

ECONOMIC ANALYSIS OF THE NEW YORK HEALTH ACT

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EXECUTIVE SUMMARY

This report analyzes the economic effects of the New York Health Act (the “Act”), which would establish a comprehensive, universal health insurance program for all New Yorkers. The Act would replace the current multi-payer system of employer-based insurance, individually acquired insurance, and federally sponsored programs (e.g., Medicare and Medicaid) with a single billing pipeline funded by broad-based progressively graduated assessments collected by the State and based on income and ability to pay, thereby reducing administrative bloat and monopolistic pricing and dramatically reducing the cost of health care to New Yorkers even while extending and improving the provision of care.

Because health care spending in New York has risen faster than income, **the share of state income spent on health care and the administration of the health care system has risen from 12% in 1991 to 16% in 2014, and is projected to pass 18% by 2024. The average cost of an employer-provided family plan in New York has risen to over \$17,500, even with an average family deductible that has risen to over \$2,200.** Because of the rising cost of health insurance and rising copayments and deductibles, growing numbers of New Yorkers are prevented from receiving needed health care.

By reducing burdensome billing expenses, administrative waste in the insurance industry, monopolistic pricing of drugs and medical devices, and fraud, the Act would save over **\$70 billion in 2019, 25% of that year’s projected health care spending, and savings will increase over time.** Some savings would be used to finance system improvements. Even after expanding coverage to the uninsured, removing barriers to access, and correcting the underpayment of Medicaid services, **the Act would save \$44.7 billion in the first year alone, nearly \$2200 per person.** Furthermore, by reducing the number of New Yorkers without health care, these improvements would **save thousands of lives each year.**

The New York Health Act would be financed with assessments collected by the State based on ability to pay. Payroll assessments would be graduated according to income, and there would be a progressively graduated assessment on non-payroll taxable personal income (e.g., capital gains, dividends and interest). These would fund health care in New York while reducing the burden on the sick, the poor, and the middle class. **While the largest savings would go to working households earning less than \$75,000, over 98% of New York households would spend less on health care under the Act than they do now.**

By lowering the burden of health insurance on business, the “New York Health Plan” (also referred to as the “New York Plan” or “the Plan”) would make businesses in New York more competitive. Investment would be drawn to New York to take advantage of the reduced cost of hiring workers. Separating health insurance from employment would also free entrepreneurial energies. **The Plan would be expected to create over 200,000 new jobs,** more than replacing those lost in insurance and in billing and insurance activities in provider offices.

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INTRODUCTION

This economic analysis explores the implications of enacting the New York Health Act if it were to go into effect in 2019. The Act would replace New York's current multi-payer system in which individuals, private businesses and government entities pay public and private insurers for health care coverage. The Act would establish the New York Health Plan to finance medically necessary care including hospitalization, doctor visits, dental, vision, mental/behavioral health, prescribed occupational and physical therapy, prescription drugs, medical devices, and rehabilitative care.¹ The Plan would offer this comprehensive coverage to all New York residents and would pay for it with broad-based, progressively graduated premiums assessed by the State on payrolls and on non-payroll income.

The New York Health Act would finance medical care with substantial savings compared with the existing multi-payer system of public and private insurers. By reducing administrative and other waste and eliminating health insurance company profits and excessive prices for drugs and medical devices, the New York Health Act would increase real disposable income for the vast majority of residents. It would simultaneously increase employment by reducing the burden of health insurance on business. Some of these savings would be used to extend coverage to the 7% of New York residents still without insurance under the Affordable Care Act; other savings would be reinvested in the health-care system to improve coverage for the growing number with inadequate coverage. In addition to improving New Yorkers' health by reducing barriers to access to health care, the Plan would eliminate the financial penalty associated with health problems. It would also reduce economic inequality by replacing the current regressive system of health insurance finance with contributions proportional to income and ability to pay.

HEALTH CARE SPENDING IN NEW YORK

Personal health care spending has been rising at an unsustainable pace in New York. Between 1991 and 2001, total health consumption spending rose at nearly 6% a year with per-capita spending rising at over 5.5% a year (see Figure 1).² The rate of increase in total health consumption slowed after 2001, but even at 5.0% per year, health care spending absorbs a growing share of the state's income. As a share of state product, health care costs have risen sharply since 1991, from 12% of state income in 1991 to 16% in 2014. With current policies, it will rise to over 18% of state income in the next decade (see Figure 2).

Health care cost inflation is squeezing disposable income for New Yorkers. If health care spending per person had risen only as fast as income, then spending in 2014 would have been 23% less, saving the average person \$2600 in 2014, or more than \$10,000 in savings for a family of four.

¹ Long-term care will be added under a plan to be developed within two years of the Act taking effect.

² Expenditures are estimated from the Centers for Medicare & Medicaid Services, Office of the Actuary, data on personal health expenditures by state linked to national expenditure projections; see appendix for details.

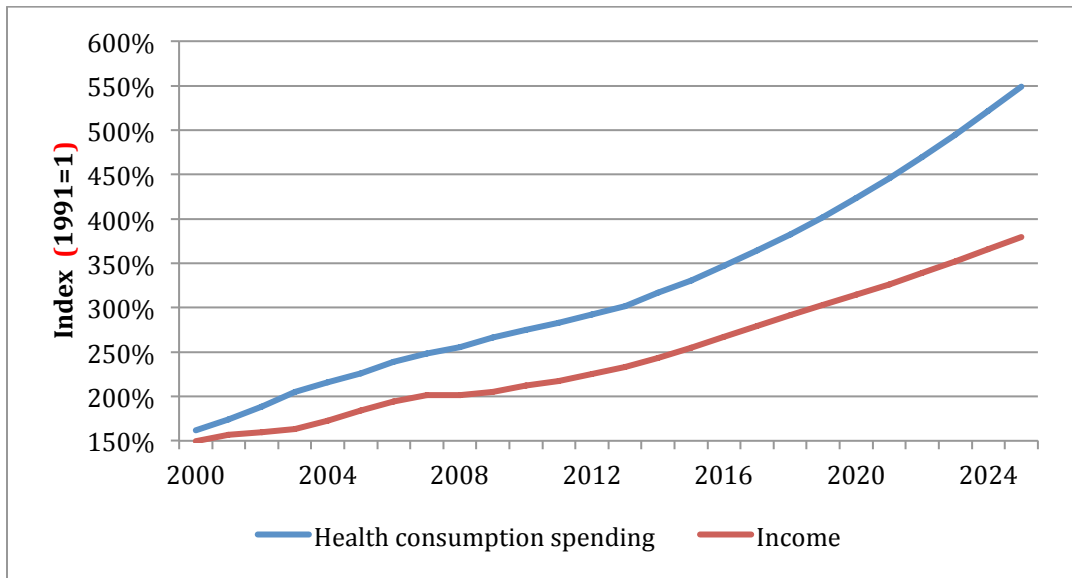


Figure 1. Health care expenditures and income, New York, 1991-2025, actual and projected.

Note: This shows an index of health consumption expenditures and Gross State Product in New York relative to per capita spending and income in 1991. GSP is from United States Bureau of Economic Analysis; health spending is from United States, Center for Medicare and Medicaid Statistics, National Health Expenditures data, <http://www.cms.gov/NationalHealthExpendData/Downloads/res-tables.pdf>

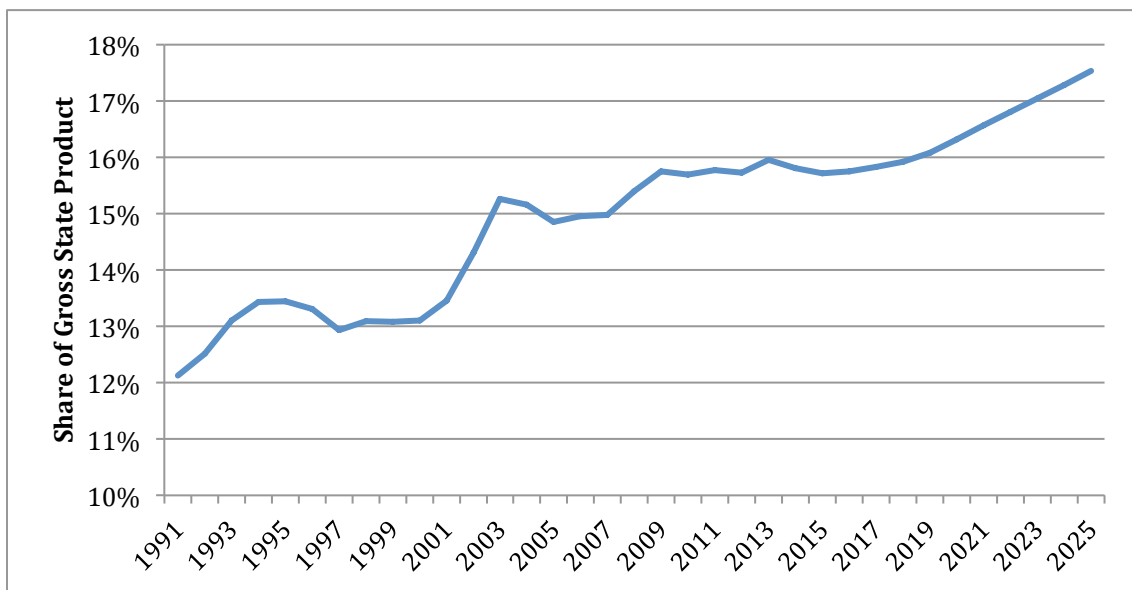


Figure 2. Health care expenditures as share of gross state product, New York, 1991-2025.

Note: This figure shows health consumption expenditures in New York divided by total income (GSP) in the state. Data for years after 2009 is a projection under current law assuming that per capita expenditures will increase at the same rate projected for the nation as a whole, and that population will continue to increase at its current rate.

Spending has increased largely because of the rising cost of health care rather than increasing utilization. This is especially true in the private market, where costs have risen significantly faster than in Medicare. Since 1969, private health insurance spending per enrollee on a common set of benefits has increased seven times as fast as the price of other commodities, nearly twice as fast as the increase for Medicare. Had all health care prices increased only as fast

as Medicare, health care spending in the United States would have risen only slightly faster than the rate of growth in national income.³

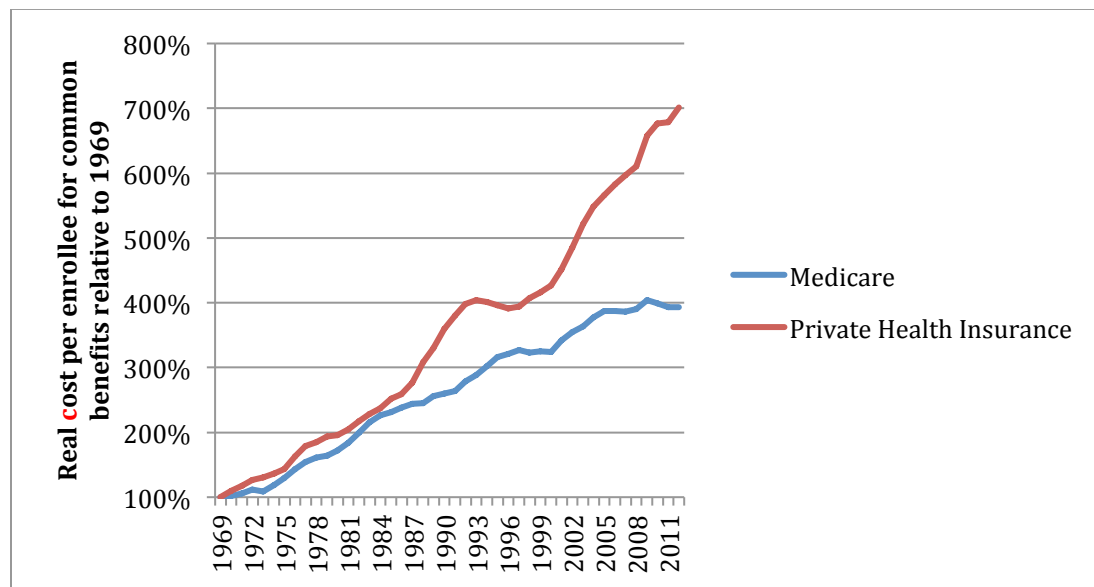


Figure 3. Growth in spending per enrollee for common benefit package, Medicare and private health insurance, 1969-2011.

HEALTH SPENDING AND HEALTH OUTCOMES: THE UNITED STATES AND NEW YORK STATE

Rising health expenditures can reflect an income effect when an affluent and aging population chooses to buy more health care of a higher quality. However, spending in New York has increased without improving health care for many residents.⁴ Despite the high quality of many world-famous hospitals and physicians, and the excellent health care some affluent New Yorkers receive, the average quality of care and the care given many less fortunate residents does not match the expense. Compared with other countries, the American health care system is uniquely inefficient. Despite spending well over twice as much per person as the average for the member nations in the Organization of Economic Cooperation and Development (OECD), life expectancy in the United States is *below* the OECD average. New York barely exceeds the OECD average despite spending a further 15% more than the average per person spending for OECD members. If the United States had achieved the same life expectancy per dollar of expenditure as did other

³ Himmelstein DU and Woolhandler S, "Cost Control in a Parallel Universe: Medicare Spending in the United States and Canada," *Archives of Internal Medicine* 172, no. 22 (December 10, 2012): 1764–66, doi:10.1001/2013.jamainternmed.272.

⁴ David M Cutler, *Your Money or Your Life: Strong Medicine for America's Health Care System* (Oxford: Oxford University Press, 2004); Gerald Friedman, "Universal Health Care: Can We Afford Anything Less?," *Dollars and Sense*, June 29, 2011, ("ARTICLE NO LONGER AVAILABLE ON-LINE"); Allan Garber and Jonathan Skinner, "Is American Health Care Uniquely Inefficient?," *Journal of Economic Perspectives* 22, no. 4 (Fall 2008): 27–50.

countries, we would live nearly six years longer. Alternatively, had we spent only as much as did other countries to reach our life expectancy, we would save \$6000 per person.⁵

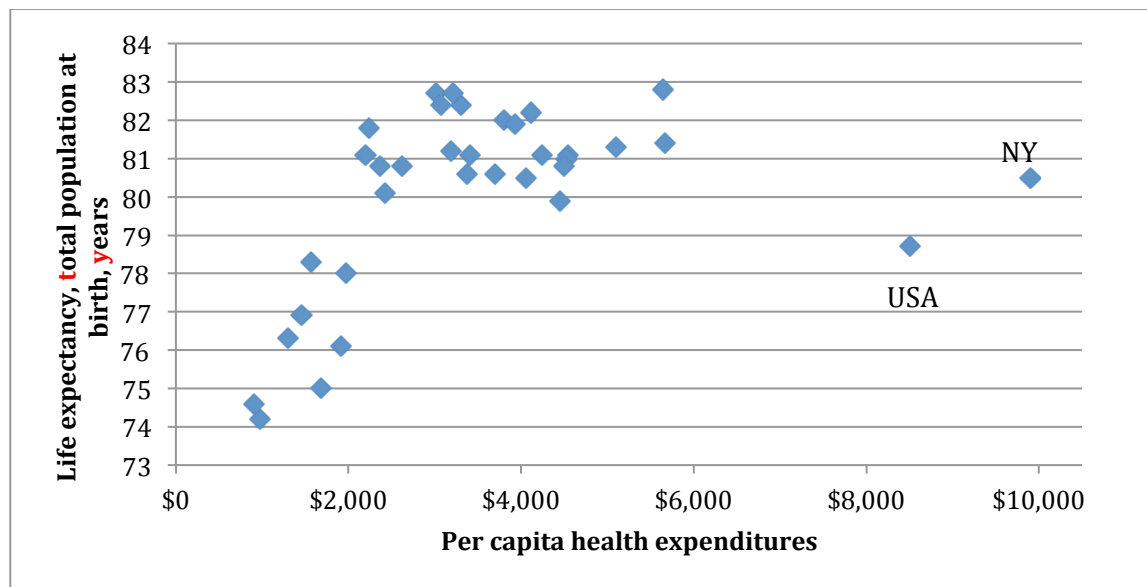


Figure 4. Life expectancy and per capita health care spending, OECD members plus New York State, 2011.

Note: Each diamond in this figure represents an OECD member nation and gives per capita health expenditures and life expectancy at birth except for the diamond labeled “NY” for New York State. Note that life expectancy increases with expenditures for the rest of the OECD but life expectancy for the United States is below the OECD average despite expenditures over \$2000 per person higher than for any other country. New York spends more than the rest of the United States and enjoys higher life expectancy. Despite spending much more than any OECD member, life expectancy in New York is only average for the OECD.

