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

A6058 (Gottfried)
S5474 (Rivera)

MEMORANDUM IN OPPOSITION

Submitted on behalf of the Blue Cross and Blue Shield Plans

The New York State Conference of Blue Cross and Blue Shield Plans strongly oppose the New York Health Act, which would completely abolish the current system of health care coverage and replace it with a government-operated single payer system paid for by $170 billion in new taxes in the first year alone, climbing to $250 billion by the tenth year of operation. A government-operated single payer system ignores the advances that New York State has made within the last decade in providing avenues for individuals to access health insurance and ensuring that health care is provided in a cost-efficient and appropriate manner. In addition, it fails to consider the significant economic impact of moving to a government-operated system, especially in less economically diverse regions of the State.

1. THE ESTABLISHMENT OF A SINGLE PAYER SYSTEM IGNORES THE SUCCESS OF NEW YORK'S EXCHANGE AND NEW DEVELOPMENTS IN THE ADMINISTRATION AND PROVISION OF HEALTH CARE SERVICES

Recent federal and state health care reform efforts, including the Affordable Care Act (ACA), expanding Medicaid, adopting and expanding the Essential Plan[1], and building the infrastructure for a state-based health benefits exchange[2], have created substantial opportunities to make affordable health insurance coverage a reality for all New Yorkers. These efforts have successfully reducing New York's uninsured rate from 12% to historic lows of less than 5% statewide and 4% in upstate, meaning that fewer than 1 million New Yorkers lack insurance coverage. During the

[1] In New York, the Essential Plan is available to individuals with incomes up to 20 of the federal poverty level from a variety of private carriers with no deductible or premium.
[2] As of March 2022, more than 6.5 million New Yorkers enrolled in comprehensive health coverage through the New York State of Health (NYSOH),

COVID-19 pandemic, the state's solid public-private partnership for providing health insurance served as a strong safety net for New Yorkers and actually resulted in a decrease in the state's uninsured rate. Focusing on securing low or no cost coverage for the remaining population is easily achievable by the State. The dramatic change to the healthcare delivery and financing system contemplated by the New York Health Plan needs to be more compelling.

Almost one-third of the uninsured in New York are eligible for free coverage through Medicaid or the Essential Health Plan Improved outreach and education could enroll these currently eligible persons into low or no-cost health insurance.

When individuals currently eligible for New York's Medicaid program and Essential Plan are accounted for, New York's actual uninsured rate is closer to 2.5% or less than 500,000 New Yorkers. If we account solely for U.S. citizens in this context,[3] the uninsured rate is between 1 and 2%. Investment in this population would cost a fraction of what is needed to impose a single payer system on New York. New York recently expanded the Essential Health Plan to undocumented seniors and for postpartum women for one year after birth. Providing access to remaining ineligible undocumented immigrants aged 19-64 would ensure universal coverage. Current federal mandates under the Affordable Care Act requiring minimum health benefits mean that any coverage offered by New York would be meaningful coverage. Focusing on enrolling these individuals into available low or no cost coverage would drive the uninsured rate in many counties of the state, especially upstate counties, to close to zero.

2. THE SINGLE PAYER SYSTEM FAILS TO ADDRESS THE INCREASING COSTS FOR MEDICAL CARE, WHICH RESULT IN HIGHER PREMIUMS FOR HEALTH INSURANCE

This Bill would contribute to, and do nothing to control what is the greatest health care threat we face, the staggering increases in health care costs. While health insurers may collect significant amounts in premiums, by law, at least 85% of such premiums go to pay for medical services. The majority of mandated spending goes to pay hospitals and pharmaceutical companies and device manufacturers for medical care. While the Bill firmly believes that significant savings may be achieved by removing the administrative expenses of multiple insurers, it fails to recognize that this is just one piece of the puzzle. Importantly, it fails to address the real key to controlling health care costs, which is price transparency and price regulation. In a *New York Times* examination of the price of medical care in the United States, the average price for standard procedures, such as colonoscopies and hip replacements, cost significantly more in the United States than other developed nations.[4]

In order to truly decrease, or even control, the amount of health care spending in New York State, any single payer system would also need to impose price regulation on medical services. While

[3] Noncitizens are a large portion of the total uninsured, constituting nearly forty percent of the overall uninsured population. Approximately one-quarter of noncitizens qualify for Medicaid, but for their immigration status. Depending on estimates of non-citizen FPL another one-third to one-half qualify for the Essential Health Plan.

[4] Data gathered by the International Federation of Health Plans show that an MRI costs, on average, $1,121 in the United States and $363 in France. An appendectomy costs $13,851 in the United States and $4,782 in Switzerland. A birth by cesarean section costs $3,676 in the United States and $606 in Canada. A bottle of Nexium -- a common acid-reflux drug -- costs $202 in the United States and $32 in Britain.

this Bill proposes that the negotiating power of a single payer would control costs, it also would allow providers to collectively bargain as a single entity against the State. Granting providers immense negotiating leverage is the best way to ensure that prices do not fall, that reimbursement for services and devices remain high and that savings are not achieved. This Bill incorrectly diagnosis the causes of health care spending and offers the wrong prescription in controlling such costs.

