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Testimony of Bill Hammond
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Before the Joint Health Committees
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Chairman Rivera, Chairman Gottfried, members of the Senate and Assembly Health Committees, thank you for the opportunity to testify today.

If ever a piece of legislation warranted thorough vetting, in full public view, it's a bill that would compel 20 million people to switch health plans, abolish tens of thousands of jobs, upend a sixth of the economy and levy the largest tax increase in the history of this or any other state.

This hearing is a welcome step, and hopefully will be the first of many.

There are four major objections to the New York Health Act.

First, the strategy of single-payer goes far beyond what's necessary to address the real problems in our health-care system.

In the name of closing gaps in coverage, the proposed legislation would replace the entire health-care financing system - including large portions that are working reasonably well and that people are happy with.

Only a small fraction of the billions to be raised through new taxes would go to help needy people who lack access to care. Most of the money would be spent on replacing the coverage of those who already have it.

Since the advent of the Affordable Care Act in 2014, New York's uninsured rate has dropped to a historic low of 5 percent, or about 1 million people. Most of that group would qualify for free coverage through Medicaid, near-free coverage through the Essential Plan, or heavily subsidized coverage through the New York State of Health exchange.

The state could further close the remaining gap - and approach universal coverage - with relatively modest and affordable steps such as boosting outreach or strengthening financial incentives. Another constructive step would be to roll back the state-imposed taxes and coverage mandates that needlessly drive up the cost of insurance.

Supporters of the New York Health Act point to single-payer systems in other countries that spend much less money compared to the U.S. while covering everyone and, in some ways,

achieving better outcomes. But the same is also true of countries with multi-payer systems, such as Switzerland and Germany.

The cost difference between those countries and the U.S. is not primarily a result of the financing mechanism. It's mostly because they pay their providers lower fees and, in some cases, restrict access to care. The U.K.'s National Health System, for example, does not cover routine mammograms until age 50 and leaves as much as three years between screenings. In New York, insurers are required to cover mammograms at least once a year starting at age 40.

The second major objection is this: Even if single-payer was the right path, this particular proposal is badly designed and leaves too many questions unanswered.

The New York Health Act is not modeled on the health-care systems used by Britain or Canada. Instead, its drafters have proposed a purist version of single-payer that exists nowhere else in the world.

Other systems use cost-sharing, referrals, prior authorization and provider networks to manage care and moderate expenses. The New York Health Act rules those things out, increasing the likelihood that that costs would go up rather than down.

Other systems leave open the option of buying private insurance or directly purchasing care. The New York Health effectively outlaws private insurance and prohibits providers from accepting payment from any payer other than the state.

Perhaps the biggest flaw is what the bill leaves out. It's highly specific about what it intends to cover, but troublingly vague about how those generous benefits will be paid for.

The legislation includes no clear plan for determining provider fees - which, after all, is the "payer" part of single-payer. The state needs a reimbursement methodology that would appropriately compensate providers for all manner of medical procedures without enabling fraud, encouraging waste or bankrupting the state government.

This is an enormous challenge that no state has previously attempted. The complexities should be hashed out publicly before votes are cast, not improvised in backroom negotiations after the law is in force.

The third major objection: Single-payer would require the largest tax hike any state has ever enacted, with dangerous and possibly catastrophic consequences for the economy.

Perhaps the most glaring absence in this legislation is the lack of a financing plan. There is no way for New Yorkers or their elected representatives to judge the merits of the proposal if they don't know how much it's going to cost or where the money will come from.

Reasonable people can disagree about the price tag, but there can be no doubt it's a big number. The rosiest scenario puts the tab at \$91 billion, the equivalent of more than doubling all state tax revenues. A more realistic estimate from the RAND Corp. would approach \$160 billion - an

overall increase of 178 percent in a state that already carries one of the highest tax burdens in the U.S.

Such a tax increase could theoretically be structured so that many or most New Yorkers would save money compared to the status quo. But that would come at the price of dramatically higher marginal rates on high-income residents – perhaps double or triple those of the next highest state – which would further weaken the state’s economic competitiveness and likely destabilize the tax base.

The fourth objection: New York’s state government is ill-equipped to manage a program of this massive scale and life-and-death consequence.

The fundamental premise of this proposal is that a state takeover of the health-care system would produce the best of all worlds: good service at low cost. Unfortunately, the track record for government-run services in New York is just the opposite: mediocre to terrible service at sky-high cost.

Three obvious examples are the MTA, the New York City Housing Authority and the state’s public school system – which are infamous, respectively, for late, overcrowded trains, mold- and lead-tainted apartments, and abysmal test scores for too many students. Why should New Yorkers expect any better from a state-run health plan?

It will be argued that single-payer does not technically amount to state control. Yet Title III of the legislation establishes a process of “collective negotiation” between providers and the state. It lays out a procedure for resolving impasses through de facto arbitration and, concerningly, stops short of banning strikes.

Those are the hallmarks of a labor-management relationship – with doctors and nurses and hospitals sitting on the labor side of the table, and Albany officials taking the role of management. Such a system would walk, talk and quack like state control.

Even assuming the state is capable of handling such a mammoth task, it would inevitably dominate the attention of lawmakers and drain resources to the detriment of other priorities more squarely in the state’s wheelhouse, such as maintaining roads and bridges and financing education.

As the ancient medical precept says, “First, do no harm.” Overly aggressive treatment can be worse than the disease.

There are real and urgent problems in New York’s health-care system, coverage gaps and other barriers to access being first among them. Lawmakers should address those ills through targeted interventions – and do everything they can to avoid the risky, radical surgery of single-payer.

A more detailed discussion of these and other issues can be found in the Empire Center's report, "Do no harm: The case against single payer in New York," a copy of which is attached as an appendix.

Thank you for listening.