Life expectancy is shorter in the United States *despite* some relatively healthy life style practices. Americans, for example, drink less, are less likely to commit suicide, and are much less likely to smoke than residents of other OECD countries.⁶ Americans, however, use the health care system less than do residents of other countries. They average only 4.1 physician consultations per person per year, compared to 6.7 for the rest of the OECD, and Americans have fewer and shorter hospital stays.⁷

Shorter life expectancy and higher spending on health care reflects the way higher prices for health care in the United States prevent Americans from seeking needed care. More than in any other OECD country, Americans, those with health insurance or those without, refrain from accessing the health care system because of cost. The proportion of sick people able to see a doctor within a day was lower in the United States than in 7 of 9 other countries, all of which had national health systems.⁸ In addition, the United States has by far the highest proportion of

⁵ Based on a regression of life expectancy on per capita expenditures in OECD members in 2011 using data from OECD Health Data, “Frequently Requested Data.”

⁶ Americans also have the highest rate of obesity. See OECD Health Data, “Frequently Requested Data”.

⁷ OECD Health Data, “Frequently Requested Data”.

⁸ Sarah Thomson et al., *International Profiles of Health Care Systems, 2013 Australia, Canada, Denmark, England, France, Germany, Italy, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United States* (Commonwealth Fund, November 2013), http://www.commonwealthfund.org/~media/files/publications/fund-report/2013/nov/1717_thomson_intl_profiles_hlt_care_sys_2013_v2.pdf.

people reporting cost-related access troubles that prevented them from seeing a doctor when sick (see Figure 5).⁹

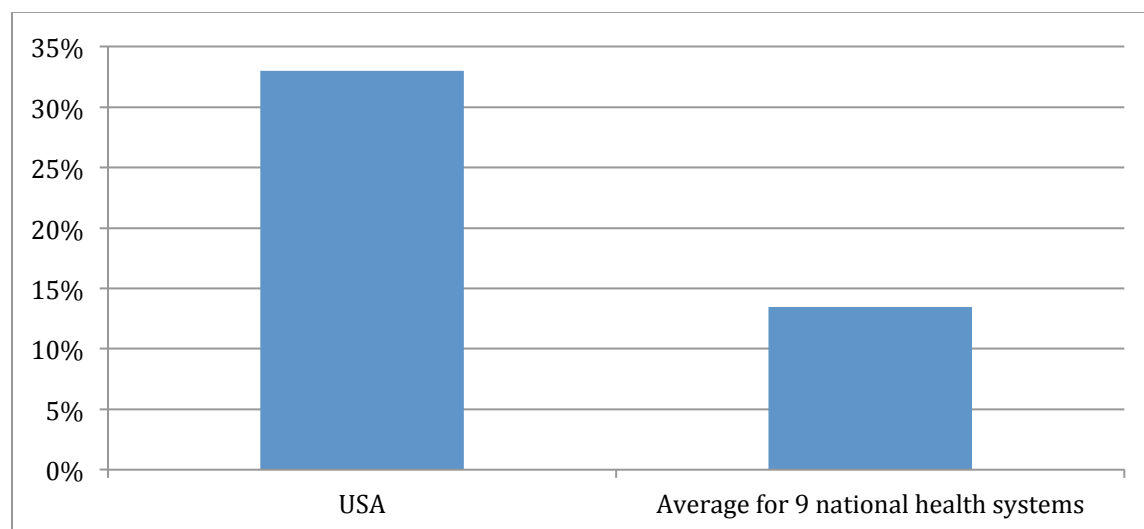


Figure 5. Proportion unable to receive needed medical care when sick, United States and other affluent countries.¹⁰

Low-income and working people have the greatest difficulty accessing our health care system, and their short life expectancy accounts for much of the shortfall in our relative life expectancy.¹¹ The life-expectancy correlation with income has been increasing in the United States, and the access problem greater, because a growing share of the cost of health care has been pushed onto workers.

RISING BARRIERS TO ACCESS TO HEALTH CARE IN NEW YORK STATE

In New York State, for example, the share of private sector workers with health insurance through their employer fell sharply from 57% of workers in 2003 to 47% in 2013.¹² Those who still have health insurance through work are paying both higher premiums and higher out-of-pocket costs for deductibles and copayments.

⁹ *Ibid.*; across over 3000 US counties, there is a strong positive relationship between age-adjusted mortality and the proportion unable to see a doctor because of cost. A regression of mortality on access difficulty has an R2 of .35. Robert Wood Johnson and University of Wisconsin, Population Health Institute, "County Health Rankings," *County Health Rankings & Roadmaps*, accessed April 28, 2014, <http://www.countyhealthrankings.org/rankings/data>.

¹⁰ Thomson et al., *International Profiles of Health Care Systems, 2013 Australia, Canada, Denmark, England, France, Germany, Italy, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United States*.

¹¹ The gap between life expectancy for rich and poor Americans has increased dramatically over the past 20 years, especially for women; see Barry P. Bosworth and Kathleen Burke, "Differential Mortality and Retirement Benefits in The Health And Retirement Study," *The Brookings Institution*, accessed April 21, 2014, <http://www.brookings.edu/research/papers/2014/04/differential-mortality-retirement-benefits-bosworth>.

¹² The proportion without employer-supplied health insurance is particularly low in New York City; see New York City Independent Budget Office, *Medicaid, Employer-Sponsored Health Insurance, and the Uninsured in New York: Regional Differences in Health Insurance Coverage*, Fiscal Brief (New York City: New York City Independent Budget Office, October 2014), <http://www.ibo.nyc.ny.us/iboreports/2014medicaid.pdf>.

In 2013, the average premium for an employer-provided family plan in New York State was nearly \$17,530 with employees directly paying over \$4200, more than twice as much as ten years earlier.¹³ Along with sharply increasing premiums, the share of plans with a deductible has nearly doubled, as has the average deductible. For a family plan, the average deductible has doubled from \$700 in 2003 to over \$1400 in 2013.¹⁴ Copayments for office visits have also risen, while insurance plans have raised the full cost of getting medical attention by putting more restrictions on access to physicians, requiring the sick to travel farther and to change doctors, or else pay out-of-pocket for seeing an out-of-network provider. Transportation and network barriers to access are especially severe in rural areas with a lower density of physicians. By cost-shifting onto the disabled, the sick, and their families, rising copayments and deductibles have undermined the purpose of insurance.

By restricting access to care, increased cost-sharing hurts the health of New Yorkers. Mortality rates are higher for New Yorkers who face higher financial and other barriers to access. Mortality rates are highest both in poor urban neighborhoods and in rural areas, especially among the uninsured and others who experience cost-related access problems.¹⁵ As in the country as a whole, New Yorkers who could not see a doctor because of cost have significantly higher mortality rates. Using the county mortality and health-care access data in Figure 6, every percentage point increase in the share of the population unable to see a doctor because of cost raises the age-adjusted mortality rate by over 1 percent. For Albany County, this means an extra 29 deaths; for the Bronx, 143; for Oswego, thirteen.

¹³ Premiums are even higher (about 20% higher) in New York City and on Long Island than in the rest of the state; see Medical Expenditure Panel Survey at the Department of Health and Human Services at the Department of Health and Human Services, http://meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp?regionid=30&year=2012.

¹⁴ The share of employees with a deductible rose from 32% in 2003 to 62% in 2013 with the average family deductible increasing from \$1048 to \$2273. This is from the Medical Expenditure Panel Survey at the Department of Health and Human Services at the Department of Health and Human Services, http://meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp?regionid=30&year=2012 http://meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp?regionid=30&year=2003

¹⁵ Using county mortality data linked with census data on the rural and urban population, the age-adjusted death rate is about 10% higher for rural residents; see Robert Wood Johnson and University of Wisconsin, Population Health Institute, "County Health Rankings."

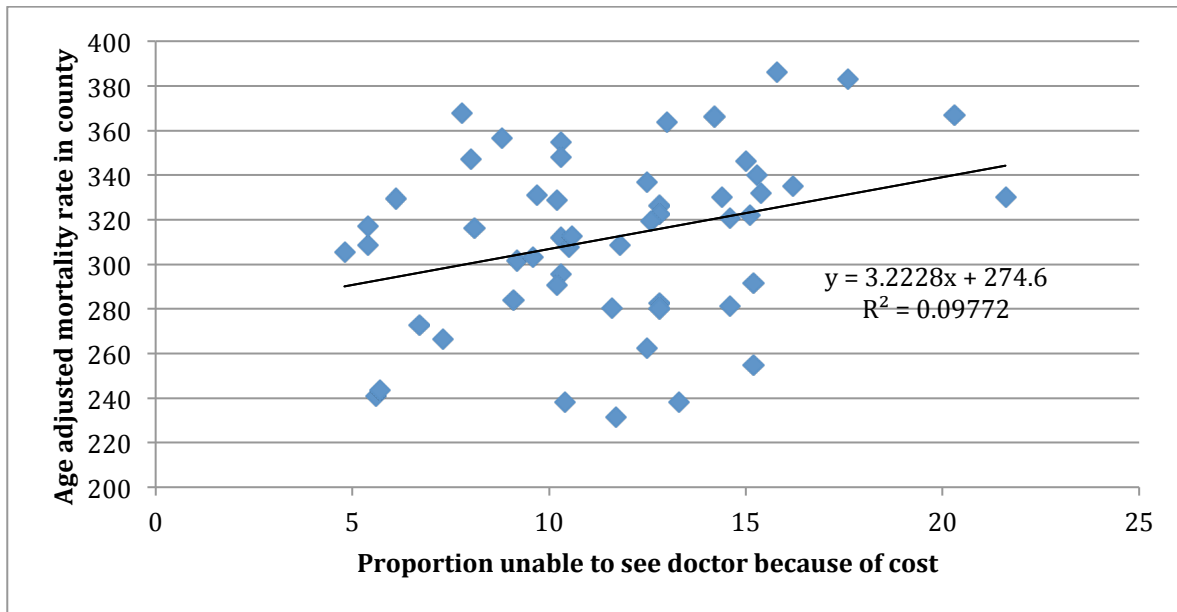


Figure 6. Age-adjusted mortality and the proportion of county residents unable to see a physician due to cost.
Note on Figure 6: Each diamond represents a New York county with the average age-adjusted mortality rate and the proportion of the population reporting that they were unable to see a physician because of cost. About 25% of the variation in the proportion unable to see a doctor was because of lack of health insurance; the rest is among those with insurance. The equation represents the regression of the county mortality rate on the proportion unable to see a doctor because of cost.

AN ALTERNATIVE FOR NEW YORK

The New York Health Act would replace most private and public health care expenditures with a single payment system that would simplify billing for providers and eliminate most billing and insurance related expenses. It would replace a complex, fragmented, and risky system with one with a more stable, single risk pool and a vastly simplified administration. Funding that imposes costs disproportionately on working families and people who need health care would be replaced by broad-based funding based on ability to pay.

The current system includes dozens of separate insurance providers, including large government programs, Medicare and Medicaid, while almost half of residents receive health insurance through employment. Looking forward to 2019, it is projected that public programs will account for over half of all health-care expenditures in the state while private insurance (including employment-based insurance for public-sector workers) will account for a third of expenditures. Private insurance covers a higher proportion of residents than of spending because these plans enroll younger and healthier people.¹⁶ The remaining projected spending, over 16%, will be out-of-pocket or from other sources (such as philanthropy).

¹⁶ Insurance expenditures have been calculated from Medical Expenditure Panel Survey at the Department of Health and Human Services, http://meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp?regionid=30&year=2012 and http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_3/2012/ic12_iiia_g.pdf for the private and public sectors respectively.

Table 1. Projected sources of spending, New York health care, 2019.

	Share of spending	Projected spending 2019 (in \$millions)
Total spending	100.0%	\$287,444
Employer administration	0.7%	\$2,026
Private employer-sponsored health insurance	17.6%	\$50,647
Government employees' insurance	6.0%	\$17,353
Individual health insurance	4.2%	\$12,086
Medicare	22.3%	\$64,002
Medicaid	23.8%	\$68,408
Childrens' Health Insurance Plan	0.5%	\$1,532
VA	1.7%	\$4,761
Retirees and senior wrap-around	3.8%	\$10,903
Workers' Comp	0.5%	\$1,442
Public health programs	2.8%	\$8,188
Other	4.9%	\$14,109
Out-of-pocket	11.1%	\$31,987

Note: Health care spending includes administrative costs in insurance companies and government agencies. Expenditures for 2019 are projected assuming the growth rate in spending in each health care category will continue as in the past in New York except for a general slowdown reflecting the slowdown in national spending estimated from data from the United States, Centers for Medicare and Medicaid Services, "Health Expenditures by State of Residence." Amounts are shown in \$millions.

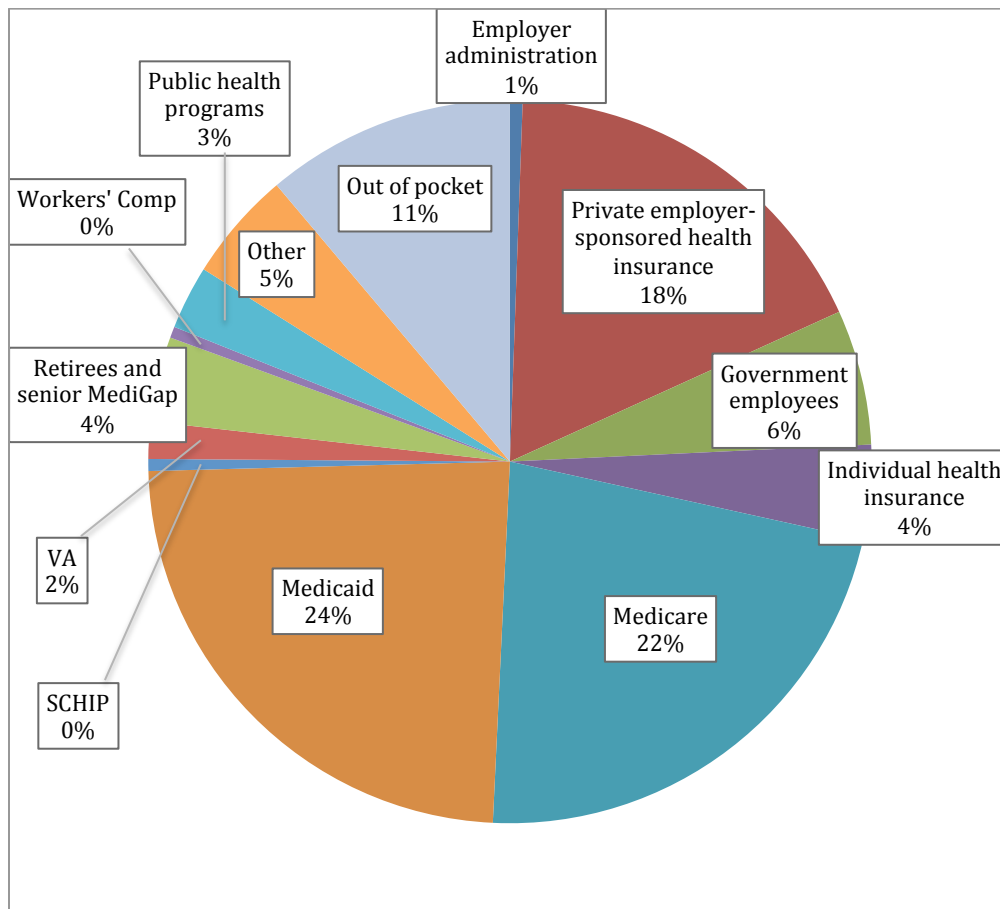


Figure 7. Sources of health care spending, NY 2019 (projected). (See also Appendix 2.)

Public sources other than spending for public employee health insurance account for over half of total expenditures, including federal programs like the Veterans Administration, Medicare for the elderly and some disabled, Medicaid for the poor (including some elderly and disabled), and Children’s Health Insurance (CHIP).¹⁷ The State of New York and county governments contribute to Medicaid and public health services.¹⁸ While publicly financed, much of Medicaid spending, along with all of CHIP and a portion of Medicare, is channeled through insurance companies, including managed care plans.

After taking into account private insurance and government programs, “out-of-pocket” expenditures have been calculated as a residual.¹⁹ Out-of-pocket spending, including copayments, insurance deductibles, out-of-network spending not reimbursed by insurers, spending by the uninsured, and charges not covered by insurance or disallowed for other reasons account for 11% of total expenditures.

¹⁷ The usual match is 50 percent. Under the Affordable Care Act (ACA), the Federal Government will reimburse states for 90-100 percent of the cost of Medicaid expansion from 2014-24.

