LEAGUE OF WOMEN VOTERS® OF NEW YORK

Update on Healthcare and the Financing of Healthcare (2019-2021) Materials

Instructions & Updated Positions

Study Documents

Appendices: Useful References

Healthcare Position Update Committee

Co-Chairs: **Barbara Thomas (LWV of Saratoga)**
Valerie King, PhD (LWV of the Hamptons, Shelter Island & North Fork)

Committee Members: **Janet B. Allen (LWV of Huntington)**
Anne Burton (LWV of Rensselaer)
Judy Esterquest, PhD (LWV of Port Washington)
Estelle Gellman, PhD (LWV of the Hamptons, Shelter Island & North Fork)
Madeline Zevon (LWV of White Plains)

Questions or Comments? Email to: LWV.NYS.Healthcare.Update@gmail.com

Instructions for Adopting the Update

Introduction: The 2019 NYS Convention charged our committee with updating the LWVNY position on Financing Healthcare (which was originally adopted in 1985 and last revised in 1991) with particular consideration of the manner in which single-payer legislation such as the NY Health Act could be fiscally viable, that is, the financial criteria we believe a single-payer system should meet, including the feasibility of implementing single-payer at the NYS level and consideration of how it might impact Medicare.

To meet this charge, we added two new sections to the proposed Position on Financing of Healthcare: Feasibility criteria for single-payer financing in NYS and favored Cost-Control Methods appropriate to guide any healthcare reform. After review, we also updated the LWVNY position on Healthcare to reflect the changes in medical practice and healthcare that have occurred in the 30 years since the positions were first adopted. (The Consensus process will conclude in the first half of 2021.)

We are asking you to make 2 decisions. In each case, compare the proposed new position to the current position:

A. **Do you accept the new position on Healthcare? YES or NO.**
No retains the current position; Yes accepts the new position

B. **Do you accept the new position on Financing of Healthcare? YES or NO.**
No retains the current position; Yes accepts the new position

Advice on Tackling These Documents for the Healthcare Update Consensus Process:

1. You can read these documents in any order; however, we recommend that you first read through the current positions and new position, applying critical thinking as you notice what's been added, omitted, and revised.
2. Whatever your approach, please review this entire package.
3. To help you consider these two decisions, footnotes on the proposed new positions provide the rationale for wording changes in the new Positions— while footnotes on documents in the study materials and the Appendix provide additional reference. You need not read them all, but you will find evidence-based support for many of your questions.
4. If possible, attend your local League Consensus discussion and participate in the consensus process. Your opinion will have greater weight as part of your local League response.
5. As a second option, for members who cannot attend their local League discussions or members of a local League not participating in the study, LWVNYS will organize virtual discussions and Q&A sessions. Individuals may then complete an individual response form if they participate in these sessions.

A. Do you accept the new Position on Healthcare? Yes or No.

If you choose NO, you are retaining the current position.

Proposed New Healthcare Position

HEALTHCARE (2021)

GOALS

The League of Women Voters of New York State (LWVNYS) believes that everyone should have access to essential physical and behavioral healthcare. New York State has a proper role in the regulation of healthcare and must assure high quality care that is affordable and accessible to all.

Resources should be devoted to health promotion and disease prevention so that people can take active responsibility for their own health. People should have opportunities to participate effectively in decisions regarding their personal health and in healthcare policy decisions.

The League believes that New York State's primary role in healthcare is to assure that quality care is available to all New Yorkers. We believe that the state should provide planning and regulations to assure everyone, including the medically indigent, access to an essential level of quality physical and behavioral healthcare. Cost containment should be an important criterion in developing regulations. Such regulation, however, should not compromise the quality of care or its accessibility.

The League supports regulatory incentives to encourage the development of cost-effective alternative ways of delivering and paying for healthcare, appropriate to all areas of NYS, with coordination across regulatory bodies to avoid undue delays and contradictory, duplicative regulations. Delivery programs may take place in a variety of settings, including the home and online, and must provide quality care, meaning consistent with "standard of care" guidelines, by trained and licensed personnel, staffed adequately to ensure their own and patient safety.

Coordination of services is essential to assure that community needs are met. As public health crises increasingly reveal, NYS should protect the health of its most vulnerable populations, urban and rural, in order to protect the health of everyone. In addition, all programs should be evaluated regularly. Provider reimbursement should include incentives for efficiency and for disease prevention and health promotion activities. Public health, environmental health and research activities should be continued.

Decisions on medical procedures that would prolong life should be made jointly by patient, family, and physician. Patient decisions, including those made prior to need, should be respected.

ESSENTIAL LEVEL OF QUALITY CARE

The League supports uniform eligibility and coverage of essential healthcare services, both physical and behavioral, ideally including coverage of services such as vision, dental, hearing, and long-term care, through public financing. Access to optional insurance coverage for care not covered by public financing should be available. The League has a strong commitment to an emphasis on preventive care, health education, and appropriate use of primary care services.

CURRENT Position on Health Care (1991)

The League of Women Voters of New York State believes that everyone should have access to basic physical and mental health care. New York State has a proper role in the regulation of health care and must assure high quality care that is affordable and accessible to all. The state should support incentives to foster the development of alternative delivery and payment methods.

More resources should be devoted to health promotion and disease prevention so that consumers can take active responsibility for their own health. Citizens should have more opportunities to participate effectively in decisions regarding their personal health and in health care policy decisions.

The League believes that NEW YORK STATE 's primary role in health care is to assure that quality care is available to all New Yorkers. We believe that the state should provided planning and regulations to assure everyone, including the medically indigent, access to a basic level of quality physical and mental health care. Cost containment should be an important criterion in developing regulations. Such regulation, however, should not compromise the quality of care or its accessibility. We support regionalization of specialized tertiary services as a means of providing access while controlling costs.

There should be coordination among regulatory bodies to avoid undue delays and contradictory, duplicative regulations.

The League supports regulatory incentives to encourage the development of alternative ways of delivering and paying for health care. Delivery programs should provide quality care, be cost effective, and be adaptable to different geographical locations. Services may take place in a variety of settings, including the home, and must be staffed by personnel who meet state standards.

Coordination of services is essential to assure that community needs are met. In addition, all programs should be evaluated regularly. Payment methods should be encouraged which include incentives for efficiency and for disease prevention and health promotion activities. Some alternatives, which should be considered for state regulation, include ambulatory surgery, alternative providers, prepayment plans and the issue of professional liability. Activities should be continued in public health and research.

Decisions on medical procedures that would prolong life should be made jointly by patient, family, and physician. Patient decisions, including those made prior to need, should be respected. To participate in public discussion of health policy and to share effectively in making policy decisions, consumers must be provided with information on the health care system and on the implications of health policy decision.

B. Do you accept the new Position on Financing of Healthcare? Yes or No.

If you choose NO, you are retaining the current position.

Proposed NEW Position on Financing Healthcare

FINANCING OF HEALTHCARE (2021)

As a continuation of the 1985 statement of position on healthcare, a two-year study and consensus on the financing of healthcare was conducted from 1989 to 1991. Following study in 2019-20, this position was updated again in 2021.

The League of Women Voters of New York State believes that any proposed healthcare financing system should provide access to essential healthcare at an affordable cost for all New Yorkers, both patients and taxpayers. The League supports the single-payer concept as a viable and desirable approach to implementing League positions on equitable access, affordability, and financial feasibility. In any proposed healthcare financing system, the League favors funding supported in part by broad-based and progressive state income taxes with health insurance access independent of employment status.

FEDERAL v STATE ROLES

Although the League prefers a healthcare financing system that includes all residents of the United States, in the absence of a federal program that achieves the goals of universal, affordable access to essential health services for New Yorkers, the League supports a healthcare program financed by NYS which includes continuation of federal funding.

FEASIBILITY

The League believes the financial feasibility of any single-payer NYS program requires:

- Levels of federal support appropriate for the cost of the program
- Sufficient cost-savings to be identified so that estimated overall program cost will approximate the cost of current overall health services (as funded from all sources) or less
- New state funding from individual taxpayers, employees and businesses, that is equitable and progressive to ensure affordability for all
- A healthcare trust fund managed by the state, that operates in a similarly efficient fashion as Social Security or Medicare trust funds.

COST-CONTROL METHODS

To reduce the impact of any tax increases, healthcare reform should contain costs. The League believes that efficient and economical delivery of care can be enhanced by such cost-control methods as:

- Reduction of administrative costs — both for this plan and for providers
- Negotiated volume discounts for pharmaceuticals and durable medical equipment to bring prices closer to international levels — or importing of same to reduce costs
- Regionalization of specialized tertiary services to ensure timely access and quality
- Evidence-based treatment protocols and drug formularies that include cost/benefit assessments of medical value

- Malpractice reforms designed both to compensate patients for medical errors and to avoid future errors by encouraging robust quality improvement processes (at individual and systemic levels) and open communications with patients
- Investment in well-care — such as prevention, family planning, patient education, primary care — to increase health and reduce preventable adverse health events/expenditures
- Investment in maternal/infant and child care, chronic disease care, and behavioral healthcare Provision for short-term and long-term home-care services to reduce institutionalization
- Innovative payment and record-keeping

Specific cost-control methods should reflect the most credible, evidence-based research available on how healthcare financing policy affects equitable access to healthcare, overall quality of care for individuals and populations, and total system costs of healthcare and its administration. Methods used should not exacerbate disparities in health outcomes among marginalized New Yorkers.

PUBLIC PARTICIPATION

The League supports public input as integral to the process for determining health care coverage and funding. To participate in public discussion of health policy and to share effectively in making policy decisions, NYS residents must be provided with information on the health care system and on the implications of health policy decisions.

# # #

CURRENT POSITION ON FINANCING OF HEALTH CARE

As announced by the State Board, November 1991

As a continuation of the 1985 statement of position on health care, a two-year study and consensus on the financing of health care was conducted from 1989 to 1991. Major concerns were the financial limitations on access to health care for the uninsured and the underinsured and the escalating cost of health care.

The current financing system which involves public programs with limited eligibility, and private insurance coverage for selected groups and selected health care treatments, does not meet League criteria for access and equity in health care as stated in the position of 1985.

The League of Women Voters of New York State supports uniform eligibility and coverage of basic health care costs through public financing. Access to optional insurance coverage for care beyond the basic level of coverage should be available. Assuming that public funds for health care are limited, the League believes that the scope of services contained in basic coverage and the cost/benefit ratio of medical treatments should be considered in efforts to contain costs. The League has a strong commitment to an emphasis on preventive care, health education, and appropriate use of primary care services.

The Federal government should be the primary vehicle for the financing of health care, determining eligibility for health care services, and determining the scope of services to be provided. The State should assume secondary responsibility in these areas.

The League should ensure that public input is an integral part of the process in determining priorities in health care coverage. Cost containment efforts should precede increased taxes or reallocation of funds from other state programs.

The League supports the single payer concept as an acceptable approach to implementing League positions on equitable access and cost containment.

The League supports the establishment of an administrative system for determining patient compensation as a modification of the tort system related to patient injury.

Overall, the League believes that universal access must be balanced by restrictions in the scope of services, and that the scope of services should be determined by knowledgeable professionals and consumers with administrative and legislative oversight.

# # #

Charge to the Healthcare Position Update Committee By the NYS 2019 Convention

"The Board is recommending an update on Financing of Health Care. Two Leagues raised questions about the New York Health Act, its impact on Medicare in the state, and how it would be financed. Our position on Financing of Health Care pre-dates the Affordable Care Act. As more information is made available through potential consideration of the New York Health Act in the state legislature, including public hearings, this is a good opportunity to update our position with current information and make sure we have member understanding and agreement."[1]

Note: The committee expanded its mission to include updating of the Position on Healthcare.

Explanation of Study Materials and the New York Health Act Model

Included in the study materials is one potential example of a single payer system operating at the state level, the New York Health Act (NYHA). This is not the only model of a single payer system and member approval of the proposed position does not mandate support of the NYHA. The proposed position would allow the State League to support different models and parts of a single payer system, or different alternative models of financing health care. The State Board would evaluate whether proposed legislation meets the criteria included in both the Healthcare and the Financing Healthcare positions to determine whether the League supports or opposes the legislation.

[1] LWVNYS 2019 Convention, Pre-Convention Kit, p.37

Summary of NY Health (NYHA)

For the full text of NY Health, go to: http://public.leginfo.state.ny.us and type: A5248

NYHA is a specific legislative proposal for single-payer healthcare that has been introduced in some form in the state legislature since 1992 and passed repeatedly by the Assembly. The bill authorizes the creation of the New York Health Program (NYH). Private insurance would no longer be allowed except for items not covered by NYH. The new coverage would be paid for by state and federal funds currently used for existing public health programs, supplemented by new state payroll taxes imposed on both employees and employers, and non-payroll taxes on individuals. These new taxes would replace private health insurance premiums and associated cost-sharing by employers and individuals, and all other out-of-pocket costs for essential healthcare: prescriptions, long-term care, dentistry, hearing, optometry, chiropractic, acupuncture, essential physical therapy, essential behavioral therapy. NY Health would also pay for long-term care and for covering the uninsured.

NYHA does not specify any tax rates other than to say they are to be progressive. Passage of the final bill would trigger a revenue proposal to be submitted to the legislature as part of the executive budget for the subsequent fiscal year. The revenue proposal would define progressively graduated tax brackets for each funding source, how the taxes will be phased in, and the initially negotiated reimbursement rates for providers, and other implementation and transition decisions.

Eligibility — Universal

- Every resident covered
- No barriers due to age, sex, income, wealth, employment, immigration or health status
- No insurance premiums; no payments at time of service: no deductibles; no co-pays; no restrictive networks (all providers will be in the same all-provider network with no private networks)
- The only health insurance plan allowed New Yorkers except for benefits not covered under NYHA

Comprehensive Benefits

- Primary & Preventive Care; Physical and Behavioral Care
- Inpatient & Outpatient Hospital Care; Prescription Drugs & Durable Medical Devices
- Dental, Vision, & Hearing Care (including dentures, glasses, hearing aids)
- Free choice of provider, including Primary Care Physician (PCP) & specialists & hospitals
- Long-Term Care: including long-term homecare for all New Yorkers, with priority for integrated community support; no Medicaid spend-down, no means tests
- Coordination of Care: to ensure access to full range of required medical services, not for gate-keeping, with no restrictions greater than original Medicare, usually by primary care providers (but also health organizations or labor unions), who will be paid for their coordination services
- Some out-of-state health services: e.g., emergency care, or care by a particular out-of-state provider deemed clinically necessary

Provider Reimbursement

- All providers will be paid directly by NYH, with no charges to patients (e.g., no “balance billing,” no “cost-sharing,” no payment at point of service)
- All providers will receive reimbursements “reasonably related to the cost of efficiently providing” their service (about current average commercial rates, above today’s Medicare rates (to ensure “an adequate and accessible supply of the health care service”; it is possible that new reimbursement methods will replace fee-for-service payments
- Reduction in administrative burden on providers: will increase available clinical time, allowing more time for (more) patients

- Rates will be negotiated with provider organizations, with providers involved in the negotiations and possible incentives offered to encourage relocation to under-served areas

General New York State Healthcare Financing

- Today, of the $300 B spent on healthcare in NYS annually,
  - public insurance (funded by taxes) pays almost 60% (Medicare, Medicaid, ACA subsidies, CHIP, Child Health Plus, etc.)
  - private (for-profit) insurance premiums pay just under a third
  - 11% of healthcare costs are paid by New Yorkers out-of-pocket (OOP)

- Under NYH, the approximately 40% of healthcare costs now paid by New Yorkers (premiums & OOP) will be paid by new progressive, graduated individual payroll and non-payroll taxes; employers will pay 80% (statutory minimum) to 100% (if negotiated) of the payroll tax
- NYH will save an estimated 17% on administrative and prescription costs, with new costs estimated to add 14% — a net savings at the state level and for most New Yorkers
- NYH will pay local contribution of Medicaid, approximately 20% of current county property taxes statewide
- The payroll exemptions of $25 K for all individuals ensures the poor pay less than now and an exemption of $50 K on the non-payroll tax protects Medicare enrollees.

Other

- NYH will seek federal waivers to pool funding from federal programs into NYH; in the absence of waivers, NYH will create a NYH Medicare Advantage Program to provide all Medicare beneficiaries healthcare with no premiums, no cost-sharing, and no gaps in comprehensive care.
- To continue current levels of federal Medicaid funding, NYH will seek waivers to continue current levels or, absent waivers, document for Centers for Medicare and Medicaid Services (CMS) the services NYH provides that are eligible for Medicaid funding.
- ERISA regulations forbid states from regulating "self-insured plans" (e.g., when a large employer chooses to constitute its own risk pool OR, in the case of NYH, when the state creates a plan with a single risk pool of almost 20 million people). Proponents of the NYHA argue that NYH will not violate ERISA because it will simply require all employers to pay a tax, allowing them to continue, if they wish, to provide their employees the health benefits they currently provide (although it is unlikely they will do this since whatever health services they provide will simply add cost while being both redundant and less comprehensive than NYH).
- "Just Transition" issues for displaced workers: employees of insurers and providers who lose their jobs as a result of the state moving from a multi-payer to a simpler single-payer financing system will receive at least two years of extended unemployment insurance, job retraining, job placement assistance, and priority hiring for new jobs created by NYH. It is expected that workers with clinical degrees will return to clinical work.
- After passage of this authorization bill and before passage of the revenue proposal within the Governor's executive budget, provision will be made for residents (who are eligible for NYH) who are employed out-of-state, and non-residents (who are not eligible for NYH) who are employed in the state; their employers will also be provided guidance, as appropriate.
- Similarly, the NYH Commissioner shall provide regulation for payment methodologies and procedures for paying for out-of-state healthcare services.

NYH vs. Status Quo: Costs, Savings and Financing

These materials are drawn from three main sources: the 2018 RAND analysis of NYHA[2]; an evaluation of the RAND analysis,[3] by Dr. Leonard Rodberg; and an economic analysis of NYHA by Dr. Gerald Friedman,[4] with additional notes from other sources, as noted.

Section 1: Current state expenditures on healthcare – the "status quo" costs
Section 2: Status quo vs estimates of NYH tax
Section 3: Detailing of NYHA effect on cost elements
Section 4: Improvements: new costs
Section 5. Transferred costs & summary
Section 6: Comparing different estimates of new taxes needed

The RAND study was commissioned by the New York State Health Foundation in 2018 to study how NYHA would affect healthcare utilization and spending; its analysis of the financial impact of adding long-term care into NYHA was the first such analysis for a state single-payer plan. Following publication of the RAND report, Rodberg summarized its findings, provided an analysis of RAND's "base case," and discussed the combination of "alternative assumptions" RAND selected. The model labeled "RAND" in this document includes $38 B in currently funded Long-Term Care (LTC), but not paying for currently unpaid LTC services, which RAND calculated as an alternative estimate. The model labeled "Adjusted RAND" uses three alternatives offered by RAND (details and rationales in Section 3), adds new costs (details and rationales in Section 4), and recalculates the total taxes required to ensure consistency with the most recent version of the legislation and its guiding principles (details in Section 5). Both Rodberg and Friedman are proponents of single payer healthcare.

1: Current state expenditures on healthcare — the "status quo" costs

Today, non-profit public insurance (funded by taxes) pays almost 60% of all state healthcare costs, while for-profit private insurance (funded by premiums and associated cost-sharing) pays just under a third; 11% of healthcare costs are paid by New Yorkers directly out-of-pocket (OOP).

