

# The Case Against AlbanyCare

Why a single-payer health plan  
would be wrong for New York

by Bill Hammond

Proponents of enacting a single-payer health plan for New York are pitching it as a cure-all—one fix that would achieve true universal coverage, allow people to see any doctor and use any hospital, abolish copays and deductibles, cut down on paperwork, and save billions of dollars in the bargain.

Forty-five billion dollars, to be precise—or so said Assemblyman Richard Gottfried of Manhattan on June 1, as the lower house passed his New York Health Act for the second year in a row.

Similarly extraordinary promises were made by Vermont Sen. Bernie Sanders in touting his “Medicare for All” proposal while campaigning for the Democratic presidential nomination.

However, these rosy scenarios depend on highly questionable math.

A close look at the research behind Gottfried’s \$45 billion savings estimate shows that it was based on tendentious assumptions, debatable methods, and a dose of wishful thinking. It’s not the kind of dispassionate analysis that lawmakers should have in hand when contemplating radical change to a system affecting the wellbeing of every New Yorker.

Meanwhile, Sanders’ assertions about his plan were disputed by the Urban Institute, a left-of-center think tank, and other more sober commentators, who warn that it would dramatically increase rather than decrease the nation’s already high health-care spending.



Beyond affordability questions, a single-payer system would impose government price control on all health-care services, eliminating any vestige of market competition in a major sector of the state economy.

It would also channel billions more dollars through New York's notoriously dysfunctional state capital, multiplying opportunities for favoritism and corruption.

By making the change on its own, New York would risk becoming a magnet for people from other states and countries in need of costly care. To make up for lost insurance premiums, the move would also entail more than doubling the tax burden of what's already the nation's most heavily taxed state.

In 2014, after four years of planning, Vermont became the latest state to reject single payer as too costly and disruptive. New York should do the same.

## 1. HISTORY AND CONTEXT

Under a true single-payer system, the government takes direct, primary responsibility for financing medical care, either through a publicly owned and operated health system (as in the United Kingdom) or by paying claims submitted by independent providers (as in Canada).

Both exist for limited populations in the U.S.: The Veterans Administration operates a U.K.-style system for former military personnel, and Medicare and Medicaid offer Canadian-style coverage for the elderly, the disabled, and the poor. In 2014, these last two programs accounted for 30 percent of the population<sup>1</sup> and 37 percent of national health expenditures.<sup>2</sup>

Yet the idea of creating a similar health plan to cover all Americans has never gotten very far in Washington.

Some legislators and advocates touted the approach during debate over President Obama's



*Assemblyman Richard Gottfried, the longtime leading advocate of a single-payer health insurance system in New York, speaks at a 2016 state Capitol rally in support of his plan.*

health reform law. At Obama's urging, however, Congress ultimately opted for a more limited, incremental approach.

Focusing on the working poor who represent most of the uninsured population, the Affordable Care Act—aka Obamacare—expanded Medicaid coverage for people below 138 percent of the poverty level and used tax credits to subsidize private insurance for people above that threshold.

Single payer has also been considered and rejected by several states. The most recent example is Vermont, where Gov. Peter Shumlin—having made single payer the centerpiece of his campaign in 2010—abandoned the concept in 2014, declaring that the tax hikes necessary to pay for the plan would harm the state's economy.<sup>3</sup> A referendum on establishing a single-payer plan for Colorado is to be decided in November.

The single-payer concept garnered more national attention during the 2016 presidential race as Vermont Sen. Bernie Sanders made his "Medicare for All" proposal a centerpiece of his campaign for the Democratic nomination.

Gottfried, now in his 30<sup>th</sup> year as chairman of the Assembly Health Committee, has been pushing for creation of a statewide single-payer plan in New York since 1992. His plan, the New York Health Act, has passed the Assembly three times: in 1992, in 2015, and, most recently, on June 1, by a vote of 86-53.<sup>4</sup> It has never come to a vote in the Senate.

## 2. SINGLE PAYER IN NEW YORK

Gottfried's New York Health Act, Assembly bill No. 5062A in the 2015-16 session, would dismantle the state's entire health-care financing infrastructure, replacing all public and private insurance with a single, government-run, taxpayer-financed health plan.<sup>5</sup>

To accomplish this, the state would need to obtain federal waivers allowing the New York Health Plan to absorb Medicaid, Medicare, and Affordable Care Act programs, along with their funding. Private health insurance, whether provided by employers or purchased independently, would effectively be banned.