¹⁸ Expenditures for Medicaid, among others, appear in the State budget along with federal reimbursements.

¹⁹ The “other” category includes some federal programs, such as the Indian Health Service, as well as philanthropic and charitable spending. Note that this procedure puts any error in the estimate of total health expenditure into the “out-of-pocket” category.

Including out-of-pocket spending, 44% of New York health-care spending will come from employment and private sector activities, including private and public employers, individuals, and businesses. The share of health care services provided by this spending, however, will remain less, only 42%. The shortfall between spending and services reflects the higher administrative burden on private sector spending. Private spending is a relatively inefficient source of health care because more of it goes to administering the health care system, including marketing, billing, and the higher salaries paid to private insurance executives.²⁰

ANTICIPATED SAVINGS FROM THE NEW YORK HEALTH ACT, 2019

The New York Health Act would have a single public program pay for services currently financed by private and public health insurance, as well as pay for medically necessary services currently purchased out-of-pocket.²¹ It would fund health care in the state, although long-term care will not be covered until a plan to be developed is adopted in the future.²² The proposed plan would cover all medically necessary spending with no out-of-pocket spending, an actuarial rate of 100%, a significantly higher rate than is covered now (89%), or than is covered under most insurance plans including the Federal Employee Benefit Program (with an actuarial rate of 87%) or so-called platinum exchange plans (with a rate of over 90 percent).²³

²⁰ The CEOs of nine large health insurers averaged nearly \$14 million in compensation in 2013, over double the average for CEOs of Russell 3000 companies, and nearly 100 times that of the head of the United States Centers for Medicare and Medicaid Services; see “CEO Pay by Industry,” *AFL-CIO*, accessed December 5, 2014, <http://www.aflcio.org/Corporate-Watch/Paywatch-2014/CEO-Pay-by-Industry>; “Healthcare-NOW! - Health Insurance CEO Pay Skyrockets in 2013,” accessed May 5, 2014, <http://www.healthcare-now.org/health-insurance-ceo-pay-skyrockets-in-2013>.

²¹ Under this proposal, because the New York Health Act would initially not cover long-term care, it is assumed that spending on long-term care would not change and there would be no administrative economies in its provision. When coverage is extended, there will be an increase in both savings and in the utilization of health-care services.

²² The New York Health Act would cover 100% of the cost of covered services and about 95% of all health care spending, including health care services covered by any of the following: Medicaid, Medicare, State public employee health benefits, the mandates of the State Insurance Law, and anything the plan chooses to add. It would not cover purely cosmetic surgery and non-medically necessary private hospital rooms. Initially, it also will not cover long-term care. For a similar program design, see Edith Rasell, “An Equitable Way to Pay for Universal Coverage,” *International Journal of Health Services* 29, no. 1 (1999): 179–88.

²³ Optimally, all necessary federal waivers will be granted to allow the incorporation of existing federal programs into the New York Health plan, including the exchange subsidies, Medicare, and Medicaid. Medicare could be brought in by establishing the State program as a Medicare Advantage plan (unlike other Medicare Advantage plans, it would operate on the principles of New York Health and would therefore have administrative costs comparable to traditional Medicare); if the Veterans Administration remains outside the plan, that would have no net effect on financing needs because it is self-funded in any case. The program would operate under Section 1332 of the Patient Protection and Affordable Care Act which allows for state innovation beginning in 2017 provided that the state plan covers at least as many people as the ACA with no extra cost to the Federal Government. See John E. McDonough, “Wyden’s Waiver: State Innovation on Steroids,” *Journal of Health Politics, Policy and Law*, May 19, 2014, 2744824, doi:10.1215/03616878-2744824; Ron Wyden, *State Waivers: How a State Could Do Health Reform Its Own Way* (Washington, D. C.: Office of Senator Ron Wyden, United States Senate, n.d.), <http://www.wyden.senate.gov/download/?id=6073398f-c82c-42f4-8da5-e004a867e01a&download=1>.; Jesse Cross-Call, “Understanding Health Reform’s Waivers for State Innovation,” *Center on Budget and Policy Priorities*, April 18, 2011, <http://www.cbpp.org/cms/?fa=view&id=3475>; Taylor Lincoln, *A Road Map to “Single-Payer”: How States Can Escape the Clutches of the Private Health Insurance System* (Washington, D. C.: Public

Through economies in administration and by reducing inflated drug and device prices, the New York Health Plan would produce substantial savings over the current health care system. While there will be savings in insurance company administrative costs and profits, and in billing and insurance related expenses now borne by physicians, hospitals, pharmacies, dentists and other health care providers, savings will be achieved *without* reducing net reimbursements to most physicians and other providers. On the contrary, health care providers serving Medicaid patients would see higher reimbursements. With over \$70 billion in savings on current services (see below), these economies would allow the plan to provide the same health services as the current system while saving 25 percent of current expenditures. Some of these savings would be used to correct problems within the health care system by extending coverage to the uninsured, raising some provider reimbursements, and removing barriers to access. New York Health would cover the costs now paid out-of-pocket by consumers for deductibles, co-pays and out-of-network care; it would also cover the cost of Medicare Part B premiums and the local government share of Medicaid costs. This is a shift in how these costs are paid, rather than a saving or increased cost to the system overall. After these adjustments, health care spending in New York would be almost 20 percent lower. Even after making significant improvements and expansions in the health care system to provide better care to all New Yorkers, the Plan will save \$45 billion in 2019, or nearly \$2200 per resident.²⁴

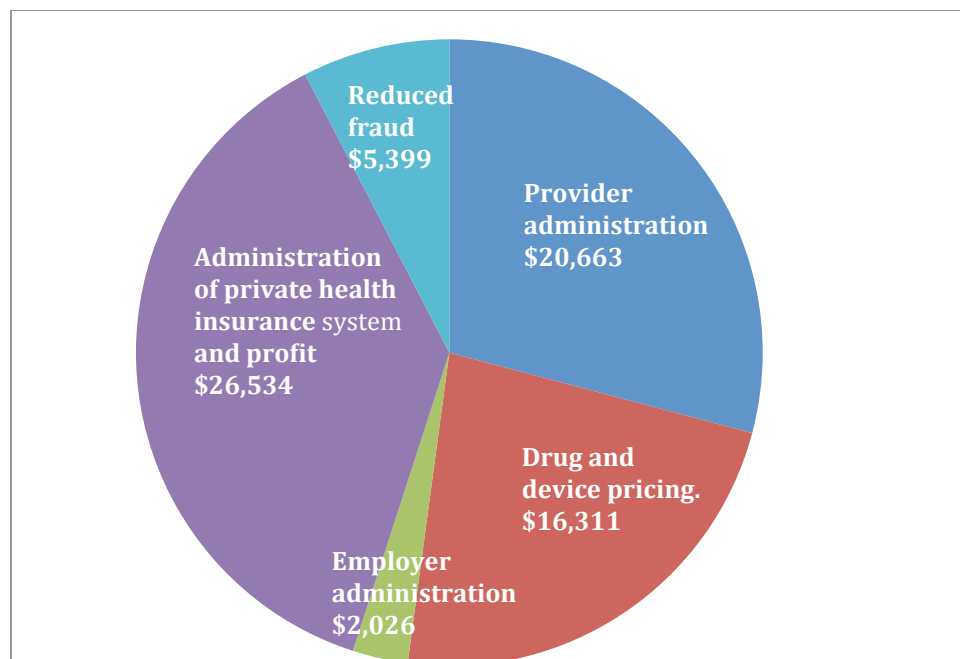


Figure 8. Savings from New York Plan, 2019, in \$millions.

Citizen, July 10, 2013), <http://www.citizen.org/documents/road-map-to-single-payer-health-care-report.pdf>. If necessary, New York Health would wrap around Medicare and other programs.

²⁴ Note that two other spending programs are built into the proposed plan but these are *not* included as expenses because they involve the assumption by the Plan of current expenses borne by New Yorkers and therefore involve a redistribution of spending without any new resources. These include the assumption by the Plan of Medicare Part B premiums paid by New Yorkers (about \$5 billion in 2019); and the assumption of the share of Medicaid paid by local governments (about \$10 billion in 2019).

Note: This shows the projected savings in \$millions from the New York Health Plan. The largest area of savings would be in the administration of the insurance system followed by savings in the billing and insurance related activities in provider offices, and in reduced market power for drug and hospital prices and for some physician practices.

Savings would come from administrative economies and by reducing anti-competitive practices especially in the pricing of drugs, pharmaceuticals, and devices.²⁵ They are summarized in the following sections.

SAVINGS IN ADMINISTRATION OF PRIVATE HEALTH INSURANCE

In the current system, almost 13% of spending is on the administration of the payment system including private insurance and employer-sponsored self-insured plans (which are administered much like insurance), as well as government insurance programs. Private health insurers spend over 15% of premiums on administrative activities, including inflated managerial salaries, redundant bill reviews, medical review programs, and other overhead, plus profit.²⁶ Private insurers also waste resources in other ways. Competition leads them to spend money on advertising and marketing their competing plans; and many insurers are too small to realize the scale economies possible with a large billing network. While public plans are much more efficient, the private system of administrative waste has spread to Medicare through the Medicare Advantage plans and to Medicaid through managed care programs. Public safety-net programs like Medicaid and CHIP also spend significant funds policing eligibility. The limited range of public insurance has undermined their efficiency by leading individuals to seek private coverage. Overhead costs are even higher in the individual insurance market, including the Medigap policies purchased by many seniors to cover insurance costs not covered by Medicare.

²⁵ Estimates of the sources of waste in the United States include Donald Berwick and Andrew Hackbarth, "Eliminating Waste in US Health Care," *JAMA: The Journal of the American Medical Association* 307, no. 14 (2012): 1513–16; Martha Coakley, *Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. C. 118G, § 6½(b) Report, 2011* (Boston, Mass.: Attorney General of Massachusetts, 2011); Massachusetts Health Policy Commission, *2013 Cost Trends Report, Annual Report* (Boston, Mass., 2013).

²⁶ The Affordable Care Act sets limits on administrative waste with minimum Medical Loss Ratios of 85% for group plans and 80% for individual plans. Nationally, health insurers refunded over \$332 million in excessive administrative charges under the ACA in 2013 to nearly 7 million subscribers; New York insurers refunded \$12,147,281 to 617,465 residents. See <http://kff.org/health-reform/state-indicator/mlr-rebates-total/>. Even under the ACA, government measures of insurance company medical loss ratios leave extensive scope for insurance companies to pass off administrative costs as medical costs. Allowable expenses include "educational outreach to members, utilization management, case management, disease management and quality management." In addition, the time period allowed for medical expenses, net premiums and re-insurance recovery are not consistently defined, leaving room for companies to inflate their Medical Loss Ratio; Families USA, "Medical Loss Ratios: Evidence from the States" (Families USA, June 2008); Maryland Insurance Administration, "Report on the Use of the Medical Loss Ratio" (Maryland, December 2009); Eric Naumburg, "Medical Loss Ratios in Maryland," July 12, 2010; a reasonable measure of the medical loss ratio for California estimated that it is only 82 percent; see James G. Kahn et al., "The Cost Of Health Insurance Administration In California: Estimates For Insurers, Physicians, And Hospitals," *Health Affairs* 24, no. 6 (November 1, 2005): 1629–39, doi:10.1377/hlthaff.24.6.1629.

In 2019, administering the third-party payer system will cost over \$30 billion; lowering these costs to the level of traditional Medicare (1.8 percent) would save nearly \$26.5 billion in 2019.²⁷

SAVINGS IN EMPLOYERS' ADMINISTRATION OF PRIVATE HEALTH INSURANCE PLANS

Employers incur significant costs in administering health insurance plans, including hiring health insurance benefit consultants. In 1999, these costs came to 4.0% of the total cost of employer-provided health insurance. Applying the same ratio to the projected health insurance spending in 2019, it is expected that New York employers will be able to save \$2.0 billion otherwise spent choosing and managing health insurance plans.²⁸

SAVINGS IN BILLING AND INSURANCE RELATED EXPENSES IN PROVIDER OFFICES AND HOSPITAL ADMINISTRATION

American health care providers (hospitals, physicians, etc.) spend significantly more time on administrative tasks than do their counterparts in countries with universal coverage systems. Physicians in the U.S., for example, devote one-sixth of their work hours on administration, including bill processing, four times the time spent by their Canadian counterparts; New York physicians and providers spend even more on administration than do providers nationally.²⁹ Simplifying the reimbursement process would save physicians nearly six hours a week.³⁰ If New York health care providers were to spend, proportionally, only as much on administration as do physicians in Canada, or 14% of revenue instead of 24%, they would save nearly \$21 billion in administrative costs.³¹

²⁷ Note that the entire Medicare program has higher administrative costs because of the costs of administering Medicare Advantage plans. Also note that there are additional administrative savings because the entire health care sector will be smaller because of savings in other areas.

²⁸ Steffie Woolhandler, Terry Campbell, and David Himmelstein, "Cost of Health Care Administration in the United States and Canada," *New England Journal of Medicine*, no. 349 (2003): 768–75; Aliya Jiwani et al., "Billing and Insurance-Related Administrative Costs in United States' Health Care: Synthesis of Micro-Costing Evidence," *BMC Health Services Research* 14, no. 556 (2014), <http://www.biomedcentral.com/content/pdf/s12913-014-0556-7.pdf>.

²⁹ Administrative payrolls are a 19% larger share of payrolls in New York (24% vs. 20%) than in the United States as a whole; this is from the BLS Occupational Employment Statistics. American hospitals spend much more on administration than do hospitals in other countries: see David U. Himmelstein et al., "A Comparison Of Hospital Administrative Costs In Eight Nations: US Costs Exceed All Others By Far," *Health Affairs* 33, no. 9 (September 1, 2014): 1586–94, doi:10.1377/hlthaff.2013.1327; a 2005 study found California physician practices spent 41% of their revenue on administration, including 14% directly on billing and insurance related expenses (see Kahn et al., "The Cost Of Health Insurance Administration In California"). In addition to hiring billing and insurance workers, American doctors also spend much more time on billing activities than do physicians in Canada: see Steffie Woolhandler and David Himmelstein, "Administrative Work Consumes One-Sixth of U.S. Physicians' Working Hours and Lowers Their Career Satisfaction," *International Journal of Health Services* 44, no. 4 (January 1, 2014): 635–42, doi:10.2190/HS.44.4.a.

³⁰ There may be a substantial increase in the number of physicians because frustrations with the insurance industry drive many physicians from medicine. The lower administrative burden would draw physicians back to medicine and would attract physicians in neighboring states to practice in New York: see Woolhandler and Himmelstein, "Administrative Work Consumes One-Sixth of U.S. Physicians' Working Hours and Lowers Their Career Satisfaction."

³¹ Woolhandler, et al., have found that providers' administrative costs are much lower in Canada, with a plan like that envisioned by the New York Health Act, than in the United States, and they estimate that a third of medical costs in provider offices in the United States are due to administrative costs, triple the rate in Canada. See

SAVINGS FROM REDUCING MARKET POWER AND PRICE DISTORTIONS: PHARMACEUTICALS AND DEVICES

A comprehensive survey published in 2007 found that drug prices are about 60% higher in the United States than in Europe or Canada.³² A more recent survey may suggest that Americans may pay an even larger penalty for excessive drug prices. The International Federation of Health Plans found that, for eight common drugs, the price in the United States is on average over three times the average price in Canada, England, or the Netherlands. In no case is the United States price lower and in only two drugs (Enbrel and Humira) are prices in United States less than twice that paid in other countries.³³ A treatment of Gleevac, a cancer drug, for example, costs \$6,214 in the United States but only \$1,141 in Canada; Copaxone, a drug for multiple sclerosis, costs \$3,875 in the United States but only \$862 in England; Nexium, for acid reflux, costs \$215 in the United States and \$23 in the Netherlands.³⁴

The inflated price of drugs reflects the market power of companies whose brand reputation is reinforced by patent protection. Inflated prices derived from market power are charged by producers who could still profit from providing the same product even at a much lower price.³⁵ When market power is reduced with the removal of patent protection, for example, patients can buy the same drug for much lower prices. The entry of two new producers when a drug goes

Woolhandler, Campbell, and Himmelstein, "Cost of Health Care Administration in the United States and Canada"; Dante Morra et al., "US Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers," *Health Affairs* 30, no. 8 (2011): 1443–1450, doi:10.1377/hlthaff.2010.0893. Health-care providers spend nearly eight times as much collecting bills as do other businesses: see Bonnie B. Blanchfield et al., "Saving Billions Of Dollars—And Physicians' Time—By Streamlining Billing Practices," *Health Affairs*, April 29, 2010, 10.1377/hlthaff.2009.0075, doi:10.1377/hlthaff.2009.0075.