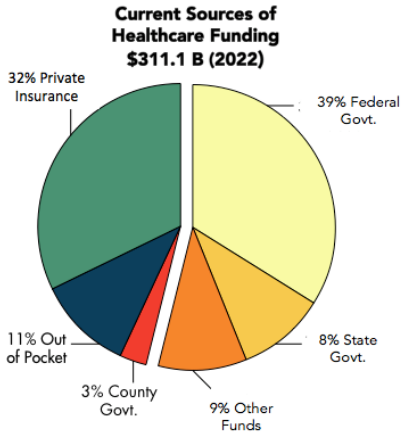

Figure 1: Current Sources of Healthcare Spending, Source Liu & Rodberg

[2] Jodi Liu, *et al*., An Assessment of the NY Health Act, RAND Corporation, August 2018, RAND Policy Researcher, https://www.rand.org/pubs/research_reports/RR2424.html.

[3] Leonard Rodberg, Summary & Evaluation of the RAND Corporation's Assessment of the NYHA. Dr. Rodberg is the Research Director of the NY Metro Chapter of Physicians for a National Health Program; creator and director of InfoShare, a comprehensive public access database on the neighborhoods of NYC and NYS; and Professor Emeritus of Urban Studies at Queens College/CUNY http://www.infoshare.org/main/Summary_and_Evaluation_of_the_RAND_report_-_LRodberg.pdf.

[4] Gerald Friedman, Economic Analysis of NYHA, 2015. Dr. Friedman is a professor of economics at the University of Massachusetts at Amherst and an advocate of single payer, https://www.nyhcampaign.org/study.

NYHA will replace current expenditures on for-profit private insurance, some OOP,[5] and county Medicaid contributions with progressive payroll and non-payroll taxes.

Funding from Medicare, Medicaid, CHIP, the ACA, NYS, and other public sources (55% of current funding) will continue under NYHA, with NYHA paying federal premiums, as required, e.g., for Medicare Part A, Part B, and Part D. Note that long term care (LTC) is currently funded by every source: Medicaid and Medicare by the federal government, Medicaid by NYS, Medicaid by NYS Counties, OOP on LTC by NYS residents, and private insurance (particularly LTC insurance).

2: Status quo costs vs projected funding under NYHA

The RAND assessment concludes that NYHA can provide universal coverage[6] with no cost-sharing for less than the status quo cost[7] (Figure 2 on left). Conservative adjustments to this analysis increase the total savings, reducing the overall tax burden[8] (Figure 3 on right).

Projected Healthcare Funding Under New York Health Act

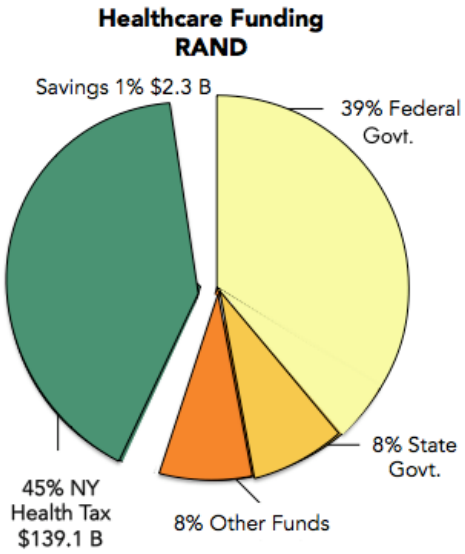

Figure 2: RAND Projection of NYHA Funding, $311.1B Total Spend (2022), Source Liu

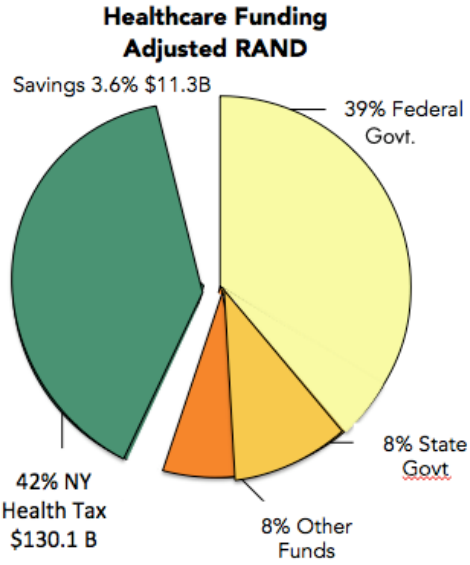

Figure 3: Adjusted RAND Projection of NYHA Funding, $311.1 B Total Spend (2022), Source Liu & Rodberg

As Figures 2 and 3 illustrate, federal and state taxes will continue to fund 55% ($169.8 B) of NYS healthcare under NYHA, while the NYH Tax will replace County Medicaid contributions, insurance premiums, and out-of-pocket expenditures (most significantly, expenses associated with long-term home care, current for-profit insurance cost-sharing, and patients' expenditures for essential healthcare not covered by their policies). RAND projects the total of all expenditures for the 2022 status quo at $311.1 B.

[5] Ibid., Rodberg, "Some out-of-pocket payments would continue, such as those for non-medically-necessary services and over-the counter, non-prescription drugs. A substantial portion of current out-of-pocket spending is for long-term care, which would be covered by NY Health."

[6] RAND's cost analyses were based on the 2018 NYHA bill; because that version called for LTC to be implemented two years after NYHA passage, RAND analyzed the cost of the bill both with and without paying for currently unpaid LTC. The current bill covers LTC as part of comprehensive coverage, so this discussion of RAND's estimates includes RAND's cost projections for currently paid (but not unpaid) LTC.

[7] "Our analysis finds that the NYHA could expand coverage and maintain or reduce total health care spending, assuming the state can reduce administrative expenses and restrain provider payment growth," Liu, p.viii.

[8] These additional costs include elements that RAND did not consider, including amendments (improvements) made to the NYHA bill since 2018. These are detailed below; see Rodberg.

RAND projects that total spending for NYHA (including all services mentioned in the summary) will require $139.1 B in new taxes, less than the $141.3 B currently spent on private insurance and out-of-pocket costs resulting in an estimated savings of $2.3B in the first year (0.8%), with total savings to increase over time. NYHA, like other single-payer systems, will more successfully control costs than for-profit financing systems creating more savings in future years.[9] Adjusted RAND — including both savings and additional costs (as detailed in Sections 3 and 4) — projects $103.3 B in required new state taxes, replacing the current $141.3 B expenditures (a savings of $11.3 B), with increased savings over time.

3: Detailing of NYHA effect on cost elements

RAND identified eight critical cost elements within the current healthcare system and analyzed how NYH would affect each, estimating the savings/added costs separately. Figure 4 displays all eight elements, showing the status quo and total savings estimated by RAND and by Adjusted RAND. The two categories called out by RAND — administrative costs and healthcare services costs — are separately considered below.

Note that, in this section, the RAND discussion explains the savings/increases RAND estimated to project $139.1 B in required new taxes within total healthcare costs of $308.9 B), while the Adjusted RAND discussion of those savings/increases projects requiring $103.3 B in new NYH taxes (within total healthcare costs of $273.1 B). Section 4 describes new costs that Adjusted RAND adds (not included in RAND) to project requiring $130.1 B.

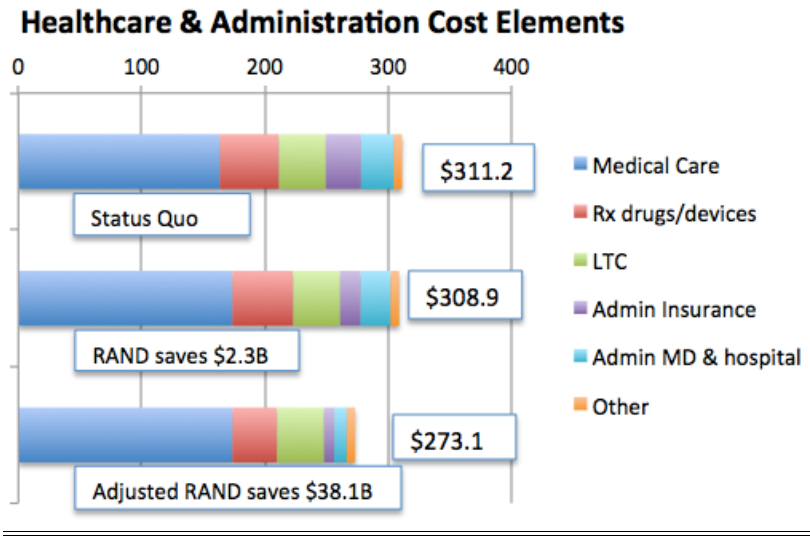

Figure 4: Healthcare & Administration Cost Elements, Source Liu & Rodberg

Currently, healthcare administration costs in the U.S. are the highest in the developed world,[10] two to three times more than many OEDC countries.[11] Administrative costs for providers and for insurers include Billing and Insurance Reimbursement (BIR) and claims denials, as well as a rapidly growing market for out-sourced third-party administrative review. This cost does not include significant provider time spent on appeals and prior authorizations, time lost to clinical care.

Because single-payer systems simplify billing, reimbursement, and authorizations, RAND separated administration costs from healthcare services costs (medical care and prescriptions) to analyze how NYHA would affect each. Both RAND and Adjusted RAND project the greatest savings within Administrative costs (albeit

[9] Liu, p. ix.
[10] Uwe Reinhardt, "Where Does the Health Insurance Premium Dollar Go?" JAMA Forum, 2017, https://newsatjama.jama.com/2017/04/25/jama-forum-where-does-the-health-insurance-premium-dollar-go/
[11] Emily Gee, "Excess Administrative Costs Burden the U.S. Health Care System" Center for American Progress, 2019, https://www.americanprogress.org/issues/healthcare/reports/2019/04/08/468302/excess-administrative-costs-burden-u-s-health-care-system/

different degrees of saving). Both project Medical Care to increase costs (because covering the uninsured and under-insured will increase utilization of providers and more demand for their services).

Similarly, cost projections for drugs and devices require netting out the effect of negotiated discounts on drug prices, on the one hand, with the effect of increased utilization (dispensing more prescriptions) caused by the elimination of cost-sharing, on the other. Reducing administration costs would help cover the cost of universal coverage because the cost of serving each patient would decrease. Eliminating cost-sharing would further reduce administration costs as well as reducing the overall cost of healthcare (see Pro/Con on Cost Sharing). Using RAND data and its multiple micro-simulation scenarios, Adjusted RAND calculated $17.1 B in new costs for covering everyone and eliminating financial barriers to care.

Administration Costs: Status Quo Costs $55.7 B
RAND projects $41.8 B with $13.9 B in savings;
Adjusted RAND projects $19.1 B with $36.5 B in savings

RAND estimates total current administration costs — from insurers, providers, NYS, and employers who offer healthcare to employees — at $55.7 B. Under NYH, RAND projects $11.9 B savings from eliminating private insurance administration and $2 B savings on administration by providers (physicians and hospitals) — for a net savings of $13.9 B. The conservative adjustments to RAND estimated $20.2 B in savings for private insurance administration and $16.3 B for provider administration (physicians and hospitals) — for a net savings of $36.5 B.

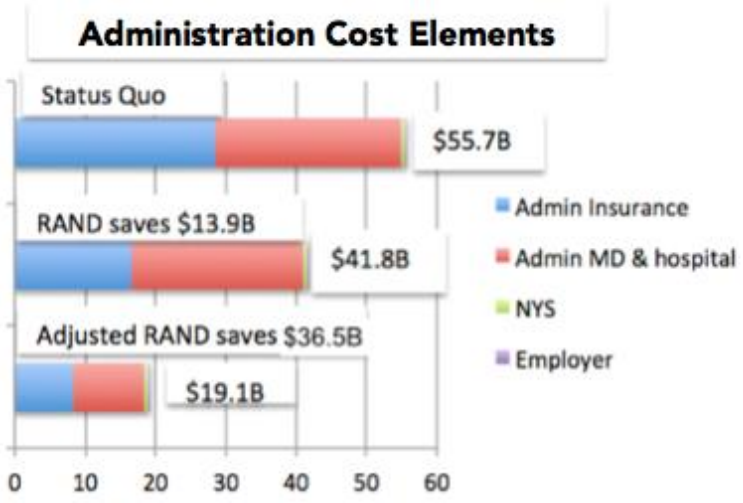

Figure 5: Administration Cost Elements, Source Liu & Rodberg

Adjustments increase RAND's projected administrative savings, as follows:

1. RAND assumed a "blended" administrative rate of 6% by combining the administrative overhead of original Medicare, Medicare Advantage (MA) Plans, and Medicaid Managed Care (MMC) organizations. Traditional Medicare (a single-payer plan) is a better analog for NYHA than federal plans with private insurers (Medicare Advantage and Medicaid Managed Care) that include profit, marketing, and significant gate-keeping/eligibility tests within their administrative costs (10-14% for MA and 8% for MMC) — whereas Medicare administration is estimated at 1.1%[12] to 2%[13]. Adjusted RAND uses RAND's more conservative alternative estimate of 3% for NYHA, rather than RAND's blended rate of 6%. This increases the insurance administration savings from the $11.9 B that RAND projected to a savings of $20.2 B for Adjusted RAND.

[12] Austin Frakt, NYT, 2018, http://pnhp.org/news/frakt-on-medicare-for-all-as-the-answer-to-sky-high-administrative-costs/
[13] Kaiser Family Found., "Medicare Spending and Financing," https://www.kff.org/wp-content/uploads/2013/01/7731-03.pdf

2. Many studies assess the excess administrative burden on providers (hospitals and physicians)[14] as 13% (to 17%), far greater than RAND's assumed 8% savings.[15] Rodberg also points to an apparent flaw on p. 28 of the RAND study that removes 13% of provider administrative costs, rather than reducing total costs. As a correction, Rodberg conservatively assumes 10% savings on administrative costs for providers. This increases the $2 B savings RAND projected to a total savings of $16.3 B savings for provider administration projected by Adjusted RAND.

As noted above, both RAND and Adjusted RAND find the greatest savings in administrative costs because single-payer plans reduce the complexity of multiple payers (with different reimbursement rules), differing benefits policies per payer, differing eligibility certifications and prior authorizations.

Healthcare Services Costs: Status Quo Costs $255.4 B
RAND projects $267 B with cost increases of $11.6 B;
Adjusted RAND projects $253.9 B with cost savings of $1.5 B

RAND estimates an increase of $10.4 B for medical care after combining estimates for reduced provider reimbursement with projections for increased utilization of healthcare services. Because all New Yorkers would gain comprehensive health services with no cost-sharing, RAND estimates that patient demand for physician services would increase by about 15% and for hospital services by about 10% — but projects the cost of delivery to be about half of theoretical demand, due to "congestion,"[16] meaning wait times and supply constraints. RAND assumes that standard reimbursement to providers under NYHA would pay somewhat below Medicare rates. (On average, private insurance pays physicians about 25% more than Medicare while Medicaid pays physicians about a third less than Medicare.)

RAND projects drug costs would increase $1.2 B— estimating a negotiated cost savings of 10% below Medicare Part D prices plus increased demand because of universal access and no cost-sharing.

Combining these two — $10.4 B plus $1.2 B — gives RAND $11.6 B in increased Healthcare Services costs. Drug prices in the U.S. are more than 30% to 50% higher than peer countries for the same drugs.[17] A U.S. Congress 2019 report found US drug prices average twice as much as peer countries,[18] and that these high prices are not caused by other countries' "free-riding" on the U.S.[19]

[14] Cutler & Lye, "The (Paper)Work of Medicine," J Econ Perspect, 2011, https://www.ncbi.nlm.nih.gov/pubmed/21595323 "For every office-based physician in the United States, there are 2.2 administrative workers. That exceeds the number of nurses, clinical assistants, and technical staff put together. One large physician group in the United States estimates that it spends 12 percent of revenue collected just collecting revenue (Blanchfield, Heffernan, Osgood, Sheehan, and Meyer, 2010)" and "In the United States, there are 1.5 administrative personnel per hospital bed, compared to 1.1 in Canada. Duke University Hospital, for example, has 900 hospital beds and 1,300 billing clerks."

[15] Kahn, "The Cost of Health Insurance Admin in CA," 2005, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.24.6.1629.
See 2020 article that finds "health care bureaucracy cost Americans $812 billion in 2017, more than one-third (34.2%) of total expenditures for doctor visits, hospitals, long-term care, and health insurance - the expenditure categories for which we had administrative cost data. A single-payer system would have saved the U.S. more than $600 billion in administrative expenditures in 2017 alone." https://annals.org/aim/article-abstract/2758511/health-care-administrative-costs-united-states-canada-2017?eType=EmailBlastContent&eId=3421f919-21f0-45b8-bfce-1c661152bc1d

[16] Liu, p.43.

[17] Emily Miller, "US Drug Prices vs the World," DrugWatch, BMJ, 2018 https://www.drugwatch.com/featured/us-drug-prices-higher-vs-world/

[18] U.S. House of Representative Committee on Ways and Means. "Painful Pill to Swallow: U.S. vs. International Prescription Drug Prices." September 2019.

[19] Donald Light, "High US drug prices not due to other nations' free riding," 2018 https://pnhp.org/news/high-us-drug-prices-are-not-due-to-other-nations-free-riding/

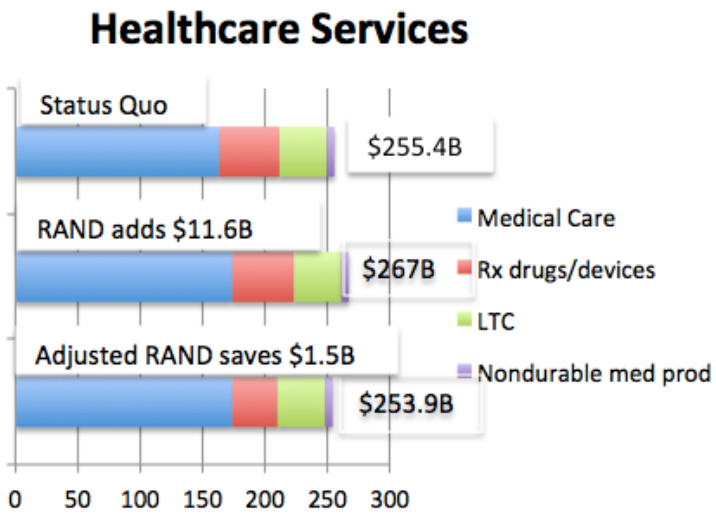

Figure 6: Healthcare Services Cost Elements, Source Liu & Rodberg

Adjusted RAND accepts the RAND $10.4 B increase in medical care cost as a reasonable projection for the cost of providing universal coverage without cost-sharing, but questions "congested" delivery, as discussed below. It projects $11.9 B in savings for drugs and devices.

Multiple experiences of introducing large numbers of new patients into a health system (Medicare/Medicaid and the ACA in the US; universal programs in Canada, Taiwan, and elsewhere) have shown no evidence of longer wait times or constrained supply of services.[20] Further, analyses of the time required for managing insurer appeals, denials, and prior authorizations, suggest that eliminating these will give physicians enough additional clinical time to more than offset increases in utilization.[21]

Adjusted RAND questions using Medicare Part D drug prices as a benchmark, since Medicare is prohibited from negotiating lower drug prices. RAND assumes NYHA's negotiations would save 10%. Medicaid negotiations for 9M New Yorkers achieve, on average, 33% savings on medications below Medicare Part D prices, while the VA achieves about 50%[22] below for its 9M veterans. Negotiating for 20M New Yorkers, NYH could be expected to achieve that or more. Adjusted RAND accepts RAND's micro-simulation of patient care-seeking and physician care-providing behavior and RAND's alternative (and more conservative) estimate of a 33% reduction in drug costs. Rather than projecting a $1.2 B increase in costs, these project a savings of $11.9 B over current costs.

As above, the two calculations from Adjusted RAND must be added together — increased cost for medical care of $10.4 B plus $11.9 B savings for drugs and devices — sum to $1.5 B net savings.

