



Updated Analysis of the Economics of the New York Health Act

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Executive Summary

Recent economic analyses of the New York Health Act show that a universal, single-payer health care system is the only plan that will provide universal, guaranteed health care at less cost than the status quo. Using CMS projections of health care spending and State income projections, we have updated earlier results to project the economic impact of the New York Health Act if it is fully implemented in 2025. It will generate net savings of \$16.8 billion, or 4.8% of total expected costs, as compared with projections for the status quo. In answer to the commonly-asked question, "How much will the New York Health Act cost?", the answer is that it will actually save nearly 5% of what we now spend.

Many also ask "How are you going to pay for it?" The answer is that, unlike in the current system, it will be paid for fairly in accordance with ability to pay. The sample progressively-graduated tax brackets and rates proposed in the earlier report (and widely distributed thereafter) will continue to fully fund the system.

The New York Health Act creates the New York Health plan which will provide coverage for every New York resident and every non-resident working full-time in New York, with no premiums, deductibles, or co-pays. Benefits will be comprehensive including primary, preventive, specialty, hospital, mental health, reproductive health care, dental, vision, prescription drug, medical supply, and long-term care (home care and nursing home). The Act will be financed through a progressively-graduated payroll tax that replaces premiums and all out-of-pocket expenses. (At least 80% of the payroll tax will; be paid by employers, with up to 20% of the tax paid by employees. Employers could agree to pay a higher percentage, for instance, through collective bargaining.) There will also be a progressively-graduated tax on non-payroll (investment) income.

In 2018, the nonpartisan RAND Corporation performed an economic [analysis](#) of this legislation. The principal findings of the RAND report were that the New York Health Act will cover everyone, improve benefits, eliminate cost-sharing, cost no more than New York is now spending, and provide savings for almost all New Yorkers.

Following its publication, this author performed an [evaluation](#) of the RAND report's methodology which led to some modified conclusions, including a finding that savings will be considerably greater than RAND projected. This report updates and confirms those findings.

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1. Introduction

The New York Health Act will transform the way health care in New York State is financed, creating a progressively-funded system that will pay for health care and long-term care services for all residents of New York, as well as non-residents who work full-time in New York. This report updates and extends the economic analysis of the Act performed in 2018 by the RAND Corporation and by this author.

The principal findings of the [RAND report](#) were that the New York Health Act will cover everyone, improve benefits, eliminate cost-sharing, and provide savings for almost all New Yorkers. In short, New York can afford a universal single payer health care system under which patients will not face any financial barriers when seeking care. In fact, New York Health will lead to significant savings for New York. A [report](#) prepared by this author in 2018, following publication of the RAND study, confirmed this finding and improved upon it in several respects. This report updates and further confirms the conclusions of the RAND study.

RAND's "base" case found only minimal savings, but they offered alternative assumptions that led to more substantial savings and lower costs. These alternative assumptions are consistent with the findings of many authoritative studies, as well as historic experience. Our earlier [report](#) used these alternative assumptions and fixed an error in the RAND report involving provider administrative costs (this error was corrected in a [later RAND study](#)).

The New York Health program will be paid for by a combination of existing federal and state funds and new, progressively-graduated taxes on payroll income and currently-taxable non-payroll income (e.g., capital gains and dividends). The income brackets and rates are not specified in the New York Health Act but are to be enacted by the Legislature within a year of its enactment. An example of such tax brackets and rates, which provides the necessary funds, is shown in this report.

2. Background

More than two dozen economic analyses of single payer plans have been [conducted](#) since the early 1990s. These include studies of both national plans and state-level plans conducted by such organizations as the Lewin Group (a subsidiary of UnitedHealth), the Urban Institute, the Political Economy Research Institute of UMass/Amherst, and the RAND Corporation. Others have been conducted by persons and groups identified as supporters or opponents of single payer health care. One was a [study](#) of the New York Health Act conducted for the Campaign for New York Health by Prof. Gerald Friedman of UMass/Amherst. Finally, there was the RAND study in 2018. All have reached the same general conclusion: Everyone can be insured for comprehensive care while spending no more than we are spending now. Most find net savings ranging from a few percent to 15%.

This report focuses on the cost and savings of the New York Health Act. Several analyses have looked the job displacement and broad economic impact of these types of plans. The strong consensus is that New York Health and plans like it would put substantial funds back in the pockets of consumers and employers and produce a significant increase in jobs. ([Here](#) is one example.) The New York Health Act provides that some of the New York Health revenue will be used to assist displaced workers.