³² McKinsey Global Institute, "Accounting for the Cost of Health Care in the United States," January 2007, 56, http://www.mckinsey.com/mgi/rp/healthcare/accounting_cost_healthcare.asp. A survey found that drug prices negotiated by the Veterans Administration in 2005 were 48% lower than those offered by Medicare drug plans, themselves somewhat lower than standard drug store prices. See McKinsey Global Institute, "Accounting for the Cost of Health Care in the United States"; Austin Frakt, Steven D. Pizer, and Roger Feldman, *Should Medicare Adopt the Veterans Health Administration Formulary?*, SSRN Scholarly Paper (Rochester, NY: Social Science Research Network, April 14, 2011), <http://papers.ssrn.com/abstract=1809665>; International Federation of Health Plans, *2013 Comparative Price Report: Variation in Medical and Hospital Prices by Country* (International Federation of Health Plans, 2014), <http://static.squarespace.com/static/518a3cfee4b0a77d03a62c98/t/534fc9ebe4b05a88e5fbab70/1397737963288/2013%20iFHP%20FINAL%204%2014%2014.pdf>.

³³ International Federation of Health Plans, *2013 Comparative Price Report: Variation in Medical and Hospital Prices by Country*.

³⁴ Ibid.

³⁵ At \$1000 a pill in the United States, \$84,000 for a full course of treatment, Gilead Science's new Hepatitis C drug Sovaldi has produced more profit in one year than Gilead spent on R and D for over a decade. Almost half of all revenue to Gilead in 2014 was profit. Despite large sales elsewhere, 84% of Sovaldi revenues were in the United States because of hard bargaining by foreign governments and insurers to secure lower prices than are paid by Americans; see David Belk, "Gilead Sciences: A Profile in Congressionally Guaranteed Profiteering," *The Huffington Post*, accessed February 9, 2015, http://www.huffingtonpost.com/david-belk/gilead-sciences-a-profile_b_6641194.html; Jaimy Lee, "Gilead's 2014 Profit Margin Nears 50%, Fueled by Hep C Drugs," *Modern Healthcare*, accessed February 15, 2015, <http://www.modernhealthcare.com/article/20150203/NEWS/302039949&cachebust=JHMQ>; Andrew Pollack, "Gilead Revenue Soars on Hepatitis C Drug," *The New York Times*, April 22, 2014, <http://www.nytimes.com/2014/04/23/your-money/gilead-revenue-soars-on-hepatitis-c-drug.html>.

“off patent” typically lowers prices by 50%, and prices fall by 80% or more when there are eight or more producers.³⁶ The large penalty paid in the United States for drugs still under patent protection suggests that even the 60% figure understates the role of market power in inflating drug prices. A single agency negotiating prices for 20 million New Yorkers should be able to negotiate dramatically lower prices.³⁷ If the New York Health Plan were to negotiate prices that were 37% lower, less than the savings achieved by the Veterans Administration, it would save over \$16 billion.³⁸

SAVINGS FROM REDUCED FRAUD

Fraudulent billing, including duplicate billing and billing for services not rendered, accounts for between 3% and 10% of health care spending in the United States, including an error rate in federal programs of over 9 percent.³⁹ This includes the “accidental fraud” caused by duplicate billing due to the confusing nature of the insurance process.⁴⁰ The New York Health Act would reduce fraud in three ways. Eliminating multiple payers would immediately eliminate the possibility of duplicate billing. It would also simplify the process of tracking bills. In addition, public authorities would have greater subpoena and prosecutorial powers, giving them more power to stop fraud. By reducing fraud and “accidental” overcharging, the New York Health Plan could, conservatively, save 2.5% of total costs, or over \$5 billion.⁴¹

Altogether, projected gross savings on current health care activities come to almost \$71 billion in 2019, 25% of projected health care spending that year. These are gross savings before any

³⁶ Center for Devices and Radiological Health, “About the Center for Drug Evaluation and Research - Generic Competition and Drug Prices,” WebContent, accessed August 1, 2014, <http://www.fda.gov/AboutFDA/CentersOffices/OfficeofMedicalProductsandTobacco/CDER/ucm129385.htm>.

³⁷ Under this plan, the New York Plan would buy drugs in bulk at negotiated prices for a formulary list and then resell them to local pharmacies and health care providers. Drug prices negotiated by the Veterans Administration and other federal agencies, other than for Medicaid, were 48% lower in 2005 than those offered by Medicare drug plans themselves, which are somewhat lower than standard drug store prices. McKinsey Global Institute, “Accounting for the Cost of Health Care in the United States”; Frakt, Pizer, and Feldman, *Should Medicare Adopt the Veterans Health Administration Formulary?*

³⁸ Similar bargaining with device manufacturers will produce savings of \$59 million: McKinsey Global Institute, “Accounting for the Cost of Health Care in the United States,” p. 56. As is done with the VA, after enactment of the New York Health Act, the State would establish a formulary list of covered drugs and negotiate prices with producers. It would then make these drugs available at the reduced prices to pharmacies and other private vendors.

³⁹ Kathleen King and General Accounting Office, “Medicare and Medicaid Fraud, Waste, and Abuse” (United States Senate, Subcommittee on Federal Financial Management, March 9, 2011), <http://www.gao.gov/new.items/d11409t.pdf>; National Health Care Anti-Fraud Association, *Testimony of the National Health Care Anti-Fraud Association to the House Insurance Committee* (Harrisburg, PA: House of Representatives, Commonwealth of Pennsylvania, January 28, 2010), <http://www.docu.com/view/7d4b3344492e717c21f4767dcad3ae16/National-Health-Care-Anti-Fraud-Association.pdf>.

⁴⁰ Anyone who has tried to interpret a hospital bill can appreciate how easy it would be to make mistakes.

⁴¹ This savings estimate is made after accounting for increases in utilization due to the universal coverage plan’s extension of coverage and elimination of copayments and deductibles. The estimate of savings from fraud reduction is conservative compared with, for example, that of the Lewin Group, which regularly assumes that 5% of claims are fraudulent and that 20% of these would be detected with enhanced subpoena powers without taking into account the reduction in duplicate claims under a system like that proposed for New York.

expansions or improvements in the provision of medical services. They are itemized in Figure 8 and in Table 2:

Table 2. Savings (in \$millions) from New York Health Act, 2019.

Current spending (ACA), 2019	\$ 287,444	100.0%
Health care provider billing operations	\$ 20,663	7.2%
Negotiated pricing of drugs and devices	\$ 16,311	5.7%
Administration of third-party payer system (insurance companies, governments, and employers)	\$ 28,560	9.9%
Reduced fraud	\$ 5,398	1.9%
Gross savings (savings on current activities)	\$ 70,932	24.7%
Net spending on current activities	\$ 216,512	75.3%

Note: This table reports the projected savings (in \$ millions) according to where the savings are to be achieved. The savings are calculated by applying a savings percentage estimate to each category of spending as described in the text and Appendix 3.

EXPANDED AND IMPROVED COVERAGE UNDER NEW YORK HEALTH PLAN

Gross savings would come to over \$70 billion. Savings accrued would allow New York to expand access to care for those still without insurance, reduce out-of-pocket costs and barriers to access for those with insurance, and finance an extensive program to help those workers displaced by the New York Health Plan.

The Affordable Care Act would significantly expand health insurance coverage in New York. Medicaid expansion and new enrollments through the State exchange are expected to extend health insurance coverage to over 800,000 New Yorkers by 2019, reducing the share without insurance from 11% to 7 percent.⁴² This will still leave nearly 1.3 million New Yorkers without insurance, leading to 1,000 extra deaths each year due to the lack of health insurance.⁴³ Nor does the ACA coverage expansion significantly address the problem of *underinsurance*, in which

⁴² "ACASignups.net," text, *ACASignups.net*, accessed April 1, 2014, <http://acasignups.net/>; Kaiser Family Foundation, "State Health Facts.org," n.d.; Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014* (Washington, D. C.: United States Congress, Congressional Budget Office, April 2014), https://www.cbo.gov/sites/default/files/45231-ACA_Estimates.pdf.

⁴³ This includes 276,000 undocumented immigrants without insurance in addition to the 1,000,000 citizens still uninsured under the ACA. Mortality is estimated by applying a 40% higher mortality rate to the estimated mortality rate for the insured population; see Andrew Wilper, et al., "Health Insurance and Mortality in US Adults," *American Journal of Public Health* 99, no. 12 (n.d.): 1–8; Note that this 40% figure is higher than the 25% estimated by an earlier study, Institute of Medicine (US) Committee on the Consequences of Uninsurance, "Estimates of Excess Mortality Among Uninsured Adults," 2002, <http://www.ncbi.nlm.nih.gov/books/NBK220638/>.

additional deaths would be attributable to high deductibles and co-pays that leave insured New Yorkers unable to afford needed care.⁴⁴

Nationally, the Gallup organization found that 34% of American households *with* health insurance report at least one person going without health care last year because of cost, and for most of them it was for a serious condition. The rate was 57% for those without health insurance.⁴⁵ In New York, a comparison of county age-adjusted mortality with the proportion of the county population reporting cost-related access problems (those that “could not see doctor due to cost”) shows a significant relationship between the two. The age-adjusted mortality rate increases by nearly 25% when comparing the rate where the proportion with access troubles reaches the level experienced in the United Kingdom (4%), compared to the rate in New York.⁴⁶ Many deaths in New York State may be associated with restrictions on access to care.⁴⁷

UNIVERSAL COVERAGE

While the uninsured do use doctors and hospitals, their per capita health care spending is only 55% of the average for the population as a whole. Because of the age structure of the uninsured (much younger than those with health coverage), it is expected that when insured their care would cost 85% as much as for a currently insured person.⁴⁸ The difference, 30% of per capita spending times the number of uninsured, is the cost of covering the uninsured with universal coverage. Expanding coverage to the more than 1.3 million New Yorkers uninsured under the ACA will cost over \$4 billion.⁴⁹

⁴⁴ This can be seen in the regression of county-by-county mortality rates on the proportion of New Yorkers reporting that they could not see a doctor because of cost. See Figure 6; Robert Wood Johnson and University of Wisconsin, Population Health Institute, “County Health Rankings.”

⁴⁵ Rebecca Riffkin, “Cost Still a Barrier Between Americans and Medical Care,” *Gallup*, November 28, 2014, <http://www.gallup.com/poll/179774/cost-barrier-americans-medical-care.aspx>.

⁴⁶ Note that even counties with relatively low rates of access troubles, such as Nassau, Suffolk, Putnam, or Tompkins, have a higher proportion unable to see a doctor because of cost than do residents of the United Kingdom. While these counties have relatively low age-adjusted mortality compared with the rest of New York, this analysis suggests that some residents die prematurely even in these counties with relatively successful health care systems because they have difficulty accessing the system.

⁴⁷ See the data at <http://www.countyhealthrankings.org/> reported in Figure 6.

⁴⁸ Jack Hadley and John Holahan, “The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending” (Kaiser Commission on Medicaid and the Uninsured, May 10, 2004), (“the page you are looking for either doesn’t exist or may have moved”). Coverage expansion is relatively inexpensive because those in the population without insurance are relatively young, would spend only about 85% as much on health care as the general population, and currently spend 55% as much as the average.

⁴⁹ It is also possible that expanded access will eventually lower health care costs. There is a jump in health care activity when people reach Medicare age followed by a drop after new Medicare recipients address pent-up health care needs. There is also evidence that continued access to primary care reduces long-term health care spending; see Donald Fruge, *Impact of Primary Care on Healthcare Cost and Population Health: A Literature Review* (Rhode Island Department of Health, February 23, 2012), <http://www.health.ri.gov/publications/literaturereviews/ImpactOfPrimaryCareOnHealthcareCostAndPopulationHealth.pdf>; James Reschovsky et al., *Paying More for Primary Care: Can It Help Bend the Medicare Cost Curve?*, Issue Brief (Commonwealth Fund, March 2012), http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Mar/1585_Reschovsky_paying_more_for_primary_care_FINALv2.pdf.

INCREASED UTILIZATION

Expenditures will increase if eliminating deductibles, co-payments, limited provider networks and other restrictive insurance policies leads to more utilization among those already insured.⁵⁰ In Canada, the elimination of co-payments and deductibles with the establishment of a system of universal health care in 1971 led to an increase in utilization of 3 percent. Utilization would increase more in New York in 2019 because increased “cost-sharing” by insurance companies – imposing financial barriers to care – has contributed to the slowdown in health care spending since 2008.⁵¹ Removing these higher barriers to access – deductibles and co-pays – will therefore lead to more utilization. Since the data (above) shows that there is widespread inability to access needed health care because of cost, this increased utilization will be a key *benefit* of the New York Health Act. However, its cost must be counted. If half of the real slowdown in health care spending since 2008 is due to rising co-pays and deductibles and other increased financial barriers to access, then health care utilization will increase by 1.5% beyond the experience of Canada in the early 1970s, for a total increase of 4.5%, at a cost of \$11 billion.⁵² To be sure, some of this increased utilization, especially of primary care, will lead to savings in other areas of health care, and some will lead to savings in the future.⁵³

⁵⁰ There would be no increase in utilization if it is supply driven, as argued by the Dartmouth Atlas Project (see <http://www.dartmouthatlas.org/keyissues/issue.aspx?con=2937>). A correction to this approach is David Squires, *Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices, and Quality* (Commonwealth Fund, May 2012), http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/May/1595_Squires_explaining_high_hlt_care_spending_intl_brief.pdf.

⁵¹ The proportion of those with insurance reporting that they have put off medical treatment because of cost has risen sharply in the Gallup survey; Riffkin, “Cost Still a Barrier Between Americans and Medical Care.”

⁵² The slowdown in spending growth is determined after factoring out the slowdown in general price inflation. This estimate overstates the effect on utilization because there would not be the same change for the 24% of health care that is already funded through Medicare and the Veterans Administration. This also overestimates the long-term impact because greater utilization will, over time, lead to some savings from better health. There is a substantial literature on the effects of copayments on utilization. See William Manning, et al., “Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment,” *American Economic Review* 77, no. 3 (June 1987): 265; Robert Brook, et al., “The Effect of Coinsurance on the Health of Adults: Results from the RAND Health Insurance Experiment” (Rand, 1984), <http://www.rand.org/pubs/reports/R3055/>; B. Harris, A. Stergachis, and L. Ried, “The Effect of Drug Co-Payments on Utilization and Cost of Pharmaceuticals in a Health Maintenance Organization,” *Medical Care* 28, no. 10 (1990): 907–17; D. Cherkin, L. Grothaus, and E. Wagner, “The Effect of Office Visit Copayments on Utilization in a Health Maintenance Organization,” *Medical Care* 27, no. 7 (1989): 669–79; Leighton Ku, Elaine Deschamps, and Judi Hilman, “The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah’s Medicaid Program” (Center on Budget and Policy Priorities, November 2, 2004), <http://www.cbpp.org/cms/index.cfm?fa=view&id=1398>; Jonathan Gruber, “The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond” (Kaiser Family Foundation, October 2006), 6, <http://www.kff.org/insurance/upload/7566.pdf>; William Hsiao, Steven Kappel, and Jonathan Gruber, “Act 128: Health System Reform Design. Achieving Affordable Universal Health Care in Vermont,” January 21, 2011, <http://www.leg.state.vt.us/jfo/healthcare/FINAL%20VT%20Draft%20Hsiao%20Report.pdf>.

⁵³ Studies of the Medicare and of the Medicaid population have found that increased access to primary care can lead to very large reductions in health care spending; see Fruge, *Impact of Primary Care on Healthcare Cost and Population Health: A Literature Review*; Reschovsky, et al., *Paying More for Primary Care: Can It Help Bend the Medicare Cost Curve?*

MEDICAID AND MEDICARE RATE EQUITY

For some time, Medicaid and Medicare have paid physicians, hospitals, and other providers significantly less than do commercial insurers. In 2012, for example, Medicaid paid New York physicians only 87% as much for the same services as Medicare paid; and Medicare pays physicians only 80% as much as private insurers.⁵⁴ By folding Medicare and Medicaid into New York Health, the legislation would raise health care provider reimbursements \$10.8 billion.⁵⁵ This would benefit recipients as well as providers because current low reimbursement rates threaten Medicaid's viability by forcing a growing number of physicians to stop accepting patients with Medicaid insurance.⁵⁶

UNEMPLOYMENT AND JOB TRAINING FOR DISPLACED BILLING AND INSURANCE WORKERS

In 2019, there will be over 300,000 workers employed in health care administration in New York and over 26,000 employees of health insurers.⁵⁷ As many as half of the health care administrative workers and most of the health insurance workers will be displaced by the more efficient New York Plan, resulting in as many as 150,000 newly unemployed workers.⁵⁸ This displacement will be balanced immediately by the creation of positions due to the increased

⁵⁴ The Medicaid rate index is based on research by the Kaiser Family Foundation: see <http://kff.org/medicaid/state-indicator/medicaid-fee-index/?state=NY>. Medicare rates relative to private insurers are from Will Fox and John Pickering, *HOSPITAL & PHYSICIAN COST SHIFT PAYMENT LEVEL COMPARISON OF MEDICARE, MEDICAID, AND COMMERCIAL PAYERS* (Milliman, December 2008).

