THE IMPACT OF SINGLE-PAYER ON NEW YORK HOSPITALS

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Executive Summary

The New York Health Act (NYHA) is a bill that would have the state purchase comprehensive medical services for all residents, the costs to be borne by taxation. It currently has broad support in the state legislature.

The legislation would establish a single-payer health-care system. While there are various estimates of the plan's overall cost, much less attention is being given to the likely impact on hospital revenues resulting from the plan's displacement of private insurance by a government fee schedule, most likely based on Medicare reimbursement rates. Many hospitals that currently receive relatively high reimbursement rates from privately insured patients could see a significant drop in their revenues.

Key Findings

- The adoption of current Medicare reimbursement rates across the board would reduce New York hospital revenues by 17% statewide, cutting income for 77% of the state's hospitals. Total revenues would be cut by more than a quarter at 19% of the state's hospitals.

- Even if Medicare reimbursement rates were increased to maintain aggregate statewide hospital spending, revenues would still be altered, up or down, by more than 15% at about half of the state's hospitals.

- For many hospitals, the revenue cuts under either scenario would be deep enough to compromise their quality of care, trigger layoffs, and put them at risk of closure. Hospitals serving affluent downstate communities would face the biggest cuts in access to care.

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Introduction

The New York Health Act (NYHA) is a bill that would have the state purchase comprehensive medical services for all residents, the costs to be borne by taxation. It currently has broad support in the state legislature.

Proponents of the legislation, essentially a single-payer health-care plan, hope that higher-income New Yorkers would fund expansions of benefits for those lower down the income scale. There are various projections of the legislation's overall cost, but far less attention is being given to the likely impact on hospital revenues resulting from the legislation's displacement of private insurance by a government fee schedule. Many hospitals that currently receive relatively high reimbursement rates from privately insured patients could see a significant drop in their revenues.

The analysis of hospital revenues presented here is based on a reasonable assumption that, under NYHA, *all health-care services would be paid by the state using a Medicare-like reimbursement system*. This paper therefore compares payments to each New York hospital made by Medicare and other payers, including private insurance, to determine the likely financial impact of a switch from a multi-payer system that includes a portion of market-based fees to a single-payer system in which all fees are publicly regulated.

In sum: the adoption of current Medicare reimbursement rates across the board would reduce New York hospital revenues by 17% statewide, cutting income at 77% of the state's facilities. Total revenues would be cut by more than a quarter at 19% of the state's hospitals. Even if Medicare reimbursement rates were increased to maintain statewide *aggregate* hospital spending, revenues would still be altered, up or down, by more than 15% at about half of the state's facilities. A shift to Medicare fees under either scenario would tend to redistribute funds from larger to smaller hospitals, from urban to rural areas, and from lower-poverty to higher-poverty counties.

For many hospitals, the cuts would be deep enough to compromise the quality of care, trigger layoffs, and put the facilities at risk of closure. Hospitals serving affluent downstate communities would likely face the biggest cuts in access to care.

The New York Health Act

Almost a decade after the enactment of the Affordable Care Act (ACA), the nation's health-care system remains fragmented and heavily bureaucratic, and costs continue to rise. In New York, the benchmark monthly premium (for a Silver Plan) in the state's ACA health-insurance exchange increased from $343 in 2014 to $506 in 2018, and the state's per-capita health-care expenditures ($9,778) remain well above the national average ($8,045).[1] Although the state's uninsured

rate has dropped by about half, about 1 million New Yorkers are still without coverage.[2]

In response, Assemblyman Richard Gottfried and State Senator Gustavo Rivera have proposed the New York Health Act.[3] The legislation has repeatedly passed the State Assembly but, despite widespread support in the Senate, has not come up for a vote in the upper chamber. In this year's Democratic gubernatorial primary, candidate Cynthia Nixon blamed Governor Andrew Cuomo for the bill's failure.[4] Cuomo expressed support for enactment of a single-payer system at the federal level but questioned the affordability of a New York–only plan.[5] Republican gubernatorial candidate Marc Molinaro pledged to veto the proposal.[6]

Under NYHA, the state would pay for the health care of all residents currently enrolled in Medicaid, Medicare, employer-sponsored insurance, Child Health Plus, the state's Essential Plan, and the individual market. It would also expand coverage to the 6% of the state's residents who are uninsured, regardless of immigration status.[7] Coverage would include the essential health benefits required by ACA. It would also pay for dental and vision-care services that many existing insurance plans do not cover. It would use public funds to pay for all costs that are currently borne by insurers or out-of-pocket by individuals—in other words, no deductibles or copays—with the exception of long-term care, over-the-counter drugs, and elective cosmetic surgeries.[8] Providers would be prohibited from charging anything in addition to administratively established rates that the state determines are "reasonable and reasonably related to the cost of efficiently providing the health care service and assuring an adequate and accessible supply of the health care service."[9] Selling private insurance would become effectively impossible.

Medical services would be funded through a combination of payroll and non-payroll taxes, but the bill leaves specific brackets, rates, and exemptions to be determined later. NYHA would require federal waivers under the Social Security Act to restructure federal funding currently distributed to New Yorkers under Medicare, Medicaid, and the ACA exchange. The current CMS administrator, Seema Verma, has stated that she would deny any such waivers requested by states seeking to establish single-payer health-care arrangements.[10] The state's single-payer plan could also be preempted from interfering with the health benefits of self-insured employers under the federal Employee Retirement Income Security Act (ERISA), or from restricting competition among privately administered plans under Medicare Advantage and Medicare Part D.