3. How Spending Changes in a Single Payer Plan

The transition to a single payer system raises a number of unique issues, mainly involving cost reductions due to the simplified financing by a single agency:

- Sharply reduced cost of administering provider payment by eliminating expensive private insurance company overhead, marketing, and profits
- Reduced hospital and physician administrative costs including billing multiple insurers, collecting deductibles and copayments from patients, meeting insurer prior authorization requirements, and appealing denials of claims by insurance companies
- Lower drug prices through increased ability to negotiate with drug companies
- Elimination of employer benefit administrative costs, including state and local government employer costs

There will be added spending through improved coverage and expanded benefits:

- Full coverage for New Yorkers who are currently uninsured
- Elimination of deductibles, copays, restrictive provider networks, and out-of-pocket charges that will increase access to care for the currently underinsured
- Increased payments for providers currently dependent on inadequate Medicare and Medicaid reimbursements
- Compensation and retraining of workers displaced as a result of streamlined, simplified administrative services
- Paying Medicare Part B premiums and coinsurance costs now paid by Medicare recipients

The key messages of both studies were (1) the New York Health Act is affordable to New Yorkers; (2) it will reduce spending for almost all of us; (3) it will benefit the state's economy by putting more money into more New Yorkers' pockets; and (4) it will cost less than we will be spending if we continue with the status quo. This updated analysis has confirmed these findings.

RAND and we assume that federal funds for Medicaid, Medicare, and ACA subsidies will continue to flow to New York. Under New York Health, provider reimbursement for clinical services will be higher than Medicare and Medicaid now pay. Thus, there will no overall reduction in payment to providers, on average, other than reductions in due to savings in administration they experience through simplified billing.

Healthcare use under the New York Health Act will rise because, with universal coverage and no cost-sharing, New Yorkers, especially the uninsured, the underinsured, and those with low income, will use more health care than at present. The financial obstacles that today keep them from getting the care they need will be removed. RAND's microsimulation computer models show increases in patient utilization of hospital care of around 10% and physician services around 15%. However, they estimate that the quantity of services delivered will increase by about half that much because of limits in the supply of services not built into their computer models. Their models also ignore the effect on providers of a reduced administrative burden, which will free up time and resources to enable more patient care.

New York Health Act taxes will eliminate private insurance premiums and out-of-pocket expenses.

4. Healthcare Spending in the Status Quo

The RAND study estimated what New Yorkers would be spending on health care in 2022 and evaluated the impact of the New York Health Act on spending that year. We have projected these results forward to 2025, assuming that the New York Health Act is in effect that year. The federal Centers for Medicare and Medicaid Services (CMS) has [projected](#) national health care spending through 2028. We have used CMS [data](#) to compare New York's spending with national spending, by type of expenditure (hospital care, physician services, pharmaceuticals, etc.) and source of funding (Medicare, Medicaid, private insurance, and out-of-pocket costs). The state-specific data was used to create tables projecting these costs and spending to 2025:

Table 1
Healthcare Expenditures (\$ 2025 billion)

	Status Quo 2022	Status Quo 2025
Healthcare services	255.5	288.4
Medical care	163.3	183.4
Prescription drugs & devices	48.1	55.8
Nondurable medical products	6.0	6.9
Long-term care	38.0	42.3
Administration	55.7	63.3
Health plan administration	28.5	32.4
Provider administration	26.4	30.0
State financial administration	0.6	0.7
Employer health benefit administration	0.2	0.2
Total	311.2	351.7

Table 2
Source of Funding (\$2025 billion)

	Status Quo 2022	Status Quo 2025
Employer-based private insurance	84.8	93.2
Individual (non-group private insurance)	10.4	11.4
Federal government (Medicare, Medicaid, etc.)*	120.5	139.5
State government (Medicaid, etc.)	26.7	33.0
Local government (Medicaid)	7.4	7.4
Other miscellaneous payments**	27.8	30.6
Out-of-pocket payments	33.5	36.6
Total	311.1	351.7

* Not listed here are Medicare Part B premiums paid by Medicare recipients to the federal government. These amounted to \$8.5 billion 2022 and a projected \$10.1 billion in 2025. These funds are included in the Federal government amount.

