MEMORANDUM IN OPPOSITION

S.3525 (Perkins) **A.5062 (Gottfried)**

AN ACT An act to amend the public health law and the state finance law, in relation to establishing New York Health

This bill would create a universal single payer health plan called "New York Health," purportedly to provide comprehensive health coverage for all New Yorkers, to be financed by assessments based upon a graduated payroll tax (paid 80% by employers and 20% by employees, and 100% by self-employed) and a surcharge on other taxable income. Private insurance that duplicates benefits offered under New York Health could not be offered to New York residents.

The **New York State Association of Health Underwriters (NYSAHU),** comprised of licensed health insurance brokers and employee benefits consultants, which support universal health coverage by integrating existing public plans with market-based solutions to improve the availability and affordability of health insurance plans for all, **STRONGLY OPPOSES** S.3525 / A.5062.

Trying to increase health insurance coverage in New York State by addressing only the insurance aspect is only impacting the symptom of the larger underlying problem, which is the cost of health care. The rise in health insurance costs is a reflection of increases in the cost of health care.

Many of the solutions, being advocated by some lawmakers, policymakers, activists, providers, labor unions, faith-based organization, such as a single payer system, are just not realistic. Single payer proponents, in their zeal to offer a simplistic, one-step solution, gloss over the real problems in the healthcare system. The primary driver of healthcare costs in the United States is the result of our poor lifestyle choices, not

shortcomings in the healthcare system; we believe the U.S. Healthcare system is among the best in the world.

A single payer, universal healthcare solution, such as the one proposed in S.3525 / A.5062, claims to be able to provide insurance to all residents by eliminating unnecessary administrative expenses in the current insurance carrier model and using that savings to purchase government-provided insurance for all residents. Hence the healthcare activists' mantra: "Medicare for all." The flaw in that logic is that it has never been shown that the cost savings are of the magnitude claimed by these proponents.

The healthcare activists claim that Medicare operates on a bare administrative expense of only 3%. The big point they all make is comparing that 3% against the higher administrative expenses of commercial health plans and how many millions of additional people can be covered by the supposed savings. However, Medicare's 3% only represents the amount of funds spent for claims administration by Part A and Part B contractors. It ignores the overhead functions a group health insurance carrier has which includes: (a) claims administrative expenses; (b) general office expenses including contract and legal work, enrollment eligibility determinations, ID Cards production and issuance, communication materials such as benefit books, UR, general accounting, payroll taxes, benefits, etc.; (c) risk charges; (d) premium taxes' and (e) provider oversight and utilization review. Moreover, the Centers for Medicare and Medicaid Services (CMS) operations absorb much of the "general office expenses" not directly attributed to Medicare, and thus are not included in this 3%.

Another fallacy is that a single payer system will get the "bean-counters" out of medical providers' hair and "let them practice medicine." Medicare is full of rules on medical necessity, just like the commercial insurance market, so utilization review is alive and well in Medicare just as in commercial plans. And, with a single payer, doctors and other healthcare providers won't have the ability to refuse to participate in provider panels or even have input into utilization review or medical necessity rules, as they do now with commercial health insurance carriers. Moreover, Medicare does not negotiate fees or hospital reimbursements, rather the government decrees the fees paid to providers. This would not change, even if the bill allows healthcare providers to form organizations to collectively negotiate with New York Health. There can be no "collective bargaining" with a single government monopoly.

There would be no more Medicare cross-subsidization; no commercial clients on which providers could pass off excess operating losses. The federal government has for years unsuccessfully attempted to reduce provider fee reimbursements as a means to correct long term budget deficits. Price controls as a means to contain costs has not worked for the federal government's Medicare system and would not work in New York State.

As mentioned above, the proponent's administrative cost savings estimates are highly inflated. There is also an unrealistic perception that all insurance carriers could be closed on "day one" with the realized savings being immediate. It assumes that the government-run single payer system would be capable of handling the additional volume without a

significant increase in governmental costs. The savings, if they are real, would be spread over several years as insurance company obligations are run off. In addition, under the single payer model, there is no accounting for the public cost of thousands of suddenly unemployed health insurance company and producer employees.

Under the proposed legislation, the costs of providing quality healthcare with good patient outcomes would remain high and has not been addressed. The issue of ever rising medical trend, might be temporarily masked by spreading the costs of healthcare over a larger base of insured residents. However, as time goes by and without impacting the rate of increase in medical trend, the issue of affordability will return, although this time as a tax issue for the government-run entity, not as an employer-based health premium issue.

Health insurance costs in New York, just like in the rest of the country, are high. This contributes directly to the number of uninsured and the level of uncompensated care. Addressing the insurance portion of the issue is only addressing the symptom. The supply side management approach of limiting the amount paid to providers of care is at its limit. We need to begin a program which addresses the unlimited and unnecessary demand we place on our health care system. While short term measures, such as modifying the current community rating system, establishing a high risk pool, and allowing wellness program incentives should be adopted, any legislation which doesn't include measures to deal with the long term issue of bending the healthcare cost trend is shortsighted and will not fix New York's problem.

Finally, a single payer system such as New York Health would fly in the face of the federal healthcare reforms enacted under the Patient Protection and Affordable Care Act (PPACA), and would also undermine the implementation and operation of the New York State of Health Marketplace (NYSOH) established under Governor Cuomo's Executive Order No. 42 (2012).

For all of the reasons enumerated herein, we continue to oppose a government-run, single payer system, as it would stifle cost control innovation in the insurance marketplace, provider oversight, drastically cut provider reimbursement rates and, in the absence of free market controls, would ultimately lead to rationing of medical care as the only solution to contain costs.

As such, on behalf of the members of the New York State Association of Health Underwriters we are constrained to **STRONGLY OPPOSE** S.3525 / A.5062 and **URGE ITS DEFEAT**.

Respectfully submitted,

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