



# The Price of Single Payer

A Fiscal *and* Economic Analysis  
*of the* New York Health Act

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The Foundation *for* Research  
*on* Equal Opportunity



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**T**HE HIGH COST OF HEALTH CARE AND HEALTH coverage remains one of the most significant barriers to economic opportunity for Americans with incomes and wealth below the U.S. median. Many on the left believe that the existence of private health insurance is a primary barrier to covering the uninsured.

In that vein, several states—most recently, New York—have contemplated abolishing private insurance and moving to system in which the government has a monopoly on providing health coverage, also known as “single payer health care.”

On June 1, 2016, the New York State Assembly passed the “New York Health Act,” a bill sponsored by Assembly member Richard Gottfried, intended to dismantle the state’s health insurance system and replace it with a single-payer program managed by the state government in Albany.<sup>1</sup>

A report on the bill by a long-time single-payer advocate, Gerald Friedman, argues that the Act would achieve universal health coverage, reduce state health spending by over \$44 billion per year, and “create over 200,000 new jobs.”<sup>2-3</sup>

The Friedman report, however, contains critical factual and analytical flaws:

- It disregards ways in which the Act violates federal law, rendering key provisions of the Act unworkable.
- It makes exceptionally optimistic, empirically unsupportable projections of potential cost savings from a single-payer system, and fails to account for necessary spending increases.
- It does not contemplate the erosion in health care quality that may accompany single-payer health care, especially from the elimination of Medicare Advantage plans.
- And it ignores the impact of the Act’s historically high tax increases, especially on the financial services sector, and thereby on state jobs and tax revenues.

A more rigorous analysis of the Act indicates that it

would require \$87 billion in additional annual health spending by the state, but draw in \$9 billion less in tax revenues. The Friedman proposal contemplates \$91 billion per year in state tax increases, but because the plan’s aspirations for cost savings would not materialize, tax increases of \$226 billion in 2019 would be necessary to avoid deficit spending.

In 2015, the state collected \$71 billion in tax revenues, largely in the form of personal income taxes (\$44 billion), consumption and use taxes (\$15 billion) and business taxes (\$9 billion). New York Governor Andrew Cuomo estimates that in fiscal year 2019, the state will collect \$82 billion.<sup>4</sup> Hence, a \$226 billion tax increase would nearly quadruple the state’s tax burden, with severe economic impact to the state.

Without such a tax increase, the resultant budget shortfall would put many of the state’s safety-net programs and other fiscal priorities at risk. The Act could lead, at minimum, to the loss of 175,000 jobs as high-wage, high-value industries move to neighboring states. These losses would filter throughout the economy through lower consumer spending, reducing economic opportunity for those who most need it.

## KEY PROVISIONS OF THE NEW YORK HEALTH ACT

**T**HE NEW YORK HEALTH ACT PURPORTS TO BE a simple idea: to dismantle the complex web of private and public health insurance programs in New York State with a single, government-run insurer, under which “there would be no network restrictions, deductibles, or co-pays.” The plan would provide taxpayer-funded health care to all New York residents, including undocumented immigrants, “without regard to the individual’s immigration status.”

New York would ask for “federal waivers that would allow New York to completely fold [all federal] programs into New York Health,” a trust fund that would pool federal funding from Medicare, Medicaid, Family Health, and Child Health Plus. Local Medicaid funding would be folded into the trust fund.

Private insurance would be abolished. “Private insurance that duplicates benefits offered under New York Health could not be offered to New York residents,” though “existing retiree coverage could be phased out and replaced with New York Health.” Fee-for-service

Medicare would be dismantled and replaced. Medicaid would be dismantled and replaced.

**Medicare:** There are 3.3 million total enrollees in New York State in 2015, of which 37 percent (1.2 million) are enrolled in private plans through Medicare Advantage.<sup>5</sup> These Medicare Advantage plans would be abolished by the Act and replaced with a government-run insurer.

