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THE CASE FOR CHANGE

A data-driven market and landscape assessment of New York state's healthcare infrastructure and the imperative for change

February 2024

IN THIS REPORT

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FOR MORE INFORMATION

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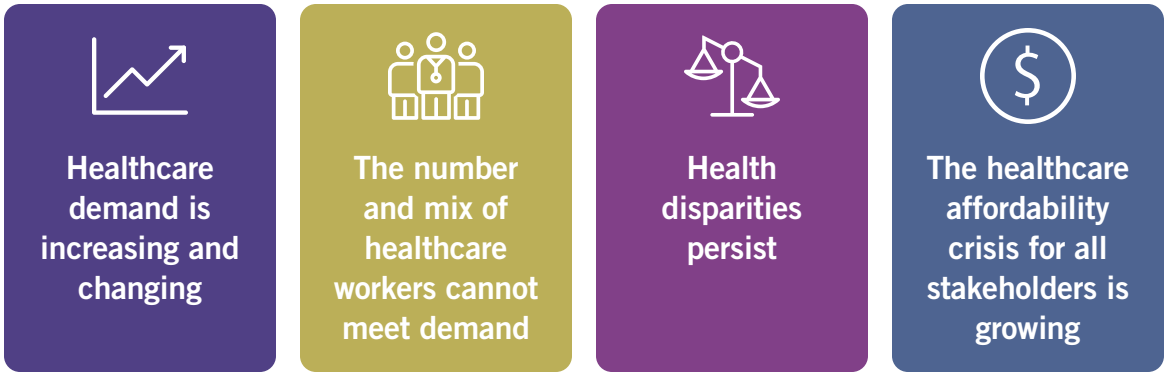
Bottom line

Four drivers are pushing New York state's healthcare delivery system to an existential cliff.



Without significant policy solutions and delivery system changes, health system market disruptions may have a domino effect across the state, impacting all providers and all New Yorkers regardless of their geography, health insurance status and demographics.

The interlaced effects of these four drivers complicate efforts to find solutions. To be effective, policy and delivery system changes must consider the direct impacts of each driver and the amplification effect the drivers have on one another.

The first step is agreeing on the problem

This paper articulates the underlying and compelling fact base for each of these drivers, providing stakeholders with a common basis for constructive and innovative thinking on essential policy and delivery system changes. Deliberation on solutions must consider the strengths of and differences among the diverse group of providers in New York state and be grounded in what is best for the health of all New Yorkers.

Then we must act

The health of all New Yorkers depends on it. We look forward to working with all interested parties to explore these drivers and develop solutions that build a future-focused healthcare system that achieves and maintains equitable access to high-quality care and affordability at all levels.

Healthcare demand is increasing and changing

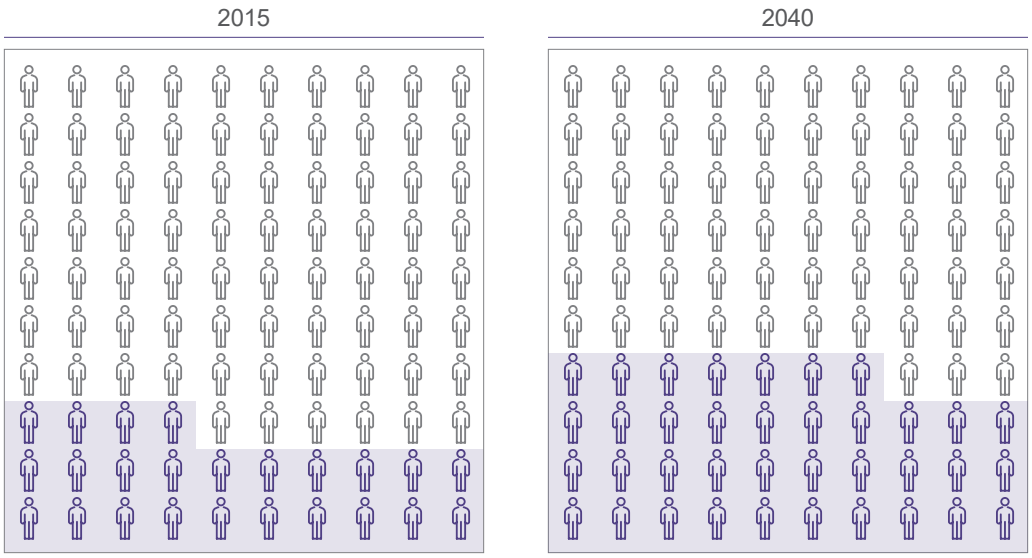
The demand for healthcare services is increasing and changing due to an aging population, advances in medicine that are leading to more chronic and costly episodes of care, and long-term care demand that cannot currently be met and will only grow in the future.

Growing imbalance in the number of senior citizens to working adults

New York state's aged dependency ratio, which relates the number of senior citizens to working-age adults, is expected to grow between 2015 and 2040 from 24 seniors per 100 working-age adults to 37 seniors, reflecting an increase in the 65+ population's percentage of the total population from 15% to 22%.[1]

New York State's Aged Dependency Ratio

Number of seniors (65+) per 100 working-age adults (18-64)