Eligibility would be universal for all residents of the state, regardless of age or immigration status. As explained in Gottfried's legislative memorandum in support of the Health Act, consumers could see any doctor and use any hospital, and coverage would be comprehensive—with no copayments, coinsurance, or deductibles of any kind.

***A bill creating a single-payer health plan for New York has been passed by the state Assembly three times in the past 24 years.***

"The benefits will include comprehensive outpatient and inpatient medical care, primary and preventive care, prescription drugs, laboratory tests, rehabilitative, dental, vision, hearing, etc.," according to his memo.

Nor would the plan collect any premiums, either from individuals or employers. Instead, the state would finance coverage with a combination of revenue from existing programs, such as Medicaid, plus two new taxes: one on payrolls, and one on non-payroll income (such as interest, dividends, and capital gains on investments).

While the bill leaves details of those tax hikes to be determined later, they would unquestionably be enormous—certainly more than doubling the total tax burden of state government.

### The question of cost

At the heart of Gottfried's argument for single payer is an assertion that a system based on private insurance is enormously wasteful. He contends that eliminating insurance companies—and their executive salaries and profits and paperwork—will save so much money that a single-payer plan can provide unlimited care

to everyone and still cost less overall than the current system.

“Of the tens of billions, hundreds of billions that we spend here in New York State on health care, 20 to 25 percent of those dollars are spent on administrative costs and profit that are of no health benefit to anybody,” Gottfried said during the floor debate on June 1.<sup>7</sup> “By taking insurance companies out of the picture, we put \$45 billion a year, more than \$2,000 per capita, ... back in the pockets of New York consumers and employers and taxpayers.”

He further projected that replacing private insurance premiums with progressive taxes would result in a net savings for all but the wealthiest 2 percent of New Yorkers.

Gottfried draws these attention-getting numbers from a fiscal analysis of the New York Health Act prepared last year by Gerald Friedman, an economics professor at the University of Massachusetts at Amherst.<sup>8</sup> Friedman avowedly favors the single-payer approach, and has written papers in support of similar legislation for Massachusetts, Maryland, and the United States as a whole.

Friedman estimates that:

- New York’s health-care system, if allowed to continue as-is, would spend a total of \$287 billion in 2019, including private insurance, government programs, and out-of-pocket expenditures.
- Switching to single payer would save \$71 billion by reducing administrative costs for insurers, employers, and providers and negotiating lower drug prices.
- Single payer would also entail \$26 billion in new spending to pay for coverage of the uninsured, an expected increase in health-care demand, and higher reimbursements for doctors and hospitals.
- After accounting for revenue from existing government programs, New York would

have to raise \$92 billion in new taxes to replace lost premium payments, cover out-of-pocket spending, finance the takeover of Medicare Part B premiums, and end Medicaid contributions by counties. (For comparison purposes, New York’s total tax collections for 2017 are expected to be \$78 billion.)

- New York’s overall health-care spending for 2019 would decrease to \$243 billion, for a net savings of \$45 billion or 16 percent.<sup>9</sup>

In short, Friedman presents single payer as a no-lose proposition – unlimited health care for everyone at lower cost than the status quo.

***The cost estimate behind the New York Health Act presents single-payer as a no-lose proposition—unlimited health care for all at lower cost than the status quo.***

A review of other studies of single payer and a close look at Friedman’s methodology raise doubt about the credibility of his conclusions.

### 3. CONTRASTING VIEWS

Friedman’s central finding—that a statewide government-operated health plan with unlimited coverage would cost dramatically less than the status quo – differs sharply from other analyses of single payer in New York and nationwide.

In July 2009, under contract with the state Health and Insurance departments, the Urban Institute prepared a study of different options for reducing the state’s uninsured rate, which then stood at 16 percent.<sup>10</sup> (As of 2014, the first year of full implementation of the ACA, New York’s uninsured rate had fallen by half, to 8 percent.<sup>11</sup>) Among the options studied was a single-payer plan similar to Gottfried’s bill, but which did not attempt to absorb Medicare.

The study found that single payer was the least costly option that would achieve 100 percent coverage of all New Yorkers.<sup>12</sup> However, it projected that aggregate spending would *increase* by about 3 percent – as opposed to the 16 percent *decrease* anticipated by Friedman.