⁵⁵ This includes \$3.8 billion for Medicare and \$6.9 billion for Medicaid. The cost of reimbursement equity is estimated for each program as the share of percentage adjustment needed to reach equity (28% for Medicare and 47% for Medicaid) multiplied by the share of spending on each program and by total spending on physician services after taking into account the savings achieved and anticipated increases (? Increases in utilization?) utilization from the expansion of coverage and the removal of barriers to access. Note that primary care rates for 2013 and 2014 were raised up to the Medicare level under the Affordable Care Act. But in 2015 they came back down.

⁵⁶ Peter Cunningham and Jessica May, "Medicaid Patients Increasingly Concentrated Among Physicians," August 2006, <http://www.hschange.com/CONTENT/866/#ib10>; American Academy of Pediatrics, "Medicaid Reimbursement: Medicaid Rates and Provider Participation," July 2009, <http://www.sdsma.org/documents/MedicaidSummerStudy.final.pdf>; Kaiser Family Foundation, "State Health Facts.org"; Ken Coleman, "Medicaid Acceptance by Healthcare Providers Drops to 1-out-of-3," *InfoStat*, February 26, 2015, <http://www.healthpocket.com/healthcare-research/infostat/medicaid-acceptance-doctors-health-care-providers-2015>; Fox and Pickering, *HOSPITAL & PHYSICIAN COST SHIFT PAYMENT LEVEL COMPARISON OF MEDICARE, MEDICAID, AND COMMERCIAL PAYERS*; "Do Medicare And Medicaid Payment Rates Really Threaten Physicians with Bankruptcy?," *Health Affairs Blog*, accessed March 2, 2015, <http://healthaffairs.org/blog/2012/10/02/do-medicare-and-medicoid-payment-rates-really-threaten-physicians-with-bankruptcy/>.

⁵⁷ This is an upper-bound estimate because many of these work for out-of-state insurers and will not be displaced; *Occupational Employment Statistics: OES Research Estimates by State and Industry, 2013*, n.d., http://www.bls.gov/oes/2012/may/oes_research_estimates_2012.htm.

⁵⁸ Note that this suggests that there are six health-care provider employees dealing with insurance billing for every worker in the insurance industry.

demand for health care workers coming with the expansion in coverage and increased utilization.⁵⁹

As will be discussed later, by dramatically reducing the cost of health care for New York employers, especially small businesses, implementation of the New York Health Act would improve the overall employment climate in New York and lead to the creation of two-hundred thousand new jobs, more than off-setting the loss in insurance company and health care administrative positions.

However, the workers who will be displaced are a serious concern. The Unemployment Insurance system will provide support for these workers for six months. Based on recent experience, over 70% of the displaced workers will have new jobs within six months. The New York Health Act provides that a portion of the revenue it raises may be used for retraining and job transition for employees who may be displaced. If the New York Health Plan funded another 78 weeks of unemployment compensation with job training to the remaining unemployed, then it would cost \$290 million in the first year and \$70 million in the second. By the end of the second year, over 99% of the displaced workers will have found new employment.

MEDICARE PART B PREMIUMS

Over 3 million New Yorkers over age 65 are eligible for Medicare with over 90% enrolling in Part B, which covers doctor visits and other outpatient procedures. Because they would have no incentive to continue to pay their premiums under the New York Health Plan, the Plan will pay these premiums at a cost of \$5 billion in 2019.⁶⁰ This is a cost to the New York Health plan, but is a reduction in cost to Medicare recipients. It does not increase health care spending overall.

LOCAL GOVERNMENTS AND MEDICAID

Almost alone among the states, New York requires that local governments pay some of the cost of the non-federal side of the Medicaid program. It is projected to be \$7.13 billion in 2019. This is a significant burden on local property taxpayers. The New York Health Plan eliminates this expense for local governments, transferring the burden from local governments to the New York Health Trust Fund. This is a cost to the New York Health Plan, but is a reduction in cost to local governments. It does not increase health care spending overall.

⁵⁹ Over 5% of workers in the financial services sector (including insurance) change jobs every month. The weekly re-employment rate from unemployment in November 2014 was 5.1 percent. Applying this rate, 26.5% of the unemployed will remain out of work after 26 weeks and 7.1% after 52 weeks. "Occupational Employment Statistics Home Page," accessed November 4, 2014, <http://www.bls.gov/oes/>.

⁶⁰ Note this money is a transfer within New York State from tax payers to the elderly and others no longer liable for premiums. It is not money leaving the New York economy or attached to resources no longer available for other purposes. The cost is estimated by multiplying the Medicare Part B premium by the number of people aged 65 and over as projected by the census. The premium is estimated as the 2015 premium times the growth in per capita spending 2015-2019.

Table 3. Program improvements under the New York Health Act, 2019.

New York Health Act program improvements	Spending (\$millions)	Program improvements as % of current spending (2019)
Universal coverage	\$ 4,024	1.4%
Increased utilization	\$ 11,158	3.9%
Medicare and Medicaid rate equity	\$ 10,841	3.8%
UI and retraining	\$ 290	0.1%
Total New York Health Plan spending	\$242,733	84.4%
Savings net of program improvements	\$ 44,710	15.6%

MOVING COSTS TO MORE EQUITABLE FUNDING

As noted above, the New York Health Act will shift several major categories of spending from their current sources to the New York Health Trust Fund. Central to the legislation is that insurance premiums now paid by private and public employers, employees, and individuals will be replaced by broad-based funding through assessments on payroll and taxable upper-bracket non-payroll income, based on ability to pay. In addition, other key elements will be covered by New York Health funding: out-of-pocket spending on deductibles, co-pays, out-of-network charges, and spending by uninsured patients, totaling \$32 billion; Medicare Part B premiums now paid by Medicare recipients, totaling \$5 billion; and the local share of Medicaid, now paid largely by local property taxes, totaling \$7.13 billion.

NET COSTS OF THE NEW YORK HEALTH ACT

The New York Health Plan would involve a dramatic shift in health expenditures in New York away from administrative activities towards the provision of health care. While *total* expenditures *fall* under the New York Health Act, more of that spending will be spent on the delivery of health care services. Administrative activities and monopoly profits are reduced so much that they allow an increase in the provision of health care even with a dramatic reduction in total spending. Instead of paying for insurance company executives, advertising, profits, and other administrative expenses unrelated to health care, payments to providers would increase in absolute amount, rising from 65% of spending to 85 percent. Under the current system, administrative costs account for nearly 30% of total health care spending and overcharging for drugs and medical devices comes to another 6 percent. Under the New York Health Plan, administrative spending would be reduced by over half, down to 15% (administrative costs of the plan, plus continuing, although reduced, administrative costs of health care providers), making more money available for the provision of health care (see Figure 9).

Beginning with projected spending under the current system and adjusting for savings and program improvements, the New York Health Plan would lower health care spending by 15%, saving almost \$45 billion in the first year. This is itemized in Tables 2, 3 and 4.

Table 4. Revenue needs and sources for New York Health Plan, projected for 2019 (\$ millions).

Health care spending, New York Health Plan, 2019 (\$millions) after savings and program improvements	\$ 242,733
Other costs being assumed by New York Health Trust Fund	
Assumption of Medicare Part B	\$ 5,077
Assumption of local Medicaid costs	\$ 7,130
Total New York Health Plan funding needs	\$ 254,941
Revenue other than New York Health Assessments, including funds that will not go into New York Health Trust Fund but will cover spending that will not be covered by the Trust Fund	
Medicare	\$ 64,002
Medicaid and SCHIP	\$ 69,940
Additional Federal Medicaid for fair reimbursement rates	\$ 3,729
Additional Federal Medicaid for coverage of uninsured who are Medicaid-eligible	\$889
Current public spending	\$ 8,188
VA	\$ 4,761
Remaining out-of-pocket spending (long-term care and services not deemed medically necessary)	\$ 11,026
ACA subsidies	\$ 1,088
Total	\$ 163,623
Revenue needed	\$ 91,318
Revenue from Assessments	
Revenue from progressive payroll assessment	\$ 59,013
Revenue from progressive assessment on dividends, interest, and capital gains	\$ 32,559
Total	\$ 91,572
Surplus	\$ 254

Note: Some of the Medicaid revenue above will go to cover long-term care until the New York Plan is extended to cover these services. Extra spending associated with the establishment of the New York Health Plan comes from the expansion of coverage and expanded access to health care services. This table includes items involving resource use and those involving approximately \$12 b. in transfers through the Plan's assumption of Medicare Part B premiums and local government's Medicaid payments.

Source: Income by source from United States Internal Revenue Service for 2012 projected to 2019 assuming all income sources increase at the rate of GDP growth, of 1.3861. Gross State Product is from Bureau of Economic Analysis, "State Income and Employment, Quarterly Personal Income".

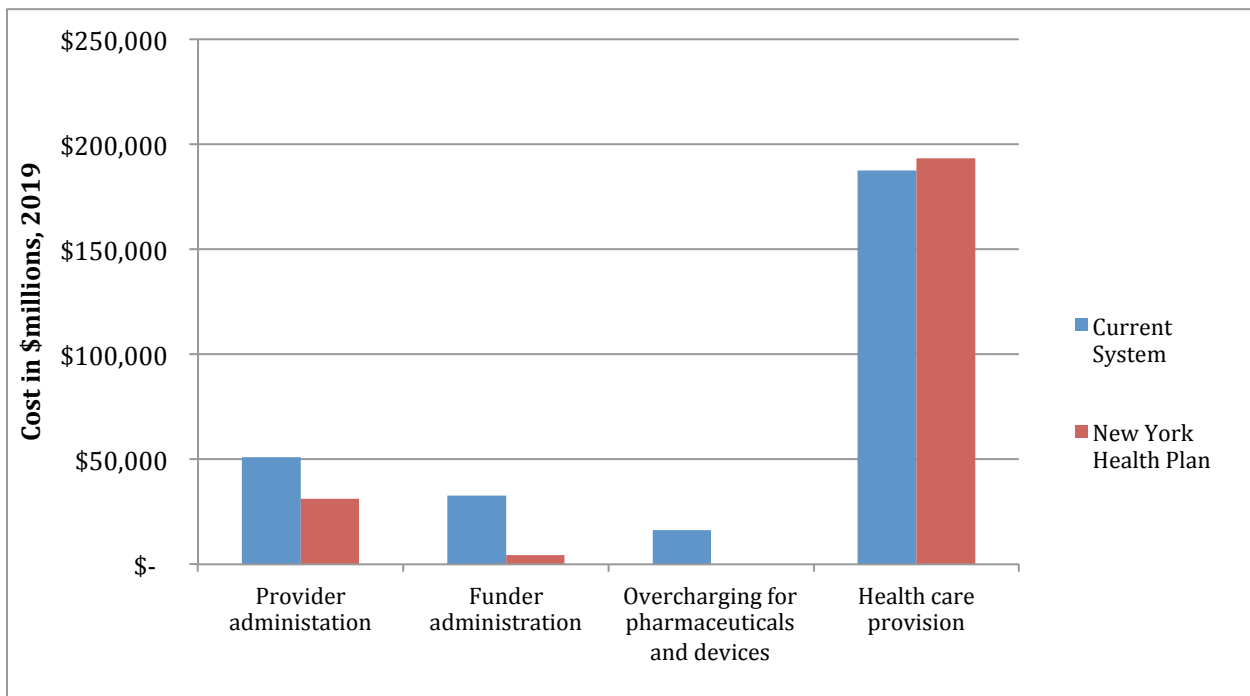


Figure 9. Shift in spending towards providers, New York Health Plan compared with current system, New York 2019.

FINANCING THE NEW YORK HEALTH PLAN

The New York Health Act would be funded by broad-based assessments based on ability to pay. There would be a progressively-graduated assessment on payroll and self-employment income (income now subject to the Medicare tax) and a progressively-graduated assessment on upper-bracket non-payroll taxable personal income (e.g., capital gains, dividends and interest). After the bill is enacted and as implementation approaches, the Governor will submit a specific revenue proposal to the Legislature. This economic analysis presents a proposal for income brackets and assessment rates and projects the revenue that would be generated.

After taking account of savings realized and additional costs, the New York Health Plan would fund \$243 billion in health care services while assuming \$12 billion in costs for Medicare Part B premiums now paid by Medicare recipients and Medicaid expenses currently paid by local governments in New York State.⁶¹ While less than what is currently spent on health care, this requires \$91 billion in New York Health revenues, even assuming continued Federal Medicare, Medicaid, and ACA payments.⁶² A funding plan is proposed which would generate nearly \$92

⁶¹ This comes to 95% of health care expenditures including 100% of spending on covered services. The remaining spending is for services deemed not medically necessary and long-term care which will be covered later. Note that NYH is also assuming \$32 billion in out-of-pocket spending by people with health coverage and spending by people without health coverage.

⁶² Governments will contribute to the plan in their function as employers through the payroll assessment. We assume that the Federal Government will agree to continue funding ACA subsidies, Medicaid and other Federal health programs at current rates even though these services will be provided more economically than is currently

billion in revenue through a combination of a progressively-graduated assessment on payrolls and a progressively graduated assessment on upper-bracket non-payroll taxable personal income (e.g., dividends, interest, and capital gains).⁶³

The progressively graduated payroll assessment would apply only to earnings above \$25,000; earnings from \$25,000 to \$50,000 would pay an assessment of 9%. Rates on higher income brackets would rise to 16% for the portion of earnings above \$200,000. The rate would be split with employers paying 80% of the assessment and employees 20 percent. This is typical for employment-based health insurance. The employer could agree to pay some or the entire employee share, presumably as a result of collective bargaining.

Income from dividends, interest, and capital gains would also be assessed at progressive rates, starting at 9% for taxable non-payroll income of at least \$25,000 to \$50,000 and rising to 16% for the portion of that income over \$200,000. The brackets are listed in Table 5.

Table 5. Suggested marginal assessment rates by income bracket.

Under \$25,000	0%
\$25,000 under \$50,000	9%
\$50,000 under \$75,000	11%
\$75,000 under \$100,000	12%
\$100,000 under \$200,000	14%
\$200,000 or more	16%

Note: At each bracket the rate applies only on the margin, that is to income above the previous level.

Because higher assessment rates are only charged against additional income, the effective assessment rate is significantly below the marginal rate, especially at low and middle-income levels. The assessment rate share of income paid in assessments is shown in Figure 10.

the case. The Medicaid program would largely be incorporated within the New York Health Plan, either as a computed lump sum (the optimal approach) or still tied to individual recipients.