Single-Payer: Overall Budget Impact

Most of the research about a New York single-payer plan has attempted to estimate the aggregate cost of the legislation for taxpayers. For example, Gerald Friedman, an economics professor at UMass Amherst, has claimed that NYHA would cut the state's overall health-care spending by $45 billion, or 15%, as of 2019 because of reductions in administrative costs and payments to medical providers. Nevertheless, he estimated that expanding coverage and replacing private health-care spending would require an additional $91 billion in taxes, on top of the currently projected state revenues of $82 billion.[11] This analysis has been disputed by Avik Roy of the Foundation for Research on Equal Opportunity. Roy estimated that a $226 billion increase in state taxes would instead be required to implement changes proposed in the legislation for 2019.[12]

The RAND Corporation, however, estimated that $139 billion in extra taxes would be needed to fund NYHA in 2022, with the cost to taxpayers rising to $210 billion in 2031.[13] The authors of the RAND report suggested that this expense could be funded by a progressive tax, with a top marginal rate (for those with incomes above $141,200 per year) starting at 18.3% in 2022 and rising to 20.0% by 2031. They further warned that the rate would have to rise to 88% if 0.5% of high earners move out of state. The payments would be on top of existing taxes from federal, state, and local governments, which already rise to a top marginal rate of 49.7% in New York City.[14]

RAND predicts that overall health-care spending under NYHA would be similar to the level under current law in 2022 but that it would reduce health-care spending by 3% by 2031. This reduction is largely the result of the assumption that hospital costs would increase less over time by shifting to the expected rate of growth of Medicare fees.[15]

Single-Payer: Financial Impact on New York Hospitals

Although NYHA is vague in describing the specific payment arrangements that its advocates claim would generate major savings to state health-care spending, it would nonetheless be fair to assume that payments to hospitals would be based on Medicare rates. This is not

just because single-payer reforms are often advertised as "Medicare for All." Rather, the basis for the assumption is that Medicare rates have been calibrated over time for the purpose of maintaining acceptable levels of access to a comprehensive range of care services in different areas—and any other arrangement would likely be an invitation to a lobbying free-for-all and chaotic special pleading by every provider.

Currently, hospital revenues consist of reimbursement rates that vary considerably from one payer to another, with Medicare and Medicaid typically paying much less than private insurers. Private insurers' payments also vary from hospital to hospital, depending on individually negotiated contracts. A hospital's revenues, in short, currently depend on what mix of payers covers its patients, and how much market leverage the hospital has in negotiating with private insurers. Hospitals that treat a larger share of privately insured patients, as well as those in the least competitive markets, command relatively high reimbursement. Hospitals that treat a larger share of Medicare and Medicaid patients, or operate in more competitive markets, receive relatively low reimbursement.

NYHA's switch to single-payer—with a single Medicare-like rate schedule for all patients at all hospitals—would transform this sector of the health-care industry. To estimate the impact, this paper compares hospitals' existing revenues—institution by institution—with those that would prevail under two alternatives:

- Current Medicare reimbursement rates;
- Spending-neutral Medicare rates—Medicare rates proportionately increased to keep *aggregate* statewide hospital revenues at current levels.

To be sure, another likely feature of any single-payer reform would be amendments tailored to secure the support of legislators by shielding their local medical providers from financial harm. The 2010 Affordable Care Act was replete with provisions, such as those colloquially known as the Louisiana Purchase, Cornhusker Kickback, or Bay State Boondoggle. No accurate estimate of the likely cost of NYHA is possible without gauging the costs involved in such provisions. Even so, estimating the effects of single-payer revenues to the state's hospitals gives one a sense of what politicians would feel pressured to offset.

Methodology

Estimating NYHA's effect on state hospital revenues begins with the "Hospital Cost Report Audited Data: 2015" from the New York State Department of Health.[16] The primary source is Exhibit 46, which itemizes "gross charges" and "allowances" (or discounts) *for each hospital* in 14 payer categories: Medicare, Medicaid, nonprofit indemnity, commercial indemnity, HMO Medicare, HMO/PPS Medicaid, HMO other, self-insured, workers' compensation, no fault, uninsured/self-pay, government, charity, and other special arrangements.

Exhibit 46 also lists Medicaid supplemental payments (including Disproportionate Share Hospital, or DSH, payments), bad debts in multiple categories, hospital surcharges (various taxes on hospital revenues), and net patient service revenue.[17] Fourteen of the state's facilities were omitted from the analysis because of their status as non-general hospitals (i.e., they specialized in psychiatric care or long-term rehabilitation) or atypical financing.

For each hospital, "gross charges" and "allowances" were grouped into four categories: Medicare combined, Medicaid combined, private insurance, and "other" (workers' compensation, no fault, uninsured/self-pay, government, charity, and courtesy). In each of those four categories, net revenue was calculated by subtracting allowances and bad debt from surcharges. DSH and other supplemental payments were added to net revenue for Medicaid. In each category, net revenue was divided into gross charges to generate a "discount rate" for each hospital.

The combined amounts for all hospitals in each category were also used to find statewide discount rates. In the aggregate, the state's hospitals collectively received 35% of gross charges. The variation between payers can then be used to compare payments between them. In the aggregate, Medicare paid 28% of gross charges, Medicaid (including DSH) 36%, private insurers 46%, and "other payers" 16%.