4. Improvements: new costs — $26.8 B to be added
$17.1 B already added in (See Section 3)

RAND's analysis includes reducing administrative costs, increasing utilization of providers and drugs, and negotiated savings on drug costs — the factors for calculating the costs of universal single-payer coverage without

[20] "The Effects on Hospital Utilization of the 1966 and 2014 Health Insurance Coverage Expansions in the United States," July 23, 2019, *Annals of Internal Medicine* https://annals.org/aim/article-abstract/2738920/effects-hospital-utilization-1966-2014-health-insurance-coverage-expansions-united ; "The Effect of Large-scale Health Coverage Expansions in Wealthy Nations on Society-Wide Healthcare Utilization," Nov 2019 in *Journal of General Internal Medicine.* https://pubmed.ncbi.nlm.nih.gov/31745857/

[21] "Allocation of Physician Time in Ambulatory Practice" Ann Intern Med, 9/6/2016.https://annals.org/aim/article-abstract/2546704/allocation-physician-time-ambulatory-practice-time-motion-study-4-specialties; "Projected costs of single-payer healthcare financing in the U.S: A systematic review of economic analyses" in PLoS Med. Jan 2020. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6961869/#pmed.1003013.ref035

[22] https://www.commonwealthfund.org/blog/2016/drug-price-control-how-some-government-programs-do-it

cost-sharing. It is silent on improvements to NYHA only contemplated in 2018, new costs that NYH will absorb because Adjusted RAND projects $38.1 B in savings to make them possible:

1. **Enhanced Physician Reimbursement: $8.8 B — RAND did not calculate in this cost**
   Currently physician income can depend on patient income, with care for Medicaid and Medicare patients being reimbursed at 25% to 50% below commercial rates. Under NYHA, reimbursements will be standardized to a level approximating average for-profit private-insurer reimbursements, with no provider facing reduced income for treating poor people.
2. **LTC: $18 B — RAND calculated this new cost but did not add it to their total**
   RAND estimated that 50% of currently informal home care (i.e., unpaid care, mainly by family members) would be replaced by paid care, but did not include this in their projection of NYH tax.
3. **Universal Coverage & No Cost-Sharing — $17.1 B already accounted for in the NYH tax**
   For these critical features of NYHA, RAND projected the cost within the discussions above of increased provider utilization, increased prescriptions/drug use, provider reimbursement, and administrative savings. Adjusted RAND accepted RAND's projections; both are already calculated within their estimates of required taxes ($139.1 for RAND and $103.3 B for Adjusted RAND, detailed in Section 3).

The two Improvements (covering currently unpaid homecare for LTC and enhanced physician fees) should be added to the Adjusted RAND calculation of required new NYH taxes (based on net savings from RAND's administrative and health services): the new total for required NYH taxes then becomes $130.1 B ($26.8 B plus $103.3 B).

This $130.1 B in new taxes replaces the RAND projection of $141.3 B in current spending on insurance premiums and out-of-pocket spending — with $11.3 B in savings (3.6%) off the status quo NYS spending of $311.1 B as displayed in Figure 3.

5: Transferred costs & summary: $27.8 B in current costs transferred to NYH, not assigned to NYH tax by RAND

NYH changes healthcare costs by reducing the cost of provider and insurance administration, and the cost of drugs, while increasing spending (by $17.1 B) to achieve universal coverage and remove financial barriers to care (cost-sharing). As seen in Section 3, replacing the current $141.3 B of private insurance and OOP spending on healthcare (not including new costs detailed in Section 4) would require $103.3 B in NYH taxes (a savings of $38.1 B associated with moving to single-payer funding).

The projected savings enables improvements and additional coverage to be incorporated into NYHA, while keeping overall spending at an estimated $11.3 B less than the current system. Adding universal LTC (converting unpaid LTC to paid LTC), and enhancing physician fees, increases healthcare spending by a total of $26.8 B ($18 B plus $8.8 B) but, even with these additional costs, the tax revenue required for NYH projects a savings — $26.8 B plus $103.3 B equals $130.1 B — vs current costs: $141.3 B.

To be consistent with the principles of the NYH program, some state healthcare costs currently paid by counties (Medicaid), individuals (OOP LTC costs), and Medicare recipients (Part B premiums) must be transferred — first by adjusting the RAND projection of total status quo expenditures on premiums and out-of-pocket (including the Medicaid portion of local property taxes) — and then including them within NYH taxes. These are current healthcare costs, not new costs or added costs; they are transfers from existing spending that RAND should have initially included in its projection of the NYH tax:

A. County Medicaid taxes ($8.3 B) — currently paid by counties

RAND did not isolate state and county taxes dedicated to healthcare. Were county Medicaid contributions to be covered by NYHA, these costs no longer need to be covered by county "property" taxes. In 2012, these taxes accounted for almost 80% of property taxes for some upstate counties and nearly 10% of NYC spending. This transfer could reduce local budgets.

B. LTC OOP ($11 B) — currently paid by individual New Yorkers

This is mainly LTC insurance, paid now by individual New Yorkers. By taking on the premium payments, NYH could reduce some of LTC costs and be consistent about eliminating all health insurance premiums currently paid by NYS residents.

C. Medicare Part B premiums ($8.5 B) — currently paid by Medicare enrollees choosing Part B

Medicare Part B requires enrollees to pay monthly premiums ($100+/month) to the federal government. Because under NY Health all New Yorkers will receive care without any additional payments, there would be no reason for Medicare recipients covered by NYHA to continue paying these premiums. To ensure all Medicare enrollees can enjoy their full Medicare Part B benefits, not just in NYS, but across the country, New York should make these payments for them; moving that cost into the NYH tax.

Transferring these three current healthcare expenditures into the status quo projection of costs (that NYH will replace) does not change the overall cost of what New Yorkers currrently spend on healthcare premiums and OOP. It does require correcting the RAND projection from 141.3 B to $169.1 B (that is, the total cost of what New York residents spend on premiums and OOP under the current system). The corrected status quo projection is $157.9 B in required NYH tax revenue, within the total status quo spending of $311.1 B.

Note: The projected $11.3 B in savings over the current cost ($311.1 B) remains, while providing universal coverage with no financial barriers, physician reimbursement that is no longer dependent on patient income, paid LTC services without out-of-pocket spending, eliminating insurance premiums (public and private), and moving state Medicaid taxes out of county budgets.

Summary: Costs, Savings and Revenue Required by NYH Tax

(2022 Dollars in Billions)

Costs and Savings of Healthcare

Status Quo (See Sections 1 & 2)	Status Quo	% of Total
ALL Healthcare Current Costs (Status Quo Today)	311.1	
From existing federal, state and county funding for healthcare	169.8	55%
From Private Insurance and OOP	141.3	45%

Healthcare Expenditures and Savings Projected Under Single-Payer	Status Quo	RAND Projected	Change Off Status Quo (cost/savings)	Adjusted RAND Projected	Change Off Status Quo (cost/savings)
Administrative Costs	55.7	41.8	(13.9)	19.1	(36.5)
Healthcare Services	255.4	267.1	11.6	253.9	(1.5)
Total Healthcare Expenditures and Savings Projected Under Single-Payer	311.1	308.9	**(2.2)**	273.1	**(38.1)**
NYHA Improvements/New Costs (See Section 4)				26.8	
Revised Total Current and Proposed Healthcare Expenditures and Savings Projected Under NYHA	**311.1**	**308.9**	**(2.2)**	**299.9**	**(11.3)**

Projected Tax Impact of NYHA

	Status Quo	RAND Projected	Change Off Status Quo (cost/savings)	Adjusted RAND Projected	Change Off Status Quo (cost/savings)
Baseline: ALL Healthcare Current Costs (Status Quo Today)	**311.1**				
From existing federal, state and county funding for healthcare	169.8				
From Private Insurance and OOP	141.3				
Tax Revenue Req'd for NYH to replace insurance premiums & OOP costs	141.3	139.1		103.3	
Cost of Improvements/New Costs				26.8	
Revised Tax Revenue Req'd by NYH (26.8 plus 103.2)				130.1	
Transferred Costs already in Status Quo (Section 5)				27.8	
Total New State Tax Amount Required to Implement NYHA				157.9	
Federal, State and other existing funding of healthcare	169.8	169.8		142	
Grand Total of Healthcare Costs	**311.1**	**308.9**	**(2.2)**	**299.9**	**(11.3)**

Figure 7 Summary: Costs, Savings and Revenue required by NYH Tax, Source Lieu & Rodberg

6: Comparing different estimates of new taxes needed to pay for New York Health in 2022 dollars

RAND and Adjusted RAND both conclude that the total cost of healthcare in New York State under the NYHA will be less than the total cost of healthcare under the status quo.

However, the NYHA will shift how New York residents pay for healthcare: with tax payments replacing premiums and out-of-pocket payments for services. The current state healthcare system is estimated to spend $311.2 B (in 2022 dollars) from all revenue sources (federal contributions, state taxes including local taxes, employer contribution to premiums, individual contribution to premiums, and individual out-of-pocket expenditures). Of this $311.2 B, RAND estimated $141.3 B comes from expenditures by New Yorkers on the costs of private insurance and OOP.

Additional tax revenue deeded to finance NYHA

In the 2019-2020 session, NYHA was revised to fully cover long-term care and to provide a payroll tax exemption for the first $25,000 for everyone and non-payroll tax exemption for the first $50,000 for Medicare enrollees. RAND did not factor all of these into its projections; adjusted RAND included them.

RAND projects NYH would save $2.3 B and Adjusted RAND projects a savings of $11.5 B (both detailed above in Section #3). This savings meant RAND projected $139.1 B in required new NYH taxes. Adjusted RAND — after savings, new costs, and transferring other currently funded healthcare costs — projected a need for $157.6 B in new NYH taxes. Estimates of the new taxes required and the impact on different taxpayer income levels depends on estimates of the total cost of the program.[23] In 2019, Avik Roy, an opinion writer who co-founded and writes for the Foundation for Research on Equal Opportunity (FREOPP, a non-academic "think tank" tied to free-market advocacy organizations), asserted that the NYHA would need $226 B in new tax revenue.[24] Currently the state is projected to collect $89.3 B in state taxes for 2022, so RAND's estimate would be an increase of 156% of total state tax revenues and Adjusted RAND would be an increase of 176%.

Structure of new taxes

Employees and employers would pay a new tax on payroll, and individuals would pay a new tax on all non-payroll income subject to state personal income tax (such as interest, dividends, capital gains, taxable pension distributions, and withdrawals from qualified savings plans above $20,000). While there are no tax brackets specified, the NYHA requires that both kinds of taxes be progressive and that the payroll tax be shared, with employers paying no less than 80% and employees paying no more than 20%. The new taxes are in addition to existing individual and payroll taxes.

For employers who currently provide healthcare for their employees, the employer portion of the new payroll tax is designed to replace health insurance premiums. Employers that do not currently provide healthcare benefits would be subject to additional costs for full-time or part-time employees who make more than $25K; for employees who make less than $25K per year, neither the employer nor the employee would pay any NYHA payroll tax.

Possible rates and brackets

In order to calculate the economic impact of shifting healthcare costs from premiums and out-of-pocket expenses to new taxes, RAND analyzed several different alternate tax household income schedules that could be used to raise the same aggregate tax revenue.[25] The distribution of who pays more or less for healthcare depends on the design of the tax schedule.

The revised NYHA exempts the first $25,000 from both payroll and non-payroll taxes for all individuals. One of the RAND proposed tax schedules exempted the lowest income tax bracket resulting in a steeper tax schedule. Under this proposed schedule taxpayers in the income bracket of $27,501-$141,200 would pay 11.1% additional tax on non-payroll income and those above $141,200 would pay 22.4% in additional tax on non-payroll income. The same brackets would be 12.8% and 25.6% in payroll taxes of which up to 20% would be paid by the employee and no less than 80% by the employer, similar to other payroll taxes.

[23] See Liu, p 73: "Our analysis finds that a single-payer approach in New York could expand coverage while reducing total health spending, assuming the state is able to negotiate modest reductions in the growth of provider payment and trim administrative expenses. While these assumptions are reasonable, they are also highly uncertain and depend on issues such as providers' bargaining power, the state's ability to administer the plan efficiently, and the federal government's willingness to grant waivers to the state. If any of these assumptions fails to hold, estimated costs to state taxpayers could increase. A further important detail is how the plan would be financed…"

[24] Avik S.A. Roy, "The Price of Single Payer: A Fiscal and Economic Analysis of the New York Health Act," Foundation for Research on Equal Opportunity, March 2, 2017. https://freopp.docsend.com/view/ j9wn535

[25] Liu, see Table B.1, p. 89.

In his analysis of the RAND report, Rodberg suggested an alternative table of marginal rates (using the same rates for payroll and non-payroll, which NYH tax calculates separately) to cover the cost of the NYHA including long-term care and other improvements.[26]

Theoretical Tax Rates for NYHA[27]	
<$25,000	0%
$25,000-$49,000	13.8%
$50,000-$74,999	16.9%
$75,000-$99,999	18.4%
$100,000-$199,999	21.6%
$200,000 and above	24.6%

Figure 8: Theoretical Tax Rates for NYHA, Source Rodberg

Impact on tax rates and possible out-migration

Payroll tax employee portion

Existing state personal income tax rates range from 4 to 8.82%.[28] For a single taxpayer at the lowest end of the Rodberg suggested tax brackets, the current state tax rate is 6.21%. The addition of the 20% employee portion of the new payroll tax would raise the tax rate on the lowest Rodberg category subject to tax ($25K-$49K) from the current individual state rate of 6.21% to 9%. The highest Rodberg category ($200K and above) is subject to two progressive individual state tax rates of 6.85% and 8.82% for $1,077.551 and above.[29]

Non-payroll tax

Because all of the non-payroll tax is paid by the individual, the impact of that tax on individuals with non-payroll income will be more significant. The state tax rate on non-payroll income could more than triple for some tax payers by adding the new NYH tax to current rates. The resulting effective tax rates on non-payroll income would make New York State taxes significantly higher than in the past. RAND noted that tax rates on non-payroll income needed to fund NYH would be much higher compared to such taxes in surrounding states and could cause out-migration. Because fifty percent of all state tax revenue from nonwage sources come from less than 1% of New York taxpayers with incomes above $1,000,000, migration of very high-income New Yorkers could erode the size of the tax base.[30] Any erosion could raise rates on other New York taxpayers.

Some academic research using IRS tax data, however, suggests that increases in revenue far offset any marginal loss of taxpayers. However, this research was done before the 2017 elimination of the SALT deduction, significantly increasing the net impact of state taxes, and tax increases that were not of the scale of the new NYH taxes.[31] Should projected revenues drop below what is needed for NYHA, the NYH Trust could recommend adjusting rates or brackets for the two named sources of revenue, or perhaps identify new funding sources.

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[26] Rodberg, p. 13.

[27] Rodberg, p. 13. Note: Rodberg considers them separately and in this table gives each the same rate — there is no requirement for this; NYHA non-payroll taxes could be taxed at a higher rate or with more brackets or at lower rates and fewer brackets (the way the IRS handles capital gains, for example]

[28] New York City residents pay a maximum combined state and local income tax rate of 12.7%.

[29] https://www.tax.ny.gov/pdf/current_forms/it/it201i.pdf#page=49

[30] Liu, p. 57-8 Note also that RAND does not write that tax flight will happen but that it **may** happen. Compare RAND's comment, about high-income households, "people could avoid taxes by moving or switching their primary residence to another state. While the literature on migration in response to new taxes is less developed than the literature on tax avoidance, there is evidence to suggest that wealthy and high-skilled individuals **may** move in response to state taxes. Because the costs of funding the NYHA would fall disproportionately on a very small subset of high-income tax filers, even a small tax migration or avoidance effect could influence the state's ability to finance the program."

[31] Drawing on the "tax returns for all million-dollar income-earners in the United States over 13 years, tracking the states from which millionaires file their taxes. Our dataset contains 45 million tax records… The most striking finding of this research

Impact of new taxes vs. healthcare cost savings

RAND analyzed the impact to different household income levels of shifting healthcare expenses from premiums and out-of-pocket expenses to the new NYH taxes. As noted earlier, the share of households who will pay more or less is dependent on the design of the tax schedule. Using a tax schedule in which the lowest bracket of taxpayers (federal poverty level of 139% and below) is exempt from NYH tax, RAND estimated that 73% of people would pay less and about 7% would pay the same.[32] (see "RAND Figure B.6." Below)

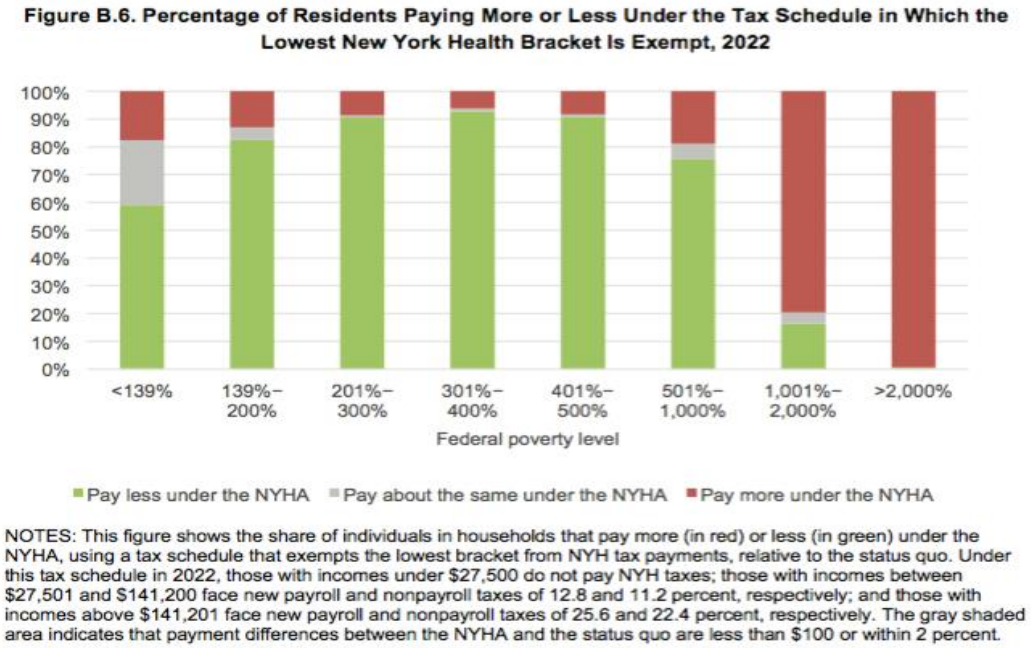

Figure 9: "RAND Figure B.6.": Percentage of Residents Paying More or Less Under the Tax Schedule in Which the Lowest NY Health Bracket is Exempt, 2022, Source Liu

is how little elites seem willing to move to exploit tax advantages across state lines in the United States…. Our core migration estimate…suggests that the revenue-maximizing top marginal tax rate on income above $1 million is much higher than the current tax rate in any state…The fact that it is the poor who…most often change their state of residence—should give pause to our understandings of migration." 2016 https://web.stanford.edu/~cy10/public/Jun16ASRFeature.pdf Also consider: "Recent research shows income tax increases cause little or no interstate migration. Perhaps the most carefully designed study to date on this issue concerned the potential migration impact of New Jersey's 2004 tax increase on filers with incomes exceeding $500,000 …At most, the authors estimated, 70 tax filers earning more than $500,000 might have left New Jersey between 2004 and 2007 because of the tax increase, costing the state an estimated $16.4 million in tax revenue. The revenue gain from the tax increase over those years was an estimated $3.77 billion, meaning that out-migration — if there was any at all — reduced the estimated revenue gain from the tax increase by a mere 0.4 percent."Tax Flight Is a Myth: Higher Taxes Bring More Revenue, Not More Migration," Center on Budget and Policy Priorities, 2011, https://www.cbpp.org/research/state-budget-and-tax/tax-flight-is-a-myth

[32] Liu, p. 91 Figure B.6

Pro/Con Considerations

The statements in this document are a reflection of specific issues and concerns discussed at length by the committee members. Many repeat explanations are laid out in the texts and footnotes of these study documents and in the Appendices. Financial and economic issues reflect analyses summarized in "Summary of the NY Health Act" and "NY Health vs Status Quo." Readers may also want to Google specific questions, noting the URLs of search results to give priority to .gov, .edu,, and peer-reviewed journals, although useful arguments can be found in many mainstream articles and editorials.