⁶³ Payrolls and income from other sources are from the IRS, State reports; 2012 data has been projected to 2019 assuming the same annual rate of growth as 1991-2012. See <http://www.irs.gov/uac/SOI-Tax-Stats-Historic-Table-2>

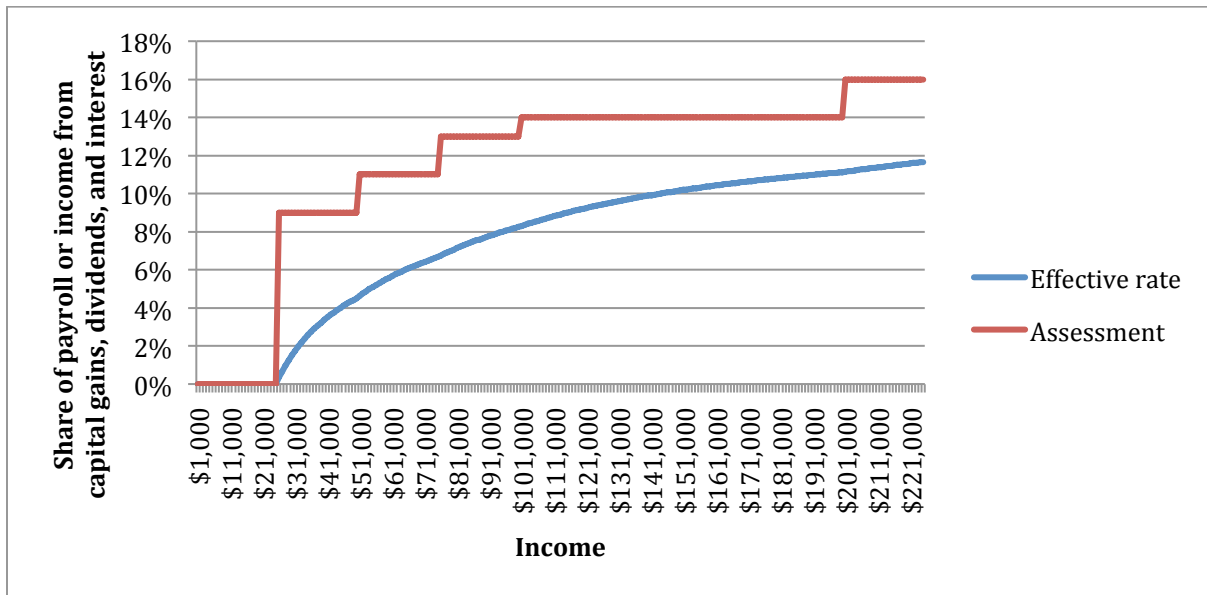


Figure 10. Assessment rate and average assessment as share of income.

The payroll assessment on the income of an employee earning \$75,000 will be 6.7 percent. The employer would be required to pay at least 80% of that, or 5.3%, much less than businesses and governments currently pay for private health insurance; for most businesses, this is a charge of 2.4% on costs.⁶⁴ For an employee earning \$50,000, the total assessment would be 4.5%, with the employer paying 3.6 percent; for an employee making \$125,000, the assessment would be 9.4% with the employer paying 7.5 percent. While establishments currently not offering health insurance benefits will pay more than they now do, most businesses will benefit from the New York Health Plan.⁶⁵ Establishments with fewer than 25 workers in 2012, for example, pay nearly 8% of their payroll for health insurance in addition to bearing the cost of managing their health insurance plan. They would see a decrease in their average contribution. Establishments with over 24 workers pay over 10% now and would enjoy substantial savings. Public employers currently pay over 15% of payroll (coming from taxpayers) and will enjoy very large savings.⁶⁶ The greater efficiency of the New York Health Act allows for savings on current spending even while improving access for New Yorkers.

⁶⁴ The Bureau of Economic Analysis reports that compensation is commonly only 60% of the cost of production, and wages are only about 70% of this. Adding 8% to wages increases costs by less than 4 percent.

⁶⁵ Of course, employees of these businesses use health care, care paid for in part by the premiums and tax dollars paid by other businesses and individuals.

⁶⁶ Because of rising health care costs under the current system, all of these employers will be spending a higher share of payroll by 2019.

Unlike the fixed premiums of traditional health insurance, payroll assessment rates under the New York Health Act will vary with income. The share of payroll paid under the Health Act is shown in Figure 10; Figure 11 shows the share of total income going to the Act's assessments. While lower-income New Yorkers will be exempt from any assessment, middle-income workers will pay between 4% and 8% of payroll in premiums and the more affluent will pay as much as 13 percent.

SHARING THE REDUCED BURDEN MORE EQUITABLY

LESSENING THE FINANCIAL BURDEN OF WORK AND POOR HEALTH

Together, the efficiency gains from the New York Health Act and shifting the basis of funding from fixed premiums per covered individual and cost-sharing to a charge related to ability to pay, combine to produce financial benefits for New Yorkers making less than \$436,000 annually (see Figure 11). Most New Yorkers will save thousands of dollars a year compared with what they and their employer currently spend on health insurance premiums and out-of-pocket costs. The largest savings will go to working families and to middle-income households, especially those with children. Even after taking account of the new assessments, most households will save from the reduction in out-of-pocket costs and elimination of premiums (see Figure 11). 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. Taxpayers will benefit because local governments and the State will save money because public employers pay relatively high premiums for relatively good insurance plans, and because their plans enroll a larger share of their employees and families.⁶⁷ Family members will, of course, receive coverage, like all New Yorkers. However, the cost will be spread across all payroll and non-payroll income and not concentrated on certain employers.

⁶⁷ Public plans provide a significant subsidy to private employers because they enroll family members of public employees who then do not take up private employers' insurance plans.

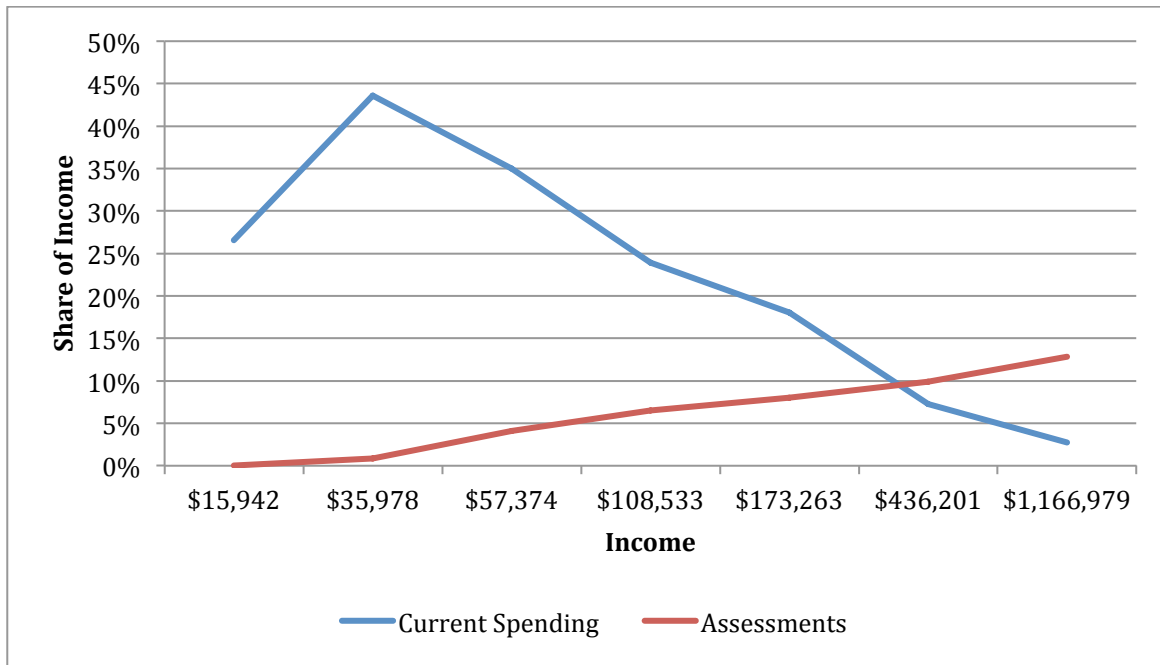


Figure 11. Spending as share of Adjusted Gross Income, current system and New York Health Plan, by household income.

Note: Current spending includes out-of-pocket spending and spending on health insurance premiums including employers' share of premiums for employer-provided plans. Plan assessments include payroll assessments, and assessments on income from capital gains, dividends, and interest. Income sources are from the IRS, Sources of Income for All New York State, at <http://www.irs.gov/uac/SOI-Tax-Stats---Individual-Statistical-Tables-by-Size-of-Adjusted-Gross-Income>.

In addition to reducing the overall cost burden of health care, the New York Plan would relieve the burden of health care spending on the sick and working families and base payments on the ability to pay. Under the current system, health care costs do not vary with income but increase with sickness. The burden of health care spending is therefore greatest for people of moderate income and the sick, rising to over a third of income for low-wage New Yorkers.⁶⁸ The New York Health Act would flip this, setting costs according to income but independently of health status.⁶⁹ The Act would do this in three ways. First, it would relieve the burden on those with health problems by providing access to quality health care to all, without financial barriers. Second, it would relieve the burden on working families by associating payroll assessments with level of earnings. Third, by including assessment on non-wage taxable income, it would treat all forms of income equally rather than targeting only wages and salaries.

⁶⁸ This, of course, contributes to the heavy burden of health care costs on families who often have lower income because of family members' health.

⁶⁹ These estimates are made using data on income by source and its distribution provided by the IRS, Sources of Income. Also see the following sources: Bureau of Economic Analysis, *State Annual Personal Income, 2011*, <http://www.bea.gov/regional/spi/>; Patricia Ketsche, et al., "Lower-Income Families Pay A Higher Share Of Income Toward National Health Care Spending Than Higher-Income Families Do," *Health Affairs* 30, no. 9 (2011): 1637 – 1646, doi:10.1377/hlthaff.2010.0712.

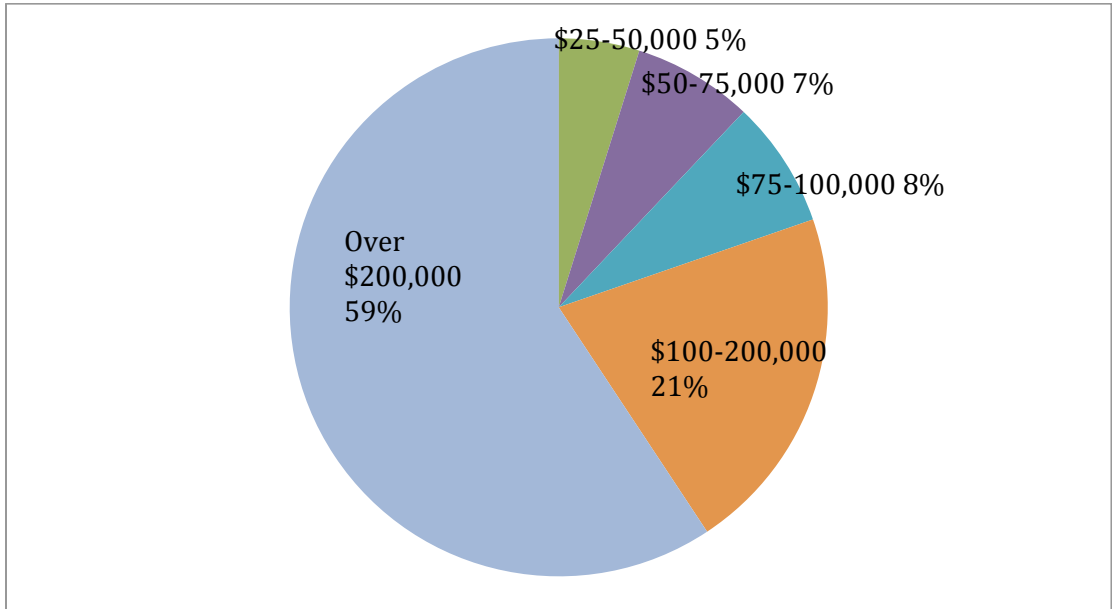


Figure 12. Share of total costs allocated to income groups under New York Health Act

SAVINGS FOR DIFFERENT NEW YORKERS

Most New Yorkers will save money from the New York Health Act depending on their family status and their current health insurance situation. Because the greatest savings go to families, the New York Health Plan can be seen as a form of child-support program. While most workers will benefit from the New York Health Plan, the gains are greater for workers in a family and for those earning less than \$100,000 (see Figures 12 and 13).

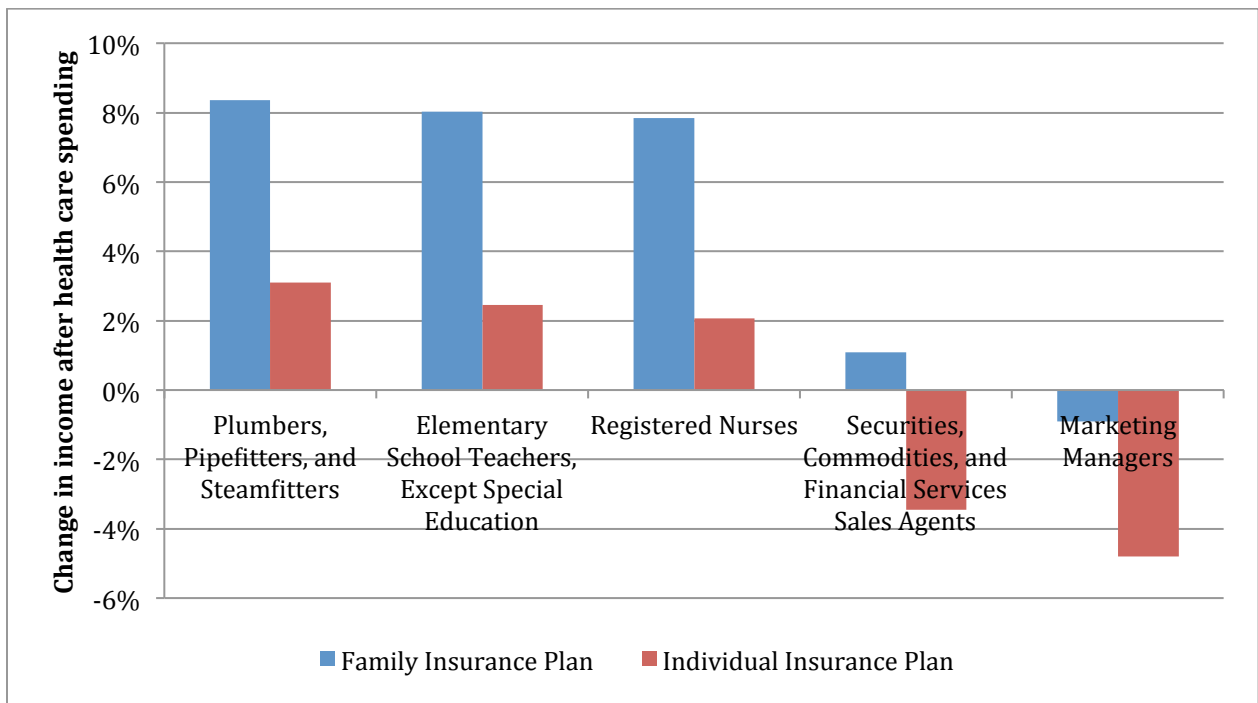


Figure 13. Cost of health care for typical New Yorkers, current system vs. New York Health Act.

Note: Effects are evaluated at the average wage of workers in the occupation according to http://www.bls.gov/oes/current/oes_ny.htm#00-0000. Insurance premiums are for the median plan on the New York Exchange at <https://nystateofhealth.ny.gov/individual/searchAnonymousPlan/search> for a family of two adults and two children under 18 or younger. Health care costs include premiums and out-of-pocket spending.

EXTENDING QUALITY HEALTH CARE TO NEW YORKERS THROUGHOUT THE STATE

The New York Health Act would save money while providing health care and saving lives throughout New York. While bringing immediate benefits to those without insurance, it would also improve care for those with inadequate insurance (which is almost everyone with insurance). And by reducing turnover in coverage and by facilitating better coordination of care, it would improve health care for everyone. The current fragmented financing system also lowers the quality of care for Americans when they do see a physician, both by inhibiting the coordination of care and by preventing the development of useful data on treatment and outcomes. The spread of insurance-based restricted provider networks with no out-of-network benefits is forcing a growing number of Americans to change doctors.⁷⁰ This includes workers who change jobs and hence insurance, as well as those whose employer changes insurance plans,

⁷⁰ A large and growing majority of ACA exchange plans have restricted networks; see Erica Coe et al., *Hospital Networks: Configurations on the Exchanges and Their Impact on Premiums*, McKinsey Center for U.S. Health System Reform (McKinsey Corporation, December 14, 2013); the Obama Administration economists saw network restrictions as essential to give insurance plans the bargaining leverage to hold down costs: see Steven Brill, *America's Bitter Pill: Money, Politics, Back-Room Deals, and the Fight to Fix Our Broken Healthcare System* (New York: Random House, 2015); many New Yorkers report having to change doctors because of insurance networks: see "Now I Have Insurance. But I Can't Use It. What Am I Supposed to Do? | The Health Care Blog," accessed March 1, 2015, <http://thehealthcareblog.com/blog/2014/01/12/i-have-insurance-but-i-cant-use-it-what-am-i-supposed-to-do-now/>; government officials recognize the problems that networks and changing networks cause for patients and continuity of care: see "How to Keep Your Own Doctor In Health Insurance Marketplace," *HealthCare.gov*, accessed March 1, 2015, <https://www.healthcare.gov/choose-a-plan/keep-your-doctor/>; Kathleen Miles, "How Obamacare Leaves Some People Without Doctors," *The Huffington Post*, April 10, 2014, http://www.huffingtonpost.com/2014/04/10/obamacare-patients-without-doctors_n_5044270.html.

or those who see a doctor who is no longer in their plan's network.⁷¹ The spread of restricted networks also inhibits the coordination of care by forcing primary-care physicians to work with different specialists depending on the patient's insurance rather than the patient's medical condition.