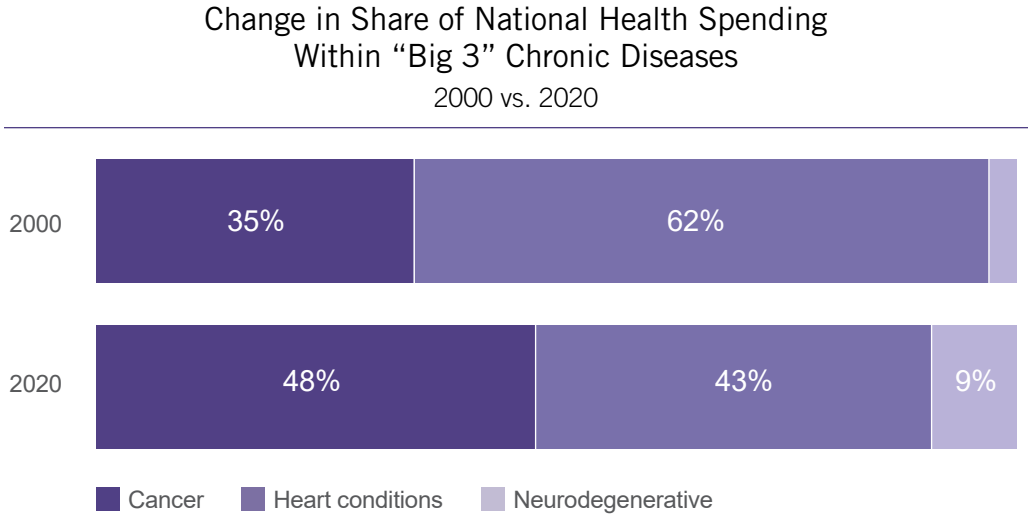


This increase will add intense financial pressure on the working-age cohort as they must fund their own growing healthcare costs and those of new and aging retirees. Per-person personal healthcare spending for those ages 65+ is 5 times higher than children and 2.5 times higher than working-age adults.[2] Complicating the problem further, younger working-age adults will have to care for aging family members, potentially straining their workforce productivity.

Shift from acute events early in life to chronic (costly) episodes later in life

Spending for cardiovascular disease has leveled off, tempered by a combination of new drug therapies, the shift to outpatient care and mechanical interventions. Patients who may have had their lives shortened by cardiovascular disease several decades ago are now living longer, leading to higher rates of many types of cancer. In addition, breakthrough cancer treatments have made many cancers survivable and chronic in nature.

As more people live longer, the prevalence of neurodegenerative diseases is also fast increasing. In 2000, cancer and neurodegenerative diseases made up 38% of national health spending among the "Big 3" chronic diseases. In 2020, that share of spending was at 57% — a nearly 20 percentage point increase.[3] This change was driven by a 518% increase in spending for neurodegenerative disease care and a 178% increase for cancer care.[4]



The prevalence of chronic conditions, further accelerated by the aging population, will also increase health spending. 18% of Medicare fee-for-service beneficiaries report 6 or more chronic conditions at an annual per beneficiary spend of $32,475. That's 5.4 times more than the $6,009 for beneficiaries reporting 2 to 3 chronic conditions.[5] This heightened per capita spend comes from more doctor visits, more services and tests, and more prescriptions filled than those with less complex care needs.

Additionally, clinicians are concerned by an increasingly physically unhealthy youth population. The childhood obesity rate in the U.S. is 19.7%,[6] compared to 5% in the 1970s.[7] Obesity is associated with chronic disease. Without intervention, this unhealthy youth population will live with the chronic conditions identified above and others for longer periods of time than were experienced by previous generations. This will contribute to more challenging patient outcomes and continued increases in care costs.

Accompanying this shift in physical care service demand is a national and state emergency in mental and behavioral health. Longstanding limitations in insurance coverage, widening mental and behavioral health workforce gaps and persistent societal stigma have taken their toll. Every year, more than 1 in 5 New Yorkers has mental disorder symptoms.[8]

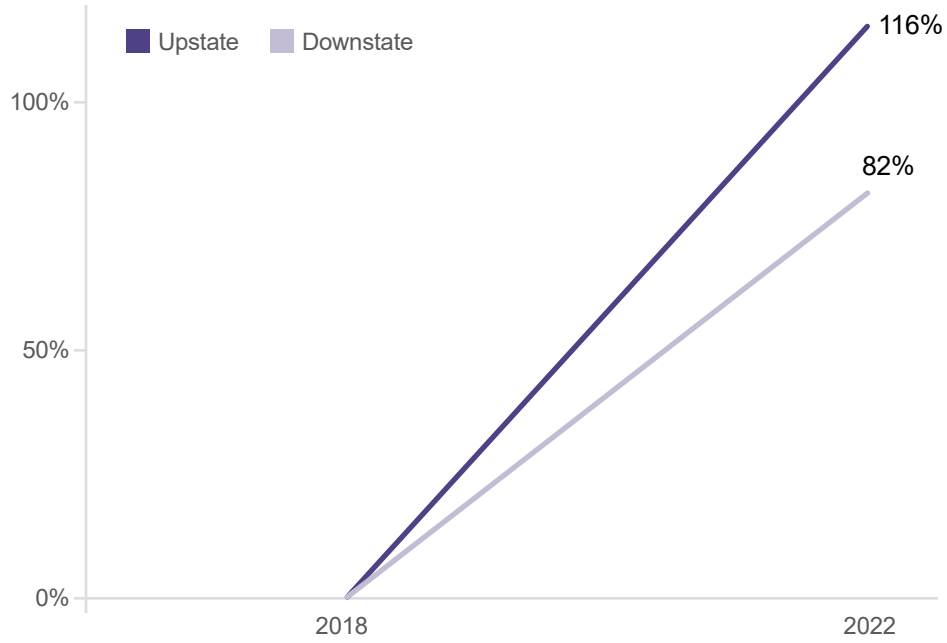
Long-term care demand that cannot be met

Meeting current demand for home-based and institutional long-term care is proving challenging, and this demand will increase as the population ages. While New York state is home to a high number of home health and personal care aides, at 25.6 per 1,000 compared to 10.5 per 1,000 nationally,[9] this has done little to slow nursing home utilization for those age 65 and over.[10] Additionally, because of Medicaid underpayment and staffing challenges, there are 5,600 fewer certified nursing home beds available today compared to 2019.[11]

Despite the high use and related expense of home-based health and personal care in New York, challenges with limited statewide capacity are apparent through the growth in total alternative level of care days at hospitals. ALC days represent unnecessary inpatient hospital days due, in part, to lack of available home-based or institutional long-term care options. ALC days increased by over 116% upstate and 82% downstate from 2018 to 2022.[12] This change, by proxy, is positioning hospitals as the only alternative infrastructure to meet the institutional long-term care needs of New Yorkers, slowing access for people who need hospital acute care services.