In May 2016, the Urban Institute published a study of Bernie Sanders' "Medicare for All" proposal, a nationwide single-payer plan similar to Gottfried's bill with one major exception: Sanders' plan covers nursing-home stays and other long-term care, while Gottfried's leaves that coverage to be added later.

Like Friedman, the Sanders campaign asserts that Medicare for All would significantly reduce overall health-care spending compared to the status quo: "Reforming our health care system, simplifying our payment structure and incentivizing new ways to make sure patients are actually getting better health care will generate massive savings," the campaign's website says. "This plan has been estimated to save the American people and businesses over \$6 trillion over the next decade."<sup>13</sup>

The Urban Institute's analysis projected just the opposite: that enrolling millions of uninsured and rolling back limits on coverage would drive costs up by 17 percent.<sup>14</sup> Instead of reducing costs by \$6 trillion over 10 years, the Sanders plan would increase them by more than \$6 trillion, the institute projected.

### Questionable assumptions

Driving the dramatic disparity in analyses are wildly different assumptions about how the existing health-care system works and about how single payer would change it.

To start, Friedman estimates that almost 13 percent of all U.S. health-care spending goes toward the administrative costs of various health plans, both public and private, including such non-medical expenses as claims review, advertising, executive salaries, and profit.<sup>15</sup> His paper does not specify how he arrived at that number, which is significantly higher than other estimates.

The Centers for Medicare & Medicaid Services' National Health Expenditures Assessment for 2014, for example, shows administrative costs of health insurance to be less than 8 percent.<sup>16</sup>

Friedman further projects that administrative costs for a statewide single-payer plan would fall to just 1.8 percent, which is the rate for traditional Medicare (not including Medicare Advantage plans offered by private insurers).<sup>17</sup> This is lower than what other experts have projected.

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***Assumptions about administrative expenses are a key variable in projecting the cost of a single-payer plan versus alternatives.***

The Urban Institute's analysis of the Sanders plan, for example, projected administrative costs of 6 percent, which is the average for all of Medicare, including privately-managed Medicare Advantage plans. The Institute's analysis said:

We do not believe that administrative costs can fall far below this level; far too many administrative functions must be conducted. One such function is rate setting for a wide array of providers, including both fee-for-service and any capitated providers that would remain—the latter would require separate payment negotiations. In the fee-for-service world, a considerable amount of care management and utilization control would be required, as would oversight and enforcement activities that prevent financial abuses by providers and ensure sufficient quality of care.<sup>18</sup>

Another analysis of the Sanders plan by Emory University Professor Kenneth Thorpe – who supported a proposed single-payer plan for the state of Vermont – projected administrative costs of 4.7 percent.<sup>19</sup>

Based on Friedman's high-end estimate of administrative expenses in the current system (13 percent), and his low-end estimate for single payer (1.8 percent), Friedman forecasts that New York would save \$26.5 billion on those costs alone as of 2019. Using the more cautious before-and-after estimates of 8 percent and

6 percent, respectively, those savings would dwindle to less than \$5 billion.

In another debatable calculation, Friedman estimates that administrative costs for hospitals, doctors' offices, and other providers would

drop from 24 percent of revenue to 14 percent – for a savings of \$21 billion to the state's health care system. He bases that on previous studies comparing the health-care systems of the U.S. and Canada.<sup>20</sup>

## Single payer for New York: Should Albany control our health care?

	CURRENT SYSTEM	SINGLE PAYER
<i>What plans are available?</i>	*Medicare *Medicaid *Veterans Administration *Workers Compensation *Other government programs *Employer-provided benefits *Privately purchased coverage	New York Health Plan
<i>Who is eligible?</i>	*The elderly or disabled *The poor *Veterans *Injured workers *Employees of firms offering benefits *Individuals who purchase coverage	All New York residents regardless of immigration status
<i>What care is covered?</i>	Varies according to plan	All office visits, tests, procedures, hospital stays, medications
<i>What providers are covered?</i>	Varies according to plan	All available providers
<i>What costs are covered?</i>	Varies according to plan	All expenses, with no copayments, coinsurance, or deductibles
<i>Who negotiates fees with providers?</i>	Federal government, state government, employers, private health plans	State government
<i>Who manages care?</i>	Federal government, state government, employers, private health plans	State government
<i>Who pays?</i>	Taxpayers, employers, employees, individual premium payers	Taxpayers

In a single-payer system affecting only one state, however, providers would still have the expense of verifying that patients live in New York and negotiating with the insurance plans of patients from other states. Out-of-state patients accounted for more than 7 percent of admissions to Manhattan hospitals in 2014, according to state Health Department data.<sup>21</sup>

To realize savings on providers' administrative costs, the system would have to pay providers less than it currently does. Yet Friedman's analysis envisions that the state plan would pay providers more, not less, than Medicaid and Medicare currently do.<sup>22</sup> Also, the bill would empower doctors to collectively bargain for higher pay.