PUBLIC HEALTH

Arguments/Reasons to FAVOR NYH as benefiting public health

1. Affordable access to essential care and the elimination of networks will encourage "continuity of care" for patients as they find family/primary care physicians and see them on an on-going basis.[33]
2. "Continuity of care" and reimbursement for time spent on patient education will increase attention to prevention and wellness, along with better management of chronic illnesses. [34]
3. Affordable access, with elimination of administrative barriers to reimbursement for patients and providers, will increase supply of services that have not been considered "profitable" because they require investments over time to achieve significant results, e.g., behavioral health, maternal/infant and child care and public health crisis preparedness.[35]
4. Unified databases through the NYH payment system will make disease outbreaks/epidemics and trending healthcare needs more visible, and allow potentially faster, more consistent tracking of medication/equipment inventory levels, with potentially faster response and better treatment.[36]

Arguments/Reasons to DISFAVOR NYH as harming public health

1. Effective patient education will require additional training for some providers.[37]
2. Current shortages of primary care and behavioral health providers will become more acute as affordable access increases demand, particularly in rural areas and healthcare deserts.[38]
3. Current healthcare disparities by race, gender, income, etc., will remain because the "social determinants of health"[39] are not solved by healthcare.[40]

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[33] See "Summary of the NY Health Act": elimination of networks means NYers will not have to change providers when changing employers or when employers change plans (about 25%/year) according to Arno Testimony 28May2019 https://www.researchgate.net/publication/334279915_Statement_of_Peter_S_Arno_before_the_New_York_State_Joint_Legislative_Hearing_Universal_Single-Payer_Health_Coverage, and "How NY Health will affect current Provider Shortages": physician perception that continuity of care improves quality and reduces cost because physicians know their patients and their history from regular visits over years.

[34] See "Summary" & "Pro/Con on Cost-Sharing."

[35] See "Summary" and "the uniquely American plethora of private insurance companies drives a squandering of resources"… "Profound administrative excesses divert resources into activities that do not improve health outcomes. They often represent the entire careers of countless highly skilled and compassionate people who could be spending their time delivering health care rather than impeding it." https://journalofethics.ama-assn.org/article/single-payer-system-would-reduce-us-health-care-costs/2012-11

[36] Taiwan's use of its National Health Insurance (NHI) database to respond to the COVID-19 pandemic exemplifies the power of a centralized data when combined with compassion to ensure trust and compliance — improving on its problematic 2003 response to SARS: https://jamanetwork.com/journals/jama/fullarticle/2762689

[37] See "How NY Health with affect current Provider Shortages": Misplaced residency incentives and reimbursement discussed here: "Study: Primary care doctors increase life expectancy," Forbes, Apr 2019 https://www.forbes.com/sites/robertpearl/2019/04/08/primary-care-does-anyone-care/#1c4fb887695f The growing public health crisis around shortage of primary care doctors, especially in rural areas, requires "substantive changes in physician payment policy" and reduced administrative burden, in "Primary care doctors extend life but US needs more of them, data show" in American Journal of Managed Care, Feb'19, https://www.ajmc.com/focus-of-the-week/primary-care-doctors-extend-life-but-us-needs-more-of-them-data-show

[38] See "Provider Shortages": Interactive U.S. govt map showing Primary Care Health Professional Shortage Areas (HPSA) across upstate NYS and within NYC: https://data.hrsa.gov/maps/quick-maps?config=mapconfig/HPSAPC.json

[39] "The answer to America's health care cost problem might be in Maryland," on using global budgeting to address social determinants of health as a healthcare serviceVox *1/22/20,* https://www.vox.com/policy-and-politics/2020/1/22/21055118/maryland-health-care-global-hospital-budget

[40] Brian Gormley, WSJ, 9/16/18 https://www.wsj.com/articles/health-care-looks-beyond-medicine-to-social-factors-1537070520 "The U.S. health-care system is geared toward medical treatments, yet an analysis of the external forces that

4. Disparities and inequities in healthcare could become more visible with better tracking/data analysis,[41] perhaps causing increased distrust of the healthcare system among populations with an historical basis for distrust.[42]

NYS PHYSICIANS & THERAPISTS

Arguments/Reasons to FAVOR NYH as benefiting physicians & therapists

1. Provider income will no longer be tied to patients' income.[43]
2. Non-clinical employees of for-profit insurers will be removed from decisions about "medical necessity," "prior approvals," and "standard of care," decisions that should be made between licensed health professional and patient, along with patient's family.[44]
3. Reimbursing providers at fair rates, fully and promptly,[45] and eliminating commercial provider networks will allow economically viable solo and small-group healthcare practices, for example, in underserved areas.[46]
4. A significant portion of office expenses (25%)[47] BIR administrative costs will be reduced.[48]
5. Reducing administrative tasks will provide physicians and therapists more hours per week for patients.[49]
6. The reimbursement of primary care vs specialty care will be better aligned with public health needs.[50]
7. Unpaid annual receivables to providers, a function of iterative BIR complexity, will be eliminated.[51]

Arguments/Reasons to DISFAVOR NYH as harming physicians & therapists:

1. Some specialists will have reduced income.[52]
2. AMCs and teaching hospitals will have less excess revenue (the non-profit equivalent of profits).
3. Some providers who own laboratories may lose income with the elimination of closed networks and the introduction of standardized reimbursement rates.
4. "Concierge" providers will need to choose between accepting NY Health reimbursement for NYS patients or cash payments from NYS patients (e.g., fee-for-service or membership). Those with out-of-state or foreign clientele may continue charging them cash or accepting out-of-state insurance.

HOSPITALS

Arguments/Reasons to FAVOR NYH as benefiting hospitals:

1. There will be a significant (20%)[53] drop in administrative costs, allowing hospital budgets to cover more healthcare services.

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contribute to a population's health found that clinical care accounts for just 20% … Social and economic forces such as income, education and community safety exert a much greater influence, at 40%..."

[41] "Reducing Racial Disparities in Health Care by Confronting Racism," Commonwealth Fund, 9/27/18 https://www.commonwealthfund.org/publications/newsletter-article/2018/sep/focus-reducing-racial-disparities-health-care-confronting failing to "consider the particular factors that may lead to worse outcomes for blacks, Hispanics, or other patients of color, may not lead to equal gains across groups — and in some cases may exacerbate racial health disparities."

[42] Regarding Black Men: "Race and Medicine: the harm that comes from mistrust," NYT 1/13/20 https://www.nytimes.com/2020/01/13/upshot/race-and-medicine-the-harm-that-comes-from-mistrust.html Regarding Black Women: "Black Women at Higher Risk for Major Diseases" WE News 2/25/05 https://womensenews.org/2005/02/black-women-at-higher-risk-major-diseases/

[43] See "Provider Shortages."

[44] Ibid.

[45] Ibid., and https://www.micromd.com/enotes/costs-of-carrying-receivables/

[46] Ibid.

[47] *American Progress* https://www.americanprogress.org/issues/healthcare/reports/2019/04/08/468302/excess-administrative-costs-burden-u-s-health-care-system/

[48] Ibid., *American Progress.*

[49] Ibid., MDs spend 2 hrs on EHR for every hour of clinical time. Sinsky, et al., "Allocation of Physician Time in Ambulatory Practice" Ann Intern Med, 9/6/2016 https://annals.org/aim/article-abstract/2546704/allocation-physician-time- ambulatory-practice-time-motion-study-4-specialties

[50] See "Provider Shortages."

[51] See "Provider Shortages.", Ibid, *American Progress*

[52] See "Provider Shortages."

[53] See "Provider Shortages,",and Ibid., *American Progress.*

2. Reduced administrative burden will allow hospital clinical staff to have more time to serve patients.[54]
3. Affordable access for essential care will reduce use of the ER for primary care, reducing hospital costs.[55]
4. Capital budgets will be separated from healthcare service budgets with investment based on patient and community need rather than patient income and volume of uninsured/underinsured care provided.[56]
5. Rural hospitals and those in health deserts will receive sufficient funds to provide needed healthcare services and needed capital expenditures.
6. AMCs will be ensured enough funds for healthcare services and teaching.
7. Regional councils will have responsibility for ensuring local community health.
8. *De facto* segregation by race/income will be reduced. [57]
9. In crises, such as experienced during COVID-19, NYS hospitals would be able to fund staff salaries and benefit from a NYS database of patients to track cases, to bulk purchase sufficient personal protective and durable medical equipment (PPE & DME), and to collaborate/coordinate inventories across NYS.

Argument/Reasons to DISFAVOR NYH as harming hospitals:

1. Based on the history of healthcare reforms (US-Medicare, ACA, Canadian & Taiwanese healthcare), the switch to SP may increase patient utilization by 10%.[58]
2. NYC public hospitals and rural hospitals currently operate at razor-thin financial margins. Should NY Health reimbursement be set at Medicaid levels, it could put some at risk for bankruptcy.[59]
3. Global budgeting at the institutional level has little history in the US, and its success may depend on resolving evolving challenges such as broader definitions of a hospital's role in community health.[60]
4. The COVID-19 pandemic has caused NYC AMCs to lose an estimated $350-450M per month each from patient surge and loss of elective healthcare; smaller hospital systems could face difficulty making payroll.[61]

NYS ECONOMY

Arguments/Reasons to FAVOR NYH as benefiting the NYS economy

1. RAND estimates NYH will create 180K new jobs and unlock entrepreneurialism by eliminating job-lock for both the new entrepreneur and those they seek to recruit.[62]
2. Economic stimulus: workers and businesses who spend less on healthcare may spend more on NYS goods and services.[63]

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[54] Ibid., Sinsky above.

[55] "Younger generations like millennials and Gen Z were even more likely (71% and 69%, respectively)" to use ER for primary care despite care in the ER being "up to 12 times more expensive than at a doctor's office, contributing $32 billion of wasted spending on hospital care that could have been delivered in a lower-cost primary care setting." "Younger Americans Use ERs as Their Primary Care Provider," *Managed Healthcare Executive*, 9/13/19. https://www.managedhealthcareexecutive.com/article/younger-americans-use-ers-their-primary-care-provider

[56] See "Summary."

[57] With patient income/insurance status no longer determining provider, minority patients can choose their providers.

[58] See "Provider Shortages" for additional context, including "Projected costs of single-payer healthcare financing in the U.S: A systematic review of economic analyses" in PLoS Med. 2020 Jan https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6961869/#pmed.1003013.ref035

[59] Per Jim Clancy, SVP, NYS Hospital Association: "The median margin for hospitals in New York State is just over 1 percent" and "Medicaid already reimburses hospitals only 73 or 74 cents for every dollar they spend to provide care," 3/10/19 Utica OD, https://www.uticaod.com/news/20190310/hospitals-warn-against-cuomos-proposed-medicaid-cuts

[60] Ibid., *Vox 1/22/20:* "By limiting how much revenue hospitals can bring in, it pushes hospitals to look at sickness as something to be treated not just within their walls, but within their community: making sure a heart disease patient has access to healthy food..."

[61] "New York's Hospital Systems Each Losing Up to $450 Million a Month Battling Coronavirus," *WSJ 4/12/20, https://www.wsj.com/articles/new-yorks-hospital-systems-each-losing-up-to-450-million-a-month-battling-coronavirus-11586703601?mod=searchresults&page=1&pos=1* and "During a Pandemic: Out-of-Work Health Workers," NYT, 4/3/20, *https://www.nytimes.com/2020/04/03/us/politics/coronavirus-health-care-workers-layoffs.html*

[62] NYHA is projected to "increase in overall employment by nearly 2 percent relative to the status quo," RAND p.53.

[63] "As the NYHA increases the progressivity of health care payments across income groups, disposable income is redistributed from higher- to lower-income households. Generally, lower-income households spend a larger share of additional income, which translates to increased consumption and, in turn, increased employment," RAND p.53

3. Could prevent bankruptcy/financial ruin from medical debt.[64]

Arguments/Reasons to DISFAVOR NYH as harming the NYS economy

1. Savings in BIR administration means loss of 150K jobs (insurer call centers and provider BIR) [65] (out of 8M NYS jobs, with average 150K job churn/month)[66]
2. Current guarantees in the bill —job training, two-years of extended unemployment, priority hiring for new jobs created by NYHA — may not be enough to ensure a "just transition."

NYS BUSINESS

Arguments/Reasons to FAVOR NYH as benefiting NYS business

1. Healthier, more productive workforce: timely access to healthcare reduces absenteeism and healthcare /worker compensation claims, over the long-term and short-term[67]
2. Cost of administering health benefits: eliminated; lower healthcare costs will be more stable to forecast[68]

Arguments/Reasons to DISFAVOR NYH as harming the NYS business

1. Some larger and corporate employers may no longer enjoy a recruiting and retention benefit.[69]
2. Under a publicly-funded plan, it will be more difficult to shift the cost of healthcare onto employees.[70]
3. For employers who don't now provide healthcare insurance the new healthcare tax expense could cause hardship.

UNIONS

Arguments/Reasons to FAVOR NYH for benefiting unions

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[64] "The impact of the NYHA on reducing poverty… According to national Census data, in 2018 medical out-of-pocket (OOP) expenses accounted for 8 million out 41.2 million people living in poverty or 19.3%. Applying this percentage to the number of people living in poverty in New York (2.73 million), amounts to 527,000 persons who would be lifted out of poverty by eliminating OOP expenditures under the New York Health Act," per Peter Arno, PhD, health economist, Senior Fellow and Director of Health Policy Research, Political Economy Research Institute. Testimony under oath 10/23/19 before NYS Senate Health Com, https://www.nysenate.gov/sites/default/files/political economy_research_institute_university_of_massachussetts_amherst_peter_arno.pdf See also US Census 2018: Figure 8: https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-268.pdf

[65] Friedman, p. 3, p.24 "This is an upper-bound estimate because many of these work for out-of-state insurers and will not be displaced, " and "Note that this suggests that there are six health-care provider employees dealing with insurance billing for every worker in the insurance industry."

[66] NYS Bureau of Labor.

[67] Milbank Quarterly, March 2003: employers who offer health insurance see improvement "on firms' productivity and profitability"; see also "A 2010 study published in the journal *Health Affairs* found that disease prevention and wellness programs led to a drop in medical costs of about $3.27 for every dollar spent on wellness programs and that absenteeism costs fell by about $2.73 for every dollar spent." https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/claims-data-disease-management.aspx "cancer and coronary heart disease were consistently among the top five conditions driving overall benefit costs, but the chronic health conditions that were most important in driving costs related to lost productivity were depression, obesity, arthritis, back/neck pain and anxiety. Addressing health risks through workplace interventions can reduce, or at least slow, rising costs that result from preventable health risks."

[68] "Businesses will benefit on average, with the greatest savings going to those that have been paying the highest health insurance premiums. These include small and mid-sized private establishments that offer health insurance at relatively high cost." Ibid, Friedman, p.5. About 30% of small businesses (under 25 workers) do not offer healthcare, but these are most frequently businesses with low-paid and part-time workers who may be exempt from NYHA taxes. Consider the workers described in this article; their low-pay would exempt them and their employers from NYHA taxes: NYTimes, "Many Low-Income Workers Say 'No' to Health Insurance," https://www.nytimes.com/2015/10/20/business/many-low-income-workers-say-no-to-health-insurance.html

[69] "For job seekers, the strength of an employer's benefits package may be nearly as valuable as salary. In fact, for a potential employee who has one or more dependents, benefits may be even more important than salary. Therefore, employers that want to hire the best, most productive employees must be prepared to pay the price in attractive, competitive health care benefits." Ibid. SHRM 2017

[70] "A major trend in managing employers' health care costs is having plan participants take on increasingly larger portions of the costs of their health care. Methods of doing this include raising the deductibles and co-payments for medical services, having participants pay larger shares of premiums, and increasing the costs of using out-of-network health providers rather than in-network providers." "Similar to the reduction in traditional pension plans, a decline in retiree health benefits has taken place over the past decade, mainly to cut costs. Only 20 percent of employers continue to offer a retiree health plan, according to the 2016 SHRM Employee Benefits Survey. Ibid. SHRM 2017.

1. NYS AFL-CIO (2.5M members), NYSUT (United Teachers, 600K members) 1199 SEIU (HC workers of Service Employees Intl, 325K NYS members), NYSNA (NYS Nurses, 37K members) and 40 other unions endorse NYHA to ensure better healthcare benefits than they have now, to take healthcare off the bargaining table to focus on wages and working conditions, to use Health & Welfare funds for welfare, and to have union-run health centers paid by NYHA, not Health & Welfare funds.[71]
2. Some union members say that rank-and-file support NYHA despite direction from leaders (who have a conflict around protecting union healthcare infrastructure & leadership benefits).
3. Public employees who are criticized for benefits more generous than those in private sector, paid by taxes, would no longer be targeted for healthcare benefits better than most in the private sector.

Arguments/Reasons to DISFAVOR NYH for harming unions

1. CSEA (Civil Service Employees, 300K NYS members) has supported SP on a national, not state basis, but expresses concerns about losing the quality and access to HC they now have and have sacrificed for (giving up wages, vacation, working conditions).
2. Some union leaders express concerns about losing a recruiting inducement, and about out-of-state members who work in the state being unable to access NYH benefits (reducing CT/NJ HC funds)
3. Some large unions run their own health plans; those running union benefit funds could lose their jobs. If NYH offers a "just transition" to those displaced by NYH (beyond retraining and unemployment pay), will it embolden workers who may be displaced in the future?

TAXPAYERS

Arguments/Reasons to FAVOR NYH for benefiting taxpayers

The basic argument: NYH will cost the state less than it currently pays for healthcare, while providing better coverage to every NY resident than any current public or private plan. Further, NYH will have progressive, not regressive, funding, i.e., today the total cost for single or family coverage is about the same for a secretary and the CEO[72] while under NYH, high-earning CEOs will pay more and median-earning secretaries will pay less.[73] New Yorkers will also have the security of knowing that workers who serve them (kitchen and table staff, ride-share drivers, retail clerks and back-office staff) will have full access to healthcare, including early diagnoses and timely treatment.

NOTE: Although the NYHA is an authorization bill, drafted to create and lay out the objectives and scope of the NYH program and how appropriations for its funding will be determined and approved, the specific funding sources, tax brackets, exclusions, and implementation will be voted on separately in an appropriations process. That said, third-party, professional, non-partisan health economists have projected the total cost of NYH will be less than current state spending on healthcare, and the tax burden on individuals is estimated to be less than current healthcare costs (premiums, cost-sharing, and OOP) for many New Yorkers. Whether the tax payer pays less or more is dependent on their income tax bracket. These economists have made assumptions about specific funding sources, income brackets, and tax rates.

Other benefits associated with equitable and affordable access, include

1. NYH covers all healthcare costs with no cost-sharing by taxpayers, ensuring universally affordable access
2. NYH separates healthcare coverage from employment status so losing/changing jobs doesn't end HC insurance

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[71] https://www.nyhcampaign.org/endorsers

[72] Emmanuel Saez and Gabriel Zucman "Make no mistake: Medicare for All would cut taxes for most Americans" Oct 2019, The Guardian. https://www.theguardian.com/commentisfree/2019/oct/25/medicare-for-all-taxes-saez-zucman "insurance premiums paid by employers are just like taxes … they reduce your wage. … they are mandatory [per ACA] … Many people believe that the United States has a progressive tax system: you pay more, as a fraction of your income, as you earn more. In fact, if you allocate the total official tax take of the United States across the population, the US tax system looks like a giant flat tax that becomes regressive at the very top. … Once private health insurance is factored in, the average tax rate rises from a bit less than 30% at the bottom of the income distribution to reach close to 40% for the middle class, before collapsing to 23% for billionaires."