Fee-for-service Medicare (Parts A and B) would also be dismantled and replaced with the new state program. All premiums would be paid by the state. Supplemental “Medigap” plans, for co-pays and deductibles, would have to be replaced by state-funded coverage.

**Medicaid/CHIP:** There are 6.4 million total enrollees in New York State as of June 2016. The Medicaid managed care contract would be withdrawn, and replaced by a state-run insurer.

**ACA Exchanges:** 271,964 adults and 215,380 children are enrolled in private qualified health plans on the New York State of Health exchange. These private plans would be abolished by the Act and replaced with a government-run insurer. All premiums, co-pays, and deductibles would be paid by the state. 379,559 individuals are enrolled in the Essential Plan, which covers exchange-eligible enrollees with incomes between

138 and 200 percent of the Federal Poverty Level.

**Non-exchange individual coverage:** In 2014, 1.1 million individuals were enrolled in private, non-ACA-based, individual insurance coverage (i.e., insurance that an individual purchased on his own, and not through an employer or public program).<sup>6</sup> These policies would be abolished, and replaced by the new state-run program.

**Veterans:** The New York Health Act does not appear to directly affect coverage provided by the Veterans’ Health Administration. However, the Friedman report does assume that VA spending in New York State is taken over by the new trust fund.

**Employer-sponsored insurance:** The New York Health Act seeks to abolish the sponsorship of private-sector employer-sponsored health insurance. Workers would enroll instead in the new state-run program. A new progressive payroll tax and a new tax on capital gains, dividends, and interest income would be assessed on New York employers, and passed on to their workers and customers in the form of fewer jobs, lower wages, and higher prices.

If New York state was permitted to capture these federal funds and redirect them into a state-run pool, as the Act contemplates, the vast majority of the state’s residents with health insurance would be forced to

**Figure 1.** Tax Revenues Needed to Fund the New York Health Act in FY 2019 (Billions \$)



**Table 1.** Estimated Savings Due to Reduced Administrative Costs & Market Power, FY 2019 (\$ Millions)

Program Savings (\$ Millions)	Savings from market power reduction (GF)				Savings from reduced admin. waste				% of savings stymied by ERISA (FREOPP)				Savings from market power reduction (FREOPP)			
	2019E	Savings Rate (GF)			2019E				Savings rate pre ERISA (FREOPP)				Net savings rate (FREOPP)			
Hospital	\$79,055	9.1%			\$7,158		\$71,898		\$93,623	9.1%	70%	2.7%			\$2,543	\$91,080
Physician	\$49,867	11.6%			\$5,810		\$44,058		\$51,994	11.6%	70%	3.5%			\$1,817	\$50,177
Other Professional	\$8,539	10.6%			\$901		\$7,638		\$8,424	10.6%	70%	3.2%			\$267	\$8,158
Dental	\$9,472	8.3%			\$785		\$8,687		\$9,534	8.3%	70%	2.5%			\$237	\$9,297
Home Health	\$11,032	3.1%			\$345		\$10,687		\$12,369	3.1%	70%	0.9%			\$116	\$12,253
Drugs	\$42,712	37.5%	\$16,017				\$26,695		\$33,284	13.9%	52%	6.6%	\$2,195			\$31,089
Durable Medical	\$2,935	10.0%	\$294				\$2,642		\$3,160	10.0%	52%	4.8%	\$150			\$3,010
Nursing Home	\$16,089	1.6%					\$16,089		\$17,533	1.6%	70%	0.5%				\$17,533
Other	\$35,100	16.1%			\$5,665		\$29,435		\$27,363	16.1%	70%	4.8%			\$1,325	\$26,038
<b>NY TOTAL</b>	<b>\$254,801</b>	<b>14.5%</b>	<b>\$16,311</b>		<b>\$20,663</b>		<b>\$217,828</b>		<b>\$257,284</b>			<b>3.4%</b>	<b>\$2,346</b>		<b>\$6,305</b>	<b>\$248,633</b>
<b>Total savings</b>							<b>\$36,974</b>									<b>\$8,650</b>

**Reductions in administrative costs and market power of health care industry are low.** The Friedman analysis projects \$36 billion in savings in 2019 due to the purported simplicity of administering a single-payer program (\$21 billion) and the ability of the state government to reduce drug and medical device prices in such a system (\$16 billion). However, because ERISA self-insured plans are exempt from state interference, savings from reduced administrative waste will be lower than expected. In addition, because 90 percent of prescription drug volume is for generic drugs, the opportunity to reduce prescription drug spending is lower than estimated. (Source: G. Friedman, FREOPP analysis)

give up the insurance they have, and enroll in the new program.

