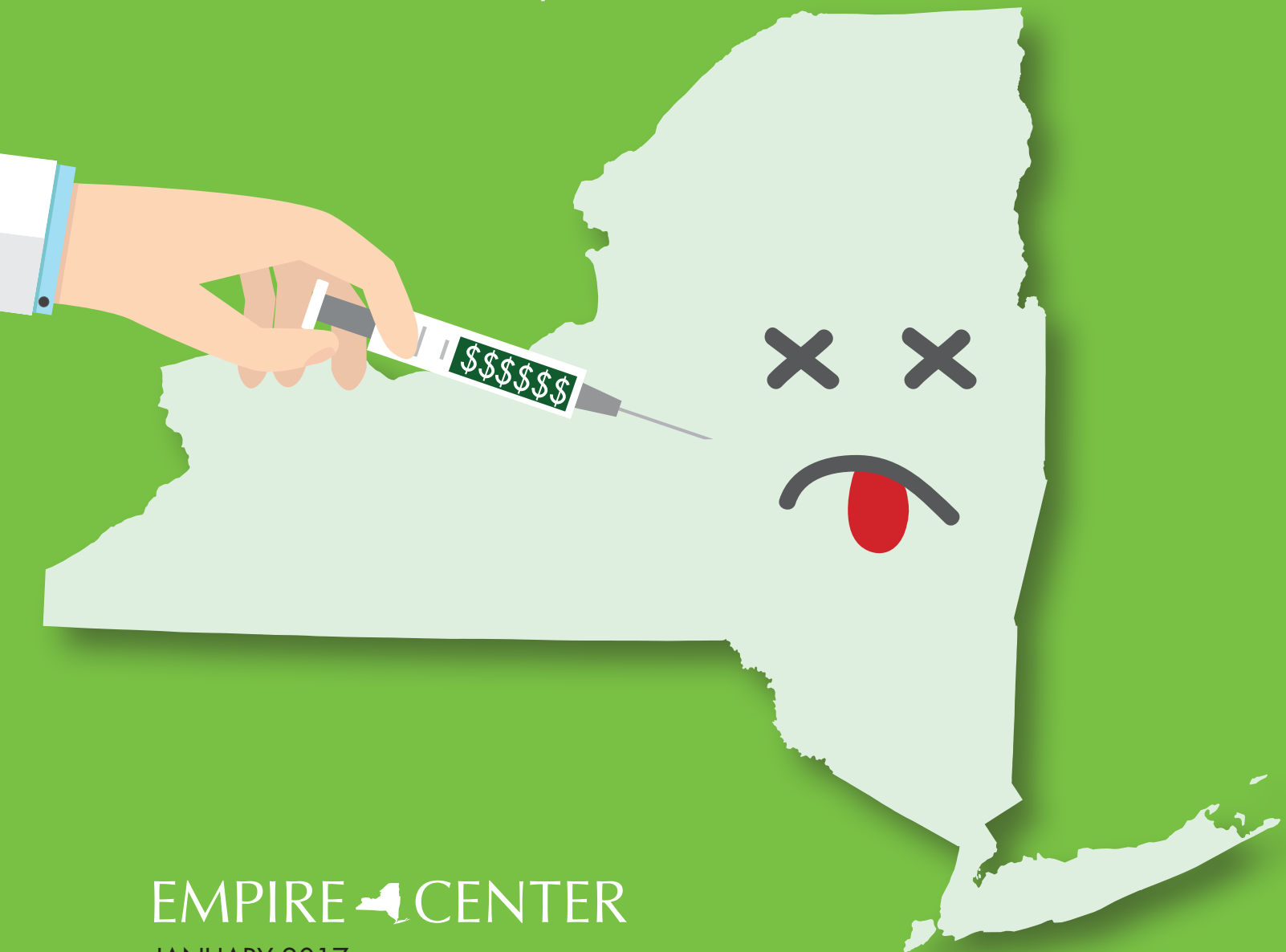


HOOKED ON HCRA:

NEW YORK'S 20-YEAR HEALTH TAX HABIT

by Bill Hammond



EMPIRE  CENTER

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ABOUT THE AUTHOR

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HOOKED ON HCRA:

NEW YORK'S 20-YEAR HEALTH TAX HABIT

WHAT YOU'LL LEARN FROM THIS REPORT:

-  The Health Care Reform Act (HCRA) began as an effort to bring market-driven change and efficiency to New York's hospital industry, but has evolved into little more than a mechanism for generating revenue.
-  HCRA's combined surcharges on health insurance and cigarettes have nearly tripled in size over the past 20 years, and now rank as the state's third-largest tax.
-  HCRA's insurance taxes hit working- and middle-class consumers as hard as the wealthy, adding substantially to the cost of health coverage for everyone.
-  Two-thirds of HCRA funds now flow into the Medicaid budget, accounting for 17 percent of the state's contribution to a program that was formerly financed with general revenues.
-  Other HCRA funds pay for questionable purposes that do not directly contribute to improving patient care or broadening coverage — such as subsidizing doctors' malpractice costs and boosting health-care workers' pay and benefits.
-  Belying its name, the almost \$1 billion HCRA-supported Indigent Care Pool distributes money to hospitals based not on how much free care they provide to the uninsured, but mostly on how much aid they have received in the past.

EXECUTIVE SUMMARY

Two decades ago, New York State deregulated hospital fees in hopes that market forces would tame spiraling healthcare costs.

In the name of smoothing the transition, the law provided hospitals with extra aid financed with special taxes on health plans and medical services.

Almost immediately, the state's per capita hospital spending and employment levels — which had been the highest in the nation — gradually moved closer to the norm, saving billions of dollars for New York taxpayers and consumers.

It was a turning point that then-Gov. George Pataki aptly dubbed the Health Care Reform Act, also known as HCRA (“hick-ruh”).

As the law marks its 20th anniversary, however, it's hard to find any “reform” left in the Health Care Reform Act. Beginning with its first renewal in 1999, HCRA has been transformed from a vehicle for positive change into a revenue source for the status quo.

Rather than phasing out the original taxes, lawmakers repeatedly extended them, hiked them, and added new ones. HCRA receipts now total \$5.5 billion per year, making it the third-largest tax in the nation's highest-taxed state.

Collected in ways that hide them from public view — and that vary from one part of the state to another — the surcharges add as much as 6.2 percent to a typical family's insurance costs, compounding the pain of skyrocketing premiums and deductibles. And HCRA taxes make no allowance for ability to pay — squeezing just as much from families in the working and middle classes as from the wealthy.

Nor is all the money spent effectively. State lawmakers have funneled HCRA funds into programs that have little or nothing to do with direct patient care — such as subsidizing doctors' malpractice premiums, boosting pay and benefits for health-care workers, or simply plugging holes in the state budget.

Today, two-thirds of HCRA monies flow into the state's Medicaid health plan, which is now available to people with incomes up to 138 percent of the federal poverty level.

Those revenues cover 17 percent of the state's cost for the program, which formerly was entirely financed with general tax revenues.

Delivering safety-net care to the uninsured — which was one of the law's original purposes — accounts for an ever-smaller share of the HCRA budget. Even that amount is spent haphazardly at best.

An analysis of HCRA's so-called Indigent Care Pool, which distributes about \$1 billion per year, shows that it pays some relatively well-off hospitals two, three, or four times the cost of the free care that they provide, while safety-net institutions doing the bulk of the charity work get pennies on the dollar.

Meanwhile, the law's complex structure has undermined accountability and fostered corruption. For many years, lawmakers earmarked seven-figure pots of HCRA money for legislative leaders to dole out as they wished, with virtually no oversight — a practice that played a key role in the federal corruption conviction of longtime Assembly Speaker Sheldon Silver. While the pork-barrel accounts have since been closed, parts of HCRA remain opaque to even the most seasoned observers of the state budget.

In the name of “reform,” in short, New Yorkers struggling to afford health coverage are paying billions in regressive taxes to finance programs that do little to improve healthcare — and, in some cases, enable dysfunction.

Many of the law's key provisions, including its major taxes, are due to expire at the end of 2017 — putting the future of HCRA squarely at the heart of the coming year's budget negotiations between Governor Andrew Cuomo and the Legislature.

Lawmakers should take the opportunity to weed out wasteful, politically-driven boondoggles, direct indigent-care dollars where they're needed most, and enact a long-term plan to wean the state away from regressive health taxes as a major source of revenue.

Above all, they should do no further harm — which means rejecting any further HCRA tax hikes or new levies, even in the face of likely funding cuts by Washington.

**IT'S TIME FOR NEW YORK TO KICK
THE HEALTH TAX HABIT.**

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1. THE HISTORY OF HCRA

The Health Care Reform Act of 1996 grew out of an earlier mega-statute that had gone badly awry: the New York Prospective Hospital Reimbursement Methodology, or NYPHRM (“nye-frum”).

Approved in 1982 and first implemented in 1983, NYPHRM was a system of price regulation that dictated the fees charged by almost every hospital in the state. It was mandatory for almost all health insurers — the exception being health maintenance organizations (HMOs), which were a small but growing phenomenon.

Under NYPHRM, regulators in the state Health Department established a basic price per day for each of the hundreds of possible medical procedures a hospital might perform, which they then adjusted upward or downward for the patient’s degree of illness, the region’s cost of living, the hospital’s financial condition, and other factors.

Fees also varied based on who was paying the bill. For-profit commercial insurers were required to pay the highest rates. Next down the ladder was Empire Blue Cross & Blue Shield, a nonprofit company considered the state’s “insurer of last resort” because it accepted high-risk customers. Medicare paid less than Empire, and Medicaid paid the lowest fees of all. Hospitals were expected to use profits from privately insured patients to offset losses on Medicaid.

Beyond this cross-subsidization, NYPHRM set aside pools of money to support charity care for the uninsured, on-the-job training for young physicians (known as graduate medical education), insurance for low-income children through Child Health Plus, and a laundry list of other “public goods.” To raise money for these public goods pools, insurers paid a tax on inpatient hospital bills averaging 5.5 percent, and hospitals paid a 1 percent tax on their inpatient revenue.¹

NYPHRM was a massively complicated system that was the subject of continual political battles at the state Capitol, as employers and insurers fought to keep a lid on rising costs and hospitals and other players angled to increase their revenue. Yet most players on all sides took for granted that the system was generally working to hold down hospital spending in New York.



That assumption turned out to be wrong. In March 1994, health consultant John Rodat — a former Health Department regulator — published an analysis that turned conventional wisdom on its head. Using federal data, Rodat showed that New York’s per capita hospital spending rate was the second-highest in the country — and growing faster than the national average — even as the state’s spending on physician care was below the norm.²

Rodat further showed that the rate at which New Yorkers were hospitalized, and the length of the average hospital stay, were both the highest of 16 states for which comparable data were available — symptoms of inefficiency that a top-down regulatory system had failed to control.³

“While New York’s policy of centralized control of hospital payments may have been relatively effective in the past, it cannot be an effective foundation for the future,” he wrote.⁴

Awoken to these unintended consequences, employers, labor unions, insurers, and advocates for the poor began agitating for reform — a cause that became a priority for newly elected Governor George Pataki after he took office in 1995. He signed the Health Care Reform Act into law on September 12, 1996, and it took effect on January 1, 1997.⁵

HOW HCRA ORIGINALLY WORKED

The central thrust of the new law was to deregulate fees paid by private health plans — which were most of hospitals’ collective revenue — thus exposing them to competitive pressure that would help contain costs. The belief was that negotiations driven by market forces would lead to a better balance between what hospitals needed in revenue, and what employers and insurers could afford to pay.