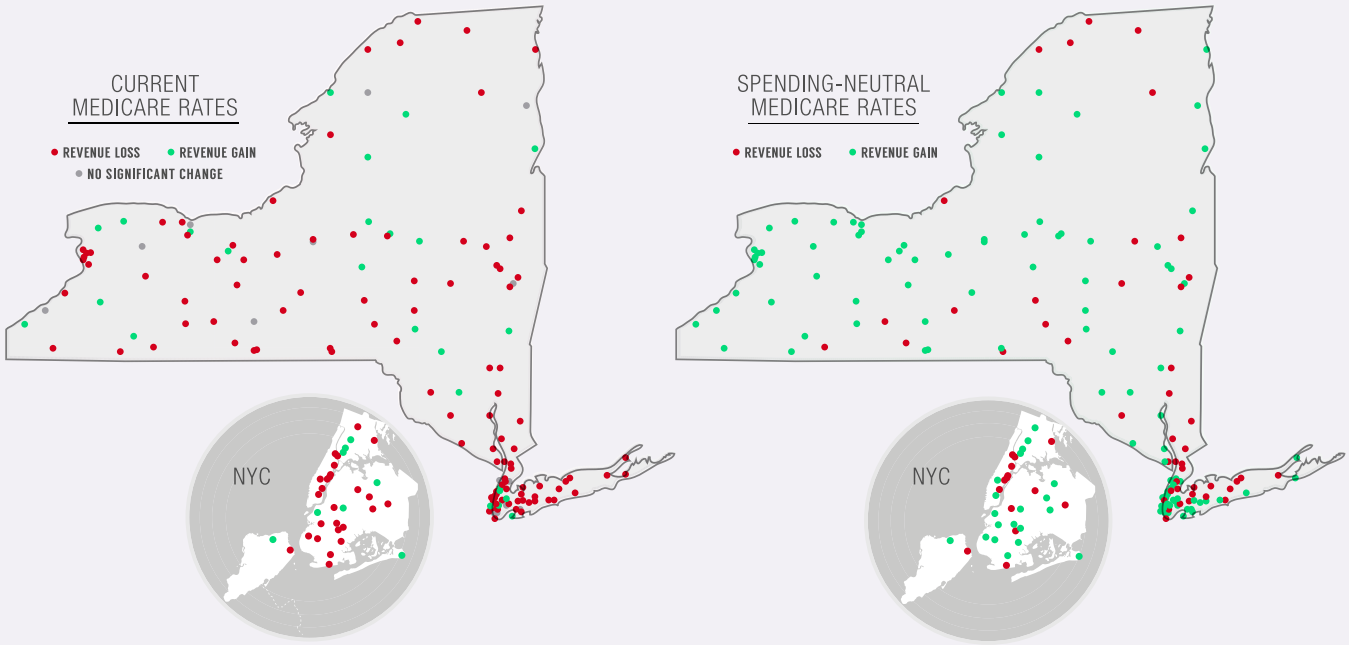
For *each* New York hospital, the impact of a transition to single-payer reimbursement (see **Appendix**) was projected by:

- Applying the Medicare discount proportion to all charges for each hospital at current Medicare reimbursement rates;
- Increasing the Medicare discount proportion by 20.5%—on average from 28% to 34%—and applying it to all charges for each hospital, to establish spending-neutral Medicare reimbursement rates.

These calculations allow us to determine the extent to which hospitals would lose by switching from privately insured to current Medicare or adjusted Medicare rates,

FIGURE 1.

NY Hospital Revenue Losses and Gains Under Single-Payer



Source: Authors' calculations from New York State, Hospital Cost Report Audited Data: 2015, Exhibit 46

relative to what they would gain from payers whose rates are currently set below these levels (**Figure 1** maps the winners and losers).

Results

- If all hospital fees were fixed at Medicare rates, annual statewide hospital spending (based on 2015 data) would fall by $10 billion, or 17% (see Appendix). Seventy-seven percent of facilities would see decreased revenues, and 23% would gain. Although hospitals would likely respond to reductions in revenue by cutting costs, 40% of the state's hospitals would, under this scenario, face revenue shortfalls greater than 15%, and 19% would lose over a quarter of their revenues—leaving many facilities at serious risk of closure.

- If Medicare rates were adjusted to be spending-neutral—keeping aggregate statewide hospital expenditures at their preexisting level ($61 billion in 2015)—111 hospitals would see increased revenues, including 66 hospitals where the gain would exceed 15%. Another 65 hospitals would see decreased revenues, including 22 where the loss would exceed 15%.

Either way, some of the biggest losers from a shift to Medicare rates would be in New York City. *Even with no change in overall hospital spending*, Queens Hospital Center would see a cut of 45% (or $228 million) in revenues, the Hospital for Special Surgery would see revenues decline by 35% ($284 million), and both Kings County Hospital Center and NYU Langone would face 32% cuts ($339 million and $537 million, respectively).