Increase in Hospital ALC Days

2018-2022 (upstate and downstate New York)



The number and mix of healthcare workers cannot meet demand

A well-trained and supported workforce is the most essential component of the healthcare delivery system. New York state's healthcare workforce will face new demands in the coming years due to the trends and challenges discussed above. In that regard, the healthcare workforce challenge is twofold: we have a supply shortage and we lack the specific types of workers trained to address New Yorkers' evolving care needs.

The healthcare workforce supply challenge

Healthcare and social assistance work are the second largest source of jobs in the U.S. This recession-resistant sector supports 21.7 million jobs nationally (14% of all jobs)[13] and 1.8 million jobs in New York state (18% of all jobs).[14] Despite the sheer size of the industry, the COVID-19 pandemic reminded the world of the essential work providers in all health professions and disciplines do and how fragile the overall system can be when the workforce is stretched beyond its capacity.

The average number of openings across healthcare occupations in New York state is 168,000 annually.[15] In turn, the state produces only about 41,000 new workers to fill healthcare workforce openings each year.[16] This major shortfall signifies a structural supply problem that requires creative interventions from government, providers and educators to leverage the skills of currently working professionals and attract new workers to the healthcare field.

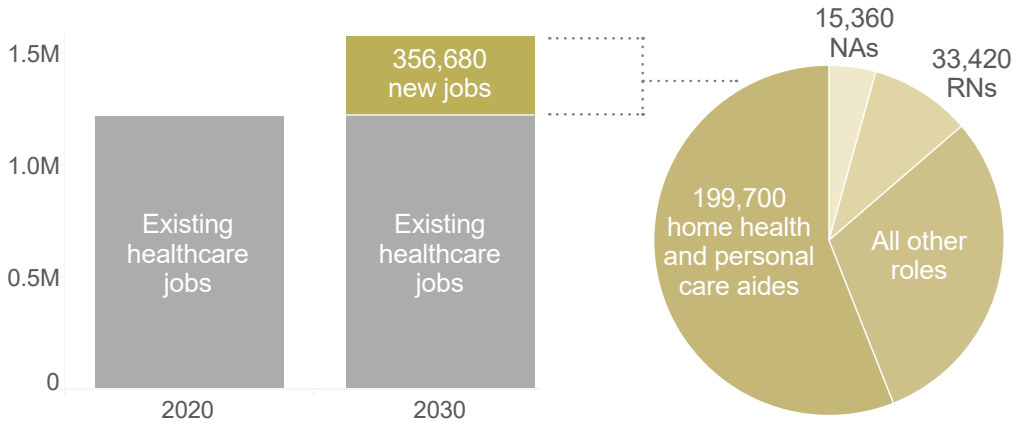
Average Annual Number of Healthcare Occupation Openings and Workers Produced in New York State

2020-2030

The healthcare workforce demand challenge

In addition to needing more workers, the types of workers also need to change. The demand for home health and personal care aides to serve the aging population and those with chronic conditions is projected to increase by 39.1% (199,700 jobs), accounting for 55% of the projected need for healthcare workers between 2020 and 2030. The demand for registered nurses and nursing assistants is projected to increase by 17% (33,420 jobs and 15,360 jobs, respectively).[17]

Employment Projections for Healthcare Occupations in New York State
2020-2030



Recruiting and retaining home health and personal care aides presents many challenges. These workers need minimal training and tend to be paid lower wages, with a median salary of about $30,000 in 2021.[18] They also lack the resources and collegial support of institutional care settings. In addition, delivering home-based care involves the physical and emotional stress of independently delivering care to medically complex patients in a wide range of often challenging environments. Complicating the delivery of care in the home are the geographic challenges of rural areas with low population density.

Digital tools and the impact of artificial intelligence on the workforce as "augmenters" to the human requirements will also need to be more fully understood to support healthcare worker abilities. Technical automation and generative AI are projected to have the highest impact on occupations related to office support, production work and food services, with an automation potential of about 80%. Health aides, technicians, wellness occupations and health professionals are projected to be least affected by these technical advances, with an automation potential of about 40%.[19]

Health disparities persist

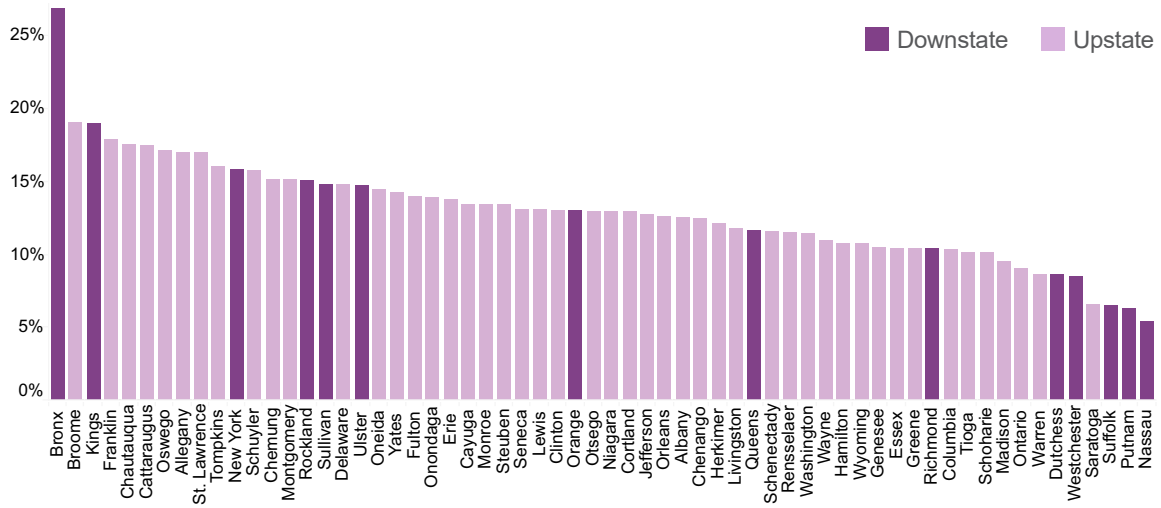
Existing disparities in patient health and access to care are driven by factors outside of the healthcare delivery system's control, including economic stability, housing, food security and access to transportation. New York state is facing a confluence of disparities, manifesting in interconnected ways: disparities in communities, outcomes and healthcare providers.