There's a larger reason to be skeptical of Friedman's savings estimates: They assume that what insurance companies spend on administration accomplishes nothing, that it fails to avoid fraud, discourage unnecessary procedures, or otherwise keep costs down. This is far from the universal view. Otherwise, insurance companies would have long ago eliminated their claims review departments in expectation of saving money and boosting profits.

Among those who see insurance companies as performing a valuable cost-control function are leaders of New York's Medicaid system, which has aggressively enrolled recipients in managed care plans as a strategy to both save money and improve care.

According to a May 2016 report by the Citizens Budget Commission, Medicaid managed care enrollment increased 46 percent between 2010 and 2015, from 3.3 million to 4.8 million, rising to three-quarters of overall enrollment.<sup>23</sup> Over the first four of those years, spending per patient declined by 17 percent, from \$10,432 to \$8,620.<sup>24</sup> Meanwhile, New York's ranking in the Commonwealth Fund's assessment of Medic-

aid quality went up, from 21st place in 2009 to 13th in 2015.<sup>25</sup>

Friedman further assumes that a statewide single-payer plan could use its bargaining clout to negotiate lower prices for prescription drugs. He projects an average discount of 37 percent, based on what the Veterans Administration receives, for annual savings of \$16 billion.<sup>26</sup> If extended nationwide, such discounts would jeopardize the economic model of an industry that invests an estimated \$50 billion a year in pharmaceutical research and development,<sup>27</sup> which is more than the entire \$32 billion budget of the National Institutes of Health.

It's true that countries with single-payer systems, such as Canada and the United Kingdom, spend much less on health care than the United States. However,

they also pay their doctors significantly lower salaries.<sup>28</sup> Canadians trying to see a specialist or schedule surgery face the longest wait times of 11 countries ranked by the Commonwealth Fund.<sup>29</sup> And Britain's National Health Service is widely understood to ration care.<sup>30</sup>

These strategies could be an effective way for New York to control costs in a single-payer system. But they would be a hard sell politically, and they are not mentioned either in Gottfried's bill or in Friedman's analysis.

#### 4. THE VERMONT EXPERIENCE

More reason to be skeptical about the workability of single payer in New York comes from the neighboring state of Vermont, which went to the brink of adopting such a plan only to finally decide it would be too costly.

Vermont was seen as a likely laboratory for reform, with a small population, a low uninsured rate (4 percent in 2014<sup>31</sup>) and a governor, Peter Shumlin, who won his first term in 2010 on a

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***Up until a few years ago, Vermont was seen as the most promising laboratory for a state-level single-payer approach—until its governor realized how much the experiment was likely to actually cost.***

promise to establish single-payer health care. In 2011, the Legislature approved Shumlin's plan to implement Green Mountain Care over four years, leaving open the question of how to pay for it. Unlike Gottfried's bill, the Vermont plan exempted companies with workers in more than one state—significantly eroding the potential tax base.

In a series of three state-ordered studies, the cost-benefit calculation grew significantly worse, as summarized in a column for *The New England Journal of Medicine*:

A 2011 study led by Harvard health economist William Hsiao provided optimistic projections: immediate system-wide savings of 8 to 12 percent and an additional 12 to 14 percent over time, or more than \$2 billion over 10 years, and requirements for new payroll taxes of 9.4 percent for employers and new income taxes of 3.1 percent for individuals to replace health insurance premiums. Two years later, a study by the University of Massachusetts Medical School and Wakely Consulting projected savings of just 1.5 percent over three years. Finally, a 2014 study by Shumlin's staff and consultants predicted 1.6 percent savings over five years and foresaw required new taxes of 11.5 percent for employers and up to 9.5 percent for individuals.<sup>32</sup>

Citing those latter numbers, Shumlin canceled the program.