## CORE ELEMENTS OF THE NEW YORK HEALTH ACT VIOLATE FEDERAL LAW

**T**HE NEW YORK HEALTH ACT ENVISIONS ABOLISHING private health insurance and replacing it with a single, state-run insurance program. However, the Act ignores the fact that federal law prohibits states from doing so.

**ERISA protects self-insured plans from state regulation.** The Employee Retirement Income Security Act, enacted by Congress in 1974, provides employers with the ability to preempt state health insurance laws if they choose to provide health insurance directly, instead of through a third-party insurer. In third-party, or group insurance, the insurance company takes on the financial risks of paying health care claims, even if those claims exceed the revenues that the insurer has received in premiums. If a company decides to self-insure, it takes on those financial risks directly.

Most large companies self-insure because there are economies of scale in doing so; in New York state in 2015, 83.2 percent of workers covered at firms with more than 1,000 employees were enrolled in self-in-

sured plans, according to the U.S. Agency for Healthcare Research and Quality.

All in all, in 2015, 53.5 percent of New York state residents with employer-sponsored health insurance were enrolled in self-insured plans protected from state interference by the Employee Retirement Income Security Act (ERISA).<sup>7</sup> With 10.2 million New Yorkers covered by employer-sponsored plans—52 percent of the population—self-insured plans cover 5.1 million New Yorkers, or 26 percent of the state population.<sup>8</sup>

In other words, ERISA prevents New York State from abolishing private health coverage sponsored by companies that self-insure their workers. This principle of preemption was upheld by the U.S. Supreme Court on March 1, 2016 in *Gobeille v. Liberty Mutual*. The State of Vermont had sought to require self-insured employer plans in that state to report data on health care utilization, pricing, and quality to the state government. The Supreme Court ruled that ERISA prohibited states from regulating self-insured employer plans, even with something as minor as data disclosure.

Indeed, the text of the New York Health Act partially anticipates this problem, declaring that a provision related to out-of-state residents working in New York “shall be null and void” if it is found “to violate federal ERISA.” Hence, an analytically accurate assessment of the New York Health Act must take into account

that it cannot apply to the one-third of New Yorkers who receive their coverage from self-insured employers.

**Medicare and Medicaid waivers.** States do not have the authority to abolish privately-administered Medicare Advantage plans, nor to pool Medicare funds into a state-run Trust Fund. Medicare is governed by Title XVIII of the Social Security Act; Medicare benefits belong to the retiree, not to the state in which he resides. The State of New York does not have the authority to appropriate Medicare funds for its own purposes. However, New York could pay Medicare's premiums and cost-sharing.

In addition, the state could refuse to license the issuance of Medicare Advantage plans in New York, effectively providing traditional fee-for-service Medicare with a monopoly. However, this would disrupt coverage for the many seniors who value Medicare Advantage coverage and who would not voluntarily relinquish it.

Medicaid, governed by Title XIX of the Social Security Act, also restricts the ability of states to tamper with the Medicaid benefit. However, Section 1115 of the Social Security Act grants the U.S. Secretary of Health and Human Services the authority to approve experimental programs that would promote the goals of Medicaid and the Children's Health Insurance Pro-

gram. If a future HHS Secretary was friendly to the goal of single-payer health care, New York could apply for a federal waiver that would allow it to redirect federal Medicaid funds into a new state-run insurance program. Without such a waiver, however, New York would not have the freedom to act on its own.