The greatest benefits will go, of course, to those who have been denied access to health care because of lack of insurance or inability to pay their cost sharing (deductibles, copayments and out-of-network charges). This includes the 1.3 million New Yorkers still without health insurance under the ACA *and* another 1.3 million more experiencing access problems despite having health insurance (see Figure 14).⁷²

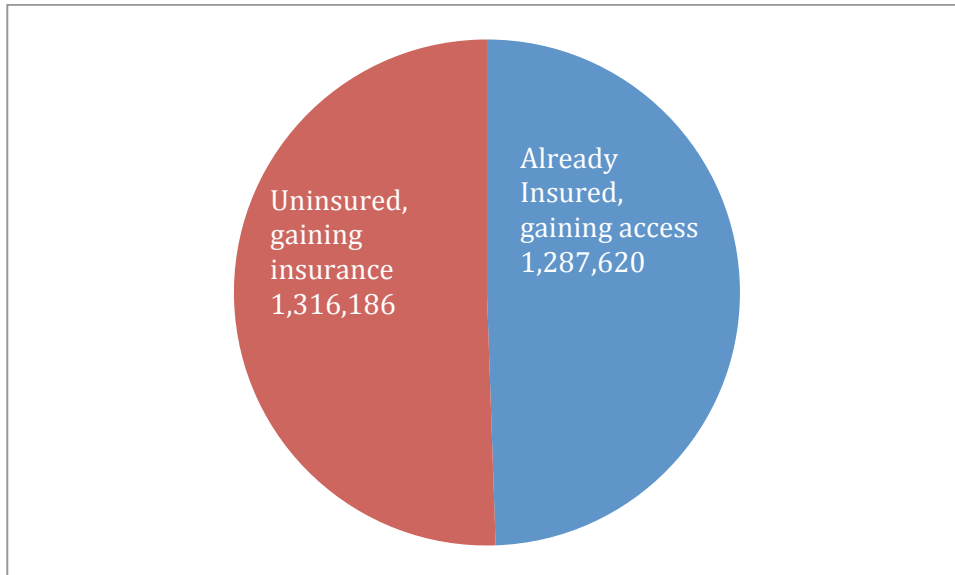


Figure 14. Effect of New York Health Plan on access to health care: number of New Yorkers who will gain access.

Throughout the state, New Yorkers will benefit when the New York Health Plan reduces financial barriers preventing them from receiving medical care. Improved access will bring economic benefits, including over \$5 billion in increased health care spending upstate.⁷³

Improved health will also bring other benefits. Lowering the proportion of New Yorkers unable to go to the doctor because of cost will lower the death rate in the state.

⁷¹ Failures of coordination between different providers account for substantial economic waste in American health care as well as much unnecessary suffering and even death. By providing continuous insurance coverage and free choice of providers, the New York Plan will naturally reduce this problem. See Berwick and Hackbarth, "Eliminating Waste in US Health Care."

⁷² Note that about 2,000,000 are unable to see a doctor because of cost, including 700,000 without insurance and 1,300,000 with health insurance.

⁷³ This is estimated as the percentage change in personal health care spending multiplied by spending in the different counties in New York State from the county health data. The expansion of health coverage and removal of barriers to access will increase demand for health care in New York. This increased demand will easily be accommodated by reducing waste in the health care system, including the time physicians now spend in dealing with the health-care system. It is also likely that the elimination of private insurance and BIR expenses will attract additional physicians to New York State.

EFFECT OF NEW YORK HEALTH ACT ON THE NEW YORK ECONOMY

The analysis thus far understates the economic gains from the New York Health Act because it uses a static model that neglects likely changes in economic parameters, such as changes in the locus of investment, employment, and entrepreneurial activity coming from the adoption of a reform that would dramatically lower the burden of health care costs. In particular, the New York Health Act would increase employment and income in New York by reducing inefficient waste, putting money back into the economy and making businesses more competitive. It will also lower the cost of government allowing lower taxes and increased investment in infrastructure and education.

HELPING LOCAL GOVERNMENTS

Local governments would benefit from the assumption of Medicaid costs by the State plan. Local governments and their taxpayers will also save billions. Downstate suburban counties would save over \$1 billion, upstate cities over \$600 million, and rural areas and elsewhere \$1.3 billion.⁷⁴

OPENING THE DOOR TO ENTREPRENEURSHIP

Many New York workers currently suffer from job-lock, discouraging them from changing jobs or opening new businesses because they fear losing their current health insurance.⁷⁵ The New York Health Act would free these workers to seek more efficient employment, liberating employers from the burden of keeping workers who would rather work elsewhere while allowing New Yorkers to find better jobs or to act on their entrepreneurial dreams.⁷⁶

By separating access to health care from employment, the New York Health Act would also free entrepreneurs to open businesses and hire workers without needing also to establish and fund health insurance. Small businesses would benefit disproportionately because new and small businesses pay particularly high health insurance rates. Small businesses and start-ups often pay lower wages, so health insurance costs are now a larger percentage of their payrolls than those of larger and more established businesses. Under the current system, a typical New York computer start-up that employs 14 people at the average salary pays health insurance premiums equal to 26% of its payroll. The New York Health Act, by contrast, would lower that burden to only 8% in payroll assessments.⁷⁷

⁷⁴ This is based on the distribution of local government Medicaid spending.

⁷⁵ The Affordable Care Act helps by providing for improved access to individual health insurance through the exchange system.

⁷⁶ David Sterret, Ashley Bender, and David Palmer, "A Business Case for Universal Healthcare: Improving Economic Growth and Reducing Unemployment by Providing Access for All," *Health Law and Policy Brief* 8, no. 2 (Spring 2014): 41–56.

⁷⁷ This is using the average wage data and premium data from the BLS at http://www.bls.gov/oes/current/oes_ny.htm#00-0000 and the Medical Expenditure Survey from the Agency for Healthcare Research and Quality at <http://meps.ahrq.gov/mepsweb/>. Because this estimate uses the average health insurance premiums for this size of establishment, it underestimates the cost facing a new small business, and the savings from the New York Health Plan.

DECLINING PAYROLL COSTS

New York employers are burdened by some of the highest health insurance costs in the country.⁷⁸ High health insurance costs have led employers to reduce the value of coverage offered their workers, to lower wages, and to lay off workers and reduce hiring.⁷⁹ By lowering the overall burden of health care spending and shifting the burden from premiums unrelated to ability to pay to progressively graduated assessments, the New York Health Act would lower the relative cost of labor to employers, giving New York employers a competitive advantage against those based in other states.

Replacing current health insurance premiums with the proposed assessments would immediately save businesses over \$2 billion now spent on administering employer provided health insurance.⁸⁰ With an average payroll premium of 8.1%, the New York Health Act would be significantly less expensive than existing private insurance. Lower benefit costs would allow New York-based businesses to lower prices, increasing sales by making New York's businesses more competitive than those elsewhere, and raise wages. Lower benefit costs would also encourage businesses in New York to adopt more labor-intensive technologies, employing more workers rather than machinery.⁸¹ On balance, the New York Health Act would increase employment in New York by about 2%, adding almost 200,000 new jobs, many more than the number of workers displaced from billing operations and insurance companies.

LIFTING THE BURDEN OF LEGACY COSTS FROM BUSINESSES AND GOVERNMENTS

While businesses and governments in New York have committed to provide health insurance to millions of retired workers, they have put aside relatively little to pay for these obligations. As a result, the State of New York, for example, has over \$56 billion in unfunded retiree health insurance liabilities, and the unfunded liabilities for businesses run into the hundreds of billions of dollars.⁸² For governments and businesses, these legacy costs, the unpaid costs of past work, burden current economic activity. For retirees, anxiety about whether their employer will honor

⁷⁸ Cathy Schoen, David Ridley, and Sara Collins, *State Trends in the Cost of Employer Health Insurance Coverage, 2003-2013* (Commonwealth Fund, January 2015), http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/jan/1798_schoen_state_trends_2003_2013.pdf.

⁷⁹ Diana Rodin and Jack Meyer, *Health Care Costs and Spending in New York State* (NYS Health Foundation, February 2014), 24, <http://nyshealthfoundation.org/uploads/resources/health-care-costs-in-NYS-chart-book.pdf>.

⁸⁰ In 1999, employer costs of administering health insurance came to 4.2% of private health insurance premiums; I have applied the same ratio here: see Woolhandler, Campbell, and Himmelstein, "Cost of Health Care Administration in the United States and Canada." Because employers bear about 75% of the cost of health care premiums, the savings is only 75% of the total.

⁸¹ It is also likely that the shift from administrative occupations will increase employment in New York at the expense of jobs in other states by bringing spending back to New York from Connecticut and other insurance centers. Comparing Bureau of Labor Statistics estimates of insurance employment with the state's population, Connecticut has nearly five-times as high a share of insurance jobs as it does population while Minnesota, New Jersey, and Ohio have two to three times as many insurance jobs.

⁸² The Pew Charitable Trusts, "The Trillion Dollar Gap: New York," accessed December 29, 2014, <http://bit.ly/1wmpptSW>; Parag Bavishi, *Retiree Medical Benefit Crisis: Evaluating Risk Financing Solutions* (Zurich NA, 2011), <http://www.zurichna.com/internet/zna/SiteCollectionDocuments/en/GlobalLife/The%20Retiree%20Medical%20Benefit%20Crisis.pdf>.

past commitments weighs heavily. By providing health care to all New Yorkers, including the elderly, the New York Health Act will remove this burden from business and from retirees. This will be an extra boon for New York businesses competing with rivals elsewhere.⁸³

FACILITATING COLLECTIVE BARGAINING

The increasing price of private health insurance has become a particular contentious issue between labor and management and a burden for unionized employers, who are significantly more likely to provide health insurance to their workers.⁸⁴ Health insurance also divides workers between older workers and those with families whose members who use more health care than younger, healthier, and single workers. By separating access to health care from employment, the New York Health Act would ease this tension in the collective bargaining process. Labor unions would be able to shift their efforts from the increasingly difficult effort to protect health benefits and concentrate on issues such as wages, pensions and vacations.

THE FUTURE OF NEW YORK HEALTH CARE

It is unclear if provisions of the Patient Protection and Affordable Care Act (ACA) of 2010 will eventually slow the increase in health care costs. Over the next decade, however, few expect the ACA to have much effect on costs except to the extent that expanding health insurance coverage to millions previously uninsured will increase health care spending.⁸⁵ Estimates of spending over the next decade are presented in Figure 16. Here we assume that the ACA will have no effect on costs with the exception of those costs resulting from extending Medicaid coverage and private insurance.⁸⁶

While expenditure data on the state level are only available through 2009, expenditures for later years through 2029 have been projected by the Centers for Medicare and Medicaid Services on the assumption that past trends will continue into the future except as modified in specified ways.⁸⁷ The slowdown in the growth of national health care spending since 2008 has been

⁸³ While these costs have been largely unfunded, some moneys have been put aside for retiree health care. The New York Health Act requires the Plan's board to produce a proposal for dealing with this and other retiree issues. Nevertheless, the Act will provide coverage for them.

⁸⁴ Richard B Freeman, *What Do Unions Do?* (New York: Basic Books, 1984); Richard B Freeman, "The Exit-Voice Tradeoff in the Labor Market: Unionism, Job Tenure, Quits, and Separations," *The Quarterly Journal of Economics* 94, no. 4 (1980): 643–73; Richard B Freeman, *What Workers Want* (Ithaca: ILR Press, 1999); the burden of costs on business is discussed in Rodin and Meyer, *Health Care Costs and Spending in New York State*.

⁸⁵ Center for Healthcare Research and Transformation, *The Patient Protection and Affordable Care Act at the State and Local Level*, June 2010, ("The page you are looking for no longer exists"); Congressional Budget Office and Joint Committee on Taxation, "Fiscal Impact of Reconciliation Act of 2010," March 20, 2010, <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>; Lewin Group, *Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers*, Staff Working Paper, (June 8, 2010), ("The page you are looking for cannot be found."); Stephanie Cutter, "Health Care Costs," *White House Blog*, January 26, 2011, <http://www.whitehouse.gov/blog/2011/01/26/health-care-costs>.

⁸⁶ Estimates of the increase in coverage through participation in Insurance Exchanges are from the Congressional Budget Office; Congressional Budget Office and Joint Committee on Taxation, "Fiscal Impact of Reconciliation Act of 2010"; Kaiser Family Foundation, <http://kff.org/statedata/>.

⁸⁷ Andrea M. Sisko et al., "National Health Spending Projections: The Estimated Impact Of Reform Through 2019," *Health Affairs* 29, no. 10 (October 1, 2010): 1933–41, doi:10.1377/hlthaff.2010.0788.

applied to estimated state spending, and it is expected that spending will increase after 2014 at the rate forecast by the CMS.⁸⁸ Two adjustments are made to project annual expenditures under the New York Health Act. First, expenditures for 2019 are adjusted downward to reflect the savings that would be realized under the Act. Expenditures in later years are projected from this based on the assumption that per-capita expenditures increase at a rate 1.1% *less* than would have been the case under the existing health care finance system.⁸⁹ This lower rate reflects the difference between the Canadian experience with a health care system like that envisioned here for New York and the experience of the United States from 1970-2008. It is less than the difference between the experience of private health insurance in the United States and the Medicare system since the early 1970s.⁹⁰ The dynamic savings would reflect the continuing savings from ending the inflation in administration and drug pricing, and the efficiency gains to be realized through better coordination of care and the use of global budgeting.

The New York Health Act would do more than produce significant savings in its first year of operation. Because of its superior dynamic efficiency, the Act would produce growing savings over time (see Figure 16). While providing health insurance coverage to all residents and allowing greater utilization of health care services, the New York Health Act would save almost 20% of health care spending in 2019 and a third in 2029.⁹¹ The Act would achieve these savings by bending the curve of rising health care costs. By controlling administrative expenses and monopoly profits, it would stabilize the growth in health care spending at a level that can be supported by the New York economy.

⁸⁸ Ibid.

⁸⁹ The lower share of administrative costs under the New York Health Plan will by itself account for a fall in the health-care inflation rate of 0.3% per annum and controlling prescription drug prices will lower the inflation rate by about as much again. It is assumed here that the other savings will come from better coordination of care leading to continued reductions in duplicate care, continued anti-fraud efforts, and improved quality of care including preventive care and reduced readmissions.

⁹⁰ From 1969 to 2012, the cost per enrollee of Medicare services rose by 7.4% per annum, 1.2 percentage points less than the 8.8% per annum for private health insurance offering “common benefits”; Table 21 in <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf>.

⁹¹ If New York had established a plan like the New York Health Plan in 2003 with the same savings as we expect now, health care spending in 2014 would have been 29% less, a \$63 billion savings, or over \$3000 per person.

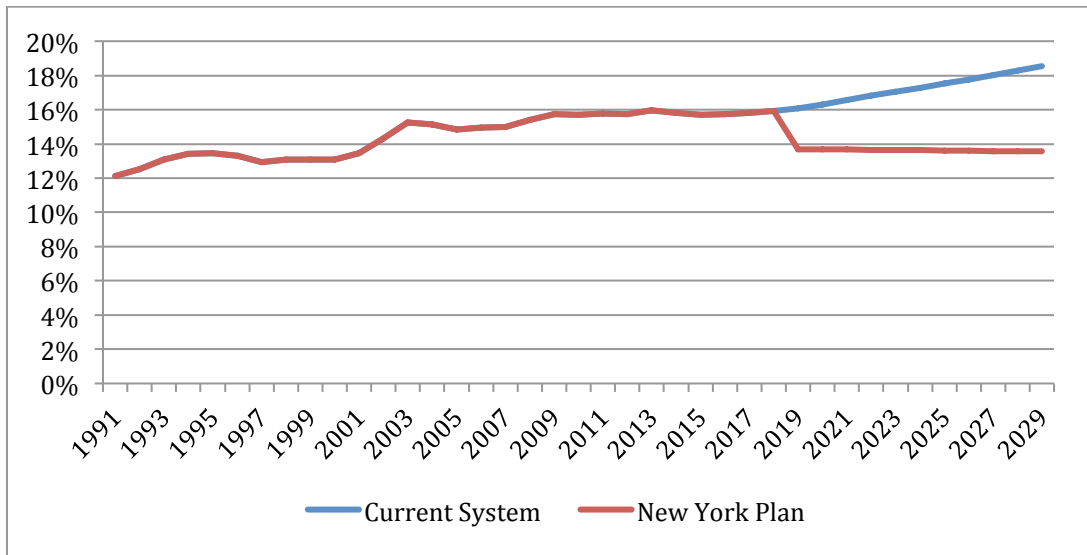


Figure 15. New York health spending as a share of Gross State Product, under current system and the New York Health Act, 1991-2029.

