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Before the Joint Legislative Fiscal Committees
February 28, 2023

Around this time three years ago, state lawmakers found themselves making painful choices about Medicaid – on the brink of a pandemic – because they had allowed spending to spin out of control when times were flush.

They are at risk of repeating that destructive cycle now.

New York's state-share Medicaid spending – which was already the highest in the nation on a per capita basis[1] – has surged by $8 billion or 20 percent in just three years. Governor Hochul's fiscal 2024 budget calls for a further increase of $3 billion or 9 percent, not including additions which might be made in the coming weeks.

This extraordinary growth has been financed, so far, by a windfall of temporary federal aid and what is likely to be a short-term surge in tax revenue.

History tells us that the current period of budget surpluses will come to an end sooner rather than later. Now is the time to restore fiscal discipline to Medicaid, or this critically important but hard-to-steer program will hit an iceberg in the foreseeable future.

Even before the coronavirus, New York's Medicaid program had drifted far from its original purpose as a safety-net health plan for the poor and disabled. In 2019, it was covering almost one-third of the state's population, and more than half its enrollees were living above the poverty line.[2]

The state's long-term goal should be to reduce dependence on taxpayer-financed health plans – by fostering the affordability and accessibility of commercial insurance. Lawmakers should also be clear that the recent growth of Medicaid costs was not entirely or even primarily a result of the pandemic response.

[1] Medicaid Financial Management Report for FY 2021
[2] See "Medicaid's Metamorphosis: How one in three New Yorkers landed in a 'safety net' health plan," Dec. 7, 2021.

Although Medicaid rolls ballooned by more than 1 million during the crisis, the new enrollees were mostly non-disabled adults with relatively modest health-care needs. Many have since founds jobs with health benefits – and would have left the program if not for a federal policy that barred states from pruning their rolls as usual during the public health emergency. Enhanced federal matching aid has largely if not entirely covered their claims.

However, a series of policy choices not directly related to the coronavirus are having a significant and ongoing impact on state-share spending.

These include:

- Loosening the "global cap," as part of last year's budget, which more than doubled the allowable growth rate for the bulk of state Medicaid spending.
- Approving across-the-board rate increases for hospitals, nursing homes and other providers.
- Raising the minimum wage for home health aides by $3 an hour over two years.
- Ramping up discretionary grants to distressed providers.
- Failing to rein in the rapidly rising expenditure on home-based personal assistance, an area where New York Medicaid has long been an outlier compared to other states.

To head off a predictable fiscal crisis, lawmakers should be looking to tamp down Medicaid spending in this year's budget, not pump it higher.

While some strategic investments might be warranted, they should be accompanied by cost-cutting efforts in other parts of program – and a long-term strategy to shrink enrollment by making commercial coverage more affordable and accessible.

Lawmakers should be particularly cautious about using Medicaid to solve real or perceived workforce shortages in parts of the health-care industry – especially in areas where Medicaid is not the dominant payor.

While some providers are struggling to recover from pandemic-related workforce losses, others have fully bounced back.

On a statewide level, the hiring situation varies considerably from one sector to another. As seen in the first chart below, nursing homes were still 16 percent below their pre-pandemic employment level as of December, while hospitals have fully bounced back and home health care is rising to new heights.