## IMPACT OF THE NEW YORK HEALTH ACT ON PUBLIC SPENDING

THE FRIEDMAN REPORT ATTEMPTS AN ANALYSIS of the fiscal effects of the New York Health Act. Friedman estimates that the Act would reduce state health spending by \$44.7 billion in 2019, and require tax increases of \$91.3 billion in the same year: more than doubling the state's tax burden.

The analysis described below arrives at a substantially different estimate: that the Act would increase state health spending by \$87.4 billion in 2019, and require tax increases of \$225.9 billion.

**Projected health spending in New York in 2019.** Friedman projects that total public and private health expenditures in 2019 will be \$254.8 billion. He calculates this figure based "on the assumption that expenditures...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

**Table 2.** Estimated Savings Due to Administration, Pricing, & Reduced Fraud, FY 2019 (\$ Millions)

Program Savings (\$ Millions)	Savings		Net savings rate	
	2019E	Rate (GF)	2019E	(FREOPP)
Current spending, 2019	\$287,444	100.0%	\$289,927	100.0%
Health care provider billing operations	\$20,663	7.2%	\$6,305	2.2%
Negotiated pricing of drugs and devices	\$16,311	5.7%	\$2,346	0.8%
Administration of third-party payer system (insurance companies, governments, and employers)	\$28,560	9.9%	\$2,899	1.0%
Reduced fraud	\$5,398	1.9%	-\$11,810	-4.1%
Gross savings (savings on current activities)	\$70,932	24.7%	-\$260	-0.1%
Net spending on current activities	\$216,512	75.3%	\$290,187	100.1%

**Fraud is likely to increase in a single-payer system.** While fraud rates for private insurers are low, Medicare and Medicaid endure high fraud rates (10 to 30 percent). Hence, moving to a single-payer system bears the risk of increasing, not decreasing, fraud. (Source: G. Friedman, FREOPP analysis)

the same degree as has national spending.”<sup>9</sup>

We estimate that total public and private health expenditures in 2019 in New York will reach \$257.3 billion. The discrepancy is driven by slightly different methodologies; we take the New York spending totals from 2009 (the last year in which the Centers for Medicare and Medicaid Services published state-based spending totals), and projected them forward based on CMS’ 2009-19 projections of future growth in national health expenditures.

Based on an estimated state population of 19.8 million, \$257.3 billion represents \$12,990 in health care spending by each resident of the state of New York.

This is a conservative estimate, as it does not account for the possibility that millions of retirees from other states could move to New York to take advantage of its state funding of all Medicare premiums and cost-sharing obligations, among other features.

***Effects of the Act on health care prices and administrative waste.*** Friedman estimates that the Act can significantly reduce the prices that health care providers charge, because the state would have unilateral control of all health care consumption. In addition, Friedman projects that because there would only be one payer of health care services, providers would be able to significantly reduce the number of people they employ to deal with billing multiple payers.<sup>10</sup> Our finding is that Friedman greatly overstates these opportunities, for three reasons in particular.

The first reason is that, as discussed above, the federal ERISA law prohibits the State of New York from taking over or regulating the health insurance plans of self-insured employers. ERISA would also prevent the state from eliminating limits on spending through self-insured plans, and thereby the provision of stop-loss insurance in this category.

As a result, providers would still need to retain large billing departments to gain reimbursement from multiple payers; i.e., the third party administrators and other vendors who manage self-insured plans and stop-loss insurance. We estimate that this reduces providers’ ability to save on administrative costs by 70 percent.

Friedman believes that Medicare enjoys lower administrative costs than private insurers, and that the Act could bring those lower administrative costs to the

portion of health care spending that flows through private insurers. However, Medicare’s ratio of administrative costs to reimbursed claims is distorted by the fact that the typical Medicare enrollee is significantly older than the median U.S. resident, and thereby a higher consumer of health care services. On an absolute dollar basis, Medicare’s per-enrollee costs are higher than those enrolled in private coverage.<sup>11</sup> While the Act could, in theory, achieve some economies of scale with regard to administrative costs, the evidence of such savings is limited in government-run insurance programs.