As a report from Public Policy Institute said in 1998, the rationale “was that the marketplace would help achieve what government lacked the political will and ability to do by itself — force greater efficiencies and reduce hospital excess capacity.”⁶

The statute’s “statement of legislative intent” declared: “The NYPHRM system does not provide the economic discipline to contain costs, affects a shrinking proportion of the market, maintains excess hospital capacity, provides incentives to train too many physicians and inappropriately targets funds for uncompensated care.”⁷

The statement further said that the new law, among its other goals, would “promote competition in the health care marketplace by increasing reliance on market incentives while reducing the role of regulation.”⁸

At the same time, however, HCRA continued subsidies for charity care and physician training — albeit at lower levels — along with other programs formerly supported by NYPHRM. To raise money for newly established “public goods” pools, the law levied two new taxes on insurance:

- An 8.18 percent “patient services surcharge” on hospital, clinic, and laboratory bills to private insurers (exempting physicians and other providers). Medicaid would pay the surcharge, too, at a rate of 5.98 percent. This would collect just over \$1 billion annually in its first years, which was earmarked for charity care and other public health programs.
- A flat per-customer fee, or “covered lives assessment,” on private insurance. Most of the \$665 million collected in the early years went to fund graduate medical education. In a striking departure from usual practice, the rate of this tax was not consistent throughout the state, but varied from place to place based on the number and size of teaching hospitals in each area. To start, it ranged from a high of \$116.75 per insured in New York City to a low of \$4.69 in the Utica-Watertown region.



**The assumption
that price
regulation
was holding
down hospital
spending turned
out to be wrong.**



The money flowed not to the state, but to a private contractor hired as a “pool administrator.” This contractor — which has been Excellus BlueCross BlueShield of Rochester for the entire history of the law — not only collected the funds, but also took charge of distributing them to hospitals according to formulas established by the state.⁹

Some of the proceeds were also used for other programs, such as expanding Child Health Plus and financing poison control centers.



HCRA'S EVOLUTION

As HCRA 1996 neared its expiration date at the end of 1999, employers and insurers lobbied for the taxes to be rolled back or repealed. They argued that health insurance taxes existed on this scale in no other state, and that they undercut the reform goals of affordability and efficiency. They questioned the need to subsidize physician education given that half the doctors trained in New York were leaving for other states. They further noted that deregulation had not triggered a wave of hospital closings or layoffs, contrary to the fears of industry officials.¹⁰

Ultimately, these arguments fell on deaf ears.

In early 2000, Pataki and the Legislature agreed on a four-year extension that not only preserved HCRA's taxing and spending scheme, but dramatically expanded it — setting a pattern that would continue through the next 12 years.

Here is a summary of the key changes:¹¹

2000

At Pataki's behest, lawmakers enlarged HCRA with two new revenue streams: a portion of proceeds from a multistate legal settlement with tobacco companies, of which New York was expected to collect \$25 billion over 25 years, and the near-doubling of the state tax on cigarettes, from 56 cents to \$1.11 per pack.

They used the new money, in part, to launch two new insurance programs — Family Health Plus for low-income parents with children, and Healthy New York, for self-employed individuals and small businesses. They also boosted subsidies to hospitals for charity care and ramped up spending on anti-smoking programs, among other increases.

In an especially significant move, they also drew on \$800 million in HCRA funds to finance existing programs, such as Medicaid and Elderly Pharmaceutical Insurance



Lawmakers hiked the original HCRA taxes, or imposed new ones, 14 times in 12 years — almost tripling annual revenues.



Coverage (EPIC) — in effect, using dollars nominally dedicated to healthcare to plug holes in the overall budget.

2002

With the state's finances reeling in the aftermath of 9/11, Pataki might have been expected to call for cuts to healthcare spending. Instead, he proposed — and lawmakers approved — an extra \$2.2 billion in Medicaid spending over four years (\$900 million from the state and \$1.3 billion in federal matching funds) specifically dedicated to higher wages and benefits for rank-and-file health-care workers.

The extension also increased the share of HCRA funding used to cover existing Medicaid expenses — and thereby balance the budget — to \$1 billion a year.

To pay for these outlays, lawmakers again hiked the cigarette tax (from \$1.11 to \$1.50 per pack) and used increased federal Medicaid funding from Washington.

In another precedent-setting move, lawmakers also relied on the anticipated proceeds from the conversion of Empire Blue Cross & Blue Shield to for-profit status. By law, a corporation making such a move must compensate the public for the value of assets accumulated while enjoying tax protection as a non-profit. Across the country, this is often accomplished by selling stock in the new company and transferring all or most of the proceeds to a charitable foundation.

With HCRA 2002, however, lawmakers opted for the state treasury to receive most proceeds from the conversion of Empire, which would ultimately exceed \$1 billion, setting aside 5 percent for what became the New York State Health Foundation.

Even by Albany standards, this was an unprecedented “one-shot” — the notorious budgeting practice of using a short-term windfall to finance ongoing expenses. Yet lawmakers would repeat the pattern with the conversions of other insurance companies in the years ahead.

The framework of HCRA 2002 emerged from closed-door negotiations between the governor and healthcare labor leader Dennis Rivera, whose politically influential union 1199SEIU endorsed Pataki for re-election a few months later.¹²



2003

The very next year, facing continuing deficits in the post-9/11 recession, lawmakers boosted HCRA funding again with increases in both the patient services surcharge (from 8.18 to 8.85 percent) and the covered lives assessment; proceeds from more insurance company conversions; and the “securitization” of the tobacco lawsuit settlement, in which the state swapped its ongoing annual payments in return for a lump-sum payout.

2005

Lawmakers again hiked the patient services surcharge (from 8.85 to 8.95 percent) and the covered lives assessment, as well as sweeping in \$2.7 billion in receipts from insurer conversions. On the spending side, they established the Healthcare Efficiency and Affordability Law for New Yorkers, or HEAL-NY, which offered \$1 billion in grants to providers to finance modernization projects.

2007

In Governor Eliot Spitzer’s first year, lawmakers hiked the covered lives assessment by \$75 million and collected \$1 billion from insurer conversions. On the spending side, they raised the eligibility ceiling for Child Health Plus from 250 percent to 400 percent of the federal poverty level and established a fund for stem cell research.

2008

As part of Governor David Paterson’s first budget, lawmakers increased the cigarette tax from \$1.50 to \$2.75 and boosted the covered lives assessment by \$70 million.

2009

Lawmakers increased the covered lives assessment by another \$120 million and hiked the patient services surcharge from 8.95 to 9.63 percent. They also levied a new \$399 million assessment on insurance companies to cover the costs of certain programs formerly financed by HCRA, including Healthy New York.

2010

Lawmakers increased the state cigarette tax from \$2.75 to \$4.35 per pack.

2011

As part of Governor Cuomo's first budget, lawmakers levied a \$40 million hospital quality contribution assessment on charges for inpatient obstetrical services, to finance a compensation program for babies injured in childbirth.

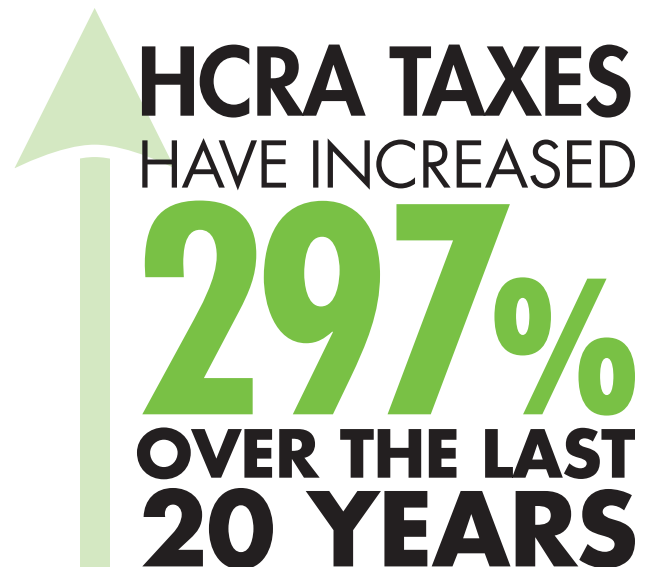
To summarize, lawmakers hiked the original HCRA taxes, or imposed new ones, 14 times in 12 years — nearly tripling annual revenues — even as they used up several billion dollars' worth of windfalls from insurance conversions and tobacco litigation. (*For more detail, please see Figure 1 in Appendix.*)

As revenues grew, the spending side of HCRA changed, too — and drifted ever further from the law's original purpose.

The pool earmarked for graduate medical education, one of the two core programs of HCRA 1996, has been left empty since 2009 — even as the tax levied to fill it, the covered lives assessment, brings in more money than ever.

The other core program of the 1996 law — subsidizing hospital care for the indigent and uninsured — continues at about \$1 billion a year, despite the major decline in New York's uninsured rate since the advent of the Affordable Care Act. The money is distributed so haphazardly that many of the neediest “safety net” hospitals receive less support, proportionally, than hospitals serving mostly privately insured patients. (*See 'Indigent Care Dollars Follow Institutions, Not Patients,' Page 17.*)

Major public health initiatives that HCRA formerly supported — Family Health Plus, Child Health Plus, EPIC, Healthy New York — have either been fully or partially replaced



**HCRA TAXES
HAVE INCREASED
297%
OVER THE LAST
20 YEARS**

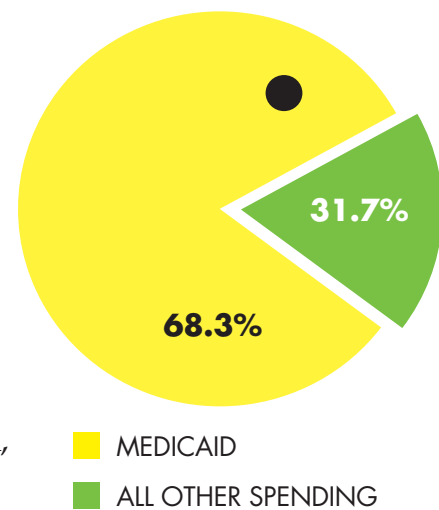


by the ACA and its federal funding. Yet the HCRA taxes enacted to support those programs have gone up, not down.

Other programs — including tobacco control efforts launched with much fanfare in HCRA 2000 — have been cut, shifted back to the general state budget, or both.

Today, HCRA primarily serves as a vehicle for funding Medicaid, a program formerly financed entirely with general tax revenues. This year, HCRA is due to transfer more than two-thirds of its revenue, or \$3.7 billion, to the Medicaid budget, accounting for 17 percent of the state's total contribution to the program. (*For more detail, see Figure 2 in Appendix.*)

WHERE THE HCRA MONEY GOES



Source: NYS Division of the Budget

DID IT WORK?

Measured against the central goal of the original law — to control spiraling hospital costs — HCRA has shown at least some success.

In the early 1990s, at the end of the NYPHRM era, per capita spending on hospitals in New York was rising faster than it was in the rest of the country. As of 1994, the state's hospital spending rate climbed to be the costliest among the 50 states and 28 percent higher than the national average. Both of those measures were the same in 1996, when Pataki signed HCRA into law.

