the medical providers' hair and “let them practice medicine.” Medicare is full of rules on medical necessity, just like the commercial insurance market, so utilization review is alive and well in Medicare, just as in commercial plans. And, with a Single Payer, doctors and other healthcare providers won’t have the ability to refuse to participate in provider panels or even have input into utilization review or medical necessity rules, as they do now with commercial health insurance carriers. Moreover, Medicare does not negotiate fees or hospital reimbursements, rather the government decrees the fees paid to providers. This would not change, even if the bill allows healthcare providers to form organizations to collectively negotiate with New York Health Plan. There can be no "collective bargaining" with a Single Payer government monopsony.

Further, there would be no more Medicare cross-subsidization; no commercial clients to whom hospitals and other healthcare providers could pass-off excess operating losses. The federal government has for years unsuccessfully attempted to reduce provider fee reimbursements as a means to correct long term budget deficits. Price controls as a means to contain costs has not worked for the federal government’s Medicare system and would not work in New York State.

As mentioned above, the proponent’s administrative cost savings estimates are highly inflated, whereas the tax implications to fund a Single Payer Plan are grossly underestimated. A salient study by the Austin, TX-based Foundation for Research on Equal Opportunity estimates that funding for the New York Health Plan in just its first year of operation would require a tax increase of $225.9 Billion, or approximately

$11,500 in additional annual taxes per State resident: https://freopp.org/how-state-based-single-payer-initiatives-crush-economic-opportunity-604ac9ac17c9. Another study by the RAND Corporation found that the annual cost of implementing the NY Health Plan would require $139 Billion per year, plus an additional $18-22 Billion to institute long term care coverage, which the amended bill now contains. Even the Sponsor's own initial estimate (excluding long term care) pegs the cost at $91 Billion per year (see Friedman study, UMass Amherst). Juxtapose this with the All Funds New York State Budget as just adopted for 2019-20, which is $175.8 Billion.

There is also an unrealistic perception that all insurance carriers could be closed on "day one" with the realized savings being immediate. This is a fallacious assertion, since health insurers' reserves would continue to be charged over several years as contractual obligations for policy claims are run off. It also assumes that the government-run Single Payer system would be capable of handling the additional volume without a significant increase in governmental costs. In addition, under the Single Payer model, there is no accounting for the public cost of thousands of suddenly unemployed health insurance company and producer employees. Moreover, the amended bill would provide for up to 2-years of unemployment benefits for "impacted employess" and would exempt taxpayers earning less than $25,000 from paying any Single Payer taxes, further adding to the overall costs of the bill.

Under the proposed legislation, the costs of providing quality healthcare with good patient outcomes would remain high and has not been addressed. However, as time goes by and without impacting the rate of increase in medical trend, the issue of affordability will return, although this time as a tax issue for the government-run Single Payer, not as an employer-based health premium issue. Health insurance costs in New York, just like in the rest of the country, remain high. This contributes directly to the number of uninsured and the level of uncompensated care.

Thus, addressing the insurance/financing portion of healthcare is only addressing the symptom not the cause. The supply-side management approach of limiting the amount paid to healthcare providers is at its limit. We need to begin a program which addresses the unlimited and unnecessary demand we place on our health care system. While short term measures, such as modifying the current community rating system, establishing a high risk pool, and allowing wellness program incentives should be adopted, any legislation which doesn't include measures to deal with the long term issue of bending down the healthcare cost trend is shortsighted and will not fix New York's problem. The issue of ever rising medical costs, is at least being addressed by fostering new models of healthcare delivery that favor value-based payments rather than fee-for-service reimbursements.

Other alternatives could also include instituting Transparency in Healthcare Pricing, to provide data-drive tools by requiring transparent pricing practices that encourage consumers to reduce their healthcare expenses by cost comparison and selection in an open healthcare marketplace.

Finally, a single-payer system such as the New York Health Plan would undermine the successful operation of the New York State of Health Insurance Exchange (NYSOH) established under Governor Cuomo's Executive Order No. 42 (2012).

For all of the reasons enumerated herein, we continue to oppose a government-run, Single Payer plan, as it would stifle innovative claims cost controls in the insurance marketplace, would lack provider oversight and increase fraudulent billings, would drastically cut healthcare provider reimbursement rates, and, in the absence of free market controls, would ultimately lead to bureaucratic rationing of medical care as the only means to contain costs.

We should instead be encouraging investments to limit systemic inefficiencies in the delivery of healthcare, reduce cost shifting between private-pay and public plans, foster behavioral lifestyle improvements in patients and institute healthcare pricing transparency.

As such, on behalf of the members of the New York State Association of Health Underwriters we are constrained to **STRONGLY OPPOSE** S.3577-A / A.5248-A and **URGE ITS DEFEAT**

Respectfully submitted,

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