The second reason is that the Act allows physicians, hospitals, and other health care providers to collude with each other to extract higher prices from the state, by “collectively negotiating with New York Health on any matter relating to New York Health, including but not limited to rates of payment and payment methodologies.” Since providers would also retain the ability to lobby state policymakers and contribute to the campaigns of elected officials, this collective bargaining provision would almost certainly lead to higher prices.

The third reason is that Friedman significantly overstates the potential for the Act to reduce spending on prescription drugs. Friedman believes the New York Health Act could reduce branded prescription pricing by 37.5 percent.

However, Friedman fails to note important aspects of the U.S. prescription drug market. First, more than 88 percent of all prescriptions dispensed in the U.S. are for generic drugs, by far the highest market share in the industrialized world.<sup>12</sup> Second, the U.S. generic drug market is highly competitive, with the lowest prices among advanced economies.

Third, pharmacy benefit managers already negotiate branded drug prices down significantly from their list prices. According to IMS health, U.S. branded prescription drug spending based on invoiced (gross) prices was \$310.7 billion in 2015, but spending net of rebates was only \$195.4 billion: a 37.1 percent reduction.<sup>13</sup>

Finally, New York already engages in de facto price regulation of prescription drugs in its Medicaid program; this fact, along with ERISA and Medicare preemption, significantly limits the opportunity for further savings.

Taking all of these factors into account, we estimate

**Table 3.** Increased Costs Due to Program Improvements, FY 2019 (\$ Millions)

Program Improvements (\$ Millions)	As % of current spending		As % of current spending	
	2019E	(GF)	2019E	(FREOPP)
Universal coverage	\$4,024	1.4%	\$16,887	5.8%
Increased utilization	\$11,158	3.9%	\$29,019	10.0%
Medicare and Medicaid rate equity	\$10,841	3.8%	\$10,841	3.7%
Unemployment insurance and retraining	\$290	0.1%	\$339	0.1%
No OOP spending by ACA exchange enrollees	\$0	0.0%	\$5,278	1.8%
Replace Medigap with NY Health Act spending	\$0	0.0%	\$9,458	3.3%
No OOP spending by non-ERISA ESI enrollees	\$0	0.0%	\$15,305	5.3%
Total New York Health Plan spending	\$242,734	84.4%	\$377,314	130.1%
Savings net of program improvements	\$44,710	15.6%	-\$87,387	-30.1%

**The New York Health Act eliminates all out-of-pocket costs.** The New York Health Act requires the State of New York to pay for all co-pays, deductibles, and coinsurance payments. That requires substantially higher spending than previous analyses have contemplated. (Source: G. Friedman, FREOPP analysis)

that the Act could reduce prescription drug spending in New York by 6.6 percent, versus the 37.5 percent estimated by Friedman.

**Government-sponsored insurers face higher rates of fraud.** Friedman believes that the Act would reduce fraud, because a single payor could be more effective at combating fraud, thereby reducing total health spending by 2.5 percent. However, the empirical evidence strongly flows in the other direction. The private sector is quite effective at preventing fraud; this is what insurers' administrative costs are directed towards. On the other hand, according to official federal estimates, improper billing reached 10.5 percent of Medicare spending and 8.4 percent of Medicaid spending in 2009, with significant evidence that fraud rates are as high as 30 percent in some states.<sup>14</sup> Hence, if non-ERISA private insurance were replaced with state-run coverage, we estimate fraud would increase by 4.1 percent of New York health spending.

**Increased spending from expanded coverage and elimination of cost-sharing.** Friedman estimates that the Act's proposed expansion of coverage to all uninsured New York residents, and elimination of patient cost-sharing, will increase 2019 spending by \$26.3 billion, excluding the cost reductions he expects the Act will achieve from monopsony power (i.e., being the

sole payor of health care claims), administrative costs, and reduced fraud. We estimate that the Act's coverage expansion and elimination of cost-sharing will increase state spending by \$77.7 billion over the same time frame.