Note: This gives total health spending (including administrative costs) under alternative plans. Expenditures under the New York Health Act start from a lower base in 2019 because of the savings discussed in the text and then grow at a rate 1.1% slower per year, based on Medicare and Canadian experience, and a little less than the projected rate of growth in income. The ACA line assumes no reduction in health care costs per covered person.

IT'S ARITHMETIC

Employment-based coverage that now costs as much as 25% of median household income still leaves those employees fortunate enough to be covered spending an additional 3.4% of their income for deductibles and other out-of-pocket costs.⁹² For households with income lower than the median, of course, the cost of health coverage is a substantially higher percentage of income. Under the New York Health Act, this report finds that the assessment on payroll for employees at the median household income level would be about 8% of payroll. It is fair to ask how this can be.

This is how: first, the New York Health plan will reduce the cost of health coverage – net – by over 15% – almost \$45 billion in 2019 – by eliminating the overcharging for drugs and medical devices, the cost of health insurance company administrative costs and profit, and the administrative costs health care providers incur in dealing with insurance companies, plus other savings, balanced against increased spending mainly for covering the uninsured and increased utilization by removing financial barriers to care. Second, the assessment on employment income will not be the only source of revenue supporting New York Health; upper-bracket non-payroll taxable income (mainly capital gains, dividends and income) – the source of major wealth in our economy – will also be subject to an assessment. Third, the assessments will be progressively graduated. Therefore, upper-bracket earners would contribute more to the cost of the Health Plan, bringing down the cost for the great majority of New Yorkers.

It's arithmetic.

⁹² Schoen, Ridley, and Collins, *State Trends in the Cost of Employer Health Insurance Coverage, 2003-2013*.

CONCLUSION: BETTER HEALTH CARE, FOUND MONEY, AND FAIRNESS

The New York Health Act would produce substantial health and economic gains for New York. The new system would create such large economies in the administration of health care that all of those currently uninsured could be given access to health care with money left over. Furthermore, by financing health care with assessments based on ability to pay, the New York Health Act would produce large savings for the great majority of New York residents. Finally, by reducing business costs, it would also lead to expansion in employment.

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APPENDIX 1: ESTIMATING NEW YORK HEALTH CARE EXPENDITURES

Annual personal health care expenditures from 1997-2009 are from the Centers for Medicare & Medicaid Services, Office of the Actuary at

<http://www.cms.gov/NationalHealthExpendData/Downloads/res-tables.pdf>

Expenditures beyond 2009 have been projected assuming the same rate of increase in per capita expenditures as for the nation as a whole from the CMS.⁹³ Total health consumption expenditures have then been estimated as the state population times projected per capita expenditures. Population data are from the United State, Bureau of the Census:

<http://quickfacts.census.gov/qfd/states/36000.html>

APPENDIX 2: ESTIMATING THE SOURCES OF NEW YORK HEALTH CARE EXPENDITURES (FIGURE 7).

Spending for employer-based insurance in 2012 is from Medical Expenditure Panel Survey of the Agency for Healthcare Research and Quality.

http://meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp?regionid=30&year=2012 and http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_3/2012/ic12_iiia_g.pdf

Spending for 2012 for public sector programs (Medicare and Medicaid) is from the Center for Medicare and Medicaid Services. Spending for 2019 is estimated by adjusting current spending for the increase in spending on these services as projected by the Center for Medicare and Medicaid Services.

Spending on individual insurance is estimated as the sum of the number of individual plans plus the number buying through the ACA exchange. Pre-ACA individual coverage data is from the Kaiser Family Foundation, State Health Facts. ACA coverage is from

<http://acassignups.net/spreadsheet-med>

ACA subsidies are the product of the number buying through the ACA exchange (from <http://acassignups.net/spreadsheet-med>), the proportion with subsidy (83%) and the average subsidy (from <http://kff.org/health-reform/issue-brief/how-much-financial-assistance-are-people-receiving-under-the-affordable-care-act/>).

Other and out-of-pocket spending are calculated as a residual: total expenditures minus private health insurance and public spending. The allocation of spending between the two is estimated using national data from the CMS, “National Health Expenditures by Type of Service and Source of Funds”.

⁹³ Sisko et al., “National Health Spending Projections”; Center for Medicaid and Medicare Statistics, *National Health Expenditure Projections 2013-2023* (Washington, D. C.: Centers for Medicare & Medicaid Services, Office of the Actuary, n.d.), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2013.pdf>.

APPENDIX 3: ESTIMATING SAVINGS FROM THE NEW YORK HEALTH PLAN

Savings have been calculated for 2019 in three steps.

First, expenditures for nine types of personal health care services have been calculated for 2019 from CMS data for 1991 through 2009 on the assumption that expenditures for that service will continue to increase from 2009-19 at the same annual rate of increase as 1991-2009 *except* that spending in New York is assumed to have slowed to the same degree as has national spending.

Table 6. Estimated 2019 personal health care expenditures (\$millions).

	1991	2009	2019 adjusted at new growth
Hospital	\$ 24,557	\$ 57,571	\$ 79,055
Physician	\$ 11,960	\$ 33,111	\$ 49,867
Other Professional	\$ 1,530	\$ 5,109	\$ 8,539
Dental	\$ 2,598	\$ 6,598	\$ 9,472
Home Health	\$ 3,034	\$ 7,692	\$ 11,032
Drugs	\$ 4,842	\$ 21,701	\$ 42,712
Durable Medical	\$ 736	\$ 1,980	\$ 2,935
Nursing Home	\$ 5,155	\$ 11,847	\$ 16,089
Other	\$ 3,617	\$ 17,236	\$ 35,100
Total:	\$ 58,028	\$ 162,845	\$ 254,801

Second, provider savings for each category have been estimated by applying a savings rate to each activity.

Table 7. Estimates of savings by activity, personal health spending, 2019 (\$millions).

	2019 adjusted at new growth	Savings rate	Savings from market power reduction	Savings from reduced administrative waste	Remaining
Hospital	\$ 79,055	9.1%		\$ 7,158	\$ 71,897
Physician	\$ 49,867	11.7%		\$ 5,810	\$ 44,058
Other Professional	\$ 8,539	10.6%		\$ 901	\$ 7,638
Dental	\$ 9,472	8.3%		\$ 785	\$ 8,687
Home Health	\$ 11,032	3.1%		\$ 345	\$ 10,687
Drugs	\$ 42,712	37.5%	\$ 16,017		\$ 26,695
Durable Medical	\$ 2,935	10.0%	\$ 293		\$ 2,641
Nursing Home	\$ 16,089	1.6%			\$ 16,089
Other	\$ 35,100	16.1%		\$ 5,665	\$ 29,435
Total	\$ 254,801		\$ 16,311	\$ 20,663	\$ 217,828

The administrative savings rate is the difference between administrative costs in Canada and the United States. The Canadian rate is estimated by Woolhandler, Campbell, and Himmelstein.⁹⁴ For hospitals, I use the updated data from Himmelstein et al.⁹⁵ The United States rate is the share of salaries for administrative positions in the 2012 Bureau of Labor Statistics, Occupational Employment Statistics.⁹⁶

It is assumed that the New York Plan agency will use its bargaining power to lower prices. A savings of 37.5% is assumed for pharmaceuticals and medical devices.⁹⁷

Savings for each activity are calculated as the savings rate times the 2019 expenditures except for uncovered services.

Administrative spending by insurance companies under the ACA is the difference between the personal health expenditures and the health consumption expenditures in the CMS National Health Expenditures. It is assumed that the sponsor administrative rate will be 1.8% of spending, the current rate under Medicare fee-for-service.

Total savings are the sum of the provider savings and administrative savings.

⁹⁴ Woolhandler, Campbell, and Himmelstein, "Cost of Health Care Administration in the United States and Canada."

⁹⁵ Himmelstein et al., "A Comparison Of Hospital Administrative Costs In Eight Nations."

⁹⁶ *Occupational Employment Statistics: OES Research Estimates by State and Industry, 2013.*

⁹⁷ McKinsey Global Institute, "Accounting for the Cost of Health Care in the United States."

APPENDIX 4: ESTIMATING THE COST OF PROGRAM IMPROVEMENTS

Three program improvements are necessarily associated with universal state coverage. The increase in the Medicaid reimbursement rate is described in the text above.

UNIVERSAL COVERAGE

Currently, the uninsured spend about 55% of the average per capita health care spending.⁹⁸ Because they are younger and healthier than the general population, it is assumed that their spending will rise to 85% when covered by the New York Plan.⁹⁹ The increase in spending with universal coverage is estimated by multiplying the increase in spending (30%) by the uninsured by their share of the New York population (6.6%). This proportion is applied to every category of personal spending *except* uncovered services, such as nursing home and long-term care.¹⁰⁰

CHANGE IN UTILIZATION

Eliminating deductibles and copayments will allow the sick to utilize the health care system more. The increase in utilization is estimated as the 3% that happened in Canada with the establishment of a universal coverage system in 1971 plus 1.5% which is half the shortfall in health care spending over the 2009-19 period that is not explained by macroeconomic circumstances. This ratio is applied to every category of personal spending *except uncovered services*, including nursing home and long-term care.

⁹⁸ Hadley and Holahan, "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending."

⁹⁹ Ibid.; Rachel Garfield, Rachel Licata, and Katherine Young, *The Uninsured at the Starting Line: Findings from the 2013 Kaiser Survey of Low Income Americans and the ACA*, 47 Million (Kaiser Family Foundation, February 2014), ("File not found."); Kaiser Family Foundation, *The Uninsured: A Primer: Supplemental Data Tables*, October 2011, ("File not found.").

¹⁰⁰ Note that the same procedure was used to estimate the increase in spending due to the ACA increase in coverage.

APPENDIX 5: REVENUE SOURCES FOR NEW YORK HEALTH CARE PLAN AND THE NET BURDEN OF THE PLAN

Adjusted Gross Income by source in New York is from the Internal Revenue Service, Statistics of Income (SOI), 2012. Spending for health insurance is from the Agency for Health Care Research and Quality, Medical Expenditure Survey.

Personal income for 2019 has been estimated as the 2012 rate times the Congressional Budget Office projection of the change in income over that period.¹⁰¹ It is assumed that income increases for all groups at the same rate.¹⁰²

Revenues are estimated as the assessment rate for each bracket of income multiplied by the income for each group.

Current expenditures are estimated from census expenditure data in Ketsche.¹⁰³

Table 8. New York State income, 2012.

	# returns	Adjusted Gross Income	Salaries and wages in AGI
			Amount
	9,362,160	700,278,388	459,546,645
Under \$1	133,150	-16,812,785	1,153,243
\$1 under \$10,000	1,567,970	8,200,960	5,432,748
\$10,000 under \$25,000	2,109,840	35,670,985	25,291,683
\$25,000 under \$50,000	2,073,820	75,273,124	61,537,019
\$50,000 under \$75,000	1,218,120	74,886,356	59,192,816
\$75,000 under \$100,000	775,340	67,105,903	51,739,865
\$100,000 under \$200,000	1,065,120	143,982,306	111,177,841
\$200,000 or more	418,800	311,971,539	144,021,430

Source: IRS, Sources of Income, <http://www.irs.gov/uac/SOI-Tax-Stats-Historic-Table-2>. Incomes are projected forward to 2019 assuming that all classes of income grow at the rate of the growth in gross state product, or 1.3861.

¹⁰¹ "An Update to the Budget and Economic Outlook: 2014 to 2024," *Congressional Budget Office*, accessed October 27, 2014, <https://www.cbo.gov/publication/45653>.

¹⁰² Because this understates income for higher groups with higher tax rates, this assumption understates revenue from the tax program.

¹⁰³ Ketsche et al., "Lower-Income Families Pay A Higher Share Of Income Toward National Health Care Spending Than Higher-Income Families Do."

APPENDIX 6: ALTERNATIVE COVERAGE OPTIONS

A LOWER ACTUARIAL RATE

The New York Health Act's costs could arguably be reduced by maintaining copayments or deductibles. Actually, it would not reduce costs; it would continue placing the burden of that cost on patients. Maintaining such fees undermines the spreading-of-risk function of the plan by shifting cost from the general public to sick individuals, and does so without regard for ability to pay.¹⁰⁴ Such charges also impose financial barriers to access, especially among working individuals and families.¹⁰⁵ As happens with the current Medicare system, lowering the actuarial rate means encouraging the purchase of wrap-around private insurance, which would raise administrative costs for private insurers while also creating extra billing expenses.

Each percentage point reduction in the actuarial rate would lower the needed revenue by over \$2 billion. Lowering the rate to 87%, the rate of the Federal Employee Benefits Program, would save \$18 billion, potentially allowing significant reductions in the needed assessment rates. The lower actuarial rate, and lower assessment rate, would reduce the redistributive nature of the program. It would also entail additional costs.

- If households buy private insurance to cover the higher deductibles and copays, it would entail significant administrative costs.
- If the state agency tried to mitigate the burden of higher copayments and deductibles on the poorest 25% of households, those with incomes of under \$25,000, it would entail additional administrative costs to check incomes and administer more complicated copayments and deductibles. This would reduce the savings from a lower actuarial rate.

CURRENTLY UNDER-COVERED SERVICES: DENTAL AND LONG-TERM CARE

This report is drafted assuming that the New York Health Plan would cover dental care. Long-term care will not initially be covered, except for short term rehabilitation. Estimates of the cost of dental coverage are different from those for other services because fewer New York residents have dental coverage now.¹⁰⁶ Currently, 58% of dental services are paid out-of-pocket.

¹⁰⁴ Low-income households could be exempted from these fees but that would require a bureaucracy to check incomes, raising the administrative burden from Medicare's 1.8% toward Medicaid's 5.7%, at a cost of \$456 million.

¹⁰⁵ Again, this effect would be mitigated by exempting the low-income, but at an administrative cost.

¹⁰⁶ By contrast, no special estimates are made for vision coverage where current out-of-pocket spending is substantially less, both in absolute amounts and as a share of the total, and there is relatively little unmet need. The American Optometry Association, for example, says that "[t]he broad penetration of vision correction devices in the U.S. population makes the primary eye care market large. But the growth rate of the market is not robust." See Jobson Medical Information, *The State of the Optometric Profession: 2013* (American Optometric Association, 2014), 10, http://www.reviewob.com/Data/Sites/1/soop_070120134.pdf.

The effect of insurance on dental expenditures is estimated from data from the Medical Expenditures Survey.¹⁰⁷ The cost of this benefit, including regular visits, preventive care, and restorative care, is estimated as the difference between the number of visits for the insured times the average cost per visit times the population. The impact of eliminating copayments is estimated assuming an elasticity of demand for dental services of 0.3.¹⁰⁸

¹⁰⁷ Brown, Erwin and Richard Manski, *Dental Services: Use, Expenses, and Sources of Payment, 1996-2000*, Research Findings (Washington, D. C.: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, January 2004), http://meps.ahrq.gov/mepsweb/data_files/publications/rf20/rf20.shtml#Table7; Barbara Bloom and Robin Cohen, *Dental Insurance for Persons Under Age 65 with Private Health Insurance: United States, 2008*, NCHS Data Brief (Centers for Disease Control, June 2010), <http://www.cdc.gov/nchs/data/databriefs/db40.pdf>; Bernard Sanders, *Dental Crisis in America: The Need to Expand Access* (Washington, D. C.: United States Senate, Subcommittee on Primary Health and Aging, Committee on Health, Education, Labor and Pensions, February 29, 2012), <http://www.sanders.senate.gov/imo/media/doc/DENTALCRISIS.REPORT.pdf>; "FastStats - Oral and Dental Health," accessed November 1, 2014, <http://www.cdc.gov/nchs/fastats/dental.htm>; "Thousands of Oregonians Gain Dental Insurance. Are They Using It?," *Portland Business Journal*, accessed November 1, 2014, <http://www.bizjournals.com/portland/blog/health-care-inc/2014/04/thousands-of-oregonians-gain-dental-insurance-are.html>.

¹⁰⁸ Jeanne Ringel et al., *The Elasticity of Demand for Health Care: A Review of the Literature and Its Application to the Military Health System* (National Defense Research Institute and Rand Health, 2005), http://www.rand.org/content/dam/rand/pubs/monograph_reports/2005/MR1355.pdf.