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MEMORANDUM IN OPPOSITION

FOR IMMEDIATE RELEASE: APRIL 16, 2021

Re: A.6058 (Gottfried)/S.5474 (Rivera) AN ACT to amend the public health law and the state finance law, in relation to establishing the New York Health Act.

This legislation would create a government-run, single payer health plan. The New York Health Plan Association (HPA) opposes A.6058/S.5474.

HPA and our member health plans believe every New Yorker deserves coverage for high-quality, affordable health care, and the work of our member health plans in implementing the Affordable Care Act and the state's Medicaid Redesign program is a major reason for New York's ability in insuring more than 95% of state residents. The New York Health Act would undo that progress and the revisions to the bill do not address its fundamental flaws – it will result in **massive new taxes** and **provide fewer choices** over doctors, treatment and coverage, and **threaten the quality of care** for all New Yorkers. Further, **voters do not support a government-run system** and instead want to build on the current system rather than starting over, and **recent measures at the federal and state levels provide the resources for New York to strengthen and enhance public and private health insurance options**.

Massive Tax Increases

An independent analysis conducted by the RAND Corp. in 2018 for the New York State Health Foundation estimated over $139 billion in new taxes would be needed in 2022 and $210 billion in 2031 to fund the New York Health Act, provided that the state received the necessary federal waivers and would be able to regulate provider rates and drug prices. The analysis noted that New York would need to increase taxes even further if the projected savings from cutting prices paid to providers don't materialize or if wealthier New Yorkers and/or New York businesses abandon the state.

The analysis noted that the cuts in provider rates are highly uncertain and based on whether the state is willing and able to regulate the prices charged by doctors, hospitals and pharmaceutical manufacturers, despite any evidence of their willingness to be paid less than they are today. Additionally, the RAND analysis was predicated on the assumption that the state would receive a federal waiver, which is doubtful. A 2020 analysis conducted for HPA examined current federal health waiver authorities, including the scope of these options, the populations each covers, and their limitations[1]. Among the authors' conclusions of whether current federal health expenditures could be placed under the control of the state:

- There are major conceptual impediments and federal law does not provide a ready pathway for state-initiated single-payer plans.
- These options are limited and conditional and do not allow for lump sum payments to the state to finance a single payer program. Medicare in particular protects the entitlement rights of its enrollees, which precludes a single payer design.
- Efforts in other states demonstrate that federal waiver authorities do not provide a ready mechanism for a state to assume control over federal health dollars.

As the authors concluded, "implementing a single payer program at the state level would require much broader authority for experimentation than is provided in current federal law." Given these limitations, it is highly unlikely that New York would be able to secure necessary federal funding to finance the New York Health Act. Absent

[1] Chen, Lanhee, and Capretta, James. "Current Federal Health Waiver Authorities Will Not Pave the Way for the New York Health Act." January 2020, https://nyhpa.org/2020/01/single-payer-medicare-and-medicaid-brief/

these federal funds, the New York Health Act would require even higher tax increases than the RAND analysis assumed.

The revised bill fails to address these issues and skirts the essential question: How much will this cost New York residents and employers?

Additionally, the new version of this bill includes a major change to the eligibility criteria, allowing anyone who lives or works in New York to be eligible for this program. This seemingly small change has the potential to dramatically increase the cost of this program.

While proponents argue that a government-run, single payer system could address these costs and be financed from savings in administration and from bulk purchasing, any administrative savings associated with a single payer system will not be sufficient to ensure coverage for every New Yorker without a massive tax increase.

Further, Vermont, the only state that has voted for a government-run, single payer system, chose not to proceed once it determined that the financing would be impractical and require significant increases in corporate and income taxes that would be detrimental to individuals, employers and the state's economy overall. In deciding to shelve its single-payer plan in 2014, former Vermont Governor Peter Shumlin stated that the costs of his proposed reform would be too great, noting:

> ***"The taxes required to replace health care premiums with a publicly financed plan that would best serve Vermont are, in a word, enormous."***

Those who tout Medicare's "low" administrative rates typically fail to note that some of Medicare's capital and benefit costs are funded elsewhere in the federal budget, and that Medicare typically contracts with health plans to process claims and offer services that benefit consumers. Administrative costs, such as care management programs for individuals with chronic conditions, claims administration and health information technology, as well as government assessments, taxes and reporting requirements, account for roughly ten percent of the premium. A government-run system is unlikely to lead to significant long-term administrative savings.