Friedman believes that expanding coverage to 1.3 million uninsured New York residents can be achieved for \$4 billion in 2019. That implies per enrollee spending of \$3,095 per year, a rate far lower than that of any existing public program in America. By contrast, as noted above, in 2019, health spending in New York is estimated to reach \$12,990 per capita. Multiplying this rate by 1.3 million yields an annual spending increase of \$16.9 billion.

The Act requires the elimination of deductibles and co-pays from health insurance plans. But Friedman does not model the fiscal impact of eliminating cost-sharing provisions from those with existing private coverage, such as coverage from the Affordable Care Act's insurance exchanges and those in the employer-sponsored market.

Eliminating cost sharing for those currently with fully insured (i.e., non-self-insured) private coverage will require at least \$20.6 billion of additional spending in 2019. Paying for supplemental coverage for Medicare

enrollees will cost no less than \$9.5 billion in 2019 (3.4 million state Medicare enrollees with a projected annual per-enrollee Medigap cost of \$2,782).

Friedman estimates that the elimination of out-of-pocket costs for patients will lead to a modest increase in health care consumption, of 4.5 percent of total costs. However, Friedman underestimates the degree of increased utilization. According to a 2009 study by the Medicare Payment Advisory Commission (MedPAC), for example, eliminating co-pays and deductibles in Medicare through so-called “Medigap” supplementary coverage increased per-enrollee spending by 33 percent.<sup>15</sup>

As noted above, for those seniors who prefer Medicare’s traditional fee-for-service coverage, as provided by Medicare Parts A and B, New York’s commitment under the Act to eliminate all premiums, co-pays, deductibles, and coinsurance payments could make New York a magnet for retirees from other states, significantly driving up the state’s costs. We do not include any potential spending increases from this phenomenon in our estimates.

### IMPACT OF THE NEW YORK HEALTH ACT ON HEALTH CARE QUALITY

**T**HE NEW YORK HEALTH ACT IS LIKELY TO REQUIRE considerably more taxpayer funding than its advocates suggest. But the bill would also affect the quality of health care delivered in New York, by replacing private health insurance with coverage run by the state government.

The Medicare Advantage program, through which the Medicare program contracts with private insurers to deliver the Medicare health benefit, has in recent years consistently outperformed the traditional federally-run fee for service Medicare program on quality and cost-effectiveness.<sup>16</sup>

Furthermore, health outcomes for those on private insurance are consistently superior to those enrolled in public health insurance programs.<sup>17</sup>

The New York Health Act would cause enormous disruption in the health insurance coverage that New Yorkers receive; the bill would abolish, effective immediately, private sector health insurance. Such disruption could have ramifications on the chronically ill and those with diseases of high morbidity and mortal-

ity, as any interruption in their ability to finance their health care consumption could cause adverse events.

### IMPACT OF THE NEW YORK HEALTH ACT ON THE STATE ECONOMY

**T**HE FRIEDMAN REPORT ESTIMATES THAT THE New York Health Act would reduce employment in health care administration by 150,000 jobs, but add 200,000 jobs elsewhere in the economy due to reduced health insurance costs, for a net increase of 50,000 jobs.

A more realistic assessment indicates that the Act would reduce employment by at least 175,000 jobs, primarily in the health care and financial services industries.

Given that the Act would nearly quadruple the state’s tax burden, its impact on the employment could be much greater than 175,000. Because the Act would not in fact reduce health insurance costs but increase them, firms would not have savings left over to hire more workers.

*Health insurance and health care administration.* The Act seeks to eliminate the private health insurance industry in the State of New York. The Friedman report estimates that these changes will result in the loss of 150,000 jobs in the health insurance and health care administration sectors. As noted above, Friedman overstates by a factor of three the impact of the Act on administrative costs. As a result, a more realistic estimate of job loss in health care administration is 67,000.

Friedman, however, may be underestimating the number of individuals employed in the health insurance industry. Friedman estimates that there are 26,000 people employed by health insurers in New York state; but in 2016, according to the New York Health Plan Association, the industry employed more than 52,000 individuals, paid \$4.4 billion annually in health care taxes, and covered 10.9 million state residents.<sup>18</sup> Those jobs and taxes would be eliminated by the Act.