[73] RAND: "Analysis using one possible progressive tax rate schedule found that:
…The top 5th percentile of New Yorkers by household compensation—a heterogeneous group whose compensation will average about $1,255,700 in 2022— would pay an average of $50,200 more per person."

3. NYH makes the expense of covering healthcare costs more progressive, increasing with income not severity/complexity of medical needs
4. Total NYH taxes will increase the state budget (currently $90 B) by about $160 B (which will include approximately $10B now paid into County property taxes); these taxes will replace the $170 B New Yorkers currently spend on healthcare premiums, cost-sharing, and out-of-pocket expenditures.[74]
5. Funds generated by NYH taxes will be dedicated, segregated funds (not mingled with the general funds), and controlled by NYH Trust, just as Medicare is controlled by CMS.
6. Fiscal conservatism: currently wasted healthcare dollars[75] could be better used on healthcare[76]

Arguments/Reasons to DISFAVOR NYH for harming taxpayers

The key arguments: NYH will be paid by progressive taxes — so that high-income New Yorkers will pay more than they pay now for healthcare (some will pay much more, depending on the magnitude of their income)[77] — because NYH will need to replace the 31% of healthcare spending currently paid for by private insurance, and the 11% for OOP.

1. State taxes will increase: It is estimated NYH will increase the state budget from its current $90 B (for FY2022) by about $160 B.[78]
2. NYH taxes for some New Yorkers are forecast to exceed their current healthcare costs; those with higher incomes will pay progressively more in healthcare taxes.
3. NYH sponsors have not yet resolved tax (and healthcare coverage) issues for NY employers of out-of-state employees and out-of-state employers of state residents.
4. Increasing state taxes may cause some wealthy New Yorkers to change residence, reducing the NYS tax base.[79]

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[74] Ibid., Rand: "After redirection of federal and state health care outlays to NYH, the additional state tax revenue needed to finance the program would be $139 billion in 2022, a 156-percent increase over total state tax revenue under the status quo."

[75] See 2020 article finding "health care bureaucracy cost Americans $812 billion in 2017, more than one-third (34.2%) of total expenditures for doctor visits, hospitals, long-term care, and health insurance - the expenditure categories for which we had administrative cost data. A single-payer system would have saved the U.S. more than $600 billion in administrative expenditures in 2017 alone." https://annals.org/aim/article-abstract/2758511/health-care-administrative- costs-united-states-canada-2017?eType=EmailBlastContent&eId=3421f919-21f0-45b8-bfce-1c661152bc1d

[76] "[T]he uniquely American plethora of private insurance companies drives a squandering of resources"…"Profound administrative excesses divert resources into activities that do not improve health outcomes. They often represent the entire careers of countless highly skilled and compassionate people who could be spending their time delivering health care rather than impeding it." https://journalofethics.ama-assn.org/article/single-payer-system-would-reduce-us-health-care-costs/2012-11

[77] "For the first time in the past hundred years, the working class — the 50 percent of Americans with the lowest incomes — today pays higher tax rates than billionaires. … Taking into account all taxes paid, each group contributes between 25 percent and 30 percent of its income to the community's needs. The only exception is the billionaires, who pay a tax rate of 23 percent, less than every other group. The tax system in the United States has become a giant flat tax — except at the top, where it's regressive …With tax rates of barely 23 percent at the top of the pyramid, wealth will keep accumulating with hardly any barrier." Emmanuel Saez and Gabriel Zucma, NYTimes, https://nyti.ms/2M7DK6C

[78] See "NYHealth vs Status Quo."

[79] 2016: Drawing on the "tax returns for all million-dollar income-earners in the United States over 13 years, tracking the states from which millionaires file their taxes. Our dataset contains 45 million tax records… The most striking finding of this research is how little elites seem willing to move to exploit tax advantages across state lines in the United States…. Our core migration estimate…suggests that the revenue-maximizing top marginal tax rate on income above $1 million is much higher than the current tax rate in any state…The fact that it is the poor who…most often change their state of residence—should give pause to our understandings of migration." https://web.stanford.edu/~cy10/public/Jun16ASRFeature.pdf

Also consider: "Recent research shows income tax increases cause little or no interstate migration. Perhaps the most carefully designed study to date on this issue concerned the potential migration impact of New Jersey's 2004 tax increase on filers with incomes exceeding $500,000 …At most, the authors estimated, 70 tax filers earning more than $500,000 might have left New Jersey between 2004 and 2007 because of the tax increase, costing the state an estimated $16.4 million in tax revenue. The revenue gain from the tax increase over those years was an estimated $3.77 billion, meaning that out-migration — if there was any at all — reduced the estimated revenue gain from the tax increase by a mere 0.4 percent."Tax Flight Is a Myth: Higher Taxes Bring More Revenue, Not More Migration," Center on Budget and Policy Priorities, 2011, https://www.cbpp.org/research/state-budget-and-tax/tax-flight-is-a-myth

Compare RAND's comment, about high-income households, "people could avoid taxes by moving or switching their primary residence to another state. While the literature on migration in response to new taxes is less developed than the

5. Generous NYH benefits may cause migration into NYS from other states.[80]
6. The NYHA does not list tax brackets or lay out how much money will be needed, and it's wrong to ask legislators to support a bill with so few funding specifics written into the bill.

QUALITY OF HEALTHCARE

Arguments/Reasons to FAVOR NYH that concern quality of care

1. Under NYH, everyone will be under the same system, the secretary and the CEO, the car-share driver and the Governor, so if there are problems, the CEO and Governor's self-interest will fix them. It won't be the multi-tiered system we have today, where some have "good plans" and most others don't.
2. Today, most knee and hip replacements are done on seniors, and there are no long delays under single-payer Medicare, while young people with private insurance wait[81] an average of 24 days for primary care visit[82] and the poor can wait longer.[83]
3. Like Medicare, NYH will be more efficient and more convenient for patients and providers than for-profit insurance; NYH is a funding system, not a healthcare delivery system, so it will not be government-run healthcare.
4. Like original Medicare, NYHA will give full choice of physicians, therapists, hospitals, etc. (no networks). By law, it will not limit which providers one can go to for care and will not dictate medical decisions.

Arguments/Reasons to DISFAVOR NYH that concern quality of care

1. Government-run anything is less efficient than privately-run anything, including healthcare.
2. When everyone has "the same" healthcare, my healthcare will be worse.[84]
3. There will be long waiting lines and quality will decrease.[85]
4. NYH will not allow choice of insurer or choice of plan for services covered by NYH.[86]

SINGLE PAYER IN VERMONT & COLORADO

Arguments/Reasons to FAVOR NYH relative to the history of single payer in VT & CO

1. Vermont's 2011 Act 48 was multi-payer reform. SP was not in the bill: it had no administrative savings and no drug price reduction.[87] It wasn't universal (omitted big employers) or comprehensive, and funding was a regressive flat tax, not offering affordable access.[88] It was a legislative & PR failure, not SP failure.

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literature on tax avoidance, there is evidence to suggest that wealthy and high-skilled individuals may move in response to state taxes. Because the costs of funding the NYHA would fall disproportionately on a very small subset of high-income tax filers, even a small tax migration or avoidance effect could influence the state's ability to finance the program."

[80] "[T]here is slim evidence to suggest that such in-migration would be common. Goodman (2016) found no evidence that states that expanded their Medicaid programs in 2014 had higher rates of in-migration than states that did not expand. Similarly, Schwartz and Sommers (2014)...[however, if] long-term care is provided as part of the NYH plan, seniors might move to New York to get free long-term care without spending down their assets." RAND 2019, p.60

[81] "Long wait times for non-urgent procedures in some countries, e.g. hip replacements in Canada, are often cited by opponents of single-payer reform as an inevitable consequence of universal, publicly financed health systems. They are not. Wait times are a function of a health system's capacity and its ability to monitor and manage patient flow. In recent years Canada has shortened wait times for non-urgent procedures by using better queuing techniques. In the case of urgent care, wait times have never been an issue [in Canada]." https://pnhp.org/what-is-single-payer/faqs/#wont-single-payer-result-in-rationing-and-long-waiting-lines

[82] An "average 24-day wait time to see a primary care physician in the U.S," Ibid., *Managed Healthcare Executive*.

[83] "[T]here can be no disguising either the human misery directly related to the lack of adequate healthcare or the "long-standing, systematic, institutionalized racial discrimination" ... It is difficult to comprehend, for example, why a poor pregnant woman in Chicago should need to wait 125 days for a consultation with a doctor at a public clinic." 1991 JAMA https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1669885/pdf/bmj00126-0007.pdf

[84] See "Summary of NY Health."

[85] See " with a decrease in billing-related administrative burden for clinicians, a 10% or greater rise in physician clinical capacity may occur, which would accommodate additional care utilization." in "Projected costs of single-payer healthcare financing in the U.S: A systematic review of economic analyses" in PLoS Med. 2020 Jan https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6961869/#pmed.1003013.ref035

[86] See "Summary of NY Health."

[87] Vermont health bill mislabeled 'single payer,'" PNHP, 4/7/2011. https://pnhp.org/news/vermont-health-bill-mislabeled-single-payer-doctors-group/

[88] Woolhandler, Himmelstein, "What happened in Vermont," 1/10/15. https://pnhp.org/news/what-happened-in-vermont-implications-of-the-pullback-from-single-payer/

2. Colorado's Amendment 69 offered comprehensive SP HC financing reform. It was opposed by NARAL, Planned Parenthood, unions, etc., because it didn't address the CO constitutional ban on abortions (arguably enshrining the ban). It put abortion on the ballot, not SP.[89]

Arguments/Reasons to DISFAVOR NYH relative to the history of single payer in VT & CO

1. Vermont passed a SP bill in 2011, but same Governor vetoed the funding plan for it in 2014 — proving SP financing impractical and unaffordable, even in a state willing to pass SP.
2. Colorado held a ballot referendum on SP in 2016 that failed 4:1, demonstrating a popular failure of SP at the voting booth.[90]

[89] "Planned Parenthood Statement of Amendment 69," 9/12/16. https://www.plannedparenthood.org/planned-parenthood-rocky-mountains/newsroom/planned-parenthood-statement-of-amendment-69

[90] "Single-payer health care failed miserably in Colorado last year. Here's why," Sept 2017. https://www.vox.com/policy-and-politics/2017/9/14/16296132/colorado-single-payer-ballot-initiative-failure

Proposed Positions with Footnotes Explaining Changes

Healthcare (2021) [Underlining indicates new wording]

GOALS

The League of Women Voters of New York State (LWVNYS) believes that everyone should have access to essential physical and behavioral healthcare. New York State has a proper role in the regulation of healthcare and must assure high quality care that is affordable and accessible to all.[91]

Resources should be devoted to health promotion and disease prevention so that people can take active responsibility for their own health. People should have opportunities to participate effectively in decisions regarding their personal health and in healthcare policy decisions. [92]

The League believes that New York State's primary role in healthcare is to assure that quality care is available to all New Yorkers. We believe that the state should provide planning and regulations to assure everyone, including the medically indigent, access to an essential level of quality physical and behavioral healthcare. Cost containment should be an important criterion in developing regulations. Such regulation, however, should not compromise the quality of care or its accessibility.

The League supports regulatory incentives to encourage the development of cost-effective alternative ways of delivering and paying for healthcare, appropriate to all areas of NYS, with coordination across regulatory bodies to avoid undue delays and contradictory, duplicative regulations. Delivery programs may take place in a variety of settings, including the home and online, and must provide quality care, meaning consistent with "standard of care" guidelines, by trained and licensed personnel, staffed adequately to ensure their own and patient safety.[93]

Coordination of services is essential to assure that community needs are met. As public health crises increasingly reveal, NYS should protect the health of its most vulnerable populations, urban and rural,[94] in order to protect the health of everyone. In addition, all programs should be evaluated regularly. Provider reimbursement should include incentives for efficiency and for disease prevention and health promotion activities. Public health, environmental health and research activities should be continued.

Decisions on medical procedures that would prolong life should be made jointly by patient, family, and physician. Patient decisions, including those made prior to need, should be respected.

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[91] In both the Healthcare Position and the Financing Healthcare Position we have substituted *essential* for *basic*, which is newer terminology and reflects current practice.

[92] Similarly, throughout both documents we have substituted *patients* or *people* for *consumers*, reflecting research that medical care does not function like a marketplace.

[93] The new statement about *coordination across regulatory bodies* embodies ideas only implied in the original position. The new statement defining *quality care* reflects LWV NY's work on safe staffing.

[94] Covid-19 hits rural residents harder: "Rural areas tend to have older populations than the national average, with more chronic health conditions that raise the risk of developing more severe cases of COVID-19. They have fewer health care providers and more uninsured residents, meaning residents often wait longer before seeking medical help," June 2020. https://medicalxpress.com/news/2020-06-rural-america-vulnerable-covid-cities.html
Covid-19 kills Blacks, Latinx, Indigenous at triple the rate of whites: "non-Hispanic black persons, Hispanics and Latinos, and American Indians/Alaska Natives…[have] rates of hospitalization or death from COVID-19 [three to five times that of] non-Hispanic white persons," while Indigenous Americans have an age-adjusted hospitalization rate for Covid-19 of 5.6 times that of non-Hispanic White Americans, CDC 6/12/20, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html.
"Universal health care is a national security issue," March 2020, "Covid-19 is exposing the dangerously high costs of our incomplete safety net. When people lack adequate health insurance, they don't go to the doctor unless and until they are very ill… rationing access to critical health care resources on the basis of ability to pay is not just unjust, but also bad for public health." https://www.justsecurity.org/69130/universal-health-care-is-a-national-security-issue/
"The root cause of health insecurity [is] the lack of access of the most vulnerable people to essential health services … Ultimately, it's the absence of universal health coverage that is the greatest threat to health security… prevention is not prevention is not only better than cure: it's cheaper," Forward to *WHO 2018 Playbook on Managing Epidemics*. https://www.who.int/emergencies/diseases/managing-epidemics/en/

ESSENTIAL LEVEL OF QUALITY CARE

The League supports uniform eligibility and coverage of essential healthcare services, both physical and behavioral,[95] ideally, including coverage of services such as vision, dental, hearing, and long-term care, through public financing.[96] Access to optional insurance coverage for care not covered by public financing should be available. The League has a strong commitment to an emphasis on preventive care, health education, and appropriate use of primary care services.

# # #

[95] We use "behavioral health" to mean "the promotion of mental health, resilience and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities. The impact of untreated behavioral health conditions on individuals' lives and the cost of health care delivery in the United States is staggering. Persons with any mental illness are more likely to have chronic conditions such as high blood pressure, asthma, diabetes, heart disease and stroke than those without mental illness. And, those individuals are more likely to use hospitalization and emergency room treatment," per HHS sub-agency Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/sites/default/files/samhsa-behavioral-health-integration.pdf

[96] 1991 impact called these out as "lower priority" for adults but "essential for children." Today "Essential" under Medicaid requires these for children. Medicare does not cover them, failing seniors. Our new language, still separates them as "preferably" (rather than "supports") to align with the older position, but "ideally" appreciates that seniors live longer, healthier lives when they can eat food, hear conversations, see well enough to navigate safely, like younger Americans. Long-term care is driven by the disabilities community, which seeks to allow members to remain productive — both House and Senate M4A bills include LTC provisions.

HEARING, DENTAL, VISION: "Among Medicare beneficiaries, 75 percent of people who needed a hearing aid did not have one; 70 percent of people who had trouble eating because of their teeth did not go to the dentist in the past year; and 43 percent of people who had trouble seeing did not have an eye exam in the past year. Lack of access was particularly acute for poor beneficiaries." https://www.commonwealthfund.org/publications/issue-briefs/2018/jan/how-medicare-could-provide-dental-vision-and-hearing-care

DENTISTRY: "Older adults are even more affected by poor oral health than their younger counterparts. Very often, seniors have multiple chronic diseases for which they are prescribed a number of medications. Side effects such as dry mouth, inflammation, infections, and mouth sores put them at severe risk for consequences to their oral health, their whole-body health, and quality of life." And "significant link between oral health and systemic diseases such as diabetes, heart disease, reflux, and respiratory infections—and now researchers are even talking about Alzheimer's disease." https://now.tufts.edu/articles/most-seniors-oral-health-goes-uncovered

HEARING: "hearing loss affects one-third of adults over the age of 65 and has a significant impact on health. Those experiencing it are at increased risk for depression, loneliness, and dementia, and may become socially isolated. Hearing loss also affects physical health, putting individuals at higher risk for falls and disability and possibly causing functional limitations such as reduced mobility or balance." https://www.statnews.com/2019/02/27/hearing-aids-medicare-coverage/

VISION "Improved sight, in turn, reduces physical injury and the onset of disabilities." https://money.com/retirement-living-longer-better/

JAYAPAL BILL: " dental and vision services, and long-term care." https://www.congress.gov/bill/116th-congress/house-bill/1384 AND

SANDERS BILL: "(9) Oral health, audiology, and vision services….(13) Home and community-based long-term services. https://www.congress.gov/bill/116th-congress/senate-bill/1129/text - toc-id25c91cb96228483495ad9de0b47b79f8

LONGTERM CARE: "If you don't include long-term supports and services, it cannot be considered a bill that is for all people because it leaves out huge portions of the population, including people with disabilities and aging Americans." https://www.modernhealthcare.com/politics-policy/sanders-medicare-all-expands-long-term-care-benefits

FINANCING OF HEALTHCARE (2021)

As a continuation of the 1985 statement of position on healthcare, a two-year study and consensus on the financing of healthcare was conducted from 1989 to 1991. Following study in 2019-20, this position was updated again in 2021.[97]

The League of Women Voters of New York State (LWVNYS) believes that any proposed healthcare financing system should provide access to essential healthcare at an affordable cost for all New Yorkers, both patients and taxpayers. The League supports the single-payer concept as a viable and desirable approach[98] to implementing League positions on equitable access, affordability, and financial feasibility. In any proposed healthcare financing system, the League favors funding supported in part by broad-based and progressive state taxes on earned and unearned income with health insurance access independent of employment status.

FEDERAL v STATE ROLES

Although the League prefers a healthcare financing system that includes all residents of the United States, in the absence of a federal program that achieves the goals of universal, affordable access to essential health services for New Yorkers, the League supports a healthcare program financed by NYS which includes continuation of federal funding.[99]

FEASIBILITY

The LWVNYS believes the financial feasibility of any single-payer NYS program requires:

- Levels of federal support appropriate for the cost of the program,[100]
- Sufficient cost-savings to be identified so that estimated overall program cost will approximate the cost of current overall health services (all funding sources) or less,[101]
- New state funding from individual taxpayers, employees and businesses to be equitable and progressive to ensure affordability for all,[102]
- A healthcare trust fund managed by the state, that operates in a similarly efficient fashion as Social Security or Medicare trust funds.[103]

COST-CONTROL METHODS

To reduce the impact of any tax increases, healthcare reform should contain costs.[104] The League believes that efficient and economical delivery of care can be enhanced by such cost-control methods as:[105]

- Reduction of administrative costs — both for this insurance plan and for providers,[106]
- Negotiated volume discounts for pharmaceuticals and durable medical equipment to bring prices closer to international levels — or importing of same to reduce costs,[107]

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[97] We estimate the consensus process, likely to begin autumn 2020, will take us into spring 2021.

[98] New location for this statement on single-payer: Instead of *acceptable*, which often has a negative connotation, we use the terms *viable and desirable*.

[99] The 1991 LWV NYS position called for the federal government to be the primary funder and determiner of services to be provided, and NYS to have secondary responsibility. Should NYS take the lead, it should determine services and funding until federal government provides at least as much.

[100] In 2020, NYS benefits from federal contributions to Medicare, Medicaid, ACA Exchange subsidies, CHIP, and other programs, particularly those serving the poor, the disabled, those aged 65 and older; if there were significant federal reductions in such funding, maintaining essential health services for all NYS residents might require benefit trade-offs.