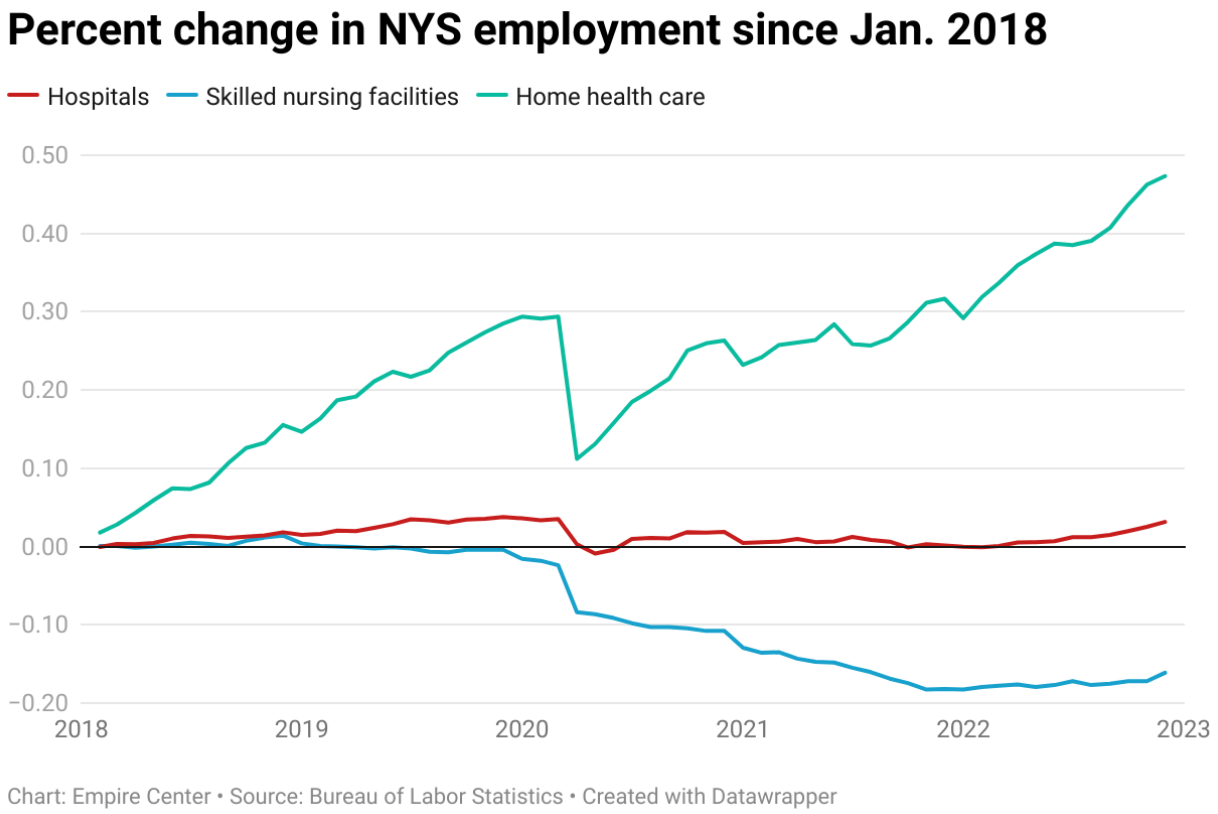
There are also disparities among regions of the state. As seen in the second chart, New York City hospitals have surged to higher employment since the pandemic, while hospital staffing elsewhere in the state remains lower than it was in 2019.

Lawmakers should be aware that even modest wage increases for health-care workers translate into a major investment of tax dollars. Last year's two-stage $3 increase in the minimum wage

for home health aides is expected to cost Medicaid $7 billion over the first four years, about half of which is to come from state resources.

A number of the governor's budget proposals deserve support, including:

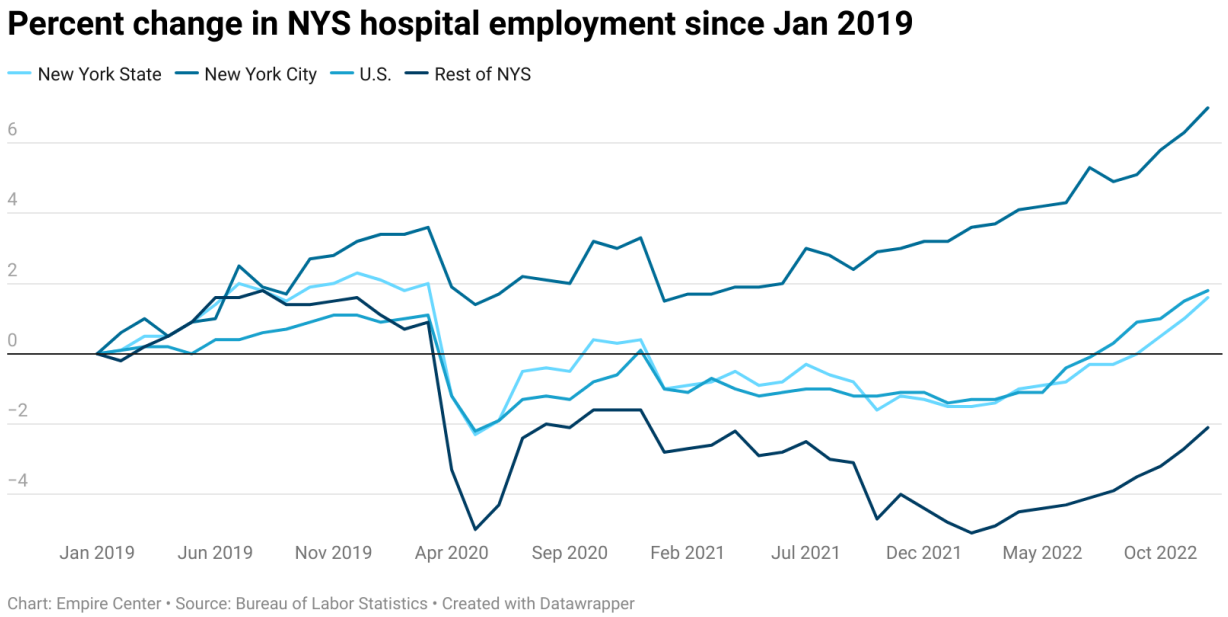
- Repealing the "prescriber prevails" policy for Medicaid, which fosters unnecessary use of costly brand-name drugs.
- Trimming Indigent Care Pool grants to low-need hospitals, which, as not-for-profit institutions, should be doing more charity care on their own.
- Loosening scope of practice limits so that professionals such as nurses and pharmacists can make fuller use of their training.
- Joining the Interstate Medical Licensure Compact, making it easier for professionals from other states to practice in New York.