Fewer Choices, Longer Wait Times & Diminished Quality

There are serious quality concerns associated with government-run, single payer systems. Even with massive tax increases, patients may still have to wait longer for treatment and won't be guaranteed to see the doctor or specialist of their choice. Evidence demonstrates that these systems fail to provide timely access to high-quality, innovative medical care to all individuals. Often, patients have less access to the latest medical technology and breakthroughs, fewer choices and longer wait-times to receive basic and specialty care.

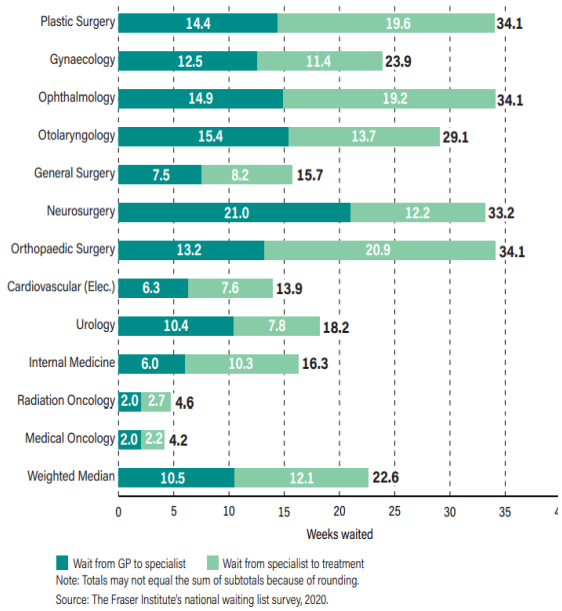
The Canadian system offers a good comparison to what is being proposed under the New York Health Act. A 2020 survey by the Fraser Institute, a non-partisan research and educational organization based in Canada, noted that waiting for treatment has become a defining characteristic of the Canadian health care system.[2]

- Its survey of specialist physicians reported a median wait time of 10.5 weeks from a referral by a general practitioner to consultation with a specialist.
- The survey also reported a median wait time of 22.6 weeks between referral from a general practitioner and receipt of treatment.
- Patients also experience significant wait times for various diagnostic technologies, including 11.1 weeks for a magnetic resonance imaging (MRI) scan, 5.4 weeks for a computed tomography (CT) scan, and 3.5 weeks for an ultrasound.

Further, physicians report that their patients are waiting more than four weeks longer for treatment (after seeing a specialist) than what they consider to be clinically reasonable.

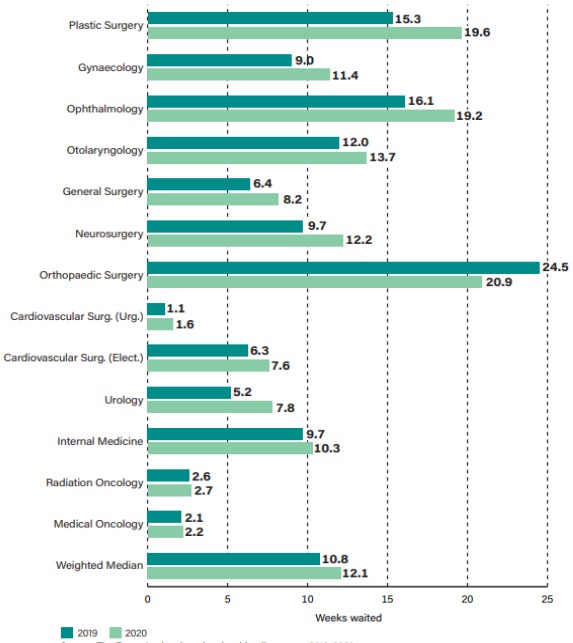
[2] Fraser Institute, *Waiting Your Turn: Wait Times for Health Care in Canada, 2020 Report*, published December 2020 https://www.fraserinstitute.org/sites/default/files/waiting-your-turn-2020.pdf