[101] Since SP saves so much, seeking to meet or beat current costs appears both pragmatic and politically sensible.

[102] This is largely from current NYS and US positions, which support equitable access for all.

[103] Like Medicare and Social Security taxes collected at the federal level, NYS taxes collected for healthcare need similar protection from non-HC purposes, rational administration, and strategic focus on public health.

[104] Carries forward the 1991 and continuing concern for cost control and healthcare's impact on taxes.

[105] These lines are adjusted from LWV US listing of cost-control methods and LWV NYS language; they build on 30 years of experience. See LWV US position.

[106] From LWV US.

[107] New, responding to dramatic increases in drug prices since 1991:"A Painful Pill to Swallow: US vs Intl Prescription Prices," by Ways & Means Comm Staff, Sept 2019. https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/U.S.%20vs.%20International%20Prescription%20Drug%20Prices_0.pdf

- Regionalization of specialized tertiary services to ensure timely access and quality,[108]
- Evidence-based treatment protocols and drug formularies that include cost/benefit assessments of medical value,[109]
- Malpractice reforms designed both to compensate patients for medical errors and to avoid future errors by encouraging robust quality improvement processes (at individual and systemic levels) and open communications with patients,[110]
- Investment in well-care — such as prevention, family planning, patient education, primary care — to increase health and reduce preventable adverse health events/expenditures,[111]
- Investment in maternal/infant care, chronic disease management, and behavioral healthcare.[112] Provision for short-term and long-term home-care services to reduce institutionalization,[113]
- Innovative payment and record-keeping.[114]

Specific cost-control methods should reflect the most credible, evidence-based research available on how healthcare financing policy affects equitable access to healthcare, overall quality of care for individuals and populations, and total system costs of healthcare and its administration.[115] Methods used should not exacerbate disparities in health outcomes among marginalized New Yorkers.[116]

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[108] From LWV NYS.

[109] Follows from 1991 LWV NYS: "cost/benefit ratio of medical treatments … to contain costs" — the phrase "evidence-based" emerged in 1990's. https://en.wikipedia.org/wiki/Evidence-based_medicine

[110] LWV NYS refers to administrative modification of tort system; language adjusted from LWV US to distinguish effective from ineffective tort reform (e.g., "From Medical Malpractice to Quality Assurance," Frank Sloan, Spring 2008, Issues in Science and Technology: https://issues.org/sloan/).

[111] Language keyed off emphasis on primary care, preventive care, and patient education in LWV NY/US.

[112] Language keyed off emphasis on primary care, preventive care, and patient education in LWV NY/US.

[113] From LWV NY/US.

[114] Based on LWV NYS: "payment methods…incentives for efficiency and for disease prevention," plus new payment and record-keeping issues that have emerged since 1991. These may include, but are not limited to, such things as moving from fee-for-service to "global" payments (e.g., prepayments or capitated payments) to providers, separating payments for capital budgets from payments for operating costs, and ensuring cost-efficiency, portability, and health value of Electronic Health Records (EHR) across all NYS patients and providers. Among the most serious issues to be considered or resolved:

Global payments: Uwe Reinhardt, who designed Taiwan's SP system, recommended "a number of powerful policy instruments to contain costs. The most powerful of these are government-set fee schedules and a global budget system." https://www.healthaffairs.org/do/10.1377/hblog20190206.305164/full/
Maryland received a waiver from the federal govt for a demonstration project on global budgeting: https://dhss.delaware.gov/dhcc/files/globaloverview.pdf At the 5-year mark, MD's All-Payer Model for hospitals found "Medicare beneficiaries had 2.8 percent slower growth in total expenditures ($975 million in savings) …relative to a comparison group." https://www.hcinnovationgroup.com/policy-value-based-care/medicare-medicaid/article/21116405/marylands-allpayer-model-saves-medicare-nearly-1-billion

Electronic Health Records/EHR: "Despite millions of dollars and thousands of hours of doctors' time, patients and their providers often find they have no way to access a patient's full medical history. Here's why it's taking so long." https://www.aamc.org/news-insights/electronic-health-records-what-will-it-take-make-them-work

Portability compromised: the average hospital deals with 16 disparate EHR venders, each a different platform: "implementing, running and maintaining all the different products have created something of mess." https://www.healthcareitnews.com/news/why-ehr-data-interoperability-such-mess-3-charts

Burden on Providers: "The digitization of healthcare promises significant improvement, including more efficient and more personalized care at lower costs, but it has also brought challenges to the industry. Notably, clinicians have reported feeling burdened by the reporting demands of EHRs—responsibilities that take away from their time and focus on patients. **These burdens are so weighty that they've become a chief cause of physician burnout**," because they reduce patient interaction, extend workdays, and create a focus on reimbursement rather than quality of care. https://www.healthcatalyst.com/insights/physician-burnout-EHR-addressing-5-top-burdens

Physician Time: "On average providers spent 4.3 ± 1.3 hours per clinic day using the electronic health record." https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6371357/

"First-year doctors spend 3 times more hours on EHRs than patient care" "Interns spend approximately 13% of their time, or three hours during a 24-hour time period, interacting with patients face-to-face during a typical day, and yet much of that is still spent multitasking," https://www.fiercehealthcare.com/tech/first-year-doctors-spend-three-times-more-hours-ehrs-than-patient-care.

[115] Over the past three decades, for example, cost-sharing (e.g., co-pays, deductibles, co-insurance) have been shown to cause people to delay or forgo necessary treatment and preventive services, reducing individual and public health and increasing total healthcare costs; for more. See "Appendix C: Pro/Con on Cost Sharing."

[116] "Rural health disparities are deeply rooted in economic, social, racial, ethnic, geographic, and health workforce factors," 10/2017, https://www.aamc.org/news-insights/health-disparities-affect-millions-rural-us-communities ;

PUBLIC PARTICIPATION

The League supports public input as integral to the process for determining health care coverage and funding. To participate in public discussion of health policy and to share effectively in making policy decisions, NYS residents must be provided with information on the health care system and on the implications of health policy decisions.[117]

# # #

"Rural county residents died from the top 5 causes of death more frequently than urban county residents. Many of these deaths were likely preventable…Residents of rural areas in the United States tend to be older and sicker than their urban counterparts. They have higher rates of cigarette smoking, high blood pressure, and obesity... They also have higher rates of poverty, less access to healthcare, and are less likely to have health insurance" CDC, https://www.cdc.gov/ruralhealth/cause-of-death.html; https://www.ruralhealthinfo.org/topics/rural-health-disparities; "Rural Americans are a population group that experiences significant health disparities … higher incidence of disease and/or disability, increased mortality rates, lower life expectancies, and higher rates of pain and suffering. Rural risk factors for health disparities include geographic isolation, lower socioeconomic status, higher rates of health risk behaviors, limited access to healthcare specialists and subspecialists, and limited job opportunities. This inequality is intensified as rural residents are less likely to have employer-provided health insurance coverage, and if they are poor, often are not covered by Medicaid," https://www.ruralhealthinfo.org/topics/rural-health-disparities

Indigenous people are dying at even higher rates (the Navajo Nation recently being the worst "hotspot" in the country) https://www.vox.com/2020/6/11/21286431/coronavirus-arizona-covid-19-cases-deaths-navajo-nation ; In rural counties, where 60 million Americans live there may be "no hospitals for hundreds of miles, the result of closures amid crushing financial pressures. Since 2010, 130 rural hospitals have shut their doors," https://www.washingtonpost.com/nation/2020/05/24/coronavirus-rural-america-outbreaks/?arc404=true ;

"Black people simply are not receiving the same quality of health care that their white counterparts receive, and this second-rate health care is shortening their lives … We have a two-tiered health care system that provides wonderful care to those with private insurance and mediocre care to those without," ABA. 2019, https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/racial-disparities-in-health-care/; "The United States is home to stark and persistent racial disparities in health coverage, chronic health conditions, mental health, and mortality. These disparities are not a result of individual or group behavior but decades of systematic inequality in American … health care systems," 5/7/20, https://www.americanprogress.org/issues/race/reports/2020/05/07/484742/health-disparities-race-ethnicity/; "Racial and income equality are too often absent from conversations about health care financing… the current health financing system also reinforces and institutionalizes inequality; unequal care may be viewed as a form of structural racism…" 2015,. http://harvardpublichealthreview.org/single-payer-health-reform-a-step-toward-reducing-structural-racism-in-health-care/; "Racial Inequity of Coronavirus," July 2020, https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latinos-african-americans-cdc-data.html?referringSource=articleShare: Black and Latino people have been disproportionately affected by the coronavirus in a widespread manner that spans the country, throughout hundreds of counties in urban, suburban and rural areas, and across all age groups…Of Latino people who died, more than a quarter were younger than 60. Among white people who died, only 6 percent were that young.

[117] New wording but maintains substance of transparency and public participation.

Appendix A

How NYH Will Affect Current Provider Shortages

Concerns about provider shortages under NYH focus on three issues:

1. **Utilization**: Will increased demand for health services by those who are currently uninsured or under-insured exceed the current capacity for providing healthcare?
2. **MD Exodus**: Will providers refuse NYH patients, retire, leave the profession, and/or leave NYS because they find NYH worse than the current healthcare funding system?
3. **PCP Shortfall**: Since the state and the U.S. today have too few primary care/frontline providers (PCPs), particularly in rural and inner-city areas, will NYH exacerbate this shortage or ameliorate it?

1. Utilization issues: NYH will not stress provider capacity

- Researchers who study healthcare reforms that have added large patient populations to existing systems (e.g., Medicare, Medicaid, the ACA, and peer nations who have moved to single-payer universal coverage over past 10 to 50 years) conclude that dramatic increases in numbers covered do not stress healthcare systems. In all cases, beginning with New Zealand in 1938 thru Taiwan in 1996 to the US in 2010, transitions were surprisingly rapid and orderly, without chaos or long lines.[118]
- Within the state, most of our currently uninsured/underinsured people who really need care now seek care from hospital ERs. Moving them to less expensive forms of care (PCP/primary care/family care) will conserve resources over today's use. It will also provide more access to patient education, preventive care, and testing, averting many expensive adverse events.
- Triage is a medical best practice, long practiced and much studied. Providers routinely prioritize those who are sick and have immediate needs over those with elective or less urgent needs. This will continue under NYH. Waiting times will not increase because NYH covers all residents, nor because it is a single-payer system.[119]
- Experts estimate NYH may increase "utilization" (i.e., demand for services) by about 10%. Most studies find physicians currently spend 10% to 50%[120] of their time dealing with billing EHR and insurance company prior authorizations. The administrative simplification of NYH will give them more time to see new patients and more time with current patients.[121]

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[118] "Previous coverage expansions in the U.S. did not result in a net increase in hospital use, but did redistribute care to those with the most pressing medical needs" in "The Effects on Hospital Utilization of the 1966 and 2014 Health Insurance Coverage Expansions in the United States," July 23, 2019, *Annals of Internal Medicine* https://annals.org/aim/article-abstract/2738920/effects-hospital-utilization-1966-2014-health-insurance-coverage-expansions-united *AND* "coverage expansions in other wealthy nations did not lead to an increase in utilization of care. This held true from New Zealand in 1938 to the U.S. in 2010" *in* "The Effect of Large-scale Health Coverage Expansions in Wealthy Nations on Society-Wide Healthcare Utilization," Nov 2019 in *Journal of General Internal Medicine* AND "Between 1964 (before Medicare) and 1966 (the year when Medicare was fully functioning) there was absolutely no increase in the total number of doctor visits in the U.S.; Americans averaged 4.3 visits per person in 1964 and 4.3 visits per person in 1966...The same thing happened in hospitals" Himmelstein & Woolhandler, *Huffington Post, 5/9/16,* https://pnhp.org/news/the-urban-institutes-attack-on-single-payer-ridiculous-assumptions-yield-ridiculous-estimates/.

[119] "Long wait times for non-urgent procedures in some countries, e.g., hip replacements in Canada, are often cited by opponents of single-payer reform as an inevitable consequence of universal, publicly financed health systems. They are not. Wait times are a function of a health system's capacity and its ability to monitor and manage patient flow. In recent years Canada has shortened wait times for non-urgent procedures by using better queuing techniques. In the case of urgent care, wait times have never been an issue [in Canada]." https://pnhp.org/what-is-single-payer/faqs/#wont-single-payer-result-in-rationing-and-long-waiting-lines

[120] MDs spend 2 hours on EHR for every hour of clinical time. Sinsky, et al., "Allocation of Physician Time in Ambulatory Practice" Ann Intern Med, 9/6/2016. https://annals.org/aim/article-abstract/2546704/allocation-physician-time-ambulatory-practice-time-motion-study-4-specialties

[121] See " with a decrease in billing-related administrative burden for clinicians, a 10% or greater rise in physician clinical capacity may occur, which would accommodate additional care utilization. Finally, increases in utilization for the uninsured and underinsured are likely to result in increased use of preventive services, which should lead to some future

- Immigrants from outside the state (either from other states or other countries) will not drive up taxpayer cost under NYH. Immigrants to the U.S. are "overall paying more toward healthcare than they use," with undocumented immigrants paying "starkly" more.[122] Studies further suggest that NYH would not make the state a "welfare magnet" for sick Americans from other states; despite extensive study, evidence fails to show that low-to-moderate income Americans moved to states that expanded Medicaid from states that did not.[123] Transient visitors to the state, not being residents, would not be eligible for NYH benefits.

2. NY Health will not trigger an exodus of MDs

- Most physicians support universal healthcare and single-payer funding.[124] PCPs, internists, emergency, and other front-line physicians — and many who currently care for Medicaid patients and/or offer charity care — will see their incomes increase,[125] as NYH sponsors expect to reimburse physicians above Medicare rates, to current commercial rates for primary care.[126] The highest paid specialists may see lower incomes, although NYH will eliminate the "unpaid receivables" (a significant cost for providers) where for-profit insurers refuse to pay for services already rendered, patients cannot afford to pay, and third-party businesses take a percentage of bills to manage payments.[127]

- All providers will benefit from having more time to spend on clinical work (interacting with patients rather than with for-profit insurers, recapturing an estimated average of $98K/year in time),[128] significant reduction of administrative costs (estimated as 25% of physician office costs and 20% hospital operating costs), and likely having medical malpractice and liability premiums reduced.[129] Rarely mentioned, NY Health will also encourage "continuity of care," which physicians regard as both improving quality of care and reducing its cost.

- Overwhelmingly, physicians accept Medicare (99% — and 40% of those who don't are psychiatrists). Although a "Kaiser Family Foundation analysis (excluding pediatricians) found that only 72% of primary care doctors were willing to accept new patients with Medicare in 2015… only 80% were willing to accept new patients with private insurance."[130]

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cost saving [25,36]" in "Projected costs of single-payer healthcare financing in the U.S: A systematic review of economic analyses" in PLoS Med. Jan 2020. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6961869/#pmed.1003013.ref035

[122] "The results were even more stark among undocumented immigrants, who were found to have lower expenditures compared to both naturalized immigrants and U.S.-born citizens and contributed a greater amount to Medicare's trust fund than they withdrew" in Modern Healthcare, Aug2018, https://www.modernhealthcare.com/article/20180808/NEWS/180809934/study-finds-immigrants-use-fewer-u-s-healthcare-resources

[123] "In both expansion and control states, changes in in-migration and out-migration following Medicaid expansions were not statistically significant… Notably, there was no obvious change in adjusted migration rates immediately following the insurance expansion. Thus, there is little evidence for anticipatory, lagged, or immediate migration effects that might have gone undetected in our main regressions" in "Moving For Medicaid? Recent Eligibility Expansions Did Not Induce Migration From Other States," Health Affairs, Jan2014, *https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.0910*

[124] Jan 2020, Amer Assn for Advancement of Science, https://www.eurekalert.org/pub_releases/2020-01/pfan-alm011620.php

[125] "Medicare for all and the myth of the 40% pay cut," Sept 2018 https://pnhp.org/news/medicare-for-all-and-the-myth-of-the-40-physician-pay-cut/

[126] Dr. Leonard Rodberg, May 2018, Testimony https://www.nysenate.gov/sites/default/files/22._ny_metro1.pdf

[127] See "Hidden cost of carrying receivables" in MicroMD, May2017, https://www.micromd.com/enotes/costs-of-carrying-receivables/

[128] $98K in 2020 dollars, "interacting with payers cost the average physician…" $83K/year in time in 2010 as "administrative costs represented about one-quarter of physician revenue and one-fifth of hospital revenue, and BIR costs accounted for roughly half of administrative expenditures for physician and hospital services covered by private insurance." "Excess Administrative Costs Burden the U.S. Health Care System" Ctr for Amer Prog, Apr2018, https://www.americanprogress.org/issues/healthcare/reports/2019/04/08/468302/excess-administrative-costs-burden-u-s-health-care-system/

[129] "Canadian doctors enjoyed a windfall in earnings during the early years of medicare … medicare enhanced physician income.…Until at least 2005, the medical profession was the top-earning trade in Canada relative to all other professions…Canadian physicians have lower practice expenses … including the lesser costs of billing, administration, and malpractice coverage" in "The Impact of Single-Payer Health Care on Physician Income in Canada, 1850–2005" Am J of Pub Health, Jul2011. *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3110239/*

[130] "The experiences in other nations have shown that there is not a net reduction in compensation with expansion of their systems to cover almost everyone." https://pnhp.org/news/the-myth-of-a-physician-exodus-under-medicare-for-all/

- As many as 78% of front-line physicians[131] now suffer from burn-out due to excessive administrative work (including electronic health records/EHR, designed for billing, not healthcare) interference by for-profit insurers with medical decisions around diagnosis and treatment, and seeing patients who cannot afford care get suboptimal care.[132] NY Health would ensure all patients access to affordable healthcare, while simultaneously reducing administrative burdens: the two most-cited causes of physician burnout.

3. NY Health will ameliorate current provider shortages

- One barrier to physicians' serving rural upstate (and large areas of NYC) is the number of uninsured and poorly insured.[133] NYHA will eliminate financial barriers to a provider's choice of practice location. Physicians will be reimbursed for every patient, regardless of where they practice, regardless of patient income, without needing recourse to collection services.[134]

- Unaffordable for-profit insurance exacerbates provider shortages in rural areas. Because of NYS-tax-supported healthcare (e.g., Essential Plan and CHIP-Plus), rural upstate NYS has lost fewer providers than other states[135] although it remains under-served.[136] More than half of US counties are without maternity wards and obstetrics providers, hundreds having closed or moved in recent decades.[137] The March of Dimes considers 2 NYS counties to be "maternity deserts" and 6 more to have dangerously low access to maternity wards and providers, which limits pre-natal and post-natal care, which drives abysmal US infant/maternal mortality rates.[138]

- NYH will reimburse providers based on the actual cost of care, and rates will be negotiated with provider organizations. This will likely lead to reduced reimbursement to the highest paid specialists but increased reimbursement to front-line physicians, likely motivating more students to enter primary care, internal care, ob-gyn, emergency care, etc.