But starting in 1997, the very first year the law took effect, New York's per capita spending began moving closer to the national average. (*For more detail, see 'Letting Market Forces Work,' on opposite page.*) As of 2009, the most recent year for which federal data are available, New York's hospital spending ranked 14th among the 50 states.¹³

However, its spending remained 19 percent higher than the national average, leaving substantial room for further improvement.

Another sign of progress in the early years of HCRA could be found in employment data. As of 1995, New York had 1,800 hospital workers for every 100,000 people, a rate fully

one-third higher than the U.S. norm. By 2002, the sixth year of deregulation, New York's rate had dropped to 1,730 per 100,000, or 23 percent above the national average.

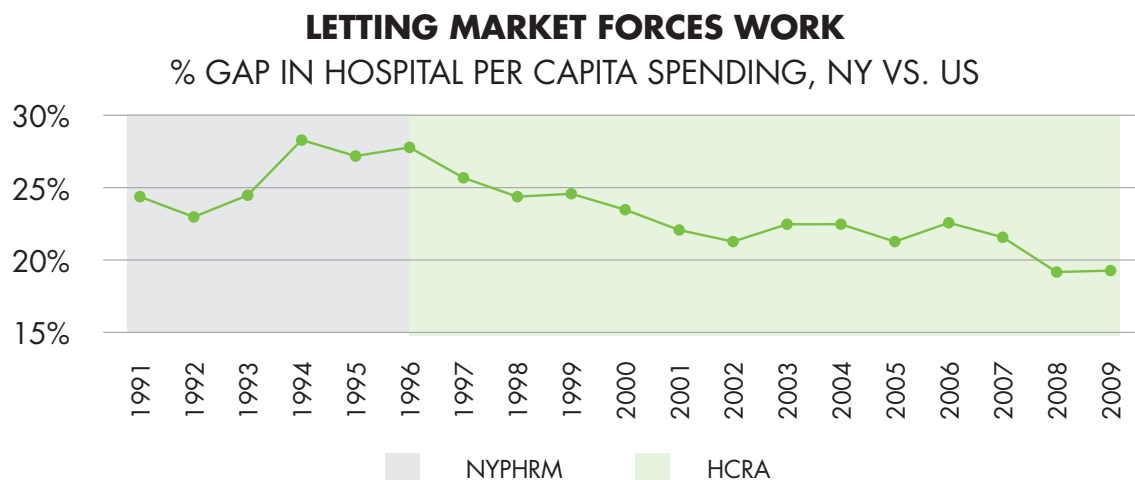
After that, New York's hospital employment crept back up to 1,800 per 100,000 for 2015. Hospital employment grew even faster in the country as a whole, leaving New York at 12 percent above the national average.¹⁴ (See Figure 3 in Appendix.)

To be sure, New York's high hospital spending is partly driven by the state's high cost of living — including wages, real estate prices, energy costs, taxes, and other factors that are far above the national norm. However, New York's hospitals also lag by measures which they should be able to control.

Take, for example, the average length of inpatient stays, a basic measure of efficiency. New York hospitals' average in 2014 was 6.9 days, the sixth-highest among the 50 states. The national norm hasn't been that high since the early 1990s.¹⁵

Despite high spending and employment, New York's hospitals also fall short by some measures of quality. In a federal report card that graded hospitals on a scale of one to five stars — based on 64 quality measures — New York's hospitals collectively received the lowest average score in the country.¹⁶

Although industry officials have disputed the methodology of this report card, there is little question that New York's hospitals collectively rate poorly on important benchmarks. For example, in 2015, 17.8 percent of all New York hospital inpatients were readmitted within 30 days of discharge, the sixth-highest rate in the country.¹⁷



Sources: National Health Expenditure Data, Centers for Medicare & Medicaid Services



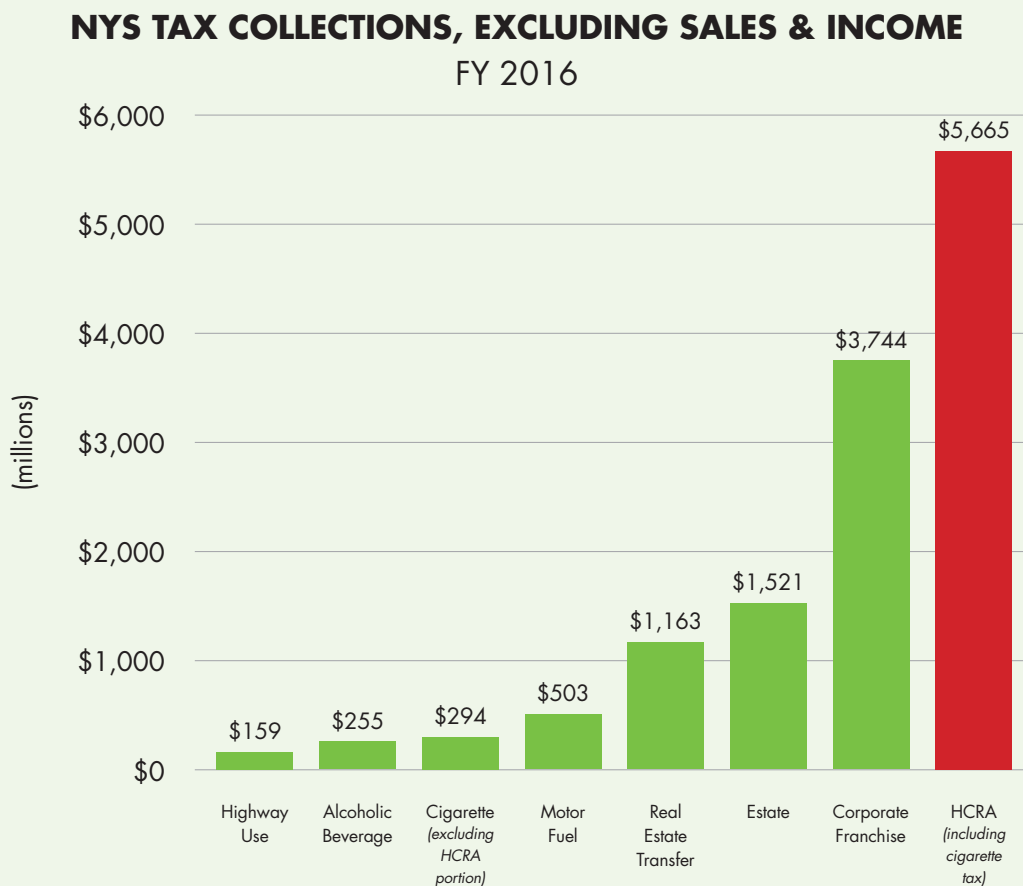
2. NEW YORK'S UNDERCOVER HEALTHCARE TAX

From their relatively modest beginnings, HCRA's insurance surcharges have mushroomed into state government's third-largest tax — behind income and sales taxes — and the single largest tax on business.¹⁸ (*See figure below.*)

With revenues of almost \$5.7 billion in fiscal year 2016, HCRA collections surpassed the estate tax, the real estate transfer tax, the motor fuel tax, the alcoholic beverage tax, and the highway use tax — combined.

While insurers are the ones who directly pay the surcharges, the money does not come out of their profits. Under the industry's accounting regulations, they can and do pass the cost along to customers.

The two main taxes — the covered lives assessment and the patient services surcharge —



Sources: New York State Department of Taxation and Finance, Division of the Budget

WHERE YOUR PREMIUM DOLLAR GOES



Typical NYC plan. Sources: Excellus BlueCross BlueShield, NYS Conference of Blue Cross and Blue Shield Plans

add substantially to the cost of health insurance at a time when many New York families and businesses are struggling to afford premiums. As a share of median silver-level individual premiums available on the state's ACA exchange for 2016, the covered lives assessment ranged from 0.16 percent in the Utica/Watertown region to 3.73 percent in New York City. (*For more detail, see Table 1 in Appendix.*)

The patient services surcharge adds between 3 percent and 4 percent, according to data provided by insurers.¹⁹

Taken together, the total impact ranges from about 3.9 percent of premiums in the Utica-Watertown region, to 6.2 percent in the New York City metropolitan area — the latter being the equivalent of paying for 23 extra days of coverage.

These taxes apply to everyone with non-Medicare coverage. Even the government-funded Medicaid program pays the patient services surcharge, albeit at the lower rate of 7.04 percent.

By making health insurance less affordable, HCRA taxes work at cross purposes with the policy goal of moving toward universal coverage.

For now, the uninsured rate is declining, both in New York and nationwide.²⁰ This is largely due to President Obama's Affordable Care Act and slower growth of insurance costs for employers. This progress could easily be undone if the ACA is repealed (as seems



likely under President-elect Donald Trump) or double-digit premium growth returns to the employer-sponsored insurance market.

In that scenario, HCRA could tend to make things worse. Its taxes would add to rising insurance costs, increasing pressure for employers to drop coverage. This would lead to higher demand for Medicaid and charity care, more financial losses for hospitals, redoubled demand for state funding, and upward pressure on HCRA taxes — a return of a vicious cycle seen under NYPHRM.

HCRA taxes are also highly regressive, affecting all New Yorkers with private health insurance without regard to their ability to pay.

The 9.63 percent patient services surcharge, which comes out of what insurers pay to hospitals and clinics, perversely imposes the highest costs on the sickest patients, costs which must then be absorbed by their insurers, employers, and coworkers. The covered lives assessment, which is a flat fee for each insured person in any given region, costs the same for the retail clerk or fast-food worker as it does for a Wall Street executive.

The covered lives assessment also varies dramatically from one part of the state to another, ranging from \$10.24 per individual in the Utica-Watertown region to \$202.82 in the five boroughs of New York City — a difference of 1,880 percent.²¹

State lawmakers designed the assessment this way to avoid compelling Utica residents to subsidize teaching hospitals in New York City that they would rarely use. Now that HCRA funding for graduate medical education has all but disappeared, the assessment revenue is mostly going to Medicaid and other broad, statewide programs. Residents of New York City — or, for that matter, Rochester, where the rate is \$104.96 — have a right to ask why they should pay so much more.

Another undesirable feature of the HCRA surcharges is that they are hidden from public view. Consumers never see an annual statement of their cost. Instead, they're invisibly baked into insurance contributions routinely deducted from their paychecks. After a major procedure, consumers might notice the patient services surcharge buried among the many charges itemized on a hospital bill, but it has no clear relation to their copayment or coinsurance.

Still, the tax has an undeniable effect — driving up health premiums, adding to the cost of hiring for businesses, and shifting more compensation away from wages and into benefits.

Cigarette taxes that finance HCRA are also regressive — in that lower-income people are more likely to smoke — but can come with the offsetting benefit of discouraging people from picking up the habit, particularly children and teenagers with limited money to spend.

However, New York's highest-in-the-nation state tax, at \$4.35 per pack, has led to widespread evasion and black-market trafficking, which both diminishes state revenue and undercuts public health goals.²²

This is especially true in New York City, where a local levy brings the total tax to \$5.85 per pack. Smugglers known as “bottleggers” can buy cigarettes in Virginia (where the tax is 30 cents per pack), sell them on the streets of New York at a steep discount off the legal price, and still turn hefty profits.

Among those known to have partaken in this lucrative business are organized crime syndicates, street gangs, and terrorist groups.²³

Meanwhile, the state no longer uses HCRA funds to finance its anti-smoking programs. Instead, these funds were shifted to the Health Department's general budget and have been reduced by more than half since 2008.²⁴

Both the patient services surcharge and the covered lives assessment are due to expire at the end of 2017. By allowing them to die — or at least starting to phase them out — Governor Cuomo and the Legislature could both make health insurance more affordable and make New York's tax code less punishing.