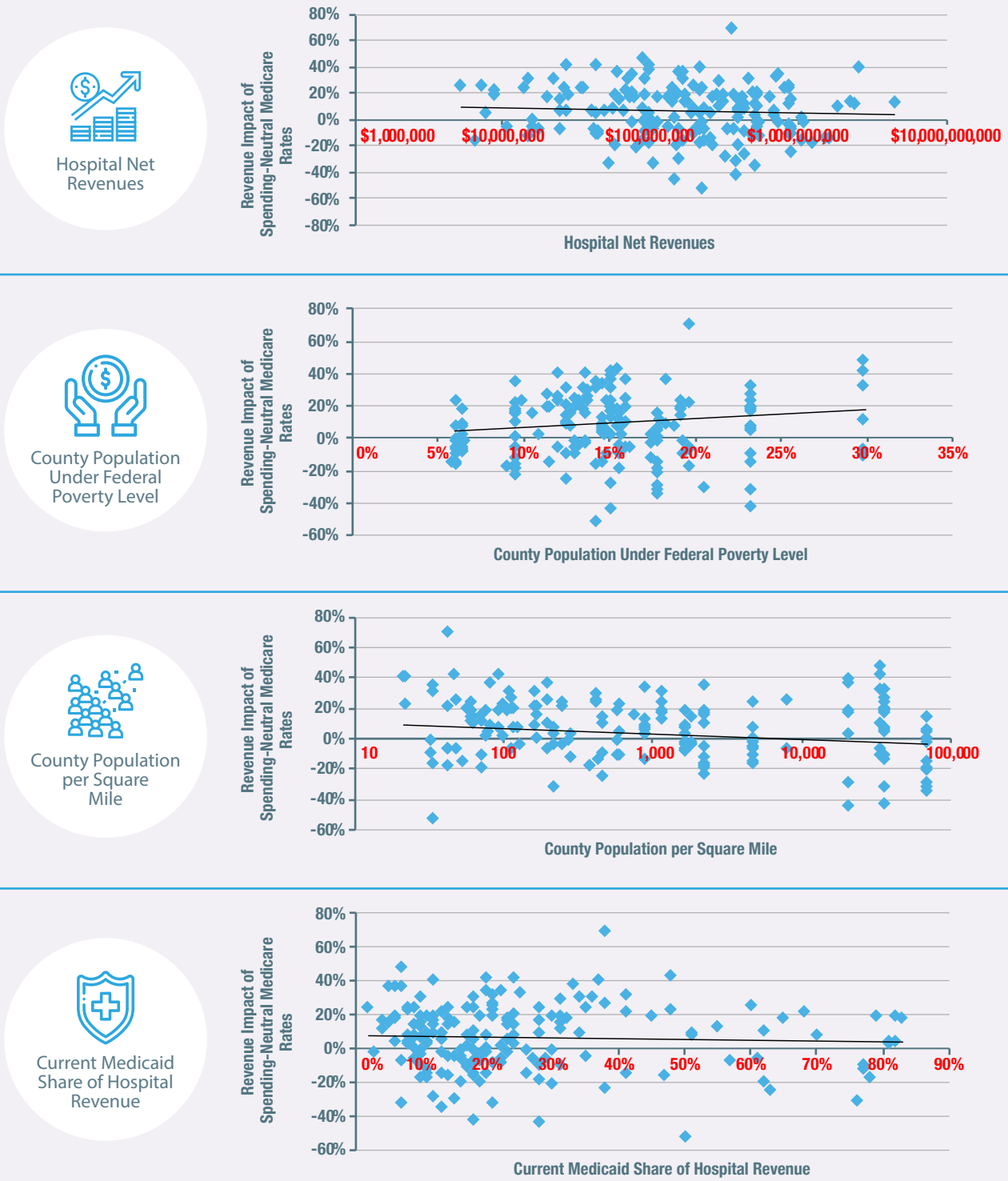
The biggest winners from a spending-neutral shift to Medicare rates would also include New York City hospitals. Lincoln Medical Center and St. Barnabas Hospital in the Bronx would see increases in revenue of 48% (or $252 million) and 42% ($140 million), respectively. Small rural hospitals in the state's North Country, such as Clifton-Fine Hospital in Star Lake and River Hospital in Alexandria Bay, would also see increases in revenues above 40% ($4 million and $7 million, respectively).

Explanation

The impact of shifting hospital payment from the current mix of public and private health-insurance reimbursement rates to a single Medicare-based schedule of fees is significantly correlated with various

FIGURE 2.

Change in Hospital Revenues After a Switch to Medicare Rates*



*Each blue diamond represents a hospital.

Source: Authors' analysis of data drawn from New York State, Hospital Cost Report Audited Data: 2015, Exhibit 46; U.S. Census Bureau, American Community Survey; Centers for Medicare and Medicaid Services, "Hospital Compare"

FIGURE 3.

Proportionate Change in New York Hospital Revenues Resulting from Switch to Medicare Payment Rates

OLS Specification	1	2	3	4
Intercept	0.724* (0.219)	0.738* (0.224)	0.691* (0.220)	0.608 (0.338)
Hospital revenue (log)	-0.029* (0.011)	-0.026* (0.011)	-0.030* (0.011)	-0.030 (0.015)
County poverty rate	0.008* (0.003)	-	0.007* (0.003)	0.011* (0.003)
County population density (log)	-0.029* (0.006)	-0.023* (0.006)	-0.025* (0.006)	-0.035* (0.007)
Hospital Medicaid share	-0.150* (0.075)	-0.111 (0.076)	–	-0.092 (0.115)
CMS hospital quality rating (1–5)	–	–	–	0.030 (0.018)
Privately owned	–	–	–	0.062 (0.068)
Critical Access Hospital	–	–	–	0.052 (0.081)
R2	0.132	0.083	0.112	0.198
n	176	176	176	142
* = p < 0.05				

Source: Authors' analysis of data drawn from New York State, Hospital Cost Report Audited Data: 2015, Exhibit 46; U.S. Census Bureau, American Community Survey; Centers for Medicare and Medicaid Services, "Hospital Compare"

features of the facilities and the communities they serve.