- While delivery of care under NY Health will remain private, single-payer funding will generate data about what kinds of services specific geographic areas most need. Review and planning by Regional Councils created by NY Health will align resource allocation with public health needs rather than duplicating

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[131] "As physicians, we have seen how frustrating computer interfaces have crowded out engagement with patients, undermining patient encounters for both physicians and patients. We felt how long work days become still longer…with a soaring burden of administrative tasks…Too many physicians find that the day-to-day demands of their profession are at odds with their professional commitment to healing and providing care. The demoralizing misalignment of the physician's values and his or her ability to meet his or her patient's needs, due to conditions beyond the physician's control, such as poverty, lack of insurance authorization, or unreasonably short appointment times, has been termed "moral injury" in "A crisis in health care: a call to action on physician burnout," Harvard School of Public Health, et al., Jan2019. https://cdn1.sph.harvard.edu/wp-content/uploads/sites/21/2019/01/PhysicianBurnoutReport2018FINAL.pdf

[132] "The *business* of health care — the gigantic system of administrative machinery in which health care is delivered, documented, and reimbursed — keeps us from pursuing that mission without anguish or conflict. We do our best to put patients first but constantly watch the imperatives of business trump the imperative of healing…When clinic or hospital policies and insurance constraints force health care professionals to deliver suboptimal care to their patients, providers feel powerless," Stat News. https://www.statnews.com/2019/07/26/moral-injury-burnout-medicine-lessons-learned/

[133] Interactive US Govt map of Medically Underserved Areas/Populations. https://data.hrsa.gov/maps/quick-maps?config=mapconfig/MUA.json

[134] "Nationally, more than one in four consumers in 2018 were reported to credit bureaus over unpaid debt, according to the Consumer Financial Protection Bureau. More than half of those reports involved medical bills" in NYTimes, 9/3/19. https://www.nytimes.com/2019/09/03/health/carlsbad-hospital-lawsuits-medical-debt.html

Another example, an ER Group of 16,000 MDs, owned by a hedge fund, sued patients but changed course after national publicity, ProPublica 11/2019. https://www.propublica.org/article/this-doctors-group-is-owned-by-a-private-equity-firm-and-repeatedly-sued-the-poor-until-we-called-them.

Similar story for hospitals suing patients, Dec 2019, KFF. https://khn.org/news/hospital-group-mum-as-members-pursue-patients-with-lawsuits-and-debt-collectors/

[135] Medicaid expansion increases viability of rural hospitals, 25% of which are in financial distress and in danger of closing, with an average operating margin of negative 8.6%, Vox, 2/18/20. https://www.vox.com/policy-and-politics/2020/2/18/21142650/rural-hospitals-closing-medicaid-expansion-states

[136] Interactive U.S. govt map showing Primary Care Health Professional Shortage Areas (HPSA) across upstate NYS and within NYC. https://data.hrsa.gov/maps/quick-maps?config=mapconfig/HPSAPC.json

[137] "Rural Maternity Wards Are Closing, and Women's Lives Are on the Line," Huffington Post, 9/25/17. https://www.huffpost.com/entry/maternity-wards-closing-mission_n_59c3dd45e4b06f93538d09f9

[138] "Nowhere to go." https://www.marchofdimes.org/materials/Nowhere_to_Go_Final.pdf

services and driving up medically questionable utilization;[139] they could, e.g., increase reimbursement rates to areas with physician shortages.

- NY Health will separate capital spending budgets from budgets for health services, so a poor rural hospital will get its first MRI machine or reopen its maternity ward before an elite urban institution gets its 5th MRI or a new lobby designed to win an *Architectural Digest* award: "When operating and capital payments are combined, as they currently are, prosperous hospitals can expand and modernize while impoverished ones cannot, threatening the viability of safety-net institutions that serve vulnerable populations. This self-stimulating relationship is dependent upon market opportunities, often not the same as public health priorities. Regions with excess capacity inevitably have excess utilization; better planning could also ensure adequate capacity in underserved areas."[140]
- As a public health priority, NY Health could use reimbursement to motivate medical schools and teaching hospitals to refocus their efforts toward primary care residency training and away from specialist training, recognizing that "adding 10 primary care physicians has a 250% greater influence on life expectancy than an equivalent bump in specialists."[141]

[139] Ed Weisbart, "A single-payer system would reduce US health care costs," AMA Journal of Ethics, Nov 2012. https://journalofethics.ama-assn.org/article/single-payer-system-would-reduce-us-health-care-costs/2012-11

[140] *Ibid.* "Today's fragmented system is akin to requiring each household in a community to anticipate their needs for the coming year and negotiate their own fees and scope of services with the local police and fire departments. Imagine instead how much of their budgets these life-saving community services would be obliged to devote to marketing to and negotiating with each household and the rampant disparities in service that would result. That is precisely what is happening today in health care, and it is absurdly wasteful. For police and fire departments, we have recognized that it is significantly less wasteful to give all citizens the same "coverage" for set prices and to administer it with regional coordination. Global budgeting is the only sensible strategy for such unpredictable yet universally needed services]. See also "The rural hospital closure crisis is driven by the supremacy of capital in our current health care delivery system. Only a system that dismantles the profit motive and prioritizes community wellbeing will truly deliver care to all who need it" in "Single Payer Could Solve the Rural Hospital Crisis," Jacobin, Jan'18, https://www.jacobinmag.com/2018/01/rural-hospitals-closure-single-payer

[141] Misplaced residency incentives and reimbursement discussed here: "Study: Primary care doctors increase life expectancy," Forbes, Apr 2019 https://www.forbes.com/sites/robertpearl/2019/04/08/primary-care-does-anyone-care/#1c4fb887695f . The growing public health crisis around shortage of primary care doctors, especially in rural areas, requires "substantive changes in physician payment policy" and reduced administrative burden, in "Primary care doctors extend life but the US needs more of them, data show" in American Journal of Managed Care, Feb'19, https://www.ajmc.com/focus-of-the-week/primary-care-doctors-extend-life-but-us-needs-more-of-them-data-show

Appendix B

How NYH Will Affect Medicare

Seniors will have both a NYH card and Medicare card — Medicare will continue under NYH but, within the state, the only card needed will be NYH, which will cover everything Medicare covers and all the gaps and cost-sharing Medicare currently doesn't cover.

Outside the state, the Medicare card remains completely portable, and NYH will cover the Medicare gaps up to the state coverage (like secondary insurance works today).

NYHA will not reduce any benefit or right currently available through Medicare.
It is expected that within a few years of passage, the state will reach agreements with providers just across the state border who serve New Yorkers and with providers in the Sun Belt and Snow Bird areas so that the NYH card will cover what Medicare does not, without the patient having to submit bills to NYH.

Working people will continue to pay into Medicare as well as paying the payroll taxes supporting NYH.
NYH will pay Medicare Part A & B premiums for all New Yorkers once they qualify for Medicare. Part D will not be necessary since NYH will qualify as fully meeting federal requirement for drug coverage. Part C will not be necessary since NYHA will cover all Medicare coverage gaps and cost-sharing, including offering full choice of providers (no networks).

The NYHA will increase benefits for Medicare beneficiaries by covering vision, dental, hearing, and long-term care (including allowing seniors to age in the "least restrictive" available environment, e.g., at home), while lowering costs by eliminating copays, deductibles, and all other cost-sharing, as well as the need to buy Medigap or Supplemental insurance. Medicare enrollees will have free choice of doctors, hospitals and other providers — with almost no prior authorizations required.

Even without federal waivers, New York can incorporate Medicaid, wrap around Medicare, and provide truly universal health care to all residents of the state at less cost than now. Federal waivers would help the system run more smoothly – for New Yorkers and for the federal government – but they are not necessary for the system to work.

NYH will eliminate the current out-of-pocket spending of Medicare recipients. More than 60 million people ages 65 and older and younger people with long-term disabilities currently rely on Medicare to help cover their costs for healthcare services, including hospitalizations, physician visits, prescription drugs, and post-acute care. However, Medicare beneficiaries face out-of-pocket costs for their insurance premiums, cost sharing for Medicare-covered services, and costs for services that are not covered by Medicare, such as dental care and long-term services and supports. In 2016, the average person with Medicare coverage spent $5,460 out of their own pocket for health care. This average includes spending by community residents and beneficiaries residing in long-term care facilities (5% of all beneficiaries in traditional Medicare). Among community residents alone, average out-of-pocket spending on premiums and health care services was $4,519 in 2016. But some groups of beneficiaries spent substantially more than others." [142]

[142] How Much Do Medicare Beneficiaries Spend Out of Pocket on Health Care?" Juliette Cubanski, Wyatt Koma, Anthony Damico, and Tricia Neuman, Nov 04, 2019 Kaiser Family Foundation. https://www.kff.org/medicare/issue-brief/how-much-do-medicare-beneficiaries-spend-out-of-pocket-on-health-care/

Appendix C

Pro/Con on Cost Sharing

NOTE: The update committee has included this as background because, although we did not include cost sharing as a disfavored cost-control method in the proposed new positions because of a conflict with the LWVUS position, it is relevant to current healthcare reform discussions in general.

Cost sharing is the share of healthcare claims (medical services or medications) covered by insurance that is paid by patients through deductibles, co-pays, and co-insurance. It does not include health insurance premiums (even when an individual "contributes" to the cost of the premium). The rationale for cost sharing is reduction of "moral hazard": when people use their own money, they will only use healthcare or medication they really need, and will obtain it from the most economical source.

Arguments which FAVOR cost sharing as a healthcare cost-control method:

1. **Cost-sharing increases personal responsibility** for selecting healthcare services by encouraging price-shopping and "consumer-directed" choices based on relative value to the patient.[143]
2. **Cost-sharing saves money by reducing demand** for less effective healthcare services, i.e., the "moral hazard" of people over-using what they get for "free." Paying for healthcare gives them "skin in the game."
3. **The Rand Health Insurance Experiment (HIE) — often cited as the "gold standard" study** on healthcare costs, demand, and outcomes — concluded that "modest cost-sharing reduces use of [healthcare] services with negligible effect on health for the average person."[144]
4. **The Rand HIE, conducted from 1974-81, found limited adverse health outcomes only among the poorest and sickest** patients, e.g., those suffering from specific chronic diseases such as hypertension, lipid disorder, diabetes, and schizophrenia.
5. **Cost-sharing reduces the tax burden for public health insurance plans**.

Arguments which DISFAVOR cost sharing as a healthcare cost-control method:

1. **Cost-sharing impedes universal access by creating financial barriers that ration healthcare services** by income, even for those with private insurance.[145] LWVNY has lobbied successfully to prevent Medicaid from charging co-pays on the grounds that cost-sharing discourages Medicaid clients from seeking essential healthcare services, resulting in serious health consequences and more expensive forms of medical care.[146]
2. **Cost-sharing doesn't control costs.** It reduces demand for the least expensive services (primary and preventive care) and also care associated with managing chronic diseases, thus decreasing health, increasing adverse health events and cost. Because excess healthcare capacity drives U.S. utilization, [147]

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[143] https://www.rand.org/capabilities/solutions/determining-the-effects-of-cost-sharing-in-health-care.html (begun in 1971).

[144] https://www.rand.org/health-care/projects/HIE-40.html The RAND HIE was a ground-breaking study that ran between 1974 and 1981, funded by HEW at a cost of $294M. To quantify price sensitivity and elasticity of cost-sharing — and the "moral hazard" — in health insurance, they "provided health insurance to more than 5,800 individuals from about 2,000 households in six different locations across the United States," enough to create randomized samples, to determine how families trade off healthcare cost against healthcare use. Each selected household received a plan that provided something between free coverage and almost no coverage up to $4,000 (in 2011 dollars)

[145] "50% of all privately insured respondents reported skipping or delaying at least one type of care because of cost,"."72% of these respondents skipped or delayed multiple types of care." *From Coverage to Care* https://www.nyhcampaign.org/report

[146] Impact on Issues, updated 2018, p. 87.

[147] "There is now ample evidence in the health policy literature to show that excess capacity in the health care system results in over-utilization, defined as an increase in utilization without a reasonably commensurate improvement in health care outcomes." https://pnhp.org/news/health-care-marketplace-creates-wasteful-excess-capacity/

reducing demand does not affect costs.[148] Further, cost-sharing increases administrative complexity (BIR costs).[149]

3. **The Rand HIE study was methodologically flawed**, invalidating its key finding that reducing needed healthcare has no adverse health consequences. Specifically, HIE was not representative of the US population (it included only people in the workforce and their dependents, not the elderly or those too sick or disabled to work) and HIE failed to account for those who exited HIE early (e.g., for health or affordability issues).
4. **Cost-sharing discourages good management of chronic diseases**, increasing medical costs, while reducing public health and labor productivity**.** Medical breakthroughs in managing many chronic diseases (hypertension, diabetes, asthma, schizophrenia, etc.) can now effectively slow disease progression and reduce expensive adverse health events but only when patients rigorously adhere to protocols.[150]
5. **Cost-sharing saves money for private insurers** but can significantly increase the cost to taxpayers, while reducing overall public health outcomes.[151]

Supplementary Reading on Cost-Sharing in Healthcare

The RAND HIE

Arguments in favor of cost-sharing continue to reference a ground-breaking study by RAND that ran 1974 to 1982, funded by HEW at a cost of $294M. To quantify price sensitivity and elasticity of cost-sharing — and the "moral hazard"[152] — in health insurance, RAND "provided health insurance to more than 5,800 individuals from about 2,000 households in six different locations across the United States,"[153] enough to create randomized samples, to determine how families trade off healthcare cost against healthcare use. Each selected household received a plan that provided something between free coverage and almost no coverage up to $4000 (in 2011 dollars).

Still described as a "gold standard," the RAND study, often called HIE —Health Insurance Experiment — concluded, broadly[154]

- Each 2% increase in cost-sharing resulted in 10% reduction in spending (less utilization)
- Households reduced spending equally for clinically important and unimportant services

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[148] https://www.rwjf.org/en/library/research/2011/12/cost-sharing--effects-on-spending-and-outcomes.html

[149] "Complexity [drives BIR costs]… determining patient insurance and cost sharing; collecting copayments …; receiving and depositing payments; … collecting from patients…," *Healthcare Imperative*, p141, Natl Acad, 2010, https://www.nap.edu/read/12750/chapter/7#143 .

[150] Per the CDC: "90% of the nation's $3.5T in annual health care expenditures are for people with chronic and mental health conditions … Preventing chronic diseases, or managing symptoms when prevention is not possible, can reduce these costs." https://www.cdc.gov/chronicdisease/about/costs/index.htm.

[151] "As Perkowski's and my analysis of 28 countries over a 10-year period concludes, one-third of all advanced countries (e.g., Canada) have no cost-sharing, and their costs cannot be distinguished from those that do have cost-sharing. The real reason for cost-sharing (in the US, at least) is to reduce the cost to the insurer and force the patient/consumer to pay part of the cost. (Note that, for the most expensive part of health care, hospitalization, cost-sharing is small and has almost no impact on usage.)" Rodberg by email, Perkowski & Rodberg, "Cost Sharing, Health Care Expenditures, and Utilization: An International Comparison,"2015, https://journals.sagepub.com/doi/abs/10.1177/0020731415615312?journalCode=joha

[152] "Moral hazard," a phrase dating to the 1600's, developed negative connotations in the 19th-C suggesting fraud or immorality by the insured. In the 1960s, a variant definition arose among economists (Arrow, Pauly) to "describe inefficiencies that can occur when risks are displaced," when "a person takes more risks because someone else bears the cost of those risks," e.g., when a patient with health insurance uses more healthcare than a patient without health insurance. Summarized from Wikipedia "Moral Hazard" and Michel Grignon, et al, "Moral Hazard in Health Insurance," *Oeconomia* 8-3, p. 367-405 (2018). https://journals.openedition.org/oeconomia/3470.

[153] "The RAND Health Insurance Experiment, Three Decades Later," Aviva Aron-Dine, et al. Published in final edited form as: *J Econ Perspect*. 2013 ; 27(1): 197–222. doi:10.1257/jep.27.1.197. https://siepr.stanford.edu/research/publications/rand-health-insurance-experiment-three-decades-later

[154] The Health Insurance Experiment: A Classic Rand Study (RAND 2006), Robert Brook, et al, https://www.rand.org/pubs/research_briefs/RB9174.html

- No reduction in health outcome accompanied reduction in spending (except for a few specific conditions in the lowest-income households)

When policy makers today discuss "moral hazard" and "skin in the game," they are referencing RAND conclusions: namely, when patients do not pay for care, they over-use it; when they must pay for it, they use less; and using less does not harm their health.

Because RAND collected so very much data across so large a population, policy makers continue to mine the HIE data. Additional conclusions include:

- Requiring people to take on cost did not influence behaviors associated with poor health (e.g., smoking, obesity)
- Cost-sharing does not significantly address drivers of cost growth since it had little effect on treatment costs, once treatment was sought
- While there appeared to be no difference in quality between the insurance categories, quality of care was rated at 62% (a 2003 national follow-up rated it at 55%)

Rebuttals to RAND

Even in the 1980's, rebuttals to RAND's findings appear, particularly around the notion that patients can make effective healthcare decisions based on cost without harming their health

Flawed statistical conclusions:

- The population sampled didn't represent the US population:
  - excluded the elderly and seriously sick
  - included only those healthy enough to be employed
- Cohorts analyzed did not include those who dropped out to return to their original medical plan after
  - being assigned to HIE high-cost plan
  - developing serious health issues

Skewed data means "the RAND finding … is spurious."[155]

This 1985 cartoon illustrated a NEJM article[156]

Medical advances — in 2019, patient compliance costs more but has greater health value

- Chronic disease management/prevention was in its infancy, with few treatments available in 1970s[157]
  - In 2019, 60% of Americans live with at least one chronic disease; 40% with at least 2; [158]
  - **"90% of the nation's $3.5T in annual health care expenditures are for people with chronic and mental health conditions."** [159]
  - "Education interventions may improve compliance with important services, but may not reduce the price sensitivity of patients… patients responded to lower copayment rates."[160]
  - US seniors of all incomes have two-to-four times as much cost-related non-adherence to drug protocols as seniors in 11 peer countries.[161]

[155] "Cracks in the moral hazard foundation" (2007): http://www.pnhp.org/news/2007/september/cracks_in_the_moral_.php
[156] "Cost Sharing in Health Insurance, a reexamination," M. Edith Rasell, NEJM 4/27/1985 accessed through https://pnhp.org/system/assets/uploads/2009/12/Cost-Sharing-Reexamination.pdf
[157] *"What Does the RAND Health Insurance Experiment Tell Us About the Impact of Patient Cost Sharing on Health Outcomes?"* https://www.ajmc.com/journals/issue/2008/2008-07-vol14-n7/jul08-3414p412-414
[158] CDC National Center for Chronic Disease Prevention and Health Promotion https://www.cdc.gov/chronicdisease/index.htm
[159] *Ibid*. https://www.cdc.gov/chronicdisease/about/costs/index.htm
[160] "What does the RAND HIE tell us about the impact of patient cost sharing on health outcomes?" Chernew, Newhouse, 2008 AJMC, accessed through https://www.ajmc.com/journals/issue/2008/2008-07-vol14-n7/jul08-3414p412-414
[161] See graphic: "Cost-related non-adherence to prescribed medicines among older adults" from BMJ study at http://dx.doi.org/10.1136/bmjopen-2016-014287, also available at https://pnhp.org/pharma/

- "We find that physician visits and prescription drug usage have elasticities that are similar to those of the RAND Health Insurance Experiment (HIE). Unlike the HIE, however, we find substantial "offset" effects in terms of increased hospital utilization. **The savings from increased cost sharing accrue mostly to the supplemental insurer, while the costs of increased hospitalization accrue mostly to Medicare**" (**estimated at six-fold increase)** for unhealthiest Medicare patients, but doubling the HC cost for others. [162]

Healthcare is not a "market"

> "Economists call the approach price discrimination, which means the identical service is sold to different buyers at different prices... Because the word rationing is anathema in the US debate on health policy, the strategy has been marketed instead under the felicitous label of consumer-directed health care," Uwe Reinhardt.[163]

The purchase of medical services and medications is not a true marketplace. Patients are seldom in a position to shop for best value: urgent care rarely allows discretion in treatment or timing of treatment; prices of services vary widely (by provider, insurer, policy); patients rarely have sufficient information to decide on the best course of treatment before seeking care; providers cannot guarantee outcomes or predict total costs:

- Cost-sharing does not control or drive down costs
- Savvier "shopping" by consumers (for necessary care) will not control costs[164]
- The for-profit insurer "business" model depends on denying care, not providing it

Fifty-plus years ago, Nobel laureate economist Kenneth Arrow published *Uncertainty and the Welfare Economics of Health Care*[165], arguing that free-market models cannot be applied to healthcare.[166] His arguments are frequently cited today to rebut arguments that free-market deregulation will "improve" HC or HC pricing.