Disparities in communities

In 2022, an estimated 2.7 million New Yorkers (14.2%) lived below the federal poverty level of $13,590 for a single adult and $27,750 for a family of four.[20] Geographic variation in poverty ranges widely, with a low of 5.4% in Nassau County and a high of 26.9% in the Bronx living below the FPL.[21] Over half of New Yorkers (54.4%) had incomes below 400% FPL, or $111,000 for a family of four.[22]

Share of New Yorkers Below the Federal Poverty Level by County

2022 (upstate and downstate New York)

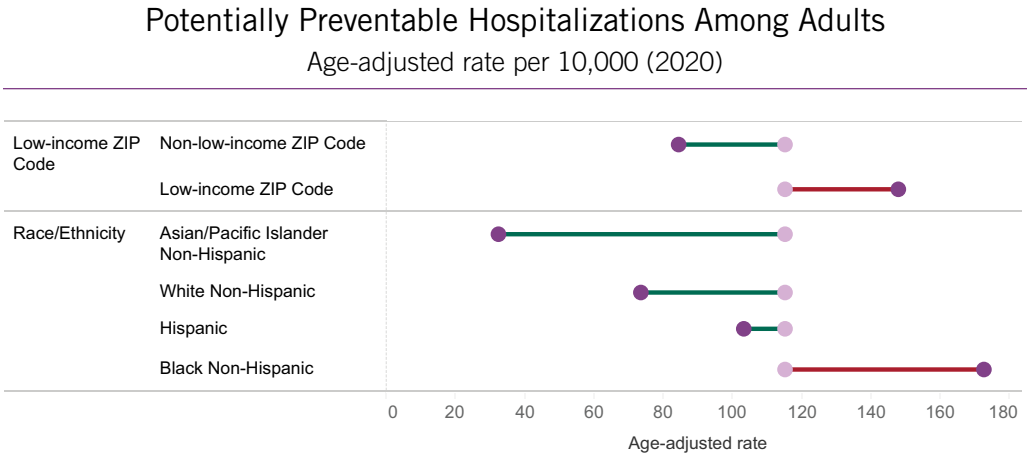


Many New Yorkers below the FPL live in areas identified as Health Professional Shortage Areas for primary and mental healthcare providers. About 3.1 million New Yorkers (15.3%) live in 36 counties designated primary care deserts and lack access to key preventive care services.[23] Layering in technology, 1.3 million New Yorkers (6.6%) live in primary care deserts without broadband access, limiting the potential for virtual care options to alleviate this healthcare service access shortfall.[24]

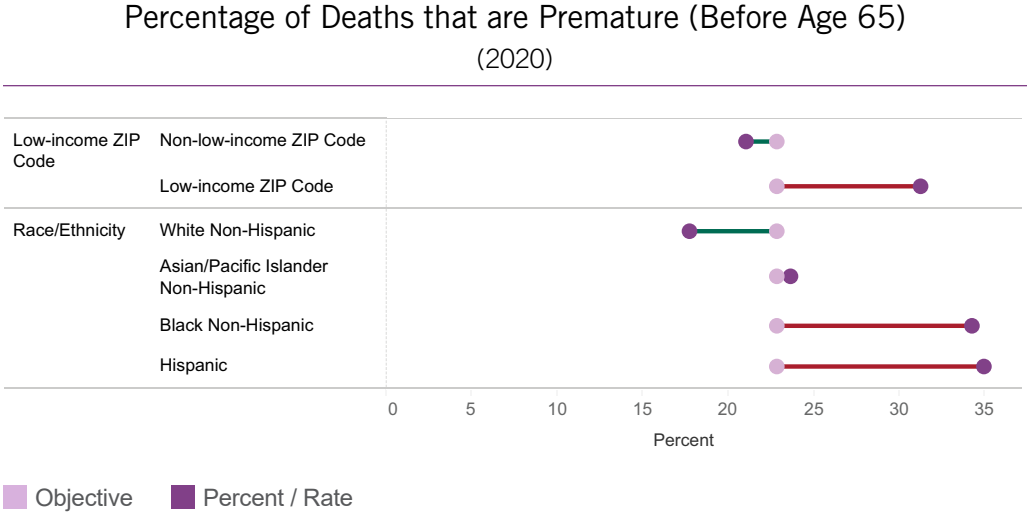
Disparities in outcomes

Disparities in clinical and public health outcomes became more widely apparent during and after the COVID-19 pandemic. Despite ongoing initiatives to address health disparities, New York state still suffers from challenging disparities in clinical and public health outcomes. Comparing the goals of prioritized measures under the state's *Prevention Agenda* health improvement plan to actual performance provides insight into these disparities, with many indicators holding clear disparities across two factors: household income and race/ethnicity.