Larger hospitals, hospitals in densely populated areas, and hospitals in counties with low poverty rates would tend to see *reductions in revenues* from a statewide spending-neutral switch to Medicare rates. Each of these predictors remains significant across a variety of different multivariate linear regression specifications (**Figures 2** and **3**). A high share of hospital revenues currently derived from Medicaid predicts more of a decline in hospital revenues, but this correlation is only significant after controlling for the poverty rate of the county in which it is located. Although Medicaid has a reputation of low rates and low participation of physicians relative to Medicare, New York's Medicaid program, on average, currently pays hospitals more for equivalent services than Medicare.[18]

Hospitals with higher CMS quality ratings, those under private ownership, and rural facilities paid as Critical Access hospitals would tend to receive *slightly higher payments* as a result of a spending-neutral shift to Medicare payment rates, but none of these three correlations is statistically significant.[19]

Holding hospitals harmless from the switch to spending-neutral Medicare rates would add an additional 6.4% (or $3.9 billion) to current New York hospital spending. Increasing spending to prevent any cuts in hospital revenues greater than 5% would raise the state's total hospital spending by 4.3% (or $2.6 billion).

Discussion

The estimates by RAND provide a useful survey of the likely statewide consequences of the reforms proposed by NYHA. However, they do not attempt to capture

the on-the-ground impact that such sweeping changes would likely impose on individual providers and communities.

Replacing the array of private and public hospital revenue streams with Medicare reimbursement rates would reduce hospital revenues statewide by 17%—from $61 billion to $51 billion. If Medicare rates were adjusted upward so that there would be no difference with the current level of aggregate hospital spending, the majority of hospitals would still experience revenue change—either up or down—by more than 15%.

The radical impact that a single-payer system would have on provider revenues is hard to avoid, and the long-term implications are likely to be significant and complex. Hospitals would be reimbursed for currently uninsured and charity-care patients at the standard rate—which should substantially increase revenues for hospitals providing a lot of uncompensated care. Currently wealthy hospitals with a mix of revenue streams including employer-sponsored insurance would find themselves with less money to spend on personnel, equipment, and facilities, while currently low-funded hospitals would have more to spend. Individual physicians would see less opportunity to increase their income through professional achievement. The highest-paid ones might choose to leave the state, potentially diminishing the overall quality of care available in New York. At the same time, physicians serving lower-income communities would pay less of an economic penalty for doing so.

Poorer communities would undoubtedly welcome an infusion of resources for their local hospitals and other providers. Higher-income residents—who might be willing to pay higher taxes for expanded medical services to lower-income residents—might be far more reluctant to accept cuts in quality and access to care at their local hospitals.

Thus a single-payer plan—in addition to its dramatic effects on medical-services levels and tax rates—would have profound financial implications for the hospitals, doctors, and other providers that manage the health care of 20 million New Yorkers and account for nearly one-fifth of the economy. Even if overall spending levels were held constant, single-payer health care would dramatically redistribute funds among institutional and individual health-care providers, significantly increasing revenue for some and significantly reducing it for others. Some hospitals would likely face losses severe enough to diminish quality of care, trigger layoffs, and threaten closure.

Appendix: Revenue Impact on New York Hospitals of Shifting to Medicare Reimbursement Rates

Hospital	City	County	Region	Medicare Rates	Spending Neutral
Albany Medical Center Hospital	Albany	Albany	Capital	-26%	-11%
Albany Memorial Hospital	Albany	Albany	Capital	-1%	19%
St Peters Hospital	Albany	Albany	Capital	-18%	-2%
Columbia Memorial Hospital	Hudson	Columbia	Capital	2%	22%
Samaritan Hospital of Troy	Troy	Rensselaer	Capital	3%	24%
St Mary's Hospital	Troy	Rensselaer	Capital	2%	22%
Burdett Birth Center	Troy	Rensselaer	Capital	-20%	-4%
Saratoga Hospital	Saratoga Springs	Saratoga	Capital	-17%	-1%
Sunnyview Rehabilitation Hospital	Schenectady	Schenectady	Capital	-4%	15%
Glens Falls Hospital	Glens Falls	Warren	Capital	-15%	2%
Auburn Community Hospital	Auburn	Cayuga	Central NY	-10%	8%
Cortland Regional Medical Center	Cortland	Cortland	Central NY	-15%	2%

Community Memorial Hospital	Hamilton	Madison	Central NY	6%	27%
St Joseph's Hospital Health Center	Syracuse	Onondaga	Central NY	-13%	4%
University Hospital*	Syracuse	Onondaga	Central NY	-26%	-11%
Crouse Hospital	Syracuse	Onondaga	Central NY	2%	22%
Oswego Hospital	Oswego	Oswego	Central NY	-20%	-3%
United Memorial Medical Center	Batavia	Genesee	Finger Lakes	0%	20%
Nicholas H. Noyes Memorial Hospital	Dansville	Livingston	Finger Lakes	-2%	18%
Highland Hospital	Rochester	Monroe	Finger Lakes	8%	30%
Rochester General Hospital	Rochester	Monroe	Finger Lakes	-1%	19%
Strong Memorial Hospital	Rochester	Monroe	Finger Lakes	-3%	17%
Monroe Community Hospital	Rochester	Monroe	Finger Lakes	3%	24%
Unity Hospital of Rochester	Rochester	Monroe	Finger Lakes	-6%	13%
Thompson Health*	Canandaigua	Ontario	Finger Lakes	-16%	1%
Clifton Springs Hospital and Clinic	Clifton Springs	Ontario	Finger Lakes	1%	21%
Geneva General Hospital	Geneva	Ontario	Finger Lakes	-4%	16%
Medina Memorial Hospital	Medina	Orleans	Finger Lakes	9%	31%
Newark-Wayne Community Hospital	Newark	Wayne	Finger Lakes	-1%	19%
Wyoming County Community Hospital	Warsaw	Wyoming	Finger Lakes	-4%	15%
Soldiers and Sailors Memorial Hospital	Penn Yan	Yates	Finger Lakes	-1%	19%
St Joseph Hospital	Bethpage	Nassau	Long Island	-10%	8%
Nassau University Medical Center	East Meadow	Nassau	Long Island	-17%	0%
Glen Cove Hospital	Glen Cove	Nassau	Long Island	-23%	-8%
North Shore University Hospital	Manhasset	Nassau	Long Island	-21%	-5%
NYU Winthrop Hospital	Mineola	Nassau	Long Island	-30%	-16%
Long Island Jewish Medical Center	New Hyde Park	Nassau	Long Island	-18%	-1%
South Nassau Communities Hospital	Oceanside	Nassau	Long Island	-18%	-2%
Plainview Hospital	Plainview	Nassau	Long Island	-29%	-15%
Mercy Medical Center	Rockville Centre	Nassau	Long Island	3%	23%
St Francis Hospital of Roslyn	Roslyn	Nassau	Long Island	-25%	-10%
Long Island Jewish Valley Stream	Valley Stream	Nassau	Long Island	-21%	-6%
Southside Hospital	Bay Shore	Suffolk	Long Island	-23%	-7%