"I have learned that the limitations of state-based financing, the limitations of federal law, the limitations of our tax capacity, and the sensitivity of our economy make [single payer] unwise and untenable at this time," he said. "The risk of economic shock is too high."<sup>33</sup>

## 5. A MASSIVE TAX HIKE FOR NY

Even under the most optimistic projections, Gottfried's single-payer plan would balloon state spending. Money currently flowing through Medicare, the VA, and private insurance plans would now flow through the New

York Health Plan. The state's annual budget, which in fiscal 2017 totals \$148 billion on an "all funds" basis (including federal Medicaid reimbursements), would have to roughly double.

To replace private premiums, Friedman estimates the state would need \$92 billion in new tax revenue.<sup>34</sup> That would represent a 119 percent increase over the state's current revenue from all taxes—income, sales, business, etc.—of \$77 billion.<sup>35</sup>

To raise that cash, Gottfried's bill calls for levying two new taxes, on payrolls and taxable non-payroll income, but leaves the details to be fleshed out later.

To fill in those blanks, Friedman proposes a payroll tax that exempts the first \$25,000 of income, then rises progressively: 9 percent up to \$50,000, 11 percent up to \$75,000, 12 percent up to \$100,000, 14 percent up to \$200,000 and 16 percent for income above \$200,000. Employers would pay 80 percent of this levy, and employees 20 percent.<sup>36</sup>

He proposes a similar tax with the same rates and brackets for non-payroll income, such as dividends, interest, and capital gains.<sup>37</sup>

Despite the magnitude of these tax hikes, Friedman projects that most employers and most individuals (up to \$436,000 of income) would save money because they would no longer have to pay health-care premiums,<sup>38</sup> which average more than \$6,000 a year for individual coverage.<sup>39</sup>

He further predicts a boost to the economy as startup businesses and individual entrepreneurs are freed from the burden of buying and managing health benefits.

But his entire analysis of who wins and who loses depends in large part on steeply progressive tax rates that shift a disproportionate share

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### ***New York's state taxes would have to increase by at least 119 percent to cover the costs of an Albany-run single-payer health insurance plan.***

of collective health costs onto the wealthy. For a high-income New York City resident, the combined marginal bite of city and state taxes would more than double, from 12.7 percent to 28.7 percent. History shows that some high-income individuals would respond by moving their primary residence to another state or not locating in New York in the first place.<sup>40</sup>

Also, Friedman's assessment rests on the assumption that single payer will dramatically reduce overall spending. If spending goes up instead, as other experts project, single payer would become a losing proposition for a much larger share of the population—and for the state's economy as a whole.

### Other drawbacks

Cost considerations are not the only reason to be leery of a New York-only single-payer plan:

- It would greatly expand the share of the state's economy controlled by Albany, thereby multiplying opportunities for corruption. (Of the many lawmakers brought down by scandal in recent years, at least four were convicted of crimes relating to health care policy and funding: state senators Pedro Espada and Carl Kruger, and Assembly members Anthony Seminerio and Sheldon Silver.
- It would establish a system of price control—with the Health Department setting fees for every test, procedure, office visit, and surgery performed within state borders—which would inevitably distort the balance of supply and demand.
- It would centralize power over the health-care system, further empowering Albany's shadow government of special interests and lobbyists.

- It would eliminate the disciplining influence of private health insurers, who are the one player in the system with a financial incentive to keep spending in check.
- It would offer benefits that would be a magnet for residents of other states in need of costly care, while imposing taxes that would put New York's economy at a competitive disadvantage for job creation.

### CONCLUSION

New York, like the country as a whole, is clearly not getting its money's worth for health care. Despite spending more per capita than any other country, the United States ranked dead last in a Commonwealth Fund comparison of health-care systems in 11 developed nations.<sup>41</sup>

But putting all or even most of the blame for that dysfunction on the existence of private health insurers is not consistent with the study's findings.

The United Kingdom's single-payer health-care system ranked No. 1 overall in the Commonwealth Fund report. But its health outcomes – including measures of avoidable illness, infant mortality, and life expectancy – were second to last, just ahead of the U.S.

Ranking No. 2 overall, and No. 2 for outcomes, was Switzerland, with a system based on compulsory private insurance. Its per capita health spending, at \$5,643 in 2014, is still dramatically lower than in the U.S., at \$8,508.

If the goal is achieving good health outcomes at a more affordable price, Switzerland's model, which harnesses rather than eliminates market competition, is the better one to follow.

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