Potentially preventable hospitalizations among adults — For this measure, disparities in outcomes are clear for lower-income (33 point difference between performance and goal) and Black New Yorkers (57 point difference between performance and goal).[25]



Percentage of deaths that are premature (before age 65) — For this measure, disparities in outcomes are clear for lower-income (8 percentage point difference between performance and goal), Black and Hispanic New Yorkers (11 and 12 percentage point difference between performance and goal respectively).[26]



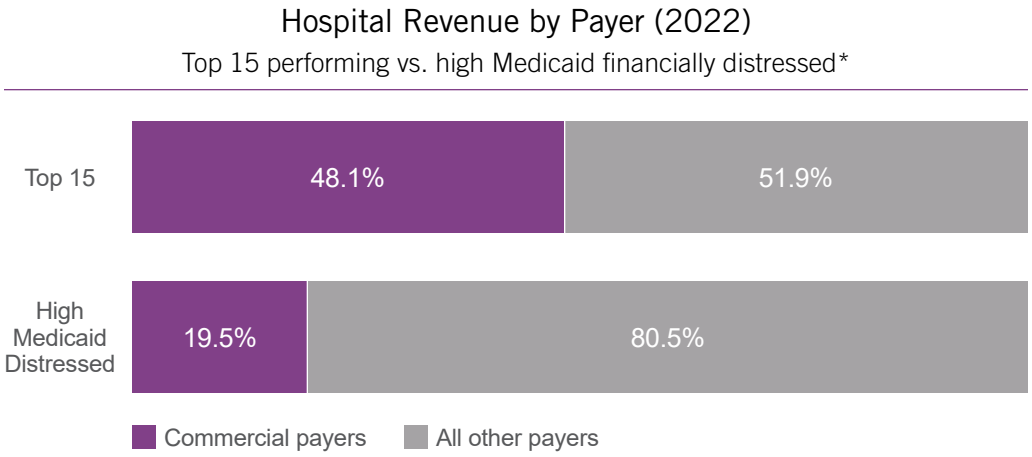
Note: Lower is better (a green line indicates performance better than the objective; a red line indicates performance worse than the objective).

A review of *Prevention Agenda* mental health goals shows higher rates of mental distress for lower-income New Yorkers, which is consistent with other indicators.[27] Rates of mental distress are reported higher for White non-Hispanic New Yorkers,[28] which is counter to many of the other indicators and potentially signals mental health access disparities for those reporting lower rates.

Disparities in providers

Economic disparities across provider types — primary care and specialty care providers, hospitals, long-term care providers, community-based organizations and others — are driven by broader economic factors impacting the communities in which they operate.

Using hospitals as an example, those in communities facing the greatest socio-economic disparities often have weaker payer mixes (a higher share of payment for services from Medicaid and Medicare, which pay below the cost of care, and lower share of payment for services from commercial insurers). In New York state, the top 15 financially performing hospitals draw 48.1% of their revenue from commercial insurers. High-Medicaid, financially distressed hospitals draw just 19.5% of their revenue from commercial insurers. This is comparable to public hospitals in New York state, which typically serve a high share of Medicaid and uninsured patients.[29]



*Top 15 defined as having a +3% operating margin and top 15 in revenue over a five-year period; high Medicaid distressed are hospitals with high Medicaid patient volumes that receive operating assistance funding from the state.

Hospitals or other providers with challenging payer mixes and providers serving those with no health insurance struggle to access the people, technology and infrastructure needed to optimize patient care experience and outcomes. This includes the need to build primary care networks, advance quality improvement initiatives, provide social care interventions and conduct healthcare community outreach and education programs.

The healthcare affordability crisis for all stakeholders is getting worse

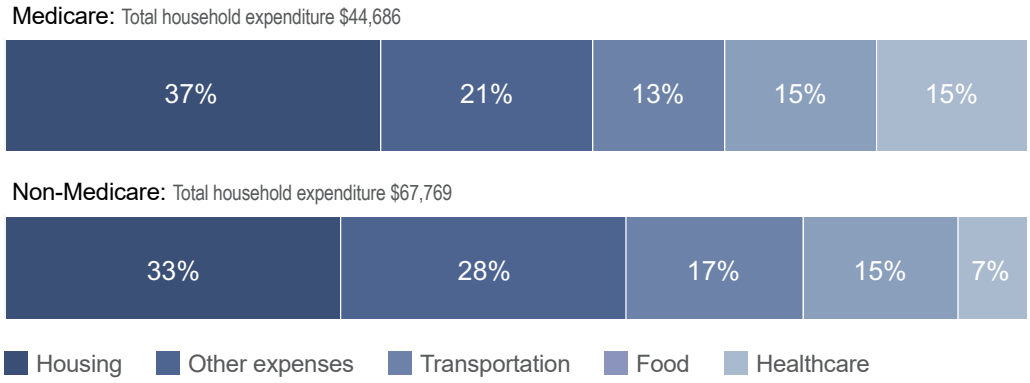
A healthcare affordability crisis is occurring nationally and in New York state, affecting consumers, employers, government and providers. As affordability challenges grow for all stakeholders in both number and scope, short-term and long-term healthcare financing decisions are impacted.

Consumer unaffordability

Healthcare affordability challenges directly impact working-age adults who must fund their own growing healthcare costs and those of new and aging retirees via taxes, health insurance premiums and direct out-of-pocket expenditures. However, healthcare affordability touches all consumers at all ages and income levels. In 2021, Medicare households reported 15% of household expenditures were used for healthcare; non-Medicare households reported 7% of household expenditures were used for healthcare.[30]

Household Spending for Medicare and Non-Medicare Households

U.S. 2021



Overall, 47% of adults in the U.S. reported difficulty affording their healthcare costs.[31]

For adults with employer-sponsored health insurance in the U.S., 46% rate the amount they pay for their premiums each month as "fair" or "poor"; 50% rate it the same way for the amount they pay out-of-pocket to see a doctor.[32] In New York state, the average annual deductible for families with employer-sponsored health insurance increased by 56% to $3,535 from 2013 to 2022 (compared to a 53% increase nationally);[33] the average annual premium for families increased by 39% to $24,368 (compared to a 33% increase nationally).[34]