Long Island Community Hospital	East Patchogue	Suffolk	Long Island	-9%	9%
Eastern Long Island Hospital	Greenport	Suffolk	Long Island	-11%	7%
Huntington Hospital	Huntington	Suffolk	Long Island	-23%	-8%
St Charles Hospital	Port Jefferson	Suffolk	Long Island	-11%	7%
John T. Mather Memorial Hospital	Port Jefferson	Suffolk	Long Island	-22%	-7%
Peconic Bay Medical Center	Riverhead	Suffolk	Long Island	-20%	-4%
St Catherine of Siena Medical Center	Smithtown	Suffolk	Long Island	-18%	-2%
Southampton Hospital	Southampton	Suffolk	Long Island	-2%	18%
University Hospital at Stony Brook	Stony Brook	Suffolk	Long Island	-23%	-8%
Good Samaritan Medical Center	West Islip	Suffolk	Long Island	-15%	2%
Vassar Brothers Medical Center	Poughkeepsie	Dutchess	Mid-Hudson	-31%	-17%
Northern Dutchess Hospital	Rhinebeck	Dutchess	Mid-Hudson	-31%	-17%
Orange Regional Medical Center	Middletown	Orange	Mid-Hudson	-25%	-9%
St Luke's Cornwall Hospital	Newburgh	Orange	Mid-Hudson	-6%	13%
Bon Secours Community Hospital	Port Jervis	Orange	Mid-Hudson	-9%	10%
St Anthony Community Hospital	Warwick	Orange	Mid-Hudson	-38%	-25%
Putnam Hospital Center	Carmel	Putnam	Mid-Hudson	-29%	-15%
Montefiore Nyack	Nyack	Rockland	Mid-Hudson	-5%	14%
Good Samaritan Hospital of Suffern	Suffern	Rockland	Mid-Hudson	-20%	-4%
Helen Hayes Hospital	West Haverstraw	Rockland	Mid-Hudson	-18%	-2%
Catskill Regional Medical Center–Hermann	Callicoon	Sullivan	Mid-Hudson	13%	36%
Catskill Regional Medical Center–Harris	Harris	Sullivan	Mid-Hudson	-9%	9%
Ellenville Regional Hospital	Ellenville	Ulster	Mid-Hudson	9%	30%
HealthAlliance Hospital Mary's Avenue Campus	Kingston	Ulster	Mid-Hudson	0%	20%
HealthAlliance Hospital Broadway Campus	Kingston	Ulster	Mid-Hudson	-9%	9%
NewYork–Presbyterian/Lawrence Hospital	Bronxville	Westchester	Mid-Hudson	-32%	-19%
Hudson Valley Hospital Center	Cortlandt Manor	Westchester	Mid-Hudson	-27%	-12%
Northern Westchester Hospital	Mount Kisco	Westchester	Mid-Hudson	-36%	-24%
Montefiore Mount Vernon Hospital	Mount Vernon	Westchester	Mid-Hudson	-8%	10%
Montefiore New Rochelle Hospital	New Rochelle	Westchester	Mid-Hudson	-3%	17%
Phelps Memorial Hospital Center	Sleepy Hollow	Westchester	Mid-Hudson	-32%	-19%

Westchester Medical Center	Valhalla	Westchester	Mid-Hudson	-21%	-6%
White Plains Hospital Center	White Plains	Westchester	Mid-Hudson	-30%	-16%
Burke Rehabilitation Hospital	White Plains	Westchester	Mid-Hudson	-2%	18%
St John's Riverside Hospital	Yonkers	Westchester	Mid-Hudson	-3%	16%
St Joseph's Medical Center	Yonkers	Westchester	Mid-Hudson	12%	35%
Nathan Littauer Hospital	Gloversville	Fulton	Mohawk Valley	-22%	-6%
Little Falls Hospital	Little Falls	Herkimer	Mohawk Valley	18%	42%
St Mary's Healthcare	Amsterdam	Montgomery	Mohawk Valley	-11%	7%
Oneida Healthcare	Oneida	Oneida	Mohawk Valley	-8%	10%
Rome Memorial Hospital	Rome	Oneida	Mohawk Valley	14%	37%
St Elizabeth Medical Center	Utica	Oneida	Mohawk Valley	4%	24%
MVHS St Luke's Campus*	Utica	Oneida	Mohawk Valley	-22%	-6%
Cobleskill Regional Hospital	Cobleskill	Schoharie	Mohawk Valley	-29%	-15%
BronxCare Health System*	Bronx	Bronx	New York City	10%	32%
Jacobi Medical Center	Bronx	Bronx	New York City	-23%	-7%
Montefiore Medical Center	Bronx	Bronx	New York City	-8%	11%
Lincoln Medical Center	Bronx	Bronx	New York City	23%	48%
St Barnabas Hospital	Bronx	Bronx	New York City	18%	42%
North Central Bronx Hospital	Bronx	Bronx	New York City	-26%	-11%
Brookdale Hospital Medical Center	Brooklyn	Kings	New York City	-3%	17%
Brooklyn Hospital Center	Brooklyn	Kings	New York City	6%	27%
NY Community Hospital of Brooklyn	Brooklyn	Kings	New York City	-2%	18%
Kings County Hospital Center	Brooklyn	Kings	New York City	-44%	-32%
NYU Langone Hospital Brooklyn*	Brooklyn	Kings	New York City	-11%	7%
Maimonides Medical Center	Brooklyn	Kings	New York City	0%	20%
NewYork–Presbyterian Brooklyn Methodist Hospital	Brooklyn	Kings	New York City	-12%	6%
Kingsbrook Jewish Medical Center	Brooklyn	Kings	New York City	3%	23%
Wyckoff Heights Hospital	Brooklyn	Kings	New York City	10%	32%
SUNY Downstate Medical Center	Brooklyn	Kings	New York City	-29%	-15%
Mount Sinai Beth Israel Brooklyn	Brooklyn	Kings	New York City	0%	20%
Woodhull Medical and Mental Health Center	Brooklyn	Kings	New York City	-25%	-10%