THE 'COVERED LIVES ASSESSMENT': A TAX THAT VARIES BY ZIP CODE

ALBANY
\$42.89

BUFFALO
\$41.39

MID HUDSON
\$39.00

NEW YORK CITY
\$202.82

ROCHESTER
\$115.21

SYRACUSE
\$60.47

**UTICA/
WATERTOWN**
\$10.24

LONG ISLAND
\$67.43

*Source: New York State
Department of Health,
2016 individual rates*



3. QUESTIONABLE SPENDING

Not all the programs financed through HCRA have lived up to the law's promise of "reform." Some, in fact, have been as regressive and counterproductive as the taxes that pay for them.

Problems with HCRA's spending priorities date back to the law's origins, when nearly all the money was devoted to two programs aimed at hospitals: a subsidy for graduate medical education and compensation for free care provided to the uninsured and indigent. The former fulfilled a questionable need; the second was spent in ways that prioritized support for institutions rather than patients.

Graduate medical education, or GME, refers to costs incurred by teaching hospitals for training young doctors. Critics questioned this part of HCRA from the beginning, noting that the state's academic medical centers were turning out more graduates than New York needed (causing many to leave the state to practice); that doctors-in-training provide low-cost labor that offsets the expense of training them; and that teaching hospitals already collected substantial GME funding through Medicare.²⁵

Lawmakers phased out the GME portion of HCRA during a budget crisis triggered by the Great Recession in 2008 and 2009.²⁶ Yet the tax created to finance GME — the covered lives assessment — continues at a higher rate than ever.

As for HCRA's charity care program, known as the Indigent Care Pool, criticism has mainly focused not on the purpose, but on how the money is distributed.

Ideally, indigent care dollars would "follow the patient" — they would reimburse providers for delivering specific care to specific people.

The Indigent Care Pool has never worked that way. Instead, it makes lump-sum grants to hospitals that have provided charity care in the past, or that serve low-income neighborhoods — with no requirement that hospitals use the money for treatment. This is analogous to replacing food stamps with checks written to grocery stores, without requiring stores to account for how much food they give away.

Plus, the size of an indigent-care grant has long related loosely, at best, to how much charity care a hospital provides. Under the current formula, some hospitals are receiving

several times more money than they lose on treating the uninsured, while safety-net institutions get pennies on the dollar. (See *'Indigent Care Dollars Follow Institutions, Not Patients,' Page 17.*)

As lawmakers expanded HCRA, they devoted a portion of the new revenues to programs that offered state-subsidized, low-cost health coverage for different groups of the uninsured or underinsured. These included Family Health Plus, for low-income parents; Healthy New York, for small businesses and the self-employed; Child Health Plus, for low-income children; and Elderly Pharmaceutical Insurance Coverage, or EPIC, for low-income elderly people.



It should be noted that Child Health Plus and EPIC were pre-existing programs that were shifted into HCRA and expanded. In effect, moving them into HCRA helped balance the state budget by freeing up general tax revenues to pay other costs.

Of the four programs, only Child Health Plus continues as a major expense. The EPIC program shrank with the advent of drug coverage through Medicare Part D. Family Health Plus was eliminated, and Healthy New York was scaled back, when federally subsidized insurance became available through the ACA. Despite these cutbacks, the HCRA taxes originally levied to support these programs continue at higher rates than ever.

As they fueled HCRA with billions in revenue from tobacco lawsuits and cigarette taxes, lawmakers set aside money for smoking prevention and cessation efforts. That spending peaked in fiscal year 2008 at \$80 million, or 14 percent of the revenues from cigarette taxes.²⁷

Since then, the program has been cut by half and shifted out of HCRA and into the Health Department's regular budget — even as the cigarette tax was hiked two more times, in 2008 and 2010. As a result, the state with the highest tax on cigarettes ranks 20th for its per capita spending on anti-smoking programs, according to the Campaign for Tobacco Free Kids.²⁸



Over the years, the burgeoning HCRA budget made room for a long list of other programs, many of which had little or nothing to do with improving the state's healthcare system.

Workforce recruitment and retention: Starting in 2002, the state used \$2.2 billion in HCRA funds over four years to boost the pay and benefits of non-supervisory health-care workers. That amount of money was enough to buy four years' worth of health coverage, at \$5,000 a person, for 110,000 uninsured New Yorkers. To this day, HCRA spends \$197 million a year on "workforce recruitment and retention" for personal care workers.²⁹

Physician excess medical malpractice: HCRA earmarks almost \$130 million per year to subsidize excess medical malpractice insurance for physicians — which was justified as necessary to prevent soaring liability premiums from driving doctors out of the state. Whether high premiums are caused by a broken litigation system or by extraordinary levels of physician negligence, shifting part of the cost to taxpayers solves nothing.

Pork-barrel spending: For many years, millions of dollars in HCRA money were set aside annually in "priority pools" to be spent at the discretion of the top leaders in the Assembly and Senate. In the mid 2000s, then-Assembly Speaker Sheldon Silver directed \$500,000 of this money to an oncologist who, in turn, gave Silver the names of asbestos patients for lucrative lawsuits — a scheme that figured in Silver's 2015 conviction on federal corruption charges. The judge who heard the case called the lack of oversight surrounding the two HCRA grants "shocking."³⁰ The balance in these pools dropped to zero as of 2012.³¹

While some smaller HCRA-funded programs continue, the law now serves mostly as a revenue-generating vehicle for the state's Medicaid program. In the 2016-17 fiscal year, HCRA is due to transfer \$3.7 billion, or 66 percent of its funds, to the Health Department's Medicaid account.³²

Factor in another \$952 million in scheduled spending from the Indigent Care Pool —



The state with
the highest tax on
cigarettes ranks
20th for its per
capita spending
on anti-smoking
programs.



which flows through Medicaid to draw down matching federal funds — and the share devoted to Medicaid amounts to 83 percent.

All told, HCRA funding now pays just over one-fifth of the state's share of the Medicaid budget.

HCRA has thus played a role in financing the rapid growth of Medicaid, which has added 1.2 million recipients since 2011 and helped drive the state's uninsured rate to an all-time low of 7.1 percent for 2015.³³

However, hidden, regressive taxes on working New Yorkers are the wrong way to finance an ever-larger entitlement program.

A better approach would be to squeeze more efficiency from New York's Medicaid program. While the state has made progress in controlling its Medicaid costs, spending per recipient remains about 25 percent higher than the national average. Narrowing that gap to 10 percent above the national average would save enough money to offset the elimination of HCRA's contribution.

As for other programs currently financed with HCRA surcharges, none is so crucial as to justify further adding to the cost of health insurance. They should be financed with existing, broad-based revenues or eliminated altogether.

INDIGENT CARE DOLLARS FOLLOW INSTITUTIONS, NOT PATIENTS

From its beginnings in 1996, a central declared purpose of the Health Care Reform Act has been to reimburse hospitals, at least partially, for providing free care to the indigent and uninsured.

The need for such support is clear. Despite recent progress in reducing the uninsured rate, 7 percent of New Yorkers, or more than 1 million people, lack coverage of any kind.³⁴ When these patients seek critical care, hospitals are legally obliged to treat them regardless of ability to pay. Some institutions serving lower-income communities annually rack up millions of dollars in unpaid bills.

Failing to compensate safety-net hospitals for this service would jeopardize their financial survival — and the healthcare of hundreds of thousands of New Yorkers.



Harder to justify, however, is the state’s methodology for fulfilling this need.

Throughout its 20-year history, the Indigent Care Pool has distributed money using arcane formulas in which the amount of free care a hospital provides is just one of many factors, and not necessarily the most important.

As a result — as critics have long argued — the system overcompensates hospitals serving relatively affluent communities while shortchanging the safety-net institutions where the need is greatest.

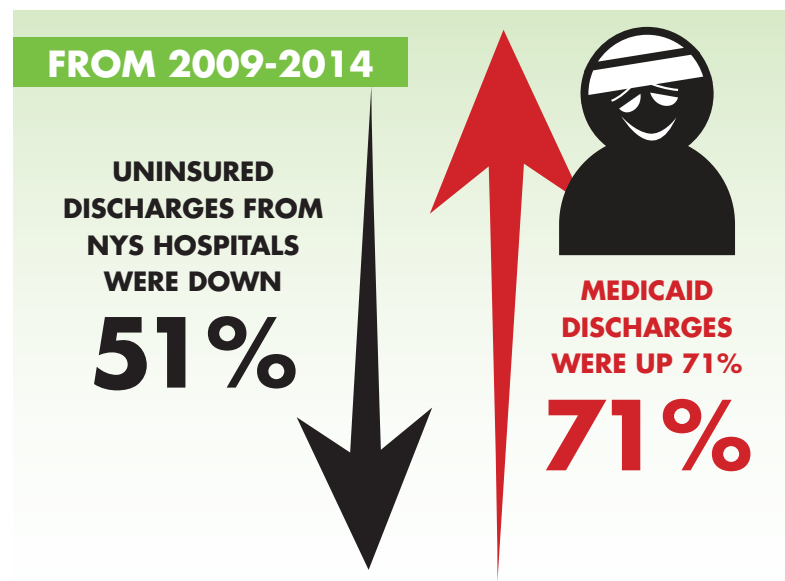
Despite two attempts at reform over the past eight years, this criticism remains as valid as ever today.

An examination of pool distributions for 2015 shows that the amount of money a hospital receives usually bears no relation to how much free care that hospital provides. Some institutions receive significantly more than the value of their charity care, while others get pennies on the dollar.³⁵ (See figure on page 23.)

There is, in fact, a small negative correlation between the neediness of a hospital’s patient population and the generosity of its payout from the Indigent Care Pool. (See *Figures 4 and 5 in Appendix.*) Hospitals serving a *higher* percentage of Medicaid patients tend to be reimbursed for a *lower* percentage of their uncompensated care — a reverse-Robin Hood effect.

Memorial Sloan Kettering Cancer Center, for example, was credited with providing \$3.9 million worth of free care for the uninsured, but was granted \$11.9 million from the Indigent Care Pool — a reimbursement of more than \$3 on the dollar.

At the other end of the spectrum was the New York City-owned Kings County



Source: Department of Health data

Hospital Center, which provided \$111 million in charity care, but collected just \$15 million from the Indigent Care Pool — a reimbursement of 14 cents on the dollar.

Similar inequities have been documented by Roosa Tikkanen of Hunter College. Tikkanen found, for example, that Jamaica Hospital in Queens and North Central Bronx Hospital treated similar numbers of uninsured patients, at about 45,000 encounters each. Yet Jamaica received \$36.4 million from the Indigent Care Pool, while North Central Bronx received just \$4.1 million.³⁶

Tikkanen's findings parallel those of multiple earlier studies by the Commission on the Public's Health System, the Community Service Society, and others.³⁷

These seemingly topsy-turvy numbers were no accident, but the result of a formula most recently overhauled in 2013. To understand how that formula functions, some historical context is necessary.

First, pre-2013 versions of the Indigent Care Pool were designed to compensate not just services provided to uninsured patients, but also “bad debt” — the unpaid bills of patients who had coverage but could not afford or simply failed to pay their share of the cost. Compensation for bad debt flowed mainly to hospitals with large numbers of insured patients.