Reduced utilization by delaying care doesn't reduce intensity of care (the number and type of services) — and the US has low utilization rates, relative to peer countries:

- The average # of contacts with physicians was less than half the rate of Germany and Japan in 1990 — both with better health outcomes in 2018:[167]
  - Americans visit physicians 4.5/year and live to expected 78.7 years
  - Japanese visit physicians 13/year and live to expected 84.2 years
  - Germans visit physicians 10/year and live to expected 81.3 years
- "Even under the extreme (and incorrect) assumption that those without health insurance use no health services at all, the utilization rate … [would be] lower than all the other countries examined, except the UK."[168] [UK now averages 6 visits/year as of 2017][169]

Financial Issue: **Medical care which is subject to price sensitivity from cost-sharing has *de minimus* effect on overall costs**:[170]

- "Shopping around" to find better prices isn't possible for patients in narrow networks or needing urgent/ER care

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[162] "Indeed, the hospital spending effect is enormous for those who are unhealthiest by this measure, with hospital spending increasing by almost $2 for every $1 saved on other spending—and Medicare's hospital spending increasing by more than $6 for every $1 saved on physician spending!"… "Our results suggest that the donut hole in coverage, by increasing coinsurance rates to 100 percent for some of the most chronically ill Medicare beneficiaries, could *increase* Medicare's costs." Amitabh Chandra, Jonathan Gruber, and Robin McKnight, "Patient Cost-Sharing and Hospitalization Offsets in the Elderly" Am Econ Rev, 3/1/2010, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2982192/

[163] https://pnhp.org/news/important-uwe-reinhardt-on-health-care-price-transparency-and-economic-theory/

[164] Robert J Wood Foundation Report on Cost-Sharing and PNHP comment, 2010, https://pnhp.org/2011/03/31/important-rwjf-report-on-cost-sharing/

[165] Accessible at https://web.stanford.edu/~jay/health_class/Readings/Lecture01/arrow.pdf

[166] This provides a 2016 interview with Arrow https://pnhp.org/news/kenneth-arrow-says-single-payer-is-better-than-any-other-system/

[167] https://international.commonwealthfund.org/stats/annual_physician_visits/

[168] *Ibid*. M. Edith Rasell, NEJM 4/27/1985

[169] *https://www.bma.org.uk › media › files › pdfs › general-practice*

[170] Robert J Wood Foundation Report on Cost-Sharing and PNHP comment, 2010, https://pnhp.org/2011/03/31/important-rwjf-report-on-cost-sharing/

- Most people are healthy, so increasing cost-sharing enough to reduce their spend by 10% would save 0.3% — 50% of our population uses 3% of healthcare dollars
- The sickest among us are focused on accessing healthcare they need and have already met deductibles
  - The sickest 20% spend 80% of healthcare dollars
  - Cost-sharing is not intended to reduce needed care for significant diseases or injury
- The remaining 30% use about 16% of healthcare dollares
  - Some of this is urgent/ER care, where price-shopping is irrelevant
  - Reducing their spending by 10% might save 1.6% of total healthcare spending

These savings total under 2% — "relatively paltry savings from creating price sensitivity… [which is offset by] the higher costs of deferred medical management"[171]

Cost-sharing has been demonstrated to result in adverse outcomes[172] that constitute a significant portion of our national healthcare costs.[173]

- For **low-income individuals and families**: low Medicaid reimbursement rates ration care:
  - Unwilling providers "balance" patient rolls based on patient income
  - Financially strapped local and state govts increase cost-sharing to balance state budgets on those with least political importance, reducing costs by reducing access
- For **those with chronic diseases**, cost-sharing at point-of-service results in the opposite of its intent: instead of reducing "over-use" or "moral hazard," inadequate disease management means **cost-sharing results in higher costs** of emergency rooms, hospitalization, even life-threatening conditions:[174]
  - Doubling co-payments reduced anti-diabetes Rx use "by 23%," "anti-hypertension by 10%"
  - When an employer raised cost-sharing by $10-$20 per Rx, 21% of patients stopped their high-cholesterol medication
  - Higher cost-sharing for Rx "led to worse physiologic outcomes… more visits to the emergency room, and even greater mortality."
  - "high cost sharing resulted in worse compliance … more hospital admissions and other poor health outcomes."
  - "Reducing copayment rates seems to have the opposite effect."
  - "higher cost sharing will reduce use of preventive or screening tests…[e.g.,] reduced use of mammography after increases in copayment rates."

For-profit insurer self-interest: cost-sharing allows "cherry picking" and "lemon dropping"
High-deductible plans attract relatively healthier consumers; disproportionate numbers of healthier enrollees cause the plans to

- "look as if they spend less than plans that cover a more normal mix of customers"
- be as much as "26% cheaper to cover, an advantage that has nothing to do with how the plan creates incentives for lower healthcare use."[175]

Most OEDC countries either provide first-dollar coverage for primary care and out-patient specialists (who accept government payments) or waive cost-sharing based on income. [176]

- No cost-sharing: Australia, Canada, Denmark, Germany, Greece, Italy, Spain, United Kingdom …
- Co-pays under $10: Belgium, France, Iceland, Portugal (60% of country pays nothing), Sweden[177]

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[171] *Ibid*. RJW Report
[172] *Ibid.* Frakt
[173] *Ibid*. "Cost-related non-adherence to prescribed medicines among older adults." Also see https://www.cdc.gov/chronicdisease/about/costs/index.htm
[174] Listed research studies cited in "What does the RAND HIE tell us about the impact of patient cost sharing on health outcomes?" Chernew and Newhouse, 2008 AJMC, accessed through https://www.ajmc.com/journals/issue/2008/2008-07-vol14-n7/jul08-3414p412-414 Googling generates dozens more studies in peer-reviewed publications.
[175] "Health Care Cost-Sharing Works — Up to a point," Frakt, 5/26/2014, NYT https://www.nytimes.com/2014/05/27/upshot/health-care-cost-sharing-works-up-to-a-point.html
[176] Ibid., Perkowski, appendix compares 28 OEDC countries on their cost-sharing for medical, hospital, and pharmaceuticals.
[177] OEDC Health System Characteristics, http://www.oecd.org/health/health-systems/characteristics.htm

Appendix D

LWVUS Position on Healthcare (1993, 2016)

Funding of Entitlements

The League of Women Voters of the United States believes that the federal government has a role in funding and providing for old-age, survivors, disability, and health insurance. For such insurance programs, participation should be mandatory and coverage should be universal. Federal deficit reduction should not be achieved by reducing Social Security benefits.

Health Care —The League's Position

Statement of Position on Health Care, as announced by the National Board, April 1993 and supplemented by concurrence to add Behavioral Health, June 2016:

GOALS: The League of Women Voters of the United States believes that a basic level of quality health care at an affordable cost should be available to all U.S. residents. Other U.S. health care policy goals should include the equitable distribution of services, efficient and economical delivery of care, advancement of medical research and technology, and a reasonable total national expenditure level for health care.

BASIC LEVEL OF QUALITY CARE: Every U.S. resident should have access to a basic level of care that includes the prevention of disease, health promotion and education, primary care (including prenatal and reproductive health), acute care, long-term care, and mental health care. Every U.S. resident should have access to affordable, quality in- and out-patient behavioral health care, including needed medications and supportive service that is integrated with, and achieves parity with, physical health care. Dental, vision, and hearing care also are important but lower in priority. The League believes that under any system of health care reform, consumers/patients should be permitted to purchase services or insurance coverage beyond the basic level.

FINANCING AND ADMINISTRATION: The League favors a national health insurance plan financed through general taxes in place of individual insurance premiums. As the United States moves toward a national health insurance plan, an employer-based system of health care reform that provides universal access is acceptable to the League. The League supports administration of the U.S. health care system either by a combination of the private and public sectors or by a combination of federal, state, and/or regional government agencies.

The League is opposed to a strictly private market-based model of financing the health care system. The League also is opposed to the administration of the health care system solely by the private sector or the states.

TAXES: The League supports increased taxes to finance a basic level of health care for all U.S. residents, provided health care reforms contain effective cost control strategies.

COST CONTROL: The League believes that efficient and economical delivery of care can be enhanced by such cost control methods as:

- the reduction of administrative costs,
- regional planning for the allocation of personnel, facilities, and equipment,
- the establishment of maximum levels of public reimbursement to providers,
- malpractice reform,
- the use of managed care,

- utilization review of treatment,
- mandatory second opinions before surgery or extensive treatment,
- consumer accountability through deductibles and copayments.

EQUITY ISSUES: The League believes health care services could be more equitably distributed by:

- allocating medical resources to underserved areas,
- providing for training health care professionals in needed fields of care,
- standardizing basic levels of service for publicly funded health care programs,
- requiring insurance plans to use community rating instead of experience rating,
- establishing insurance pools for small businesses and organizations.

ALLOCATION OF RESOURCES TO INDIVIDUALS: The League believes that the ability of a patient to pay for services should not be a consideration in the allocation of health care resources. Limited resources should be allocated based on the following criteria considered together: the urgency of the medical condition, the life expectancy of the patient, the expected outcome of the treatment, the cost of the procedure, the duration of care, the quality of life of the patient after treatment, and the wishes of the patient and the family.

BEHAVIORAL HEALTH: The League supports:

- Behavioral health as the nationally accepted term that includes both mental illness and substance use disorder.
- Access for all people to affordable, quality in- and out-patient behavioral health care, including needed medications and supportive services.
- Behavioral health care that is integrated with, and achieves parity with, physical health care.
- Early and affordable behavioral health diagnosis and treatment for children and youth from early childhood through adolescence.
- Early and appropriate diagnosis and treatment for children and adolescents that is family-focused and community-based.
- Access to safe and stable housing for people with behavioral health challenges, including those who are chronically homeless.
- Effective re-entry planning and follow-up for people released from both behavioral health hospitalization and the criminal justice system.
- Problem solving or specialty courts, including mental health and drug courts, in all judicial districts to provide needed treatment and avoid inappropriate entry into the criminal justice system.
- Health education—from early childhood throughout life—that integrates all aspects of social, emotional, and physical health and wellness.
- Efforts to decrease the stigmatization of, and normalize, behavioral health problems and care.

Appendix E

Glossary

ACA	Affordable Care Act
ACO	Accountable Care Organization: A network of health care professionals and organizations that band together to provide health care services for a defined population of patients; the network is paid to provide coordinated comprehensive care to patients and assumes responsibility for the cost and quality of that care.
AMC	Academic Medical Center is a tertiary care hospital that is organizationally and administratively integrated with a medical school. Following ACA encouragement to form ACOs, some AMCs consolidated physician practices and neighboring hospitals, growing into multibillion-dollar systems. AMCs have a tri-part mission of clinical care, education, and research. The U.S. has approximately 130 AMCs with direct ties to medical schools. AMCs operate 60 percent of the nation's Level 1 trauma centers, treating the most difficult cases. They annually graduate 17,000 doctors and train over 30,000 medical residents while conducting the majority of the National Institutes of Health's (NIH) funded research.
Behavioral Health	The promotion of mental health, resilience and well-being; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.
BIR	Billing Insurance Reimbursement — the job title for administrators involved with billing healthcare insurers and negotiating insurance reimbursement; they work for providers, insurers, and middlemen acting for providers or insurers.
Capitation	A fixed payment made to healthcare professionals or organizations for the care their patients may require during a contract period regardless of how many services are provided to patients. It may cover all services provided to the patient, or partial, covering only a selected subset of services (e.g., primary care services). A per-patient, per-month care coordination fee is an example of partial capitation.
CHIP	Child Health Insurance Program funded by Medicaid, also called Children's Medicaid.
Child Health Plus	A NYS program that funds healthcare for children in households earning too much to qualify for Medicaid.
Clinical Time	The time a provider spends engaging with patients; sometimes now differentiated from clinical documentation time, the time used completing EHR and spent on insurance, prior authorizations, appeals, other documentation, and billing negotiations.
CMS	Centers for Medicare and Medicaid Services, a federal agency that controls the Medicare Trust Fund (disbursing $740B+ annually) and administers Medicare for 51M Americans and 3.6M New Yorkers 65 and older (eligibility based on age plus 9M disabled Americans), and works in partnership with states to administer Medicaid (covers 75M Americans, including 6.2M New Yorkers: low-income adults and children, long-term care for most seniors who need care after assets have been "spent down," and some kinds of disabilities and chronic conditions needing complex care, e.g., end-stage kidney disease).
Co-insurance	See cost-sharing.
Co-pay	See cost-sharing.
Cost-Sharing	Payments made to insurers or providers above and beyond premiums. A copay is a set rate a patient pays for prescriptions, doctor visits, and other types of care. Coinsurance is a percentage of costs a patient pays after meeting his/her deductible. A deductible is the set amount a patient pays for medical services and prescriptions before his/her insurance kicks in. Contrast first-dollar coverage. These all vary by plan.
Deductible	See cost-sharing.
DME	Durable Medical Equipment, e.g. wheelchairs, walkers, scooters, stair-lifts, CPAP machines, blood glucose meters, blood-pressure monitors, hospital beds, prostheses …
EHR	Electronic Health Records, typically designed for billing and reimbursement. Providers use them in managing patient health or reviewing health history. Information includes patient

medical history, diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, and laboratory and test results. Can allow access to evidence-based tools that providers can use to make decisions about a patient's care and in some ways can automate and streamline provider workflow.

Epidemic — Per the CDC: "**Epidemic** refers to an increase, often sudden, in the number of cases of a disease above what is normally expected in that population in that area. **Outbreak** carries the same definition of epidemic but is often used for a more limited geographic area. **Cluster** refers to an aggregation of cases grouped in place and time that are suspected to be greater than the number expected, even though the expected number may not be known. **Pandemic** refers to an epidemic that has spread over several countries or continents, usually affecting a large number of people"

Essential Care/Essential Health Benefits: A set of 10 categories of healthcare services insurance plans must cover under the ACA, including doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more.

First-Dollar Coverage — Health insurance that pays the first dollar of healthcare claims, with no cost-sharing.

FFS — Fee for Service: a payment model where each healthcare service is paid separately, not bundled. Payments depend on the quantity of care, e.g., the number of procedures per patient, rather than quality of care. Compare capitated and global payments.

Global Payments (or global capitation): Capitation that can be adjusted to account for severity of illness or other significant variances from projected costs. It is sometimes described as a middle ground between fee-for-service reimbursement (in which providers are paid for each service rendered to a patient) and capitation (in which providers are paid a "lump sum" per patient regardless of how many services the patient receives) because the payer and provider share financial risk — unlike capitation where the provider assumes the risk or FFS where the insurer assumes the risk.

LTC/LTSS — Long-Term Care and Long-Term Services and Support, the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications; it can be provided long-term or short-term by professionals, friends or family in a variety of settings: in nursing homes, private assisted-living facilities, or in a patient's residence.

MA — Medicare Advantage (Part C), for-profit administration of Medicare benefits that covers, fully or partially, hospitalization, provider services, and prescriptions, typically in relatively narrow provider networks and for relatively healthy seniors who need routine healthcare rather than complex specialized care. Created in 2003 as part of Medicare Prescription Drug Improvement and Modernization Act (MMA).

Medicare Parts A & B — "Original" or "Traditional" Medicare, created in 1965. Part A covers most of in-patient care in hospitals and skilled nursing facilities (SNF), and has deductibles and flat-dollar co-insurance. Part B covers mainly out-patient care (doctor visits, tests, procedures), with deductibles and 20% co-insurance. Part A premiums range from nothing to $5.5K/year, depending on how many quarters the taxpayer paid contributions; Part B premiums depend on income, progressing from $1.7K/year (which could be paid by Medicaid) to $6K/year (individuals making over $500K/year).

Medicare Part D — For-profit administration of drug coverage under Medicare, with co-insurance and co-pays. Created with MA in 2003. Infamous for the "donut hole" where, after drug costs hit a certain limit, co-pays (flat amount) stop and co-insurance (a % of cost) begin, increasing costs to patients until a new cost threshold was reached and "catastrophic" coverage begins. The Affordable Care Act (ObamaCare) significantly reduced donut-hole liability.

Medigap Insurance — Also known as supplemental insurance. For-profit insurance designed to cover the deductibles and co-insurance gaps of original Medicare; degree of cost-sharing varies by plan.

MMC — Medicaid Managed Care, provides the delivery of Medicaid health benefits through contracted arrangements between state Medicaid agencies and insurance-run managed care organizations (MCOs) that accept fixed per-member per-month (capitation) payment for services.

Multi-payer insurance — Today, most healthcare providers are reimbursed by as many insurers and for as many plans as they choose to contract with— both for-profit (private, that is, corporate payers) and

	not-for-profit (public, that is, government payers) — thus, multi-payers (See Single Payer "SP").
NYHA	New York Health Act, a bill in the NYS legislature, also referred to as "NY Health" (meaning the plan, not the bill), and New York Health Program.
NYH	New York Health: the plan that the New York Health Act "NYHA" will create, to be administered by the NY Health Trust (like CMS).
NYS	New York State
OECD	The 37 countries belonging to the Organization of Economic Cooperation and Development (created under the 1947 Marshall Plan) that meet standards of corporate governance, anti-corruption, and environmental protection; they are the world's most economically developed countries.
OOP	Out of Pocket — what a patient spends that is not paid by health insurance, e.g., co-pays, deductibles, Over-the-Counter medications — usually includes eye glasses, dentures, hearing aids; can include DME.
OTC	Over-the-counter "pharmacy medications," as contrasted with prescription-only medications; can include analgesics like ibuprofen or aspirin, antibiotics like azithromycin or bacitracin, or anti-diarrheals like Kaopectate, etc.
Pandemic	See "epidemic," above.
PCP	Primary Care Physicians practice general medicine and include family practitioners, pediatricians, internists, ob-gyn, nurse practitioners, and physician assistants.
Provider	Physicians, hospitals, therapists, those who provide HC.
RAND HIE	Rand Health Insurance Experiment (HIE), a study that ran between 1974 and 1981, funded by the Department of Health, Education and Welfare (HEW, predecessor to the Department of Health & Human Services), to quantify price sensitivity and elasticity of cost-sharing — and the "moral hazard" — of health insurance.
Socialized Medicine	Systems that couple tax-funded (public) health insurance with government-owned and operated healthcare facilities. In the U.S., examples of socialized medicine include the Veterans Administration (serving 9M veterans) and the Indian Health Services (serving 2.6M Native Americans and Alaska Natives in 37 states): the government owns their hospitals/clinics and employs their physicians/healthcare workers. Both the VA and IHS are also single-payer systems since only one payer reimburses the healthcare services provided, which are funded through general taxes.
SP	Single payer refers to a funding system where providers bill their services to a single payer, funded by general taxes. The VA, IHS, and Original Medicare are all single-payer systems, but original Medicare (and NY Health) are not socialized medicine because SP defines healthcare funding, not healthcare delivery. Under original Medicare (and NY Health) providers work for corporations, for non-profits, in partnerships, or as solo practitioners, not the government. SP is sometimes called social insurance or public insurance. (See multi-payer.)
Tertiary Care	is highly specialized medical care usually for in-patients on referral from a primary or secondary health professional, usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities. Examples of tertiary care are cancer management, neurosurgery, cardiac surgery, plastic surgery, treatment for severe burns, advanced neonatology services, palliative, and other complex medical and surgical interventions.
Underinsured	Being unable to afford healthcare despite having health insurance coverage, usually because of cost sharing: underinsured patients/families put off seeking medical care, consulting a physician, getting prescribed treatment or tests, or taking medications as prescribed. Studies estimate that each year 40% to 50% of New Yorkers with insurance delay or forgo seeing doctors or taking prescriptions appropriately.