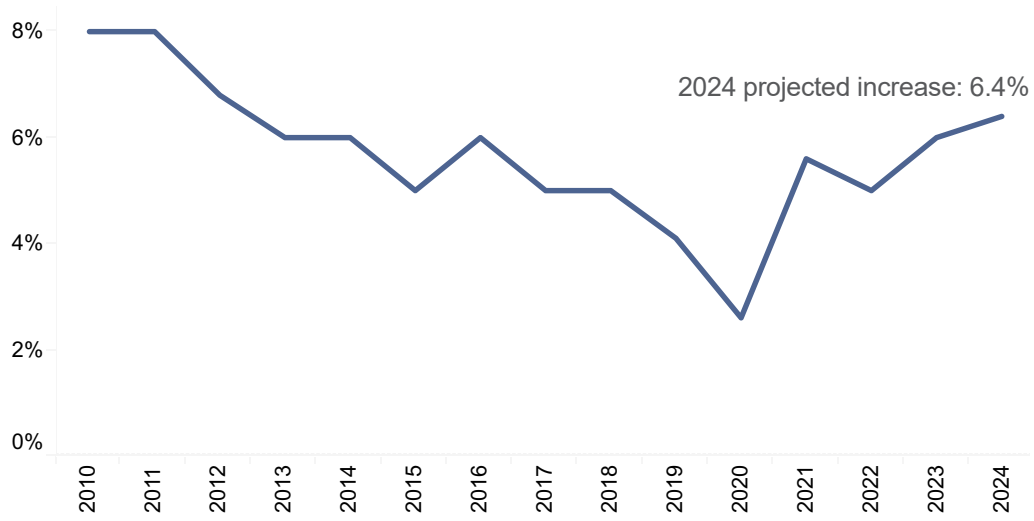
For those uninsured or under-insured, New York state is a top performing state when it comes to medical debt — ranked 9th in the country with 5.6% of New Yorkers having medical debt in collections (compared to a national average of 12.6%).[35] However, any level of medical debt is a burden. About 740,000 New Yorkers have medical debt posted to their credit reports — a practice now banned in the state — with notable disparities across communities. In New York state, higher rates of medical debt are recorded for low-income households, in rural upstate regions and for people of color.[36]

Employer unaffordability

Private-sector employers, through the cross-subsidization of government payment shortfalls to providers, also absorb a large portion of rising healthcare costs. Of the $24,368 average annual family premium for employer-sponsored health insurance coverage, employers are covering 77% of that cost.[37] For 2024, as a result of increases in labor costs, elective services, drug costs and other factors, employers on average are facing a 6.4% increase in health insurance premiums, the largest increase since 2012.[38,39]

Employer Health Insurance Premium Cost Trends

U.S. 2010-2024 (percent change per year)



Employers typically seek to maintain appealing benefit packages for recruitment and retention. Mitigating these cost increases can spur employers to reduce the number of in-network providers participating in the health insurance plan, introduce higher cost sharing through increased co-pays and deductibles and offer high-deductible health plans. 29% percent of workers were enrolled in HDHPs in 2023, a product that had 8% penetration just 15 years prior.[40] The average deductible (the dollar value a consumer must spend before any form of insurance kicks in) for a single person in a health savings account-qualified HDHP was $2,518 in 2023; it was $4,674 for a family.[41]

Provider unaffordability

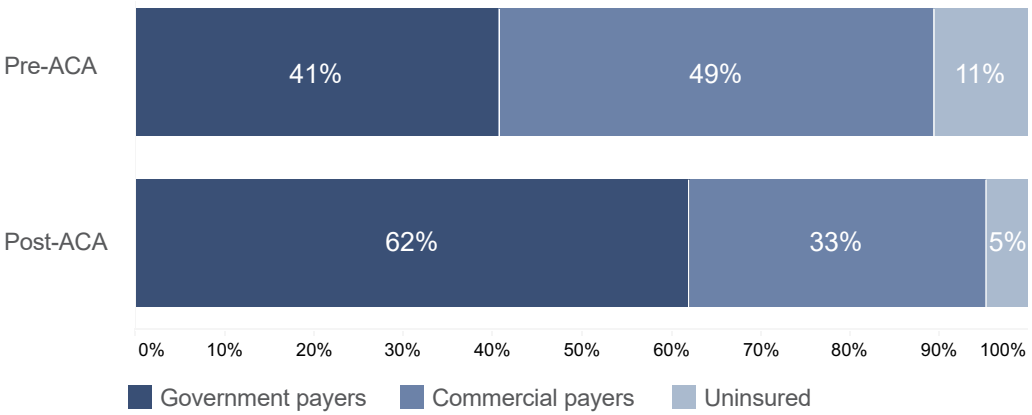
Since the inception of Medicare, reimbursement has been on a fee-for-service basis favoring interventional procedures over medical management, and subspecialty services over preventive services, primary care and mental health. In addition, in many markets, the macroeconomic funding model for healthcare has evolved to rely on significant cross-subsidization of government payment shortfalls to hospitals and other providers by private-sector/commercial insurer prices.

Government payers, namely Medicare and Medicaid, fail to cover the cost of care across all provider types. Providers with larger shares of privately insured patients typically perform better financially than peers that treat a disproportionate share of government-sponsored patients, affording them the ability to invest in people, technology and infrastructure to optimize patient care experience and outcomes.

Through coverage expansion policies spurred by the Affordable Care Act, the uninsured rate in New York state has dropped from about 11% pre-ACA to about 5%.[42] However, with this expansion, government is now the dominant insurer of New Yorkers via Medicare, Medicaid and the state's Essential Health Plan — increasing from 41% to 62% since implementation of the ACA drove increases in Medicaid and Essential Health Plan enrollment.[43] While health insurance coverage in most any form is good for consumers, this shift impacts all providers because of the financial challenges associated with government payer underpayments.

New York State Health Insurance Coverage

Pre- and post-ACA



Note: Total does not add to 100% due to rounding.

For New York state's hospitals, 71% of inpatient hospital discharges and 61% of outpatient visits are paid for by government payers.[44] With Medicaid paying just 70 cents for each dollar of care provided and Medicare paying 89 cents, this persistent underpayment forces struggling hospitals to balance finances by negotiating more favorable rates from powerful private-sector/commercial payers.[45] However, for urban and rural safety-net hospitals with the highest government payer volumes, there is no opportunity to offset these losses. This inability directly contributes to their financial distress.