Second, beginning in 2009, the pool also earmarked extra money for charity care provided by nonpublic academic medical centers — the result of a budget fix in which the former pool for graduate medical education was folded into the Indigent Care Pool as a way of drawing down additional federal Medicaid revenue.

Third, lawmakers have consistently budgeted separate allocations within the Indigent Care Pool for private and government-owned hospitals, with the latter group receiving proportionally less.

As consumer advocates had long documented, these and other measures tended to benefit hospitals serving relatively well-off communities at the expense of safety-net institutions providing the bulk of charity care.

Yet industry representatives resisted sweeping reform, on grounds that major shifts might destabilize institutions that had come to depend on the funding.



The Community Service Society has further shown that many of the hospitals receiving indigent-care funds were not proactively offering free care to the people who needed it.³⁸ Instead, they were billing indigent patients for their full charges — regardless of how much indigent care funding they received — and in some cases using heavy-handed tactics to collect.

A 2007 state law requires hospitals to offer charity care on a sliding scale to all uninsured patients up to 300 percent of the federal poverty level. However, the Community Service Society found most hospitals were not fully complying with the law and Health Department guidelines as of June 2010.³⁹

In 2008, lawmakers required hospitals for the first time to provide the Health Department with detailed information on the charity care they delivered. However, these data determined distribution of only 10 percent of the Indigent Care Pool.

The most recent reforms, enacted in 2013, grew out of recommendations from the Medicaid Redesign Team established by Governor Cuomo.

Citing research by the Commission on the Public's Health System, the team's Health Disparities Group found "little or no relationship between the actual dollars received by the hospitals [from the Indigent Care Pool] ... and the amount of health care services they provided to the uninsured." Going forward, the group wrote in its 2011 report, indigent care funding "should follow the patient."⁴⁰

The group further warned about changes in federal regulations accompanying the Affordable Care Act, which said indigent care funding for hospitals should be based on only two factors: how much uncompensated care a hospital provides to the uninsured, and how much they lose treating Medicaid patients due to the program's low fees. States that failed to comply would risk losing federal aid.

In response to those recommendations, lawmakers in 2013 enacted a new formula that includes no explicit provision for bad debt or for teaching hospitals — and uses only the amount of care provided to the uninsured and the Medicaid utilization rate to calculate a "nominal need" for each hospital.

However, the lawmakers added a "transition adjustment" that sharply limits how much any hospital's funding can change from one year to the next. For 2015, hospitals were

guaranteed to receive no less than 92.5 percent of what they got, on average, from 2010 through 2012. At the same time, the formula also capped increases. Public hospitals could receive at most 6.6 percent more, and voluntary hospitals 19.1 percent more, than their average allotment from 2010 through 2012.⁴¹

For most hospitals, this transition adjustment effectively made the rest of the formula irrelevant. Just more than half of the hospitals, or 93, were guaranteed a minimum amount that exceeded their need-based share — and, in some cases, also topped the full value of their charity care. Another 55 hospitals were capped at a maximum that was less than what they otherwise would have been entitled to, sometimes significantly so. Only 34 hospitals, or one in five, received grants based on the need-based part of the formula.

Thus, New York nominally removed bad debt and graduate medical education from its Indigent Care Pool formula — then minimized the impact of that change by adding the transition adjustment. In effect, the state has continued to reimburse hospitals as it had in the past, and diverted money from safety-net hospitals to do so, while continuing to draw federal matching funds. This would seem to run afoul of the spirit, if not the letter, of federal regulations.

Meanwhile, lawmakers continued segregating the pool based on ownership. The 2015 budget allocated \$971.7 million for private hospitals and \$136.2 million for public-sector institutions.

Government-owned hospitals collectively delivered 41 percent of the charity care, yet received just 12 percent of the pool funding. Voluntary hospitals delivered 59 percent of the charity care and received 88 percent of the pool funding.

In 2015, the hospitals' nominal need collectively amounted to \$2.2 billion, and the Indigent Care Pool had \$1.1 billion available to distribute. If the formula had simply allocated the money proportionally by need, each institution would have received about 53 cents on the dollar. Instead, private hospitals collectively received 78 percent of their nominal need, while public hospitals got just 16 percent.



Government-owned hospitals collectively delivered 41 percent of the charity care, yet received just 12 percent of the pool funding.





Particularly hard-hit by the formula are the 11 hospitals owned and operated by New York City Health + Hospitals. Located in some of the city's poorest neighborhoods, serving large numbers of undocumented immigrants ineligible for Medicaid, these institutions collectively provide one-third of the state's charity care — and receive just 8 percent of the Indigent Care Pool funding.

Like other public hospitals, city hospitals qualify for additional streams of funding that are not available to private institutions. Even so, Health + Hospitals has required repeated infusions of extra money from the city and state budgets and still faces an estimated deficit of \$1.8 billion in 2020.⁴²



Even within the public and private subgroups, the transition adjustment results in vast disparities in funding.

In a comparison of two private hospitals, Tikkanen found that NYU Langone Medical Center served 10,650 uninsured patients, compared to just 899 for Memorial Sloan Kettering. Yet each received approximately \$12 million from the Indigent Care Pool.⁴³

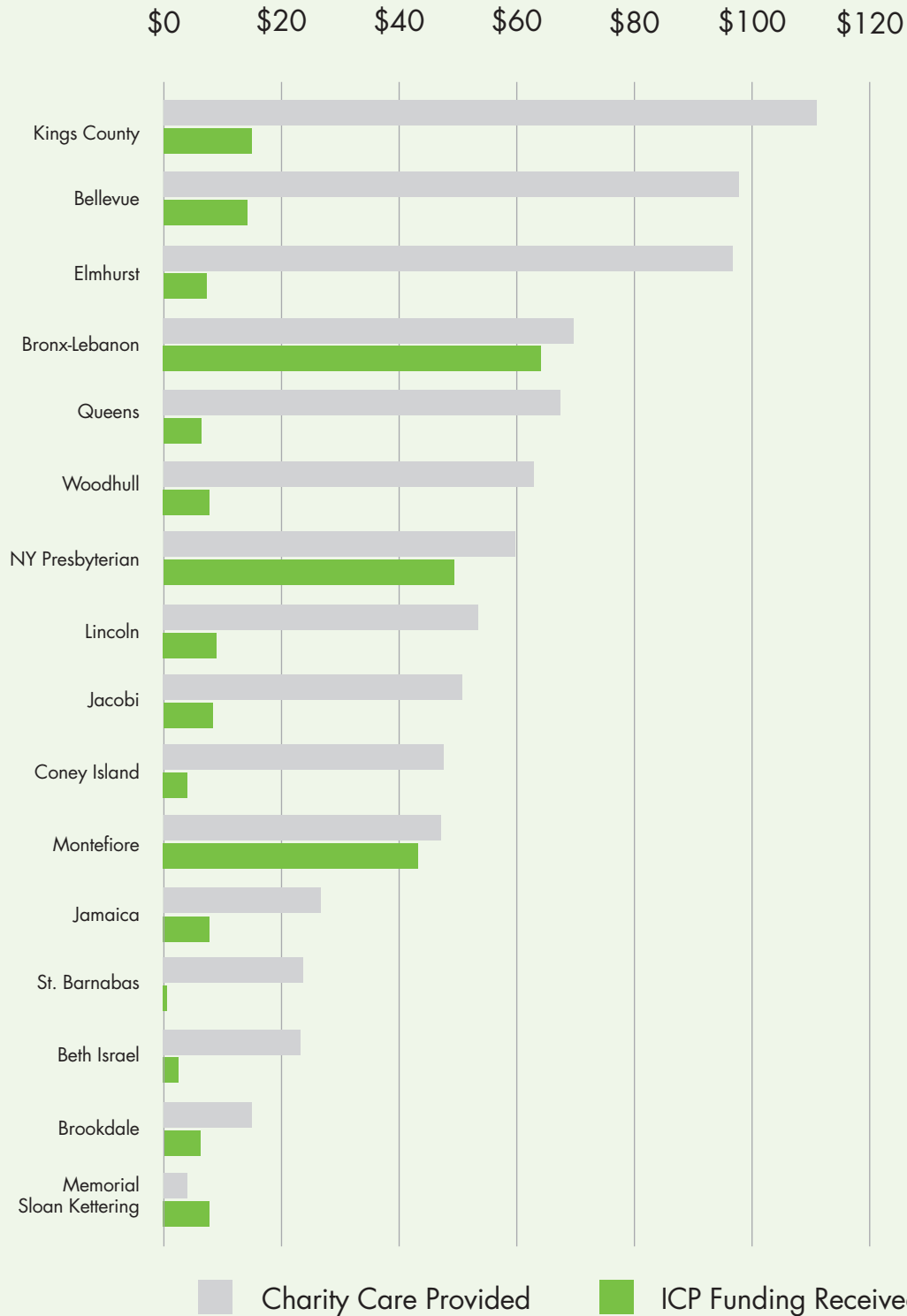
Nor are public hospitals treated even-handedly. Westchester Medical Center, which provided \$22.2 million worth of free care, received an Indigent Care Pool grant of \$8.9 million, or 40 cents on the dollar. By contrast, Kings County Hospital Center provided \$111.1 million worth of uncompensated care — the most in the state — and received a grant of \$15 million, or 14 cents on the dollar.

Figure 4 (Appendix) is a scatter plot of Indigent Care Pool distributions, with each dot representing a single hospital. The X axis shows what percent of that hospital's patients are on Medicaid (an indicator of community poverty), while the Y axis shows the relative size of that hospital's Indigent Care Pool grant (in cents on the dollar).

If hospitals were reimbursed at a flat rate, all the dots would fall on a horizontal line. If hospitals were reimbursed according to the need-based formula, with extra money for institutions with high Medicaid utilization, the dots would cluster on a line sloping upward to the right. (In fact, the 34 hospitals unaffected by the transition adjustment do

MADNESS TO THE METHOD?

INDIGENT CARE POOL FUNDING FOR SELECTED HOSPITALS, 2015
(millions)



Source: New York State Health Department spreadsheet



cluster on such a line, which is visible at the lower left.)

Instead, most of the dots are scattered across the grid with no clear pattern, starkly illustrating the inequities of the formula — with hospitals at the top receiving far more generous funding than those at the bottom.

The red dotted line represents the statistical trend. Its downward slope points to a small negative correlation: Hospitals with *smaller* Medicaid populations tend to get proportionally *bigger* grants from the Indigent Care Pool, which is exactly the opposite of what one would expect.

Figure 5 (Appendix) shows the same scatter plot with government-owned hospitals removed.

The trend line still shows a similar negative correlation between need and generosity of reimbursement.

It should be noted that demand for charity care from hospitals — the need that the Indigent Care Pool was meant to fulfill — has diminished significantly since passage of the Affordable Care Act in 2010.

In 2014, hospitals reported discharging 67,471 patients whose insurance status was either “self-pay” or “unknown” — a decline of more than 50 percent since 2009, when the number of such discharges was 138,403.⁴⁴

During that same five-year period, Medicaid discharges increased from 416,607 in 2009 to 713,347 in 2014.

The number of uninsured hospital patients likely dropped further in 2015 and 2016, given that enrollment in Medicaid and ACA-subsidized private insurance has continued to climb. As of August 2016, the New York State of Health Exchange reported enrollment of 271,964 in ACA-subsidized private health plans, and 379,559 in the Essential Plan, a low-cost, government-funded health plan for people up to 400 percent of the federal poverty level.⁴⁵



Hospitals with smaller Medicaid populations tend to get proportionally bigger grants, which is exactly the opposite of what one would expect.