Median Wait by Specialty in 2020
Weeks waited from referral by GP to treatment



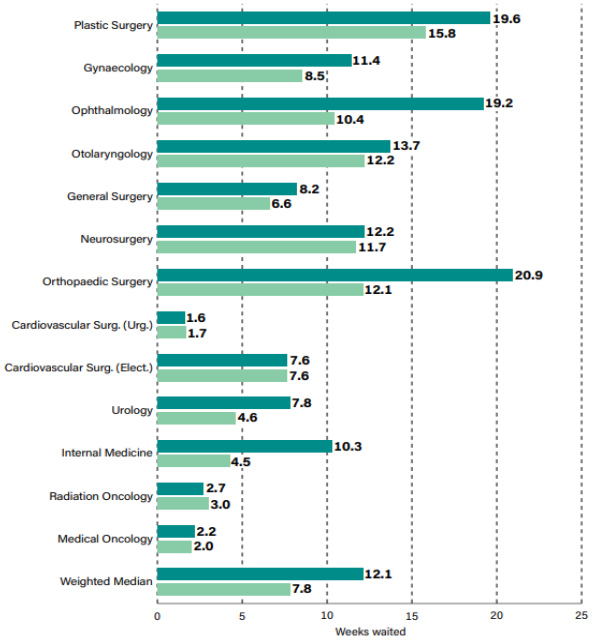
Note: Totals may not equal the sum of subtotals because of rounding.
Source: The Fraser Institute's national waiting list survey, 2020.

Wait by Specialty in 2019 & 2020
Weeks waited from appointment with specialist to treatment



Source: The Fraser Institute's national waiting list survey, 2019, 2020.

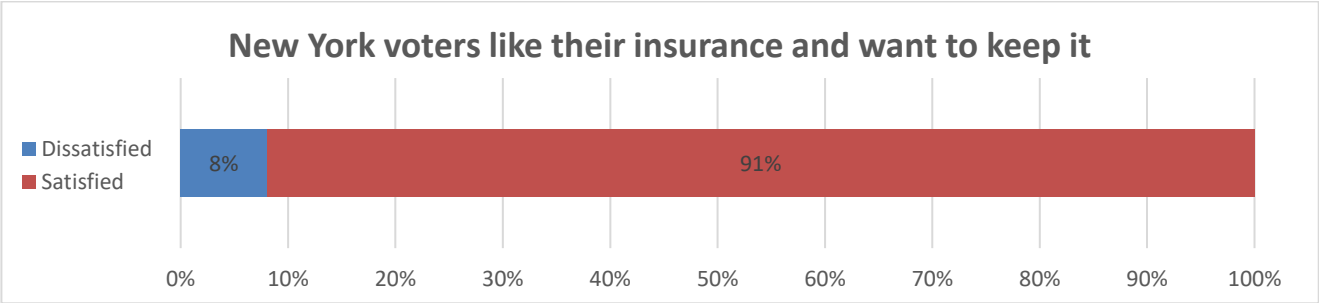
Median Actual Wait Compared to Median Clinically Reasonable wait by Specialty in 2020:
Weeks Waited from Appointment with Specialist to Treatment