New York state's nursing homes and physicians face similar challenges. 72% of nursing home patient days are for Medicaid patients,[46] with Medicaid paying only 76 cents for each dollar of care provided and very little or no private sector/commercial volume to balance their finances.[47] For New York state's physicians, Medicaid pays 57% of what Medicare pays for the same services (third lowest in the country).[48]

Government unaffordability

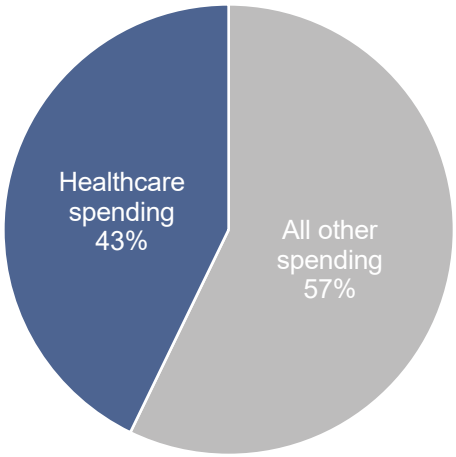
Through its Medicaid program and other health-related initiatives, New York state has demonstrated a longstanding commitment to addressing the health needs of New Yorkers.

Medicaid insures 7.6 million New Yorkers (39% of the state's population);[49] an increase of 34% as a result of the ACA's Medicaid expansion opportunities.[50] The state's Medicaid program covers 1 in 4 adults, 3 in 7 children, 3 in 5 nursing home residents, 1 in 4 Medicare beneficiaries and 4 in 9 people with disabilities.[51]

By any financial measure, this commitment has come at a steep cost. The total Medicaid and health-related spend in New York state (local, state and federal) is estimated to be $99.1 billion, reflecting 43% of the state's total budget. This reflects an increase of 113% over the last ten years.[52]

New York State Total Budget Spending

Estimated state fiscal year 2023-2024



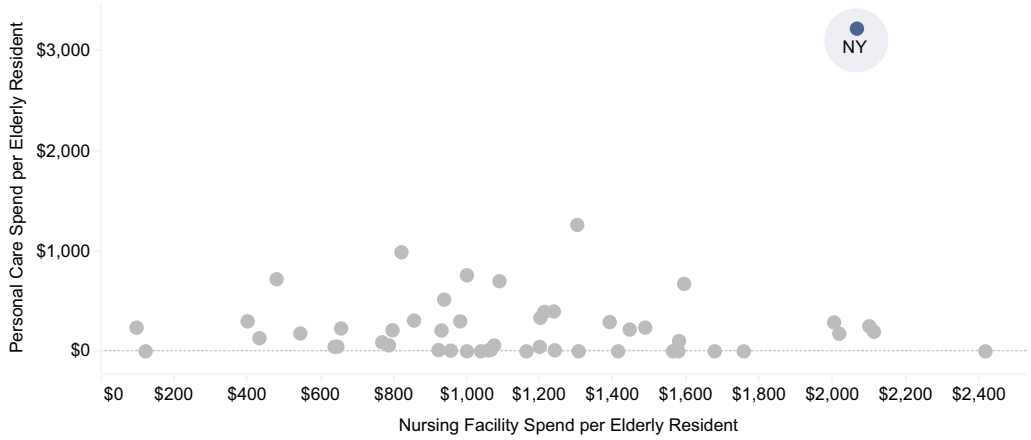
New York state's Medicaid per enrollee spending is the 6th highest in the country at $10,670 (compared to $8,651 nationally).[53] The state's Medicaid spending for adults and children is near national norms but spending on the aged and disabled is quite a bit higher, driving the high per enrollee spending value noted above. In New York, adults and children comprise 78% of enrollees and 38% of the spend. Aged and disabled individuals comprise 22% of enrollees and 62% of spend.[54]

Main drivers of the expenditures for the aged and disabled population are long-term care services and supports (both institutional and home-based care), accounting for 43.4% of the state's total Medicaid expenditures (compared to the national average of 33.4%).[55] Managed Long Term Care spending growth has been the largest driver of NYS Medicaid spending with enrollment growing at an average annual rate of 10.5% since 2014.[56,57]

One of the drivers of spending growth within the MLTC program is the Consumer Directed Personal Assistance Program. Designed to keep individuals in their communities at a lower cost of care and reduce high-cost nursing home and other institutional spending, CDPAP spending grew by 85% between 2017 and 2018, from $1.3 billion to $2.4 billion.[58] This increased spending has done little to slow nursing home utilization for those ages 65 and over, making New York state an outlier that spends about $3,200 per state resident 65 or older for personal care and about $2,000 per state resident 65 or older for nursing home care annually.[59,60]

Annual Medicaid Spending on Nursing Home Care and Personal Care by State

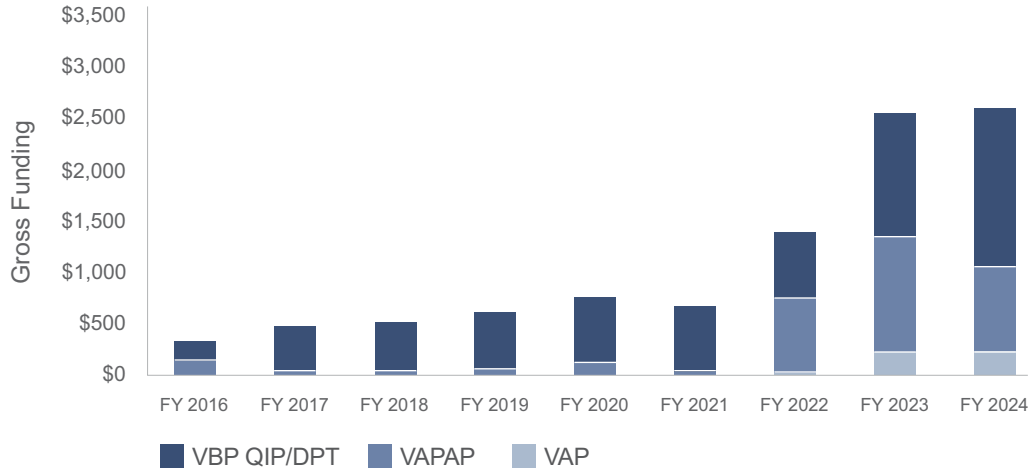
Per state resident 65 or older (federal fiscal year 2020)



New York state spending for hospital care has also introduced budget challenges. Partially because of the government payer underpayment described previously, the state invested over $2.5 billion in supportive funding in various forms in fiscal year 2024, mainly to hospitals deemed to be in financial distress — an increase of over 400% since FY 2017.[61] Since 2016, the state has also committed $6.38 billion in capital funding to hospitals and other providers with a focus on maintaining care in communities across the state, incentivizing care in the outpatient and home settings and supporting technology needs.[62] Both investments extend above and beyond the existing state spend for care services provided to Medicaid enrollees.