Despite the dramatically diminished need, spending by the Indigent Care Pool has stayed almost flat at just under \$1 billion (except in 2010, when it spiked to \$1.3 billion). As with other HCRA programs, the Indigent Care Pool demands reform — both in where the money comes from, and how it is spent.

4. A LACK OF TRANSPARENCY

It should go without saying that the public has a right to know how its tax dollars are spent. When it comes to the billions collected and spent through the Health Care Reform Act, however, following the money can be difficult.

To gather data for this report, the Empire Center filed a request under the Freedom of Information Law with the state Health Department, seeking a list of all HCRA expenditures for the 2015-16 fiscal year. The department — which is chiefly responsible for managing HCRA programs — responded that it “does not maintain records responsive to [the Center’s] request.”

It suggested that the state Budget Division might have the information in question. But the Budget Division had earlier directed the Empire Center to the Health Department.

In a second request, the Empire Center sought a copy of reports from the HCRA Pool Administrator detailing the tax money collected from health plans and grants paid out to hospitals. Although state law requires the health commissioner to assure that such reports are delivered to the Legislature on a quarterly basis, the Health Department again responded — after a four-and-a-half month delay — that it “does not maintain annual reports responsive to [the Center’s] request.”

A follow-up request to the Assembly for the Pool Administrator data was fulfilled within 36 hours.

In a third request to the Health Department, the Empire Center asked for a copy of the spreadsheet documenting the calculation of Indigent Care Pool distributions to hospitals for 2015. That request, filed on November 1, was still pending as this report went to press. For the analysis in this report, the Empire Center used a copy of the department’s spreadsheet that was provided by a knowledgeable third party, who asked to remain anonymous.



The lack of transparency is consistent with a tradition that goes back to the law's beginnings in 1996, when the Pataki administration treated most HCRA revenues, which then amounted to \$1.5 billion a year, as "off budget" transfers from insurance companies to hospitals.

As late as 2003, Governor Pataki's budget documents referred to HCRA tax proceeds as "non-state" funds.⁴⁶

That same year, then-Comptroller Alan Hevesi called for a halt to this unusual end-run around fiscal safeguards:

Policymakers have sometimes said that off-budget collections and spending protect important programs from the ups and downs of yearly budgeting. However, the reality is that off-budget actions mask the true level of State-authorized and imposed receipts and spending, which not only results in a loss of accountability to policymakers and taxpayers, but also removes important financial checks and balances that are normally performed by the Office of the State Comptroller.⁴⁷

Since then, governors and lawmakers have moved most HCRA monies into the regular budget and subjected them to the usual fiscal procedures.

Lawmakers should not consider extending HCRA in any form without treating all revenues and expenditures as the public funds that they clearly are.

CONCLUSION: THE WAY FORWARD

If such a system didn't already exist, it's hard to imagine many state lawmakers supporting the Health Care Reform Act as it works today.

They'd be voting to hike taxes by \$5.6 billion per year — one of the largest single-year increases in state history.

They'd be voting for taxes that hit the working poor as hard as the wealthy.

They'd be voting to use those regressive revenues to cover one-fifth of the cost of Medicaid, a program otherwise financed with broad-based taxes.

They'd be voting to make New Yorkers' health insurance even more expensive, and more of a drag on the economy, than it already was.

They'd be voting to spend \$1 billion a year on hospital subsidies that are more generous to hospitals in well-off communities than to safety-net institutions in poor neighborhoods.

They'd be voting to use healthcare dollars for a raft of other programs that confer special benefits on politically influential groups — such as physicians and certain unionized workers — without directly improving the health of a single New Yorker.

They'd be voting to tax cigarettes heavily enough to encourage smuggling, and then to dedicate none of the revenue to help smokers quit.

Such a plan would be unlikely to get much support from any party. Yet that is the messy reality of HCRA as it marks its 20th anniversary.

The law did not arrive at this point overnight, nor will unraveling it be politically easy. It means upsetting the status quo, rescinding benefits for influential interest groups, and giving up billions in revenue — the last being especially tricky given the uncertain future of federal funding for Medicaid under a Trump administration.

This year, however, there is no avoiding a vote on HCRA as it exists today. The pending expiration of surcharges at the end of 2017 forces Governor Cuomo and the Legislature to make a choice: They will either begin reforming the Health Care Reform Act, or perpetuate an indefensible status quo.

Here are four principles they should follow going forward:

First, stop treating HCRA revenues as a slush fund for special interests. Instead of subsidizing the state's excessively costly medical malpractice system, lawmakers should do something to fix it. Instead of earmarking money for healthcare workers' compensation, lawmakers should focus only on buying the highest-quality care at the lowest available price. Any programs they keep should be budgeted and paid for in a fully transparent and accountable fashion.

Second, find a fairer, more effective way to finance medical care for the uninsured. Money should follow patients, not institutions. Ideally, hospitals and other providers would



submit vouchers for uncompensated care that the state would partially reimburse. At the very least, what money is available should be distributed based on who is delivering care, not who has the loudest voice in Albany.

Third, commit to weaning the state away from its dependence on HCRA revenues. The surcharges were defensible as a temporary measure to smooth the transition to deregulated hospital rates, but not as a major, permanent source of revenue for the state. Lawmakers should enact a long-term plan to repeal the surcharges, reducing them by a fixed amount each year as programs are either eliminated or moved into the regular budget.

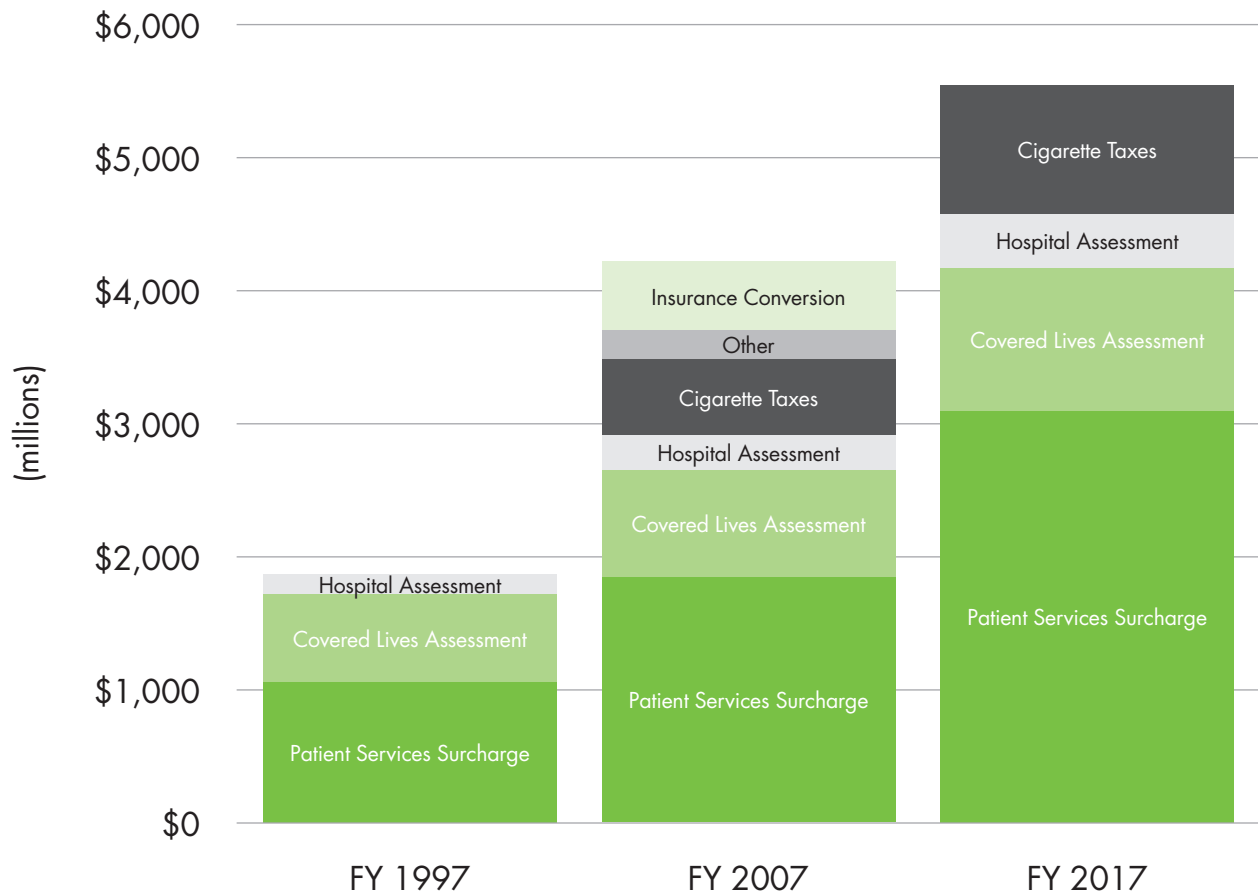
Fourth and most important: Do no further harm. That is, any increase to existing HCRA surcharges or creation of new ones must be ruled out.

Already facing a shortfall from lower-than-expected tax receipts, Albany will be scrounging for revenue to replace the federal aid it stands to lose if, as seems likely, the ACA is repealed and the Medicaid expansion is rolled back. But regressive taxes — especially ones that make health insurance even less affordable for employers and the middle class — would be the wrong way to go.

Let 2017 be the year New York faces up to, and begins to kick, its unhealthy health tax habit.