** Premiums for Medicare supplemental plans, EP, CHP, and TRICARE

These tables establish the baseline from which we will determine what the impact of the New York Health Act will be.

5. Spending and Saving under the New York Health Act

The New York Health Act will change spending in five key areas within the overall health care system:

(1) Increased spending on medical services. RAND projected that utilization of medical services would rise as a result of the expanded insurance coverage and the elimination of the financial barriers posed by out-of-pocket costs – deductibles, copays, coinsurance, and out-of-network charges. They estimated that spending would rise by **6.4%**. Using Table 1, in 2025 this increase in spending on medical services will be **\$11.7 billion**,

In addition, physicians, hospitals, and other providers find that the fees that Medicare and Medicaid pay do not fully cover the cost of providing care. RAND presents data that can be used to estimate what it will cost to raise these rates to levels that will cover their expenses, as required by §5105.4.(a)(ii) of the New York Health Act..

RAND estimates that physician service revenues in the status quo 2022 will be \$47.7 billion; from this, we project \$53.6 billion to 2025. Raising this to a level where all physicians will be reimbursed at private insurance rates, but removing their insurance-related administrative costs, which RAND did not separate out (see below), this will add **\$9.6 billion** to the status quo 2025 projection.

Combining these two sources of increased spending, the net increase in the cost of providing medical services will be **\$21.3 billion**.

(2) Added spending for long-term care. RAND estimated that including long-term care services in the services covered by the New York Health Act, using the same principles of universality and no cost sharing as for medical care, would add about \$18 billion to the cost in 2022. They assumed that 50% of informal home care (unpaid care provided mainly by family members) will be replaced by paid care, with 90% of this increase going to home care and 10% to nursing home care. This leads to a doubling in paid home care and a 10% increase in nursing home care.

RAND's results are consistent with an [estimate](#) made by a Physicians for a National Health Program-NY Metro Working Group in 2016. It found that New Yorkers at that point were spending about \$11 billion annually on long-term care insurance and out-of-pocket payments for long-term care (this is in addition to the \$27 billion already being spent by Medicaid). New York Health could save New York families that expense and relieve them of much of the personal and economic burden of providing unpaid care to their loved ones.

Taking over the current private-sector spending and replacing unpaid care with care paid for by New York Health would cost a total of \$29 billion in 2022. Projecting this to 2025, extending long-term care to all who need it will add expenditures of **\$20.1 billion** in new spending to the **\$12 billion** being spent already by individuals and families. The overall cost of long-term care to the New York Health program will then be **\$32.1 billion**, along with \$30.3 billion already being spent by New York's Medicaid program.

(3) Savings in administering health coverage. The simplification in billing and claims processing brought about by the New York Health Act will reduce the cost of processing claims for reimbursement. Currently, we spend billions of dollars each year on multiple health plans' bureaucratic overhead, marketing, and profit which contribute nothing to health care. Experience

with Medicare, fee-for-service Medicaid, the Canadian single payer health care system, and other universal systems [shows](#) that the cost of administering the New York Health plan will be less than **3% of the cost of medical care and long-term care services**. Using Table 1, this implies that health plan administration costs, including those currently spent by employers and by the State, will be reduced for a saving of **\$26.5 billion**.

Further savings may come from changing the way providers are paid. Initially, the Act assumes that payment will be, as it is now in nearly all cases, by the fee for service method. However, unified funding allows facilities to be funded in other ways, for instance, by an annual or “global” budget. But no matter how providers are paid, the simplification of a single payer system will greatly reduce the administrative cost of providing that funding.

(4) Savings in provider administration. Under New York Health, physicians, hospitals, and other providers will no longer spend time and money dealing with countless different health plans, coverage disputes, deductibles, copays, etc. Numerous studies (as examples, see [here](#) and [here](#) and [here](#)) show that these billing- and insurance-related costs borne by health care providers amount to around 13% of the cost of providing health care services in this country. In their study of the New York Health Act, RAND very much underestimated these costs. The following year, they corrected this in their [study](#) of national Medicare for All programs.

If we conservatively assume that these excess costs are currently **10% of the cost of medical care** (see [here](#) and [here](#)), then the simplified single payer system will achieve a **saving of \$18.3 billion**.