Interfaith Medical Center	Brooklyn	Kings	New York City	-1%	19%
Ellis Hospital	Schenectady	Kings	New York City	-13%	4%
Bellevue Hospital Center	New York	New York	New York City	-29%	-15%
Mount Sinai Beth Israel	New York	New York	New York City	-5%	14%
Harlem Hospital Center	New York	New York	New York City	-33%	-19%
Hospital For Special Surgery	New York	New York	New York City	-45%	-35%
Lenox Hill Hospital	New York	New York	New York City	-41%	-29%
Memorial Sloan Kettering Cancer Center	New York	New York	New York City	-18%	-2%
Metropolitan Hospital Center	New York	New York	New York City	-34%	-21%
Mount Sinai Hospital	New York	New York	New York City	-13%	5%
New York Eye and Ear Infirmary of Mount Sinai	New York	New York	New York City	-4%	15%
Mount Sinai St. Luke's	New York	New York	New York City	-12%	6%
NYU Langone	New York	New York	New York City	-43%	-32%
NewYork–Presbyterian Hospital	New York	New York	New York City	-16%	1%
Elmhurst Hospital Center	Elmhurst	Queens	New York City	-40%	-28%
St John's Episcopal South Shore	Far Rockaway	Queens	New York City	16%	39%
Flushing Hospital and Medical Center	Flushing	Queens	New York City	13%	36%
NewYork–Presbyterian Queens	Flushing	Queens	New York City	-15%	3%
Long Island Jewish Forest Hills	Forest Hills	Queens	New York City	-3%	16%
Jamaica Hospital	Jamaica	Queens	New York City	-2%	18%
Queens Hospital Center	Jamaica	Queens	New York City	-54%	-45%
Staten Island University Hospital	Staten Island	Richmond	New York City	-22%	-6%
Richmond University Medical Center	Staten Island	Richmond	New York City	5%	26%
Champlain Valley Physicians Hospital	Plattsburgh	Clinton	North Country	-13%	4%
Elizabethtown Community Hospital	Elizabethtown	Essex	North Country	2%	23%
Moses-Ludington Hospital	Ticonderoga	Essex	North Country	17%	41%
Alice Hyde Medical Center	Malone	Franklin	North Country	-18%	-2%
Adirondack Medical Center	Saranac Lake	Franklin	North Country	-25%	-10%
River Hospital	Alexandria Bay	Jefferson	North Country	18%	42%
Carthage Area Hospital	Carthage	Jefferson	North Country	-2%	17%
Samaritan Medical Center	Watertown	Jefferson	North Country	-10%	8%
Lewis County General Hospital	Lowville	Lewis	North Country	17%	41%

Gouverneur Hospital	Gouverneur	St. Lawrence	North Country	1%	21%
Massena Memorial Hospital	Massena	St. Lawrence	North Country	-22%	-6%
Claxton-Hepburn Medical Center	Ogdensburg	St. Lawrence	North Country	-31%	-17%
Canton-Potsdam Hospital	Potsdam	St. Lawrence	North Country	-23%	-7%
Clifton-Fine Hospital	Star Lake	St. Lawrence	North Country	42%	70%
Lourdes Hospital*	Binghamton	Broome	Southern Tier	-14%	3%
United Health Services, Inc	Binghamton	Broome	Southern Tier	-27%	-13%
Arnot Ogden Medical Center	Elmira	Chemung	Southern Tier	-15%	3%
St Joseph's Hospital of Elmira	Elmira	Chemung	Southern Tier	-10%	8%
Chenango Memorial Hospital	Norwich	Chenango	Southern Tier	-20%	-4%
O'Connor Hospital	Delhi	Delaware	Southern Tier	12%	34%
Margaretville Hospital	Margaretville	Delaware	Southern Tier	8%	30%
A. O. Fox Tri-Town Campus	Sidney	Delaware	Southern Tier	-61%	-53%
Delaware Valley Hospital	Walton	Delaware	Southern Tier	-30%	-16%
Bassett Medical Center	Cooperstown	Otsego	Southern Tier	-8%	10%
Aurelia Osborn Fox Memorial Hospital	Oneonta	Otsego	Southern Tier	-5%	14%
Schuyler Hospital	Montour Falls	Schuyler	Southern Tier	0%	20%
Ira Davenport Memorial Hospital	Bath	Steuben	Southern Tier	-33%	-19%
Guthrie Corning Hospital*	Corning	Steuben	Southern Tier	-25%	-10%
St James Mercy Hospital	Hornell	Steuben	Southern Tier	-7%	12%
Cayuga Medical Center of Ithaca	Ithaca	Tompkins	Southern Tier	-43%	-31%
Cuba Memorial Hospital	Cuba	Allegany	Western NY	4%	25%
Jones Memorial Hospital*	Wellsville	Allegany	Western NY	-22%	-6%
Olean General Hospital	Olean	Cattaraugus	Western NY	-7%	12%
Brooks Memorial Hospital	Dunkirk	Chautauqua	Western NY	-1%	19%
TLC Health Network	Irving	Chautauqua	Western NY	-6%	13%
UPMC Chautauqua*	Jamestown	Chautauqua	Western NY	-2%	17%
Westfield Memorial Hospital	Westfield	Chautauqua	Western NY	3%	24%
Erie County Medical Center	Buffalo	Erie	Western NY	-10%	8%
Mercy Hospital of Buffalo	Buffalo	Erie	Western NY	-12%	6%
Roswell Park Cancer Institute	Buffalo	Erie	Western NY	-13%	4%
Sisters of Charity Hospital	Buffalo	Erie	Western NY	-10%	9%