APPENDIX

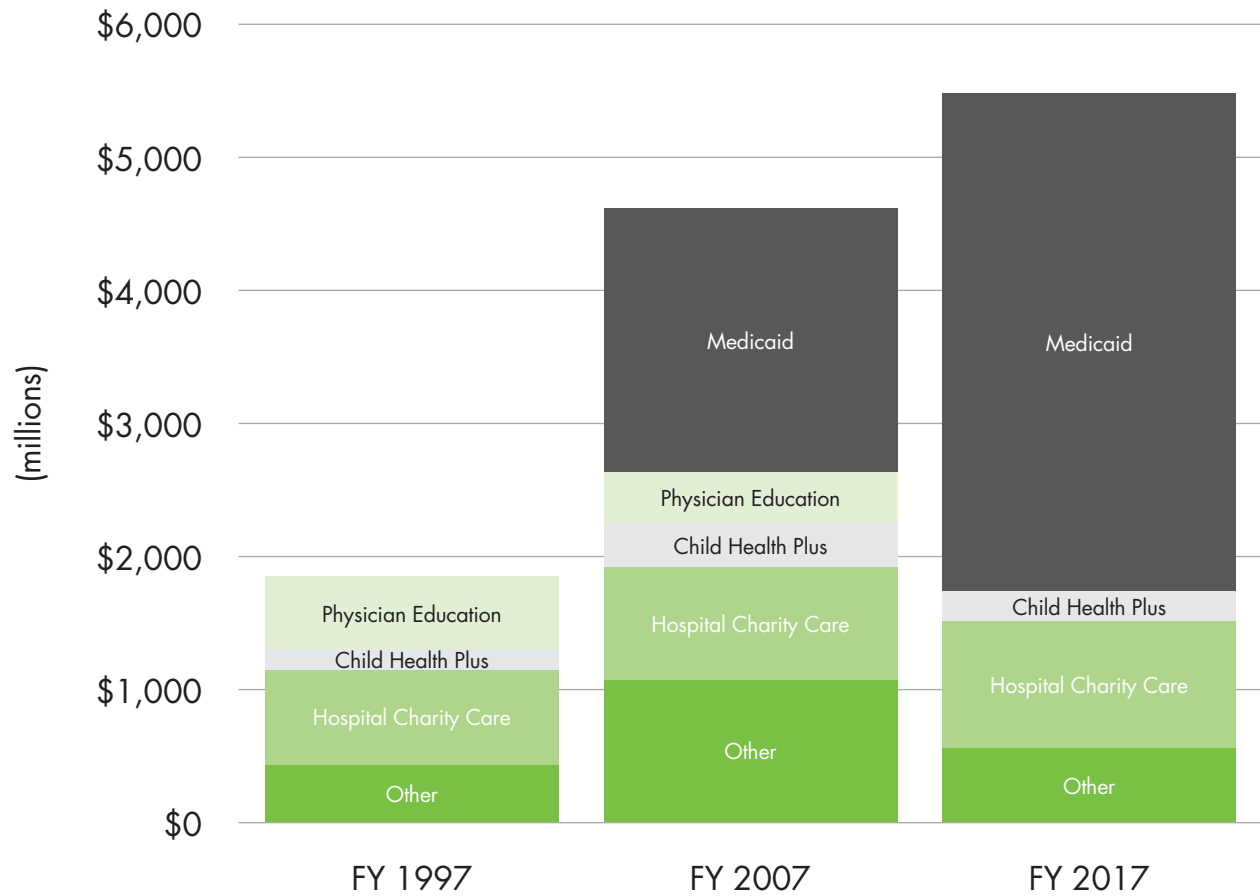
**FIGURE 1:
HOW HCRA BECAME NY'S 3RD-LARGEST TAX**