(5) Savings from reduced prices for drugs and medical devices. New York’s Medicaid program achieves a 33% reduction in drug prices (Table 2.3 in the RAND report). New York Health, negotiating for all 20 million New Yorkers, would be able to negotiate the same kind of reduction. RAND projected that pharmaceutical and medical device spending would increase by 13.9% as a result of better coverage and elimination of cost sharing. Combining that increase in volume with the reduction in price leads to a saving of **\$13.4 billion** below what would be spent in the status quo.

Savings

Taken altogether, we find using well-documented values for administrative savings and drug price reductions as well as RAND’s estimate for increased spending on services, and projecting to 2025, that there will be **total savings [(2)+(3)+(4)] of 58.2 billion**, as shown below:

Table 3
Savings under the New York Health Act (2025 \$ billion)

Health plan administration, marketing, profit	26.5
Health care provider administration	18.3
Prescription drugs and devices	13.4
Total	58.2

Spending increases [(1)+(5)] will total **\$41.4 billion**, shown below:

Table 4
Added spending under the New York Health Act (2025 \$ billion)

Increase in medical services	11.7
Enhanced provider fees	9.6
Universal long-term care	20.1
Total	41.4

As a result, there will be **net savings** (Table 3 minus Table 4) from the New York Health Act of **\$16.8 billion**, or **4.8%** below projected 2025 status quo spending. Total spending is reduced from **\$351.7 billion** to **\$334.9 billion** under the New York Health Act. These results are shown in more detail in Table 5 below.

Table 5
Health Care Expenditures Under the New York Health Act in 2025 (\$ Billions)

	Status Quo	New York Health Act	Difference	% Change
Health care services	288.4	316.4	28.0	10.0%
Medical care	183.4	204.7	21.3	11.6%
Prescription drugs & devices	55.8	42.4	-13.4	-24.0%
Nondurable medical products	6.9	6.9	0.0	0.0%
Long-term care	42.3	62.4	20.1	47.5%
Administration	63.3	18.5	-44.4	-70.8%
Health plan administration*	32.4	0.0	-26.3	-79.4%
State financial administration*	0.7	6.8		
Provider administration	30.0	11.7	-18.3	-61.0%
Employer health benefit administration	0.2	0.0	-0.2	-100.0%
Total savings			-58.2	
Total additional spending			41.4	
Total	351.7	334.9	-16.8	-4.8%

* Private insurance administration is replaced by State administration, so these are combined in this table.

6. Shifting Some Current Spending to the New York Health Tax

In addition to expanding access to health care and lowering the total cost of health care and of insurance coverage, the New York Health Act will have those funds paid more fairly. Today a large part of the spending for health care and coverage, especially including insurance premiums, deductibles, copays, and out-of-network charges, comes from individuals without any regard for fairness or ability to pay. Under the New York Health Act, these various ways of extracting funds from people will be replaced with funding from the broad-based progressively graduated New York Health tax, based on ability to pay.

Some particular funds currently entering the health care system come from sources that should not be paying them when there is a unified, progressive plan like the New York Health Act in place. These include Medicare Part B premiums paid by Medicare recipients and the

“local share” of Medicaid costs paid by county governments in New York State. These are not increases in spending; they are simply changes in the source of funds.

(1) Medicare Part B premiums: Currently, Medicare recipients who wish to receive coverage for physician services must pay a monthly premium amounting to more than \$100 per month. Under the New York Health Act, the State will take over the payment of Part B premiums, so that full federal Medicare funds will continue to flow to New York. According to RAND, that will cost \$8.5 billion in 2022. Projecting that to 2025, we estimate that it will cost **\$10.1 billion** to cover all Part B premiums.

(2) County Medicaid payments: Currently, New York State requires that counties and New York City pay a “local share” of the state’s Medicaid bill. The local share is statutorily capped and is projected to be about **\$7.4 billion** by 2025. For many counties, this is a significant burden on local property taxes. The New York Health Act provides that the New York Health plan will pick up the local share, using revenue from the New York Health tax. Counties can choose to use the savings to reduce their regressive property taxes, increase their spending for local services, or a combination of these.

Eliminating insurance premiums, deductibles, and out-of-pocket medical and long-term care expenses; picking up the Medicare Part B premium; relieving counties of the Medicaid local share are not new expenditures. Each is simply a significant and welcome shift of spending from one pocket (families, employers, Medicare recipients, county governments) to another (the New York Health Act). They will all use New York Health taxes, but they do not represent additional spending. Total spending on health care will remain, as we saw in the previous section, substantially below status quo projections.