*Financial services.* Financial services are the engine of the New York state economy. According to the New York State Department of Labor, two key subsectors of the financial services industry—credit intermediation and securities—employed 350,000 state residents in

2014, representing more than 3.5 percent of the state's labor force.<sup>19</sup>

Because financial services jobs often pay high wages, the industry represents a critical part of the state's revenue base. The Office of the New York State Comptroller has estimated that the securities industry alone accounted for 19 percent of state tax collections in State Fiscal Year 2014, totaling \$13.2 billion.<sup>20</sup>

Many New York-based financial institutions, such as hedge funds, private equity funds, and venture capital funds, are organized as pass-through partnerships in which income is taxed at the individual level. Today, the common sources of interest income—most notably U.S. Treasury and Savings bonds—are exempt from New York personal income taxes. In addition, bonds issued by the State of New York and its localities are exempt from New York personal income taxes.

Dividends and capital gains are treated as ordinary income for state tax purposes; hence, in 2015, the state tax rate for dividends and capital gains was 6.65 percent for those earning more than \$80,150; 6.85 percent for those earning more than \$214,000; and 8.82 for those earning more than \$1.07 million.

The Friedman report estimates that the Act will raise state taxes on dividends, interest, and capital gains by \$32.6 billion in 2019 alone. These funds would be raised, in Friedman's proposal, by a new, progressive tax on such gains starting at 9 percent for those with incomes above \$25,000 per year, and topping out at 16 percent on those with incomes above \$200,000 per year.

For an individual making \$215,000 per year, the Friedman proposal would more than triple the state tax rate on capital gains and dividends, and tax for the first time many interest-bearing securities.

Given the intensely competitive nature of the financial services industry, it would be conservative to estimate that 25 percent of securities firms and individuals, totaling 87,500 jobs and \$3.7 billion in tax revenue, would relocate from the state by 2019 in order to protect themselves from the new tax.

The departure of these high-wage jobs could enact significant downstream effects on the state economy, leading to the loss of another 20,000 jobs in sectors such as retail and dining. For example, in 2014, New York state lost 126,000 tax filers to other states, the

largest number of any state that year.<sup>21</sup> It would be conservative to estimate that between the departure of other high net worth households and slower economic growth, New York state could lose another \$1 billion in tax revenue.

*Taxes on general employers and individuals.* On top of the new taxes on capital gains, dividends, and interest income, Friedman proposes instituting a new, progressive payroll tax beginning at 9 percent and topping off at 16 percent for those earning more than \$200,000. This tax would drive more employers out of the state, and would not raise enough revenue to replace health insurance costs for those on ERISA-based plans.

The Act contemplates replacing local Medicaid spending with state Medicaid spending, but does not require the repeal of local property taxes. Hence, New York homeowners will be taxed twice: once with local property taxes, and then secondly with the new payroll, capital gains, dividend, and interest income taxes.

Finally, because the Friedman report overstates cost savings by \$71 billion per year, underestimates spending increases by \$61 billion per year, and understates revenue losses by at least \$9 billion per year, the plan would need to raise an additional \$134 billion in annual tax revenue, above and beyond the \$91 billion proposed by Friedman, in order to avoid larger state deficits.

## CONCLUSION

OVER A PERIOD OF EIGHT DECADES, THE United States has compounded several policy mistakes that have made health care services uniquely expensive and left tens of millions uninsured. These twin problems have understandably attracted the interest of public-spirited policymakers and scholars.

However, the evidence as to the ability of single-payer health care to improve the quality of the delivery of care in the United States is mixed. Most importantly, federal law is so dominant in the area of health care policy that there is very little flexibility that states have to single-handedly improve the quality and affordability of health care in their jurisdictions.

A number of other states have tried and failed to enact single-payer health care systems. Most recently, in

## Conclusion

2014, Vermont tried and failed to build a system quite similar to the one contemplated in the New York Health Act; indeed, in some ways, it was slightly more fiscally conservative.