New York State's Supportive Funding to Financially Distressed and Other Hospitals and Providers

State fiscal years 2016-2024 (dollars in millions)

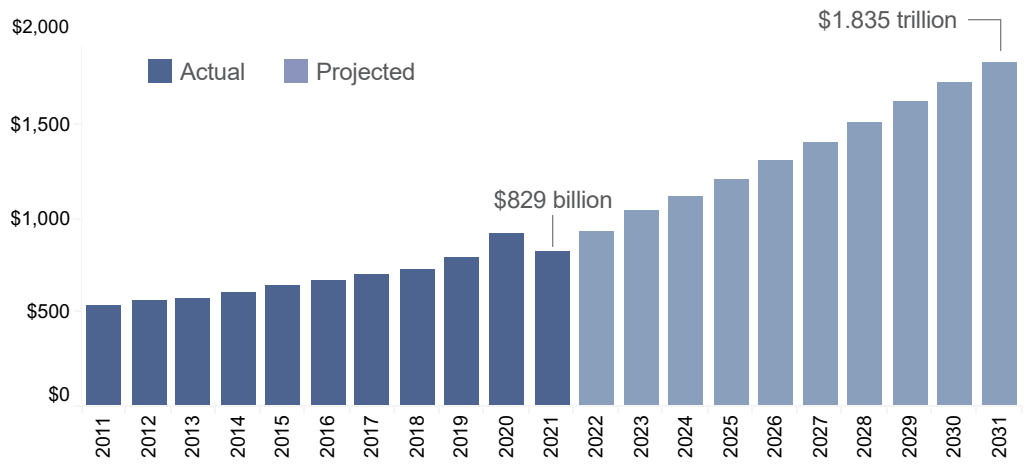


State efforts like transferring control of the Medicaid program to managed care plans, including for-profit health plans (1997); a first Medicaid redesign effort — Medicaid Redesign Team I and its signature Medicaid Global Spending Cap (2011); an expansive federally sponsored Delivery System Reform Incentive Payment Program (2014-2020); and a second Medicaid redesign effort — MRT II (2022), among other efforts have yielded mixed results in curbing utilization and costs and establishing the most appropriate infrastructure and incentives to deliver high-quality care in the most appropriate setting. From 1995 to 2024, total New York state budget growth is 3.6x compared to Medicaid and healthcare-related cost growth at 5.1x.[63]

From a federal perspective, while Medicare spending per beneficiary has flattened over the last few years ($12,459 in 2023), the growth in the aging population along with a shift in disease burden from acute events early in life to chronic (costly) episodes later in life is expected to increase Medicare spending per beneficiary by about 40% by 2033.[64] Total Medicare spending, which makes up 10% of the total federal budget, is expected to increase by 121% to $1.835 trillion from 2021 to 2031.[65]

National Medicare Benefits Spending

2011-2031 (dollars in billions)



Looking beyond the Medicare program, U.S. debt held by the public currently stands at $24.3 trillion or 97% of the nation's gross domestic product.[66] With 65% of federal spending defined as mandatory (mainly Social Security, Medicare and Medicaid),[67] funding these priorities along with increases in federal spending for security, infrastructure and other needs is expected to lead to new federal budget deficits and subsequently increase federal debt obligations. Given current and anticipated spending trends, the federal debt will balloon to an estimated $46.4 trillion (118% of GDP) by 2033.[68]

Where we go from here

The growing and changing demand for de-centralized healthcare and social services, chronic workforce shortages, health disparities and an unsustainable healthcare financing system present a grave threat to healthcare system stability and patient care. The fusion of these drivers is creating an exponentially dangerous and fast-approaching existential cliff — symptoms of which we are already experiencing.

Inaction is not an option. It would leave New Yorkers without access to care and create down-the-road problems that are even more expensive and complicated to fix.

To avoid this, we propose a "Now, Near and Far" framework for action.[69] "Now" we need immediate action to stabilize our healthcare system and protect patient access to care, using existing tools and remedies. "Near" solutions are needed in the next few years to drive meaningful change within the existing healthcare finance and delivery structure. "Far" means developing long-term solutions that ensure stability and sustainability for the future; to achieve this, we must contemplate a fundamental re-build of healthcare in New York state.

All stakeholders, including healthcare providers, government, business, consumers, insurers and others, must come together to develop solutions that build a future-focused healthcare system that achieves and maintains equitable access to high-quality care and affordability at all levels.

There are no quick, easy or inexpensive solutions to these dynamic and complex problems. Stakeholders must determine and coalesce around two core strategies: how to effectively and efficiently meet the increasing and changing patient care demand and how to reduce demand (and its costs) by improving health and providing timely, appropriate and cost-effective care.

The facts set forth in this paper show the urgent need for fundamental change and provide a solid foundation for stakeholders to discuss and determine what that change will be. While the work ahead will consider additional data as they are introduced to the discussion, the problems facing our healthcare system are clear from the outset.

We are eager to engage with all interested parties and existing efforts, understanding that this issue is bigger than any of us. We must work together toward effective and lasting solutions. The health of all New Yorkers depends on our collective leadership and collaboration.

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