3. THE IMMEDIATE IMPACT OF THIS BILL WOULD BE A STATE-SPONSORED ELIMINATION OF JOBS FOR A SUBSTANTIAL PORTION OF NEW YORK RESIDENTS

Perhaps the most immediate and damaging impact of this Bill would be the extreme economic impact on the residents of New York State by abolishing the current health insurance industry and replacing it with a government-operated system. A 2021 report prepared by Union College estimates New York would lose more than 160,000 jobs as a result of imposing a single payer system.[5] Even the economic analysis prepared in support of the bill, shows that, "[a]s many as half of the health care administrative workers and most of the health insurance workers will be displaced by the more efficient New York Plan, resulting in as many as 150,000 newly unemployed workers"[6] As New York continues to reel from the devastating impact of the COVID-19 pandemic, it is hard to believe that the State, through this legislation, is actually setting up a scenario where job losses will be extreme and wide-spread.

The legislation's supporting economic analysis report blissfully assumes that the job losses will be offset by new job creation. This fails to consider that the New York Health Plan will be largely funded by employer contributions, which means that the cost of health care remains a barrier for new business development. The sponsors of this legislation are betting that the New York economy can grow at a significant pace simply due to a change in the way health care is delivered, in numbers that are not even seen on a national level. The true result of this legislation is that a large number of New York residents, especially those in regions with less diverse economies, will lose jobs and have no opportunities in the industry that they have spent years gaining experience and knowledge.

4. THE IMPLEMENTATION OF A SINGLE PAYER SYSTEM WOULD REQUIRE HISTORIC TAX INCREASES THAT WOULD MORE THAN DOUBLE THE NEW YORK STATE BUDGET

The 2018 RAND analysis of the previous versions of this bill- versions that were less expansive in coverage and required member cost sharing- found that the taxes necessary to support the New York Health Act were $139 billion in the first year, climbing to $210 billion by year ten.[7] This would cost New Yorkers a staggering $2 trillion in additional taxes over a ten-year period. And there is abundant evidence that the RAND report drastically underestimates the amount of taxes necessary to support the program. For example, in its tax analysis, RAND did not include long-

[5]Davies, Lewis S.; Gao, Jia and Schmidt, Stephen J., The Economic Impact of the New York Health Act,, May 2021.
[6] Friedman, Gerald, *Economic Analysis of the New York Health Act*, March 2015.
[7] https://www.rand.org/pubs/research_reports/RR2424.html pg x.

term care spending, nor did it include the elimination of cost sharing in later versions of the bill. Likewise, RAND has a substantial range of outcomes related to provider reimbursement, prescription drug costs, and administrative costs that would raise the overall costs of the New York Health Act, and therefore also increase the tax burden. Thus, the eye-popping tax increase of $139 billion in the first year of implementation is actually the best-case scenario for the Act.

In addition to being the largest state tax increase in American history, this tax increase is nearly two times the amount of tax revenue collected by the state today. In fiscal year 21-22, the department of tax and finance reported that the State collected $80.4 billion in tax revenue.[8] RAND estimates that in the first year of single payer the State would need to collect $139 billion in addition to the current $80.4 billion collected, resulting in a $220 billion tax burden to New Yorkers- almost exactly the size of total spending in the FY22-23 budget. Indeed, understanding our current tax revenue collections demonstrates just how challenging it would be to actually collect the revenues necessary to fund the program. According to tax and finance, about $55 billion in revenues came from personal income tax collection. Over one-quarter of that total, or $14.5 billion came from the taxation of Wall Street bonuses.[9] The New York Health Act targets this exact cohort to pay for single payer, which places its financing on unstable ground. RAND estimates that if a mere 50,000 of these high earners (Wall St has about 196,000 employees) were to relocate, the tax burden on everyday New Yorkers would have to quadruple from current estimates to pay for the program.[10] And the New York Health Act practically assures this outcome, by increasing tax rates on top earners to rates over 60% when state, local and federal taxes are combined.

It is critical to note that sum reflects just the cost of **tax increases**, which is less than half the actual **cost** of the program. The cost of implementing single payer is in fact $309 billion in the first year, rising to $460 billion in year ten. Thus, the cost of the program is roughly $4.55 trillion over a ten-year period, roughly two times the amount of expenditures New York State is projected to spend over the same period. The cost of the program would subsume and overwhelm every other type of spending in the budget.

For the foregoing reasons, the New York State Conference of Blue Cross and Blue Shield Plans strongly opposes enactment of this legislation.

Respectfully submitted,

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[8]https://www.tax.ny.gov/research/collections/fy_collections_stat_report/2020_2021_annual_statistical_report_of_ny_state_tax_collections.htm

[9] https://www.osc.state.ny.us/files/reports/osdc/2021/pdf/report-12-2022.pdf pg 13

[10] https://www.rand.org/pubs/research_reports/RR2424.html pg 58