7. Paying for the New York Health Plan

Taking into account the various savings and costs identified above, the following sources will provide funding under the New York Health Act:

Table 6
Source and amount of Funding under the New York Health Act in 2025 (\$ billion)

	Status Quo	NY Health Act
Federal government (Medicare, Medicaid, etc.)	129.4	129.4
State government (Medicaid, etc.)	33.0	33.0
Total continuing funds	162.4	162.4
Employer-based private coverage	93.2	
Individual (non-group private insurance)	11.4	
Local government	7.4	
Other miscellaneous payments	30.6	
Out-of-pocket payments	36.6	
Medicare Part B premium	10.1	
Ended funds	189.6	
New York Health Tax		172.5
Total	351.7	334.9
Net savings		16.8

With the federal government continuing its current payments for health care in New York, and the State paying its share of Medicaid, the New York Health tax will have to raise **\$172.5 billion** in 2025. This tax will replace **\$189.6 billion** in current spending on private coverage, out-of-pocket costs, Medicare Part B premiums, and local Medicaid costs. This is a net saving of **\$16.8 billion** for all those who use and currently pay for health care in this state.

The New York Health Act provides that there will be new progressively graduated taxes on payroll (work-related salary, wages, self-employment) and non-payroll (non-work-related dividends, interest, capital gains) income. It further provides that the first \$25,000 of annual income (\$50,000 for Medicare recipients) in each category is exempted from taxation.

The legislation does not specify what the tax brackets or rates will be. That will be set by the Legislature closer to actual implementation, taking into account actual income and inflation levels. We have [proposed](#) a **sample tax structure** shown in Table 7(rev). It is modeled on a proposal made [earlier](#) by Gerald Friedman, updated to yield the revenue projected to be needed to carry out the provisions of the Act, including long-term care.

Table 7 (rev)
Sample Structure for New York Health Tax

Income Range	Marginal Total Tax Rate	Effective Total Tax Rate	Employer Share at Least	Employee Share Up To
Under \$25,000	0%	0%	0%	0%
\$25,000 -\$49,999	6.4%	2.1%	1.7%	0.4%
\$50,000 -\$74,999	7.8%	4.1%	3.3%	0.8%
\$75,000 -\$99,999	8.5%	5.3%	4.2%	1.1%
\$100,000 -199,999	10.0%	7.1%	5.95%	1.4%
\$200,000 or more	11.3%	<9.0%	<7.2%	<1.8%

Note that the marginal rate applies only to income within that particular bracket. The effective rate at any particular level reflects the fact that income in lower brackets is taxed at lower rates than income in higher brackets. The Act provides that the taxes paid by employees will be no greater than one-fifth of what is shown in this table; at least four-fifths of the tax is paid by the employer. An employer may agree to pay a higher share of the tax, for instance, through collective bargaining. A self-employed person pays the full tax. Note that, for Medicare recipients, the first \$50,000 of income is tax exempt.

This sample tax structure assumes that the tax on payroll and non-payroll income use the same brackets and tax rates. The New York Health Act does not require this, and they could, in practice, be different. (The Act does specify that the low-bracket exemptions apply to both work-related and non-work-related income.) For simplicity, this model uses the same rate structure for both types of income.

We have estimated the revenue raised by this tax plan in 2025 using State [projections](#) of income. **We find that this plan provides the funds necessary to support the system in 2025.** About one-third of the total revenue comes from the non-payroll tax. Employers will pay about 54% of the total, approximately what they now contribute to health care funding.

8. Conclusion

This analysis, like the earlier RAND study and many other studies of single payer plans, has demonstrated that the New York Health Act is a feasible plan that New York can afford and that will benefit the vast majority of its residents. In fact, it is far more affordable than the status quo, with the cost of health coverage continuing its inflationary rise. The RAND study and many others show that the vast majority of New Yorkers will spend less on health care and insurance coverage than they do now. Furthermore, by putting more money in the pockets of average New Yorkers, it will benefit the general New York economy as well, creating as many as [200,000 new jobs](#). While this paper has focused on the savings and spending under the New York Health Act, we should continue to recognize that what really counts are its broader benefits including improved health care access for all New Yorkers, reduced health disparities, reduced poverty, and increased savings as the plan continues to limit growth in future health care costs. All New Yorkers will benefit.