Kaleida Health Systems	Buffalo	Erie	Western NY	-7%	12%
Kenmore Mercy Hospital	Kenmore	Erie	Western NY	-13%	4%
Bertrand Chaffee Hospital	Springville	Erie	Western NY	11%	33%
Mount St Mary's Hospital	Lewiston	Niagara	Western NY	3%	24%
Eastern Niagara Hospital	Lockport	Niagara	Western NY	5%	26%
Niagara Falls Memorial Medical Center	Niagara Falls	Niagara	Western NY	8%	29%
			Total:	**-17%**	**0%**

*Hospital has merged or changed name since 2013.

Note: Coney Island Hospital has been omitted from the analysis because of the exceptional nature of its DSH revenues.

Source: Authors' calculations drawn from New York State, Hospital Cost Report Audited Data: 2015

Endnotes

[1] KFF (Henry J. Kaiser Family Foundation), Marketplace Average Benchmark Premium, 2014–18; idem, Health Care Expenditures per Capita by State of Residence, 2014.

[2] U.S. Census Bureau, "Health Insurance Coverage in the United States: 2017," Table 6: Percentage of People Without Health Insurance Coverage by State: 2013, 2016, and 2017.

[3] State of New York, New York Health Act, A.4738/S.4840.

[4] Karen DeWitt, "Single-Payer Health Care an Issue in New York Governor's Race," WSKG.org, Aug. 30, 2018.

[5] Bill Hammond, "Single-Payer Fact Check," Empire Center for Public Policy, Aug. 31, 2018.

[6] Robert Harding, "Molinaro Pledges to Veto Universal Health Care Bill if Elected NY Governor," auburnpub.com, July 26, 2018.

[7] Census Bureau, "Health Insurance Coverage in the United States: 2017," Table 6.

[8] NYHA requires the state to develop a plan for adding long-term care coverage within two years of passage.

[9] Section 5105, subsection 4.

[10] Virgil Dickson, "Verma Will Reject Any Single-Payer State Waivers," Modern Healthcare, July 25, 2018.

[11] Gerald Friedman, "Economic Analysis of the New York Health Act," April 2015.

[12] Avik Roy, "The Price of Single Payer," Foundation for Research on Equal Opportunity, March 2017.

[13] Jodi L. Liu et al., "An Assessment of the New York Health Act: A Single-Payer Option for New York State," RAND.org, 2018. The report acknowledged that their projections do not fully account for dynamic effects on business, labor supply, or other tax-avoidance activities by those remaining in the state. RAND estimated that eliminating cost-sharing, preferred-provider networks, claims review, and gatekeeping of access to specialty services would help reduce medical administrative costs from $82 billion to $59 billion in 2031, but would not have any impact on the level of fraud and abuse.

[14] See New York Income Tax Calculator (smartasset.com): 37% federal + 8.82% state + 3.88% local.

[15] Liu et al., "An Assessment of the New York Health Act," p. 30.

[16] New York State, "Hospital Cost Report Audited Data: 2015."

[17] A DSH serves a large number of Medicaid and uninsured patients; see "Medicaid Disproportionate Share Hospital (DSH) Payments," Medicaid.gov.

[18] MACPAC (Medicaid and CHIP Payment and Access Commission), "Hospital Payment: A Comparison Across States and to Medicare," April 2017.

[19] Much unexplained variance remains after controlling for each of these factors. This may be partly due to omitted variables (such as differences in patient mix or the degree of market power currently enjoyed by each hospital) or imperfection in model specification, but it also suggests a large random component to the changes in revenues associated with the switch to Medicare rates. To the extent that this is the case, cuts may be felt as an arbitrary imposition, and increases in payments may fail to advance specific public goods.

Abstract

The New York Health Act (NYHA) is a bill that would have the state purchase comprehensive medical services for all residents, the costs to be borne by taxation. It currently has broad support in the state legislature.

The legislation would establish a single-payer health-care system. While there are various estimates of the plan's overall cost, much less attention is being given to the likely impact on hospital revenues resulting from the plan's displacement of private insurance by a government fee schedule, most likely at Medicare reimbursement rates. Many hospitals that currently receive relatively high reimbursement rates from privately insured patients could see a significant drop in their revenues.

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