Other proposals in the executive budget should be revised or rejected:

Increasing the local share of Medicaid costs. The governor is proposing to intercept federal Affordable Care Act funds that are currently flowing to local governments. This would cost an estimated $343 million for New York City and $281 million for the other 57 counties. She is also proposing to continue intercepting $150 million of the city's sales tax revenue.

This would effectively reverse an eight-year-old freeze on the Medicaid local share, which was one of the most important reforms of the past decade. The local share is an unfair burden on county finances that should be reduced or eliminated, not expanded.



Extending HCRA taxes on health insurance. The executive budget would continue $5.2 billion worth of health insurance surcharges for another three years, through fiscal 2026.

These surcharges, levied under the state's misleadingly named Health Care Reform Act, directly add to the cost of insurance, making coverage less affordable and accessible. They're one reason that New Yorkers pay some of the highest premiums in the contiguous United States.[3]

Taxing health insurance is a counterproductive way to raise money for Medicaid – yet HCRA surcharges are the fourth-largest source of revenue in the state budget.

If state-share Medicaid spending had been held to 3 percent growth over the past four years, Medicaid costs would be $5 billion lower than they are now – and the revenue from HCRA surcharges would no longer be needed.

Carving out the pharmacy benefit. The governor is proposing to go forward with a Cuomo-era plan to "carve out" the pharmacy claims from Medicaid managed care, reversing a key reform of the original Medicaid Redesign Team.

The administration projects that having the Health Department directly pay pharmacy bills would reduce costs – but says most of the savings would be redirected to hospitals and clinics to offset their expected losses under the federal 340b program.

[3] See "Hooked on HCRA: New York's 24-Year Health Tax Habit," March 11, 2020.

(The 340b program is dysfunctional, in that it incentivizes overuse of costlier brand-name drugs. But it has become a major source of revenue for some safety-net providers. Reform should be handled at the national level.)

Carving out the pharmacy benefit would undermine the purpose of managed care, which is meant to monitor and coordinate all types of care their clients receive, including prescription drugs. The original carve-in from a decade ago also led to substantially lower pharmacy costs for Medicaid, an indication that plans were better suited to oversee the benefit than the Health Department was.

Hiking taxes on cigarettes. The governor is proposing to increase the state's cigarette tax from $4.35 to $5.35 per pack, with a goal of further reducing the smoking rate, especially among young people.

However, the hike would also lead to more cigarette smuggling, which is already rampant in New York. According to analysis by the Mackinac Center for Public Policy in Michigan, more than half of the cigarettes consumed in New York are supplied by smugglers – the highest rate in the country.[4]

The Budget Division projects that state tax revenues would decline after the hike, ostensibly because of reduced smoking. However, the money flowing to criminal smuggling organizations undoubtedly would go up.

Expanding the Essential Plan. The Hochul administration is seeking revised authority to raise the eligibility ceiling for the state's Essential Plan from 200 percent to 250 percent of the federal poverty level.

This would save money for an estimated 91,000 new enrollees – but it also would remove a relatively healthy group from the state's risk pool for direct-purchase health insurance. According to the state's draft waiver application to the federal government, this would trigger a 3 percent premium increase for some 300,000 consumers and cause 3,000 to drop coverage.[5]

The state should be looking to make insurance more affordable across the board – not saving money for some at the expense of others.

Enacting 'pay and pursue' for hospital claims. The governor's budget would exempt certain emergency-related hospital services from the usual claims review by health plans. Insurers would be required to such costs up front and seek reimbursement after-the-fact for claims that are rejected.

The state estimates this will add $37 million to state-share Medicaid spending in the first year and could be expected to have a similar cost impact on health plans statewide.

[4] https://taxfoundation.org/cigarette-taxes-cigarette-smuggling-2022/
[5] See "The Hochul administration seeks more federal money for its overfunded Essential Plan," Feb. 16, 2023.

The utilization review process is already regulated by the state and gives providers an opportunity to appeal contested claims.

The state should avoid unnecessarily intervening in contractual disputes in a way that is likely to further drive up health costs.