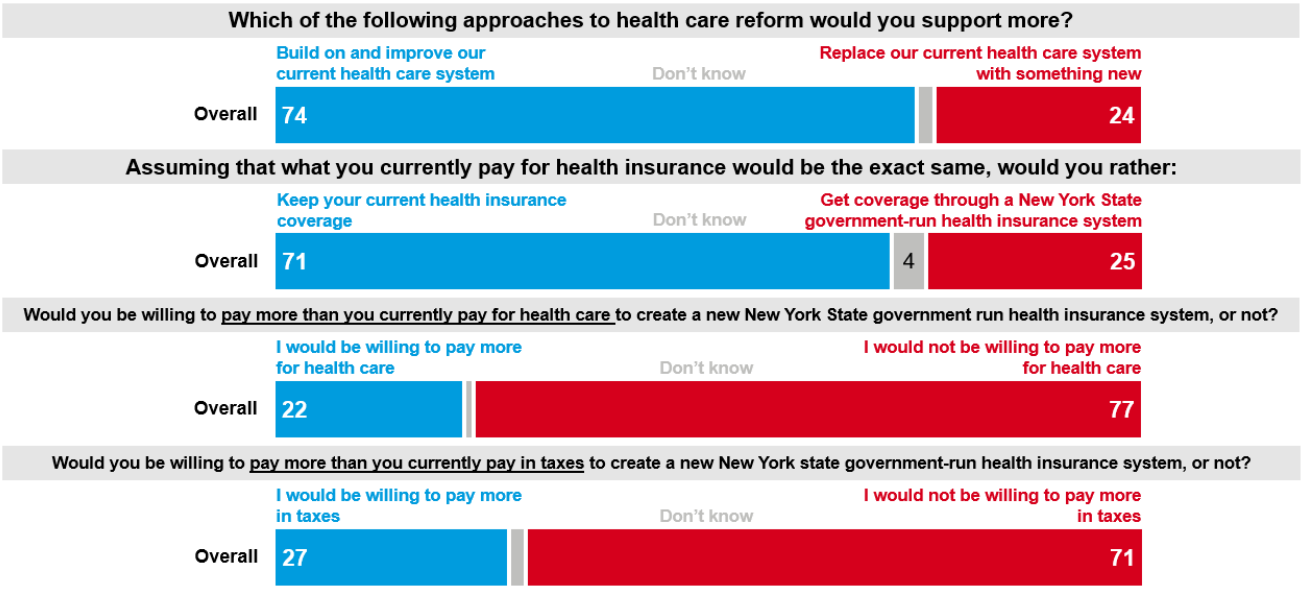


Source: The Fraser Institute's national waiting list survey, 2020.

Voters support fixing the current system rather than starting over.
According to a statewide poll of 601 registered voters released by The Business Council of New York State in February, New Yorkers are generally satisfied with their current health insurance coverage (91%). When forced to choose between the current system and a government-run program, voters clearly prefer the current system over change. They want to build on the current system (74%) instead of replacing it (24%) and would rather keep their

current coverage (71%) than get it through a New York State government run system (25%). In addition, overall they are not open to paying more for their health care (22% willing to pay more/77% not willing) or pay more in taxes to fund a new system (27% willing to pay more/71% not willing).





Existing Measures to Expand Coverage

Over the last decade, New York has made remarkable progress in expanding access to health care coverage to millions of residents, achieving near universal health care coverage made possible through the state and private sector working together. This public-private partnership has also been responsible for helping New Yorkers maintain coverage at a time when they needed it most to ensure that patients would have access to medical care during the pandemic.

Recent measures at the federal and state levels provide the resources for New York to expand existing programs to ensure that New Yorkers can access and keep their coverage. Among the measures:

Federal

- **The Families First Coronavirus Response Act** provided a temporary 6.2% increase in federal Medicaid funds (FMAP) to state Medicaid programs through the duration of the COVID-19 public health emergency. This additional funding was intended to ensure that states had the necessary resources to provide continuous Medicaid coverage irrespective of changes in an individual's circumstances. It also included a Medicaid option for states to cover COVID-19 testing for the uninsured through the duration of the public health emergency with the federal government picking up 100% of the cost.

- **The American Rescue Plan (ARP)**, signed into law March 11, 2021, contains a number of key provisions that strengthen both public and private health insurance coverage and temporarily expands subsidies for health insurance, including:
  - Subsidies to defray the cost of COBRA premiums for those who have lost employer-sponsored insurance;
  - Enhanced premium tax credits for individuals who enroll through the health insurance marketplaces;
  - Free marketplace health insurance for individuals who receive unemployment insurance benefits in 2021;
  - Requires Medicaid and CHIP coverage of COVID-19 vaccines, treatment (including prescription drugs), and treatment of conditions that complicate COVID-19 treatment, without the imposition of cost-sharing charges; and
  - Options for states to provide longer postpartum health coverage for new mothers.

State

- **Enrollment in the state's official health plan marketplace surged** by nearly 885,000 people from February 2020 to February 2021, with enrollment increases concentrated in Medicaid and the Essential Plan. This public-private partnership has served as an important safety net for consumers during the public health emergency as over 5.8 million New Yorkers – nearly one in three residents – are enrolled in health coverage through the NY State of Health.

- **The FY2021-2022 state budget expands access to the Essential Plan** by removing premium payments for enrollees up to 200% of the federal poverty level. The Essential Plan has been an extremely successful program for providing high quality coverage to low-income individuals and certain immigrants, which now covers nearly 900,000 New Yorkers. Eliminating the monthly premium will make coverage more affordable for tens of thousands of New Yorkers and is likely to increase coverage to an additional 100,000 people.

- The state budget also draws down federal funding to **extend postpartum coverage** for a year after giving birth. Eligible women will be enrolled in a qualified health plan upon their disenrollment from Medicaid.

Rather than continuing to devote attention to a system that ultimately will lead to higher taxes, limit access and restrict options, the focus needs to be on efforts to expand coverage, address costs, and improve quality without disrupting current coverage options for employers and consumers.

For all these reasons, the New York HPA **OPPOSES** A.6058/ S.5474.