The Vermont plan required insurers to cover 94 percent of expected claims, leaving the rest to co-pays and deductibles; the New York Health Act requires insurance to pay 100 percent of claims.<sup>22</sup> Despite this relative conservatism on the part of Montpelier, the Vermont plan would have required a 160 percent increase in state taxes. Peter Shumlin, the state's Democratic governor, abandoned the single payer plan, concluding that it would have been "detrimental to Vermonters."

In 2014, 1.7 million New York residents—including undocumented immigrants—lacked health insurance: 8.7 percent of the state population.<sup>23</sup> There are far less costly, and far less disruptive, ways to expand coverage to this population, but they cannot be achieved through unilateral state action.

Those who wish to ensure that every New Yorker has access to health coverage will be best served by working with the U.S. Congress to reform the existing system, instead of abolishing federally subsidized coverage options that consumers today prefer.

In the meantime, the state could reform the regulatory structure of its non-group health insurance market, for example by ending the practice of requiring that all individuals in the state pay the same premium regardless of age. This regulation, often called age-based community rating, does more than any other to drive up the cost of health insurance for those who do not have it today.

Ultimately, far-reaching health reform that solves these problems once and for all must come from statutory changes at the federal level, such as those contemplated in FREOPP's *Transcending Obamacare*.<sup>24</sup>

These changes, unfortunately, are entirely beyond the scope of the New York State legislature.

# Endnotes

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# About the Author

**A**VIK ROY IS THE PRESIDENT of the Foundation for Research on Equal Opportunity (FREOPP), a non-profit, non-partisan think tank that conducts original research on expanding economic opportunity to those who least have it.

Roy's work has been praised widely on both the right and the left. *National Review* has called him one of the nation's "sharpest policy minds," while the *New York Times*' Paul Krugman described him as man of "personal and moral courage."

He has advised three presidential candidates on policy, including Marco Rubio, Rick Perry, and Mitt Romney. As the Senior Advisor to Perry's campaign in 2015, Roy was also the lead author of Gov. Perry's major policy speeches. The *Wall Street Journal* called Perry's address on intergenerational black poverty "the speech of the campaign so far."

Roy also serves as the Opinion Editor at *Forbes*, where he writes on politics and policy, and manages The Apothecary, the influential *Forbes* blog on health care policy and entitlement reform.

NBC's Chuck Todd, on *Meet the Press*, said Roy was one "of the most thoughtful guys [who has] been debating" health care reform. MSNBC's Chris Hayes calls The Apothecary "one of the best takes from conservatives on that set of issues." Ezra Klein, in the *Washington Post*, called The Apothecary one of the few "blogs I disagree with [that] I check daily."



Roy is the author of *Transcending Obamacare*, published by FREOPP in 2016, and *How Medicaid Fails the Poor*, published by Encounter Books in 2013. He serves on the advisory board of the National Institute for Health Care Management, and co-chaired the Fixing Veterans Health Care Policy Taskforce.

Roy's writing has also appeared in *The Wall Street Journal*, *The New York Times*, *The Washington Post*, *USA Today*, *The Atlantic*, *National Review*, *The Weekly Standard*, and *National Affairs*, among other publications.

He is a frequent guest on television news programs, including appearances on Fox News, Fox Business, NBC, MSNBC, CNBC, Bloomberg, CBS, PBS, and HBO.

From 2011 to 2016, Roy served as a Senior Fellow at the Manhattan Institute for Policy Research, where he conducted research on the Affordable Care Act, entitlement reform, universal coverage, international health systems, and FDA policy. Previously, he served as an analyst and portfolio manager at Bain Capital, J.P. Morgan, and other firms.

He was born and raised near Detroit, Michigan, and graduated from high school in San Antonio, Texas. *USA Today* named him to its All-USA High School Academic First Team, honoring the top 20 high school seniors in the country. Roy was educated at the Massachusetts Institute of Technology, where he studied molecular biology, and the Yale University School of Medicine.



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