Sources: Office of the State Comptroller, Division of the Budget



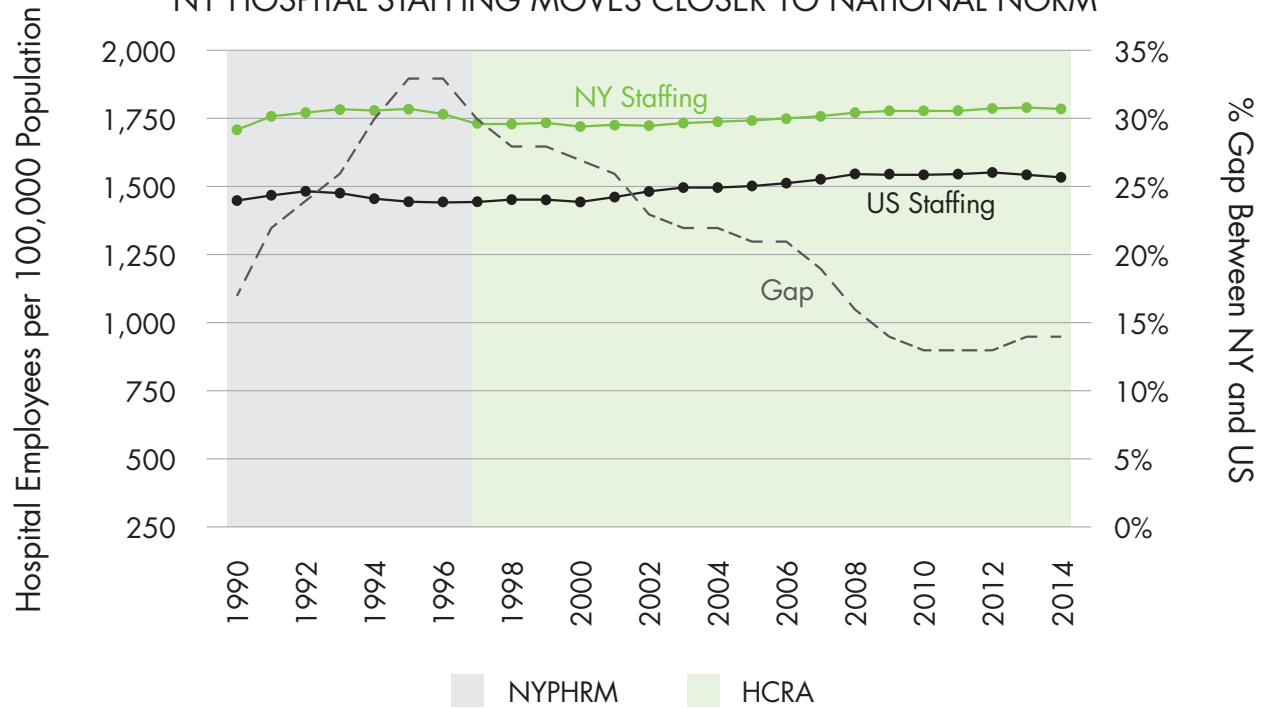
FIGURE 2:
HCRA SPENDING, THEN & NOW
THREE-FOLD GROWTH & A SHIFT TO MEDICAID



Sources: Office of the State Comptroller, Division of the Budget

FIGURE 3: LETTING MARKET FORCES WORK

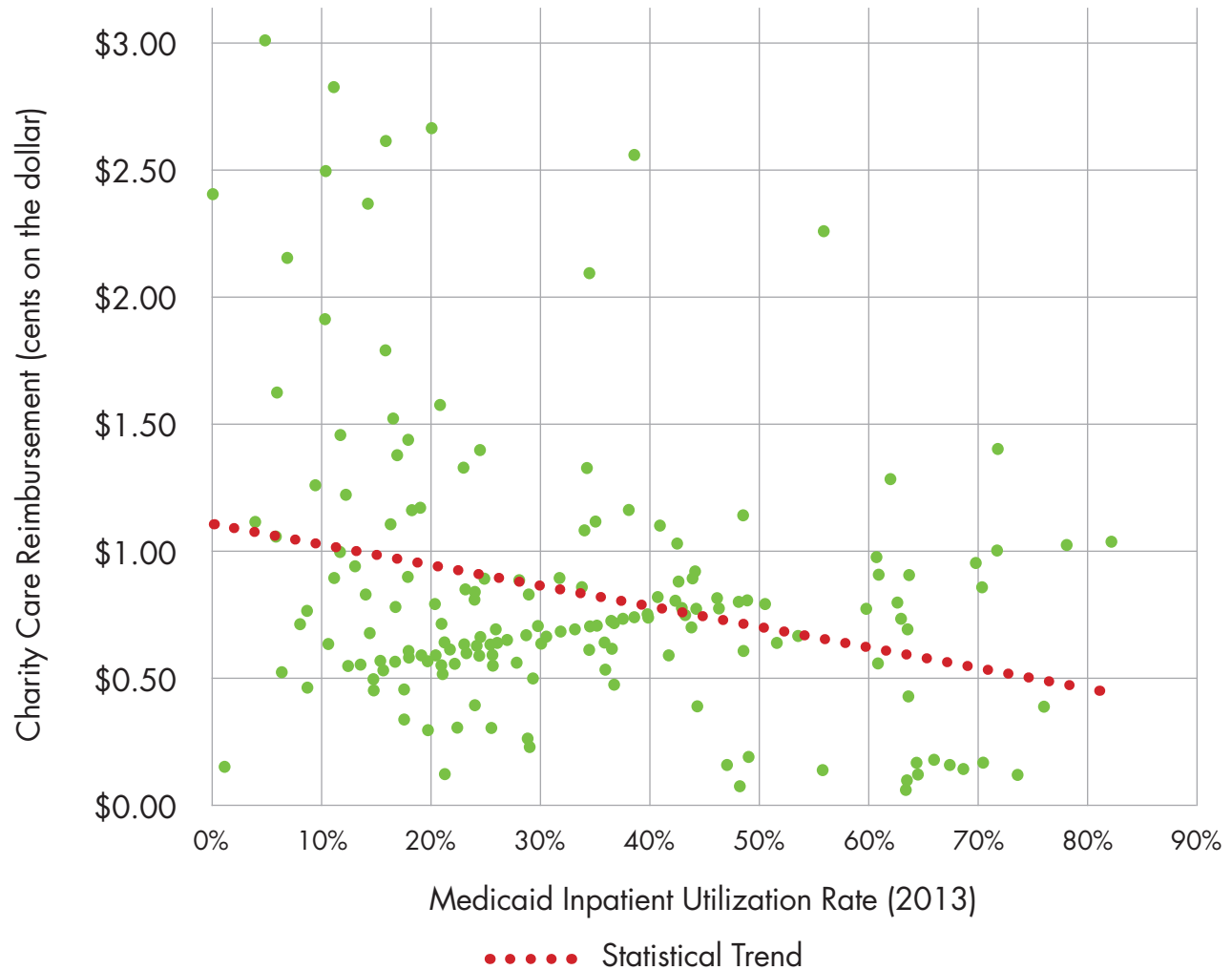
NY HOSPITAL STAFFING MOVES CLOSER TO NATIONAL NORM



Source: Bureau of Labor Statistics

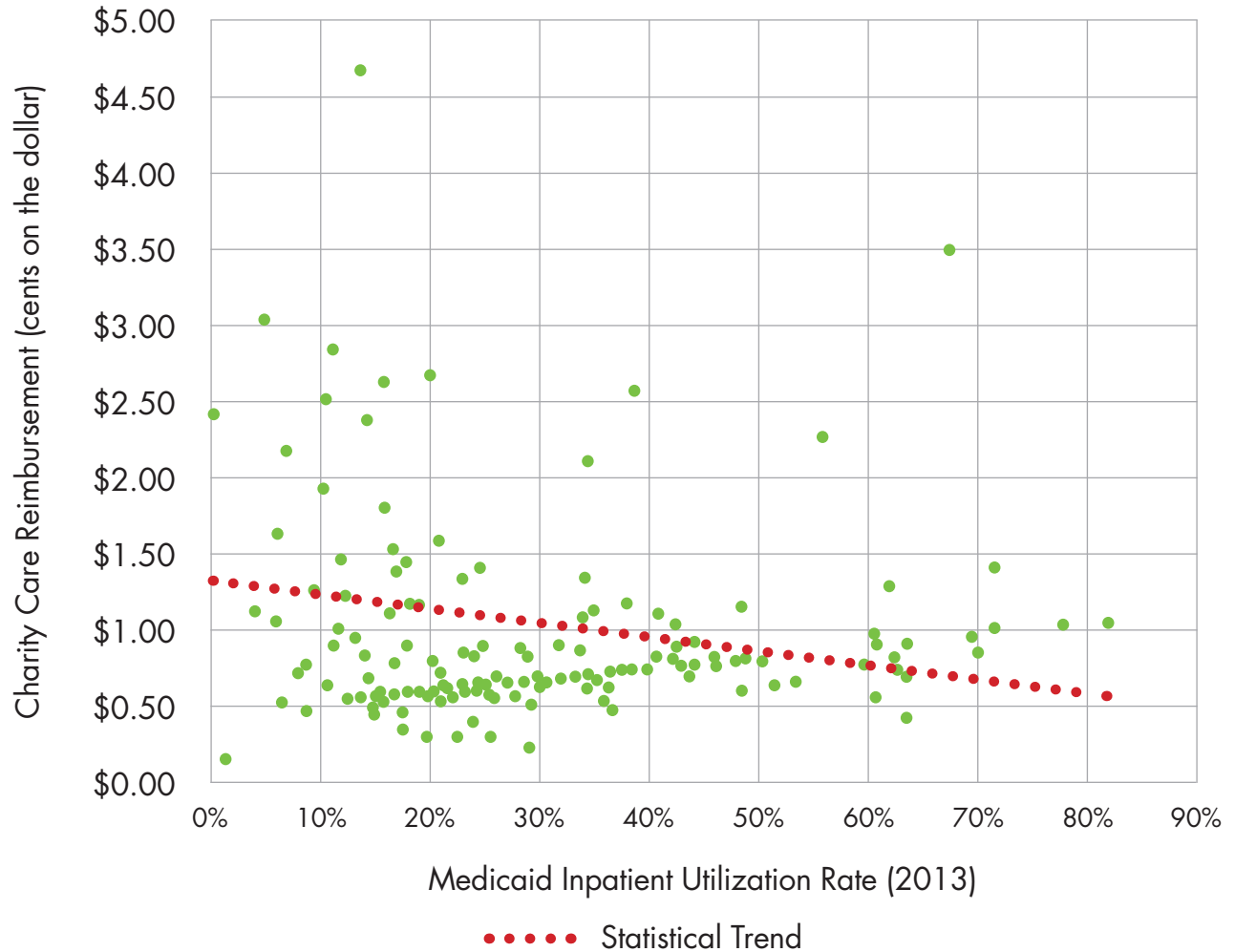


**FIGURE 4:
2015 INDIGENT CARE POOL DISTRIBUTIONS**



Source: Empire Center analysis of Health Department data

**FIGURE 5:
2015 ICP DISTRIBUTION, VOLUNTARY HOSPITALS ONLY**



Source: Empire Center analysis of Health Department data



**TABLE 1:
THE COVERED LIVES ASSESSMENT AS A PERCENTAGE OF
SINGLE-COVERAGE PREMIUM, 'SILVER' LEVEL PLANS**

HEALTH PLAN	ALBANY	BUFFALO	MID HUDSON	NEW YORK	ROCHESTER	SYRACUSE	UTICA	LONG ISLAND
Affinity			\$ 384.84	\$ 394.73				\$ 403.43
CDPHP	\$ 467.15		\$ 565.48			\$ 523.90	\$ 503.16	\$ 514.58
Emblem	\$ 542.59		\$ 542.82	\$ 452.79		\$ 542.59	\$ 542.59	\$ 514.58
Crystal Run			\$ 341.32					
Empire Assurance	\$ 490.51		\$ 578.54	\$ 526.82			\$ 780.77	\$ 484.89
Empire HMO	\$ 515.31		\$ 607.78	\$ 553.45			\$ 830.14	\$ 509.41
Excellus	\$ 575.55	\$ 551.59	\$ 575.55		\$ 432.91	\$ 537.05	\$ 575.55	
Fidelis	\$ 374.89	\$ 353.19	\$ 420.27	\$ 408.04	\$ 377.26	\$ 377.65	\$ 373.31	\$ 395.41
HealthFirst				\$ 422.41				\$ 422.41
Health Now	\$ 475.12	\$ 416.10			\$ 403.45	\$ 475.12	\$ 530.16	
IHBC		\$ 400.07						
Metro Plus				\$ 369.04				
MVP HP	\$ 469.82	\$ 426.89	\$ 575.46	\$ 487.66	\$ 412.41	\$ 536.87	\$ 503.59	
North Shore LIJ			\$ 424.95	\$ 406.04				\$ 424.95
Oscar				\$ 466.68				\$ 466.68
Oxford OHP			\$ 555.97	\$ 555.97				\$ 555.97
UHCNY			\$ 555.37	\$ 555.37				\$ 555.37
Wellcare	\$ 448.54		\$ 448.54	\$ 448.54				
Median Monthly Premium	\$ 475.12	\$ 416.10	\$ 555.37	\$ 452.79	\$ 407.93	\$ 530.39	\$ 536.38	\$ 475.79
Median Annual Premium	\$ 5,701.44	\$ 4,993.20	\$ 6,664.44	\$ 5,433.48	\$ 4,895.16	\$ 6,364.62	\$ 6,436.50	\$ 5,709.42
Covered Lives Assessment	\$ 42.89	\$ 41.39	\$ 39.00	\$ 202.82	\$ 115.21	\$ 60.47	\$ 10.24	\$ 67.43

Sources: Department of Financial Services, Department of Health

ENDNOTES

- 1 Office of the State Comptroller, "The Health Care Reform Act (HCRA): The Need to Restore Accountability to State Taxpayers," April 2003. (www.osc.state.ny.us/reports/health/hcra.pdf)
- 2 John Rodat, "Hospital Reimbursement Revisited," Empire State Report, March 1994.
- 3 Ibid.
- 4 Ibid.
- 5 Chapter 639 of the Laws of 1996.
- 6 Public Policy Institute of New York State, "Misguided Money: A Reexamination of the \$2.6 Billion in Subsidies Provided by Taxpayers and Insurance Surcharges to Help Finance New York's Medical Institutions," November 30, 1998. (www.bcnys.org/ppi/misgdcnt.htm)
- 7 Chapter 639.
- 8 Ibid.
- 9 Office of the State Comptroller, "The Health Care Reform Act (HCRA): State Fiscal Years 2002-03 and 2003-04," October 2004. (www.osc.state.ny.us/reports/health/hcra102104.pdf)
- 10 Op. cit., Public Policy Institute.
- 11 Legislative history drawn from bill text; Division of the Budget financial plans; Office of the State Comptroller, "The Health Care Reform Act (HCRA): State Fiscal Years 2002-03 and 2003-04," October 2004; and a slide deck prepared by the Health Department for the Health Care Reform Act Modernization Task Force, May 2015.
- 12 Adam Nagourney, "Union Crosses Party Lines for Pataki," The New York Times, March 20, 2002. (www.nytimes.com/2002/03/20/nyregion/union-crosses-party-lines-for-pataki.html)
- 13 National Health Expenditure Data, Centers for Medicare & Medicaid Services. (www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html)
- 14 Bureau of Labor Statistics.
- 15 American Hospital Association, "Trendwatch Chartbook 2016," Table 3.2. (www.aha.org/research/reports/tw/chartbook/2016/table3-2.pdf)
- 16 Based on data from Hospital Compare at Medicare.gov. (www.medicare.gov/hospitalcompare/search.html)
- 17 Patrick Conway and Tim Gronniger, "New Data: 49 states plus DC reduce avoidable hospital readmissions," The CMS Blog, Centers for Medicare & Medicaid Services, September 13, 2016. (blog.cms.gov/2016/09/13/new-data-49-states-plus-dc-reduce-avoidable-hospital-readmissions/)
- 18 Fiscal Year Tax Collections: 2015-16," New York State Department of Taxation and Finance. (www.tax.ny.gov/research/collections/fy_collections_stat_report/2015_2016_annual_statistical_report_of_ny_state_tax_collections.htm)
- 19 Excellus BlueCross BlueShield, "The Facts About Taxes on New Yorkers Who Purchase Private Health Insurance," Fall 2015 (www.excellusbcbs.com) and data provided by the New York State Conference of Blue Cross and Blue Shield Plans.
- 20 United States Census Bureau, "Health Insurance Coverage in the United States: 2015," September 13, 2016. (www.census.gov/library/publications/2016/demo/p60-257.html)
- 21 New York State Department of Health. (www.health.ny.gov/regulations/hcra/gme/2016_surcharges_and_assessments.htm)
- 22 Gordon Fairclough, "In New York, a Black Market for Illegal Cigarettes Thrives," Wall Street Journal, December 27, 2002. (www.wsj.com/articles/SB1040938577857473793)
- 23 International Consortium of Investigative Journalists, "Tobacco Underground." (www.icij.org/project/tobacco-underground)



- 24 Office of the State Comptroller and Division of the Budget.
- 25 Public Policy Institute.
- 26 Office of the State Comptroller cash basis reports. (<http://www.osc.state.ny.us/finance/cbr.htm>)
- 27 Ibid.
- 28 Campaign for Tobacco-Free Kids, "Broken Promises to Our Children: A State-by-State Look at the 1998 State Tobacco Settlement 17 Years Later," December 8, 2015. (<http://www.tobaccofreekids.org/microsites/statereport2017/>)
- 29 Division of the Budget, "FY 2017 Enacted Budget Financial Plan," May 2016. (<https://www.budget.ny.gov/budgetFP/FY2017FP.pdf>)
- 30 Susanne Craig and Benjamin Weiser, "Doctor in Sheldon Silver's Corruption Trial Denies Improper Relationship," The New York Times, November 5, 2015. (http://www.nytimes.com/2015/11/06/nyregion/witness-in-sheldon-silvers-corruption-trial-denies-improper-relationship.html?_r=0)
- 31 Office of the State Comptroller cash basis reports.
- 32 Division of the Budget.
- 33 Census Bureau, "Health Insurance Coverage in the United States: 2015," September 13, 2016. (<http://www.census.gov/library/publications/2016/demo/p60-257.html>)
- 34 Ibid.
- 35 Details of the calculation of Indigent Care Pool distributions for 2015 are drawn from a Health Department spreadsheet obtained by the Empire Center from third party.
- 36 Roosa S. Tikkanen, Steffie Woolhandler, and David Himmelstein, "The New York Indigent Care Pool: Is there a relationship between hospital allocations and uninsured patient volumes among New York City hospitals?" Poster presented at American Public Health Association Annual Meeting and Expo, October 29 to November 2 in Denver, Colo.
- 37 See, for example: Alan Sager, "Paying New York State Hospitals More Fairly for Their Care to Uninsured Patients," Commission on the Public's Health System, September 2011. (http://www.cphsnyc.org/cphs/reports/paying_new_york_state_hospitals/)
- 38 Elisabeth R. Benjamin, Arianne Slagle, and Carrie Tracy, "Incentivizing Patient Financial Assistance: How to Fix New York's Hospital Indigent Care Program," February 2012. (<http://lghhttp.58547.nexcesscdn.net/803F44A/images/nycss/images/uploads/pubs/IncentivizingPatientFinancialAssistanceFeb2012.pdf>)
- 39 Ibid.
- 40 Final Recommendations of the Medicaid Redesign Team Health Disparities Working Group, October 20, 2011. (https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrtcompanion.pdf)
- 41 Op. cit., Health Department spreadsheet.
- 42 City of New York, "One New York: Health Care for our Neighborhoods: Transforming Health + Hospitals," April 26, 2016. (<http://www1.nyc.gov/assets/home/downloads/pdf/reports/2016/Health-and-Hospitals-Report.pdf>)
- 43 Op. cit., Tikkanen et al.
- 44 Statewide Planning and Research Cooperative System (SPARCS), accessed at Health.Data.NY.gov.
- 45 New York State of Health, "2016 Open Enrollment Report," August 2016. ([http://info.nystateofhealth.ny.gov/sites/default/files/NYSOH%202016%20Open%20Enrollment%20Report\(2\).pdf](http://info.nystateofhealth.ny.gov/sites/default/files/NYSOH%202016%20Open%20Enrollment%20Report(2).pdf))
- 46 New York State Executive Budget 2003-2004, Appendix II, p. 164.
- 47 Office of the State Comptroller, "The Health Care Reform Act (HCRA): The Need to Restore Accountability to State Taxpayers," April 2003. (www.osc.state.ny.us/reports/health/hcra.pdf)

